Awareness, Attitudes and Strategies for Coping with Mental Health within the Farming Community

Annabelle Kehoe

Submitted in partial fulfilment of the requirements of the Bachelor of Arts degree (Psychology Specialization) at DBS School of Arts, Dublin.

Supervisor: Dr. Pauline Hyland

Head of Department: Dr. Sinead Eccles

April 2013

Department of Psychology

DBS School of Arts

'In a disordered mind, as in a disordered body, soundness of health is impossible'

(Cicero)

Acknowledgements

I would like to acknowledge my appreciation of the kind assistance and support received by many throughout the duration of my dissertation.

Firstly, sincere thanks are due to my supervisor Dr. Pauline Hyland who has supervised and guided this work from the beginning. Her sustained interest, support and unfailing kindness are sincerely appreciated.

To macra members, a special thank you for giving up their valuable time to participate in this study.

To the staff of Dublin Business School and my Psychology class, thank you for an enjoyable and rewarding two years.

Finally, warmest thanks are due to my family and Martin. I would not have made it through these two years without your support. Words alone cannot express the thanks I owe to my mother for her valuable help, guidance and encouragement throughout my college years.

Abstract

The aim of the present study was to investigate the awareness, attitudes and strategies for coping with mental health within the farming community. Participants consisted of ninety-three male (n = 58) and female (n = 35) members of Macra na Feirme who volunteered to partake in the study. A paper-based questionnaire was given to each participant and confidentiality and anonymity were assured. Participant's mental health impairment was investigated using the *General Health Questionnaire (GHQ12* – Goldberg, 1992). Attitudes towards mental illness were measured using *Attitudes towards Mental Illness Scale* (Cates, Burton and Woolley, 2005) and the *Brief COPE Questionnaire*(Carver,1997) was used to explore how participants have been coping with stress in their lives. The data collected was analysed using Independent t-tests and Pearson's correlation. Overall, the study found that there is a clear absence of awareness among the farming community of some of the available mental health services and evidently the services are not being used. A significant difference on attitudes towards mental illness exists between males and females. In relation to coping strategies females resort to religion and use of emotional support while males predominantly are in denial and use substances to cope.

Table of Contents

Section	*Page Number*
Acknowledgements	iii
Abstract	iv
Table of Contents	v
1. Introduction	1
2. Method	18
2.1 Participants	18
2.2 Design	18
2.3 Materials	18
2.4 Procedure	21
3. Results	22
4. Discussion and Recommendations	32
References	46
Appendix 1 – Authorisation from Macra Head Office to carry out the Research	52
Appendix 2 – Advertisement in Macra's National Newsletter	53
Appendix 3 – Cover Letter of Questionnaire	54
Appendix 4 – Questionnaire	55
Appendix 5 – Help Sheet	60
Appendix 6 – Pearson's Correlation Statistics	61
Appendix 7 - Pearson's Correlation Complete Results	64

1. Introduction

Many people may experience a mental health problem at some stage in their lives. Many are frightened of the idea of mental health problems, being labelled with psychosis, schizophrenia, bipolar disorder or depression, ear-marked as being different from the rest of society. A recent 2012 study by 'See Change', the National Mental Health Stigma Reduction Partnership, on mental health attitudes revealed that while 94% of people in Ireland feel that mental health problems can affect anyone, one in two people would not want anyone to know if they had a mental health problem. In response to these shocking statistics, the author has decided to delve into the issue further with particular emphasis on young people from the farming community. The purpose of this study is to explore the awareness, attitudes and strategies for coping with mental health within the farming community.

Mental Health in the Farming Community

Despite the idyllic image of farming as a calm and healthy way of life, agriculture accounts for the highest rate of suicide among all industries (McCurdy & Carroll, 2000). Farmers and their families are exposed to a variety of physical health risks such as exposure to harmful chemicals (Gerrard, 1998), physically demanding work and long working hours in all weather conditions (McCurdy & Carroll, 2000). In addition, farming is associated with psychological hazards such as stress (Booth & Lloyd, 2000), anxiety, depression (Eisner, Neal & Scaife, 1998) and suicide (Page & Fragar, 2002). Farming businesses function in a context of weakening terms of trade for agricultural produce, unpredictable commodity markets, reduced opportunity of off-farm employment, increasing cost of farm machinery and production, loss of farm or livelihood due to crop or production failure and varying government policy on environmental and economic issues (Elkind, Carlson & Schnabel, 1998).

In addition to these drawbacks, farming operates dually as a way of life and occupation and the role as farmer overlaps between work, family and home (Melberg, 2003). According to Swisher, Lorenz, Conger and Elder (1998) farmers usually live close to their parents and parents-in-law. This may inflict demands and responsibilities including conflict over roles between generations and family members and responsibility for dependent relatives. Weigel, Weigel and Blundall (1987) explain how family problems may become work problems which results in family tensions such as sibling rivalry and favouritism. These family tensions take on additional meaning when a large enterprise is at stake (Kohl, 1976). Unfortunately, it is the younger generation on farms who are adversely affected in such circumstances (Marotz-Baden &Mattheis, 1994).

As there is no mandatory age for retirement among farmers, many tend to work well beyond the typical retirement age, which may result in issues around farm succession and tension between two generations on the farm (Australian Bureau of Statistics (ABS), 2003). Interestingly, Weigel et al. (1987) found in their study on intergenerational differences on family farms, that the younger generation suffer higher levels of stress, perceive lower levels of support and are generally less satisfied with life. Martoz-Baden and Matheis (1994) contend that a huge contributing factor in this is the economic and managerial control of the older generation.

Established in 2010, ‘See Change’ is Ireland’s national stigma-reduction programme, working to change mindsets about mental health problems and end the stigma attached. ‘See Change’ target young males from 18-24 in the farming rural community as well as partnering with over 50 organisations to share capacity and mobilise change. The organisation uses social networks and its most recent online story-sharing initiative ‘Making a Ripple’ is having a very large positive impact. Additionally, ‘See Change’ joins and engages with

communities and local groups on the ground for example Macra na Feirme (See Change, 2011).

In 2012, 'See Change', commissioned a survey of Irish attitudes towards mental health problems. This research was co-funded by the National Office for Suicide Prevention and the National Disability Authority. The main findings of the survey were that 15% of farmers now claim experience with mental health problems. This represents the largest increase in direct personal experience in any group. Positively 91% of those surveyed revealed that there is an increased awareness and understanding of mental health, mental health problems, stigma and support services. Similarly, 56% of the sample population revealed that there has been some improvement in attitudes around the outcomes for recovery from a mental health problem. Moreover, 79% of participants confirmed that there has been some softening of attitudes towards the integration of people with mental health problems. Encouragingly, there is an increased willingness (91% of participants) to seek professional help for a mental health problem. These are interesting yet worrying findings and they will form the backdrop of the author's research. Unfortunately, other findings highlighted that 72% of farmers would not want others to know about their mental health problem. Furthermore, 33% explained that they would delay seeking treatment for fear of letting others know and 39% would hide a mental health problem from friends. In terms of perceived support, 22% believe that a partner would end a relationship if a mental health problem was diagnosed and a further 29% believe that friends would react by distancing themselves (See Change, 2012). The 'See Change' vision is that every person in Ireland can be open and positive about one's own mental health and that of others.

Mental Health may be defined as ‘a state of emotional and social well-being in which the individual realises his or her own abilities, can manage the normal stresses of life, can work effectively, and is able to play a role in his or her community’ (World Health Organisation, WHO, 2012). Similarly, Epp (1988:7) describes mental health as

‘*the capacity of the individual, the group, and the environment to interact in ways that promote subjective well-being, the optimal development and use of mental health abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice, and the attainment and preservation of conditions of fundamental equality’*.

Access to all types of servicesespecially health are particularly poor in remote rural areas (Gregoire, 2002). This inaccessibility appears to be combined with a greater sensitivity to the stigma attached to mental health problems and concerns about confidentiality in small rural communities (Sherlock, 1994). Rost’s 1993 study confirmed that perceived stigma about mental health interventions and services has a negative impact on help-seeking behaviour in rural areas. According to Booth, Briscoe and Powell (2000), farmers tend to present with somatic symptoms of anxiety and depression as opposed to psychological symptoms.

In the UK, farming is the largest occupational group associated with suicide accounting for approximately 1% of all suicides (Booth, Briscoe & Powell, 2000). After accidents, suicide is the most common cause of death among young farmers (Gregoire, 2002). Hawton, Simkin and Malmberg (1998) confirmed the factors linked with suicide in farmers include not having a confidant, worries about finance, legal problems, physical health and

relationships. The most common factor accounting for 82% of suicides among farmers was the existence of mental health problems. A Northumberland survey of 203 farmers found that men felt protected by being married or having a confidant at home. In contrast, married women were found to be at greater risk of suffering with mental health problems due to the strain of being the main support for their spouse (Paxton & Sutherland, 2000).

Dealing with Stress

Gregoire (2002) describes the lifestyle of farmers as inseparable from their work, not only because of the long working hours but also because the majority live on their farms in an isolated location. Holidays are taken by few farmers and their livelihood is controlled by unpredictable weather conditions and crop and animal diseases. Essentially, this unique group of people have their work linked with every aspect of their lives, the lives of their families and across several generations (Gregoire, 2002). Many studies across the UK including those by Hawton, Simkin and Malmberg (1998); Knudsen and Wilson (1985); and Eberhardt and Pooyan (1990) identify financial worries, time pressures, cumbersome paperwork and administration as the most important factors associated with illness. Similarly, McGregor, Willock and Deary's (1995) study found paperwork to be the highest ranked stressor. In addition, geographical and social isolation are often referred to as major psychosocial risk factors affecting farmer's health and which may lead to shrinkage of their social networks (Raine, 1999).

Strategies to Assist Farmers

Farming life is associated with high stress levels (Walker & Walker, 1988). This coupled with farming families having limited knowledge of mental health issues and the stigma associated with mental health as a hindrance to seeking assistance, are the main

reasons for the author's decision to target mental health strategies (Monograph, 2000). Strategies such as placing articles in the farming media, self-help materials and leaflets being distributed to farmers as well as educating the next generation may heighten awareness and educate and provide coping strategies in an effort to de-stigmatize the problems and encourage the seeking of assistance (Gregoire, 2002). Similarly, non-governmental organizations specialising in health promotion activities may offer support, advice and counselling services in rural communities. Services for example the 'Farm and Rural Stress Line', 'See Change', 'GROW' and 'Samaritans' organisations provide telephone and face to face contact with trained staff or with volunteers within the farming community. They also help farmers in accessing specialist assistance (Gregoire, 2002). Despite this available assistance, a number of challenges remain for example, how to encourage farmers to seek assistance for mental and physical health problems, how to recognise the problems and how to make primary care accessible in more rural areas.

Strategies employed for suicide prevention are equally important. Actions to predict, prevent, detect and treat mental health and stress problems may have an indirect effect on suicide (Sher, 2004). In a similar vein, Gregoire (2002) maintains formal and informal methods to control farmers' access to firearms may affect suicide rates. Firstly, farmers' resistance to restrictions made on access to firearms which they consider are essential tools for their work, may challenge intervention. Secondly, findings by Hawton et al. (1998) advocate that farmers who commit suicide rarely have restricted access to firearms, despite the concerns of close relatives and others. Thirdly, practical support for farmers with worries concerning finance, retirement, housing and retraining for career change promises to diminish the hopelessness associated with suicide. Lastly, social supports, such as self-help groups and

befriending schemes for those in more isolated areas may have considerable protective influence (Gregoire, 2002).

Moreover, Walker and Walker (1988) add a sense of personal failure associated with the loss of the family farm or lack of personal meaning with life. Furthermore, data exists that suggest rural decline and economic deprivation are additional factors in male suicide as well as the established belief that farmers do not like to complain or ask for help (Saunderson& Langford, 1996).

The World Health Organisation (WHO) (2012) has identified depression as affecting more than 350 million people of all ages, in all communities. Furthermore, the Central Statistics Office (CSO) reported 525 suicides in Ireland in 2011. Among these were 96 suicide deaths in the 5 to 24 age group (one case of a child between 5-14 years and the remaining 95 of persons aged 15-24). It is these statistics and the vulnerability of this particular group that have led to the author's decision to include this age group as part of the current study.

Macra na Feirme

Macra na Ferime better known as Macra, is a national organisation which provides young people between the ages of 17 and 35 with the opportunity to meet new people and get involved in sports, travel, drama and debating. Macra's main aim is to help young farmers get established in farming and assist them through learning and skills development. The organisation works with and represents the views of young farmers both nationally and internationally. Each county and region within Macra has a Young Farmers Development Group which organises events, discussion groups, competitions and annual trips abroad to

conferences. This organisation offers an essential outlet for young people living in isolated areas of rural Ireland. Therefore, the sample of the farming community for the research study will be sourced in the Macra na Feirme organisation.

Attitudes to Mental Health

In a 'See Change' survey, 57% of Irish farmers revealed that if they had mental health problems they would not want it known; 42% of farmers would hide its diagnosis from friends; and 27% would delay seeking help for fear of someone knowing about it. This attitudinal problem among Ireland's farming community today must be explored (Cadogan, 2012, *para. 7*). This explains why the National Suicide Research Foundation (2012: 4) reported that deaths by suicide are both an individual and a societal tragedy and therefore measures to reduce suicide risk must be embraced. Key outcomes of the report are that mental health risk factors linked with suicide include mood disorder, mental disorder in the family, history of deliberate self-harm and lifetime alcohol abuse in the year prior to death. For the most part, the deceased is in contact with their GP or mental health service in the year prior to death, and those who contact their GP do so at least four times. Similarly, the report highlights the continuing challenges in relation to contact with health services – difficulties in accessing health care services, in sticking to treatment appointments and lack of compliance with instructions related to prescribed medication (The National Suicide Research Foundation 2012: 8). One recommendation made in the report is to improve access to health care services for people who have participated in deliberate self-harm, people at high risk of suicide and those with many mental health and social problems (The National Suicide Research Foundation 2012: 9). It is the shared view of Yoshimasu, Kiyohara, and Miyashita (2008) that common factors linked with suicide include substance related disorder, psychiatric disorder, adverse mental status, adverse employment status and previous self-harm

behaviours. Research by Bedford, O'Farrell and Howell (2006) found that in the Republic of Ireland there is an association between suicide and alcohol misuse/abuse.

Foster (2011) points to attitudes towards life events. The impact of life events is reflected in our attitudes and reactions to our current economic crisis in Ireland as expressed byAlmasi, Belso, Kapur, Webb, Cooper, Hadley, Kerfoot, Dunn, Sotonyi, Rihmer and Appelby(2009). Fortune, Stewart, Yadav and Hawton (2007) and Harwood, Hawton, Hope, Hariss and Jacoby (2006) reveal how help-seeking behaviours have been explored to detect which factors occur between the onset of suicidality and the completed act. Encouragement from family members and friends to get professional help tends to be key in changing attitudes and in preventing eventual death. These stark findings are frightening and thus have lead to this research in an effort to increase people's awareness of the available help and support.

UK studies have revealed similar findings to those carried out in Ireland. In the UK, between 2000 and 2010, a study published in the British Medical Journal (cited in the Irish Times, 2012, *para. 5*) found that each annual 10% increase in the number of unemployed people, was associated with a 1.4% increase in the number of male suicides. Farming is a pressurised occupation in Ireland's current climate and consequently some farmers may suffer from mental health problems (Lobley, Johnson, Reed, Winter & Little, 2004). GROW, a worldwide mutual support organisation in Ireland supports people suffering from mental health problems. It reveals that the recession has led to an increase in mental health illness issues (McMahon, 2013, *para. 1).* Mary French, Coordinator of GROW Ireland north-east region informed the Irish Times Newspaper that "financial pressures and unemployment have caused a spiraling of conditions among those who have been suffering from mental

health issues and we've noticed a big increase in the number of enquiries to our help groups so far this year"(McMahon, 2012, *para. 2*). In a similar vein, CEO of GROW Ireland explains how older people in rural areas may have little contact with the outside world during the week apart from the post office of which many have now closed down. She describes how younger people may feel left behind because their friends have emigrated. She cautions that feelings of loneliness and isolation are now common in small communities and if not addressed early, can lead to stress, anxiety and depression. GROW is delighted to confirm that despite the perception that it is mainly women who use counseling services to help cope with mental health problems, its statistics show 48% of those who use the service are male (McMahon, 2012, *para. 10*).

The findings of Qin, Agerbo and Westergaard-Nielsen (2000) indicate that mental illness is the predominant factor found in suicides of both genders. Murphy (2000) found that substance misuse disorders are generally more common in male suicides and individuals with schizophrenia who kill themselves are also mainly male (De Hert&Peuskens, 2000). On the contrary, Harris and Barraclough (1997) found that eating disorders, especially anorexia nervosa is mainly suffered by females. Qin et al. (2000) also found that more females seek help from general practitioners for mental health problems. This may be because of the type of therapy available. Gender differences in terms of verbal expression ability and the reluctance of many males to share emotional problems may explain why some of the usual talking therapies are initially less attractive to some males. The need for a change in male attitudes to therapies is highlighted and may therefore be considered as an effective coping strategy.

The author specifically draws attention to Ni Laoire's (2001) research on attitudes to education. It is Ni Laoire's (2001) view that men predominate among those who stay in rural areas and tend to have fewer educational qualifications and less social mobility in comparison to the predominantly female migrant group. Ni Laoire (2001) outlines the lack of research on this 'stayer group' especially as it is the centre of a rapidly changing society. Additionally, she highlights the rising level of male suicide in rural areas in Ireland and the UK. It is because of rising suicide numbers that many voluntary organisations are emerging in an effort to deal with the phenomenon of rising stress levels among farmers.

The current research aims to make a beneficial contribution in exploring mental health issues, in raising people's awareness of mental health and the assistance or coping strategies available. The author's research may enhance on the work of Baume and Clinton (1997), Gallagher and Sheehy (1994) and more recently, Ni Laoire (2001). It is widely known as per Clancy's 1998 study that in Ireland as a whole, farmers' daughters participate in higher education more so than farmer's sons. It is predominantly the educated female population who move away while males tend to remain in their local area (Ni Laoire, 1999). For many young men the farm may be a constraint, tying them to home and the local area on a daily and possibly on a long term basis. Generally, this results in them leaving the parental home at a later stage, if at all. Hannan and O Riain (1993) argue that prolonged parental dependence may be stressful especially if the person is tied to home until migration or marriage.

Young farmers are omitted from Hannan and O Riain's (1999) study and this highlights another gap in the literature regarding the circumstances of young farmers in rural Ireland. It is common in rural Ireland for young men to remain in their local area for farming reasons and for the Gaelic Athletic Association (GAA). This is associated with a sense of

belonging to a masculine, pub and football culture (Ni Laoire, 2001). In the past, time spent abroad was considered a prerequisite for career progression in Ireland. Local rural life was seen as a narrow and somehow restricted existence (Mac Laughlin, 1997). Unfortunately, due to high unemployment today, emigration is a reality for many. A Barnardos report on youth suicide in 1999 suggested that as a society we expect a lot of young men in terms of responsibilities while not encouraging emotional expression. One may argue that emotional expression may be the key to work off stress and reduce depression and suicide.

Gallagher and Sheehy's (1994) study indicates a link between living alone and suicide while other studies maintain that marriage is protective of men's psychological health (Kelleher, Keeley& Corcoran, 1997b). This correlates with the claim in social psychology that the degree of social support experienced by an individual may be a significant factor in coping with mental health issues (Clark, 2005). This refers to the individual's perceptions about the amount of support they receive from family, friends and work colleagues thus suggesting that people living alone have weaker social support outlets (Hurley & Bissett, 1995). One may conclude that having social outlets may be a valuable coping strategy in the maintenance of positive mental health.

The Samaritans in 2000 suggested that there was a link between occupation and suicide claiming that those groups most as risk included those in rural occupations such as farmers and vets. In light of this revelation the availability of firearms to farmers may be disputed. An article by Cadogan (2012, *para. 2*) recognised financial pressures as a further contributing factor to stress among farmers.

Coping with Mental Health

Common risk factors for suicide in farmers include feeling stressed, helpless and unable to cope. Similarly, poor coping abilities such as loss of resilience, difficulties in adapting to change, perfectionism and problem solving difficulties add to these risk factors. Further common causes involve self-esteem issues and alcohol misuse to cope with stress and depression (Better Health, 2012). However, some farmers erect barriers to seeking help and hence, use denial as a coping strategy. They are reluctant to admit to having depression which may be because depression is mistakenly viewed as a sign of weakness rather than a medical condition. Men tend to believe that talking about problems is inappropriate. Similarly, the lack of anonymity from living in a small community means farmers find difficulty with asking for help from someone they know (Better Health, 2012).

'Heads Held High' seminar (2012) explored concerns relating to the increase in suicide rates particularly among men. It was acknowledged that young people by nature tend to withdraw, which is a natural part of growing up and self-exploration. Speakers at the seminar included Michael Noble, Mental Health Ireland and Therese Hicks, a psychotherapist with over 20 years' experience. They encouraged parents to be diligent, to talk to the young person and not to be afraid to ask difficult questions. Both speakers recommended that to embark on the road of recovery one should abstain from using drugs and alcohol. Likewise, positive psychology was suggested as a useful, healthy and practical way of coping. Mindfulness techniques may also support other coping strategies. The seminar revealed that despite stigma reductions in recent times, work remains to be done in supporting people to speak out. This coping strategy may be promoted through developing local support groups where people can share their problems (Heads Held High Seminar Report, 2012).

The 2001 foot and mouth disease outbreak was a typical example of a widespread and devastating disaster which affected all farmers. Millions of animals were slaughtered and travel to and from farms was restricted. Farmers and their families were isolated and the effective delivery of health services was hampered (Walsh &Howkins, 2002). Peck (2005) discovered that farmer's means of coping with foot and mouth disease was to turn to family, friends and veterinary surgeons for support. Peck suggested that talking about worries and seeking help may dramatically improve an individual's quality of life and helps one cope with stress. It was found that few farmers approached health or social services, mainly because they did not perceive their response to the disaster as illness (Peck, 2005). This is consistent with reluctance of farmers to admit to, and seek help for an emotional problem.

Farmers typically pride themselves on self-sufficiency and independence. The most acceptable sources of support were from within the agricultural community or from anonymous sources such as self-help advice through print, telephone and internet. It is an interesting finding that farmers turned to veterinary surgeons for advice during this crisis. Thus, it may be beneficial for mental health specialists to work with and train veterinary surgeons and others who work closely with farmers. Such teaching may be introduced into the veterinary curriculum in the future. Mollica, Cardozo and Osofsky (2004) offer effective coping strategies to deal with mental illness. These strategies are referred to as 'psychological first aid' which consist of listening, conveying compassion, ensuring basic needs, mobilizing support from family members and significant others, group meetings and shared activities. Furthermore, for the few farmers who would accept more specialist support, computerized cognitive-behavioural therapy (CCBT) may be worth considering. Kaltenthaler, Parry and Beverley (2004) confirm the effectiveness of this therapy in the treatment for anxiety and depression and especially for farmers who are restricted to their farms or who reside in

remote areas. In addition, the method is anonymous which makes it more appealing to farmers.

According to Better Health(2012) the following positive steps may be taken to tackle mental health issues. The key is to talk about one's worries with other people. Consult one's doctor. Browse through websites to gain education on mental health. Always remember that you are not alone. Discovering that others also experience mental health problems can reduce one's feelings of isolation and helplessness. Discuss and share problems and feelings with family members or a trained counsellor. Make contact with other farming families in the local community. This may lead to building a professional network, a safe place to share thoughts, feelings and problems while at the same time having fun and relieving stress. Contact government organisations such as Teagasc or IFAC Nationwide Accountants to discuss financial difficulties is suggested. In some cases one may be eligible for financial assistance.

Extensive research by Rudin (2006) and Paul (2005) suggest that religious people are happier and less stressed. Religion offers many benefits such as social contact and support that result from religious pursuits. The mental activity which comes with optimism and from volunteering, learned coping strategies that enhance one's ability to deal with stress, and psychological factors such as 'reason for being' are all byproducts from having strong religious beliefs.

A survey by Kosmin & Lachman (1993), found that people with no religious affiliation appear to be at greater risk for depressive symptoms more so than those affiliated with a religion. The 2008 Legatum Prosperity Index reports that there is a positive link between religious engagement and wellbeing. It found that people who state God as being

very important in their lives are on average, more satisfied with their lives, having accounted for their income, age and other individual characteristics.

Smith, McCullough and Poll's (2004) study contends that high 'religiousness' predicts a lower risk of depression and drug abuse and fewer suicide attempts as well as more reports of satisfaction with life and a positive sense of well-being. A related study by Moreira-Almeida, LotufoNeto and Koenig (2006) concluded that higher levels of religious involvement are positively associated with indicators of psychological well-being. These indicators include life satisfaction, happiness, positive affect and higher morale as well as reduced depression, suicidal thoughts and substance abuse.

The Study Rationale

The literature review reveals that there are many publications available on mental health. However, very few recent studies focus on the farming community in Ireland. This investigation hopes to explore the level of awareness, attitudes towards and strategies to cope with mental health within the farming community. It is then planned to share the findings with organisations such as Macra na Feirme, the Irish Farmers Association (IFA) and mental health services. Finally, a strategy action plan will be devised and put in place in an effort to bridge the existing gaps in awareness levels, attitudes and coping strategies.

The research hypotheses adopted for this study are as follows:-

- ***Hypothesis One:*** Men will have higher levels of mental health impairment than women signifying that they have mental health issues.

- ***Hypothesis Two:*** Men are more likely to have a lower score on attitudes to mental health signifying their denial of having a mental issue.

- ***Hypothesis Three:*** In relation to coping strategies women are more likely to use emotional support and more active coping in comparison to men

- ***Hypothesis Four:*** In relation to coping strategies men are more likely to use denial and self-blame in comparison to women

- ***Hypothesis Five:*** In relation to coping strategies men are more likely to use religion compared to women

- ***Hypothesis Six*****:** To examine age differences across all psychological variables

2. Methodology

2.1 Participants

Ninety three participants took part in the study (N=93), 35 females (N=35, 38%) and 58 males (N= 58, 62%). These participants ranged from two age categories, under 25 (N=54, 58%) and over 25 (N= 39, 42%). The population sample was specifically targeted from the organisation Macra na Feirme because of the rural nature of the study. Participants were asked to complete the anonymous questionnaire if they were over the age of 18 and from a farming background. Participation was on a voluntary basis.

2.2 Design

This was a quantitative mixed design questionnaire study comprising of correlational and between group elements. Gender and age were the independent variables and all scale data including general health, attitude and coping strategies were the dependent variables. Independent t-tests were conducted to examine the difference between males and females on general health, attitudes towards mental health and coping strategies. Similar tests were conducted to explore the differences in age (under and over 25) on each of the variables. In addition, correlations were examined between general health, attitude and various coping strategies.

2.3 Materials

A self-administered paper-based questionnaire (See Appendix 4) was provided to participants who volunteered to take part in the research study. The survey included a section to gather demographic information including gender and age, a table investigating participant's awareness and use of a sample of mental health services and three published questionnaires as follows:-

1. The *General Health Questionnaire (GHQ12)*designed by Goldberg (1992) was used to detect and identify cases of mental health disorder and to measure the degree of the disorder. Participants were instructed to respond to each of the questionnaire's 12 items according to whether they had experienced a particular symptom of behaviour recently using a four-point Likert-scale; 'less than usual', 'no more than usual', 'rather more than usual' or 'much more than usual.' Total scores can range from 0 to 36. The closer the score to 0, the less mental health impairment and the nearer the score to 36, the greater mental health impairment. An example of a question asked was 'have you recently been feeling unhappy and depressed?' The author expected to find men indicating either 'rather more than usual' or 'much more than usual' and that overall men would have higher general health scores than women meaning they have higher mental health impairment. The GHQ has an internal consistency range of between 0.82 to 0.90, as assessed by Cronbach's alpha (Goldberg, 1992).

2. The *Attitudes towards Mental Illness Scale* designed by Cates, Burton and Woolley (2005) was used to measure attitudes towards mental illness. The questionnaire consisted of 11 Likert-type questions using a four-point scale; strongly disagree, disagree, agree, and strongly agree. Items 2, 3, 4, 5, 6, 9 and 10 of the questionnaire were reverse codedbefore scoring. After recoding, all responses were added up to compute an overall attitude towards mental illness score. Total scores ranged from 0 to 33. A total score closer to 33 signified a higher positive attitude towards mental illness and a total score closer to 0 indicated a poor attitude towards mental illness. An example of a question asked was 'mental illness is nothing to be ashamed of'. If a participant answered 'strongly agree' to this question they would score 4 which would indicate a positive attitude towards mental illness. The author would expect to find that women would yield higher scores than men meaning they have a

more positive mental health attitude. The Attitudes towards Mental Illness Scale has an internal consistency of 0.32, as assessed by Cronbach's alpha (Cates, Burton and Woolley, 2005). A value above 0.7 is good so this internal consistency may need to be watched.

3. The *Brief COPE Questionnaire* designed by Carver (1997) deals with ways individuals have been coping with stress in their lives. Participants were advised to respond to each of the 28 items using one of following four responses; 'I haven't been doing this at all; I've been doing this a little bit; I've been doing this a medium amount; I've been doing this a lot. Scales were computed as follows. Items 1 and 19 related to self-distraction. Substance use involved items 4 and 11. Items 2 and 7 were connected to active coping. Use of emotional support related to items 5 and 15. Denial included items 3 and 8. Questions 10 and 23 addressed use of instrumental support. Behavioural disengagement involved items 6 and 16. Items 18 and 28 dealt with humour. Venting related to items 9 and 21 and items 20 and 24 signified acceptance. Positive reframing featured in items 12 and 17. Items 22 and 27 were connected with religion. Planning incorporated items 14 and 25 and finally, questions 13 and 26 related to self-blame. The maximum participants could score for each question was 4 therefore, each of the 14 strategies (each with 2 questions) was marked out of 8. An example of a statement in the questionnaire was 'I've been trying to find comfort in my religion or spiritual beliefs'. If a participant answered 'a lot' they scored 4. The higher the score out of 8 on a particular strategy the more frequently the participant uses that coping strategy. The author would expect to find that men use more negative coping strategies such as denial, self-blame and substance use. The Brief Cope Questionnaire has an internal consistency of 0.93, as assessed by Cronbach's alpha (Carver, 1997).

After all questionnaires were collected, the data was entered into Statistical Package for Social Sciences (SPSS) for analysing.

2.4 Procedure

Participants were advised they must be over 18 years old to take part and be from a farming background. Participation was voluntary and confidential. The author targeted the population sample through means of advertisement in Macra's National Weekly Newsletter and through attendance at national events and various macra meetings informing members of the study and inviting their participation. These various selection methods ensured a national representative sample was present. Many National Council Representatives (NCRs) contacted the author directly by email advising that they wished to take part and requested questionnaires be sent to them for distribution at County Executive meetings. The author responded immediately expressing sincere gratitude for participation, posting questionnaires to the authorised address and followed up with a telephone call to provide clear instructions. Additionally, a cover letter (See Appendix 3) was attached to each questionnaire advising participants that the questionnaire was anonymous and confidential and participation was completely voluntary. Moreover, it was highlighted that completion and submission of a questionnaire meant the participant was consenting to participate in the study. Anonymity was maintained on all occasions when questionnaires were returned. A help-sheet (See Appendix 5) was distributed to all participants. Contact details of the various mental health services mentioned in the survey were included. It took approximately ten minutes on average to complete the questionnaire.

3. Results

This section will report the results of the study in three parts. Firstly, it will outline the descriptive statistics of GHQ, Attitudes and Coping Strategies. Secondly, participants' awareness and use of various mental health services will be presented and finally, results of independent t-tests and correlations between variables will be described.

3.1 Descriptive Statistics

The following table gives an overview of scores for males and females on general health and attitudes towards mental health issues.

Table 1*Descriptive Statistics of GHQ and Attitudes*

Variable	Mean	Standard Deviation
General Health (GHQ)	10.69	4.75
Attitude	25.69	2.71

The average score for males and females on GHQ was 10.69 (SD = 4.75) out of a total score of 36.

Attitudes of males and females averaged out at 25.69 (SD = 2.71) from a total score of 33.

One specific question asked in the GHQ questionnaire related to the extent to which participants were feeling unhappy and depressed recently. Figure 1 below illustrates the results.

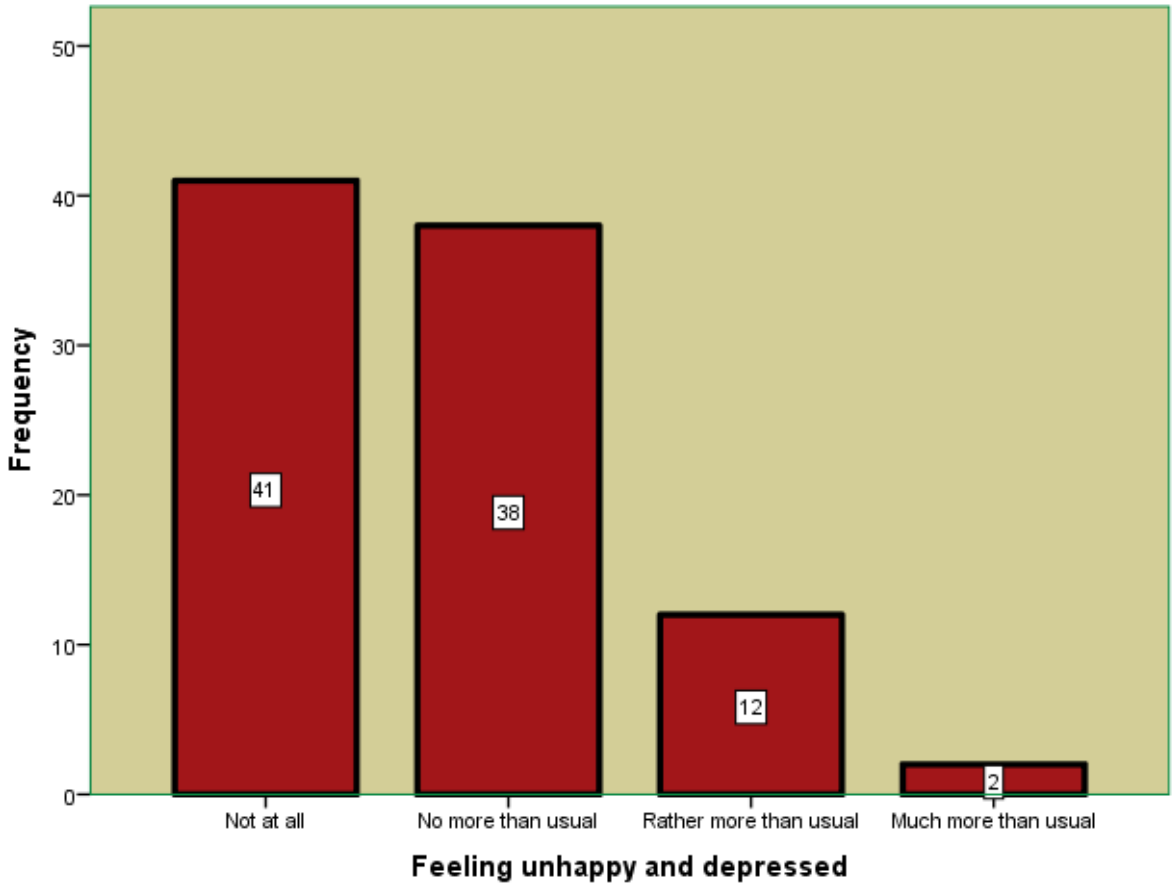


Figure 1*Participant's Feelings of Unhappiness and Depression*

Figure 1 demonstrates that on average participants answered 'not at all' or 'no more than usual' in relation to feeling unhappy or depressed. The bar chart depicts that 14 out of 93 participants are feeling unhappy or depressed more than usual.

Table 2*Descriptive Statistics of Coping Strategies*

Variable	Mean	Standard Deviation
Self-distraction	3.83	1.58
Active coping	3.99	1.75
Denial	2.58	1.1
Substance use	2.55	1.16
Use of emotional support	3.45	1.51
Use of instrumental support	3.42	1.45
Behavioural Disengagement	2.42	0.91
Venting	3.1	1.14
Positive reframing	4.0	1.68
Planning	4.06	1.89
Humour	3.43	1.62
Acceptance	4.15	1.76
Religion	3.13	1.55
Self-blame	3.6	1.73

In terms of coping strategies employed, a mean of between 2 and 5 out of a total of 8 was scored.

Denial (mean = 2.58, SD = 1.1), substance use (mean = 2.55, SD = 1.16) and behavioural disengagement (mean = 2.42, SD = 0.91) may be regarded as an unhelpful means of coping.

Coping strategies that scored means closer to 8 included positive reframing (mean = 4.0, SD = 1.68), planning (mean = 4.06, SD = 1.89) and acceptance (mean = 4.15, SD = 1.76).

Table 3 below presentsa list of various mental health services available. Beside each service are the numbers of participants out of a total of 93 who were aware/unaware of the particular service and the number of participants out of a total of 93 who have used or not used each of the services. For clarity purposes the author has arranged the services in order of awareness from highest to lowest in order to highlight where awareness is lacking.

Table 3 *Participant's Awareness and Use of Mental Health Services*

Service	Aware	Unaware	User	Non-User
Samaritans	89 (96%)	4 (4%)	2 (2%)	91 (98%)
Aware	81 (87%)	12 (13%)	1 (1%)	92 (99%)
Rape Crisis Net	75 (81%)	18 (19%)	0	93 (100%)
Console	69 (74%)	24 (26%)	1 (1%)	92 (99%)
+ Options	55 (59%)	38 (41%)	0	93 (100%)
Young Mental Heal	55 (59%)	38 (41%)	0	93 (100%)
Nat'l Drugs & HIV	36 (39%)	57 (61%)	0	93 (100%)
GROW	26 (28%)	67 (72%)	0	93 (100%)
Bodywhys	24 (26%)	69 (74%)	0	93 (100%)
Farm & Rural	15 (16%)	78 (84%)	0	93 (100%)
Shine	9 (10%)	84 (90%)	0	93 (100%)

As can be seen in Table 3 above, the most well-known services are Samaritans (96%), Aware (87%), Rape Crisis Network (81%) and Console (69%). As expected, three of these services were also the services used.

Two services tailored to this particularstudy's population sample, the Farm and Rural Stress Line and Young Mental Health Ireland scored only 16% and 59% respectively.

Shockingly, only 4 out of 93 participants were found to be using any of the aforementioned services.

3.2 Inferential Statistics

A series of independent t-tests were conducted to examine the study's six hypotheses. Results of the tests will be presented according to the relevant hypotheses in the following three tables (Tables 4, 5 and 6 below).

Table 4: *Independent Samples T-test table displaying differences between males and females on General Health and Attitudes towards Mental Health.*

Variables	**Groups**	**Mean**	**SD**	***T***	***Df***	***P***
GHQ	Males	10.60	5.42	-.246	90.79	0.40
	Females	10.83	3.42	-	-	-
Attitude	Males	26.07	2.99	1.77	91	0.04
	Females	25.06	2.04	-	-	-

Note:p significant at .05 level

Hypothesis One claimed that men will have higher levels of mental health impairment than women. An Independent t-test found that there was **no statistically significant**

difference between males and females on mental health impairment (t (90.8) = -.25; p = 0.40, 1-tailed). Therefore, the **null hypothesis was accepted**.

Hypothesis Two stated that men are more likely to have a lower score on attitudes to mental health than women. An Independent t-test found that there was a significant difference between males and females on attitudes towards mental health. (t (91) = 1.77; p = .04, 1-tailed). However, the significance was in the opposite direction because when looking at the means, men show a slightly higher score (Mean = 26.07, SD = 2.99) than females (Mean = 25.06, SD = 2.04) which suggests men have a more positive attitude than women. Therefore, the hypothesis was rejected and the **null hypothesis was accepted**.

Table 5: *Independent Samples T-test table displaying differences between males and females on various Coping Strategies employed.*

Variables	Groups	Mean	SD	*T*	*Df*	*P*
Self-distraction	Males	3.67	1.58	-1.32	91	0.09
	Females	4.11	1.55	-	-	-
Active coping	Males	3.95	1.65	-0.29	91	0.39
	Females	4.06	1.94	-	-	-
Denial	Males	2.71	1.26	1.63	90.92	0.05
	Females	2.37	0.73	-	-	-
Substance use	Males	2.69	1.34	1.76	89.99	0.042
	Females	2.31	0.72	-	-	-
Emotional support	Males	3.16	1.37	-2.5	91	0.00
	Females	3.94	1.63	-	-	-
Instrumental sup.	Males	3.36	1.53	-0.49	91	0.31
	Females	3.51	1.34	-	-	-
Behaviouraldiseng.	Males	2.45	1.01	0.39	91	0.35
	Females	2.37	0.73	-	-	-
Venting	Males	3.00	1.12	-1.05	91	0.15
	Females	3.26	1.17	-	-	-
Positive reframing	Males	4.05	1.77	0.38	91	0.35
	Females	3.91	1.54	-	-	-
Planning	Males	4.12	1.96	0.37	91	0.36
	Females	3.97	1.79	-	-	-
Humour	Males	3.24	1.47	-1.46	91	0.07
	Females	3.74	1.82	-	-	-
Acceptance	Males	4.05	1.79	-0.7	91	0.25
	Females	4.31	1.73	-	-	-
Religion	Males	2.93	1.37	-1.60	91	0.06
	Females	3.46	1.77	-	-	-
Self-blame	Males	3.53	1.74	-0.41	91	0.34
	Females	3.69	1.73	-	-	-

Note:p significant at .05 level.

Hypothesis Three maintained that in relation to coping strategies, women are more likely to use emotional support and active coping mechanisms in comparison to men. An Independent t-test found that there was a **significant difference** between males and females on use of emotional support as a coping strategy (t (91) = -2.50; p = .01, 1-tailed). Therefore, the **null hypothesis was rejected**in relation to use of emotional support.

Similarly, an Independent t-test was run to establish if there was a significant difference between males and females on active coping as a strategy. **No significant difference** was found (t (91) = -.289; p = .38, 1-tailed). Therefore, the **null hypothesis was accepted**in relation to use of active coping strategies.

Hypothesis Four alleged that in relation to coping strategies men are more likely to use denial and self-blame in comparison to women. An Independent t-test found that there was **no significant difference** between males and females on use of denial as a coping strategy (t (90.92) = 1.627; p = .05, 1-tailed). Therefore, the **null hypothesis was accepted**in relation to use of denial.

Similarly, an Independent t-test was run to see if there was a significant difference between males and females on self-blame as a coping strategy. **No significant difference** was found (t (91) = -.407; p = .34, 1-tailed). Therefore, the **null hypothesis was accepted** in relation to self-blame.

Hypothesis Five claimed that in relation to coping strategies men are more likely to use religion more than women. An Independent t-test found that there was a **no significant difference** between males and females on use of religion as a coping strategy (t (91) = -1.60; p = .06, 1-tailed). Therefore, the **null hypothesis was accepted**.

Table 6: *Independent Samples T-test table displaying differences between under 25's and over 25's on all variables - General Health, Attitudes and Coping Strategies employed.*

Variables	Groups	Mean	SD	*t*	*Df*	*P*
GHQ	U 25	10.80	4.45	0.26	91	0.80
	O 25	10.54	5.19	-	-	-
Attitude	U 25	26.04	3.00	1.47	91	0.14
	O 25	25.21	2.18	-	-	-
Self-distraction	U 25	3.87	1.58	0.23	91	0.82
	O 25	3.79	1.59	-	-	-
Active coping	U 25	3.83	1.62	-1.01	91	0.32
	O 25	4.21	1.92	-	-	-
Denial	U 25	2.80	1.31	2.54	79.31	0.01
	O 25	2.28	0.60	-	-	-
Substance use	U 25	2.56	1.19	0.07	91	0.94
	O 25	2.54	1.12	-	-	-
Emotional support	U 25	3.37	1.52	-0.61	91	0.55
	O 25	3.56	1.52	-	-	-
Instrumental sup.	U 25	3.31	1.41	-0.81	91	0.42
	O 25	3.56	1.52	-	-	-
Behavioural Diseng.	U 25	2.50	1.09	1.10	83.74	0.27
	O 25	2.31	0.57	-	-	-
Venting	U 25	3.06	1.19	-0.41	91	0.69
	O 25	3.15	1.09	-	-	-
Positive reframing	U 25	3.78	1.63	-1.51	91	0.13
	O 25	4.31	1.72	-	-	-
Planning	U 25	3.81	1.81	-1.51	91	0.13
	O 25	4.41	1.96	-	-	-
Humour	U 25	3.26	1.64	-1.20	91	0.23
	O 25	3.67	1.58	-	-	-
Acceptance	U 25	3.98	1.69	-1.09	91	0.28
	O 25	4.38	1.86	-	-	-
Religion	U 25	2.83	1.16	-2.05	58.17	0.05
	O 25	3.54	1.90	-	-	-
Self-blame	U 25	3.57	1.70	-0.11	91	0.91
	O 25	3.62	1.79	-	-	-

Note:p significant at .05 level

Hypothesis Six intended to examine age differences across all psychological variables. An Independent t-test found that there was a **significant difference** between under 25s and over 25s on the use of denial as a coping strategy (t (79.31) = 2.54; p = .01, 2-tailed). Therefore, the **null hypothesis was rejected**.

Similarly, an Independent t-test found that there was a **significant difference** between under 25s and over 25s on the use of religion as a coping strategy (t (58.17) = -2.05; p = .05, 2-tailed). Therefore, the **null hypothesis was rejected**.

In addition to the above tests, the author ran a Pearson's correlation to test for relationships between general health, attitude and various coping strategies. The Pearson's Correlation chart and complete results can be viewed in Appendix 6 and 7. However, some noteworthy initial results were as follows:- A Pearson correlation coefficient found that there was a moderate, positive, significant relationship between general health and venting (r (93) = .38, $p < .01$). Similarly, a moderate positive significant relationship was found between general health and self-blame (r (93) = .44, $p < .01$). Interestingly, a strong positive significant relationship was found between denial and substance use (r (93) = .63, $p < .01$)

4. Discussion and Recommendations

The aim of this research was to investigatethe levels of awareness of mental health among the farming community, to examine the main attitudes towards mental health among rural young adults and to explore the strategies employed to cope with mental health problems among this young farming population. The rationale for the study was to help bridge the gap between awareness and use of mental health services in order to tackle the growing problem of suicide in rural Ireland. Much research has been carried out on mental health in rural Ireland but little research has been done on young rural adults specifically. The findings will be discussed based on the six hypotheses and literature in the field will be drawn upon. Secondly, recommendations on what strategies can be put in place to improve the mental health of young people will be given to Macra na Feirme and to mental health services. Thirdly, limitations of the study will be addressed and finally, recommendations will be made for future research.

Hypothesis One:Men will have higher levels of mental health impairment compared to women thus, signifying that they have mental health issues.

Results confirmed that there was no significant difference between males and females on mental health impairment. An Independent t-test revealed that men (mean = 10.60, SD = 5.42) have lower levels of mental health impairment in comparison to women (mean = 10.83, SD = 3.42). Therefore, the hypothesis was not supported. This finding was unexpected as farming is associated with psychological hazards such as stress (Booth & Lloyd, 2000), anxiety, depression (Eisner, Neal & Scaife, 1998) and suicide (Page & Fragar, 2002). One may wonder if a similar result had been found if the population sample consisted of an equal number of males and females. At the same time, Qin, Agerbo and Westergaard-Nielsen (2000) indicated that mental illness is the predominant factor found in suicides of both

genders and that perhaps females have more mental health impairment. Mary French, Coordinator of GROW Ireland north-east region advised the Irish Times Newspaper that "we've noticed a big increase in the number of enquiries to our help groups so far this year about mental health issues" (McMahon, 2012, *para. 2*). Perhaps these enquiries were coming from men.

An alternative interpretation of this interesting finding is that the reason for women having higher mental health impairment may be due to them being the main social support for their male partner. This view correlates with Paxton & Sutherland's (2000) research which found that men feel protected by being married or having a confidant at home. In contrast, married women were found to be at greater risk of suffering with mental health problems due to the strain of being the main support for their spouse. Moreover, Kelleher, Keeley & Corcoran's (1997b) study maintained that marriage is protective of men's psychological health.

Hypothesis Two: Men are more likely to have a lower score on attitudes to mental health which signifies their negative outlook on having a mental issue.

Results from an Independent t-test found that there was a significant difference on attitudes towards mental health between males and females. ($t(91) = 1.77$; $p = .04$, 1-tailed). However, the significance was in the opposite direction because the means showed a slightly higher score on attitudes to mental health for males (Mean = 26.07, SD = 2.99) than for females (Mean = 25.06, SD = 2.04). Therefore, it may be suggested that men have a more positive attitude than women. This finding did not support the hypothesis. Interestingly, the 2012 'See Change' survey revealed that 57% of Irish farmers said if they had mental health problems they would not want it known. Similarly, 42% of farmers would hide the diagnosis

from friends and 27% said they would delay seeking help for fear of someone knowing about it. These comments seem to contradict the findings of this particular research namely that men have a more positive attitude towards mental health issues. Again, this finding may be due to the imbalance between male and female respondents.

However, the research does appear to correlate with GROW's statistics which show that 48% of those who used their service in 2012 were male (McMahon, 2012, *para. 10*). Moreover, in 2012, 'See Change', commissioned a survey of Irish attitudes towards mental health problems and found that 56% of the sample population revealed that there has been some improvement of attitudes around the outcomes for recovery from a mental health problem. Likewise, 79% of participants confirmed that there has been some softening of attitudes towards the integration of people with mental health problems.

Hypothesis Three: In relation to coping strategies women are more likely to use emotional support and active coping mechanisms compared to men

This hypothesis was supported when an Independent t-test found that there was a significant difference between males and females on the use of emotional support as a coping strategy ($t(91) = -2.50$; $p = .01$, 1-tailed). In addition, women scored a higher mean of 3.94 ($SD = 1.63$) in comparison to men (mean = 3.16, $SD = 1.37$). In relation to active coping as a strategy, no significant difference was found ($t(91) = -.289$; $p = .38$, 1-tailed) however when looking at the mean scores women scored a higher mean of 4.06 ($SD = 1.94$) in comparison to men (mean = 3.95, $SD = 1.65$). Qin, Agerbo and Westergaard-Nielsen's (2000) research which found that more females seek help from general practitioners for mental health problems supports this revelation. One may ask does education play a part in one's ability to seek emotional support and actively cope. It is well known as per Clancy's 1998 study that in

Ireland as a whole, farmers' daughters participate more in higher education than farmer's sons. It is predominantly the female educated population who move away while males tend to remain in their local area (Ni Laoire, 1999). This may explain men's greater sensitivity to the stigma attached to mental health problems and concerns about confidentiality in small rural communities (Sherlock, 1994). In fact, Booth, Briscoe and Powell (2000) found that when farmers did eventually pluck up the courage to visit their GP they tended to present with somatic symptoms of anxiety and depression as opposed to psychological symptoms.

Men may not be seeking emotional support because many of their friends have emigrated. CEO of GROW Ireland cautions that feelings of loneliness and isolation are now common in small communities and if not addressed early, may lead to stress, anxiety and depression (McMahon, 2012, *para. 2*).

Hypothesis Four: In relation to coping strategies men are more likely to use denial and self-blame in comparison to women

An Independent t-test found that there was no significant difference between males and females on the use of denial as a coping strategy ($t(90.92) = 1.627$; $p = .05$, 1-tailed). However, the result may be different if this test was run again on a larger population sample. After all, men scored a higher mean of 2.71 (SD = 1.26) in comparison to women (mean = 2.37, SD = 0.73) which may suggest men are likely to use denial and self-blame as coping strategies. Denial is clearly evident in findings from 'See Change's (2012) survey of Irish attitudes towards mental health problems. This survey revealed how 72% of farmers would not want others to know about their mental health problem, 33% would delay seeking treatment for fear of letting others know, 39% would hide a mental health problem from

friends and 29% confirmed belief that friends would react by distancing themselves (See Change, 2012). These shocking figures hugely support this study's hypothesis on denial.

Similarly, an Independent t-test found no significant difference between males and females on self-blame as a coping strategy (t (91) = -.407; p = .34, 1-tailed). On examination of mean scores it was revealed that women scored a higher mean of 3.69 (SD = 1.73) in comparison to men (mean = 3.53, SD = 1.74). Therefore, the hypothesis was not supported. Contrary to this finding, Ni Laoire's (2001) study found that for many young men the farm may be a constraint, tying them to home and the local area on a daily and possibly long term basis. Generally, this results in them leaving the parental home at a later stage, if at all. One would imagine that this tie may be frustrating for the young male and can lead to self-blame for not revealing their true feelings to their parents. In a similar vein, Hannan and O Riain (1993) argued that prolonged parental dependence may be stressful especially if the person is trapped at home until migration or marriage. However, these research studies do not explain why women use self-blame more as a coping strategy.

Despite the findings of this particular study that men use self-blame less than women as a coping strategy, Melberg (2003) reveals why farmers may use self-blame as a coping strategy. Melberg describes how farming operates dually as a way of life and occupation and the role of farmers can become blurred between work, family and home. Therefore, the farmer can become trapped and feels he or she has no one else to blame but themselves for their mental health problems. Equally, Walker and Walker (1988) highlight self-blame when they explain how farmers add a sense of personal failure if there is a loss of the family farm or if their life lacks personal meaning.

Hypothesis Five: In relation to coping strategies men are more likely to use religion in comparison to women

An Independent t-test found that there was no significant difference between males and females on the use of religion as a coping strategy (t (91) = -1.60; p = .06, 1-tailed). However, it was conveyed that women scored a higher mean of 3.46 (SD = 1.77) in comparison to men (mean = 2.93, SD = 1.37). Therefore, the hypothesis was not supported. Despite the lack of support for this particular hypothesis, it was interesting to reveal how religion is used as a coping strategy for mental health issues among farming and rural communities. Research by Rudin (2006) and Paul (2005) suggest that religious people are happier and less stressed. Likewise, Kosmin & Lachman (1993) found that people with no religious affiliation appear to be at greater risk for depressive symptoms than those affiliated with a religion. From a personal point of view, the author herself has attended macra events and noticed the deep faith expressed by young rural people. Despite a late night of socialising it is extraordinary the turnout at mass the following morning by these young people. Perhaps more young people should follow in the footsteps of these macra members especially when Smith, McCullough and Poll's (2004) study reveals that high 'religiousness' predicts a lower risk of depression, drug abuse and fewer suicide attempts as well as a high level of satisfaction with life and a positive sense of well-being.

Hypothesis Six: To examine age differences across all psychological variables

Rost's 1993 study confirmed that perceived stigma about mental health interventions and services has a negative impact on help-seeking behavior in rural areas. This research was supported when an Independent t-test found that there was a significant difference between under 25s and over 25s on use of denial as a coping strategy (t (79.31) = 2.54; p = .01, 2-tailed) with under 25s (mean = 2.80, SD = 1.31) using denial more than those over 25 (mean

= 2.28, SD = 0.60). Gregoire (2002) contends that after accidents, suicide is the most common cause of death among young farmers. The Central Statistics Office (CSO) reported that in Ireland in 2011, 95 suicides were of persons aged between 15 and 24 and the most common factor accounting for 82% of suicides among farmers was the existence of mental health problems. This problem has to stop. 'See Change' Ireland's national stigma-reduction programme targets young males from 18-24 in the farming rural community. This organisation's online story-sharing initiative 'Making a Ripple' may be the perfect solution for this under 25 population, the age group affected most by suicide. Hearing other young people's stories about how they have come through mental health problems and survived may have a large impact as opposed to listening to adults preaching about where to seek help. The fact that 'See Change' partners with Macra na Feirme would make it easier for these young individuals to see this 'Making a Ripple' online help tool (See Change, 2011).

A Barnardos report on youth suicide in 1999 suggests that as a society, though we demand a lot from young men in terms of responsibilities, emotional expression is not encouraged. This research confirms the finding that over 25s use emotional support (mean = 3.56, SD = 1.52) more so than their under 25 year old counterparts (mean = 3.37, SD = 1.52). In general, there is no mandatory age for retirement among farmers, many tend to work well beyond the typical retirement age which may result in issues around farm succession and tension between two generations on the farm (Australian Bureau of Statistics (ABS), 2003). Coupled with isolation and no one to turn to except the most senior farmer, it is not surprising that young people under 25 do not seek emotional support. After all, this may be perceived by the older generation on the farm as a weakness. Weigel, Weigel and Blundall's (1987) research sums up the intergenerational differences on family farms very well when it

highlights that the younger generation suffer higher levels of stress, perceive lower levels of support and are less satisfied with life.

In addition to the hypotheses, the author carried out a Pearson's Correlation and found a strong positive significant relationship between denial and substance use ($r(93) = .63$, $p < .01$). This disturbing finding coupled with males using denial as a coping strategy supports Murphy's (2000) contention that substance use disorders are generally more common in male suicides. Similarly findings from Yoshimasu, Kiyohara, and Miyashita (2008) claim that common factors linked with suicide include substance related disorder and adverse mental status. Moreover, Bedford, O'Farrell and Howell (2006) found that in the Republic of Ireland there is an association between suicide and alcohol misuse/abuse.

Mental Health Impairment

On examination of the means it was revealed that men and women share similar scores on mental health impairment. Women scored a mean of 10.83 (SD = 3.42) while men closely behind scored a mean of 10.60 (SD = 5.42). Bearing in mind that the closer the score is to 36 the greater is the general health impairment, these figures would appear to be normal. Despite this appearance of normality, these figures may imply that women are as much at risk, if not more so than men when it comes to mental health impairment. Thus, women must not be forgotten when marketing services for mental health issues. Moreover, these figures may suggest that perhaps men don't suffer from mental health as much or social media advertising may be working when mental health services are marketed. On the other hand, the population sample may be questioned on its representativeness for the farming rural community. Despite the participant's being from a farming background they may now be living in the city and are not experiencing rural isolation as before.

The reliability of the pre-existing questionnaires may also be questioned. While the scales show internal reliability and consistency, in some cases participants disclosed that their answers to the questionnaire did not entirely match their opinion. This is extremely important especially when dealing with a sensitive area like mental health where people's lives may be at risk. If the questionnaire is not actually representing the participant's views then the research findings may not be valid. To overcome this problem, the author recommends that this research be supported by qualitative data such as focus groups where participants are asked to explain their answers in more detail. Additionally, comprehensive interviews where open-ended questions may uncover interesting and helpful ideas to help put more tailored interventions in place to assist rural and farming youth and in turn reduce the growing problem of suicide.

Awareness and Use of Mental Health Services

Deplorable statistics were revealed in relation to awareness of certain services available to this young population. An organisation such as Shine which is dedicated to supporting and educating people who are affected by mental health issues had the lowest score of 10% in terms of awareness of the service. Even more disturbing was the disclosure that only 16% of participants were aware of the Farm and Rural Stress Line. Considering 62% of the population sample were young males, the majority possibly farmers, this revelation is worrying especially seeing as this service is the most tailored for this specific audience. Perhaps if rural youth were more aware of this service statistics for suicide among 15 to 24 year olds would be considerably reduced.

To add to these eye-opening statistics, it was shockingly discovered that only four participants used the currently available services which address mental health issues as well

as eating disorders, bereavement, drugs and pregnancy. Imagine, a mere 4% of participants had utilised these professional services. This revelation questions the marketing of these services. The Farm and Rural Stress Line and Young Mental Health Ireland were found to have zero usage. The non-use of these two most tailored services designed for this population sample highlights the need to conduct a needs analysis of current interventions to target this vulnerable age group. After all, there is no point is putting alternative supports in place if the present services are not being utilised to their full capacity. Gregoire (2002) reminds us that the majority of young farmers live on farms in isolated locations. This drawback must be taken into consideration when reviewing marketing campaigns for these mental health services. Perhaps a door-to-door approach by a qualified mental health practitioner may be more beneficial where the young farmer may talk about their worries in the comfort of their own home. This method would address the finding of the National Suicide Research Foundation report (2012:8) that there are difficulties in accessing health care services and in sticking to treatment appointments as well as a lack of compliance with instructions related to prescribed medication. If the young people have a professional checking in on them, they have no reason but to be compliant.

Applications of the Research

As a current macra member, the author is open to working closely with Macra na Feirme to put strategies in place to assist fellow macra members with mental health issues. These interventions may be in the form of local discussion groups in each county where members can meet to discuss issues and share information. There is the option of setting up mental health talks by services such as the farm and Rural Stress Line or Youth Mental Health Ireland on a quarterly basis at County Executive meetings. Alternatively, a young person who has overcome mental health illness may be open to sharing his/her story. Each

macra club has its own Facebook page so it may be beneficial to advise all Public Relations officers to join the Facebook pages of mental health services such as the Farm and Rural Stress Line, Console, the Samaritans and Young Mental Health Ireland. All these organisations have freely available information and contact details on their page that macra members can access at their own discretion. A further suggestion would be to include a module on mental health as part of club and county officer training. This module would raise awareness and offer information and guidance on what to do if one has a mental health issue or is one knows someone who requires assistance.

In addition to working with Macra na Feirme, the author may partner with mental health services such as the Farm and Rural Stress Line and provide assistance in marketing their services. Though a key service tailored to the needs of rural and farming populations it is clearly not doing enough according to this study's findings. A further possibility is the creation of an online toolkit to assist young people if they have a mental health issue. This online toolkit would be freely available through Macra na Feirme and all mental health service websites. Within the toolkit there may be helpful guidance documents, an interactive blog where visitors to the site may ask questions and get information and professional advice. Presentations, e-learning tools such as webinars and podcasts and other interactive portals could also be made available. This online tool would aim to be user-friendly and be available through all mobile devices 24/7. The author of this study has been part of a project which creates a similar online tool for managers in her work organisation and she could bring many ideas to the fore should Macra na Feirme and the various mental health services be interested in developing such an intervention.

Study Limitations and Recommendations for Future Research

A number of limitations must be acknowledged in the present study. Preferably, the author would have liked to carry out a large scale study with a greater number of participants. Unfortunately due to time constraints this was not possible. The dissertation had to be completed over a short period of time. Time constraints posed problems for the primary research in trying to meet with macra members at poorly attended and infrequent club meetings.

Further limitations included the narrow focus due to word count stipulation. The aforementioned limitations meant the absence of a broader exploration of mental health issues among this vulnerable population. Qualitative research in the form of interviews and focus groups may have supported the quantitative questionnaire. This would have meant richer data and a reduction in the objectivity of responses which comes with self-report data.

Each questionnaire was short and compiled of easily understood questions which could be completed in 10-15 minutes. This allowed participants with incomplete second level education and those with literacy problems to complete the questionnaires with ease. However, when entering the data into SPSS the author noted that some participants ticked the same box for every question which may indicate laziness or a lack of understanding.

A key area for further research is revealed by Paxton & Sutherland (2000) who found that married women are at greater risk of suffering with mental health problems due to the strain of being the main support for their spouse. In the farming community especially, media seems to target males more than females when it comes to mental health issues. The present study confirmed that men have lower mental health impairment and have a more positive

attitude than women. Perhaps this is because their female partner takes on their problems. Further research into this area is critical for fear that the tables will turn and female suicides will increase.

An interesting revelation in this study was the use of religion as a coping strategy for mental health issues. Future research may build on Rudin (2006) and Paul's (2005) studies which suggest religious people are happier and less stressed. A similar study with rural community as the sample population may prove extremely beneficial because individuals in remote areas have fewer places to socialize. The trip to mass every weekend to meet others and to ask God for guidance and assistance may be welcomed. Religion may be the saving grace for some rural people and leads to a more positive sense of wellbeing.

Conclusion

This study set out to investigate the awareness, attitudes and strategies for coping with mental health within the farming community. The extent to which the literature is reciprocated in the lifestyle of young adults in the farming community was identified. The overall conclusion drawn was that there is a clear absence of awareness among the farming community of some of the available services and evidently, the services are not being used. A significant difference on attitudes towards mental illness exists between males and females. In relation to coping strategies females resort to religion and use of emotional support while males predominantly are in denial and use substances to cope.

The primary research unearthed that there is an ever-increasing problem around the lack of use of available mental health services and therefore recommendation was made to conduct a needs analysis of existing services to target the young vulnerable audience.

This dissertation may provide some ideas for organisations like Macra na Feirme who deal with young people from the farming community and most especially for macra members themselves. For this reason, the author concludes with some final food for thought for rural youth:-

'The greatest wealth is health'

(Virgil)

References

ABS (Australian Bureau of Statistics) (2003).*Australian Social Trends. Family and Community – Living Arrangements: Farming Families.* Canberra: Bureau of Statistics.

Almasi, K., Belso, B., Kapur, N., Webb, R., Cooper, J., Hadley, S., Kerfoot, M., Dunn, G., Sotonyi, P., Rihmer, Z. &Appelby, L. (2009). Risk factors for suicide in Hungary: A case-control study. *BMC Psychiatry,* 9, 1-9.

Barnardos, (1999).*Responding to Youth Suicide and Attempted Youth Suicide in Ireland.* Policy briefing I. Dublin: Barnardos.

Barry, M.M., Doherty, A., Hope, A., Sizsmith, J. & Kelleher, C.C. (2000). 'A community needs assessment for rural mental health promotion'. *Health Education Research,* 15(3), 293-304.

Baume, P. & Clinton, N. (1997).Social and cultural patterns of suicide in young people in rural Australia. *Australian Journal of Rural Health,* 5, 115-120.

Bedford, D., O'Farrell, A. & Howell, F. (2006).Blood alcohol levels in persons who died from accidents and suicide. *Irish Medical Journal,* 99, 80-83.

Better Health (2012). *Farmers – talk about your worries.* [Web log post]. Retrieved from http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Farmers_talk_about_your_worries

Booth, N., Briscoe, M. & Powell, R. (2000). Suicide in the farming community: methods used and contact with health services. *Occupational and Environmental Medicine,* 57,9,642-644.

Booth, N.J. & Lloyd, K. (2000). Stress in Farmers. *The International Journal of Social Psychiatry,* 46,1,67-73.

Borowsky, I.W., Ireland, M. &Resnick, M.D. (2001). 'Adolescent Suicide Attempts: Risks and Protectors'. *Paediatrics,* 107(3)(March), 485-493.

Cadogan, S. (2012, August 16). *Don't bottle up your wet weather farming blues.* [Web log post]. Retrieved from http://www.irishexaminer.com/farming/profile/dont-bottle-up-your-wet-weather-farming-blues-204247.html

Carver, C. S. (1997). You want to measure coping but your protocol's too long: Consider the Brief COPE. International Journal of Behavioral Medicine, 4, 92-100.

Cates, M.E., Burton, A. R., & Woolley, T. W. (2005). Attitudes of Pharmacists Toward Mental Illness and Providing Pharmaceutical Care to the Mentally Ill.*The Annals of Pharmacotherapy*, 39, 1450-1455.

Central Statistics Office (2012).*Births, Deaths and Marriages 2011.*[Web log post]. Retrieved from http://www.cso.ie/en/newsandevents/pressreleases/2012pressreleases/pressreleasevitalstatisticsfourthquarterandyearlysummary2011/

Cicero, [Web log post]. Retrieved from http://www.quotegarden.com/health.html

Clancy, P. (1998).*Who goes to college?* Second national survey. Dublin: Higher Education Authority.

Clark, C.M. (2005). *Relations between Social Support and Physical Health.*[Web log post]. Retrieved from http://www.personalityresearch.org/papers/clark.html

Corrigan, P. (2004). 'How Stigma Interferes With Mental Health Care'. *American Psychologist,* 59(7), 614-625.

De Hert, M. &Peuskens, J. (2000). Psychiatric aspects of suicidal behaviour: schizophrenia. *The International Handbook of Suicide and Attempted Suicide.* (edsK.Hawton& C. Van Heeringen). Chichester: John Wiley & Sons.

Eberhardt, B.J. &Pooyan, A. (1990). Development of the farm stress survey: factorial structure, reliability and validity. *Educational Psychology Measurem*50,393-402.

Eisner, C.S., Neal, R.D. &Scaife, B. (1998).Depression and anxiety in farmers.*Primary Care Psychiatry,* 4,101-105.

Elkind, P.D., Carlson, J.E. & Schnabel, B. (1998). Agricultural hazards reduction through stress management. *Journal of Agromedicine,* 39,2,159-165.

Epp, J. (1988). *Mental Health for Canadians: Striking a Balance.* Minister of Supplies and Services: Ottawa.

Fortune, S., Stewart, A.,Yadav, V. &Hawton, K. (2007). Suicide in adolescents: Using life charts to understand the suicidal process. *Journal of Affective Disorders,* 100, 199-210,

Foster, T. (2011). Adverse life events proximal to adult suicide: a synthesis of findings from psychological autopsy studies. *Arch Suicide Research,* 15, 1-15.

Gallagher, A. & Sheehy, N. (1994). Suicide in rural communities.*Journal of Community and Applied Social Psychology,* 4(3), 145-155.

Gerrard, C.E. (1998). Farmer's occupational health: cause for concern, cause for action. *Journal of Advanced Nursing,* 28,1,155-163.

Goldberg, D. and Williams, P. (1988).*A User's Guide to the General Health Questionnaire.*Windsor: NFER-NELSON.

Goldberg, D. (1992) .*General Health Questionnaire (GHQ-12).*Windsor: NFER-NELSON.

Gregoire, A.(2002). The mental health of farmers.*Occupational Medicine,* 52, 8, 471-476.

Hannan, D. & O Riain, S. (1993).*Pathways to adulthood in Ireland: causes and consequences of success and failure in transitions among Irish youth.* General Research Series, Paper No. 161. Dublin: Economic and Social Research Institute.

Harris, E.C. &Barraclough, B. (1997).Suicide as an outcome for mental disorders. A meta-analysis.*British Journal of Psychiatry,* 170, 205-228.

Harwood, D.M.J., Hawton,K.,Hope,T.,Hariss, L. & Jacoby, R. (2006). Life problems and physical illness as risk factors for suicide in older people: A descriptive and case-control study. *Psychological Medicine,* 36, 1265-1274.

Hawton, K. Simkin, S. &Malmberg, A. (1998).*Suicide and Stress in Farmers.* London: The Stationery Office.

Heads Held High (2012, October 11). *Mental Health Seminar.* The Grand Hotel Wicklow.

Hurley, L.&Bissett, F. (1995).*Young people and suicide.* Dublin: Irish Youthwork Press.

Irish Times (2012, August 16). *UK suicide rise linked to recession.*[Web log post]. Retrieved from http://www.irishtimes.com/newspaper/world/2012/0816/1224322256216.html

Kaltenthaler. E., Parry, G. & Beverley, C. (2004). Computerised cognitive behavior therapy. *Behavioural and Cognitive Psychotherapy,* 32, 31-55.

Kelleher, M.J., Keeley, H.S.& Corcoran, P. (1997b). 'Suicide in Ireland: Statistical, social and clinical considerations'. *Archives of Suicide Research,* 3, 13-24.

Kosmin, B.A. & Lachman, S. (1993).*One nation under God: religion in contemporary modern society.* New York: Harmony Books.

Knudsen, C. & Wilson, C. (1985).*Agriculture Sector Survey.* Battlefords, Saskatchewan: Battlefords Branch of the Mental Health Association in Saskatchewan.

Kohl, S. (1976).*Working Together: Women and Family in Southwestern Saskatchewan.*Toronto: Holt Rinehart and Winston of Canada.

Lobley, M., Johnson, G., Reed, M., Winter, M. & Little, J. (2004). Rural Stress Report Final Report.*Centre for Rural Research,* University of Exeter.

Mac Laughlin, J. (1997). The new vanishing Irish: social characteristics of 'new wave' Irish emigration. Page 133-157 in J. Mac Laughlin ed., *Location and dislocation in contemporary Irish Society: emigration and Irish identities.* Cork: Cork University Press.

Marotz-Baden, R. &Mattheis, C. (1994). Daughters-in-law and stress in two generation farm families. *Family Relations,* 43,2,132-137.

McCurdy, S. & Carroll, D.J. (2000).Agricultural Injury.*American Journal of Industrial Medicine,* 38,463-480.

McGregor, M., Willock, J. &Deary, I. (1995).Farmer Stress.*Farm Management,* 9,57-65.

McMahon, A. (2013, February 21). *Mental health illness issues on the rise in northeast.* [Web log post]. Retrieved from http://www.irishtimes.com/news/health/mental-health-illness-issues-on-the-rise-in-northeast-1.540915?mode=print&ot=example.AjaxPageLayout.ot

McMahon, A. (2012, August 21). *Mental health illness issues on the rise in northeast.* [Web log post]. Retrieved from http://www.irishtimes.com/newspaper/health/2012/0821/1224322573040.html

Melberg, K. (2003). Farming, stress and psychological well-being: the case of Norwegian spouses. *SociologiaRuralis,* 43,1,56-76.

Mollica, R.F., Cardozo, B.L. & Osofsky, H.J. (2004).Mental health in complex emergencies.*Lancet,* 364, 2058-2067.

Monograph, A. (2000).*Promotion, Prevention and Early Intervention for Mental Health*.Commonwealth Department of Health and Aged Care, Canberra.

Moreira-Almeida, A. LotufoNeto, F. & Koenig, H.G. (2006). Religiousness and mental health: a review. *Revista Brasileira de Psiquitria,* 28, 3, 242-250.

Murphy, G.E. (2000). Psychiatric aspects of suicidal behaviour: substance abuse. *The International Handbook of Suicide and Attempted Suicide.* (edsK.Hawton& C. Van Heeringen) p.135-146. Chichester: John Wiley & Sons.

National Suicide Research Foundation (2012).*First Report of the Suicide Report and Information System.*Retrieved from http://www.nsrf.ie/reports/Reports_2012/SSISReport2012.pdf

Ni Laoire, C. (1999). Gender issues in Irish rural outmigration. Page 223-237 in P.Boyle and K. Halfacres eds., *Migration and gender in the developed world.* London: Routledge.

Ni Laoire, C. (2001). A Matter of Life and Death? Men, Masculinities and Staying 'Behind' in Rural Ireland *Sociologia Ruralis,* 41(2)(April), 220-246.

Page, A.N. &Fragar, L.R. (2002).Suicide in Australian Farming, 1988-1997.*Australian and New Zealand Journal of Psychiatry,* 36,81-85.

Paul, P. (2005, January 9). The New Science of Happiness.Time Magazine.[Web Log Post]. Retrieved from http://www.time.com/time/magazine/article/0,9171,1015870,00.html

Paxton, R. & Sutherland, R. (2000).*Stress in Farming Communities: Making Best Use of Existing Help.* Newcastle: North Tyneside & Northumberland NHS Trust.

Peck, D.F. (2005). Foot and mouth outbreak: lessons for mental health services. *Advances in Psychiatric Treatment,* 11, 270-276.

Qin, P., Argebo, E. &Westergaard-Nielsen, N. (2000).Gender differences in risk factors for suicide in Denmark.*British Journal of Psychiatry,* 177, 546-550.

Raine, G. (1999). Causes and effects of stress on farmers: a qualitative study. *Health Education F,* 48,259-270.

Rost, K. (1993). Rural-urban differences in stigma and the use of care for depressive disorders in US. *F Rural Health,* 9, 57.

Rudin, M. (2006, April 30).*The Science of Happiness.*BBC News. [Web Log Post]. Retrieved from http://news.bbc.co.uk/2/hi/programmes/happiness_formula/4783836.stm

Saunderson, T.R. & Langford, I.H. (1996).A study of the geographical distribution of suicide rates in England and Wales 1989-92 using empirical Bayes estimates.*Social Science and Medicine,* 43,489-502.

See Change (2011). [Web log post].*See Change End of Year Report 2011.* Retrieved from http://www.seechange.ie/images/stories/See_Change_end_of_year_report_2011_website.pdf

See Change (2012). *Irish Attitudes towards Mental Health Problems.*[Web log post].Retrieved from http://www.seechange.ie/images/stories/See_Change_Research_2012_Irish_attitudes_towards_mentl_health_problems.pdf

Sher, L. (2004).Preventing Suicide.*QJ Medicine,* 97, 677-680.

Sherlock, J. (1994). *Through the Rural Magnifying Glass.*London: Good Practices in Mental Health.

Smith, T., McCullough, M. & Poll, J. (2004). Religiousness and Depression: Evidence for a Main Effect and Moderating Influence for Stressful Life Events. *Psychological Bulletin,* 129, 4, 614-636.

Swisher, R.R., Lorenz, G.H., Conger, F.O. & Elder, R.D. (1998). The long arm of the farm: how an occupation structures exposure and vulnerability to stressors across role domains. *Journal of Health and Social Behaviour,* 39,1,72-89.

The Samaritans (2000, June).*Suicide Statistics 1998.*[Web log post]. Retrieved from http://www.samaritans.org.uk/sams.html/suistats.htm

Virgil. [Web log post]. Retrieved from http://www.quotegarden.com/health.html

Walker, J.L. & Walker, L.S. (1988). Self-reported stress symptoms in farmers. *Journal of Clinical Psychology,* 44,1,10-16.

Walsh, M. &Howkins, D. (2002).Lessons from a farmers' health service.*Nursing Standard,* 16, 33-40.

Weigel, R.R., Weigel, D.J. &Blundall, J. (1987). Stress, coping and satisfaction: generational differences in farm families. *Family Relations,* 36,1,45-48.

World Health Organisation (2012).*World Mental Health Day.*[Web log post].Retrieved from http://www.who.int/mediacentre/events/annual/world_mental_health_day/en/index.html

Yoshimasu,K.,Kiyohara, C. & Miyashita, K. (2008). Suicidal risk factors and completed suicide: Meta-analyses based on psychological autopsy studies. *Environmental Health & Preventative Medicinem*13, 243-256.

Appendix 1 – Authorisation from Macra Head Office to carry out the Research

From: Aoife Helly [ahelly@Macra.ie]
Sent: 01 November 2012 11:24
To: Annabelle
Subject: RE: Annabelle's Thesis

Hi Annabelle,

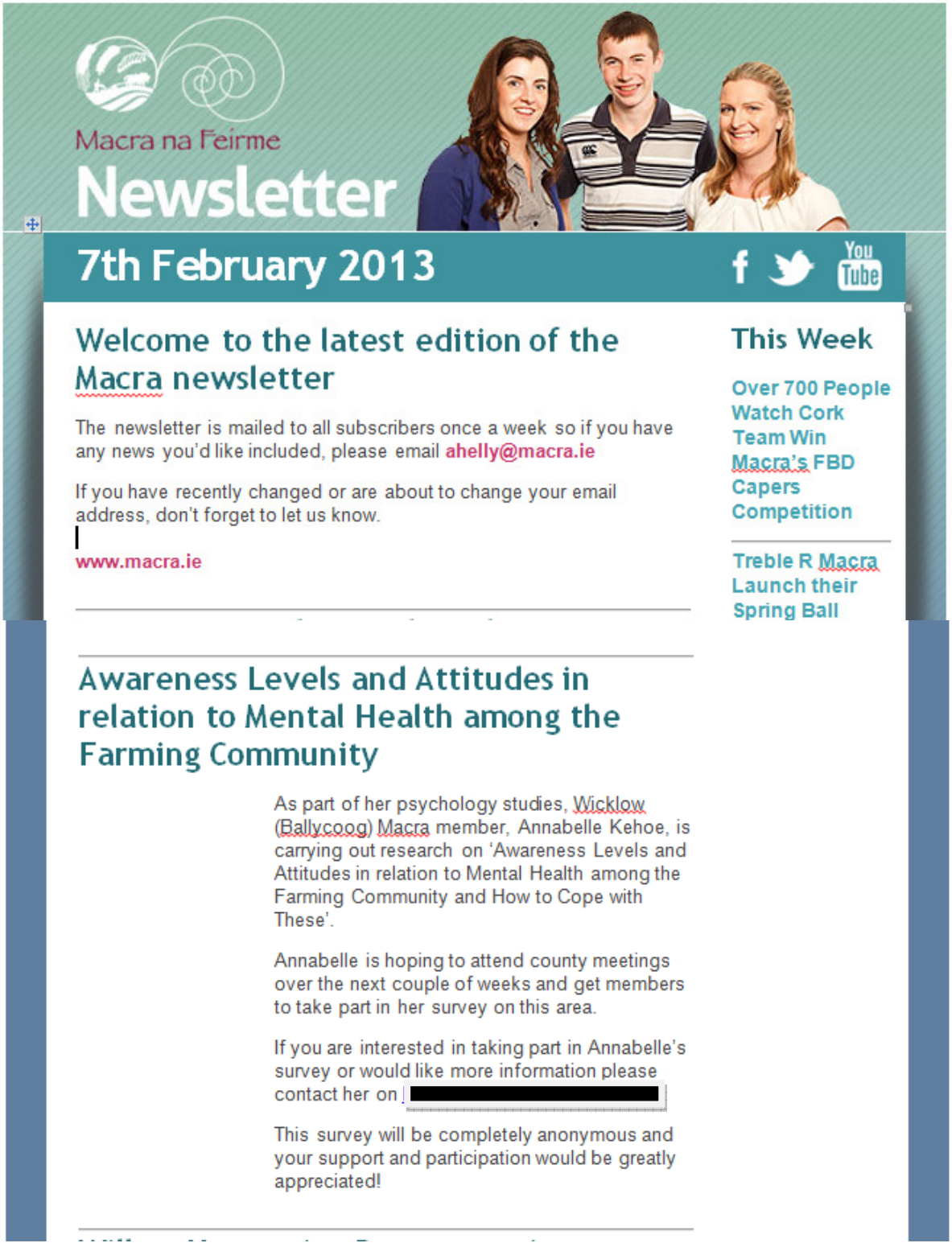
Apologies the rally was this weekend, so I've been a bit busy. It should be fine to do that study but I would like to see the questionnaire before distribution to make sure it's suitable.

I hope we can help you with your research.

Best,
Aoife

Aoife Helly | Public Relations Manager | Macra na Feirme | The Irish Farm Centre. Bluebell, Dublin 12 Direct Line: 01 426 89 07 | Mobile 087 970 2336 | Main Office: 01 426 8900 | Email: ahelly@macra.ie
Twitter: @MacranaFeirme | Facebook: facebook.com/MacranaFeirme | Website: www.macra.ie

Appendix 2 – Advertisement in Macra's National Newsletter



Macra na Feirme

Newsletter

7th February 2013

Welcome to the latest edition of the Macra newsletter

The newsletter is mailed to all subscribers once a week so if you have any news you'd like included, please email ahelly@macra.ie

If you have recently changed or are about to change your email address, don't forget to let us know.

www.macra.ie

This Week

Over 700 People Watch Cork Team Win Macra's FBD Capers Competition

Treble R Macra Launch their Spring Ball

Awareness Levels and Attitudes in relation to Mental Health among the Farming Community

As part of her psychology studies, Wicklow (Ballycoog) Macra member, Annabelle Kehoe, is carrying out research on 'Awareness Levels and Attitudes in relation to Mental Health among the Farming Community and How to Cope with These'.

Annabelle is hoping to attend county meetings over the next couple of weeks and get members to take part in her survey on this area.

If you are interested in taking part in Annabelle's survey or would like more information please contact her on [redacted]

This survey will be completely anonymous and your support and participation would be greatly appreciated!

Appendix 3 – Cover Letter of Questionnaire

Awareness Levels and Attitudes in relation to Mental Health among the Farming Community and How to Cope with These

My name is Annabelle Kehoe and I am conducting research in the Department of Psychology that explores awareness levels and attitudes in relation to mental health issues among the farming community and how to cope with these. This research is being conducted as part of my studies and will be submitted for examination.

You are invited to take part in this study and participation involves completing and returning the attached anonymous survey. While the survey asks some questions that might cause some minor negative feelings, it has been used widely in research. If any of the questions do raise difficult feelings for you, help sheets with contact information for support services will be handed out afterwards.

Participation is completely voluntary and so you are not obliged to take part.

Participation is anonymous and confidential. Thus responses cannot be attributed to any one participant. For this reason, it will not be possible to withdraw from participation after the questionnaire has been collected.

The questionnaires will be securely stored and data from the questionnaires will be transferred from the paper record to electronic format and stored on a password protected computer.

It is important that you understand that by completing and submitting the questionnaire that you are consenting to participate in the study.

Should you require any further information about the research, please contact Annabelle Kehoe, [redacted]. My supervisor can be contacted at [redacted] or [redacted].

Thank you for taking the time to complete this survey.

Appendix 4 – Questionnaire

Note: You can only complete this questionnaire if you are over 18 and from a farming background.

General Information

- Gender? Male ☐ Female ☐
- Age? Under 25 ☐ Over 25 ☐

Your own mental health

How has your health been in general over the last few weeks? Please circle the answer which you think most nearly applies to you.

1	**Have you recently been able to concentrate on whatever you are doing?**	Better than usual	Same as usual	Less than usual	Much less than usual
2	**Have you recently lost much sleep over worry?**	Not at all	No more than usual	Rather more than usual	Much more than usual
3	**Have you recently felt that you are playing a useful part in things?**	More so than usual	Same as usual	Less useful than usual	Much less useful
4	**Have you recently felt capable about making decisions about things?**	More so than usual	Same as usual	Less so than usual	Much less capable
5	**Have you recently felt constantly under strain?**	Not at all	No more than usual	Rather more than usual	Much more than usual
6	**Have you recently felt you couldn't overcome your difficulties?**	Not at all	No more than usual	Rather more than usual	Much more than usual
7	**Have you recently been able to enjoy your normal day to day activities?**	More so than usual	Same as usual	Less so than usual	Much less than usual
8	**Have you recently been able to face up to your problems?**	More so than usual	Same as usual	Less able than usual	Much less than usual
9	**Have you recently been feeling unhappy and depressed?**	Not at all	No more than usual	Rather more than usual	Much more than usual
10	**Have you recently been losing confidence in yourself?**	Not at all	No more than usual	Rather more than usual	Much more than usual
11	**Have you recently been thinking of yourself as a worthless person?**	Not at all	No more than usual	Rather more than usual	Much more than usual

12	**Have you recently been feeling reasonably happy all things considered?**	More so than usual	About same as usual	Less so than usual	Much less than usual

Awareness of Mental Health Services available

Please mark yes/no in the boxes beside:

(i) the services you are aware of from the list and

(ii) any services you have used in the past from the list.

Services	**Are you aware of this service? Yes/No**	**Have you ever used this service? Yes/No**
The Farm & Rural Stress Line		
Samaritans		
GROW		
Aware		
Shine		
Bodywhys		
Mental HealthIreland/ Young Mental Health Ireland		
Console		
National Drugs & HIV HELPLINE		
+ Options		
Rape Crisis Network		

Attitudes to Mental Health

The following statements express various opinions about mental illness and the mentally ill.

Using the scale below, please circle what you think is the relevant answer.

1.	Most patients in mental hospitals are not dangerous	Strongly Disagree	Disagree	Agree	Strongly Agree
2.	It is easy to recognise someone who once has a mental illness	Strongly Disagree	Disagree	Agree	Strongly Agree
3.	We cannot expect to understand the bizarre behaviour of mentally ill persons	Strongly Disagree	Disagree	Agree	Strongly Agree
4.	Mentally ill people are not intelligent	Strongly Disagree	Disagree	Agree	Strongly Agree
5.	Most mentally ill persons haven't the ability to tell right from wrong	Strongly Disagree	Disagree	Agree	Strongly Agree
6.	Most mentally ill people don't care how they look	Strongly Disagree	Disagree	Agree	Strongly Agree
7.	Most people have mental and emotional problems	Strongly Disagree	Disagree	Agree	Strongly Agree
8.	Mental illness is nothing to be ashamed of	Strongly Disagree	Disagree	Agree	Strongly Agree
9.	Mentally ill people are ruled by their emotions; normal people are ruled by their reason	Strongly Disagree	Disagree	Agree	Strongly Agree
10.	A mentally ill person is in no position to make decisions about even everyday living problems	Strongly Disagree	Disagree	Agree	Strongly Agree
11.	There is nothing about mentally ill people that makes it easy to tell them from normal people	Strongly Disagree	Disagree	Agree	Strongly Agree

Coping Strategies

These items deal with ways you've been coping with the stress in your life. Circle your answer and make it as true FOR YOU as you can.

1.	I've been turning to work or other activities to take my mind off things.	Not at all	A little bit	A medium amount	A lot
2.	I've been concentrating my efforts on doing something about the situation I'm in.	Not at all	A little bit	A medium amount	A lot
3.	I've been saying to myself "this isn't real."	Not at all	A little bit	A medium amount	A lot
4.	I've been using alcohol or other drugs to make myself feel better.	Not at all	A little bit	A medium amount	A lot
5.	I've been getting emotional support from others	Not at all	A little bit	A medium amount	A lot
6.	I've been giving up trying to deal with it.	Not at all	A little bit	A medium amount	A lot
7.	I've been taking action to try to make the situation better.	Not at all	A little bit	A medium amount	A lot
8.	I've been refusing to believe that it has happened.	Not at all	A little bit	A medium amount	A lot
9.	I've been saying things to let my unpleasant feelings escape.	Not at all	A little bit	A medium amount	A lot
10.	I've been getting help and advice from other people.	Not at all	A little bit	A medium amount	A lot
11.	I've been using alcohol or other drugs to help me get through it.	Not at all	A little bit	A medium amount	A lot
12.	I've been trying to see it in a different light, to make it seem more positive.	Not at all	A little bit	A medium amount	A lot
13.	I've been criticizing myself.	Not at all	A little bit	A medium amount	A lot
14.	I've been trying to come up with a strategy about what to do.	Not at all	A little bit	A medium amount	A lot

15.	I've been getting comfort and understanding from someone.	Not at all	A little bit	A medium amount	A lot
16.	I've been giving up the attempt to cope.	Not at all	A little bit	A medium amount	A lot
17.	I've been looking for something good in what is happening.	Not at all	A little bit	A medium amount	A lot
18.	I've been making jokes about it.	Not at all	A little bit	A medium amount	A lot
19.	I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	Not at all	A little bit	A medium amount	A lot
20.	I've been accepting the reality of the fact that it has happened.	Not at all	A little bit	A medium amount	A lot
21.	I've been expressing my negative feelings.	Not at all	A little bit	A medium amount	A lot
22.	I've been trying to find comfort in my religion or spiritual beliefs.	Not at all	A little bit	A medium amount	A lot
23.	I've been trying to get advice or help from other people about what to do.	Not at all	A little bit	A medium amount	A lot
24.	I've been learning to live with it.	Not at all	A little bit	A medium amount	A lot
25.	I've been thinking hard about what steps to take.	Not at all	A little bit	A medium amount	A lot
26.	I've been blaming myself for things that happened.	Not at all	A little bit	A medium amount	A lot
27.	I've been praying or meditating.	Not at all	A little bit	A medium amount	A lot
28.	I've been making fun of the situation.	Not at all	A little bit	A medium amount	A lot

Appendix 5 – Help Sheet

Awareness Levels and Attitudes in relation to Mental Health among the Farming Community and How to Cope with These

Thank you for taking part in my research project. Here are some helpful details for your information. Should you require any further information about my research, please contact me (Annabelle Kehoe) on [redacted].

Services	Area of specialisation	Contact Details
The Farm & Rural Stress Line	Mental Health	1800 742 645
See Change	Mental Health	Seechange.ie 01 860 1620
Samaritans	Mental Health	1850 609090
GROW	Mental Health	1890 474 474
Aware	Mental Health	1890 303302
Shine	Mental Health	1890 621631
RECOVERY International Ireland	Mental Health	01 6260775
Teen-Line Ireland	Mental Health	1800-833-634
Mental Health Ireland/ Young Mental Health Ireland	Mental Health	info@mentalhealthireland.ie
Console	Suicide and Bereavement	1800 201 890
National Drugs & HIV HELPLINE	Drugs and Alcohol	1800 459 459
Gay Switchboard Dublin	Sexuality	01 872 1055
Cura HELPLINE	Sexual Health and Pregnancy	1850 622626
+ Options	Sexual Health and Pregnancy	Freetext LIST to 50444 or www.positiveoption.ie
Amen	Abuse, Domestic Violence & Rape	046 9023718
Rape Crisis Network	Abuse, Domestic Violence & Rape	1800 778888
Bodywhys	Eating Disorders	1890 200 444

Appendix 6 – Pearson's Correlation Statistics

Variable		GHQ	Attit	Self Dis	Act Cope	Den	Sub Use	EmotSupp	Inst Sup	Beh Dis	Vent	Pos Ref	Plan	Hum	Acc	Rel	Self Bla
GHQ Total	Pearson																
	Sig 2T																
	N																
Att Total	Pearson	.19															
	Sig 2T	.06															
	N	93															
Self Dis	Pearson	.27**	-.01														
	Sig 2T	.01	.93														
	N	93	93														
Act Cope	Pearson	.24*	.12	.52**													
	Sig 2T	.02	.26	.00													
	N	93	93	93													
Denial	Pearson	.29**	.20	.43**	.24*												
	Sig 2T	.01	.07	.00	.02												
	N	93	93	93	93												
Sub Use	Pearson	.47**	.06	.32**	.20	.63**											
	Sig 2T	.00	.60	.00	.05	.00											
	N	93	93	93	93	93											
Emot Support	Pearson	.29**	-.02	.37**	.46**	.12	.13										
	Sig 2T	.01	.84	.00	.00	.30	.21										
	N	93	93	93	93	93	93										

* *p* significant at .05 level.
** *p* significant at .01 level.

Var		GHQ	Attit	SelfDis	ActCope	Denial	SubUse	EmotSupp	InstSupp	BehDis	Vent	PosRef	Plan	Hum	Accept	Rel	SelBla
InstSupp	Pears	.39**	-.03	.47**	.53**	.08	.17	.74**									
	Sig 2T	.00	.80	.00	.00	.46	.11	.00									
	N	93	93	93	93	93	93	93									
BehDiseng	Pears		.16			.70**	.68**	.04	-.00								
	Sig 2T	.42**	.12	.36**	.12	.00	.00	.69	.98								
	N	.00	93	.00	.26	93	93	93	93								
		93		93	93												
Vent	Pearson	.38**	.12	.36**	.42**	.22*	.35**	.59**	.53**	.28**							
	Sig 2T	.00	.26	.00	.00	.04	.00	.00	.00	.01							
	N	93	93	93	93	93	93	93	93	93							
Positive Reframe	Pearson	.3**	.01	.58**	.55**	.21*	.09	.47**	.60**	.14	.39**						
	Sig 2T	.00	.93	.00	.00	.05	.40	.00	.00	.18	.00						
	N	93	93	93	93	93	93	93	93	93	93						
Plan	Pearson	.5**	.12	.56**	.74**	.28**	.36**	.58**	.73**	.21*	.52**	.66**					
	Sig 2T	.00	.27	.00	.00	.01	.00	.00	.00	.05	.00	.00					
	N	93	93	93	93	93	93	93	93	93	93	93					
Humour	Pearson	.17	-.20	.54**	.45**	.21*	.33**	.42**	.38**	.16	.38**	.52**	.54**				
	Sig 2T	.12	.06	.00	.00	.05	.00	.00	.00	.14	.00	.00	.00				
	N	93	93	93	93	93	93	93	93	93	93	93	93				

Accept	Pearson	.20*	-.09	.49**	.55**	.09	.22*	.53**	.56**	.07	.45**	.59**	.65**	.60**
	Sig 2T	.05	.41	.00	.00	.40	.04	.00	.00	.52	.00	.00	.00	.00
	N	93	93	93	93	93	93	93	93	93	93	93	93	93

Var		GHQ	Att	Self Dis	Act Cope	Den	Sub Use	Em Sup	Inst Sup	Beh Dis	Vent	Pos Ref	Plan	Hum	Acc	Rel	Sel Bla
Rel	Pea	.09	.12	.16	.38**	.03	-.09	.36**	.28**	-.06	.29**	.28**	.35**	.14	.40**		
	Si 2T	.40	.27	.13	.00	.81	.40	.00	.01	.56	.00	.01	.00	.17	.00		
	N	93	93	93	93	93	93	93	93	93	93	93	93	93	93		
Self Bla	Pea	.44**	.07	.43**	.44**	.34**	.54**	.37**	.40**	.34**	.54**	.28**	.62**	.49**	.35**	.15	
	Si 2T	.00	.50	.00	.00	.00	.00	.00	.00	.00	.00	.01	.00	.00	.00	.16	
	N	93	93	93	93	93	93	93	93	93	93	93	93	93	93	93	

* *p* significant at .05 level.
** *p* significant at .01 level.

Appendix 7 – Pearson's Correlation Complete Results

The Pearson's Correlation Table in Appendix 6 highlights that a significant relationship was found between general health and self-distraction, denial, use of emotional support, venting and self-blameat the 0.01 level (2-tailed).

The mean score for general health was 10.69 (SD = 4.75) and for self-distraction was 3.84 (SD = 1.58). A Pearson correlation coefficient found that there was a weak positive significant relationship between general health and self-distraction ($r(93) = .27$, $p < .01$).

The mean score for general health was 10.69 (SD = 4.75) and denial was 2.58 (SD = 1.10). A Pearson correlation coefficient found that there was a weak positive significant relationship between general health and denial ($r(93) = .29$, $p < .01$).

The mean score for general health was 10.69 (SD = 4.75) and for use of emotional support was 3.45 (SD = 1.51). A Pearson correlation coefficient found that there was a weak positive significant relationship between general health and use of emotional support ($r(93) = .29$, $p < .01$).

The mean score for general health was 10.69 (SD = 4.75) and venting was 3.10 (SD = 1.14). A Pearson correlation coefficient found that there was a moderate positive significant relationship between general health and venting ($r(93) = .38$, $p < .01$).

The mean score for general health was 10.69 (SD = 4.75) and self-blame was 3.59 (SD = 1.73). A Pearson correlation coefficient found that there was a moderate positive significant relationship between general health and self-blame ($r(93) = .44$, $p < .01$).

A significant relationship was found between general health, active coping and acceptance at the 0.05 level (2-tailed).

The mean score for general health was 10.69 (SD = 4.75) and active coping was 3.99 (SD = 1.75). A Pearson correlation coefficient found that there was a weak positive significant relationship between general health and active coping ($r(93) = .24$, $p < .05$).

The mean score for general health was 10.69 (SD = 4.75) and acceptance was 4.15 (SD = 1.76). A Pearson correlation coefficient found that there was a weak positive significant relationship between general health and acceptance ($r(93) = .20$, $p < .05$).

No significant relationship was found between general health and attitude, humour and religion.

No relationship was found between attitude and the other variables at the 0.01 level (2-tailed) or 0.05 level (2-tailed).

The majority of coping strategies correlated with each other due to their similarity in nature. Some interesting examples of significant correlations at the 0.01 level (2-tailed) included a moderate positive significant relationship between active coping and use of emotional support ($r(93) = .46$, $p < .01$), a moderate positive significant relationship between active coping and religion ($r(93) = .38$, $p < .01$), a strong positive significant relationship between denial and substance use ($r(93) = .63$, $p < .01$), a weak positive significant relationship between venting and religion ($r(93) = .29$, $p < .01$) and a moderate positive significant relationship between self-blame and behavioural disengagement ($r(93) = .34$, $p < .01$).

Similarly, various relationships were found among coping strategies at the 0.05 significance level (2-tailed). A weak positive significant relationship was found between denial and active coping ($r(93) = .24$, $p < .05$), a weak positive significant relationship between humour and denial ($r(93) = .21$, $p < .05$), a weak positive significant relationship between positive reframing and denial ($r(93) = .21$, $p < .05$), a weak positive significant relationship between venting and denial ($r(93) = .22$, $p < .05$) and a weak positive significant relationship substance use and acceptance ($r(93) = .22$, $p < .05$).