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ORIGINAL RESEARCH

Women, isolation and bush babies

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ABSTRACT

This qualitative study illuminates the health care and life experiences of women on isolated pastoral stations in remote Australia who look after babies and children. The women care for their families in singular isolation, caught in the culture of the bush. Adaptation to or retreat from such a life is a unique process for each woman.

Introduction

For farming families who live and work in remote Australia, the bush has its own unique rewards but also inevitable problems that evolve during the process of survival. Those who work the land become intimate with its severe reality and adapt their lives accordingly, by using a variety of behaviours and technologies, and by the utilisation of the limited services available to them.

With the recent introduction of Australia-wide funding for services provided by female doctors in remote areas (a women's health initiative), it is pertinent to review the health and wellbeing experiences of women in who live in an isolated environment. Humphreys et al stated that distance, as an element of satisfaction with health services, was not as much an issue as it was once thought to be[1]. Humphreys et al also stated that people would travel distances to consult a doctor if the communication with their doctor was good. This may be so, but how does travelling distances affect the experience of using health services if a baby or small child is involved?

While the literature on the subject highlights broad medical and social issues, women's individual experiences have not been considered important nor worthy of being reported. This is apparent in the *Life Has Never Been Easy* report[2] in which rural women gave the very clear message that the provision of basic services were crucial in mitigating the undesirable effects of isolation. Coakes and Gail also found social factors such as financial, educational, employment and service issues were of particular concern because women

believed that the lack of these factors impacted on family quality of life[3]. Coakes and Gail also suggested that traditional attitudes in rural communities affected health-service utilisation by women. This may be because females are said to have higher rates of acute illness and non-fatal conditions than males[4].

It is said that the culture of rural life affects the perception of illness of rural dwellers. In a study by Elliot-Schmidt and Strong, urban dwellers rated illness or disability as discomfort caused by pain or cosmetic unattractiveness; whereas rural dwellers equated illness and/or disability with the affect it had on their productivity [on the farm][5]. Other studies and reports have discussed the concern of rural women about the lack of choice in medical practitioners[6-8].

Some of the questions the present study sought to explore are the affect on women's health and wellbeing of living in a remote area, especially during early postnatal recovery, and why women regard having the option of consulting a female doctor as not only attractive but also necessary.

Participants

The participants were 15 remote-area women living on isolated pastoral stations in South Australia, and a focus group of seven remote-area women from an isolated mining town. In total, 22 participants were interviewed in depth.

Remote classification

'Remote' was defined as 'distant from urban centres where supplies of goods and services, and opportunities for social interaction are concentrated'[9]. An alternative to this definition is the experience of having to drive hundreds of miles over potholed, dirt roads. These roads may be dusty or a quagmire, depending on the season, and often impassable. In addition, those who live in remote areas must contend with flies, snakes, spiders, scorpions and other pests, as well as floods and drought. They rarely see a person apart from immediate family for days, weeks or sometimes months on end.

Recruitment and selection

Selection of the women was based on the criteria that they lived on remote pastoral stations in South Australia, and that they had children or were pregnant. Women were recruited by distributing information through the Remote and Isolated Children's Exercise (RICE) service to female service-users. After receiving information, potential participants contacted the researcher by telephone in order to enrol in the study. Participants were also recruited through the Country Women's Association's (CWA) air time on a Very High Frequency (VHF) radio broadcast, during which the researcher discussed the project. In this way, women who were not part of the RICE-serviced group were recruited.

Remote-area focus group

An information letter was sent to a particular remote-area health service, which distributed the letter to women in contact with the service, as well as to women who consulted the doctor in that service area. Potential focus-group participants indicated their interest to the researcher. The focus group was held at the local town community health centre.

Interview process

Most remote-area women were visited by the researcher in their own home. Willingness to travel to remote homesteads was an essential element of the researcher establishing credibility with the women. Understanding the distances the participants had to travel and the environment in which they lived, assisted the researcher by accurately informing the prompt questions.

The presence of toddlers at the homesteads visited often made interviewing impossible. If that was so, an appointment was made for a phone interview at a more convenient time. In one case, a participant's friend travelled 150 km to baby-sit in order to allow the woman to be

interviewed. A satisfactory number of on-site interviews, however, were achieved.

Methodology

The methodology was informed by and adapted from the philosophical work of Max van Manen[10]. Van Manen's methodological premise reflects a practice of phenomenological enquiry, where human knowledge and understanding may be gained by analysing the reflective descriptions of people who have lived a particular experience, for example that of pregnant women working in a remote area, isolated from community, friends and family. Another lived experience is that of young, first-time mothers without close networks and supports, or the way women manage family needs and work at the same time, what they do in certain situations and the meaning of these experiences to them. This method of enquiry is neither deductive nor empirical but consists of pointing to and elucidating what is given. In this way, we were able to begin to question and to identify particular phenomena occurring for women in rural and remote locations.

Open-ended questions were used so that descriptions could develop according to the experiences of the particular participant. To begin the process, questions focussed on the following: family/historical background; initial reason for the move to remote life; activities related to this process; supports, services and networks; health and wellbeing; self, family and related experiences; having 'bush' babies; good, bad and unusual experiences; personal change; reasons for staying or leaving; and community, relationships and friendships.

Analysis

Analysis focused on the nature of each woman's experience by: (i) considering their particular experiences of the physical body, (lived body - corporeality); (ii) looking at their everyday relationships and their community (relationality or communality); and (iii) considering a particular experience in relation to time (lived time - temporality).

Van Manen's method was adapted so that each phenomenon was presented as an interrelated part of a life narrative about the body at a given time and within a given community relationship. This narrative approach allowed significant patterns and themes to appear across participant fields.

Validation of data

In order to validate the data, the research results were sent to the participants involved for their comment and feedback. There was strong support by the participants for the findings and a request for further participatory research to be developed in this area. They felt the insights that had been offered to them through the research participation would allow them to develop processes to meet their own needs, as is indicated in the 'Recommendations' section. The whole process, they expressed, gave them control over their own destiny.

In order to offer insight into the process of analysis, excerpts of conversation from participant transcripts have been included in the 'Results' section. The excerpts illustrate the concepts in the participants' own words. The transcripts presented in the body of this article are those which best reflect and articulate a particular concept.

Results

A significant amount of information emerged from this study but three interrelated, significant phenomena recurred:

1. Aloneness.
2. The paradox of community and communication.
3. It's a woman's role.

Aloneness and bush women

For women on the land, being alone often begins as a feeling of isolation in the latter stages of pregnancy when they are

not as independent or physically active as they have been and they can no longer join their partner in farming activities. Their advancing pre-natal state means they become confined to the homestead:

> It is, yeah. Like with me particularly, you find that you could go a fair while - then, you haven't gone out and seen anything on the place or you haven't left the house.

When birth is imminent, this aloneness is compounded when, as is usual medical practice in remote areas, the woman is sent to be near the hospital where the baby will be born. This can occur up to 8-10 weeks prior to giving birth, and the hospital may be from 200 to 800 km or more away from home. For some, that means waiting for the birth of a new baby by themselves in a strange town, or living with parents in another state. 'Going it alone' can be a devastatingly lonely time. Due to the nature of farm work, the partner may be excluded from late pre-natal and birth experiences except for brief visits. This diminishes an important time of togetherness:

> It was hard for Y [partner] too, because he was really glowing through this pregnancy as I was, and loved to see the tummy get bigger and all the movements. And he'd had 3 months where he couldn't do that. I think one time he came down he got down there at 2 o'clock in the morning and he was gone by 3 o'clock that same afternoon. That was the only time he had with me. He didn't have that touching and watching the tummy grow and feeling all the movements that the baby was making inside of me, and it was really hard for him.

The woman has to cope alone at a physically and emotionally vulnerable time, when she is most in need of support, love and reassurance. If it is not her first baby, she may have other children with her to care for by herself. Due to the nature of station work, children cannot be left for the partner to manage. The cost of travel, accommodation and maintaining two households puts an enormous strain on the family budget.

The length of stay in hospital post-birth is usually less than 5 days unless there are complications. Discharge for these women means back to the station, which may include a plane flight and a long drive to manage alone:

> And they let me stay in 5 days, which was really, really good but a week after having the baby I was at home basically back on the station by myself.

This may not be unusual for a new mother in the city, but in remote areas the options of support and companionship are unavailable due to distance. Due to loss of friends and no-one but the baby to talk to, women may experience a high degree of loneliness:

> Yeah, I do. Yeah I do get lonely. My husband reckons I talk too much at night sometimes. It's probably 'cos I haven't had an adult conversation for weeks or days or months - years... Yeah. I've lost some friendships I think since I've been out here because for some reason they don't make the effort.

The loss of old friends and being alone so much can take its toll. In the present study, a surprising number of women developed symptoms of post-natal depression after returning home. Their symptoms included continuous weeping, extreme anxiety, exhaustion and a desperate need to 'escape'. They said their symptoms were worse when they were alone, with no support or physical and emotional relief from babies who often cried incessantly.

> He was a rather difficult baby. He used to scream for hours on end, like there was just constant screaming... When he was about 6 weeks old we took him to the paediatrician in Adelaide (had to drive him down there). He thought he had a gastric reflux, so he had medication which did help, but yes, he still used to scream for hours on end, especially at night time. You'd just want to go to bed and this child would be just screaming. You'd have him over your shoulder just pacing up and down. It was really hard. You just felt like you didn't have any support, like nowhere to go like to get help.

Many women saw no-one apart from their partner, until their 6-week post-natal check-up. Even then, their symptoms often went unrecognised. This was because the women masked their symptoms, believing they were 'not coping' when they 'should be able to cope'. This attitude of 'soldiering on' and the 'my mother managed out here' myth appeared to be perpetuated in some rural families by the partner. When women tried to fit in with the expectations of others, discussion of problems that occured following the birth of a baby became the 'problem of the baby' or physical problems, such a difficulty with breastfeeding. This perpetuated and reinforced avoidance of women's mental-health issues and serious lack of supports. For some, emotional turmoil caused relationship problems. Alcohol abuse was not uncommon. When a woman returned home with nothing resolved she risked a deterioration in her mental wellbeing:

> I was still emotional, like crying all the time, and just couldn't control it. And the panic and anxiety attacks would, you know, sort of - I couldn't do anything. I just sort of used to sit there and couldn't let X out of my sight because I was paranoid that something was going to happen to her. I wasn't suicidal or anything like that. I just sort of was really down on myself thinking, oh, everyone will be better off without me and all this sort of stuff. I never thought of hurting myself or X, but I just sort of thought sometimes I'd just be better off getting in the car and just going, and everyone would be happy and that sort of thing.

Some women left a difficult, unsupported situation to seek physical and emotional support from their family in another town or state:

> I couldn't understand, [that] I'd wanted this baby for so long and got it, and then I just?. I never hated him. I loved him, I wanted him. I did everything right with him and by him, but I just cried all the time. And I couldn't face other people. I couldn't deal with anyone else's... And I was usually quite an organiser. I couldn't get organised.
>
> *How did you come to terms with that in the end? What did you do?* [researcher]
>
> I ended up leaving and went home back to Mum and Dad for a while and took 16 months on my own with X to feel confident enough to face up to everything again.

It was often only at this point of retreat that the problem was recognised by the woman's family and subsequently treated when the women was persuaded to see a doctor. Some women, however, have remained undiagnosed.

The paradox of communication and community

For a number of women, aloneness and loneliness has been managed by phone calls or email to friends and relatives from their 'other life', as some termed it. The telephone has provided opportunities for people in rural and remote communities to participate in the broader community, but by its very scope this bypasses participation in local community. The demise of the 'party line' and loss of the VHF radio, once used by many as a source of both local communication and knowledge about people in the local community, has dissipated the interactive function of local community:

> The phone has made it good in one way, but also in others it has, in a lot of ways, isolated people I think.
>
> *Can you expand on that a little?* [researcher]
>
> Well, where once upon a time you'd be working around and you'd have the transceiver going in the background, or you'd listen in at sessions and you'd hear the good news and the bad news via the telegram or phone call, 'cos of course they're not private. You sort of caught up - oh, so-and-so did this; oh, they got such-and-such for their wool - you know, all the little things that were happening, and the transceiver was in a fairly accessible area of the house so that you were hearing things going on and off all day. Some of the

> people you wouldn't know, but you'd know of them. But these days, you never hear about or see or have anything to do with those people. They're not someone next door or close by, and therefore you don't have that contact.

The development of rural and remote communities is through social interaction at a local level but this process has been seriously impeded. Much as people once complained about the lack of privacy, the older forms of communication were an essential element in remote community development in terms of local knowledge and keeping in touch, especially for women. The CWA achieved much of their interaction on 'air time'. This is still the case, but the number of members is dwindling. Young women are not joining because they do not have, or cannot afford, the VHF link-up necessary for participation. In addition, they are unsure of the relevance the organisation to someone of their [young] age. With the advent of managers for conglomerate-owned pastoral holdings, the mentoring of young women by older women in the rural family has also diminished.

When and if people discovered that someone was in distress, however, they tried to help:

> There were a few people, like there was a young woman about two and a half hours from here, when she first came up there was no telephone and I did speak with her, the owners actually said that she was very lonely and we arranged to speak and we used to speak every Saturday on the [VHF] radio. And that went on for 2 years, I did eventually meet her but in 2 years we got the telephone and that was the end of that, but yeah for quite some time I had no idea who she was except that she was a mum with a couple of young kids and didn't have anybody to speak with.

The other side of this dilemma is that older women are also are left on their own when their children go away to school or leave the property to find other forms of work, because often farms are unable to support more than the one male worker and his family. There is a paradox in this for the rural and remote community. The advances in technology offer the rewards of keeping people in touch with the outside world, but this is at the expense of local community. The process of communication facilitates the demise of remote communities once sustained by local, interactive communication.

It's a woman's role

It has been established in previous research[3] that male-female relationships in rural and remote areas follow traditional patterns and that women are predominantly associated with nurturing and caring roles. This is evident in remote areas in relation to health care. On isolated stations women are usually the informal custodians of the Royal Flying Doctor Service (RFDS) health box and that means they tend to all the health problems or accidents on the property. Many women are unprepared for this and have little knowledge to assist them manage such events. This has a serious side:

> *What happened with that? How'd he get hit on the head?* [researcher]
>
> It's a long story, but yeah, they were trying to put this tank up on an overhead tank stand. They were sorting out this jib thing to lift this tank, and it came down. It was a round metal solid ball that hit him on the top of the head. It sort of laid him flat. I think we had two hours before the RFDS plane came. It's a bit scary.

Partners in the outback also need prompting to take care of their own health. Lack of proactive health behaviour in rural men is a serious problem, but the following anecdote looks at the lighter side:

> (laughs) *Actually, it sounds like X* [small son] *actually helped him to have his tetanus injection.* [researcher]
>
> Yeah, well Dad wouldn't have had it done actually. Only that X needed his four-year-old injections, and I said, 'Well, it's time for you to have yours done'. But

> it was quite funny because X was quite pleased that he got Winnie the Pooh bandaids and Dad got none.

Life can also be frightening in the middle of nowhere when women are by themselves. When the men are away and women are alone, they must contend with unwelcome visitors to the property who may demand goods and services and can be threatening. There are also occasions when a station worker 'goes on a drunk' or there are 'beasties' to contend with:

> Snakes I absolutely loathe. They frighten me to death. I have killed them, yes. We have scorpions in our house. That's my big fear. They're only around like for a month of the year, but they really bother me that they will get up into the blankets of the children. I have been bitten by a scorpion, so I do know the pain. Although the scorpions we have here are so big, I had a girlfriend tell me they look like yabbies.

The study also uncovered evidence of unpaid hours female medical practitioners work to meet the needs of women in remote communities. This is an example of women's nurturing approach to health care. In this context, the nurturing is the empathy that female practitioners offer to other women who are their patients. This sustains women who are experiencing an 'emotional drought' and they return home feeling listened to and nurtured. When feasible, female practitioners spend extra time with outback women and allow them to talk through issues of concern. Both station women and remote-town women made it very clear they liked and needed the kind of caring a female doctor offered in the doctor-patient relationship:

> And yes, that is typical Y. She might have been going through your records at 9 o'clock at night, and if she thought there was something that you might be waiting to hear or be worried about, she would ring.
>
> *She'd ring?* [researcher]
>
> She'd ring.
>
> *She was really, really caring?* [researcher]
>
> Yes she is.
>
> *And that came across as the patient?* [researcher]
>
> Yes.

These women believe that caring, empathy, communication and listening are essential elements in their healing process and health. There was considerable discussion about the way women communicate with each other that is different from the way they communicate with men. As one participant said: 'It's a woman thing'. It is this 'women's culture of caring' that isolated women miss:

> The thing you miss, you don't realise but you do, is having a chat with other women. You actually don't have that. It's all guys the whole time.
>
> *It's a very male-orientated arena, isn't it?* [researcher]
>
> It is. And after a bit, you think, 'Go!'. (Laughs) 'I could kick them!' (Laughs) I think that's just normal anyway. I've got another girl... who I get on very well with, and we ring up now and again and have a chat with each other. She's 2 hours south of [a remote town]. So again, it's all on the phone really. It's nice just talking to people on the phone. That cheers you up, doesn't it, if you're feeling a little bit down?

Another participant offered this explanation:

> X [partner] often says, 'Why can't you talk to me like you do your girlfriends?' But I can't even explain that to him. It's just different. It's not like you're gossiping or bitching or anything. You just need them. Because they're a woman and they can understand perhaps; I don't know.

Discussion

What has arisen from the interviews in the present research is that women's life, work and health issues in the bush are not only impacted upon by, but also firmly embedded in the medical and social culture of remote Australia, regardless of the women's profession or role in life.

This social concept of women places them within an ideological coding that describes and typifies their behaviors in a universalising schema (that is, it describes expected social roles within particular settings, communities and cultures) which may then identify them as atypical within a family and/or a work setting (their social culture)[11]. Each person must 'play their part' to fit into a particular society or/and community. The role a woman must play is covertly perpetuated within a society that is still deeply immersed in what Smith termed the 'mothering discourse', or what a woman must do to 'mother' someone, be it a child or adult (eg the common statement, 'You pour the tea and play mother' describes an expected role of women in our society)[12]. This phenomenon of cultural coding applies to women in the outback, and it emerged convincingly in the present research. It is, as Smith points out, a discourse in 'managing' women's relationships with their children, their employment and with society[12].

The distance and isolation factors in remoteness exacerbate the process of coding, affecting women's health and wellbeing, and placing some women at particular risk of developing depressive disorders, especially if the signs and symptoms are undiagnosed. Hospitals and medical practitioners must be aware that information about the signs of post-natal depression should be provided for a woman who is returning to a remote area after childbirth. This should be part of the discharge plan for isolated women. When such women return for their 6 week post-natal check up, medical practitioners must ask 'the hard questions' regarding the woman's mental health and wellbeing, and not just concentrate on the physical health of the baby and mother.

In a time of aloneness, women seek a 'women's culture' of empathy, caring, support and understanding that they find only in other women. This alleviates the hardship and loneliness of a male-dominant environment. Female general practitioners are wholeheartedly welcomed by women, often for companionship and as a woman to talk to, as well as for the provision of much-needed health services.

Recommendations

In the development of information to be included in post-natal discharge planning, hospitals should consider the implications of the discharge of a mother and baby to a remote area. These women should be provided with information about mental health and wellbeing and what to do if certain mental signs and symptoms appear.

When the results of the present study were reviewed by both young mothers and older women in the remote community where the study took place, the women suggest developing supportive 'mum mentors' in the local community. They believed this idea could be canvassed through newsletters, health services and when the CWA had their 'on air' day. In this way, those interested in participating in such a process could be identified, and the mandate of the CWA may be given new relevance for younger members.

Finally, medical practitioners who work in the outback, or who are attached to local hospitals should ask 'hard questions' regarding the mental health of young mothers, especially in the early stages of post-natal recovery when women are most vulnerable and may feel isolated. Formal support mentors in the medical profession are as important as informal mentors in the local community because they are alert for early signs of depression and are able to offer timely treatment and counselling, relevant to the remote community context.

Conclusion

This paper provides but a glimpse into the lives of remote-area women who have 'bush babies'. In particular, it

describes the evolution of women in a rural society where the unchanging, universal culture regarding women ignores woman's needs to a point where their health and wellbeing are at risk.

In an age of technology, remote communities need to be creative in fostering their own development, linking old ways with the new in order to meet the needs of a new generation.

Women have become trapped by their own competencies, especially that of nurturing, and women are caught in a form of cultural ambiguity that epitomises the 'way' of the outback. This will continue unless health and welfare agencies and governments recognise these paradoxes within our own culture and develop programs that do not perpetuate these cultural myths about women and their designated role in society.

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