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MENTAL HEALTH IN RURAL AREAS: TO WHAT EXTENT DO STOICISM, STIGMA, AND COMMUNITY AFFILIATION PREDICT MENTAL HEALTH HELP-SEEKING BEHAVIORS?

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MENTAL HEALTH IN RURAL AREAS: TO WHAT EXTENT DO STOICISM, STIGMA, AND COMMUNITY AFFILIATION PREDICT MENTAL HEALTH HELP-SEEKING BEHAVIORS?

A DISSERTATION APPROVED FOR THE

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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Abstract

This study sought to explore the relationship between stoicism, stigma, and community affiliation on mental health help-seeking behaviors within rural communities. A relationship between mental health stigma and decreased mental health help-seeking behaviors has been established among both rural and urban communities, however, it is known that mental health stigma is increased in rural communities (Smalley & Warren, 2012a; Smalley & Warren, 2012b; Cantrell, Valley-Gray, Cash, 2012; Larson, Corrigan, & Cothran, 2012; Middleton, et al., 2003). The concept of stoicism has been studied within medical and philosophical literature (Murray et al., 2008), identifying that people who espouse more stoic attitudes are less likely to seek help for physical health reasons. However, there has been little, if any, focus on the impact that stoic attitudes have on mental health help-seeking, and certainly not in the rural United States. The third predictor variable, community affiliation, is comprised of the concepts of community attachment and community involvement, and is a new term that was utilized in the present study. The term affiliation highlights the concept of social connectedness, alliance, fellowship, and ownership that community attachment and community involvement do not embody. The current study explored (a) to what extent do the predictor variables of stoicism, stigma, and community affiliation predict mental health help-seeking behaviors in rural communities; and (b) which predictor variable accounted for the most variance when entered into the hierarchical regression model. While all predictor variables were found to be significant during the preliminary linear regression analyses stage, during the multiple regression analysis, stoicism emerged as the most significant predictor of decreased mental health help-seeking, followed by stigma. Conversely, community affiliation became non-significant when entered into the total multiple regression model.

Introduction

Ninety-seven percent of the United States' land area is considered rural, with roughly 60 million Americans (19.3%) residing in these rural areas (US Census Bureau, 2016). Yet, more than 85% of Mental Health Professional Shortage Areas (MHPSAs) are in rural areas (Gustafson, Preston, & Hudson, 2009; Bird, Dempsey, & Hartley, 2001). Given that depression rates in rural areas exceed those of urban areas (Brown, Warden, & Kotis, 2012; Probst, Laditka, Moore, Harun, & Powell, 2005), there are increased suicide rates in rural areas when compared to urban areas (Mickelson, Brenner, Haws, Yurgelun-Todd, & Renshaw, 2011; Hirsh, 2006; Singh & Siahpush, 2002), and the suicide rate for rural American teenagers is nearly double that for teenagers in urban areas (McCarthy, 2015), the lack of information about mental health provision in the rural United States is alarming.

While the dearth of literature about rural mental health is problematic, what is equally problematic is that psychological concepts and studies are often normed on urban populations and automatically applied to rural populations with disregard to the differences in urban vs. rural living (Cantrell, Valley-Gray, & Cash, 2012; Smalley & Warren, 2012b; Wagenfeld & Buffum, 1983). Considering that rural residents compose more of the population than any specific racial, ethnic, or sexual orientation group, it is of value to consider the unique contexts and conditions in which rural residents live (Smalley & Warren, 2012b). Moreover, much of the research that does examine rural areas fallaciously deems rural populations as homogenous, layering blanket assumptions from one rural area to another (Ciarlo & Zelarney, 2000). In reality, rural areas are rich with differing cultures, characteristics, economies, and climates (Ciarlo & Zelarney, 2000). Troubled by the homogenizing and blanketed assumptions about rural mental health, Smalley

and Warren (2012b) commented, “Despite the abundant evidence pointing to the importance of considering and incorporating cultural themes into mental health treatment, the recognition of rurality as a *bona fide* multicultural issue has not been embraced by the mental health field” (p. 38). Understanding that rural communities are rich, complex, and varied from region to region, it is clear that the extant data and social constructs that have been normed on urban populations should not automatically be generalized as “truth” for rural populations. However, many of the current scales and measures have been normed on urban populations and are consistently used for rural populations (Ciarlo & Zelarney, 2000). Thus, it is one of the goals of the proposed study to contribute to the literature by elucidating specific cultural and demographic information about rural populations, while additionally studying specific variables as they relate to rural life to begin filling the literature gap that exists regarding the uniqueness of rural life.

Of note, it is important to highlight that identifying rurality as a cultural point of interest is not in response or opposition to the focus on other oppressed and underserved groups. Identifying rural culture as a bona fide multicultural issue (Smalley & Warren, 2012b) can be problematic, as it has the potential to be seen as elevating the struggles experienced within rural culture to the same status of severity as other oppressed cultural groups, and could be invalidating to oppressed racial or ethnic groups. Rural peoples are typically not actively oppressed, as are many racial and ethnic groups, but are instead a group of people with cultural similarities (e.g., low population density, agricultural heritage, etc. (Smalley & Warren, 2012b)) who are underrepresented and underserved. Identifying rural culture as a bona fide multicultural issue has the potential to coopt the focus from other racial or ethnic groups to focus on largely white-identified people, as, according to Housing Assistance Council (2012), rural areas are comprised of 77.8% of people who identify as White- not Hispanic. Therefore in the framework

utilized in this dissertation the focus of including rurality into cultural conversations is on identifying and studying an underserved and understudied group of people.

While the culture of rural life is not homogenous and varies from community to community, there are also components that are characteristic of rural living which unify and define what makes rural populations unique from their urban counterparts. Rural individuals may develop shared attitudes which reflect environmental adaptations that are necessary to be successful living in a rural area (Lutterman, 2004). For example, Lutterman (2004) posited "farmers and ranchers may find it difficult to access services because they live outside of city limits, work seven days a week, lack understanding of the services that exist, and fear the stigma for the acceptance of services" (p. 9).

While adapting to the challenges of rural life (e.g., distance to services, limited employment) is necessary for prosperous living in a rural community, adapting to one's own mental health needs in a rural area seems to be limited (Smalley & Warren, 2012a; Lutterman, 2004). As mentioned previously, in general, rural areas have increased suicide rates when compared to their urban counterparts; in some areas, the urban/rural suicide rate difference is 300% (Smalley & Warren, 2012a). While increased suicide rates are common throughout rural communities, additional characteristics of rural life include an emphasis on independence (Cantrell et al., 2012), as well as a promotion of "a strong work ethic… rugged individualism, religiosity and patriotism, and a focus on family and community-oriented life" (Hirsch, 2006, p. 191). Gerrard, Kulig, and Nowatzki (2004) further contended that "traditional theoretical frameworks do not capture the rural experience of isolation, which results from geographical isolation but leads to feelings of emotional and intellectual isolation" (p.65). Rural populations are also characterized by low population density, agricultural heritage, greater experienced

poverty, insular social connections, individualistic attitudes, increased religious affiliation, self-reliance, mental health stigma, distance from mental health care, isolation, and lower education level. (Smalley & Warren, 2012b; Judd, et al., 2006). Additionally, individuals from rural areas also embody stoic values or a general stoic approach to not only financial stressors and physical pain, but to mental health struggles as well (Judd, Jackson, Komiti, Murray, Fraser, Grieve, & Gomez, 2006; Lutterman, 2004; Moore, Grime, Campbell, Richardson, 2013). Cantrell et al., (2012) further defined rural communities as "high context cultures… where people rely on one another for support in a variety of social organizations" (p. 215).

Rural communities are also highly socially connected, and due to the intertwined social connections that exist in rural areas, Rothenbuhler, Mullen, DeLaurell, and Ryu (1996) identified that individuals in rural communities experience greater feelings of attachment to their communities and are often more involved in and concerned about community activities than their urban counterparts. For the purposes of the proposed study, social connectedness, community attachment, and community involvement are collectively referred to as community affiliation.

Because rural areas often consist of high context, socially intertwined and proximate communities (Cantrell et al., 2012; Parr & Philo, 2003) residents may be aware of what their peers are doing at any given time (Cantrell et al., 2012; Smalley & Warren, 2012a). Given that the acceptability of receiving mental health services in rural areas is lower than in urban areas due to lack of understanding of mental health issues as well as traditional, rural, individualist attitudes (Smalley & Warren, 2012a), combined with decreased anonymity of rural life, mental health is more stigmatized in rural areas than in urban areas. The stigmatization of mental health issues in rural areas often precludes rural individuals from seeking mental health treatment if needed (Larson, Corrigan, & Cothran, 2012; Smalley & Warren, 2012a).

Despite the need to seek mental health treatment, when compared to urban dwelling individuals, rural individuals do not seek mental health help 50% of the time (Berry & Davis, 1978). The underutilization of mental health assistance in rural areas has been well established for nearly 50 years, and the trend toward rural individuals underutilizing mental health assistance has remained steady since the mid-1990s (Slama, 2004). The lack of seeking mental health help may be attributed to inappropriate cultural practices from mental health providers, but it may also be due to the social stigma that exists regarding seeking mental health help. Parr & Philo (2003) attributed part of the lack of treatment to mental health help seeking being seen as culturally "risky," or outside the cultural norm of stoicism and individualism (Parr & Philo, 2003). Judd, et al., (2006) further elucidated that there are additional reasons why there is an inequity in mental health help seeking which may be "due to less availability or accessibility of services, or the failure to provide services in a culturally appropriate way…in rural areas" (p.770). Cantrell, et al., (2012) suggested that whether a person chooses to engage or avoid mental health services is highly dependent on the culture in which the person lives. Moreover, Hirsch (2006) contended that negative attitudes and social stigma surrounding mental health may play significant roles in reduced mental health help seeking in rural areas.

Given that there has been a shift toward general cultural competency in counseling psychology (Smalley & Warren, 2012b) in combination with the American Psychological Association's accreditation requirement for psychology training programs to "provide students with relevant knowledge and experiences about the role of cultural and individual diversity in psychological phenomena as they relate to the science and practice of professional psychology" (American Psychological Association, 2006), it seems prudent to include information about rural culture into training programs' cultural training model by recognizing rural culture as a *bona fide*

multicultural issue. However, this inclusion has yet to be incorporated into mental health training (Smalley & Warren, 2012b). Failure to establish basic competencies regarding rural life can impede client progress, lead to poor rapport, can lead to practitioners misunderstanding and misrepresentation of mental health issues in rural clients, and can encourage a general sense of mistrust from rural individuals who do seek treatment (Smalley & Warren, 2012b). Such interactions with mental health professionals can damage the already highly stigmatized view of mental health in rural areas, further contributing to the leading to the underutilization of mental health services (Smalley & Warren, 2012a; Smalley & Warren, 2012b).

While there is an understanding in the current literature that mental health is underutilized in rural areas worldwide, largely due to stigma, (Wrigley, Jackson, Judd, & Komiti, 2005; Smalley & Warren, 2012a; Smalley & Warren, 2012b; Rost, Smith, & Taylor, 1993), there is little understanding of underlying constructs other than stigma that may be contributing to this underutilization. In the case of the proposed study, it is suggested that factors which may lead to underutilization of mental health services, are stigma, stoicism and community affiliation. The purpose of this research is to explore whether stigma, stoicism, and community affiliation predict underutilization of mental health help seeking. More specifically, it is an exploration of whether stoic attitudes, high levels of community affiliation, and high levels of mental health stigma in rural populations preclude seeking mental health treatment. Given that there is a general dearth of literature regarding rural mental health, as well as what factors underlie the underutilization of mental health services in rural populations, this study could be a valuable contribution to the literature on rural mental health. With greater understanding of rural mental health, providers may learn to engage with rural mental health help seekers in culturally relevant ways, perhaps

beginning to bridge the gap between rural individuals and their comfortability in seeking mental health help.

Literature Review

As noted previously, there is a paucity of literature that specifically focuses on rural mental health (Smalley & Warren, 2012a). It should also be noted that a significant portion of the literature that does exist regarding rural mental health has been conducted outside of the United States, namely in the British Isles, Australia, and New Zealand **(**Judd, Jackson, Komiti, Murray, Fraser, Grieve, & Gomez, 2006; Pinnock, O'Brien, & Marshall, 1998; Wrigley et al., 2005; Fuller, Edwards, Procter, & Moss, 2000; Hill, Pritchard, Laugharne, & Gunnell, 2005; Caldwell, Jorm, & Dear, 2004; Middleton, Gunnell, Frankel, Whitley, & Dorling, 2003). As previously highlighted, it is important to note that what has been established through the literature as consistent for rural areas outside of the rural United States should not be presumed as truth for rural areas in the rural United States. However, given that a significant portion of the extant literature that is outlined in this review is based on research that was conducted outside of the United States, it serves as a starting point to bridge the gap regarding rural literature specific to the United States. Despite the limitations of utilizing a literature base that is heavily influenced by sources outside of the United States, it is important to incorporate the existing literature about rural communities and rural life to add richness and depth into the understanding of rural mental health. Considering the trend of underutilization of mental health services in rural areas is a worldwide phenomenon (Berry & Davis, 1978; Slama 2004; Smalley & Warren, 2012a; Smalley & Warren, 2012b), that there is increased stigma of mental health in rural areas worldwide (Slama, 2004), rural areas are underserved worldwide (Gustafson, et al., 2009; Bird, et al., 2001), that there is limited data specific to rural mental health help-seeking, particularly in the United

States (Cantrell et al., 2012; Smalley & Warren, 2012b; Wagenfeld & Buffum, 1983; Ciarlo & Zelarney, 2000) , and that there is continued non-acknowledgment of rural living as a diversity issue (Smalley & Warren, 2012a; Smalley & Warren, 2012b), it is important to specifically explore what makes rural areas unique, particularly regarding mental health help-seeking behaviors.

This literature review will not explore resiliency in rural populations. While resiliency is a quality that individuals in rural areas often demonstrate, and resilience and stoicism are often conflated with one another, resilience can be defined as "'bouncing back' from adversity, coping, and acquiring skills, such as problem solving and learning" (Gerrard et al., 2004, p. 59) and that resiliency is "both proactive and reactive" (Gerrard et al., 2004, p. 59). Stoicism, rather, may be conceptualized as more of a personality trait that may result in failure to recognize or acknowledge mental health struggles as issues of concern or may result in failure to seek assistance for mental health issues until an individual is in crisis (Judd et al., 2006). This review will also not explore "informal" forms of mental health help-seeking behavior. Informal help-seeking, for the purposes of this study, is classified as seeking assistance from peers, friends, family, self-help books, social media, coworkers, or religious/spiritual leaders who are not trained to provide specialist mental health support (Rickwood & Thomas, 2012).

Rural

According to Larson et al., (2012), "Rural settings are characterized by a population that is physically distant but socially proximate, whereas urban settings involve a population that is physically proximate but socially distant" (p. 53). More specifically, rural, according to the proposed study, as delineated according to the U.S. Department of Agriculture, is classified as, "nonmetro counties" which include a combination of open countryside, rural towns consisting of

fewer than 2,500 people, and more urban areas with populations ranging from 2,500 to 50,000 (Cromartie & Parker, 2016). Thus, for the purposes of the proposed study, rural will be classified as any area that is characterized by a population ranging from 1 – 50,000. While there are many different classifications for what is considered to be rural, Smalley and Warren (2012a) contended that the varied definitions of what it means to be rural contributes to the dearth of literature on serving rural populations' mental health needs because there is no consistent definition of what rural actually is. Thus, there is a lack of prevalence and outcome data with which to conduct and compare research (Smalley & Warren, 2012a).

Rural areas are also characterized by increased age when compared to urban areas (Day, Hays, & Smith, 2016). According to the United States Census Bureau, rural America is older than urban America, with the average age of urban dwellers being 36 years and the average range for rural individuals as 43 years with higher levels of the "Baby Boomer" population in their 50s and 60s in rural areas (Day et al., 2016).

Stoicism

While stoicism is a concept that is widely explored in the field of philosophy, it has not yet been widely explored in the field of psychology (Murray et al., 2008). In the work that has been done specific to the psychology field, there has been **"**little acknowledgement of the sociocultural factors that play a role in the development of 'stoic attitudes' and behavior" (Moore, et al., 2013, p. 162). Stoicism, as defined by the creators of the Liverpool Stoicism Scale is defined "as a lack of emotional involvement and expression, and exercising emotional control or endurance" (Wagstaff & Rowledge, 1995, p. 181). Stoicism is largely associated with "silence, non-admission and endurance of adversity, such as pain, without complaint or (help seeking)" (Moore, Grime, Campbell, & Richardson, 2013, p. 160). As a concept, stoicism is

important to explore, as individuals who endorse stoic attitudes may be less likely to acknowledge mental health symptoms as problematic, or may choose not to seek mental health treatment until they are in crisis (Judd, et al., 2006). Stoicism as a factor that precludes individuals from seeking mental health treatment has not been widely studied in psychological literature, but has been reference in the medical literature. Further, more stoic attitudes have been related to negative perceptions toward seeking help for health-related reasons (Pinnock, et al., 1998).

Yong, Gibson, Horne, and Helme (2001) identified that stoicism may develop in response to certain contextual factors such as politics, culture, and social norms during transformative and developmental periods in an individual's life. Moore et al., (2013) supported this supposition, and further added the contextual nuances of culture and gender as influences on a person's level of stoicism. Additionally, both Moore et al., (2013) and Yong et al., (2001) further stated that stoicism is more common in older generations. Given that the age range in rural areas skews older than in urban areas (Day et al., 2016), and that older individuals typically are more religious than younger individuals (Hayward & Krause, 2015), stoicism may be linked not only age, but also to religious beliefs, particularly Christian religious beliefs (Dillon & Savage, 2006). Given that stoicism was largely incorporated by Christianity since its inception (Still & Dryde, 1999) and that rural areas in the United States typically abide by traditional Christian beliefs, religious ties may also contribute to level of stoicism within rural communities.

As mentioned previously, rural residents are on average older than urban residents. To examine differences in stoic attitudes, Yong et al., (2001) conducted a study on pain attitudes and stoicism. Through this research, the authors identified that older adults are less likely to report pain symptoms, and that this tendency toward more stoic perceptions of pain increases with age.

Yong et al., (2001) identified that a reticence to report pain may reflect historical and sociocultural influences such as experiences with world war and the Great Depression, and that stoic attitudes developed during these times out of necessity. While the larger proportion of Baby Boomers that exists in rural areas did not experience world war or the Great Depression, they were likely raised in environments by caregivers who did experience these world events, thus translating these attitudes onto their progeny (Yong et al., 2001; Moore et al., 2013).

Stoicism has been cited as a quality that is reflected in farming or more rural communities, and is said to have developed out of necessity. Due to the nature of rural communities physical location, rural people have to be self-reliant (Judd et al., 2006). In the 1998 study on older men's concerns about their urological health, Pinnock et al. identified that the characteristic of stoicism was evident in the patients who chose not to seek medical help. Pinnock et al., (1998) identified that those who chose not to seek medical treatment "feared uncovering something that was wrong… or because they would have to take time off work and, therefore, let others down" (p. 167). While not all rural areas are farm towns, many rural areas are agrarian, and as such, hold agrarian values (Judd et al., 2006).

There is a limited literature base involving stoicism as a variable for study. One of the primary sources for information regarding stoicism as a measurable construct may be found in a seminal article about a measure that examines stoicism through the development of the Liverpool Stoicism Scale (LSS) (Wagstaff & Rowledge, 1995). To establish the construct of stoicism, Wagstaff and Rowledge (1995) developed a scale to test the hypotheses that British men would be more stoic than British women, that stoicism would be related to negative attitudes toward the poor, and that individuals who identified as more stoic would be less emotive when presented with emotionally laden content (Wagstaff & Rowledge, 1995). While this study only included 62

total participants ranging from 20-50 years old, the Liverpool Stoicism Scale (1995) demonstrated internal consistency, external validity and supported the aforementioned hypotheses, providing support for the general construct of stoicism as outlined by Wagstaff and Rowledge (1995). While the construction of the LSS as a measure for stoicism appears statistically rigorous, what is not known from the establishment of the Liverpool Stoicism Scale is specific demographic information. Rather, the study highlights that the scale was normed on participants from "various occupations and backgrounds in Britain" (Wagstaff & Rowledge, p. 182). Thus, specific demographic information is left unclear, particularly related to the living locations of the participants of the study. As it is understood now, the construct of stoicism embodies the same characteristics for men and women (Wagstaff & Rowledge, 1995) though, in the western world, men display stoic characteristics more commonly than women (Gunell & Martin, 2004).

Gaitniece-Putāne (2005) built on the Wagstaff and Rowledge (1995) study and sought to establish whether the construct of stoicism as established by Wagstaff and Rowledge (1995) was culturally consistent with the construct of stoicism in Latvia. Gaitniece-Putāne (2005) outlined that given Latvia's history of invasion, intergenerationally observed stoic values, limited emotional expression, lack of study on the concept of stoicism in Latvia, and the fact that stoicism is often conflated with hardiness, a cross-cultural examination of stoicism was appropriate. Through factor analysis, Gaitniece-Putāne (2005) found that the translated Latvian version of the Stoicism Scale demonstrated adequate internal consistency and validity, and was subsequently appropriate to be used on the Latvian population (Gaitniece-Putāne, 2005).

Additionally, Murray et al., (2008) sought to confirm the psychometric properties of the LSS given that the LSS had not been used in its native language for a study since 1995. To do so,

Murray et al., (2008) utilized mail-out questionnaire studies in rural Australia. Through the examination of 467 responses, with 59.7% (n = 252) of the responses being female, with the mean age being 52.7 years Murray et al., (2008) found that the LSS had "adequate psychometric properties… support for internal reliability… and test-retest reliability… comparable to that reported for better-researched personality constructs" (p. 1377).

In a study conducted by Judd et al., (2006), the researchers sought to examine the role of stoicism, self-efficacy, and perceived stigma in predicting rural residents seeking help for mental health issues. Judd et al., (2006) identified self-efficacy and stoicism as "agrarian values" or qualities that are particularly evident in rural communities in Australia. Through examining 467 rural Australian residents, Judd et al., (2006) found that only 27.5% (n = 129) of participants sought help for mental health issues, that help-seeking behaviors were positively associated with higher levels of distress and lower levels of stoicism, and that women were more likely to seek help for mental health reasons than men. While in general, women seek help for mental health reasons more frequently than men (Judd et al., 2006; Oliver, Pearson, Coe, & Gunnell, 2005), Judd et al., (2006) posited that the effect of gender on mental health help seeking may be more pronounced in rural than urban areas due to rural areas typically abiding by more traditional gender roles. Moreover, Judd et al., (2006) suggested that in rural Australia, urban men seek treatment for mental health issues more frequently than rural men, and that rural men complete suicide with greater frequency than urban men (Caldwell, et al., 2004). Judd et al., (2006) further contended that people in areas with high levels of stoicism may not only choose to seek mental health treatment less frequently than those who endorse lower levels of stoicism, but they may also inaccurately report fewer mental health symptoms because they do not determine them to be indicative of mental illness. Because of this limited recognition of mental health issues, rural

individuals may not seek mental health treatment until symptoms are debilitating and reach crisis level (Judd et al., 2006; Smalley & Warren, 2012a). While the Judd et al., (2006) study provided a clear snapshot into the impact that stoicism can have on mental health treatment in rural areas, this study was conducted on an Australian population and cannot be assumed to be synonymous with a population in the rural United States, again reiterating the importance of conducting a similar study on a United States population.

While stoicism as a trait may have a detrimental impact on whether individuals may seek mental health treatment when they are in need, the benefits of stoicism should not be neglected to be mentioned. In a study conducted by Spiers (2006) examining pain and stoicism in home-care nurse-patient interactions, Spiers identified that, while stoic attitudes may preclude patients from receiving the nursing care they need, stoicism may also have positive implications, such as allowing a patient to "save face" and preserve their social identities. Stoicism may also contribute to the ability for one to be resilient, allowing stoic individuals to be more self-reliant and foster an ability to assertively meet their own needs (Fuller, et al., 2000; Gerrard, et al., 2004).

Community Affiliation

The present study is concerned with two different types of ties to the community: community attachment and community involvement. Together, community attachment and community involvement are referred to as community affiliation. While different, community attachment and community involvement are comprised of similar enough qualities that to separate them as individual variables would likely lead to conflation and multicollinearity.

Community attachment. Community attachment, according to Quarnberg (2011), "refers to how sentimentally rooted a person is in a particular geographical community" (p. 8).

Rothenbuhler et al., (1996) expanded on this definition, and asserted that "attachment implies feeling a part of the community - seeing oneself as belonging. Attachment also means that this sense of belonging is positively evaluated, that one is happy and proud to belong" (p. 447). Further, Theodori and Luloff (2000) cited that attachment is highly correlated with a person's feelings of rootedness to a place, and that the length that someone resides in a community is positively associated with more community attachment (Quarnberg, 2011; Theodori & Luloff 2000). McMillan and Chavis (1986) supported the aforementioned suppositions, and added that attachment to the community may include that the community can meet the needs of its residents. Additionally, Kassarda and Janowitz (1974) found that length of residence is the most highly correlated with community attachment.

Research stemming back to the 19th century (Toennies, 1887) has been concerned with the impact that towns becoming more densely populated and urbanized would have on social ties. It was believed that "urbanization and industrialization transform relationships in society from primary contacts to secondary contacts and local community thus declines" (Crowe, 2010, p. 622). Wirth (1938) also contended that increased population within itself was a prime reason for weakened social bonds. In contrast to this, in a more contemporaneous study, Kasarda and Janowitz (1974), identified that indeed urbanization may play a role in decreasing social bonds and community attachment, and that there are more elements at play than mere population density, such as length of residence and age. Goudy (1990) extended this research, but focused on rural populations. Rather than size and population density creating community attachment by the nature of their existence, instead, Goudy (1990) viewed community attachment as a choice that is based on social preferences and individual characteristics. Goudy (1990) further remarked "Although size and density may be related to many aspects of mass society, other variables

generally are of greater importance when community attachment is examined" (p. 196). Fischer (1975) supported this, and contended that it is not size or population density in and of itself that contributes to what appears to be less community involvement in urban communities. Instead, Fischer (1975) posited that larger populations contribute to the development of subcultures within the community at large where individuals who are part of those subcultures may claim attachment to those subcultures rather than the larger community itself.

Moreover, given the prevalence of internet availability, Quarnberg (2011) studied internet access and internet use and its impact on community satisfaction, community attachment, and community experience in rural communities in Utah. Quarnberg (2011) found that there was a connection between internet access and community satisfaction and further made the supposition that the more satisfied with a community a person is, the more attached they become. Internet access, different than internet use, is important for community satisfaction and subsequent attachment because having access to the internet may provide rural individuals access to goods or services that were not readily available within their community without the use of the internet, increasing their experience of community satisfaction and attachment. Quarnberg (2011) also found that, rather than for socializing or keeping in touch with friends, family, or acquaintances, individuals in rural areas often live in the same community as their friends and family members and "rural communities as people-rich areas and close knit areas where interaction is high and people interact with one another frequently. The Internet might be an unneeded tool for maintaining contact and networks for people" (p. 31). While internet access, according to Quarnberg (2011) does impact one's level of community satisfaction, it does not seem to impact socializing capacities. Given that the primary source of data for the proposed study will be gathered via online survey, it may be important to explore whether the Quarnberg (2011)

supposition regarding internet access, internet use, and community attachment and involvement are consistent with a rural population outside of Utah.

Community involvement. Community involvement is an important aspect of rural life, and is one that has had limited focus in extant literature. Rothenbuhler et al., (1996) identified community involvement as someone who "thinks about community affairs, stays caught up in the news, interacts with other people over community issues, works on community problems, and corresponding activities" (p. 447). Rothenbuhler et al., (1996) further suggested that community involvement is positively associated with education, age, localism of routine activities, length of residence, and number of children in the home. Rothenbuhler (1991) additionally identified community involvement as something that is defined by four questions: "How often one keeps up with the local news, how often one gets together with people who know what's going on locally, how often one has ideas for improving things locally, and how often one works to bring about changes in the community" (p. 65), and in a later text, cited that they expected community involvement to be negatively associated with population density (Rothenbuhler et al., 1996). Rothenbuhler et al., (1996) based their suppositions about community involvement on Emile Durkheim's writings from *The Division of Labor in Society*, hypothesizing that increased population density leads to increased social estrangement, and contended that, as population density increased, opportunities for community involvement decreased.

As mentioned previously, rural areas are physically distant but socially proximate (Larson et al., 2012). As such, people living in rural areas are often privy to what their fellow community members are involved in at any given moment, as decreased privacy is a real aspect of rural living (Smalley & Warren, 2012a). In addition to increased peer visibility, it has been

noted that social cohesion/social integration are key aspects of rural life, and that levels of social integration and involvement are higher in rural vs. urban areas (Hill, Pritchard, Laugharne & Gunnell, 2005). What is known is that due to the deeply interconnected and involved nature of rural areas as well as high levels of mental health stigma, rural people care about what their fellow community members think, and a culture of fear about what others would say about them should they seek mental health services may preclude them from seeking treatment (Parr & Philo, 2003). This fear, rooted in stigmatized perspectives of mental health treatment, is fueled by the interconnectedness of rural communities, as the quick flow of information through these communities may result in being labeled by all the people one knows in their community as someone who utilizes mental health treatment (Rost, Smith, & Taylor, 1993).

In a study by Rothenbuhler et al., (1996), researchers sought to examine the link between communication, community attachment, and community involvement by exploring local media consumption. To do so, survey data was gathered from 400 residents in Iowa to develop a structural equation model that linked community attachment and involvement to "newspaper use, local television news use, age, education, number of children in the home, localism, and population density" (Rothenbuhler et al.,1996, p. 445). With these variables in mind, Rothenbuhler et al., (1996), based on "The Community Press in an Urban Setting" by Janowitz (1952), predicted that the number of children in the home, age, and education level would predict community attachment and involvement. Rothenbuhler et al., (1996) suggested that as people age, they become more involved in community affairs and become more settled, thus leading to increased community involvement. The results of this study provide rationale for gathering more information regarding age, population density, education level, and applying it to a behavioral health model, as it is known that rural areas are comprised of older individuals, of more married

individuals, and of more households with children (Day et al., 2016), and that no such study examining the aforementioned variables has yet to be examined within the counseling psychology field.

Stigma

Stigma, as conceptualized by Byrne (2000), is defined as a sign of disgrace or discredit which sets a person apart from others. It is widely cited that the stigma that is attached to mental illness is increased in rural areas (Cantrell, Valley-Gray, Cash, 2012; Larson, Corrigan, & Cothran, 2012; Smalley, & Warren, 2012; Middleton, et al., 2003), and is evidenced by rural areas having available services, but individuals underutilizing them (Judd et al., 2006). Stigmatization of mental illness influences rural areas by "impacting on willingness to seek therapy, ability to disclose ongoing mental illness, and the level of support an individual is able to receive from their family and peers" (Larson et al., 2012, p. 61). Moreover, Judd et al., (2006) suggested that individuals living in towns with populations that are less than 2,500 were more likely to have stigmatized views of mental health than their urban counterparts, and that these attitudes predicted willingness to seek help in rural residents. Byrne (2000) supported Judd et al., (2006), and suggested that mental health is so problematic that "shame overrides even the most extreme of symptoms" (p. 65). Larson et al., (2012) further indicated that, when considering stigma, it is important to differentiate between public stigma and self-stigma, as both public and self-stigma contribute to underutilization of mental health services.

Public stigma. According to Larson et al., (2012) public stigma consists of "stereotypes, prejudice, and discrimination" (p.49). To break down this definition, Larson et al., (2012) abide by Hilton and von Hippel's (1996) definition of stereotypes; stereotypes are beliefs about social groups and why those social groups fit together. Larson et al., (2012) further identified that

stereotyping provides efficiency in the way that people make sense of the social groups around them. Next, prejudice, according to Hilton and von Hippel (1996), is viewed as "the application of social stereotypes" (p. 256). Larson et al., (2012) further elaborated on this definition and suggested that prejudice involves "awareness and agreement of negative stereotypes" (p. 50). This awareness and agreement may subsequently lead to behavioral reactions in response to stereotypes and prejudice – otherwise known as discrimination. Discrimination, according to Larson et al., (2012), "describes behavioral reactions connected to the negative emotional responses produced by prejudice" (p. 50). Byrne (2000) further posited that stereotypes allow individuals to "maintain social distance" (p. 66) by dismissing those whom they stereotype, thus further stigmatizing and isolating the stereotyped person(s).

Self-stigma. Related to public stigma, self-stigma occurs when "individuals internaliz[e] public stigma by accepting and applying negative stereotypes to themselves" (Larson et al., 2012). Self-stigma may result in what Goffman (1963) termed a "spoiled identity" in which individuals isolate themselves, experience decreased self-esteem, experience increased self-discrimination, and may result in self-stigmatized individuals avoiding mental health treatment to avoid being labeled with a mental illness (Larson et al., 2012). While not all individuals who are a part of a stigmatized group will experience self-stigma, those who identify or have been publically identified as part of a stigmatized group may be more likely to internalize public stigma (Larson et al., 2012).

Consideration of all forms of stigma is so important that Smalley & Warren (2012) placed a call to action for rural mental health practitioners to be proactive and address increased stigma areas in rural settings, stating that "rural practitioners must consider the impact of the culture of stigma surrounding rural regions and be prepared to pursue unique ways of

counteracting its effects" (Smalley & Warren, 2012, p. 42). Sing and Siahpush (2002) identified that stigma surrounding mental health may be so significant in rural areas that suicide deaths may be underreported, and instead indicated as accidental, perhaps reducing the sense of urgency and focus that should be placed on promoting mental health treatment in rural areas.

Stigma, in and of itself, even lent itself to rural individuals being reluctant to recognize and acknowledge when they have mental health issues, thus limiting the help they sought, if any help was sought at all (Fuller, et al., 2000). Further, even if rural individuals seek mental health treatment, a study by Phillips (1963) suggested an additional nuance to mental health help seeking, and identified that individuals who were seen in psychiatric facilities or by mental health professionals were seen as more vulnerable and were more stigmatized than those who were seen by religious officials or primary care physicians for identical problems.

Moreover, stigma is not limited to those who are seeking mental health treatment. Byrne (2000) suggested that because of the generally negative perception toward those seeking mental health treatment in rural areas, physicians may be reluctant or neglect to ask about mental health struggles in their patients. This "don't ask don't tell" philosophy around mental health struggles compounds the element of secrecy surrounding mental health issues in rural communities. Secrecy, Byrne (2000) stated, "acts as an obstacle to the presentation and treatment of mental illness at all stages" (p. 65).

Attitudes Toward Mental Health Help-Seeking

At present, there is no consensus as to what help seeking entails regarding mental health services, and Rickwood and Thomas (2012) identified that 46% of studies on help-seeking provided no clear definition of help-seeking for mental health reasons. However, Rickwood and Thomas (2012) identified help seeking as "an active and adaptive process of attempting to cope

with problems or symptoms by using external resources for assistance" (p. 180). The proposed study abides by this conceptualization of help seeking, and adds the additional layer of limiting the aforementioned "external resources" to mental health professionals such as psychologists, counselors, social workers, psychiatrists, religious spiritual leaders who have been trained in the provision of mental health treatment, and nurses who specialize in the provision of mental health treatment.

In a study attempting to develop a conceptual framework for help-seeking for mental health problems, Rickwood and Thomas (2012) conducted a systematic review of the literature that conceptualized and measured help-seeking for mental health reasons. Through this study, Rickwood and Thomas (2012) identified that over half of the extant studies (54%) focused on urban populations while only 6% of the studies examined participants from rural areas. Moreover, nearly half of the studies (47%) neglected to include the cultural background of the participants (Rickwood & Thomas, 2012). This dearth of information about both rural areas and cultural specifics further highlights the importance of the proposed study in meaningfully adding to the literature focused on rural individuals and cultural differences.

The most commonly cited measure to examine attitudes toward help-seeking for mental health reasons is the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale developed by Fischer and Turner (1970). The ATSPPH was developed to gain greater understanding about the attitudes and interpersonal reasons for choosing to seek mental health help, as no such scale existed at the time of the development of the ATSPPH. Fischer and Turner (1970) also noticed that fear of being stigmatized for mental health reasons seemed to deter persons in need from seeking help for their mental health struggles.

Social Networking Theory

In a study examining social ties at individual and community levels, Granovetter (1973) explored how social connections both individually and on the community level leads to dissemination of thoughts, information, ideas, and communication within those social networks. Granovetter (1973) further posited that, the more frequently individuals interact with one another, the more likely they are to form friendship relationships with that person. Choosing to conceptualize the proposed study through social networking theory is appropriate because it allows the data to be examined by specifically looking at what going on at the microlevel in rural communities (Granovetter, 1973). While ultimately frequency of interactions and ease of forming friendships in a small community can be touted as a strength of living in a rural area, what this dynamic may create, depending on the community or friend group's level of stigma surrounding mental health, the person who is struggling with mental health issues may feel like they have "more to lose" regarding their social standing within their circle, thus precluding them from seeking the help they require (Lutterman, 2004; Moore, Grime, Campbell, & Richardson, 2013; Linn, & Husaini,1987). For example, Walker (1977) stated that a dense network "may trap the individual within a limited set of normative expectations, information and social contacts, rather than fulfill his need to make a transition to new social roles" (p. 36). Both Granovetter (1973), Wilcox (1981) and Hirsch (1980) supported this general idea, identifying that social networks that are less interconnected are associated with positive adjustment and "inversely related to the ability to obtain new information crucial to one's social mobility" (Kuo & Tsai, 1986, p. 136). This is particularly relevant to rural communities which are insular, tight knit, and limited to individuals who are within a proximate distance to their community. Should an individual identify as an outlier with their beliefs, issues, or characteristics, they risk being

exorcised from their social group. Thus, maintaining the status quo of general belief systems appears to be an important quality of any socializing, but particularly rural socializing given the increased visibility in rural areas.

Farina and Ring (1965) examined the social impact of awareness of mental health issues by conducting a study exploring the influence that believing a coworker is mentally ill has on performance of a two-person cooperative task. Farina and Ring (1965) examined 60 male undergraduate students at the University of Connecticut. While this study is demographically and numerically limited, what Farina and Ring (1965) found was that when a coworker is viewed as mentally ill, the other member of the cooperative-task dyad identified that they preferred to work alone, and subsequently attributed any inadequacies in the task performance on the mentally ill participant. What is even more troubling about this finding is that this generally standoffish, biased mentality is sustained despite objective measures of performance determining that there is no deficit in ability on behalf of the mentally ill participant. Farina and Ring (1965) suggested that "these findings attest to the importance of believing another to be mentally ill as a factor in interpersonal relationships" (p. 50), and further suggested that, even in the face of sympathy or generally positive feelings toward their coworker, the negative attitudes toward mental illness had a pervasive effect on interpersonal relationships that developed. Moreover, Farina and Ring (1965) further suggested that the perception of mental illness influences the non-mentally ill person's decision to interact with a mentally ill person in various ways, despite mental illness being only peripherally related to the interaction (e.g., whether to hire or befriend an individual with known mental illness). This can be particularly important in rural communities, as there are limited resources for not only businesses but also socializing. In a following study, Farina, Allen, and Saul (1968) showed that not only do those without mental

illnesses treat those who struggle with mental issues aversively, but also noted that the stigmatized mental health sufferers also behave differently after finding out that someone knows that they struggle with mental health issues, assuming that others will make assumptions about their mental health history. Thus, "what a person reportedly says about himself significantly influences the interpretation of his behavior by another even though the behavior does not justify that interpretation" (p. 51), and can subsequently impact the ability to create business and forge new relationships.

Slama (2004) further commented on the socially connected nature of rural areas and identified that, while rural areas are comprised of fewer people than urban areas, those who live in rural areas are more likely to know each other. With this in mind, Slama (2004) identified a concept that afflicts rural areas called the "goldfish bowl effect, in which rural individuals are aware that other people are very interested in their lives and in talking to others about them" (p. 10) in spite of the isolation that is involved in living in a rural area. Thus, rural individuals are often not only aware of when their peers are visiting the grocery store, but also may be aware of when they visit mental health practitioners. While Gerrard et al., (2004) identified that rural communities are often close knit, they also posited that a lack of privacy was a "double-edged sword," meaning that community closeness allowed for support, the social proximity of rural life increased concern of being seen as a "failure" or placed challenges on leading a private life.

In combination with the levels of mental health stigma in rural areas, due to the nature of rural areas being "physically distant but socially proximate" (Larson et al., 2012, p. 53), individuals struggling with mental illness may feel limited in their ability to seek mental health treatment due to lack of anonymity in rural areas (Larson et al., 2012). Larson et al., (2012) as well as Komiti, Judd, and Jackson (2006) further elaborated that rural individuals may "fear

being recognized entering a mental health clinic and having that information spread rapidly through local gossip networks" (p. 53). Crowe (2010) further supported this, and suggested that "Because local community members are embedded within their local surroundings… it is important to analyze the ways in which a community's social network structure affects an individual's attachment to the local community" (p. 633).

With consideration to the previous variables of stoicism, stigma, community affiliation that are known to specifically impact mental health help-seeking in rural areas, as well as the lack of literature regarding rural populations, the following research questions were developed:

Question 1: To what extent does stoicism predict mental health help seeking behaviors after controlling for relevant demographic information?

Question 2: To what extent does stigma predict mental health help seeking behaviors after controlling for relevant demographic information?

Question 3: To what extent does community affiliation predict mental health help seeking behaviors after controlling for relevant demographic information?

Question 4: Which variable (stoicism, stigma, or community affiliation) is the most significant predictor for mental health help seeking behaviors after controlling for relevant demographic information?

Method

Participants

Two hundred twenty-two participants living in the rural United States were used as participants. Participants were not limited by age, race/ethnicity, sexual orientation, gender, ability/disability status, or education level. Individuals who were born and raised in rural areas but are no longer living in rural areas were excluded from the study. Participants' racial

backgrounds included White (n= 167, 75%), Black (n=20, 9%), Asian (n=13, 5.9%), Hispanic/Latino (n=11, 5%). Participants' gender identities included Male (n=118, 53.2%), Female (n=103, 46.4%). Participants' self-identified sexual orientations included Heterosexual (n=178, 80.2%), Bisexual (n=31, 14.2%), Gay (n=3, 1.4%), Lesbian (n=5, 2.3%). See Appendix G for further detail.

Participants selected for the study also identified as currently living in nonmetro counties, with populations ranging from 1-50,000 individuals. Rural individuals are an important population to study because they are largely understudied, underserved in regard to both mental and physical health, and they comprise 19.3% of the United States' population (US Census Bureau, 2016). A key aspect of this study was gaining a greater understanding about rural people to provide insight into the mental health of roughly 60 million Americans (US Census Bureau, 2016).

Participants were recruited through the use of Mechanical Turk, "a crowdsourcing web service that coordinates the supply and demand of tasks that require human intelligence to complete" (Paolacci, Chandler, & Ipeirotis, 2010, p. 411). Participants who utilize Mechanical Turk complete the tasks, including survey taking, in exchange for a small wage. For the purposes of this study, survey participants were paid a wage of .50 cents per survey. While payment for tasks on Mechanical Turk may be as low as $.01 it very rarely reaches $1. The payment of .50 cents per survey taker was chosen for the study due to the survey being relatively brief in duration (15-30 minutes) and the amount of funding the researcher obtained for this research. A question exists regarding why participants choose to participate in Mechanical Turk for such a small payout. Participants who utilize Mechanical Turk report that earning additional money is a

primary driver for participation on the site, and that it is a "fruitful way to spend free time" as opposed to watching television (Paolacci, et al., 2010).

Mechanical Turk was chosen for this study due to both the practicality of utilizing an online survey recruitment tool but also due to Mechanical Turk (and other Internet subject pool populations) being closer to demographically representing the United States population than recruitment from a university subject pool (Paolacci, et al, 2010). Additionally, given that rural areas may be challenging to access due to location, Mechanical Turk provides the opportunity to reach rural peoples via the use of the internet. While Mechanical Turk is a service that is available worldwide, it is also being selected because the a large portion of individuals who utilize Mechanical Turk are from the United States, which was of particular interest given that the study was focused on filling the literature gap that exists surrounding rural mental health in the United States. Thus, participants in this study were limited to those who were identified by Mechanical Turk to currently live in the United States.

Users on Mechanical Turk are anonymous to the researchers viewing their responses and the researchers may require the users to earn "qualifications," or participate in a pre-screening to identify who can participate in particular tasks (Paolacci, et al., 2010). For this study, participants were asked to answer the screening question of "Does the population of the community you currently live in, or live nearest to, include a population of 50,000 people or fewer?" A drawback to all Internet-based experiments, including Mechanical Turk, is that participants have been found to be less attentive than participants who are actively participating in an experiment in a lab (Oppenheimer, Meyvis, & Davidenko, 2009). However, where online experiments, including Mechanical Turk, may struggle with decreased attentiveness, they are less susceptible to experimenter effects than participants who are in a laboratory (Paolacci, et al., 2010).

Measures

Participants were asked to provide answers to a number of demographic questions, such as age, gender, sexual orientation, race/ethnicity, religious/spiritual beliefs, marital status, education level, income level, history of mental health services for self or close others and information on whether those services were helpful, and information about whether they currently live in nonmetro counties. Following the demographic questions, the measures assessing for stoicism, mental health stigma, and community affiliation were presented in random order to mitigate any priming effects.

Stoicism (Liverpool Stoicism Scale (LSS); Wagstaff & Rowledge, 1995). The LSS is a 20-item self-report questionnaire that measures views of stoicism, including lack of emotional involvement, lack of emotional expression, and exercising emotional control or endurance. Items on the survey include, "I tend to keep my feelings to myself," "Getting upset over the death of a loved one does not help," and "One should keep a stiff upper lip." Participants are asked to respond with the level to which they agree or disagree with each statement on a 5-point Likert scale ranging from 1 – 5 (1 = *Strongly Disagree* to 5 = *Strongly Agree*). Higher scores on the LSS reflect greater stoicism (for full scale see Appendix A). The LSS has been found to have adequate internal reliability (Cronbach's alpha = .83) and adequate test-retest reliability (r=. 82, p<.001) (Murray et al., 2008). The LSS was chosen for this study because it is the only validated instrument that measures stoicism as a construct. It was also chosen because it has been shown to have cross cultural validity (Gaitniece-Putāne, 2005; Murray et al., 2008). While the LSS has been used on a rural Australian sample (Judd, et al., 2006), that is the only exclusively rural sample that was found to have used the LSS, and the LSS has not been utilized on a rural United States-based sample. It was beneficial to explore whether results on the LSS for this study were

consistent with results found previously, and will continue to be important to study with both rural and non-rural populations.

Mental Health Stigma (Community Attitudes Toward Mental Illness (CAMI); Taylor & Dear, 1981). The CAMI is a 40-item scale intended to measure public stigma against people with mental illness. Items on the survey include, "The mentally ill should be isolated from the rest of the community" and "One of the main causes of mental illness is a lack of self-discipline and will power." Participants are asked to respond with the level to which they agree or disagree with each statement on a 5-point Likert scale ranging from 1 – 5 (1 = *Strongly Agree* to 5 = *Strongly Disagree*). Higher scores on the CAMI reflect more stigma against individuals struggling with mental health concerns. The CAMI was found to have adequate internal reliability (Cronbach's alpha = .89) and adequate test-retest reliability (r=.94, p <.0001) (Taylor & Dear, 1981). For full scale, see Appendix B.

The CAMI was chosen for this study to gather a greater understanding regarding rural community perspectives toward mental health. Taylor and Dear (1970) developed the CAMI to assess and predict community attitudes toward (then) newer community-based mental health services. Taylor and Dear (1970) identified that their study was important, as citizen opposition to mental health could block needed mental health services in a particular area, leading to mental health help seekers being required to travel greater distances and subsequently being less likely to receive necessary care. The CAMI is also widely used both nationally and internationally to examine community attitudes toward mental illness and has even been used in a study exploring the effect of a social media campaign on reducing mental health stigma over a five-year period (Sampogna et al., 2017). Considering that mental health stigma is greater in rural areas (Smalley & Warren, 2012a), it was important to utilize the CAMI on a specifically rural population

through this study to gather more data regarding United States rural communities' perspectives on mental health treatment. It is hoped that through gathering greater understanding about rural mental health, mental health services may increase or be more beneficial to individuals who are able to seek treatment.

Attitudes Toward Seeking Mental Health Help (Attitudes Towards Seeking Professional Psychological Help Short Form (ATSPPH-SF); Fischer & Farina, 1995). The ATSPPH-SF is a 10-item scale intended to measure attitudes about seeking professional help for psychological problems. The short form is based on the original 29-item Attitudes Towards Seeking Professional Psychological Help scale (Fischer & Turner, 1970), however, the ATSPPH-SF was adapted with reworded items to represent a more contemporary terminology. Items on the survey include, "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts," and "A person should work out his or her own problems; getting psychological counseling would be a last resort." Participants are asked to respond with the level to which they agree or disagree with each statement on a 4-point Likert scale ranging from 1 – 4 (1 = *Strongly Agree* to 4 = *Strongly Disagree*). Higher scores on the ATSPPH-SF reflect more positive attitudes toward mental health help seeking. The ATSPPH-SF was found to have adequate internal reliability (Cronbach's alpha = .84), adequate test-retest reliability (r= .80, p <.001) and correlated with the original ATSPPH at .87 (Fischer & Farina, 1995).

Additionally, Picco et al., (2016) explored the factor structure of the ATSPPH-SF to determine whether there were any sociodemographic differences in mental health help-seeking attitudes. Survey data were collected from residents in Singapore and factor analysis and exploratory factor analysis were performed to explore the validity of the factor structure on the ATSPPH-SF. Through factor analysis, Picco et al., (2016) established that the ATSPPH-SF

formed three dimensions," "Openness to seeking professional help," "Value in seeking professional help," and "Preference to cope on one's own" (p. 1). Through linear regression analyses, Picco et al., (2016) also uncovered that "age, ethnicity, marital status, education, and income were significantly associated with the ATSPPH-SF factors" (p. 1). For full scale, see Appendix C.

Further, Elhai, Schweinle, and Anderson (2008) examined the reliability and the validity of the ATSPPH-SF by examining data from both college students and primary care patients in the Midwestern United States. Elhai et al., (2008) cited that the ATSPPH-SF demonstrated adequate internal consistency, and, through factor analysis, the ATSPPH-SF demonstrated a two-factor model, "Openness to seeking treatment for "Openness to Seeking Treatment for Emotional Problems, and Value and Need in Seeking Treatment" (p. 320).

The ATSPPH-SF was chosen as the best fit for this study due to its wide usage through the psychological literature. It was also chosen due to its brevity, ease of understanding, ease of access, and adequate validity and reliability statistics. In contrast to the CAMI, the ATSPPH-SF was chosen to gather information regarding individual, rather than community, viewpoints toward seeking mental health help.

Community Affiliation (Community Attachment Scale; Theodori, 2004), (Community Involvement Scale; Rothenbuhler, 1991). The Community Attachment Scale is an 11-item scale intended to measure feelings of attachment toward the community in which one lives. Items on the survey include, "I feel loyal to the people in the community," and "The future success of this community is very important to me." Participants are asked to respond with the level to which they agree or disagree with each statement on a 4-point Likert scale ranging from 1 – 4 (1 = *Strongly Disagree* to 4 = *Strongly Agree*). High scores on the Community Attachment

Scale indicate high levels of community attachment. The Community Attachment Scale was found to have adequate internal reliability (Cronbach's alpha = .93) (Theodori, 2018).

The Community Attachment Scale was chosen due to scale availability and the scale's use in the literature. While community attachment is referenced frequently in the literature, the only scale that was found to have statistical backing and the most use was the Community Attachment Scale (Theodori, 2004) Further, the Community Attachment Scale has been used in at least four publications (Theodori, 2004; Theodori, A., & Theodori G., 2015; Theodori, 2018; Kyle, Theodori, Absher, Jun, 2010) as well as a dissertation (Theodori, A., 2014) with statistical success. For full scale, see Appendix D.

The Community Involvement Scale is based on the work by Stamm and Fortini-Campbell (1983) regarding the relationship between community ties and newspaper use in Seattle, Washington addressing the aforementioned questions:

> How often one keeps up with the local news, how often one gets together with people who know what's going on locally, how often one has ideas for improving things locally, and how often one works to bring about changes in the community. (p. 65)

Rothenbuhler (1991) conducted similar research on a very different Midwestern population but contained similar results to the original Stamm and Fortini-Campbell (1983) findings, indicating that the scale measures similar constructs across regions in the United States (Guttman Scale reproducibility = .94). Respondents to this scale are asked to respond with the level to which they agree or disagree with each of the previously mentioned questions on a 5-point scale with response options of: Frequently, Occasionally, Seldom, Never, and Don't Know. Rothenbuhler (1991) suggested to dichotomizing the response scores by scoring "occasionally" and "frequently" with a score of 1, and "seldom" and "never" with a score of 2 to best fit the model

and allow for empirical response distributions. Higher scores on the Community Involvement Scale indicates lower community involvement.

A Guttman Scale was developed for this measure to assign numerical values to qualitative data that was collected through a phone survey of 400 Iowa residents consisting of multiple topics including "communication, leisure activity, …community topics, as well as demographics" (Rothenbuhler, 1991, p. 67). After conducting a matrix of gamma correlations among the four items were moderately associated (ranging from .34 to .45), with the exception of the questions regarding ideas about improving things in the community and getting together with others who know what is going on in the community having a gamma of only .18 (Rothenbuhler, 1991). The correlation between mean adjacent mean differences and inter item correlations is -.93 (Rothenbuhler, 1991). The order of the items in the scale were specifically chosen from least involved to most involved in community activities, with the baseline of community involvement being the question of "How often do you keep up with local news" (Rothenbuhler, 1991).

This scale was chosen for two primary reasons: scale availability and sample norm. Community involvement is a concept that is referenced in the literature, however, it is most often measured in a qualitative manner via focus groups and interviews. As such, it was challenging to find a quantitative measure that was appropriate for this study. The Community Involvement Scale is one of two scales that were found which measure general level of community involvement (rather than referencing the kind of activities that one is involved in), and is the only scale that was published and included statistical data. The other scale that was found was a scale that was not published and was developed for a master's level course in statistics.

Additionally, this scale has been normed on a Midwestern, rural population (Rothenbuhler, 1991). While questions to develop the Community Involvement Scale initially

were created by using an urban, west coast sample from Seattle (Stamm & Fortini-Campbell, 1983), Rothenbuhler (1991) was able to utilize this scale to measure community involvement in a rural, Midwestern population with success and reproducibility. For full scale see Appendix E.

Procedure

This study consisted of multiple assessments compiled into an online survey through the Qualitrics survey system to promote ease of access. The survey took around 15 to 20 minutes to complete. Participants, particularly those who struggle with mental health issues, had the potential to experience minor psychological discomfort by being in the study, given that some of the survey pertained to stigmatized viewpoints regarding mental health issues. The benefits of being in the study included the possibility of providing data that could add to the current literature base about rural mental health and the psychosocial factors that may impede mental health help-seeking in rural communities. The information gathered from the completed study could result in future interventions in rural communities that promote mental health awareness and education which contribute to decreased stigmatization of mental health issues in rural areas. In regard to compensation, following the completion of the survey, participants were provided the opportunity to enter their email address for a random drawing. Those participants who provided their email addresses were entered into a random drawing from which three participants received a $20 amazon.com gift certificate. The email addresses were not linked to their completed survey. Participation in the study was completely voluntary.

If participation was withdrawn or declined, participants were not penalized, nor did they lose benefits or services unrelated to the study. If someone decided to participate in the study, they were able to decline to answer any question and could choose to withdraw at any time by clicking on the “Exit Survey” button on the bottom left of the window. If participants chose to

withdraw from the survey, or upon completion of the survey, contact information for the National Suicide Prevention Hotline, as well as the Psychology Today therapist directory were provided on the exit page, in case participants felt triggered or needed to find a mental health provider in their area. Participants were also given information about basic information on the nature and possible benefits of participating in mental health services. Additionally, information about this study, as well as information that the participant was able to withdraw from the survey at any point without penalty, were provided in a consent form. All participants were asked to consent prior to starting the survey. Subsequently, in any published reports that develop from this study, no information will be included that could possibly identify participants. The survey responses were housed securely on the Center for Educational Development and Research (CEDaR) server and only approved researchers had access to these records. No identifying information was gathered to keep the survey responses anonymous. The survey was posted in English on Qualtrics after approval of the study was obtained from the University of Oklahoma Institutional Review Board (IRB).

Statistical Analyses

Preliminary Data Analyses

Survey data was entered into SPSS software. Preliminary analyses (e.g., Pearson correlation and ANOVAs) were conducted to examine the relationships among the variables, including demographic variables. Identity based demographic information was found to be relevant, and included gender, ethnicity, age, sexual orientation, relationship status, and religious status. It was decided to control for identity based demographic information because identity based characteristics are not behaviorally based (e.g., have you sought mental health treatment or do you work/go to school in your community). Rather, for the purposes of this study, identity

based demographics were considered to be identity traits rather than situation specific behaviors or states of mind. Thus, identity based demographics were controlled for in the linear regressions as well as the multiple regression analysis in order to more accurately examine the relationships between the predictor variables of stoicism, stigma, and community affiliation and the criterion variable of mental health help-seeking behavior.

Primary Statistical Analyses

The statistical analyses were a series of linear regressions and a final multiple regression to explore interactions between each variable in the total model. A multiple regression design was chosen as most appropriate to explore the final model of the study based on the following definition as a guide: "multiple regression is a statistical method for studying the separate and collective contributions of one or more predictor variables of a dependent variable" (Heppner, Owen, Thompson, Wampold, & Wang, 2016). The initial analysis involved a series of linear regressions to investigate amount of variability of each predictor variable (e.g., stigma, stoicism, community affiliation) that uniquely contributed to the prediction of the criterion variable, mental health help-seeking. The series of linear regressions were followed by a hierarchical multiple regression which explored which variable (e.g., stigma, stoicism, community affiliation) the majority of the variance was attributed. A multiple regression design was chosen because the study was interested in learning more about the relationship between several predictor variables (e.g., stigma, stoicism, and community affiliation) on the criterion variable of mental health help-seeking behaviors.

Results

Preliminary Analyses

After running a power analysis, a sample size of 76 was deemed adequate. However, given availability of funds to contribute to Mechanical Turk for data collection, a sample size of 230 was sought, with the final sample being 222.

Prior to running the series of regression analyses, preliminary analyses were performed to explore normality, linearity, and homoscedasticity (see Table 1). After assessing for normality of data utilizing Levene's homogeneity of variance test, data were found to be in the normal range, per Hahs-Vaughn and Lomax (2013). To assess for internal consistency of the measure, Cronbach's alpha level was analyzed and determined to be in the acceptable to good range, .780, Cronbach's alpha based on standardized items, .800.

Table 1

Summary of Means, Standard Deviations, Skewness, and Kurtosis

Predictor	Mean	Standard Deviation	Skewness	Kurtosis
Stigma	2.92	0.47	-0.78	4.05
Stoicism	2.90	0.51	-0.61	2.72
Community Affiliation	2.38[a]; 2.52[b]	.56[a]; .73[b]	0.57	0.35
Total Model	2.73	0.55		

Note. [a] = Attachment; [b] = Involvement

Primary Analysis

Simple linear regressions.

To answer Question 1, *To what extent does stoicism predict mental health help seeking behaviors after controlling for relevant demographic information?*, a simple linear regression analysis was conducted to predict help seeking behaviors based on level of stoicism. A significant regression equation was found ($F(10, 207) = 20.391$, $p < .000$, with an R^2 of .496 and

an adjusted R^2 of .472. Mental health help seeking behaviors changed .421 for every one unit change in stoicism (See Table 2). Thus, the results suggest that stoicism significantly predicts mental health help-seeking behavior in the positive direction. That is, more stoicism predicts less mental health help-seeking behavior.

Table 2

Summary of Linear Regression with Stoicism Predicting Mental Health Help Seeking Behavior Compared to Demographic Data

Mental Health Help Seeking						
Predictor	R^2	Adjusted R^2	ΔR^2	*B*	*F*	*p*
Demographics						
Stoicism	.496	.472	.237	.421	20.39	.000

To answer Question 2, *To what extent does stigma predict mental health help seeking behaviors after controlling for relevant demographic information?,* a simple linear regression analysis was calculated to predict mental health help seeking behaviors based on mental health stigma. A significant regression equation was found (F(10, 207) = 15.29, $p <$. 000, with an R^2 of .425 and an adjusted R^2 of . 397. Mental health help seeking behaviors changed .405 for every one unit change in stigma (See Table 3). Thus, the results suggest that stigma significantly predicts mental health help-seeking behavior in the positive direction. That is, more stigma predicts less mental health help-seeking behavior.

Table 3

Summary of Linear Regression with Stigma Predicting Mental Health Help Seeking Behavior Compared to Demographic Data

Mental Health Help Seeking						
Predictor	R^2	Adjusted R^2	ΔR^2	*B*	*F*	*p*
Demographics						
Stigma	.425	.397	.166	.405	15.29	.000

To answer Question 3, *To what extent does community affiliation predict mental health help seeking behaviors after controlling for relevant demographic information?*, a third simple linear regression analysis was conducted to predict mental health help seeking behaviors based on levels of community affiliation. A significant regression equation was found (F(11, 206) = 7.978, p <. 000, with an R^2 of .299 and an adjusted R^2 of .261. Mental health help seeking behaviors changed (.118 attachment; .039 involvement) for every one unit change in affiliation (See Table 4). Thus, the results suggest that both community attachment and community involvement significantly predict mental health help-seeking behavior in the positive direction. That is, the more community attachment and community involvement, i.e., community affiliation, the less mental health help-seeking behavior is predicted.

Table 4

Summary of Linear Regression with Stigma Predicting Mental Health Help Seeking Behavior Compared to Demographic Data

Mental Health Help Seeking						
Predictor	R^2	Adjusted R^2	ΔR^2	*B*	*F*	*p*
Demographics						
Community Affiliation	.299	.261	.039	.118[a]; .039[b]	7.978	.000

Note. [a] = Attachment; [b] = Involvement

Multiple regression.

To answer the final question, Question 4, *Which variable (stoicism, stigma, or community affiliation) is the most significant predictor for mental health help seeking behaviors after controlling for relevant demographic information?*, a four step hierarchical regression was conducted with mental health help seeking as the dependent variable.

The hierarchical multiple regression revealed that at step one, identity based demographic variables contributed significantly to the regression model, (F[9, 208] = 8.09, p = .000, $R^{2=}$ .259, Adjusted R^2 = .227, and accounted for 25.9% of the variance in help seeking behaviors.

Introducing the stigma variable at step 2 explained an additional 16.6% of the variation in mental health help seeking behaviors, and this change in R^2 was significant, (F[10, 207] = 15.29, and p = .000, R^2 = .425, Adjusted R^2 = .397. When added to the model, stigma increased the predictability of mental health help seeking behavior by 16.6%.

Adding stoicism to the regression model explained an additional 9.9% of the variation in mental health help seeking and the change in R^2 was significant, (F[11, 206] = 20.611 and p =

.000, R^2 = .524, Adjusted R^2 = .499. When added to the model, stoicism increased the predictability of mental health help seeking behavior by 9.9%.

Adding community affiliation to the regression model explained an additional .6% of the variation in mental health help seeking behavior and the change in R^2 was not statistically significant, (F(13, 204) =17.67, p = .291, R^2 = .530, Adjusted R2 = .500. When added to the model, community affiliation increased the predictability of mental health help seeking behavior by .6%.

When all three independent variables were included in stage 4 of the regression model, community affiliation was not a significant predictor of mental health help seeking behaviors. Together, the three independent variables, stigma, stoicism, and community affiliation accounted for 53% of the variance in mental health help seeking behaviors (See Table 5).

The order of entry into the multiple regression model was based on information gathered from the literature focused on mental health stigma, stoicism, and community affiliation. While stigma was predicted to be the most significant predictor of help seeking behaviors, when regressions were run separately on each variable, stigma, stoicism, and community affiliation, it was found that each variable significantly predicted help seeking behaviors, with stoicism accounting for the most variance in the model.

The results of the current study indicated that stoicism and stigma were always predictors of mental health help seeking behaviors, however, community affiliation was not. Stoicism, over and above identity-based demographic information accounted for the most variance in mental health help-seeking behaviors. While all variables individually significantly predicted help seeking behaviors when they were examined separately, when community affiliation was added into the total model, community affiliation became non-significant.

Table 5

Summary of Hierarchical Regression Model for Demographics, Stoicism, Stigma, and Community Affiliation Predicting Mental Health Help Seeking Behaviors

	Mental Health Help Seeking					
Predictor	R^2	Adjusted R^2	ΔR^2	β	*F*	*p*
Step 1						
Demographics	.259	.227	.259		8.09	.000
Step 2						
Stigma	.425	.397	.166	.234	15.29	.000
Step 3						
Stoicism	.524	.499	.099	.415	20.61	.000
Step 4						
Community Affiliation	.530	.500	.006	.009[a]; .085[b]	17.57	.291

Note. [a] = Attachment; [b] = Involvement

Discussion

The purpose of this study was to explore the influence of stoicism, stigma, and community involvement on mental health help-seeking behaviors. A hierarchical multiple regression analysis was utilized to examine the relationships between the predictor variables and their contributions to mental health help-seeking behaviors and will be discussed in order of strongest to weakest predictor of mental health help-seeking behaviors.

Stoicism

The strongest predictor of mental health help-seeking behavior, stoicism, was addressed through the first research question, "To what extent does stoicism predict mental health help seeking behaviors after controlling for relevant demographic information?". To address this research question, a simple linear regression analysis was conducted and found that stoicism significantly predicted mental health help seeking behaviors. Stoicism remained a significant predictor of mental health help-seeking behaviors when included in the full hierarchical regression model, with a β value of .415.

It was surprising that stoicism emerged as a more significant predictor of mental health help-seeking behavior than stigma, given stigma's large presence in the literature and its frequent referral as the primary contributing factor to lack of mental health help-seeking (Larson, et al., 2012; Smalley & Warren, 2012a; Smalley & Warren 2012b; Moore et al., 2003; Lutterman, 2004; Cantrell et al., 2012; Parr & Philo, 2003). However, it stands to reason that stoicism was the most significant predictor, considering that stoic values and attitudes of self-reliance are predominant identity-based characteristics that often impact rural identities (Smalley & Warren, 2012a; Smalley & Warren, 2012b). Stoicism, as opposed to stigma, emerges as a character trait, whereas stigma is more of a belief system or choice.

Considering that stoicism has emerged as the most significant predictor of mental health help-seeking behaviors, it follows that stoicism should studied more in-depth in the future. The concept of stoicism has not been widely studied in the field of psychology and there has been little exploration of stoicism in the sociology of any chronic illness, including chronic mental illness (Moore et al., 2013). However, stoicism has been studied in both philosophical contexts

and in medical research (Murray et al., 2008; Pinnock et al., 1998). The current study uniquely contributes to the literature base by specifically honing in on stoicism in a mental health context. While, based on previous literature, it is not surprising that stoicism predicts decreased mental health help-seeking, it is a concept about which it is important to gain greater understanding because stoicism is ingrained into rural culture. Understanding stoicism in a rural context as opposed to an urban context is valuable because stoicism appears to be a cultural norm in rural communities rather than an exception (Judd et al., 2006; Smalley & Warren, 2012a; Smalley & Warren 2012b; Moore et al., 2013).

Although, on the whole, stoicism is a concept that has been cited as being prevalent throughout rural communities, it has been identified as a trait that is typically more common in older generations, such as the Baby Boomers (Moore et al., 2013; Yong et al., 2001). However, the average age of the participants in the current study was 23 years. Given that the participants in the current study were relatively young and the results indicate that stoicism continues to be a factor that precludes mental health help seeking in this younger generation, the current study is unique and important as it gathered information regarding younger participants. It is hoped that the information gathered from this study will bolster the literature base surrounding all ages of rural people and their stoic attitudes toward mental health help-seeking. Knowledge of younger generations' adherence to a more stoic attitude surrounding help-seeking could speak to the close family ties and intergenerational connectedness of rural areas and help explain higher suicide rates in adolescents and young adults, as well (Hirsch, 2006).

Additionally, what the present study adds to the literature is a specific focus on the relationship between stoicism and mental health treatment in the United States. As mentioned in the literature review, the bulk of the research on rural mental health has been conducted outside

of the United States (Judd et al., 2006; Pinnock et al., 1998; Wrigley et al., 2005; Fuller et al., 2000; Hill et al., 2005; Caldwell et al., 2004; Middleton et al., 2003). While the current study corroborated many of the findings regarding rural mental health in other countries (i.e., higher levels of stoicism and stigma predict decreased mental health help-seeking) it remains important to illuminate roadblocks to mental health treatment in the rural United States to further shine light onto the ways practitioners can reach and treat rural Americans in culturally savvy ways.

Culturally pervasive stoicism in rural life may be heightened by a lack of education and understanding about mental health and mental health services. Not only are rural individuals less likely to understand and acknowledge when they have a mental health problem (Caldwell et al., 2004), but rural residents also generally lack understanding about what mental health services are and what they can provide (Berry & Davis, 1978) when compared to their urban counterparts. A consequence of limited understanding and awareness could be the tendency to maintain a "stiff upper lip" (Wagstaff & Rowledge, 1995) because alterative reactions to stoicism are not possible.

Further, the findings from the present study align with research conducted by Pinnock et al. (1998) regarding people who are more stoic being less likely to seek out and receive help of any kind. Rural attitudes are often rooted in self-reliance (Fuller et al., 2000; Slama, 2004; Smalley & Warren, 2012b) and to admit that one needs help would not only violate the self-reliant attitudes espoused by rural residents, but would also lead to a person having to admit that they have not just any problem, but a mental health problem, potentially resulting in being personally stigmatized for seeking mental health help (Fuller et al., 2000).

Stigma

The current study also adequately explores the second research question, "To what extent does stigma predict mental health help seeking behaviors after controlling for relevant demographic information?", and found that stigma was the second most significant predictor of mental health help-seeking behavior. To address this research question, a simple linear regression analysis was conducted and, contrary to what was predicted, stigma emerged as the second most significant predictor of mental health help seeking behavior, behind stigma, with a β value of .234. Together, the three independent variables, stigma, stoicism, and community affiliation accounted for 53% of the variance in mental health help seeking behaviors.

It was unexpected for stigma to emerge as the second-most significant predictor of mental health help-seeking behaviors, as stigma is cited throughout the literature a primary roadblock to seeking mental health-services(Larson, et al., 2012; Smalley & Warren, 2012a; Smalley & Warren 2012b; Moore et al., 2003; Lutterman, 2004; Cantrell et al., 2012; Parr & Philo, 2003). More to this end, the present study corroborates previous literature's assertion that higher levels of perceived stigma are associated with more negative attitudes towards help-seeking among rural residents (Judd et al., 2006; Smalley & Warren, 2012a; Smalley & Warren, 2012b; Slama, 2004).

In addition to increased mental health stigma, there are common threads that, when combined, specifically characterize rural living, including self-reliance, individualism, strong work ethic, and focus on family life (Hirsch, 2006; Slama, 2004; Smalley & Warren, 2012a; Smalley & Warren, 2012b). It is from these perspectives that Hirsch (2006) indicated rural mental health stigma is rooted, deterring people from seeking potentially lifesaving treatment. The present study buttressed Hirsch's (2006) understanding of rural qualities and perspectives

toward mental health help-seeking through its exploration of stigma and attitudes toward seeking professional mental health treatment. By exploring the intersections between rural qualities, identities, and attitudes, this study lent to a greater understanding of underlying nuances that underlie the concept of stigma. By diving deeper into the constructs that make up stigma, it allows mental health practitioners the ability to begin to pinpoint where the most significant avenues are to intervene and combat rural mental health stigma. This idea is supported by an article by Larson et al., (2012), and is best illustrated by the following quote,

> The stigmatization of mental illness impacts on mental health service delivery across the spectrum in rural areas by impacting on willingness to seek therapy, ability to disclose ongoing mental illness, and the level of support an individual is able to receive from their family and peers (p. 61).

Through the contribution of the present study to the understanding of rural mental health stigma, practitioners can gain further insight into the most efficacious way to reach rural people where they need it most, whether that be through family support, through self-empathy, or through providing culturally appropriate community education about mental health.

Community Affiliation

The new concept of community affiliation was an individual significant predictor of mental health help seeking behaviors. However, when included in the total model, community affiliation became a non-significant predictor; when all three independent variables were included in stage 4 of the regression model, community affiliation was no longer a significant predictor of mental health help seeking behaviors.

Community affiliation, comprised of the concepts of community involvement and community attachment, was determined to be an important variable for the current study as it

was hypothesized that the more affiliated one is with the nearest community, the less likely they would be to seek mental health treatment. That is, the more a person feels like they belong to, wants to be involved in, and are interested in creating change within their community, the less likely they are to seek mental health treatment. Given that the extant literature cites rural areas as high context, socially connected communities (Cantrell et al., 2012; Parr & Philo, 2003) as well as that the acceptability of receiving mental health treatment is lower in rural than in urban areas (Smalley & Warren, 2012a), it followed that community affiliation would lead to decreased mental health help seeking. However, what the current study suggests is that reduced mental health help seeking is most deeply rooted in mental health stigma. Or, when both community affiliation and stigma were added into the total multiple regression model, stigma accounted for the variance, subsuming community affiliation under the umbrella of stigma. Community affiliation, on its own, is a predictor but it can be better accounted for by the presence of mental health stigma.

Interpretation

With consideration to the large literature base surrounding mental health stigma, it was surprising that stoicism emerged as the most significant predictor of mental health help-seeking behaviors. While stoicism has been referenced within both philosophical and medical literature, it has not been heavily researched in within psychology (Murray et al., 2008). Given that qualities such as self-reliance and individualism are seen as a character traits that are of value within rural communities (Smalley & Warren, 2012a; Smalley & Warren, 2012b) it follows that stoicism would also be a highly regarded trait. Considering that rural communities are "physically distant but socially proximate" (Larson et al., 2012), it also stands to follow that, in order to maintain ones standing within their community, they must also maintain the stoic social

norm by espousing stoic attitudes. Additionally, given the somewhat unpredictable nature of the agricultural or ranching work that often characterizes rural life, particularly due to weather, it may be adaptive for rural people to maintain a stoic attitude. Giving into emotion when crops or livestock fails may impede rural people's ability to continue to engage in work-tasks, with the knowledge that their yield, and subsequent livelihood, may irreparably suffer. However, while stoic attitudes may benefit rural people when it is related to farming or ranching, their tendency to deny or ignore emotional reactions may lead not acknowledging when mental health issues become of concern.

It is not entirely surprising that stigma accounted for a significant amount of variance in mental health help seeking behaviors, (Larson, Corrigan, & Cothran, 2012; Smalley & Warren, 2012a, Parr & Philo, 2003). However, it was surprising that community affiliation became entirely non-significant when entered into the regression equation. What this suggests is that stigma may be subsume community affiliation. That is, while community affiliation is a barrier on its own, is a road block to mental health treatment largely due to visibility. In other words, if someone is a prominent or involved member of a community in which mental health treatment is stigmatized, that person may be less likely to seek treatment due to both their knowledge of the level of stigma that exists within their community as well as their community standing. Should mental health stigma not be present within a community, then the amount of affiliation one has within their community would likely have little to no impact on a person's choice to seek mental health treatment. While community affiliation is not a significant predictor in and of itself, it is an important nuance to consider when understanding mental health stigma.

Regarding stigma, part of the impetus behind the present study was that the literature base surrounding stigma cites often identifies stigma as being the reason why treatment is not

sought, but does not pursue the concept of stigma further. To this researcher, simply stating that stigma is the "reason" for a particular result is one-dimensional explanation. The results of this study suggested that stigma is a topic that cannot necessarily be accepted at face value. Rather, this study identified that stigma may be a more nuanced concept, and, in order for practitioners to combat it most effectively, should be understood in a depthful and robust way to challenge the mental health stigma that exists in many settings.

Additionally, people in rural areas have historically been minimally explored among researchers, particularly regarding rural mental health (Smalley & Warren, 2012a; Smalley & Warren 2012b). There has been a recent increase in media attention regarding the importance of mental health, perhaps largely due to a torrent of celebrity suicide deaths in 2018, and rural communities have also received recent press. For example, National Public Radio produced a story focused on the mental health of farmers, with a powerful opening line of "Suicide rates among farmers are higher than other profession in the United States" (Snell, 2018). Given that rural areas comprise 97% of the United States' land area is considered rural and that 60 million Americans endorse living in rural areas (US Census Bureau, 2016) continued study of rural areas is a trend that should undoubtedly continue. It was one of the goals of the present study to provide a unique contribution in this area, and attempted to do so by exploring a new concept, community affiliation as it pertains to rural mental health. While ultimately community affiliation was better accounted for by the presence of stigma, this study revealed that there may be depth and nuance to the concept of stigma that is important to explore as it contributes to researchers' understanding of the role that stigma plays in mental health treatment.

In summation, stoicism and stigma are always predictors of help seeking behaviors, however, community affiliation is not. Stoicism, over and above identity-based demographic

information and community affiliation, accounted for the most variance on help seeking behaviors when community affiliation and stigma were both present. These results indicated that, while all variables individually significantly predicted help seeking behaviors when they were examined separately, when entered into the total model, the variance caused by community affiliation can be better accounted for by mental health stoicism.

Conclusions

This study has implications for mental health practitioners nationwide, but may be of particular interest to practitioners who work in rural areas. By contributing clinical understanding about concerns specific to rural mental health, practitioners will have a greater knowledge base to pull from when working with rural people. Practitioners may also obtain more understanding of the unique contexts and conditions that face rural people who seek mental health services.

Moreover, with greater understanding about concepts that influence mental health help seeking in rural communities, mental health services may be presented in ways that seem "palatable" to rural individuals until the rural zeitgeist surrounding mental health changes to one that is more favorable. Rural areas continue to be underserved and mental health services in rural areas are underutilized (Wrigley, Jackson, Judd, & Komiti, 2005; Smalley & Warren, 2012a; Smalley & Warren, 2012b; Rost, Smith, & Taylor, 1993). Perhaps with greater understanding of rural communities, not only will practitioners be more apt to choose rural communities to serve with their practice, but rural individuals may feel more comfortable participating in mental health services if they are confident that their practitioners will understand the uniqueness and richness of rural living. Understanding rural living is essential for psychologists who purport to espouse a social justice practice and psychologists have an ethical responsibility to understand and advocate for increased understanding of rural mental health.

Limitations

A primary limitation to this study is the living context of the participants. While individuals in rural areas may have access to the Internet and other resources, the rural individuals who were sampled may be unique insofar as they not only have Internet access, but they also are Internet savvy enough to understand and utilize Mechanical Turk. This sample may have represented a unique subset of rural individuals who may not be as representative as if we were to gather a sample using postal service mailers or in person surveys.

An additional limitation is that this study provides general information about individuals from various rural areas across the United States rather than nuanced information about specific rural regions of the country. While there are qualities of rural areas that are similar (e.g., insular social connections, individualistic attitudes, increased religious affiliation) (Smalley & Warren, 2012a) not all rural areas are homogenous. The study helped fill the gap of literature that exists surrounding rural mental health, however, it may lack meaningful nuance in regard to the regional differences in perspectives about mental health help seeking. With this in mind, in the demographic questionnaire, it may have been enlightening to inquire about the regions of the United States where participants were living. Having that extra data point may have proved to be a launching point for a study-in-depth of rural people and their mental health concerns.

Additionally, this study was a self-report measure exploring relationships rather than an experimental study. While this study was anonymous, self-report measures may involve concerns with "image management" or wanting to answer the survey in a way that was not genuine or presented themselves in an overly positive light. Nevertheless, despite being a self-report measure, what this study does provide is a starting point to data gathering to serve as a launch point for future studies and potential experimental interventions such as mental health

education programs or mental health focused town discussions. Further, because this study was a correlational study, causation cannot be determined. However, the development of an a priori theoretical framework built upon previous research findings strengthen the validity of this study's findings.

Additionally, the measures utilized in this study may have benefitted from wording/language updates to include more inclusive language (e.g., utilizing person-first language and changing "mental disturbance" to "mental health concern," etc.), as well as utilizing American English spellings (e.g., changing "counsellor" to "counselor" and "neighbourhood" to "neighborhood") as this study was performed in the United States. Utilizing unfamiliar spellings may have impacted participants' interpretations of the relevance of the study or caused undue confusion while responding to the survey.

Future Directions

Many future directions may be identified from this research. However, a primary direction of future research may be to develop a curriculum or training plan for psychology or social work training programs to teach trainees about rural culture as a diversity issue. Slama (2004) placed a call to action to the APA, and subsequently training programs, to include rural culture into discussions of cultural competency and training. This inclusion has yet to be recognized (Smalley & Warren, 2012b) and it is hoped by continued research on rural culture, framing it as a diversity issue, concerns related to rural life may be disseminated to both the APA and training programs for inclusion.

Furthermore, the knowledge gained from the current study suggests that a psychoeducational intervention for the public in rural areas may be appropriate. Albarracin and Shavitt (2018) suggested that, to create attitude change, "values, general goals, emotions,

linguistic processes, evaluative processes, life span and developmental aspects, and temporal and spatial context" (p. 304) should be explored. In rural areas, appropriate methods of appeal to rural people may be through the aforementioned values and linguistic processes that Albarracin and Shavitt (2018) noted. Appealing to rural values may be a salient entry point, given that rural areas are generally more religious than urban areas (Still & Dryde, 1999). Utilizing a values laden approach is supported by research conducted by Wolsko, Ariceaga, and Seiden (2016) which cited that attitude change can occur by utilizing advocacy to appeal to values. With consideration to Wolsko et al. (2016) and the knowledge that rural areas are generally more religious than urban areas, linking mental health advocacy to religious values (e.g., love one another; do unto others as you would have done unto you) may create more empathic responses and attitude changes toward mental health within rural communities.

More specifically, it would be appropriate to utilize mental health advocates, mental health professionals, physicians, clergy, or other professional and credible community members as resources to speak in community forums such as religious services, Bible studies, men's and women's groups, Veterans of Foreign Wars (VFW) facilities, coffee shops, or other local groups to begin conversations about mental health. By using shared spaces and open forums to open up conversations surrounding mental health, it may encourage mental health conversations to become part of regular, everyday conversation, similar to conversations about physical health issues. Additionally, incorporating mental health questions and assessments into physical healthcare appointments may also bring language surrounding mental health issues into the rural vernacular. A point of consideration may be to include mental health professionals as part of a medical team so that conversations about mental health issues may become more normative and commonplace, especially when they occur within the presence of a likely-trusted source of

information in a primary care physician. In a review by Alfasi (2004), it was found that behavioral consultations can be useful, even when patients are not being seen for mental health concerns, as mental health professionals can help complete and coordinate a biopsychosocial assessment for more wraparound services. Further, mental health professionals can "lay eyes" on individuals seeking treatment for medical reasons and work to screen for potential mental health issues.

Further, asking community members who have been touched by mental health issues, whether themselves or adjacently, may be important. Removing the veil of misinformation surrounding mental health struggles may demystify the concept of mental health for people who are less familiar with mental illness. Further, knowing that friends, family, and/or community peers have been affected by mental health concerns may increase the relevance that mental health concerns have to people who hold mental health stigma and practice stoicism with their own health. Honing in on the idea of personal relevance is supported by research conducted by Pham (1998), which indicated that the more someone feels something is relevant toward them, the more likely they are to advocate for or support the topic at hand. By explicitly including mental health as a topic of conversation within rural communities, increased awareness about what constitutes mental illness, how to treat mental illness, as well as "proof" that people with mental health concerns live in their communities could lead stoic individuals to feeling less alone and more likely to reach out for help. It may also be of benefit to gather and present data regarding individuals who are seeking and benefitting from mental health services as a way to normalize mental health treatment and encourage those who are hesitant about seeking treatment to get the care they need. Additionally, by highlighting the incidence and prevalence of mental health concerns within a close-knit community, a trend toward destigmatization of mental health

concerns may occur, as having contact with others outside of a group, known in social psychology as intergroup contact, decreases feelings of prejudice (Allport, Clark, & Pettigrew, 1954; Mallett et al., 2008; Pettigrew, 1998; Pettigrew & Tropp, 2006).

Moreover, describing mental health as a result of more familiar concepts, such as stress, hormones, or chemical imbalances, may make it more palatable for a rural audience to ingest. By explaining mental health as something that is comprised of a mind and body connection, rather than a personal fault or something that mars the family reputation, people may be more likely to incorporate mental health into their entire health zeitgeist. Perhaps by explaining mental health in relation to, rather than in opposition to physical health, buy-in for mental health treatment may increase. Exploring mental health as something that is akin to calling the fire department if there is a fire on the horizon or speaking with a cardiologist if someone has had a heart attack, mental health treatment can become a normalized response to symptoms such as anxiety or depression.

Inviting a holistic understanding to health by incorporating both mental and physical health can also highlight the concepts of personal responsibility and family accountability that are cornerstones to rural culture **(**Hirsch, 2006) by encouraging rural people to care for their own health as a way to ensure that they can continue to care for their families. More to this end, another way to reach rural individuals may be to hone in on the characteristic of rugged individualism that is generally espoused in rural culture (Hirsch, 2006). By being brave enough to go against the status quo and seek mental health treatment in the face of known stigma and a cultural preference for stoicism, a rural person can embody the rugged individualistic beliefs that are culturally accepted and valued.

Future research should also include an exploration into the role that stoicism plays in rural communities, particularly regarding mental health. While mental health stigma is highly

referenced throughout the literature, stoicism is not. The results of this study indicate that stoicism plays a significant role in whether or not people seek mental health treatment. Thus, continuing to explore the meaning of stoicism in rural communities will be important. More to this end, exploring racial/ethnic, gender, and religious differences in the expression of stoicism will also be important to include, contributing to a more nuanced understanding of rural people.

Moreover, it will be important to study specific rural regions of the United States to further contribute to the literature base on rural mental health. As mentioned throughout this study, rural communities are not homogenous. Being able to specifically speak to different viewpoints that individuals from each region of the United States could paint a detailed picture of what is precluding rural residents from seeking mental health treatment, especially considering suicide rates in the United States, but particularly rural areas, have increased sharply over from 1999-2016 (Suicide Rising Across the US, 2018). Learning more about what makes rural areas unique and susceptible to contributors of suicide will be essential to future research.

Further, it may be enlightening to explore a qualitative study regarding barriers to mental health treatment in rural areas. A qualitative grounded theory exploration of rural people would elicit specific, in depth, and detailed information about the lived experiences of rural people who have sought mental health treatment and/or who have chosen not to seek mental health treatment despite being in need, and would add richness and depth to the literature and lend voice to a generally understudied, often misunderstood group.

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Appendix A

Liverpool Stoicism Scale (LSS)

The scale is scored on a 5-point Likert scale *Strongly agree agree neutral disagree strongly disagree* **(* items are scored negatively)**

1. I tend to cry at sad films.*
2. I sometimes cry in public.*
3. I do not let my problems interfere with my everyday life.
4. I tend not to express my emotions.
5. I like someone to hold me when I am upset.*
6. I do not get emotionally involved when I see suffering on television.
7. I would consider going to a counsellor if I had a problem.*
8. I tend to keep my feelings to myself.
9. I would not mind sharing my problems with a male friend.*
10. It makes me uncomfortable when people express their emotions in front of me.
11. I don't really like people to know what I am feeling.
12. I rely heavily on my friends for emotional support.*
13. I always take time out to discuss problems with my family.*
14. One should keep a 'stiff upper lip'.
15. I believe that it is healthy to express one's emotions.*
16. Getting upset over the death of a loved one does not help.
17. I would not mind sharing my problems with a female friend.*
18. 'A problem shared is a problem halved.'*
19. I would not cry at the funeral of a close friend or relative.
20. Expressing one's emotions is a sign of weakness.

Wagstaff, G.F. & Rowledge (2001). *The Liverpool Stoicism Scale*. Liverpool: University of Liverpool.

Appendix B

Community Attitudes of the Mentally Ill Scale (CAMI)

Please rate your level of agreement to each of the following statements about mental illness using the following scale:

SD- Strongly Disagree
D- Disagree
NA- No Answer
A- Agree
SA- Strongly Agree

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.
SA A N D SD

b. More tax money should be spent on the care and treatment of the mentally ill.
SA A N D SD

c. The mentally ill should be isolated from the rest of the community.
SA A N D SD

d. The best therapy for many mental patients is to be part of a normal community.
SA A N D SD

e. Mental illness is an illness like any other.
SA A N D SD

f. The mentally ill are a burden on society.
SA A N D SD

g. The mentally ill are far less of a danger than most people suppose.
SA A N D SD

h. Locating mental health facilities in a residential area downgrades the neighbourhood.
SA A N D SD

i. There is something about the mentally ill that makes it easy to tell them from normal people.
SA A N D SD

j. The mentally ill have for too long been the subject of ridicule.
SA A N D SD

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.
SA A N D SD

l. As far as possible mental health services should be provided through community- based facilities.
SA A N D SD

m. Less emphasis should be placed on protecting the public from the mentally ill.
SA A N D SD

n. Increased spending on mental health services is a waste of tax dollars.
SA A N D SD

o. No one has the right to exclude the mentally ill from their neighbourhood.
SA A N D SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.
SA A N D SD

q. Mental patients need the same kind of control and discipline as a young child
SA A N D SD

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.
SA A N D SD

s. I would not want to live next door to someone who has been mentally ill.
SA A N D SD

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.
SA A N D SD

u. The mentally ill should not be treated as outcasts of society.
SA A N D SD

v. There are sufficient existing services for the mentally ill.
SA A N D SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.
SA A N D SD

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.
SA A N D SD

y. The best way to handle the mentally ill is to keep them behind locked doors.
SA A N D SD

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.
SA A N D SD

aa. Anyone with a history of mental problems should be excluded from taking public office.
SA A N D SD

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.
SA A N D SD

cc. Mental hospitals are an outdated means of treating the mentally ill.
SA A N D SD

dd. The mentally ill do not deserve our sympathy.
SA A N D SD

ee. The mentally ill should not be denied their individual rights.
SA A N D SD

ff. Mental health facilities should be kept out of residential neighbourhoods.
SA A N D SD

gg. One of the main causes of mental illness is a lack of self-discipline and will power.
SA A N D SD

hh. We have the responsibility to provide the best possible care for the mentally ill.
SA A N D SD

ii. The mentally ill should not be given any responsibility.
SA A N D SD

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.
SA A N D SD

kk. Virtually anyone can become mentally ill.
SA A N D SD

ll. It is best to avoid anyone who has mental problems.
SA A N D SD

mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.
SA A N D SD

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.
SA A N D SD

Scoring:
1 = strongly agree
5 = strongly disagree

Reverse Score: a, i, q, y, gg, b, j, r, z, hh, c, k, s, aa, ii, d, l. t, bb, jj

Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia bulletin*, *7*(2), 225.

Appendix C

Attitudes Toward Professional Psychological Help Seeking – Short Form

INSTRUCTIONS: Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely honest.

0 = Disagree 1 = Partly Disagree 2 = Partly Agree 3 = Strongly Agree

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

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

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

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

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

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

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

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

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

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

Scoring
Reverse score items 2, 4, 8, 9, and 10, then add up the ratings to get a sum. Higher scores indicate more positive attitudes towards seeking professional help.

[Adapted From Fischer, E., and Farina, A. (1995). Attitudes toward seeking psychological professional help: A shortened form and considerations for research. Journal of College Student Development, 36, 368-373.]

Appendix D

Community Affiliation

Community Attachment Scale

Please read the following statements and indicate whether you "strongly disagree," "disagree," "agree," or "strongly agree." *Circle one answer for each item*.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**
a. Overall, I am very attached to this community.	1	2	3	4
b. I feel like I belong in this community.	1	2	3	4
c. The friendships and associations I have with other people in this community mean a lot to me.	1	2	3	4
d. If the people in this community were planning something, I'd think of it as something WE were doing rather than THEY were doing.	1	2	3	4
e. If I needed advice about something, I could go to someone in this community.	1	2	3	4
f. I think I agree with most people in this community about what is important in life.	1	2	3	4
g. Given the opportunity, I would move out of this community.	1	2	3	4
h. I feel loyal to the people in this community.	1	2	3	4
i. I plan to remain a resident of this community for a number of years.	1	2	3	4
j. I like to think of myself as similar to the people who live in this community.	1	2	3	4
k. The future success of this community is very important to me.	1	2	3	4

Scoring:
"To calculate a composite community attachment score, strongly disagree (1) disagree (2) agree (3), strongly agree (4). Thus, high scores indicated high levels of community attachment, whereas low scores reflected low levels of community attachment" (Theodori, A., Theodori, G., 2015, p. 385).

Appendix E

Community Affiliation

Community Involvement Scale

The following are questions about your involvement in your community or the community nearest where you live:

1. How often do you keep up with the local news in your community?

Frequently Occasionally Seldom Never Don't Know

2. How often would you say you have ideas for improving things in your community?

Frequently Occasionally Seldom Never Don't Know

3. How often do you get together with people who know what's going on in your community?

Frequently Occasionally Seldom Never Don't Know

4. How often do you work to bring about changes in your community?

Frequently Occasionally Seldom Never Don't Know

Frequently and Occasionally both receive a score of 1.

Seldom and Never both receive a score of 2.

Don't know receives a score of 0.

The higher the score on the Community Involvement Scale, the less involved a person is in their community

Rothenbuhler, E. W. (1991). The process of community involvement. *Communications Monographs*, *58*(1), 63-78

Appendix F

Demographic Questionnaire

(1) Age:_____

(2) Sex:
a. Male
b. Female

(3) Gender:
a. Male
b. Female
c. MtF Transgender
d. FtM Transgender
e. Queer
f. Please Specify_____

(4) What is the highest level of education completed?
a. Less than high school
b. High school/GED
c. Some college
d. 2-year college degree
e. 4-year college degree
f. Master's degree
g. Doctorate degree
h. Professional degree
i. Other (please specify): _____

(5) Household Income Level:
a. Under $20,000
b. $20,000 - $29,999
c. $30,000 - $39,999
d. $40,000 - $49,999
e. $50,000 - $59,999
f. $60,000 - $69,999
g. $70,000 - $79,999
h. $80,000 - $89,999
i. $90,000 - $99,999
j. $100,000 to $109,999
k. $110,000 to $119,999
l. $120,000 to $129,999
m. $130,000 to $139,999
n. $140,000 to $149,999
o. over $150,000

(6) Relationship Status:
a. Single
b. Partnered/Committed
c. Married
d. Separated
e. Divorced
f. Widowed
g. Please Specify_____

(7) Ethnicity/Race (select all that apply):
a. Black/African Descent
b. White/European Descent
c. Latino/Hispanic
d. Asian/Pacific Islander
e. Native American
f. Multi-racial/Multi-ethnic
g. Please Specify _____

(8) Sexual Orientation/Identity:
a. Gay
b. Lesbian
c. Bisexual
d. Heterosexual/Straight
e. Please Specify_____

(9) Religious/Spiritual Beliefs
a. Jewish
b. Christian
c. Muslim
d. Mormon
e. Hindu
f. Sikh
g. Buddhist
h. none
i. Please Specify _____

(10) Size of nearest community to which you live/belong:
a. 1 – 5,000
b. 5,001 – 10,000
c. 10,001 – 15,000
d. 15,001 – 20, 000
e. 20,001 – 25,000
f. 25,001 – 30, 000
g. 30,001 – 35, 000
h. 35, 001 – 40, 000
i. 40,001 – 45, 000

j. 45, 001 – 50,000
k. 50, 001 – above

(11) Are you now or have you or someone close to you previously been involved in mental health services?
a. yes
b. no

(12) If yes, have mental health services been helpful to you/them?
a. yes
b. no

(13) If yes, who has been the primary provider of your/their mental health services?
a. primary care physician
b. master's level counselor
c. social worker
d. psychiatrist
e. psychologist
e. Please Specify _____

Appendix G

Summary of Demographic Information

Demographics	N	%
Gender	222	
Male	118	53.2
Female	103	46.4
Queer	0	0
Ethnicity	221	
American Indian/Alaskan	5	2.3
Asian	13	5.9
Black	20	9
White	167	75
Hispanic/Latino	11	5
Hawaiian	1	.5
Biracial	2	.9
Other	2	.9
Sexual Orientation	222	
Heterosexual	178	80.2
Gay	3	1.4
Bisexual	31	14.2
Lesbian	5	2.3
Other	2	.9
Religious/Spiritual Beliefs	222	
Christian	140	63.1
Muslim	3	1.4
Latter Day Saint	1	.5
Hindu	6	2.7
Sikh	1	.5
Buddhist	3	1.4
None	57	25.7
Other	10	4.5
How important are your Religious/Spiritual Beliefs?	220	
Extremely Important	36	16.2
Very Important	59	26.6
Moderately Important	35	15.8
Slightly Important	29	13.1
Not at All Important	13	5.9
I am Not Religious	48	21.6
What is your Relationship Status?	222	

Married	107	48.2
Widowed	3	1.4
Divorced	14	6.4
Separated	3	1.4
Never Married	68	30.9
Partnered/Committed	25	11.4

Mean Age	23
Median Age	23
Mode Age	30