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lainie krumenacker

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EXAMINING STIGMA IN RURAL MENTAL HEALTH CARE SETTINGS: A MIXED METHODS APPROACH

A Thesis
Presented to
The Faculty of the Department of Psychology
Murray State University
Murray, Kentucky

In Partial Fulfillment
of the Requirements for the Degree
of Master of Science in Clinical Psychology

By Lainie K. Krumenacker
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Abstract

More than half of Americans will be diagnosed with a mental illness in their lifetime (CDC, 2021), yet stigma towards mental health affects both patients and providers. Although programs exist to address stigma, improve cultural competency among providers, and educate families on the importance of support, facilities are often limited on programs they provide due to allocation of resources and funds. Without a shift in treatment and programing, stigma will continue to impact patient care and outcome.

This study explored stigma among mental health providers in rural communities, while exploring potential differences in treatment among patients due to race. Mental health care providers completed a semi-structured interview based on relevant literature about mental illness, resources for patients and demographics of patients. This interview was followed by additional measures assessing stigma and proximity to mental illness.

Results from this study indicated that a provider's exposure or proximity to mental health, is not a protective factor against stigma. Furthermore, providers endorsed a general irritation and impatience towards patients, which may suggest provider burnout. Regarding the qualitative data from the semi-structured interview, findings suggest provider knowledge of mental health stigma, as well as common biases in diagnosing.

These findings may help us further understand the relationship between stigma and mental health providers which could provide incentive to redesign treatment for mental health patients, incorporating specific programs to target stigma and cultural humility while providing support for both patient and provider.

Keywords: mental health, stigma, rural, cultural competency

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Introduction

According to the National Institute of Mental Health (NIMH), nearly one in five adults suffer from a diagnosable mental illness (NIMH, 2020). Overall, mental illness does not ostensibly discriminate, as it can impact all persons, regardless of age or race. Prevalence rates for certain conditions (e.g., clinical depression and anxiety), however, tend to be higher among females than males and in those with two or more races (NIMH, 2020). Regarding treatment options for mental disorders, patients often report the biggest barrier in receiving effective treatment as the cost of treatment (Statista, 2018). For example, according to a recent market intelligence report by Open Minds (2020), national spending on mental health services in the United States totaled $225.1 billion in 2019. Furthermore, payment for mental health services is disparate. According to GoodTherapy.org, a mental health directory for laypersons, the “average” cost of therapy ranges from $65 to $250 or more per session (GoodTherapy.org, 2019). Empirical findings also support the notion that many prospective patients may not actively seek treatment for mental health-related concerns due to an ability to pay for these services (Rowan et al., 2013).

Notwithstanding these relevant financial concerns for individual patients, stigma against mental illness is also a significant barrier to mental health treatment. Stigma can be defined as negative attitudes, beliefs, and behaviors associated with an individual or group. Goffman (1963) describes stigma as an attribute that is “deeply discrediting.” With individuals being “disqualified” from full social acceptance. Regrettably, there appears to be clear associations between individuals in distress who wish to seek help and whether they feel they are able to comfortably disclose their problems to others

(Thornicroft, 2008). For example, individuals suffering from mental illness may not seek treatment, in fear that they will be regarded negatively by their peers, loved ones, or even their provider (Shrivastava et al., 2012). Stigma manifests when an individual is thought to have qualities or characteristics that violate social norms or what is socially acceptable in that culture (Link & Phelan, 2001). These violations may lead persons in our society to ostracize other individuals. Symptoms indicating mental illness are often stigmatized and while many symptoms may remit after one has received appropriate care, treatment does not mitigate the effects of stigma overall as a risk factor. For example, an individual diagnosed with schizophrenia may complete a course of treatment and no longer suffer from its primary symptoms. Nonetheless, the individual will still carry the “label” of schizophrenia and as such, may be subjected to stigmatizing comments from others. Indeed, a strong literature base supports the notion that stigmatization and higher levels of “expressed emotion” (i.e., critical, or hostile comments made to a person with a mental illness by members of their family) serve as risk factors for relapse in schizophrenia (Ma et al., 2021). In addition, individuals may experience “internal stigma” or self-stigmatization; that is, the shame an individual feels regarding their illness or the expectation of discrimination from others (Gray, 2002). As such, these persons may be concerned about causing shame to themselves or to their families (Thornicroft, 2008).

Regarding the "labels” that one may carry, it is likely that certain mental illnesses, such as anxiety and depression may be less stigmatized than serious mental illnesses (e.g., schizophrenia or bipolar disorder) because of the general population’s exposure and familiarity with these conditions. For example, the greater the interpersonal contact or the more experience an individual has with mental illness, the less stigmatizing and discriminatory they tend to be (Wallace, 2012).[1] Individuals who are more familiar with mental illness through experience with friends or family are less likely to hold stigmatizing views towards mental illness (Corrigan, 2001), as contact reduces fear or the perception of danger (Link & Cullen, 1986). Indeed, common mental disorders include diagnoses from the depressive or anxiety spectrum, which increases the likelihood that an individual may come into contact with a person struggling with one of these diagnoses. Schizophrenia and bipolar disorder, on the other hand, have lower prevalence rates. Overall, 52.9 million adults (21%) in the United States have been diagnosed with any mental illness, whereas 14.2 million (5.6%) have been diagnosed with a serious mental illness (NIMH, 2020). Given these discrepancies (i.e., in prevalence rates, one's familiarity with specific mental disorders, and so forth), the general population may instead rely on media as a source of information on serious mental illness, which may be unreliable and portray individuals as dangerous and limited in their abilities (Riles et al., 2021; Wahl, 2003). Fortunately, a heartening line of research has emerged to suggest that broad-based mental health education may reduce stigma in the population as a whole (e.g., Javed et al., 2021), which, in turn, may improve access to mental health services. However, more research is needed to assess the effects of stigma *after* the individual has sought services or has begun mental health treatment.

Mental Health Provider's Perceptions of Patients

Although the general population's stigma may be a result of a lack of contact with specific populations, one would expect those working directly with patients to be less

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[1] This statement is not meant to imply that disorders like anxiety or depression are not stigmatized. In fact, there appears to be a common misunderstanding or erasure of these conditions in films and media depicting mental illness (Riles et al., 2021).

stigmatizing toward persons with mental illness. However, research suggests that mental health care providers are just as susceptible to stigma as the general population. In fact, a study conducted by Corrigan et. al (2014) showed that when compared to primary care providers, mental health providers showed no difference in their expectations about treatment response (i.e., the extent to which a patient improves throughout treatment). Stigmatizing beliefs concerning a patient's abilities may be influenced by the provider’s perception of a poor prognosis and the patient fostering dependence, as in they will always need to rely on services due to their diagnosis (Charles, 2015). Corrigan et al. (2014) found that providers who exhibit stigmatizing qualities, were more likely to believe patients would not adhere to treatment, such as medication. Sadow et. al. (2002) advises that providers who are stigmatizing may inadvertently interfere with effective treatment. When a provider encourages medication with little family or patient involvement or they hold additional beliefs about a patient’s ability, this may influence a patient’s decision about treatment (Charles, 2015). This supports the hypothesis that a provider's outlook on patient adherence to treatment is related to the provider’s prior personal experiences with mental illness (i.e., exposure or proximity) and their comfort level (Corrigan et al., 2014), rather than the provider’s education and their current experiences with individuals. The less comfortable a provider is with using mental health services themselves, the more stigmatizing they may be toward patients (Corrigan et al., 2014). This notion is also corroborated in an article by Wallace (2012) who researched and compiled literature regarding health providers seeking mental health services. In this article, providers believed they would be stigmatized by their colleagues if they sought out mental health treatment, making it less likely they would seek services in fear that they would look incompetent, which, in turn, perpetuates the stigma that seeking mental health services means one is “impaired.” This vicious cycle may lead certain providers to have a generalized, stigmatizing view of patients seeking mental health services (Wallace, 2012). However, stigmatization against the labels of mental illness itself (e.g., “common” v. “severe” presentations) is not the only factor; that is, there is convincing evidence for the role of intersectionality – that the patient’s and provider’s race and ethnicity may interact to lead to more stigmatizing behaviors.

Experience of Mental Health Care by Race

As noted previously, cost of mental health treatment may be one reason for not seeking services, but at a racial/ethnic level of analysis, White[2] adults are more likely to seek mental health treatment, whereas Black adults are more likely to receive treatment only upon entering inpatient commitment (SAMSHA, 2015). Results from a 2020 study completed by Quinn et al., suggest that minorities are likely to experience multiple types of stigma and may anticipate stigma based on previous experiences of racial discrimination therefore, they attempt to conceal their race or symptoms of mental illness, leading to increase distress and ultimately a delay in treatment. This sentiment is shared by Gary (2005), who suggests that minority groups suffer from “double stigma.”

Consider the discussion of prevalence statistics from earlier – if 5.6% of adults are diagnosed with a serious mental illness (with less than 1% being schizophrenia), how is it that Black Americans are 2.4 times more likely to be diagnosed with schizophrenia compared to White Americans (Herbst, 2021)? Is this due to a delay in treatment of

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[2] This thesis will correspond to updated APA style when referring to specific racial and ethnic groups (cf. https://apastyle.apa.org/style-grammar-guidelines/bias-free-language/racial-ethnic-minorities), wherein these groups are designed by proper nouns and are capitalized. “White” refers to persons of European ancestry, whereas “Black” refers to persons of African origin.

mental illness or due to the quality of that treatment? According to the American Psychiatric Association (2017), Black Americans often receive poorer quality of care. Mental health providers communicate differently with White patients than with Black patients. For example, a study conducted by Johnson et al. (2004) found that providers were 23% more "verbally dominant" (e.g., leading the conversation in such a way that makes it hard for the other individual to participate) and engaging in 33% less patient-centered communication when interacting with Black patients compared to White patients. Patient-centered communication is important for care as patient engagement leads to better patient recall of information, treatment adherence, and satisfaction with care (Johnson et al., 2004). A study conducted by van Ryn and Burke (2000) found physicians rated Black and low-income patients lower on intelligence and their likelihood to adhere to medical advice when compared to White patients; as such, this explicit bias may lead to poorer quality of care and possible misattribution of symptoms.

According to Mental Health America (2022), Black adults are more likely to have feelings of sadness, hopelessness, and worthlessness than White adults and are more likely to experience factors known to exacerbate medical and psychiatric illnesses, such as poverty and discrimination. Strangely, however, Black patients are more likely to be diagnosed with schizophrenia rather than a mood disorder compared to White adults who present with the same symptoms (American Psychiatric Association, 2017).[3] Further, only one in three Black adults who need mental health care receive it (Mental Health America, 2022). So, why are Black adults more likely to be diagnosed with schizophrenia

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[3] Although the diagnostic criteria for schizophrenia are not relevant to this thesis, it should be noted the hallmark symptoms required for a formal diagnosis of schizophrenia involve the presence of hallucinations, delusions, or disorganized speech per current psychiatric nosology. Categorically, then, schizophrenia should be entirely separate from clinical depression based on its symptom presentation.

rather than mood disorder when compared with White adults with the same symptoms? Factors such as lack of diversity among mental health providers, lack of cultural competency, and general distrust in the health care system may contribute to misdiagnoses and overdiagnoses (American Psychological Association, 2017).

Nagendra’s model (as discussed in Olbert, 2018) proposes two probable causes for this overdiagnosis of schizophrenia in Black adults. The first cause concerns assessment bias during case conceptualization (Herbst, 2021). For example, clinicians may interpret an individual's fears or anxiety about social factors as paranoia or hallucinations instead of taking them into consideration as valid concerns, so Black Americans with severe depression are more likely to be misdiagnosed as having schizophrenia (Herbst, 2021). The second most likely cause, which is supported by a recent report from Rutgers University (2019), is that Black Americans experience more environmental risk factors for the development of schizophrenia such as poverty, discrimination, and malnutrition early on in life and when compared to the general population, Black Americans are less likely to be offered evidence-based medication therapy or psychotherapy (American Psychiatric Association, 2017). This lack of an evidence-based approach includes the overuse of first-generation antipsychotics in Black patients, even with FDA approval of second-generation antipsychotics (Cook et al., 2015). Second generation antipsychotics are recommended as first-line treatment as they may be more effective in targeting negative symptoms in illnesses such as schizophrenia and have fewer severe side effects (Mallinger et al., 2006). However, Black patients are more than twice as likely to receive these higher potency first-generation antipsychotics when compared to White patients (Cook et al., 2015), and yet Black patients are two times less likely to receive antidepressant medications when compared with White patients with similar symptoms (Remmert, 2022). As mentioned before, this population has the most difficulty receiving care, whether it be due to insurance, distrust in the mental health system or bias among providers and yet they are experiencing the most environmental risk factors, stigma included.

Effects of Stigma within the Healthcare System

The consequences of stigma can be detrimental and can impede on an individual's personal relationships, their education and work. Individuals with mental illness receive unequal treatment for mental health and ultimately their physical health as well, which could contribute to higher morbidity rates and premature mortality (Thornicroft, 2016). Mortality rate for serious mental illness is more than twice the rate of the general population. Explanations for this distinction include evidence that substance use is higher among those with mental illness, which can lead to liver or cardiac conditions, and that the risk of suicide is pronounced for these populations (Berren et al., 2006).

Mental illness stigma creates serious barriers to access and quality care and is even a concern among healthcare providers themselves as a barrier for seeking treatment. Individuals with mental illness report feeling dismissed or dehumanized by health care providers, being given insufficient information and treatment options, even being told by providers they would never get well while using stigmatizing language (Knaak, 2017). In addition, physical symptoms may be misattributed to a patient's mental illness through a process of diagnostic and treatment overshadowing, creating delays in the diagnoses of a physical ailment (Jones et al., 2008). There is a high rate of physical comorbidity in mentally ill patients which often has poor clinical management, further reducing life expectancy for this population (Firth et al., 2019). While stigma impacts healthcare providers' own willingness to seek treatment and is maintained by stigma in their workplace (Knaak, 2017), research shows the more comfortable a provider is in seeking treatment, the less stigmatizing they will be toward patients (Corrigan et al., 2014).

Factors Mitigating the Effects of Stigma

Interventions to reduce stigma among health care providers are uncommon and typically consist of continuing education and informational approaches which result in short term improvements (Thornicroft, 2016). When considering cultural competency among health care providers, current approaches have been criticized for leading to further stereotyping and disempowerment of patients, instead of focusing on programs with approaches that include cultural safety and cultural humility (Kirmayer, 2012). Recent research emphasizes the importance of approaching stigma reduction with a goal of systemic cultural change with strong support from leadership (Knaak & Patten, 2016). A preponderance of research supports social contact as being the most effective way to reduce stigma, which can include hearing testimonies from individuals with mental illness about their recovery and experiences within the healthcare system (Knaak et al., 2014). Social contact does not automatically mean improved intergroup relations, however. The most effective social contact is when there is equal status between groups or participants and common goals (Thornicroft, 2016). These improvements can be made through programs that have been specifically developed to combat stigma, while promoting staff health and well-being (Knaak et al., 2017). For this to be possible, facilities require access to the appropriate programs and resources; however, funding for mental health services is often limited.

Many countries face the challenge of trying to provide mental health services with inadequate resources for interventions, particularly in low- and middle-income communities. (Kakuma et al., 2011). A study conducted by Corrigan et al. (2004) regarding allocating resources to mental health services found that the decisions made were related to attitudes and emotions, rather than mental health friendly decisions. Policy makers are just as influenced by their own attitude, which impacts decision making and this emphasizes the need for advocacy-based strategies (Corrigan et al., 2004). According to The Lancet Mental Health group (2007), possible strategies to scale up services for individuals include placing mental health on the public-health priority agenda by strengthening the public mental health leadership and integrating mental health into general care. While there is a need to prioritize mental health on the public agenda and implement the necessary programs, strengthening support for individuals should be an additional area of focus.

A study conducted by Fasihi et al. (2019) found a relatively strong correlation between social support and mental health, recommending that authorities hold seminars for families of school students, older adults, and other vulnerable groups to raise awareness and recommended that counseling centers teach strategies for receiving social support. Social support is a key coping resource for individuals. It can be emotional, informational, or practical. Support can lead to confidence and higher self-esteem. Individuals who have higher self-esteem and believe they are in control of their lives are more likely to participate in problem solving behavior (Turner & Brown, 2009). This is especially relevant for individuals with serious mental illness, who often have smaller social networks and experience difficulty developing and maintaining relationships (McCorkle et al., 2007).

Overview

The CDC (2021) projects more than half of Americans will be diagnosed with a mental illness in their lifetime, yet stigma against mental illness is not only relevant but considered a risk factor, affecting patient and provider alike. Although programs exist that may combat stigma, improve cultural competency among providers, and educate families on the importance of support, facilities are often limited on programs they provide due to allocation of resources and funds. Without a shift in treatment and programing, stigma will continue to impact patient care and outcome.

This study further explored stigma among mental health providers, while exploring potential differences in treatment among patients due to race. This study asked questions regarding provider's personal proximity to mental health and perception of mental health resources. Findings from this study may help us further understand the relationship between stigma and mental health providers which could provide incentive to redesign treatment for mental health patients, incorporating specific programs to target stigma and cultural humility while providing support for both patient and provider.

Reflective Local Practice

As detailed in the Method section further below, this thesis aimed to recruit participants from western Kentucky and southern Indiana. Although the research has been summarized discussing the effects of stigma within overall healthcare settings, the United States continues to struggle with providing adequate mental health care in rural communities, and yet it has been advocated that providers with specialized training for rural settings can help alleviate this problem (Jameson & Blank, 2007). In Kentucky, 71% of the population live in communities that do not have enough mental health providers to meet their needs, whereas in Indiana approximately 65% of the population does not have adequate access to mental health care; however, in bigger cities such as New York, only 20% of their population have unmet mental health needs (National Alliance on Mental Illness, 2021). Analyses conducted by Jensen et al., (2020) show common themes among mental health providers attending to these rural communities, including that they face unique challenges, with rural communities having a distinct culture and the requirement of innovative ideas for resourcing.

So, in addition to a focus on maintaining a framework of intersectionality, this project emphasized the role of *reflective local practice* (RLP; cf. Sandeen et al., 2018). In the realm of clinical practice, mental health providers should continue to expand their self-awareness of one's own cultural influences (i.e., be *reflective*), have geographic-specific knowledge of the area in which they treat patients (*local*), and to seek opportunities for cultural humility and/or expansion of one's cultural competence (*practice*). Applied to a research setting, the RLP approach emphasizes the provider's internal processes related to conceptualization, diagnosis, and treatment decisions. This thesis, then, will couch the results within the rural settings of western Kentucky and southern Indiana.

Hypotheses

The hypotheses for this thesis are as follows:

Quantitative Hypotheses

1. The greater the personal proximity a mental health provider has to mental illness (i.e. they or a close friend or family member has been diagnosed with a mental illness) the less stigmatizing they will be.
2. Compared to other forms of stigmatization (e.g., being irritated when talking to the patient), mental health providers will be more likely to stigmatize patients on the basis of treatment adherence and dependence (e.g., assuming patients will have difficulty making treatment choices for themselves).

Qualitative Hypotheses

1. Compared to patients with more common mental disorders (i.e., depression and anxiety diagnoses), patients with serious mental illnesses (i.e., schizophrenia and bipolar disorder) will be more stigmatized by mental health providers.
    a. That is, mental health providers will endorse more stigmatizing behaviors associated with patients with schizophrenia compared to patients with more common mental disorders.
2. Patients with limited support will be more stigmatized by mental health providers when compared with patients who have consistent support.
    a. That is, mental health providers, will endorse more stigmatizing behaviors with patients who have limited support, when compared with patients who have consistent support.
3. There will be differences in treatment recommendations offered by mental health providers when comparing Black patients to White patients.

   a. Mental health providers will endorse treatment differences in race, specifically, recommending first generation antipsychotics in Black patients when compared with White patients.
   b. Mental health providers will endorse treatment differences in race, specifically, recommending antidepressants for treatment of depression in White patients when compared to Black patients.
4. Compared to White patients, mental health providers' responses to the qualitative interview will include more stigmatizing statements for Black patients.

Methods

Participants

This study recruited mental health providers from communities in southern Indiana and western Kentucky. These participants were recruited for their relevant rural backgrounds and as well as convenience sampling.

Mental health providers intended for this study included psychiatrists, psychologists, psychiatric nurses, social workers, and therapists. However, no psychiatrists participated in this study. Participants included a total of 31 mental health providers for the survey portion of this study, with 11 participants completing the semi-structured interview. All participants obtained advanced degrees. Specific professions of the 11 participants who completed interviews included 4 clinical directors, 5 master level practitioners, 1 psychiatric nurse practitioner and 1 doctorate level psychologist. Participants were between the ages of 24 and 61 (*M* = 39.46 , *SD* = 9.49), with 81% of participants disclosing their ethnicity as White, 6% Black, 3% American Indian or Alaskan Native, 3% Multiracial, 3% Hispanic or Latino and 3% other. Participants were primarily biologically female 87%, 10% were Male and 3% preferred not to say. For frequencies of demographics see Table 1 and Table 2 below.

Table 1

Frequencies for Biological Sex

Biological Sex	Frequency	Percent
Female	27	87.10%
Male	3	9.68%
Prefer not to say	1	3.23%
Total	31	

Table 2

Frequencies for ethnicity

Ethnicity	Frequency	Percent
American Indian or Alaskan Native	1	3.23%
Black, not of Hispanic origin	2	6.45%
Hispanic or Latino	1	3.23%
Multiracial	1	3.23%
Other	1	3.23%
White	25	80.65%
Total	31	

Procedure

Individual, semi-structured interviews took place using a guide of questions and prompts that were developed by the principal investigator and reviewed by the principal investigator’s mentor based on relevant literature and prior research (see Claire, 2014; Dar, 2021; Lietz et al., 2014; Rodriguez, 2022). The semi-structured interview took 30-45 minutes, with approximately five minutes spent prior to the interview to build rapport and gain informed consent. Interviews were recorded with a recording device and transcribed using the transcription program, sonix. Upon completion of the interview, the participant completed a battery of questionnaires within Qualtrics (see below). In the case that an in-person interview could not be conducted, a telephone or Zoom interview was completed, with a Qualtrics link sent to those participants to complete measures. Participants were then debriefed and thanked for their time. Recordings were deleted upon confirmation that there was no error made within the transcriptions.

Measures

Semi-Structured Interview

The semi structured interview employed for this study asked open ended questions developed by the principal investigator and reviewed by the principal investigator's mentor. Questions were based on relevant literature and prior research (see Claire, 2014; Dar, 2021; Lietz et al., 2014; Rodriguez, 2022). The interview included questions about mental illness, resources for patients, and demographics of patients. See Appendix A for full interview.

Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS)

To measure mental health provider stigma, the Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS) was used. The MHPSASS is a 20-item questionnaire assessing the following four domains: Irritation and Impatience ($\alpha = .76$), Choice and Capacity ($\alpha = .66$), Adherence and Dependence ($\alpha = .66$), and Devalue and Depersonalize ($\alpha = .55$). With adequate overall internal consistency measured at $\alpha = 0.82$. Participants rated their responses on a 7-point Likert scale for a maximum total score of 120. This measure was used as a quantitative measure of stigma and demonstrated favorable psychometric properties, including face validity, content validity, construct validity, and internal consistency, making it a reliable measure which has been evaluated in additional research (Charles & Bentley, 2017). See Appendix A for full measure.

Demographics

The demographics questionnaire developed by the principal investigator and reviewed by the principal investigator's mentor, included basic background information and questions regarding participant's proximity to mental illness. See Appendix A for full measure.

Results

Quantitative Hypotheses

To test Hypothesis 1 (regarding proximity and stigmatization), a correlation analysis was conducted to examine the magnitude of the relationship between the proximity question on the demographics survey and total MHPSASS scores. As written, the proximity question allowed for the respondent to indicate whether themself, a close friend, or family member had been treated for mental health concerns. Responses were coded as "1" for each affirmative response, with higher numerical values on this item being indicative of greater proximity to mental illness. Thus, a negative correlation between the proximity item and total MHPSASS scores would provide support for Hypothesis 1. A Pearson's correlation was conducted to test for a relationship between proximity and total MHPSASS scores. While no correlations were found for total MHPSASS scores, a modest correlation was observed between the Irritation and Impatience subscale and the Devalue and Depersonalize subscale, See Table 3 below.

Table 3

Variable	1	2	3	4	5
1.Proximity	-				
N	30				
2. Irritate	-.03	-			
N	30	31			
3. Choice	.25	.31	-		
N	30	31	31		
4. Adhere	.05	.12	.32	-	
N	30	31	31	31	
5. Devalue	.09	.43*	.29	.22	-
N	30	31	31	31	31

* indicates $p < .05$

To test Hypothesis 2 (assessing within-group differences among various forms of stigmatization), a repeated-measures ANOVA was conducted to assess whether scores on the Adherence and Dependence subscale of the MHPSASS were significantly higher than scores on the Irritation and Impatience, Choice, and Capacity, and Devalue and Depersonalization subscales. Mauchly's test, $\chi2$ (5) = 14.72, p = .012 indicated a violation of sphericity, thus Greenhouse-Geisser adjustment was made ε= .73. The results indicated that there was a significant difference among the various forms of stigmatization, y, F (2.37, 65.82) = 80.74. MSE = 2401.79, $p < .001$. Upon further analysis, a post hoc test indicated that there was not a significant difference between scores of the Adherence and Dependence subscale and the Choice and Capacity subscale, as hypothesized. However, significant differences were observed when comparing the Irritate and Impatience subscale, $p < .001$, 95% CI [-16.33, -7.61] and the Devalue and Depersonalization subscale, $p < .001$, 95% CI [3.46, 8.86]. Specifically, Adherence and

Dependence subscale scores (*M* = 14.16, *SD* = 4.87) were significantly lower than Irritate and Impatience subscale scores (*M* = 26.13, *SD*= 7.702) but significantly higher than Devalue and Depersonalization subscale scores (*M* = 8, *SD* = 3.49). Bonferroni adjustment was used to determine significance, with α = .0083.

Table 4

Source		Type III Sum of Squares	df	Mean Square	F	Sig.
Stigma	Sphericity Assumed	5269.637	3	1756.546	80.735	<.001
	Greenhouse-Geisser	5269.637	2.194	2401.693	80.735	<.001
	Huynh-Feldt	5269.637	2.374	2219.492	80.735	<.001
	Lower-bound	5269.637	1.000	5269.637	80.735	<.001
Error (Stigma)	Sphericity Assumed	1958.113	90	21.757		
	Greenhouse-Geisser	1958.113	65.824	29.748		
	Huynh-Feldt	1958.113	71.228	27.491		
	Lower-bound	1958.113	30.000	65.270		

Table 5

	Mean	Std. Deviation	N
Irritate sum	26.13	7.702	31
Choice sum	15.87	4.433	31
Adhere sum	14.16	4.866	31
Devalue sum	8.00	3.493	31

Table 6

(I) Stigma	(J) Stigma	(I-J)	Std. Error	Sig.[b]
Irritate	Choice	10.258*	1.368	<.001
	Adhere	11.968*	1.543	<.001
	Devalue	18.129*	1.251	<.001
Choice	Irritate	-10.258*	1.368	<.001
	Adhere	1.710	.977	.543
	Devalue	7.871*	.859	<.001
Adhere	Irritate	-11.968*	1.543	<.001
	Choice	-1.710	.977	.543
	Devalue	6.161*	.956	<.001
Devalue	Choice	-18.129*	1.251	<.001
	Adhere	-7.871*	.859	<.001
	Devalue	-6.161*	.956	<.001

Based on estimated marginal means

*. The mean difference is significant at the .05 level.

b. Adjustment for multiple comparisons: Bonferroni.

Qualitative Hypotheses

The principal investigator uploaded recordings of each interview to the software, Sonix. Sonix then generates transcriptions, providing the user with accuracy percentages. Accuracy for transcriptions in this study were no less than 98%. Sonix can distinguish between multiple speakers and is considered a highly secure software to ensure media files remain protected. Additionally, all transcriptions were then read by the principal investigator and checked for errors, utilizing the recording and back up transcription which were created in real time during interviews with the use of a word document and dictation tool. In reviewing the transcriptions, no major errors were found. Transcriptions were then analyzed by the principal investigator. Themes and categories found were highlighted and organized utilizing a codebook in excel. To test for inter-coder reliability, the principal investigator's mentor read and analyzed transcriptions independently. The principal investigator and mentor then met to compare codes, categories and themes found. Discrepancies were discussed and amended. A table was created to further organize the codebook for efficacy. Original transcriptions and codebook were then uploaded to the Open Science Framework (OSF; https://osf.io/brjx8/). OSF is a platform used by researchers with the intent to make scientific research transparent and accessible to all. Original recordings of interviews were then deleted.

Due to lack of prescribing physicians recruited for the interview portion of this study, Qualitative hypotheses 3a and 3b could not be addressed. Regarding Qualitative hypothesis 1, mental health providers endorsed more stigmatizing behaviors for patients with more serious mental illness (i.e., schizophrenia and bipolar disorder) compared to patients with more common mental illness (i.e., depression and anxiety). With more than half of providers identifying serious mental illness as the most challenging diagnoses to work with while using stigmatizing language. Statements made include, “Those people [individuals experiencing psychosis or schizophrenia] on the unit tend to be a lot more difficult because they may have erratic or agitated or aggressive behavior” and “a lot of those [individuals diagnosed with borderline personality disorder] patients…tend to be what we would call like alumni, frequent flyers, whatever, like they're kind of in and out of treatment and everything. So, I mean, that can get kind of hectic and trying to get them the right resources and the right treatment and everything too.”

For Hypothesis 2, providers endorsed more stigmatizing behaviors and circumstances for patients with limited social support when compared to patients with more social support. With more than half of providers stating a worse prognosis for individuals with limited social support. Statements made include, “I want to say like a night and day difference [between individuals with support and without], because if you have that family support, if you have that good support system, you can overcome anything…It's as powerful as therapy. It can be as powerful as, you know, putting someone on medication” and “It is challenging, especially like so limited social support and particularly with individuals with serious mental illness. It becomes problematic because you don't even have the support to get them to the hospital to stabilize them…They're less likely to be successfully treated, unfortunately.”

For Hypothesis 4, when compared to White patients, mental health providers responded with more stigmatizing statements regarding Black patients. All 11 providers agreed that race has an impact on mental illness and that there are no training requirements for working with minorities. More than half of providers stated common stereotypes and diagnosing bias with black patients. Statements made include “I would say black individuals tend to get more intense diagnoses such as schizophrenia than other demographics. So, when we see somebody making the same complaint and they're black, you tend to go to schizophrenia” and “There is a lot more antisocial and narcissistic personality disorder diagnosis in the black community, but I feel like that's because there is a cultural misunderstanding…I think that sometimes people can be viewed as narcissistic when in fact they've been taught to be a certain way, and that's very culturally driven.” To review the table with provider quotes, see Appendix B

Discussion

Research suggests that providers working directly with mental health clients are not without stigma and in fact, are just as susceptible to the stereotypes blanketing this field as the general population (Corrigan et al., 2014). Sadow et. al (2002) state that stigmatizing patients may inadvertently interfere with effective treatment. This is consistent with findings from a study conducted by Chan and Tsui (2023), which suggests that a client’s perceived stigma from a provider has significant negative effects, specifically on recovery which ultimately leads to service disengagement. Furthermore, studies found that a provider’s willingness to receive services themselves, as well as their personal experience (i.e., exposure or proximity) can impact their overall stigma towards mental health (Corrigan et. al., 2014).

The aim of this study was to further understand stigma in mental health care settings while considering racial disparities, specifically, in rural communities. A mixed methods approach was utilized to study the relationship between stigma in rural mental health providers while examining a provider’s personal proximity to mental health. While the hypothesis that the greater personal proximity a mental health provider had to mental illness, the less stigmatizing they would be, was not supported in our findings, this may be reflective of a small sample size (*N*=31) or an indication that a provider’s personal proximity is not a protective factor against stigma. Nevertheless, results of this study suggest that mental health providers hold stigmatizing views towards their clients, or in the very least recite common stereotypes within their field. It was hypothesized that compared to other forms of stigmatization, mental health providers would be more likely to stigmatize patients on the bias of treatment adherence and dependence (Corrigan et al., 2014). Our results indicated that mental health providers endorsed more stigmatization relating to a general irritation and impatience towards their patients rather than treatment compliance. This may communicate provider burnout which is often associated with changes in behavior and mood, such as irritability (Fischer et al., 2007).

During the interview portion of this study, providers endorsed more stigmatizing statements towards individuals with serious mental illness as hypothesized and supported in previous research (Riles et al., 2021; Wahl, 2003; Wallace, 2012). Providers stated that individuals with serious mental illness would have a worse prognosis, with limited support and would likely be in treatment for the rest of their lives. This is not to say that providers did not make stigmatizing statements regarding individuals diagnosed with more common mental illness, such as anxiety and depression. Providers made statements such that individuals with depression are often non-compliant and offered reasoning such as lack of motivation.

Regarding social support, providers associated a lack of support with serious mental illness, as stated above, and often assigned blame to the patient for that lack of support. While smaller social networks for individuals with serious mental illness is well documented in relevant literature, studies found that low self-esteem and little opportunity to interact with individuals outside of social service professionals, may be more representative for why peoples with serious mental illness have smaller social networks (McCorkle et al., 2007). Additionally, providers stated a poorer prognosis for individuals with lack of support, be it familial, friend or community. This is consistent with a previous study which found a strong correlation between social support and mental health (Fasihi et al., 2019).

While the hypothesis regarding specific treatment differences (i.e., medication) in race were unable to be addressed due to lack of psychiatrist participation, the hypothesis regarding general racial disparities was addressed. Providers acknowledged discrimination towards minorities in the mental health field and suggest a lack of cultural competency. This sentiment is shared by Kirmayer (2012) who proposed a lack of cultural humility and safety training among providers. Specifically, providers reported a diagnosing bias-with a greater number of black patients being diagnosed with severe mental illness. This is consistent with the literature that black Americans are 2.4 times more likely to be diagnosed with serious mental illness compared to white Americans (Herbst, 2021), with lack of cultural competency being a contributor to misdiagnoses and overdiagnoses (American Psychological Association, 2017). It is important to recall Nagendra’s model, discussed in Olbert (2018), which mentions two probable causes for overdiagnosis in Black adults. One being bias and the other being that black adults are at an increased risk for environmental factors, such as poverty and discrimination. Providers went on to describe the importance of representation in the field for minorities, especially in rural communities.

In reference to their rural communities, providers reported a need for psychoeducation to reduce stigma within the population and described essential needs such as additional providers and access to basic resources. This is consistent with literature stating rural communities struggle to provide adequate health care (Jameson & Blank, 2007) with a distinct culture and unique challenges (Jensen et al., 2020). Recommendations made by providers included community-based clinics, transportation for patients, preventative programs, and integrated services. Furthermore, providers stated that primary care providers require better training for treating and diagnosing mental illness, in addition to knowing their communities' resources. Integrated mental health and primary care is well researched and proves beneficial for both patient and provider alike. Collaboration among professionals minimalizes the need for follow up appointments. Integrated care allows patients to get both physical and mental health care in the same place, making it more likely for individuals to utilize that resource (Felker et al., 2004).

This study considered factors such as racial disparities, unique challenges for rural communities, all while gathering input from providers regarding perceived community needs. The implications of the findings are that providers are aware of the bias in this field and are willing to acknowledge common stereotypes and discrimination. While historically facilities focused on informational trainings such as modules and videos to reduce stigma -one must question whether these trainings only serve as a sort of confirmation bias for providers. This is not to say that providers are intentionally stigmatizing their patients, or that stereotypes do not hold some value for simplifying our fast-moving social environment. Rather, that the negative consequences for stereotyping often outweigh the positive, as they become automatic and resistant to change.

It is important to discuss whether there is a distinction between what is true to a diagnosis and mental health stigma. Is a provider’s knowledge of a diagnosis an accurate representation of how patients present or is how a patient presents influenced by stigma and bias? The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a handbook used by mental health professionals to assist in diagnosing. Included in this handbook are descriptions of diagnoses, base rates, and other criteria. While health care providers around the world depend on the DSM for diagnosing, it is not without controversy. In a recent study by Masuda et al. (2020) researchers discuss bias within the manual and suggest vague concepts of mental disorders, bias within diagnostic criteria itself in addition to clinician bias. In the most recent revision of the DSM there are claims to have greater cultural sensitivity, however, researchers argue that the manual only states the critiques of being ethnocentric without changing how they appraise culture within the diagnostic criteria (Bredstrom, 2017). While knowledge of diagnoses may be the result of professional experience, it is the responsibility providers to take into consideration within their practice, the origin of diagnoses and subsequently the formation of the DSM.

For clinical practice, this means that providers are cognizant of the stigma within their profession and that being aware of stigma has little impact. Perhaps this will provide incentive to restructure training requirements for providers and consider rehabilitation needs of patients, with reflection on the impact that strong social support has on mental health. As discussed in earlier paragraphs, mental health stigma is considered a barrier to treatment, with the most effective way to reduce stigma being social contact in a setting where all participants are on equal footing (Thornicroft, 2016). This method for reducing stigma is well researched and documented and while most mental health facilities struggle to obtain funding for resources, having a conversation with colleagues regarding ineffective training methods may be a good place to start-emphasizing that effective trainings for providers means more efficient, successful treatment for patients.

Limitations & Future research

Content coding was completed between two professionals, however, an inter-rater reliability score to achieve consensus cannot be provided. It is important to note the potential for researcher bias when reviewing the qualitative data; specifically, because both content coders were aware of the hypotheses of the present thesis, they may have been more likely to classify statements as stigmatizing. Moreover, while internal consistency for the overall MHPSASS measure is considered good $\alpha > 0.8$, two of the subscales displayed acceptable internal consistency $\alpha > 0.6$, and one displayed poor $\alpha > 0.5$.

Recruitment efforts were made but no psychiatrists participated in this study. This limited the sample to providers who did not prescribe medications, thus hypothesis 3 was unable to be discussed. Another limitation of this study is the relatively small sample size. While N=11 participants for the qualitative portion of this study was appropriate, a sample size of N=31 for the quantitative measures may suggest low statistical power. Additionally, this study focused on specific rural communities in northwestern Kentucky and southern Indiana, findings should not be generalized to other populations.

Future studies may way to expand on the qualitative research to include more specific questions. Future studies may also want to include questions regarding mental health provider's respective trainings and the methods of those trainings (i.e., modules). Researchers may ask providers if they are required to complete Continuing Education Units (CEUs) and if so, whether providers can choose the topics or are there topics that are required? Future studies may want to recruit a larger sample size with psychiatrist participation so medication differences among patients can be explored.

Lastly, but most importantly, future research should include input from minority groups. Perspective from mental health providers with different cultural backgrounds may further our understanding of cultural training needs. It is critical to note that as of 2021, 81% of psychologists were white, 8% Hispanic, 5% black, 3% Asian, .13% American Indian or Alaskan native, and .03% native Hawaiian or Pacific islander (American Psychological Association, 2021).

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Appendix A - Measures

Semi-Structured Interview

Mental Illness

1. What diagnosis is most prevalent in your field?
2. What diagnosis has been the most challenging?
3. What diagnosis do most recurring patients have?
4. What treatment is recommended for someone with depression?
    a. What does their prognosis look like?
5. What treatment is recommended for someone with schizophrenia?
    a. What does their prognosis look like?

Resources

1. How often do patients report limited social support?
2. Is there a diagnosis often associated with less social support when compared with others?
3. Is it challenging to work with patients who have limited social support?
    a. With patients who have limited support, how will their prognosis compare with those who have more consistent support?
4. Do you feel your community has the resources it needs to appropriately treat mental illness?
    a. What recommendations do you have to improve treatment of mental illness?
5. What training needs do you think is required for working with Black patients?
    a. White patients?
    b. What about for working with other races?

Demographics

1. Do you believe where one grows up has an impact on mental illness? For example, someone growing up within a rural community compared to an urban community.
2. How diverse is the population that you currently work with?
    a. For example, for every 10 patients you have, how many are white? How many are black? How many are non-black/non-white?
3. Does race have an impact on mental illness? How so?
    a. Is there a diagnosis that is more prevalent in one race when compared to another?
    b. Does severe mental illness impact one race more than another?
4. Does race impact treatment response? That is, is there a recommended treatment for one race and something different for another race with the same diagnosis?

a. What treatment might you recommend for a black male with schizophrenia
b. What treatment might you recommend for a white male with schizophrenia
c. What treatment might you recommend for a black male with depression
d. What treatment might you recommend for a white male with depression

Mental Health Provider Self-Assessment of Stigma Scale (MHPSASS)

Please answer the following questions using the scale below:

> 1– Strongly Disagree 2 – Disagree 3 – Somewhat Disagree 4 – No opinion 5 – Somewhat Agree 6 – Agree 7 – Strongly Agree.

1. It's hard not to sometimes be irritated with patients who have serious mental illnesses. ______
2. When my patient's family calls too many times, I can become irritated. ______
3. Even though I try not to, I can sometimes be impatient with my patient. ______
4. If a patient is behaving in an annoying manner, I find that I am less likely to return their calls. ______
5. Sometimes, I wish my patient would hurry up when speaking with me. ______
6. Because I sometimes find it hard to hide my irritation, I can be short with my patients. ______
7.When a patient isn't trying hard enough in their recovery, I may not go out of my way to help them. ______
8. When a patient calls me too often, I get irritated with their neediness. ______
9. When I review treatment options with my patient, I find myself sometimes emphasizing what I would prefer, setting aside the other options available. ______
10. When families ask if their loved one will achieve common life goals, I may try to minimize expectations, so they aren't disappointed. ______
11. When a family member of a patient diagnosed with a serious mental illness asks if their loved one will ever get better, I try to minimize their expectations, so they aren't disappointed. ______
12. My patient's treatment plan may not reflect their goals, but rather goals that I think are realistic, to make sure they are successful in achieving these goals. ______
13. If I think my patient would benefit from a particular service, I find myself continuing to suggest this to them, even if they've declined. ______
14. When a patient of mine is not taking prescribed medication, they are probably resistant to being treated. ______
15. Patients with serious mental illnesses have a hard time making good choices for themselves, so service providers need to help them. ______
16. If a patient is relapsing with symptoms of mental illness, there is likely some part of their treatment plan they haven't been following. ______

17. My patient, diagnosed with a serious mental illness, will probably always need to take medication to function. ______
18. In some instances it may be necessary to make decisions for my patient, without their collaboration, for their own good. ______
19. When my patient is very symptomatic, I sometimes do not need to fully explain my actions to them. ______
20. In the past, I have occasionally made reference to a patient using a diagnostic label they have,
instead of their name. ______

Demographics Survey

Directions: Answer each of the following questions

1. Age: ______

2. Biological sex assigned at birth (circle one):

   Male Female

4. How do you prefer to identify your gender?__________________

5. What is the highest level of education you have completed?

   ______ High school

   ______ Some college

   ______ 2-year college degree

   ______ 4-year college degree

   ______ Advanced degree (e.g., Masters or Doctoral degrees)

   ______Medical degree (e.g., Psychiatrist or M.D.)

6. What year did you graduate? ______

7. What is your current job title? ______

8. What is the primary population you work with? ______

9. What percentage of your patients are black? ______

10. What percentage of your patients are white? ______

11. What percentage of your patients are non-black/non-white? ______

12. Were you born in the United States?

    Yes No

13. If you were not born in the United States, where were you born? _____________
14. If you were not born in the United States, at what age did you move here? ______
15. Is English your first language? ______
16. If English is not your first language, at what age did you start speaking English fluently? ______
17. Please indicate your ethnicity by checking the appropriate description:
    - ______ American Indian or Alaskan Native
    - ______ Asian or Pacific Islander
    - ______ Black, not of Hispanic origin
    - ______ Hispanic or Latino
    - ______ White, not of Hispanic origin
    - ______ Other

18. What is your religious preference?
    - ______ Protestant Christian
    - ______ Roman Catholic
    - ______ Evangelical Christian
    - ______ Jewish
    - ______ Muslim
    - ______ Hindu
    - ______ Buddhist
    - ______ Atheist
    - ______ Agnostic
    - ______ Other

19. What is the total yearly income (in US dollars) for everyone in your household put together? (If you are a dependent of your parent(s), select their household income.)

    ______ Less than 10,000
    ______ 10,000-14,999
    ______ 15,000 – 24,999
    ______ 25,000 – 34,999
    ______ 35,000 – 49,000
    ______ 50,000 – 74,999
    ______ 75,000 – 99,999
    ______ 100,000 – 149,999
    ______ 150,000 – 199,999
    ______ 200,000 or more
    ______ Don’t know

20. How would you describe the area that you identify with (e.g., your hometown, or where you have spent most of your life)? (Please choose one)

    ______ Rural (2,500 or fewer residents)
    ______ Small town (more than 2,500 but fewer than 20,000)
    ______ Town/small city (20,000-100,000 resident)
    ______ Large city (more than 100,000 residents)

21. Has someone you known been treated for mental health concerns?
    a. If yes: (Click all that apply) Friend
       Family Co-worker

    b. What was the treatment? (Click all that apply) medication
       therapy

both

unknown

22. Have you been treated for mental health concerns?
    a. Yes or No

    b. If yes, what was treatment? (Click all that apply)

       medication

       therapy

       both

    c. What is the status? (Click all that apply)

       Completed

       Ongoing

       Partial No

23. Have you ever been formally diagnosed with a mental disorder? That is, has a mental health professional ever told you that you have a mental disorder? ______

    What was the diagnosis? (As far as you remember) ____________

24. Has someone close to you ever been formally diagnosed with a mental disorder? ______

    If yes, circle all that apply: Friend Family Coworker

    What was the diagnosis? (As far as you remember) ____________

25. In your opinion what challenges are unique to Indiana/Kentucky for mental health providers and the mental health population? ____________

Appendix B - Qualitative table

Rural Mental Health Provider's Perspective

Theme	Sub theme	Specifics	Provider quotes
Diagnosis			
	Challenging		
		Borderline personality	"a lot of those [individuals diagnosed with borderline personality disorder] patients…tend to be what we would call like alumni, frequent flyers, whatever, like they're kind of in and out of treatment and everything. So, I mean, that can get kind of hectic and trying to get them the right resources and the right treatment and everything too."
		Bi-polar	"When people are hypomanic or particularly irritable and kind of pressured speech, it's really difficult to interrupt them and kind of redirect them. And my primary focus is information gathering. So, it requires a lot of redirection and interruption"
			"Believe it or not, that one [bipolar disorder] comes up a lot. And there's a lot of confusion between our team in terms of medication management."
		Schizophrenia	"Those people [individuals experiencing psychosis or schizophrenia] on the unit tend to be a lot more difficult because they may have erratic or agitated or aggressive behavior."
Treatment			
	Depression		"We use CBT for, I mean, we do some other things on the side, but mostly CBT."
			" CBT is like the typical go to, which I mean is a lot of what we do here as well. So, I would say that's probably your typical treatment route that most people would take"
			"Usually it's cognitive behavioral therapy, some variation of behavioral activation techniques and different techniques to improve awareness of the cycle of negative thoughts"
			"I would say most evidence based is cognitive behavior therapy and potentially paired with pharmacological intervention"
			"Depends on how severe the depression . . . therapy is a great place to start."
			"We use evidence-based treatment models. We use AAC, we use DDT. Several of our clinicians are trained in Neurofeedback as well as Emdr"

		“I use behavioral activation kind of my go to and then kind of coupled with CBT.”
		“We typically utilize cognitive behavioral therapy.”
	Schizophrenia	“Typically, that would be medication”
		“Treatment for schizophrenia usually is medication management. And then you can do like skills building, whether it be social skills and different types of coping skills on how to like not to get hospitalized or arrested.”
		“I would say pharmacological intervention, first and foremost. Potentially therapeutic intervention as well.”
		“That's not something that we can cure…compliance with medications is huge…and then support from like the community, um, because a lot of them [individuals with schizophrenia]…they're either homeless or they live in group home and things like that.”
		“Primary treatment is going to be an antipsychotic of some kind and that is really kind of dependent on their presentation.”
		“Medications, typically long acting injectables, would be our preferred for schizophrenia.”
		“a mixture of medication, supportive network of people around them is probably the best bet”
		“Reality testing, stabilization, and medication management.”
Prognosis	Depression	“If [patients] they are able and willing to cooperate, then I think there's a good prognosis for at least improvement.”
		“ I would say it's pretty it's pretty good”
		“Depends on how long they've suffered with it [depression]. Um, I mean, it is treatable, but the more chronic cases are problematic because, um, they have a lot of stories about how they can't do certain things.”
		“I would say within 6 to 8 weeks I would start seeing improvement after if they're consistently coming and dedicated to getting help”
		“ People usually respond to treatment pretty well as long as they're compliant.”
	Schizophrenia	“Their [schizophrenia] prognosis is much poorer and typically have multiple recurrences of symptoms throughout their life and just don't have a great quality

			of life overall and typically have co-occurring substance use disorders and all of these other things.”
			“[regarding schizophrenia prognosis]… You take eight steps forward to take 14 steps back.”
			“ If they are willing to stay on their medication and the medication continues to work for them, I think that it's a fairly good prognosis . . . it often happens that they don't want to stay on the medication, or the medication stops working for them.”
			“Schizophrenia tends to be one of the more chronic conditions. So even if you have just one psychotic episode, you tend to have the negative symptoms be a little bit more persistent and problematic, but it tends to be one of those more chronic ones.”
			“ they're able to have maybe some quality of life if they're taking their medication, if they have that support, the community support”
			“Their [individuals diagnosed with schizophrenia] prognosis is much poorer and typically have multiple recurrences of symptoms throughout their life and just don't have a great quality of life overall and typically have co-occurring substance use disorders…”
			“Pretty pervasive…they can be non-compliant with medication.”
			“Some [individuals diagnosed with schizophrenia] are more receptive to what we can offer than others.
Social Support			
	Limited		
		Depression	“Because they tend to isolate themselves from their support”
		Substance use disorder	“they've alienated all of their social support.”
		Serious mental illness	“Borderline personality disorder” “schizophrenia” “Psychosis”
	Challenges	Lack of resources	“When is somebody going to feel the most depressed when they don't have adequate housing, when they don't have adequate income, when they don't have adequate support in their life, that's when their symptoms recur. That's when they feel stressed. That's when they feel down on themselves”

			“One major trend we've seen with residential treatment is that there is nowhere for these [patients] to go [once treatment is complete]… so we have long haulers.”
			“We have a very common denominator of history of trauma…associated with being removed from the home and things like that.”
		High risk of relapse	“You don't know if they’re taking their medication, if they're having suicidal thoughts ... it's very challenging because you feel…like your job is not done, like something is not finished... it's challenging because… it's the high risk of relapse. They don't have that support. And… it's basically out of your control, out of your supervision. So, anything can happen.”
			“That's a difficult thing to do… to strengthen social support because there's a reason that they [patients] don't have it”
	Prognosis		“Probably terrible . . . the better the support system, the more successful you're going to be regardless. I mean, and honestly, like, I mean, even without putting much effort into treatment yourself, like I feel like that's a big component of it.”
			“It is challenging, especially like so limited social support and particularly with individuals with serious mental illness. It becomes problematic because you don't even have the support to get them to the hospital to stabilize them…They're less likely to be successfully treated, unfortunately.”
			“I want to say like a night and day difference I want to say like a night and day difference [between individuals with support and without], because if you have that family support, if you have that good support system, you can overcome anything…It's as powerful as therapy. It can be as powerful as, you know, putting someone on medication.”
			“Outcomes would be less favorable [for individuals with limited social support].”
			“While their prognosis can be good, I do think that our [patients] with less support and resources do struggle a lot more”
			“… it takes them a lot longer. I would see them as a much longer-term client than I would someone who does have good social support because that's a really strong protective factor.”
			“I do find that lack of support…worsens prognosis.”
Race			
	Discrimination		

"I think more severe diagnoses and like if there's ADHD and like a black child and a white child that the white child might get ADHD and the black child gets like the gets a conduct disorder"

" Even schizophrenia and severe bipolar. There's higher incidences of that getting diagnosed in particularly black male, cisgender male populations than white, but don't know if that's our . . . that's probably our fields biases."

"I would say black individuals tend to get more intense diagnoses such as schizophrenia than other demographics. So, when we see somebody making the same complaint and they're black, you tend to go to schizophrenia."

"Discrimination definitely exists and need to be addressed"

"There has to be really strong addressing of racial disparity, of systemic racism and how, you know, being the sad black boy or the angry black boy can affect you, but also, like, statistically, how the world is not going to be the best for you…"

"Certain races are more likely to be treated differently based on their environment…an African American client who grows up in a more rural community might grow up getting kind of more ostracized and made fun…which I think could have an impact on their mental health."

"Anecdotally I feel like I see…indications of probably drug use during pregnancy more in the black population and more indication of alcohol use during pregnancy in the white population… I think when you tie all that together…we have unfortunately these stereotypes that are confirmed to be true in some instances, we do see that different races have different types of mental health difficulties for a variety of reasons."

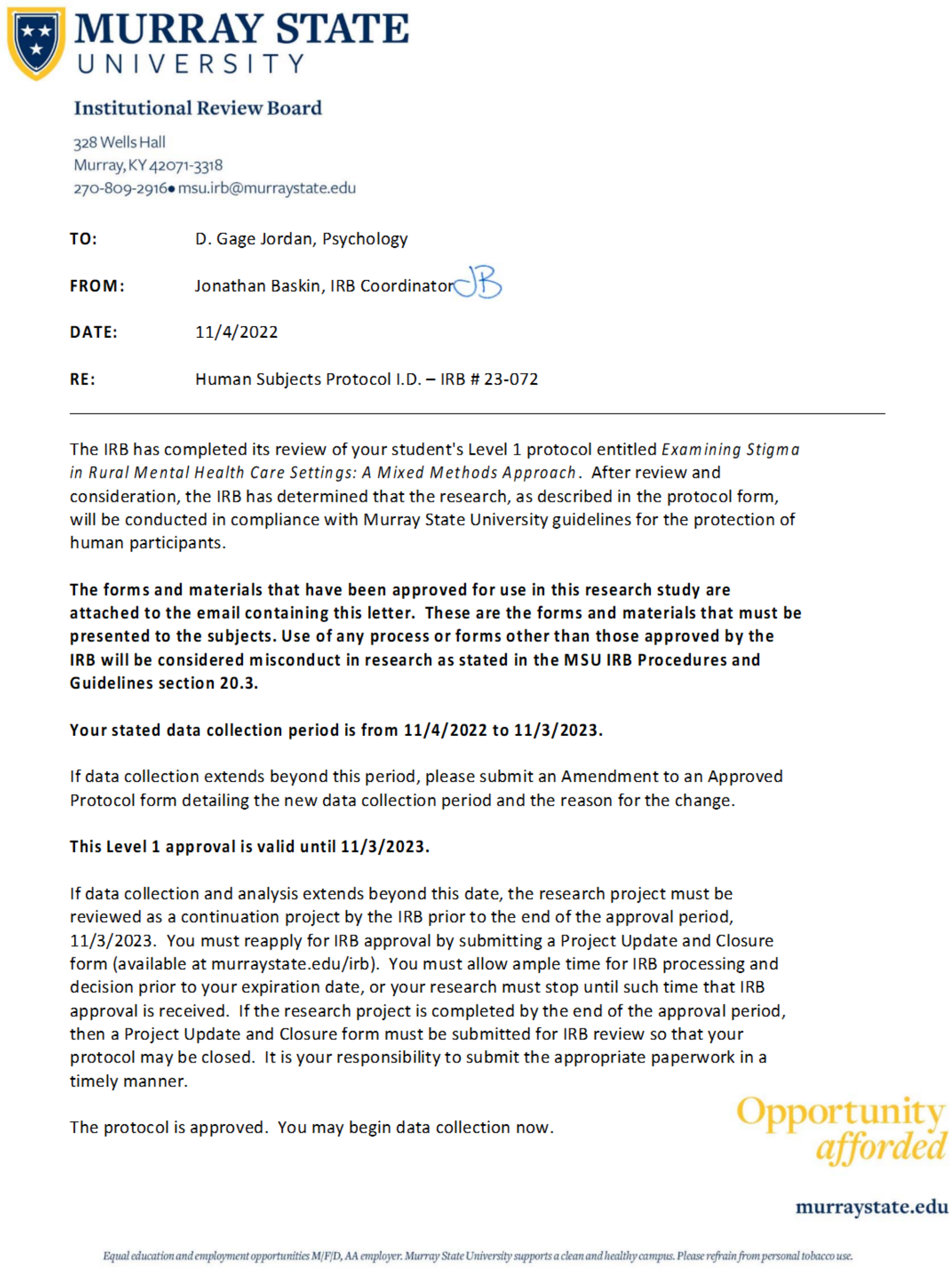
"There is a lot more antisocial and narcissistic personality disorder diagnosis in the black community, but I feel like that's because there is a cultural misunderstanding…I think that sometimes people can be viewed as narcissistic when in fact they've been taught to be a certain way, and that's very culturally driven."

"I see delusional disorder more often in the black population"

	Cultural differences	Representation	“Some cultures can be very sensitive to like how you talk to them…let's say for, for instance, and I've seen this a lot…a white person treating a black person, a black person is not going to respond well to their treatment. But if you put a black patient with a black doctor, they will…I'm not sure if it's the attitude of the or if it's the misconception…But I've seen that conflict a lot.”
			“Encouraging and supporting providers of color… more individuals of color in the field”
			“ People of other races are more inclined to be a lower socioeconomic status and therefore going to have a higher incidence of mental health problems.”
			“We have a lot of techs on the unit that are African American…advocating for the [patients] to…let them do their hair because having braids or having locks…these are things that improve self-esteem, and we shouldn't be like trying to limit.”
			“I think with what I have witnessed, it's more so about the therapist client bond.”
			“ I think that being culturally sensitive can impact how we might present something or how we might go about interacting with someone”
Geographic area			
	Rural		“I feel like it's just rural and, you know, everyone is. Set in their ways. And, you know, a lot of patients that I talk to a lot, unfortunately, a lot of their family just thinks that, oh, you know, you should just be able to just get over it, like just be happy.”
			“Speaking to a rural community [the needs] in general, it's it's access…I think that it starts with university training programs, right? That are able to attract and produce mental health professionals, certify and train them, um, to be able to then go out into our smaller, more rural secluded communities and provide those services...I think also along with university-based training programs comes education and advocacy almost probably...is going to reduce stigma in any community as well.”
			“I think people [in rural communities] have a little bit more of a difficult time admitting that there may be something that they do need help with. So, I feel like they reach out a little bit less.”
			“ [patients] from rural areas, tend to need more psychoeducation to understand what is bipolar…They just haven't been exposed much because there's not much services in their areas.”

Recommendations	“We need more funding focused on preventative programs rather than reactive programs… that would allow for more interdisciplinary collaboration”
	“University training programs”
	“More community-based clinics”
	“Medication management.”
	“Having more providers available would be a good start and a realistic place to start.”
	“Primary care providers…knowing their resources and actually being able to utilize them more appropriately, [primary care providers] having a better understanding of, um, medication management for psychiatric disorders”
	“The primary care that people do have access to for those individuals [primary care provider] to have better training and greater comfort with treating and or diagnosing and treating mental illness beyond…depression”
	“If there were a lot more support services for families, especially families that have those limited finances. Transportation has been actually a pretty big barrier…technology is a big barrier”
	“ Internet and the media has had a lot of influence on the number of clients that we see…it's mostly just them saying, well, everyone could go to therapy… there aren't enough therapists to go around here. So, there are people with more severe mental illness that are on that wait list”
	“If they [patients] self-medicate, for example, they're going to go back to prison as opposed to get mental health care. So, I think there needs to be an intersect between the judicial system and the mental health system and we need more available mental health care, especially in rural communities.”

Appendix C – IRB Approval Letter



MURRAY STATE
UNIVERSITY

Institutional Review Board

328 Wells Hall
Murray, KY 42071-3318
270-809-2916● msu.irb@murraystate.edu

TO: D. Gage Jordan, Psychology

FROM: Jonathan Baskin, IRB Coordinator JB

DATE: 11/4/2022

RE: Human Subjects Protocol I.D. – IRB # 23-072

The IRB has completed its review of your student's Level 1 protocol entitled *Examining Stigma in Rural Mental Health Care Settings: A Mixed Methods Approach*. After review and consideration, the IRB has determined that the research, as described in the protocol form, will be conducted in compliance with Murray State University guidelines for the protection of human participants.

The forms and materials that have been approved for use in this research study are attached to the email containing this letter. These are the forms and materials that must be presented to the subjects. Use of any process or forms other than those approved by the IRB will be considered misconduct in research as stated in the MSU IRB Procedures and Guidelines section 20.3.

Your stated data collection period is from 11/4/2022 to 11/3/2023.

If data collection extends beyond this period, please submit an Amendment to an Approved Protocol form detailing the new data collection period and the reason for the change.

This Level 1 approval is valid until 11/3/2023.

If data collection and analysis extends beyond this date, the research project must be reviewed as a continuation project by the IRB prior to the end of the approval period, 11/3/2023. You must reapply for IRB approval by submitting a Project Update and Closure form (available at murraystate.edu/irb). You must allow ample time for IRB processing and decision prior to your expiration date, or your research must stop until such time that IRB approval is received. If the research project is completed by the end of the approval period, then a Project Update and Closure form must be submitted for IRB review so that your protocol may be closed. It is your responsibility to submit the appropriate paperwork in a timely manner.

The protocol is approved. You may begin data collection now.

Opportunity
afforded

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