



# Psychosocial health and prevention of crisis in rural areas – Results of a pilot panel on psychosocial problems, subjective burden, and utilization of help in Germany

Stefanie Neumann<sup>a,b,\*</sup>, Michael Soyka<sup>a,c</sup>, Andreas G. Franke<sup>b,d</sup>

<sup>a</sup> Ludwig-Maximilians-University Munich, Clinic of Psychiatry and Psychotherapy, Munich, Germany

<sup>b</sup> University of Applied Sciences Neubrandenburg, Germany

<sup>c</sup> Medical Park Chienseeblick, Bernau-Felden, Germany

<sup>d</sup> University of Applied Labour Studies, Mannheim, Germany

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## ABSTRACT

**Subject:** Medical care, psychological help, and social support are often required in psychosocial problem situations and crises. Without an ICD-10-classification, psychosocial crises are not legally entitled to treatment with medical and psychotherapeutic care according to the German Social Code. However, untreated psychosocial crises often lead to mental disorders.

**Methods:** A pilot study was conducted among 399 participants using a mixed-methods approach in a rural district in North Germany, which led to the collection of epidemiological data on psychosocial problems and coping strategies among the population.

**Results:** The majority of respondents attributed high degrees of relevance to health; however, only a few were satisfied. Half of the respondents had somatic symptoms, and just under one third had mental disorder symptoms. Respondents also had family problems. Overall, women were more vulnerable than men. Respondents used more aid in the form of consultation from friends or partners than from professional social services.

**Discussion:** Regarding the utilization of help, it is striking that particularly the unemployed often did not seek help in the presence of psychosocial crises. Although there are many social services available in the rural study area, only a minimal number of respondents were aware of their existence. The lack of utilization of these services suggests a relatively low level of knowledge and acceptance of psychosocial professional groups' competences as well as the general psychosocial self-help and self-care system among the population.

**Conclusion:** An interdisciplinary psychosocial care system could provide the population with adequate services and prevention approaches.

## 1. Introduction

Psychosocial health is characterized by individuals' well-being, satisfaction, self-confidence, and ability to maintain interpersonal relationships (World Health Organization, 2015). Depending on their living conditions, individuals spend their entire lifespan completing different tasks and satisfying different requirements. Personal life crises triggered by adverse events or adverse social circumstances can cause a so-called "psychosocial crisis" (Filipp, 1990), for which successful management is important for maintaining psychosocial and mental health.

The term psychosocial crisis describes an excessive and overly burdensome demand (Caplan, 1964) and is divided into four stages:

shock, reaction, adaptation, and re-orientation (Cullberg, 1978). In a value-neutral description psychosocial crisis is defined as a decision, turning point, climax or conflict in the broadest sense (Klauer & Greve, 2005). Psychosocial crises are those critical life events that, statistically, have occurred independent of the individuals' behavior and past symptoms of a disorder and are unpredictable and uncontrollable loss events (Klauer & Filipp, 1995). As a risk factor, the accumulation of critical life events must also be considered. Psychosocial crises are perceived, understood and evaluated in a subjective manner, meaning that subjective, personal and individual experience and behavior are the decisive factors for well-being (Ciompi, 2016).

A psychosocial crisis has an external origin, and affected individuals feel stress that goes beyond a maximum subjective burden. In addition,

\* Corresponding author at: University of Applied Sciences, Brodaer Str. 2, 17033 Neubrandenburg, Germany.

E-mail address: [stefie.neumann@googlemail.com](mailto:stefie.neumann@googlemail.com) (S. Neumann).

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individuals suffering from psychosocial crises are at significantly higher risk of developing mental, psychiatric or psychosomatic disorders. Although psychosocial crises in all stages can limit individual performance and social functioning, systematic data about prevalence rates and diagnosis in alignment with the WHO's International Classification of Disorders, 10th Version (Dilling, Mombour, & Schmidt, 1991), are missing. Therefore, specific treatments for psychosocial crises are not outlined. The German health insurance system, based on the Fifth book of the German Social Code (SGB V; Sozialgesetzbuch V), does not cover the therapeutic costs of a psychosocial crisis.

Under the assumptions that psychosocial crises are considered to be a precursor to mental disorders, the described significant deficit in healthcare and health-related care systems is particularly noticeable in rural areas (Jacobi, 2009; Jacobi et al., 2014), where mental disorders are often occur because of social dynamics and demographic transformations (Glaesmer, Gunzelmann, Martin, Brähler, & Rief, 2008; Hessel, Gunzelmann, Geyer, & Brähler, 2000).

Especially in rural areas, access to all types of potentially effective mental treatments is limited. The major barriers include a lack of care infrastructure (Wagenfeld, 2003), financial concerns such as insufficient coverage problems (Fox, Merwin, & Blank, 1995), and beliefs regarding the appropriateness of treatment, including the stigma surrounding mental health treatment (Jameson & Blank, 2007; Mukolo, Heflinger, & Wallston, 2010).

The current research data on psychosocial crises and interventions are highly inconsistent due to different definitions and interpretations of the concept of psychosocial crisis and therefore are difficult to compare. In addition, to date, no systematic, interdisciplinary and integrated services exist for the care of people experiencing psychosocial crises in rural areas. At a national level, demand, care and effectiveness of prompt outpatient psychosocial counseling and interventions in research and development are increasingly being discussed. However, studies primarily focus on specific disease contexts that are intended to legitimize implementation and action demands (i.e., Diehl & Schneider, 2011; Grabe et al., 2005).

International studies often associate psychosocial crisis projects with specific target groups, such as HIV/AIDS sufferers (Rachlis et al., 2013), individuals with bipolar disorder (Beynon, Soares-Weiser, Woolacott, Duffy, & Geddes, 2008), students (Vonk, 1997), or referenced emergency situations in a pastoral context (Perren-Klingler, 2015). In addition, the "mismatch" of psychosocial needs and their care is discussed internationally (Vannieuwenborg, Buntinx, & De Lepeleire, 2015).

Overall, the available data do not explain (1) how people in rural areas manage psychosocial crisis situations, (2) how high their subjective burden is, and (3) what resources and help they provide and utilize in case of a psychosocial crisis.

The investigated district of Mecklenburgische Seenplatte (MSE), which is in the southeast part of the state of Mecklenburg-Vorpommern (M-V) in northern Germany, is the epitome of a rural area with a considerable lack of professional psychosocial aid for psychosocial crises. A total of 261,816 inhabitants live in the district, which has an area of 5470 square kilometers (48 inhabitants per square kilometer); 65,175 of the inhabitants live in the city of Neubrandenburg (NB), the regional center. The present pilot study examined epidemiological data on psychosocial crises caused by various psychosocial problems. In addition, the study examined which aids are utilized in situations of psychosocial crises. It did so by administering an online survey and conducting structured interviews in public places, asking participants about their experiences, needs and attitudes regarding psychosocial crises.

## 2. Methods

The pilot survey addressed the population in the rural area of MSE. Information about the survey was provided via the local print medium

(Nordkurier) and digital media (Facebook pages of the district, the city and NB surrounding areas). The entire study took place over a period of five months (01.03.2016 to 31.07.2016).

A uniform questionnaire was provided to the participants 1) via web-based software ([http://ww3.unipark.de/uc/sozialer\\_versorgungbedarf/](http://ww3.unipark.de/uc/sozialer_versorgungbedarf/)) and 2) in personal interviews at public places in Neubrandenburg using exactly the same questionnaire as that was used online.

Before answering the questions, respondents were informed in writing (online) or verbally (face-to-face) about the meaning and purpose of the study. Subsequently, the term "psychosocial crisis" was defined to the participants. Prior to answering the first question, participants were required to confirm that they are at least 18 years old and participating voluntarily and that they could discontinue their involvement at any time. Additionally, they were assured that the survey and evaluation were anonymous so that they could not be personally identified.

The questionnaire was developed by the authors of the study and focused on the subject of psychosocial crises. The interview procedure was based on the questionnaire; interview questions were posed exactly according to the questionnaire.

In summary, the online questionnaire as well as the structured interviews included open and closed questions with dichotomous answers (yes/no) or answers on four- and five-point Likert scales. In the online version, no questions could be skipped, and the answers could not be changed. Participants were asked about any psychosocial situations they experienced that resulted in psychosocial crises and about how they handled these situations. In detail, participants were asked, using a Likert scale, about the individual relevance of their psychosocial life (i.e., family, marriage/partnership, occupation, residential situation, etc.); their psychosocial crisis (the following possibilities were presented to the participants: current, over the past 24 months, ever); the degree of the burden of problem situations; their utilization of aid (variants that could also be combined were partners, children/parents, relatives, friends, neighbors, general practitioners, other specialist physicians, counseling centers, psychotherapeutic psychologists, psychiatrists); and their utilization of aid to address (a) somatic/health problems, (b) mental health and psychological disorders, and (c) social problems (possible answers included four options ranging from "in any case" to "not at all"). In addition, they were asked to give dichotomous answers to questions about professional psychosocial counseling centers, specifically in relation to their knowledge about the centers, and their sources of information, and they were asked to give answers based on a Likert scale about their preferred attributes in consultants (possible answers included four options ranging from "in any case" to "not at all"). The parameters of the demographic data were age/year of birth, gender, and employment status.

A unique feature of the online version of the questionnaire was that, at the end of the survey, the "Done" button had to be used to submit the content.

The mixed methods approach was chosen because it resulted in a higher response rate for the interview procedure and enabled the highest possible degree of privacy to reduce the proportion of socially desired answers.

The analysis was performed with SPSS. Mean values (MV) are given with standard deviations (SD); p-values are generated by t-tests and are given with confidence intervals (level 95%). The study was approved by the responsible ethics committee (Neubrandenburg University of Applied Sciences; Reg.-No: 207.06.15/Ilgoe).

## 3. Results

### 3.1. Sample

A total of 399 subjects participated in both surveys (online questionnaire + interview). Respondents were 18–83 years old (mean:

**Table 1**  
Characteristics of independent variables.

		Men	Women	Total
Marital status	Single	43	58	101
	Unmarried with partner	28	138	166
	Married	19	78	97
	Divorced	6	17	23
	Widowed	2	7	9
Total		98	298	396
Employment status	Employed	49	115	164
	Only opportunity job (no student)	0	5	5
	Unemployed	6	20	26
	Retired	7	19	26
	Student	37	136	173
Total		99	295	394

32.86 years old, SD = 12.81); 75.1% were women (n = 299), and 24.9% were men (n = 99). More details are given in Table 1.

3.2. Relevance and satisfaction of psychosocial issues by gender

As indicated on a scale of 1 (not important/satisfied) to 5 (very important/satisfied), the areas of "health", "family", and "marriage/partnership" were most relevant. Almost all respondents felt that health was important or very important (91.1%, n = 359, MV = 4.49 SD = 0.874), but not even half of the respondents were satisfied or very satisfied with their health (47.3%, n = 186, MV = 3.32, SD = 0.967). The findings were similar for family life (importance: 84.0%, n = 331, MV = 4.37, SD = 1.062, compared to satisfaction: 65.2%, n = 257, MV = 3.79, SD = 1.013).

In the gender comparison, women ranked all areas significantly higher than men: family life (t-test, p = .000, CI = -0.719/-0.278), partnership (t-test; p = .000, CI = -0.723/-0.253), health (t-test, p = .002; CI = -0.478/-0.112), income and financial safety (t-test, p = .038, CI = -0.435/-0.012), and occupation and career (t-test, p = .008, CI = -0.545/-0.084). In addition to the three areas of health, friends and leisure, women were happier than men; however, significant differences were found only in family life (t-test, p = .000, CI = -0.732/-0.315) and in marriage/partnership (t-test; p = .000, CI = -0.974/-0.464). More results are shown in Table 2.

3.3. Psychosocial crisis and degree of burden

Respondents were asked multiple-choice questions about the areas that had caused them problems in the last 24 months. Almost a third (n = 385, 29.5%) of the answers concerned health (both physical and mental). Half of respondents (n = 193, 50.1%) had physical symptoms and almost one third (n = 129, 33.5%) had mental symptoms in the last 24 months. Slightly less than half of the respondents (n = 176, 45.7%) reported experiencing family problems or marriage/partnership problems (n = 153, 39.7%). A total of 143 (37.1%) respondents identified problems with managing agencies and public authorities (such as the German "Job Center" for long-term unemployed people, "Employment

Agency" for unemployed people, "Public Social Welfare Office" for socially disadvantaged people, "Public Health Office" etc.), and 129 (33.5%) were dissatisfied with the circumstances surrounding their job.

Other frequently mentioned problems included isolation and loneliness (n = 60, 15.6%), housing situations (n = 57, 14.8%), unemployment (n = 50, 13.0%) and long-term care of relatives (n = 40, 10.4%). An overview of the areas of life associated with a psychosocial crisis is shown in Fig. 1.

Only in the long-term care of relatives were there gender differences (t-test, p = .008, CI = -0.164/-0.024); the caregivers were primarily female. Conversely, men reported significantly more problems in the areas of legal drug addiction (p = .017, CI = 0.012/0.125) and unsatisfactory housing conditions (p = .014, CI = 0.019/0.169). Women and men did not fundamentally differ in the problems that had occurred.

If the respondents were confronted with one or more of the aforementioned psychosocial crisis in the last 24 months, they were asked to estimate the extent of the stress on a scale from 1 (low burden) to 5 (high burden). A t-test with a mean test value of 3 showed significant results (MV = 3.53, SD = 1.015, p = .000, CI = 0.42/-0.63). Overall, women reported higher burdens more frequently than men (t-test: p = .015; CI = -0.576/-0.062).

3.4. Utilization of aid

In the next step, the respondents were asked multiple-choice questions about where they sought help for a psychosocial crisis they had suffered. More than half of them (n = 246, 64.4%) turned to friends and acquaintances, slightly fewer turned to marriage/life partners (n = 227, 59.4%) and just under half turned to children or parents (n = 176, 46.1%). Approximately one in ten did not use any help at all (n = 43, 11.3%), sought help on the internet and forums (n = 39, 10.2%), or consulted a general practitioner (n = 37, 9.7%). Additionally, 5.8% (n = 22) sought help from psychotherapists, psychologists or psychiatrists, and only 3.1% (n = 12) used a social service or counseling center.

There were gender differences in the use of aid: men reported more often than women that they did not seek help at all (t-test, p = .017, CI = 0.015/0.148). Women more often consulted their partners (t-test; p = .001, CI = -0.295/-0.081) or used social facilities and counseling centers (t-test, p = .048, CI = -0.082/0.000).

As expected, younger respondents (t-test with a test value of 30 years) turned to their parents (p = .003, CI = -0.253/-0.051) as well as to friends and acquaintances (p = .001; CI = -0.256/-0.062). In contrast, older respondents more often visited general practitioners (p = .000, CI = 0.054/0.171) or other specialists (p = .012, CI = 0.011/0.094). Only one difference became apparent in relation to employment, which is that non-employed persons were more likely to have no aid (p = .036; CI = -0.133/-0.004).

Three-quarters of respondents (n = 283, 76.5%) would only begin an active search for help if they reached a burden level of 4 (MW = 4.08, SD = 0.958), as measured by the stress scale.

In addition, the respondents were asked to indicate what level on

**Table 2**  
Means of relevance of and satisfaction with psychosocial life areas using Likert scales (1 = not important/ not satisfied, to 5 = very important/ very satisfied).

	Relevance MV (SD)			Satisfaction MV (SD)				
	N	Men	Women	Total	N	Men	Women	Total
Family life	394	3.99 (1.192)	4.49 (0.989)	4.37 (1.062)	394	3.40 (1.156)	3.92 (0.930)	3.79 (1.013)
Marriage & partnership	389	3.87 (1.220)	4.36 (1.054)	4.24 (1.114)	392	3.13 (1.308)	3.84 (1.158)	3.67 (1.235)
Health (somatic/mental)	394	4.27 (1.000)	4.57 (0.819)	4.49 (0.8740)	393	3.43 (0.867)	3.28 (0.998)	3.32 (0.967)
Housing situation	394	3.83 (1.012)	4.02 (0.926)	3.98 (0.950)	393	3.74 (1.059)	3.83 (0.978)	3.80 (0.996)
Leisure & hobbies	394	3.94 (0.904)	3.85 (0.978)	3.87 (0.960)	392	3.56 (0.884)	3.43 (0.903)	3.47 (0.901)
Friends & acquaintances	394	4.05 (0.933)	4.13 (0.937)	4.11 (0.935)	393	3.77 (0.888)	3.74 (0.878)	3.75 (0.881)
Income & financial safety	394	3.84 (1.182)	4.07 (0.941)	4.02 (1.009)	393	3.13 (1.136)	3.13 (1.101)	3.13 (1.107)
Occupation & career	390	3.73 (1.189)	4.04 (1.040)	3.97 (1.086)	387	3.42 (1.154)	3.42 (1.038)	3.42 (1.066)

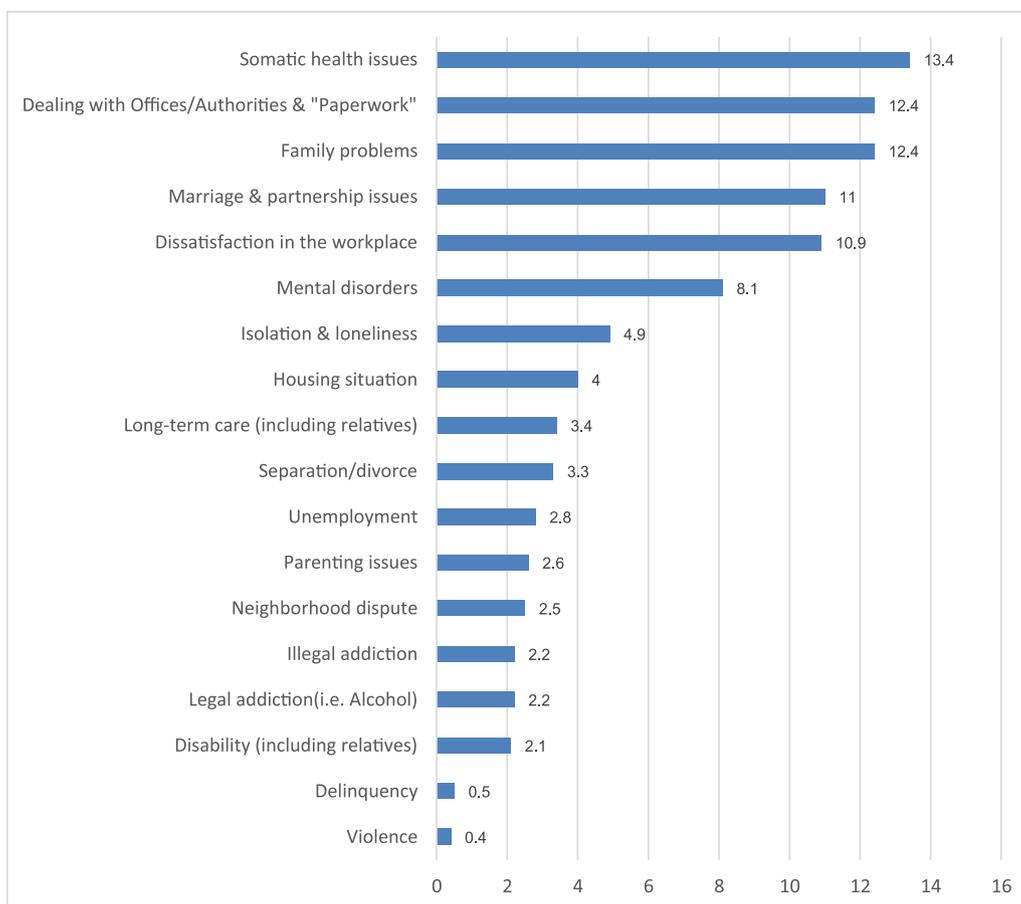


Fig. 1. Frequencies of crises of the last 24 months in%.

the stress scale of 1 (low) to 5 (high) they would have to reach before actively seeking aid in the first place. Overall, the highest level of stress felt was for mental health problems (MV = 4.20, SD = 0.870), followed by somatic health problems (MV = 4.09, SD = 0.833) and then social problems (MV = 3.99, SD = 0.924).

The level of stress at which respondents would seek help with mental health problems was lower among men (MV = 4.08, SD = 0.990) than among women (MV = 4.23, SD = 0.827). Concerning marital status, there were no differences.

### 3.5. Mental health problems – who helps?

Finally, in relation to a) somatic/health, b) psychological/mental health, and c) social problems, the respondents answered a hypothetical question about what aid they would use. An overview of the utilization of aid is shown in Fig. 2.

With regard to a) and b), the utilization of aid to address mental health problems should be discussed in more detail. Women and men did not differ in their utilization of aid to address mental health problems. Over age 30, respondents increasingly used primary care physicians ( $p = .000$ ; CI = 0.963/–0.452), other medical specialists ( $p = .000$ ; CI = –0.856/–0.249) and psychotherapists ( $p = .001$ ; CI = –0.740/–185); over age 60, respondents turned to agencies and public authorities ( $p = .000$ ; CI = –1.271/–0.364). Respondents who were employed used general practitioners ( $p = .000$ ; CI = –0.729/–0.296) and other medical specialists ( $p = .003$ ; CI = –0.581/–0.116). Non-working people reported a lower level of burden at which they would actively seek aid (MV = 4.11, SD = 0.898,  $p = .000$ ; CI = 0.125/0.387).

### 3.6. Conditions of professional consultative services

Counseling centers were underrepresented as a source of targeted psychosocial support, although more than half of the subjects knew about counseling centers in the vicinity, e.g., for family, unemployment or care ( $n = 205$  each, 65.7%), disability ( $n = 217$ , 69.6%) and addiction ( $n = 190$ , 60.9%). They obtained information from friends ( $n = 207$ , 60.2%), the internet ( $n = 170$ , 49.4%) or family members ( $n = 141$ , 41.0%). A quarter of respondents ( $n = 83$ , 24.1%) obtained information from agencies and public authorities, and approximately one in five ( $n = 66$ , 19.2%) obtained information from primary care physicians.

Almost all subjects would prefer personal counseling ( $n = 319$ , 90.6%); the gender of counselors would be insignificant for most of them ( $n = 266$ , 74.7%). On a scale of 1 (not relevant at all) to 5 (very important), respondents indicated that empathy (MV = 4.68, SD = 0.705) and solution demonstration (MV = 4.34, SD = 0.896) were relevant. As indicated on the same scale, confidentiality (MV = 4.39, SD = 1.333) and the qualifications of personnel (MV = 4.20, SD = 1.285) at a counseling center were considered significant. If a general practitioner referred respondents to a counseling center ( $n = 55$ , 15.6%), the majority ( $n = 43$ , 78.2%) would accept the reference.

## 4. Discussion

The pilot survey focused on problematic psychosocial situations, their subjective meaning and the knowledge and utilization of different health care or healthcare-related systems in a rural area of the federal state Mecklenburg-Vorpommern in Northern Germany.

The results show strong preferences in relation to somatic and

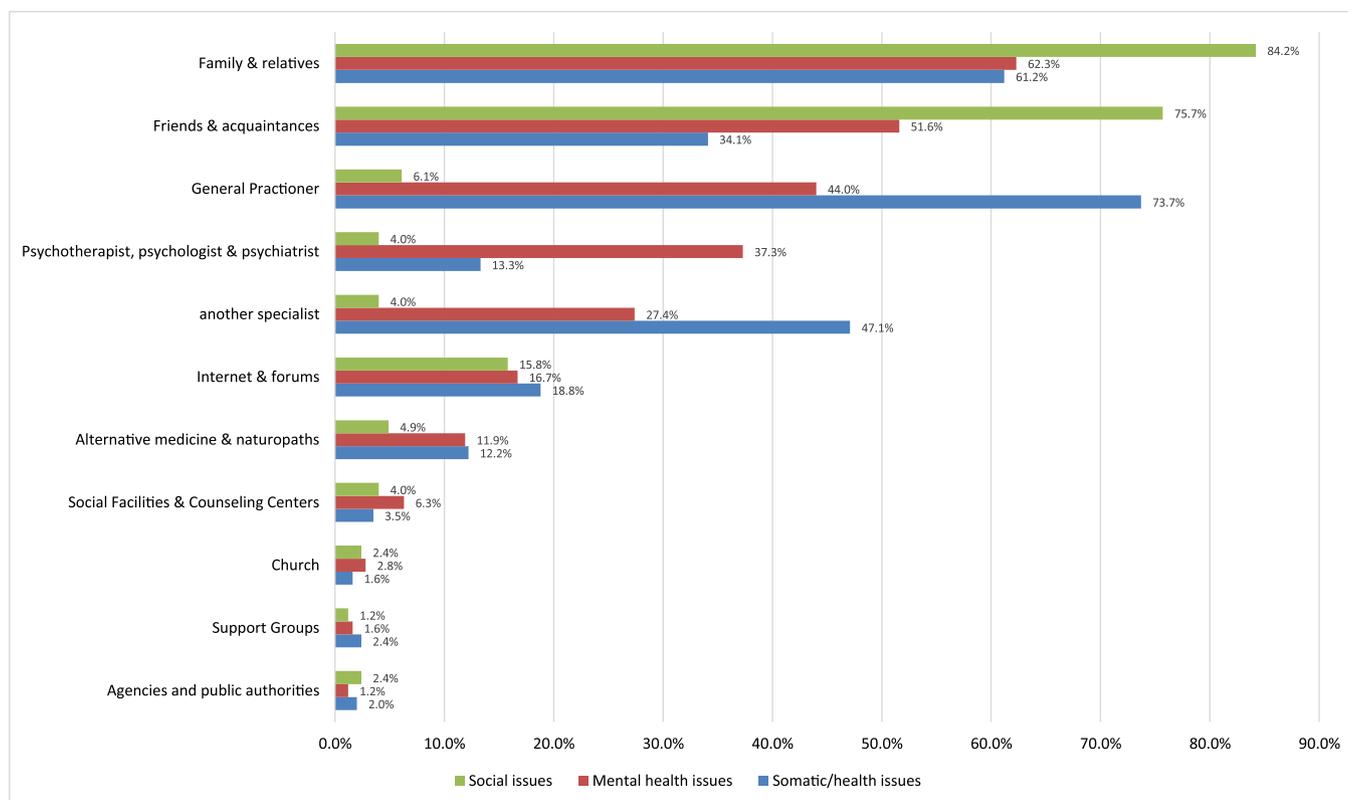


Fig. 2. Primary search for aid based on the type of psychosocial problems/issues (social, mental, somatic).

mental health problems and simultaneously a low level of satisfaction, which confirms previous findings (i. e., Hinz, Hübscher, Brähler, & Berth, 2010). The pilot study data on the subjective assessment of the presence of physical and mental disorder symptoms are in line with the prevalence data of the Adult Health Study in Germany (DEGS) (Kurth, 2012).

Regarding family life, nearly half of all respondents in the pilot study reported family problems. In this and many other psychosocial areas, women reported a significantly higher relevance than men. The higher relevance of family problems among women is in line with ample evidence in previous studies (Hormann, 2013; Jurczyk & Thiessen, 2011; Liebold, 2013). Furthermore, in alignment with other studies, women are exposed to high levels of stress (Hapke et al., 2013) associated with, e.g., family care activities (Jacobs, Schwinger, Klauber, Greß, & Kuhlmeier, 2016) or the challenge of reconciling work and family life (Richardson, Traavik, & Burke, 2016; Stockman, Bonney, & Sheng, 2016). They are more satisfied overall with their family life than men.

Moreover, one in ten respondents identified common psychosocial crises, e.g., social isolation or unemployment, as problematic. First, the influence of objective and subjective social isolation, in general, is a risk for a higher mortality rate (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015) and impairs psychosocial functioning, particularly mental and physical well-being (Cacioppo & Cacioppo, 2014). Second, being employed or working in precarious conditions is a risk factor for health problems, especially among young people (Vancea & Utzet, 2017).

With regard to legal drug addiction, men in our study showed significantly more problems. However, because of the lack of differentiation between legal and illegal drugs in our study, the results are difficult to compare to those of other studies. In Germany, men have a higher rate of consumption of legal drugs such as alcohol and tobacco but not prescription drugs (de Matos, Atzendorf, Kraus, & Piontek, 2016).

To address a psychosocial crisis, the majority of the respondents

chose informal help systems consisting of family members and friends, and approximately one out of ten participants sought online help or did not use any help at all. With regard to the utilization of general health services, the pilot study showed that older respondents in particular visited general practitioners. This confirms the results of previous studies showing that primary care physicians are viewed as the appropriate providers in cases of not only physical distress but also psychological and psychosocial distress (Jacobi, Klose, & Wittchen, 2004), especially among older people (Lehnert & König, 2012). On the one hand, this aspect can be explained by the current waiting times: a primary care consultation has a waiting period of one day (Schellhorn, 2007), whereas waiting times for the first appointment in a psychotherapeutic practice in the district of M-V is more than 18 weeks (Federal Chamber of Psychotherapists, 2011). This may support and explain the findings of the present study. On the other hand, the disproportionate utilization of consulting centers recommended by general practitioners underlines the gatekeeper system in German healthcare (Höhne, Jedlitschka, Hobbler, & Landenberger, 2009; Zentner, Garrido, & Busse, 2010): General practitioners are responsible for channeling, steering or guiding clients (Hessel, Geyer, & Brähler, 2000).

The observed gender differences in the use of help may be related to the fact that men often do not seek help at all, whereas women use social services and advice centers much more often, at least in the present pilot study. Both results replicate the findings of previous studies (i.e., Thode, Bergmann, Kamtsiuris, & Kurth, 2005).

A characteristic result of our study is that unemployed people often did not seek help for mental health problems. However, when they were actively seeking help, they paradoxically needed a lower level of stress at which to do so than those in gainful employment. One explanation may be that in our culture, the search for external support is mostly associated with negative attributions. Additionally, the acceptance of support during a psychosocial crisis may be related to personal experiences such as failure, stigmatization, or a sense of incompetence (Kieselbach, 1990). In contrast, employed male and female

respondents' use of primary care physicians, other medical specialists, and psychotherapists can be explained by the fact that this group is increasingly subject to socioeconomic-related needs (e.g., job retention, recovery with so-called "sickness certificates") (Herrmann, Haarmann, & Bærheim, 2015). Regarding mental health, utilization of help, and the prevention of crisis, some research questions remain open. Future studies would need to provide more results of comparisons of employees and unemployed individuals or explicitly focus on unemployed individuals.

Overall, it remains unexplained why designated counseling centers and social services are not recognized as professional help and do not appear to be an alternative for many respondents without general practitioners guiding them to the aforementioned treatment options. In our sample, professional services were generally not used: however, information on counseling centers is available. Respondents' ideas about counseling centers and their conditions correspond to the characteristics of family-oriented or self-help-oriented help in which trust, interest, empathy, commitment and especially relationship work are relevant. This could also explain the high utilization of the amateur assistance system independently of the problematic situation. This assumption was previously noted by Schomerus (2009) and Grunow (1986a, 1986b).

Overall, previous research has confirmed that social support promotes well-being, especially in rural areas, e.g. Australia (i.e., Kutek, Turnbull, & Fairweather-Schmidt, 2011), specific areas of Africa (i.e., Ae-Ngibise, Doku, Asante, & Owusu-Agyei, 2015) and specific areas of or Asia (i.e., Yip et al., 2007). While stress is detrimental to well-being, social support is the best indicator of well-being and, among other aspects, acts as a stress buffer (Cohen & Wills, 1985). However, various studies often refer to specific diseases such as dementia (i.e., Innes, Morgan, & Kostineuk, 2011), care systems (i.e., Bryant, Garnham, Tedmanson, & Diamandi, 2018) or the target group of the elderly (i.e., Begle et al., 2011). Family and social support is a key resource for well-being, which has been empirically proven in several studies (i.e., Holt-Lunstad, Smith, & Layton, 2010). Based on family social support in families affected by cancer, Rait (1989) describes five categories that might be applicable to psychosocial crises. First, the family gives emotional support regardless of their own consternation. Second, the family is in charge of care decisions, Third, the family is an immediate place of care. Fourth, the family shares burdens in the disease consequence. Fifth, the family is grants stability in change-marked stages of life.

At this point, the field of social work becomes available to promote disease coping and to reduce or eliminate subsequent psychosocial crisis, which, due to method-based interventions, provides emotional relief for families. Social work not only uses knowledge and skills of curative medicine and psychology, it also benefits from adapting attitudes and behaviors adequately according to the occupation and situation (Galuske & Müller, 2012), thus providing intervention needs, imparting necessary knowledge, and providing orientation and solution competence, e.g., with social counseling on social assistance and placement of further help and self-help groups or with psychosocial crises counseling with comprehensive information transfer.

Respondents' perceptions of insufficient care also suggest that the acceptance and knowledge of psychosocial care in the population are relatively low; similar findings were reported by Hessel et al. (2000) for the use of psychotherapy. However, in the case of non-use of psychotherapy, the aspect of (self-) stigmatization may play an important role (Schomerus, 2009). Another reason could be the long waiting times, which are well known in the population. In 2017, the psychiatric guideline was adapted in Germany, and it now includes a stipulation for the introduction of psychotherapy emergency rooms. In this way, the problem could be partially addressed in the future. User data that can be compared to these findings in the district of MSE are not yet available.

Further essential reasons for the lack of medical/psychological

assistance include individual and social barriers, a deficit of knowledge and motivation, a lack of low-threshold medical and/or psychological treatment services, and a lack of care services in the outpatient setting, as previously noted by Görden and Engler (2005) as well as Spitzbart (2004). However, people in psychosocial crises require timely professional help in the form of low-threshold, individual and psychosocial care services to address acute problems in the personal, health and social lives of clients and their families. In the long term, psychosocial care should be designed to occur in an outpatient setting and be more client-oriented, similar to the "Act on the Further Development of Care and Compensation for Psychiatric and Psychosomatic Benefits", which came into effect on January 1, 2017, and promotes in-patient-equivalent psychiatric treatment in the home environment (Gemeinsamer Bundesausschuss, 2017). Ensuring multi-professional health and social care treatment teams could treat people who have psychosocial crisis conditions on an outpatient basis or in their usual living environment (home treatment). Through appropriate permanent therapy contacts and integrated multimodal psychiatric-social work treatment, individual assistance might also be used.

## 5. Limitations

It is important to note the limitations of the study. It is a non-representative study with a small sample; the data therefore do not facilitate reliable conclusions about the whole population. The results are not representative of Germany or other countries, and they are not representative of non-rural areas with other characteristics in patient-centered or client-centered care. Furthermore, the study included significantly more women than men, so there is a gender bias that limits the generalization of the data. Additionally, the sample was formed through convenience sampling. The presented data must be considered pilot or preliminary data.

The mixed-method approach of the present study is a methodological strength, as it was selected to ensure the recruitment of elderly study participants who often do not have online access or often do not like online media. Furthermore, the interviewers were instructed to ensure that the questionnaire was answered in a structured manner to obtain quantitative data.

However, the two methods used have a different degree of privacy, which leads to different directions of results. The chance of socially desirable and influenced responses was not negligible in the structured interviews and must therefore be taken into account in the interpretation of the data.

## 6. Conclusion

The results of the study may seem to suggest that although psychosocial crises persist in the rural population, knowledge of psychosocial care services is low among clients. If additional medical, psychological or psychiatric outpatient treatment and care services are lacking or clients fail the reimbursement criteria for any type of mental disorder and its treatment, they fall through a "grid of care".

A possible solution could be an association of interdisciplinary psychosocial service providers who could adequately care for the rural population with psychosocial crises. The networking of different sectors through the cooperation of medical and non-medical professions, e.g., social work, could ensure transitional or alternative care. Psychosocial counseling centers need to be accepted and funded to become part of the "care landscape".

## Conflicts of interests

The authors confirm that there are no conflicts of interest.

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