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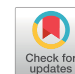
"Get over it and move on": The impact of mental illness stigma in rural, low-income United States populations



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ABSTRACT

Understanding the stigma associated with mental health concerns is essential to increasing utilization of mental health services in rural, economically deprived communities. This research study examined mental illness stigma in a sample of rural, low-income mental healthcare consumers and explored preferred attributes in mental healthcare providers that may help combat stigma. Qualitative methodology using a qualitative content analysis approach was used to reach an understanding of the subjective experiences of 53 ($N = 53$) rural, low-income persons who received mental health treatment. In regards to views that my cause stigma, the themes *Faking and Pretending; Get Over It!;* and *God is all you Need* were identified. The theme *Fear and Shame* was identified in relation to how participants perceived their experiences with a mental illness. Regarding the possible negative consequences of seeking help for mental health concerns, the theme *Negative Judgement and Perceived as Weak* was identified. Finally, the most noted preferred attribute in a mental health provider was to be *Nonjudgmental and an Active Listener*. The results suggest that the influence of stigma, mental health literacy, how to treat a mental health concern, and help-seeking behaviors are distinctive in rural, low-income populations. Implications for mental health counseling and research are discussed.

1. Introduction

In rural America, the prevalence of mental health concerns is similar to that of urban populations – in a 2016 national survey, 18.7% of residents (approximately 6.5 million citizens) in nonmetropolitan counties had a mental health concern, and 3.9% (approximately 1.3 million) experienced thoughts of suicide (Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality, 2017). Although the prevalence of mental health concerns is similar, the amount of and access to mental health services are vastly different in rural areas. Rural residents have far fewer options for servicers, and many rural areas have no healthcare services at all (Rural Health Information Hub; RHIhub, 2017). Rural residents often have to travel great distances to receive services, are less likely to be insured for mental healthcare, and have lower mental health literacy (i.e., the ability to recognize a mental health concern when it arises and how to cope with one when it occurs (RHIhub, 2017).

The acceptability of mental health issues represents another significant barrier to accessing mental healthcare services for low-income individuals and families living in rural communities (Smalley, Warren, & Rainer, 2012; Stewart, Jameson, & Curtin, 2015). Persons from rural, low-income areas often delay seeking mental health treatment until symptoms have intensified (Smalley et al., 2012). Subsequently, they face a greater likelihood of hospitalization related to mental health challenges compared to those in more urban and suburban environments (Stewart et al., 2015). Difficulty recognizing mental health symptomology, accepting diagnoses, and seeking timely and ongoing treatment for mental health concerns has been attributed to mental illness stigma (Polaha, Williams, Heflinger, & Studts, 2015).

Mental illness stigma refers to the labeling and devaluing of a person based on negative beliefs, attitudes, and perceptions about mental health issues that results in status loss, discrimination, or stereotyping (Liegghio, 2017; Stewart et al., 2015). Broadly, mental illness stigma can be conceptualized as public stigma and self-stigma. Public stigma is understood as stigma from the general public representing stereotypes, prejudices, and discrimination related to mental illness (Crowe, Averett, & Glass, 2016). Self-stigma is the notion that a person internalizes the negative attitudes of others about mental health issues,

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resulting in lowered self-esteem and self-worth (Crowe et al., 2016). Public stigma may induce self-stigma because individuals internalize the stereotypes and prejudices of the communities in which they live and work (Simmons, Yang, Wu, Bush, & Crofford, 2015).

The small size of rural, low-income communities where characterizations such as having close-knit social networks, conservative values, and a general lack of privacy makes it difficult for residents to seek mental health treatment, further perpetuating these stigmas (Polaha et al., 2015; Smith, Mao, Perkins, & Ampuero, 2011). In addition to creating barriers to seeking mental health treatment, stigma can influence a person's self-perception, educational attainment, employment, and social and family relationships (Corrigan, Watson, & Barr, 2006; Liegghio, 2017). Rural low-income residents who have heightened risks for both self and public stigma are important targets for research attention (Simmons et al., 2015). Hence, the goal of the present research was to examine the influence of mental illness stigma in rural, low-income populations and to explore providers attributes that may help to combat stigma.

2. Literature review

2.1. Rurality, economic disadvantage, and stigma

There are striking mental and physical health disparities for those in multiple disadvantaged groups (e.g., low socioeconomic statuses, having mental or physical challenges, racial/ethnic minorities) (Allen, Wright, Harding, & Broffman, 2014; Murry, Heflinger, Suiter, & Brody, 2011; Skosireva et al., 2014). Food and housing insecurities, social isolation, educational inequities, and the inability to access and afford adequate physical and mental healthcare are the perils faced by low-income individuals and families living in rural areas throughout the United States (U.S.) (Goodman, Pugach, Skolnik, & Smith, 2013; Imig, 2014). Low-income rural residents with mental health concerns are further disadvantaged, with mental illness stigma exacerbating their marginalization (Hill, Cantrell, Edwards, & Dalton, 2016).

As an example, men residing in economically deprived rural areas are more likely to forego mental healthcare due to gender stereotypes about mental health problems that encourage men to ignore mental health concerns and avoid help-seeking behaviors (Alang, 2015). Likewise, studies have shown that low-income, rural women simultaneously experience both public and self-stigma in relation to mental health concerns and have higher rates of depression (Simmons et al., 2015; Snell-Rood et al., 2017). Low-income rural women report concerns related to the quality of mental health treatment received, stigma related to specific disorders (e.g., depression), as well as a cultural expectancy of self-reliance which deters help-seeking behavior (Snell-Rood et al., 2017).

The impact of stigma in rural, economically disadvantaged communities also affects children and adolescents who experience mental health challenges (Murry et al., 2011). Polaha et al. (2015) surveyed rural parents' perceptions of stigma regarding seeking mental health services for their children. The researchers found that greater perceived stigma was related to parents being less willing to seek services for their children in mental healthcare centers and schools. Likewise, other researchers found that rural parents reported that *stigma by association* (i.e., stigmatizing attitudes from teachers and administrators regarding a child's mental health challenges) deterred them from seeking treatment for their children (Heflinger, Wallston, Mukolo, & Brannan, 2014; Van der Sanden, Bos, Stutterheim, Pryor, & Kok, 2015). Along with the parents of children with mental health concerns, siblings, or peers may also experience stigma by association due to their close contact with an individual with a mental health concern, making it less likely that those affected will receive necessary mental healthcare (Corrigan & Miller, 2004; Liegghio, 2017; Muralidharan, Lucksted, Medoff, Fang, & Dixon, 2016; Murry et al., 2011). Apparent from the existing research, the impact of stigma on seeking mental health treatment for children and adults is wide-ranging in rural, low-income communities in the U.S.; however, similar challenges exist and may be even more pronounced among vulnerable populations in low and middle income countries (LMICs) that experience economic deprivation and lack of mental health resources (Abera, Robbins, & Tesfaye, 2015; Vostanis, Maltby, Duncan, & O'Reilly, 2018).

2.2. Provider stigma

In addition to public and self-stigma that exist and prevent many from seeking mental health services, researchers have explored how mental health consumers from rural, low-income backgrounds experience further stigma from their mental healthcare providers. Provider stigma encompasses the mental health provider endorsing common stereotypes about mental illness, such as perceiving clients as dangerous or blaming clients for mental health concerns (Corrigan, Druss, & Perlick, 2014; Kingdon, Sharma, & Hart, 2004). Wang, Link, Corrigan, Davidson, and Flanagan (2018) surveyed 350 mental health service users to explore the association of provider stigma and its influence on internalized stigma (i.e., self-stigma). The researchers found that perceived negative affective reactions and perceived social distance from mental health providers were positively associated with client disempowerment (Wang et al., 2018). Furthermore, researchers indicated that low-income mental health service consumers reported feeling demeaned by providers and frustrated with ineffective treatment regimens, which may contribute to a decreased utilization of mental health services (Allen et al., 2014; Snell-Rood et al., 2017). It is ethically important for mental healthcare providers to be aware of both their conscious and unconscious biases and judgments and aversive behaviors that perpetuate stigma in clients from historically disadvantaged groups to increase mental health service utilization.

2.3. Objective

Although existing research has laid important groundwork on the topic of those in rural, low-income settings, and the stigmas and related challenges they face related to mental healthcare, more studies are needed to examine the pervasive impact of stigma for populations who face multiple disadvantages. Specifically, researchers have called for studies that examine cultural and contextual variables using differentiated research methodology to better capture localized attitudes around stigma in rural, low-income populations and their experiences with mental health providers (Corrigan et al., 2014; Polaha et al., 2015; Smith, Li, Dykema, Hamlet, & Shellman, 2013).

To further understand the impact of stigma for those who face multiple disadvantages, and answer this call for research, the aim of this study was twofold (1) to examine attitudes toward mental illness and stigma in a sample of rural, low-income residents who identified as having a mental health concern and (2) to explore what attributes rural, low-income mental health consumers prefer in mental health providers that may help to combat stigma. For the purposes of this study, mental health consumer is defined as any person with a mental health related issue who has received professional mental health services. The overarching research question guiding this study was: What are the attitudes toward stigma for rural, low-income mental health consumers?

3. Method

3.1. Design

The Institutional Review Board at the first author's university approved the study (Study ID: UMCIRB 17-000976) prior to conducting research. This study employed qualitative methodology, using conventional qualitative content analysis. Content analysis is a research method used for the subjective interpretation of the content of text data through a systematic data reduction and classification process of coding

and identifying themes or patterns (Hsieh & Shannon, 2005, pp. 1278) which enables researchers to understand social reality, with the purpose of providing knowledge, new insights, and a representation of facts in a scientific manner (Elo & Kyngas, 2007; Zhang & Wildemuth, 2009).

3.2. Recruitment and procedure

Participants were recruited from the general U.S. population. A recruitment email was sent which included a link to an electronic survey used for data collection. Participants who completed the survey received a small compensation (e.g., points towards a gift card). Part One of the electronic survey consisted of demographic questions to gather respondent characteristics (e.g., gender, ethnicity, age, income), as well as whether or not participants had experience with mental health treatment. Part Two of the survey consisted of six instruments used as quantitative measures. It is beyond the scope of the current manuscript to analyze participants' responses to Part Two of the survey. Rather, the current qualitative study analyzed responses to open-ended questions (Part Three) regarding perceptions of mental health concerns, stigma, seeking support, and desirable counselor attributes. These were: (1) What are some of the negative views your culture has about mental illness that might cause stigma? (2) How do you think mental illness stigma applies (or doesn't apply) to people you know, or people in general? In other words, have you known people who have feared seeking mental health treatment because of stigma? (3) If yes, then what were the fears, hesitations, or possible negative consequences of seeking help for mental health treatment? (4) What qualities or traits would you look for in a counselor, or other type of mental health professional, if you were to seek help for a mental health concern?

In order to qualify for inclusion in the current research, participants must have indicated that they lived in a rural setting, were low-income (self-identified as participating in one or more Federal Safety Net programs serving low-income persons), and had received mental health services in the past or present (answered yes to demographic question). The researchers extracted a sample of 53 ($n = 53$) participants who met inclusion criteria for this study out of a sample of 632.

3.3. Participants

Of the 53 participants, the majority identified themselves as female ($n = 41$, 77.4%; male, $n = 12$, 22.6%). There were 20 (37.7%) European American participants, 17 (32.1%) African American participants, and 16 (30.2%) participants identified as Latin American. Participants' ages ranged from 18 to 79. Twenty-seven participants (50.9%) sought mental health treatment from a mental health professional, 16 (30.2%) went to a medical doctor, and ten (18.9%) went to the emergency department at a medical center. Twenty participants (37.7%) received counseling/therapy and medication, 15 (28.3%) received counseling/therapy only, and 18 (33.9%) received medication only. When asked what the participant had sought mental health treatment for, 17 people (32.1%) indicated depressive disorders, 17 (32.1%) reported anxiety disorders, 11 (20.8%) said multiple disorders, four (7.5%) reported Bipolar disorder. The other mental health conditions listed were: psychotic disorders (n = 1, 1.9%), and other (n = 3; 5.7%).

3.4. Data analysis

Analysis of the data was informed by recommendations for qualitative content data analysis from Elo and Kyngas (2007); Hsieh and Shannon (2005), and Zhang and Wildemuth (2009). An inductive approach to conventional content analysis was used by studying raw data (i.e., qualitative findings) and making evidenced-based inferences through organizing codes (Elo & Kyngas, 2007; Finfgeld-Connett, 2014; Hsieh & Shannon, 2005). This analysis method enabled the researchers to classify large portions of data into smaller content categories based on similarity and cohesion (Crowe et al., 2016; Krippendorff, 2013). Two research team members extracted the sample data of 53 participants from the large dataset, using the inclusion criteria noted previously. Key words and phrases were specified as the unit of analysis for the data (Insch, Moore, & Murphy, 1997). The data analysis process proceeded as follows: (1) Researchers read all text responses to each open-ended survey question independently to obtain a sense of the whole; (2) The text responses were re-read to identify similarities in participants' responses. The researchers highlighted words and statements that captured key concepts and made notes in the margins of the documents (i.e., open coding); (3) Key words (i.e., codes) and specific participant quotes were identified and sorted based on the response to questions and recorded in a codebook (the codebook contained definitions of codes, rules for assigning codes, and participants' quotes; (4) Codes were re-sorted and collapsed to identify emerging themes and placed into meaningful coding categories; (5) The coding scheme was applied to the entire corpus of text. The data sorting process was repeated until the data was understood as responding to the research question.

Trustworthiness was accounted for using several methods. The researchers utilized reflexive journaling to account for biases related to study data, increasing dependability (Finfgeld-Connett, 2014) and used triangulation to ensure coding validation (Hays & Singh, 2012). The researchers met frequently to discuss emerging themes, negotiate any differences in interpretation of the data, and reach consensual agreement of the findings (Zhang & Wildemuth, 2009). An auditor from an unaffiliated academic institution who had expertise in the research topic and knowledge of qualitative methodology was used to ensure credibility of the findings.

4. Results

Each open-ended survey question is presented below with the primary themes identified and interpreted. The themes serve as a basis for discussion and implications for mental health counseling and research.

4.1. What are some of the negative views your culture has about mental illness that might cause stigma?

4.1.1. Theme 1: Faking and pretending

Several participants used the verbatim terms *"faking"* or "*pretending*" when asked to describe the negative views people in their culture held in relation to mental illness stigma.

The participants described how their mental health concerns were often discredited by members of their immediate family or by persons within their communities. For example, one participant stated: "*People seem to think others with mental illness are faking it in the area I live in.*" Relatedly, another participant responded that people in his community with mental health concerns are perceived as using their mental health issues to avoid responsibilities, stating: *"That someone is just pretending so they don't have to do something they don't want to."* Participants also described that members of their families and communities perceived that persons with mental illnesses were "*out for attention*" and are often still labeled by the proverbial term *"crazy."*

4.1.2. Theme 2: Get over it!

The second significant theme in response to the negative views held within the rural, low-income culture about mental illness that might influence stigma is the perception that people diagnosed with a mental health concern should simply "*get over it.*" Participants reported that due to the unfamiliarly with mental illness symptomology and treatment within rural, low-income communities, the general expectation is that a person with a mental illness is expected to recover or improve without receiving professional services. For example, a participant stated:

"I feel my culture is uneducated on many things, especially mental illness and can in fact ignore symptoms of depression and expects the person suffering to just get over it and move on."

Similar sentiments were shared by another participant who stated that family members and others in her close social group expected her to "*get over it without help from a professional*."

4.1.3. Theme 3: God is all you need

The third, and final theme, in response to the negative views held within the rural, low-income culture about mental illness that might influence stigma is the perception that people with mental health diagnoses, such as depression and anxiety, should simply seek "*God*" for the answers to their problems. For example, one participant acknowledged hearing the following from family and friends about mental health concerns: "*That we don't have mental illness we just need to seek God not medication"* and "*people do not go for mental help, just pray and ask God to show you the way."* Further, additional participants reported that they were informed by family and friends that their mental health concerns were resultant from disloyalty to religious or spiritual values and that the only resolve for a mental illness was through prayer. A participant shared: "*In my culture they figure that if you get depressed that the only thing you can do is pray. They figure it's something you aren't doing or aren't connected enough to God if you get depressed"* and "*You are not right with God. I am a Christian minister with depression. One of my church leaders told me this."* Responses from various participants appeared to affirm the belief in a higher order solely to address mental health concerns. For example, a participant reported: "*People treat me rudely and unkind and when they called me crazy I lived in darkness…but today I live with Jesus Christ who is in control of my new life."*

4.2. How do you think mental illness stigma applies (or doesn't apply) to people you know, or people in general? In other words, have you known people who have feared seeking mental health treatment because of stigma?

4.2.1. Theme 1: Fear and shame

Participants identified that they experienced either fear or shame in regard to seeking mental health treatment. Most participants reported being "*ashamed*" of their mental health concerns and fearful of how they would be perceived by close family members if they revealed their mental health diagnoses. As an example, one participant stated: "*I was afraid to tell my parents that I felt depressed because of feeling ashamed and fear of how they would judge me or of disbelief."* As illustrated in the following quote, feelings of fear and shame were continuously noted in response to participants personally accepting their mental health concerns as well as being hesitant to disclose to others and seek initial treatment: "*This is why most people fear treatment, because admitting is the first step, but is also known as the hardest, too."* Inclinations of fear and shame were constant narratives in most participants' responses and were further elucidated in the responses to the next survey question.

4.3. What were the fears, hesitations, or possible negative consequences of seeking help for mental health treatment?

4.3.1. Theme 1: Negative judgement and perceived as weak

Nearly all participants reported the perception that people who sought mental health treatment in rural, low-income communities would be either judged negatively or perceived as weak. Judgement was a frequently used term by several participants. Participants made the following statements to describe depictions of negative judgment: "*people judge you and don't trust you*" and "*people are afraid that saying anything about having it [mental illness] would change their friends' views of them and impact their interactions*." Likewise, one participant perceived that a person who sought mental health services "*would be looked down on for seeking mental health treatment."* Many participants described the possibility that a person could lose his or her job or other sources of monetary income because of the negative perceptions associated with seeking mental health treatment.

Furthermore, participants responded that people in the rural, low-income culture are often labeled as "*weak*" for seeking mental health treatment. For example, one participant stated: "*People fear being seen as weak if they admit they have mental health issues. They are scared of looking weak."* Similar sentiments were shared by another participant who stated that a person in his culture may be hesitant to seek mental health care due to *"being scared of looking weak and not wanting to be labeled."*

4.4. What qualities or traits would you look for in a counselor, or other type of mental health professional, if you were to seek help for a mental health concern?

4.4.1. Theme 1: nonjudgmental and an active listener

The primary attributes that rural, low-income mental health consumers sought in mental health providers were being "*nonjudgmental"* and *"willing to listen."* Participants stressed the need for providers to suspend judgement and biases they may have towards their low-income status. For example, one participant shared he preferred: *"Someone who wouldn't judge and their body language showed no signs of rejection of me."* Similarly, another participant stated she sought a provider who "*doesn't judge or invalidate my mental illness.*"

The second most frequently stated attribute sought in mental health providers was the willingness to "*listen.*" Participants described past experiences of providers rushing through appointments and failing to adequately assess and address their mental health concerns. A participant described a preference for the following qualities in a mental health provider: *"someone who would actually be interested in getting to the root of the problem and actively listen to me and try to help me."* Correspondingly, other participants made the following statements regarding attributes they prefer in mental health providers: *"Someone who can listen and not get frustrated easily"* and *"someone who listens and pays attention."*

5. Discussion

The aim of this study was to further understand how stigma impacts mental health concerns and treatment in rural, low-income populations. Additionally, the researchers sought to explore what attributes rural, low-income mental health consumers look for in mental health providers that may help to combat stigma. In addressing the first study aim, data revealed that negative views toward mental health concerns continue to exist in rural, low-income communities. This finding is consistent with prior research that has generally examined mental illness stigma in rural areas or with low-income populations (Stewart et al., 2015). However, the current study further amplified views toward mental healthcare that are held within the context of the rural, low-income U.S. culture specifically. Per participants' reports, mental illness symptomology continues to be misunderstood within this culture. Subsequently, findings from the current study indicated that rural, low-income persons with existing mental health concerns are often not given credence regarding their mental health challenges. These findings correspond with research that purports low mental health literacy among persons from historically marginalized groups (Lincoln et al., 2017); yet, the current study allowed the researchers to more fully understand the impact of stigma and low mental health literacy specifically among the rural poor.

Findings indicated that rural, low-income persons with mental health concerns may be perceived as seeking mental health treatment to evade various responsibilities (e.g., securing employment). This perception is indicated in other research studies related to the negative judgement low-income adults living in the U.S. experience when seeking supportive services to support their physical, mental, or financial wellbeing (Pruitt, 2016). Similarly, research studies conducted in non-western, LMICs have also indicated that stigma and socio-

cultural factors affect the recognition of mental illness and thus beget lower mental health literacy (Mathur Gaiha, Sunil, Kumar, & Menon, 2014; Vostanis et al., 2018). For example, Mathur Gaiha et al. (2014) administered a survey to explore mental health literacy and attitudes toward mental illness across five states in India and found that most respondents were unaware of what constitutes mental illness and how to access mental healthcare services. Moreover, cultural beliefs among populations in some LMICs that delineate mental illness as an "evil spirit" or attribute having a mental illness to "sins in one's past life" often take prominence over accurate information of what constitutes a mental illness (Abera et al., 2015; Mathur Gaiha et al., 2014). Consequently, high levels of unmet need, limited resources, negative attitudes toward individuals with mental illnesses, and stigma impact the utilization of mental healthcare in both high-income and LMICs and continues to be a global concern.

Considering the shortage of mental health professionals in rural, economically deprived communities in the U.S. (Murry et al., 2011; RHIhub, 2017) and LMICs (Bruckner et al., 2011), residents often have limited exposure to mental healthcare services. This limited exposure may be one factor that contributes to the fear or shame adults in the sample mentioned. In addition to the shortage of mental health services in rural settings, accessibility issues in rural communities may contribute to stigma related to mental health treatment, as residents in these settings may not have insurance for mental health services and may not be able to travel long distances to receive services if they do exist (RHIhub, 2017). Children and adolescents attending schools in rural U.S. communities may have access to professional school counselors who can help them to navigate seeking mental health services; however, the utilization of these services is still dependent upon parents' fears or sense of shame about their children being seen by a counselor (e.g., stigma by association). These findings correspond with studies in LMICs that experience extreme deprivation that leave children with high rates of unmet mental health needs due to resource gaps compounded by stigma, the lack of cultural adaptations of interventions, and the absence of specialist services in these countries (Hassan, Vostanis, & Bankart, 2012; Vostanis et al., 2018).

As a result of stigma, including negative stereotypes (e.g., uneducated, dirty, violent, and lazy), low-income individuals living in rural areas in the U.S. may be apprehensive to seek mental healthcare services from professionals who carry similar prejudgments (Smith et al., 2013). Mental healthcare providers who hold negative stereotypes toward the populations they serve may display provider stigma which exacerbates public and self-stigma which hinders the treatment process (Smith et al., 2013). Participants in the current study identified how particular attributes such as being nonjudgmental and attentive to all presenting concerns may improve the therapeutic relationship which could possibly increase the utilization of mental healthcare services among rural, low-income populations. Working with a mental healthcare provider who demonstrates all three components of Carl Rogers' (1957) core conditions (i.e., Unconditional Positive Regard and Acceptance, Genuineness, and Empathy) as well as attending to nonverbal expressions (Corey, 2016) may be essential to establishing a therapeutic counseling relationship with persons from rural, low-income backgrounds who are seeking help for mental health concerns.

5.1. Implications for counseling practice

Several important clinical implications can be gleaned from the research findings. First, the data suggest that there is in fact much stigma associated with mental health and seeking treatment among rural, low-income client populations. Participants reported perceptions that someone with a mental health concern was pretending to avoid responsibilities, that persons with a mental health concern could recover or improve on their own, and that mental health treatment was sometimes deemed unnecessary. For mental health professionals in rural areas, these attitudes must be addressed before mental health concerns can be understood as worthy of treatment, just as any physical health concern might be. Education and information designed to increase mental health literacy such as knowing the signs and symptoms of a mental health concern, ways to manage mental health issues, and the relationship between mental health and chronic health conditions may be of importance in rural, economically disadvantaged communities. Additionally, building partnerships with other professionals (e.g., medical doctors, social workers) using an integrated approach may help to build workforce capacity to address mental health concerns in rural, low-income communities (Crumb, Larkin, Johnson, Smith, & Howard, 2018).

Additionally, a finding from the current study that may shed light on the nuanced experience of those in rural, low-income communities and fear associated with seeking mental health treatment was the consequence of job loss that was mentioned by participants in this study. For those in rural communities, where job opportunities are less, and where many are already classified as low-income, the threat of a job loss related to a mental health concern may be more serious than for those in urban settings, where jobs are more plentiful. Mental health professionals may want to address this fear in intake sessions and continuously stress the notion of confidentiality when working in rural settings.

Another significant finding in the current study suggested that people with mental health concerns should rely solely on a higher power or prayer to cope with mental illness. Clinicians might choose to go beyond the traditional four walls of a mental health agency or office and build or strengthen relationships with leaders in their communities who are non-mental health professionals but who are a source of support and a resource when mental health related issues arise, particularly religious leaders. This finding is consistent with other research on the role of the church and the role church parishioners play in coping with mental health concerns (Avent & Cashwell, 2015). Partnering with churches in rural areas may be one way to assist in destigmatizing mental health concerns, in the rural, low-income culture. If those who use religion and spirituality can continue to use this as a means of coping *and* also seek professional mental health treatment, rather than pray *or* seek mental health treatment, perhaps those in rural communities will feel more comfortable seeking professional services.

5.2. Limitations

As with any research, the current study is not without limitations. First, self-report data was used, which is subject to threats to validity (Hays & Singh, 2012). The survey was sent electronically and participants typed in responses to the open-ended questions; hence, the researchers could not follow-up with any additional questions or comments as might have been possible in a face-to-face focus group or individual interview. Second, the sample was gathered from across the U.S., making it impossible to explore regional differences in perceptions among rural, low-income individuals. Last, it is important to note that the sample for this study consisted of low-income, rural residents in the U.S. and does not provide a contrasting view of mental health literacy, stigma, and help-seeking behaviors in low-income urban and suburban populations of the U.S. or in higher-income rural populations across the U.S.

6. Conclusion

This study sought to examine the attitudes toward mental health treatment and stigma of those in rural communities who identified as low-income, as well as their preferred characteristics of mental health providers. Researchers interested in continuing this line of inquiry with stigma in rural, low-income populations may consider quantitative designs in order to assess the degree to which the findings related to stigma and provider characteristics are similar in larger samples in rural

locations. Perhaps of particular importance for scholars is the notion of mental health literacy in rural, low-income areas, and investigating ways to increase this so that mental health symptomology is better understood and stigma and preconceived, harmful beliefs are lessened. The data and implications gleaned from this study adds to the growing body of literature that supports mental health providers to work more comprehensively with rural, low-income mental health consumers and to identify ways to increase the utilization of mental health services in these communities.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.mhp.2019.01.010.

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