Iowa State University
Digital Repository

Graduate Theses and Dissertations | Iowa State University Capstones, Theses and Dissertations

2016

Mental Health Stigma in Religious Communities: Development of a Quantitative Measure

Lily A. Mathison
Iowa State University

Follow this and additional works at: http://lib.dr.iastate.edu/etd

Part of the Psychology Commons, and the Religion Commons

Recommended Citation

Mathison, Lily A., "Mental Health Stigma in Religious Communities: Development of a Quantitative Measure" (2016). *Graduate Theses and Dissertations*. 15767.
http://lib.dr.iastate.edu/etd/15767

This Thesis is brought to you for free and open access by the Iowa State University Capstones, Theses and Dissertations at Iowa State University Digital Repository. It has been accepted for inclusion in Graduate Theses and Dissertations by an authorized administrator of Iowa State University Digital Repository. For more information, please contact digirep@iastate.edu.

المنارة للاستشارات

www.manaraa.com

Mental health stigma in religious communities: Development of a quantitative measure

by

Lily Amelia Mathison

A thesis submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

Major: Psychology

Program of Study Committee:

Nathaniel Wade, Major Professor
David Vogel
Marcus Crede

Iowa State University

Ames, Iowa

2016

Copyright © Lily Amelia Mathison, 2016. All rights reserved.

المنارة للاستشارات

www.manaraa.com

TABLE OF CONTENTS

ABSTRACT iii

CHAPTER 1. OVERVIEW 1
The Present Study 2

CHAPTER 2. LITERATURE REVIEW 4
The Impact of Stigma 4
Goffman's Foundational Work on Stigma 5
Link and Phelan's Four Components of Stigma 7
Labeling Effects and Mental Illness 9
Public vs. Self-Stigma 10
Mental Illness Stigma vs. Help-Seeking Stigma 12
Attitudes toward Counseling, Intentions to Seek Counseling, and Stigma 13
Self-Stigma of Mental Illness vs. Self-Stigma of Help-Seeking 14
Internalized Stigma Model 14
Religious Mental Health Stigma 15
Conclusions 31

CHAPTER 3. METHODS 32
Participants 32
Measures 33
Procedures 40

CHAPTER 4. RESULTS 45
Attention Check 45
Sample 1: Exploratory factor analysis 45
Internal consistency reliability 47
Sample 2: Confirmatory factor analysis 47

CHAPTER 5. DISCUSSION 53
RMHSS versus RBAMI 53
Limitations 56
Future Directions 57
Conclusion 58

CHAPTER 6. REFERENCES 59

CHAPTER 7. APPRENDICES 71
APPENDIX A: STUDY MATERIALS 71
APPENDIX B: IRB APPROVAL SHEET 85

ACKNOWLEDGEMENTS 86

المنارة للاستشارات
www.manaraa.com

ABSTRACT

While mental health stigma is a burgeoning field of research, little work has been done on whether mental health stigma in different subcultures is the same or different as the general population. There is qualitative evidence that beliefs about the etiology and effective treatments for mental illness differ in religious communities as compared to the general population, but efforts to quantify this difference have been sparse and reflect poor methodology. The purpose of the present study is to create and validate a measure of mental health stigma in religious communities. Items will be generated using extant literature and revised after expert review and piloting. In Study 1, the items were tested with 703 undergraduate students at a large Midwestern university. Exploratory Factor Analysis was then used to determine a factor structure with good fitting items. In Study 2, items were retested with a second sample of undergraduate students at the same university, to conduct a Confirmatory Factor Analysis, to cross-validate the scale, and to measure convergent and discriminate validity using several scales measuring related constructs. The outcome is a psychometrically strong, valid self-report instrument to measure mental health stigma in religious communities.

المنارة للاستشارات

www.manaraa.com

CHAPTER 1. OVERVIEW

A Surgeon General report named mental illness stigma “the most formidable obstacle to future progress in the arena of mental illness and health” (Abdullah & Brown, 2011; U.S. Department of Health and Human Services, 1999). Considering that one epidemiological study, the National Comorbidity Survey – Revised (NCS-R), estimated that 26.2% of adult Americans have a diagnosable mental illness in a given year, this stigma has significant impact on the health of Americans (Kessler, Chiu, Demler, & Walters, 2005). In a given year at most one-third of those with a diagnosable mental disorder will seek treatment from a mental health professional (Bathje & Pryor, 2011). While approximately 80% of all people with a mental disorder eventually seek treatment, the median delay between first onset of the disorder and first treatment contact is nearly *ten years* (Wang, Berglund, Olfson, & Kessler, 2004). Many factors contribute to this finding, but mental health stigma is one of the most powerful factors (Bathje & Pryor, 2011; Henderson, Evans-Lacko, & Thornicroft, 2013).

Most research on mental illness and help-seeking stigma has focused on the general population without looking at factors that may be unique to specific subcultures. While the general population may be hesitant to use mental health services, those in religious communities underutilize them even more (Mayers, Leavey, Villianatou, & Barker, 2007; Ng, Nyunt, Chiam, & Kua, 2011; Trice & Bjorck, 2006). While many factors account for this treatment gap, one influence comes in the form of mental illness and help-seeking stigma that are unique to those communities. Common religious beliefs, particularly among the Abrahamic traditions, indicate that the main causes of mental illness are moral weakness, sin, or unfaithfulness with religious practices such as praying, reading the Bible, or worshiping (Hartog & Gow, 2005; Trice & Bjorck, 2006). In this paper, this stigma will be referred to as religious mental health stigma.

المنارة للاستشارات
www.manaraa.com

Little research has been conducted in the area of religious mental health stigma. There has been research conducted on attitudes of religious communities toward mental illness including the etiology of the disorders and appropriate treatments as well as the referral behavior of religious leaders (e.g. Farrell & Goebert, 2008; Jones, Cassidy, & Heflinger, 2012, etc.). Researchers, however, have taken few steps to integrate religious mental health stigma into existing research regarding mental health stigma. What research has been done has conflated public stigma of mental illness and help-seeking. Self-stigma has not been addressed at all.

In a unique attempt to further research mental health stigma in religious communities, Wessellmann and Graziano (2010) created a measure of religious beliefs about mental illness, the only measure in the literature of which I am aware. They made the distinction between religious and secular beliefs about mental illness. While this scale has many valuable elements, there are several limitations. It has several questions that only apply to Christians, the focus is solely on public stigma – self-stigma is not addressed. In addition, the psychometric properties of the measure are lacking. For example, the items were not reviewed by a panel of experts nor were they piloted, a readability analysis was not conducted, and test-retest reliability was not assessed.

The Present Study

In the present thesis, I generate a self-report scale to measure religious mental health stigma across two studies. In the first study items are generated using the extant literature and then assessed for their psychometric properties. Students at a large Midwestern university complete the measure, then exploratory factor analysis is conducted to determine what factors emerge and to determine which items have the factor loading to justify retention. In the second study the retained items are given to a new set of participants to test the reliability and validity of

المنارة للاستشارات

www.manaraa.com

the measure. The creation of this measure allows researchers in the future to measure religious mental health stigma in order to predict such outcomes as help-seeking intentions, treatment adherence, and prejudice against those with mental illness.

المنارة للاستشارات
www.manaraa.com

CHAPTER 2. LITERATURE REVIEW

The stigma of mental illness has been a burgeoning field of research over the past fifteen years. Link and Phelan's seminal article "Conceptualizing Stigma" provided a needed framework for future mental health stigma research (2001). Mental health stigma was then broken down into the concepts of public stigma and self-stigma (i.e. Ben-Porath, 2002; Corrigan, Kerr, & Knudsen, 2005; Vogel & Wade, 2009), and then further the stigma of mental illness and of seeking psychological services or help-seeking stigma (i.e. Komiya, Good, & Sherrod, 2000; Tucker, Hammer, Vogel, Bitman, Wade, & Maier, 2013). Mental health stigma in religious communities has only been researched in a roundabout way – in a systematic review of the literature only four of 1423 articles identified through various PsycINFO searches dealt directly with mental illness stigma in religious communities (Mathison & Wade, 2014). That said, research on related areas provides valuable background knowledge, such as religious beliefs about the etiology of mental illness, accepted methods of treatment for mental illness in religious communities, religious leaders' understanding of and training in mental health issues, and the differences in belief across race and ethnicity. Before breaking down the components of stigma and its manifestations in religious communities, however, it is important to understand their impact.

The Impact of Stigma

Mental health stigma is one of the most powerful of all stigmas; its effects pervasive and grievous (Abdullah & Brown, 2011; Bathje & Pryor, 2011; Ben-Porath, 2002). In 2007, a group called the Behavioral Risk Factor Surveillance System (BRFSS) surveyed adults in 37 U.S. states and territories about their attitudes toward mental illness, using the 2007 BRFSS Mental Illness and Stigma module. Based on 2007 BRFSS data most adults with mental health symptoms (78%) and without mental health symptoms (89%) agreed that treatment can help

المنارة للاستشارات
www.manaraa.com

persons with mental illness lead normal lives. Though 57% of the total sample believed that people are caring and sympathetic to persons with mental illness, only 25% of adults who actually experienced mental health symptoms believed so (Centers for Disease Control and Prevention, 2010). Furthermore, 68% of Americans do not want to have a person with mental illness marry into their family and 58% do not want one in their workplace (Mental Health America of Eastern Missouri, 2011). People with mental illnesses often face discrimination in employment, housing, health care, and social interaction (Bathje & Pryor, 2011). Not only does the individual with a mental illness experiences the effects of stigma but so does their family and friends (Corrigan, Kerr, & Knudsen, 2005; Stanford, 2007).

The effects of mental health stigma are formidable in the lives of those with mental illness as well as their friends and family. But to know the effects is not the same as understanding the ways in which it works. A theoretical understanding of the construct of stigma is key in addressing stigma. The forerunners of research in mental health stigma studied stigma as a general concept, creating a framework from which research on mental health stigma could build.

Goffman's Foundational Work on Stigma

Erving Goffman's 1963 work *Stigma: Notes on the Management of Spoiled Identity* broke ground for the study of stigma. He categorized stigma into three types: physical stigma, stigma of character traits, and stigma of group identity. Physical stigma refers to physical abnormalities such as blindness or need of a wheelchair. Stigma of character traits includes traits such as having a record of mental disorders, imprisonment, addiction, homosexuality, suicide attempts, or radical political behavior. Stigma of group identity refers to the stigma against the

المنارة للاستشارات
www.manaraa.com

members of an identifiable group, for example, a particular race or religion. In contrast, he refers to a non-stigmatized individual as a "normal."

Goffman (1963) describes several important implications of having a stigma. He posits that normals "believe the person with a stigma is not quite human" (p. 5). This, at its core, is stigma – that by considering a stigmatized individual as not quite human, normals are not required to treat such an individual with the dignity and respect owed a human. Along these lines Goffman states, "On this assumption [normals] exercise varieties of discrimination, through which [they] effectively, if often unthinkingly, reduce his life chances" (p.5). Because of the negative effects of being stigmatized, an individual with a stigmatized trait will attempt to conceal this trait if at all possible.

Here it is necessary to divide stigmatized individuals into two groups, those who are *discredited*, whose stigmatized trait is immediately apparent, and those who are *discreditable*, whose stigmatized trait is not immediately apparent. Those with a physical stigma and some of those with a group stigma (e.g. as indicated by skin color or religious dress) are discredited while those with a character trait stigma or others with a group stigma (e.g. those with an ambiguous skin color) are discreditable. Those with a discredited stigma are prey to the discrimination attached to their stigma immediately. Those with a discreditable stigma, on the other hand, can conceal the trait and avoid the negative effects of stigma, but must ever be wary of the possibility of being found out (Goffman, 1963).

Unfortunately, Goffman (1963) suggests that even if an individual can conceal a stigmatized trait from the outside world, "the stigmatized individual tends to hold the same beliefs about identity" that normals do (p.7). In both discredited and discreditable individuals, his can lead to self-hatred and self-disgust because one does not see oneself as completely human.

www.manaraa.com

Shame about the stigmatized trait, therefore, can be present whether others are aware of the trait or not. Between the expected discrimination from others and the negative self-evaluation, a stigmatized individual may resort to isolating themselves in defense. If s/he is discreditable rather than discredited though, s/he may choose to avoid disclosing the trait in order to avoid discrimination. While this may save them from overt discrimination, the stigmatized individual in effect isolates themselves by always presenting an incomplete picture of him/herself, leading all the same to feelings of isolation (Goffman, 1963).

Goffman's (1963) insights into stigma apply easily to mental health stigma. Mental health stigma is a character trait stigma and a person with mental illness is discreditable. Thus, such a person may conceal their mental illness from others in order to avoid discrimination. However, even if s/he does, s/he is still prey to negative self-evaluations based on his/her mental illness. As opposed to an individual that cannot escape his/her stigmatizing trait such as an ex-convict, a person with mental illness can avoid both outside discrimination and negative self-evaluation by denying the fact that s/he has a mental illness at all. This has profound implications for mental health treatment, which will be discussed at length below. First, though, it is useful to understand the components of stigma.

Link and Phelan's Four Components of Stigma

In their influential article "Conceptualizing Stigma" Link and Phelan (2001) described stigma as having four components encompassing five factors: 1) labeling, 2) stereotyping, 3) separation, and 4) status loss and discrimination. The first component, labeling, is the social process by which any given human trait is singled out and deemed salient by a particular society. Labeling is not only the process that attaches a name, it is the process by which that trait gains

المنارة للاستشارات
www.manaraa.com

importance in a society. The labels "black" and "white" do not describe actual skin tones and yet these labels have tremendous influence.

The second component of stigma consists of the link between a label and a negative stereotype. Link and colleagues (1999) conducted a vignette study that illustrated this well. Participants reported on their beliefs about how dangerous former mental hospital patients are (endorsement of a negative stereotype). Then, the participants were presented with several vignettes describing symptoms and experiences of a protagonist, half of whom were randomly labeled as "former back-pain patients" and the other half as "former mental patients." Then the participants were assessed for rejecting responses toward the protagonist. When the protagonists were labeled as former back-pain patients, endorsement of the dangerousness of mental patients did not predict rejecting responses. However, when the protagonists were labeled as former mental patients, endorsement of the dangerousness of mental patients was a strong predictor of rejecting responses. It was only when the protagonist was labeled that the negative stereotype had any effect on him/her.

The third component, separation, is the implication that there is an "us" who do not have this label and are very different from "them" who do have the label. For example, separation is revealed when one compares the common use of the adjective "schizophrenic" to describe a person with schizophrenia compared to a person with hypertension, who is never called a "hypertensive."

The fourth component includes both status loss and discrimination. Status loss refers to the lower levels of power and prestige held by those who are stigmatized. Status loss results in concrete inequities within small groups, such as when individuals choose not to sit next to a homeless person or dismiss a woman's opinion when working on a group project. Note that

المنارة للاستشارات
www.manaraa.com

instances such as these can easily pass without notice unless one looks for them and considers their implications and impact. Status loss is not necessarily evident to the casual observer. Furthermore, the significance of status loss is not held in a single instance, but in the collection of similar instances that work to reinforce the message that one person is worth more than another (Link & Phelan, 2001). Discrimination, both individual and systematic, is more overt. Individual discrimination includes overt behavior such as rejecting a job application from or refusing housing to an individual with a stigmatized trait. Institutional discrimination are the structures within a particular institution that disadvantage a stigmatized person regardless of an individual's attitudes or opinions about said person. For example, the use of SAT scores works to the advantage of those who were raised in areas with good schools and to the disadvantage of those who go to poor schools. As white individuals by and large live in wealthier school districts and/or have greater access to private schools and racial/ethnic minorities by and large live in poor urban areas, the gap in quality of K-12 education results in institutionalized racism against racial and ethnic minorities (Link & Phelan, 2001).

Labeling Effects and Mental Illness

In another influential article, Link (1987) discussed the effects of labeling specifically on individuals with mental illness. He hypothesized that long before an individual becomes a mental patient s/he learns how others devalue and discriminate against them. When an individual enters psychiatric treatment and the label of "mental patient" is now applied to him/her, the individual goes through a process of self-devaluation and fear of rejection. Link surveyed 429 community residents 164 psychiatric patients of the Washington Heights section of New York City who both had and had not been labeled as mental patients and assessed their endorsement of the belief that others devalue and discriminate against mental patients. Endorsement of those beliefs were

المنارة للاستشارات

www.manaraa.com

associated with demoralization, income loss, and unemployment in the labeled group over the unlabeled group (Link, 1987).

Here we see a concrete example of how stigma theory has a real world impact on those with mental illness. In this example, we see the interplay between public stigma and self-stigma, as was suggested by Goffman, constructs which were refined as follows.

Public vs. Self-Stigma

Public stigma. Public stigma includes the negative stereotypes, prejudice, and discrimination of those publically labeled as mentally ill. In addition, public stigma affects more than those with a mental illness, friends and family members and even mental health provider groups (Corrigan, 2005). Neighborhoods with psychiatric hospitals experience its deleterious effects, as evidenced by the not in my backyard (or NIMBY) phenomena protesting against the building of new mental health centers in the United Kingdom and United States (Cowan, 2003; Zippay & Sung, 2008). Public stigma threatens two central concerns for those with mental illness, procuring and keeping gainful employment and obtaining safe and comfortable housing. In a study conducted by Farina and Felner (1973) a male confederate interviewed at 32 businesses, all giving the same history. In half of the interviews, though, the confederate also reported a past psychiatric hospitalization. Later analyses found that the interviewers were less friendly and supporting when the hospitalization had been reported.

Public stigma also has contributed to the criminalization of the mentally ill (Corrigan, 2005). With the deinstitutionalization in the late 20th century in the United States, more people with serious mental illnesses (PSMI) are being processed through the criminal justice system rather than through psychiatric hospitals. This is not to say that PSMI are more likely to commit crimes, but rather that they are being arrested for incidents related to their mental illnesses, such

المنارة للاستشارات
www.manaraa.com

as public-offender crimes related to psychotic or manic episodes, and taken to jails for processing rather than psychiatric hospitals. In addition, due to the high co-morbidity rate of substance abuse and serious mental illnesses such as schizophrenia, many PSMI are arrested for drug possession or public intoxication. While serious mental illness does not cause substance abuse, per say, treating the serious mental illness is a far more constructive intervention than imprisonment (Lurigio, 2013).

Self-stigma. Self-stigma, on the other hand, occurs when an individual with mental illness internalizes public stigma, leading to lower self-esteem, self-efficacy, and hope for one's future (Corrigan, 2005; Vogel, Wade, & Haake, 2006). As suggested by Goffman "the stigmatized individual tends to hold the same beliefs about identity" (p.7) as the general public, namely that stigmatized individuals are less than human (Goffman, 1963). Link's (1987) study of labeling effects on ex-mental patients described above provides an excellent example – those who endorsed stigmatizing beliefs about mental patients experienced worse outcomes, such as loss of income and unemployment, than those who did not. Self-stigma also has a considerable effect on whether an individual will seek psychological services, be compliant with treatment, and/or continue ongoing therapy (Tucker et al., 2013). This can significantly hinder recovery from mental illness, compounding an already troubling problem.

Furthermore, Vogel, Bitman, Hammer, and Wade (2013) found that public stigma predicted the development of self-stigma in a longitudinal study of 448 college students in a large Midwestern university. At time one (T1) and then again at time two (T2) three months later they collected measures of public and self-stigma. They found that endorsed public stigma at T1 predicted self-stigma at T2, but not the other way around. This suggests that public stigma is internalized as self-stigma over time.

المنارة للاستشارات
www.manaraa.com

Mental Illness Stigma vs. Help-Seeking Stigma

The stigma of mental illness is certainly troubling in that it appears to reduce treatment usage and result in other negative outcomes for people with psychological symptoms and concerns. However, a related, but distinct, stigma also appears to play an important role in the help-seeking process. The stigma associated with seeking psychological services is "the perception that a person who receives psychological treatment is undesirable or socially unacceptable" (Vogel, Wade, & Haake, 2006; p. 325). Those who were labeled as having sought counseling or as having been hospitalized have been shown to be rated less favorably and treated more negatively than those who were not labeled (Vogel, Wade, & Hackler, 2007). The help-seeking stigma and mental illness stigma are related in that both require that the stigmatized individual be labeled, consistent with general stigma theory. However, help-seeking stigma is distinct in that those who endorse the stigma believe that those who seek treatment are weaker or less adequate than those who attempt to handle their concerns on their own or with the help of family, friends, or community leaders (Komiya, Good, & Sherrod, 2000). Consistent with the distinction above between public stigma and self-stigma, an individual who would seek psychological treatment could fall prey to both stigmas. An individual may see him or herself as less adequate or weak as a result of seeking treatment (Vogel, Wade, & Hackler, 2007).

In a study of 380 undergraduates, Ben-Porath (2002) found a difference in stigma against those with depression symptoms and those who had both depression symptoms and had sought help from a therapist. In this study, participants were given one of four short case vignettes that were identical except for the presenting problem – back pain vs. symptoms of depression – and whether the individual had sought help – from the university health center for back pain, from a therapist for depression symptoms, or no help sought. She found that the target that had

المنارة للاستشارات
www.manaraa.com

symptoms of depression was rated as being more emotionally unstable than the individual who had back pain. This indicates a stigma against those with depression (i.e., mental illness stigma). However, the target who had both symptoms of depression and had sought help from a therapist was rated as the most emotionally unstable of the four. This indicates not only that there is a stigma of seeking help for a mental illness (in particular depression) but also that help-seeking stigma had an effect over and above mental illness stigma (Ben-Porath, 2002).

While it is important to understand the components of mental illness and help-seeking stigma, there is still a need to understand the path by which stigma affects help seeking intentions. Vogel and colleagues completed a serious of studies to help make that connection.

Attitudes toward Counseling, Intentions to Seek Counseling, and Stigma

Vogel and Wester (2003) found that one of the most proximal predictors of intentions to seek counseling was attitudes toward counseling. Previous research had shown that approach factors, such as lack of social support, level of distress, and previous experience with counseling, were important indicators of attitudes toward counseling. These indicators, however, gave an incomplete picture. The researchers therefore tested the effects of avoidance factors in addition to approach factors. Avoidance factors included low tendency to self-disclose distressing information, high anticipated risk associated with self-disclosure, low anticipated utility of self-disclosure, and high tendency to self-conceal. In addition, previous research had tied these indicators to attitudes toward counseling under the assumption that attitudes predicted the decision to seek counseling. Vogel and Wester, however, asserted that one's attitude may or may not predict behavior, as one may have a positive attitude about counseling but not seek it, or have a negative attitude and seek it anyway. They therefore measured attitudes toward seeking counseling as well as intentions to seek counseling, reasoning that intentions would be a more

المنارة للاستشارات

www.manaraa.com

proximal measure of behavior. In two studies with 477 college students Vogel and Wester showed that avoidance factors predicted negative attitudes toward counseling which in turn predicted low intention to seek counseling.

Vogel, Wade, and Hackler (2007) tied together research on public and self-stigma, attitudes toward counseling, and willingness to seek help. In a study of 680 undergraduates at a large Midwestern university, they used structural equation modeling to test the hypothesis that the relationship between public stigma and willingness to seek counseling was indirectly mediated through self-stigma and attitudes toward counseling. The results of the SEM analysis supported their hypothesis, finding that public stigma predicted self-stigma, which negatively predicted attitudes toward counseling, which predicted willingness to seek counseling.

Self-Stigma of Mental Illness vs. Self-Stigma of Help-Seeking

It is necessary to understand the nuanced relationship between mental illness and help-seeking stigma as well. Mental illness stigma includes the attitudes and discrimination against a person with a mental illness. Help-seeking stigma, in contrast, is the stigma associated with the act of seeking psychological services for that mental illness (Tucker et al., 2013). Vogel, Wade, and Hackler (2007) found that self-stigma fully mediated the relationship between public stigma and attitudes toward counseling. Tucker and colleagues found that it was the self-stigma of help-seeking, rather than the self-stigma of mental illness, that was the most powerful predictor of willingness to seek help.

Internalized Stigma Model

While Tucker and colleagues helped clarify the distinction between the self-stigmas of mental illness and seeking help, a more complete model was needed to tie together the relationship between the public and self-stigmas of mental illness and seeking help. In a study of

المنارة للاستشارات

www.manaraa.com

448 undergraduates, Lannin and colleagues (2015) developed a model to better explain their relationship. Their "Internalized Stigma Model asserts that both types of stigma are related – yet distinct – barriers to recovery" (p.82). Public stigma can lead to internalization as self-stigma for both mental illness stigma and the stigma of seeking help. In addition, the model expands the previous models by showing the relationship between stigma and self-esteem as well as intentions to seek counseling. These findings are important as they have real world implications for the development of interventions. Most interventions are currently focused only on addressing the public stigma of mental illness. Based on this model, the most effective interventions aimed at increasing use of mental health services may not address public stigma but rather a more proximal predictor of intentions to seek counseling, the self-stigmas of mental illness and seeking help and self-esteem as a result of self-stigma.

Religious Mental Health Stigma

Most research that has been conducted has focused on the general population, the studies discussed above being no exception. There is reason to believe, however, that many religions have their own interpretations of mental illness. Both Christianity and Judaism, for example, believe that mental illness can be the result of ongoing sin in one's life (Rabinowitz, 2014). That said, the link between mental illness stigma and religion has only been indirectly drawn in the literature. While my intention is to focus in on the Abrahamic religions (i.e. Christianity, Judaism, and Islam), the extant literature has focused disproportionately on Christians. The summary of research that follows will therefore apply primarily to Christians, but will attempt to bring in findings about Judaism and Islam whenever possible.

Definitions. For the purpose of this study, *Religious mental health stigma* (RMHS) will be conceptualized as the public and self-stigma of mental illness and psychological help-seeking

المنارة للاستشارات

www.manaraa.com

in religious communities, paying special attention to beliefs about sin and morality and religious/spiritually-oriented beliefs about causes and treatments of mental illness. While RMHS includes stigma found in any religion, this study will focus on assessing the stigma in the Abrahamic religions. *Religious public stigma of mental illness* (RPSMI) is defined as the stigma a religious community holds toward an individual who has been labeled as having a mental illness. *Religious public stigma of psychological help-seeking* (RPSPHS) is defined as the stigma a religious community holds toward an individual who has sought psychological services. *Religious self-stigma of mental illness* (RSSMI) is defined as the religious public stigma of mental illness that has been internalized by an individual who has been labeled as having a mental illness. *Religious self-stigma of psychological help-seeking* (RSSPHS) is defined as the religious public stigma of psychological help-seeking that has been internalized by an individual who has sought psychological services.

The continuum of Christian beliefs about mental illness. It is important to note that not all religious individuals, or indeed all Christians, hold the same beliefs about mental illness. In the articles reviewed, religious individuals fell on a continuum. On one end some individuals strongly endorsed the biomedical model of mental illness. Psychological and psychiatric problems were viewed as illnesses and treatment was valued and encouraged when appropriate. On the other end of the continuum some individuals strongly endorsed a spiritual or religious conceptualization of mental illness (Hartog & Gow, 2005). Prayer, reading the Bible, and healing ministries were examples of treatments that seemed appropriate (Borras, Mohr, Brandt, Gillieron, Eytan, & Huguelet, 2007; Crosby & Bossley, 2012; Hartog & Gow, 2005; Leavey, 2010; Lyles, 1992; Mayers, Leavey, Villianatou, & Barker, 2007; McLatchie & Draguns, 2001; Payne, 2009; Stanford, 2007; Trice & Bjorck, 2006). Strong spiritual or religious beliefs about

المنارة للاستشارات
www.manaraa.com

mental illness were in the minority and were more frequently seen in more conservative, Pentecostal, or fundamentalist congregations (Mayes, et al., 2006; Lyles, 1992; Payne, 2009; Stanford, 2007). Biomedical beliefs about mental illness were most common in liberal/progressive congregations. The majority of congregations/religious individuals fell somewhere in between, endorsing both biomedical and spiritual/religious beliefs.

This will act as an important frame of reference. The findings discussed below are not exhaustive descriptions of the beliefs Christians hold about mental illness. As mentioned above, religious beliefs about mental illness occur alongside secular beliefs. The following is rather meant to reflect those beliefs that are most strongly influenced by religiosity.

Christian and Muslim beliefs about mental illness. The most fundamental difference between secular and religious mental illness stigma is the difference in beliefs about the cause of mental illness. Demonic influence, whether seen as demonic oppression or possession, was a frequently cited cause that has no secular counterpart. On the other hand, whereas secular stigma might call mental illness “personal weakness” religious stigma would call it “moral or spiritual weakness.” Beliefs about the causes of mental illness are key to understanding beliefs about effective treatments. If one believes one has a spiritual problem then one looks for a spiritual solution.

Demonic influence is a hallmark of Judeo-Christian beliefs about mental illness. It is important to note that demonic influence does not exclusively refer to demonic possession. In one study, demonic influence was found to be presented as the oppression of the enemy, Satan, or spirits/demons. The study quoted an author who described her own experience with depression: “...Satan took advantage of a time when I dove off a cliff of closeness with God to coax me into a pit of despair, confusion, and depression” (Webb, Stetz, & Hedden, 2008, p. 703).

المنارة للاستشارات

www.manaraa.com

Demonic influence in this sense was found to be the most commonly portrayed source of depression in a Christian's life. Another study noted that the demonic causation of psychological symptoms seemed like "diffuse" attempts to fit their experience into their religious framework. This article noted that clients perceived that their disorder had a demonic causality for mental disorders both with and without psychotic features (Pfeifer, 2000).

Still, demonic possession itself was believed to be a cause of mental illness within some Christian communities such as Pentecostals, Catholics, and Anglicans. Deliverance, also known as exorcism, is believed to be the appropriate way to eradicate a demon. Different communities allow different persons to conduct the deliverance. In hierarchical churches such as the Anglican and Catholic churches priests go through specific training to perform the ritual (Leavey, 2010). In many Pentecostal traditions, the deliverer is someone who has demonstrated a Holy Spirit given gift to expel demons. While many believe strongly that it is imperative to expel demons whenever a demon possession is identified – much as many believe it imperative to take someone who is very ill to a doctor – deliverance rituals can, at times, have unintended negative consequences. In fact, the deliverance ritual itself can be a traumatic experience, resulting in the victimization or re-victimization of the person receiving the deliverance. At times, injuries and even deaths have resulted (Mercer, 2013).

Demonic possession has been named as a possible cause of psychotic symptoms in Muslim regions, as well. One author pointed to the similarities between descriptions of demonic possessions and some psychotic behaviors such as "They put thoughts in my mind that are not mine" or "My feelings and movements are controlled by others in a certain way" (Irmak, 2014, p. 775). Muslim traditional healing, or Koranic healing, is common in many cultures in the Middle East. Koranic healers use scripture from the Koran in a healing ritual to exorcise evil

المنارة للاستشارات
www.manaraa.com

spirits, known as Jinn (Al-Krenawi, 1999). A faith healer in Turkey reported that three months after expelling evil spirits patients with schizophrenia were symptom free (Irmak, 2014). It is worthy of note that Koranic healers have a good reputation among the public and Islamic scholars (Al-Krenawi, 1999). Prominent social work, medical, and psychological scholars have advocated the use of Koranic healers (e.g. Irmak, 2014; Al-Krenawi, 1999).

Beliefs about the causes of mental illness have serious theological implications for many Christians. A popular doctrine posits that if one has enough faith, prays or is prayed for correctly, reads the Bible dutifully, and regularly attends worship services then one will have a sound mind, free of fear and emotional problems (Webb, Stetz, & Hedden, 2008). A set of beliefs termed the "emotional health gospel" (Carlson, 1998, p. 29). When an individual does experience emotional problems, people with these beliefs might conclude that they are not living a good Christian life. What a mental health professional would call a mental disorder is therefore interpreted as spiritual failure. As a note, these beliefs were more common for depression and anxiety than for disorders that were seen as having a clearer biological basis such as schizophrenia in samples in Australia, California, and in various Christian self-help bestsellers (Hartog & Gow, 2005; Trice & Bjorck, 2006; Webb, Stetz, & Hedden, 2008).

An inventive qualitative analysis of 14 Christian self-help bestsellers by Webb, Stetz, and Hedden (2008) gave a revealing depiction of the emotional-health gospel. This article sought to better understand how mental illness was portrayed by Christian media, focusing on bestselling books. The popularity of these books reveals their influence; for example, Joyce Meyer's *Battlefield of the Mind* has sold 3 million copies and Joel Osteen's *Your Best Life Now* has sold over 4 million (Amazon.com). Failure as a Christian was a commonly noted cause of depression. Authors warned that ''If you do not pray, you will either be habitually depressed or obsessed

المنارة للاستشارات
www.manaraa.com

with your own ego...'' and ''...sometimes depression is caused by our own sin" (Webb, et al., 2008, p. 704). Negative emotions, such as anger, ingratitude, or guilt were another commonly cited cause. One author went as far as to say that ''intolerance, agitation, short temperedness mark our behavior. Clinical depression, a mental health problem largely caused by pent-up anger, becomes a real possibility'' (Webb, et al., 2008, p. 705). Prayer, self-discipline, and willpower were portrayed as bulwarks to keep out depression. One author stated, ''It's even possible to live without negative emotions. God will take them off us like a thick blanket if we ask him to. But we have to pray'' (p. 706.) Another asserted that ''if you are depressed you have to understand that nobody is *making* you depressed... You are choosing to remain in that condition'' (p. 706). The authors of this study note that the representations of depression in these books are gross oversimplifications. There is no acknowledgement of the biopsychosocial complexities found in decades of research on the disorder. Recovery from depression was portrayed as a quick, if not immediate, process – not one that can last weeks or even years.

Although most Christians, even those in Pentecostal or conservative communities, believed there was some biomedical component to mental illness (Matthews, 2008; Trice & Bjorck, 2006), religious beliefs about mental illness still impact psychological help-seeking. In a study of Protestant Christians in the Southeastern United States, 18.9% of 540 participants agreed that "emotional/mental/relationship problems such as depression, anxiety, intense grief, loneliness, thoughts of self-harm or substance abuse problems are solely religious/spiritual in nature" (Royal & Thompson, 2012, p. 197). Even among those who did not endorse this item it was common to believe that a person should only go to a mental health professional as a last resort (Royal & Thompson, 2012). Several studies reported that Christians believed that the primary treatment should come from the church or individuals associated with the church (e.g.

المنارة للاستشارات
www.manaraa.com

Crosby & Bossley, 2012; McLatchie & Draguns 2001; Royal & Thompson, 2012). After all, a spiritual problem requires a spiritual solution. The treatment could be through pastoral or church staff counseling or, in rarer cases, through spiritual healing ministries (Huang, Shang, Shieh, Lin, & Su, 2011; Leavey, 2010; Lyles, 1992). Spiritual health ministries may include deliverance rituals such as those discussed above, but may also be activities that involve miraculous healing through prayer in church services or meetings or through multi-session, biblically-based programs (Village, 2005). Studies on referral behavior of Christian clergy have shown them open to referring congregants to mental health professionals, especially those that identify as Christian themselves, but rarely doing so (e.g. Jones, Cassidy, & Heflinger, 2012). Competing beliefs about mental illness causes and treatments accounts for some of this discrepancy, but research has shown that clergy by and large have little, if any, education on identifying and treating mental illness (Farrell & Goebert, 2008; Jones, Cassidy, & Heflinger, 2012; VanderWaal, Hernandez, & Sandman, 2012).

Christian clergy and mental illness. Thirty-nine percent of Americans with a serious personal issue turn to leaders in their religious community in times of need - even when their crisis is directly tied to a mental illness (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). In this way, clergy serve an important role in mental health treatment as frontline mental health workers. In a sample of 235 college students in Southeast Texas, men were significantly more likely to seek help from a religious advisor than women, who were more willing to seek psychological help (Crosby & Bossley, 2012). In contrast, one study found that 71% of the 98 Protestant church leaders felt inadequately trained to recognize mental illness (Farrell & Goebert, 2008). Another study found that less than half of their sample of 179 clergy in the New York and Connecticut had any clinical pastoral education (Moran, Flannely, Weaver, Overvold, Hess, &

www.manaraa.com

Wilson, 2005). Even the knowledge of available mental health services is lacking (Jones, Cassidy, & Heflinger, 2012; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

In one study by Farrell and Goebert (2008), members of the clergy were given two vignettes to read – one describing an individual in a manic state typical of Bipolar Disorder and the other in depressive episode seen in Major Depressive Disorder. The clergy were asked to identify symptoms of mental illness and to decide whether they would refer these individuals to mental health professionals or provide counsel themselves. Nearly 40% of those who admitted to having inadequate training to recognize mental illness indicated they would counsel the individuals described in these vignettes (Farrell & Goebert, 2008). This discrepancy is disconcerting, especially considering that medication prescribed by a physician is strongly recommended in managing the manic episodes of Bipolar Disorder and/or to prevent future manic episodes (Butcher, Hooley, & Mineka, 2014). This study found that ministers with as little as 5 hours of mental health training were more likely to be adequately prepared to identify mental illness (Farrell & Goebert, 2008).

Reasons that Christians are more likely to seek help from religious advisors are varied. One reason is that seeking help from religious advisors carriers less stigma than seeking help from mental health professionals (Crosby & Bossley, 2012). Another reason is that Christians may be concerned that the mental health professional would discredit or undermine their faith or that the experience would weaken their faith (Mayers, et al., 2007). For this reason, even when clergy did refer congregants to a mental health professional they would generally send them to one known to be Christian (Mayers, et al., 2007; McLatchie & Draguns 2001; Moran, et al., 2005). However, a qualitative study in London found that even when Christians were initially hesitant about seeking secular-based therapy they still found it helpful. In fact, most reported that

المنارة للاستشارات
www.manaraa.com

the experience strengthened their faith whether or not there was a match in the spirituality or religious affiliation between therapist and client (Mayers, et al., 2007). This indicates that mental health professionals can facilitate treatment in a way that respects and even promotes spiritual or religious well-being; something many Christians do not expect. This result notwithstanding, there is still a need to incorporate religion into diversity training for mental health professionals (Crosby & Bossley, 2012). This might be especially salient for counseling religious minorities who may harbor more negative views of counseling and experience greater stigma.

Race and ethnicity. Abdullah & Brown (2011) noted that race had a major effect on mental health stigma. Ethnic and cultural minorities generally hold stronger stigmatizing beliefs than do Caucasians, though – as with white Christians – there is a wide range of beliefs. People from primarily Black and Hispanic churches, particularly more conservative and Pentecostal ones, tended to endorse more spiritual etiologies and spiritual treatments for mental illness than those from primarily white churches (Cinnirella & Loewenthal,1999; Leavey, 2010; Lyles, 1992; Payne, 2009). Reasons behind this tendency are multifaceted, ranging from lower levels of education, immigrant status, lack of access to mental health care, higher levels of religiosity, and concerns about racial differences between the clinician and the client (Caplan, et al., 2011; Lyles, 1992). Among many immigrants, a dual system of beliefs has been found – that of mainstream Western medicine and that of religious or traditional folk-beliefs (Caplan, et al., 2011).

Along these lines, immigrants from developing countries tend to endorse religious/spiritual explanations for mental illness. African immigrants to the United Kingdom reported high beliefs in demonic possession and demonic influence and low endorsement of psychological or medical causes and treatments for the mentally ill. Exorcism/deliverance was frequently believed to be the most appropriate treatment among clergy (Leavey, 2010). A study

المنارة للاستشارات
www.manaraa.com

on attitudes toward mental illness in Benin City, Nigeria was indicative of mental health stigma in some African cultures. Eighty percent of the 107 Nigerians who completed the surveys preferred that those with mental illness be in residential facilities outside of their vicinity even though 63% agreed that mental hospitals were more akin to prisons than a place for treatment. It was also believed that those with mental illness should be treated like children by 68% of the sample. The influence of Pentecostal beliefs was evident as over 50% of the clergy identified as such (Igbinomwanhia, James, & Omoaregba, 2013). Other samples have indicated large proportions of Pentecostals in African immigrants as well (Leavey, 2010).

In a similar vein, a higher percentage of Protestant African American congregations are conservative and/or Pentecostal than white congregations. One study found that of 51 African American churches in California surveyed, 35% of African American churches were conservative, 33% of were Pentecostal, and 22% were non-denominational (another Christian group that can tend to be conservative). Only 10% were mainline protestant – churches that more frequently endorse the biomedical model of mental illness (Payne 2009). In the study, African American pastors were far more likely to endorse items like ‘‘Depression is hopelessness that happens when one does not trust God’’ and ‘‘Depression is due to a lack of faith in God’’ than European American pastors. Furthermore, European Americans were 6 times more likely to agree that “Depression is a biological mood disorder’’ than African American pastors (Payne, 2009, p.361).

In addition, African American clergy – who are particularly important figures in many African American circles - have wary attitudes regarding mental health services. One study of African American pastors in the New Haven area of Connecticut indicated about half of the 99 interviewed had received specialized training for pastoral counseling for use with serious

المنارة للاستشارات
www.manaraa.com

problems. They also were willing to exchange referrals with secular mental health professionals in their area, but tended to have a lack of information on available services. Even among these pastors, though, about half agreed or strongly agreed that those with severe depression or anxiety could cure themselves if they put their mind to it (Young, Griffith, & Williams, 2003). Interviews with clergy in another study revealed strong faith in religious coping. One pastor reported, "A person with a strong spiritual balance can almost take more than a person without it because their spiritual balance will help them cope." Another stated, "I guarantee you, bring me anybody with whatever problem, and it will be gone in six months…if they follow the Word" (Lyles, 1992). Worthy of note is that African American clergy conduct more pastoral counseling than European American clergy, in part because of higher rates of poverty and limited access to services (Young, Griffith, & Williams, 2003).

Poverty and access were not the only barriers to referrals to mental health professionals, however. Many pastors felt uncomfortable referring congregants because they believed the professional would not respect their religious beliefs. Another salient factor was that they were concerned that a professional (usually assumed to be non-black) would not be able to relate to blacks or might even be prejudiced against them. In a striking example, one black woman had seen two white therapists of the same religious background but had not disclosed previous sexual abuse from her parents because she was concerned that "white people assume that black people can't control their sex drives and I didn't want to be stereotyped." While this may or may not have been what the therapists actually believed, the client did not feel safe discussing issues regarding race (Lyles, 1992). A study of clergy referral attitudes and behavior in Michigan likewise reported that over half of the African American clergy (n=22) indicated they were likely or very likely to refer a congregant to a mental health professional of the same ethnicity rather

المنارة للاستشارات
www.manaraa.com

than one of a different ethnicity (VanderWaal, Hernandez, & Sandman, 2012). It seems then that the low utilization of mental health services by African American Christians is influenced both by a tendency toward more conservative or Pentecostal sects of Christianity and a concern about racism in treatment.

While Hispanic immigrants experience significant barriers to access such as status as an undocumented immigrant, lack of insurance, and language barriers, these factors may not be enough to explain the exceptionally low level of help-seeking. To give an example of the rate of help-seeking, in the Los Angeles Epidemiologic Catchment Area (ECA) study only 11% of Mexican Americans who had experienced a mental disorder in the last six months sought any kind of mental health treatment compared to 22% of whites with mental disorders (USDHHS, 2001). Religion, in particular Christianity, is a significant part of Hispanic culture. In one study 90% of a sample of 177 Hispanic adults recruited from a primary care office in Queens, NY was Christian (Caplan, et al., 2011). More than half of Hispanic Christians identity as charismatic or Pentecostal (Caplan, et al., 2011). Furthermore, religiosity was significantly correlated with higher endorsement of the perceived stigma of seeking help for depression from friends, coworkers, and family. The use of complementary or alternative medicine is commonplace in Hispanic communities. This includes prayer as well as the use of traditional healing practices such as *curanderismo*, a form of folk medicine with spiritual healing and the maintenance of harmony and balance with nature. Estimates of use of alternative medicine in the Mexican and Mexican American population from range from 50-75% (Caplan, et al., 2011).

Limited research has been done with Asian immigrants to the United States, but what research has been done points to low endorsement and utilization of mental health services. Research on the referral behavior of Asian American clergy in California indicated low rates of

المنارة للاستشارات
www.manaraa.com

referrals to mental health professionals. In fact, only 27% of the 103 clergy sampled could name even a single provider or mental health agency to use as a referral (Yamada, Lee, & Kim, 2012). Clergy were far more likely to refer a congregant to a general practitioner rather than a mental health professional. Knowledge of mental illnesses and possible treatment options appear to increase the likelihood of a referral, findings that were also found in African American populations (Yamada, Lee, & Kim, 2012). A study with an elderly population in Singapore found that even though religious individuals, including Christians, were more likely to have a mental disorder, they were less likely to use mental health treatment (Ng et el., 2011). In a study of Christian clergy in Singapore, the most commonly endorsed etiology of mental illness was a Traditional Christian one. This included descriptions such as “lack of obedience to scripture,” and “failing to have their minds renewed by God’s word,” and “sin.” Etiologies from mainstream Western medicine such as poor coping and organic etiologies were also endorsed, but not as strongly (Matthews, 2008). The above findings indicate that although less is understood about the reasons behind the phenomena it is clear that this population is wary of mental health treatment.

Negative implications. Negative beliefs about mental health in religious communities can have serious implications. On the more mild side, negative beliefs can lead to ignorance of the mental health needs of church members and a lack of assistance from the church for families with mental illness (Farrell & Goebert, 2008, Leavey, Loewenthal, & King 2007; Rogers, Stanford, & Garland, 2012). In addition, these beliefs can lead to led to non-adherence with psychiatric treatment, increasing the risk of relapse and hospitalization, and lack of medical treatment for those with severe mental illness. This lack of consistent care can result in an increase in high risk symptoms such as suicidal ideation and behavior and psychotic or manic

المنارة للاستشارات

www.manaraa.com

episodes (Borras, Mohr, Brandt, Gillieron, Eytan, & Huguelet, 2007; Mitchell & Romans, 2003). In rare but significant cases Christian church members were discouraged and even forbidden to take psychiatric medication and/or were told they did not have a mental illness despite having a diagnosis from a mental health professional (Stanford, 2007).

Measures of religious mental health stigma. In an effort to prevent these negative consequences, more research needs to be conducted on the nature and the effects of mental health stigma in religious communities. In order to reliably measure mental health stigma in religious communities, a psychometrically sound scale is key (Heppner, Wampold, & Kivlighan, 2008, p.228). Although Wessellmann and Graziano (2010) created a scale to measure this construct, the Religious Beliefs about Mental Illness (RBAMI) scale, its scale construction and psychometric properties make its validity questionable. That said, its uniqueness in the literature warrants a brief overview of their findings.

The RBAMI scale made a distinction between religious and secular beliefs about mental illness. Religious beliefs are related to secular beliefs, but differ in significant ways. Secular beliefs about mental illness were broken down into fear/danger, controllability, and anger. Fear/danger described the fear individuals had of those with mental illness due to perceived unpredictability or dangerousness. Controllability referred to how much individuals believed that those with mental illness were responsible for their condition and could control their symptoms and reactions. Anger was simply how angry an individual felt toward those with mental illness. Religious beliefs were broken down into two factors: morality/sin and spiritually-oriented causes and treatments. The morality and sin factor referred to beliefs that mental illness was the result of immorality, sin, or failure to adhere to religious practices and principles. Spiritually-oriented causes and treatments encompassed beliefs that demonic influence was largely responsible for

المنارة للاستشارات

www.manaraa.com

mental illness and that prayer or working with religious advisors was the appropriate course of treatment. The morality and sin factor was the most salient, accounting for 71% variance in the findings. The spiritually-oriented causes and treatments factor accounted for 12% of the variance. A difference in attitudes toward depression and schizophrenia was found. Persons with schizophrenia were found to evoke more fear and depression was found to be considered more controllable (Wesselmann & Graziano, 2010). Unfortunately, the theoretical and psychometric limitations of the RBAMI scale make these conclusions tentative at best.

First, the items in the scale are limited by Christian-centric language. The authors offer items that only pertain to Christianity, although they claim to be assessing the broader category of "religion." This is a significant drawback to a scale that purports to assess beliefs about mental illness that are informed by other religions, such as Islam or Judaism. Another drawback is that there are no items that take into consideration particularly salient aspects of other religions. For example, in Judaism there is a strong belief that God doesn't give one anyone more trials than one can handle. While many Jews find this belief helpful, it could lead to stigma against mental illness should one feel that one cannot psychologically or emotionally handle a situation through their religion. In Islam there is strong belief that struggles in this life are Allah's way of testing his followers, so seeking psychological/psychiatric help is equivalent failing the test spiritually. In addition, there is overlap in Christian perceptions of mental illness with Judaism or Islam. In Judaism, like in Christianity, there is a conception that mental illness is indicative of sin (Rabinowitz, 2014, p. 248). In Islam, like some more conservative Christian communities, there exists a conception that jinn, similar to demons, can harass or possess individuals and that symptoms of mental illness are the effects of such activity (Hedayat-Diba,

المنارة للاستشارات
www.manaraa.com

2014, p.302). Were the RBAMI scale worded in a more inclusive way, it could apply to all Abrahamic religions rather than just Christianity.

Second, the RBAMI purports to be a measure of stigma but does not cover the various types of stigma. First, the scale only assesses public stigma, there are no questions that measure self-stigma. Bathje and Pryor (2011) found that these two aspects of stigma play different roles in attitudes toward seeking mental health counseling. Furthermore, the measure does not take into account the distinction between mental illness stigma and help-seeking stigma as emphasized by Tucker and colleagues (2013). In fact, only one of the sixteen items even addresses help-seeking behaviors. Considering that the self-stigma of help-seeking is a stronger predictor of attitudes toward seeking help than the self-stigma of mental illness, items assess self-stigma should be paramount. Also, no distinction is made between inpatient and outpatient therapy; the wording of the items only references outpatient therapy. Despite the fact that the stigma of seeking outpatient therapy and the threat to one's status, self-esteem, etc. is very real, the stigma of inpatient hospitalization may be far worse. In a qualitative study Roe and Ronen (2003) examined the experiences of individuals who had hospitalized on a psychiatric unit. Clients reported that after being hospitalized they found who would actually be willing to support them and who would not. One client described it well when she said that after the hospitalization some "think that you are a mental case and you are crazy, and they won't ever talk with you again." Many clients described how being hospitalized made their self-esteem plummet to the extent that they judged how well they were doing by how long they were able to go without being hospitalized. Because the RBAMI does not address these aspects of mental health stigma, it gives an incomplete picture of stigma in religious communities.

المنارة للاستشارات

www.manaraa.com

Third, the RBAMI scale lacks psychometric validity. The items were generated without the use of focus groups or consultation with other experts in the field, steps recommended by Lee and Lim (2008) in order to check construct validity. This step alone might have alleviated the omissions detailed above. In addition, the items were not pilot tested before scale validation was conducted in order to assess for readability. Furthermore, the test-retest reliability of the measure was not measured, making it impossible to know if the data collected from the survey reflects the participants' attitudes toward mental illness in general or only at a certain point in time. Because of this neglect of the recommended procedures for scale construction, use of the RBAMI for further research is cautioned.

Conclusions

Mental health stigma in religious communities is pervasive and powerful. While it looks similar to general mental health stigma, there are significant differences such as the perceived interplay between sin and morality and mental illness as well as religious beliefs about the etiology of and effective treatments for mental illness. This is an area that has received scant attention in the research literature. What research does exist has been primarily qualitative or descriptive. There is a need for research that attempts to use quantitative methods to measure and further study the effects of stigma as well as, one day, reliably measure change in stigmatizing attitudes as a result of interventions. Only one article exists, to my knowledge, which has attempted to measure religious mental health stigma in a systematic way; by creating a scale. The use of this scale, due to theoretical and psychometric limitations, however is cautioned against.

In order to address this hole in the literature, it is the purpose of the present study to create a psychometrically strong scale integrating mental health stigma research with religious beliefs about mental illness.

المنارة للاستشارات

www.manaraa.com

CHAPTER 3. METHODS

Participants

Participants of Sample 1 were 704 undergraduate students who were enrolled in 100- and 200-level psychology and/or communications studies classes at Iowa State University who signed up to be part of the SONA participant pool and volunteered to be part of a screening survey for the semester. The sample was 57% female (n = 704; with n = 302 males and n = 1 with no response) and were racially/ethnically 83.1% European American or White (n = 585), 3.7% Latino American (n = 26), 3.4% Asian American/Pacific Islander (n = 24), 3.2% African American or Black (n = 23), 1.6% multi-racial American (n = 11), 0.4% Native American (n = 3), and 2.8% International Students (n = 20). For year in school, 55.8% were in their first year of college (n = 393), 25.9% in their second year (n = 182), 10.9% in their third year (n = 77), and 7.1% were in their fourth year or beyond (n = 50). Students who were part of Sample 2 were not included in this sample.

In Sample 2, 326 undergraduate students who were also enrolled in 100- and 200-level psychology and/or communications studies classes at Iowa State University participated. The sample was 60.5% female (n = 197), 38.6% male (n = 126), and 0.9% transgender or gender non-conforming (n = 3). As far as race/ethnicity, the sample was 81.4% European American/White (n = 265), 0.9% African American/Black (n = 3), 4.7% Latino/Hispanic American (n = 15), 9.3% Asian or Asian American (n = 30), 0.3% Native American (n = 1), 1.2% Middle Eastern or Arab (n = 4), 1.9% Biracial American (5 individuals were Caucasian/African American and 1 was African American/Asian), and 0.3% "other" (n = 1). Eight percent of the sample were international students (n = 26). The mean age was 19.5 with a range of 18-32. For reported religion, 67.8% (n = 221) reported they were Christian with 39.9%

المنارة للاستشارات
www.manaraa.com

of the sample Protestant (n = 130) and 23.9% Catholic (n = 78) with 4.0% identifing as Christian but not reporting their affiliation (n = 13), 12.3% no religious affiliation (n = 40), 1.5% Muslim (n = 5), 0.3% Jewish (n = 1), 4.0% Buddhist (n = 13), 8.6% Agnostic (n = 28), 9.2% Atheist (n = 30), 0.6% Pagan (n = 2), 0.3% Hindu (n = 1), 0.3% Taoist (n = 1), 0.6% Spiritual but not religious (n = 2), and 2.5% other, not specified (n = 8).

Measures

Religious Beliefs about Mental Illness (RBAMI). This 16-item scale, designed by Wesselmann and Graziano (2010), has a two-factor structure (see Appendix A). The first factor is *Sin/Moral Responsibility* and the second *Spiritually-Oriented Causes/Treatments*. The RBAMI was designed to measure themes believed to be involved in religious beliefs about mental illness such as demon possession, unrepentant sin, and prayer. Items include statements such as, "Persons suffering from mental illness are being tormented by the Devil" and "Moral weakness is the main cause of mental illness" (Wesselmann and Graziano, 2010, p.410). Items are rated on a 5-point Likert-scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Five items are reversed scored so that higher scores reflect less endorsement of religious beliefs about mental illness. Both Factor 1 (nine items, $\alpha = .88$) and Factor 2 (seven items, $\alpha = .72$) had acceptable reliability. This measure was first normed using undergraduates at a Midwestern university ($n = 142$), then cross-validated using a more diverse sample ($n = 232$) gathered through various internet means. The second sample included individuals from 14 countries. Cronbach's alpha for the present study was 0.89 for factor 1 and 0.80 for factor 2.

Religious Commitment Inventory-10 (RCI-10). Worthington and colleagues (2003) developed this 10-item inventory to measure religious commitment in religious and nonreligious communities and in various religious traditions such as Christianity, Islam, and Buddhism. Items

المنارة للاستشارات

www.manaraa.com

include statements such as "My religious beliefs lie behind my whole approach to life." Items are rated on 5-point Likert-scale from 1 (*not true at all of me*) to 5 (*totally true of me*). The internal consistency for the full scale was reported as .93 and the 3-week test-retest reliability was .87. Evidence for construct validity was demonstrated by a moderate correlation (r = .54, p < .003) with endorsement of the *salvation* value in Rokeach's Value Survey (in an overwhelmingly Christian sample) as well as frequency of religious activities (r = .72). Evidence for discriminate validity was demonstrate by low, nonsignificant correlations to morality and a single item measure of spirituality as exemplary human characteristics (r = .09 and r = .10; Worthington, et al., 2003). Cronbach's alpha for the present study was .95.

Knowledge Test of Mental Illness (KTMI). Michaels and Corrigan (2013) developed this 14-item faux knowledge test (i.e., error-choice test) as a measure of mental illness stigma that circumvents endorsement of items that are considered socially preferable but do not reflect the participant's actual attitudes. The instructions support this illusion:

> This is a test of your knowledge about mental illness. The questions on the test are taken from findings of scientific research. You are not expected to have read the research reports, but by using your experience and general knowledge you should be able to pick the correct answer. Some people will do much better than others because of their training in medicine, rehabilitation, or psychology. Read each question carefully and select the response you consider to be the correct answer. THERE IS NO PENALTY FOR GUESSING. There is no limit for the completion of this test, but you should work as rapidly as you can.

Items include statements or questions purporting to assess knowledge of mental illness, as reflected by the title of the questionnaire. One such item is, "People with severe mental illness cannot maintain private residences." The participant is then required to choose whether the item is "true" or "false." In other items, the participant is required to choose the "correct" choice. One such item is, "The divorce rate among the general population is about 50%. What is the divorce rate among people who experience mental illness?" The participant must choose either "Greater

www.manaraa.com

than 70%" or "Less than 50%." The National Comorbidity Study found that 48.2% of respondents diagnosed with a psychiatric disorder before or during their first marriage subsequently divorced, suggesting that the divorce rate among those with mental illness is less than 50%, comparable to that of the general population (as cited in Michaels & Corrigan, 2013). A choice of "greater than 70%," then, indicated more negative attitudes toward those with mental illness (Michaels & Corrigan, 2013). Cronbach's alpha for the present study was .95.

The KTMI demonstrates construct validity through its positive relationship with the Attribution Questionnaire (r = .25 to .47, $p < 0.05$) and inverse relationships with the Self-Determination Scale (r = -.31 to -.40, $p < 0.05$) and the Empowerment Scale (r = -.34 to -.49, $p < 0.05$). No significant relationships were observed with self-stigma measures (recovery, empowerment). Test-retest reliability in the initial paper ranged from 0.50 to 0.70 (Michaels & Corrigan, 2013).

Stigma Scale for Receiving Psychological Help (SSRPH). Komiya, Good, and Sherrod (2000) developed this 5-item, unidimensional scale to measure the public stigma of seeking psychological services. Items are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and the scores are summed so that higher scores indicate higher public stigma of seeking psychological services. Items include statements such as, "Seeing a psychologist for emotional or interpersonal problems carries social stigma." The SSRPH demonstrates construct validity through its correlation with attitudes toward seeking psychological services (r = -.40, p < .001), and, in line with other research of the stigma of seeking psychological services, women's scores (M = 5.10, SD 2.88) were significantly lower than men's (M = 6.86, SD = 3.03, $F(1,282) = 26.3$, $p < .0001$). It has acceptable internal consistency ($\alpha = .72$). Cronbach's alpha for the present study was .81.

المنارة للاستشارات
www.manaraa.com

Beliefs about Devaluation-Discrimination (DD). Link (1987) developed this 12-item scale to measure how much a person believes that the general public will devalue and discriminate against a person with a mental illness, connoting the public stigma of mental illness. As discussed in the literature review, devaluation occurs when an individual experiences status loss whereas discrimination include the negative consequences of increased social distance. Items are scored on a 6-point Likert scale from 1 (*strongly agree*) to 6 (*strongly disagree*). Half the items are reverse coded such that higher scores indicate more public stigma against mental patients. Items reference a "mental patient" or an individual who has entered a mental hospital such as "Most people would willingly accept a former mental patient as a close friend." A final score is calculated by summing the scores, then dividing by the number of items answered. It was first normed using a sample of 429 community residents and 164 psychiatric patients in the Washington Heights section of New York City, as described in the literature review (Link, 1987). The DD shows adequate internal consistency overall ($\alpha = .76$; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Support for convergent validity comes from the measure's moderate correlation with demoralization in repeat-treatment mental health patients ($r = .48$; Link, 1987). Evidence of discriminant validity comes primarily from the scale's face validity and its low, nonsignificant correlation with measures of compliance (Link, 1987; Tucker et al., 2013). Cronbach's alpha was .85 in this sample.

Self-Stigma of Seeking Help (SSOSH). This 10-item questionnaire has a unitary factor structure and measures the decrease in self-esteem and self-efficacy resulting from being labeled as a seeker of psychological help (Vogel & Wade, 2009). Items are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and include statements such as, "Seeking psychological help would make me feel less intelligent." The SSOSH demonstrates good

المنارة للاستشارات
www.manaraa.com

construct validity through correlations with intentions to seek counseling, attitudes toward counseling, and the public stigma for seeking help (Vogel et al., 2006). It has been shown to distinguish between those who seek help and those who do not. Finally, the SSOSH demonstrates discriminant validity through its zero-order, non-significant correlation with self-esteem ($r = .06$; Vogel et al., 2006), and demonstrates acceptable test-retest reliability over a period of 2 months ($\alpha = .72$) and has high internal consistency ($\alpha = .89$; Tucker et al., 2013). Cronbach's alpha for the present study was .91.

Self-Stigma of Mental Illness (SSOMI). Tucker, et al (2013) developed this 10-item scale to measure the self-stigma of being labeled as having a mental illness. This scale was developed as a parallel to the Self-Stigma of Seeking Help (SSOSH) Scale. Items are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and include statements such as "If I had a mental illness, I would be less satisfied with myself." Half the items are reverse scored such that higher scores represent greater self-stigma associated with having a mental illness. Evidence for convergent validity was demonstrated through it strong, positive correlation with the modified Self-Stigma of Depression (SSD) Scale ($r = .73$, $p < .001$). Discriminant validity for the SSOMI comes from its small, negative correlation with self-esteem ($r = -.25$, $p < .001$). It has high internal consistency, with Cronbach's alpha being .91 in the original study (Tucker et al., 2013). Cronbach's alpha for the present study was .92.

Attitudes toward Seeking Professional Psychological Services – Short Form (ATSPPS-SF). Fischer & Farina (1995) developed this 10-item questionnaire as a revision of the original 29-item ATSPPS (Fischer & Turner, 1970) to measure attitudes toward seeking help. The revised version correlates strongly ($r = .87$) with the original, suggesting that the two are measuring the same construct. Items are rated on a 4-point Likert-scale from 0 (*disagree*) to 3

المنارة للاستشارات
www.manaraa.com

(*agree*) and include items such as "A person should work out his or her own problems; getting psychological counseling would be a last resort." Half of the items are reverse-scored such that higher scores denote higher agreement with seeking psychological services. Evidence of convergent validity comes from correlation of the short form with the use of professional psychological services (r = .39). Test-retest reliability after 1 month was good (r = .80) as was internal consistency (r = .84; Tucker et al., 2013). Cronbach's alpha in the present study was .77.

Intentions to Seek Counseling Inventory (ISCI). Cash, Begley, McCown, & Weise (1975) developed this 17-item inventory to measure how likely respondents were to seek psychological services should they experience any of the presenting concerns listed such as depression, loneliness, or difficulties dating. Items are rated on 6-point Likert-scale from 1 (*very unlikely*) to 6 (*very likely*). Responses are summed with higher scores indicating a greater likelihood of seeking help for those presenting concerns. Evidence for convergent validity comes from its ability to detect differences in college students' intentions to seek psychological services when clinicians are presented as more or less physically attractive. Additionally, the ISCI relates to the perceived significance of a presenting concern and to attitudes toward seeking help (r = .36; Kelly & Archer, 1995; Tucker et al., 2013). Cronbach's alpha in the present study was .90

Marlowe-Crowne Social Desirability Scale (MCSD). Social desirability is especially important to measure in stigma research as with other research on prejudice and discrimination. Tourangeau and Yan (2007) reported that individuals underreport racist attitudes in survey research. Much of mental health stigma theory comes from prejudice and discrimination research including that based on racism (e.g. Goffman, 1963; Link & Phelan, 2001). It follows, then, that attitudes against individuals with mental illness would also be underreported. Along these lines, Michaels and Corrigan (2013) reported that in stigma research an individual may endorse a more

المنارة للاستشارات
www.manaraa.com

socially acceptable answer than one that reflects their 'true' beliefs in order to escape social opprobrium. Henderson and colleagues found that, in doing research on mental health stigma, data collection method was important in controlling for social desirability and acquiescence bias. They reported that online self-report surveys are "clearly preferable" to face-to-face interviews (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012; p.153). In their study, for example, they found that whereas 12.2% of the online sample reported having a mental illness, only 4.6% of the face-to-face interview participants did so (Henderson, et al., 2012).

The most widely used social desirability scale was originally developed by Crowne and Marlowe (1960) based on items from the Minnesota Multiphasic Personality Inventory. It has a true-false response format to questions such as, "I sometimes feel resentful when I don't get my way." It was originally purported to have two factors, social desirability bias and acquiescence bias. Loo and Thorpe (2000) found that these two factors only accounted for 17.3% of the variance, leaving a significant amount of the variance unaccounted for. While several shortened versions have been developed, Loo and Thorpe recommend using the full, original version as the shortened versions focused on only these constructs. The full, 33-item version will therefore be used in this study. Internal consistency reliability analyses in Loo and Thorpe's study was adequate (α = .64 - .78; 2000). Cronbach's alpha was .71 in the present study.

International Personality Item Pool – Neuroticism Scale (IPIP-N). Goldberg (1999) developed the International Personality Item Pool as a broad-bandwidth personality inventory with items in the public domain with items measuring the Big-Five factor markers. There are two versions of the full inventory, one with 50-items and the other with 100. For the purposes of this study we will only use the 10-item neuroticism scale pulled from the 50-item version. Items are rated on a 5-point Likert-scale from 1 (*very inaccurate*) to 5 (*very accurate*). Five of the items

المنارة للاستشارات

www.manaraa.com

are keyed in the positive direction and five in the negative direction (e.g., "Often feel blue" and "Seldom feel blue"). The scale has an internal consistency of .86 (Goldberg et al., 2006) and correlates highly (r = .83) with the neuroticism subscale of the NEO-Five Factor Inventory (Gow, Whiteman, Pattie, & Deary, 2005). Cronbach's alpha for the present study was .87.

Attention Checks. Random responses from even 5% of participants can have a significant impact on observed correlations (Credé, 2010). It is highly recommended that researchers make every attempt to identify and eliminate such random responders (Osborne & Blanchard, 2011; Tucker, 2013). The present study will identify random responding by requiring the participant to answer correctly both of two items prompting a specified response (e.g., "Please select *Strongly Disagree* for this item").

Religious/ Spiritual affiliation, familiarity with mental illness, and demographic questionnaire. Participants are asked to report their age, gender, religious/spiritual affiliation, and frequency of attendance to religious/spiritual meetings, services, or events. Participants are also asked their familiarity with mental illness by selecting all that apply of the following choices: none, media (books, movies, TV, etc.), taken a class, personal experience (self), personal experience (family member), or personal experience (other: please specify). If the participants select any of the "personal experience" options, they are asked to report with which mental illness(es) they are familiar.

Procedures

After receiving approval from the IRB committee at Iowa State University, procedures of the scale construction followed those recommended by Heppner, Wampold, and Kivlighan (2008).

المنارة للاستشارات

www.manaraa.com

Item generation. Items were generated based on existing items in the RBAMI, SSOSH, SSOMI, ATSPPS-SF, and SSRPH as wells as on information found through the literature review. Items integrated religious beliefs about mental illness and psychological help-seeking and items based on general stigma research. Items represented initially were categorized into four groups: religious public stigma of mental illness (RPSMI), religious public stigma of psychological help-seeking (RPSPHS), religious self-stigma of mental illness (RSSMI), and religious self-stigma of psychological help-seeking (RSSPHS). Items were also included that reflect the sin/morality and spiritually-oriented causes/treatments factors as measure by the RBAMI. Lily Mathison and Nathaniel Wade reviewed the items and added additional items to help cover all of the elements of the construct. Then two experts, one in help-seeking stigma and scale validation and one in quantitative psychology, specifically scale construction, reviewed the items and directions. Both offered suggestions and items and the directions were revised as appropriate. Then, the items and directions were reviewed for readability by a freelance editor and writer with 15 years of editing experience.

Expert panel review. A panel of nine experts in the areas of religion (Christianity and Judaism), religious counseling, and mental health stigma reviewed the items generated for the scale. This panel assessed the items for content validity and had the option of generating additional items and suggesting topics or domains that still needed to be covered, though no additional topics were suggested. At each step, items were revised, deleted, or added as recommended by Heppner et al. (2008).

Experts had experience with a religious community and had expertise in the field of mental health and/or mental health stigma. When asked which religion they were most familiar with, four reported Judaism and four Christianity (one did not answer the question). Of those

المنارة للاستشارات
www.manaraa.com

who reported they were familiar with Christianity, one reported being familiar with the church of Latter Day Saints. Of the eight that reported their education level, five held a doctor of philosophy in Psychology, Human Development, or Behavioral Neuroscience, one held a Masters in Counseling Psychology, and two held a Bachelors in Psychology (both were graduate students in a doctoral Counseling Psychology program). Occupations of the reviewers included tenure-track or tenured professor, staff psychologist at a university counseling center, and graduate student. After the expert panel reviewed the items and directions and their comments were reviewed and incorporated, there were 44 items for testing.

Readability analyses. Two readability analyses were conducted. The first was the Flesch Reading Ease formula (Flesch, 1948), which used the average number of words per sentence and the average number of syllables per word to calculate a number between 0-100, with higher numbers signifying easier reading. The RMHSS received a score of 50.6 using this formula. The second measure was the Flesch-Kincaid Grade level index (FKG; Flesch 1979), which also used the average number of words per sentence and average number of syllables per word to calculate the reading level to a U.S. grade-school level. The RMHSS was considered to be at a grade level of 10.0 using this scale. Because reading researchers have criticized objective readability formulas for being simplistic (Lenzner, 2014), the items were also subjectively assessed for readability by a professional editor and by experts reviewing the items. This included suggestions for rewording items to make them simpler or more understandable and reformatting to make the scale easier to read.

Sample 1. In the first study, 704 student participants completed an online survey during mass-testing of SONA participants in early September 2015. Data collected included informed consent, the items of the RMHSS created during the previous steps, university emails, and

المنارة للاستشارات

www.manaraa.com

student IDs. Sample 1 included participants who only completed mass-testing and were not a part of Sample 2 (described below).

Sample 2. During the semester, SONA participants had the opportunity to complete the questionnaire packet, which was provided as an online study through SONA starting at the end of September 2015 and continuing into January 2016. All SONA participants over the age of 18 were eligible whether they participated in mass-testing or not. This was called Sample 2 and includes 326 participants. The questionnaire packet included the full set of items from the new measure of religious mental health stigma as well as the Religious Beliefs about Mental Illness scale (RBAMI; Wesselmann and Graziano, 2010), Stigma Scale of Receiving Psychological Help (SSRPH; Komiya, Good, and Sherrod, 2000), Knowledge Test of Mental Illness (KTMI; Michaels and Corrigan, 2013), Beliefs about Devaluation-Discrimination (DD; Link, 1987) scale, Self-Stigma of Seeking Help (SSOSH; Vogel & Wade, 2009) scale, Self-Stigma of Mental Illness (SSOMI; Tucker, Hammer, Vogel, Bitman, Wade, & Maier, 2013) scale, Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF; Fischer & Farina, 1995), Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975), Marlowe-Crowne Social Desirability Scale (MCSD; Crowne & Marlowe, 1960), International Personality Item Pool- Neuroticism Scale (IPIP-N; Goldberg, 1999), Religious Commitment Inventory-10 (RCI-10; Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley, & O'Connor, 2003), and Religious/ Spiritual affiliation, familiarity with mental illness, and demographic questionnaire (demographic questionnaire).

After data were collected for both Samples 1 and 2, the email IDs and student IDs were compared for the two data sets. If the participant was found to be in both data sets, their data was deleted from Sample 1. There were 11 participants in Sample 2 who did not report either their

www.manaraa.com

student ID or their email ID. These were deleted from Sample 2 to ensure that there was no possibility of a participant whose data was in Sample 1 also being in Sample 2. (See Table 1 below.)

Table 1. *Overview of Samples for the Scale Construction and Examination*

Sample	**Sample Name**	**N**	**Scales**	**Test/Analyses**
1	Mass-Testing (MT) Only	704	RMHSS	EFA
2	Full Questionnaire (FQ) Only (not MT)	326	All Scales	CFA Validity/Reliability

المنارة للاستشارات

www.manaraa.com

CHAPTER 4. RESULTS

Attention check. Participants who answered either or both of the two attention checks incorrectly were eliminated from the sample for analysis purposes. T-tests were used to evaluate if there was a significant difference between the demographics of those who did answer the attention checks correctly and those who did not. There was no difference between the groups in terms of ethnicity, religion, whether or not they were international students, or age. There was a significant difference between the gender of those who answered the attention check correctly and those who didn't, with men being more likely to incorrectly answer them (p = .001).

Sample 1: Exploratory factor analysis. Using data from Sample 1, I conducted an exploratory factor analysis (EFA) as recommended by Heppner et al. (2008) with principle axis factoring extraction and a Direct Oblimin (oblique) rotation. Principle axis factoring was chosen over principle components analysis per the recommendations of Howard (2016) and Worthington and Whittaker (2006). An oblique rotation was determined to be the most appropriate as, according to stigma theory, any factors found would most likely be correlated and oblique rotation allows for this possibility (Howard, 2016; Worthington & Whittaker, 2006). Direct Oblimin was chosen as the oblique rotation as it was suggested as the most preferred over Promax by Howard (2016). The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was 0.97. KMO values range from 0 to 1, with higher numbers indicating better sampling adequacy. Howard (2016) recommends that the KMO should be above .60 before performing an EFA, as this indicates that latent factors may be present and an EFA may be performed.

The number of factors to retain was determined by Cattell's scree test, in which one looks at a plot of the Eigenvalues of each factor and identifies where the "elbow" of the plot resides. All factors above that point are retained while those below are discarded (DeVellis, 2003). In the

المنارة للاستشارات
www.manaraa.com

case of the RMHSS, the elbow was determined to start at factor three. Factors one and two were, therefore, retained while factors three and below were not.

In terms of retaining items, Tabachnick and Fidell (2013) recommend a minimum factor loading of .32, whereas Howard cites 0.40 as a "good" factor loading (2016). Howard further recommends use of the .40-.30-.20 rule, namely that satisfactory items will load onto their primary factor above 0.40, load onto alternative factors below 0.30, and demonstrate a difference of 0.20 between their primary and alternative factor loadings (2016).

Worthington and Whittaker recommend that the length of the scale be considered along with internal consistency of the scale scores in determining the number of items to retain (2006). As there were two factors, it was considered that 5 items per factor would be a good number, as the objective was to create a short measure, so long as all of the main theoretical components of the concept were assessed. The top 5 items in the two factors were therefore retained. (See Table 1.) Upon closer inspection of the items chosen for the first factor, I determined that two of the items were redundant with other items. I then deleted these items and chose the two items with the next highest factor loadings in their stead. In addition, upon inspection of the chosen 10 items I discovered that a key concept from the literature was missing: the concept of demon/spirit attack/possession/oppression. As this item still had an acceptable factor loading (.78), I included it in the scale as an 11th item. Factor 1 accounted for 43.31% of the variance while factor 2 accounted for 26.12%.

While the two factors both refer to religious mental health stigma broadly, Factor 1 deals more with personal religious beliefs about mental health care while Factor 2 refers to religious community beliefs about mental illness in particular. The full title for Factor 1 will therefore be Personal Religious Beliefs about Mental Health Care and be called "Personal" for short. On the

المنارة للاستشارات
www.manaraa.com

other hand the full title for Factor 2 will be Religious Community Beliefs about Mental Illness and be called "Community" for short.

Internal consistency reliability. Cronbach's alpha was calculated to measure the internal consistency reliability of the scores on the scale. It was 0.83 for Sample 1. A correlational analysis was conducted with the Marlowe-Crowne Social Desirability scale to measure the extent that social desirability is measured by the new scale. As hypothesized, the correlation was small at .17 (p = .002).

Sample 2: Confirmatory factor analysis. Next, the data from Sample 2 were analyzed to test the reliability and validity of the scores on the new scale. Internal consistency reliability was examined again with Cronbach's alpha and was determined to be 0.82 for Sample 2. Using data from Sample 2, I tested construct validity by calculating correlations between the scores on the new scale and scores on existing scales including the RBAMI, SSRPH, KTMI, SSOSH, DD, SSOMI, ATSPPH-SF, ISCI, MCSD, IPIP-N, and RCI-10. Table 3 illustrates the measures used for validity and the correlations found.

Using data from Study 2, I conducted a confirmatory factor analysis (CFA) to compare four models (see Table 4). Model 1 was a single-factor model, assuming that the items measure one construct, which was called religious mental health stigma (RMHS). Model 2 was a two-factor orthogonal model (which does not allow the two factors to correlate) based on the factor structure from the EFA. Model 3 was a two factor Oblique model (which allows the two factors to correlate). Model 4 was a two factor bifactor model, assuming that the items measure two constructs as found in the EFA, but at the same time measure a single construct, RMHS.

CFA Model Comparisons were employed to decide on the best fitting model. Global fit indexes were also examined. These included the comparative fit index (CFI), Tucker-Lewis

المنارة للاستشارات
www.manaraa.com

Index (TLI), Root Mean Square Error of Approximation (RMSEA), and the Standardized Root Mean Square Residual (SRMS) with cutoffs for the CFI and TLI > .95 and the RMSEA and SRMS <.06 as suggested by Hu and Bentler (1999). The results were then examined to determine which model best balanced parsimony with fit (using chi-square difference tests). It was determined that the best fitting model was the two factor bifactor model, as shown in figure 1 below.

Analyses of Variance (ANOVA) were used to determine if differences in responses on the RMHSS exist between racial/ethinic, religious affiliation, international/domestic, and gender groups. The means between different genders and religious affiliations were tested using ANOVAs and were not significantly different. However, race/ethnicity (European American versus minority groups) and international/domestic were. As the number of minorities in any one group was – unfortunately – too small to test differences between groups, the mean difference between European Americans and minority groups on the RMHSS was found. There was a significant difference ($F = 14.65$, $df = 320$, $p < .001$) with the mean for minority groups (24.87, *SD* = 5.84) higher than that for European Americans (21.72, *SD* = 5.72). As for international versus domestic there was a significant difference ($F = 24.75$, $df = 322$, $p < .001$) with international students' mean (21.83, *SD* = 5.60) being higher than domestic students' (27.58, *SD* = 6.28). A Pearson correlation was used to determine if there was a significant relationship between age and the RMHSS; there was no significant correlation, although this is not surprising given the restricted range on age in the current sample.

Finally, a Pearson's correlation was used to estimate the test-retest reliability using those participants who participated in both Mass-Testing and SONA (Sample 1 + Sample 2). Unforunately, there were very few participants who completed both data collection (n = 32). The resulting correlation ($r = .34$) was non-significant.

www.manaraa.com

Table 2

Loadings on Factors 1 and 2 for RMHSS items.

Item	Factor 1 Loading	Factor 2 Loading
35. I would feel as if I were failing religiously if I got help from a mental health professional.	**.89**	
26. I would feel less devoted to my religion if I took psychiatric medication.	**.87**	
28. Taking psychiatric medication would feel like giving up on *God or the divine*.	**.86**	
43. Getting help from a mental health professional is against my religious or spiritual beliefs.	**.85**	
16. If I struggled with a mental illness, it would be a result of my own sin.	**.84**	
38. Taking psychiatric medication would feel like giving up on my religion.	.83	
12. If I had a mental illness I would think that I had not been following my religious beliefs devotedly.	.83	
14. I would feel less devoted to my religion if I went to a therapist for psychological help.	.81	-.12
23. If I had a mental illness I would be afraid that I was not on the right religious path.	.81	
37. **A person who is devoted to their religious beliefs and practices would not have psychological difficulties.**	**.81**	
29. Mental illness results from the sins or wrongs an individual has committed.	.80	
18. If I was diagnosed with a mental illness I would worry that I might not gain access to the afterlife (i.e. heaven).	.79	
40. A person with a mental illness is being attacked, oppressed, or possessed by spirits (e.g. demons, jinn, dybbuk).	**.78**	.13
32. Getting help from a mental health professional is against my religious community's beliefs.	.78	-.23
22. If I had a mental illness I would feel rejected by *God or the divine*.	.77	-.17
25. I would feel inadequate if I went to a therapist for psychological help instead of *God or the divine*.	.76	.18
19. Seeking a therapist for psychological help should be a last resort, only to be used after seeking help from one's religion.	.72	.27
6. Seeing a mental health professional would feel like giving up on *God or the divine*.	.72	-.14
36. The only mental health provider a member of my faith should see is one who shares my religious beliefs.	.71	.23
31. *God or the divine* only gives me situations I can handle, so there is no need for me to seek help from a mental health professional.	.67	.32
4. If I had a mental illness I would feel that I was not doing the will of *God or the divine*.	.67	-.13
10. If I were struggling emotionally or mentally I would think I was being influenced by demons or evil spirits.	.66	.16
34. Mental illness is the result of sin being in the world.	.65	.21
9. Taking psychiatric medication is against my religious community's beliefs.	.64	-.25
41. Seeking a therapist for psychological help is only appropriate for very serious problems; otherwise, one should seek help from one's religion.	.63	.36
33. Prayer is a better treatment for mental illness than mental health care.	.61	.53
11. A person should work out his or her own problems with the help of *God or the divine* instead of seeking mental health care.	.60	.46

المنارة للاستشارات
www.manaraa.com

Table 2 continued

42. I would be afraid to tell people in my religious community if I were taking psychiatric medication.	.60	.22
39. Most people in my religious community would think less of a person with mental illness.	.59	-.38
30. If I were experiencing a serious emotional crisis reading my religious text (e.g. Bible, Koran, Torah) would be more effective than seeking mental health care.	.58	.48
15. I would never tell people in my religious community if I struggled with a mental illness.	.58	-.29
13. I would be afraid to tell people in my religious community if I went to a therapist for psychological help.	.57	-.24
2. Getting help from a mental health professional is somewhat inappropriate for religious people regardless of what the problem is.	.57	
44. I would feel more comfortable talking with a religious leader about my problems than a mental health professional.	.52	.50
20. Most single people in my religious community would be reluctant to marry an individual with mental illness.	.33	-.17
8. If I were experiencing a serious emotional crisis I would be confident that I could find relief by spending more time in prayer.	.20	.68
5. Most people in my religious community would believe that a person with a mental illness were just as devoted to their religion as any other person in that community.	-.22	**.65**
17. Most people in my religious community would be willing to accept a person with mental illness as a close friend.	-.21	**.64**
1. Most people in my religious community would treat a person with mental illness just as they would treat anyone else.	-.15	**.59**
27. A person should first turn to their religious beliefs and practices if they feel like they have an emotional or mental health concern.	.49	.55
3. Most people in my religious community believe that having a mental illness is a sign of personal failure.	.45	-.55
7. Most people in my religious community would willingly accept a religious leader who had a mental illness.	-.13	**.55**
24. Most people in my religious community would accept a person with mental illness as a children's religious teacher.		**.50**
21. Getting help from a mental health professional could help me spiritually.		.34

المنارة للاستشارات

www.manaraa.com

Table 3

Correlations between the RMHSS and Other Measures.

Measure	Acronym	RMHSS	RMHSS-1	RMHSS-2	RBAMI-1	RBAMI-2
Religious Mental Health Stigma Scale – Full	RMHSS	---	.79**	.77**	.54**	.32**
Religious Mental Health Stigma Scale – Personal	RMHSS-1	.79**	---	.24**	.73**	.54**
Religious Mental Health Stigma Scale – Community	RMHSS-2	.77**	.24**	---	.14*	.01
Religious Beliefs about Mental Illness, Factor 1	RBAMI-1	.54**	.73**	.14*	---	.67**
Religious Beliefs about Mental Illness, Factor 2	RBAMI-2	.32**	.54*	.01	.67**	---
Stigma Scale of Receiving Psychological Help	SSRPH	.32**	.21**	.30**	.09	-.07
Knowledge Test of Mental Illness	KTMI	.22**	.16**	.19**	.27**	.21**
Beliefs about Devaluation-Discrimination	DD	.22**	.03	.31**	-.06	-.16**
Self-Stigma of Seeking Help	SSOSH	.40**	.31**	.32**	.18**	.14*
Self-Stigma of Mental Illness	SSOMI	.22**	.13*	.22**	.08	.02
Attitudes Toward Seeking Psychological Help	ATSPPH-SF	.34**	.34**	.19**	.32**	.32**
Intentions to Seek Counseling Inventory	ISCI	-.08	-.02	-.11*	-.02	-.05
Marlowe-Crowne Social Desirability Scale	MCSD	.17**	.22**	.05	-.08	-.14*
Neuroticism Scale	IPIP-N	.13*	.12*	.09	.02	-.04
Religious Commitment Inventory-10	RCI-10	-.04	-.27**	.21**	.35**	.49**

*** Correlation is significant at the 0.01 level (2-tailed)*
**Correlation is significant at the 0.05 level (2-tailed)*

www.manaraa.com

Table 4

Goodness-of-Fit Indicators for the Competing Models of the 11-item RMHSS

Model	***df***	**χ^2**	**CFI**	**TLI**	**RMSEA(CI)**	**SRMR**	**AIC**
One General Factor	44	489.85	.69	.61	.18 [.16, .20]	.15	8156.23
Two Factor Orthogonal	44	145.68	.93	.91	.08 [.07, .10]	.11	7812.05
Two Factor Obilque	43	126.82	.94	.93	.07 [.06, .09]	.05	7795.20
Two Factor Bifactor	33	77.36	.97	.95	.06 [.05, .08]	.03	7765.74

Note: RMHSS = Religious Mental Health Stigma Scale; CFI = Comparative Fit Index; RMSEA = Root-Mean Square Error of Approximation; CI = 90% Confidence Interval for RMSEA; SRMR = Standardized Root-Mean-Square Residual; AIC = Akaike's Information Criterion

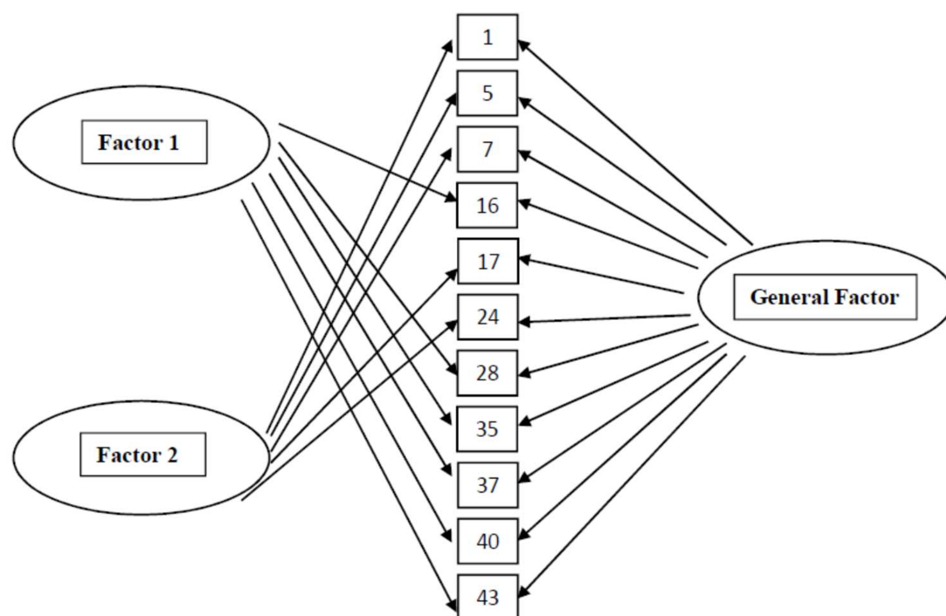

Figure 1

Two Factor Bifactor Model

المنارة للاستشارات
www.manaraa.com

CHAPTER 5. DISCUSSION

An 11-item quantitative measure of mental health stigma in Christian and Jewish communities was developed over the course of this study. The extant literature has focused on qualitative and descriptive research, with only one article doing any quantitative research on the topic. The measure of religious mental health stigma developed in this study had strong psychometric support. In addition, the measure incorporates theory on public stigma and self-stigma of mental illness and help-seeking and is more applicable to religions other than Christianity. The goal was to develop a psychometrically sound measure of mental health stigma in Jewish and Christian communities and, considering internal consistency, goodness of fit indeces, and measures of external validity, it appears that, overall, this goal was accomplished.

RMHSS versus RBAMI

While the RMHSS was intended to replace the RBAMI in use, it appears that the two scales may be measuring different constructs based on correlations between the scales. This indicates that, depending on the goal of a study, the RMHSS or the RBAMI may be an appropriate fit. The below table summarizes the relationships between the RMHSS, each of its factors and the two RBAMI factors. As indicated on the table, the overall RMHSS correlates moderately with the two RBAMI factors. Looking at each RMHSS factor, the first factor correlates strongly with the two RBAMI factors but the second only weakly correlates with the first RBAMI factor and does not correlate at all with the second. This indicates that there is some overlap between the RMHSS Factor 1 and the RBAMI, but the second appears to be picking up on something the RBAMI is not. Factor 2 of the RMHSS looks at perceived opinions of one's religious community. This, apparently is not accounted for in the RBAMI.

Looking at the correlations between the RBAMI and RMHSS and the other scales, the RMHSS, in this sample, performs better overall relating to established stigma scales. For

www.manaraa.com

example, the RMHSS has significant correlations with the SSRPH and the SSOMI while the RBAMI does not. This indicates that the RMHSS accounts for both the public stigma of seeking psychological help and the self-stigma of mental illness better than the RBAMI. In fact, the RMHSS significantly correlates in some way to all of the stigma scales. It makes sense that the RMHSS would correlate with the stigma scales better than the RBAMI, as the items were constructed specifically to incorporate existing stigma theory while the RBAMI was not.

One area where the RBAMI appears to have out-performed the RMHSS is in its factors' weak or zero-level correlations with the IPIP-N and the MCSD. The RMHSS full scale and factor 2 correlate significantly, albeit weakly, with both (Factor 1 is not related to either scale). Nonsignificant correlations between the RMHSS and the IPIP-N and MCSD would indicate that the new religious stigma scale is not related to neuroticism and socially-desireable responding.

The RMHSS and RBAMI also related to another scale differently – the Religious Commitment Inventory (RCI-10). This scale was included as a measure of external validity and it was hypothesized that there would be a positive correlation between the RCI-10 and the RMHSS. While there was, indeed, a positive correlation between the two RBAMI factors and the RCI-10, there was no significant correlation between the full RMHSS. However, when looking at the correlations between the RMHSS Factors 1 and 2 and the RCI-10, this makes sense as Factor 1 is positively correlated with it whereas Factor 2 is negatively correlated. This is particularly interesting because Factor 2 of the RMHSS was the factor that had no correlation with the two RBAMI scales, indicating that it captures a construct that the RBAMI does not. It appears that as perceptions of mental health stigma in a religious communities increase, religious commitment decreases. This relationship seems to indicate that, for whatever reason, people that

المنارة للاستشارات
www.manaraa.com

are more committed to their religion perceive that their religious community holds less stigmatizing beliefs about mental illness and mental health care.

It is notable, however, that in looking at the full RMHSS, the two RMHSS factors and the two RBAMI factors, only RMHSS factor 2 correlated with the scale that included items that measured perceptions of the religious community. Using structural equation modeling, Vogel and Wester (2003) found that the most proximal predictor of intentions to seek counseling was attitudes toward seeking counseling. Furthermore, the Internalized Stigma Model (Lannin, et al., 2015) suggests that the self-stigma of seeking help and mental illness were closer predictors of intentions to seek counseling than were public stigma. It is therefore possible that, given their significant correlations with other stigma measures but not the ISCI, the RMHSS may represent constructs that are more distally related to intentions to seek counseling.

One benefit of using the RMHSS over the RBAMI is that, according to the CFA conducted in this study, it has a bifactor structure that allows the use of both its factors separately and the full scale as a whole. In contrast, the reported factor structure for the RBAMI is a 2-factor structure, requiring that the two factors be analyzed separately and not as a whole. Theoretically, this is an important distinction, as this indicates that the two factors within the RMHSS combine to create a unified construct. The RBAMI scale, with its two factors, does not appear to measure a unified construct. In addition to the theoretical implications, this has implications for its ease of use as well. The RMHSS can be used as a scale with two subscales or one general scale, depending on what the user is interetested in. The RBAMI must be used as two separate scales.

Finally, in consideration of the factor structures of the RMHSS and RBAMI, the RMHSS performed better on goodness-of-fit indeces in their respective CFA analyses. In fact, while the

المنارة للاستشارات
www.manaraa.com

two factor bifactor RMHSS model met the cutoffs set by Hu and Bentler (1999) for the comparative fit index (CFI), Tucker-Lewis Index (TLI), Root Mean Square Error of Approximation (RMSEA), and the Standardized Root Mean Square Residual (SRMS), the two factor RBAMI did not meet the cutoffs for the RMSEA or the CFI. According to the CFI, the two factor bifactor RMHSS was a better fit for its data than the two factor RBAMI by a factor of 0.1 (RMHSS CFI = .97; RBAMI CFI = .87). This indicates that the RMHSS has a stronger, more stable factor structure than the RBAMI.

Limitations

It is important to note some limitations of this study. First of all, the items of the RMHSS were primarily created by two individuals who were most familiar with Protestant Christianity. While the authors made an attempt to make the items more generally applicable to religions in general, it is possible that they may not fit as well with other Christian groups, Judaism, Islam, Buddhism, Hinduism, or any other religion. It may be said that this was partially assuaged by the fact that several of the expert reviewers were familiar with different religious groups including Reformed and Conservative Judaism and Latter Day Saints, but the fact remains that it may or may not work as well outside of a Protestant Christian population.

Another limitation was the homogenous nature of the samples in this study. They were primarily European American Christians (both Catholic and Protestant) in their late teens or early twenties and all were undergraduates in a large Midwestern university in the United States. Considering the literature has shown that racial/ethnic minorities – especially Latino and African American individuals – tend to be more religious than white individuals, examining the RMHSS with a more ethnically-diverse sample would be important.

المنارة للاستشارات
www.manaraa.com

Future Directions

There are several direction in which this study can be taken. First of all, the scale should be cross-validated in a more diverse sample in terms of race/ethnicity, religion, geography, education, age, and socio-economic status. A community sample, rather than a sample of undergraduates, would be a great place to start.

Once the scale has been cross-validated in a more diverse sample, the relationships between religious mental health stigma as measured by the RMHSS and other mental health stigma constructs should be studied more closely. Considering that structural equation modeling has shown that public and self-stigmas of mental illness and help-seeking are differentially related, it is possible that RMHSS may play a role in the internalized stigma model or one similar to it. In addition, religious stigma might play a moderating role in some contexts, such as devote Christians considering seeking mental health care.

Finally, now that there is a measure of religious mental health stigma, it can be possible to see if it may change over time, specifically in response to interventions which target lowering it. Interventions would be important in order to mitigate the negative implications of high religious mental health stigma. This can include ignorance of the mental health needs of church members and a lack of assistance from the church for families with mental illness (Farrell & Goebert, 2008, Leavey, Loewenthal, & King 2007; Rogers, Stanford, & Garland, 2012). In addition, these beliefs can lead to led to non-adherence with psychiatric treatment, increasing the risk of relapse and hospitalization, and lack of medical treatment for those with severe mental illness. This lack of consistent care can result in an increase in high risk symptoms such as suicidal ideation and behavior and psychotic or manic episodes (Borras, Mohr, Brandt, Gillieron, Eytan, & Huguelet, 2007; Mitchell & Romans, 2003). In rare but significant cases Christian

المنارة للاستشارات
www.manaraa.com

church members were discouraged and even forbidden to take psychiatric medication and/or were told they did not have a mental illness despite having a diagnosis from a mental health professional (Stanford, 2007). Interventions to decrease religious mental health stigma could possibly lower unnecessary suffering in the lives of religious individuals.

Conclusion

The creation of the religious mental health stigma scale is an important step in contiunuing the research in this area. First of all, it makes possible doing quantitative research in the area – something that has been sorely lacking. In addition, in the creation of the scale, it was discovered that there appears to be at least two distinct elements to religious mental health stigma, personal beliefs and beliefs of the religious community. These appear to relate to other, secular stigma scales in similar but distinct ways, including the interesting difference in how each factor differentially relates to religious commitment. The religious community beliefs about mental illness factor appears to be the most unique in this study, as it had no correlation with the previously developed Religious Beliefs about Mental Illness scale. It will be important to do future research on how these elements of religious mental health stigma relate to help-seeking processes.

المنارة للاستشارات
www.manaraa.com

CHAPTER 6. REFERENCES

Abdullah, T. & Brown, T. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review*, 31, 934-948.

Al-Krenawi, A. (1999). Social work and Koranic mental health healers. *International Social Work*, 42(1), 53-65.

Amazon.com. (1996-2014). *Battlefield of the Mind: Winning the Battle in Your Mind* by Joyce Meyer. Retrieved from http://www.amazon.com/Battlefield-Mind-Winning-Battle-Your/dp/0446691097.

Amazon.com. (1996-2014). *Your Best Life Now: 7 Steps to Living at Your Full Potential* by Joel Osteen. Retrieved from http://www.amazon.com/Your-Best-Life-Now-Potential-ebook/dp/B0042JSPQ6/ref=sr_1_1?s=books&ie=UTF8&qid=1398732331&sr=1-1&keywords=your+best+life+now.

Bathje, G.J. & Pryor, J.B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, 33(2), 161-177.

Ben-Porath, D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behavior and the presence of depression. *Journal of Social and Clinical Psychology, 21*, 400-413.

Bornsheuer, J., Henriksen, R., & Irby, B. (2012). Psychological care provided by the church: Perceptions of Christian church members. *Counseling & Values*, 57(2), 199-213.

Borras, L., Mohr, S., Brandt, P. Y., Gillieron, C., Eytan, A., Huguelet, P. (2007). Religious beliefs in schizophrenia: Their relevance for adherence to treatment. *Schizophrenia Bulletin*, 33(5), 1238-1246.

المنارة للاستشارات
www.manaraa.com

Butcher, J.N., Hooley, J.M., & Mineka,S. (2014). *Abnormal Psychology (16th ed.).* Boston: Pearson.

Caplan, S., Paris, M., Whittemore, R., Desai, M., Dixon, J., Alvidrez, J., Escobar, J., & Scahill, L. (2011). Correlates of religious, supernatural and psychosocial causal beliefs about depression among Latino immigrants in primary care. *Mental Health, Religion & Culture*, 14(6), 589-611.

Carlson, D.L. (1998). Exposing the Myth That Christians Should Not Have Emotional Problems. *Christianity Today*, 42(2). Retrieved from http://www.christianitytoday.com/ct/1998/february9/8t2028.html.

Centers for Disease Control and Prevention. (2010). Attitudes Toward Mental Illness: 35 States, District of Columbia, and Puerto Rico. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a3.htm.

Cinnirella, M. & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: a qualitative interview study. *British Journal of Medical Psychology*, 72(4), 505-524.

Corrigan, P., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventative Psychology*, 11, 179-190.

Cowan, S. (2003). NIMBY syndrome and public consultation policy: The implications of a discourse analysis of local responses to the establishment of a community mental health facility. *Health and Social Care in the Community*, 11(5), 379-87.

Crede, M. (2010). Random responding as a threat to the validity of effect size estimates in correlational research. *Educational and Psychological Measurement, 70,* 596-612.

المنارة للاستشارات
www.manaraa.com

Crosby, J.W. & Bossley, N. (2012). The religiosity gap: preferences for seeking help from religious advisors. *Mental Health, Religion, & Culture*,15(2), 141-159.

Crowne, D. & Marlowe, D. (1960). A new scale of social desirability independent psychopathology. *Journal of Consulting Psychology*, 24: 349-354.

Cummings, J.P. & Pargament, K.I. (2010). Medicine for the Spirit: Religious Coping in Individuals with Medical Conditions. *Religions*, 1(1), 28-50.

DeVellis, R.F. (2003). *Scale Development: Theory and Applications (2nd Ed.).* Thousand Oaks, CA: SAGE Publications.

Farina, A. & Felner, R.D. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology*, 82(2), 268-272.

Farrell, J. L., & Goebert, D. A. (2008). Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. *Psychiatric Services*, 59(4), 437-440.

Fischer, E.H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, *36*, 368-373.

Fischer, E.H., & Turner, J. (1970). Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*, 79-90.

Flesch, R.F. (1948). A New Readability Yardstick. *Journal of Applied Psychology,* 32: 221-33.

Flesch, R.F. (1979). *How to Write in Plain English: A Book for Lawyers and Consumers*. New York, NY: Harper

Gallup Poll Organization. (2008). *Americans believe religion is losing clout*. Wilmington, DE: Scholarly Resources.

المنارة للاستشارات
www.manaraa.com

George, L.K., Ellison, C.G., & Larson, D.B. (2002). Explaining the Relationships between Religious Involvement and Health. *Psychological Inquiry*, 13(3), 190-200.

Goldberg, L. R. (1999). A broad-bandwidth, public domain, personality inventory measuring the lower-level facets of several five-factor models. In I. Mervielde, I. Deary, F. De Fruyt, & F. Ostendorf (Eds.), *Personality Psychology in Europe*, Vol. 7 (pp. 7-28). Tilburg, The Netherlands: Tilburg University Press.

Goldberg, L. R., Johnson, J. A., Eber, H. W., Hogan, R., Ashton, M. C., Cloninger, C. R., & Gough, H. C. (2006). The International Personality Item Pool and the future of public-domain personality measures. *Journal of Research in Personality*, *40*, 84-96.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* New York, NY: Simon & Schuster, Inc.

Gow, A. J., Whiteman, M. C., Pattie, A., & Deary, I. J. (2005). Goldberg's 'IPIP' Big-Five factor markers: Internal consistency and concurrent validation in Scotland. *Personality and Individual Differences*, *39*, 317-329.

Hartog, K. & Gow, K. M. (2005) Religious Attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion, & Culture*. 8(4): 263-276.

Hedayat-Diba, Z. (2014). *Handbook of Psychotherapy and Religious Diversity* (2nd Ed). Richards, P.S. & Bergin, A.E. (eds). Washington, DC: American Psychological Association.

Henderson, C., Evans-Lacko, S., Flach, C., & Thornicroft, G. (2012). Responses to Mental Health Stigma Questions: The Importance of Social Desirability and Data Collection Method. *The Canadian Journal of Psychiatry*, 57(3): 152-160.

المنارة للاستشارات
www.manaraa.com

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help-seeking, and public health programs. American Journal of Public Health, 103(5), 777-780.

Howard, M.C. (2016). A review of exploratory factor analysis decisions and overview of current practices: What we are doing and how can we improve? *International Journal of Human-Computer Interaction*, 32(1), 51-62.

Hu, L.-T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling*, 6, 1–55.

Huang, C. L. C., Shang, C. Y., Shieh, M. S., Lin, H. N., & Su, J. C. J. (2011). The interactions between religion, religiosity, religious delusion/hallucination, and treatment-seeking behavior among schizophrenic patients in Taiwan. *Psychiatry Research*, 187, 347-353.

Igbinomwanhia, N. G., James, B. O., & Omoaregba, J. O. (2013). The attitudes of clergy in Benin City, Nigeria towards persons with mental illness. African journal of psychiatry, 16(3), 2013, 196-200.

Irmak, M. K. (2014). Schizophrenia or Possession? *Journal of Religion and Health*; 53(3), 773-777.

Jones, D.L., Cassidy, L., & Heflinger, C.A. (2012). "You can talk to them. You can pray." Rural clergy responses to adolescents with mental health concerns. *Rural Mental Health*, 2012 (Spring/Summer), 24-33.

Jorm, A., & Wright, A. (2008). Influences on young people's stigmatizing attitudes toward peers with mental disorders: National survey of young Australians and their parents. *British Journal of Psychiatry, 192*, 144-149.

المنارة للاستشارات

www.manaraa.com

Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV Disorders in the National Comorbity Survey Replication (NCS-R). Archives of General Psychiatry, 62(2), 617-627.

Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology, 42,* 40–46.

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

Komiya, N., Good, G., & Sherod, N. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*, 138-143.

Lannin, D., Vogel, D., Brenner, R., & Tucker, J. (2015). Predicting self-esteem and intentions to seek counseling: The internalized stigma model. *The Counseling Psychologist*, 43(1), 64-93.

Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science and Medicine*, 65(5), 548-559.

Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry*, 47(4), 571-590.

Lee, D. & Lim, H. (2008). Scale Construction. In *Research Design in Counseling (3rd. Ed).* Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (*eds*). Belmont, CA: Brooks/Cole, Cengage Learning.

Link, B.G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52(2): 96-112.

المنارة للاستشارات
www.manaraa.com

Link, B. G., Cullen, F. T., Struening, E. L., Shrout, P. E., & Dohrenwend, B.P. (1989). A modified labeling theory approach to mental disorders: an empirical assessment. *American Sociological Review,* 54, 400-423.

Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27; 363-385.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A., & Pescosolido, B.A. (1999). Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, & Social Distance. *American Journal of Public Health*, 89(9); 1328-33.

Loewenthal, K. M., Macleod, A. K., Lee, M., Cook, S., & Goldblatt, V. (2002). Tolerance for depression: are there cultural and gender differences? *Journal of Psychiatric and Mental Health Nursing*, 9, 681-688.

Loo, R. & Thorpe, K. (2000). Confirmatory Factor Analysis of the full and short versions of the Marlowe-Crowne Social Desirability Scale. *Journal of Social Psychology*, 140(5): 628-635.

Lurigio, A. (2013). Forty years after Abramson - Beliefs about the criminalization of people with serious mental illness. *International Journal of Offender Therapy and Comparative Criminology*, 57(7), 763-5.

Lyles, M. R. (1992). Mental health perceptions of Black pastors: Implications for psychotherapy with Black patients. *Journal of Psychology and Christianity*, 11(4), 368-277.

Mathews, M. (2008). Explanatory models for mental illness endorsed by Christian clergymen: The development and use of an instrument in Singapore. *Mental Health, Religion & Culture*, 11(3), 287-300.

المنارة للاستشارات

www.manaraa.com

Mathison, L.A. & Wade, N.G. (2014, August). Religious Mental Health Stigma as a Unique Barrier to Care: A Critical Review of the Literature. In N.G. Wade (Chair), *Religion and Spirituality in Counseling: The Cutting Edge*. Symposium conducted at the meeting of the American Psychological Association, Washington, DC.

Mayers, C., Leavey, G., Villianatou, C., & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy*, 317-327.

McLatchie, L. R., & Draguns, J. G. (2001). Mental Health Concepts of Evangelical Protestants. *The Journal of Psychology*, 118(2), 147-159.

Mental Health America of Eastern Missouri (2011). Articles: Mental heath, treatment, and stigma statistics. Retrieved from http://mha-em.org/index.php?option=com_content&view=article&id=132:mental-health-treatment-and-stigma-statistics&catid=12:media.

Mercer, J. (2013). Deliverance, demonic possession, and mental illness: some considerations for mental health professionals. *Mental Health, Religion, & Culture*, 16(6), 595-611.

Michaels, P. & Corrigan, P. (2013). Measuring mental illness stigma with diminished social desirability effects. *Journal of Mental Health*, 22(3): 218-226.

Mitchell, L. & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: their relevance for illness management. *Journal of Affective Disorders*, 75(3), 247-257.

Moran, M., Flannely, K. J., Weaver, A. J., Overvold, J. A., Hess, W., & Wilson, J. C. (2005). A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area. Pastoral Psychology, 53(3), 255-266.

www.manaraa.com

Ng, T. P., Nyunt, M. S. Z., Chiam, P. C., & Kua, E. H. (2011). Religion, health beliefs and the use of mental health services by the elderly. *Aging & Mental Health*, 15(2), 143-149.

Osborne, J.W., Blanchard, M.R. (2011). Random responding from participants is a threat to the validity of social science research results. *Front. Psychology, 1,* 220.

Patil, V.H., Singh, S.N., Mishra, S., Donovan, D.T. (2007). "Parallel Analysis Engine to Aid Determining Number of Factors to Retain" [Computer Software]. Available from http://smishra.faculty.ku.edu/parallelengine.htm.

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

Pfeifer, S. (2000). Religious interpretations of mental distress - empirical findings and clinical implications. *Psyche en Geloof*, 11(2), 86-97.

Rabinowitz, A. (2014). *Handbook of Psychotherapy and Religious Diversity* (2nd Ed). Richards, P.S. & Bergin, A.E. (eds). Washington, DC: American Psychological Association.

Reynolds, W. (1982). Development of reliable and valid short forms of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology*, 38(1): 119-125.

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.

Royal, K. D. & Thompson, J. M. (2012). Measuring Protestant Christians' willingness to seek professional psychological help for mental illness: A Rasch Measurement Analysis. *Journal of Psychology and Christianity*, 31(3), 195-204.

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

المنارة للاستشارات
www.manaraa.com

Stanford, M. S. & Philpott, D. (2011). Baptist senior pastors' knowledge and perceptions of mental illness. *Mental Health, Religion, and Culture*, 14(3), 281-290.

Stier, A. & Hinshaw, S. (2008). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*, 102(2): 106-117.

Tabachnick, B.G. & Fidell, L.S. (2013). *Using Multivariate Statistics (6th Ed.)*. Boston: Pearson.

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.

Trice, P. D. & Bjorck, J. P. (2006). Pentecostal perspectives on causes and cures of depression. *Professional Psychology*, 37(3), 283-294.

Tucker, J., Hammer, J., Vogel, D., Bitman, R., Wade, N., & Maier, E. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, 60(4), 520-531.

U.S. Department of Health and Human Services (1999). Mental health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Retrieved from http://profiles.nlm.nih.gov/ps/access/NNBBHS.ocr.

United States Department of Health and Human Services (USDHHS) (2001). *Mental health: Culture, race and ethnicity – a supplement to mental health: A report of the surgeon general (US Public Health Service No. 01-3613).* Rockville, MD: Substance Abuse and Mental Health Services Administration.

المنارة للاستشارات
www.manaraa.com

VanderWaal, C.J., Hernandez, E. I., & Sandman, A. R. (2012). The Gatekeepers: Involvement of Christian clergy in Referrals and collaboration with Christian social workers and other helping professionals. *Social Work and Christianity*, 39(1), 27-51.

Village, A. (2005). Dimensions of belief about miraculous healing. *Mental Health, Religion, and Culture*, 8(2), 97-107.

Vogel, D., Wade, N., & Hackler, A. (2007). Perceived public stigma and the willingness to seek counseling: Mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54(1), 40-50.

Vogel, D. & Wester, S. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology*, 50(3), 351-61.

Wang, P.S., Berglund, P.A., Olfson, M., & Kessler, R.C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research*, 39(2), 393-416.

Webb, M., Stetz, K., and Hedden, K. (2008). Representation of mental illness in Christian self-help bestsellers. *Mental Health, Religion, & Culture*, 11(7), 697-717.

Wesselman, E. D., & Graziano, W. G. (2010). Sinful and/or Possessed? Religious Beliefs and Mental Illness Stigma. *Journal of Social and Clinical Psychology*, 402-437.

Worthington, E., Wade, N., Hight, T., Ripley, J., McCullough, M., Berry, J., Schmitt, M., Berry, J., Bursley, K., & O'Connor, L. (2003). Religious Commitment Inventory – 10: Development, refinement, and validation of a brief scale. *Journal of Counseling Psychology*, 50(1), 84-96.

Worthington, R.L. & Whittaker, T.A. (2006). Scale development research: A content analysis and recommendations for best practices. *The Counseling Psychologist*, 34(6), 806-838.

المنارة للاستشارات

www.manaraa.com

Yamada, A., Lee, K. K., & Kim, M. A. (2012). Community mental health allies: Referral behavior among Asian American immigrant Christian clergy. *Community Mental Health Journal*, 48, 107-113.

Young, J. L., Griffith, E. E. H., & Williams, D. R. (2003). The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatric Services*, 54(5), 688-692.

Zippay, A. & Sun, K.L. (2008). Neighbors' perceptions of community based psychiatric housing. *Social Science Review*, 82(3), 395-417.

المنارة للاستشارات

www.manaraa.com

CHAPTER 7. APPEDICES

APPENDIX A: STUDY MATERIALS

RMHSS - CJ
DIRECTIONS: Please read each statement and click the circle corresponding to the degree to which you agree or disagree with the statement.

In answering, please refer to the following definitions:

For the phrase *God or the divine* please think of a word or phrase that best fits your concept of the one supreme being or deity such as Yahweh, Jesus, Allah, or G-d.

Mental illness, for the purpose of this study, refers to any mental illness recognized by mental health professionals, including but not limited to depression, anxiety, bipolar, schizophrenia, substance use disorders, and personality disorders.

Psychiatric medication refers to any medication used to treat mental illness, including but not limited to antidepressants (e.g. Prozac), antianxiety medication (e.g. Xanax), antipsychotics (e.g. Seroquel), and mood stabilizers (e.g. lithium).

Mental health professional refers to any professional trained in the treatment of persons suffering from mental illness including but not limited to psychologists, clinical social workers, marriage and family therapists, substance abuse counselors, and psychiatrists.

Factor 1: Personal Religious Beliefs about Mental Health Care (Personal)
16. If I struggled with a mental illness, it would be a result of my own sin.
28. Taking psychiatric medication would feel like giving up on *God or the divine*.
35. I would feel as if I were failing religiously if I got help from a mental health professional.
37. A person who is devoted to their religious beliefs and practices would not have psychological difficulties.
40. A person with a mental illness is being attacked, oppressed, or possessed by spirits (e.g. demons, jinn, dybbuk).
43. Getting help from a mental health professional is against my religious or spiritual beliefs.

Factor 2: Religious Community Beliefs about Mental Illness (Community)
1. Most people in my religious community would treat a person with mental illness just as they would treat anyone else.
5. Most people in my religious community would believe that a person with a mental illness were just as devoted to their religion as any other person in that community.
7. Most people in my religious community would willingly accept a religious leader who had a mental illness.
17. Most people in my religious community would be willing to accept a person with mental illness as a close friend.
24. Most people in my religious community would accept a person with mental illness as a children's religious teacher.

المنارة للاستشارات
www.manaraa.com

<u>RMHSS – Mass Testing and SONA</u>
DIRECTIONS: Please read each statement and click the circle corresponding to the degree to which you agree or disagree with the statement.

In answering, please refer to the following definitions:

For the phrase *God or the divine* please think of a word or phrase that best fits your concept of the one supreme being or deity such as Yahweh, Jesus, Allah, or G-d.

Mental illness, for the purpose of this study, refers to any mental illness recognized by mental health professionals, including but not limited to depression, anxiety, bipolar, schizophrenia, substance use disorders, and personality disorders.

Psychiatric medication refers to any medication used to treat mental illness, including but not limited to antidepressants (e.g. Prozac), antianxiety medication (e.g. Xanax), antipsychotics (e.g. Seroquel), and mood stabilizers (e.g. lithium).

Mental health professional refers to any professional trained in the treatment of persons suffering from mental illness including but not limited to psychologists, clinical social workers, marriage and family therapists, substance abuse counselors, and psychiatrists.

1. **Most people in my religious community would treat a person with mental illness just as they would treat anyone else.**
2. Getting help from a mental health professional is somewhat inappropriate for religious people regardless of what the problem is.
3. Most people in my religious community believe that having a mental illness is a sign of personal failure.
4. If I had a mental illness I would feel that I was not doing the will of *God or the divine*.
5. **Most people in my religious community would believe that a person with a mental illness were just as devoted to their religion as any other person in that community.**
6. Seeing a mental health professional would feel like giving up on *God or the divine*.
7. **Most people in my religious community would willingly accept a religious leader who had a mental illness.**
8. If I were experiencing a serious emotional crisis I would be confident that I could find relief by spending more time in prayer.
9. Taking psychiatric medication is against my religious community's beliefs.
10. If I were struggling emotionally or mentally I would think I was being influenced by demons or evil spirits.
11. A person should work out his or her own problems with the help of *God or the divine* instead of seeking mental health care.
12. If I had a mental illness I would think that I had not been following my religious beliefs devotedly.
13. I would be afraid to tell people in my religious community if I went to a therapist for psychological help.

المنارة للاستشارات
www.manaraa.com

14. I would feel less devoted to my religion if I went to a therapist for psychological help.
15. I would never tell people in my religious community if I struggled with a mental illness.
16. **If I struggled with a mental illness, it would be a result of my own sin.**
17. **Most people in my religious community would be willing to accept a person with mental illness as a close friend.**
18. If I was diagnosed with a mental illness I would worry that I might not gain access to the afterlife (i.e. heaven).
19. Seeking a therapist for psychological help should be a last resort, only to be used after seeking help from one's religion.
20. Most single people in my religious community would be reluctant to marry an individual with mental illness.
21. Getting help from a mental health professional could help me spiritually.
22. If I had a mental illness I would feel rejected by *God or the divine*.
23. If I had a mental illness I would be afraid that I was not on the right religious path.
24. **Most people in my religious community would accept a person with mental illness as a children's religious teacher.**
25. I would feel inadequate if I went to a therapist for psychological help instead of *God or the divine*.
26. I would feel less devoted to my religion if I took psychiatric medication.
27. A person should first turn to their religious beliefs and practices if they feel like they have an emotional or mental health concern.
28. **Taking psychiatric medication would feel like giving up on *God or the divine*.**
29. Mental illness results from the sins or wrongs an individual has committed.
30. If I were experiencing a serious emotional crisis reading my religious text (e.g. Bible, Koran, Torah) would be more effective than seeking mental health care.
31. *God or the divine* only gives me situations I can handle, so there is no need for me to seek help from a mental health professional.
32. Getting help from a mental health professional is against my religious community's beliefs.
33. Prayer is a better treatment for mental illness than mental health care.
34. Mental illness is the result of sin being in the world.
35. **I would feel as if I were failing religiously if I got help from a mental health professional.**
36. The only mental health provider a member of my faith should see is one who shares my religious beliefs.
37. **A person who is devoted to their religious beliefs and practices would not have psychological difficulties.**
38. Taking psychiatric medication would feel like giving up on my religion.
39. Most people in my religious community would think less of a person with mental illness.
40. **A person with a mental illness is being attacked, oppressed, or possessed by spirits (e.g. demons, jinn, dybbuk).**
41. Seeking a therapist for psychological help is only appropriate for very serious problems; otherwise, one should seek help from one's religion.
42. I would be afraid to tell people in my religious community if I were taking psychiatric medication.

المنارة للاستشارات
www.manaraa.com

43. **Getting help from a mental health professional is against my religious or spiritual beliefs.**
44. I would feel more comfortable talking with a religious leader about my problems than a mental health professional.

RBAMI

Factor 1:

1. Moral weakness is the main cause of mental illness.
2. People suffering from mental illnesses are not going to their places of worship enough.
3. Mental illnesses result from an immoral or sinful lifestyle.
4. People suffer from mental illnesses because they are not sorry for their sins.
5. A person suffering from a mental illness is not relying on their faith or religious values like they should.
6. A person suffering from a mental illness is not praying enough.
7. People have mental illnesses because someone else sinned against them.
8. Mental illnesses are a result of Original Sin.
9. A person's relationship with God has nothing to do with their suffering from a mental illness.*

Factor 2:

10. Demons are NOT responsible for causing the symptoms of mental illness.*
11. Compared to a religious leader, a counselor/therapist would be much better at helping someone with a mental illness.*
12. Persons suffering from mental illness are being tormented by the Devil.
13. Mental illnesses should be healed by having people pray for the afflicted person.
14. Prayer is NOT the only way to fix a mental illness.
15. God's healing is all a person suffering from a mental illness needs—nothing else should be relied on.
16. It is superstitious to believe a person suffering from mental illness is possessed by demons.*

RCI

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious organization.
10. I keep well informed about my local religious group and have some influence in its decisions.

SSRPH

1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.

المنارة للاستشارات

www.manaraa.com

3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.
4. It is advisable for a person to hide from people that he/she has seen a psychologist.
5. People tend to like less those who are receiving professional psychological help.
6. People think it is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.

Knowledge Test of Mental Illness

This is a test of your knowledge about mental illness. The questions on the test are taken from findings of scientific research. You are not expected to have read the research reports, but by using your experience and general knowledge you should be able to pick the correct answer. Some people will do much better than others because of their training in medicine, rehabilitation, or psychology. Read each question carefully and select the response you consider to be the correct answer. THERE IS NO PENALTY FOR GUESSING. There is no limit for the completion of this test, but you should work as rapidly as you can.

1. One type of psychotherapy, cognitive-behavioral therapy, has been shown to reduce the psychotic symptoms of schizophrenia.
   a. True
   b. False
2. Considering people with schizophrenia, what is the average number of separate hospitalizations for their mental illness over a one-year period of time?
   a. 4 or more
   b. 2 or less
3. People with severe mental illness cannot maintain private residences.
   a. True
   b. False
4. People with schizophrenia should be allowed to use an online dating service.
   a. True
   b. False
5. People with schizophrenia make up what percent of the homeless population?
   a. 5%
   b. 25%
6. Adolescents with schizophrenia are frequently truant from school.
   a. True
   b. False
7. People with severe mental illness are capable of establishing an intimate long-term relationship of a sexual nature.
   a. True
   b. False
8. People with schizophrenia benefit the least from services like psychotherapy.
   a. True
   b. False
9. People with schizophrenia are likely to steal from their family members.
   a. True
   b. False

المنارة للاستشارات
www.manaraa.com

10. Based on the capabilities of people with schizophrenia, school counselors should recommend beginning a job-training program rather than continuing in the regular curriculum.
    a. True
    b. False
11. For those with serious mental illness, what percent of treatment should be dedicated to medication compliance?
    a. Greater than 80%
    b. Less than 50%
12. Neglectful parenting is somewhat responsible for the beginning of a serious mental illness.
    a. True
    b. False
13. A person with schizophrenia is capable of being a physician or medical doctor.
    a. True
    b. False
14. The divorce rate among the general population is about 50%. What is the divorce rate among people who experience mental illness?
    a. Greater than 70%
    b. Less than 50%

DD

Directions: Please read each statement and check the circle corresponding to the scale number that indicates how much you agree or disagree with the statement.

1. Most people would willingly accept a former mental patient as a close friend.
2. Most people would believe that a person who has been in a mental hospital is just as intelligent as the average person.
3. Most people believe that a former mental patient is just as trustworthy as the average citizen.
4. Most people would accept a fully recovered former mental patient as a teacher of young children in a public school.
5. Most people believe that entering a mental hospital is a sign of personal failure.
6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time.
7. Most people think less of a person who has been in a mental hospital.
8. Most employers will hire a former mental patient if s/he is qualified for the job.
9. Most employers will pass over the applicant of a former mental patient in favor of another applicant.
10. Most people in my community would treat a former mental patient just as they would treat anyone.
11. Most young people would be reluctant to date an individual who has been hospitalized for a serious mental disorder.
12. Once they know a person has been in a mental hospital, most people will take his or her opinions less seriously.

المنارة للاستشارات
www.manaraa.com

SSOSH

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

SSOMI

Directions: People at times find that they face mental health problems. This can bring up reactions about what mental illness would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react if you were to have a mental illness.

1. I would feel inadequate if I had a mental illness.
2. My self-confidence would NOT be threatened if I had a mental illness.
3. Having a mental illness would make me feel less intelligent.
4. My self-esteem would decrease if I had a mental illness.
5. My view of myself would not change just because I had a mental illness.
6. It would make me feel inferior to have a mental illness.
7. I would feel okay about myself if I had a mental illness.
8. If I had a mental illness, I would be less satisfied with myself.
9. My self-confidence would remain the same if I had a mental illness.
10. I would feel worse about myself if I had a mental illness.

ATTSPPH-SF

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. 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.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

المنارة للاستشارات

www.manaraa.com

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

ISCI

Instructions: Below is a list of issues people commonly bring to counseling. How likely would you be to seek counseling/therapy if you were experiencing these problems?

Relationship difficulties
Concerns about sexuality
Depression
Conflict with parents
Speech anxiety
Difficulty in sleeping
Inferiority feelings
Difficulty with friends
Self-understanding
Loneliness
Difficulties dating
Choosing a major
Test Anxiety
Academic work procrastination

MCSD

1. Before voting I thoroughly investigate the qualifications of all the candidates.
2. I never hesitate to go out of my way to help someone in trouble.
3. It is sometimes hard for me to go on with work if I am not encouraged.
4. I have never intensely disliked anyone.
5. On occasion I have doubts about my ability to succeed in life.
6. I sometimes feel resentful when I don't get my way.
7. I am always careful about my manner of dress.
8. My table manners at home are as good as when I eat out in a restaurant.
9. If I could get into a movie without paying and be sure I was not seen I would probably do it.
10. On a few occasions, I have given up doing something because I thought too little of my ability.
11. I like to gossip at times.
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. No matter who I'm talking to, I'm always a good listener.
14. I can remember "playing sick" to get out of something.
15. There have been occasions when I took advantage of someone.
16. I'm always willing to admit it when I make a mistake.
17. I always try to practice what I preach.
18. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.
19. I sometimes try to get even rather than forgive and forget.

المنارة للاستشارات
www.manaraa.com

20. When I don't know something I don't mind at all admitting it.
21. I am always courteous, even to people who are disagreeable.
22. At times I have really insisted on having things my own way.
23. There have been occasions when I felt like smashing things.
24. I would never think of letting someone else be punished for my wrong-doings.
25. I never resent being asked to return a favor.
26. I have never been irked when people expressed ideas very different from my own.
27. I never make a long trip without checking the safety of my car.
28. Where have been times when I was quite jealous of the good fortune of others.
29. I have almost never felt the urge to tell someone off.
30. I am sometimes irritated by people who ask favors of me.
31. I have never felt that I was punished without cause.
32. I sometimes think when people have a misfortune they only got what they deserved.
33. I have never deliberately said something that hurt someone's feelings.

IPIP-N

How Accurately Can You Describe Yourself?

Describe yourself as you generally are now, not as you wish to be in the future. Describe yourself as you honestly see yourself, in relation to other people you know of the same sex as you are, and roughly your same age. So that you can describe yourself in an honest manner, your responses will be kept in absolute confidence.

Indicate for each statement whether it is 1. Very Inaccurate, 2. Moderately Inaccurate, 3. Neither Accurate Nor Inaccurate, 4. Moderately Accurate, or 5. Very Accurate as a description of you.

1. Get stressed out easily
2. Am relaxed most of the time.
3. Worry about things.
4. Seldom feel blue.
5. Am easily disturbed.
6. Get upset easily.
7. Change my mood a lot.
8. Have frequent mood swings.
9. Get irritated easily.
10. Often feel blue.

Demographic Questionnaire

Age (in years):

Gender:

Race/Ethnicity:

المنارة للاستشارات

www.manaraa.com

International Student?

- Yes
- No

Please select which best describes your religious/spiritual beliefs (select all that apply):

- Christian, Protestant
- Catholic
- Christian, Other (Please Specify):
- Islam
- Judaism
- Buddhism
- Agnosticism
- Atheism
- None
- Other (Please Specify):

If you attend religious/spiritual meetings, services, or activities please specify how frequently:

- Less than once per month
- Once per month
- 2-3 times per month
- Once per week
- More than once per week
- I used to attend religious/spiritual meetings, services, or events but do not now
- I do not religious/spiritual meetings, services, or events nor have I in the past

Familiarity with mental illness (Select all that apply)

- None
- Taken a class
- Personal experience, Self
- Personal experience, Family Member
- Personal experience, Other (Please Specify):

If you selected "personal experience" above, please specify with which mental illness(es):

المنارة للاستشارات
www.manaraa.com

Materials Sent to First Two Expert Reviewers

My name is Lily Mathison and I am a doctoral student in Counseling Psychology at Iowa State University. For my master's thesis, I am endeavoring to create a measure of religious mental health stigma. This information would be used in future research and/or in clinical settings to better understand patients' concerns and experiences. To make this measure the best it can be I need input from experts and professionals in the fields of religion and mental health – which is why I have contacted you. It would be extremely helpful if you would take a few moments to review and comment on the four items listed below.

Religious Mental Health Stigma Survey

I. Please review the definitions of religious mental health stigma and comment on the appropriateness or inappropriateness of the definition. Your insights on how these definitions fits or do not fit with certain religious groups are particularly welcomed.

Definitions

For the purpose of this study, *Religious Mental Health Stigma* (RMHS) is conceptualized as the public and self-stigma associated with mental illness and seeking psychological help in religious communities. Of special interest are beliefs about sin, morality and beliefs about the spiritual and/or religious causes and treatments of mental illness. While RMHS may possibly be found in any religion, this study is limited to assessing the stigma in the Abrahamic religions (Judaism, Christianity and Islam).

Religious public stigma of mental illness (RPSMI) is defined as the stigma that emerges from the beliefs, practices, and/or traditions of a religious community toward individuals considered mentally ill.

Religious public stigma of psychological help-seeking (RPSPHS) is defined as the stigma that emerges from the beliefs, practices, and/or traditions of a religious community toward individuals who seek and/or receive mental health care.

Religious self-stigma of mental illness (RSSMI) is defined as the religious stigma of mental illness that has been internalized by an individual who has a mental illness, causing them to devalue and stigmatize themselves.

Religious self-stigma of psychological help-seeking (RSSPHS) is defined as the religious stigma of mental illness that has been internalized by an individual who seeks and/or receives mental health care, causing them to devalue and stigmatize themselves.

Mental illness, for the purpose of this study, refers to any mental illness recognized by mental health professionals, including but not limited to depression, bipolar, schizophrenia, substance abuse, and personality disorders.

المنارة للاستشارات
www.manaraa.com

Psychiatric medication refers to any medication used to treat mental illness, including but not limited to antidepressants (e.g. Prozac), antipsychotics (e.g. Seroquel), and mood stabilizers (e.g. lithium).

Mental health professional refers to any professional trained in the mental health field who provides counseling for mental illness, psychotherapy, or talk therapy. Some examples include psychologists, clinical social workers, marriage and family therapists, substance abuse counselors, and psychiatrists who do talk therapy.

II. Please rate the degree to which these items assess each respective facet of religious mental health stigma, as defined above.

RHMSS

DIRECTIONS: Please read each statement and click the circle corresponding to the degree to which you agree or disagree with the statement.

In answering, please refer to the following definitions:

God or the divine will serve as a placeholder for the word or phrase that best describes your concept of the one supreme being or deity. Other such names may include Yahweh, Jesus, Allah, or G-d.

Mental illness, for the purpose of this study, refers to any mental illness recognized by mental health professionals, including but not limited to depression, bipolar, schizophrenia, substance abuse, and personality disorders.

Psychiatric medication refers to any medication used to treat mental illness, including but not limited to antidepressants (e.g. Prozac), antipsychotics (e.g. Seroquel) and mood stabilizers (e.g. lithium).

Mental health professional refers to any individual who does counseling for mental illness, psychotherapy, or talk therapy. Some examples include psychologists, clinical social workers, marriage and family therapists, substance abuse counselors, and psychiatrists who do talk therapy.

Religious Public Stigma Mental Illness

1. A person with a mental illness is being attacked, oppressed, or possessed by spirits (e.g. demons, jinn, dybbuk).
2. A person who is faithful to their religious beliefs and practices would not have psychological difficulties.
3. Mental illness results from the sins an individual has committed.
4. Mental illness is the result of sin being in the world.
5. Most people in my religious community would be willing to accept a person with mental illness as a close friend.
6. Most people in my religious community would think less of a person with mental illness.

المنارة للاستشارات

www.manaraa.com

7. Most single people in my religious community would be reluctant to marry an individual with mental illness.
8. Most people in my religious community would accept a person with mental illness as a children's religious teacher.
9. Most people in my religious community would believe that a person with a mental illness is just as faithful to their religion as any other person in that community.
10. Most people in my religious community would willingly accept a religious leader who had a mental illness.
11. Most people in my religious community would treat a person with mental illness just as they would treat anyone else.
12. Most people in my religious community believe that having a mental illness is a sign of personal failure.

Religious Public Stigma of Psychological Help-Seeking

13. Prayer is one of the best treatments for mental illness.
14. Getting help from a mental health professional is somewhat inappropriate for religious people.
15. A person should first turn to their religious beliefs and practices if they feel like they have an emotional or mental health concern.
16. Getting help from a mental health professional is against my religious community's beliefs.
17. Taking psychiatric medication is against my religious community's beliefs.
18. A person should work out his or her own problems with the help of *God or the divine*.
19. Seeking a therapist for psychological help should be a last resort, only to be used after seeking help from one's religion.
20. Seeking a therapist for psychological help is only appropriate for very serious problems; otherwise, one should seek help from one's religion.
21. The only mental health provider a member of my faith should see is one who shares our religious beliefs.
22. Secular (nonreligious) therapists do more harm than good.
23. Secular (nonreligious) therapy is not helpful because it rests on beliefs that are wrong.
24. A secular (nonreligious) therapist can be just as effective as a nonreligious therapist can.

Religious Self-Stigma of Mental Illness

25. If I was struggling emotionally or mentally I would think I was being influenced by evil spirits (e.g. demons, jinn, dybbuk).
26. If I struggled with a mental illness, it would be a result of my own sin.
27. I would never tell people in my religious community if I struggled with a mental illness.
28. If I had a mental illness I would feel rejected by *God or the divine*.
29. If I had a mental illness I would feel that I was not doing the will of *God or the divine*.
30. If I had a mental illness I would think that I had not been following my religious beliefs faithfully.
31. If I had a mental illness I would be afraid that I was not on the right religious path.
32. If I was diagnosed with a mental illness I would worry that I might not gain access to the afterlife (i.e. heaven).

المنارة للاستشارات
www.manaraa.com

Religious Self-Stigma of Psychological Help-Seeking

33. Taking psychiatric medication would feel like giving up on *God or the divine*.
34. Taking psychiatric medication would feel like giving up on my religion.
35. Seeing a mental health professional would feel like giving up on *God or the divine*.
36. Seeing a mental health professional would feel like giving up on my religion.
37. I would feel less faithful to my religion if I went to a therapist for psychological help.
38. I would feel less faithful to my religion if I took psychiatric medication.
39. I would be afraid to tell people in my religious community if I went to a therapist for psychological help.
40. I would be afraid to tell people in my religious community if I were taking psychiatric medication.
41. Getting help from a mental health professional could help me spiritually.
42. I would feel as if I were failing religiously if I got help from a mental health professional.
43. I would feel more comfortable talking with a religious leader about my problems than a mental health professional.
44. I would feel inadequate if I went to a therapist for psychological help instead of *God or the divine*.
45. Getting help from a mental health professional is against my religious or spiritual beliefs.
46. *God or the divine* only gives me situations I can handle, so there is no need for me to seek help from a mental health professional.
47. If I were to experience a serious emotional crisis I would be confident that I could find relief by going to my place of worship/prayer.
48. If I were experiencing a serious emotional crisis I would be confident that I could find relief in reading my religious text (e.g. Bible, Koran, Torah).
49. If I were experiencing a serious emotional crisis I would be confident that I could find relief by spending more time in prayer.
50. If I were experiencing a serious emotional crisis I would be confident that I could find relief by through the prayers of a religious leader.

Other

51. All things that happen, both good and bad, are the will of *God or the divine*.

Open questions:

What is the first thing you would do to get help if you believed you were having a mental breakdown?

III. Please list two or more items that are relevant to the issue of religious mental health stigma that are not captured in the items above or reword an above item to make it more applicable.

IV. Please list any other thoughts/concerns/ideas/etc. you might have concerning religious stigma and mental illness.

المنارة للاستشارات

www.manaraa.com

APPENDIX B: IRB APPROVAL SHEET

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

Date: 8/18/2015

To: Lily Mathison
W113 Lagomarcino Hall

CC: Dr. Nathaniel Wade
W112 Lagomarcino

From: Office for Responsible Research

Title: Attitudes towards Mental Illness/Religion

IRB ID: 15-325

Approval Date: 8/17/2015 **Date for Continuing Review:** 8/16/2017

Submission Type: New **Review Type:** Expedited

The project referenced above has received approval from the Institutional Review Board (IRB) at Iowa State University according to the dates shown above. Please refer to the IRB ID number shown above in all correspondence regarding this study.

To ensure compliance with federal regulations (45 CFR 46 & 21 CFR 56), please be sure to:

- **Use only the approved study materials** in your research, **including the recruitment materials and informed consent documents that have the IRB approval stamp.**
- **Retain signed informed consent documents for 3 years after the close of the study**, when documented consent is required.
- **Obtain IRB approval prior to implementing any changes** to the study by submitting a Modification Form for Non-Exempt Research or Amendment for Personnel Changes form, as necessary.
- **Immediately inform the IRB of** (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems involving risks** to subjects or others.
- **Stop all research activity if IRB approval lapses**, unless continuation is necessary to prevent harm to research participants. Research activity can resume once IRB approval is reestablished.
- **Complete a new continuing review form** at least three to four weeks prior to the **date for continuing review** as noted above to provide sufficient time for the IRB to review and approve continuation of the study. We will send a courtesy reminder as this date approaches.

Please be aware that IRB approval means that you have met the requirements of federal regulations and ISU policies governing human subjects research. **Approval from other entities may also be needed.** For example, access to data from private records (e.g. student, medical, or employment records, etc.) that are protected by FERPA, HIPAA, or other confidentiality policies requires permission from the holders of those records. Similarly, for research conducted in institutions other than ISU (e.g., schools, other colleges or universities, medical facilities, companies, etc.), investigators must obtain permission from the institution(s) as required by their policies. **IRB approval in no way implies or guarantees that permission from these other entities will be granted.**

Upon completion of the project, please submit a Project Closure Form to the Office for Responsible Research, 1138 Pearson Hall, to officially close the project.

Please don't hesitate to contact us if you have questions or concerns at 515-294-4566 or IRB@iastate.edu.

المنارة للاستشارات
www.manaraa.com

AKNOWLEDGEMENTS

I would like to take this opportunity to thank those who helped me with various aspects of conducting research and the writing of this thesis. First and foremost, I would like to thank Dr. Nathaniel Wade for his guidance, flexibility, and encouragement throughout the process. His energy and excitement are contagious, his insights have proven valuable, and his support has been indispensable throughout the last few years. I would also like to thank my committee members for their efforts and contributions to this work: Dr. Marcus Crede and Dr. David Vogel. I would additionally like to thank Dr. Meifen Wei for her aid in running analyses and all of the expert panelists who reviewed my scale and provided their invaluable suggestions.

المنارة للاستشارات

www.manaraa.com