

The Perceived Stigma of Mental Health Services Among Rural Parents of Children With Psychosocial Concerns

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Abstract

Objective To examine parents' perceptions of stigma regarding mental health services for their child, consider stigma in the context of novel service delivery settings (e.g., telehealth, primary care, and schools), and evaluate stigma with other factors known to influence service access. **Methods** 347 caregivers of children with psychosocial concerns completed surveys regarding their perceptions of stigma, service delivery settings, and barriers to care. **Results** Parents endorsed low levels of stigma around services. Greater perceived stigma was related to less willingness to seek services in a mental/behavioral health center or schools but not in other settings, even when other barriers were considered. Having a younger child and a history of prior services was associated with greater willingness to seek services. **Conclusions** Stigma does appear to present as a barrier, but only for some parents. Providing mental health services to young children and their parents in some nontraditional settings may increase access.

Key words: integrated care; rural mental health; school mental health; stigma; telehealth.

Access to effective mental health treatments is limited in rural areas, where barriers include provider shortages (Wagenfeld, 2003), financial concerns such as inadequate insurance coverage problems with travel and transportation (Fox, Merwin, & Blank, 1995), and beliefs about the appropriateness of mental health treatment including the stigma surrounding it (Jameson & Blank, 2007; Mukolo, Heflinger, & Wallston, 2010). Of these, stigma around mental illness and service-seeking is often cited as a top barrier for those in rural communities owing to their characterization as having strong social support networks, conservative values, and a general lack of privacy (e.g., word travels fast, everybody knows everybody; Bray, Enright, & Easling, 2004).

The only empirical studies examining rural individuals' perceptions of stigma surrounding mental health services have focused on adults. One study showed that residents in rural Appalachia cited stigma as a barrier to treatment more often (28%) than those in a comparison sample outside the region (22%; Appalachian Regional Commission and NORC, August, 2008). In another study, Hoyt, Conger, Valde, & Weihs (1997) found that adults in rural areas perceived more stigma around mental health services than their urban counterparts (e.g., anticipated embarrassment if the community were to find out). Importantly, greater perceived stigma was associated with less willingness to seek services.

Stigma as a Barrier for Rural Children's Services

Recently, more attention has been focused on perceptions of stigma around children's mental illness and mental health services (see Mukolo et al., 2010 for a review). The National Stigma Study—Children (NSS-C) was the first large-scale survey of adults' beliefs about child mental health concerns. In sum, studies from the NSS-C demonstrated that the public holds stigmatizing views about children with behavioral problems and those who are seeking treatment (Pescosolido, Fettes, Martin, Monahan, & McLeod, 2007). The NSS-C did not, however, directly assess perceptions of stigma held by parents with ongoing concerns about their *own children's* behavior. This is important because these parents may be making choices about seeking mental health services. Moreover, the study did not explicitly evaluate a rural sample.

Thus, at least three gaps are evident (Mukolo et al., 2010). First, prior work has focused on the stigma surrounding mental health concerns in children (e.g., depression, attention deficit/hyperactivity disorder), but not on the perceived stigma *about seeking services*, particularly psychosocial treatments with a psychologist, counselor, or therapist. We argue that perceived stigma about the services themselves may represent beliefs more proximal to the decision to seek services, with implications for developing service delivery mechanisms in rural areas. Second, prior work did not specifically target *parents of children with mental health concerns*. For these individuals, stigma around service-seeking may be more currently and personally relevant, directly and practically impacting actual decisions about getting help. Finally, prior work has not focused on stigma among *rural* parents. As described above, widespread claims that rural residents are particularly stymied by stigma are supported by only a few studies using adult samples. This study was the first to address these gaps.

As researchers have focused on the dissemination of empirically supported treatments, they have begun to consider factors such as stigma that influence community-level service delivery. One strategy for combating the effects of stigma on access to mental health services is to use service delivery settings that may not be associated with the stigma of mental illness. For example, integrating mental health services into primary care may have the advantage of increasing confidentiality in rural areas; with this change in location, those seeking treatment do not have to worry about members of the community noticing their motor vehicle parked outside the mental health center. Other emerging settings for providing mental health services include telemental health (e.g., mental health services delivered by two-way videoconferencing) and school-based mental health (e.g., specialty mental health

services available in the school). A review of the literature supporting telepsychiatry showed a growing body of empirical support, with 63 studies published in the 30 years between 1970 and 2000, but another 68 published within the subsequent 3 years (Monnier, Knapp, & Frueh, 2003). Likewise, a growing body of literature supports the integration of mental health services into the schools (e.g., Rones & Hoagwood, 2000). It is unknown, however, to what extent these settings might be perceived as stigmatizing in the context of accessing mental health services.

Individual and Family Factors Influencing Access

Although stigma may be a leading barrier to care among rural individuals, many factors influence an individual's decision to access mental health services. Thus, the extent to which perceived stigma functions as a barrier is best assessed using a comprehensive conceptual model. This study draws on the Behavioral Model of Health Services Use (Andersen, 1995), integrating three categories of established factors influencing service utilization and outcomes at the individual and family level (Lunn et al., 2011). First, *predisposing characteristics* are those linked to the likelihood of using services, determined by previous research or theory. Second, *need characteristics* reflect the reasons for the service and have been described as the most powerful predictor of service use. Finally, *enabling characteristics* are those that either support or pose barriers to service use. Stigma, an enabling characteristic and the focus of this study, has been shown to be a powerful deterrent to service use, as discussed above.

Present Study

The present study addressed three aims. The first was to examine rural parents' perceived stigma around seeking mental health services for their children. We assessed stigma using a new, empirically validated measure that taps parents' perceptions of the public stigma around seeking mental health services for their children (Williams & Polaha, 2014), and is based on prior conceptualizations of public stigma (e.g., Corrigan, 2004). Second, we aimed to examine the associations between perceived stigma and parents' willingness to seek mental health services for their children in traditional versus nontraditional mental health service settings (e.g., integrated primary care, school health, and videoconferencing). We hypothesized that rural parents who viewed mental health services as stigmatizing would be less willing to seek services in traditional (i.e., mental/behavioral health center, private practice) than nontraditional service settings. Third, we aimed to examine the relative contribution of stigma as a barrier to seeking care from

various service delivery settings in the context of predisposing, need, and enabling characteristics known to influence service seeking at the individual/family level.

Method

Participants

Participants were 347 parents (biological, step, adoptive, or foster) of children aged 4–16 years whose ratings of their child's behavior were in the borderline to significant range on the Pediatric Symptom Checklist (PSC; Jellinek, Murphy, & Burns, 1986). We included borderline scores in an attempt to capture participants with a broader range of prior mental health service experiences as well as more variable ongoing concerns and attitudes about pursuing treatment. The participants were mostly mothers of the targeted child (79.8% vs. 7.8% fathers, 12.4% “other” such as grandparent), White (94.2% vs. 2.9% Hispanic, 0.6% Black, 0.6% Asian, and 1.6% other race), and had at least a high school education (88.7% mothers, 74.1% fathers). The children were predominantly male (57.9%) with a mean age of 9.21 years ($SD = 3.43$, range = 4–16) and a mean PSC score of 28.87 ($SD = 7.72$, range = 20–54).

Procedure

All study procedures were approved by the East Tennessee State University's institutional review board. A two-part procedure was employed. First, research assistants approached parents attending a visit with their child at one of eight primary care clinics in rural Appalachia (i.e., southwest Virginia and northeast Tennessee) and provided a brief overview of the study along with a letter of consent (waived written consent) and a screening measure. The screening consisted of a demographics questionnaire and the PSC (Jellinek et al., 1986). This procedure was conducted daily for 4–8 weeks at each site. The number of weeks at each site varied in an effort to recruit an equal number of participants from small- and large-sized practices. In total, 2,672 parents completed screeners. Of these, 727 (27.2%) were identified for the second part of the study because their child scored in the borderline to significant range on the PSC (total score ≥ 20).

Second, we contacted eligible parents by telephone to describe the full study. Those interested were mailed a survey packet to return by mail, which included another letter of consent. Of the 727 parents initially identified through screening, 156 were unreachable by telephone, 113 declined to participate, 105 agreed to participate but did not return the packet, and 6 had more than four items missing on the PSC, yielding an overall response rate of 47.7%. There were some significant differences between the parents who completed the full study ($N = 347$) versus

those who were unreachable, declined, or did not return the measures. Full study participants had slightly younger children than nonparticipants ($M = 9.13$ years vs. $M = 9.73$ years, $t(723) = 2.33$, $p < .05$), higher scores on the PSC ($M = 28.87$ vs. $M = 27.56$, $t(708) = -2.23$, $p < .05$), and previously talked with more professionals about their child's behavior problems ($M = 3.04$ vs. $M = 2.72$, $t(725) = 3.17$, $p < .05$). Participants did not differ significantly in terms of child gender, parent education, or race/ethnicity.

Measures

As mentioned above, the Behavioral Model of Health Service Use based on areas of emphasis established in the health services literature. Specifically, predisposing characteristics targeted in this study included the demographics of age, race, and education (Andersen & Aday, 1978). We used mother's education, as is typical in pediatric research (e.g., Cook et al., 2004). In addition, a child's previous use of mental health services has been shown to increase the likelihood of future service use (e.g., Jones, Heflinger & Saunders, 2007) and, thus, was included as a predisposing characteristic. Need characteristics reflect the reason for service use; we assessed the child's psychosocial functioning via the PSC (Jellinek et al., 1986) and “caregiver strain,” which refers to the negative and emotional impact on families caring for a relative with special needs and is a powerful predictor of service-seeking (Brannan, Heflinger, & Bickman, 1997). Enabling characteristics targeted in this study include rurality, perceived barriers to care (Brannan & Heflinger, 2006), and perceived stigma of mental health services (Williams & Polaha, 2014).

Pediatric Symptom Checklist

The PSC (Jellinek et al., 1986) is a screening instrument designed to identify psychosocial concerns among parents of children aged 4–16 years presenting to primary care settings. It consists of 35 statements (e.g., “Complains of aches and pains,” “Spends more time alone,” and “Distracted easily”) to be rated by the parent as occurring *never* (0), *sometimes* (1), or *often* (2). A total score of ≥ 28 (for children aged 6–16 years) and ≥ 24 (for ages 4 and 5 years) is considered clinically significant (Jellinek et al., 1986). In the present study, a “borderline” score of ≥ 20 was used to attempt to capture a more variable sample. The PSC is considered to be valid and reliable (Jellinek, Murphy, & Robinson, 1988) with strong internal consistency (Murphy et al., 1996). For this study, the total PSC score demonstrated strong internal consistency ($\alpha = .85$).

Demographics

These questions included: (1) the respondent's relationship to the child (mother, father, or other), (2) the

child's age in years, (3) the child's gender, (4) race/ethnicity, (5) mother education (did not complete high school, high school, 2 years college, ≥ 4 years college), (6) county of residence, and (7) parent name and telephone number. County of residence was coded using Rural-Urban Continuum Codes (RUCC; [Economic Research Service, 1999](#)). RUCC are a classification scheme differentiating metropolitan and nonmetropolitan counties. Codes range from 1 to 9, with "1" being most metropolitan and "9" being most rural counties.

Parents' Perceived Stigma of Service Seeking

An 11-item subscale of the Parents' Perceived Stigma of Service Seeking (PPSSS) was used to measure public stigma (e.g., "some people might look down on me"; "my child's teacher would treat him or her unfairly"; "I would be worried that people in town would find out") perceived by parents about seeking mental health services for their children ([Williams & Polaha, 2014](#)). Statements were rated on a 6-point scale (1 = *strongly disagree*, 6 = *strongly agree*). Prior research supports the instrument scores' validity and reliability ([Williams & Polaha, 2014](#)). Internal consistency in the present study was strong ($\alpha = .93$).

Prior Services

To assess previous service seeking, parents responded to one item: "Some parents who are concerned about their child's behavior or emotions talk about that concern with a counselor, therapist, or psychologist. Have you ever talked about concerns you have about your child's behavior or emotions with a counselor, therapist, or psychologist?" Prior treatment seeking was coded as 0 (*yes*) or 1 (*no*).

Service Seeking—Places

This measure was designed to assess parents' willingness to seek services for their children in traditional versus nontraditional service delivery settings. Specifically, six items assessed parents' willingness to seek help from a mental health professional working in the school, church, doctor's office, videoconferencing, private practice, and "a center designed to provide mental/behavioral health services." These six locations were selected to represent both traditional and nontraditional delivery settings where mental health services are already delivered in some communities (i.e., real-world models). Parents rated their level of agreement with each statement (e.g., "I would be willing to see a counselor, therapist or psychologist working in the given setting") using a Likert scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*).

Barriers to Getting Help for My Child

This index consists of 13 dichotomous items (0 = *no*, 1 = *yes*) that caregivers may face when they seek

services for their child ([Brannan & Heflinger, 2006](#)). Examples include long waitlists, lack of financial resources, provider shortages, and a lack of knowledge about where to seek help. Parents endorsed all items they perceived as barriers and the sum was calculated. Internal consistency was not assessed, as this measure was an index rather than a scale.

The Caregiver Strain Questionnaire

The Caregiver Strain Questionnaire (CGSQ) is a 21-item self-report instrument asking caregivers to report on the impact of caring for a child with emotional and behavioral problems ([Brannan et al., 1997](#)). Caregivers are asked to use a 5-point scale from 1 (*not at all*) to 5 (*very much*) to report how much of a problem each occurrence was in the past 6 months owing to the child's behavior. The measure includes domains such as disruption of relationships, demands on time, negative health effects, and financial strain. The CGSQ has demonstrated reliability and validity ([Brannan et al., 1997](#)) with good internal consistency and construct validity across multiple studies ([Brannan & Heflinger, 2006](#)). Internal consistency for the caregiver strain scale in the present study was strong ($\alpha = .92$).

Analysis Plan

To assess the first study aim examining rural PPSSS for their children, descriptive analyses were conducted on PPSSS scores. The second aim examining the relation between perceived stigma and parents' willingness to seek mental health services for their children across service settings was assessed using bivariate correlations. The third aim was assessed using hierarchical regression analyses. Specifically, to assess the relative contribution of parents' perceived stigma to their willingness to seek services for their children in the context of other variables, we conducted a hierarchical multiple regression with predisposing factors (prior treatment, child age, parent race/ethnicity, and education), need factors (PSC score and caregiver strain), and enabling factors (barriers and rurality) entered in the first step, and parents' perceived stigma entered in the second step. Adding perceived stigma incrementally allowed for determination of stigma's unique role in explaining parents' willingness to seek services, above and beyond the predisposing, need, and enabling factors already determined to influence service seeking. Separate analyses were conducted using each potential location of services as the dependent variable (e.g., willingness to seek services at a doctor's office was assessed in a separate set of analyses than willingness to seek services at a school).

Results

Aim 1: Perceived Stigma

Descriptive statistics for parents' perceived stigma can be found in [Table I](#). The mean level of public stigma for parents fell below the mid-point of the Likert scale ($M = 2.58$, 6-point scale in which 1 = *strongly disagree*, 6 = *strongly agree*). Thus, on average, parents reported that they "slightly disagreed" or "somewhat disagreed" with the items tapping public stigma around getting mental health services for their child.

Aims 2 and 3: Contribution and Relative Contribution of Perceived Stigma to Parents' Willingness to Seek Treatment

Bivariate correlations revealed that the higher the level of perceived public stigma, the less willing parents were to seek services for their children at all locations (r s from $-.12$ to $-.19$). Next, we assessed the independent contribution of public stigma perceived by parent to their willingness to seek services for children in the context of other predisposing, need, and enabling factors (the third study aim) using hierarchical regression. [Table II](#) depicts results of the two steps (Models 1 and 2). Because the only difference between the two steps was the addition of public stigma, and the findings for the remaining variables were similar at both steps, we present the results for predisposing, need, and enabling factors from the first step only. As shown in Model 2, after accounting for predisposing, need, and other enabling factors, perceived public stigma was uniquely predictive of less willingness to

seek services in school (accounting for 1.4% of the variance) and a mental/behavioral health center (accounting for 2.0% of the variance).

Although not a study aim, [Table II](#) also depicts the independent contribution of predisposing, need, and other enabling characteristics on parents' willingness to seek services for their children. As shown in Model 1, even after all other characteristics are controlled, the more barriers parents perceived, the less willing they were to seek services for their children at church and at a doctor's office. Additionally, the predisposing characteristics of prior treatment and child age were independently associated with parents' willingness to seek services; parents who had sought prior treatment for their children were more willing to seek services for them at all settings except church and videoconferencing, while those with older children were less willing to seek services for their children at school. Finally, the need characteristic of PSC score was uniquely associated with greater willingness to seek services from the child's school.

Discussion

This study was the first to examine perceptions of stigma around mental health services among rural parents with ongoing psychosocial concerns about their children. In addressing our first study aim, we were surprised to find that parents reported relatively low levels of public stigma associated with seeking services for their children. This finding is inconsistent with prior research with adults ([Hoyt et al., 1997](#)) as well

Table I. Descriptive Data on Main Study Variables Among Parents ($N = 347$)

Variable	Frequency	Percent	Mean \pm SD	Range
Predisposing characteristics				
Prior treatment	225	64.8		
Child's age (years)			9.21 \pm 3.43	4–16
Majority race/ethnicity	327	94.2		
Highest grade of mother education				
Did not complete high school	35	10.1		
Completed high school	134	38.6		
Two years of college	116	33.4		
Four years of college or more	47	13.5		
Need characteristics				
PSC total (all ages)			28.57 \pm 7.80	20–54
Caregiver strain			50.57 \pm 16.15	19–100
Enabling characteristics				
Barriers				
More rural	129	37.2	2.89 \pm 2.15	0–13
Public stigma			2.58 \pm 1.08	1–6
Service seeking				
School			4.42 \pm 1.48	1–6
Church			4.04 \pm 1.59	1–6
Doctor's office			5.10 \pm 1.00	1–6
Private office			5.16 \pm 1.00	1–6
Behavioral health center			4.94 \pm 1.10	1–6
Two-way videoconferencing			3.07 \pm 1.64	1–6

Note. PSC = Pediatric Symptom Checklist.

Table II. Hierarchical Regression Examining Contribution of Public Stigma to Willingness to Seek Services in Various Settings (N = 347)

Model	Predictors	School ^a			Church			Doctor's office			Private office			Behavioral health center ^b			Two way videoconferencing		
		B	SE	β	B	SE	β	B	SE	β	B	SE	β	B	SE	β	B	SE	β
1 & 2	Predisposing characteristics																		
	Prior treatment (ref = yes)	-.55**	0.18	-.18	.11	0.2	.03	-.33**	0.12	-.16	-.37**	0.12	-.18	-.42**	0.14	-.18	.44*	0.38	.06
	Child age	-.07**	0.02	-.15	.01	0.03	.01	-.02	0.02	-.07	-.02	0.02	-.08	-.01	0.02	-.04	-.00	0.03	-.01
	Race/ethnicity (ref = White)	.63	0.33	.1	.78*	0.38	.12	.27	0.22	.07	.03	0.23	.01	-.10	0.25	-.02	.44	0.38	.06
	Mother edu—DNCHS	-.24	0.27	-.05	.06	0.3	.01	.04	0.18	.01	.05	0.19	.02	-.22	0.2	-.06	-.12	0.31	-.02
	Mother edu—2 yr	-.24	0.18	-.08	-.03	0.2	-.01	-.14	0.12	-.07	-.03	0.13	-.02	-.03	0.14	-.01	.35	0.21	.1
	Mother edu—4 year or more	-.52*	0.25	-.12	.09	0.28	.02	-.25	0.17	-.09	.05	0.17	.02	-.03	0.19	-.01	.25	0.28	.05
	Need characteristics																		
	PSC total	.04***	0.01	.2	.01	0.01	.05	0	0.01	.01	.01	0.01	.1	.02*	0.01	0.12	.03*	0.01	.12
	Caregiver strain	-.01	0.01	-.10	-.00	0.01	-.04	0	0	.05	0	0	0	0	0	0.05	-.00	0.01	.01
	Enabling characteristics																		
	Barriers	-.04	0.04	-.05	-.14**	0.04	-.19	-.08**	0.03	-.18	-.04	0.03	-.09	-.07*	0.03	-.13	-.08	0.04	-.10
	RUCC (ref = less rural)	.24	0.16	.08	.27	0.18	.08	-.06	0.11	-.03	.09	0.11	.04	-.09	0.12	-.04	-.06	0.19	-.02
1	ΔR^2	.109***			.060*		.080**			.062*		.092***		.063*					
2	Public stigma	-.18*	0.08	-.13	-.10	0.09	-.07	-.06	0.06	-.06	-.08	0.06	-.09	-.16**	0.06	-.16	-.10	0.09	-.07
2	ΔR^2	.014*			.004		.003			.007		.020**		.003					
2	Total R ²	.123			.064		.083			.069		.112		.006					

Note. DNCHS = Did Not Complete High School; PSC = Pediatric Symptom Checklist; RUCC = Rural-Urban Continuum Codes.

^aSignificant effect of stigma for willingness to seek at school (95% CI = -.34, -.02).

^bSignificant effect of stigma for willingness to seek at behavioral health center (95% CI = -.28, -.04).

* $p < .05$, ** $p < .01$, *** $p < .001$.

as the working theory that rural individuals view mental health services as stigmatizing (e.g., Bray et al., 2004; Jameson & Blank, 2007).

There are several potential explanations for this finding. First, there are so few well-designed studies documenting the presence of stigmatizing beliefs around services that it may be that the phenomenon has never been true—or, at least, is not true for parents. Research focused on parents' uptake of child mental health services has provided descriptions of help-seeking patterns and experiences (e.g., Reid et al., 2011), but has not explored the underlying meaning and attributions parents experience in this process; for example, parents may see help-seeking as evidence of "good parenting," outweighing any negative effects of perceived stigma. Second, one of the best-designed studies in this area (Hoyt et al., 1997) was published almost 20 years ago. Since then, there have been numerous campaigns focused on decreasing stigma around mental illness (e.g., "Stomping out Stigma"; Heeney & Watters, 2009), which may have had an impact on decreasing stigma population-wide.

Alternatively, it may be that more sophisticated methods are needed to accurately capture nuanced attitudes around mental health services. Consistent with qualitative studies of adults (Scattolon, 2003), the first author's observations in rural primary care have revealed anecdotal evidence that stigmatizing attitudes are prevalent, especially regarding specific providers or centers. Future studies should incorporate cultural and contextual variables (such as the names of specific services available in that area) and use mixed methods strategies to better capture localized attitudes around services. It is noteworthy that those with lower levels of psychosocial concerns and less prior service history were less likely to participate in this study. This study limitation underscores the need for new strategies to engage those who may shy away from questions about mental health, possibly owing to stigma itself.

Our second aim was to examine the relationship between perceived stigma and parents' willingness to seek services in traditional versus nontraditional settings. Six potential settings were presented to parents: two were conceptualized as traditional (mental/behavioral health center and private practice) and four as nontraditional (school, primary care, church, and telehealth). Overall, parents endorsed a high level of willingness to be seen by a psychologist, counselor, or therapist in all of these settings except telehealth. We hypothesized that, in the absence of other factors related to service-seeking, parents reporting higher levels of perceived stigma would be less willing to seek services in traditional settings. Consistent with this hypothesis and one prior study (Hoyt et al., 1997), results showed that the more stigma parents perceived, the less willing they were to seek services for their children across all settings.

In contrast, recent research with other populations (e.g., college students and rural Australian adults) concluded that perceived stigma had little to no effect on adults' seeking of mental health services (Golberstein et al., 2009; Komiti, Judd, & Jackson, 2006). Owens and colleagues (2002) reported that only 2.5% of urban parents in their study identified stigma as a barrier to seeking mental health treatment for their children in need of services. Our study may provide additional evidence that perceived stigma among rural parents is associated with service-seeking in ways that differentiate this population from others. However, inconsistent methods and measures across studies prevent a definitive conclusion on this point, highlighting the need for future research to replicate findings with rigorous designs and methods.

Our third aim examined the relative contribution of stigma as a barrier in the context of predisposing, need, and enabling characteristics known to influence service seeking at the individual/family level (Lunn et al., 2011). Results showed that, after accounting for these additional characteristics, parents' perceived stigma remained significantly related to less willingness to seek services at a mental/behavioral health center and at their child's school. At the same time, perceived stigma was not associated with willingness to seek services in a private practice, primary care, church, or by telehealth. These findings were consistent with our hypothesis, except that we conceptualized private practice as a traditional mental health setting, and willingness to seek services from a private practice did not appear to be related to stigma after other factors were considered. It may be that rural parents are unfamiliar with this setting (i.e., there are not many private practices in rural areas) and/or the word "private" influences how stigmatizing (i.e., less available to the public) that setting would be.

We conceptualized the school as a "nontraditional" setting in this study and were interested to find that, as with traditional mental/behavioral health centers, parents who perceived mental health service seeking as stigmatizing were less willing to seek services at their child's school, controlling for other predisposing, enabling, and need characteristics. This finding was not surprising, given the very public nature of school settings where concerns about being "labeled" may be greater, perhaps especially in rural areas. These results have particular salience when considered alongside our finding that the older the children were, the less willing parents were to seek services for them at school. These data are consistent with current literature showing that, while parents are satisfied with school-based mental health (Lazicki, Vernberg, Roberts, & Benson, 2008), adolescents report stigma to be a significant barrier to accessing these services (e.g., Bowers, Manion, Papadopoulos, & Gauvreau, 2013). Others have reported that parents who pursue

mental health treatment for their adolescents describe them as embarrassed about getting help and as seeing it as a sign of weakness (Moskos, Olson, Halbern, & Gray, 2007). It certainly stands to reason that as children get older, their own perceptions of stigma would impact parents' willingness to seek services. Future research should evaluate the way in which parent and adolescent attitudes interact to impact care seeking, with particular consideration of the school setting.

One unanticipated study finding was that prior treatment by a psychologist, counselor, or therapist was related to *increased* willingness to accept services across all potential service settings, except for church and telehealth. In addition, parents with younger children endorsed greater willingness to seek services. One interpretation of these results is that developing services in novel settings where there is broad "reach" to younger children may fuel attendance to more traditional service delivery settings over time. This underscores the idea that a "portfolio" of intervention types and settings are necessary for the greatest impact when disseminating treatments (Kazdin & Blase, 2011). The availability of easy-access, brief, or more palatable "low dose" options such as those demonstrated in the primary care behavioral health model (Strosahl, 1998) may increase future commitment to more comprehensive treatment in a wider range of settings. Future research should evaluate how accessing brief treatments in one setting might influence willingness to access services in another setting, especially community mental health.

Limitations

One weakness of this study was the use of surveys that included generalized questions about stigma and willingness to seek services. That is, the wording of the questions may have lacked enough specificity to be meaningful. As discussed above, empirical and anecdotal evidence suggests results may have been different if the questions engaged real-world contexts (i.e., names of actual agencies or organizations in a given community), rather than using general terms for service settings. For example, the study's findings regarding parents' low willingness to access services by telehealth are not consistent with studies showing parents are highly satisfied with telehealth (Jacob, Larson, & Craighead, 2012). Still, if parents respond to these generic descriptions of mental/behavioral health centers, schools, or telehealth unfavorably, it suggests that attention should be paid to how services in these settings can best be presented, marketed, and developed.

Other limitations to this study include our recruitment strategy that (1) identified only parents attending a primary care clinic (i.e., not all rural parents), (2) underrepresented fathers, and (3) resulted in a moderate return rate as discussed above. In addition, our survey strategy limited our results to reported willingness

rather than actual service use and may have lacked some internal validity in that demand characteristics influenced participants' responses. Finally, we lacked family income and health insurance data, a major predisposing characteristic known to influence service-seeking (Cook et al., 2004). Future research should consider these limitations.

A number of potential participants declined to participate or did not return their survey packets. It may be that those participants also perceived more stigma around seeking mental health services for their children and could explain the modest overall level of stigma found in the study. However, as reported above, those who were full participants of the study reported more behavior problems among their children than those who declined. Thus, those who declined to participate may have seen the study as less relevant for them. Further, although the overall level of stigma may be limited by the specific sample, we still found that even modest levels of stigma were linked with less willingness to seek mental health services for children.

Conclusions

This study addresses key gaps in the literature by assessing the effects of perceived public stigma on the willingness of rural parents to seek mental health services for their at-risk children from a variety of traditional and nontraditional services settings. Our findings suggest that, in general, stigma may be less of a factor in rural parents' treatment-seeking decisions than previously suggested, especially in the context of other important predisposing, enabling, and need factors. However, parents who perceive stigma around getting mental health services for their child also report decreased willingness to seek services from mental/behavioral health and schools. Additional research is needed to evaluate how stigma may be more nuanced based on contextual factors (e.g., stigma around a specific community service) and how researchers can study this phenomenon among those who shy away from stigmatizing activities such as mental health services and the research about them. Finally, future studies should use methods from emerging dissemination and implementation research to discover how stigma impacts choices in the context of specific interventions and programming.

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