

# In My Own Words: Exploring Definitions of Mental Health in the Rural Southeastern United States



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The following study assessed the utility of the U. S. Department of Health and Human Services' definition of mental health among participants in the rural Southeastern United States. Using deductive coding, qualitative results revealed that participants do not conceptualize mental health in comprehensive terms. Rather, they tend to describe mental health with a focus on cognition. The sample articulated "well-being" to describe mental health; however, they most often connected it to cognition. The findings suggest that rural communities could benefit from mental health education with a holistic approach and that the use of the term *well-being* provides a pathway for clinical connections. Future research should consider interviewing rural participants to gather more detail on their definitions and understanding of mental health.

**Keywords:** mental health, education, cognition, rural, well-being

Mental illness is a pervasive health care concern in the United States. Even though approximately one fifth of adults experience mental health concerns in any year, only 70% of those in need of mental health services seek care (National Alliance on Mental Illness, 2015). Because of how common and widespread mental health conditions are in the United States, mental health professionals have become increasingly aware that educating the public about mental illness is of utmost importance. *Mental health literacy* (MHL; Jorm, 2012), or the knowledge and beliefs about disorders that assist in the recognition, prevention, or management of a mental health concern, is one way those who are struggling with mental health concerns can manage mental illnesses more effectively. Improving MHL can have the capacity to positively impact negative attitudes, biases, or assumptions that are associated with having a mental illness as well as assist with help-seeking so those who have a mental illness will receive necessary treatment (Crowe, Mullen, & Littlewood, 2018; Jorm, 2012; Kutcher, Wei, & Coniglio, 2016). Researchers have consistently demonstrated that a stigma still exists toward seeking help for mental health concerns and that reducing that stigma is of utmost importance (Kalkbrenner & Neukrug, 2018).

Increasing help-seeking behaviors might best be done through first exploring attitudes and perceptions, as cognitions are closely tied to emotions and behaviors. Therefore, the current study is framed through the theoretical lens of cognitive behavioral therapy (CBT; A. T. Beck, 1970). CBT is based on the notion that how one thinks, feels, and acts are all intertwined. Specifically, one's thoughts impact how one feels and behaves. Because of this, negative or unrealistic thoughts may contribute to psychological distress. When a person feels distressed, the way that they interpret situations may become skewed or distorted, which then impacts their behavior. From the lens of CBT, one's decision to not seek treatment for a mental health concern may be closely tied to the thoughts and feelings they hold about negative associations about mental illness. Counselors who practice from a CBT perspective work with clients to identify and eliminate cognitive distortions in order to minimize painful emotions

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and promote more adaptive behaviors. CBT has been applied to diverse populations and found to be effective with various presenting concerns (A. T. Beck, 1970; J. S. Beck, 2011; Crumb & Haskins, 2017).

Cognitive distortions exist as they relate to having a mental health concern, and researchers have shown that rural residents with mental health concerns fear being negatively labeled, stereotyped, and discriminated against and thus are apprehensive to seek mental health care services (Crumb, Mingo, & Crowe, 2019). Therefore, it is vital that counselors and other mental health providers consider how clients' thoughts, beliefs, experiences, and other contextual factors contribute to their understanding of mental illness. Intentional acknowledgment of the factors that influence clients' perceptions, attitudes, and behavior may enhance treatment efficacy for rural residents (Crumb & Haskins, 2017). Along with exploring negative thoughts related to mental health, researchers also have considered MHL, or one's understanding of mental health, as it impacts behaviors.

## Mental Health Literacy (MHL)

Health literacy researchers suggest low health literacy is related to a number of negative health outcomes, including higher instances of chronic illness, lower usage of health care programs, higher costs of health care, and premature death (Baker et al., 2007; Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011). The World Health Organization (WHO; 2013) posits that health literacy is more important than demographic factors (e.g., income, employment, status, education, race, ethnicity) as they relate to health status. Perhaps because of this, the importance of health literacy is well established in the health professions.

In a 2011 literature review on health literacy outcomes, Berkman and colleagues found that lower levels of health literacy were related to more hospitalizations, increased emergency center use, misuse of medications, confusion with medication instructions, higher death rates, and poorer overall health among the elderly. Baker and colleagues (2007) had similar findings related to the impact of poor health literacy on health outcomes. In Baker et al.'s cohort study ( $N = 3,260$ ), inadequate health literacy independently predicted mortality and death because of cardiovascular disease in elderly populations. They concluded that health literacy is an influential component of overall health.

Compared to general health literacy, the same cannot be said specifically for MHL in the field of mental health. In fact, knowledge of mental health concerns is greatly lacking and largely ignored (Jorm, 2012). The most current study related to MHL found that MHL had a negative relationship to self-stigma of mental health concerns and help-seeking, signifying that when a person knows more information about mental health, they have less stigma about mental health concerns and engage in more help-seeking behaviors (Crowe et al., 2018). In this same study, health outcomes (i.e., blood pressure and body mass index) were assessed to test whether MHL was related to improved physical health. Results were nonsignificant, suggesting that there was not a relationship between MHL and physical health outcomes.

Regional disparities and sociodemographic variations in treatment utilization and efficacy reflect a crucial need for increasing MHL in rural areas in particular (Smalley, Warren, & Rainer, 2012; Snell-Rood et al., 2017). Although prevalence rates of mental health concerns are similar to urban and suburban regions, the amount of and access to mental health services differ vastly in rural regions. Rural residents have fewer options for services, and in fact many rural areas have no health care services at all (Rural Health Information Hub, 2017). Residents in rural regions must travel greater distances for mental health services, are less likely to have health insurance, and have lower MHL (Rural Health Information Hub, 2017). Therefore, professional literature and research studies that assist with raising knowledge about

MHL are warranted, as the current literature based on this topic is lacking, especially as it relates to types of settings and samples of the population. Thus, the current study was an attempt to address this gap in the literature. The following section focuses on what is known about mental health in rural areas and highlights the salient issues that are of importance to clinicians and researchers alike.

### **Mental Health in Rural Areas**

The mental health of rural residents is of importance, as 16% of the U.S. population lives in rural areas (Rainer, 2012). Of those living in the rural United States, 90 million residents live in areas that have been designated as Mental Health Professional Shortage Areas and are lacking mental health professionals and resources (Health Resources & Services Administration, 2011). Researchers, practitioners, and recipients of mental health services purport the underutilization of mental health services and inadequacies in the quality of mental health care among rural populations (Smalley et al., 2012; Snell-Rood et al., 2017). Specifically, factors related to acceptability, accessibility, and availability intensify rural mental health disparities across the United States (Office of Rural Health Policy, 2005; Smalley et al., 2012).

A study completed in Australia sought to explore perceptions about mental health in a rural sample (Fuller, Edwards, Procter, & Moss, 2000). Themes revealed a reluctance to acknowledge mental health concerns and seek help from a professional. Results also demonstrated there is a mental health stigma that is particular to rural communities. Although the study provided an initial look at how mental health can be understood in rural areas, the sample consisted of mental health professionals and others who were knowledgeable about mental health issues rather than those from the general client population.

Mental health stigma is one of the most common reasons for unmet mental health needs in rural areas (Alang, 2015; Stewart, Jameson, & Curtin, 2015). For example, residents in rural communities report fear of taking psychotropic medications and that seeking treatment for mental health might adversely impact their employment (Snell-Rood et al., 2017; Stewart et al., 2015). Resultantly, rural clients who experience mental illness enter mental health care later, present with more serious symptoms, and often require more intensive treatment (Smalley et al., 2012). Insufficient MHL, such as misinformation related to common mental health disorders and treatment, can lead to lower rates of recognizing symptoms of depression, anxiety, and an array of other mental health concerns among rural residents in various ethnic and age groups (Kim, Saw, & Zane, 2015).

A quantitative study conducted by Alang (2015) investigating the sociodemographic disparities of unmet health care needs revealed men in rural areas were more likely to forgo mental health care because of gender stereotypes about mental health problems that encourage men to ignore mental health concerns and avoid help-seeking behaviors. Similarly, Snell-Rood et al. (2017) found that rural women face issues with mental health treatment quality and stigma related to specific disorders such as depression as well as a cultural expectancy of self-reliance, which impacts treatment efficacy. Study participants shared that the quality of counseling in their rural settings was unsatisfactory because of counselors recommending coping strategies that were “inconsistent” with their daily routines and beliefs, not offering adequate “direction” on how to approach treatment for their concerns, and having a lack of therapeutic interaction (Snell-Rood et al., 2017). Because of negative perceptions of the quality of mental health treatment, many women in the study were ambivalent in regard to seeking professional help. Rather, they relied on their personal approaches to symptom management (e.g., avoidance, reflection, and prayer).

Accessibility of mental health services is a significant concern in rural areas. Rural residents face challenges in finding transportation to facilities for professional care. Consequently, rural residents often forgo attaining adequate and timely mental health treatment (Alang, 2015; Hastings & Cohn,

2013). Rural residents often depend on alternative sources such as faith-based organizations to address mental health concerns (Bryant, Moore, Willis, & Hadden, 2015) or ignore the prevalence of mental health symptomology altogether (Snell-Rood et al., 2017). Unfortunately, researchers indicated that rural residents seek treatment for mental health disorders after they have become progressively worse, resulting in more extensive treatment, which is often unavailable or costly for rural clients (Gore, Sheppard, Waters, Jackson, & Brubaker, 2016; Hastings & Cohn, 2013; Snell-Rood et al., 2017). Deen and Bridges (2011) suggested these delays in seeking mental health treatment are associated with low MHL.

Treatment availability for mental health care in rural areas is fragmented because of critical shortages in mental health care providers in these communities (El-Amin, Anderson, Leider, Satorius, & Knudson, 2018; Snell-Rood et al., 2017). Practitioner shortage is attributed to difficulty in recruiting and retaining professionals for rural practice as well as practitioners' limited understanding of cultural norms and effective interventions to address mental health needs in rural communities (Fifield & Oliver, 2016; Hastings & Cohn, 2013). Among practitioners who provide clinical services in rural areas, many report feeling incompetent to work with the population because of receiving fewer training opportunities to learn how to work with rural populations, less access to consultation resources, and professional isolation (Hastings & Cohn, 2013; Jameson & Blank, 2007). Fifield and Oliver (2016) found the most common need of rural-area mental health professionals was training opportunities specific to rural mental health counseling. Pointedly, rural mental health service providers are encouraged to tailor interventions and informational material to meet the needs of the specific communities in which they practice (Crumb, Haskins, & Brown, 2019; El-Amin et al., 2018). For example, a qualitative study examining the experience of rural mental health counselors found it was necessary for rural counselors to modify their interventions to include community-based interventions and expand their roles to include consulting, advocacy, and case management to effectively meet the needs of rural clientele (Crumb, Mingo, & Crowe, 2019). In 2012, rural-specific supplemental materials and curricula were integrated into the standard Mental Health First Aid program, a training course disseminated by the National Council for Behavioral Health to address gaps in MHL by teaching skills to help individuals identify, understand, and respond to mental illness (El-Amin et al., 2018; National Council for Behavioral Health, 2019). Based upon extant research evidence, cultural distinctions in rural living impact MHL and, subsequently, the quality of mental health care in rural regions of the United States.

Despite the above-mentioned disparities, there are opportunities for improving the mental health care of those in underserved rural areas. By becoming familiar with how rural residents in the United States define mental health and investigating the sociodemographic idiosyncrasies in the meaning of mental health for rural residents in specific regions of the United States, mental health practitioners can understand how to better address needs, counter structural barriers to treatment, and improve overall mental health care in rural areas. As far as we are aware, there are no studies that have examined how those in rural communities define and conceptualize mental health. Thus, the current study was designed to fill this gap in the literature.

This study sought to understand how individuals in the rural Southeast define and conceptualize mental health in order to explore MHL and serve as a guidepost to providing culturally relevant services to residents in these regions. Areas in the Southern United States have a high concentration of rural residents who potentially have less access to mental health services, which may influence their overall MHL (El-Amin et al., 2018). Furthermore, we know little about how rural populations define mental health and the knowledge and beliefs that undergird their understanding of mental health. Rather, we have definitions of mental health that are taken from large national and international entities (e.g., U.S.



Department of Health and Human Services, Centers for Disease Control and Prevention [CDC], WHO) that offer broad ways of understanding the term. These definitions, although useful, may not capture distinctions associated with region, socioeconomic status, or cultural group differences. Understanding how groups of people view mental health has many benefits to enhancing MHL. A more specific understanding of mental health concepts can serve as a foundation to increase the utilization of mental health services, improve the quality of care, and enhance clients' ability to communicate concerns. If there are to be greater gains in prevention, intervention, and management of mental health in rural, southern regions of the United States, we need a comprehensive understanding of aspects that are included in perceptions of mental health—using their own words.

## **Methods**

### **Procedures**

Prior to data collection, the Institutional Review Board at a Southeastern U.S. university granted approval to complete the study to explore MHL. Data were collected via a paper-and-pencil survey. Research team members approached patients waiting for a regularly scheduled medical appointment with their primary care physician to complete the survey. Paper copies were stored in a locked filing cabinet within a locked office. The family medical center was located in a rural area of a state in the Southeastern United States. The family medical center where the research took place also housed a mental health provider who received referrals from the medical doctors at the same site. The research team asked permission to collect data on-site, and the lead physician at the center agreed. The mental health provider provides services to many of the same patients who receive medical care at the office. This study was part of a larger, quantitative research investigation on mental health, mental health stigma, and MHL (Crowe et al., 2018). Because of the expansive nature of the dataset, however, this article only focuses on the qualitative components of the survey.

### **Participants**

Using published guidelines for in-person recruitment, the research team approached patients as they waited in the waiting room and asked if they would be interested in joining the research study (Felsen, Shaw, Ferrante, Lacroix, & Crabtree, 2010). When participants elected to participate in the study, they completed an informed consent and survey in the waiting area or in an exam room while waiting for the medical professional. All data were collected over the course of approximately six months. Incentives were not offered to participants and all participants could choose to opt out of participation at any time.

Participants included 102 individuals, including 65 females (63.7%) and 37 males (36.3%). A total of 70 participants identified as White (68.6%), 25 identified as Black/African American (24.5%), four identified as multiracial (3.9%), two did not know or endorsed the "other" category (2%), and one identified as Asian (1%). Regarding age, 30 (29%) participants were age 60 and above, 21 (21%) were between the ages of 50–59, another 21 (21%) were between the ages of 40–49, 14 (14%) were between the ages of 30–39, 14 (14%) were between the ages of 19–29, and two (2%) were 18 or younger. Fifty-six participants (55%) were married, while 27 (26%) were single. A total of 15 (15%) were separated/divorced, and four (4%) were widowed. One hundred and twelve participants were asked to complete the survey, and 102 individuals completed the materials, yielding a 91% useable response rate. Demographic information is summarized in Table 1.

Table 1

*Demographic Information*

Characteristic	<i>n</i>	%
<b>Gender</b>		
Male	37	36.3
Female	65	63.7
<b>Ethnicity</b>		
African American/Black	25	24.5
Caucasian/White	70	68.6
Multicultural	4	3.9
Other	2	1.9
Asian	1	0.9
<b>Age</b>		
18 or younger	2	1.9
19–29	14	13.7
30–39	14	13.7
40–49	21	20.6
50–59	21	20.6
60+	30	29.4
<b>Marital status</b>		
Married	56	54.9
Single	27	26.5
Separated/Divorced	15	14.7
Widowed	4	3.9
<b>Seeking treatment for</b>		
Physical health concerns	88	86.3
Mental health concerns	3	2.9
Both	2	2
<b>Treatment status</b>		
Never sought treatment	54	52.9
Sought treatment in the past	48	47.1
<b>Length of treatment</b>		
1 year or less	18	17.6
1–4 years	11	10.8
5–10 years	9	8.8
11–25 years	5	4.9
<b>Description of treatment</b>		
Not at all helpful	1	1
Somewhat helpful	9	8.8
Generally helpful	10	9.8
Very/Extremely helpful	28	23.3

(continued)

(continued)

Characteristic	<i>n</i>	%
Family mental health		
No immediate family member with a mental illness	66	64.7
Immediate family member with a mental illness	26	25.4
Not sure	10	9.8
Would you seek treatment for mental health concerns in the future?		
Yes	78	76.5
No	3	2.9
Not sure	21	20.5

## Measures

For purposes of the current analysis, an open-ended question prompted participants: “In your own words, please describe what you believe the term *mental health* refers to.” Analysis was completed by comparing and contrasting the participant responses to this prompt with the U.S. Department of Health and Human Services (HHS; 2019) definition of mental health. This definition states that:

Mental health includes emotional, psychological, and social well-being. It affects how we think, feel, and act. Mental health helps determine how we handle stress, relate to others, and make choices. It is important at every stage of life, from childhood and adolescence through adulthood. . . . Many factors contribute to mental health problems, including: biological factors, such as genes or brain chemistry; life experiences, such as trauma or abuse; [and] family history of mental health problems. (para. 1–2)

We elected to use this definition as opposed to similar definitions of mental health offered by WHO or the CDC because each member of the research team chose it as the most comprehensive of the three. Although there were many overlaps in the three definitions (i.e., all three descriptions mention well-being and handling or adjusting to stressors, and included some dimension of biological, psychological, and social aspects), the HHS definition also included the notion of life stages, past life experiences, and how these factors impact mental health.

## Data Analysis

The deductive qualitative analysis method (Gilgun, 2011) was used to analyze participant responses to the open-ended prompt. In deductive coding, the researchers begin with existing codes, as deductive coding is utilized to test existing theories or frameworks. Because the current research was attempting to test the HHS definition, deductive analysis was considered the most fitting analysis method by the research team.

Deductive analysis attempts to understand how a particular theory or framework is useful or not (Gilgun, 2011). In deductive coding, data is sorted as it fits with existing concepts, or codes, within a framework. Deductive coding includes levels of analysis, including open coding, axial coding, and

selective coding (Strauss & Corbin, 1990). According to Gilgun (2011), during open coding, the data is read line by line, sentence by sentence, and is placed as it is understood within the existing concept(s) with which it best aligns. Axial coding then occurs to refine the existing theory or framework via further analysis of data that is already placed within concepts. This data is then reconsidered to attend to groupings or subthemes within the concept to see if further details of a theory/framework are possible. Selective coding within deductive analysis is when the data is further examined to see if there is possible reduction to a single category or core concept. Selective coding is also an attempt to refine and further consider the existing framework to determine its utility and add to its use. As well, lines or sentences that do not fit existing concepts are noted. This is referred to as negative case analysis.

In the current research, the open coding analysis process was conducted repeatedly to consider and reconsider the data and its fit to the concepts within the HHS (2019) definition of “think, feel, and act.” These three concepts in the HHS definition were evident as the most salient. To aid in coding, these three HHS concepts were further understood by utilizing several online dictionaries (e.g., Google dictionary, Merriam-Webster, dictionary.com, and Cambridge English Dictionary) to define each concept. For example, the *think* code included all participant responses that are associated with this term via dictionaries, including *intellectual, cerebral, brain, cognitive, and rational*. The research team continually used several dictionaries to understand participant responses that were not exact or clear upon first reading. For example, *state of mind* was coded as *think* because of it being defined as a cognitive process and the condition of a person’s thoughts. Axial coding then occurred through the research team reconsidering the fit of the responses to the existing codes and if further codes could be developed via negative case analysis. As demonstrated below, axial coding produced a negative case analysis, that of *overall well-being*. Selective coding occurred through the team considering all codes and the utility of the original framework or, in this case, the HHS definition. This utility or lack thereof is further considered in the discussion below.

The entire analysis process was completed by two members of the research team independently. Independent coding enhances credibility in the analysis process, a technique promoted among qualitative researchers (Lincoln & Guba, 1985). The two researchers met on two occasions to discuss their findings and found consistency in their coding in both meetings. This consistency is often found when pre-existing codes with set definitions are utilized, as was the case in this analysis.

## Results

The following section presents the results of the deductive coding of the data in comparison to the HHS definition of mental health, specifically the concepts of how we “think, feel, and act.” The existing concepts used as codes for analysis included the psychological, emotional, and social well-being—how we think, feel, and act. Sample quotes from participants (Ps) are provided. The research team also presents further points of possible refinement of the definition and sense of a core concept.

### Concepts Used to Describe Mental Health

**Think, feel, and act.** Only 15 participant responses provided support for a definition of mental health that encompassed all three aspects found in the HHS (2019) definition of “think, feel, and act.” One participant stated, “mental health to me personally is the state of one’s condition of emotional, mental, social and physical well-being” (P2), and another shared that mental health is the “ability to succeed, fully participate in social, emotional and occupational and recreational leisure” (P3). Thus, there was only a small subset of participants who viewed mental health as comprehensively as federally defined.



**Well-being.** It should be noted that although most participants did not provide comprehensive definitions that specifically mentioned all three concepts of *think*, *feel*, and *act*, as used by HHS, there were 23 participants in the sample who used the term *well-being*. As indicated in the following, *well-being* was not seen as specific to one area but rather an overall experience. One participant stated, “More than a sense of psychiatric disease—overall well-being” (P4), and another shared, “Overall health of a person—their well-being” (P5). Thus, for many of our participants, a comprehensive definition of mental health they demonstrated was the general term *well-being*.

**Think.** The most salient concept found among our participants was related to cognition, thinking, the mind or brain, or the term *mental*. Thirty-four responses focused solely on mental health as being how we think, including statements such as “state of mind” (P6), “mental health refers to your thoughts” (P7), and “brain imbalance” (P8). These responses suggest that the cognitive aspect of mental health is a primary way these rural participants conceptualize mental health. We also saw this demonstrated in other definitions provided by the participants that had *think* in combination with either *feel* or *act*.

**Think and feel.** The next most salient conceptualization provided by participants included elements of both cognition and emotion—how we think and feel. Eighteen participants provided responses in this code, including “mental health is my ability to cope, how I think, rational thinking, and my emotional stability” (P9) and “state of mind and feeling of well-being” (P10). It is noteworthy that again when discussing cognition and emotion, there was frequent use of the phrase *well-being*, even when limited to just *think* and *feel*, thus further supporting the term *well-being*.

**Think and act.** Cognition or thinking was further salient and used in connection with behavior, or how we think and act. Conceptualizations from these 10 participants included statements such as “condition of one’s mind and if any affect [sic] on behavior” (P11) and “well-being in thought and action” (P12). Again, also noted is the use of the term *well-being*, even when specifying *think* and *act*.

**Non-salient concepts within the HHS definition.** There were other conceptualizations of the term *mental health* that supported aspects of the HHS definition. There were seven participants who focused solely on feelings—how you feel. Although there were five participants who only focused on mental health as behavior or how one acts, neither of the singular concepts were considered salient in participant responses because of infrequent responses.

**Other non-salient concepts.** Also provided by participants were concepts focused specifically on a mental health diagnosis such as “depression” (P16, P17) and “depression, bipolar” (P18). Also, it is interesting to note that although not salient, a few participants saw mental health as a function of physical health. This was demonstrated in definitions such as “condition of health” (P19) and “special help for the sick or assist those that have some type of disease” (P20). It is important to note that a few responses were unclear or too vague and could not be categorized, such as “Don’t know” (P21, P22).

## Summary

Overall, participants’ responses suggest a strong tendency toward cognitive aspects of mental health rather than a comprehensive definition that can be found when looking in formal sources, such as the HHS definition (2019). However, a negative case that emerged was that these rural participants did provide the term *well-being* as an overall comprehensive definition for mental health. Frequency counts for each concept can be found in Table 2. In the following section, we discuss these findings.

Table 2

*Frequencies According to HHS Definition Code*

HHS Definition Codes	Participant Response Count
Think	34
Think and Feel	18
Think, Feel, and Act	15
Think and Act	10
Well-Being	23

## Discussion

In the current study, we explored MHL, specifically focusing on the efficacy of the HHS mental health definition in a rural, Southeastern U.S. sample. We sought to understand how this population conceptualized the term *mental health*. The current research literature provides very little information about this topic, so the following study offered initial findings to offer professional counselors and researchers implications and areas for further investigation.

It is important to reflect on the ways results from this sample of rural residents compare to the existing knowledge about the larger public's MHL levels and ideas about mental health. Jorm (2000, 2012) noted that lack of MHL among individuals inhibits their ability to recognize mental health concerns when they arise. Although MHL may be an area for more intensive focus across all populations and settings (Jorm, 2000, 2012), results from this study suggest that there are a number of unique considerations in rural areas. Moreover, it is important to situate the current findings in the context of the challenges faced by rural residents. Knowing how those in rural communities define mental health, in their own words, will lend mental health practitioners information about how to communicate and connect effectively to increase the utilization of mental health services, improve the quality of care, and enhance clients' ability to communicate concerns. If there are to be greater gains in prevention, intervention, and management of mental health in rural regions of the United States, a nuanced understanding of perceptions about mental health may offer a starting point.

### Well-Being

In terms of the HHS definition, the current sample supported the concept of well-being. Although well-being was not necessarily connected concretely to the specific terms of *think*, *feel*, and *act*, it was often associated with one or two other concepts as well as used singularly as a holistic definition. Research on well-being has been of increasing interest in the past two decades (Dodge, Daly, Huyton, & Sanders, 2012), and many of the current national and international definitions of mental health refer to well-being (LaPlaca, McNaught, & Knight, 2013). Recent attempts have been made in the literature to more clearly articulate the definition of well-being (Dodge et al., 2012; LaPlaca et al., 2013), as this concept is being used to determine policy and practice on many national stages.

Current definitions of well-being combine elements of the psychological, social, and physical. However, these descriptions also focus on the ratio of resources to challenges that individuals and communities experience, and some have described well-being as the equilibrium between the two (Dodge et al., 2012). Thus, well-being should be considered within the context of social issues, economics, and service provision. This definition of well-being can be particularly useful for rural

communities and populations, as resources and service provision are often lacking in rural communities (Health Resources & Services Administration, 2011). Our finding that participants connected with and utilized the concept of well-being suggests that both counseling practitioners and researchers should utilize the term and seek to better understand it, especially those working with rural communities and clients. However, participants in the current study did not provide an expansive level of detail in their conceptualization of well-being; rather, they focused on the cognitive or physical aspect of well-being.

### **Cognitive and Biological Focus**

When comparing the current sample's definitions to the HHS definition of mental health, the think/cognitive aspect of mental health was most supported and relevant to these rural participants. Most participants believed that mental health describes how individuals think, followed by those who described it as a combination of thoughts and feelings. As noted in the literature review, HHS (2019) considers mental health as impacting the way individuals think, feel, and act. In the current sample, however, only a small fraction of participants defined mental health as a combination of thoughts, feelings, and behaviors. Instead, participants considered mental health from a cognitive and biological perspective, focusing on the brain and chemical imbalances. Thus, results of this study suggest that individuals in rural communities might lack a holistic understanding of mental health.

Our findings add to the literature by providing context for rural individuals' perceptions and possible explanations for treatment and help-seeking patterns. Rural residents may be especially vulnerable to misinformation about mental health disorders because of mental illness stigma, a cultural expectancy of self-reliance to resolve mental health concerns, and ascertaining mental health-related information from nonprofessionals (e.g., family members, religious leaders; Smalley et al., 2012; Snell-Rood et al., 2017), thus further underscoring the importance of improving MHL in rural communities. In the current study, for example, many participants listed only one component of mental health (e.g., brain imbalance, thoughts), suggesting that their understanding of the concept of mental health is lacking. The focus on the biological composition of the brain in mental health is consistent with definitions of mental illness promoted by organizations such as the National Institute of Mental Health. Thus, although participants' definitions of mental health are not incorrect, in many ways the focus is narrow and not comprehensive. Study participants excluded emotions and when speaking about biology focused on the brain, which potentially discounts somatic manifestations of mental illness (e.g., stomach pains).

A more comprehensive understanding of mental health, with a specific focus on the connection between emotions, behaviors, and somatic symptoms, could potentially assist rural residents with becoming more conscious of signs and symptoms related to common mental health concerns such as anxiety and depression (Kim et al., 2015). It seems important for mental health educators, organizations, and counseling practitioners in rural communities to provide education that broadens the beliefs about the nature of mental health. Educational campaigns and direct work that are more inclusive and broadly focused could be of benefit.

### **Implications for Professional Counselors**

Professional counselors and related mental health practitioners in rural areas noted they need training opportunities focused on clinical issues that are important in rural settings (Fifield & Oliver, 2016). Thus, the results from this study may offer mental health professionals guidance for reaching residents in rural communities and providing efficacious mental health services. Foremost, counselor training programs could consider developing courses with a specific focus on rural populations, which can assist counseling students in increasing their understanding of the culture of rural settings, how rural residents comprehend mental illness, and effective counseling practices in rural communities (Crumb, Mingo,

& Crowe, 2019; Rollins, 2010). For example, counselors in training would be privy to facts such as how many people living in rural areas across the United States face additional life stressors, including poverty and housing and food insecurities, that impact their mental health and well-being.

The results of this study also illustrate the importance of building partnerships and collaborative relationships in rural communities, as rural residents may present varied concerns (e.g., concerns about physical health, family members, finances, spirituality) to counselors when seeking help. Thus, building both informal and formal professional support networks in rural communities is vital. Counselors in rural communities may consider building resources with physicians, faith-based organizations, and other mental health providers for consultation purposes (Avent, Cashwell, & Brown-Jeffy, 2015; Crumb, Mingo, & Crowe, 2019).

El-Amin et al. (2018) suggested programs such as rural-focused Mental Health First Aid to help increase MHL in rural communities. Because access to mental health services is often limited and/or non-existent in rural communities, counselors and related mental health professionals should be more intentional in implementing these forms of programming because of the large number of residents who reside in rural communities who have not yet been helped (El-Amin et al., 2018). Trainings such as this may assist with MHL, as well as mental health stigma, which has been associated with MHL in rural areas (Crowe et al., 2018).

Last, the focus on cognition in participants' definitions of mental health may indicate a positive response to more cognitive-based theories such as CBT (A. T. Beck, 1970) and rational emotive behavioral therapy (Ellis, 1962). As this study was framed through the lens of CBT and the notion that cognition impacts emotions and behaviors, this theory and related interventions may fit well when working with clients in the rural United States. This type of "matching" related to how clients in the rural parts of the United States understand mental health (with a more cognitive focus) might lead to increased participation in counseling and therapy in rural areas. This might be a way for practitioners to join with the client initially, at the beginning of the therapeutic relationship, in order to "speak the same language." However, given the findings of the current study, although individuals may have a natural inclination toward more cognitively focused theories, it is incumbent upon mental health professionals to challenge individuals to consider the ways emotions and behaviors are connected to their mental health as well. CBT fits this model well; however, scholars have also found ways to integrate other theories to provide an even more comprehensive and culturally responsive theoretical framework for clients. For example, one of the suggested interventions in Crumb and Haskins' (2017) integration of CBT and relational cultural theory is to "apply cognitive restructuring through relational resilience" (p. 268). This technique could be especially beneficial to rural communities, as it honors the focus of cognitions while also considering how these thoughts and messages may be related to a broader systemic and environmental influence (Crumb & Haskins, 2017).

In sum, counselors should be aware that many of their clients may present with low MHL. Thus, education and awareness about mental health, diagnoses, and symptomatology may be an integral part of the treatment process. Counselors should consider this intentionality in education as a part of their role as advocates for their clients (Crumb, Haskins, & Brown, 2019).

### **Limitations and Future Directions**

As with all research, the current study is not without limitations. First, the qualitative responses received from participants were often brief. The study team was able to analyze responses, but future qualitative research on the topic of MHL in rural samples might include a focus group design or

individual interviews rather than paper-and-pencil surveys to get an in-depth look at how those in rural areas define mental health. Also, future research could seek to further understand the concept of well-being as used by rural participants, looking more in depth at all components (cognition, emotion, and behavior). Future research studies could also investigate the reasons for a focus on cognitive aspects of mental health. As it is impossible to separate cognition from emotion and behavior, this study found that many participants seemed to focus on cognition rather than a more comprehensive understanding of cognition as it related to choices in behaviors and affect. The current study took place in a medical center, and participants who were approached to participate may have felt pressure to complete the survey or answer in a way that was socially desirable. The sample was a convenience sample and may not be representative of others in the rural Southeast.

Large scale quantitative studies might offer scholars interested in MHL the opportunity to use validated instruments to measure literacy and perceptions about mental health in rural samples. Assessments such as the Mental Health Knowledge Schedule (Evans-Lacko et al., 2010) have been used in recent research (Crowe et al., 2018) to measure mental health knowledge. The Revised Fit, Stigma, & Value Scale (Kalkbrenner & Neukrug, 2018) is another scale measuring barriers to counseling such as stigma, values, and personal fit. These types of assessments can measure levels of recognition, familiarity, and attitudes toward mental health conditions in order to measure MHL and perceptions of mental health stigma.

## Conclusion

This qualitative study investigated the HHS definition of mental health to determine if it was representative of rural Southeastern participants' definitions. This assisted with answering the call for more research on the mental health of rural residents (Simmons, Yang, Wu, Bush, & Crofford, 2015) in order to provide better services to this population. Most participants demonstrated a conceptualization that included cognition, as well as well-being, and were more concrete in their conceptualization of mental health when compared to the more comprehensive HHS definition. A promising result from this study was that many participants seemed willing to seek mental health treatment in the future. Rural communities could benefit from mental health education with a holistic approach. Future research should consider interviewing rural populations to gather more detail on their definitions and understanding of mental health. The results provided interventions for professional counselors and related mental health clinicians, particularly those in rural settings, to integrate into their present work, pointed to the need for educational campaigns on mental health in rural areas, and highlighted areas for future research exploration.

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