4-2020

Attitudes and Beliefs of Christian Denominations Toward Mental Health

Javier Velez

Attitudes and Beliefs of Christian Denominations Toward Mental Health

Javier A. Velez

Florida School of Professional Psychology

Patricia S. Dixon, Psy.D.
Chair

Gary Howell, Psy.D.
Member

A Clinical Research Project submitted to the Faculty of the Florida School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Tampa, Florida
April, 2020

The Doctorate Program in Clinical Psychology
Florida School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

Javier A. Velez

has been approved by the
CRP Committee on April 16, 2020
as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

Examining Committee:

Patricia S. Dixon, Psy.D
Committee Chair: Patricia S. Dixon, Psy.D.

Member: Gary Howell, Psy.D.

Abstract

This empirical study assessed common attitudes and beliefs toward mental health services in the varying denominations of Christian churches. Specifically, the objective of this study was to identify the effects of Christian denomination on attitudes toward seeking mental health treatment and to identify whether there are racial and age differences that also impact those attitudes within the church. The study sought to answer the following questions: (a) What is the difference in attitudes and beliefs between different races toward mental health services in the church among Christians? (b) Is there an age difference in attitudes and beliefs toward mental health services in the church among Christians? (c), Is there a difference in Christian denomination and attitudes/beliefs toward mental health services in the church? and (d) Will there be a difference among individuals with higher versus lower levels of spirituality regarding mental-health-seeking behaviors within the church? The sample consisted of 232 adults ranging from 18 to 74 years old instructed to complete the Mental Health Seeking Attitudes, the Attitudes Toward Seeking Professional Psychological Help, and the Spiritual Health Inventory. Data were analyzed using two-way between-group analysis of variance to address research questions one and two. A one-way between-group analysis of variance was conducted for the third hypothesis, and a multivariate analysis of variance was used to address the fourth research question. Results did not support the hypotheses of the study. However, implications for these results as well as possible future directions are discussed.

ATTITUDES AND BELIEFS OF CHRISTIAN DENOMINATIONS TOWARD MENTAL HEALTH

Dedication

This dissertation is dedicated to my family and friends who have supported me on my educational journey. Thank you for helping me see this adventure to the end. I would not be here without your love and support.

Table of Contents

Page

CHAPTER I: INTRODUCTION

The position of religion and spirituality in mental health has been a subject of attraction and debate throughout history (Millon, 2004). The attitude toward the psychological aspects of religion is now far removed from the magical, fabled, and demonological explanations of the human mind and behavior that have existed throughout time. Several shifts in modern thought in the last two centuries have led to an increase in the empirical investigation of religion and spirituality's influence on mental health. The literature surrounding the topic of religion, spirituality, and mental health has dramatically expanded. Many health and social care regulators have begun to require that mental health practitioners consider the influences of religion and spirituality in clients' presentations and their subsequent care (e.g., Accreditation Council on Graduate Medical Education, 1994; American Psychological Association, 2002). The purpose of this chapter is to provide readers an overview of the current literature surrounding religion, spirituality, and mental health, to assess and consider the potential relevance of varying denominations of Christianity for their clients.

What are Religion and Spirituality?

In the past, the use of the terms "religion" and "spirituality" have been interchangeable (Zinnbauer & Pargament, 2005). However, Western societies have begun to note a move toward leaving aspects of organized religion toward a more individualized faith resulting in a necessary distinction between the terms (Hill, Burdette, Ellison, & Musick, 2000). This distinction has been noted in individuals' self-designations as "religious" and/or "spiritual" (Shahabi et al., 2002). Although a large proportion of the American psychological literature continues to use the terms "religion" and "spirituality" interchangeably, research needs to consider the unique meanings attached to each term. Important distinctions between these two concepts have been highlighted

in various studies. For example, participants in a U.S. survey defined religiousness as the observance of traditional, institutionally based rituals and belief systems. Spirituality was most often defined as a personal experience, connection, or relationship with transcendence or a higher power and was considered inclusive of more traditional forms of observance (Zinnbauer et al., 1997).

Link Between Religion and Mental Health

Empirical studies in the past have discovered a positive association between religion and better health (Koenig, 1998; Koenig & Larson, 2001). Additionally, preceding research has well documented the protective functions that religion plays in the lives of Americans, particularly minorities (Koenig & Larson, 2001; Pargament, Koenig, & Perez, 2000). Religious beliefs and behaviors are associated with lower rates of several mental disorders, including depression, better physical health, and reduced levels of mortality (Koenig & Larson, 2001). As such, religion and spirituality have been identified as an essential part of an individual's life, yet have been absent in research and theory (Carlson, McGeorge, & Toomey, 2014).

When examining individual studies, the relationship between religion/spirituality and mental health appears to be inconsistent and often contradictory. A meta-analysis in 1983 reviewed 30 outcomes from 24 empirical investigations. Results from the analysis by Bergin indicated that approximately half of the outcomes (47%) were considered beneficial, 23% negative, and 30% demonstrated no relationship at all (Bergin, 1983). Nonetheless, two further meta-analyses published in 2003 investigated the relationships among religion, spirituality, psychological distress (Hackney & Sanders, 2003), and depression (Smith, McCullough, & Poll, 2003). When analyzed together, findings lend support to the notion that a relationship among religion, spirituality, and mental health exist, and the nature of this relationship depends upon the

type of faith being evaluated. Moreover, the results note that it is the meaning (e.g., use of religion or spirituality in coping, personal devotion) rather than the mere substance of religion or spirituality (e.g., ideological beliefs, religious or spiritual behaviors) that holds the most impactful association with mental health.

Most research on the predisposing and protective roles of religion and spirituality has focused on the risk of depression (Braam et al., 2004; Ellison & Flannelly, 2009). For example, a study conducted with 607 African American participants found that those whose religious/spiritual beliefs provided them with "a great deal" of day to day guidance at initial assessment were half as likely to experience major depression three years later (Ellison & Flannelly, 2009). Other longitudinal studies link religion and spirituality to a reduced risk of general psychological distress among midlife women (King, Cummings, & Whetstone, 2005); reduced substance use and dependence among adolescents (Good & Willoughby, 2011); prevention of alcohol-use disorders among at-risk drinkers (Borders, Curran, Mattox, & Booth, 2010); reduced risk of eating disorders among young women (Homan & Boyatzis, 2010); and decreased suicide attempts (Rasic, Robinson, Bolton, Bienvenu, & Sareen, 2011). There have also been several findings of prolonged life among those who are religious or spiritual (e.g., Kark et al., 1996; Koenig, 1999; Musick, House, & Williams, 2004). Overall, most studies lead to the conclusion that religious and spiritual beliefs are protective.

As such, in the last two decades, many therapists and researchers have highlighted the importance of including spirituality and religion in therapeutic dialogue with clients (Holmberg, Jensen, & Ulland, 2017). Moreover, religiousness/spirituality and mental health have been tested as a central part of research questions or hypotheses in studies of the social and medical sciences in the new field of epidemiology of religion (Koenig & Larson, 2001; Levin, 1994). The

percentage of Americans who identify with some form of religion is over 85% according to Newport (2009) polls conducted in 2008, with over 77% identifying as Christian, approximately 2% as Jewish, 1% as Muslim, and 1% as Buddhist, Hindus, and others. According to these polls, more than three-fourths of the U.S. population considers itself religious. The hope is that by gaining a greater understanding of the various ways in which religion and spirituality interact with mental health, practitioners may be able to consider the role of religion and spirituality in their conceptualizations of clients' difficulties and strengths in a more nuanced and integrated manner (Havighurst & Downey, 2009).

Holmberg et al. (2017) found that spirituality contributes to forming people's ethics and value and relationships with others. Moreover, they found that to be spiritual is not a static state but a process that develops and changes through life. It can be related to nature, art, music, meditation, prayer, and a relationship with a higher power, such as God or Allah. It can provide a sense of wholeness, integrity, and meaning as well as connectedness with other people.

Christianity and Mental Health: A Brief History

According to the "Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health," a report of the Surgeon General, (Manson, 2003) all Americans underuse formal mental health services. However, ethnic minorities are less likely to utilize mental health services, specifically outpatient services, than White Americans (Manson, 2003). Historically, research has documented that among Americans with perceived or actual clinical needs, White Americans were more likely to be receiving active treatment than Hispanic Americans or African Americans (Kohn-Wood & Hooper, 2014). This disparity in treatment utilization has become a focus of mental health policy and research.

The federal government has focused on transforming the mental health delivery system by investigating and ultimately eliminating the barriers that currently discourage minorities from utilizing mental health care. In 2001, President Bush signed the New Freedom Initiative, which seeks to promote access to community life for people with disabilities. As a part of this initiative, the New Freedom Commission on Mental Health was formed to assess the current mental health system and suggest changes that positively affect mental health outcomes. Based on their findings, the commission emphasized the importance of understanding underlying factors, both structural factors (i.e., accessibility and availability of services) and attitudes, which may affect utilization among minorities (New Freedom Commission on Mental Health, 2003).

However, as it has long been understood and previously stated, individuals experiencing psychological distress are more likely to seek help from religious leaders than from any other professional (Chalfant et al., 1990). Research has shown that religious support can play a crucial role in recovery from psychiatric illness (Yangarber-Hick, 2004). However, religion can also be a barrier to better states of mental health. There is a long history of suspicion and, at times, antagonism between psychiatry and religion. Freud famously stated that religion represents a "defense against childish helplessness" and went on to conclude, "surely [such] infantilism is destined to be surmounted" (Pargament & Lomax, 2013, p. _). Negative religious attitudes similar to the sentiments of Freud within psychiatry and other mental health disciplines were commonplace for much of the 20th century. As stated by Pargament and Lomax (2013), "there has been a history of troubled relations that has marked mental health treatment and religion" (p. _). Religion was often stereotyped as defensive or regressive characters, fostering a passive retreat from problems, the outright denial of pain and suffering, or florid symptomatology.

Often, religious issues were ignored in clinical settings, as illustrated by the occasional references to religion within major psychological texts and journals. Some religious groups reciprocated with negative attitudes of their own toward psychiatry and discouraged or prohibited adherents from seeking psychiatric treatment (Bobgan & Bobgan, 1987). For example, as stated in *Psychoheresy: The psychological seduction of Christianity*, "[the church] has seen a grievous transition from faith in God and His Word to faith in the psychological systems of men" (Bobgan & Bobgan, 1987, p. _). As such, there began to be a gulf between counseling psychology and the Bible. The text goes on to equate the psychological way is limited to serving what the Bible calls the "flesh" or the "old man," while the biblical way equates to nourishing and ministering to the new life in Christ. The text appears to provide the ideology of seeing the psychological as "sinful" or "incorrect" while the utilization of just Scripture and the church to treat mental health concerns as "correct" or "holy."

Religion as a problem. This picture has begun to change in recent years, reflecting the growth of theory and research on religion, psychological functioning, and psychiatric disorders as well as a recognition of the need for a culturally sensitive approach to psychiatric care. The field is now moving to a more nuanced understanding of religion, one that is cognizant of its double-sided capacity to support and strengthen people grappling with serious mental illness or exacerbate their pain and suffering. For example, although people with serious mental illness are more likely to report that religion is a resource than a source of problems, a significant minority indicate that their faith contributes to their sense of anger, guilt, suffering, and despair (Smith et al., 2003). Several researchers have begun to examine a related concept, religious struggles, defined as questions, tensions, and conflicts about spiritual issues within oneself (intrapsychic), with others (interpersonal), and with God (divine; Pargament, Murray-Swank, Magyar, & Ano,

2005). For example, within the study conducted by Pargament et al., one young woman described divine struggles related to her bipolar illness:

> I'm suffering, really suffering. My illness is tearing me down, and I'm angry at God for not rescuing me, I mean really setting me free from my mental bondage. I have been dealing with these issues for 10 years now, and I am only 24 years old. I don't understand why he keeps lifting me up just to let me come crashing down again. (p. _)

It is essential to distinguish how religious struggles result from or contribute to psychopathology. Secondary religious struggles are elicited by significant traumas, including the diagnosis of a serious mental illness, which can shake or shatter an individual's most fundamental values and worldview. In this vein, according to one national survey of people in the United States, a wide variety of forms of psychopathology were associated with higher levels of religious struggles. Primary religious struggles trigger subsequent psychological problems. Several longitudinal studies have tied religious struggles to declines in mental health, physical health, and even greater risk of dying (Exline & Rose, 2005). The findings of researchers Mannheimer and Hill (2015) identified examples of primary religious struggles that may trigger psychological problems. One example was conservative Protestants who had lower church attendance than religious expectations exhibited higher levels of psychological distress, depressive symptoms, and anxiety than those conservative Protestants who met or exceeded this religious expectation. Additionally, they observed that falling short of normative patterns for reading religious Scripture was associated with higher levels of psychological distress and depressive symptoms. Researchers stated that the fear of sanctions, judgment, and feelings of inadequacy when comparing themselves to others within the congregation might trigger these symptoms.

Religion as a resource. When examining research regarding religion as a resource, researchers have expanded Freud's view that religion helps control undesirable sexual and aggressive urges. More recent theorists have emphasized the evolutionary advantages of religiously based mechanisms that foster the regulation of human impulses and desires (McCullough & Willoughby, 2009). Consistent with this theory, a number of empirical studies have shown robust ties between religiousness and greater behavioral restraint concerning substance use, crime and delinquency, suicidality, and sexual promiscuity. Research has also found that individuals with more severe and persistent mental illness may find the self-regulation offered by religion particularly valuable. In one study of Swiss patients with schizophrenia or schizoaffective disorder, greater use of religious coping was predictive of fewer negative symptoms and better social functioning and quality of life three years later (Mohr et al., 2011).

Sociologist Emil Durkheim argued that one of the most important resources that religion provides for its participants is a sense of connectedness and identity. He stated, "the idea of society the soul of religion" (Pargament, & Lomax, 2013, p. _). Several studies have documented that individuals who are more involved in public religious expressions (e.g., worship attendance) report a larger network of social relationships and greater social support (Pargament et al., 2005). Additionally, researchers have found that religion may offer comfort to individuals who have struggled with attachment issues with primary caregivers or other interpersonal relationships. This comfort is brought about by building a more secure attachment to sacred beings (e.g., God, Jesus, Holy Spirit) who are perceived as more available and more accessible than the individuals who may have caused the initial attachment difficulties (Garzon & Tilley, 2009). Several studies have linked the individual's perceptions of a secure relationship with God to lower levels of psychological distress (Wade, Worthington, & Vogel, 2007).

Many theorists have upheld the belief that among the many functions of religion, a resource provided is the emotional comfort provided. Christianity, in large part, alleviates the individuals' anxieties in a world of powerful forces that point to the finiteness and frailty of humanity. Many studies have supported this theoretical perspective (Pargament & Lomax, 2013). For example, higher levels of religiousness have been associated with lower levels of depression, especially among people facing more severe life stressors (Smith et al., 2003) and less anxiety and perceived stress among patients with panic disorder (Bowen, Baetz, & D'Arcy, 2006).

Moreover, research indicates that the way people choose to use their religious beliefs can influence their mental health in opposite directions, depending on how mental health is defined or measured. It is of greater value to measure the use or application of one's religious beliefs rather than whether they identify as religious (Randolph-Seng, Nielsen, Bottoms, & Filipas, 2008). As an example, Murphy et al. (2000) found religious beliefs to be a significant predictor of less depression and hopelessness. While Smith et al. (2003) found the inverse of Murphy et al. Similarly, Schnittker (2001) found the relationship between religiosity and depression to vary depending on whether it was measured in terms of attendance at services, the salience of religion, or spiritual help-seeking. The relationship between religiosity and mental health depends on how the question is asked.

If religiousness is simply defined as church membership or superficial agreement with religious beliefs, then the more religious the person, the more mental health problems he or she may have. However, if the depth of religious commitment is assessed, then the more religious the person, the fewer mental health problems he or she may have (Ten Kate, de Koster, & van der Waal, 2017). Unless one defines religiosity as including individuals' commitment to believe and follow the tenets of their religion, it becomes difficult to determine precisely how religion

influences their lives. This failure to fully assess religion as a construct can help explain why certain religious variables have been uncorrelated or negatively correlated with mental health in past research.

Additionally, throughout recent years, there has been a push toward focusing on the differences between Catholics and Protestants when it comes to mental health (Stanford, 2007). However, within the varying denominations of Protestant Christianity, there may be differences in their attitudes and beliefs toward mental health service, which can ultimately impact the mental health assistance the members seek as well as the therapeutic relationship that is eventually formed with these individuals. Furthermore, as stated by Sue, Zane, Nagayama Hall, and Berger (2009), a culturally competent clinician is sensitive to his or her personal values and biases and how these may influence perceptions of the client, the client's problem, and the counseling relationship. Moreover, the clinician should know of the client's culture, worldview, and expectations for the counseling relationship. As such, a deeper understanding of how the varying denominations within Protestant Christianity may impact attitudes and beliefs toward mental health service is imperative for the clients who may be seen.

Purpose of CRP empirical study. This empirical study assessed common attitudes and beliefs toward mental health services in the varying denominations of Christian churches. Specifically, the objective of this study was to identify the effects of Christian denomination on attitudes toward seeking mental health treatment and to identify whether there are racial and age differences that also impact those attitudes within the church.

CHAPTER II: LITERATURE REVIEW

Attitudes Toward Mental Health Services in the Church

One prominent gap in the literature has been the limited inclusion of racial and ethnic minority populations with mental illness and the effects of religion in coping with those issues. Most studies conducted on clinical populations have relied primarily or exclusively on European Americans, calling into question the extent to which the previously mentioned findings could be generalized to other racial and ethnic minority groups with mental illness (Koenig & Larson, 2001). While African Americans and Latinos are often underrepresented in clinical literature, these populations constitute a significant percentage of the population seeking mental health services. For example, African Americans are more likely than any other ethnic group to rely on emergency psychiatric services (Neighbors, 2007).

Over the last few years, African Americans have become more represented in psychological research, allowing for further development of the general understanding and importance of religion in the lives of this minority population. Historically, religion has been documented as a traditional form of coping for many within the community. Religious beliefs have been important in the lives of African Americans with 85% of African Americans reporting being fairly or very religious (Taylor & Chatters, 1991). More specifically, African Americans demonstrate high levels of both public and private religious behaviors, including religious participation (i.e., church attendance), spiritual readings, and prayer (Taylor et al., 2004). Furthermore, previous research has established the protective role that religion plays in the lives of Americans, particularly minorities (Pargament et al., 2000; Koenig & Larson, 2001). Specifically, religious beliefs and behaviors are associated with lower rates of several mental

disorders, including depression, better physical health, and reduced levels of mortality (Koenig & Larson, 2001; Pargament et al., 2000).

The African American church has fulfilled several important roles for African Americans. These roles include providing refuge from oppression as well as providing for both the social and economic welfare of the individual (Taylor, Chatters, & Levin, 2004). Compared to European Americans, African Americans have been found to participate in more religious activities (e.g., prayer and church attendance) and profess a higher degree of religiosity (Levin, Taylor, & Chatters, 1995). According to some scholars, this higher degree of religiosity among African Americans appears to stem from the aid that religion provides in understanding and counteracting the negative social and economic conditions that afflict many in this population. Also, the numerous individual benefits (e.g., unity, moral guidance, control, and support) received from having faith (Taylor & Chatters, 1991). Jang and Johnson (2004) found that within a large community sample of African American women, those who reported being religious not only had more social support but also tended to be less distressed than women who were not religious.

While there has been a recent increase in the study of African Americans, religion, and its link to mental health, the Latinx population remains significantly unrepresented. Except for a few empirical studies, little is known about the religion-mental-health link as it applies to Latinos, especially for those who have a psychiatric illness (e.g., Ellison, Finch, Ryan, & Salinas, 2009). As a group, the Latinx population has become the largest ethnic minority group in the United States. Currently, there are 47.8 million Latinos in the United States, comprising 15.5% of the total U.S. population. By the year 2050, according to the newest census projections, the number of Latinx individuals is expected to double (U.S. Census Bureau, 2010). Even though

exact estimates are few, the number of Latinx individuals who identify as religious are approximately equal to or higher than the general U.S. adult population (Rojas, 1996). For example, a study using data from three generations of Mexican Americans found that the overwhelming majority (80%) of respondents self-identified as Catholic (Stolley & Koenig, 1997). There is also evidence that Latinx individuals use religion as a primary means of coping during difficult times (Connell & Gibson, 1997).

Many of the religious studies conducted on the views and beliefs regarding mental health within the Latinx population are now quite dated (e.g., Levin & Markides, 1985; Levin, Markides, & Ray, 1996; Markides, Levin, & Ray, 1987). Moreover, the studies conducted focused primarily on Mexican Americans living within the Southwest region of the United States. Consequently, the generalizability of these previous findings is called into question. Specifically, on how they may or may not apply to the experience of those of the Latinx population today as well as the implications of other Latinx ethnic groups (e.g., Dominicans, Peruvians, Puerto Ricans, & Brazilians) living in other regions of the United States remains unknown. The few empirical studies completed show the salutary effects of religion on Latino physical and mental health. Specifically, there are positive outcomes found between religious involvement and arthritis (Abraido-Lanza, Vasquez, & Echevarria, 2004), cognitive decline (Hill, Angel, Ellison, & Angel, 2005), mortality risk (Hill et al., 2006), and depressive symptoms (e.g., Ellison et al., 2009) among older Latinx individuals.

Another minority group that is often missing when discussing religion and its impact on mental health are those identifying as Asian or Asian Americans. Recent studies continue to report troublingly low rates of service utilization among Asian Americans in comparison to their counterparts (Cheon, Chang, Kim, & Hyun, 2016). A possible factor related to this gap in the

literature is “Asian American” is often treated as a homogenous group while, in reality, it is a heterogeneous group. Consequently, studies on those identifying as Asian Americans provide only general information regarding mental distress risk factors and potential barriers to service use. Also, this research often takes on the myth of uniformity, assuming that the general findings apply to any Asian American group because of shared culture, regardless of ethnicity (Chang & Myers, 1997).

What also remains relatively unexplored is the mental health disparity particularly salient in a religious context of Asian Americans. According to Hurh (1998), Korean Americans’ church involvement is greater than that of any other Asian immigrant groups. Studies report that 61% to over 70% (Min & Kim, 2002) of Koreans in the United States attend church regularly. Implying that the church is important in Korean American lives. Indeed, studies have reported Korean churches’ significant roles in the lives of Korean immigrants as a religious, social, and educational center, “providing a home away from home” (Park, Murgatroyd, Raynock, & Spillett, 1998, p. 316). For example, Korean immigrant elders identified faith organizations as a preferred place to receive social services. Furthermore, Korean Americans were significantly more likely to seek help from religious leaders, pastors, or clergy than other Asian American counterparts (Tirrito & Choi, 2004).

Cheon et al. (2016) focused on mental health disparities impacting Christian Korean Americans. They reported consistent findings from previous research regarding barriers to seeking professional services among Korean Americans. Mental illness stigma, structural barriers to service utilization, and mistrust of mental health professionals and services were identified as general barriers to seeking mental health services. In addition, intrapersonal (e.g., denial of their own problems) factors combined with the Korean immigrant lifestyles (e.g.,

downward mobility) were identified as typical barriers to utilizing services. However, participants also reported that collaboration between mental health professionals and pastors would allow the religious leaders to have an informal consultation with professionals as needed and invite professionals to provide psycho-education to church members. More importantly, they indicated seeing the collaboration as a necessity to assuaging mental health stigma. Because of the lack of research within this area of race/ethnicity, religion, and its impact on mental health, the present study contributes to the aforementioned information on mental health within minority populations, and the link religion may play within these communities.

Denominational Attitudes/Beliefs Toward Mental Health

Before the discoveries and advances of science, the history of medicine and religion were intertwined. In the past, throughout the world, the individual who provided medical care was also the one who provided spiritual care. More recently, however, science has discounted spirituality and religion in patient care, reserving this function for clergy (Koenig & Larson, 2001; Levin, 1994). Two studies have discovered that approximately 25-40% of Americans have pursued counseling services from a pastor or spiritual leader (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Wang, Berglund, & Kessler, 2003). Moreover, data from the National Comorbidity Survey found that, within a year, almost one-fourth of those seeking help from clergy for a mental health problem have a serious mental illness. However, the majority of these individuals are seen solely by clergy, and not by mental health professionals or other health care providers (Wang et al., 2003).

As a result, pastors and spiritual leaders within the church are in a critical position to serve as the gatekeepers to mental health services in their congregations (Chalfant, Heller, & Roberts, 1990). The individual or family knows them, their ability to diminish stigma, offer free

services, level of credibility, and their ability to frame the problem in spiritual terms that are more comfortable for the client (Bohnert et al., 2010). However, additional studies have noted that others may not seek help from pastors or other spiritual leaders for fear that they or the congregation may interpret their struggles as spiritual weakness or moral failure (Sternthal, Williams, Musick, & Buck, 2010).

Chalfant et al. (1990) wrote that individuals experiencing psychological distress are more likely to seek help from religious leaders than from any other professional. Furthermore, the negative influences of the anti-psychiatry movement of the 1960s and 1970s (Adams, 1970; Mowrer, 1961; Szasz, 1961) continue to be well known in the Christian community today. This reduces the possibility of a more holistic attitude toward treating mental illness that integrates both religious and psychiatric resources (McMinn, Meek, Canning, & Pozzi, 2001). The anti-psychiatric movement during that time continued to perpetuate the idea that the roots of mental illness are solely spiritual in nature (e.g., personal sin, lack of faith, lack of church attendance), as a result, should be treated in a pastoral counseling context separate from all secular psychiatric or psychological involvement (Stanford, 2007).

Even though the tension between the Christian church and the mental health profession continues, attempts to integrate the two have been made. Sensitivity to and understanding of religious issues is recognized by the American Psychological Association (2002). Psychologists, in general, are becoming more open to religious and spiritual issues (McMinn, Aikins, & Lish, 2003), and Christian leaders have become more educated about the biosocial causes and effective treatments of mental disorders (Lafuze, Perkins, & Avirappattu, 2002). Currently, religious and spiritual beliefs and practices are increasingly recognized as factors in patient-clinician relations and concerning the quality of life.

According to Burke, Chauvin, and Miranti (2005), religion and spirituality attempt to help individuals to (a) learn to accept one's self; (b) forgive others and one's self; (c) acknowledge one's shortcomings; (d) accept personal responsibility; (e) let go of hurts and resentments; (f) deal with guilt; and (g) modify self-destructive patterns of thinking, feeling, and acting. As such, there has been a significant reintegration between medicine and spirituality (Ziegler, 1998a). Religion is now becoming accepted as influencing patient outcomes. The reconciliation process of religion/spirituality and health care has come about by public demand, partly because patients were dissatisfied with medical technologies' ability to deliver the highest quality of life in treatment and recovery (Hufford, 2005; Ziegler, 1998a).

Furthermore, Holmberg et al. (2017) found that clients desire to be respected, acknowledged as spiritual beings, and believe it to be professional to include spirituality in treatment. Therefore, it is of great importance that therapists be respectful, dialogue with partners, and do not shy away from opening conversations about spirituality. The clients are waiting to be invited, but they do not want to embarrass the therapist. Therefore, therapists need to expand their understanding and ways of looking at the world, so they do not overlook the spiritual dimension in clients' lives (Holmberg et al., 2017).

Despite this trend of seeing and advocating for the need of psychotherapy to include the spiritual and religious aspects of clients' lives in the treatment process, and while there has been a recent increase in the literature related to the importance of addressing spirituality in therapy, it would appear there is still a large gap between the number of articles related to spirituality compared to the importance that therapists place on spirituality in practice (Carlson, Kirkpatrick, Hecker, & Killmer, 2002). Moreover, there seems to be a gap in research on how deviation from religious norms may impact the mental health of those seeking services. Mannheimer and Hill

(2015) defined religious deviance as behavior that is recognized as violating the expectations, rules, and norms of one's religious group. All religious groups establish standards for religious practice and virtuous living, and these standards function to reveal the imperfections of religious affiliates (Exline & Rose, 2005). For this reason, religious deviance and "problems associated with virtuous living" (Exline & Rose, 2002) can be considered another important form of religious struggle.

Deviating from religious norms, like that of seeking professional help when dealing with mental illness and not seeking treatment solely within the church, can affect a congregant's mental health by invoking punishment. Ellison and Lee (2010) noted, "religious communities often attempt to guide the behavioral choices and lifestyles of their members, and those who deviate from normative conduct can be the focus of informal social sanctions, in the form of gossip, criticism, or even ostracism" (p. _), which may result in strained social relationships that are likely to end in the loss of social support. Psychologically, failing to meet religious standards could contribute to feelings of guilt and shame (Abu-Raiya, Pargament & Magyar-Russell, 2010). The threat of divine retribution for going against the church and the loss of meaning and purpose might also lead to psychological distress (Abu-Raiya et al., 2010; Ellison & Lee, 2010; Exline & Martin, 2005).

Christian Counseling

Around the world, there is increasing use in paraprofessional counselors (lay counselors). Lay counselors are those individuals who lack formal credentialing, training, and experience as licensed mental health professionals; yet, they are involved in the care of emotionally hurting people (Garzon & Tilley, 2009). Examples of lay counseling can be seen in the use of hotlines, peer counseling, home visitation programs, and church-based ministries. Tan (1991, 1992, 1997)

defined three usual models in providing lay counseling services. The first of these models was the “informal,” which provides support or services in natural settings, restaurants, homes, churches, through informal friendships. These counselors may have some basic training in mental health services and no ongoing supervision. In the second model, or what is referred to as the informal organized model, paraprofessionals may still aid in informal settings, but they receive systematic training and ongoing supervision. Finally, in the formal organized model, lay counselors provide services in more official settings such as a community agency or a church counseling center, receive regular supervision, and are usually trained by mental health professionals. Sometimes, hybrid models that combine the informal organized and formal organized models occur (Tan, 1998).

Garzon and Tilley (2009) reviewed the literature on the models being used within churches and stated that the models appear to derive from evangelical Christian or charismatic-related contexts. Furthermore, after consulting various databases, dissertations, and faculty members at various integration-focused psychology programs, the discussed models included: active listening, cognitive and solution-focused approaches, inner healing approaches, and mixed models. Within the active-listening model, the approaches combine Rogerian principles such as empathy, positive regard, and basic listening skills with spiritual resources such as prayer and the Scriptures in the care of hurting people. Garzon and Tilley (2009) stipulated that lay counselors are usually trained in listening skills and lay caring methods. Stephen Ministry (Haugk, 1984; Haugk, 2000) represents a classic example of these types of church models. Pre-established Stephen Leaders and select lay members of the congregation receive 50 hours of training in the Stephen Ministry model. Topics include confidentiality, active listening, feelings, assertiveness,

setting boundaries for helping, and ministering in specific situations (i.e., divorce, grief and loss, crises, and childbirth; Haugk, 2000).

These lay members are taught how to recognize when to refer people to mental health professionals or other resources (Haugk, 2000). After completing training, the individuals are appointed by their congregation to serve as Stephen Ministers. Stephen Ministers utilize a process-oriented active-listening skills approach, which is coupled with the sensitive use of spiritual resources such as prayer and sharing Bible stories, themes, and promises (Haugk, 1984). Typically, a Stephen Minister meets for an hour weekly with a "care receiver" who is screened, prepared, and assigned by a Stephen Leader (Haugk, 2000). Peer supervision with Stephen Leaders occurs twice monthly. Continuing education is available, and Stephen Leaders have access to Stephen Ministry consultation and resources (Haugk, 2000). The efficacy of the Stephen Ministry has not been studied in controlled scientific trials.

Like traditional cognitive psychotherapy, cognitive lay approaches focus on the role of automatic thoughts, self-talk, and core beliefs in creating distress (Garzon & Tilley, 2009). These approaches actively incorporate Scripture and prayer as key methods of cognitive restructuring. Solution-focused lay models of counseling are just beginning to emerge (Holland, 2007). These approaches help a client envision a future without the problem and build on client strengths and resources in moving toward problem resolution.

Christian inner healing has been defined as "a range of 'journey back' methodologies that seek, under the Holy Spirit's leading, to uncover personal, familial, and ancestral experiences that are thought to contribute to the troubled present" (Hurding, 1995, p. 297). Some techniques appear (to most professionals) to be similar to psychodynamic and experiential psychotherapies; however, inner healing emphasizes prayer-filled encounters with Christ as the change

mechanism instead of therapist-mediated or psychological theory-derived activities. A charismatic Christian perspective is also prominent. John and Paula Sandford's (1982) Elijah House Ministry is described as an example of inner healing ministries. The Sandfords apply biblical concepts of facing one's sinfulness, dying to self fully on the cross of Christ through confession and repentance, and rising into the fullness of Christ's resurrection life as core concepts in their healing approach (Sandford & Sandford, 1982). Although they do not present an intervention formula for all clients, they believe that often sinful reactions to childhood wounding(s)—i.e., inner vows or bitter root judgments—lead to an unbelieving heart or sinful coping pattern. Because of this, they might advocate ministering both to the adult person within the session and to the psychological representation of the wounded child, though they acknowledge that it is possible to repent for present patterns that began in childhood without necessarily revisiting specific childhood memories.

Training for the Sandfords' approach is done through their Elijah House Ministry. Basic schools I and II and internship programs are offered (Sandford & Sandford, 1982). Elijah House staff offer live basic schools annually in the Spokane, Washington area. Churches may use a training program on video that is spread out over many weeks. Both live and video training programs consist of teachings, workbooks, literature, homework, and small groups where people pray for each other as they learn each segment of the program. Graduates of basic schools I and II may apply for an internship experience. Initial internships typically involve receiving personal ministry, observing ministry for four weeks, and participating on ministry teams for eight weeks (Sandford & Sandford, 1982). Having counseling experience prior to an internship is encouraged but not required.

Mixed approaches may bear some similarities to previously described lay counseling model categories; yet, they contain sufficient differences to place them into a separate category. Specifically, they may reflect a greater emphasis using several different psychological theoretical perspectives (Garzon et al., 2009), a more in-depth examination of the role of the flesh and the demonic in emotional distress (e.g., Anderson, 2000a, 2000b), or both. As stated by Garzon and Tilley (2009), one eclectic lay model and one theologically in-depth model were found in the research. These models are described below.

Eclectic with an integrated cognitive-behavioral component (E-CBT). Lay Christian counseling models with an eclectic base that incorporates a clear cognitive-behavioral component have received two outcome studies (Toh, Tan, Osburn, & Faber, 1997). Rogerian, psychodynamic, and family systems elements also composed the eclectic base of these approaches. Freedom in Christ Ministries (FICM) proposes that the unbiblical lies Christians believe often lead to spiritual and psychological distress (Anderson, 2000a). These lies can arise from the flesh, demonic deception, and messages received from popular culture (Anderson, 1990b, 2000b). Seven key areas (described as "the steps to freedom," or "the steps" in FICM literature) are seen as essential to resolve personal issues. These include confession and renunciation of occult/non-Christian religious involvement; confession of defensive strategies outside of Christ; the forgiveness of others, self, and God; confession of rebellion to the proper authority; repentance for areas of pride; confession and repentance in areas of habitual sin, and confession of family generation sin patterns (Anderson, 2000b). For a more in-depth description of FICM, see Garzon et al. (2009).

Research demonstrates the effectiveness of some kinds of paraprofessional counseling. Durlak (1979) reviewed 42 studies comparing professional and paraprofessional counselors. The

studies focused primarily on mildly to moderately disturbed clients. Nonetheless, Durlak found no difference in client outcomes, and some studies suggested paraprofessionals provided better care. Given the number of studies conducted, one might anticipate strong current evidence for the effectiveness of lay Christian counseling. Yet, some conservative Christian groups, such as Nouthetic biblical counseling (e.g., Adams, 1970), exhibit a high distrust of psychology, thus, have little interest in research or collaboration with mental health professionals.

Doctrine and its Effect on Seeking Mental Health Treatment

Within the United States, data from the Centers for Disease Control and Prevention (2013) reported that suicide was the tenth leading cause of death in 2013. More recent data from 2015 show that an estimated 18.1% of all U.S adults had a mental illness that same year (National Institute of Mental Health Statistics, 2015). However, despite the prevalence of mental illness and the increasingly high need for mental health care, patients with mental illness continually fail to receive adequate or timely treatment. Stigma and misunderstanding of mental illness are among the reasons millions of people do not promptly seek appropriate medical attention, thereby distressing both those affected and their families and communities (Almanzar et al., 2014).

Among the diverse subdivisions of the U.S. population, Christians continue to be a powerful social force that not only affects current understandings of mental illness but is also affected by those understandings. Christianity and Christian leaders maintain an incredibly powerful presence as well as a large influence in the lives of millions of U.S. citizens and billions of people worldwide, to whom both the belief system and its leaders convey essential messages of how to understand topics of love, hope, and healing. Nonetheless, the overwhelming majority of church leaders continue to resist speaking openly about mental illness (Almanzar,

2017). Historically, the Christian community has been actively involved in ministries of healing and stressed the importance of caring for the human body. However, as at least one study has suggested, among the various groups of Christians, members of more theologically conservative Christian groups generally have more negative attitudes toward people who face mental health difficulties, primarily because of the association of mental illness with personal sin and demonic possession (Gray, 2001). Although a movement has emerged intending to raise awareness of mental illness in U.S. churches, it has failed to reach the entire Christian population in the country (Warren, 2017).

As previously stated, the relationship among religion, spirituality, and mental health has been a subject of great interest, and a predominant focus of recent studies has been on the important connection between religious activities, mental health, and spiritual wellness. However, the nature and significance of that relationship remain controversial topics (Hathaway, 2008). For instance, many Christian Pentecostals range in their response to medical interventions from total rejection to complete acceptance (Bialecki, 2011). Despite Christianity's influence on the world regarding mental health and healing, the religion's core beliefs about mental illness prevent Christians from seeking timely mental health treatment (Almanzar, 2017).

For example, Mercer (2013) outlined some of the historical and influential contexts of the Pentecostal denomination as well as an explanation of the deliverance belief system. Many Pentecostals and related groups believe that the treatment of mental health problems cannot be complete without deliverance. The study writes that Pentecostalism is usually considered an aspect of evangelicalism, a Protestant Christian movement that began in the 1700s (Mercer, 2013). Evangelical thinking places the utmost significance on conversion or being ‘‘born again,” the reliance on biblical inerrancy, a prominence on Jesus' death and resurrection as the

cornerstone of salvation, and the importance of actively spreading the gospel. Pentecostals share these beliefs; yet, in addition to a focus on Jesus' death, Pentecostals also place an extreme significance on the works of the Holy Spirit, which are seen as central to salvation and life events. These include such gifts of the Holy Spirit as casting out of demons and speaking in tongues (Ngong, 2010).

Further stated by Mercer (2013), within the Pentecostal doctrinal viewpoint, mental illnesses, including autism, bipolar disorder, depression, anxiety, and schizophrenia, all have their direct causes in the presence of demons who have entered the individual's body. These demons, who are servants of Satan but not usually Satan himself, are spiritual, but can operate through material bodies, and disturbed behaviors are indicators of the demonic presence. Deliverance, also known as exorcism or expulsion of demons, is the primary mode of treatment for mental illnesses. Deliverance is often carried out with a group attending a scheduled church service. There is usually a deliverance team rather than a single deliverer, and the team is encouraged to include both men and women. As such, deviating from doctrinal norms such as seeking professional mental health treatment may prove to be difficult for those of the Pentecostal denomination.

In 2007, Matthew S. Stanford studied 293 self-identified Christians who completed an online survey addressing a range of psychiatric disorders, including mood disorders (39.9%), schizophrenia and other psychotic disorders (30.4%), anxiety disorders (15.7%), substance use disorders (6.8%), eating disorders (4.1%), and other forms of mental illness (3.1%). Results indicated that churches were significantly more likely to dismiss women's mental illnesses than those of men or to tell women more often than men to avoid taking psychiatric medication, if not both. Although most mentally ill congregants from the survey responded in a manner that

indicated believing they were accepted by their churches, approximately 30% of them reported negative interactions with their congregations. These interactions include abandonment, the church equating mental illness with the work of demons, and the suggestion that the mental disorder had resulted from personal sin (Stanford, 2007).

In a 2012 study published by Baylor University that examined 5,899 members of 24 Christian churches representing four Protestant denominations, only 27% of people with mental illness and their families reported attending church. A major reason expressed by respondents who reported nonattendance was that they did not feel welcome at their churches. By extension, the study highlighted that although most families with mentally ill members wanted their churches to assist them in dealing with mental illness, most of their churches neglected to address such illness in their congregations (Rogers, Stanford, & Garland, 2012).

In 2002, another research group surveyed 1,031 United Methodist pastors in Indiana and Virginia about the causes of mental disorders, their perceptions of people with mental disorders, and their views on medications and other treatments. Interestingly, although most pastors attributed mental disorders to scientific causes, 484 respondents (47%) disagreed with the statement, “Mental patients are no more dangerous than an average citizen,” whereas only 243 (24%) agreed. In short, nearly half of all surveyed pastors perceived that people with mental disorders are more dangerous than the average citizen (Lafuze et al., 2002). In another study, Jennifer Shepard Payne conducted a survey with 204 Protestant pastors in California regarding how they perceive depression. According to her findings:

> Mainline Protestants . . . were very committed to their view that depression is caused by medical or biological conditions rather than spiritual causes. This is a significantly different belief than that of Pentecostals, who were more likely to believe that depression

was caused by spiritual problems or moral problems rather than biological reasons. (Payne, 2009, p. _)

The findings highlight considerable stigma and misinformation among Christians about mental illness, its causes, and applicable treatment approaches. These factors can contribute significantly to the lack of recognition and undertreatment of Christians with mental health disorders. Moreover, a vast majority of Christians surveyed believe that prayer alone is the standard treatment for mental illness. As a consequence of this belief system, many Christians are liable to refuse clinical intervention and psychotropic medications as primary treatment approaches. This form of neglect can delay additional treatment and further increase the morbidity, mortality, and possibility of life-threatening consequences among mentally ill Christians (Almanzar, 2017).

Findings from the literature show that many Christians surveyed believe that many, if not all, mental illnesses result from sinful lifestyles and that only via repentance and getting right with God, so to speak, can people with mental illness find relief from their conditions. Christians who adhere to that belief often discontinue treatment for mental illness without discussing their decision with their doctors, largely because of their belief that complete healing occurred at a church service or prayer meeting. However, such discontinuation can put patients at risk of experiencing acute or reoccurring episodes related to their mental health conditions (e.g., manic or psychotic episodes). It is also common among Christians who experience active, prominent symptoms of mental health conditions to delay treatment for years as they wait to be healed by God (Numbers & Larson, 1996.)

A large number of people struggle with mental illness in Christian communities, yet appear to feel isolated and rejected by their churches. It is imperative that Christian churches

consider how they should interact with such members of their communities, as well as those indirectly affected by mental illness. Psychiatrists and mental health providers can play a pivotal role in educating Christian patients on mental illness and its interaction with faith and spiritual practices. Although the literature on specific perceptions of Christians concerning mental illness remains scarce, the studies described above offer insights into Christian attitudes toward mental illness that perpetuate stigma and the underuse of mental health services among Christians. It was the goal of the present study to add to the knowledge of Christian attitudes toward mental illness by examining possible differences among denominations.

CHAPTER III: METHODS

Participants

The sample consisted of 232 adults ranging from 18 to 74 years old (M = 29.78, SD = 10.26). The total sample included 43 males (18.5%), and 189 females (81.5%). Among the 232 participants, 150 of them (64.7%) identified as Hispanic/Latinx, 47 (20.3%) as White or Caucasian, 16 (6.9%) as Black or African American, and 19 (8.2% as other (Asian, Native American, multiracial, Native Hawaiian/Pacific Islander). Additionally, 128 (55.2%) of the participants identified as nondenominational Christians, 67 (28.9%) as Assemblies of God/Pentecostal, 8 (3.4) as Presbyterian, and 29 (12.5%) as other (Baptist, Episcopal, Mormon, Methodist). There were no individuals who failed to indicate their gender, race, or denomination.

Measures

Mental-health-seeking attitudes (MHSA) were measured with a series of questions that assessed perceived need for treatment, level of perceived usefulness of services, and perceived benefit of utilizing services. These questions were created by the research team using guidelines outlined by Ajzen and Fishbein(1980) to directly elicit beliefs regarding health behaviors. Responses ranged from 1 = not at all confident/strongly disagree to 4 = very confident/strongly agree. Representative items from this scale were, “How confident are you that seeing a mental health professional for an emotional problem would be helpful?” The scale was found to be internally consistent in this sample (= .81). Items that were worded negatively were reverse coded so that higher scores indicated more favorable attitudes toward treatment seeking. Item scores were averaged to create a composite mental health service attitude score that was used in the analyses. However, within this study, because of an internal consistency estimate (Cronbach’s alpha) of .50, this measure was not used in the final analysis.

Mental health help-seeking attitudes. Participants were instructed to complete the ATSPPH was developed by Fischer and Turner (1970), which originally consisted of 29 items and was revised to a short form by Fischer and Farina (1995). The 10-item Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) was used to measure general attitudes toward seeking professional psychological help. Items were rated on a 4-point Likert-scale (3 = agree, 0 = disagree), where items 2, 4, 8, 9, and 10 were reverse scored. Scores were then summed, with the higher scores indicating more positive attitudes toward seeking professional help. Total scores ranged from 0 to 40. The correlation between the 10-item short form and the original 29-item scale was 0.87 (Fischer & Farina, 1995). Fischer and Farina reported an internal consistency estimate (Cronbach's alpha) of .84. Test-retest revealed reliability estimates of r =.80 over one month. The authors reported an adequate concurrent validity estimate of r = .39 in comparison to the ATSPPH scale scores and whether individuals sought professional help when experiencing serious emotional or personal problems. Participants were instructed to complete the SHI developed by Korinek and Arredondo, (2004), a 32-item scale that assesses a person's spirituality. Each item was scored by the respondent with negative items being reverse scored (4, 7, 9-10, 12-15, 17, 19, 22, 24, 26, 29). All item scores were summed for a single spiritual health score. Reliability was demonstrated by a Cronbach's alpha for the patient self-report SHI of r = 0.89. Analysis of data from the present [1992] study produced a Cronbach's alpha for the patient SHI of r = 0.77.

Procedures

The study survey was distributed online to adults in the United States. Participants were recruited from the campuses and other community facilities, as well as online via Facebook, LinkedIn, Twitter, and Instagram. Prior to completing the survey, the participants were given an

informed consent form with details of the research purpose, procedure, freedom of withdrawal, confidentiality, and data security. After signing the informed consent form, the participants were asked to complete the survey that consists of the ATSPPH-SF, MHSA, and the SHI. All data were scored and inputted in the Statistical Packages for Social Sciences for data analysis.

Analytical Strategy

Data were examined for statistical outliers and missing data. Two-way between-group analysis of variance (ANOVA) was used to address research questions one and two, which examined the relationship between MHSA, race/ethnicity, age, and denomination and intent to utilize mental health services. It was hypothesized: (a) those who identified as a racial or ethnic minority (Black/African American, Hispanic, Asian, Native American, bi-racial) would report more negative attitudes and beliefs toward mental health services within the church; individuals identifying as White would report more positive attitudes and beliefs toward mental health services within the church, (b) those who identified as younger would have more positive attitudes and beliefs toward mental health services within the church; a one-way between-group ANOVA was conducted for the third hypothesis, which stated (c) nondenominational Christians would report more positive attitudes/beliefs toward mental health services in the church compared to their denomination claiming Christian counterparts.

To address the fourth research question, MANOVA was used to examine a possible difference among Christian individuals with higher versus lower levels of spirituality regarding mental-health-seeking behaviors within the church. It was hypothesized that those with reported higher levels of spirituality would have lower mental health-seeking behaviors within the church.

CHAPTER IV: RESULTS

The normality was assessed for total score of ATSPPH (M = 32.12, SD = 4.3), and the Total Spiritual Health Inventory (TSHI; M = 146.03, SD = 15.84). When using the 5% trimmed mean for total score of ATSPPH (32.26) compared to the original mean (32.12), no extreme outliers skewed the data. When using the 5% trimmed mean for TSHI (146.32) compared to the original mean (146.03), no extreme outliers skewed the data.

Results of normality for the ATSPPH indicated that it was non-normally distributed. The Kolmogorov-Smirnov value (K-S) for ATSPPH (K-S = .000; p = .000) was not significant, suggesting a violation of normality. However, this is quite common in larger samples. Nonetheless, a transformation was performed because of concerns about non-normality; following the transformation, the data met the assumption of normality. The values on the normal probability plots followed a line, suggesting a relatively normal distribution. The detrended normal Q-Q plots for the continuous outcome variable showed various scores that deviated from the straight line, but there was no clustering that indicated any violations. In addition, a boxplot of the scores related to ATSPPH indicated there were no possible outliers.

While examining the results of the skew value (-.232) for TSHI, the data analyzed indicated clustering at the high end of the bell curve with kurtosis (-.287) suggesting a flat distribution. In addition, the K-S value for TSHI (K-S = .200; p = .000) was significant, suggesting a normal distribution. The values on the normal probability plots were fairly linear, suggesting a relatively normal distribution. The detrended normal Q-Q plots for the continuous outcome variable showed various scores that deviated from the line, but there was no clustering that indicated any violations. In addition, a boxplot of the scores related to TSHI indicated there were no possible outliers.

Hypothesis One

To answer the first hypothesis, which stated that those who identified as a racial or ethnic minority (Black/African American, Hispanic, Asian, Native American, bi-racial) would report more negative attitudes and beliefs toward mental health services within the church whereas individuals identifying as White would report more positive attitudes and beliefs toward mental health services within the church, a two-way between-groups ANOVA was conducted to explore the impact of race/ethnicity and Protestant denomination on attitudes toward seeking professional psychological help, as measured by the Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF). Participants were divided into four groups according to their self-identified race or ethnicity. (White/Caucasian, Hispanic/Latinx, Black/African American, other). Results indicated that there were no violations of the assumptions underlying ANOVA, as Levene's test of equality of error variances was not significant, $F(11, 218) = .952$. Additionally, there were no statistically significant differences at the $p < .05$ level in ATSPPH scores for the four groups: $F(7, 218) = .633$, $p = .02$. There was no statistically significant main effect for race/ethnicity $F(3, 218) = .842$, $p = .00$. The main effect for denomination, $F(3, 218) = .698$, $p = .00$, did not reach statistical significance. As such, the first hypothesis was not supported.

Hypothesis Two

To address the second hypothesis, which postulated, that those who identified as younger would have more positive attitudes and beliefs toward mental health services within the church, a two-way between-groups ANOVA was conducted to explore the impact of age on attitudes toward seeking professional psychological help, as measured by the ATSPPH-SF. Participants were divided into three groups according to their age (group one: 18 to 25; group two: 26 to 29;

group three: 30 and above). Results indicated that there were no violations of the assumptions underlying ANOVA ,as Levene's test of equality of error variances was not significant, $F(10, 220) = .319$. There was no statistically significant difference at the $p < .05$ level in ATSPPH scores for the three age groups: $F(6, 220) = .863$, $p = .01$. There was no statistically significant main effect for age $F(2, 220) = .785$, $p = .00$, or the main effect for denomination, $F(3, 220) = .915$, $p = .00$, did not reach statistical significance. As such, the second hypothesis was not supported.

Hypothesis Three

To answer the third hypothesis, which stated that nondenominational Christian's would report more positive attitudes/beliefs toward mental health services in the church compared to their denomination claiming Christian counterparts, a one-way between-groups ANOVA was conducted to explore the impact of denomination attitudes toward seeking professional psychological help, as measured by the ATSPPH-SF. Participants were divided into four groups according to their self-identified denomination (group one: Assemblies of God/Pentecostal; group two: Presbyterian; group three: nondenominational; group four: other). Results indicated that there were no violations of the assumptions underlying ANOVA, as Levene's test of equality of error variances was not significant, $F(3, 228) = .806$. Results indicated that there was no statistically significant difference at the $p < .05$ level in ATSPPH scores for the four groups: $F(3, 228) = .793$, $p = .00$. As such, the third hypothesis was not supported.

Hypothesis Four

To address the fourth hypothesis, which stated that those with reported higher levels of spirituality would have lower mental-health-seeking behaviors within the church, a one-way between-groups MANOVA was performed to investigate denominational differences in attitudes

toward seeking professional psychological health and levels of spirituality. Two dependent variables were used: TSHI and total ATSPPH. The independent variable was Christian denomination. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no serious violations noted. There was no statistically significant difference between denominations with ATSPPH, $F(3, 228) = .337$, $p = .01$; partial eta squared=.015, or TSHI $F(3, 228) = .374$, $p = .01$; partial eta squared=.014 with Wilk's $\Lambda = .014$ As such, the hypothesis was not supported.

CHAPTER V: DISCUSSION

This study explored the impact of race/ethnicity, age, level of spirituality, and Christian denomination on an individual's ATSPPH. To explore these relationships, the study divided each variable into an individual hypothesis to better understand the impact it had on attitudes toward mental health services. Within the first hypothesis, which stated that those who identify as a racial or ethnic minority (Black/African American, Hispanic, Asian, Native American, bi-racial) would report more negative attitudes and beliefs toward mental health services within the church and individuals identifying as White would report more positive attitudes and beliefs toward mental health services within the church, the results of the study demonstrated that this hypothesis was not supported, as there was no significant impact that race/ethnicity had on seeking mental health services, therefore, suggesting that race/ethnicity does not play a role in positive or negative attitudes toward mental health within the varying denominations of the Protestant church.

While these were the findings within this study, it is of note that previous literature speaks of an opposite view. Remarkably, the literature on mental health attitudes and race/ethnicity speaks of the varying differences because of cultural stigma and histories of oppression (Neighbors, 2007). Possible explanations for the divergence and lack of support for this finding may be because of an inadequate sample size of the varying races/ethnicities, as 150 of the participants (64.7%) identified as Hispanic/Latinx, 47 (20.3%) as White or Caucasian, 16 (6.9%) as Black or African American, and 19 (8.2% as other (Asian, Native American, multiracial, Native Hawaiian/Pacific Islander). Not having ample members of the African American/Black, White or Caucasian, or Asian, Native American, multiracial, Native Hawaiian/Pacific Islander could have played a role in not seeing the impact race/ethnicity has on

the attitudes toward mental health services within the church. Additionally, there may have been instrumentation problems, as the measures utilized may have assessed for a general attitude toward mental-health-seeking behaviors but not necessarily willingness to seek mental health services.

As such, an individual's cognitive dissonance may play a vital role in understanding that mental health services are a positive thing, but his or her willingness to seek out services could be impacted by race/ethnicity. Therefore, future studies could expand the literature by possibly exploring an individual's willingness to seek out services in conjunction with attitudes to better understand how possible cognitive dissonance plays a role in mental health attitudes within the church. Furthermore, in expanding the sample to have a better representation of various races/ethnicities, one could better ascertain the true impact race and ethnicity play in the relationship between mental health services and the church, especially when considering the previous literature that emphasizes the role cultural and racial identities play in seeking mental health services.

The second hypothesis sought to understand the impact between age and ATSPPH. The hypothesis stated that those who identified as younger would have more positive attitudes and beliefs toward mental health services within the church. Results indicated that the hypothesis was not supported, as there was no difference between the three age groups (group one: 18 to 25; group two: 26 to 29; group three: 30 and above). Consequently, these results propose that age does not play a role in seeking professional psychological help within the denominations of the Protestant church. The lack of findings may be because the sample was not broad enough to capture varying views among the age groups. As research has started to demonstrate a decline in the stigma surrounding mental health-seeking behaviors among younger generations, the current

sample may have added to the body of literature demonstrating this general trend in mental-health-seeking behaviors (Romer & Bock, 2008). In expanding the age ranges to have better representation, future studies may be able to better understand the trends in seeking professional psychological help within the church. Additionally, as there was little research on the role age plays within the church overall, further exploration of how age impacts the understanding of religion, spirituality, and Christian denominations may be necessary to better learn how age impacts the church and mental-health-seeking behaviors.

The third hypothesis of this study explored the impact denomination had on ATSPPH. This hypothesis postulated that nondenominational Christian's would report more positive attitudes/beliefs toward mental health services in the church compared to their denomination claiming Christian counterparts. The results of the analysis conducted indicated that there was no significant impact between denomination and attitudes toward seeking psychological help. Thus, the original hypothesis could not be accepted, suggesting that denomination does not play a role in seeking professional psychological help within the Protestant church. Possible explanations for this may be because the category of Protestant denomination stems from a social construct and focuses more on doctrinal viewpoints versus lifestyle viewpoints. However, as there are various denominations within America and worldwide, and seeing how the sample was made up of predominantly nondenominational Christians, it may be beneficial to widen the sample. By broadening the sample, one may be able to ascertain the impact of denomination more adequately on mental-health-seeking behaviors.

The fourth hypothesis sought to understand the impact between age, levels of spirituality, and overall ATSPPH. The hypothesis stated that those with reported higher levels of spirituality in older age groups would have lower mental-health-seeking behaviors within the church.

Results indicated that the original hypothesis was not supported. Consequently, these results propose that age and levels of spirituality do not play a role in seeking professional psychological help within the Protestant church. As previously stated above, possible explanations for this outcome may be because the sample was not broad enough to capture varying views among the age groups. As such, widening the age groups analyzed and, therefore, expanding the possible pool of degrees of spirituality might allow for a more adequate understanding about how age and levels of spirituality impact mental-health-seeking behaviors among protestant Christians.

General Limitations

The present study established some evidence on the relationship among age, denomination, degree of spirituality, and race/ethnicity on mental-health-seeking behaviors, and attitudes toward mental health. However, there were limitations to the study that, if considered in future research, might allow for a deeper understanding of these intersecting points. For example, the length of the survey could have been a deterrent from more people answering. In future research, using measures with a smaller number of questions while not sacrificing the content necessary might allow people to answer more readily. Furthermore, the data collected were self-report data. Self-reported data are limited by the fact that they rarely can be verified. One must take what the individual says, and bias is unable to be questioned. For example, the bias of attribution (the act of attributing positive events and outcomes to one's own agency but attributing negative events and outcomes to external forces) may have played a role in how participants answered questions. In future research, it might be beneficial to consider whether bias plays a role and account for bias in measure selection and analyzing data.

Another limitation of the present study was access. Having limited access to various denominations, age groups, and races/ethnicities may have played a role in being able to ascertain the relationships between these variables and mental-health-seeking behaviors. As some churches, pastors, and other leaders were asked to participate in the survey and share the survey with others, the willingness of the individuals to share the survey added to the limited access. Last, the time frame given to complete the present study might have impacted the ability to gather a larger sample, thus, better ascertain the relationship of the variables.

Future Directions

Although the research did not support the hypotheses, future studies regarding the topic of mental health and Christianity must consider exploring further how age plays a role within the church overall, as this appeared to be an under-researched topic. Furthermore, it may be beneficial to focus on how to better build the sample, as the current study had a large sample size that identified as nondenominational, which could have skewed the results. As such, further exploration into the belief system and how they may view mental health and how members of this denomination feel about seeking out services may be beneficial to explore. Additionally, when looking at the survey that was not able to be used in this study, the MHSA, it may be helpful to focus in on specific questions within the survey like that of "How embarrassed would you be if your church members knew you were getting professional help for an emotional problem?" or "If I had an emotional problem, most people in my church would expect me to get help from a professional," as these may help shed further light on how individuals within a denomination perceive their ability and willingness to seek professional psychological help. Finally, exploring the level of cognitive dissonance individuals may have regarding seeking services may yield important information. For example, an individual may hold the belief that

others need to seek services but would not do so themselves. As such, accounting for this in future research may facilitate a better understanding of the relationship between Christianity and mental health.

References

Abraido-Lanza, A. G., Vasquez, E., & Echevarria, S. E. (2004). En las manos de Dios [in God's hands]: religious and other forms of coping among Latinos with arthritis. *Journal of Counseling and Clinical Psychology, 72*(1), 91-102.

Abu-Raiya, H., Pargament, K. I., & Magyar-Russell, G. (2010). When religion goes awry: Religious risk factors for poorer health and well-being. In P. Verhagen, H. M. Van Praag, J. J. Lo´pez-Ibor Jr, J. Cox, & D. Moussaoui (Eds.), *Religion and psychiatry: Beyond boundaries* (pp. 389-411). West Sussex: Wiley.

Accreditation Council on Graduate Medical Education. (1994). *Special requirements for residency training in psychiatry*. Chicago, IL: Author.

Adams, J. E. (1970). *Competent to counsel*. Phillipsburg, NJ: Presbyterian and Reformed Publishing.

Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior.* Englewood Cliffs, NJ: Prentice-Hall.

Almanzar, S., Shah, N., Vithalani, S., Shah, S., Squires, J., Appasani, R., & Katz, C. L. (2014). Knowledge of and attitudes toward clinical depression among health providers in Gujarat, India. *Annals of Global Health, 80*(2), 89-95.

Almanzar, S. (2017). Christianity and mental illness: Evil or sickness? *EC Psychology and Psychiatry, 4*(5), 181-188.

American Psychological Association. (2002). *American Psychological Association ethical principles of psychologists and code of conduct.* Washington, DC: Author.

Anderson, N. T. (2000a). *Victory over the darkness: Realizing the power of your identity in Chris*t, first/second edition. Ventura, CA: Regal Books.

Anderson, N. T. (2000b). *The bondage breaker*, first/second edition. Eugene, OR: Harvest House Publishers.

Bergin, A. E. (1983). Religiosity and mental health: A critical reevaluation and meta-analysis. *Professional Psychology: Research and Practice, 14*, 170-184. doi:10.1037//0735-7028.14.2.170

Bialecki, J. (2011). No caller-ID for the soul: Demonization, charismas, and the unstable subject of Protestant language ideology. *Anthropological Quarterly, 84*, 679-704.

Braam, A. W., Hein, E., Deeg, D. J. H., Twisk, J. W. R., Beekman, A. T. F., & van Tilburg, W. (2004). Religious involvement and 6-year course of depressive symptoms in older Dutch citizens: Results from the longitudinal aging study Amsterdam. *Journal of Aging & Health, 16*, 467-489. doi:10.1177/0898264304265765

Bobgan, M., & Bobgan, D. (1987). *Psychoheresy: The psychological seduction of Christianity*. San Francisco, CA: East Gate.

Bohnert, A., Perron, B., Jarman, C., Vaughn, M., Chatters, L., & Taylor, R. J. (2010). Use of clergy services among individuals seeking treatment for alcohol use problems. *The American Journal on Addictions, 19*(4), 345-351.

Borders, T. F., Curran, G. M., Mattox, R., & Booth, B. M. (2010). Religiousness among at-risk drinkers: Is it prospectively associated with the development or maintenance of an alcohol-use disorder? *Journal of Studies on Alcohol and Drugs, 71*, 136-142.

Bowen, R., Baetz, M., & D'Arcy, C. (2006). Self-rated importance of religion predicts one-year outcome of patients with panic disorder. *Depression & Anxiety (1091-4269), 23*(5), 266-273. https://doi-org.nl.idm.oclc.org/10.1002/da.20157

Burke, M. T., Chauvin, J. C., & Miranti, J. G. (2005). *Religious and spiritual issues in counseling: Applications across diverse populations*. New York, NY: Brunner-Routledge.

Carlson, T. D., Kirkpatrick, D., Hecker, L., & Killmer, M. (2002). Religion, spirituality, and marriage and family therapy: A study of family therapists' beliefs about the appropriateness of addressing religious and spiritual issues in therapy. *American Journal of Family Therapy, 30*(2), 157-171.

Carlson, T., McGeorge, C., & Toomey, R. (2014). Establishing the validity of the spirituality in clinical training scale: Measuring the level of integration of spirituality and religion in family therapy training. *Contemporary Family Therapy: An International Journal, 36*(2), 310-325. doi:10.1007/s10591-013-9278-y.

Centers for Disease Control and Prevention. (2013). *Web-based injury statistics query and reporting system*. National Center for Injury Prevention and Control.

Chalfant, H. P., Heller, P. L., & Roberts, A. (1990). The clergy as a resource for those encountering psychological distress. *Review of Religious Research, 31*(3), 305-313.

Chalfant, H. P., Heller, P. L., Roberts, A., Briones, D., Aguirre-Hochbaum, S., & Farr, W. (1990). The clergy as a resource for those encountering psychological distress. *Review of Religious Research*, (3), 305. https://doi.org/10.2307/3511620

Chang, C., & Myers, J. E. (1997). Understanding and counseling Korean Americans: Implications for training. *Counselor Education and Supervision, 37*, 35-49. doi:10.1002/j.1556-6978.1997.tb00529.x

Cheon, H.-S., Chang, E., Kim, P. Y., & Hyun, J. H. (2016). Mental health disparities impacting Christian Korean Americans: a qualitative examination of pastors' perspectives. *Mental Health, Religion & Culture, 19*(6), 538-552. https://doi.org/10.1080/13674676.2016.1213712

Connell, C., & Gibson, G. (1997). Racial, ethnic, and cultural differences in dementia caregiving: Review and analysis. *Gerontologist, 37,* 355-364.

Durlak, J. (1979). Comparative effectiveness of para- professional and professional helpers. *Psychological Bulletin, 86*, 80-92.

Ellison, C. G., & Flannelly, K. J. (2009). Religious involvement and risk of major depression in a prospective nationwide study of African American adults. *Journal of Nervous & Mental Disease, 197*, 568-573. doi:10.1097/NMD.0b013e3181b08f45

Ellison, C. G., Finch, K. B., Ryan, N. D., & Salinas, J. J. (2009). Religious involvement and depressive symptoms among Mexican-oring adults in California. *Journal of Community Psychology, 37*(2), 171-193.

Ellison, C. G., & Lee, J. (2010). Spiritual struggles and psychological distress: Is there a dark side of religion? *Social Indicators Research, 98*(3), 501-517.

Exline, J. J. (2002). Stumbling blocks on the religious road: Fractured relationships, nagging vices, and the inner struggle to believe. *Psychological Inquiry, 13*(3), 182-189.

Exline, J. J., & Rose, E. (2005). Religious and spiritual struggles. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 315-330). New York, NY: Guilford Press.

Exline, J. J., & Martin, A. (2005). Anger toward God: A new frontier in forgiveness research. In E. L. Worthington Jr (Ed.), *Handbook of forgiveness research* (pp. 73-88). New York, NY: Guilford Press.

Fischer E. H., Farina A. (1995). Attitudes toward seeking professional psychological help: a shortened form and considerations for research. J. Coll. Stud. Dev. 36, 368–373.

Fischer E. H., Turner J. L. (1970). Orientations to seeking professional help: development and research utility of an attitudes scale. J. Couns. Clin. Psychol. 35, 79–90. 10.1037/h0029636

Garzon, F. L., & Tilley, K. (2009). Do lay Christian counseling approaches work? What we currently know. *Faculty Publications and Presentations*, 54. http://digitalcommons.liberty.edu/ccfs_fac_pubs/54

Garzon, Fernando L.; Worthington, Jr., Everett L.; Tan, Siang-Yang; and Worthington, R. Kirby, "Lay Christian Counseling and Client Expectations for Integration in Therapy" (2009). Faculty Publications and Presentations. Paper 53. http://digitalcommons.liberty.edu/ccfs_fac_pubs/53

Good, M., & Willoughby, T. (2011). Evaluating the direction of effects in the relationship between religious versus non-religious activities, academic success, and substance use. *Journal of Youth & Adolescence, 40*, 680-693. doi:10.1007/s10964-010-9581-y

Gray, A. J. (2001). Attitudes of the public to mental health: a church congregation. *Mental Health, Religion, and Culture, 4*(1), 71-79.

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion, 42*, 43-55. doi: 0.1111/1468-5906.t01-1-00160

Hathaway, S. (2008). Religious involvement, attitude toward seeking professional psychological help, and preference for alternative mental health settlings (Doctoral dissertation). University of Missouri, Columbia, MO.

Haugk, K. (1984). *Christian caregiving: A way of life*. Minneapolis, MN: Augsburg Publishing.

Haugk, K. (2000). *Stephen Ministry training manual,* Volume 1. St. Louis, MO: Stephen Ministry.

Havighurst, S. S., & Downey, L. (2009). Clinical reasoning for child and adolescent mental health practitioners: The mindful formulation. *Clinical Child Psychology & Psychiatry, 14*, 252-272. doi:10.1177/1359104508100888

Hill, T. D., Angel, J. L., Ellison, C. G., & Angel, R. J. (2005). Religious attendance and mortality: An 8-year follow-up study of older Mexican Americans. *Journal of Gerontology: Social Sciences, 60*, 102-109.

Hill, T. D., Burdette, A. M., Ellison, C. G., & Musick, M. A. (2006). Religious attendance and the health behaviors of Texas adults. *Preventive Medicine, 42,* 309-312.

Hill, P., Pargament, K. I., Hood, R. W., McCullough, M. E., Sawyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour, 30*, 51-77. doi:10.1111/1468-5914.00119

Holland, J. (2007). Solution-Focused lay pastoral care. *Journal of Family and Community Ministries*, 22-30.

Holmberg, Å., Jensen, P., & Ulland, D. (2017). To make room or not to make room: Clients' narratives about exclusion and inclusion of spirituality in family therapy practice. *Australian & New Zealand Journal of Family Therapy*, *38*(1), 15-26.

Homan, K. J., & Boyatzis, C. J. (2010). The protective role of attachment to God against eating disorder risk factors: Concurrent and prospective evidence. *Eating Disorders, 18*, 239-258. doi:10.1080/10640261003719534

Hufford, D. J. (2005). *An analysis of the field of spirituality, religion, and health. Area 1 field analysis*. Retrieved from https://www.metanexus.net/archive/templetonadvancedresearchprogram/pdf/TARP-Hufford.pdf

Hurding, R. F. (1995). Pathways to wholeness: Chris- tian journeying in a postmodern age. *Journal of Psychology and Christianity, 14*, 293-305.

Hurh, W. M. (1998). *The Korean Americans*. Westport, CT: Greenwood Press.

Jang, S. J., & Johnson, B. R. (2004). Explaining religious effects on distress among African Americans. *Journal for the Scientific Study of Religion*, (2), 239. Retrieved from https://login.ezproxy.net.ucf.edu/login?auth=shibb&url=https://search.ebscohost.com/login.aspx?direct=true&db=edsjsr&AN=edsjsr.1388125&site=eds-live&scope=site

Kark, J. D., Shemi, G., Friedlander, Y., Martin, O., Manor, O., & Blondheim, S. H. (1996). Does religious observance promote health? Mortality in secular vs. religious Kibbutzim in Israel. *American Journal of Public Health, 86*, 341-346. doi: 10.2105/AJPH.86.3.341

King, D. E., Cummings, D., & Whetstone, L. (2005). Attendance at religious services and subsequent mental health in midlife women. *International Journal of Psychiatry in Medicine, 35*, 287-297. doi:10.2190/DEB0-B55Y-7EW6-8D7B

Koenig, H. G. (1999). Does religious attendance prolong survival? A six-year follow-up study of 3,968 older adults. *Journals of Gerontology-Series A Biological Sciences and Medical Sciences, 54*, 370-376. doi:10.1093/gerona/54.7.M370

Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. San Diego, CA: Academic Press.

Koenig, H. G., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry, 13*, 67-78. doi: 10.1080/09540260124661

Kohn-Wood, L. P., & Hooper, L. M. (2014). Cultural Competency, Culturally Tailored Care, and the Primary Care Setting: Possible Solutions to Reduce Racial/Ethnic Disparities in Mental Health Care. *Journal of Mental Health Counseling*, *36*(2), 173–188. https://doi-org.nl.idm.oclc.org/10.17744/mehc.36.2.d73h217l81tg6uv3

Korinek, A. W., & Arredondo, R. (2004). The Spiritual Health Inventory (SHI). Alcoholism Treatment Quarterly, 22(2), 55-66.

Lafuze, J. E., Perkins, D. V., & Avirappattu, G. A. (2002). Pastors' perceptions of mental disorders. *Psychiatric Services, 53*, 900-901.

Levin, J. S. (1994). Religion and health: Is there an association, is it valid, and is it causal? *Social Science and Medicine, 38*(11), 1475-1482.

Levin, J. S., Markides, K. S., & Ray, L. A. (1996). Religious attendance and psychological well- being in Mexican Americans: A panel analysis of three-generations data. *Gerontologist, 36,* 454-463.

Levin, J. S., Taylor, R. J., & Chatters, L. M. (1995). A multidimensional measure of religious involvement for African Americans. *The Sociological Quarterly, 36*(1), 157-173

Mannheimer, A. H., & Hill, T. D. (2015). Deviating from religious norms and the mental health of conservative Protestants. *Journal of Religion and Health*, *54*(5), 1826-1838. https://doi.org/10.1007/s10943-014-9951-y

Manson, S. M. (2003). Extending the boundaries, bridging the gaps: crafting Mental Health: Culture, Race, and Ethnicity, a Supplement to the Surgeon General's Report on Mental Health. *Culture, Medicine & Psychiatry*, *27*(4), 395–408. https://doi-org.nl.idm.oclc.org/10.1023/B:MEDI.0000005479.04694.e2

Markides, K. S., Levin, J. S., & Ray, L. A. (1987). Religion, aging, and life satisfaction: An eight-year, three-wave longitudinal study. *Gerontologist,27,* 660-665.

McCullough, M. E., & Willoughby, B. L. B. (2009). Religion, self-regulation, and self-control: associations, explanations, and implications. *Psychological Bulletin*, (1), 69. Retrieved from

https://login.ezproxy.net.ucf.edu/login?auth=shibb&url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgao&AN=edsgcl.192052033&site=eds-live&scope=site

McMinn, M. R., Aikins, D. C., & Lish, R. A. (2003). Basic and advanced competence in collaborating with clergy. *Professional Psychology: Research and Practice, 34*, 197-202.

McMinn, M. R., Meek, K. R., Canning, S. S., & Pozzi, C. F. (2001). Training psychologists to work with religious organizations: The Center for Church-Psychology Collaboration. Professional *Psychology: Research and Practice, 32*, 324-328.

Mercer, J. (2013). Deliverance, demonic possession, and mental illness: Some considerations for mental health professionals. *Mental Health, Religion & Culture, 16*(6), 595-611. https://doi.org/10.1080/13674676.2012.706272

Millon, T. (2004). *Masters of the mind: Exploring the story of mental illness from ancient times to the new millennium*. Hoboken, NJ: John Wiley & Sons.

Min, P. G., & Kim, J. H. (Eds.). (2002). *Religions in Asian America: Building faith communities*. New York, NY: AltaMira Press.

Mohr, S., Perroud, N., Gillieron, C., Brandt, P.-Y., Rieben, I., Borras, L., & Huguelet, P. (2011). Spirituality and religiousness as predictive factors of outcome in schizophrenia and schizo-affective disorders. *Psychiatry Research, 186*, 177-182. https://doi.org/10.1016/j.psychres.2010.08.012

Mowrer, O. H. (1961). *The crisis in psychiatry and religion*. Princeton, NJ: Van Nostrand Co.

Murphy, P. E., Ciarrocchi, J. W., Piedmont, R. L., Cheston, S., Peyrot, M., & Fitchett, G. (2000). The relation of religious belief and practices, depression, and hopelessness in persons with.. *Journal of Consulting & Clinical Psychology*, *68*(6), 1102. https://doi-org.nl.idm.oclc.org/10.1037/0022-006X.68.6.1102

Musick, M. A., House, J. S., & Williams, D. R. (2004). Attendance at religious services and mortality in a national sample. *Journal of Health & Social Behavior, 45*, 198-213. doi:10.1177/002214650404500206

National Institute of Mental Health Statistics. (2015). *Any mental illness among U.S. adults*.

Neighbors, H. (2007). Race, ethnicity, and the use of services for mental disorders: Results from the national survey of American life. *Archives of General Psychiatry, 64*(4), 485.

New Freedom Commission on Mental Health Subcommittee on Rural Issues: Background paper (2007). *Journal of Rural Mental Health, 31*(4), 66–91. https://doi.org/10.1037/h0095978

Newport, F. (2009). This christmas, 78% of Americans identify as Christian. https://news.gallup.com/poll/124793/this-christmas-78-americans-identify-christian.aspx

Ngong, D. (2010). *The Holy Spirit and salvation in African Christian theology*. New York, NY: Peter Lang.

Numbers, R. L., & Larson, D. R. (1996). The Adventist tradition. In R. L. Numbers & D. W. Amundsen (Eds.), *Caring and curing: The early Christian tradition*. New York, NY: Macmillan.

Pargament, K. I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, *56*, 519-543.

Pargament, K. I., & Lomax, J. W. (2013), Understanding and addressing religion among people with mental illness. *World Psychiatry, 12*, 26-32. doi:10.1002/wps.20005

Pargament, K. I., Murray-Swank, N. A., Magyar, G. M., & Ano, G. G. (2005). Spiritual struggle: A phenomenon of interest to psychology and religion. In W. R. Miller & H. D. Delaney (Eds.), *Judeo-Christian perspectives on psychology: Human nature, motivation, and change* (pp. 245-268). Washington, DC, US: American Psychological Association. http://dx.doi.org/10.1037/10859-013

Park, H., Murgatroyd, W., Raynock, D. C., & Spillett, M. (1998). Relationship between intrinsic-extrinsic religious orientation and depressive symptoms in Korean Americans. *Counselling Psychology Quarterly, 11*, 315-324. doi:10.1080/09515079808254063

Payne, J. S. (2009). Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. *Community Mental Health Journal 45*(5), 355-365.

Randolph-Seng, B., Nielsen, M. E., Bottoms, B. L., & Filipas, H. (2008). The relationship between ethnicity, Christian orthodoxy, and mental health. *Mental Health, Religion & Culture*, *11*(8), 795–805. https://doi-org.nl.idm.oclc.org/10.1080/13674670802084788

Rasic, D., Robinson, J. A., Bolton, J., Bienvenu, O. J., & Sareen, J. (2011). Longitudinal relationships of religious worship attendance and spirituality with major depression, anxiety disorders, and suicidal ideation and attempts: Findings from the Baltimore epidemiologic catchment area study. *Journal of Psychiatric Research, 45*, 848-854. doi:10.1016/j.jpsychires.2010.11.014

Rogers, E. B., Stanford, M., & Garland, D. R. (2012) The effects of mental illness on families within faith communities. *Mental Health, Religion & Culture, 15*(3), 301-313. doi:10.1080/13674676.2011.573474

Rojas, D. Z. (1996). Spiritual well-being and its influence on the holistic health of Hispanic women. In S. Torres (Ed.), *Hispanic voices: Hispanic health educators speak out* (pp. 213-229). New York, NY: NLM Press.

Romer, D., & Bock, M. (2008) Reducing the stigma of mental illness among adolescents and young adults: The effects of treatment information, *Journal of Health Communication*, *13*(8), 742-758.

Sandford, J. L., & Sandford, P. (1982). *The transformation of the inner man*. Tulsa, OK: Victory House.

Schnittker, J. (2001). When is faith enough? The effects of religious involvement on depression. *Journal for the Scientific Study of Religion*, *40*(3), 393–411. https://doi-org.nl.idm.oclc.org/10.1111/0021-8294.00065

Shahabi, L., Powell, L. H., Musick, M. A., Pargament, K. I., Thoresen, C. E., Williams, D., . . . Ory, M. A. (2002). Correlates of self-perceptions of spirituality in American adults. *Annals of Behavioral Medicine, 24*, 59-68. doi:10.1207/S15324796ABM2401_07

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*, 614-636. doi:10.1037/0033-2909.129.4.614

Stanford, M. (2007). Demon or disorder: A survey of attitudes toward mental illness in the Christian church. *Mental Health, Religion & Culture*, *10*(5), 445-449.

Sternthal, M. J., Williams, D. R., Musick, M. A., & Buck, A. C. (2010). Depression, anxiety, and religious life: A search for mediators. *Journal of Health and Social Behavior, 51*(3), 343-359.

Stolley, J. M., & Koenig, H. (1997). Religion/spirituality and health among elderly African Americans and Hispanics. *Journal of Psychosocial Nursing & Mental Health Services, 35*(11), 32-46. Retrieved from https://login.ezproxy.net.ucf.edu/login?auth=shibb&url=https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=107238058&site=eds-live&scope=site

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual review of psychology*, *60*, 525–548. https://doi.org/10.1146/annurev.psych.60.110707.163651

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York, NY: Paul B. Hoeber.

Tan, S.-Y. (1991). Religious values and interventions in lay Christian counseling. Journal of Psychology and Christianity, 10(2), 173-183.

Tan, S.-Y. (1992). The Holy Spirit and counseling ministries. The Christian Journal of Psychology and Counseling, 7(3), 8-11.

Tan, S.-Y. (1998). The spiritual disciplines and counseling. Christian Counseling Today, 6(2), 19-46.

Taylor, R. J., & Chatters, L. M. (1991). Religious life. In J. S. Jackson (Ed.), *Life in Black America* (pp.105-123). Thousand Oaks, CA: SAGE.

Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: the role of clergy in Black churches. *Social Work*, *45*(1), 73-87. https://doi.org/sw/45.1.73

Ten Kate, J., de Koster, W., & van der Waal, J. (2017). The Effect of Religiosity on Life Satisfaction in a Secularized Context: Assessing the Relevance of Believing and Belonging. Review of religious research, 59(2), 135–155. https://doi.org/10.1007/s13644-016-0282-1

Tirrito, T., & Choi, G. (2004). Ethnically diverse elders: A community action model faith-based initiatives and aging services. In F. E. Netting & J. W. Ellor (Eds.), *Faith-based initiatives and aging services* (pp. 123-142). Binghamton, NY: Haworth Pastoral.

Toh, Y-M., & Tan, S. Y. (1997). The effectiveness of church-based lay counselors: A controlled outcome study. J*ournal of Psychology and Christianity, 16*, 260-267.

U.S. Census Bureau. (2010). 210 *Census data*. Retrieved May 1, 2011, from: http://2010.census.gov/2010census/data.htm

Wade, N., Worthington, E., & Vogel, D. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research*, *17*, 91-105.

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, *38*(2), 647-673. https://doi.org/10.1111/1475-6773.00138

Warren, K. (2017). Hope for mental health.

Yangarber-Hicks, N. (2004). Religious Coping Styles and Recovery from Serious Mental Illnesses. *Journal of Psychology and Theology*, *32*(4), 305–317. https://doi.org/10.1177/009164710403200403

Ziegler, J. (1998a, September 2). Spirituality returns to the fold in medical practice. *Journal of the National Cancer Institute, 90*, 1255-1257.

Zinnbauer, B. J., & Pargament, K. I. (2005). Religiousness and spirituality. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 21-42). New York, NY: Guilford Press.

Zinnbauer, B. J., Pargament, K. I., Cole, B., Rye, M. S., Butter, E. M., Belavich, T. G., . . . Kadar, J. L. (1997). Religion and spirituality: Unfuzzying the fuzzy. *Journal for the Scientific Study of Religion, 36*, 549-564. doi:10.2307/1387689