

Rowan University

Rowan Digital Works

---

Theses and Dissertations

---

12-9-2011

## An investigative study of the influence of religion on help seeking behaviors in the field of mental health

Kristen Darroch

Follow this and additional works at: <https://rdw.rowan.edu/etd>



Part of the [Psychiatric and Mental Health Commons](#)

---

### Recommended Citation

Darroch, Kristen, "An investigative study of the influence of religion on help seeking behaviors in the field of mental health" (2011). *Theses and Dissertations*. 91.

<https://rdw.rowan.edu/etd/91>

This Thesis is brought to you for free and open access by Rowan Digital Works. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of Rowan Digital Works. For more information, please contact [graduateresearch@rowan.edu](mailto:graduateresearch@rowan.edu).

AN INVESTIGATIVE STUDY OF THE INFLUENCE OF RELIGION ON HELP  
SEEKING BEHAVIORS IN THE FIELD OF MENTAL HEALTH

by  
Kristen Darroch

A Thesis

Submitted to the  
Department of Psychology  
College of Liberal Arts and Sciences  
In partial fulfillment of the requirement  
For the degree of  
Master of Arts  
at  
Rowan University  
November 29, 2011

Thesis Chair: Matthew Miller, Psy.D.

© 2011

Kristen Darroch

## **Dedication**

*I would like to dedicate this manuscript to my family for all of their support and encouragement.*

## Acknowledgments

I would like to express my appreciation to Dr. Miller who proved to be a mentor to me during my years of graduate study at Rowan University. I thank him for his support and guidance with this project.

## ABSTRACT

Kristen Darroch

### AN INVESTIGATIVE STUDY OF THE INFLUENCE OF RELIGION ON HELP SEEKING BEHAVIORS IN THE FIELD OF MENTAL HEALTH

2009/2010

Matthew Miller, Psy.D.

Master of Arts in Clinical Mental Health Counseling

The present study was undertaken to assess the influence of religion on help seeking behaviors regarding mental health. Participants ( $n = 167$ ) were volunteers from three different churches of Christian denominations who anonymously completed questionnaires regarding their religiosity and their attitude toward seeking help from a mental health professional. Analysis of the data found that subjects who belonged to liberal denominations of Christianity were more likely to seek help from a mental health professional for mental health issues than subjects belonging to more traditionally conservative denominations of Christianity. The study also found that subjects belonging to conservative denominations of Christianity scored higher on an instrument assessing religiosity. Future efforts to bring the mental health and faith communities together must focus on factors of conservative faiths that may be deterring church members from seeking help for mental health issues.

## TABLE OF CONTENTS

CHAPTER	PAGE
Abstract	v
I. Introduction	1
Statement of the Problem	1
Significance of the Study	2
Purpose of the Study	2
Literature Review	2
II. Method	11
Context of the Study	11
Instrumentation	12
IV. Results	15
V. Discussion	17
Conclusions	17
Recommendations	19
Summary	20
References	22
Appendices	31

## LIST OF FIGURES

FIGURE	PAGE
Figure 1. Mean Attitude Toward Seeking Professional Help by Denomination	27
Figure 2. Mean Religiosity Scores by Denomination	28
Figure 3. Mean Attitude Toward Seeking Professional Help by Gender	29
Figure 4. Mean Attitude Toward Seeking Professional Help by Education Level	30



## LIST OF TABLES

TABLE	PAGE
Table 1. Participant Demographics	25

## CHAPTER I

### Introduction

Recent research suggests that cultural and ethnic groups conceptualize mental illness in different ways and plan treatments based on their exclusive understandings of the causes of mental illness (Jorm et al., 1997). Attitudes about mental illness derived from culture can influence help-seeking behaviors and willingness to participate in treatment (Bjorck & Trice, 2006). Given that help-seeking behaviors and treatment compliance will vary across groups, effectiveness of treatment may also vary. While some individuals feel it is appropriate to seek help from a mental health professional for mental illness, others practicing religion may feel as though they should turn to their faith and their religious leader for help. A person who practices religion is a person who has a connection to a community with shared beliefs and rituals, for example someone who regularly attends a church, temple, or synagogue and participates in the rituals and practices shared by the congregation (Koenig, 2004). While some individuals will seek help from mental health professionals and some will seek help from their religious leader, others may neglect to seek help at all (Bjorck & Trice, 2006).

Religiosity refers to the practice of the beliefs of an organized and institutional religion (Rose, Westefeld, & Ansley, 2008). As stated, a person will often consider him or herself to be religious when they follow the practices and the faith of their church. This is not to be confused with spirituality, which denotes a person's beliefs about their personal relationship with a higher being (Rose et al., 2008). This study will look exclusively at religion. Does religion influence help seeking behavior related to mental illness?

Because religion is a prominent part of culture, mental health professionals are bound to encounter issues relevant to religion and religious diversity in their practices. Psychotherapists are likely to see concerns or hesitation from some individuals seeking treatment. Research suggests that religiosity does, in fact, influence the counseling experience and is therefore a relevant issue to both the client and the psychotherapist (Rose et al., 2008). Clients with high religiosity may enter therapy with concerns. One concern of potential clients who consider themselves to be religious is that the psychotherapist may attempt to alter the client's religious beliefs in order to make these beliefs more compatible with the therapist's beliefs and the way that the therapist conceptualizes the client (Rose et al., 2008). Keating and Fretz (1990) found that highly religious Christians are less likely to seek counseling from a mental health professional because they anticipate that counseling will be incompatible with practices of their faith. A possible explanation for this fear of incompatibility is that most Christian religions emphasize a faith in God that involves prayer and praise during a time of need (Keating & Fretz, 1990). Christians do not want to be seen as though they do not have faith in God by seeking help from a mental health professional.

Christians who are reluctant to seek help for mental health issues do not operate on an unfounded fear. Psychology in its very beginning justified religion from a psychological viewpoint, thus contradicting religious beliefs. Sigmund Freud (1856-1939) is known as the father of psychoanalysis and is one of the most commonly known historical figures of psychology among today's society. Freud wrote a statement against religion in his book *The Future of Illusion*, writing,

“When the growing individual finds that he is destined to remain a child forever, that he can never do without protection against strange superior powers, he lends

those powers the features belonging to the figure of his father; he created for himself the gods whom he dreads, whom he seeks to propitiate, and whom he nevertheless entrusts with his own protection. This his longing for a father is a motive identical with his need for protection against the consequences of his human features to the adult's reaction to the helplessness which he has to acknowledge – a reaction which is precisely the formation of religion" (Freud, 1927).

It is then no wonder that people belonging to religious communities abiding by the beliefs of their religion would be reluctant to turn to psychology for mental health concerns given that historically, psychology justified religion as a manifestation or mere reaction driven by fear and helplessness (Freud, 1927).

Another concern of potential clients who consider themselves to be religious may be that a secular therapist will ignore or misunderstand the client's faith (Keating & Fretz, 1990). This becomes a relevant issue when statistics show that 60% of psychotherapy clients often use religious language to describe their experiences and their mental health (Rose et al., 2008). These concerns are often enough to deter someone with mental health issues from seeking counseling, therefore preventing treatment and relief of their symptoms.

The aforementioned concerns are relevant for members of the Pentecostal community, who have many reasons to be less inclined to seek help from a counselor. One reason is that Pentecostals are taught to exercise faith for miraculous healing rather than assistance from a secular source during times of ill health (Bjorck & Trice, 2006). Therefore, seeking help in psychotherapy may be viewed as being a bad Christian or not practicing what the faith preaches (Bjorck & Trice, 2006). Another reason why Pentecostals may not seek help from a mental health professional is that Pentecostals tend to view suffering as an important maturation in the process of developing and

constructing faith (Bjorck & Trice, 2006). If they are to seek help from a secular source for their illness or struggles rather than suffering or combating the struggle independently, it is assumed that they will not fully mature in the faith. Furthermore it is likely that because some clergy feel as though interventions from a mental health professional compete with interventions that are spiritually-based, Pentecostal religious leaders may discourage the congregation from seeking help from a professional (Bjorck & Trice, 2006). This presents a problem, as many religious leaders are viewed as “gatekeepers” in communities in regards to mental health treatment (Standford & McAlister, 2008).

What might bring an individual to seek treatment for a mental illness? In order to assess this, the influence of religion on the etiology and diagnosis of mental illness must be understood. Beliefs among various religious groups regarding psychological disorders heavily influence their admittance of a problem, how or even if they choose to seek help, and their beliefs regarding the cause of the mental illness (Bjorck & Trice, 2006). This is evident again in the example of the Pentecostal community, the largest group of Christians in the world, excluding Catholics. Pentecostals practice traditional Evangelical beliefs that include the existence of one personal God, the divinity of Jesus Christ, and nature of humans to be sinful (Bjorck & Trice, 2006). Negative emotions that the mental health profession would typically associate with a mood disorder such as worry, anxiety, depression, or anger are described in Pentecostal teachings at the “works of the devil” (Bjorck & Trice, 2006) and the recommended treatment according to the faith is dependence in God and faith in miraculous healing. If this person were to seek help from a mental health professional, the diagnosis would likely be depression and a

treatment plan would be created based on this diagnosis. How a person is treated for their symptoms is dependent upon the perceived etiology of the disorder. Because the diagnosis of mental illness can be viewed as a subjective procedure (Wadsworth & Checketts, 1980), it is possible that there may be errors in the diagnostic process.

Research conducted by Lewis and Lewis (1985) sought to further explore the work of Wadsworth and Checketts (1980) in regards to the impact of religious affiliation on therapists' judgments of patients. The study investigated the effects of religious affiliation of both therapists and clients on therapist's attraction to working with the clients, their prognosis of the clients, and their diagnosis of the clients (Lewis & Lewis, 1985). Seventy-seven psychologists participated in the study, were divided in religious or non-religious groups, and then listened to an audio taped therapy session of a client. The psychologists were asked to give a prognosis and diagnosis of the client based on the audiotape of the session (Lewis & Lewis, 1985). The researchers concluded from their study that although the religious patient was perceived by the therapist to require fewer sessions for successful treatment, religion was viewed to have a significantly greater impact on the problems of the religious patient as compared to the non-religious patient (Lewis & Lewis, 1985).

Religion is not the only factor that has been researched in regards to demographics of attitudes toward seeking professional help for mental illness. Other factors previously researched include level of education and scholastic major (Fischer & Cohen, 1972). Fischer & Cohen (1972) concluded from their study that differences in education level in help seeking behaviors were significant. Attitudes of college juniors and seniors were more favorable toward help seeking than those of college freshman and

sophomores, and attitudes of the college freshman and sophomores were more favorable toward help seeking than those of high school students (Fischer & Cohen, 1972). The study did not explore the confounding variables of education level and age. These results from Fischer and Cohen's (1972) study corroborate what has been researched of Pentecostal beliefs. Traditionally Pentecostals took an anti-intellectual stance, feeling as though formal education may be a hindrance to the "Holy Spirit's blessing" (Trice & Bjorck, 2006). Pentecostal leaders often discouraged their parishioners from seeking advanced education (Trice & Bjorck, 2006).

The demographic factor most relevant to the present study is, as mentioned, religion. Previous research has been conducted on the role of religion as a factor of help seeking regarding mental health, as well as religion related to one's general mental health status. A study by Reger and Rogers (2002) asked 359 participants to complete a survey to assess religious coping. The results revealed that over 79 percent of those with persistent mental illness used some type of religious activity or had some type of religious belief that reportedly helped them cope with their symptoms and daily difficulties (Reger & Rogers, 2002). 76 percent of the participants in this study perceived religiosity to be between moderately helpful and the most important thing that keeps them going (Reger & Rogers, 2002). Reger and Rogers (2002) demonstrate in their study the importance of religion in coping with mental illness. They argue that mental health professionals may need to alter their assessments to inquire about the role of religion in the client's lives, considering the patterns of religious or non-religious coping that are most beneficial in confronting their symptoms of mental illness (Reger & Rogers, 2002).

In order to evaluate differences in help seeking behaviors among the major Christian denominations specifically, differences in the belief systems of those denominations should be explored. Discussed here are the beliefs and practices of Baptists, Lutherans, Presbyterians, Roman Catholics, Methodists, and Pentecostals.

Baptists believe that forgiveness is a Divine mandate, that God commands them to forgive others and love their enemies. Members of the Baptist community also abide by the core belief that God is merciful and just (Exline, 2008). The organization of Baptists is congregational, meaning that the members of the congregation hold frequent meetings and vote on major decisions within the church, and the authority for this denomination is the Scripture (Major Christian Denominations, 2009). The worship style of Baptists varies from staid or strict to evangelistic or enthusiastic, and they tend to engage in extensive missionary activity by traveling to engage in charity or religious work where needed. Baptists also believe that no authority can stand between the believer and God, and they are strong supporters of church and state separation (Major Christian Denominations, 2009).

Lutherans are among the largest group of Protestants today. Founded by Martin Luther in 1517, Lutheranism stresses the doctrine of justification by faith alone and the authority of the scripture alone (Religion Facts, 2009). The worship style of Lutherans is relatively simple, and is a formal liturgy with an emphasis on the sermon. They consider themselves to be generally conservative in personal and social ethics, and their doctrine is salvation by grace alone through faith (Major Christian Denominations, 2009). Their beliefs are expressed in confessions, which are collected in the Book of Concord, regarded as an authority for practice by all Lutherans (Religion Facts, 2009).



Presbyterian belief and practice center on the Bible and the sovereignty of God (Religion Facts, 2007). The PC(USA) summarizes Presbyterian beliefs to be that God is the ultimate authority and that knowledge of God comes from the Bible, particularly the New Testament. Presbyterians also believe that it is everyone's job to share the Good News of our salvation through Jesus Christ with the world. The Presbyterian Church is governed at all levels, clergy and laity, both men and women. (Religion Facts, 2007). The present study researches members of the traditionally liberal PC(USA) congregation and not members of Presbyterian Church in America (PCA), which is traditionally more conservative in its beliefs and rituals.

The largest Christian group by far, Roman Catholics hold to the doctrine of the Trinity, the divinity of Christ, and the inspiration of the Bible. What sets Catholics apart from the other denominations is that their beliefs include the special authority of the pope, the ability of the saints to mediate on behalf of others, the concept of Purgatory to purify between death and entering into heaven, and that the bread used in communion truly becomes the body of Christ when blessed by a priest (Religion Facts, 2006).

Authority as practiced by Methodists is the scripture, interpreted by tradition, reason, and experience. This is to say that Methodists do not believe in literal interpretation of the scripture. Methodist is a denomination within Protestantism. Regarding worship style, a Methodist service varies widely by denomination, local church, and geography (Major Christian Denominations, 2009).

The worship style of Pentecostals is a liberally structured service with inspiring hymns and sermons, concluding in spirit baptism. The Pentecostal doctrine contains

usually Protestant traditional beliefs, with an emphasis on the direct presence of God in the Holy Spirit (Major Christian Denominations, 2009).

This study will evaluate the differences between liberal Christian denominations, conservative Christian denominations, and Roman Catholicism. Roman Catholics are to be evaluated separately as they represent the largest Christian denomination and the denomination itself can range from liberal to conservative regarding practice. Denominations are divided based on tradition and practice. For the purpose of this study, the definitions of “liberal” and “conservative” are developed based on tradition and values and denominations are categorized based on their descriptions above. “Liberal” denominations of Christianity are characterized by diversity of opinion, and a sense of ability to express views outside of conservative orthodoxy and tradition (Liberal Christianity, 2010). With liberal denominations of Christianity a non-literal view of Scripture is common, often viewing the Bible as a book written by men who were inspired by God rather than the literal word of God. Non-traditional views of heaven and hell are also common, many even believing that there is no such thing as “hell.” Within liberal sects of Christianity is a sense of inclusiveness and community, evident in their “left-winged” views on salvation, women, homosexuality, and creation (Liberal Christianity, 2010). This study will categorize Presbyterian (PCUSA) and Methodist denominations as liberal denominations. Baptist, Lutheran, Episcopalian, and Pentecostal will be categorized as conservative denominations.

There are a number of factors that will influence the likelihood that an individual will seek help as well as the effectiveness of treatment. The purpose of this study is to determine if an individual’s religious denomination within Christianity influences their

reported mental health help seeking behavior. It is hypothesized that individuals belonging to more traditionally conservative sects will be less likely to seek help from a mental health professional, and that individuals belonging to more liberal sects will be more likely to seek help from a mental health professional. It is also hypothesized that members of traditionally conservative Christian denominations will demonstrate higher religiosity than members of traditionally liberal Christian denominations. This present study hypothesizes a negative correlation between scores on religiosity scales and attitude toward seeking professional help for mental health.

## CHAPTER II

### Method

#### *Participants*

Participants ( $n = 167$ ) were recruited from churches of different Christian denominations. Major denominations studied included Baptist ( $n = 81$ ), Methodist ( $n = 1$ ), Pentecostal ( $n = 5$ ), Presbyterians ( $n = 58$ ), and Roman Catholic ( $n = 8$ ). Some subjects reported themselves to be non-denominational ( $n = 6$ ), and others reported themselves to be “other” ( $n = 6$ ). Of the participants studied, 72 were male (43%) and 95 were female (57%) and the ages ranged from 18 to 84. Education level of participants was reported as middle school or less (1%), some high school (2%), high school graduate (15%), some college (22%), college graduate (28%), some graduate or professional school (10%) and graduate or professional school graduate (22%). 95 participants (57%) reported to have prior counseling experience while 72 participants (43%) reported to have none.

Subjects were included in the study if they attend church regularly and test high for religiosity. The Dimensions of Religiosity Scale was administered to test for this and determine the subject’s inclusion in the study.

The treatment of participants was in accordance with the ethical standards of the APA. All participants provided informed consent for the study, and the voluntary nature of the study was presented to them both verbally and in written format on the consent. Participants received questionnaires only upon request to researcher.

## *Assessments*

The instruments in the study were all self-report. Subjects completed a demographic information sheet, the Attitude Toward Seeking Professional Help Scale of Fischer and Turner (1970), and the Dimensions of Religiosity Scale developed by Joseph and DiDuca (1997). Subjects had unlimited time to complete the questionnaires.

*Demographics.* On the demographic information sheet, subjects were asked to answer questions including gender, age, income level, educational background, religious denomination, and prior counseling experience. These factors are included in the results, in order to analyze trends relating to these demographic factors and scores on the instruments.

*Attitude Toward Seeking Professional Help Scale.* The Attitude Toward Seeking Professional Help Scale (ATSPHS) was developed to assess attitudes toward seeking psychotherapy (Fischer & Turner, 1970). The items on the scale are Likert format, consisting of 29 items. The subjects answered (1) = agree, (2) = probably agree, (3) = probably disagree, and (4) = disagree. After reverse scoring of 18 of the items, the sum of all 29 items resulted in a total score serving as a composite measure of the subjects' help-seeking attitude. A high total score represents a positive attitude toward seeking professional help in mental health services. The internal consistency reliability of the scale is .83, and the 2-month test-retest reliability is .84 (Strohmer, Biggs, & McIntyre, 1984).

*Dimensions of Religiosity Scale.* The Dimensions of Religiosity Scale is a 20-item self-report measure of religious preoccupation, guidance, conviction, and emotional involvement. Each item is answered on a 5-point Likert scoring system that ranges from

strongly agree (5) to strongly disagree (1). One item for the Dimensions of Religiosity Scale was reverse coded. The internal reliability is .94 for emotional involvement, .95 for conviction, .94 for preoccupation, .90 for guidance, and a total score reliability of .95 (Joseph & Diduca, 2007). This study did not look at the subscales individually. The Dimensions of religiosity scale was administered to evaluate the subjects' level of commitment to their religion. If the subject scored below at 50 on the DRS, their data was not included in the study because it would not accurately represent the attitude of that denomination. No subjects who participated in the study scored below the cut off range.

When scoring the assessments, the researcher found that 24 subjects were missing three or fewer responses. The missing data was assigned a neutral value so as to still be included in the study without skewing the results. Subjects missing more than three responses were excluded from the results. As a result, one subject was excluded from this study.

### *Procedure*

The experimenter contacted the pastors of churches of the major Christian denominations, explaining the study and asking permission to present the study to his/her congregation in order to collect participants. When the pastor agreed to allow his/her church members to participate in the study, the experimenter attended the church with all of the assessment materials. The participants reported to their church voluntarily for worship. The experimenter presented the study to the members of the congregation, and asked for their participation in the study. Subjects were told that they would be participating in a study on religion and help-seeking behaviors. When the subject

volunteered to participate in the study, he or she provided informed consent for their participation in the study. Subjects then received a packet containing the demographic questionnaire, the ATSPHS, and the DRS. Subjects were instructed not to write their name on anything in order to ensure anonymity. Subjects were instructed to complete the packet at that time, however 2 subjects did not have time to complete them at the time and willingly mailed their completed questionnaires back to the researcher anonymously. The experimenter collected the completed packets that day.

## CHAPTER III

### Results

A one-way analysis of variance was conducted to evaluate the relationship between attitudes toward seeking help from a mental health professional and religion. The independent variable was the subjects' denomination of Christianity as per their response on the demographic sheet, later categorized into "liberal" or "conservative." The dependent variables were the scores on both the Dimensions of Religiosity Scale and the Attitude Toward Seeking Professional Help Scale. The ANOVA was significant,  $F(1,143) = 4.66, p = .03$ . The strength of the relationship between liberal or conservative Christian sects and score on the Attitude Toward Seeking Professional Help Scale, as assessed by  $\eta^2$ , resulted in denominational affiliation accounting for 3.2% of the variance of the dependent variable.

An independent-samples  $t$  test was conducted and was significant,  $t(121) = 2.14, p = .03$ , supporting the hypothesis that Christians of liberal sects score higher in measurements of attitudes toward seeking professional help than Christians of conservative sects. The 95% confidence interval for the difference in means was wide, ranging from .42 to 9.71.

As evidenced by scores on the Attitude Toward Seeking Professional Help Scale, analyses showed that subjects belonging to liberal denominations of Christianity ( $M = 60.99, SD = 14.29$ ) were more likely to seek help from a mental health professional compared to members of conservative Christian denominations ( $M = 55.92, SD = 13.59$ ).

Additionally, analyses showed that subjects belonging to conservative denominations of Christianity (in this study these denominations were Baptist and



Pentecostal) scored significantly higher compared to liberal Christians,  $F(1,142) = 5.29, p = .02$ , on the Dimensions of Religiosity Scale indicating a high level of commitment to their faith and a closer relationship to God and their church.

Comparisons among demographic factors were also analyzed. A one-way analysis of variance was conducted to evaluate the relationship between gender and mean overall score on the Attitude Toward Help Seeking Scale, as well as mean total score on the Dimensions of Religiosity Scale. The dependent variables were the assessment score means and the independent variable was gender. Regarding Attitude Toward Seeking Professional Help, the ANOVA was significant  $F(1, 164) = 6.67, p = .01$ . Women scored significantly higher on the Attitude Toward Seeking Professional Help Scale than men. Regarding scores on the Dimensions of Religiosity Scale, women again scored significantly higher,  $F(1, 165) = 4.35, p = .04$ . This significant difference is plotted in Figure 3.

Comparison tests were also run to assess significance in differences in Attitude Toward Seeking Professional Help among level of education. A one-way analysis of variance was conducted to evaluate this relationship, but the ANOVA showed that there was no significant difference  $F(6, 159) = 1.13, p = .35$ . The results somewhat reflect previous research in that the lowest mean score on the Attitude Toward Seeking Professional Help Scale belonged to the groups with the lowest level of education, those with the highest education of high school or below. Refer to Figure 4 for the plotted means.

## CHAPTER IV

### Discussion

#### *Conclusions*

Overall, the hypothesis and research did support the findings. Findings concluded that members of liberal Christian denominations were more likely to seek help from a mental health professional than members of conservative Christian denominations. Findings also concluded that members of liberal Christian denominations scored lower on the Dimensions of Religiosity scale overall, as was hypothesized given the liberal nature of their religious beliefs.

Additional findings showed that women on average scored higher than men on the Attitude Toward Seeking Professional Help Scale. This is in support of the studies that have found that women are more likely to enter into counseling than men (Gove, 1984). In this particular study, education level did not have a significant impact on attitude toward seeking professional help. One possible reason that this did not support the Fischer & Cohen (1972) study is that there was not an even spread in this particular demographic. Demographic percentages exhibited in Table 1 show that only 18% of participants had lower than a college level education. This is likely due to the fact that the participants in this study come from a high socioeconomic status. If the study had been conducted in varying types of communities (urban, rural, suburban), there may have been a more even representation of level of education, which may have yielded different results.

The implications of this study are that there must be more collaboration between church leaders and mental health professionals. As discussed, there are several negative

consequences to those who may require therapy not seeking help from a professional. With clergy and church leaders viewed as gatekeepers to community resources (Stanford & McAlister, 2008) the collaborative process should begin here. Research has shown, such as in the study by Bjork & Trice (2006), that more conservative denominations tend to take a negative view on therapy and interpret seeking professional help as a weakness or not having faith in God. A more modern approach needs to be taken as more studies are showing that not seeking therapy when needed can be detrimental to someone's health and sometimes even fatal depending on the diagnosis. Epidemiologic studies suggest that school and job failure or dysfunction, teenage pregnancy, and violent or unstable marriages are associated with early-onset untreated mental disorders (Kessler et al., 1997). Single disorders will often progress to complex comorbid disorders that are more difficult to treat and more likely to recur than less complex conditions when left untreated (Kessler et al., 2007). In addition to these studies, clinical trials have shown that timely intervention can decrease the likelihood of suicide (Meltzer et al., 2003).

With the availability and widespread utilization of evidence-based treatments, skeptics should no longer question the effectiveness of mental health counseling. Studies and research have proven that certain interventions are effective for treating specific diagnoses, even specific to age groups and other demographics (Kazdin, 2003). If there was a more accurate and modern representation of mental health counseling presented to the population, especially conservative Christians, there may be a more positive attitude toward seeking professional help overall. If there were more of collaboration between church leaders and mental health professionals, this message would be quickly spread throughout the faith community.

There were several interesting findings worth noting related to this study and the process of collecting data. After contacting many churches, three accepted, three declined, and many never responded. Still, data was collected from both liberal and conservative denominations of Christianity. Data was collected from two Presbyterian Churches and one Baptist Church. Researcher was unable to get a response from a Catholic Church for the study. Worth noting is the difference in the interpretation of the questions in the Attitude Toward Seeking Professional Help Scale. In the two Presbyterian churches, the packets were given to the volunteers and little to no questions were asked prior to the volunteers returning the completed packets. At the Baptist Church, however, many people waited to ask this researcher questions regarding specific meaning and interpretations of phrases used. Many subjects from the Baptist Church wrote in comments on their interpretations of certain questions, most related to God and their faith. Before collecting all of the data to analyze, this was telling of a significant difference between the subjects' responses.

#### *Limitations and Future Research*

In order to strengthen the study, visitations to more churches to include more subjects overall would be beneficial. Catholicism should also be investigated in a future study, as it was intended to be in this study. It would be beneficial to expand this study and explore other religions outside of Christianity. This research can serve as a basis for further research that may explore Judaism, Islam, or other religions and their influence on seeking professional help for mental health issues. Further research can also be done on the various demographic factors on a deeper level to explore the influence of education,

gender, age, income, and previous counseling experience on attitudes toward seeking professional help for mental health issues.

The Dimensions of Religiosity Scale was a sufficient scale for the purpose of this study, however in further research, several instruments should be used in order to measure the subject's commitment to their religion, how often the he or she attends church, what other church activities he or she may be involved in, etc. Something else that would be interesting to investigate would be the influence of one's profession on their attitude toward seeking mental health counseling. While conducting this study, some subjects mentioned that either they themselves were professionals in the mental health field or they had spouses or family members working in the mental health field. It is possible that this would lead to a more liberal view of psychotherapy regardless of religion.

Because this study relied on self-report scales, it is subject to the limitations of self-report scales. The assessments used in this study relied on reading comprehension and the interest of the participant. The assessments are also highly subject to the social desirability bias, given the nature of the research and the questions answered by participants. Alternative measures of religion are needed.

As clergy are said to be gatekeepers for the mental health field, clergy and other church leadership positions should assess their attitude toward seeking professional help and what influences this. Many church leaders have some background in counseling that was required during training for their profession, and it would be interesting to see if there was variance in this training, how this training may affect their own help seeking

behaviors, and how it may effect how they assist members of their congregation that approach them with mental health concerns.

Mental health professionals would benefit from further investigation of what specific aspects of counseling tend to deter conservative Christians from seeking help, as well as to develop an understanding for why the significant difference between members of liberal denominations and conservative denominations, as was exhibited in this current study. The joining of Christian faith and counseling, commonly known as Christian Counseling, is what bridges the gap between religion and counseling (Bufford, 1997). As reviewed in the literature, clients of counselors tend to feel more comfortable with their therapy when the therapist shares their religious views (Rose et al., 2008). Those that are committed to their Christianity and feel as though their faith plays a role in their mental health will likely seek help from a Christian Counselor and feel comfortable doing so, leading to a more positive outcome.

## References

- Bjorck, J. P., & Trice, P. D. (2006). Pentecostal perspectives on causes and cures of depression. *Professional Psychology: Research and Practice, 37*(3), 283-294.
- Bufford, R. K. (1997). Consecrated Counseling: Reflections on the distinctive of Christian counseling. *Journal of Psychology and Theology 25*, 111-122.
- Exline, J. J. (2008). Beliefs about God and Forgiveness in a Baptist Church Sample. *Journal of Psychology and Christianity 27*(2), 131-139.
- Fischer, E. H., & Cohen, S. L. (1972). Demographic correlated of attitude toward help seeking professional psychological help. *Journal of Consulting and Clinical Psychology, 39*(1), 70-74.
- Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*, 70-90.
- Freud, S. (1927). *The Future of an Illusion*. New York: W.W. Norton & Company.
- Gove, W. R. (1984). Gender differences in mental and physical illness: The effects of fixed roles and nurturant roles. *Social Science and Medicine, 19*, 50-73.
- Jorm, A., Korten, A., Jocomb, P., Christensen, H., Rodgers, B., & Pollitt, P. (1997). Public beliefs about causes and risk factors for depression and schizophrenia. *Social Psychiatry Psychiatric Epidemiology, 32*, 143-148.
- Joseph, S. & Diduca, D. (2007). The dimensions of religiosity scale: 20-item self-report measure of religious preoccupation, guidance, conviction, and emotional involvement. *Mental Health, Religion & Culture, 10*(6), 603-608.
- Kazdin, A. (2003). *Evidence-based psychotherapies for children and adolescents*. The Guilford Press.
- Kessler R. C., Angermeyer M., Anthony J. C., et al. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World Psychiatry, 6*, 168-176.
- Kessler, R. C., Berglund, P. A., Foster, C. L., Saunders, W. B., Stang, P. E., Walters, E. E. (1997). Social consequences of psychiatric disorders, II: Teenage Parenthood. *American Journal of Psychiatry, 154*(10): 1405-1411.
- Koenig, H. G. (2004). Religion, Spirituality, and Medicine: Research Findings and Implications for Clinical Practice. *Southern Medical Journal, 97*(12), 1194-1200.

- Lewis, K. N. & Lewis, D. A. (1985). Impact of religious affiliation on therapists' judgment of patients. *Journal of Consulting and Clinical Psychology*, 53(6), 926-932.
- Liberal Christianity. (2009). Church Education Resource Ministries. Retrieved 2:35 July 26, 2010 from [http://www.cerm.info/bible\\_studies/Topical/liberal\\_christianity.htm](http://www.cerm.info/bible_studies/Topical/liberal_christianity.htm)
- Meltzer H.Y., Alphas L., Green A.I., et al. (2003). Clozapine treatment for suicidality in schizophrenia: International Suicide Prevention Trial (InterSePT) *Arch Gen Psychiatry*. 60, 82–91.
- Major Christian Denominations. (2009). History.com. Retrieved 10:58, Jul 14, 2009, from <http://www.history.com/encyclopedia.do?articleId=227134>.
- Reger, G. M., & Rogers, S. A. (2002). Diagnostic differences in religious coping among individuals with persistent mental illness. *Journal of Psychology and Christianity*. 21(4), 341-348.
- Religion Facts – Catholicism. (2006). ReligionFacts.com. Retrieved 11:07, Jul 14, 2009 from <http://www.religionfacts.com/christianity/denominations/catholicism.htm>.
- Religion Facts - Lutheranism. (2009). ReligionFacts.com. Retrieved 11:00, Jul 14, 2009 from <http://www.religionfacts.com/christianity/denominations/lutheranism.htm>.
- Religion Facts – Presbyterianism. (2007). ReligionFacts.com. Retrieved 11:05, Jul 14, 2009 from <http://www.religionfacts.com/christianity/denominations/presbyterianism.htm>.
- Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2008). Spiritual issues in counseling: Clients' beliefs and preferences. *Psychology of Religion and Spirituality*, S(1), 18-33.
- Sanford, M. S. & McAlister, K. R. (2008). Perceptions of Serious Mental Illness in the Local Church. *Journal of Religion, Disability & Health*, 12(2), 144-153.
- Strohmer, D. C., Biggs, D. A., and McIntyre, W. F. (1984). Social comparison information and judgments about depression and seeking counseling. *Journal of Counseling Psychology*, 31(4), 591-594.
- Toussaint, L., & Jorgensen, K. M. (2008). Inter-parental conflict, parent-child relationship quality, and adjustment in Christian adolescents; forgiveness as a mediating variable. *Journal of Psychology and Christianity*, 27(4), 337-346.



Wadsworth, R. D., & Checketts, K. T. (1980). Influence of religious affiliation of psychodiagnosis. *Journal of Consulting and Clinical Psychology, 48*(2), 234-240.

Table 1. Participant Demographics

Demographic	Percentage	
Christian Denomination	Conservative	52%
	Liberal	35%
	Other	13%
Gender	Male	43%
	Female	57%
Annual Income	Under \$10,000	7%
	\$10,000-\$20,000	7%
	\$21,000-\$40,000	13%
	\$41,000-\$60,000	22%
	\$61,000-\$80,000	14%
	\$81,000-\$100,000	14%
	\$101,000 or more	19%
	Highest Level of Education	Middle school or less
Some high school		2%
High school graduate		15%
Some college		22%
College graduate		28%
Some graduate or professional school		10%
Graduate or professional school graduate		22%
Marital Status	Married	75%

	Single	15%
	Divorced	6%
	Widowed	4%
Previous counseling experience	Yes	57%
	No	43%
Insurance	Yes	93%
	No	6%

Figure 1.

### Attitude Toward Seeking Professional Help by Denominational Affiliation

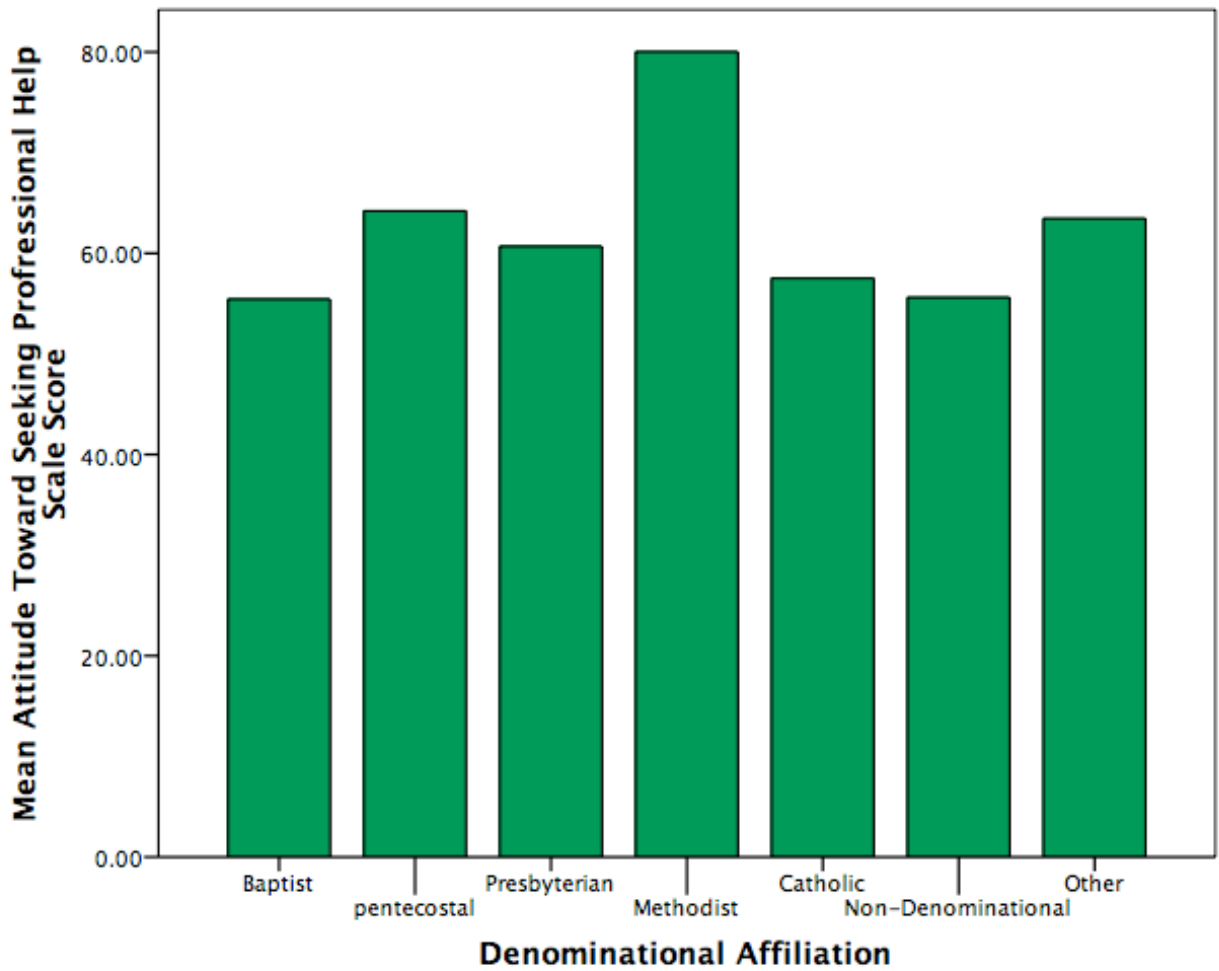


Figure 2.

### Mean Religiosity Scores by Denominational Affiliation

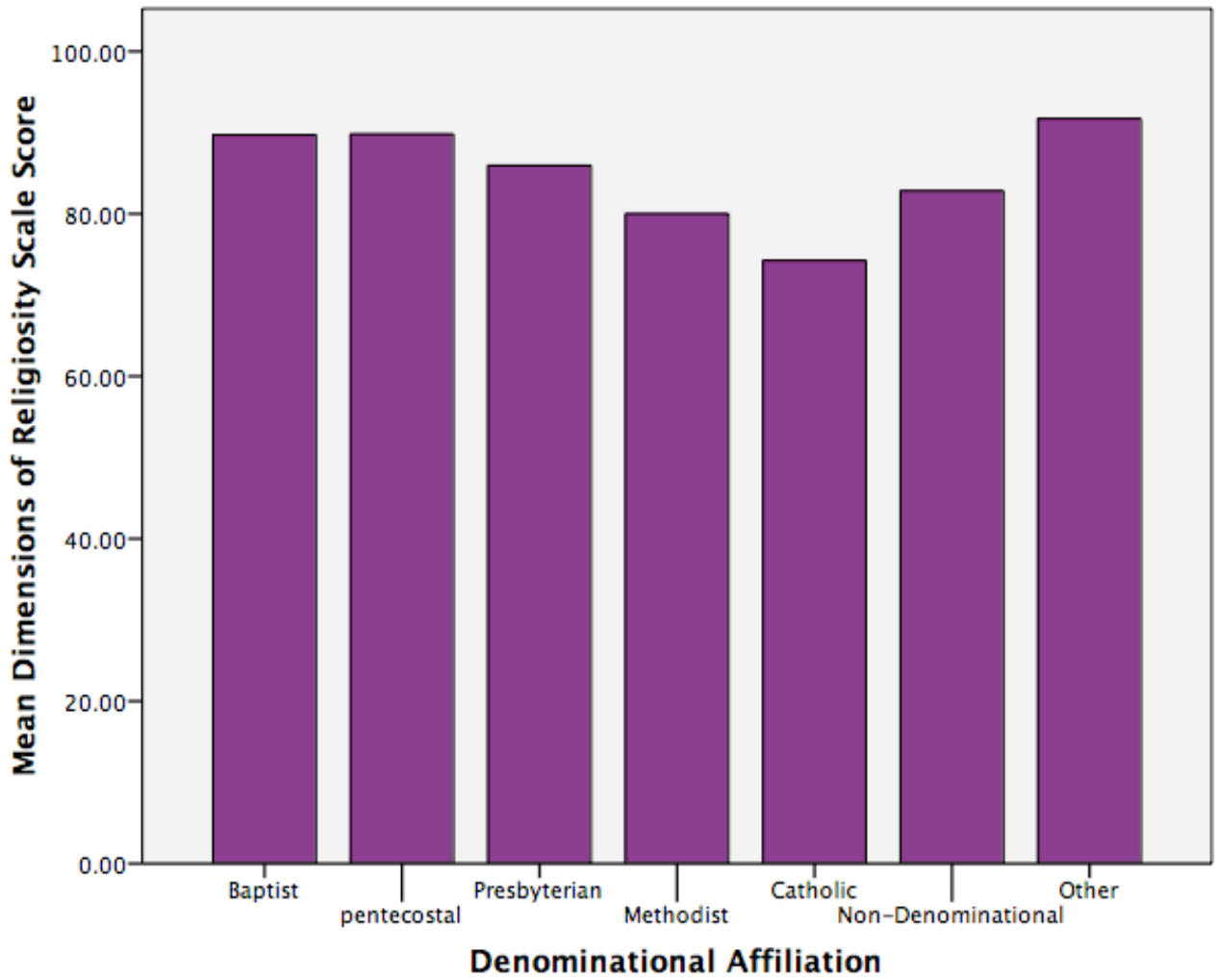


Figure 3.

**Attitude Toward Seeking Professional Help by Gender**

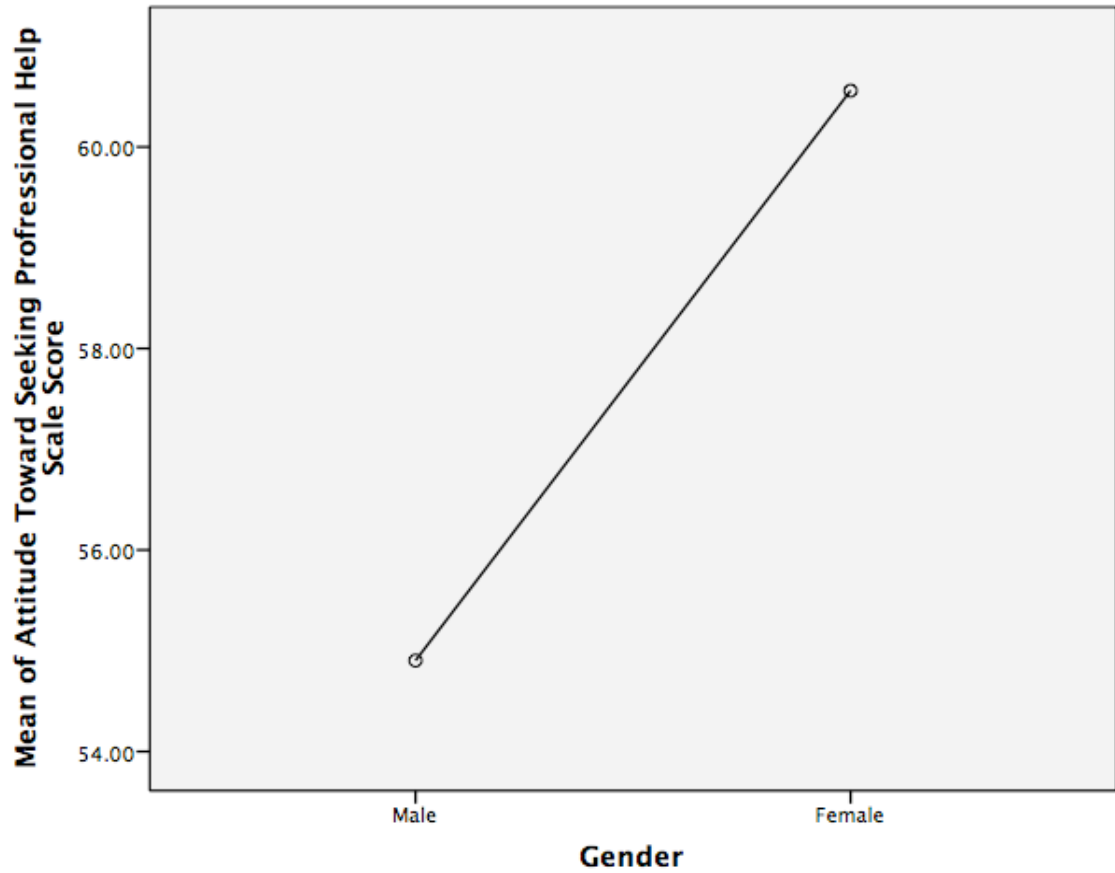
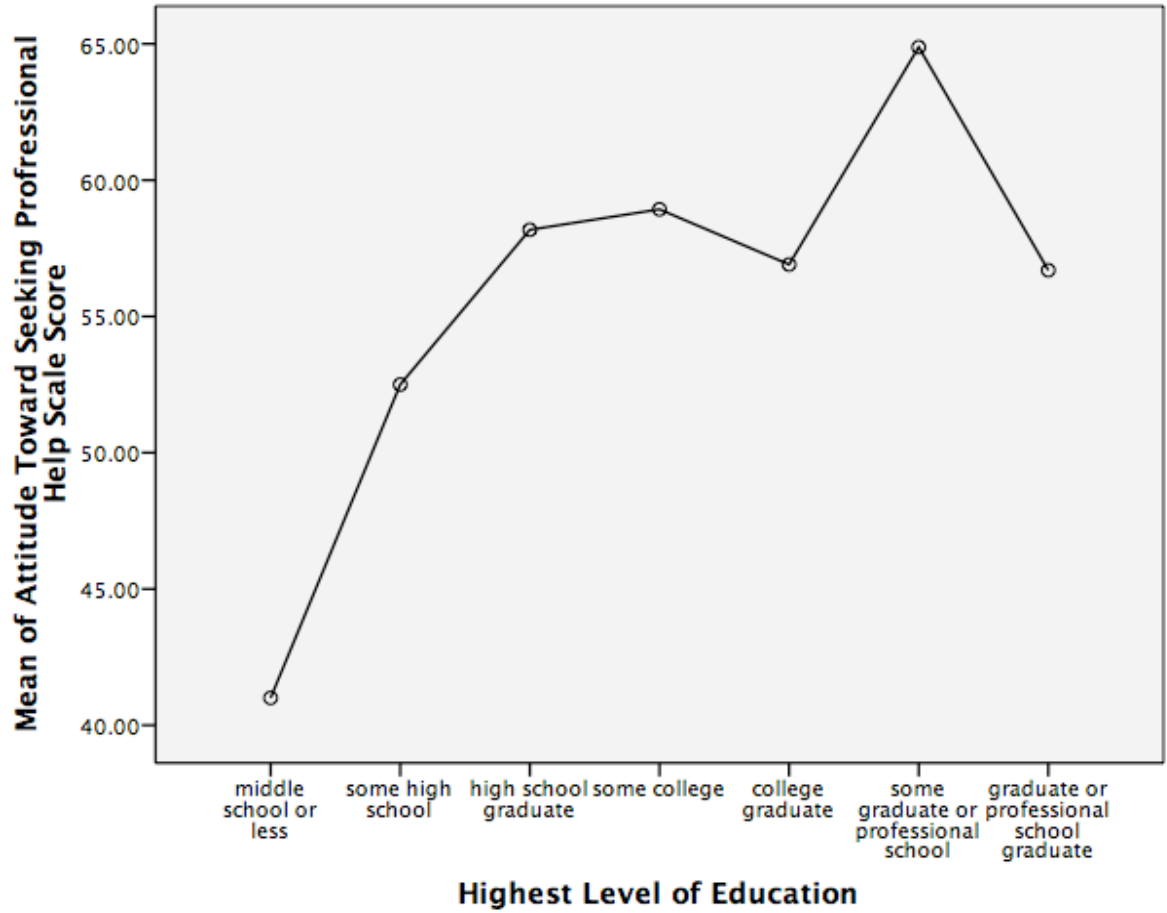


Figure 4.

### Attitude Toward Seeking Professional Help by Education Level



Appendix A

Demographic Questionnaire

1. Gender  Male  
 Female
2. Age
3. Approximate annual income:  
 Under \$10,000  
 \$10,000-\$20,000  
 \$21,000-\$40,000  
 \$41,000-\$60,000  
 \$61,000-\$80,000  
 \$81,000-\$100,000  
 \$101,000 or more
4. Check the highest educational level you have attended  
 Middle school or less  
 Some high school  
 High school graduate  
 Some College  
 College Graduate  
 Some graduate or professional school  
 Graduate or professional school graduate
5. Marital Status: Married  Single  Divorced  Widowed
6. Have you ever participated in individual, family, or group counseling?  
 yes  no
7. What is your denominational affiliation?  
 Baptist  Presbyterian  Pentecostal  
 Episcopalian  Roman Catholic  
 Lutheran  Methodist



8. Do you have insurance currently? \_\_\_\_\_ Yes \_\_\_\_\_ No

## Appendix B

### Dimensions of Religiosity Scale

**Please read the following statements and indicate to what extent you agree or disagree with each one.**

Strongly disagree = 1

Disagree = 2

Neither disagree or agree = 3

Agree = 4

Strongly agree = 5

1. I feel happy when I think of God	1	2	3	4	5
2. I will always believe in God	1	2	3	4	5
3. My thoughts often drift to God	1	2	3	4	5
4. Being a Christian is a joyous way to live	1	2	3	4	5
5. I am sure that Christ exists	1	2	3	4	5
6. I think about God all the time	1	2	3	4	5
7. I pray for guidance	1	2	3	4	5
8. My thoughts turn to Jesus every day	1	2	3	4	5
9. God does not help me to make decisions	1	2	3	4	5
10. I know that God hears my prayers	1	2	3	4	5
11. Prayer lifts my spirits	1	2	3	4	5
12. Everything that happens to me reminds me of God	1	2	3	4	5
13. I try to follow the laws laid down in the Bible	1	2	3	4	5
14. I know that Jesus will always be there for me	1	2	3	4	5
15. I cannot make important decisions without God's help	1	2	3	4	5
16. I am certain that God is aware of everything I do	1	2	3	4	5
17. When I am feeling miserable, thinking about Jesus helps to cheer me up	1	2	3	4	5
18. I like to talk about Jesus	1	2	3	4	5

19. Jesus' life is an example to me	1	2	3	4	5
20. God fills me with love	1	2	3	4	5

## Appendix C

### Attitude Toward Seeking Professional Help Scale

**Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement, probable agreement, probable disagreement, or disagreement. Please express your frank opinion in rating the statements by circling your response. There are no “wrong” answers, and the only right ones are whatever you honestly feel or believe. It is important that you answer every item.**

1. Although there are clinics for people with mental troubles, I would not have much faith in them.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
  
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
  
3. I would feel uneasy going to a psychiatrist because of what some people would think.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
  
4. A person with a strong character can get over mental conflicts by him/herself, and would have little need of a psychiatrist.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me, or a member of my family.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
9. Emotional difficulties, like many things, tend to work out by themselves.
  1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
10. There are certain problems that should not be discussed outside of one's immediate family.
  1. Agreement
  2. Probable Agreement

3. Probable Disagreement
  4. Disagreement
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
12. If I believe I was having a mental breakdown, my first inclination would be to get professional attention.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
14. Having been a psychiatric patient is a blot on a person's life.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement

16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

17. I resent a person, professionally trained or not, who wants to know about my personal difficulties.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

20. Having been mentally ill carries with it a burden of shame.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

21. There are experiences in my life I would not discuss with anyone.

1. Agreement
2. Probable Agreement
3. Probable Disagreement

4. Disagreement
22. It is probably best not to know everything about oneself.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
25. At some future time I might want to have psychological counseling.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
26. A person should work out his own problems; getting psychological counseling would be a last resort.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement
  4. Disagreement
27. Had I received treatment in a mental hospital, I would not feel that it ought to be covered up.
1. Agreement
  2. Probable Agreement
  3. Probable Disagreement



4. Disagreement

28. If I thought I needed psychiatric help, I would get it no matter who knew about it.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.

1. Agreement
2. Probable Agreement
3. Probable Disagreement
4. Disagreement