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THE INFLUENCE OF INCOMER STATUS: THE ROLE OF RURAL
BACKGROUND, KNOWLEDGE OF MENTAL HEALTH SERVICES, STIGMA,
AND CULTURAL BELIEFS ON HELP-SEEKING ATTITUDES

by

Sarah E. Herzberg

A DISSERTATION

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Under the Supervision of Professor Michael J. Scheel

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THE INFLUENCE OF INCOMER STATUS: THE ROLE OF RURAL
BACKGROUND, KNOWLEDGE OF MENTAL HEALTH SERVICES, STIGMA,
AND CULTURAL BELIEFS ON HELP-SEEKING ATTITUDES

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University Of Nebraska, 2013

Adviser: Michael Scheel, Ph.D.

The purpose of this study was to explore the impact of incomer status, rural background, knowledge and familiarity with mental health services, rural cultural beliefs about mental health and perceived stigma on help-seeking attitudes in a rural Southwest Iowa area. Participants were 106 rural residents over the age of 18 recruited from a rural health clinic. A multiple regression analysis was performed resulting in rural cultural beliefs about mental health being the only statistically significant predictor of help-seeking in the model. Individuals who indicated identifying with rural cultural beliefs were less likely to report positive help-seeking attitudes. Implications of the findings for rural researchers and practitioners are discussed.

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CHAPTER ONE: INTRODUCTION TO THE PROBLEM

Obtaining and providing mental health treatment in rural areas comes with many challenges. The New Freedom Commission on Mental Health's Subcommittee on Rural Issues presented a paper in June 2004 documenting the barriers that impact utilization of mental health services in rural areas offering the conclusions that individuals seeking treatment for crisis 'medical care' will utilize a system that is responsive to their needs and individuals will find a similar structure and experience whether they live in a rural location or an urban setting. The same responsiveness has not been the case when considering mental health care and the structural and experiential limitations are especially significant in rural America. Rural residents face the barriers of availability, accessibility, and acceptability of mental health treatment and as a result have a very different "experience of care" in comparison to medical care. The shortcomings of mental health care in addressing the mental health needs of rural individuals results in a "delay of care, inconsistent care, or no care." (New Freedom Commission on Mental Health, 2004, p. 1).

Given the above mentioned mental health shortcomings in rural areas, this study was designed to focus on barriers to mental health treatment in rural areas by specifically addressing factors that influence help-seeking attitudes and behaviors. Previous research is limited in addressing mental health help-seeking in rural areas. Researchers have addressed barriers to mental healthcare (Fox, Blank, Rovnak, & Barnett, 2001; Smalley, Yancey, Warren, Naufel, Ryan, & Pugh, 2010), utilization of mental healthcare (Smith, Peck, & McGovern, 2004), and access to mental healthcare, (Safran, Mays, Huang,

McCuan, Pham, Fisher, McDuffie, & Trachtenberg, 2009; Stamm, Lambert, Piland, & Speck, 2007).

A complicating factor is noted by Nicholson (2008) who suggests that research is encumbered by what is meant by “rural”, a term that is very difficult to define. She states that the definitions of rural and urban are more fluid than fixed. Nicholson identifies the reality that boundaries change, by rural areas being absorbed into urban areas. She also points out that in today’s society individuals are more mobile, moving from rural to urban settings and vice versa. An individual who lives in a rural area may not have been born there and thus, may embody a very different cultural background than local peers or neighbors. She explains that rural communities are likely to consist of individuals who are both local to the area and others who are incomers or new to an area. She suggests that this distinction is often not made in research, having significant repercussions in understanding the “true” picture of rural mental health.

Research already riddled with the challenge of defining rurality, is more likely to look at current residence as opposed to place of birth. A need exists to research the differences between individuals who are “local” to a rural area versus individuals who are “newcomers” as, “attitudes to mental health, help –seeking behaviors, and actual mental health may differ greatly between these two groups” (Nicholson, 2008, p. 5). Although Nicholson does not specify how the groups differ, if this is, in fact, the case, outreach programs with the resources used to meet the needs of rural residents may need to make use of a broadened approach to effectively target individuals who fail to seek needed treatment due to rural cultural beliefs and attitudes that are counter to a willingness to

seek mental health services. Mental Health treatment may need to be more culturally congruent or at least culturally sensitive to rural culture.

Purpose of the Study

The purpose of this empirical study was to explore factors partially based on previous research by Aloud (2004) that influence the dependent variable, help-seeking attitudes in rural individuals residing in Southwest Iowa, and will make a cultural distinction between participants by assessing degree of rurality. Further distinctions were made by identifying individuals on a continuum defining them as more local or more of an incomer based on their self-report, as well as by questions assessing their connectedness and engagement in their current community. The study specifically examined the influence on help-seeking attitudes of the following variables: a) Rurality; b) Incomer status; c) Rural cultural beliefs about mental health; d) Knowledge and familiarity with mental health services; e) Perceived stigma toward mental healthcare; and f) Use of informal help-seeking resources.

Rurality and Incomer Status

There is much discussion in the literature regarding how rurality is to be defined. This study used a multidimensional approach. Based on research by Jones-Hazledine, McLean, and Hope (2007), rurality was assessed by participants completing a demographic questionnaire asking them to respond to the following items: What is the population of your current residence; What is population of the place you have spent the majority of your life as well as classifying their current residence on a continuum from farm residence to town residence. Participants then rated themselves on a continuum of

1-5. One represented “rural” or a country person and 5 represented “urban” or a city type person. A single rurality score was derived from summing all the rurality items.

Individuals were asked to identify themselves on a continuum as either a local or an incomer and respond to survey items that explored their connectedness to their current community resulting in measuring the variable of local and incomer status. Items included responses to comfort level in their community as well as how their values matched their current community. It was hypothesized that by further defining rural individuals as more local or more of an incomer, further distinctions could be made within a rural population.

Theoretical Framework

Aloud (2004) in his work studying help-seeking within Arab-Muslim culture created a framework for exploring help-seeking attitudes entitled Help-Seeking Pathways for Arab-Muslims (HSPAM). Based on past help-seeking models and theories (Cauce, Domenech-Rodriguez, Paradise, Cochran, Shea, Srebnik, & Baydar, 2002; Goldsmith, Jackson & Hough, 1988; Kaudushin, 1969; as cited in Aloud, 2004; Wills and Depaulo, 1991) and the literature on the Arab-Muslim culture, Aloud identified the most influential variables affecting help-seeking attitudes for this population to include, “cultural and traditional beliefs about mental health problems, knowledge and familiarity with formal services, perceived societal stigma, and the use of informal-indigenous resources” (Aloud, 2004, p. ii). The proposed research adapted Aloud’s model and research to rural culture with the purpose of capturing the influences of rural culture and of local and incomer cultures or degree of incomer status on participants’ help-seeking attitudes.

Aloud (2004) initially proposed a three stage model of help-seeking (HSPAM) involving 1) Problem recognition; 2) Decision to seek help; and 3) Service selection. Each stage is influenced by a set of identified factors. Problem recognition is impacted by (a) cultural beliefs, (b) knowledge of mental health problems, and (c) health styles. The decision to seek help is influenced by (a) perceived stigma, (b) attitudes toward providers, and (c) a family or community network. Service selection, in turn, is influenced by (a) use of informal resources, (b) awareness of formal resources, (c) acculturation level as well as both (d) institutional and economic factors. All stages are influenced by the demographic variables of age, education and income and the model itself is umbrella-ed by Arabic and Islamic Culture. The proposed study was guided by a modification of Aloud's framework in adapting it to rural culture. (See Figure 1.)

Proposed through the current study and based on the help-seeking literature involving rural populations (Fuller, Edwards, Procter, & Moss, 2000; Hoyt, Conger, Valde, & Weihs, 1997; Jackson, Judd, Komiti, et al., 2007; Judd, Jackson, Komiti, Murray, Fraser, Grieve & Gomez, 2006), Aloud's HSPAM model was modified to explore help-seeking attitudes in a rural population.

Aloud emphasizes that the framework of his model is quite expansive and would require multiple studies to validate. Thus, as an initial step, Aloud simplified the model to explore the attitudinal component of help-seeking. Help-seeking attitude is also an identified area of need when considering rural populations. Attitudinal factors in rural areas have not been extensively explored and warrant further research (Jackson et al., 2007). Thus, the current study focused exclusively on attitudes toward help-seeking of

individuals in rural areas and also investigated the distinction between individuals who were new to rural areas (incomers) and those who were local to rural areas. Consistent with Aloud's model, help-seeking attitudes included the influence of beliefs about mental health, knowledge and familiarity of services, use of informal services, and perceived stigma toward mental health (see Figure 2).

The Hypothesized Rural Help-Seeking Model

In summary, the HSPAM framework, as stated above, was modified to explore help-seeking attitudes of a rural population. Attitudinal factors derived from Aloud's model assessed in this study were (1) rural culture and traditional beliefs about mental health; (2) knowledge and familiarity of mental health services; (3) perceived stigma; and (4) the use of informal resources such as church and family (See Figure 3). Rurality was assessed through a method that combined population of current residence, living situation, population of the place an individual has lived the longest and a self-report of perceived rurality (Jones-Hazledine et al., 2007). Local versus incomer status was assessed by individuals self-identifying as more local or as more of an incomer along with survey questions that assessed connectedness to the community.

Research Questions

Thus the following independent variables were relevant to the proposed investigation: (1) rurality; (2) incomer status; (3) beliefs about mental health; (4) knowledge and familiarity about services; (5) use of informal services; (6) perceived stigma. The cogent dependent variable was help-seeking attitudes. The research questions to be investigated were:

1. How do rurality and incomer status influence help-seeking attitudes in a rural context?
2. What are the predictive and comparative contributions of the following variables to the prediction of help-seeking attitudes of rural residents in the Southwest Iowa area: (a) Rural cultural beliefs about mental health; (b) Knowledge and familiarity with mental health services; (c) Perceived stigma (d) Use of informal resources; (e) Degree of rurality; (f) Degree of incomer status?

Hypotheses

Research Hypothesis 1: Rurality, incomer status, rural cultural beliefs about mental health, knowledge and familiarity with mental health services, use of informal services and perceived stigma will form a statistically significant predictive model of help-seeking attitudes in a rural population.

Research Hypothesis 2: Rurality and incomer status will be the strongest predictors of help-seeking attitudes with rurality and help-seeking having a negative correlation and incomer status and help-seeking having a positive relationship.

Table 1

Predicted Correlations

	Rural Cultural Beliefs	Knowledge and Familiarity of Resources	Perceived Stigma	Use of Informal Resources	Help-Seeking
Rurality High	+	+	+	+	-
Incomer Status	-	-	-	+	+

Significance of the Study

A study exploring the impact of rural background on help-seeking attitudes is important for several reasons. Using a multidimensional measure of rurality and identifying research participants by incomer status may help to discern a more complete picture of rural culture and its influence on help-seeking attitudes. Differences between individuals who are more local or more of an incomer can inform practitioners and clinicians in their efforts to reach out to individuals who need mental health treatment but for a variety of reasons are not seeking it out. This is particularly important as research suggests that although the prevalence of mental health issues tends not to differ when comparing rural to less rural areas, the more rural the area, the higher the suicide rate (Wagenfeld, Murray, Mohatt & DeBruyn, 1994). This suggests that rural people with mental health problems are less likely to address them to prevent a catastrophe such as suicide. Rural local-incomer differences may suggest a need for changes in policy and outreach as the issues confronting each group may be related to group specific barriers. Addressing these barriers could assist rural centers in better meeting the immediate and critical needs of community members.

Delimitations

Delimitations exist when conducting research, as the scope of study has to be narrowed in an effort to make the study feasible. For the current study information was gathered in one administration and was not longitudinal in nature. In addition it is not possible to measure all individuals living in rural areas. Participants were limited to rural residents in Southwest Iowa.

Limitations

There were also limitations. The sample used may lead to restrictions in generalization due to data being gathered in a Midwestern rural community. There are likely differences between rural individuals in the Midwest and other parts of the country. In addition, mental health help-seeking and stigma are sensitive issues which could lead to social desirability bias in participant responses. Demographic information was obtained by self-report which may or may not necessarily reflect reality when individuals are making choices about mental health resources.

Definition of Terms

Rural.

Defining what is meant by rural has been a challenge in the literature (Fraser, Judd, Jackson, Murray, Humphreys, & Hodgins, 2002; Ricketts, Johnson, Webb, & Taylor, 1998). The U.S. Census Bureau defines rural by exclusion, that is, what is “not urban.” They define an urbanized area as an area of 50,000 people or more and an urban cluster as an area having at least 2,500 people and less than 50,000. According to this definition, the 2010 Census suggest that 19.3% of the United States population can be classified as rural within 95% of the countries land mass.

The Office of Rural Health Policy (ORHP) further defines rural based on census tracts. Areas with 400 square miles in area and a population density consisting of 35 people or less per square mile are considered rural. The ORHP definition places 20% of

the nation's population in rural areas consisting of 90% of the area in the United States (United States Department of Health and Human Services, 2012).

Initially using the census framework to obtain a rural sample, the current study used a multidimensional approach to define rurality with participants by having them report demographic information regarding their current residence, the place they have resided the longest as well as through self-report of how rural or country they are versus city or urban.

Incomer.

An incomer is an individual who settles in an area where he or she was not born (Encarta World Dictionary, 2009). A rural incomer was identified as an individual who had spent the majority of his or her life in a rural area, but had relocated to a new rural area. For the current study, incomer status was defined using a self-report continuum, as well as the connectedness and fit an individual reports experiencing as a member of their community.

Stigma.

Blaine (2000) defines stigma as a type of flaw in a person such as a personal or physical aspect that is regarded as being socially unacceptable. Corrigan (2004) further defines two types of stigma: public stigma and self-stigma. Public stigma is a belief or perception that is held by a community or a group about an aspect of an individual that the group sees as socially unacceptable. Vogel, Wade, and Haake (2006) discuss public stigma as that which contributes to individuals being deterred from seeking mental health

services. They further state that the act of seeking mental health treatment is often viewed as “socially unacceptable.”

Help-seeking attitude.

Attitudes are defined as associations between objects in our social world and the evaluation of these objects (Baron and Byrne, 1994). Help-seeking attitudes are defined as one’s evaluation toward seeking assistance. Specifically, for this study the assistance was for mental health problems.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents a review of the literature relevant to the exploration of help-seeking attitudes in rural areas. The need for rural research and the aspects of availability (Are there services and resources?), accessibility, (Can one get to the resources?) and acceptability (Is one willing to utilize resources?) are detailed as they frame the barriers influencing help-seeking attitudes. The multiple dimensions of rurality as well as further distinctions among individuals who are incomers to a rural area were explored. The influences of rural culture on mental health beliefs, knowledge and familiarity with mental health services, stigma and mental illness, and the use of informal resources in rural communities are explored as they pertain to help-seeking in rural communities.

The Need for Rural Research

In recent decades the nation has recognized disparities in mental health. In 2006 the Federal Collaborative for Health Disparities Research (FCHDR) identified mental health disparities as a priority needing attention. Specifically, mental health disparities are substantial when evaluating the needs of rural Americans who lack sufficient access to mental health resources (Safran et al., 2009). In addition to deficits in access to mental health services, Human and Wasem (1991) included availability and acceptability as barriers facing rural populations. With twenty-five percent of individuals in the United States living in rural areas and 90% of the nation's landmass identified as rural (U.S. Health and Human Services Rural Task Forces, 2002), it is imperative that research studies address these disparities.

As early as 1979, organizations identified the need for research to address rural mental health issues to inform policy and practice. Advocacy and coordination of services as well as obtaining qualified professionals to serve rural areas has been emphasized (Cedar & Salasin, 1979). Decades that have followed have seen programs arise to attempt to address rural mental health disparities (Human and Wasem, 1991). However, disparities remain. Even with awareness, rural mental health issues are often “under examined” and unchanged despite efforts to commit to diversity and multiculturalism (Harowski, Turner, Le Vine, Schank, & Leichter, 2006; U.S. Department of Health and Human Services, 2005).

Researchers have explored the impact of these disparities that exist among ethnic minority populations. Recently the “diversification of diversity” has broadened to include rurality. Rural areas present various cultural challenges. Constantine, Hage, Kindaichi, and Bryant (2007) in their work on social justice issues identified nine hallmark competencies to consider when working with diverse cultural populations. The authors identify the importance of being “knowledgeable about the various ways oppression and social inequities can be manifested at the individual, cultural, and societal levels” (p. 25). They go on to encourage counselors to “conceptualize, implement and evaluate comprehensive preventive and remedial mental health intervention programs that are aimed at addressing the needs of marginalized populations” (p. 25). Marginalized populations are groups left out or powerless. The challenges of availability and accessibility to mental health services and deficits in attention to rural needs illustrate the marginalization of this cultural group.

Research is needed to explore issues impacting rural communities. Comparisons between rural and urban areas show a similarity in the prevalence of mental health issues (Wagenfeld et al, 1994). Although prevalence is similar, accessibility and availability of mental health services are not. In addition, the one exception to prevalence is suicide rates. Rural areas have markedly higher suicide rates (Advancing Suicide Prevention, 2005). Specifically research findings show rural teens and older rural adults to have higher rates. This is a trend consistent over time and shows suicide rates to be higher with populations that are identified as more rural (Roberts, Battaglia & Epstein, 1999; Wagenfeld, Murray, Mohatt, & DeBruyn, 1994).

According to Advancing Suicide Prevention (2005), suicide is the second leading cause of death in populations that are largely rural. In the period from 1970-1997, rural males had a 37 percent higher rate of suicide as compared to their urban counterparts. More recent studies show suicide rates to be as much as 54% more prevalent in rural areas as compared to urban areas (Johnson, Gruenewald, & Remer 2009). This data may not reflect the reality of the phenomenon, as close-knit communities may have coroners who are willing, for the sake of a family in the community, to label a death as accidental instead of suicide. In addition, a suicide in a rural community might have a wider impact, as rural areas are characterized as having closer social networks. In an urban setting, most individuals in the area may not have had any contact with an individual who has taken his or her life. However, an individual who takes his or her life in a rural community may have been someone that a community member went to school with or knew through contact at a local convenience store or restaurant.

Potter et al. (2001) suggest a link between suicidality and greater geographic mobility. The proposed study looking at incomer status is being conducted to shed further light on the impact of geographic mobility in rural areas and how this relates to individuals' attitudes toward seeking mental health treatment. If the factors of rurality and geographic mobility are related to an increase in suicidality, further characterizing a rural population based on degree of incomer status may reveal differences in help-seeking attitudes; which in turn is connected to mental health outcomes such as improved treatment and a lower mortality rate. It is possible that an individual's connectedness or lack of connectedness to a community stemming from incomer status could be related to negative mental health outcomes.

Wagenfeld et al. (1994) points out that compared to individuals from urban areas, rural individuals typically seek care later. As a consequence they may present with more serious symptoms requiring more intensive treatment and in some cases treatment too late to save a life. Thus, identifying factors that influence help-seeking attitudes in rural areas is imperative as rural individuals face mental health challenges.

Challenges in Defining Rurality

In addition to other challenges to research in rural areas concerning mental health treatment, there does not appear to be an agreed upon approach to defining rurality. Literature on this topic has suggested that even when rurality is defined more broadly, it does not capture the diversity of a rural population (Nicholson, 2008). Further defining what is meant by rural, by looking at individuals based on incomer status can elucidate the barriers of accessibility, availability, and acceptability that impact rural residence.

As indicated in the existing literature, suicide risk, as well as limits to access and availability of resources indicate that rural mental health issues need to be addressed and research in this area is limited (Fraser, Judd, Jackson, Murray, Humphrey, & Hodgins, 2002; Roberts, Battaglia and Epstein, 1999; Wagenfeld et al., 1994). Cumes (1998) identifies a “vicious cycle.” A lack of research regarding rural issues leads to a lack of information, which, in turn, leads to less funding and less resources. The current study explored help-seeking attitudes in rural individuals by exploring incomer status in an effort to gain an understanding of resources and contexts that can contribute to the development and maintenance of services.

Accessibility

Accessibility implies that a service is obtainable. The issue of accessibility presents challenges in rural areas in regards to knowledge of services available, transportation limitations, and being able to finance treatment (New Freedom Commission on Mental Health, 2004; Nicholson, 2008).

Individuals must know both when they need to seek treatment and where they can go to obtain services. Rural individuals tend to enter treatment later than their urban counterparts (Lambert & Agger, 1995; Wagenfeld et al 1994). Research has suggested that rural residents may enter therapy later because of a perception of not needing therapy. In addition rural people tend to perceive less care being available to them (Lambert & Agger, 1995). Rost, Fortney, Fischer, and Smith (2002) identify that because individuals have a lowered perception of the need for services, even small barriers, when they do seek help may prevent individuals from seeking treatment.

Rural areas are also faced with the dilemma of whether or not to advertise mental health services. There is a need to “market” and provide information regarding available rural mental health resources so that rural individuals can be aware of them. However, this may stretch a system already faced with limited resources. As the current study explored the variable, rural incomers, it was hypothesized that differences may be revealed as these incomers may not be aware of local services and if outreach and advertisement is limited, rural locals may be better informed about established services since they have been part of the community longer than those new to the area.

Access is also hindered by transportation. Rural areas often have very limited access to public transportation. (Murray & Keller, 1991; Nichols, 2008; Strong, Delgrosso, Burwick, Jethwani, & Ponza, 2005). Strong et al. (2005) found that forty percent of rural counties did not have a formal means of public transportation. In addition families may be hundreds of miles from the closest service provider. The nearest treating counselor or psychiatrist may be more than an hour drive, as data suggest that one-third of communities with a population of less than 2500 do not have professionals to address mental health necessities (Advancing Suicide Prevention, 2005).

With rural areas lacking adequate public transportation, this barrier becomes greater as one third of the nation’s poor reside in rural areas (Human & Wasem, 1991). Research shows that distance from available services reduces treatment-seeking behavior with the greater the distance associated with a lower probability of using the service (Veitch, 1995); deficiencies in seeking treatment are further amplified by poverty and low socioeconomic status.

Again, looking at individuals who are identified as rural incomers, additional barriers to transportation may exist. This is specifically the case for low-income incomers, as they may already have limited transportation resources, and may not have information regarding the local public transportation methods that do exist, if in fact they are available.

Rural individuals also face financial barriers in an attempt to access mental health care. Individuals in rural areas are less likely to have private insurance to cover services and have longer periods of time of being uninsured (Strong et al., 2005). In addition to being disproportionately uninsured as compared to their urban counterparts, rural individuals who are self-employed or work for small businesses may face the challenges of being underinsured. They may have basic health benefits for physical issues, but lack mental health coverage (Mohatt, 1997). Low-income rural incomers, depending on from where they have relocated, may not be aware of how to access state or county payment or insurance programs to help pay for services such as Medicaid or county funded sliding scale fee services.

Availability

Rural communities face availability barriers both related to a lack of individual providers and with mental health systems such as hospitalization resources. Often rural areas lack providers that are trained to meet rural cultural needs. In addition, providers that are available may be scarce with eighty-five percent of mental health professional shortages existing in rural areas. Staff may come from urban areas and not have an adequate understanding of rural culture (Bird, Dempsey, & Hartley, 2001; Harding,

Vanpelt, & Ciarlo, 2000; Hartly, Korsen, Bird, & Agger, 1998; NCFMH, 2004) because many graduate programs do not train therapists to work in rural communities (Murray and Keller, 1991). Historically, the recruitment and retention of psychologists and mental health providers who can adequately serve the needs of a rural setting has been difficult (Jackson, Komiti, Fraser, Murray, Robbins, Pattison & Wearing, 2007).

Rural areas often not only have less access to mental health professionals, but also less access to psychiatric hospitalization (Gamm, Tai-Seale, & Stone, 2002; Strong et al., 2005; Wagenfeld, 2000). In fact, in some rural areas psychiatric hospitalization is already virtually nonexistent (Wagenfeld, Goldsmith, Stiles, & Manderscheid, 1988).

Hartley (2004) discussed the boost to rural health that occurred in the late 80's when the Office of Rural Health Policy was charged with addressing the issue of rural hospitals that had been unable to survive. He goes on to reflect that the "preservation" of these hospitals was to ensure "equitable access." The last decade and a half has seen the development of Critical Access Hospitals (CAH). This program is designed to help rural hospitals continue to provide medical services, but results in more limited services being provided, specifically limiting reimbursement for services that are not deemed as "core." Not being identified as a "core" service, in-patient psychiatric services become a casualty. Because there is no funding or reimbursement for services, rural in-patient units are forced to close. With rural areas already being limited as far as psychiatric hospitalization, this has further decreased available in-patient mental health services (Wagenfeld et al., 1994). A decrease of availability of this service may influence an

individual's attitude toward help-seeking if they believe their needs cannot be adequately addressed due to a lack of needed services.

The lack of availability of services becomes even more desolate for specialty populations such as the chronically mentally ill, children, older adults, and minorities. Murray and Keller (1991) identify that some rural communities do not have the necessary resources to support the care of the individual with chronic mental illness. They go on to point out that the individual with a chronic mental illness may be able to blend in, living in an urban area, but in a rural area is "noticed." In addition, Wagenfeld (2000) notes that in rural areas with a population between 2500 and 20,000 often no child psychiatrists are in residence. Further literature illustrates that close to 75% of rural counties have no psychiatrist and 95% have no child psychiatric services (Advanced Suicide Prevention, 2005).

Acceptability

Stigma is a barrier for individuals in rural areas. The New Freedom Commission on Mental Health (2004) identifies stigma in terms of "urban assumptions" as compared to "rural reality." They suggest that the urban assumption is that stigma "is simply an attitudinal barrier to the appropriate use of mental health services that can be overcome with education" (pg. 15). The rural reality, however, suggests that it is difficult for rural individuals to keep their help-seeking private and this public knowledge thus can have an impact in their lives both personally and professionally as the rural environment encompasses close-knit social networks. Mental Health Centers in small rural communities often are challenged by the issue of individuals' vehicles being seen by

friends and/or family when parked at the facility when seeking services. This can impact job opportunities, employment settings, or family relationships.

Acceptability in policy is illustrated, again, through the development of the Critical Access Hospital. The Medicare Rural Hospital Flexibility Program of the 1997 Balanced Budget Act led to the development of the Critical Access Hospital (CAH). Designed as an effort to help financially strained rural hospitals keep services, CAHs are identified as hospitals with less than 25 acute beds, and must be located 35 miles from the nearest hospital. The program resulted in a cost-based reimbursement for core services helping rural hospitals with this designation continue financially (Joynt, Harris, Orav, & Jha, 2011). The program, however, does not provide the same reimbursement for psychiatric services forcing many rural hospitals that have provided in-patient psychiatric care, to close their units. Just as CAHs present a barrier in regard to availability, the policy behind the program illustrates the issue of acceptability in public policy. In-patient psychiatric services are already extremely limited in rural areas. With current policies they face further challenges.

Again the need for rural research is imperative. With individuals being faced with the barriers of accessibility, availability, and acceptability, rural community members seek treatment later, and as suggested by the research on suicidality (Advancing Suicide Prevention, 2005), this can have dire consequences.

Rurality

As stated earlier, defining rurality is challenging. Many definitions exist. Ricketts, Johnson-Webb, and Taylor (1998) identify the concept of rurality as “multidimensional” and several explanations exist because no single description adequately defines it for all uses. Jones-Hazeldine, McLean, and Hope (2007), citing Provose (1996), explain that current definitions of rurality may be best at categorizing rural “places,” but not necessarily rural “people.” The challenge to defining rural people lies in the fact that rural people are diverse people. Thus, including the various aspects of diversity of rural people is a difficult task, yet important to the validity of research conducted about rural people. Identifying individuals as rural incomers can help to further distinguish within group differences.

Common definitions for rurality include Census Bureau Data defining rural areas as areas with fewer than 2500 residents and open areas or frontiers, along with fewer people per square mile (Ciarlo & Zelarney, 2000). Other definitions describe “rural” through exclusion, with rural being defined as land masses that are not urban (Stamm, Lambert, Piland, & Speck, 2007). Researchers argue that when research dichotomizes rural and urban populations to make comparisons the result is very general and can lead to misguided or misleading conclusions (Fraser, Judd, Jackson, Murray, Humphreys, & Hodgins, 2002; McDade & Adair, 2001).

A lack of a cohesive and agreed upon definition complicates both funding issues and policy solutions for improving health care access. This becomes increasingly complex as current definitions do not assess the diversity of rural people. Jordan and Hargrove (1987)

explored the implications of categorical definitions of rurality. They suggest that definitions are often useful for research and policy purposes. However, categorical definitions may inadvertently present a picture of a homogenous rural group.

Addressing gaps in the rural literature, Jones-Hazeldine, Mclean and Hope (2007) addressed the challenge of defining rural solely by categorical means as they explored rural individuals' willingness to seek help from therapists about whom they had prior knowledge. Jones-Hazeldine et al.'s study looked at 153 participants recruited from a rural primary care clinic. Rurality was assessed asking participants to respond to questions such as, "the population of the participant's current community of residence, the length of time they have resided in that area, the name and population of their birthplace, and the name and population of the location in which they have spent the majority of their life" (p. 4). The study also had participants identify themselves as rural versus urban on a five-point scale. The results of the study did not support their hypothesis that level of rurality was associated with an individual's preference for a provider of whom they may have some prior knowledge. However, the study demonstrates that the setting utilized may be termed "frontier" suggesting that there may not have been enough variability to distinguish rural from less rural. Even though a significant result was not found, Hazledine-Jones et al. discussed anecdotal findings as she described research participants asking questions about her rural origin and upon discovering she was from the area and a "local" seemed to be more willing to participate in the study.

The current study utilized a modified version of Jones-Hazeldine et al.'s. (2007) multi-method approach to obtain a broader definition of rurality. In addition, participants responded to questions regarding their connectedness to their community and their personal assessment as to whether they saw themselves as incomers or locals to further explore the dimensions of rural individuals.

Rural Incomers and Rural Locals

Citing the exception of urban drift theory applied to individuals with Schizophrenia, Nicholson (2008) identifies that few researchers explore the impact of place of birth. She goes on to state that there is even less available research looking at the differences between rural locals and rural incomers. Nicholson (2008) goes on to express that this is the case “even though attitudes to mental health, help-seeking behaviors, and actual mental health may differ greatly between these two groups” (p. 5).

Differences are likely to emerge in looking an individual's identification with his or her current community. Individuals who identify as more local to an area may hold beliefs that are more consistent with the community culture and customs. These individuals may have more knowledge regarding the availability of local resources. This could be anything from what mechanic in town does the best work, to the best place in town to get a good meal. It is likely that individuals who are local to an area or who have resided in an area longer would also know more about local mental health resources. Even if it is the case that they do have more knowledge of local mental health resources, they may be plagued with a higher degree of perceived stigma. More individuals in town may recognize their vehicle, should it be parked at a local mental health center or they

may have a current or past social relationship with a mental health center's employee such as attending the same school, church, or other social group.

Incomers to a community face different challenges. Individuals who are not local to an area may have less knowledge of local services and may or may not hold similar cultural beliefs. Individuals who have relocated to an area and have mental health needs may not know what services are available or where to obtain these services. In addition, many rural communities may not have services that are available in the town an individual has relocated too, causing an individual who may already be unfamiliar with a new area to have to further explore surrounding communities.

The goal of the present study was to further explore a rural population by defining individuals based on their self-report of identifying as more of a local or more of an incomer, as well as their connection and engagement within their community. The hope was to explore the differences that may exist between individuals who are local to a community as compared to individuals who are incomers and in turn use the knowledge of differences to improve help-seeking attitudes and behaviors in rural communities.

Influences of Rural Culture on Mental Health Beliefs

As the literature has suggested, it is difficult to define what is meant by rurality. This, in turn, influences the task of exploring rural culture and further exploring its impact on mental health beliefs.

Wagenfeld and Buffum (1983), in their article exploring the problems facing rural mental health services, identified several values of rural clients that can influence the decision to seek mental health treatment. Specifically they identify, "emphasis on

fatalism, orientation to the here and now, self-reliance, beliefs about the nature of man, practicality, and mistrust of outsiders” (Wagenfeld & Buffum, 1983, p. 92). Human and Wasem (1991) further explore the acceptability of seeking mental health services in a rural area echoing Wagenfeld and Buffum (1983) by identifying that rural cultures often have a “tradition” of being self-reliant or taking care of their own problems. They go on to identify that the acceptability of services is influenced by an individuals’ beliefs about what causes mental illness and beliefs about who is the appropriate person to treat it.

The influence of rural culture impacts the lens through which individuals view the world. For the present study, the influence of rural cultural beliefs about mental health was explored as these beliefs impact help-seeking attitudes.

Knowledge and Familiarity with Mental Health Services

Even though recent literature suggests that mental health knowledge and literacy plays an essential role in influencing help-seeking, few published studies explore the knowledge about mental health issues of rural residents (Griffiths, Christensen, & Jorm, 2009). Hill and Fraser (1995) in their study of local knowledge and mental health reform found that mental health reform fails to see that utilization of services is guided by definitions rural individuals have of symptoms and treatment. They refer to this as, “local knowledge.” They go on to state that knowledge and “local beliefs serve as a template for local behavior and the use of local resources” (p. 560). The current study aimed to assess knowledge and familiarity of mental health services within a rural Midwestern population.

Even if individuals are familiar with symptoms that suggest a need for professional help, they may not know where to seek help. Often in rural communities, mental health services may not be located in the town an individual resides creating further barriers regarding knowledge of services. Fox, Blank, Rovnyak, and Barnett (2001) in their study of barriers to help seeking in a rural impoverished population found that nearly fifteen percent of respondents cited “not knowing where to go” as a barrier to seeking mental health care and treatment. Hill (1988) in her study of the rural south found that 80% of individuals who were identified as poor reported being “unaware” of formal mental health resources. Wrigley, Jackson, Judd, and Komiti (2005) found that individuals identified that they would seek help, but didn’t know who to get help from.

Other researchers have identified that the general public does not have sufficient knowledge about mental health treatment (Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2011) and although there may be a plethora of information available it is not always accurate and for some there may be limited access (Thornicroft, Rose, Kassam, & Santorius, 2007).

The present study aimed to assess the knowledge base and familiarity of available mental health services in a Southwest Iowa rural area and the impact of this knowledge on help-seeking attitudes. Research suggests that in order to improve mental health services and service delivery in rural areas, an understanding of local knowledge of symptoms and services is imperative (Hill & Fraser, 1995). Again, further exploring this rural population by looking at degree of incomer status was hypothesized to reveal further information and illuminate barriers that may be present within the group.

Stigma and Mental Illness

Even when individuals identify a need to seek professional help, a fear of being categorized as deficient or different in some way may prevent them from moving forward with seeking treatment. Corrigan (2004) discusses stigma as a social-cognitive process motivating individuals to avoid labels associated with mental illness. Stigma is a form of prejudice involving, cognitive, affective and behavioral aspects (Corrigan, Watson, Garcia, Slopen, Rasinski, & Hall, 2005).

A consensus exists in the general public about the stigma of mental illness (Corrigan & Penn, 1999; Hinshaw & Cicchetti, 2000). A stigma also exists for individuals who suffer from physical disabilities, but there appears to be more disapproval of individuals with mental health issues (Corrigan & Penn, 1999). Research even suggests that individuals anticipate stigma if they become labeled with a mental illness (Day, Edgren, & Eshleman, 2007). This stigma influences help-seeking attitudes and behaviors (Corrigan, 2004).

A study in the *New England Journal of Medicine* found that a fear of stigmatization influenced help-seeking behaviors of soldiers returning home from combat (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004). The study showed that even though some soldiers returned home and struggled with mental health issues such as Post Traumatic Stress Disorder, less than half sought treatment. Wrigley, Jackson, Judd, and Kimiti (2005) found that a positive attitude toward help-seeking is related to lower perceived stigma. In addition, if individuals held stigmatized views of mental health treatment or felt their community held these views, they were more reluctant to seek help.

Bathje and Pryor (2011) identified that stigma is linked to avoiding treatment on two levels. First, people do not want to have the label of being considered “mentally ill.” By not seeking treatment, an individual can avoid knowing if they in fact have a diagnosable mental health concern. Secondly, by seeking help, one is accepting that they are a person in need of help. Corrigan (2004) goes as far as to identify stigma as a “significant health concern” because of its immense barrier to help-seeking. Research findings suggest that stigma not only impacts an individual’s decision to seek treatment, but can also impact their willingness to be open in sessions and continue treatment (Sirey, Bruce, Alexopoulos, Perlick, Rave, Friedman, et al., 2001).

At times the stigma of mental illness may even outweigh an individual’s perception of severity of symptoms. Associated stigma may be seen as worse than the illness (Corrigan & Penn, 1999; Day, Edgren, & Eshelman, 2007). Individuals connect revealing a mental illness with negative consequences (Aromaa, Tolvanen, Tuulari, & Wahlbeck, 2010). Wrigley et al. (2005) found that perceived stigma rather than symptom severity influenced help-seeking. In addition, the act of seeking help may be seen as being just as stigmatizing as the disorder or issue itself (Ben-Porath, 2002).

The impact of stigma not only influences those seeking treatment. Research findings indicate that consumers and practitioners alike ascribe to mental health stigma (Lyons & Ziviani, 1995; Mirabi, Weinman, Magnetti, & Keppler, 1985; Skinner, Berry, Griffith, & Byers, 1995). Stigma not only impacts help-seeking attitudes and behaviors, but can impact self-esteem (Bathje & Pryor, 2011) and achievement of personal goals and aspirations (Corrigan & Wassel, 2008). Wahl (1999) found that stigma resulted in

individuals limiting themselves with employment as well as out of fear that their mental health issues would be revealed.

The issues of stigma in mental health and help-seeking treatment are amplified in rural settings. Thorngren (2003) reflects on the “fishbowl” atmosphere of the rural environment where it is harder to disguise treatment seeking due to individuals living in close proximity with close-knit social groups. Thorngren goes on to identify stigma stemming from the fear of the unknown relationship with a provider. Rural areas present special challenges with rural therapists having multiple roles in a community. Although dual relationships are discouraged within APA guidelines, multiple roles exist with a rural clinician possibly attending the same church as a client or having children in the same school or grade level.

Literature also suggests that stigma is perpetuated by rural culture. The cultural characteristics of a rural environment that encourage autonomy and self-reliance (Kelleher, Taylor, & Rickert, 1992) as well as a mistrust of outsiders (Wagenfeld & Buffum, 1983) encourages stigma.

The present study recognized the influence of stigma on help-seeking behaviors and its impact in a rural setting. If stigma is better understood through research, clinicians and practitioners can be in a better place to advocate for mental health consumers and help treatment use adherence (Corrigan, 2004). By specifically looking at stigma through the lens of rural locals and rural incomers further distinctions can be made as to how help-seeking attitudes are impacted.

Use of Informal Resources

When individuals are confronted with life's difficulties they may choose to seek outside support. Specifically when considering where to turn for help with psychological issues, several studies suggest that individuals are most likely to and prefer to seek help from informal sources instead of formal resources (Boldero & Fallon, 1995; Hight, Hickie, & Davenport, 2002; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Oliver, Pearson, Coe, & Gunnell (2005) found that individuals with minor mental health problems were more likely to seek help from friends and family. Other research has indicated that individuals at times will choose not to seek help at all. Deane, Wilson, and Ciarrochi (2001) found that even when suicidal ideation is present, adolescents will sometimes report not seeking informal or formal resources.

Wilson et al. (2005) in their development and analysis of the General Help-Seeking Questionnaire explored help-seeking in 218 high school students. Results showed that adolescents were more likely to use informal sources with friends being the preferred help source. In reviewing the data on formal preferences, individuals were more likely to report an intention of seeking help from a medical doctor for emotional problems and a mental health profession if suicidal ideation was present. In addition, when looking at help-seeking in rural areas, researchers have found that compared to doctors in urban settings, rural medical doctors are less likely to treat individuals for mental health reasons (Caldwell, Jorm, Knox, Braddock, Dear, & Britt, 2004).

Formal and informal help-seeking in rural areas has been addressed. Girio-Herrera, Owens, and Langberg (2013) examined perceived barriers to help-seeking among parents

of at-risk kindergartners in several rural communities. Consistent with previous rural research, (Elliott-Schmidt & Strong, 1997) in their sample of 597 participants, only a third of the sample that was identified as at-risk saw their children as having problems needing attention. Parents were more likely to seek help from informal sources and if they did seek formal assistance it was often from a medical doctor or from school personnel. Over half of the sample identified at least one barrier that would make it difficult to obtain formal mental health services. The study identifies the need for interventions to help parents identify problems or difficulties their children may be experiencing and to address the barriers that may prevent utilization of formal mental health resources. Again, the challenges of availability, accessibility, and acceptability of mental health services impact rural areas as well as the challenges of identifying interventions to help those in need of services to recognize the problem, have knowledge of services, and feel that seeking these services can be helpful.

Weinert and Long (1987) also explored rural individuals use of informal and formal help-seeking. They found that rural individuals were less likely to seek professional help and more likely to utilize friends and family for support as compared to their urban counterpart. Their research also found that rural participants were more likely to identify as self-reliant.

The delay between onset of symptoms and seeking professional or formal treatment has been explored in Australia's rural areas. A sample of 124 individuals identified as having anxiety and depressive symptoms were assessed to further explore the delay in professional treatment initiation. The study found that in general there was a delay of

18.7 years between symptom onset and professional treatment across all disorders.

Social phobia had the longest delay in treatment seeking with the average delay of 28.02 years. Several factors were found to contribute to the delay including living in a remote or very remote area (Green, Stain, & Hunt, 2012).

Griffiths, Crisp, Barney, and Reid (2011) reviewed 417 surveys exploring the perceived advantages and disadvantages of seeking informal support from family and friends. Results indicated that 80% of the sample identified advantages and 40% identified at least one disadvantage. Individuals identified social support, emotional support, and informational support as the primary benefit of seeking informal support. Cited disadvantages in the same sample included stigma, inappropriate support, and the family member's lack of knowledge. The study goes on to cite, that although family and friends can be helpful and may even encourage the use of more formal mental health services and resources, seeking help from some family may be "unhelpful" or even "toxic."

Other studies have suggested that informal help-seeking can be unhelpful. Rickwood's (1995) study exploring the effectiveness of help-seeking for personal problems in adolescents found that problems can be created when adolescents share problems with each other and mutually disclose concerns.

Although there can be challenges in seeking support from informal sources, in general informal resources can be helpful and in some rural areas may be what is available. Research has suggested that often individuals prefer to seek a help source that is close or easily available (D'Avanzo et al., 2012). Fraser et al. (2002) suggests looking at the,

“mediating role of social networks and use of mental health services and the role of the informal sector in supporting people with mental health problems,” (p. 293). Others suggest “linking” informal and formal mental health care services and symptoms (Hill & Fraser, 1995).

The goal of the present study was to explore the factors that influence help-seeking in a rural population by exploring both formal and informal help-seeking preferences.

Help-seeking Attitudes

Research findings indicate that the majority of individuals who struggle with mental health concerns do not seek help for their issues (Kessler, Bruce, Koch, Laska, & Leaf, 2001). In fact, research has found that less than one third of individuals with psychological concerns actually seek help (Andrews, Issakidis, & Carter, 2001). In addition, less than 25% of individuals with a DSM diagnosis will use psychological services in their life-time even though 70-80% of individuals who do seek help will be better off (Prochaska, 2001).

Help-seeking involves utilizing an outside entity when one finds he or she is unable to manage their problems. When exploring help-seeking attitudes, individuals must cognitively address the benefits and barriers as they evaluate whether to endorse seeking outside help.

Several factors influence one’s willingness to seek help including gender, education level, ethnicity, and age (Cauce, Rodriguez, Paradise, Cochran, Shea, Srebnik & Baydar, 2002; Fischer & Turner, 1970; Jones-Hazledine, McLean, & Hope, 2007). Andrews et al. (2001), in their sample of 10,641 Australian adults, found that the individuals most likely

to favor help-seeking were women, aged 25-54 who were disabled and had been married. Individuals who were least likely to favor help-seeking included men who did not have the same risk factors. Similar findings were found in a sample in the United Kingdom with Bebbington et al. (2000) identifying that the only individuals who seemed to seek help appropriately were educated women in their child bearing years. The population least likely to seek help was men with limited or no family responsibilities.

Jones-Hazledine et al. (2007) in their study of 153 rural primary care clients found that individuals who were married, more educated, and Caucasian were more likely to seek help for mental health concerns. In addition, consistent with help-seeking in rural areas, individuals were more likely to seek help if the problem was identified as being more severe. Consistent with this research, Bebbington et al. (2000) found that the main reason an individual sought help from their primary care provider was the severity of the problem. Jablensky et al. (2000) found that individuals with psychotic disorders were most likely to have contact with health services when compared to individual's with affective or substance abuse disorders.

Oliver, Pearson, Coe, and Gunnell (2005) found that individuals preferred to seek help from a lay source if they had a minor problem. Consistent with the literature they found that men were less likely to engage in help-seeking behaviors. Judd, Komiti, and Jackson (2008) in their sample of 579 rural residents explored that higher levels of help seeking in women may be due to their reports of less stoicism and stigma.

Research has also addressed factors that decrease the likelihood of help-seeking behaviors and influence less favorable help-seeking attitudes. Pierce and Brewer (2012)

used a phenomenological approach to explore ways to promote mental health services and help-seeking by exploring barriers to help-seeking. Interviewing 17 participants who had either experienced mental health issues, had a family member with mental health issues, or were a professional working with individuals with mental health concerns, they explored these barriers to help-seeking. Six themes emerged: stigma, concerns with confidentiality, having had a previous negative experience with mental health services, not recognizing symptoms as needing services, rural stoicism, and not knowing what resources were available or how to access these services. Other researchers have discovered similar findings. Boyd et al. (2011) in their study exploring preferences and intentions of 201 adolescents in rural Australia toward help-seeking found a perceived limit of resources, perceived proximity, confidentiality concerns, and travel barriers to be the identified barriers. Boyd et al. (2011) as well as others (e.g., Cauce et al., 2002) have found that adolescents tend to underutilize help services.

Vogel, Wester, and Larson (2007) explored five avoidance factors related to help-seeking: 1) social stigma, 2) treatment factors, 3) fear of emotion, 4) anticipated utility and risks, and 5) self-disclosure. Rughani, Deane, and Wilson (2011) in their study of adolescents found that if participants perceived help-seeking as beneficial they were more likely to hold favorable attitudes toward help-seeking. This suggests the importance of media campaigns to inform health consumers of the benefits of seeking help for their concerns and issues. Rural areas where individuals often wait for their problems to be “severe” before seeking treatment may benefit from publicizing mental health services, because delay in treatment can lead to less favorable outcomes.

There is a need for rural research. Rural areas face the challenges of accessibility, availability, and acceptability of mental health resources. The present study aimed to address these challenges by further exploring rurality, income status, the influence of rural cultural beliefs about mental health, knowledge and familiarity with mental health services, stigma, and the use of informal resources on help-seeking attitudes.

CHAPTER THREE: METHODOLOGY AND DESIGN

Participants

Participants were 106 individuals residing in the Southwest Iowa area. Sample size was determined based on a power analysis with an r^2 of 0.4 and an alpha level of .05 indicating a need for at least 90 participants. The sample consisted of 88 females and 18 males from a nonclinical population. All participants were over the age of 18 and ranged in age from 22-90. The ethnic background of the sample consisted of 98 Caucasians, three Asian Americans, one Latin American/Hispanic, two Native Americans, and two individuals who identified as having two or more races. In an effort to obtain a sample representative of the area, participants were recruited while visiting the local rural health primary care clinic. The center is located in Atlantic, Iowa a community of approximately 7000 people, serving rural individuals within approximately 35 mile radius from Cass and surrounding counties in Southwest Iowa. Participants were offered \$5.00 each for their participation.

Instrumentation

The current study explored the following independent variables: (1) Rurality, (2) Local/Incomer status, (3) Influences of Rural Culture on Mental Health Beliefs, (4) Knowledge and Familiarity with Mental Health Services, (5) Perceived Stigma and (6) Use of Informal Resources. The dependent variable was help seeking attitudes. The instruments used to measure these variables are described next.

Demographic Questionnaire

A demographic instrument included in Appendix A was used to assess gender, age, race/ethnicity, level of education, marital status, income level, health insurance status, religious affiliation and employment status.

Local/Incomer Status

Incomer status was assessed by individuals answering four questions related to their connectedness to their current community. Individuals were asked to respond on a 4 four-point scale from “Strongly Agree” to “Strongly Disagree.” Items included responding to statements such as, “This community feels like ‘home’ to me.” Individuals were also be asked to identify how they would describe themselves on a continuum which ranged from “I would consider myself a Local: someone born and raised in this community and connects with local values and customs” to “I would consider myself an incomer/newcomer: someone who was not born in this community and has settled here and does not connect with local values and customs.” Prior to administration of the research questionnaire, a focus group was administered the Incomer Status portion of the questionnaire and feedback was obtained regarding the clarity of items and the ability to distinguish individuals as incomers versus individuals who would be considered more local to the community.

Rurality

Modeled after Jones-Hazledine, Mclean, and Hope’s (1997) study focusing on the impact of a client’s knowledge of a local provider on rural help-seeking behaviors,

rurality was assessed multidimensionally. The researchers initially defined rurality with six items. After performing a component analysis two separate components emerged. Component 1 defined current rural living situation and consisted of population of home town, living situation, self-definition, and population of the place lived most. These four items were used for the current study. A demographic questionnaire was utilized asking participants to respond to a 4 four-point scale identifying the population of their current hometown. The scale was created using the Census Bureau's definitions of urban and urban cluster with '1' representing a hometown with a population of 50,000 or more; '2' 2500-49,999; '3' 1000-2499; '4' less than 1000 (United States Department of Health and Human Service, 2012). Individuals were also asked to define their living situation on a scale of 1-4 with '1' representing living in town and '4' representing a "living in the country." Individuals were asked to identify the population of the place they have lived the longest with a 4 four-point scale with '1' being a residence with a population of 50,000 or greater; '2' 2500-49,999; '3' 1000-2499; '4' less than 1000 (United States Department of Health and Human Service, 2012). Participants were then asked via self-report to rate themselves on a four-point scale with "1" representing the most "rural" or (country- type person) and "4" being the most "urban"(city- type of person). The score for rurality was calculated by summing the 4 items of the rurality scale.

Rural Cultural Beliefs about Mental Health

A 14-item measure, the Herzberg Rural Cultural Beliefs about Mental Health Scale (HRCBMH) was created for the purposes of this study. DeVillis (as cited in Worthington & Whittaker, 2006) suggests steps in the construction of new measures. First researchers

should clearly identify the construct to be measured. Items are then created for the instrument, followed by a decision regarding the format of the instrument. Items should then be reviewed by an expert panel. Consideration should be given for validation items. The items are then administered to a focus group. Assessment and evaluation of items is done followed by decisions to adjust the length of the measure.

Informed by the current literature on rural mental health beliefs (Human & Wasem, 1991; Slama, 2004; Smith, 2003) and literature on the Health Belief Model (Glanz, Marcus Lewis, & Rimer, 1997; Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988) items ask participants to respond using a 4-point Likert scale, (i.e. “1 = Do not believe, 2 = Somewhat do not believe, 3 = Somewhat believe, 4 = Believe) to items representing statements consistent with rural mental health beliefs.

The Health Belief Model includes four factors: (1) Perceived Susceptibility; (2) Perceived Severity; (3) Perceived Benefits; and (4) Perceived Barriers (Glanz, Marcus Lewis, & Rimer, 1997; Rosenstock, 1966; Rosenstock, Strecher, & Becker, 1988). Applying research on rural cultural beliefs to this model indicates that rural individuals tend to believe they are less susceptible to mental illness. It is posited that this is due to less knowledge. Research shows that rural individuals enter treatment later with more severe symptoms, as they often perceive less severity with their issues and concerns. Rural individuals may perceive less benefit in therapy due to a culture of self-reliance. In addition there are several perceived barriers presented in the literature when addressing the beliefs about rural mental health including availability, acceptability, and accessibility (Human & Wasem, 1991; Slama, 2004; Smith, 2003).

Items were first created based on the literature and then reviewed by a panel of rural experts consisting of case managers, mental health counselors, psychiatric nurses, psychiatric nurse practitioners, and a psychologist. An initial content analysis was conducted through expert judges assessing the meaningfulness and redundancy of each of the items and the scale as a whole. Minor wording changes were made after this review. The instrument was then administered to a focus group of 30 individuals. This resulted in a Coefficient Alpha of .918. Further evaluation of items was done with feedback suggesting the redundancy of some items and an item recommendation. This resulted in five items being deleted and the addition of one item to address religious beliefs. The original 22 items were then decreased to 17 based on findings of the initial instrument construction process.

After data collection for the study was completed, a reliability analysis was conducted to obtain further information regarding the construction of and further need for revision of the instrument. A Coefficient Alpha of .70 or higher was desired. In reviewing the item analysis, three items were removed, “I or someone in my family could be susceptible to mental illness,” “Some physical problems are due to psychological causes such as stress,” and “If an individual is struggling with personal problems prayer can be helpful,” to address reliability of the instrument. The removal of the three items resulted in a Coefficient Alpha increasing from .668 to .764.

Knowledge and Familiarity of Mental Health Services

Knowledge and familiarity of mental health services was assessed using the Knowledge and Familiarity of Mental Health Services Scale (KFFMHS-Revised).

Originally developed and used by Aloud (2004) with a Cronbach's Alpha of .88, the measure was modified to specifically address an individual's knowledge of mental health services. This 11-item measure explores how familiar individuals are with the types of problems that may require professional services, as well as availability of services, and how much is known about mental health disorders, treatment interventions, and individual eligibility. Aloud's original measure also looked at familiarity of specific roles of providers. For the current study these items were removed and replaced with questions assessing knowledge of confidentiality, structure of appointments, and knowledge of the client/clinician relationship. For the first two items, participants are asked to respond on a four-point Likert scale ranging from "not at all" familiar to "very familiar." The remaining items assess knowledge. Participants were asked to respond on a 4 four-point Likert scale responding that they know: Nothing, Very little, Some, or A great deal. One item was modified to address the population in the current study. The item addressing "Arab and Muslim" professionals, was changed to reflect "rural" professionals.

Perceived Stigma

Stigma was measured using a modified version of the Perceived Stigma Scale (PSS). Created by Wrigley, Jackson, Judd, & Komiti (2005), the PSS is based on Link's (1987) Perceived Devaluation-Discrimination Measure (PDD). The PDD is a 12-item scale assessing individual's perceptions of what "most people believe" about how one might devalue or discriminate against someone who has been identified as having a mental health history (Link, 1987). It can be used for individuals in treatment for mental health

issues, but can also be used in assessing beliefs from the general public (Link, Yang, Phelan, & Collins, 2004). Participants were asked to respond to statements using a six-point Likert scale.

The PSS uses the original 12 items of the PDD, but differs in that the PSS modified the American cultural wording and added four items to assess perceptions relevant to a specific community. For example, item 14 states, “This community would be supportive and caring towards someone who experienced a mental illness.” The PSS also incorporates a four-point Likert scale ranging from “strongly agree” to “strongly disagree.” Scores range from 16-64 with a higher score indicating a lower level of perceived stigma. Measures of internal consistency with the PSS have been good with Wrigley et al., (2005) finding a Cronbach’s Alpha of 0.80. Another study obtained good internal reliability with a Cronbach’s Alpha of 0.84 (Komiti, Judd, & Jackson, 2006).

For this study, the English wording was not changed. However, there were some modification in wording. For example, the PDD uses language referring to individuals as “mental patients.” Modification was done changing this to “mental health patient.” In addition, the original measure included items that refer to patients seeking help from or entering hospitals. Because out-patient therapy is a more common entry to treatment, items were broadened to capture both in-patient and out-patient treatment avenues. For example, an item that read, “Most people think less of a person who has been in a mental hospital,” would be revised to read, “Most people think less of a person who has been in a mental health hospital/clinic.” The references specifying gender and sexual orientation were also modified, as to be more inclusive. The item, “Most young women would be

reluctant to date a man who has been hospitalized for a serious mental disorder, was changed to reflect “most young women/men would be reluctant to date someone who has been hospitalized for a serious mental disorder.”

Attitudes Toward Help-Seeking

Attitudes toward help-seeking was operationalized using the Attitudes Toward Seeking Professional Psychological Help Scale-Shortened Form (ATSPPHS). Fischer and Turner (1970) developed a 29-item instrument to assess help-seeking attitudes for mental health issues. The original version produced scores from 0-87 with a higher score indicating more favorable attitudes toward help-seeking. Test-retest reliability obtained over a two month period was .84.

Fischer and Farina (1995) created a shortened version of the scale. Ten items from the original scale were used requiring participants to respond on a four-point Likert scale. Participants are asked to respond to the items on a continuum from agree, partly agree, partly disagree, and disagree. Internal Consistency for the shortened form yielded a reliability estimate of .84 (Cronbach’s alpha) as compared to .83 and .86 in two samples using the original 29-item measure. Fischer and Farina (1995) conclude that the shortened measure is comparable in terms of test characteristics and due to its brevity can lend itself to be more conducive in research.

Procedures

Following approval from the Human Subjects Review Board at the University of Nebraska-Lincoln and permission from the rural health primary care clinic, participants were solicited through a request of the researcher at the primary care clinic. Participants

who confirmed that they were residing in a rural area and were at least 18 years of age consented to the project. Survey completion took approximately 10-15 minutes.

Participants were paid \$5.00 for their completed survey. All completed surveys are kept in a locked box with only the researcher having access.

Design of the Study

Correlations and then multiple linear regression were employed to test hypotheses.

A correlation matrix was constructed based on the zero-order correlations among the salient variables of the study. Next, a multiple regression analysis was performed to test the capacity of the model in the prediction of help-seeking attitudes. The predictive model formed through the regression equation allowed for comparison of the individual contributions of each variable to the prediction of help-seeking attitudes. Simultaneous entry of all variables into the regression equation was used.

CHAPTER 4: RESULTS AND DATA ANALYSIS

The data were analyzed guided by the research questions and hypotheses. The goal was to more clearly understand help-seeking preferences in a rural population by broadening the definition of rurality and specifically looking at how individuals who identify as local in a community and individuals who identify as incomers in a community view help-seeking. Specifically this chapter is a presentation of (a) demographic characteristics of the participants; (b) gender comparisons; (c) an analysis of preferences for help-seeking by demographic variable; (d) correlations among variables of the research study and means for all variables measured; and (e) results of the multiple regression analysis forming a predictive model of help-seeking.

Demographic Characteristics

One-hundred ten questionnaires were administered with three not returned and one returned unfinished. Nine individuals who were approached did not participate in the study. Seven voiced that they were not interested, and two indicated visual difficulties.

Table 2 provides characteristics of participants including gender, race/ethnicity, marital status, level of education, health insurance status, household income, and employment status. Means and standard deviations for each demographic variable are presented for each of the research variables.

For this study's sample, the participants were primarily female (83%), Caucasian (92%), married, (76%), worked full-time (64.1%), and participated in commercial or group insurance programs (64.1%). As can be seen in Table 2, there was more

variability in the sample on the dimensions of education and household income. Of note, participants were afforded the opportunity to identify as transgender, however, no participants did. One participant elected not to report household income.

Table 2

Means and Standard Deviations of demographic variables for Help-seeking, Rurality, Local/Incomer Status, Stigma, Knowledge of Mental Health, and Rural Cultural Beliefs about Mental Health

Variable	N	<u>ATSPPHS</u> Mean (SD)	<u>Rural</u> Mean (SD)	<u>LIQ</u> Mean (SD)	<u>LICON</u> Mean (SD)	<u>PSS</u> Mean (SD)	<u>KFFMHS-R</u> Mean (SD)	<u>HRCBMH</u> Mean (SD)
Gender								
Male	18	18.16 (4.80)	9.67 (3.09)	8.22 (2.90)	7.69 (6.07)	39.00 (6.38)	25.11 (9.10)	28.44 (6.89)
Female	88	18.69 (4.32)	10.43 (3.04)	7.92 (2.45)	5.06 (5.49)	39.57 (6.26)	32.16 (7.99)	26.71 (6.27)
Race/Ethnicity								
Asian Am	3	16.67 (4.51)	10.33 (4.51)	8.00 (2.00)	11.67 (3.61)	37.67 (3.51)	20.67 (2.08)	27.00 (5.57)
Latin Am/Hispanic	1	26.00	13.00	4.00	0.00	35.00	39.00	26.00
Caucasian	98	18.55 (4.39)	10.35 (3.01)	8.02 (2.54)	5.49 (5.49)	39.38 (6.29)	30.97 (8.49)	27.13 (6.56)
Native Am	2	17.00 (1.41)	7.50 (0.70)	8.00 (0.00)	4.50 (5.66)	46.50 (2.82)	31.00 (8.48)	24.50 (0.71)
Two or more Races	2	22.00 (4.24)	9.50 (4.95)	7.50 (3.53)	1.00 (1.41)	41.50 (6.36)	42.00 (2.83)	24.00 (4.24)
Marital Status								
Married	81	18.96 (4.47)	10.95 (3.10)	7.64 (2.16)	4.54 (5.10)	39.00 (6.34)	31.07 (9.07)	26.82 (6.32)
Never Married	10	16.40 (3.02)	9.30 (2.40)	10.60 (2.27)	10.35 (4.53)	41.80 (5.27)	30.60 (4.17)	28.50 (4.60)
Separated	4	22.25 (4.11)	7.75 (2.06)	7.75 (1.70)	8.50 (6.28)	43.00 (8.87)	32.75 (13.04)	23.50 (3.32)
Divorced	4	20.50 (2.65)	7.00 (1.15)	6.50 (2.65)	2.75 (4.01)	41.25 (7.46)	33.75 (7.23)	23.00 (4.16)
Widowed	3	14.67 (4.04)	8.33 (0.57)	11.00 (3.46)	13.50 (1.50)	40.33 (2.89)	25.00 (4.58)	36.67 (9.07)
Cohabiting	4	15.50 (3.31)	11.00 (2.94)	7.50 (5.07)	6.62 (7.36)	37.25 (4.72)	29.50 (5.97)	27.25 (8.73)

Table 2 (cont.)

Variable	N	<u>ATSPPHS</u> Mean (SD)	<u>Rural</u> Mean (SD)	<u>LIQ</u> Mean (SD)	<u>LICON</u> Mean (SD)	<u>PSS</u> Mean (SD)	<u>KFFMHS-R</u> Mean (SD)	<u>HRCBMH</u> Mean (SD)
Level of Education								
Less than H.S.	1	17.00	9.00	9.00	12.00	42.00	30.00	17.00
GED/H.S.	33	17.27 (3.98)	9.27 (2.82)	8.60 (2.47)	6.98 (6.42)	40.06 (5.02)	26.76 (9.06)	29.33 (7.04)
Some College	27	19.44 (5.09)	9.89 (3.03)	8.33 (2.76)	5.39 (5.17)	39.29 (7.49)	31.26 (7.27)	26.74 (5.94)
Assoc. Degree	24	19.88 (4.91)	11.63 (2.73)	7.04 (2.42)	2.83 (4.04)	40.83 (6.55)	35.04 (7.12)	25.13 (6.48)
Bachelor Degree	16	18.31 (3.18)	11.25 (3.33)	7.50 (2.28)	5.88 (5.21)	36.44 (5.96)	33.31 (8.43)	26.19 (5.41)
Master's Degree	4	18.00 (2.58)	10.75 (3.59)	7.75 (2.36)	7.38 (4.90)	38.25 (5.44)	27.75 (9.81)	25.00 (3.56)
Doctoral Degree	1	18.00	8.00	7.00	4.00	43.00	40.00	21.00
Health Insurance Status								
None	9	16.56 (4.19)	9.11 (2.42)	8.56 (3.34)	7.50 (7.19)	38.11 (6.62)	29.22 (8.39)	27.22 (6.74)
Medicaid/Title 19	8	18.75 (4.98)	7.88 (1.64)	9.63 (3.46)	10.93 (5.28)	42.13 (6.88)	28.88 (8.98)	31.00 (9.39)
Medicare	7	18.14 (4.22)	9.86 (2.19)	7.29 (2.81)	6.93 (6.65)	37.71 (5.93)	25.29 (6.68)	30.86 (5.67)
Commercial/Group	75	18.65 (4.32)	10.69 (3.02)	7.75 (2.27)	4.68 (4.88)	39.44 (6.33)	32.01 (8.45)	26.35 (5.96)
Medicare & Medicaid	2	21.00 (5.66)	7.50 (2.12)	9.50 (0.70)	6.00 (8.45)	44.00 (2.83)	37.00 (9.89)	25.50 (6.36)
Medicare & Comm.	5	21.00 (5.24)	12.20 (4.81)	7.97 (2.52)	3.40 (5.16)	38.80 (5.07)	27.20 (10.28)	25.40 (6.23)

Table 2 (cont.)

		<u>ATSPPHS</u>	<u>Rural</u>	<u>LIQ</u>	<u>LICON</u>	<u>PSS</u>	<u>KFFMHS-R</u>	<u>HRCBMH</u>
Variable	N	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Household Income								
Less than 5,000	2	19.00 (2.83)	9.50 (0.70)	8.50 (0.70)	9.75 (3.18)	40.00 (2.83)	25.00 (7.07)	29.00 (1.41)
5,000-9,999	2	12.50 (3.54)	8.00 (0.00)	13.00 (2.83)	10.50 (6.36)	41.50 (0.70)	27.00 (8.49)	41.50 (7.78)
10,000-19,999	10	18.60 (5.13)	8.00 (1.56)	8.60 (3.13)	11.05 (5.27)	43.40 (7.66)	34.40 (6.94)	24.80 (4.08)
20,000-29,999	14	19.43 (4.03)	10.57 (3.72)	8.64 (2.95)	8.21 (6.55)	39.79 (4.21)	29.43 (6.87)	28.00 (7.40)
30,000-39,999	11	18.55 (4.72)	9.63 (3.20)	8.45 (2.77)	5.31 (6.59)	38.45 (4.89)	29.00 (11.00)	26.91 (7.69)
40,000-49,999	10	18.70 (5.52)	10.60 (2.50)	8.90 (2.69)	4.95 (5.16)	37.90 (10.16)	29.00 (9.06)	25.80 (7.33)
50,000-59,999	11	18.91 (3.33)	8.45 (2.33)	7.63 (1.43)	3.00 (3.39)	40.36 (5.16)	31.55 (8.71)	26.09 (4.97)
60,000-69,999	16	18.81 (5.17)	10.69 (3.13)	7.44 (2.03)	4.22 (4.14)	37.56 (4.97)	31.31 (10.29)	25.25 (5.18)
70,000 or higher	29	18.31 (4.05)	11.76 (2.89)	6.89 (2.04)	3.39 (4.32)	39.34 (6.70)	32.07 (8.15)	28.07 (6.04)
Employment Status								
Unemployed	15	17.07 (4.68)	8.67 (2.61)	9.13 (2.99)	8.83 (6.20)	38.60 (5.04)	26.93 (8.59)	28.40 (6.84)
Part-Time	11	19.81 (5.06)	10.63 (3.35)	7.36 (2.01)	4.63 (5.84)	44.64 (7.39)	31.36 (7.69)	27.73 (7.22)
More than 1 Part-Time	3	21.00 (3.61)	10.00 (2.00)	6.67 (2.53)	0.83 (1.04)	44.33 (8.02)	31.67 (10.79)	25.67 (6.66)
Full Time	68	18.62 (4.38)	10.54 (3.03)	7.84 (2.49)	4.91 (4.81)	38.83 (6.07)	32.26 (8.25)	26.44 (6.29)
Retired	9	18.78 (3.23)	10.89 (3.41)	8.22 (2.22)	7.05 (7.56)	37.78 (4.74)	27.11 (10.00)	28.56 (5.88)

Note. ATSPPH measures Help-seeking; Rural measures Rurality; LIQ measure Local/Incomer status using the Local Incomer Questionnaire; LICON measures Local/Incomer status using the Local Incomer Continuum; PSS measures perceived stigma; KFFMHS-R measures Knowledge and Familiarity of Mental Health; and HRCBMH measures Rural Cultural Beliefs about Mental Health.

Participants were also asked to indicate how many times in the last five years they had sought treatment from a mental health professional. The majority of the sample indicated they had never sought mental health treatment (76.4%). Approximately 8.5% indicated they had sought treatment one or two times, 4.7% indicated they had sought treatment three to five times, and 10.4% indicated they had sought treatment more than five times. Comparisons of this study's data with the National Comorbidity Replication Survey indicated a slightly lower number of individuals seeking treatment as the NCSR found that 68.1% of their sample had not sought psychological treatment from a mental health professional (National Comorbidity Replication Survey).

Gender Comparisons

T-test comparisons by gender were also conducted comparing male and female responses on the dependent variable of help-seeking. Contrary to the literature, (Bebbington et al., 2000; Fischer and Turner, 1970; Judd, Komiti, & Jackson, 2008) no significant differences were found between males ($M = 18.17$, $SD = 4.80$) and females ($M = 18.69$, $SD = 4.33$); $t(104) = -4.61$, $p = .645$ with the current sample.

Further mean comparisons did reveal a statistically significant result with reported knowledge and familiarity of mental health resources with females ($M = 32.16$, $SD = 7.99$) reporting more knowledge than males ($M = 25.11$, $SD = 9.10$); $t(104) = -3.33$, $p = .001$. Statistically significant result by gender were not present with the other variables utilized in the study.

Mental Health Preferences Based on Group Membership

A Chi-square analysis was planned to assess individual's preferences for mental health treatment, as individuals were asked to rank from whom they would seek outside help for

mental health or psychological issues. However, although the sample was random and adequate in size, enough representatives per category for each demographic variable were not obtained to complete a chi-square analysis. Even so, 42% of the sample identified that they would first seek outside help from their family doctor, followed by 26% who stated they would seek help from a family member. Fifteen percent stated that they would first seek assistance from a mental health provider, followed by 10% reporting a close friend, and 3% identifying a priest or pastor and 3% identifying they would seek help from nobody.

Individuals were asked to identify whom they would seek help from second and third as well (See Table 3) with 29% and 27% identifying they would seek help from a mental health professional and family doctor, respectively as a second choice. Preferences for a third choice varied with 30% stating they would select a mental health professional as their third option for outside help-seeking, 16% identified they would seek help from a close friend, and 15% identified they would not seek help from anyone as a third option. Results indicate that a higher percentage of the sample indicated a preference for seeking outside help from a mental health professional if they had already utilized their first or second preference (30%). When compared to individuals selecting a first and second preference for outside help-seeking, a higher percentage indicated they would seek help from “nobody” as their third preference (15%).

Table 3**Preferences for Seeking Outside Help**

Preference for outside help Preference	First Preference	Second Preference	Third
	(%)	(%)	(%)
Mental Health Provider	15	29	30
Family Doctor	42	27	10
Close Friend	10	11	16
Priest/Pastor	3	6	14
Family member	26	21	14
Nobody	3	6	15

Note. N = 106

Mental health preferences by gender and education level were also reviewed. For men, 39% identified they would first seek treatment from a family doctor. Thirty-three percent stated they would seek help first from a mental health provider. Seventeen percent identified that they would not seek help from anyone as their first preference for outside help. Females also identified their family doctor as their top preference (43%) and 30% stated that it would be a family member. No females indicated that they would fail to seek help from someone as a first preference (See Table 4).

Table 4**Preferences for Seeking Outside Help by Gender.**

	Male	Female
	(%)	(%)
First Preference		
Mental Health Provider	33	11
Family Doctor	39	43
Close Friend	0	11
Priest/Pastor	0	3
Family member	11	30
Nobody	17	0
Second Preference		
Mental Health Provider	17	32
Family Doctor	33	26
Close Friend	0	14
Priest/Pastor	0	6
Family member	28	19
Nobody	22	2
Third Preference		
Mental Health Provider	11	34
Family Doctor	11	10
Close Friend	22	15
Priest/Pastor	11	15
Family member	11	15
Nobody	33	11

Note. For males, n = 18. For females, n = 88.

In reviewing the preferences for seeking outside help by level of education, all levels with the exception of individuals with Bachelor's degrees identified that their top preferences for seeking outside help for mental health issues was their family doctor (Less than High school, 100%; GED/High School, 48%; Some college, 37%; Associates, 46%; Masters, 50%; and Doctorate, 100%). Sixty-three percent of individuals with Bachelors level educations indicated that a family member would be their first choice (See Table 5).

Table 5
Preferences for Seeking Outside Help by Education

	Less than High School (%)	GED or High School (%)	Some College (%)	Associates (%)	Bachelors (%)	Masters (%)	Doc (%)
First Preference							
Mental Health Provider	0	12	33	8	6	0	0
Family Doctor	100	48	37	46	31	50	0
Close Friend	0	12	4	21	0	25	0
Priest/Pastor	0	6	4	0	0	0	0
Family member	0	18	19	25	63	25	0
Nobody	0	3	4	0	0	0	100
Second Preference							
Mental Health Provider	0	18	30	33	50	25	0
Family Doctor	100	21	26	33	31	0	100
Close Friend	0	15	7	8	19	0	0
Priest/Pastor	0	3	11	4	0	25	0
Family member	0	36	15	21	0	25	0
Nobody	0	6	11	0	0	25	0

Third Preference

Mental Health Provider	0	15	30	38	44	50	100
Family Doctor	100	9	4	25	0	0	0
Close Friend	0	27	11	13	13	0	0
Priest/Pastor	0	15	19	8	19	0	0
Family member	0	9	19	17	13	25	0
Nobody	0	24	19	0	13	25	0

Note. Less than High school (n = 1). GED or High School (n = 33). Some college (n = 27). Associate degree (n = 24). Bachelors degree (n = 16). Masters (n = 4). Doctorate (Doc) (n = 1).

Correlations and Research Measures

Preliminary analysis was done tabulating means, standard deviations, ranges, and reliability coefficients for the measures of the study variables (See Table 6).

Table 6

Means, Standard Deviations, Ranges, and Reliability Coefficients for Measures of the Study Variables

Instrument	Mean	SD	Range	N	Coefficient Alpha
ATSPPHS	18.60	4.39	9-30	106	.810
Rural	10.30	3.05	5-16	106	.681
LIQ	7.97	2.52	4-15	106	.725
LICON	5.50	5.49	0-17	106	
PSS	39.47	6.25	16-58	106	.885
KFFMHS-R	30.96	8.57	12-44	106	.954
HSRCB	27.0	6.39	17-47	106	.764

For Attitudes Toward seeking Professional Psychological Help Scale-Shortened (ATSPPHS), higher scores indicate more favorable views toward seeking professional help. In measuring Rurality, higher scores indicate individuals self-identifying as being more rural. Local and Incomer status was measured in two ways. For the Local Incomer

Questionnaire (LIQ) higher scores indicate an individual identifying as being more of an incomer in their local community. Similarly for the Local Incomer Continuum (LICON), higher scores indicate individuals self-identifying as being more of an incomer in their local community. For the Perceived Stigma Scale (PSS) higher scores indicate less stigma toward mental health services. The Knowledge and Familiarity of Mental Health Services Scale-Revised (KFFMHS-R) indicates higher scores for more knowledge of mental health services. Finally, for the Herzberg Rural Cultural Beliefs about Mental Health Scale (HRCBMH), higher scores indicated a stronger identification with rural cultural beliefs.

Zero-order correlations were tabulated for all variables. Table 7 displays the correlations among variables and statistical significance of the correlations. Reviewing correlations between independent variables and the dependent variable of help-seeking show the highest zero-order correlation between help-seeking and rural cultural beliefs about mental health ($r = -.642$), followed by knowledge and familiarity of mental health services ($r = .454$). Individuals who had more favorable attitudes toward help-seeking tended to have less traditional rural beliefs about mental health. Individuals who had a less favorable attitude toward help-seeking tended to hold more traditional rural cultural beliefs. Individuals who reported having more knowledge of mental health services also tended to report having more favorable attitudes toward help-seeking. Of specific interest for this study, were the variables of rurality and incomer status. The relationship between measures of rurality and help-seeking, although statistically significant, was lower ($r = .185$). Individuals who reported being more rural also reported more favorable attitudes toward help-seeking. Significant correlations were also found between help-

seeking and both measures of local versus incomer status with $r = -.248$ for the Local Incomer Questionnaire (LIQ) and $r = -.292$ for the Local Incomer Continuum (LICON). Participants who identified themselves as being more of an incomer tended to report less favorable views of help-seeking. The correlation between the dependent variable of help-seeking and stigma was not statistically significant ($r = .089$). In conclusion, looking at the zero order correlations, it was hypothesized that rurality and incomer status relationships would be stronger. This was not demonstrated through the correlational analysis.

Table 7
Correlation Matrix

	ATSPPHS	Rural	LIQ	LICON	PSS	KFFMHS-R	HRCBMH
ATSPPHS	1.0	.185*	-.248**	-.292**	.089	.454***	-.642***
Rural		1.0	-.235**	-.264**	-.008	.124	-.153
LIQ			1.0	.621**	-.101	-.225**	.281**
LICON				1.0	.009	-.269**	.309**
PSS					1.0	-.024	-.055
KFFMHS-R						1.0	-.549***
HRCBMH							1.0

Note.

* $p < .05$ ** $p < .01$ *** $p < .000$

Multiple Regression Analyses

Prior to performing the regression analysis, tests were performed to assure that no multiple linear regression assumptions had been violated: a) linearity; b) normality; c) multicollinearity. Scatter plots were reviewed to determine linearity and to check for outliers in the data resulting in the criteria of linearity being met. Tests for normality

were performed by reviewing a histogram of the regression standardized residual and reviewing normal probability of regression standard residual plots. Visual review indicated there were no serious violations of normality. Tests for multicollinearity were also performed. Correlation coefficients were reviewed indicating no violation. Tolerance measures were higher than .2 and Variance Inflation Factors were lower than 10, thus the assumption of multicollinearity was not violated.

As indicated, the study's first research hypothesis predicted that rurality, incomer status, rural cultural beliefs about mental health, knowledge and familiarity with mental health services, and perceived stigma would form a statistically significant predictive model of help-seeking attitudes in a rural population. Multiple regression analyses were utilized to determine the predictive model of help-seeking comprised of the predictor variables. Two analyses were performed. The first regression analysis determined the regression equation for help-seeking attitudes using the predictors: (a) rurality, (b) perceived stigma, (c) knowledge and familiarity of mental health resources, (d) rural cultural beliefs about mental health, and e) local versus incomer status as measured by the LIQ to form a predictive equation.

As was described earlier, two methods were used initially to determine local incomer status. These were the use of a four-item questionnaire and the use of a continuum of local to incomer asking individuals to rate themselves. Because the correlation between the questionnaire (LIQ) and the continuum (LICON) was only $r = .621$, it was determined that the two measures demonstrated enough difference from each other to perform two separate regressions, one using the LIQ measure and a second using the LICON measure of local incomer status.

The regression model using the five predictors that included the LIQ accounted for a statistically significant amount of variance in the criterion, help-seeking, ($R^2 = .440$, $F(5, 100) = 15.685$, $p < .001$). The five predictor model produced only one statistically significant individual predictor, rural cultural beliefs about mental health with a β of $-.538$ ($t(100) = -5.870$, $p < .000$) indicating that the more an individual identifies with rural cultural beliefs, the less they are likely to report a preference for mental health help-seeking.

Table 8

Simultaneous Multiple Regression to Predict Help-seeking using Local/Incomer Questionnaire (LIQ)

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i> (100)	<i>p</i>
Rurality	.109	.112	.076	.975	.332
LIQ	-.071	.140	-.041	-.508	.612
PSS	.042	.053	.060	.793	.430
KFFMHS-R	.073	.046	.142	1.577	.118
HRCBMH	-.370	.063	-.538	-5.870	.000

Note. $N = 106$. $R_{\text{total}} = .663$. $R^2_{\text{total}} = .440$. $F(5, 100) = 15.685$, $p < .000$

The second regression analysis used the same set of predictor variables except the measure of local versus incomer status LIQ was replaced with the LICON. LICON is a continuous measure of local and incomer status. The model using the four previously mentioned variables with the LICON resulted in a statistically significant regression model $R^2 = .443$ ($F(5, 100) = 15.89$, $p < .000$). As with the first model, Rural Cultural Beliefs about mental health was the strongest and only statistically significant individual predictor with a $\beta = -.530$ ($t(100) = -5.791$, $p < .000$).

Table 9**Simultaneous Multiple Regression to Predict Help-seeking using Local/Incomer Continuum**

Variable	<i>B</i>	<i>SE B</i>	β	<i>t</i> (100)	<i>p</i>
Rurality	.097	.112	.067	.868	.388
LICON	-.059	.065	-.074	-.917	.362
PSS	.046	.053	.065	.866	.388
KFFMHS-R	.070	.046	.137	1.515	.133
HRCBMH	-.365	.063	-.530	-5.791	.000

Note. $N = 106$. $R_{\text{total}} = .665$. $R^2_{\text{total}} = .443$. $F(5, 100) = 15.892$, $p < .000$

In conclusion, the study's first hypothesis was supported as the variables did produce a statistically significant predictive model of help-seeking attitudes in a rural population. However, the study's second hypothesis indicating that rurality and incomer status would be the strongest predictors of help-seeking attitudes was not supported.

CHAPTER FIVE: DISCUSSION

This chapter presents the summary of the study's findings, conclusions that can be drawn from the data in relationship to the existing literature base, as well as limitations of the study and recommendations for further research.

Summary of the Research

The purpose of this study was to explore factors that influence help-seeking in a rural population and to evaluate differences in help-seeking that may be related to an individual's identification as either a rural local or a rural incomer. Five factors: a) rurality; b) Local/Incomer status; c) Rural cultural beliefs about mental health; d) Knowledge and familiarity with mental health services; and e) Perceived stigma were examined as to their influence on help-seeking attitudes.

One hundred six rural residents, age 18 and above, presenting to a rural medical clinic, either as patients or visitors in Southwest Iowa completed the research surveys consisting of a demographic questionnaire with items assessing rurality, local/incomer status, and mental health preferences, as well as measures of perceived stigma (PSS), knowledge and familiarity with formal mental health services (KFFMHS-R), rural cultural beliefs about mental health (HRCBMH), and help-seeking attitudes (ATSPPHS). Cronbach's Alphas of the study's instruments ranged from .68-.95 resulting in acceptable to excellent internal consistency. The internal consistency for rurality was the lowest of the measures at .68, but was judged to be adequate. Thus, reliable measures were used to assess the influence of the research variables on help-seeking.

Research questions were investigated pertaining to the influence of rurality and incomer status on help-seeking attitudes as well as exploring the comparative

contributions of the predictor variables and their relative contributions to the prediction of help-seeking attitudes of rural residents in a Southwest Iowa community. The research questions investigated were: (1) How do rurality and incomer status influence help-seeking attitudes in a rural context? and (2) What are the predictive and comparative contributions of the following variables to the prediction of help-seeking attitudes of rural residents in the Southwest Iowa area: (a) Rural cultural beliefs about mental health; (b) Knowledge and familiarity with mental health services; (c) Perceived stigma; (d) Use of informal resources; (e) Degree of rurality; (f) Degree of incomer status?

Correlational and multiple linear regression analyses were utilized to test the study's two hypotheses. Hypothesis One was that rurality, incomer status, rural cultural beliefs about mental health, knowledge and familiarity with mental health services, and perceived stigma, would result in a statistically significant predictive model of help-seeking attitudes in a rural sample. Hypothesis two was that rurality and incomer status would be the strongest predictors in comparison to the other predictor variables in the prediction of help-seeking attitudes.

Results indicated that several factors influence help-seeking in a rural population. Overall, the findings supported Hypothesis One by producing a statistically significant model, but did not show support for Hypothesis Two that rurality and incomer status would be the strongest predictors through their contributions of unique variance to the predictive equation in comparison with Knowledge, Rural Cultural Beliefs, and Perceived Stigma.

To explain and interpret the predictive model, correlational analyses were performed. Statistically significant correlations between help-seeking and four variables (i.e.,

rurality, incomer status, knowledge and familiarity with mental health resources, and rural cultural beliefs about mental health). The correlational results were interpreted as the more rural an individual was and the more knowledge he or she had of mental health resources, the more likely the person was to endorse positive attitudes toward help-seeking. The more an individual identified as an incomer and identified as having more rural cultural beliefs about mental health, the less likely they were to have favorable attitudes toward help-seeking. Contrary to previous research findings (Hoge et al., 2004; Sirey et al., 2001; Kelleher et al., 1992; Wagenfeld & Buffum, 1983; Wrigley et al., 2004), perceived stigma was not significantly correlated in its relationship to help-seeking attitudes. The multiple regression analyses utilizing the five predictor variables yielded results indicating Rural Cultural Beliefs as the only variable in this study's model contributing statistically significant unique variance to the prediction of help-seeking attitudes.

This study was intended to explore the relationships between rurality and local/incomer status on help-seeking in rural areas. Both rurality and local/incomer status correlated with help-seeking, as more rural orientations indicated more positive help-seeking attitudes and individuals identifying as incomers reporting less favorable help-seeking attitudes. However, the obtained models did not account for a large amount of unique variance apart from other variables for rurality and local/incomer status. And as stated above, the only statistically significant predictor variable in the model was rural cultural beliefs about mental health. Thus, Hypothesis Two, suggesting that rurality and incomer status would be the strongest unique predictor of help-seeking attitudes was not supported. Hypothesis One suggested that together, rurality, incomer status, rural

cultural beliefs about mental health, knowledge and familiarity with mental health services, and perceived stigma would produce a statistically significant predictive model of help-seeking. This hypothesis was supported with rural cultural beliefs about mental health as the strongest single predictor of help-seeking attitudes. The more an individual identified with rural cultural beliefs the less likely they were to have favorable attitudes toward help-seeking. Conversely, the less an individual endorsed rural cultural beliefs the more they would show favor to help-seeking attitudes toward mental health treatment.

Some initial predictions were also made regarding correlations between rurality and incomer/local status and the dependent variable help-seeking as well as with the other independent variables. These predictions are reviewed in Table 10 and the direction and significance level achieved of correlations that actually resulted from the analyses are displayed in Table 11.

Table 10

Predicted Correlations

	Rural Cultural Beliefs	Knowledge and Familiarity of Resources	Perceived Stigma	Use of Informal Resources	Help- Seeking
Rurality High	+	+	+	+	-
Incomer Status	-	-	-	+	+

Table 11**Obtained Correlations**

	Rural Cultural Beliefs	Knowledge and Familiarity of Resources	Perceived Stigma	Use of Informal Resources	Help- Seeking
Rurality High	-	+	+	-	+*
Incomer Status	+**	-**	+		-**

Note.

* $p < .05$ ** $p < .01$ *** $p < .000$

As can be seen, results of the study showed both consistencies and inconsistencies with the initial predictions. Three initial predictions were confirmed. These were: the relationships between Rurality and Knowledge, Rurality and Stigma, and Incomer status and Knowledge. It was believed that individuals who identified as rural would have more knowledge and familiarity with resources. It was predicted that if they were indeed rural, this would indicate the likelihood that they were from the area where the research was done and they would likely be familiar with local resources. This correlation was positive, but not significant. Thus any association between the two variables could also be explained as due to random error. The data showed a relationship that indicated the more rural an individual was the more stigma they would have. However, this relationship was also not statistically significant. The prediction that incomer status

would negatively correlate with knowledge and familiarity of resources was supported as statistically significant.

It was predicted that incomer status would negatively correlate with rural cultural beliefs about mental health. This was not found to be the case. Individuals who identified as incomers tended to identify more with rural cultural beliefs. This was a statistically significant relationship and could be due to incomers coming from other rural areas instead of from cities. It was also predicted that incomers would demonstrate lower scores on measures of stigma and would have a more favorable view of help-seeking. Results of the current study showed just the opposite that individuals who indicated that they were more of an incomer in an area had more stigma and less favorable views of help-seeking. The relationship between stigma and incomer status was not statistically significant. The relationship between incomer status and help-seeking was significant as measured by both assessments of local and incomer status, however it was not in the predicted direction.

It was predicted that if rurality was high, individuals would identify more with rural cultural beliefs and be less likely to view help-seeking favorably. This was not shown in the data, but the correlation between rurality and rural cultural beliefs was not statistically significant. It was expected, that there would be a positive relationship between rurality and rural cultural beliefs. This suggests that just because an individual lives in a rural area, they do not necessarily ascribe to traditional rural values and beliefs. Thus, overall, these results lend partial support for the validity of the measure used in this analysis but also raise questions as to why some variables were not correlated as predicted.

Comparisons with Aloud's Model

The framework for this study was based on the work of Aloud (2004) in his evaluation of the factors that contributed to the help-seeking attitudes of an Arab-Muslim population. As in Aloud's work, a statistically significant model was obtained using the variables of knowledge and familiarity of mental health, stigma, and cultural beliefs. However, Aloud's model and the present one diverged in several ways. In Aloud's work he found that cultural beliefs, stigma, and knowledge were statistically significant in predicting help-seeking for an Arab-Muslim population. The current study found only that rural cultural beliefs significantly contributed unique variance to the prediction of help-seeking.

Knowledge and Familiarity

Hill and Fraser (1995) explored what they referred to as "local knowledge" and mental health reform. Specifically they addressed that "local knowledge" impacted utilization of resources. The current study found a positive relationship between knowledge and familiarity of mental health resources and processes with help-seeking attitudes. The less knowledge an individual had regarding resources, the less likely they were to report positive attitudes toward help-seeking. Aloud's (2004) research found that knowledge and familiarity of formal mental health resources did contribute unique variance to his model of help-seeking. In the current study, the factor contributing significant unique variance to the prediction of help-seeking was rural cultural beliefs about mental health. The study showed a negative relationship between knowledge and rural cultural beliefs. The more knowledge an individual had of formal mental health services, the less likely they were to ascribe to more traditional rural cultural beliefs. It is possible that due to the

shared variance between knowledge and rural cultural beliefs in the current study's model, knowledge, although important, did not uniquely predict of help-seeking.

Rural Cultural Beliefs and Rurality

Further, a negative correlation was found between rural cultural beliefs about mental health help-seeking attitudes, suggesting that the more an individual identified with rural cultural beliefs the less likely they were to have a favorable attitude toward help-seeking. In areas where individuals adhere to more traditional rural cultural beliefs about mental health, individuals may be less likely to hold favorable attitudes toward help-seeking and in turn may be less likely to seek needed help. This is consistent with previous research findings suggesting that although mental health issues in rural and urban areas are similar in prevalence, rural individuals tend to seek treatment later, with more severe symptoms, and have higher rates of suicide as compared to their urban counterparts (Advancing Suicide Prevention, 2005; Lambert & Agger, 1995; Wagenfeld et al., 1994). In addition, the current study found that 76.4% of the sample reported never having sought treatment from a mental health professional. This confirms that within the current sample, the majority of individuals do not have experience seeking help for mental health concerns from a mental health professional. Again the primary factor contributing to help-seeking in the current study was rural cultural beliefs about mental health suggesting that this is an area to further explore as professionals work to target, engage, and provide mental health services to rural residents. The hope is that by being able to address barriers such as those related to rural cultural beliefs, these individuals can be identified sooner, and ways can be found to help rural individuals to then seek help soon. Gaining the help that is needed sooner for mental illness may prevent more severe pathology from developing

and making it possible to intervene before mental illness gets out of hand for a given individual.

Rurality by itself did not predict negative attitudes toward help-seeking and in fact the current study found a positive, but non-significant, relationship between rurality and help-seeking. Thus, results may also indicate that it is not rurality itself that is connected to less favorable attitudes of help-seeking, but may be related more to rural individuals who possess traditional rural cultural beliefs about mental health. In an argument against stereotyping rural individual, the results of this study indicate the possibility that one could be classified as rural, but have less traditional rural cultural beliefs.

Stigma

Previous research found more favorable attitudes toward help-seeking related to lower perceived stigma (Hoge, 2004; Wrigley, Jackson, Judd, & Kimiti, 2004). Results from this study did not show a statistically significant relationship between help-seeking and stigma. Past literature has suggested that stigma is perpetuated by rural culture due to its traditional emphasis on autonomy and self-reliance (Kelleher, Taylor, & Rickert, 1992). Results in the current study did not indicate statistically significant relationships between perceived stigma and rurality, or between stigma and rural cultural beliefs about mental health. One possible explanation for the current findings could be due to the high number of females in the sample. Judd et al. (2008) found that in their sample of 579 rural individuals, women tended to report less stigma which resulted in higher levels of help-seeking. Because most of the sample in the current study was made up of women, the sample may have been biased toward less stigmatized views of help-seeking. If more

men had participated it is possible that the findings of stigma would have differed from what was actually found. Such speculation should be investigated.

Mental Health Help-seeking Preferences

Preferences for outside help-seeking were also assessed with much of the sample identifying that they would first seek outside help for a mental health concern from their family doctor. Comparisons by gender also showed that a higher percentage of both males and females elected to go to their family doctor first as compared to seeking help from a mental health provider, close friend, a priest or pastor, a family member, or not seeking help from anyone. This was also the case when comparisons were made by level of education as well. For individuals with less than a high school degree, a GED or high school degree, some college, an associate's degree, a master's degree, and individuals with a doctorate, the majority identified a preference of seeking outside help from a family doctor as their first choice. In contrast, the majority of individuals with bachelor's degrees identified that their first preference for help-seeking would be a family member, followed by a preference for a family doctor.

Some research suggests that individuals may be more likely to and prefer to seek informal sources of support (Boldero & Fallen, 1995; Highet, Hickie, & Davenport, 2002; Oliver, 2012; Wilson, Deane, Ciarrochi, & Rickwood, 2005). Participants in this sample were asked to identify their preferences for seeking outside support for mental health issues. Contrary to the above cited research, a higher percentage of the sample identified a more formal preference of seeking assistance from their family doctor. Girio-Herrera, Owens, and Langberg (2013) in their study on at-risk kindergarteners and help-seeking found that parents were most likely to seek help from informal resources.

However, consistent with the current study, if individuals did seek more formal resources, it was from their medical provider, not a mental health provider. Thus, this study's results were consistent with some of the literature that suggests that treatment or concerns regarding mental health are more likely discussed with a medical provider, or that medical providers are the starting point for individuals to connect with mental health services (Del Piccolo, Saltini, & Zimmerman, 1998; Elhai, Voorhees, Ford, Sam Min, & Frueh, 2009; Wang, Demler, Olfson, Pincus, Wells, & Kessler, 2006).

Weinert and Long (1987) explored the use of formal and informal help-seeking identifying that rural individuals were less likely to seek formal help and were more likely to utilize family and friends when compared to their urban counterpart. Their research went on to suggest that rural individuals identified themselves as being more "self-reliant." The current research study found that the largest percentage of the sample preferred to seek formal assistance from their medical provider first for a mental health concern. The second highest preference was from a family member. Only 3% of the sample identified that they would not seek help from anyone suggesting that individuals may not focus on being self-reliant when considering treatment for mental health concerns. These results could have been impacted by the gender make-up of the sample. Contrary to the Weinert and Long study that was 65% females, the current study's sample was 83% female. When comparing preference for outside help between males and females in the current study, no female identified that her first preference was to not seek informal or formal help and 17% of the males identified that their first preference would be to seek outside help from "nobody." Thus the difference between men and

women's preferences was evident in the results indicating the need to include gender as an important variable in future research of help-seeking in rural cultures.

Limitations

There are limitations with the current study. The sample utilized for the study came from a rural area in Southwest Iowa. The results of the study may not generalize to other rural areas in other parts of the U.S. or areas with a more culturally diverse population. The current sample lacked diversity by consisting mostly of women, who were married, educated, and had commercial insurance. A larger sample size may have revealed more diversity through more influence accounted for by higher numbers of culturally and ethnically diverse individuals. The current sample limits generalizability of results to other rural areas, even those in other parts of the Midwest.

Although obtaining participants in rural areas through medical clinics is typically a positive approach in obtaining a representative rural sample, there are drawbacks. A bias in the sample might be that the sample was recruited within a medical facility and as such may be made up of individuals who tend to seek help. In addition, the majority of the sample indicated that they had health insurance coverage of some type. This may be excluding a sample of the population that is not seeking help for either physical or mental health issues due to a lack of coverage. Help-seeking, however, could change with the 2012-2013 implementation of the Affordable Care Act which requires insurance coverage and could influence the barrier that prevents seeking care due to an individual not having insurance coverage. Again future research within the age of the Affordable Care Act is indicated.

The survey methods employed for this study could also have inherent limitations. The self-report nature of the measures could influence the study findings, as individuals may wish to represent themselves in a socially desirable manner. Generalizations can be limited due to the lack of randomization of participants or not using other research designs that are experimental in nature. The correlational nature of this study prohibits making causal inferences about the study variables. However, due to the limited research on rural populations a correlational survey design was utilized.

In addition, there may have been an order effect. The measures administered to the sample were given in the same order for each participant. Rotating the order of the measures on the protocol would address this issue.

Internal validity issues could be of concern as well. The measures of, incomer/local status, and rural cultural beliefs about mental health were designed specifically for the current research study. Although initial procedures were performed to pilot the measures, further evidence for the reliability and validity of the measures would help to add confidence in their use. Using the rural cultural beliefs scale with other populations may also help to determine if it is, in fact, measuring “rural” cultural beliefs and not just “traditional” beliefs in general. Future research should look further into the assessment of rurality, what it means to be a rural local or rural incomer, and assessing rural cultural beliefs about mental health. The current study makes a contribution in this way by including rural local and rural incomer as variables considered during this investigations and serves as a starting point for defining what it means to be a rural local or an incomer.

Implications of Study

The results from this study exploring factors that influence help-seeking attitudes in rural communities have significant implications for mental health professionals, medical providers, researchers, and public policy.

The initial goals of the study were to explore the impact of rurality and incomer status on help-seeking. As research has addressed there are challenges in defining rurality (Nicholson, 2008; Jones-Hazldine et al., 2007). In addition, Nicholas (2008) suggests that rural areas consist of rural locals and rural incomers. She points out that the literature often does not distinguish the differences in these two groups. The current study addressed this deficit in the literature in an effort to discriminate between rural local and rural incomer by specifically looking at the differences that exist with help-seeking attitudes. Although the current study did not find that identifying as rural local or rural incomer was a significant factor as indicated through the regression model formed, a statistically significant relationship was found between incomer status and help-seeking attitudes. Future exploration into how locals and incomers are defined could influence results.

Individuals who identified themselves as more of an incomer were less likely to have favorable attitudes toward help-seeking. This has both implications for research and for clinical work. With individuals who identify themselves as incomers reporting less favorable attitudes toward help-seeking, it may be beneficial to design clinical outreach programs that target individuals who are new to rural areas or who express feeling disconnected from the community. One possible avenue may be through a joint effort with the local school as schools would have access to families moving into an area. This

could be of benefit as the current study also found a relationship between individuals who identified as incomers reporting having less knowledge about mental health services and individuals who identified as more local reporting more knowledge. Further more, individuals reporting more knowledge also reported more favorable attitudes toward help-seeking. This research provides a starting point in looking at differences between the groups and also suggests that further research is needed to gain clarity about the influence of incomer status on help-seeking.

Individuals in this study, also indicated that their first preference in seeking help for mental health concerns would be to discuss the issues with their medical provider. This suggests that improved relationships between medical providers and mental health professionals may be beneficial in helping rural individuals to become aware of available resources and aware of treatment options. Using medical providers as liaisons could decrease treatment gaps and may help rural individuals seek treatment sooner, rather than waiting until a problem becomes severe. Providing information about mental health services and mental health concerns in waiting areas of medical clinics could also be an avenue with rural individuals.

Rural research is relatively limited, no matter what topic is being examined. Rural Cultural Beliefs would probably be an important variable for all types of research concerning social attitudes in rural areas. Although the variables used in this research may influence help-seeking, the current study found that the single unique predictor of help-seeking was rural cultural beliefs about mental health. Further development and validation studies of the Herzberg Rural Cultural Belief about Mental Health Scale could be helpful in exploring the factors that prevent or encourage individuals to seek help for

mental health problems. Implications of the design and use of the Herzberg Rural Cultural Beliefs scale in the current study provide a starting point for further exploration.

In addition, research informs policy and policy dictates funding. The current research provides direction in exploring the factors that influence help-seeking in rural areas. Results could be used to inform policy makers about the importance of specifically addressing the needs of those in rural areas from a unique cultural perspective. That is, evidence from this study points to the existence and validity of rurality as a distinct culture. It provides a window of exploration as to what factors influence individuals to seek help and could provide evidence for clinicians and professionals as they seek funding to develop programs that can target individuals who are not utilizing resources and services.

Future Research

The current research endeavor provides a foundation for further exploration of rural individuals in the area of mental health beliefs. Specifically continuing to look at the similarities and differences between rural locals and rural incomers could help to further define the needs of a rural population. The current study did not distinguish between incomers who came from rural areas and incomers who came from more urban settings. This distinction could illuminate further differences. A mixed methodology including a qualitative component could be useful in further exploring the nuances of what it means to be a rural local and what it means to be a rural incomer. A qualitative component could also be helpful in gaining a more in-depth and richer understanding of rural people's beliefs about help-seeking.

In addition, although the number of participants who identified as ethnic minorities were low in the current sample, exploring the help-seeking attitudes and preferences of ethnic minority individuals in rural areas could also provide data to aid in outreach to minority groups. Culture and ethnicity could be broken down into not only ethnicity defined by race but also culture defined by age, sexual orientation, gender, and disability to name just a few aspects of diversity.

The current study found that individuals prefer to seek help from medical doctor first for mental health problems. Further research exploring programs that link medical with professional psychological resources would be helpful. Hill and Fraser (1995) suggest “linking” formal and informal resources. As stated earlier, a stronger relationship between medical and mental health professionals could help bridge the accessibility and acceptability gaps present in rural communities. Finally, this research explored help-seeking attitudes using self-report measures. Ultimately, in order to provide adequate services to the underserved and individuals who underutilize resources, exploration of actual help-seeking behaviors is important.

In conclusion, research exploring rural issues and populations regarding mental health utilization is limited. With comparisons between rural and urban individuals showing a similar report of prevalence of mental health concerns, but differences in severity of symptoms when first seeking treatment, and differences in severity of outcome with rural areas having a higher incidence of suicide, it is imperative that the rural research base from which clinician’s draw is expanded. Exploring the rural population, by assessing and defining rural locals and rural incomers is important by delineating characteristics of rural individuals. The current study found that it wasn’t necessarily the population or

characteristics of the place from which individuals hailed that determined their attitudes toward help-seeking. Rather, more relevant was the more traditional rural cultural beliefs held by some rural people. Individuals who identified as incomers, surprisingly, held more traditional rural cultural beliefs. Further understanding of these nuances, specifically with help-seeking, can help clinicians more effectively identify and reach out to individuals to help meet their mental health needs.

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Appendix A

Demographic Information, Rurality and Income Status

Factors Influencing Rural Help-Seeking Questionnaire

The following section includes some general background information. Please respond to the following items by checking the appropriate answer. It is important that you answer each item. No name will be asked, so no one will know this information belongs to you. Thank you for your participation.

Demographic Questionnaire

For the following items please check only one.

1. What is your gender? ☐ Male ☐ Female ☐ Transgender
 2. What is your race/ethnicity?
☐ African American ☐ Asian American ☐ Latin American/Hispanic (any race) ☐ Caucasian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Two or more races
 4. What is your Marital Status?
☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabiting
 5. What is the highest level of education you have attained?
☐ Less than High School
☐ GED/High School Diploma
☐ Some College
☐ Associates Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctoral Degree
 6. What is your household annual income?
☐ Less than 5,000
☐ 5,000-9,999
☐ 10,000-19,999
☐ 20,000-29,999
☐ 30,000-39,999
-

☐ 40,000-49,999

☐ 50,000-59,999

☐ 60,000-69,999

☐ 70,000 or higher

7. What is your Health Insurance Status?

☐ No Health Insurance

☐ Medicaid or Title 19

☐ Medicare

☐ Commercial/Group Insurance

8 What is your employment status?

☐ Unemployed

☐ Part-Time

☐ More than one Part-time job

☐ Full-Time

Please fill in the following blanks:

What is your Religious Affiliation?

What is your date of birth? (Month/Day/Year)

Rurality

What is the name of your current home town? _____

What is the name of the town in which you were born? _____

What is the name of the town in which you have lived the longest? _____

Please circle one response for the following items.

1. What is the population of the town in which you currently reside?

1	2	3	4
More than 50,000	2,500-49,999	1,000-2,499	Less than 1,000

2. How would you describe your current living situation?

1	2	3	4
Living in town			Living in the Country

3. What is the population of the place you have lived the longest?

1	2	3	4
More than 50,000	2,500-49,999	1,000-2,499	Less than 1,000

4. How would you describe yourself on the following scale:

1	2	3	4
Urban Person			Rural Person

5. How long have you lived in your current community? (Please specify in years and months

___years ___months

Please answer the following questions about the community that you **currently reside** in. Please **circle one**.

1. I feel my values match those in this community.

Strongly Agree Agree Disagree Strongly Disagree

2. I and my family volunteer or participate in community events (e.g.; school, church, festivals).

Strongly Agree Agree Disagree Strongly Disagree

3. This community feels like "home" to me.

Strongly Agree Agree Disagree Strongly Disagree

4. Even though I live here, I still feel a closer tie to a former community I lived in.

Strongly Agree Agree Disagree Strongly Disagree

Please place an "X" on the line below nearest to the description that most fits with how you would identify yourself.

I would consider myself a **Local**: someone born and raised in this community and connects with local values and customs

I would consider myself an **incomer/newcomer**: someone who was not born in this community and has settled here and does not connect with local values and customs.

Appendix B

Mental Health Preferences

Mental Health Preferences

To whom would you go to **First** if you were considering seeking outside help for mental health/psychological issues?

☐ Mental Health Professional ☐ Family Doctor (MD/DO) ☐ Close Friend
☐ Priest/Pastor ☐ Family member ☐ Nobody

To whom would you go to **Second** if you were considering seeking outside help for mental health/psychological issues?

☐ Mental Health Professional ☐ Family Doctor (MD/DO) ☐ Close Friend
☐ Priest/Pastor ☐ Family member ☐ Nobody

To whom would you go to **Third** if you were considering seeking outside help for mental health/psychological issues?

☐ Mental Health Professional ☐ Family Doctor (MD/DO) ☐ Close Friend
☐ Priest/Pastor ☐ Family member ☐ Nobody

Please circle one.

In the past five years, approximately how many times have you visited a mental health professional (psychiatrist, psychologist, or a clinical social worker) for a mental health or psychological concern?

Never 1 or 2 times 3 to 5 times More than 5 times

Appendix C

Herzberg Rural Cultural Beliefs about Mental Health Scale (HRCBMH)

Below are statements regarding your belief about mental illness or psychological problems. Please carefully read each statement and respond **Do not believe, Somewhat do not believe, Somewhat believe or Believe**.

Herzberg Rural Cultural Beliefs about Mental Health Scale (HRCBMH)

4 four-point Likert Scale responses:

Do not believe Somewhat do not believe Somewhat believe Believe

1. If I had a mental health problem I would seek professional help.

Do not believe Somewhat do not believe Somewhat believe Believe

2. I or someone in my family could be susceptible to mental illness.

Do not believe Somewhat do not believe Somewhat believe Believe

3. Due to barriers (e.g. transportation, finances, distance, availability of services) it is easier for people to handle mental health problems on their own rather than to seek professional help.

Do not believe Somewhat do not believe Somewhat believe Believe

4. Individuals with mental health problems need to learn to handle them on their own.

Do not believe Somewhat do not believe Somewhat believe Believe

5. When I have a personal problem, I tend to see it as not serious.

Do not believe Somewhat do not believe Somewhat believe Believe

6. Most mental health problems can be handled without professional help.

Do not believe Somewhat do not believe Somewhat believe Believe

7. Some physical problems are due to psychological causes such as stress.

Do not believe Somewhat do not believe Somewhat believe Believe

8. A mental health problem would have to be very severe for a person to seek professional help.

Do not believe Somewhat do not believe Somewhat believe Believe

9. People in my community are at risk for mental health problems.

Do not believe Somewhat do not believe Somewhat believe Believe

10. Anyone could suffer from mental health problems.

Do not believe Somewhat do not believe Somewhat believe Believe

11. Most people do not struggle with mental health problems

Do not believe Somewhat do not believe Somewhat believe Believe

12. I would not seek professional mental health treatment because then others in the community would find out.

Do not believe Somewhat do not believe Somewhat believe Believe

13. I know a great deal about mental health problems.

Do not believe Somewhat do not believe Somewhat believe Believe

14. Seeking help for a mental health problem would be beneficial.

Do not believe Somewhat do not believe Somewhat believe Believe

15. If someone has a mental health problem, they should just deal with it.

Do not believe Somewhat do not believe Somewhat believe Believe

16. If people have problems with mental health, they should leave it up to Fate- whatever will be, will be.

Do not believe Somewhat do not believe Somewhat believe Believe

17. If an individual is struggling with personal problems, prayer can be helpful.

Do not believe Somewhat do not believe Somewhat believe Believe

Appendix D

Knowledge and Familiarity with Formal Mental Health Services (KFFMHS)
(Aloud, 2004)

Below are statements pertaining to your knowledge and familiarity with mental health and psychological disorders, types of formal services, as well as mental health professional providers.

Knowledge and Familiarity with Formal Mental Health Services

(KFFMHS-Revised)

(Aloud, 2004; Herzberg, 2013)

1. How **familiar** are you with the types of problems that might require professional mental health or psychological intervention (e.g. mental instability, an abnormal fear or feeling, a depressed mood, etc.)?

1.__ Not at all 2.__ Very little 3.__ Somewhat 4.__ Very familiar

2. How **familiar** are you with the **availability** of mental health and psychological services in your community (e.g. location, phone number, type of care)?

1.__ Not at all 2.__ Very little 3.__ Somewhat 4.__ Very familiar

3. How much do you know about **Confidentiality** within mental health services?

1.__ Nothing 2.__ Very little 3.__ Some 4.__ A great deal

4. How much do you know about the **structure** of a mental health appointment (e.g. length of appointments, how often one is seen)?

1.__ Nothing 2.__ Very little 3.__ Some 4.__ A great deal

5. How much do you know about the nature of the client/clinician relationship (e.g. knowing or seeing the counselor outside of appointments)?

1.__ Nothing 2.__ Very little 3.__ Some 4.__ A great deal

6. How much do you know about **formal medical/behavioral** mental health or psychological disorders or diagnoses (e.g. depression, anxiety, schizophrenia, etc.)?

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

7. How much do you know about the nature of **treatment models/clinical interventions** (e.g. psychotherapy used in professional mental health clinics) in mental health practice?

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

8. How much do you know about **how to get** professional mental health or psychological counseling services when needed (e.g. procedures and requirements)?

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

9. How much do you know about common **drug treatments** prescribed to individuals with mental health or psychological problems?

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

10. How much do you know about the **rural professionals** who practice mental health or psychological counseling within your local community (Southwest Iowa)

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

11. How much do you know about your **eligibility for mental health care** under your current health insurance plan?

1.__Nothing 2.__Very little 3.__Some 4.__A great deal

Appendix E

Perceived Stigma Scale (PSS) (Wrigley, Jackson, Judd, & Komiti, 2005)

Below are statements concerning your perceptions of mental health treatment. Please carefully read each statement and indicate whether you **Strongly Agree, Agree, Disagree, or Strongly Disagree**.

Perceived Stigma Scale (PSS) (Wrigley, Jackson, Judd, & Komiti, 2005)

1. Most people would willingly accept a former mental health patient/client as a close friend.

Strongly Agree Agree Disagree Strongly Disagree
2. Most people believe that a person who has been in a mental hospital/clinic is just as intelligent as the average person.

Strongly Agree Agree Disagree Strongly Disagree
3. Most people believe that a former mental health patient/client is just as trustworthy as the average citizen.

Strongly Agree Agree Disagree Strongly Disagree
4. Most people would accept a fully recovered former mental health patient/client as a teacher of young children in a public school.

Strongly Agree Agree Disagree Strongly Disagree
5. Most people feel that entering a mental hospital/clinic is a sign of personal failure.

Strongly Agree Agree Disagree Strongly Disagree
6. Most people would not hire a former mental health patient/client to take care of their children, even if he or she had been well for some time.

Strongly Agree Agree Disagree Strongly Disagree
7. Most people think less of a person who has been in a mental hospital/clinic.

- | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|-----|---|-------|----------|-------------------|
| 8. | Most employers will hire a former mental health patient/client if he or she is qualified for the job. | | | |
| 9. | Most employers will pass over the application of a former mental health patient/client in favor of another applicant. | | | |
| 10. | Most people in my community would treat a former mental health patient/client just as they would treat anyone | | | |
| 11. | Most women/men would be reluctant to date a person who has been hospitalized for a serious mental disorder. | | | |
| 12. | Once they know a person was in a mental hospital/clinic, most people will take his/her opinions less seriously. | | | |
| 13. | People with mental illness would be treated poorly in this community if people found out about it. | | | |
| 14. | This community would be supportive and caring towards someone who experienced mental illness. | | | |
| 15. | People would gossip about a person who had mental illness. | | | |

Strongly Agree Agree Disagree Strongly Disagree

16. Many people would be wary of someone who had been hospitalized for mental illness

Strongly Agree Agree Disagree Strongly Disagree

Appendix F

Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (ATSPPHS)

(Fischer and Farina, 1995)

Below are some statements concerning your perceptions of seeking formal mental health or psychological services. Please carefully read each statement and indicate whether you **Strongly Agree, Agree, Disagree, or Strongly Disagree** with each one. I am interested in your perceptions and beliefs in regard to mental health counseling services.

**Attitudes Toward Seeking Professional Psychological Help: A Shortened
Form (ATSPPHS) (Fischer and Farina, 1995)**

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

Strongly Agree Agree Disagree Strongly Disagree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

Strongly Agree Agree Disagree Strongly Disagree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

Strongly Agree Agree Disagree Strongly Disagree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

Strongly Agree Agree Disagree Strongly Disagree

5. I would want to get psychological help if I were worried or upset for a long period of time.

Strongly Agree Agree Disagree Strongly Disagree

6. I might want to have psychological counseling in the future.

Strongly Agree Agree Disagree Strongly Disagree

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

Strongly Agree Agree Disagree Strongly Disagree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

Strongly Agree Agree Disagree Strongly Disagree

9. A person should work out his or her problems; getting psychological counseling would be a last resort.

Strongly Agree Agree Disagree Strongly Disagree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

Strongly Agree Agree Disagree Strongly Disagree

Thank you for your participation.

Appendix G

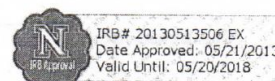
Participant Informed Consent Form



COLLEGE OF EDUCATION AND HUMAN SCIENCES
Educational Psychology

Participant Informed Consent Form

Identification of Project:



Title: The Influence of Income Status: The Role of Rural Background, Knowledge of Mental Health Services, and Perceived Stigma, on Help-seeking Attitudes

Purpose of the Research:

The purpose of this study is to understand factors that contribute to help-seeking in rural areas. You must be 18 years of age or older to participate. You are invited to participate in this study because you are a resident of rural Iowa and considered a legal adult in the state of Iowa and are utilizing services through a rural medical clinic. It is the desire of this study to learn information about help-seeking attitudes to better inform community members about local services, and to address help-seeking needs.

Procedures:

After being approached by the researcher, you will be given an option of participating in the current study. You will be asked to complete questionnaires on rural cultural beliefs, knowledge of mental health services, beliefs about mental health services, and help-seeking attitudes. Completion time of the questionnaires is 10-15 minutes and will be administered and completed in the waiting area of the Atlantic Medical Center.

Benefits:

There are no direct benefits to you as a research participant, however, participating in this study will help add to the literature on rural help-seeking. Aggregated information can be used to design outreach programs to better serve the mental health needs of this rural community.

Risks and/or Discomforts:

There are no known risks or discomforts associated with this research.

Page 1 of 2



Confidentiality:

Any information obtained during this study which could identify you will be kept strictly confidential. The data will be stored in a locked cabinet in the investigator's office and will only be seen by the investigator during the study and for 3 years after the study is complete. The information obtained in this study may be published in a scientific journal or presented at a scientific meeting but the data will be reported as aggregated data.

Compensation:

You will receive \$5.00 for completing the Rural Help-seeking questionnaire.

Opportunity to Ask Questions:

You may ask questions concerning this research and have those questions answered before agreeing to participate in or during the study. Or you may contact the primary investigator, Sarah Herzberg at (712) 249-9540. Please contact the University of Nebraska-Lincoln Institutional Review Board at (402) 472-6965 to voice concerns about the research or if you have any questions about your rights as a research participant.

Freedom to Withdraw:

Participation in this study is voluntary. You can refuse to participate or withdraw at any time without harming your relationship with the researcher, the University of Nebraska, or the Atlantic Medical Center, or in any other way receive penalty or loss of benefits to which you are otherwise entitled.

Consent, Right, to Receive a Copy:

You are voluntarily making a decision whether or not to participate in this research study. Completing the survey and returning it to this researcher certifies that you have decided to participate having read and understood the information presented. Please keep this form for your records.

Name and Phone number of Investigator(s)

Sarah Herzberg, MS, LMHC, Principal Investigator Phone: (712) 249-9540

Michael J. Scheel, Ph. D., Supervising Investigator Phone: (402) 472-0573

Appendix H

Letter of Support for Data Collection

**FAMILY PRACTICE**

Seann M. Atkinson, DO Brian S. Fiedler, DO
 Stacey L. Bean, PA-C Mary K. Fuller, PA-C
 Todd C. Bean, MD Scott A. Hixson, PA-C
 Elaine K. Berry, MD Jodi L. Stowater-Goodrich, PA-C
 Sarah M. Brend, PA-C Angela B. Weppeler, MD
 Vanessa K. Cook, MD Tressa A. Wilcox, MD

OBSTETRICS/GYNECOLOGY

James W. Brown, MD, OB/GYN, FACOG

March 25, 2013

Institutional Review Board
 University of Nebraska-Lincoln
Research Compliance Services
 312 N. 14th St., Ste 209, Alex West
 Lincoln, NE 68588-0408

Re: Letter of Support: Sarah Herzberg, Counseling Psychology

Dear Sir/Madam:

This is a letter of support for Ph.D. candidate, Sarah Herzberg, to conduct her research, titled, "The Influence of Incomer Status: The Role of Rural Background, Knowledge, of Mental Health Services and Perceived Stigma, on Help-seeking Attitudes" within the Atlantic Medical Center facilities. We understand that the researcher will use the collected data for research purposes only and will strictly adhere to the guidelines set forth by the University of Nebraska-Lincoln, Institutional Review Board. The Atlantic Medical center will provide adequate support for the researcher by giving her access to the facility for data collection.

The Atlantic Medical center appreciates this opportunity to support and help Ms. Herzberg, as her research pursuits will provide valuable information for our community.

Sincerely,

Sue Marsh
 Sue Marsh

Atlantic Medical Center, Asst. Administrator

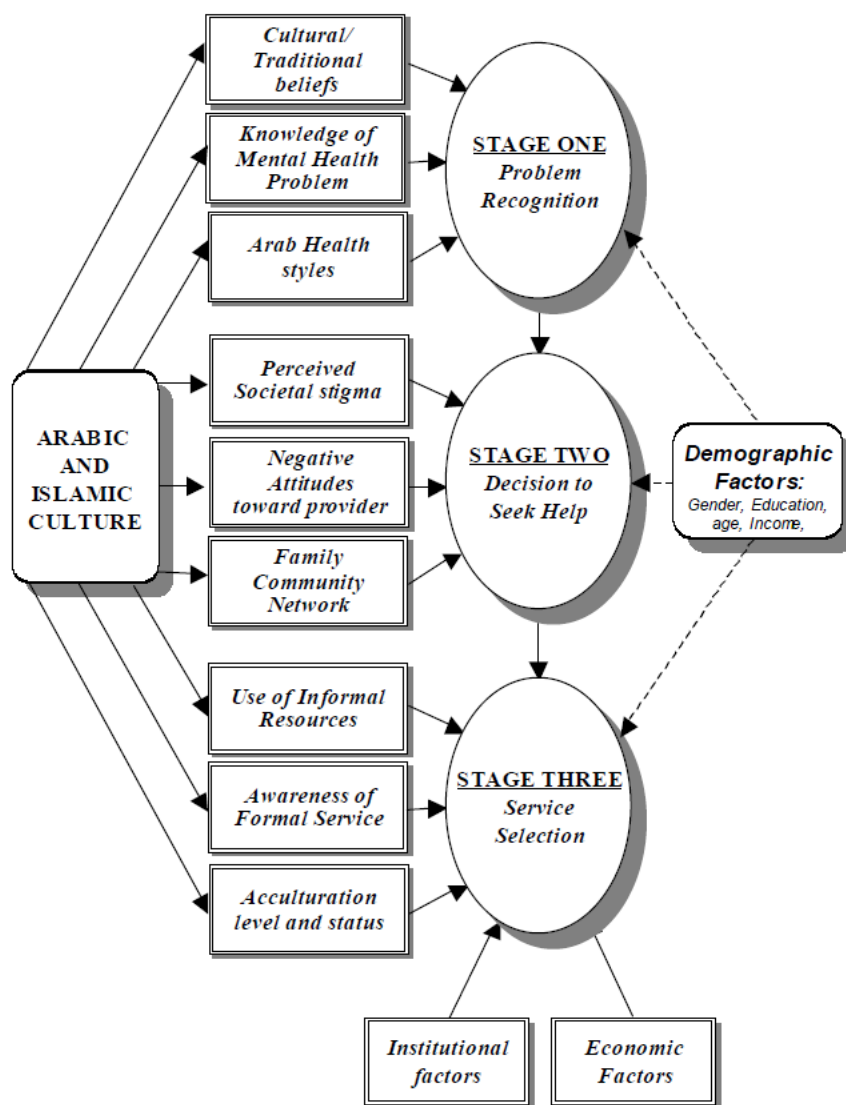


Figure 1: A Model of Mental Health Help-Seeking Pathways and Modifying Factors Among Arab-Muslim Populations (p. 36, Aloud, 2004)

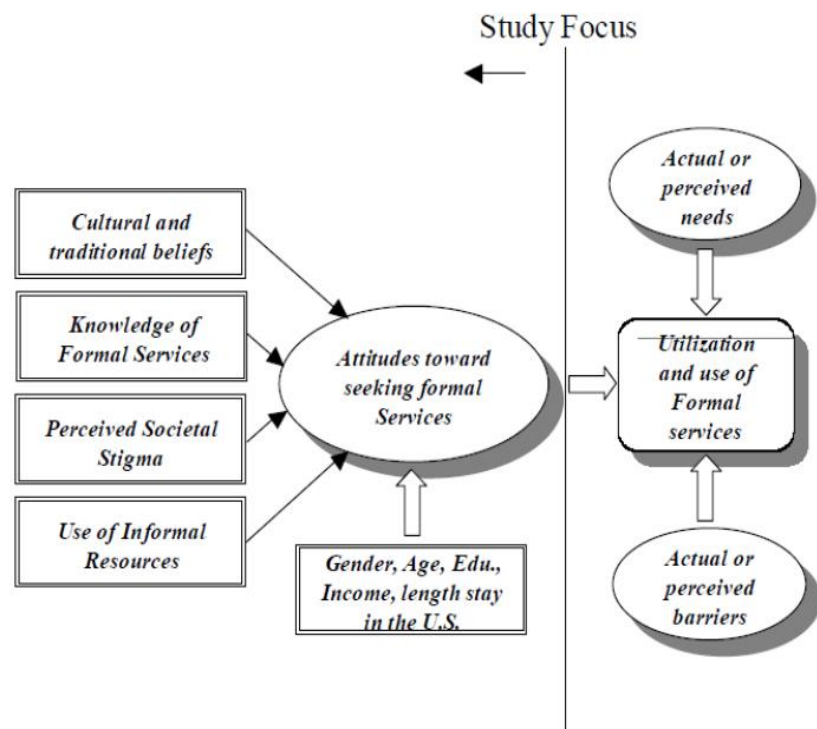


Figure 2: Factors Affecting Arab-Muslim Attitudes Toward Formal Mental Health Services (p. 39, Aloud, 2004).

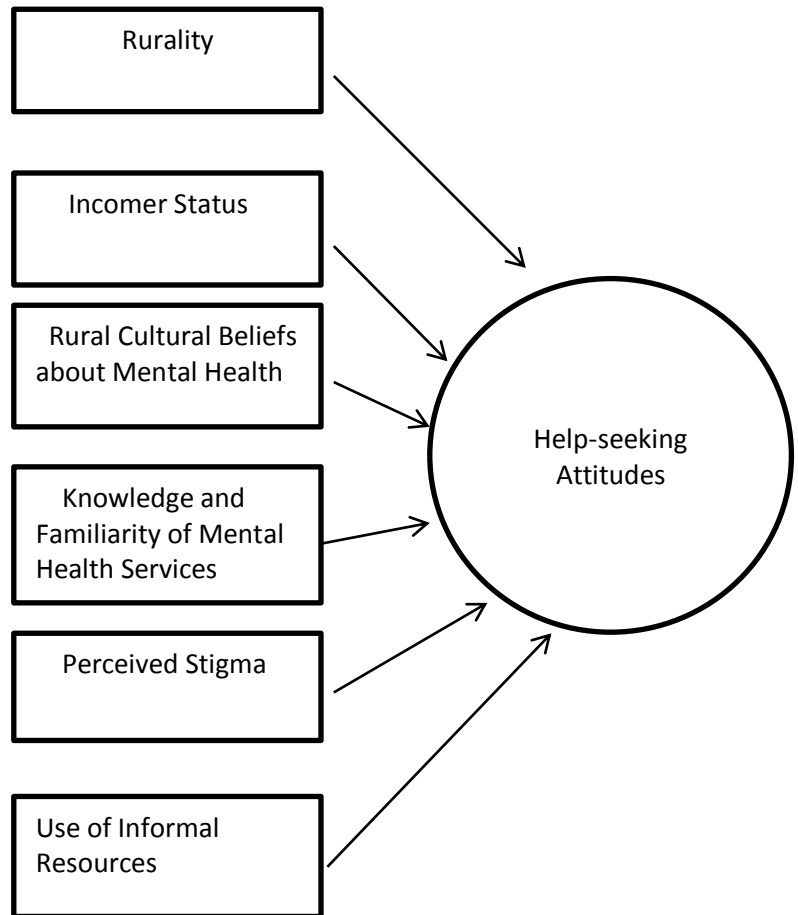


Figure 3: Factors Affecting Rural Help-seeking Attitudes

