# No Longer an Outsider:
# Affecting Rural Mental Health Stigma through Community Involvement

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## Abstract

Previous research has shown that rural mental health practitioners (MHP) face issues with stigma towards seeking services, and stigma related to mental health services as a whole (Stewart, Jameson, & Curtin, 2015; Larson & Corrigan, 2010). Rural MHPs are often viewed as outsiders, which can also be a barrier (Bischoff et al. 2014). Other research has shown that both living in the rural community where they practice, and being involved in that community may reduce these barriers (Malone & Dyck, 2011). A total of 422 participants who were recruited through an introductory psychology class and a social media/web based snowball method were included in the study. Participants were randomly assigned to conditions where they would rate a described MHP using the Counselor Rating Form-Short version, complete the Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS), and fill out demographic measures designed to determine the rurality of the participants. Multivariate analysis showed that MHPs described as being involved in the community were rated significantly higher than MHPs described as not being involved. Multiple regression analysis found that participants' rurality was positively associated with their ratings of MHPs described as residing in the community and being involved in the community, commuting to the community and being involved, and residing in the community and not being involved. The findings of the study suggest that community involvement can significantly improve perceptions of MHPs which in turn can reduce self-imposed barriers to seeking mental health services.

# No Longer an Outsider: Affecting Rural Mental Health Stigma through Community Involvement

Rural settings and communities present a special set of challenges and opportunities to mental health practitioners. Rural areas generally have a unique culture and environment that contributes to a variety of differences in the prevalence of specific mental health disorders (McDonald, Curtis-Schaeffer, Theiler, & Howard, 2014; Smalley, Yancy, Warren, Naufel, Ryan, & Pugh 2010; Rueter, Holm, Burzette, Kim, & Conger, 2007), barriers to seeking services (Bischoff et al. 2014; Larson & Corrigan, 2010; Stewart, Jameson, & Curtin, 2015) and ethical challenges (Helbok, 2003; Turchik, Karpenko, Hammers, & McNamara, 2007; Werth, Hastings, & Riding-Malon, 2010). Mental health practitioners are in a unique position to have a positive impact on rural communities, but more research is needed to refine techniques that are specific to working in rural settings.

## Defining "Rural"

An important aspect in research concerning rural communities is how "rural" is defined. Definitions of rural vary greatly across time and the type of research being conducted. The United States Census Bureau (2010) reported that 19.3% (about 59 million) of the U.S. population lived in areas classified as rural. The U.S. Census Bureau does not classify differing levels of rural areas, only that all areas that do not meet qualifications for being an Urbanized Area (with minimum populations of 50,000) or Urban Cluster (consisting of populations ranging from 2,500 to 50,000) are considered rural. An obvious problem with using this definition is the dichotomy that it creates which classifies a wide range of varied communities with a single label that lacks descriptors necessary to differentiate between these communities.

In order to more accurately describe rural residents and communities, a definition that allows for greater differentiation is necessary. One of the best ways to accomplish this is to

define rurality along a continuum or at least as having multiple levels that allow for greater specificity (McDonald et al., 2014). Furthermore, a definition that only specifies variables at the community level may improperly classify individuals within those communities (such as a person who resides in a rural community, but was raised in an urban setting), creating a need for the definition to differentiate at an individual level. To apply multi-level understandings of rurality, each contributing variable must be defined. Population of a community or area is only one variable, and research suggests that it is not the most important in accurately defining rurality.

Some of the more potentially useful variables are included in descriptions of the "rural mindset", which is inclusive of cultural similarities among rural communities (Provorse, 1996a). One of these variables that works to capture the rural mindset is the hometown in which an individual grew up in, and more importantly, the hometown of the parents. This variable can determine the cultural background and values that are passed down to the next generation, which also helps properly identify individuals as having a rural mindset whether or not they are currently living in a community that would be considered rural based on current population. Another important factor when reconsidering how rural individuals should be identified is to focus on those who fit the "extreme rural" classification (Provorse, 1996a). Individuals within this category are identified through the extent of the actual experience living in rural settings. More specifically, time spent living and or working on a farm or ranch could be used as this type of life experience, which would promote and reinforce prototypical rural values such as a culture of individualism, relative isolation, and reliance upon factors such as weather.

For the purposes of this paper, population of current residence, hometown, parents' hometown, as well as time spent living in an "extreme" rural setting such as a farm or ranch will

serve as the primary bases for defining rurality. Because an individual with a rural mindset may not have grown up in a hometown or cite a parent's hometown as being rural based on population alone, an additional variable of subjective rurality or how rural an individual personally views themselves to be will also be used.

**Challenges and Barriers to Care**

Details concerning diagnoses and types of problems commonly found in rural areas are useful to adequately prepare a mental health professional to work in a rural setting. People in rural areas tend to suffer from higher rates of depression, substance abuse, domestic violence, and child abuse than their urban counterparts (McDonald et al., 2014; Smalley et al., 2010; Rueter et al., 2007). Beyond the common disorders faced in rural settings, severe disorders are also more prevalent compared to urban areas. The increased severity is partially due to individuals in rural settings waiting significantly longer to seek treatment, and then utilizing available treatment less often than individuals in urban areas (Green, Hunt, & Stain, 2011; Rueter et al., 2007). As individuals wait to seek treatment, the possibilities for symptoms to become more severe, and for maladaptive coping strategies to be reinforced and increase in frequency, increases. Empirical research suggests that some progress has occurred in rural areas in recent decades (Green et al., 2011). During the initial interest in rural mental health, spurred by the "farm crisis" of the late 1970s and early 1980s, residents of rural areas were very reluctant to seek services, and services were not readily available (Childs & Melton, 1983). However, recent research indicates that at least 23% of individuals in rural communities seek services within the first year of symptom onset (Green et al., 2011).

Another significant structural barrier to receiving mental health care is a function of the geographically isolated nature of rural communities. Accessibility and availability of mental

health services in rural areas can vary widely (Smalley et al., 2010). Accessibility problems generally include the driving distance to a mental health provider and financial problems associated with lower average incomes in rural settings when compared to more urban areas. Researchers across the decades have consistently noted also the relative lack of availability of mental health providers in rural areas as compared to more urban areas (Childs & Melton, 1983; Gale, Shaw, & Hartley, 2010).

In addition to structural and supply and demand based barriers to obtaining services, there are barriers to seeking mental health services that are influenced by cultural norms. One of the self-imposed barriers to mental health services is that rural residents may view mental health services as an urban practice (Bischoff et al., 2014). Seeking services is also constrained by the perception of the counseling and therapy process being incompatible with rural culture and values. The strong emphasis on being self-sufficient can prevent rural individuals from working with a therapist due to therapy involving asking another person for aid (Bischoff et al., 2014). Misconceptions about the benefits of seeking services further contribute to self-imposed barriers. An individual living in a rural setting may hold beliefs that seeking services is in indication of weakness and these beliefs may bring about negative consequences as a result of social and self-imposed stigma (Bischoff et al., 2014; Larson & Corrigan, 2010).

Stigma surrounding seeking out mental health services affect clients who are currently receiving care as well. Rural values involving self-sufficiency can go beyond the social stigma and result in an internalization of the beliefs of weakness and inadequacy in individuals seeking services (Larson & Corrigan, 2010). The self-stigma becomes another area of concern for rural mental health practitioners as the internalization of the stigma can exacerbate symptoms of anxiety and depression. The degree to which self-stigma has an effect has also been found to be

related to the level of rurality, with more isolated areas reporting greater self-stigma (Stewart et al., 2015). Stigma towards seeking services can also have a significant effect on children in rural settings. Nearly 50% of parents in one rural sample reported being reluctant to refer their child for mental health services because they believed therapy would make their child an outsider and that negative effects of social stigma would be maintained into adulthood (Pescosolido, Perry, Martin, McLeod, & Jensen, 2007). A primary tenet of the current research project is that mental health practitioners working in rural settings may be in a unique position to decrease stigma, while remaining cognizant of the additional concerns that adopting a pro-active stance toward mental health services might have in a rural setting.

**Ethical Concerns**

Working in rural settings presents a variety of difficulties to clinicians. In addition to these challenges and barriers ethical concerns faced when working in rural communities are often not a concern in more metropolitan areas. The increased likelihood of ethical violations results in mental health practitioners facing difficult decisions and what appear to be unresolvable dilemmas while attempting to provide the best care for their clients. The higher incidence of potential ethical challenges can serve as a barrier to practitioners looking to work in rural settings. For example, these ethical dilemmas can occur in situations where clients' children go to the same school as the practitioner. The dilemma could be that a client's disorder is outside of a practitioner's realm of competence without any appropriate referral sources. A practitioner may need to shop at stores owned by a client's family, creating difficulties related to objectivity based on how the practitioner is treated. Mental health practitioners in rural settings often face ethical dilemmas related to competence, assessment, and confidentiality (Turchik et al., 2007; Werth, Hastings, & Riding-Malon, 2010). For example, maintaining competence might be

challenging because the physical distance from large metropolitan areas limits practitioners' abilities to access other professionals for consultation and support. The ability to attend continuing education or receive supervision from qualified mentors may also be impaired. In the area of assessment, lack of funding could tempt a practitioner to use outdated test materials or be less thorough or, incomplete when selecting the assessment instruments. In regards to confidentiality, rural communities have a level of interpersonal intimacy and awareness not found in urban settings. Rural residents generally know a considerable amount about one another, which increases the difficulty of maintaining confidentiality. One of the most prevalent ethical concerns when working in rural settings is in multiple relationships with current and possible prospective clients (Helbok, 2003).

While the size of rural communities can vary, the definition of rural being used considers the population to be small, generally around 2,500 residents or less. The small populations and closeness of these communities leads to increased chances for difficulties with multiple relationships. Multiple relationships can occur in attending the same religious services as clients, or eating at a restaurant or shopping in stores that a client may own or work at (Weth et al., 2010). Mental health practitioners must be cautious of the difficulties of multiple relationships in their daily activities in a way that is not customary in urban areas.

Contacts and interactions with clients outside the relative ethical safety of the professional office or clinic setting are difficult to avoid, and may sometimes even be necessary. Helbok (2003) asserts that some instances of multiple relationships will be impossible to avoid in a rural setting. Opportunities for multiple relationships, or even repeated outside of session contacts with clients occur due to involvement in similar activities such as the parent-teacher association or a need to purchase goods from a client (either directly or from a store where they

work). In rural communities a practitioner may also simply come in contact with clients often in the community, leading to difficulties with maintaining boundaries as clients or the practitioner perceive the other as an acquaintance in addition to the established relationship. Despite the unavoidable nature of dual relationships, there are still distinctions to be made dependent upon what the relationship entails. An accidental meeting with a client while engaging in daily activities where a brief conversation or greeting occurs is generally viewed as being distinctly different from a personal friendship with a client (Barbopoulous & Clark, 2003). Family members of practitioners may also unintentionally develop relationships with friends or family members of clients. A practitioner's significant other may become friends with a client, or a practitioner's child may become friends with a client's child at school or in extracurricular activities, leading to difficulties with confidentiality. The additional need in rural settings to carefully navigate the course of dual relationships can serve as a deterrent to practicing in a rural setting, which could lead to some practitioners' decision not to live in the community they serve.

Related to the issue of multiple relationships is the problem of practitioner visibility within the community. As stated previously, rural communities have a tendency to have high levels of interpersonal connectedness; as such, a practitioner serving a rural community has little personal privacy when compared with an urban counterpart. The lack of privacy often leads to past, current, and prospective clients having personal knowledge about the practitioner and or their family. A practitioner's ability to control for how much others in a small community know about their family is limited due to a lack of diversity in schools for their children to attend and the actions and visibility of other family members that are not under obligation to reduce their presence or actions within the community. Practitioners tend to view the lack of privacy as another drawback to working in rural settings (Hastings & Cohn, 2013). The visibility of a

practitioner in a rural setting serves as a degree of unintentional self-disclosure that can have a significant effect on clients, as information such as a practitioner's ideological beliefs could negatively impact rapport and even deter prospective clients from seeking services. Visibility can also be problematic in the pressure it places on practitioners to uphold a high moral reputation and appearance within the community (Malone & Dyck, 2011).

Despite the drawbacks of visibility, the irony of being a mental health professional in a rural setting is that high social visibility has also been posited as a necessary component in a successful rural practice (Helbok, 2003). While the potential for practitioner visibility to deter prospective clients does exist, it may be outweighed by the need for practitioners to be accepted by the community. Community involvement is necessary for practitioners to gain acceptance within the community and reduce the notion of being an "outsider" (Malone & Dyck, 2011). A mental health practitioner is generally faced with the nearly equally undesirable options of risking high visibility in order to improve community acceptance, or to avoid visibility in the community as a way to protect personal privacy and risk being viewed as an "outsider."

There are a variety of methods implemented by rural mental health practitioners to avoid ethical lapses related to multiple relationships and confidentiality. A direct method is to avoid social interaction within the community, though this can obviously lead to practitioners feeling isolated, does not address the potential for accidental meetings, and can maintain a view of the practitioner as an outsider. Another option is to provide a comprehensive account of possible situations and descriptions of boundaries in an informed consent form (Mullin & Stenger, 2013; Helbok, 2003; Werth et al., 2010). Theoretically, having a comprehensive Informed Consent document allows for many of the foreseeable circumstance to be addressed before services are provided; however, it is difficult to anticipate all potential circumstances where a multiple

relationship might occur. Reviewing and discussing the elements of a comprehensive informed consent form prior to the initiation of therapy services can serve as a reminder to both professional and client that aids in helping practitioners avoid ethical lapses. However, informed consent cannot do much more than address potential boundary issues and prepare clients for encounters outside of sessions, and informed consent cannot fully address concerns due to visibility in the community and how this might impact future potential clients.

Overall, the possibilities for mental health practitioners to encounter ethical dilemmas, including the social and professional isolation inherent in rural settings, can serve as significant deterrents to working and/or living in rural settings. Despite the noted difficulties, many mental health practitioners do find work in rural settings to be rewarding, and several methods of improving the quality of care and reducing the stigma associated with seeking services have been shown to be effective.

**Community Involvement**

One of the ways that mental health practitioners can help to reduce client' self-imposed barriers to seeking services is through involvement in the community. Involvement can take a variety of forms, with each type of involvement presenting unique ways to reduce structural and/or self-imposed barriers to mental health services. The following section explores some ways in which mental health practitioners' adopting an intentional approach to being more visible and involved in their communities can improve the quality of services provided.

Mental health practitioners in rural areas are faced with the difficulty of providing services when funding is likely low and stigma around seeking health is high. One of the ways that mental health practitioners currently address barriers to services is through collaborative

care. By working in conjunction with other health care providers, mental health practitioners are able to utilize a greater network of resources which results in a reduction to several barriers to service (Riding-Malon, & Werth, 2014; Bischoff et al., 2013; Smalley et al., 2010). Many individuals seeking services in rural communities end up receiving services from a primary care physician. By collaborating with health providers in rural areas, mental health practitioners can help implement screening for mental health issues in order to better direct potential clients to the most appropriate services. Collaboration also opens up the opportunity of utilizing office space in the same clinic as the primary care physician, which is useful in reducing the fear potential clients may associate with being seen at a mental health practitioner's office.

Health care providers are not the only individuals in rural communities with whom collaboration can help reduce barriers to care as other prominent individuals can also aid mental health practitioners. Hall and Gjesfjeld (2013) found that while many individuals in rural areas seek help with mental health issues from local clergy members, clergy members report referring individuals to available mental health professionals only 10% of the time. These findings suggest that collaborating with clergy members in rural communities could be a valuable way to guide individuals seeking help to mental health practitioners when appropriate. Collaborations with physicians and clergy are not mutually exclusive; both provide practical ways to improve client outcomes as well as provide mental health practitioners possibilities to improve their visibility within the community.

**Current Study**

Although visibility in rural communities can increase the risk of ethical dilemmas, increasing visibility could also have a positive influence on perceptions of mental health services and providers. The actual level of visibility or involvement in a community that is necessary to

improve perceptions of mental health services likely varies significantly between communities, yet there are some components of involvement that are consistent. Simple activities such as shopping at local stores and attending local events in the community have been cited as having the potential for positive outcomes (Bischoff et al., 2014). Involvement in a community can include any number of activities, though common areas of involvement include volunteering at schools, involvement with local religious institutions, and leadership positions within the community (Doherty & Beaton, 2000; Morris, 2006). Areas that are most important will likely vary between communities as local cultures may place greater meaning in different activities. Improving visibility through intentional actions allows mental health practitioners great flexibility when involving themselves in communities to supplement direct collaboration with health care professionals or clergy. Community involvement could serve to directly affect self-imposed barriers to mental health services as mental health practitioners who work to involve themselves are less often seen as outsiders (Helbok, 2003). Increased involvement in communities makes mental health practitioners more available to individuals who may be curious about mental health services. Community involvement also serves as a way for mental health practitioners to learn more about the unique culture of the community, which in turn provides a better understanding of clients.

The focus of this study is to better understand the degree to which community involvement can reduce rural cultural barriers to seeking mental health services. While previous research has focused on rural mental health practitioners' methods to reduce ethical dilemmas and improve availability and accessibility of services in practical ways (e.g.; location, scheduling, fees, etc.), the current study seeks to add to the somewhat limited literature on how altering the perceptions rural residents have of the mental health providers themselves may

modify their willingness to seek mental health services (Bischoff et al., 2014; Smalley et al., 2010; Helbok, 2003). In order to see if perceptions of a mental health practitioner (MHP) can be affected by residence/community involvement, there must be a way for participants to evaluate a described MHP. The Counselor Rating Form short version (CRF-S) is specifically designed to measure perceptions of MHPs. The items on the CRF-S allow for individuals to rate the MHP on their trustworthiness, attractiveness (how warm/empathetic they appear), and the degree to which they appear to be an expert (Corrigan & Schmidt, 1983). The scale provides the ability to see how perceptions are altered on general socially desirable traits as well as those important to MHPs.

In addition, the previous research has benignly, and somewhat naively, assumed that the mental health practitioner being evaluated resided in the community that they serve, with the assumption being especially prevalent when explaining ethical considerations. This assumption may occur at least partially due to the fact that many of the ethical concerns, especially those related to the potential for becoming involved in dual relationships, can be alleviated by the mental health practitioner choosing to live in a different community. The current reality is that most providers of mental health services in rural settings do not reside in that same community, but rather commute a few days each week, often utilizing a satellite office within community mental health centers (Gale, Shaw, & Hartley, 2010). Living in another community and merely "dropping in" to provide service may promote being viewed as an outsider, which exacerbates misconceptions about the nature and benefits of seeking mental health services to guide behavior. The purpose of the current study is to demonstrate the extent to which rural residence and community involvement can be intentionally utilized, not to avoid ethical issues, but rather

to address such issues in a more overt and intentional manner, by improving attitudes towards seeking mental health services.

The following specific hypotheses will be examined in the current study:

1. Individuals' attitudes towards seeking services will be positively associated with overall ratings of a mental health practitioner depicted in the vignettes across all levels.

2. Ratings of mental health practitioners depicted as residing within the rural community *and* being highly involved in the community will be significantly higher than ratings for mental health practitioners depicted as not being involved in the community, regardless of residence.

3. Ratings of mental health practitioners depicted as commuting to the rural community *and* being highly involved in the community will be significantly higher than ratings for mental health practitioners depicted as not being involved in the community, regardless of residence.

4. Favorable perceptions of mental health practitioners (as measured by the CRF-S) described as being involved in the community will be positively associated with the rurality of participants.

## Method

### Participants

With approximately 19% of the U.S. population living in rural areas it was deemed necessary to increase the sample size using the two recruitment methods to obtain a representative sample of rural individuals. 69 participants were excluded due to incomplete data and 107 were excluded due to a failure of a comprehension check, with a total of 176 being excluded.

Participants for this study were recruited using two methods. Overall the study consisted of 422 participants, with 72 (17%) identifying as male, 350 (83%) as female, and 0 as other. Overall age ranged from 18 to 85 with a mean age of 42.6 (SD = 18.69) years. 115 participants who completed the study were students at a small Midwestern university. Of the participants in the university sample, 36 (31%) were male, 79 (69%) female, and 0 other. Ages in the university sample ranged from 18 to 60 with a mean age of 20.0 (SD = 5.98) years. In the university sample, 95 (82%) of the participants where White, 8 (7%) were African American, 6 (5%) were Hispanic/Latino/a, 3 (2.6%) were Native American, and 3 (2.6%) reported ethnicity as Other. In the university sample, the mean score across all measures of rurality was 3.01 (SD = .94) out of a possible 7.25 where a score of 7.25 indicates the most rural. Participants recruited through the university were students in an introductory psychology class and received course credit for participation. Students accessed the survey via a link to the online survey hosted on SurveyMonkey was posted in an online service that corresponded with the class.

307 participants were gathered using a snowball method on a popular social networking website and through an email sent to individuals who registered their email addresses with the Kansas Sampler Foundation, 36 (12%) were male, 271 (88%) female, and 0 other. The social

networking sample participant ages ranged from 19 to 85 with an average age of 51.1 (SD = 14.22) years. For the snowball sample, 288 (94%) of the participants where White, 1 (0.3%) was African American, 10 (3%) were Hispanic/Latino/a, 3 (1%) were Native American, and 5 (2%) reported ethnicity as Other. For the snowball sample, the average overall rurality score was 4.30 (SD = 1.5) out of 7.25, where a score of 7.25 indicates the most rural. Participants recruited through the snowball method and the email list were provided a link to the online survey hosted on SurveyMonkey and asked to "share" the link with their friends on a popular social media service.

## Materials

**Degree of rurality**. A demographic section of the questionnaire (see Appendix A) was included in order to assess age, gender, ethnicity, and the degree to which an individual perceives themselves as rural versus urban along a continuum based on four variables. The four variables include the town the participant was born in, the town(s) the participant's parents were born in, time spent on a farm, and the individual's subjective self-rating of rurality. The four variables were assessed using seven items. The variables were chosen and items were designed based on previous research (Albin, 2011; Provorse, 1996a).

***Participant's hometown***. As in the Albin (2011) study, rurality was first identified through the participant's report of the county in which the participant was born. The rurality of the county was assessed using the Rural-Urban Continuum Codes (see Table 1 for full description of codes; United States Department of Agriculture, 2013). Counties are divided into three major distinctions based on metropolitan population and population adjacent to a metropolitan area which range across a 9-point scale. Ratings of 1-3 correspond to a metro area, while ratings of 4-7 correspond to a non-metro area, and ratings of 8-9 indicate a non-metro area

that is “completely rural”. For individuals who were only able to identify the city and state, the county was identified using the information provided.

***Parent’s hometown*.** In addition to the hometown the participant was born in, participants also reported the hometown of their parents. For participants that provided hometown information for two parents, the score based on the Continuum Codes was summed and then divided by 2 in order to attain an average representation of the parents’ hometown. In cases where participants were only able to list one parent, the score was not averaged with any other scores.

***Farm influence*.** Another item asked participants to state the amount of time they had spent on a farm in an average year. Consistent with previous research (Albin, 2011), a 5-point scale was used where 1 = *none*, 2 = *less than one week*, 3 = *less than one month*, 4 = *more than one month, but less than three months*, and 5 = *more than three months*.

***Subjective rating of rurality*.** As in previous research (Albin, 2011) the variable of subjective rurality was assessed with three questions. The first question asked participants how they viewed themselves via four categorical labels such as *city person*, *suburban person*, *small-town person*, and *country person*, scored as 1, 2, 3, and 4, respectively. Participants could also select a fifth item, *I don’t think of myself in such terms*, in the case that they did not identify with any of the labels provided in which case the item was omitted. The next item asked participants to indicate along a 6-point Likert scale where they would prefer to live, with scores indicating, 1 = *very rural*, 2 = *rural*, 3 = *somewhat rural*, 4 = *somewhat urban*, 5 = *urban*, and 6 = *very urban*. This item was adapted from the original survey which made use of a continuum that was altered to better suit the online hosting service. The final item asked participants to indicate using a 6-point Likert scale how they describe themselves with scores ranging from 1 = *a rural person* to 6

= *an urban person*. This item was adapted from the original survey which made use of a continuum that was altered to better suit the online hosting service. The second and third items were reverse scored and all three scores were then summed and divided by 3 in order to obtain an average subjective rating of rurality with higher scores indicating participants view themselves as being "more rural" or "less urban".

***Overall Rurality Score***. Scores from all four categories were summed and then divided by four, providing an overall rating of rurality for each participant. This overall rurality score could range between 1 and 7.25, with higher scores indicating persons considered to be more rural, and lower scores more urban.

**Attitudes toward seeking mental health services**. To access participants' attitudes toward seeking mental health services, the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) was administered. The IASMHS is a 24-item questionnaire (see Appendix B) that measures an individual's perceptions of mental health services as they relate to seeking services for themselves and attitudes towards others seeking services (Mackenzi, Knox, Gekoski, & Macaulay, 2004). The scale consists of 24 total items, and each item is scored on a 5-point Likert scale (0 = *disagree*, 1 = *somewhat disagree*, 2 = u*ndecided*, 3 = *somewhat agree*, and 4 = *agree*) where participants rate their level of agreement to statements such as "People should work out their own problems; getting professional help would be a last resort" and "It would be relatively easy for me to find the time to see a professional for psychological problems". The ratings on all items are summed, scores can range from 0 to 96 with higher scores indicating more positive attitudes towards seeking mental health services and lower stigma. The measure also includes three subscales including Psychological Openness, Help-Seeking Propensity, and Indifference to Stigma. For the purposes of this experiment only the full scale score will be

utilized as the full scale provides adequate information related to individual's preexisting stigma and the full scale provides the highest internal consistency. The measure produced sufficient internal consistency (IASMHS full scale α = .87; sample α = .87) using a community sample consisting of 246 participants (Mackenzi, et al., 2004). Test-retest reliabilities reported have also been sufficient (IASMHS full scale and subscales *r* = .64-.91).

**Evaluations of a mental health professional.** To assess participants' evaluations of a mental health practitioner, the Counselor Rating Form – Short Version (CRF-S) was administered. The CRF-S is a 12-item measure (see Appendix C) designed to create a concise method for rating counselor effectiveness based on three dimensions (Corrigan & Schmidt, 1983). The 12 items are distributed along three subscales with four items included in each scale. The first scale is designed to measure "Attractiveness", which consists of items containing the traits "friendly", "likeable", "sociable", and "warm" (Corrigan & Schmidt, 1983). The second scale is designed to measure "Expertness", consisting of the descriptors "experienced", "expert", "prepared", and "skillful". The third scale measures "Trustworthiness" and consists of the descriptors "honest," "reliable," "sincere," "trustworthy." Two additional items of "competent" and "ethical" were added as well in order to assess the degree to which individuals' perceptions about the ethics of the mental health practitioner were affected by the vignettes. Each item on the CRF-S uses a 7-point Likert scale (ranging from *Not very* scored as a 1 and located on the far left side of the scale to *Very* scored as a 7 and located on the far right) where participants are asked to assess the degree to which the therapist/counselor fits or expresses a given character trait. The CRF-S has been shown to have sufficient reliability through tests of internal consistency (α = .63- .89; Epperson & Pecnik, 1985; sample full scale, α = .97; sample Attractiveness, α = .96; sample Expertness, α = .95; sample Trustworthiness, α = .93; sample Ethical component, α =

.91) and split-half reliability (.91 for attractiveness, .90 for expertness, .87 for trustworthiness; Ponterotto & Furlong, 1985). The CRF-S has also shown sufficient construct validity through confirmatory factor analysis (factor loadings items on the attractiveness subscale ranged from .72-.94; expertness subscale = .77-.92; trustworthiness subscale = .64-.84; Corrigan & Schmidt, 1983; Ponterotto & Furlong, 1985).

**Experimental vignettes**

The materials presented to participants contained one of four possible vignettes (see Appendix D) which were assigned in a randomized pattern. Each vignette described one of four individuals whose description varies based on two variables. The first variable is residence in the rural community, where the individual described in the vignette either clearly resided in the rural community where they are also employed as a mental health professional, or was clearly described as living in a community that is different from the one in which they were employed. This variable will be labeled Residence, with the two levels of local (resides) and distant (commutes). The second variable was the degree of community involvement and was categorized as either high or low. In the vignettes the community involvement variable included descriptions of four different activities, and the high level of involvement included descriptions of: 1) volunteering at a school in the rural community, 2) offers workshops and education programs in their area of professional expertise, 3) organizing fundraising at a church in the rural community, and 4) helping to organize and manage resources for an annual community festival in the rural community. The low level of the community involvement variable was contrasted by describing an individual who was not actively involved in the local schools, has recently declined an opportunity to give a presentation concerning substance abuse in the rural community, is openly spiritual but not involved in any church functions, and has in the past

declined opportunities to help organize the rural community's annual festival. Participants were randomly assigned a vignette which resulted in a close distribution of participants across conditions (resides/involved = 118, commutes/involved = 99, resides/uninvolved = 94, commutes/uninvolved = 111). The individual described in the vignettes was referred to as the "mental health worker" to avoid possible bias related to gender. After reading the assigned vignette, participants were asked to answer two questions (see Appendix F) that served as an attention check. The first asked "Does the mental health worker live in the small community that they serve?" with the "yes" or "no" response option. The second asked "Does the mental health worker involve themselves in the community they serve?" with the "yes" or "no" response option.

**Procedure**

All participants accessed the questionnaire on SurveyMonkey.com and were presented with an informed consent form (see Appendix E) to read and review before accessing the questionnaire. If choosing to consent, participants were presented with the demographic questions, the IASMHS, one of the vignettes, the CRF-S, and finally the two manipulation check items. After completion of this sequence, participants were provided with a debriefing statement (see Appendix G) which included contact information for the principal investigator, and thanked for their participation. Institutional Review Board approval for this research obtained 10/1/2016.

**Statistical Analyses**

1. Independent sample T-tests were conducted comparing the various samples obtained on ALL variables measured. First, to rule-out pre-existing differences in the two sub-samples on the dependent variables of the IASMHS or CRF-S. Second, identify pre-

existing differences between participants self-identifying as rural vs. urban on the IASMHS or CRF-S.

2. Bivariate correlations were computed across all pairs of measured variables to assess for associations between the variables of rurality and IASMHS (attitudes) and the CRF-S scores from the randomized conditions.

3. There was no significant relationships between participants' rurality and scores on the IASMHS with the CRF-S and significant correlations between all of the dependent variables were found. To account for these findings, a series of multiple analysis of variance (MANOVA) and post-hoc tests using the Bonferroni test were run to assess for the effect the different levels of the independent variable had on the dependent variables. The test also assessed for the differences between the levels of the independent variable.

4. A multiple linear regression was run to measure the effect of participants' rurality and the vignette they read on the ratings they provided on the CRF-S total score. The rurality data was centered and dummy variables created for the levels of the independent variable. The levels of resident/involved, commute/involved, and resident/uninvolved were compared to the commute/uninvolved condition which served as a control.

## Results

### T-tests

Independent T-tests were run to determine whether significant differences existed between the university and snowball sub-samples. Results show that on average participants' differed significantly between the samples in regards to gender ($M_{\text{university sample}} = 1.31$, $SE = .466$; $M_{\text{snowball sample}} = 1.12$, $SE = .322$; $t(156.68) = 4.151$, $p = .000$), age ($M_{\text{university sample}} = 20.01$, $SE = 5.977$; $M_{\text{snowball sample}} = 51.14$, $SE = 14.221$; $t(414.95) = -31.619$, $p = .000$), and rurality ($M_{\text{university}}$

$_{\text{sample}}$ = 3.01, *SE* = .935; $M_{\text{snowball sample}}$ = 4.30, *SE* = 1.50; *t*(326.692) = -10.563, *p* = .000). Levene's test was significant for all three comparisons, leading to the use of the adjusted degrees of freedom and *t* values. The results also showed a significant difference between the university and snowball sample in respect to their scores on the IASMHS ($M_{\text{university sample}}$ = 57.6 , *SE* = 15.47; $M_{\text{snowball sample}}$ = 69.9, *SE* = 13.23; *t*(420) = -8.155, *p* = .000). The threshold for significance was adjusted for these tests with Bonferroni's correction producing a $p < .005$ required to reach statistical significance. The significant differences in self-ratings of rurality were expected as the snowball sample was intended to reach a more rural group. For the remaining tests the variables of age, gender, rurality and scores on the IASMHS were controlled for when possible.

**Intercorrelations among Variables**

Partial correlations were conducted to assess for the association between participants' attitudes toward mental health services as represented by scores on the IASMHS and the CRF-S total and subscales, while controlling for rurality, age, and gender. The threshold for significance was adjusted using Bonferroni's correction which moved the threshold for significance from $p < .05$ to $p < .008$. Results did not reveal significantly significant relationships between participants' scores on the IASMHS and the CRF-S total and subscale scores (CRF-S total, *r* = .058, *p* = .120; CRF-S trustworthiness, *r* = .055, *p* = .129; CRF-S expertness, *r* = .044, *p* = .184; CRF-S attractiveness, *r* = .065, *p* = .092; ethical component, *r* = .042, *p* = .198). Therefore, hypothesis #1 was not supported.

Additional partial correlations were conducted to assess for the association between participants' rurality and the CRF-S total and subscale scores while controlling for age, gender, and attitudes toward mental health services. Bonferroni's correction was applied again, with the

threshold for significance adjusted from $p < .05$ to $p < .008$. Results did not reveal statistically significant relationships between participants' self-ratings of rurality and CRF-S total and subscale scores (CRF-S total, $r = .022$, $p = .658$; CRF-S trustworthiness, $r = .017$, $p = .731$; CRF-S expertness, $r = .035$, $p = .480$; CRF-S attractiveness, $r = -.023$, $p = .638$; ethical component, $r = .099$, $p = .042$).

Prior to the main analyses, partial correlations were conducted to assess the strength of the relationships between the CRF-S total scores and scores derived for each of the four subscales of the CRF-s while controlling for participants' gender, age, rurality, and scores on the IASMHS. The threshold for significance was adjusted using Bonferroni's correction which moved the *p*-value from $p < .05$ to $p < .01$. Results showed a significant relationship between the CRF-S total score and all four of the CRF-S subscales (CRF-S trustworthiness, $r = .953$, $p < .000$; CRF-S expertness, $r = .926$, $p < .000$; CRF-S attractiveness, $r = .921$, $p < .000$; ethical component, $r = .926$, $p < .000$). The results show strong convergent validity, indicating that the subscales of the CRF-S should not be considered "unique."

**Tests for Differences between Conditions**

A lack of significant associations between participants' ratings on the CRF-s total scale and subscales with both their self-reported rurality and scores on the IASMHS necessitated a change in the planned analyses. In finding that the dependent variables were highly inter-correlated, the decision was made to run a multiple analysis of variance (MANOVA) to determine the effect of the vignette that participants' read on the ratings of the described mental health practitioner. Using Roy's largest root, there was a significant effect of the vignette on participants' ratings of the mental health counselor on the CRF-s and its subscales, $\Theta = 1.853$, multivariate $F(4, 417) = 193.194$, $p < .000$. Separate follow-up univariate ANOVAs on the

outcome variables also showed significant vignette effects on the full set of scores derived from the CRF-S (CRF-S total scale, $F(3, 418) = 127.385$, $p < .000$; CRF-S attractiveness, $F(3, 418) = 242.793$, $p < .000$; CRF-S expertness $F(3,418) = 60.372$, $p < .000$; CRF-S trustworthiness, $F(3,418) = 81.489$, $p < .000$; and the ethical component, $F(3,418) = 58.908$, $p < .000$). It is important to note that for the above ANOVA. Levene's test for equality of error variances was significant for the CRF-S trustworthiness subscale $p = .005$, indicating that the variable violated the assumption of equality of variance.

Post hoc tests using the Bonferroni test revealed no significant mean differences ($p = 1.00$) when comparing the vignette describing the MHP as residing/involved and the vignette describing the MHP as commuting/involved across all of the dependent variables derived from the CRF-S (CRF-S total scale, Mean difference = -.331, *SE* = 2.09; CRF-S attractiveness, Mean difference = -.089, *SE* = .606; CRF-S expertness, Mean difference = -.139, *SE* = .673; CRF-S trustworthiness, Mean difference = -.105, *SE* = .675; ethical component produced a Mean difference = .003, *SE* = .365).

However, the post hoc tests *did* revealed significant mean differences ($p < .000$) between the vignette describing the MHP as residing/involved and the vignette describing the MHP as residing/uninvolved across all of the CRF-S derived dependent variables (CRF-S total scale, Mean difference = 30.577, *SE* = 2.117; CRF-S attractiveness, Mean difference = 11.971, *SE* = .615; CRF-S expertness, Mean difference = 6.701, *SE* = .682; CRF-S trustworthiness, Mean difference = 8.179, *SE* = .685; and the ethical component Mean difference = 3.726, *SE* = .371). The post-hoc tests also revealed that the mean differences between the vignette describing the MHP as residing/involved and the vignette describing the MHP as commuting/uninvolved were significant at $p < .000$ across the full set of dependent variables derived from the CRF-S (CRF-S

total scale, Mean difference = 27.524, *SE* = 2.025; CRF-S attractiveness, Mean difference = 11.365, *SE* = .588; CRF-S expertness, Mean difference = 6.134, *SE* = .653; CRF-S trustworthiness, Mean difference = 6.798, *SE* = .655; ethical component, Mean difference = 3227, *SE* = .355).

The post hoc tests revealed that the mean differences between the vignette describing the MHP as commuting/involved and the vignette describing the MHP as residing/uninvolved were significant at $p < .000$ across the full set of dependent variables derived from the CRF-S (CRF-S total scale, Mean difference = 30.908, *SE* = 2.205; CRF-S attractiveness, Mean difference = 12.06, *SE* = .641; CRF-S expertness, Mean difference = 6.839, *SE* = .711; CRF-S trustworthiness, Mean difference = 8.285, *SE* = .713; ethical component, Mean difference = 3.723, *SE* = .386. The post-hoc tests also revealed that the mean differences between the vignette describing the MHP as commuting/involved and the vignette describing the MHP as commuting/uninvolved were significant at $p < .000$ across the full set of dependent variables derived from the CRF-S (CRF-S total scale, Mean difference = 27.855, *SE* = 2.117; CRF-S attractiveness, Mean difference = 11.454, *SE* = .615; CRF-S expertness, Mean difference = 6.273, *SE* = .682; CRF-S trustworthiness, Mean difference = 6.904, *SE* = .685; ethical component, Mean difference = 3.224, *SE* = .371).

In sum, the results suggest that the vignettes had a significant impact on participants' perceptions of the described MHP. In particular, results indicate that ratings of the MHP who was described as being involved in the rural community were significantly higher than ratings for the MHP described as not being involved in the rural community regardless of whether or not the MHP was described as living in the rural community. The findings suggest that hypotheses #2 and #3 were supported.

## Regression

A multiple linear regression was conducted to measure the effect of participants' self-reported rurality and the vignette they read on the CRF total score assigned to the MHP described in the vignette. A significant regression equation was found, $F(7,414) = 58.179$, $p < .000$, with an $R^2$ of .496. Dummy variables were coded for each possible vignette and interactions between rurality and the four levels of the vignette were tested. There was a significant interaction effect for rurality and the levels of the vignette, all when compared to the vignette describing a MHP as commuting to a rural community and not being involved in the community (rurality x resides/involved, $\beta = .167$, $p = .001$; rurality x commute/involved, *standardized* $\beta = .135$, $p = .005$; rurality x resides/not involved, $\beta = .122$, $p = .007$). The results, which are summarized in Table 2, reveal that there was a significant positive relationship between rurality and the ratings on the CRF-s total score for all of the vignettes except for the one describing the MHP as commuting to the community and not being involved in the community. This finding supports the second part of hypotheses #2 and #3.

## Discussion

The current study set out to improve understanding of the impact of rural culture on stigma towards seeking mental health services and how MHPs can affect individuals' perceptions of them. Previous studies have provided evidence that stigma towards MHPs and help-seeking behavior is higher in rural communities when compared to the sentiments expressed by individuals' residing in more urban communities (Stewart, et. al., 2015; Bischoff et al., 2014; Larson & Corrigan, 2010). The findings of the current study did not support this previous literature, and in fact were in some ways in direct contrast, suggesting that perceptions of MHPs among rural residents are strongly influenced by the level of community involvement a MHP

demonstrates. In addition, the current study also found that attitudes towards seeking mental health services may not be a reliable predictor of how a specific MHP will be judged.

Previous studies have provided evidence that improved MHP visibility within rural communities can lead to improved attitudes towards MHP and improve help-seeking behavior (Bischoff et al., 2014; Malone & Dyck, 2011; Helbok, 2003). In the previous literature, the difficulty in determining what elements led to more positive perceptions and interactions between residents/clients and MHPs may have been an artifact of the implied assumption that the MHP lived in the rural community that they are serving. Anecdotal evidence suggesting that this assumption does not hold true from many, if not most, MHPs serving rural communities provides impetus for the current investigation. The results of this study are consistent with past findings that community involvement and visibility can significantly improve perceptions of MHPs. The study was also able to provide evidence that living within the rural community was not always a predictor of positive perceptions of MHPs. The results of this study suggest that MHPs planning to work in rural settings could potentially improve perceptions of mental health services and themselves by involving themselves in the community in a variety of ways without the need to reside in the community they serve. By not living in the served community MHPs are able to choose what activities they are going to be involved in and thus have improved control over how and when they are visible within a community. With the ability to control the level of visibility within a community, MHPs can potentially improve perceptions of themselves and their services without exposing themselves to the additional ethical risks involved with living in a small community. What this study has shown is that residence is not required in order to improve perceptions of MHPs, meaning that MHPs have the potential to improve perceptions of

themselves and can reduce self-imposed stigma towards seeking mental health services through a proactive approach to visibility in the form of community involvement.

It is interesting to note that ratings of the MHP were significantly higher when the individual was described as being involved in the community as opposed to not being involved. This finding suggests that visibility in the form of community involvement is a good predictor of positive perceptions regardless of the setting. Breaking down the analyses by the vignette presented did highlight something that was described in previous research (Bischoff et al., 2014; Malone & Dyck, 2011; Helbok, 2003). Participant's degree of rurality was positively associated with higher ratings for MHPs described as residing in the community and being involved, commuting and being involved, and residing in the community and not being involved. The previously identified negative stigma against MHPs providing services in rural communities was only evident for MHPs described as residing outside the community they served *and* being uninvolved.

While the positive relationship between rurality and community involvement was predicted, it was interesting to see the positive relationship between rurality and ratings of an MHP described as residing in the community while not being involved. The present study set out to determine whether the most significant predictor of positive perceptions was residence or community involvement, and the results show that residence within a rural community was still seen as important to rural individuals, albeit significantly less important than community involvement. In addition to this, the negative relationship between rurality and attitudes toward MHPs, previously described as the "outsider perception" (Malone & Dyck, 2011, Helbok, 2003) was only evident when the MHP suffered the "double whammy" of not living in the community they served, and being uninvolved in community activities.

The current study was not without limitations, and these limitations should be considered when interpreting the results. One of the most significant is the highly skewed gender representation within the sample. With women making up about 83% of the sample, it is difficult to generalize the data. Perhaps attitudes towards seeking services are becoming more positive for rural individuals, a trend that would not support previous findings showing significantly less positive attitudes among rural individuals (Stewart, Jameson, & Curtin, 2015). However, it is also plausible that the results showing more positive attitudes towards seeking mental health services are due to a difference between attitudes between female and male participants. Previous research has repeatedly reported that women generally have a more positive attitudes toward mental health services (Mackenzi, et al., 2004). It is also possible that female participants were more greatly influenced by the independent variable of community involvement, which may be considered an even more favorable trait by women. This potential confound does limit the ability to generalize the results across genders. Another limitation is the way in which participants in the snowball sample were recruited to participate in the study. The executive director of a foundation directed at preserving rural culture allowed access to the foundation's email list which included around 10,000 individuals. While not all participants in the snowball sample were individuals from the email list, there is a possibility that the positive ratings of the MHP were affected by these specific rural participants. It is possible that individuals who associate themselves with the foundation would have an interest in presenting rural culture in a positive light. There is a chance that association with the foundation could have had a very minor impact, and the ability to include more rural individuals in study was important as access to rural participants can be difficult. In addition, another limitation is that way that rurality was assessed. The demographic measure used to assess for rurality featured uneven scoring for different variables, meaning that

when rurality was averaged, some factors impacted the score to a greater degree. The participant's hometown and parents' hometowns ended up having a much larger impact on the scoring than the time spent on a farm or the subjective rurality measures. Future analyses will be run with the components of rurality weighted to create equal contributions from each section, and to isolate each component and run the analyses for every component separately. An important consideration in future research into rural mental health issues should be to access a more balanced population in regards to gender as this may provide improved insight into the overall perceptions of community involvement, visibility, and help-seeking behavior.

The use of the CRF-S to measure perceptions of a MHP was effective in that the rating scale is designed to measure perceptions of MHPs (Corrigan, & Schmidt, 1983). What is not clear is if the scores on the CRF-S accurately represent an in-group vs out-group perception. As a purely quantitative study, the measure of individuals' perceptions of the presented MHP was shaped by the CRF-S and thus detail was lost in the effort to make the study highly accessible. Additionally, the samples were collected primarily from individuals residing in a single Midwestern state and were lacking in ethnic diversity, limiting the ability to generalize results to all members of settings where rural culture flourishes in the US.

Future research into the ability for MHPs to positively affect help-seeking behavior in rural communities should consider utilizing qualitative methods to provide greater detail about the characteristics that improve perceptions of MHPs and what those improved perceptions really mean to more rural individuals. Future research may also consider directly testing the effect of more positive perceptions of MHPs. While this study tested the effect that previously existing attitudes had on perceptions of mental health practitioners, it did not specifically address the degree to which more positive perceptions affected those attitudes

The importance of community involvement in perceptions of MHPs was shown in this study, but the study did not separate out which components of community involvement provided the greatest effect. While the types of activities integrated into the vignettes developed for this study reflect traditional assumptions about settings that are an important part of traditional rural culture (e.g.; church and local schools), the findings are insufficient to offer specific recommendations that MHPs striving to improve how they are perceived by a rural constituency should engage in these specific activities. It is quite possible that the effects of community involvement identified in the current study may be more general in nature, so that involvement in any type of "visible" community involvement would have a similar effect. After all the idea that in order to maximize effectiveness in rural practice a MHP must engage in a multitude of community organizations/projects may seem overwhelming. This is especially true given the fact that many MHPs engaged in the practice of rural mental health serve more than one community. An understanding of what organizations/projects are the most important to rural individuals could allow for MHPs to maximize positive perceptions without creating a potentially overwhelming time commitment.

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## Appendix: A

## Demographic Information

Please answer these questions to describe yourself.

1. _____Female _____ Male
2. Age _____
3. Ethnicity

   _____ Caucasian

   _____ African American

   _____ Asian American

   _____ Hispanic/Latino/a American

   _____ Native American

   _____ Other: _____
4. What is your "hometown"? (Only county and state are required. City is not required if you can provide the county and state. Provide what information you can)

   City _____

   County _____

   State _____
5. Which of the following best describes how you think about yourself?
   a. City person
   b. Suburban person
   c. Small-town person
   d. Country person
   e. I don't think of myself in such terms

6. What is your **father's** "hometown"? (Only county and state are required. City is not required if you can provide the county and state. Provide what information you can)

   City _____

   County _____

   State _____

7. What is your **mother's** "hometown"? (Only county and state are required. City is not required if you can provide the county and state. Provide what information you can)

   City _____

   County _____

   State _____

8. Along the provided continuum, indicate where you would most like to live.

| Pick one | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| | very rural | somewhat rural | | | somewhat urban | very urban |

9. Which of the following best describes how much time you spend on a farm or ranch in an average year? Include visits to friends or relatives, vacations, recreational outings, etc.

   a. None

   b. Less than one week.

   c. Less than one month.

   d. More than a month, but less than three months.

   e. More than three months.

10. Along the provided continuum, indicate along the line to describe how you think of yourself.

| Pick one | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| | A "rural" person | | | | | an "urban" person |

## Appendix: B

### *Inventory of Attitudes Towards Seeking Mental Health Services (IASMHS)*

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns, emotional problems, mental troubles,* and *personal difficulties.*

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

| | | Disagree | Somewhat Disagree | Undecided | Somewhat Agree | Agree |
|---|---|---|---|---|---|---|
| 1. | There are certain problems which should not be discussed outside of one's immediate family | 0 | 1 | 2 | 3 | 4 |
| 2. | I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems | 0 | 1 | 2 | 3 | 4 |
| 3. | I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems. | 0 | 1 | 2 | 3 | 4 |
| 4. | Keeping one's mind on a job is a good solution for avoiding personal worries and concerns. | 0 | 1 | 2 | 3 | 4 |
| 5. | If good friends asked my advice about a psychological problem, I might recommend that they see a professional. | 0 | 1 | 2 | 3 | 4 |
| 6. | Having been mentally ill carries with it a burden of shame. | 0 | 1 | 2 | 3 | 4 |
| 7. | It is probably best not to know *everything* about oneself. | 0 | 1 | 2 | 3 | 4 |
| 8. | If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy. | 0 | 1 | 2 | 3 | 4 |
| 9. | People should work out their own problems; getting professional help should be a last resort. | 0 | 1 | 2 | 3 | 4 |
| 10. | If I were to experience psychological problems, I could get professional help if I wanted to. | 0 | 1 | 2 | 3 | 4 |
| 11. | Important people in my life would think less of me if they were to find out that I was experiencing psychological problems. | 0 | 1 | 2 | 3 | 4 |
| 12. | Psychological problems, like many things, tend to work out by themselves. | 0 | 1 | 2 | 3 | 4 |
| 13. | It would be relatively easy for me to find the time to see a professional for psychological problems. | 0 | 1 | 2 | 3 | 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. | There are experiences in my life I would not discuss with anyone. | 0 | 1 | 2 | 3 | 4 |
| 15. | I would want to get professional help if I were worried or upset for a long period of time. | 0 | 1 | 2 | 3 | 4 |
| 16. | I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it. | 0 | 1 | 2 | 3 | 4 |
| 17. | Having been diagnosed with a mental disorder is a blot on a person's life. | 0 | 1 | 2 | 3 | 4 |
| 18. | There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help. | 0 | 1 | 2 | 3 | 4 |
| 19. | If I believed I were having a mental breakdown, my first inclination would be to get professional attention. | 0 | 1 | 2 | 3 | 4 |
| 20. | I would feel uneasy going to a professional because of what some people would think. | 0 | 1 | 2 | 3 | 4 |
| 21. | People with strong characters can get over psychological problems by themselves and would have little need for professional help. | 0 | 1 | 2 | 3 | 4 |
| 22. | I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. | 0 | 1 | 2 | 3 | 4 |
| 23. | Had I received treatment for psychological problems, I would not feel that it ought to be "covered up." | 0 | 1 | 2 | 3 | 4 |
| 24. | I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems. | 0 | 1 | 2 | 3 | 4 |

Appendix: C

On the following page, each characteristic is followed by a seven-point scale that ranges from "not very" to "very". Please select a point on the scale that best represents how you viewed the therapist.

| | Not Very | | | | | | Very |
|---|---|---|---|---|---|---|---|
| Friendly | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Likeable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Sociable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Warm | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Experienced | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Expert | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Prepared | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Skillful | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Honest | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Reliable | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Sincere | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Trustworthy | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Competent | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Ethical | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

# Appendix: D

## Vignettes

**Resides/Involved:** This mental health worker lives in a small community (less than 2500 residents) and provides mental health services to the residents of that community. The mental health worker volunteers at the local high school by offering workshops and education on substance abuse. This mental health worker is also involved in organizing fundraising at a church in the community, and helps organize and manage resources for an annual community festival.

**Commute/Involved:** This mental health worker commutes 1 hour each way on a daily basis to a small community (less than 2500 residents) and provides mental health services to the residents of that community. The mental health worker volunteers at the local high school, offering workshops and education on substance abuse. This mental health worker is also involved in organizing fundraising at a church in the community and helps organize and manage resources for an annual community festival.

**Resides/Uninvolved:** This mental health worker lives in a small community (less than 2500 residents) and provides mental health services to the residents of that community. The mental health worker has recently declined an opportunity to present an educational workshop on substance abuse at the high school in the community. This mental health worker describes themselves as being spiritual, but is not involved in any church functions in the community. The mental health worker has also declined offers to help organize an annual community festival.

**Commute/Uninvolved:** This mental health worker commutes 1 hour each way on a daily basis to a small community (less than 2500 residents) and provides mental health services to the residents of that community. The mental health worker has recently declined an opportunity to present an educational workshop on substance abuse at the high school in the community. This mental health worker describes themselves as being spiritual, but is not involved in any church functions in the community. The mental health worker has also declined offers to help organize an annual community festival.

## Appendix: E

## Informed Consent

The Department of Psychology supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate you are free to withdraw at any time, without penalty. All participants must be at least 18 years of age in order to participate in the study.

This study is concerned with how mental health practitioners are perceived. You will be asked to provide some demographic information, including information about where you grew up and where your parents grew up. You will also be asked questions about your attitudes toward and perceptions of mental health service providers. More specifically, you will read one or more short vignettes and then asked to respond to several questions concerning the individual(s) described in the vignette. You should be able to complete the study in no more than 30 minutes.

Your participation is solicited, but strictly voluntary. Do not hesitate to ask any questions about the study. Be assured that your name or other identifying information will not be associated with the research findings in any way, and that your responses are completely confidential. Your participation in this study is sincerely appreciated.

Sincerely,

Ryan Smalley

Lead Investigator:

Ryan Smalley

ryan.smalley@washburn.edu

By clicking the "Next" button at the bottom of this page you are acknowledging that you have read the above informed consent and are agreeing to participate in the study.

Tables

Table 1.0
*2013 Rural-urban Continuum Codes*

| Code | Description |
|---|---|
| Metropolitan | |
| 1 | Counties in metro areas of 1 million population or more |
| 2 | Counties in metro areas of 250,000 to 1 million population |
| 3 | Counties in metro areas of fewer than 250,000 population |
| Nonmetropolitan | |
| 4 | Urban population of 20,00 or more, adjacent to a metro area |
| 5 | Urban population of 20,00 or more, not adjacent to a metro area |
| 6 | Urban population of 2,500 to 19,999, adjacent to a metro area |
| 7 | Urban population of 2,500 to 19,999, not adjacent to a metro area |
| 8 | Completely rural or less than 2,500 urban population, adjacent to a metro area |
| 9 | Completely rural or less than 2,500 urban population, not adjacent to a metro area |

Table 2.0
*Relationship Between Participant Rurality and Treatment Condition*

| | *B* | *SE B* | β | *p* |
|---|---|---|---|---|
| Step 1 | | | | |
| Constant | 52.883 | 1.453 | | .000 |
| Dummy HH1 | 27.524 | 2.025 | .586 | .000 |
| Dummy LH1 | 27.854 | 2.117 | .560 | .000 |
| Dummy HL1 | -3.053 | 2.146 | -.080 | .156 |
| Step 2 | | | | |
| Constant | 52.885 | 1.457 | | .000 |
| Dummy HH1 | 27.521 | 2.030 | .586 | .000 |
| Dummy LH1 | 27.851 | 2.123 | .560 | .000 |
| Dummy HL1 | -3.055 | 2.151 | -.080 | .156 |
| Rurality Centered | -.013 | .504 | -.001 | .979 |
| Step 3 | | | | |
| Constant | 53.341 | 1.442 | | .000 |
| Dummy HH1 | 27.153 | 2.004 | .578 | .000 |
| Dummy LH1 | 27.481 | 2.096 | .552 | .000 |
| Dummy HL1 | -3.494 | 2.123 | -.069 | .101 |
| Rurality Centered | -2.952 | .916 | -.208 | .001 |
| Interaction rurality*Dummy HH1 | 4.679 | 1.340 | .167 | .001 |
| Interaction rurality*Dummy LH1 | 3.860 | 1.358 | .135 | .005 |
| Interaction rurality *Dummy HL1 | 3.879 | 1.437 | .122 | .007 |