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Review Articles

Sociocultural Barriers to Mental Healthcare in Vulnerable Rural Populations: A Systematic Review

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Abstract

Objective To synthesize sociocultural barriers to mental health help-seeking among rural U.S. populations, with focused attention to vulnerable groups (LGBTQ+/sexual & gender minorities, racial/ethnic minorities, women/perinatal, veterans, and youth), and to integrate findings within ecosocial, social stress, and minority stress frameworks. **Methods** A systematic PubMed review (2000–2025) was conducted using predefined inclusion criteria for qualitative or mixed-methods studies with a substantial qualitative component. Eligible studies involved U.S. rural or non-metropolitan participants or providers and examined sociocultural barriers to mental health care. Studies focusing solely on structural barriers were excluded. Of 221 records screened, 26 met criteria. Barrier themes were coded and summarized by frequency. **Results** The most common barriers were public stigma (75 percent of studies), mistrust of providers (63 percent), self-stigma (50 percent), and confidentiality concerns tied to small-town visibility (42 percent). Additional themes included low perceived need, rural identity and insularity, cultural and religious beliefs, language and mental health literacy gaps, low provider affirmingness, and population-specific norms such as military culture and stoicism. Three barrier mechanisms were identified: visibility leading to stigma and nondisclosure, competence gaps leading to mistrust and disengagement, and structural frictions producing pre-encounter attrition. Across groups, participants emphasized that identity-affirming competence and safety mattered more than generic welcoming gestures. **Conclusions** Rural underutilization of mental health services reflects the layering of ecosocial constraints (scarcity, distance, cost), social stress processes (stigma, role norms, low perceived need), and minority stress (non-affirming care, disclosure fears). Interventions should combine competence guarantees with reliable first-contact access and privacy-protective delivery models. Limitations include use of a single database, heterogeneous rural definitions, and reliance on predominantly qualitative designs.

Keywords: Rural health, mental health, racial disparities

1.Introduction

Mental health disparities remain a critical concern within the field of social epidemiology, where the interplay of biological, psychological, and structural determinants gives rise to unequal burdens of disease across populations. Depression, one of the most prevalent mental health disorders globally, is both a cause and consequence of these inequalities. Its progression – often characterized by chronicity, recurrence, and comorbidity – can culminate in suicide, a leading cause of premature mortality. From a social epidemiological perspective, depression and suicide represent not only individual pathologies but also population-level outcomes that emerge from broader social conditions, including deprivation, discrimination, and the erosion of social support.

Major risk factors for suicide include male sex, adolescence or elder age, personal or family history of suicide, adverse childhood experiences, comorbid substance use, social or financial loss, and lack of social support [1]. Of particular interest in the past few decades is the phenomenon of social contagion,

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or the interpersonal transmission of suicidal behavior through exposure within families, schools, and communities [2]. Such contagion dynamics illustrate how individual despair can propagate within vulnerable social networks, transforming suicide into a collective rather than an isolated outcome, resulting in "hotspots" as described by Abrutyn and Mueller [3].

The distribution of depression and suicide is fundamentally shaped by social context. Socioeconomic disadvantage as manifested in unemployment, income loss, and low educational attainment correlates with greater depressive symptom burden and suicidality [4]. Structural inequities, including racial and gender discrimination, environmental stressors, and limited access to mental health resources, compound this vulnerability [5]. Marginalized populations, particularly those in rural communities, experience these risks in concentrated form: diminished wealth, occupational exposures, and weakened social capital limit opportunities for prevention and recovery.

Within the United States, rural residents face a widening mental health burden. Suicide rates in rural areas have nearly doubled between 2000 and 2020[6]. Among youth, the disparity is striking: between 1996 and 2010, suicide rates in rural counties were nearly twice those of urban counterparts, and rural–urban gaps continued to widen for males even after adjustment for socioeconomic variables [7]. Despite these alarming trends, rural populations consistently underutilize mental health services, a pattern attributed not only to shortages of providers but also to pervasive sociocultural barriers such stigma, mistrust, and rigid norms of self-reliance [8,9].

Rural suicide risk is further stratified by identity and social position. Among racial and ethnic minorities, suicide deaths have risen across all groups, with particularly steep increases among American Indian and Alaska Native populations [10]. Cultural conceptions of distress also diverge from Western diagnostic models; for example, older rural Mexican Americans often describe depressive symptoms using culturally specific idioms rather than biomedical terminology [11]. Among Hispanic and Asian American individuals, lower perceived importance of mental health and stronger family-based coping norms contribute to lower help-seeking intent [12].

Gender and sexual minorities face parallel and compounding risks. Lesbian, gay, and bisexual adults report substantially higher rates of suicidal ideation, planning, and attempts across all age and racial groups [13], while sexual and gender minority individuals often describe suicidal behavior as more socially acceptable within their communities – a reflection of minority stress and internalized stigma [14].

For youth, suicide has become the second leading cause of death among those aged 10–34[15]. Recent analyses reveal a sharp rise in suicide deaths among LGBTQ+ youth between 2014 and 2019, with the proportion of decedents identifying as sexual or gender minorities increasing from 13% to 20%, particularly among transgender and questioning youth [16]. These findings underscore the intersectional vulnerabilities that arise from rural isolation, developmental transition, and minority stress.

Veterans represent another high-risk group, with suicide rates of 32.0 per 100,000 – nearly double that of nonveterans [17]. The socialization processes of military service, often grounded in masculine ideals of stoicism and endurance, may discourage emotional disclosure or help-seeking [18]. These cultural scripts are especially salient for women and minority veterans, who must navigate both institutional gender norms and broader social stigma. For instance, sexual and gender minority veterans exhibit higher suicide risk than their heterosexual peers, with intersecting patterns of race, gender, and religion shaping vulnerability [19]. American Indian and Alaska Native soldiers face suicide rates 1.5 times higher than White non-Hispanic service members, and hazard rates are rising among Hispanic and Black veterans post-deployment [20].

Although several reviews have examined general and attitudinal barriers to mental health care in rural populations [8,9], there has been limited synthesis of research focusing on vulnerable subpopulations – including youth, racial and ethnic minorities, women, veterans, and sexual and gender minorities – who collectively bear disproportionate risks for both depression and suicide. The present review seeks to address this gap by systematically examining sociocultural barriers to mental health help-seeking in rural America, integrating findings across diverse populations and applying a social epidemiological lens to clarify how social structures, cultural norms, and intersecting identities shape vulnerability and care utilization.

2.Methods

A systematic search of PubMed was conducted to identify qualitative and mixed-methods studies published between January 1, 2000, and September 2025. The search string was: ("Mental Health Services"[Mesh] OR "mental health"[tiab] OR psychiatric[tiab] OR psychotherapy[tiab]) AND ("Rural Population"[Mesh] OR rural[tiab]) AND ("Social Stigma"[Mesh] OR "Trust"[Mesh] OR stigma[tiab] OR trust[tiab] OR privacy[tiab] OR attitude*[tiab] OR belief*[tiab] OR cultural[tiab] OR sociocultural[tiab] OR perception*[tiab] OR "help seeking"[tiab] OR barrier*[tiab]) AND ("United States"[Mesh] OR "United States"[tiab] OR USA[tiab] OR U.S.[tiab] OR Appalachia*[tiab]) AND (qualitative[tiab] OR interview*[tiab] OR "focus group*"[tiab] OR themes[tiab] OR ethnograph*[tiab]) . The search strategy was restricted to peer-reviewed journal articles published in English and involving U.S.-based populations. Titles and abstracts were screened for relevance, and full texts were reviewed when eligibility could not be determined from the abstract alone.

Studies were selected according to predefined inclusion and exclusion criteria. Eligible studies were required to (A) report on primary empirical research using qualitative methods (e.g., interviews, focus groups, ethnography) or mixed-methods with a substantial qualitative component; (B) include participants who identified as a ethnic, racial, gender, or sexual minority; had veteran status; identified as women; or were youth or adolescents residing in rural or non-metropolitan areas of the United States, or mental healthcare providers working in such areas and with such populations; (C) have a primary focus on barriers to mental healthcare access, with particular attention to sociocultural dimensions; and (D) be published in a peer-reviewed journal in English between 2000 and 2025. Studies were excluded if they (E) were systematic reviews, meta-analyses, commentaries, editorials, or dissertations; (F) focused exclusively on urban or suburban populations or populations outside the United States; (G) addressed only structural or economic barriers (such as provider shortages, transportation, or insurance coverage) without substantial analysis of sociocultural factors; or (H) were otherwise irrelevant to the topic of mental healthcare access and utilization.

The search initially yielded 221 records. Following application of the eligibility criteria, 26 studies were retained for inclusion in the synthesis. The study selection process followed PRISMA guidelines; however, due to the semi-systematic design, grey literature and additional databases were not searched.

A standardized extraction matrix was developed to capture key study characteristics, including population, sample size, setting, design, data collection method, analytic approach, and identified sociocultural barriers. Thematic coding was applied inductively and deductively, with barrier categories refined iteratively (e.g., stigma, mistrust, confidentiality concerns, cultural/religious influences). Barriers were then summarized by frequency across studies.

All included studies were appraised using the CASP (Critical Appraisal Skills Programme) qualitative checklist. Each study was assessed on clarity of aims, appropriateness of design and recruitment, reflexivity, data collection and analysis, ethics, and clarity of findings. Criteria were coded as Yes, Partial, No, or Can't Tell, and overall rigor was judged as low, moderate, or high concern. Quality ratings were not used to exclude studies, but informed the interpretation and weighting of findings in the synthesis.

3.Results

This review includes 26 studies published between 2006 and 2024. The earliest study (Willging et al., 2006) explored help-seeking among sexual and gender minorities in rural New Mexico, while the most recent contributions appeared in 2024, reflecting increasing scholarly attention to sociocultural determinants of rural mental health over the past two decades. Notably, nearly three-quarters of the studies were published after 2015, suggesting a marked growth of interest in the qualitative investigation of access barriers in the last decade.

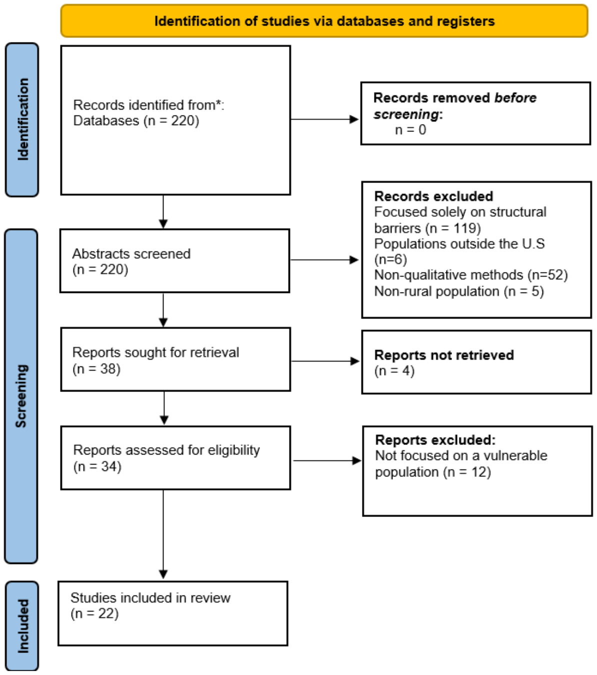

Figure 1. PRISMA flow diagram

The studies covered a diverse geographic spread across the United States. Multiple papers examined the Appalachian region (e.g., Gandy et al., 2021; Williams et al., 2022; Snell-Rood et al., 2017, 2019; Hill et al., 2016), while others focused on the rural South including Georgia, South Carolina, Arkansas, and Mississippi Delta contexts (Pryor et al., 2023; Haynes et al., 2017). Several were set in the rural Midwest, often with American Indian populations (Hack et al., 2014; Broffman et al., 2017). Studies also appeared from the Mountain West (Ingelse and Messecar, 2016; Hanson et al., 2023), the Pacific Northwest (LeMasters et al., 2021), and scattered VA service regions covering Maine, Colorado, Wisconsin, and California (Possemato et al., 2018; Cheney et al., 2018; Fischer et al., 2016; Koenig et al., 2016). Collectively, the studies capture a cross-section of rural experience from the Southeast to the Plains and Western frontier.

Of the 26 included studies, five focused on sexual and gender minorities in rural contexts (Pryor et al., 2023; Gandy et al., 2021; Williams et al., 2022; Teti et al., 2021; Willging et al., 2006) [21,22,23,24,25], four on racial or ethnic minority populations including Latinos, African Americans, and American Indians (Stacciarini et al., 2016; Haynes et al., 2017; Hack et al., 2014; Broffman et al., 2017) [26,27,28,29]., six on veterans (Ingelse and Messecar, 2016; Possemato et al., 2018; Cheney et al., 2018; Fischer et al., 2016; Koenig et al., 2016) [30,31,32,33,34], and six on women, including those who were pregnant, postpartum, or incarcerated (Snell-Rood et al., 2017; Hanson et al., 2023; Snell-Rood et al., 2019; LeMasters et al., 2021; Hill et al., 2016; Jesse et al., 2008) [35,36,37,38,39,40]. Two papers examined youth and early childhood populations (Graves et al., 2024; Vuyk et al., 2016).[41,42]

Methodologies were predominantly qualitative, with semi-structured interviews, focus groups, and ethnographic approaches most common. Several employed community-based participatory research (CBPR) methods or mixed designs integrating survey and qualitative data (e.g., Gandy et al., 2021; Cheney et al., 2018; Vuyk et al., 2016). Sample sizes ranged from as few as 7 participants (Hanson et al., 2023) to more than 60 (Cheney et al., 2018), with most studies drawing from purposive or convenience samples within rural counties, community organizations, or Veterans Affairs systems.

Table 1. Overview of Reviewed Papers

ID	Population	First Author	Year	Journal	Region	Sample	Design & Data Collection
1	G&S Minorities	Pryor EK	2023	Southern Medical Journal	Georgia; South Carolina	n=62 SGM respondents (subset of larger LGBTQ survey N≈436; mean age ≈32.5; majority White; varied identities)	Qualitative; online open-ended survey responses, one-time
2	G&S Minorities	Gandy ME	2021	IJERPH	West Virginia; Appalachia	n=24 (18 adults; 6 minors/parent proxies); mean age ≈28.7; ≈83% White; varied TGD identities	Mixed methods (CBPR); online survey + 4 Zoom focus groups + async forum
3	G&S Minorities	Williams KA	2022	Journal of Gerontological Social Work	Rural South-Central Appalachia	n=11; all White; 10 cisgender, 1 transgender; most ⩾BA	Qualitative; semi-structured interviews 30–120 min, audio-recorded
4	G&S Minorities	Teti M	2021	IJERPH	Midwest (non-metropolitan town)	n=25 (12 TGNC patients; 13 providers); majority White	Qualitative; semi-structured phone interviews ~30–45 min
5	G&S Minorities	Willging CE	2006	Psychiatric Services	Rural New Mexico	n=38; 42% Hispanic, 34% AI, 21% White; 53% male, 39% female, 8% transgender	Ethnographic qualitative; 90–120 min baseline + 6-mo follow-ups
6	Racial/Ethnic Minorities	Stacciarini JM	2016	Issues in Mental Health Nursing	North Florida	n=15 FBO leaders (47–72 y/o; bilingual; Catholic/Protestant)	Qualitative (CBPR); in-depth bilingual interviews, audio-recorded
7	Racial/Ethnic Minorities	Haynes TF	2017	Psychiatric Services	Arkansas Delta	7 focus groups; N=50 (providers, clergy, students, persons w/ MI)	Qualitative (grounded theory, CAB); 90-min focus groups
9	Racial/Ethnic Minorities	Hack SM	2014	Cultural Diversity & Ethnic Minority Psychology	Rural Midwest	n=14 AI; ~79% female; mean age ≈48; varied diagnoses	Qualitative (modified CQR); in-home interviews 19–63 min
10	Racial/Ethnic Minorities	Broffman L	2017	Journal of Rural Health	South Dakota (rural + reservation)	N=33 (MH=18; SUD=9; co-occurring=6); 34% AI	Qualitative; 30–60 min phone interviews; $20 incentive

11	Intersectional (Women, Veterans)	Ingelse K	2016	Archives of Psychiatric Nursing	Central Oregon	n=10 women veterans; avg age ˜51; 8/10 MST	Qualitative descriptive; in-depth interviews 60–120 min
12	Veterans	Possemato K	2018	Journal of Traumatic Stress	Upstate New York	N=27 across 4 focus groups; mostly male/White; varied eras	Mixed methods; 4× 90-min focus groups + self-report measures
13	Veterans	Cheney AM	2018	BMC Health Services Research	Maine; Arkansas; California	N=66; ages 20–70; racially mixed; prior VA MH use	Mixed methods (CDA); freelist, pile sort, interpretation interviews
14	Veterans	Fischer EP	2016	Journal of Rural Health	AR; CO; ME; WI	n=25 veterans + 11 providers; mostly male/White	Qualitative; semi-structured interviews Jun 2013–Jul 2014
15	Veterans	Koenig CJ	2016	Journal of Rural Health	West & Mid-South U.S.	n=37 veterans; n=52 staff	Pre-implementation formative eval; semi-structured interviews, site visits
16	Women	Snell-Rood	2017	Psychology of Women Quarterly	Central Appalachia (KY & surrounding)	n=28 women, ages 25–64; mostly low-income; White majority	Qualitative (grounded theory); in-depth interviews 60–120 min
17	Women	Hanson	2023	MCN	Rural Montana	n=7; ages 24–37; mostly White, 2 AI; pregnant/postpartum	Qualitative (narrative inquiry); web-based video interviews 15–30 min
18	Women	Snell-Rood	2019	Rural and Remote Health	Central Appalachia (KY jails)	n=24 incarcerated women; low-income; all White	Qualitative secondary analysis; MI session transcripts
20	Intersectional (Women, Racial & Ethnic Minorities)	LeMasters	2021	Health Education & Behavior	North Carolina (Robeson County)	N=7; avg age 25; majority AI; all mothers	Qualitative exploratory (CBPR, photovoice); 5 photovoice sessions
21	Women	Hill	2016	Journal of Rural Health	South Central Appalachia	18 female patients + 4 NPs; mean age 47; 78% below poverty	Qualitative case study; semi-structured face-to-face interviews
22	Women	Jesse	2008	Issues in Mental Health Nursing	Rural southeastern U.S.	21 women (16 AA, 5 White); low-income, rural	Focus groups (race-stratified); 4 FG + 2 interviews
23	Youth	Graves	2024	Psychiatric Services	Rural Western Kentucky	18 adults (parents, teachers, providers, public health)	Qualitative; semi-structured interviews; field notes
24	Youth	Vuyk	2016	Infant Mental Health Journal	Southwest Kansas	Quant: 29 providers; Qual: 16 provider interviews	Mixed methods; session data over 20 weeks + interviews 10–45 min

Most included studies demonstrated clear research aims and employed qualitative or mixed-methods designs well suited to their exploratory questions. Common approaches included in-depth interviews, focus groups, and community-engaged strategies, all of which provided valuable insight into the sociocultural dimensions of help-seeking in rural contexts. The majority of studies described ethical approval and provided adequate detail on data collection and analysis, supporting the validity of their findings.

Nevertheless, several recurring limitations were evident across the sample. Most studies relied on nonprobability/convenience sampling, which limits representativeness and generalizability. Reflexivity was inconsistently addressed, with relatively few papers explicitly considering the influence of researcher positionality or power dynamics. Sample sizes were often small, reflecting both the challenges of rural recruitment and the focus on hard-to-reach populations. In some cases, the depth of data was reduced by reliance on open-text survey responses or field notes rather than verbatim transcripts, which constrained transparency in analysis. Taken together, the overall quality of evidence can be judged as moderate. While no study was fatally flawed, the limitations in sampling, reflexivity, and analytic transparency temper confidence in transferability. At the same time, several papers stood out for their methodological rigor and transparency – most notably Willging (2006), Williams (2022), Cheney (2018), LeMasters (2021), and Vuyk (2016) – which offered richer accounts and stronger audit trails. These examples demonstrate the value of sustained, well-documented engagement and provide models for future research in this area.

4.Discussion

This review identified recurring sociocultural barriers that constrain mental health help-seeking behavior among rural U.S. populations, particularly within vulnerable groups. Across 26 qualitative and mixed-methods studies published between 2000 and 2025, the most frequently observed barriers were public stigma (75%), mistrust of providers (63%), self-stigma (50%), confidentiality concerns (42%), and low perceived need (27%). Less common but conceptually significant themes included rural identity insularity, cultural and religious beliefs, language and mental health literacy gaps, low provider affirmingness, military cultural norms, and masculinity or stoicism norms. These findings extend prior rural mental health syntheses by illustrating how these broad themes interact with intersecting social identities and localized cultural expectations.

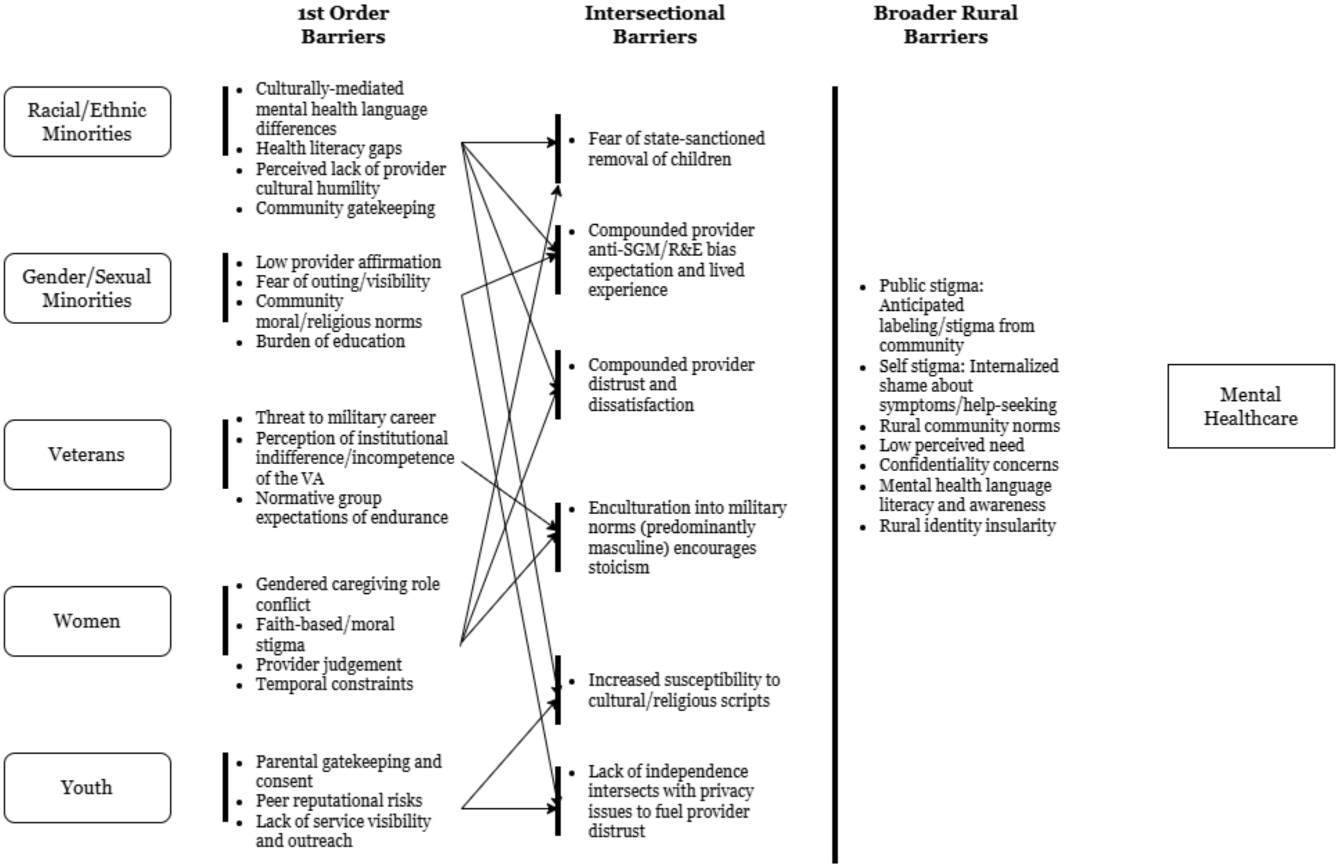

Figure 2. Diagrammatic representation of barriers to accessing rural mental healthcare

Public stigma and self-stigma together form the central deterrent to engagement. Participants repeatedly described reputational risks associated with being "seen" seeking help in close-knit communities: "You don't want to park your car in front of the clinic… everyone knows what you drive".[41] These perceptions align with Link and Phelan's conceptualization of stigma as a process of labeling and social exclusion reinforced by power differences. Self-stigma further internalizes these social judgments and fosters shame; self-reliance narratives such as "I thought I was weak if I couldn't handle it on my own" further amplify these effects [35].

Mistrust of providers emerged as a second-order but pervasive mechanism. Several studies documented expectations of bias or cultural incompetence particularly among racial/sexual minorities and fears that disclosure could produce harm: "If I told the VA counselor the truth, it would be used against me" [32]. Provider transience and inadequate training in culturally responsive or identity-affirming care amplify this distrust. For many participants, non-affirming or proselytizing encounters ("The counselor asked if I'd tried being straight") terminated future care seeking altogether [25].

Confidentiality concerns further compound stigma and mistrust, uniquely intensified by rural social geography. Respondents noted the impossibility of anonymity – "Everybody knows everybody, so if you see the therapist, your business is out there" – which converts potential help-seeking into reputational risk management [21]. This aligns with Ferris-Day et al. who identified confidentiality fears as a primary barrier even in general rural samples [9].

Low perceived need represents a subtler but equally powerful barrier. Many respondents normalized distress as an expected part of rural life: “I just thought feeling down was normal around here – nothing a doctor could fix” [25]. This reflects local illness constructions where endurance is valued. Rural identity and self-reliance ideals, often gendered through stoicism and masculinity norms, reinforce the minimization of emotional suffering (“You just suck it up, that’s how men around here deal with it” [37]. These norms may transform help-seeking into a threat to moral identity rather than a sign of resilience.

While public stigma, mistrust, and confidentiality fears also dominate the broader rural mental health literature, this review identifies additional group-specific patterns. Vulnerable populations uniquely emphasize low provider affirmingness and cultural or religious incongruence, indicating that beyond general rural skepticism, marginalized groups experience added layers of misrecognition. Military and masculine cultural norms, meanwhile, transform stigma into occupational or identity risk, linking emotional disclosure to weakness or career jeopardy. Thus, vulnerability is shaped by the intersection of rural context with identity-specific systems of meaning.

Synthesizing across studies, these mechanisms map onto ecosocial, social stress, and minority stress frameworks. From an ecosocial perspective, geographic isolation, limited workforce stability, and thin institutional privacy constitute structural conditions that embed stigma and constrain exposure to supportive settings [43]. Social stress theory explains how chronic strain arising from poverty, constrained roles, and social control norms accumulate into emotional distress while simultaneously suppressing coping help-seeking [44]. Among marginalized subgroups, minority stress processes compound these effects through prejudice expectations, concealment, and internalized stigma [45]. Collectively, these frameworks suggest that rural underutilization reflects a chain of pre-encounter attrition (i.e many individuals never initiate contact) rather than explicit denial of care – ultimately, the effect is the same.

Practice and Policy Implications

Across studies, several strategies consistently mitigated barriers. Trusted messengers and peers such as veteran peer navigators, maternal support groups, or community health workers help normalize care through shared experience. Embedded care in familiar hubs (primary care, schools, home-visiting, or faith settings) lowers visibility costs and integrates mental health into routine contexts. Participants valued visible competence signals such as inclusive language, non-proselytizing policies, and correct pronoun use over generic friendliness, emphasizing that perceived competence drives trust more than symbolic allyship. Continuity and reliability – including consistent providers and rapid follow-up – counteracted churn, while privacy-protective practices (neutral signage, discrete scheduling, telehealth booths) directly addressed confidentiality fears. Finally, plain-language literacy efforts that explain symptoms and care pathways may convert low perceived need into informed help-seeking.

Beyond replicating these strategies, this synthesis highlights novel recommendations: (a) pair stigma-reduction campaigns with explicit competence guarantees, not one without the other; (b) design systems around the first contact (reducing wait times and ensuring returned calls) to prevent silent attrition; (c) institutionalize peer and identity-concordant outreach as core infrastructure; (d) monitor pre-encounter metrics such as unreturned calls and missed scheduling as quality indicators; and (e) integrate privacy-by-design principles into service delivery, from neutral billing descriptors to community-based telehealth pods.

Limitations and Future Directions

This review has several important limitations. First, the search was restricted to a single database (PubMed), which may have excluded relevant studies published in psychology, sociology, or interdisciplinary journals not indexed in biomedical databases. Although PubMed coverage of rural and health services literature is substantial, future reviews should expand to include PsycINFO, CINAHL, and Sociological Abstracts to capture work on social context, identity, and community dynamics that may use different terminologies. Second, while the inclusion criteria emphasized qualitative and mixed-method designs, heterogeneity in data collection and analytic depth across studies introduces variability in quality and interpretability. Several reports relied on survey free-text or brief interviews, limiting contextual richness.

Geographically, most included studies were concentrated in the rural South, Midwest, and Appalachia, with sparse representation from New England, the Pacific Northwest, and Mountain West regions. These omissions are consequential: rurality in these underrepresented areas may differ in sociodemographic composition, health infrastructure, religiosity, and political climate which are all factors likely to shape stigma and help-seeking differently. Future research should purposely recruit participants from these regions and consider comparative designs to capture within-rural variation.

Finally, although this synthesis focused on sociocultural rather than structural barriers, the two are deeply intertwined. Structural frictions such as workforce shortages and distance amplify stigma and mistrust by reducing continuity and privacy. Future studies should model these mechanisms jointly, using longitudinal or mixed-method approaches to clarify how sociocultural barriers evolve across the help-seeking pathway. Expanding to include intervention evaluations – especially those that integrate identity-concordant care and community engagement – would strengthen the evidence base for practical translation.

Statements and Declarations

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References

[1] Orsolini, L., Latini, R., Pompili, M., Serafini, G., Volpe, U., Vellante, F., Fornaro, M., Valchera, A., Tomasetti, C., Fraticelli, S., Alessandrini, M., La Rovere, R., Trotta, S., Martinotti, G., Di Giannantonio, M., & De Berardis, D. (2020). Understanding the complex of suicide in depression: From research to clinics. *Psychiatry Investigation, 17*(3), 207–221. https://doi.org/10.30773/pi.2019.0171

[2] Forum on Global Violence Prevention, Board on Global Health, Institute of Medicine, & National Research Council. (2013, February 6). *The contagion of suicidal behavior*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK207262/

[3] Mueller, A. S., Dana, L., & Abrutyn, S. (2024). *Life under pressure*. Oxford University Press.

[4] Kirkbride, J. B., Anglin, D. M., Colman, I., Dykxhoorn, J., Jones, P. B., Patalay, P., Pitman, A., Soneson, E., Steare, T., Wright, T., & Griffiths, S. L. (2024). The social determinants of mental health and disorder: Evidence, prevention and recommendations. *World Psychiatry, 23*(1), 58–90.

[5] Phillips, J. A., & Hempstead, K. (2022). The role of context in shaping the relationship between physical health and suicide over the life course. *SSM–Population Health, 17*, 101059. https://doi.org/10.1016/j.ssmph.2022.101059

[6] Centers for Disease Control and Prevention. (2024, May 14). *Suicide in rural America as a public health issue*. https://www.cdc.gov/rural-health/php/public-health-strategy/suicide-in-rural-america-prevention-strategies.html

[7] Fontanella, C. A., Hiance-Steelesmith, D. L., Phillips, G. S., Bridge, J. A., Lester, N., Sweeney, H. A., & Campo, J. V. (2015). Widening rural-urban disparities in youth suicides, United States, 1996–2010. *JAMA Pediatrics, 169*(5), 466–473. https://doi.org/10.1001/jamapediatrics.2014.3561

[8] Cheesmond, N. E., Davies, K., & Inder, K. J. (2019). Exploring the role of rurality and rural identity in mental health help-seeking behavior: A systematic qualitative review. *Journal of Rural Mental Health, 43*(1), 45–59. https://doi.org/10.1037/rmh0000109

[9] Ferris-Day, P., Hoare, K., Wilson, R. L., Minton, C., & Donaldson, A. (2021). An integrated review of the barriers and facilitators for accessing and engaging with mental health in a rural setting. *International Journal of Mental Health Nursing, 30*(6), 1525–1538. https://doi.org/10.1111/inm.12929

[10] Carter, S. P., Campbell, S. B., Wee, J. Y., Law, K. C., Lehavot, K., Simpson, T., & Reger, M. A. (2022). Suicide attempts among racial and ethnic groups in a nationally representative sample. *Journal of Racial and Ethnic Health Disparities, 9*(5), 1783–1793. https://doi.org/10.1007/s40615-021-01115-3

[11] Letamendi, A. M., Ayers, C. R., Ruberg, J. L., Singley, D. B., Wilson, J., Chavira, D., Palinkas, L., & Wetherell, J. L. (2013). Illness conceptualizations among older rural Mexican-Americans with anxiety and depression. *Journal of Cross-Cultural Gerontology, 28*(4), 421–433. https://doi.org/10.1007/s10823-013-9211-8

[12] Van Doren, N., Zhu, Y., Vázquez, M. M., Shah, J., Grammer, A. C., Fitzsimmons-Craft, E. E., Eisenberg, D., Wilfley, D. E., Taylor, C. B., & Newman, M. G. (2024). Racial and ethnic disparities in barriers to mental health treatment among U.S. college students. *Psychiatric Services, 75*(9), 839–846. https://doi.org/10.1176/appi.ps.20230185

[13] Ramchand, R., Schuler, M. S., Schoenbaum, M., Colpe, L., & Ayer, L. (2021). Suicidality among

sexual minority adults: Gender, age, and race/ethnicity differences. *American Journal of Preventive Medicine, 62*(2). https://doi.org/10.1016/j.amepre.2021.07.012

[14] Rafajko, C. R., & Muehlenkamp, J. J. (2025). Suicide scripts among sexual and/or gender minority adults. *Suicide and Life-Threatening Behavior, 55*(2), e70012. https://doi.org/10.1111/sltb.70012

[15] National Institute of Mental Health. (2025, March). *Suicide*. https://www.nimh.nih.gov/health/statistics/suicide

[16] Ream, G. L. (2022). Trends in deaths by suicide 2014–2019 among lesbian, gay, bisexual, transgender, queer, questioning, and other gender/sexual minority (LGBTQ+) youth. *Journal of Adolescent Health, 71*(5), 609–615. https://doi.org/10.1016/j.jadohealth.2022.06.017

[17] Ramchand, R. (2022). Suicide among veterans: Veterans' issues in focus. RAND Health Quarterly, 9(3), 21. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9242579/

[18] Rimalt, N. (2007). Women in the sphere of masculinity: The double-edged sword of women's integration in the military. *Duke Journal of Gender Law & Policy, 14*(2), 1097–1120. https://scholarship.law.duke.edu/djglp/vol14/iss2/9

[19] Yin, Y., Workman, T. E., Blosnich, J. R., et al. (2024). Sexual and gender minority status and suicide mortality: An explainable artificial intelligence analysis. *International Journal of Public Health, 69*, 1606855. https://doi.org/10.3389/ijph.2024.1606855

[20] Brenner, L. A., Forster, J. E., Walsh, C. G., Stearns-Yoder, K. A., Larson, M. J., Hostetter, T. A., Hoffmire, C. A., Gradus, J. L., & Adams, R. S. (2023). Trends in suicide rates by race and ethnicity among members of the United States Army. *PLOS ONE, 18*(1), e0280217. https://doi.org/10.1371/journal.pone.0280217

[21] Pryor, E. K., Tyre, M., Brands, S., Flinn, R. E., Stepleman, L. M., & Holt, N. R. (2023). Barriers to mental health care identified by sexual and gender minority individuals in Georgia and South Carolina. *Southern Medical Journal, 116*(3), 264–269. https://doi.org/10.14423/smj.0000000000001524

[22] Gandy, M. E., Kidd, K. M., Weiss, J., Leitch, J., & Hersom, X. (2021). Trans*Forming access and care in rural areas: A community-engaged approach. *International Journal of Environmental Research and Public Health, 18*(23), 12700. https://doi.org/10.3390/ijerph182312700

[23] Williams, K. A., Dakin, E. K., & Lipschutz, A. (2021). LGBT+ older adults in rural South Central Appalachia: Perceptions of current and future formal service needs. *Journal of Gerontological Social Work, 65*(2), 1–22. https://doi.org/10.1080/01634372.2021.1953661

[24] Teti, M., Bauerband, L. A., Myroniuk, T. W., & Koegler, E. (2021). Listening to transgender patients and their providers in non-metropolitan spaces: Needs, gaps, and patient–provider discrepancies. *International Journal of Environmental Research and Public Health, 18*(20), 10843. https://doi.org/10.3390/ijerph182010843

[25] Willging, C. E., Salvador, M. D., & Kano, M. (2006). Brief reports: Unequal treatment: Mental health care for sexual and gender minority groups in a rural state. *Psychiatric Services, 57*(6), 867–870. https://doi.org/10.1176/appi.ps.57.6.867

[26] Stacciarini, J. M., Vacca, R., Wiens, B., Loe, E., LaFlam, M., Pérez, A., & Locke, B. (2016). FBO leaders' perceptions of the psycho-social contexts for rural Latinos. *Issues in Mental Health Nursing, 37*(1), 19–25. https://doi.org/10.3109/01612840.2015.1076914

[27] Haynes, T. F., Cheney, A. M., Sullivan, J. G., Bryant, K., Curran, G. M., Olson, M., Cottoms, N., & Reaves, C. (2017). Addressing mental health needs: Perspectives of African Americans living in the rural South. *Psychiatric Services, 68*(6), 573–578. https://doi.org/10.1176/appi.ps.201600208

[28] Hack, S. M., Larrison, C. R., & Gone, J. P. (2014). American Indian identity in mental health services utilization data from a rural Midwestern sample. *Cultural Diversity and Ethnic Minority Psychology, 20*(1), 68–74. https://doi.org/10.1037/a0033349

[29] Broffman, L., Spurlock, M., Dulacki, K., Campbell, A., Rodriguez, F., Wright, B., McConnell, K. J., Warne, D., & Davis, M. M. (2017). Understanding treatment gaps for mental health, alcohol, and drug use in South Dakota: A qualitative study of rural perspectives. *The Journal of Rural Health, 33*(1), 71–81. https://doi.org/10.1111/jrh.12167

[30] Ingelse, K., & Messecar, D. (2016). Rural Women Veterans' Use and Perception of Mental Health Services. Archives of psychiatric nursing, 30(2), 244–248. https://doi.org/10.1016/j.apnu.2015.11.008

[31] Possemato, K., Wray, L. O., Johnson, E., Webster, B., & Beehler, G. P. (2018). Facilitators and barriers to seeking mental health care among primary care veterans with posttraumatic stress disorder. *Journal of Traumatic Stress, 31*(5), 742–752. https://doi.org/10.1002/jts.22327

[32] Cheney, A. M., Koenig, C. J., Miller, C. J., Zamora, K., Wright, P., Stanley, R., Fortney, J., Burgess, J. F., & Pyne, J. M. (2018). Veteran-centered

barriers to VA mental healthcare services use. *BMC Health Services Research, 18*, 591. https://doi.org/10.1186/s12913-018-3346-9

[33] Fischer, E. P., McSweeney, J. C., Wright, P., Cheney, A., Curran, G. M., Henderson, K., & Fortney, J. C. (2016). Overcoming barriers to sustained engagement in mental health care: Perspectives of rural veterans and providers. *The Journal of Rural Health, 32*(4), 429–438. https://doi.org/10.1111/jrh.12203

[34] Koenig, C. J., Abraham, T., Zamora, K. A., Hill, C., Kelly, P. A., Uddo, M., Hamilton, M., Pyne, J. M., & Seal, K. H. (2016). Pre-Implementation Strategies to Adapt and Implement a Veteran Peer Coaching Intervention to Improve Mental Health Treatment Engagement Among Rural Veterans. The Journal of Rural Health, 32(4), 418–428. https://doi.org/10.1111/jrh.12201

[35] Snell-Rood, C., Hauenstein, E., Leukefeld, C., Feltner, F., Marcum, A., & Schoenberg, N. (2017). Mental health treatment seeking patterns and preferences of Appalachian women with depression. *American Journal of Orthopsychiatry, 87*(3), 233–241. https://doi.org/10.1037/ort0000193

[36] Hanson, M. N., Reese, S., & Newcomer, S. R. (2023). Challenges in accessing mental health care during pregnancy and postpartum in rural Montana. *MCN: The American Journal of Maternal/Child Nursing, 48*(5), 252–257. https://doi.org/10.1097/NMC.0000000000000937

[37] Snell-Rood, C., Staton, M., & Kheibari, A. (2019). Rural women's first-person perspectives on the role of mental health in substance use. *Rural and Remote Health, 19*(4), 5279. https://doi.org/10.22605/RRH5279

[38] LeMasters, K. H., Bledsoe, S. E., Brooks, J., Chavis, S., Little, E., Pevia, K., Daniel, L., Jordan, K., Schindler, A., Lightfoot, A. F., & MI-PHOTOS Project. (2022). The MI-PHOTOS Project: Understanding the health and wellbeing of rural historically marginalized mothers through photovoice. *Health Education & Behavior, 49*(5), 828–837. https://doi.org/10.1177/10901981211057095

[39] Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors influencing mental health screening and treatment among women in a rural South Central Appalachian primary care clinic. *The Journal of Rural Health, 32*(1), 82–91. https://doi.org/10.1111/jrh.12134

[40] Jesse, D. E., Dolbier, C. L., & Blanchard, A. (2008). Barriers to seeking help and treatment suggestions for prenatal depressive symptoms: Focus groups with rural low-income women. *Issues in Mental Health Nursing, 29*(1), 3–19. https://doi.org/10.1080/01612840701748664

[41] Graves, J. M., Beese, S. R., & DeJong, T. L. (2024). Mental health services utilization by rurality: Evidence from the National Institutes of Health All of Us Research Program. *Rural Mental Health, 48*(4). https://doi.org/10.1037/rmh0000267

[42] Vuyk, M. A., Sprague-Jones, J., & Reed, C. (2016). Early childhood mental health consultation: An evaluation of effectiveness in a rural community. *Infant Mental Health Journal, 37*(1), 66–79. https://doi.org/10.1002/imhj.21545

[43] Krieger, N. (2001). Theories for social epidemiology in the 21st century: An ecosocial perspective. *International Journal of Epidemiology, 30*(4), 668–677. https://doi.org/10.1093/ije/30.4.668

[44] Pearlin, L. I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*(3), 241–256.

[45] Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

[46] Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363