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"It's Easier to go to the Beer Store Than Ask for Help": A Qualitative Exploration of Barriers to Health Care in Rural Farming Communities

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Farming is a challenging occupation, not only due to its physical and mental demands but also its sensitivity to environmental, sociocultural, and policy changes. Because of external stressors and often an internal drive to succeed, farmers in rural areas have high rates of prescription drug use, excessive alcohol use, depression, and suicide. Past research has not focused extensively on help-seeking behaviors in the farming community. This study explored perceived barriers to seeking and receiving physical and mental health care in rural farmers. In-depth interviews (30 min–1 hr) were conducted with full-time rural Georgia farmers ($n = 15$) in 10 counties throughout the state. Thematic analysis identified themes and patterns in transcribed interview recordings. Four main themes were identified that related to barriers to accessing care: (a) cultural norms in the farming community; (b) normative beliefs about health care in the farming community; (c) stigma around mental health in the farming community; and (d) formal health care concerns. Future programs that address cultural norms, normative beliefs, and stigma associated with health care should be coupled with policy changes to increase access to health care in rural areas.

Public Health Significance Statement

This article identifies sociocultural norms in rural farming communities that create unique barriers to accessing health care beyond the formal health care concerns commonly found in rural areas.

Keywords: rural health care, barriers to care, stigma, farming community, normative beliefs

Farming is a physically and mentally demanding occupation. Farmers face direct exposure to physical hazards, working with heavy machinery and dangerous chemicals in unpredictable environments (Thelin & Holmberg, 2010). In addition to immediate risks to physical health, farmers face unique stressors such as environmental changes, economic fluctuations, isolation from family and community, and changes in policy and regulations that impact their health and well-being (Braun, 2019; Substance Abuse and Mental Health Services Administration, 2019). A significant proportion of farmers in the United States are self-employed, meaning that while they may do contract work for corporate entities, they are impacted by fluctuations in market prices more than large commercial operations (United States Department of Agriculture, 2017a). Farmers with

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high-stress levels or living with mental health issues may be less productive and more vulnerable to alcohol consumption and mental health disorders, leading to difficulty maintaining relationships and managing the demands of daily life (Rural Health Information Hub, 2022). Maladaptive coping strategies, such as the use of alcohol, tobacco, and other drugs may result in increased distress, depression, poor health outcomes, and suicide in this group (Brumby et al., 2013; Fraser et al., 2005).

Farmers have few touchpoints with the traditional health care system. Health care resources in rural areas are sparse, creating geographic barriers to receiving quality health care and compounding health issues in the farming community (Southwest Rural Health Research Center, and Texas A&M School of Public Health, 2021). Even when health care services are available in rural areas, they are underutilized due to financial barriers, perceived lack of quality, stigma, and a belief in self-reliance among farmers (Hagen et al., 2022). Farmers are less likely to have health insurance or receive Medicare or Medicaid, exposing them to higher health-related financial risks (USDA, 2017a). Mental health care resources are even more limited in rural areas. Many people in rural areas rely on their primary care physicians for all health services, even though some are ill-equipped to treat mental health disorders (Jameson & Blank, 2007).

Many farmers do not believe in mental health issues and stigmatize those who seek mental health care (Jameson & Blank, 2007). Public stigma gives rise to stereotypes, prejudice, and discrimination (Corrigan, 2004), as well as self-stigma influencing farmers' normative beliefs and negative attitudes about seeking mental health care (Stewart et al., 2015). Stigmatization of mental health care is rooted in farmers' adherence to traditional stereotypes about masculinity, reinforced by a predominantly male farming community (USDA, 2017a). The impact of masculinity on health in different populations has been widely studied, including examinations of how traditional masculine ideals impact men's mental and physical health (George & Fleming, 2004). Conforming to masculine norms influences not only engagement with providers but overall health literacy as well (Jarrett et al., 2007). This lack of engagement is evident in rural farmers who believe self-reliance and masculinity should be enough to address mental health concerns (Milner et al., 2019; Staniford et al., 2009). These barriers to mental health care contribute to high rates of self-medicating with alcohol and other substances in rural farmers (Roy et al., 2013).

Existing research on health care for farmers in the United States focuses primarily on health outcomes or health issues linked to occupational factors (Scheyett et al., 2019). This research includes the utilization of health care, examining expenditures, insurance coverage, and county-level resources as a proxy for access (American Farm Bureau, 2021; Turner et al., 2018). There is a gap in understanding barriers to health care services in the farming population, especially barriers to accessing mental health care. Farmers are less likely to seek health services and few health interventions have been implemented to address barriers in the agricultural community (Brew et al., 2016). No published studies used in-depth interviews with rural farmers to understand barriers to health care in the United States. Barriers to care in high-risk, hard-to-reach populations need to be identified to inform outreach programs for vulnerable groups such as farmers. A pilot study in Michigan using a focus group highlighted a need to understand barriers to care in farming populations throughout the country due to regional differences (Wright et al., 2021). The specific objective of this study was to explore perceived barriers to seeking and receiving physical and mental health care in rural farmers.

Method

Setting

This study used data collected from full-time family farmers whose farms are organized as a sole proprietorship, partnership, or family corporation. Family farms exclude farms organized as nonfamily corporations or cooperatives, as well as farms with hired managers (USDA, n.d.). Respondents resided in 10 rural Georgia counties. Most of the state is rural, with 120 of Georgia's 159 counties classified as nonmetropolitan (USDA, 2017b). Agribusiness is Georgia's leading industry and the state has 42,439 farms. The 10 counties selected for this study were geographically dispersed and participants were recruited so that different types of farming were represented in the sample.

Participant Recruitment

Full-time farmers participated in 35-min to 1-hr interviews. Full-time farmers derive 75% of their income from farming, this was the sole inclusion criteria for this study. Researchers were interested in interviewing full-time farmers instead of farm workers or farm managers, due to reported differences in stress, job satisfaction, and health care access (Basey et al., 2022). Recruitment strategies included: advertising interviews with cooperative extension agents; sharing information with farmers at community meetings; and asking farmers to share study opportunities with fellow farmers. Word-of-mouth recruitment from fellow farmers was the most successful recruitment strategy, with 87% of participants resulting from snowball sampling.

Data Collection

Researchers collected data from a total of 15 rural full-time farmers. The research team traveled to 12 farms to conduct 13 of the interviews in–person and two of the interviews were conducted online. The interview script was based on a recently conducted literature review highlighting gaps in data collection and was developed with faculty and staff familiar with research in the field (Watanabe-Galloway et al., 2022). The interviews followed a script to collect data and procedures were identical to decrease interview bias. Interview responses varied in duration based on how farmers responded to each question. Some farmers offered more nuanced perspectives in response to interview questions. Respondents were asked a total of 17 questions including: "How does the way that other members of your community view mental health issues impact your likelihood of seeking treatment for issues with mental health you may be experiencing?" "If you have experienced any negative health effects as a consequence of farming, were you able to receive treatment?" and "Is there an existing treatment option for mental health issues or substance abuse issues in your area that you are aware of?" Researchers used structured follow-up questions to explore dominant themes based on the previous literature (Raine, 1999). Data collection were stopped once saturation was observed in interview responses. Participation was voluntary and participants could decline to answer any question or terminate the interview at any time. All participants provided verbal and written informed consent and received $100 for participation. This study was approved by the institutional review board.

Data Analysis and Interpretation

Audio tapes from the interviews were transcribed and cross-checked by researchers to ensure accurate documentation. The research team derived specific thematic categories from each interview, then developed a coding dictionary based on a preliminary review. The coding dictionary included keywords and quotes that represented topics conveyed in the transcripts. Researchers searched for each code to ensure all interviews included information related to identified themes. Researchers broke text down by question to reveal thematic categories and highlight relevant interview responses, then created a table listing themes, subthemes, and quotes.

Results

Participant Characteristics

A total of 15 rural farmers were interviewed in 10 counties throughout the state. Most farmers interviewed were male (93%), with one female farmer interviewed. Many farmers had been managing their own operations for 5–10 years (53%) and had grown up in a farming community. Participants represented a wide range of generations of farmers. Most farmers interviewed ran a mixed operation with a combination of row cropping and livestock.

Physical health issues reported by farmers included: chemical burns, blisters and lacerations, chronic pain from repetitive motion, overweight/obesity, mouth ulcers, chest pain, acid reflux, and injuries from farming equipment. Mental health issues reported by farmers included anxiety and posttraumatic stress disorder (PTSD). PTSD was identified in farmers who had traumatic injuries on the farm or knew others who had a serious farming-related accident. Anxiety was self-reported by 80% of participants, with symptoms including excessive worrying, loss of sleep, and physical manifestations like mouth ulcers and weight loss.

A majority of the farmers preferred to see their primary care physician (PCP) for health issues. Of the farmers who identified their PCP as a trusted

health care resource, 80% said they would talk to their PCP about mental health issues if they felt like it became a problem. Only 36% of the farmers knew of mental health care resources in their area.

Four main themes were identified that related to barriers to accessing care: (a) cultural norms in the farming community (b) normative beliefs about health care in the farming community, (c) stigma around mental health in the farming community, and (d) formal health care concerns. Each of these themes and their associated subthemes are described below, and an overview can be found in Table 1.

Formal Health Care

Farmers' primary concerns were access to health care, with many citing the time and travel

Table 1
Themes Identified for Barriers to Care

Themes	Concepts	Quotes
Formal health care challenges	• Physical distance • Low resources • Disconnect from PCP • Insurance concerns • Accessibility of mental health care services	"We're 30 minutes, 40 minutes from the nearest hospital? In all honesty, they ain't that great of ones that far, and it's kind of one of those things." "You're paying out of pocket for all that wear and tear. And there's no way you can combat that."
Cultural norms in farming community	• Pride • Privacy/anonymity • Masculinity	"That's kind of how I look at it. Just suck it up and get over yourself, type deal. I don't think it makes you less of a man by talking about it. I'm just not going to go out and start talking about what is going on." "… farmers are so much more prideful and they had to hide that pride. And it may be there's a lot of people in this world that don't show what they are really going through." "My doctor, look, I go to church with him. you see him out and I know doctor patient confidentiality and everything but … almost like maybe I'm going to go to a doctor outside my local county, that way I don't have to see them out and about in town."
Normative beliefs	• Self-reliance • Generational gaps • Trivialization/under prioritization of mental health care • Resilience	"I'm comfortable talking to y'all about it but I wouldn't spend my hard-earned cash to talk to a therapist about it." "In a way it feels like a flaw that you have that I can't deal with something I'm supposed to be able to deal with." "I'm one of those guys where if something goes wrong, I'm going to the doctor. Now a lot of guys our age are not going to do that. I've learned it's better to go ahead and get checked out because [uncle] passed away a couple of years ago. He wouldn't go to the doctor. His daddy was the same way, and if they would have gone, things would have been prevented."
Stigma	• Public stigma • Self-stigma	"I guess like, yeah if word gets out that you're going to get help or whatever people will talk." "Oh he just can't take the stress. Or they wouldn't want to get help if the word got out …. I just worry about what people would say."

Note. PCP = primary care physician.

commitments required to receive care as major barriers due to physical distances from resources. Many farmers also reported stress about the quality of care available in their area, reporting concerns about the impact that isolation would have on their ability to receive care. The majority of interview participants (93%) had not seen a mental health care professional. Twenty percent had received anxiety medications through their PCP.

Low resources in rural areas and proximity to quality care were the most described source of stress and often resulted in farmers commuting long distances to access reliable sources of care. When asked about accessibility of care in their area, one farmer responded, "There's doctors here but if you want to get anything done, you got to go [two counties over]." One farmer expressed frustrations with trying to balance mental health care and responsibilities on the farm, "I drove over 35 minutes one way to speak to a therapist. But then a lot of times things came up on the farm and I had to cancel." In addition to frustrations about distance from services, farmers spoke about the challenges of leaving operations to see physicians who were insensitive to their work schedules. One farmer expressed frustrations when seeing her local doctor: "Essentially we just keep paying for them to tell us, you have to take time off, you have to take time off work."

When farmers were able to access care, financial concerns with cost or inadequate insurance coverage were another significant barrier. One farmer described the impact working on a farm had on her husband as "The physical aspect is bad. His hips are messed up his joints just from carrying the buckets of chickens. And good luck getting a good insurance [plan] because you're self-employed." When asked how a lack of insurance coverage impacted their consumption of health care, one farmer said "You just pay for it and put it on a card and hope you make that money back. You probably won't, but you hope so."

Farmers also expressed a lack of knowledge about how to approach receiving assistance with mental health issues. Farmers frequently reported a lack of access to mental health care and uncertainty of how to find care if they did need it. One farmer said "I wouldn't exactly know where to start. I'd probably ask my wife." Another responded "Yeah there was nothing around here. I know my local doctor but no [mental health resources]." Farmers who lived closer to metropolitan areas knew more about mental health care services than farmers who lived in more isolated areas.

Cultural Norms in Farming Communities

Pride, privacy, and masculinity emerged as cultural norms influencing help-seeking behaviors in the farming community. Many interview participants (66%) mentioned pride as a barrier to accessing health care, connecting resilience within the community to tendencies of isolationism in some cases. One farmer said "People are reluctant to ask for help. I think it's pride." Another farmer acknowledged dissonant beliefs within their community, stating "People are reluctant to ask for help. People aren't reluctant to give help, but people are reluctant to ask for help." Pride not only impacted farmers' willingness to reach out to others but also influenced their own perceptions of other's coping strategies. One farmer mentioned "Farmers are very independent … proud. So I feel sure they do a good job [hiding maladaptive coping strategies]."

Privacy emerged as another major barrier to seeking both physical and mental health care in interview participants, with 27% of farmers reporting this theme. This was most evident when discussing mental health care resources. Farmers were concerned about community awareness of those who appeared to be struggling with their mental health, noting a reluctance to even attend a community meeting on the topic. One farmer said, "everybody in the community knows that you're having the meeting and they drive by and 'oh, there's [Farmer Name] truck."

The impact of conventional masculine ideals, such as the desire to appear strong and resilient to challenges, was expressed by several participants. Several farmers expressed concerns that publicly seeking care, especially for mental health issues, would make them look feeble to their community, with one farmer saying: "I don't want people to see me go here [mental healthcare office] because they think I'm weak." One farmer mentioned that farmers' spouses were crucial influences on help-seeking behavior, stating: "Depends on if they have a wife or not. He is not going to go out and get help and support and things like that on his own." These masculine ideals also influenced participants' willingness to discuss stress and mental health with other

farmers, even when both parties may have been experiencing similar stressors. Elaborating on this, one farmer said "you know all these farmers, they are rough and tough and they don't really talk to each other about that. I guess it is almost a man thing. Yeah, you want to be tough, not show your weakness." Notably, these sentiments were not the same for physical health issues. One farmer stated "we rely on each other. You know anybody who had an unexpected issue or death in the family. We go down the road to help them plant or help them spray." Informal conversations happening about health and mental health in the farming community can influence normative beliefs and the likelihood of seeking care.

Normative Beliefs

Normative beliefs around self-reliance, resilience, generational gaps, and trivialization of mental health care were linked to a general avoidance of care within farming communities. Every interview participant acknowledged the impact of these normative beliefs on their readiness to seek out and access care. Participants discussed self-reliance in the farming community and its influence on willingness to acknowledge services, with one farmer describing his father's generation this way: "They don't need help, they can handle it themselves." Self-reliance was also reported by current farmers about general medical care with one farmer saying, "We are 100% fending for ourselves. It's our problem and it's not anyone else's problem. We treat ourselves." Another farmer reported that instead of going to a follow-up appointment for a broken bone he "just cut [his] casts off [and] got better that way."

Generational differences about self-reliance were discussed by several interview participants. Many participants noted farmers of past generations would be reluctant to sit down to discuss health with providers in the first place, with one interviewee stating "I think they [older farmers] would be more guarded .... I think it definitely takes trust to have those kinds of conversations." One farmer recounted his experience being confronted by community members who found out that he had been prescribed medication to manage symptoms of anxiety:

> Some older people found out that I was taking medicine for treatment. They were like, you know, you don't need that. You shouldn't be freaking out .... You should just have enough faith that you shouldn't be freaking out. But I was like I got a whole lot of faith baking [seeds burned in drought] out there.

Most farmers felt like there was a generational shift occurring in acceptance of mental health care. One farmer reported, "As for the younger generation I think they've come around to tend to want help and talk to people." Many interview participants reported dissatisfaction with health care providers, stating that many doctors did not understand their lifestyle, so much so that one farmer said "[It is] easier to go to a beer store than ask for help." Provider distrust and lack of agricultural knowledge could be contributing to self-reliance in the young farmer population.

The trivialization of care for farmers' issues was particularly evident when discussing help-seeking behavior for mental health care. Farmers frequently downplayed their own stress, with one farmer saying: "I'm not dealing with nothing, I can handle it." Other farmers echoed these feelings, describing their views of engaging with mental health services this way: "I don't think it's nobody else's problem for me to go and vent to, [I] just keep it bound up inside of me, I guess," Another farmer responded, "Am I going to take an hour or two out of my day to go wallow in my self-pity?"

In interviews, farmers downplayed their struggles to appear more resilient. This minimization of personal struggles was frequently observed and may contribute to low rates of engagement with health care services within rural farming communities. This could be linked to beliefs passed down by prior generations. For example, one farmer said: "These older guys think they're these mountains and they're just going to stand up through the storm no matter what [...] and a lot of these older guys are not willing to show any sign of weakness." Several interview participants seemed to aspire to the same level of resilience that they had seen in their predecessors, despite acknowledging that they were experiencing considerable stress themselves and witnessing members of earlier generations experience negative health outcomes that they attributed to poor stress management. One farmer explained how the challenges faced by earlier generations had molded his own views about accessing care, stating "I'm inoculated to a certain level of stress. My dad and granddad have been down that road way more times than I have." This same farmer reported hesitancy in reaching out for mental health care services.

Stigma

Fear of being stigmatized by community members for seeking mental health care was commonly reported by interview participants (53%). When explaining how perceptions of community members would impact their likelihood of seeking mental health care, one farmer said "Everybody likes to keep their image up. [In small towns] you see these people you've grown up with regularly every day." Based on farmer responses, it was clear that individuals who were seen accessing care for mental health would be perceived as having some shortcoming or inability to handle the stress of the job. One farmer commented that community members would see it as a "big sign of weakness" and others in the community would believe that "he can't cope, that would be the sentiment."

Public stigma associated with mental health care in farming communities may lead to internalized self-stigma. Farmers who had been treated for mental health disorders reported stigma associated with prescribed medication. One farmer reported that after being prescribed medication to help manage anxiety, he had members of his community tell him that he "should have enough faith to not worry." Other farmers openly expressed a dislike of medications that had an impact on the user's mood, such as antidepressants.

Discussion

Many farmers reported a combination of cultural norms, normative beliefs, stigma, and formal health care issues influencing their help-seeking behaviors. Farmers' accounts, coupled with existing literature on rural health challenges (Gong et al., 2019), highlight important gaps in primary health care, requiring adaptations to practice to better serve farming populations. While long wait times and securing appointments at primary care providers are problems reported among the general population (Zhou et al., 2015), the unpredictability of farmers' working hours exacerbated access to health care issues. In addition, respondents believed that physicians did not understand the demands of agriculture work and schedule constraints, which came off as insensitive to the farming population. Provider knowledge of the agriculture industry and the lifestyle of farmers increases the likelihood of farmers engaging in health-seeking behavior (Gerrard, 2000; Rosmann, 2005). An additional study by Hagen et al. calls for providers, resources, and messaging to be tailored to farmers' needs through an individualized approach, and also normalizing mental health care and increasing awareness of existing services (Hagen et al., 2022). Training physicians in rural areas to understand agriculture and the realities for farming life could lead to higher quality of care in farmers and increased credibility in the farming community, particularly for mental health care services.

Barriers to care were more apparent for mental health care with a combination of cultural norms in the farming community, stigma, and normative beliefs influencing farmers' intentions to engage with mental health services. Even when farmers described scenarios in which they would consider going to therapy or a similar intervention, they expressed concerns about their privacy and the negative impact that publicly seeking care for a mental health disorder would have on other community members' perceptions. These themes are consistent with previous literature illustrating barriers to mental health care in rural areas and underutilization of existing services (Schultz et al., 2021). Many of the farmers were still seeing the same family doctors they had seen their entire lives and worried about disclosing mental health information to someone they see at church or around their hometown. Some even mentioned seeing doctors outside of their local county, but this is difficult due to geographic isolation and a lack of physicians in rural areas (Kepley & Streeter, 2018).

Mental health awareness campaigns aimed at dispelling public stigma have the potential to increase the utilization of mental health care services for farmers in rural areas. Farmers have identified social media-based awareness campaigns as helpful in decreasing stigma associated with mental illness and trust messages that are developed by individuals who have agricultural backgrounds (The Do More Agriculture Foundation, 2020). The use of positive messaging to counter negative normative perceptions of mental health services in rural agricultural communities may increase mental health help-seeking within the farming industry. Positive messaging could also be developed to target farmers' spouses, as several farmers reported that their wives influenced their decisions to engage in mental health help-seeking behavior.

Positive messaging to counter masculine subjective norms could be used to address the complex interaction of gender with help-seeking behavior. This relationship should be the focus of future research and programs specifically targeting the spouses of farmers in rural areas may be useful for increasing engagement with mental health services in these communities. The impact of subjective norms on engagement with medical care in rural areas has not been extensively researched, although one qualitative study of men in labor-intensive jobs found that subjective norms, particularly from spouses and family members, were effective at increasing help-seeking behavior and engagement with care (Mahalik & Backus Dagirmanjian, 2018).

Rural farming communities have unique cultural characteristics that pass from generation to generation, and the insular nature of these remote communities may delay the adoption of new beliefs and practices. Self-reliance is a source of pride in the farming community and has been identified as a barrier for mental health care (Pattyn et al., 2014). Participants discussed a distinct generational gap in willingness to discuss mental health, let alone seek treatment. Many participants reported that their parents' generation would be unwilling to participate in a discussion about stress or mental health. Older generations in rural areas place more stigma on mental health care, and the influence of their normative beliefs should not be underestimated (Ramos et al., 2015). Younger farmers appeared more open to discussion of mental health and seeking care. Further research should be conducted to determine the most effective strategies for altering the cultural norms of rural farming communities to increase willingness to engage in help-seeking behavior and care utilization.

Some of the barriers to health care access identified were related to accessibility of health care providers in rural areas. Issues raised in interviews included lack of access to services due to low resources, time constraints to travel to resources in distant counties, and problems with insurance coverage. Programs that address normative perceptions and breakdown stigma associated with health care should also be coupled with health policy changes that reduce geographic barriers to care, novel strategies to improve provider shortages, health insurance policies that meet farmers' needs, and improved technological access to support telehealth.

Qualitative interviews identified factors that influenced the help-seeking behaviors of farmers; however, this methodology limits the number of participants involved in the study due to the time required to collect data. Convenience sampling was used to source interview participants with a range of perspectives informed by agricultural specialties and regional differences in experience. Another limitation of this study was that information about the age of farmers was not collected by researchers. The interviews took place in one Southeastern state. Expanding the scope of interviews beyond a single state would offer additional insights into barriers to care faced by farmers. An additional limitation of this study was that it only included a single female farmer.

Public Health Implications

These results indicate that there is not only a need for increased access to care in rural communities but also a need for greater cultural competence among those who provide health care in rural farming communities. Another recently conducted qualitative study of farmers in Canada also found that a lack of practitioner awareness of the realities of farm life was a major barrier for farmers trying to engage with mental health services (Hagen et al., 2022). This article identified specific themes that need to be incorporated into training for rural care practitioners, including formal health care concerns, cultural norms, normative beliefs, and stigmatization of mental health care. Future research should seek to identify barriers to care that exist for farmers outside of the state of Georgia. This study highlighted specific cultural and normative beliefs that impact farmers help-seeking behavior; future research should explore if these barriers also apply to broader populations.

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