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Identifying Perceived Barriers to Seeking Psychological Help Among Rural Youth

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A B S T R A C T

Objective: This study aimed to identify and explore the perceived sociocultural, structural, and psychological barriers that prevent rural youth in Greece from seeking professional psychological help.

Methods and Materials: This qualitative study employed a phenomenological design to capture the lived experiences of rural youth regarding help-seeking for mental health concerns. A purposive sample of 22 participants aged 18–25 from rural areas across Greece was selected. Data were collected through in-depth semi-structured interviews conducted face-to-face and via online platforms until theoretical saturation was reached. Each interview lasted between 45 and 70 minutes and was audio-recorded with participants' consent. Transcripts were analyzed using Braun and Clarke's thematic analysis approach, supported by NVivo 14 software to code, categorize, and identify recurring patterns. Ethical standards, including confidentiality, informed consent, and participant anonymity, were strictly maintained throughout the research process.

Findings: Analysis revealed four major themes explaining barriers to professional help-seeking: (1) cultural and social stigma, including fear of labeling, gender norms, and family expectations; (2) structural and logistical barriers such as distance, financial hardship, and lack of local services; (3) psychological and personal factors, including low mental health literacy, self-stigma, and fear of self-disclosure; and (4) interpersonal and environmental influences involving peers, family, schools, and community norms. These themes reflect the intertwined effects of cultural identity, limited infrastructure, and individual beliefs on help-seeking behaviors. The results indicate that stigma, limited perceived behavioral control, and restrictive social norms jointly contribute to the low utilization of psychological services among rural youth.

Conclusion: The study underscores that addressing help-seeking barriers requires multifaceted interventions integrating cultural sensitivity, mental health literacy, and accessible rural services. Promoting community-based psychoeducation and destigmatization campaigns may enhance openness toward professional psychological support among rural Greek youth.

Keywords: *Rural youth; help-seeking barriers; stigma; mental health literacy*

1. Introduction

Adolescence and young adulthood represent critical developmental periods in which mental health concerns often first emerge, yet help-seeking for psychological difficulties remains alarmingly low among young people globally. Despite an increased awareness of mental health issues, numerous studies have highlighted the persistent gap between the prevalence of psychological distress and the willingness to seek professional help (Ariyati, 2024; O'Donnell et al., 2025; Omari et al., 2024). This gap is particularly pronounced in rural populations, where limited access to mental health services, cultural stigma, and gendered expectations create unique barriers to help-seeking behavior (Boyd-Bais & Papps, 2025; Medrano et al., 2025). Rural youth often experience overlapping disadvantages—including geographic isolation, fewer educational and occupational opportunities, and restricted access to confidential services—that compound their reluctance to seek psychological assistance.

Understanding the psychological, social, and structural barriers to help-seeking among rural youth is critical for designing culturally sensitive and contextually appropriate interventions. Evidence suggests that mental health literacy, perceived stigma, and attitudes toward professional help play decisive roles in shaping help-seeking intentions (K et al., 2024; Özkan & Özbıçakçı, 2024; Saboohi et al., 2025). In particular, adolescents and young adults in nonurban regions may internalize beliefs that frame emotional vulnerability as weakness, thereby normalizing self-reliance and silence (Medrano et al., 2025; Sianko et al., 2025). These beliefs often emerge from collective cultural norms emphasizing endurance and self-control rather than emotional expression. Consequently, exploring the subjective perceptions and lived experiences of rural youth is vital to understanding the multifaceted nature of help-seeking barriers.

Across international contexts, research has increasingly emphasized that help-seeking among adolescents is influenced by a complex interplay of individual, social, and environmental determinants. According to (Cavelti et al., 2024), sociodemographic variables such as gender, socioeconomic status, and urban versus rural residence significantly affect attitudes toward mental health care. Adolescents living in rural settings often perceive fewer opportunities for confidentiality and encounter stronger social stigma than their urban counterparts. Similarly, studies by (Aras & Peker, 2024) and (Aras & Peker, 2025a) demonstrated that attitudes toward psychological help and intentions to seek therapy are closely aligned with constructs of the Theory of Planned Behavior (TPB)—namely, attitudes, subjective norms, and perceived behavioral control. Within this theoretical framework, negative community norms and limited perceived control due to service scarcity contribute to reduced help-seeking intention.

Cultural and gender-specific expectations also play critical roles. In a mixed-methods study conducted in Hong Kong, (Chen et al., 2024) found that adolescents' coping strategies following peer suicidality were deeply tied to their cultural values, where help-seeking was often viewed as a loss of face. Similar gender-related barriers were documented in Ireland, where male university students expressed higher suicide stigma and lower help-seeking attitudes than females (O'Donnell et al., 2025). In India, studies revealed that adolescents' readiness to seek psychological assistance was strongly related to their mental health literacy and perceived community stigma (K et al., 2024; Sharma & Sharma, 2025). These findings collectively suggest that sociocultural constructs—ranging from collectivist beliefs to gendered socialization—are central to understanding global variations in mental health help-seeking among youth.

Rural contexts intensify these barriers by combining socio-spatial isolation with tight-knit community structures that heighten fear of exposure and gossip (Boyd-Bais & Papps, 2025). Among rural women in particular, social networks often function as both sources of emotional support and surveillance, limiting disclosure of mental health struggles. Similarly, rural men in patriarchal cultures such as those in Mexico face cultural scripts of *machismo* that discourage emotional openness while valuing stoicism and resilience (Medrano et al., 2025). The related construct of *caballerismo*, although more positive, emphasizes responsibility and control, which can still hinder open discussion of psychological vulnerability. Research conducted by (Widyarini & Linsiya, 2025) using the TPB framework in Indonesia found that adolescents' help-seeking intentions were strongly mediated by perceived social approval and subjective norms. When these norms discourage emotional disclosure, individuals are more likely to adopt avoidance or denial as coping strategies.

In Greece and similar Mediterranean societies, rural communities are often characterized by collectivist orientations that reinforce social reputation, family honor, and emotional restraint. Such cultural orientations may explain why many rural youth internalize stigma and resist

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seeking formal mental health care, instead turning to family members, peers, or religious figures for informal support. (Ariyati, 2024) similarly noted that in religiously conservative regions, self-stigma and public stigma interact, leading adolescents to perceive therapy as a moral or spiritual failure. The overlap between moral codes and cultural expectations thus creates a "double stigma"—one related to mental illness and another tied to perceived moral weakness.

Mental health literacy (MHL) has emerged as a key determinant of help-seeking behavior. It encompasses knowledge about mental health disorders, recognition of symptoms, and awareness of available professional resources. Studies in both Asian and Middle Eastern contexts underscore the strong association between MHL and help-seeking attitudes (Özkan & Özbıçakçı, 2024; Saboohi et al., 2025). For example, (Saboohi et al., 2025) demonstrated that a culturally adapted mental health literacy curriculum for Iranian students significantly improved their willingness to seek psychological help. Similarly, (K et al., 2024) found that adolescents in Kerala, India, who received mental health education exhibited higher perceived self-efficacy and reduced stigma. In another study from Maharashtra, (Madhuri & P., 2024) observed that youth with greater mental health knowledge were more capable of recognizing psychological symptoms and expressing readiness to seek support.

Digital literacy also plays an increasingly influential role, especially in regions where in-person mental health resources are scarce. The study by (Özkan & Özbıçakçı, 2024) introduced a web-based MHL education program for adolescents, which successfully enhanced their recognition of mental health issues and reduced misconceptions about therapy. However, while online resources provide promising alternatives, technological limitations and concerns about confidentiality often reduce their utility in rural settings. These findings suggest that improving both mental and digital literacy may mitigate some rural barriers, but deeper cultural and social transformations remain necessary to normalize help-seeking.

Stigma—both public and self-directed—continues to serve as one of the most powerful deterrents to seeking psychological help among adolescents (Ariyati, 2024; Sampoornam, 2025). Public stigma refers to negative societal attitudes toward individuals with mental health challenges, while self-stigma involves the internalization of these prejudices. (Sampoornam, 2025) found that a culturally tailored psychoeducation program in rural India significantly reduced stigmatizing attitudes among adolescents and improved help-seeking behavior. Similarly, (Ariyati, 2024) demonstrated that self-stigma strongly mediated the relationship between public stigma and counseling intentions in students attending religious schools. When adolescents perceive mental illness as socially undesirable or morally deficient, they are more likely to avoid seeking formal help—even when they recognize the need.

The internalization of stigma often interacts with emotional regulation patterns learned in early family and social environments. In their study of psychosocial determinants of adolescent disclosure, (Sianko et al., 2025) emphasized that willingness to disclose personal difficulties depends not only on perceived stigma but also on emotional safety and trust in relationships. Youths who anticipate judgment or misunderstanding are more likely to suppress emotional distress, engage in self-reliant coping, or seek informal help from peers. The same dynamic is reflected in the Greek rural context, where emotional expression is often equated with weakness and self-control is culturally rewarded.

Gender differences further shape the willingness to seek psychological help. According to (O'Donnell et al., 2025), male students in Irish universities exhibited significantly lower help-seeking attitudes compared to female students, reflecting enduring stereotypes that discourage vulnerability. In rural settings, these gender norms are often magnified, as traditional expectations valorize male stoicism and discourage emotional openness. In contrast, women may face moral scrutiny or gossip for publicly discussing emotional struggles, as observed in rural farming communities by (Boyd-Bais & Papps, 2025). Similarly, in patriarchal societies, young women risk being labeled as "emotionally unstable" or "unfit for marriage" if they seek therapy, illustrating how gender intersects with cultural stigma.

The findings of (Medrano et al., 2025) in rural Mexico deepen this understanding by distinguishing between *machismo*—a harmful masculine ideal emphasizing dominance and control—and *caballerismo*, which stresses family protection and responsibility. Both constructs influence help-seeking behaviors by framing psychological vulnerability as incompatible with masculine identity. (Aras & Peker, 2025a) similarly noted that adolescents' intention to seek psychological help can be enhanced through targeted interventions addressing gendered beliefs and social approval patterns. This suggests that gender-responsive

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mental health education could play a crucial role in dismantling the cultural stereotypes that perpetuate avoidance of therapy.

The Theory of Planned Behavior (TPB) provides a valuable framework for understanding adolescent help-seeking intentions. According to (Widyarini & Linsiya, 2025), TPB posits that behavior is guided by three central determinants: attitudes toward the behavior, subjective norms, and perceived behavioral control. In the context of mental health, negative attitudes toward therapy, disapproval from significant others, and perceived lack of access collectively suppress help-seeking intention. (Aras & Peker, 2025b) empirically validated this framework by developing reliable scales for assessing adolescents' attitudes and intentions toward psychological help, demonstrating that interventions targeting these determinants can effectively increase help-seeking behavior. (Aras & Peker, 2025a) further tested an intervention program based on this model and found significant improvements in both attitudes and behavioral intentions post-intervention. These findings highlight the importance of structured educational programs and targeted psychoeducation in reshaping norms and attitudes among youth.

(Saboohi et al., 2025) and (Sampoornam, 2025) similarly found that school-based or community-based psychoeducation programs can reduce stigma and improve perceived behavioral control, thereby enhancing help-seeking readiness. Furthermore, the integration of digital MHL tools, as shown by (Özkan & Özbıçakçı, 2024), provides scalable and accessible avenues for youth engagement. However, for rural youth, such interventions must be adapted to account for cultural sensitivity, technological access, and trust-building within close-knit communities.

Despite these advancements, considerable gaps remain in understanding the specific perceptions and lived realities of rural youth regarding mental health care. Much of the current evidence originates from urban populations or school-based samples, with limited qualitative inquiry into how rural cultural identities and community dynamics shape mental health behavior (Cavelti et al., 2024; Omari et al., 2024). Furthermore, existing interventions are often modeled after Western paradigms, which may not align with local values and collective norms. Studies such as (Madhuri & P., 2024) and (K et al., 2024) underscore the need for contextually grounded research that reflects regional variations in literacy, social cohesion, and service infrastructure.

In Greece, rural youth face additional cultural and infrastructural constraints, including limited access to mental health professionals, economic hardship, and strong community surveillance that amplifies stigma. Although national initiatives have sought to expand digital mental health resources, these efforts remain insufficient to address deep-seated social and cultural deterrents. Therefore, a nuanced exploration of the perceived barriers to seeking psychological help among Greek rural youth is urgently needed.

The present study aims to identify and explore the perceived barriers to seeking psychological help among rural youth in Greece through a qualitative exploration of their lived experiences.

2. Methods and Materials

2.1. Study Design and Participants

This study adopted a qualitative research design aimed at exploring and identifying the perceived barriers to seeking psychological help among rural youth in Greece. The qualitative approach was chosen to allow an in-depth understanding of participants' subjective experiences, beliefs, and socio-cultural factors that shape help-seeking behaviors. The study employed a phenomenological framework to capture the lived experiences and personal meanings attached to mental health and help-seeking within rural contexts.

A total of 22 participants were recruited through purposive sampling to ensure diversity in gender, age (18–25 years), educational background, and geographical location within rural areas of Greece. The inclusion criteria required participants to (a) be residents of rural communities, (b) identify as youth (ages 18–25), and (c) have some awareness or experience with mental health challenges either personally or among peers. Participants were recruited through community centers, youth organizations, and local social media networks.

Data collection continued until theoretical saturation was achieved—that is, when no new themes or insights emerged from additional interviews, and data redundancy was observed.

2.2. Measures

Data were collected using semi-structured interviews, which allowed flexibility for participants to express their perspectives while ensuring consistency in key discussion

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topics. The interview guide included open-ended questions focusing on participants' understanding of psychological help, perceived barriers to seeking professional support, cultural beliefs regarding mental health, and preferred coping mechanisms. Example questions included:

- "How do people in your community usually deal with psychological or emotional problems?"
- "What might make it difficult for young people here to seek help from a psychologist or counselor?"
- "What kind of reactions do you expect from others if someone seeks psychological help?"

Each interview lasted between 45 and 70 minutes and was conducted either face-to-face or via secure online video calls, depending on participants' availability and location. All interviews were audio-recorded with consent and subsequently transcribed verbatim in Greek, then translated into English for analysis. Field notes were also taken to capture contextual and nonverbal cues during interactions.

2.3. Data Analysis

Data were analyzed using thematic analysis following Braun and Clarke's six-step framework. The analysis aimed to identify, code, and interpret recurrent themes representing the barriers perceived by rural youth in seeking psychological help. The process began with familiarization through repeated readings of transcripts, followed by initial open coding to label significant statements and meanings. Codes were then organized into broader categories and refined into overarching themes.

To ensure rigor and transparency, the analysis was supported by NVivo 14 software, which facilitated systematic coding, data retrieval, and visualization of emerging relationships among themes. The research team engaged in peer debriefing and reflexive journaling throughout the process to minimize researcher bias and enhance credibility.

Finally, the trustworthiness of findings was established through triangulation of data sources, member checking with selected participants, and maintaining a detailed audit trail documenting the analytic process.

3. Findings and Results

The study included 22 rural youth participants from different regions of Greece, aged between 18 and 25 years (M = 21.4). Among them, 12 were female (54.5%) and 10 were male (45.5%). Most participants were undergraduate students (n = 9; 40.9%), followed by high school graduates (n = 6; 27.3%), vocational training students (n = 4; 18.2%), and university graduates (n = 3; 13.6%). In terms of employment, 8 participants (36.4%) reported part-time work, 6 (27.3%) were unemployed, 5 (22.7%) were full-time employed, and 3 (13.6%) were studying without employment. The majority were single (n = 18; 81.8%), while 4 (18.2%) were in committed relationships. Participants represented rural communities from Epirus (n = 5; 22.7%), Thessaly (n = 6; 27.3%), Central Macedonia (n = 7; 31.8%), and Peloponnese (n = 4; 18.2%). All participants were native Greek speakers, and none had previously sought formal psychological services. This demographic distribution ensured a diverse representation of rural youth experiences across different social, educational, and geographic contexts in Greece.

Table 1

Themes, Subthemes, and Concepts (Open Codes)

Main Categories (Themes)	Subcategories	Concepts (Open Codes)
1. Cultural and Social Stigma	1.1. Fear of Labeling	Being called "crazy"; Shame in community; Gossip and judgment; Family reputation concerns; Fear of social exclusion
	1.2. Gender Norms and Masculinity	"Men don't cry" belief; Suppression of emotions; Pressure to appear strong; Perceived weakness; Lack of male role models seeking help
	1.3. Family Expectations	Family denial of mental illness; Parents urging self-reliance; Pressure to protect family image; Discouragement from external help
	1.4. Community Surveillance	Everyone knows everyone; Privacy impossible; Fear of others finding out; Rumors spreading; Trust issues with locals
	1.5. Religious and Traditional Beliefs	Seeing distress as lack of faith; Advice to pray instead of seek help; Cultural reliance on elders; Fatalistic attitudes
2. Structural and Logistical Barriers	2.1. Limited Access to Services	Long travel distances; Lack of transportation; Scarce local clinics; Limited availability of psychologists
	2.2. Financial Constraints	High cost of therapy; Lack of insurance coverage; Preference for free informal support; Prioritizing work over health

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	2.3. Shortage of Professionals	Only one psychologist per region; Long waiting lists; Low quality of rural mental health infrastructure; Lack of specialized youth services
	2.4. Technological Limitations	Weak internet connection; Lack of private space for online therapy; Distrust in telehealth; Limited awareness of digital tools
	2.5. Institutional Neglect	Low government investment; Mental health seen as secondary; No school counseling programs; Absence of outreach initiatives
	2.6. Bureaucratic Difficulties	Complicated referral process; Lack of information on services; Inefficient local administration
3. Psychological and Personal Factors	3.1. Lack of Awareness and Knowledge	Misunderstanding mental health terms; Confusing stress with illness; Lack of mental health education; Denial of problem
	3.2. Fear of Self-Disclosure	Fear of being misunderstood; Hesitation to talk about emotions; Difficulty trusting professionals; Fear of emotional exposure
	3.3. Low Self-Efficacy	Feeling helpless; Belief that therapy won't help; Past failed attempts; Internalized stigma
	3.4. Preference for Self-Management	Relying on self-control; Distracting with work or hobbies; Talking only to friends; "I can handle it myself" attitude
4. Interpersonal and Environmental Influences	4.1. Peer Pressure and Social Modeling	Peers mocking mental help; None of friends go to therapy; Peer normalization of silence; Lack of supportive networks
	4.2. Parental Attitudes and Support	Parents' disbelief in therapy; Emotional distance; Lack of communication; Advice to "toughen up"
	4.3. School and Educational Environment	Teachers ignoring emotional issues; Lack of mental health curriculum; Overemphasis on academic success; Absence of counseling services
	4.4. Media Representation	Negative portrayals of therapy; Stereotypes of "crazy" people; Minimal awareness campaigns; Unrealistic depictions of recovery
	4.5. Rural Cultural Identity	Pride in resilience; Distrust of outsiders; Collectivist values; Pressure for conformity; Resistance to "urban ideas" like therapy
	4.6. Migration and Exposure Effects	Youth returning from cities seek help more; Exposure to modern values; Cultural clash between urban and rural norms

1. Cultural and Social Stigma

A central barrier identified among rural youth in Greece was the deep-rooted *cultural and social stigma* surrounding psychological help-seeking. Participants described a pervasive fear of being labeled or judged, particularly in close-knit rural communities where "everyone knows everyone." Many respondents expressed that seeking psychological assistance would be equated with being "crazy" or "unstable," making them vulnerable to gossip and social exclusion. One participant stated, *"If people in my village knew I was seeing a psychologist, they'd think something was seriously wrong with me. It's better to stay silent."* Gender expectations further intensified this stigma, as young men reported internalizing beliefs that emotional expression signals weakness. As one male participant reflected, *"In my family, men don't cry or talk about feelings — it's seen as weakness."* Family expectations and religious traditions also reinforced the barrier, where reliance on prayer or advice from elders was considered more acceptable than professional help. Several participants highlighted that parents often discouraged therapy to "protect the family's image" or insisted that "time and faith" would heal emotional struggles. The collective impact of these cultural pressures created an environment where mental distress was normalized but professional help remained socially unacceptable.

2. Structural and Logistical Barriers

Participants also emphasized significant *structural and logistical obstacles* to accessing mental health care. Many rural areas lacked psychologists or counseling centers, forcing youth to travel long distances or face long waiting lists. As one interviewee commented, *"The nearest psychologist is two hours away, and I don't have a car or money for the bus."* Financial constraints were a recurring theme, with many young people indicating that therapy was unaffordable without insurance coverage or state assistance. Furthermore, participants described a general institutional neglect of rural mental health, reflected in the absence of school counselors, community outreach programs, and mental health education. The limited technological infrastructure also hindered the potential of online therapy: unstable internet connections, lack of privacy at home, and low trust in virtual sessions were common complaints. One participant explained, *"I tried an online session, but my connection dropped three times — it just made me more anxious."* Overall, structural inequalities combined with bureaucratic inefficiencies created a system that was perceived as inaccessible and unresponsive to rural youth needs, thereby reinforcing the cycle of silence and avoidance.

3. Psychological and Personal Factors

Beyond cultural and systemic influences, several *personal and psychological factors* contributed to reluctance in seeking help. Many participants admitted lacking

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knowledge about mental health or misinterpreting emotional distress as normal stress. This limited awareness often delayed help-seeking until symptoms became severe. One participant shared, *"I didn't know anxiety could be something real. I just thought I was weak."* Fear of self-disclosure and low self-efficacy were additional barriers; several respondents expressed skepticism about whether therapy could actually help, while others feared being misunderstood or judged by professionals. As one young woman stated, *"Talking to a stranger about my feelings feels impossible — I wouldn't even know where to start."* A strong preference for self-management was also evident, as participants described coping strategies like working harder, social withdrawal, or confiding only in trusted friends. This self-reliant mindset, while protective in rural cultures, often discouraged professional intervention. Collectively, these internal barriers revealed how personal beliefs and emotional insecurity interact with broader societal pressures to impede help-seeking behavior.

4. Interpersonal and Environmental Influences

Finally, *interpersonal and environmental dynamics* were found to significantly shape rural youths' perceptions of psychological help. Peer influence played a decisive role, with many participants describing peer groups that trivialized or mocked therapy. One respondent noted, *"My friends joke that therapy is for city people, not for us."* Similarly, parental attitudes were often dismissive, as emotional expression was discouraged within families. Several participants reported hearing phrases such as "just toughen up" or "don't overthink it," reflecting emotional neglect and lack of open communication at home. Educational institutions also failed to provide supportive frameworks, with teachers often ignoring signs of distress or prioritizing academic achievement over well-being. Participants further pointed to negative media portrayals that equate therapy with severe mental illness, reinforcing stereotypes and misinformation. Rural cultural identity itself was a complex factor: while pride in resilience and self-reliance strengthened community cohesion, it simultaneously discouraged vulnerability and help-seeking. One participant summarized this paradox succinctly: *"We grow up being told to handle things ourselves — asking for help feels like betraying who we are."* These interpersonal and environmental patterns collectively revealed how help-seeking behaviors are not only personal decisions but are embedded in broader social networks and cultural narratives that define what is "normal" or "acceptable" in rural Greek life.

4. Discussion and Conclusion

The findings of this study reveal a complex network of sociocultural, structural, and psychological barriers that discourage rural youth in Greece from seeking professional psychological help. Thematic analysis identified four major themes—cultural and social stigma, structural and logistical barriers, psychological and personal factors, and interpersonal and environmental influences—which together explain why mental health service utilization remains limited despite increasing awareness. These results highlight that help-seeking is not a simple behavioral decision but rather a deeply contextual process shaped by values, expectations, and access constraints within rural settings.

One of the most salient findings was the pervasive influence of stigma within rural communities. Participants expressed fears of being labeled as "crazy" or "weak," echoing the cultural codes that link psychological help with personal or familial failure. This result aligns closely with prior studies showing that stigma—both public and self-directed—remains the most powerful deterrent to professional help-seeking among adolescents (Ariyati, 2024; Sampoornam, 2025). In conservative and collectivist societies, mental illness is often seen through moral or spiritual lenses, where emotional struggles are attributed to lack of faith, poor character, or family shame (Ariyati, 2024). The participants' reliance on prayer or informal family advice rather than therapy mirrors such findings and reflects the entanglement of religion, morality, and identity in rural Greek culture.

These findings also support the broader literature showing that stigma is culturally reinforced by social norms and gender expectations. (Boyd-Bais & Papps, 2025) demonstrated that rural women experience a dual burden of community scrutiny and familial expectations, which often silences open conversation about emotional health. Similarly, (Medrano et al., 2025) reported that among rural Mexican men, ideals of *machismo* discouraged emotional disclosure, paralleling the male participants in this study who viewed vulnerability as a loss of strength. (O'Donnell et al., 2025) likewise found that male students in Ireland expressed significantly lower help-seeking attitudes than females, emphasizing the global persistence of gendered barriers. Thus, across diverse contexts, help-seeking reluctance is not only psychological but also a social performance constrained by cultural narratives of masculinity, family honor, and communal reputation.

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Importantly, the internalization of stigma among participants suggests a powerful link between cultural identity and self-perception. Youth described therapy as incompatible with local definitions of resilience and moral integrity—a phenomenon consistent with the self-stigma pathway identified by (Sampoornam, 2025), where adolescents internalize public prejudices and convert them into self-blame. The qualitative accounts from Greek participants, such as fearing gossip or shame from neighbors, reinforce the argument by (Sianko et al., 2025) that disclosure decisions are strongly influenced by anticipated social judgment and emotional safety. Therefore, interventions in rural settings must go beyond awareness-raising and address the deeper moral and relational dimensions of stigma that shape identity formation in adolescence.

The second major theme concerned structural inequities that limit access to professional care. Participants frequently mentioned travel distance, lack of local psychologists, financial constraints, and weak internet infrastructure as deterrents. These issues reflect the broader global evidence of rural disadvantage in mental health service provision (Boyd-Bais & Papps, 2025; Medrano et al., 2025). As in the present study, respondents in Ireland and India reported that practical barriers such as cost, transportation, and privacy are as significant as attitudinal ones (K et al., 2024; Sharma & Sharma, 2025). In Greece, where public health services are centralized in urban areas, such logistical challenges are magnified for rural populations with limited mobility and lower income.

The results also support the findings of (Cavelti et al., 2024), who emphasized that sociodemographic variables—especially geographic isolation—directly predict lower help-seeking rates among adolescents. The absence of mental health facilities in rural schools and the scarcity of counseling resources reflect systemic neglect similar to patterns reported in other European regions. Furthermore, limited access interacts with cultural stigma, as participants feared that traveling to urban mental health centers would expose their private struggles to public scrutiny. This combination of logistical hardship and social surveillance produces what could be termed a "double invisibility": young people neither access local help nor feel comfortable seeking distant services.

Digital solutions, while promising, were not perceived as fully viable by participants due to weak internet connectivity and privacy concerns during online sessions. These findings parallel (Özkan & Özbıçakçı, 2024), who tested a web-based mental health literacy program for adolescents and highlighted that technological barriers can restrict digital interventions' effectiveness in nonurban contexts. Although the integration of digital platforms can reduce service gaps, this study suggests that such initiatives must be adapted to infrastructural realities and accompanied by training to build trust in virtual therapy.

The third theme revealed deeply personal barriers related to awareness, self-efficacy, and coping orientation. Many participants described low mental health literacy (MHL) and uncertainty about when emotional distress warrants professional help. This limited awareness reflects the patterns identified by (Saboohi et al., 2025) and (Madhuri & P., 2024), who reported that students with low literacy often fail to recognize symptoms as psychological in nature and instead normalize suffering as "everyday stress." In the current study, several participants articulated beliefs that "therapy won't help" or "it's better to manage things alone," illustrating both cognitive and motivational resistance to external intervention.

The sense of personal inefficacy identified among rural youth also resonates with findings by (K et al., 2024), where adolescents' lack of confidence in their ability to access and benefit from therapy reduced their help-seeking intentions. According to the Theory of Planned Behavior (TPB), perceived behavioral control—one's belief in their capacity to perform the behavior—is a major determinant of intention (Aras & Peker, 2024; Widyarini & Linsiya, 2025). Participants' narratives demonstrated low perceived control not only due to logistical barriers but also emotional factors such as fear of self-disclosure and mistrust of professionals. The reluctance to open up to a stranger mirrors (Omari et al., 2024), who found that self-esteem and prior experiences of invalidation significantly predicted adolescents' avoidance of professional help.

Moreover, the preference for self-management observed in this study supports (Aras & Peker, 2025a) and (Aras & Peker, 2025b), who showed that attitudes toward help-seeking can be modified through interventions that challenge negative beliefs about therapy and emphasize autonomy within professional support. Participants' reliance on friends or religious figures, while culturally adaptive, often reinforced cycles of avoidance by providing temporary comfort without addressing deeper issues. Collectively, these findings confirm that psychological barriers are intertwined with social identity and self-concept, making them more resistant to change than purely informational deficits.

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The fourth theme underscored the powerful influence of interpersonal networks and environmental context on help-seeking behavior. The youth in this study described peers, parents, and educators as either potential facilitators or barriers, depending on their attitudes. Peer influence was particularly pronounced: when friends dismissed or mocked therapy, individuals were less inclined to pursue it, reflecting the social modeling mechanisms identified by (Sianko et al., 2025). This peer dynamic demonstrates how group norms within rural youth culture can perpetuate avoidance behaviors and normalize silence around mental health struggles.

Parental attitudes also emerged as critical. Participants reported that parents often minimized emotional distress or urged them to "toughen up," consistent with findings from (O'Donnell et al., 2025) and (Medrano et al., 2025), who noted that intergenerational transmission of stigma perpetuates avoidance. Schools, another key environment, were often perceived as unsupportive: teachers prioritized academic performance over emotional well-being, and few institutions offered counseling services. This absence of institutional care parallels (Saboohi et al., 2025) and (Sampoornam, 2025), who both showed that school-based psychoeducation programs are vital in shaping early attitudes toward mental health.

Media and cultural narratives further reinforced ambivalence toward therapy. Negative portrayals of psychological services and sensationalized depictions of "madness" shaped participants' perceptions, echoing global findings on the media's role in mental health stigma (Chen et al., 2024). At the same time, participants who had been exposed to urban or online discourses expressed greater openness toward therapy, suggesting that contact with modern, destigmatized narratives can shift attitudes over time. This supports (Cavelti et al., 2024), who observed that exposure to positive models and accurate information predicts greater likelihood of help-seeking.

Ultimately, these interpersonal and environmental findings confirm that help-seeking is a socially embedded process. As (Widyarini & Linsiya, 2025) argued within the TPB framework, subjective norms—what individuals believe others expect them to do—play a decisive role in shaping behavioral intentions. For rural youth, these norms are tightly bound to communal expectations of privacy, emotional control, and self-sufficiency. Thus, effective interventions must operate not only at the individual level but also within families, peer groups, and educational institutions to recalibrate collective norms around mental health.

The convergence of these findings with TPB and MHL models underscores the multidimensional nature of help-seeking barriers. According to TPB, attitudes, subjective norms, and perceived behavioral control jointly predict behavioral intention (Aras & Peker, 2024; Widyarini & Linsiya, 2025). Each component was evident in the present study: negative attitudes (stigma), restrictive norms (community and family expectations), and low control (structural and psychological obstacles) all diminished participants' willingness to seek help. The success of TPB-based interventions in prior studies—such as (Aras & Peker, 2025a) and (Aras & Peker, 2025b)—suggests that targeting these determinants through psychoeducation and community engagement can meaningfully improve outcomes.

Furthermore, the role of mental health literacy complements TPB by providing a knowledge foundation for positive attitudes and perceived control. As shown by (Saboohi et al., 2025), MHL-based interventions significantly increased adolescents' help-seeking intentions, while (K et al., 2024) emphasized that literacy must be culturally relevant to be effective. The current study's participants demonstrated clear informational gaps—many were unsure when or how to seek help—reinforcing that improving MHL could be a critical first step in rural outreach. Combining MHL education with TPB-informed strategies, particularly those adapted for rural delivery, could thus form a comprehensive approach to promote help-seeking.

Finally, the findings align with the cross-cultural studies of (Madhuri & P., 2024) and (Omari et al., 2024), confirming that socioeconomic context, self-esteem, and access intersect to shape youth behavior. Whether in Greece, India, or Mexico, the interaction of structural inequality and cultural stigma produces similar patterns of avoidance. As globalization and digitalization reshape youth identities, future programs must integrate cultural sensitivity with modern communication strategies to normalize therapy as a valid and accessible form of self-care.

5. Limitations & Suggestions

This study, while offering valuable insights, is not without limitations. First, the qualitative design restricts generalizability beyond the sample of 22 rural Greek participants. Although theoretical saturation was reached, larger samples across different regions would capture greater

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diversity in cultural and socioeconomic conditions. Second, self-report interviews may be influenced by social desirability bias, as participants might have under- or over-stated their stigma or attitudes to align with perceived expectations. Third, the research relied on English-translated transcripts, which may have diluted subtle cultural meanings or idiomatic expressions originally conveyed in Greek. Additionally, the study focused solely on youth aged 18–25; including older community members, educators, or parents could offer richer perspectives on intergenerational influences. Finally, the absence of quantitative measures limits the ability to statistically compare variables such as gender or educational level in relation to help-seeking intentions.

Future studies should adopt mixed-methods designs to triangulate qualitative insights with quantitative indicators of literacy, stigma, and behavioral intention. Comparative analyses between rural and urban Greek youth could reveal the magnitude of contextual disparities in help-seeking behavior. Furthermore, longitudinal research would clarify how exposure to educational campaigns or digital interventions modifies attitudes over time. Collaboration with schools, youth centers, and local health agencies may enable participatory research that empowers youth to co-design awareness programs. Cross-national studies could also illuminate cultural universals and specificities in rural mental health attitudes, particularly across Mediterranean or collectivist contexts.

Practitioners and policymakers should prioritize community-based psychoeducation to increase mental health literacy and dismantle stigma at the grassroots level. Integrating mental health education into school curricula can help normalize emotional discourse from an early age. Training primary-care providers and teachers to recognize psychological distress would facilitate early referral and intervention. Establishing mobile counseling units and tele-mental-health platforms adapted for low-connectivity areas could reduce access barriers. Finally, public awareness campaigns featuring relatable local figures and positive narratives about seeking help may gradually reshape cultural perceptions, promoting openness, resilience, and psychological well-being among rural youth.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed to this article.

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