January 2019

A Consensual Qualitative Review Exploring Mental Health Stigma And Its Impact On Psychological Help-Seeking Among Fundamentally Religious Individuals

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A CONSENSUAL QUALITATIVE REVIEW EXPLORING MENTAL HEALTH STIGMA AND ITS IMPACT ON PSYCHOLOGICAL HELP-SEEKING AMONG FUNDAMENTALLY RELIGIOUS INDIVIDUALS

by

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A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota

August
2019

This dissertation, submitted by Teresa Louise Huff-Pomstra, in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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Degree Doctor of Philosophy

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Teresa Louise Huff-Pomstra
May 24, 2019

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ACKNOWLEDGMENTS

I wish to express my sincere gratitude to the members of my advisory Committee for their guidance, support, and input during this process of producing a dissertation study. I also want to thank Trevor Waagen, Neha Batool, and Joel Cote-Kanning for their work and contribution in analyzing the transcripts and data. You made this project possible!

To my dad, for always pushing me academically, and to my mom, for believing I can do anything. Most of all, to Mareah, my incredible partner and best friend, for supporting and encouraging me every long step of the way. You make it all worthwhile.

ABSTRACT

Despite the wide range and availability of mental health (MH) treatment and resources, individuals with MH concerns often do not seek out treatment, with stigma presenting as a significant barrier to help-seeking. Various multicultural factors may interact with stigma, such as race or gender, and together may impact the HS process. One factor in particular, one's religious beliefs, may be influential in how someone goes about addressing their MH. Religious faith holds an important place for many Americans, with 77% professing identification with some religion (Pew Research Center, 2014). The goal of this Consensual Qualitative Research project was to explore how those holding fundamental Christian beliefs experienced MH and stigma and how they navigated seeking help for their mental health. Five themes/domains emerged from the data collected from nine participants: (a) Religion provides guidance and greater purpose; (b) Faith alleviates mental health concerns; (c) Perceived support from religious community /"family"; (d) Perceived stigma; and (e) Religious identities guide help-seeking behavior. The results provided insights into the roles God and religious belief hold for fundamental Christians, and how this guides the ways they seek out assistance, including who they trust in addressing MH concerns. Findings revealed overall preferences for Christian sources of support and help, including religious practices such as prayer. Also discussed are implications of these findings, specifically for client care and counselor training programs. Finally, future directions for research are suggested.

CHAPTER I

INTRODUCTION

"Imagine if you got blamed for having cancer."
Public service campaign, bringchange2mind.org advocacy organization

Mental health issues have become widespread and commonly experienced in the modern age, affecting individuals across the lifespan. Concerns involving psychological well-being range from stress, experienced almost as routinely as the common cold, as shown in a 2006 US survey indicating 57% of American adults experienced at least moderate amounts of stress in the two weeks prior to the survey (Evers et al., 2006), to serious and persistent mental illnesses such as schizophrenia. In 2014, statistics gathered on Americans aged 18 or older indicated 43.6 million (or 18.1%) individuals in this population experienced a mental illness, defined as any emotional, behavioral, or mental disorder (Substance Abuse and Mental Health Services Administration, or SAMHSA, 2014). Furthermore, among adults 18 and older, it was estimated that 9.8 million individuals experienced a serious mental illness in the previous year. Taken together, these numbers reflect a staggering 53.4 million American adults exhibited mental health symptoms to the level of being reflected in a diagnosis.

To understand how these numbers translate into mental health conditions, the National Alliance on Mental Illness (NAMI) reports that 1 out of every 100 adults lives with schizophrenia; 16 million adults experience major depression; and 42 million Americans over 18 have an anxiety condition (NAMI, 2017). However, these statistics

only reflect those who sought out treatment in some way; they fail to capture the numerous others who did not receive mental health services. Tracking trends related to mental health conditions presents a formidable challenge, considering that when seeking help for psychological struggles, some individuals turn to psychological sources of support such as counseling or medication, though others may call upon clergy or self-help resources such as books or videos. Increasingly, people turn to their primary care physician when experiencing symptoms, particularly those related to anxiety and depression (Olfson, Kroenke, Wang, & Blanco, 2014).

Encouragingly, a plethora of mental health treatments have emerged in the last several decades. Extensive empirical research has been conducted on the efficacy of a wide range of psychological treatments addressing mental health concerns ranging from depression and anxiety to chronic and persistent illnesses such as schizophrenia. Despite the existence of treatments available, large-scale studies have shown that less than 40% of those dealing with mental health issues seek out professional assistance of any kind (Vogel, Wade, & Haake, 2006; Corrigan, 2004); furthermore, only 11% of those facing psychological concerns specifically seek out mental health-related professionals such as a counselor (Vogel et al., 2006). Globally speaking, a startling 70% or more of individuals diagnosed with a mental illness do not receive any mental health care, in part due to the presence of prejudice and discrimination (Henderson, Evans-Lacko, & Thornicroft, 2013). Given this troubling large number of untreated individuals, understanding what compels—or deters—people to seek out mental health interventions is important in removing barriers and increasing help-seeking behaviors.

Help-seeking related to mental health has received considerable attention in terms of understanding the variables that influence individuals to get professional treatment for their concerns. In a meta-analysis reviewing 40 years of data related to help-seeking among American university students, researchers discovered that between the years 1968 and 2008, attitudes toward help-seeking became increasingly negative (Mackenzie, Erickson, Deane, & Wright, 2008), with this outcome consistent with research reflecting that public stigma has increased over time as well (Pescosolido et al., 2010). Interestingly, their analysis showed that though attitudes have declined, treatment for specific disorders such as depression has risen. This rise is due primarily to increased use of pharmacotherapy, as rates of psychotherapy use have dropped. A 2004 study conducted in Australia demonstrated barriers such as lack of knowledge regarding participants' symptoms, i.e. not recognizing symptoms as mental health-related, delayed adult patients experiencing anxiety (Thompson, Hunt, & Issakidis, 2004).

The individual distress and impact mental health issues have upon its sufferers is apparent, but mental health issues have also become a serious public health threat. NAMI (2014) reports that adults with serious mental illnesses who have not received treatment experience an increased risk of developing chronic health conditions, with these same individuals dying an average of 25 years earlier than peers, in large part due to having treatable medical conditions. Additionally, suicide has emerged as the 10th leading cause of death in the U.S., and the second cause of death for individuals aged 15 to 24. Pragmatically speaking, $193.2 billion is lost in wages each year as a result of serious mental illness. Without question, efforts to understand help-seeking and its

influences are vital to addressing these public concerns and increasing the number of individuals who seek treatment.

Under the umbrella of attitudinal barriers to seeking mental health treatment, stigma has arisen as a primary factor. Numerous studies have linked stigma to decreased help-seeking (Mackenzie et al., 2008; Thompson et al., 2004; Vogel, Wade, & Hackler, 2007) and propose that reducing stigma should have a considerable impact on help-seeking. However, stigma is a complex construct fueled by cultural and societal influences that reflect various groups' attitudes. Stigma toward mental health issues has been linked to race, for example Asian-Americans and African-Americans (Alvidrez, Snowden, & Kaiser, 2008), and socio-economic status (Doornbos, Zandee, DeGroot, & De Maagd-Rodriguez, 2013). Although salient variables such as race and income have been explored and documented in relation to stigma, a review of the literature where religion was included as a primary cultural factor indicated that it has received little recognition in the stigma literature, despite religion being recognized as important to many individuals and instrumental in shaping beliefs and values (Adams et al., 2018; Williams, 2015).

Given the prevalence of mental health issues, their negative impact on individuals and society as a whole, and the gaps between seeking and receiving effective treatment, exploring variables that make a difference in understanding why individuals with mental health concerns do not take advantage of available help presents as a worthy endeavor with numerous potential positive outcomes. With religiosity's widespread influence over the formation of actions and attitudes (Wesselmann & Graziano, 2010) and the

documented links it has to negative viewpoints such as discrimination and prejudice (Allport & Ross, 1967; Kirkpatrick, L.A., 1993; Laythe, Finkel, Bringle, & Kirkpatrick, 2002), it stands out as a potentially powerful influence in the understanding of stigma. Therefore, this study delves into religiosity and its connection to help-seeking and stigma.

Literature Review

Barriers to Help-Seeking

Barriers to help-seeking (HS) for mental health concerns range across several factors, both practical and attitudinal in nature. The World Health Organization (2012) produced an in-depth report on depression and provided insights into barriers to treatment, noting that help-seeking can be deterred by lack of resources including a lack of trained providers. Lack of resources may include individuals' concerns about treatment costs; Simon et al. (2004) conducted a study across the United States and Western Europe and discovered that participants viewed out-of-pocket costs as the primary barrier to getting treatment. Other salient factors included travel difficulties, fear of stigma, and concerns about adverse side effects from medication. In a 2013 qualitative study involving focus groups of Black, Hispanic, and White women, researchers found that HS barriers spanned economic issues such as lack of insurance or finances, difficulty in securing transportation, and low availability of affordable clinics, and psychosocial issues including stigma and lack of trust in the mental health systems available to them (Doornbos et al., 2013). For these participants, stigma was characterized by not wanting to appear "crazy" and avoiding feeling ashamed. A reluctance to trust providers was described as concerns over the confidentiality of information shared, believing their

issues would be shared with other agencies such as Child Protective Services, and fear it would be used against them. Furthermore, Doornbos et al.'s (2013) study noted that cultural factors played into barriers to treatment as participants relayed experiences of feeling discriminated against for their racial identities or their low socioeconomic status.

Reasons for failing to seek out mental health services also encompass factors such as gender, particularly for men (Wendt & Shafer, 2016; Rice et al., 2017), and an individual's community, cultural or otherwise, i.e. college campus or the military (Chen, Romero, & Karver, 2015; Horn, Stanley, Schneider, & Joiner, Jr., 2017). Research pertaining to men and mental health help-seeking notes that men endorse formal HS far less than women for depression, a common mental health concern (Wendt & Schafer, 2016), with some evidence that this lack of endorsement stems in part from the idea that getting help runs counter to masculine ideals of independence and rejecting weakness (Primack, Addis, Syzdek, & Miller, 2010). Rice et al.'s 2017 study demonstrated that men who experienced depressive symptoms over a prolonged period of time, i.e. 4 months, endorsed the highest barriers to HS, with researchers suggesting this may reflect a tendency to minimize or fail to recognize mental health symptoms.

Regarding one's community, several studies have examined the relationship between college students, campus culture, and help-seeking. Chen, Romero, and Karver (2015) found perceived campus barriers, including peers and faculty members' attitudes, to getting help was significantly negatively associated with help-seeking intentions; relatedly, a 2009 study utilizing 5,555 participants from 13 universities across the United States found students reported higher levels of perceived public stigma over personal

stigma, underscoring other research that has shown personally held attitudes are impacted by public views and perceptions. A meta-analysis conducted by Horn et al. (2017) included 111 peer-reviewed studies examining military members' usage of mental health services. Their analysis pinpointed several factors related to reduced HS specific to military personnel, including concerns their military career would be adversely impacted via losing respect from peers or unit leaders or not receiving advancement or opportunities, pragmatic barriers such as difficulty getting time off or scheduling an appointment, particularly if deployed overseas, and fear of stigma, expressed across the studies as embarrassment or being perceived as week. Taken together, the above studies demonstrate that HS is impacted by societal, practical, and personal barriers, with societal barriers varying based on the subgroup in question.

Stigma as attitudinal barrier. As previously mentioned, a primary factor well-documented in psychological literature that contributes to this phenomenon of decreased help-seeking is the presence of stigma (Vogel et al., 2006; Corrigan, 2004; Bathje & Pryor, 2011). Importantly, understanding the connections between stigma and mental health involves exploring who is affected by stigma and for what reasons. Several social-cultural influences have been named in the stigma literature as contributors to whether an individual with mental health issues seeks psychological help, particularly those included or identified with a minority group. For example, several studies have shown that Asian-Americans hold various cultural beliefs that hinder the propensity to seek help for psychological issues, i.e. believing mental illness is associated with demonic activity or attributing emotional struggles to mental weakness or a flawed personality (Han & Pong,

2015; Lee et al., 2009). Similarly, studies focused on exploring how stigma affects African-Americans have reported attitudes such as fear of being perceived as "crazy," and community values centered on resilience and handling one's own problems (Alvidrez et al., 2008).

Another social-cultural variable potentially interfering with psychological help-seeking is an individual's religious beliefs. Social psychology research has explored the connections between religion, prejudice, and stigmatization, but few studies have looked specifically at mental health stigma and attitudes toward those who seek mental health services and religious beliefs (Wesselmann & Graziano, 2010). In a two-part study examining Christian-based beliefs and mental illness, Wesselmann and Graziano (2010) demonstrated that religious beliefs about mental illness manifested in two ways—viewing mental illness as sin or a moral failure, and attributing mental health problems as spiritually-based or caused as opposed to psychologically induced. Furthermore, they observed parallels between negative secular beliefs about mental health and these two dimensions. Given their findings, stigma and attitudes toward mental illness and treatment may have a unique expression in religious individuals and/or communities, distinct from secular beliefs or current models of stigma. If this is the case, psychological help-seeking among the religiously-oriented may be affected in ways not yet recognized or understood in the mental health field.

Stigma as a Construct and Model

In 1963, sociologist Erving Goffman described stigma as an attitude that manifests when someone is perceived as possessing negative qualities deemed contrary to

what has been established as socially acceptable by the greater community (Goffman, 1963, p. 12), resulting in society regarding said individual as less than in some way. More recently, Corrigan (2004) reinforced Goffman's definition and applied it to mental health by characterizing stigma as a negative label placed on those having a mental illness or disorder. The ramifications of stigma and discrimination demonstrated toward those with mental illness are serious and often interfere with and delay treatment, if treatment is even sought (Abbey et al., 2011). Stigma may even play a role in interfering with physical healthcare treatment. Corrigan et al. (2014) conducted a study looking at how mental health stigma affected health care providers' treatment of people with mental illness, and found significant correlations between holding a negative attitude toward patients with mental illness and willingness to provide certain medical services. Essentially, providers with stigmatizing attitudes held a lower perception of treatment adherence in those with mental illness, resulting in less willingness to provide certain services such as prescription refills and referrals to a specialist.

Various conceptualizations have been applied to stigma during the last four decades as an attempt to understand and parse out its mechanisms and features. Among the more prominent ideas stands Elliott et al. (1982), who construed stigma as resulting from the perception that the one stigmatized is deviant in some way and therefore disqualified from social interactions due to being incompetent, threatening, or harmfully inconsistent. Other researchers have categorized stigmatized characteristics as "marks" that connect individuals to undesirable traits that separate them from others (Jones et al., 1984, as cited by Brohan, 2010); this conceptualization includes six dimensions that

define stigma: concealability, course, disruptiveness, aesthetics, origin, and peril (Major & O'Brien, 2005). Even evolutionary psychology has formulated theory regarding stigma, namely that stigma results as an adaptive strategy to maintain and secure a group's survival when interpersonal threats are present (Park, Faulkner, & Schaller, 2003). Under this model, stigma is functional in cases where it is imperative to avoid disease, acting as a mechanism that identifies and removes those who pose an infectious threat to the group (Kurzban & Leary, 2001).

What is important to note among the different viewpoints on stigma is the common thread of the greater group or "society" setting the standard for acceptable behavior. In essence, stigmatization arises from a particular subgroup's values and preferences specific to that group and not necessarily shared by other groups. It is this vantage point that may be useful in explaining how stigma occurring in religious groups may have distinct characteristics related to religiosity that may not affect those outside the subgroup.

A specific model of stigma that fits the stigma-religiosity group involves the related constructs of public stigma and self-stigma. Public stigma refers to society's view that due to some negative characteristic, an individual is considered unacceptable (Corrigan, 2004). Corrigan et al.'s (2002) model of public stigma involves three main parts—stereotypes, prejudice, and discrimination, with stereotype defined as a negative attitude or belief about a group; prejudice as agreement with such beliefs; and discrimination as some type of behavioral response to the person prejudiced against. As applied to mental health, it encompasses the negative terms and perceptions the greater

public uses regarding those with a mental illness, casting them in a negative light (Vogel, Bitman, Hammer, & Wade, 2013; Corrigan, Kuwabara, & O'Shaughnessy, 2009). In a study measuring public attitudes toward those with mental illness, drug addiction, or a physical disability, participants read and responded to vignettes detailing an individual's attendance at a community event. The individual was either labeled as having a mental illness, drug addiction, or a physical disability, namely use of a wheelchair (Corrigan, Kuwabara, & O'Shaughnessy, 2009). The study's outcomes demonstrated that those vignette characters with a mental illness evoked more negative attitudes from the participants than those with a physical disability and were more apt to be avoided. Other negative, real-life outcomes have been associated with public stigma, such as housing discrimination and being unable to secure employment (Corrigan et al., 2009).

Several common stereotypes exist that contribute to the public stigmatization of persons with mental health issues. One of the most prevalent is the notion that those with mental illness are dangerous or violent (Corrigan, 2004; Corrigan et al., 2010; Link et al., 1999); media outlets in particular have contributed significantly to this characterization by portraying real and fictional individuals using stereotypes (Stuart, 2003). A stereotype of this kind often evokes fear in the observer, with fear representing an emotional response (Overton & Medina, 2008; Link et al., 1999) leading to a behavioral response that often involves distancing self from the stigmatized person (Corrigan et al., 2001). In one stand-out study, researchers presented participants with various vignettes depicting individuals with a range of mental health issues, from serious cocaine dependence to being a "troubled" individual, and asked them to rate their perception of causes, potential

for violence, and likelihood of interacting with the described individuals (Link et al., 1999). Results indicated that in addition to non-stigmatizing attitudes such as stress in the character's life and a chemical imbalance, participants attributed the causes of the various conditions to explanations such as bad character (cocaine dependence) and how the person was raised (alcohol dependence). Furthermore, respondents indicated significant levels of unwillingness to interact with (social distancing) the depicted persons, with 90% stating they were unwilling to have contact with someone abusing cocaine. Social distancing involves how willing individuals are to interacting with people from other groups (Bogardus, 1926). Even major depression garnered a substantial 47% of participants stating they would not want to interact with someone having this diagnosis. Finally, regarding risk of violence, every mental illness condition (major depression, cocaine dependence, and schizophrenia) reflected a belief that the condition in question significantly increased this potential. This body of research speaks to the ways public stigma manifests toward those with mental health conditions, resulting in measurable behaviors of discriminating and distancing.

Public stigma directed at those having a mental health condition only comprises part of the picture of its effects on individuals with such disorders; in addition to stigmatizing those with psychological concerns, the public also stigmatizes the act of seeking out mental health services to address one's issues (Vogel, Wade, & Hackler, 2007). Ben-Porath's 2002 study involving participants reviewing scenarios of people seeking help for depression demonstrated that those who sought help were regarded as having lower levels of self-confidence and less emotional adjustment (Ben-Porath, 2002),

as compared to those with a back injury and those who experienced depression. Simply stated, the combination of experiencing depression *and* needing help to alleviate it garnered the strongest stigmatization. Such attitudes may interfere with seeking treatment by individuals distancing themselves from the stigmatized behavior, however helpful it may be. Corrigan (2004) posited that members of a stigmatized group may simply deny their belonging to the group and avoid all associations, what he describes as "label avoidance." One particularly negative label individuals hope to avoid is being perceived as "mentally ill" (Bathje & Pryor, 2011), which may be avoided by not seeking counseling. Thus, the connection between public stigma and decreased help-seeking is readily seen.

Self-stigma. The second form stigma often takes is self-stigma. Self-stigma involves the internalization of public stigma, essentially, as individuals with a mental health illness or concern view themselves as socially unacceptable and with low esteem (Vogel et al., 2006; Vogel, Bitman, Hammer, & Wade, 2013). This link between public and self-stigma, demonstrating that public stigma becomes internalized as self-stigma, was tested by Vogel et al (2013) using two stigma scales—the Stigma Scale for Receiving Psychological Help (SSRPH), designed to measure public stigma with items such as "Seeing a psychologist for emotional or interpersonal problems carries social stigma;" and the Self-Stigma of Seeking Help (SSOSH) scale, utilizing items like, "I would feel inadequate if I went to a therapist for psychological help," to measure self-stigma. Results of this study, conducted over three months' time, confirmed that public stigma resulted in higher levels of self-stigma (Vogel et al, 2013). Admittedly, limiting

exposure to public stigma is a difficult task, but understanding how it manifests in individuals as self-stigma provides opportunity to reduce self-stigma and its effects on the person (Corrigan, 2004). Bathje and Pryor (2011) found that lower levels of sympathy coupled with an awareness of public stigma served as a significant predictor of self-stigma. Furthermore, the presence of sympathy toward a peer struggling with mental health issues resulted in lower likelihoods of experiencing low self-esteem (self-stigma) and more positive views toward seeking help.

Self-stigma creates a significant barrier to a positive view of self, as it is routinely evidenced in low self-esteem and/or low self-efficacy (Corrigan, 2004). Those who have internalized public stigma may adopt society's view that they are, indeed, weaker, less capable, or disturbed due to their mental health status (Lannin, Vogel, Brenner, Abraham, & Heath, 2015). Research aimed specifically at persons experiencing depression suggests that self-stigma leads to avoidance behaviors (socially isolating, hiding their depression), which in turn reinforces the perception of being stigmatized and may exacerbate symptoms; ultimately, this process may prevent the individual from getting help (Kanter, Rusch, & Brondino, 2008). Unfortunately, a common and potentially debilitating outcome of possessing self-stigma is the tendency to avoid seeking out psychological treatment (Vogel et al., 2006; Vogel et al., 2007; Lannin et al, 2015; Corrigan, 2004).

Past research has established connections between public and self-stigma, help-seeking attitudes, and the willingness to attend psychological counseling (Vogel et al., 2007). In their 2006 study measuring self-stigma, Vogel and colleagues developed the

SSOSH scale and utilized it to examine the impact of self-stigma on help-seeking attitudes and behavior. Results of their five-part study revealed that those individuals possessing higher levels of self-stigma held less positive views of seeking treatment; conversely, those with low self-stigma reported a greater tendency to seek out psychological services. With consideration that the first step one usually takes in obtaining mental health assistance is gathering information, Lannin et al. (2015) posited that those possessing high levels of self-stigma would be reticent to even seek out information related to counseling. Controlling for gender and level of distress, this study's results demonstrated higher percentages of obtaining mental health and counseling information in those holding less self-stigma (Lannin et al., 2015). This stigma-driven resistance to seeking help for psychological concerns is partly explained by the need to maintain one's self-image. For those high in self-stigma, Miller (1985) suggested that refusing to pursue psychological help could serve as an attempt to preserve a positive view of self, in accordance with self-affirmation theory that posits people are motivated to maintain a favorable self-image (Lannin, Guyll, Vogel, & Madon, 2013). In this light, self-stigma is viewed as a threat that must be avoided; by avoiding treatment, the individual neutralizes the associated threat of being viewed as psychologically flawed (Lannin et al., 2013).

In addition to image preservation, help-seeking behavior is affected by attitudes that accompany it. Using the theory of reasoned action as their framework, Vogel and colleagues surmised that attitudes toward mental health treatment are shaped by perceived stigma, which then curtails the desire to seek help (Vogel et al., 2007). Ajzen

and Fishbein's (1980) theory of reasoned action explains that intended actions are directly affected by the attitude held toward said action, and these attitudes are affected by the outcomes expected of the action. In other words, if counseling is perceived as reinforcing someone's stigmatized view that those who seek counseling are "crazy," then a negative attitude is likely to arise toward the act of attending counseling (Vogel et al., 2007). Other studies have demonstrated similar outcomes between self-stigma and negative attitudes toward seeking mental health treatment (Bathje & Pryor, 2011; Vogel et al., 2006).

Limitations of Current Stigma Research

In reviewing the literature on HS, public stigma, and self-stigma, it is readily seen that many factors contribute to whether individuals experience stigma resulting in interference with help-seeking behaviors for mental health issues. As discussed, public stigma arises from negative attitudes held by a particular group or community towards a certain behavior—in this study, mental health symptoms or concerns. The current body of research reflects ample exploration of the connections between, for example, racial minority groups and mental health stigma, primarily among adults and college students in these categories (Han & Pong, 2015; Alvidrez et al., 2008; Miranda et al., 2015; Henderson et al., 2013). Studies such as Han & Pong's (2015) and Lee et al., (2009) regarding Asian-Americans' HS behaviors make general reference to cultural factors influencing or interfering with stigma, but do not focus or provide in-depth exploration on how *specific* cultural factors such as religion and religious beliefs and values bring influence. It is not uncommon for academic discussions and scholarship regarding

multiculturalism in the United States to overwhelmingly emphasize race and ethnicity with little attention paid to religion (Williams, 2015). This lack of consideration for religion/religiosity as a salient cultural variable in the formation of stigma presents a considerable gap worth exploring in understanding how stigmatized attitudes might form and disseminate among various religious groups and emerge as a unique form of public and/or self-stigma.

One study emphasizing religiosity as an important variable related to mental health HS demonstrated that for African-Americans, high levels of religious involvement and greater personal importance of religious beliefs correlated with lower usage of formal mental health services (Lukachko, Myer, & Hankerson, 2015). Stigma related to HS with religiosity as an intervening variable was not included in this study, but it serves to illustrate that associations exist between religiosity and HS behavior.

A similar gap exists in the current literature on self-stigma. Expansions on the construct of self-stigma have considered attachment style as an intervening variable (Cheng, McDermott, & Lopez, 2015), sympathy as a possible protective factor against the formation of self-stigma (Bathje & Pryor, 2011), and analysis of self-stigma's effect on actual HS behaviors including seeking mental health information (Lannin et al, 2015). However, potential relationships between one's personally held values and beliefs such as religion and the presence of self-stigma have not been emphasized. Referring to Lukachko et al.'s 2015 study on African-Americans and HS, subjective religiosity, referring to one's personal level of religiosity including spiritual belief and practice, significantly impacted the tendency to seek mental health services. What has not been

explored is whether one's religiosity, including personal beliefs, might also impact or be part of the presence of self-stigma as related to mental health issues and HS. It is widely recognized that religion and its accompanying beliefs significantly shape human behaviors and attitudes (Wesselmann & Graziano, 2010), so establishing and understanding religion's role regarding stigma and help-seeking could expand stigma-reduction efforts and increase participation in treatment among this subculture. With 187.3 million adults in the US indicating a religious affiliation, and 65.5% of those stating religion is "very important" to them (Pew Research Center, 2014), the positive ramifications of discovering connections between stigma, religiosity, and HS could be wide-reaching.

Possible Effects and Connections between Religiosity and Stigma

As referenced earlier, the clear majority of research on stigma has focused on secular, or nonreligious, aspects of this construct. Furthermore, much has been explored and written regarding stigma's effects on both attitudes toward help-seeking and help-seeking as a behavior. What has not been explored in -depth is the possible ways religiously-shaped attitudes toward mental illness and psychological treatment may contribute to the construct of stigma and help-seeking behavior.

Defining religiosity. A substantial challenge always faced when studying religiosity and fundamentalism is operationalizing these constructs in a meaningful, consistent way. Literature from theology, anthropology, sociology, and psychology highlights and defines various aspects of religion, with respect to each discipline's purview. Even within religious groups and denominations, for example conservative

Protestantism, doctrines and dogmas differ widely (Woodbury & Smith, 1998), with no one set of beliefs capturing the entirety of the group. However, a few broad definitions and concepts can be applied to provide a general model describing religious fundamentalism.

Religious fundamentalism refers to beliefs that embrace a specific body of tenets. Beliefs include deriving authority and morality from God or a supernatural source, relying on sacred inspiration for truth and guidance rather than secular, or worldly, experiences (Liht et.al, 2011; Altmeyer & Hunsberger, 2004; Woodbury & Smith, 1998), and adhering to what Liht et.al (2011) deemed "context-unbound truth," described as belief in truths or principles that are universally applied and adhered to, regardless of context or circumstance. Altmeyer and Hunsberger (1992) provide a succinct definition that encapsulates the major components of fundamentalism, namely:

> The belief that there is one set of religious teaching that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity; that this essential truth is fundamentally opposed by evil forces which must be vigorously fought against ... and those who believe and follow these fundamental teachings have a special relationship with deity (p. 118).

As a result, the fundamentalist's religious beliefs hold ultimate authority and direct one's view of and interactions with the world (Kirkpatrick, Hood, & Hartz, 1991). In concert with context-unbound truth, fundamentalists typically use a strictly literalist approach to interpreting scripture (Woodbury & Smith, 1998). Biblical literalism has been illustrated and measured in the literature with descriptions such as, "The Bible means exactly what

it says. It should be taken literally, word for word, on all subjects" (Perry, 2013), as opposed to a historical document containing symbolic stories. Overall, the characteristic that sets fundamentalism apart from other forms of religiosity is an unwavering commitment and submission to religious authority (Blogowska & Saroglou, 2013).

For religious fundamentalists, therefore, God, the Bible, and biblical/religious teachings comprise their foundation and reference point for all matters, over and above other influences present in the world. Blogowska and Saroglou's (2013) study aptly illustrated one way this religious authority may exert influence over fundamentalists by discovering that reading biblical texts altered participants' attitudes toward various outgroups. Further, they discussed the distinction between religious fundamentalism and general religiosity, noting that biblical texts influenced the fundamentalist participants but not those subscribing to a general form of religiosity; they surmised the more general form does not have the necessity of submission attached to it.

Within various religious systems and denominations, a broad range of faith beliefs exist, dependent on the religious group in question. With Catholicism, emphasis is placed on the Church's authority as a major voice in determining doctrines and followers' beliefs and actions; conversely, among the conservative Protestant branch of Lutheranism, fundamentalism and adherence to the theologian Martin Luther's teachings predominate (Davidson & Quinn, 1976). On the dimension of mental illness having a spiritual vs psychological origin, Roman Catholic individuals depart from fundamentalist and orthodox outlooks on mental health by endorsing this viewpoint significantly less than Protestants and those from non-denominational affiliations (Wesselmann &

Graziano, 2010). Therefore, it appears that type of religious belief directly influences how mental illness is understood.

Religiosity & conceptualizing mental health. Though research has not been conducted specifically on the proposed relationship between religious belief/religiosity, mental health stigma, and help-seeking behavior, studies have been conducted that seek to understand how religiously-oriented individuals manage mental health concerns. To begin, importance must be placed on *how* religious persons conceptualize their emotional concerns, as this may serve to shape their efforts at getting help. Simply stated, they may see their concerns as religiously-derived and not psychological in origin (Wamser, Vandenberg, & Hibberd, 2011; Wesselmann & Graziano, 2010). White et al. (2003) observed that mental illnesses such as schizophrenia were credited to demonic influence (as cited by Wesselmann & Graziano, 2010, p. 405); Trice and Bjorck's 2006 study with Pentecostal Bible college students discovered demonic oppression and/or possession was believed to be a significant cause of depression (m=6.43 on a 1-7 scale). In some cases, a religious group may dismiss symptoms of a mental illness such as depression, citing that the devout simply cannot be depressed (Loewenthal & Cinnirella, 1999). As noted earlier, Wesselmann and Graziano's (2010) empirically-based study demonstrated that participants who adhered more strongly to a fundamentalist religious belief system tended to believe that mental illness was caused by sinful behavior, and both fundamentally and orthodoxly-oriented religious persons were more inclined to attribute the mental illnesses of schizophrenia and depression to spiritually-based causes, not psychological ones.

Indirectly, general views on suffering from and responsibility for illness may undergird and support these religious frameworks. Lowenthal (1997) postulated that Judeo-Christian beliefs regarding suffering frame it as having a kind of divine purpose and in a sense, deserved, and illness has long been perceived as a punishment of sorts for those who have committed wrongdoings (Weiner, 1993). Lerner (1991) has conceptualized this belief in suffering in his construct of the *just world belief,* which takes the view that people develop the position that in life, what is earned is what is deserved (i.e., if suffering is experienced, there is a belief it is deserved by the victim). Relatedly, Corrigan et al. (2009) pointed out that stereotypes surrounding those with mental illness impact others' helping behavior toward the person with a disorder, in that believing someone holds responsibility for his or her illness reduces helping behavior. However, this same behavior increases when someone is not held responsible for their condition. In their development of scale items loading to factors related to religious beliefs about mental illness, Wesselmann and Graziano (2010) found that believing mental illness has sinful or spiritual causes positively correlated with the factor of *controllability*, or taking responsibility for one's illness.

Weiner's (1993) theoretical proposal of perceived responsibility and social motivation further supports the connection between controllability and offering help; his research demonstrates that when persons possess problems perceived to be beyond their control (i.e. obesity resulting from thyroid malfunction or contraction of AIDS from a blood transfusion), sympathy and help are elicited from others. Conversely, if obesity or AIDS appear to result from perceived personal moral failure, such as overeating and

having unprotected sex, help-giving is often refused and anger is projected at the individual. Finally, Brickman et al.'s (1982) models of helping encapsulate how responsibility for one's problems and resulting solutions is attributed, specifically whether one is to blame for causing a problem, and whether said individual is responsible to find a solution to the problem. The moral model of helping illustrates the viewpoint that individuals are responsible for both their problems and the solutions; this stance stems from the belief that people cause their own problems and cannot be helped by others, as they must help themselves.

Wesselmann and Graziano's findings support the idea that religious persons at times attribute mental health problems to other sources, lending an important insight on why the fundamentally religious may seek out spiritual help over psychological treatment. Going even further, if mental illness is actually viewed as not an illness at all, but rather a reflection of one's religious devotion or lack thereof, or resulting from some variety of moral failure, it is speculated that this could create situations where persons suffering from a mental health condition not only seek out different solutions, but evoke stigma from other devotees by appearing to be outside the religion's acceptable norms and subsequently treated like the "sinner" they are perceived to be—someone lacking faith or displeasing God in some fashion. As previously referenced, how people perceive someone's controllability of the condition at hand has been linked with stigma (Kurzban & Leary, 2001). As a result, religious members may likely believe a member with a mental health or substance use condition can and most importantly, *should*, have control

over and even eliminate it. This stance would oppose seeing biological forces related to illness as contributing or causal factors.

Beyond influencing how a religious person conceptualizes mental illness or assigns responsibility, religious beliefs impact what type of help is elicited, whether spiritually or psychologically based. Crosby and Bossley (2012) conducted a survey-based study examining the propensity for participants to seek religious care (i.e., clergy) versus psychological care (i.e., counseling) for a psychologically-based issue. After controlling for gender, religiosity positively correlated with a preference for religiously-grounded help, and simultaneously demonstrated a negative correlation between religiosity and psychological care (Crosby & Bossley, 2012). In rating solutions for depression, Pentecostal college students rated faith-based approaches the highest, with Bible reading receiving top endorsement (Trice & Bjorck, 2006). Furthermore, these same students viewed lingering, or ongoing, depression as remaining unresolved due to lack of faith or failing to diligently apply one's faith (Trice & Bjorck, 2006). In a 2016 qualitative study, Polish Catholic priests were interviewed regarding the means they use to seek emotional support and cope with personal issues. Across the sample of 12 priests, religious supports were most frequently sought out, with professional psychological help viewed as a resource only as a "last resort" and for issues related to addiction or requiring psychiatric care (Pietkiewicz & Bachryj, 2016); additionally, they cited fear of stigma from the Church and society as a deterrent to accessing psychological supports.

These examples demonstrate that oftentimes religious followers prefer religious help over psychological. What is *not* clear is the role religiously-motivated stigma may

potentially be filling in influencing persons with mental health concerns to seek out other forms of help apart from those specifically designed to address those concerns; part of this study's focus will be on exploring these factors.

Religiosity's Connection to Prejudice

A key area of established theory and research to consider in exploring whether religious stigma exists as an expression of stigma involves the connection between fundamental religiosity and prejudice. As previously referenced, stigma has been linked with discrimination towards those belonging to a stigmatized group. The term "stigma" involves multiple meanings and understandings, including stereotyping, separation of stereotyped persons into various categories reflecting an "us versus them" mentality, and discrimination, at times reflected in behaviors such as devaluation and exclusion (Abbey et al., 2011).

The difficulty found in conceptualizing and defining religiosity, fundamentalism, and orthodoxy is also prevalent in untangling what aspects or expressions of religiosity influence or predict prejudice and discrimination, including which groups are the target of such attitudes. Allport and Ross's (1967) seminal work around religious orientation and prejudice demonstrated findings of higher levels of prejudice in those who attend church and those who do not, and that individuals who adopt an extrinsic (focused on outward religious expressions) religious orientation reflect more prejudice than those with an intrinsic (inward personal emphasis on devotion and values) orientation. Their initial study's sample included members of Roman Catholic and various Protestant denominations and specifically measured ethnic prejudice. They concluded that

internalizing one's religious values such as love and compassion prompts the believer to regard others more highly and respectfully, precluding prejudice; alternatively, those who exercise their beliefs from external motivations such as personal gain or fitting in with acceptable norms, do so to secure their own interests and rights, similarly to the role prejudice serves in helping its adherents feel secure and within acceptable social boundaries (Allport & Ross, 1967).

Religious fundamentalism. Research studies following Allport and Ross's initial findings have considered a wide range of concepts related to intrinsic and extrinsic religiosity. Laythe et al. (2002) explored concepts related to fundamentalism, demonstrating that religious fundamentalism (RF) predicted prejudice within a model containing two key components—authoritarianism and Christian orthodoxy. Numerous studies have shown a positive relationship between authoritarianism and RF (Laythe et al., 2002; Altmeyer & Hunsberger, 2004; Altmeyer & Hunsberger, 1992; Asp, Ramchandran, & Tranel, 2012), with shared characteristics such as submission to those in authority, conventionalism, and an unquestioning approach to life in general (Laythe, Finkel, & Kirkpatrick, 2001). Within the context of this study, Christian orthodoxy was defined as reflecting content of beliefs instead of how the beliefs are held, as fundamentalism demonstrates (Hunsberger, 1995).

Importantly, within the model established, RF did not significantly predict ethnic racism when considered alone, but when authoritarianism was introduced as a mediating factor, together they significantly predicted racism; when Christian orthodoxy was considered, it served to negatively predict prejudice (Laythe et al., 2002). However, all

three components—RF, authoritarianism, and Christian orthodoxy—positively predicted homosexual prejudice, with RF and authoritarianism emerging as the strongest predicators and irrespective of one another.

Religious texts. This mix of results regarding which group received prejudicial attitudes may be explained by another common attribute of RF—reliance on sacred scriptures such as the Bible to provide teaching, guidance, norms, and authority. In a three-part 2013 study conducted with primarily Catholic adults and Polish students in Belgium and Poland, respectively, researchers explored the role religious texts (in this case, the Christian Bible) might play in affecting prosociality, or acting in ways beneficial toward others or society in general (Kenrick et al, Social psych textbook ref) . The study found that in part one, Bible passages promoting violence in general led participants to fail to demonstrate help to unknown persons in need; during the second part of the study, those high in fundamentalism exhibited higher prosociality after reading a New Testament text focused on God's command to help others unconditionally (Blogowska & Saroglou, 2013). In the final third of the study, part one's results were repeated, with fundamentalists demonstrating a lack of prosociality toward an outgroup, specifically atheists (Blogowska & Saroglou, 2013). Admittedly, these results apply to a specific group in a specific culture, but they demonstrate that those high in RF are sensitive to and are influenced by their religion's texts and beliefs. A common teaching among RF groups is that same-sex relationships are sinful and unnatural. With Blogowska and Saroglou's findings in mind, such a teaching would likely influence RF adherents to

show low prosociality towards gays and lesbians; in effect, demonstrate prejudice against them.

Internalized religiosity. Finally, another 2013 study conducted with Catholic college students in Italy highlighted another aspect of the connection between religiosity, prejudice, and values, specifically acting prosocially, and conformity, or maintaining traditional cultural and social rules. Whereas previous researchers have explained various aspects of religiosity as intrinsic vs extrinsic, or included authoritarianism and orthodoxy as mediating and/or moderating variables, for example, Brambilla, Manzi, Regalia, and Verkuyten (2013) focused on two ways religiosity may be internalized—in an identified manner, meaning adhering to beliefs out of personal conviction and personally choosing said beliefs; or as introjected religiosity, described as holding to beliefs and religious behaviors based on social pressure and the approval of others. The researchers focused narrowly on prejudice directed at Muslims and how religion is internalized, with results showing that identified internalization was more strongly correlated ($p<.05$) with lower prejudice, when prosociality was introduced as a mediating value. In other words, when participants held religious beliefs out of a sense of personal conviction as compared to doing so based on societal approval, they demonstrated less prejudice toward Muslims when that personal conviction was mediated by acting in ways beneficial to others. Unexpectedly, though, introjected religiosity did not correlate with prosociality or prejudice (Brambilla, Manzi, Regalia, & Verkuyten, 2013). However, in a follow-up study, introjected religiosity predicted prejudice in a model where that religiosity was mediated by valuing conformity to established social norms. What these

results indicate is being religious takes different forms and when considered in conjunction with someone's values, different impacts may be made on prejudice. Untangling these differences is important to better understanding the relationship between these two constructs.

Summary

Clearly, connections exist between religiosity, RF, and prejudice and can be demonstrated through various constructs and ideas related to authority, conformity, and the given religion's teachings and norms. For reasons already outlined in this review, it is speculated that RF may connect with stigma in some ways yet to be discovered toward those with mental health illnesses or concerns, if those with such issues are perceived to be outside of the group's norms. This perceived violation of norms may manifest in a variety of ways, such as failing to apply one's faith and beliefs as the group advises or instructs, or acting in ways considered strange or wrong to the members of the religious group.

Another connection between stigma and religiosity involves believing mental illness is spiritually-based, sinful, or purposely brought on by either human or divine action and attributes the cause to factors other than those psychologically related. If religiously-based beliefs serve as a source of stigma in some unique way, including them in the body of research on stigma could fill a considerable gap in the current literature. Within the public-self stigma model, the connection between public and self-stigma is recognized as public stigma becoming internalized and expressed as self-stigma. Given what is known about religiosity as an important multicultural factor that influences

discriminatory and prejudiced attitudes and significantly impacts individuals' attitudes and behaviors, exploring potential ways religiosity interacts with public and self-stigma is warranted to explain phenomena that might be occurring that the current models of stigma do not capture. If a relationship is found between religious stigma, help-seeking, and type of help sought (psychological vs. religious), treatment efforts and stigma-reducing programs can be tailored to address the needs of religiously-oriented individuals.

Stemming from the above review is an informed speculation that within the range of stigma types, behaviors, and attitudes, religiosity may be an influencing factor among fundamentally religious individuals; this might emerge as a unique experience and impact this population's views and practices around mental health and HS. The aim of this study is to explore the elements of religiosity, stigma, and help-seeking among individuals who self-identify as fundamentally religious Christians and gain a fuller, more personal understanding of how these individuals experience stigma and mental health. Studying individual experiences may reveal relationships or connections among these constructs.

CHAPTER II

METHODOLOGY

The focus of this qualitative study was gaining understanding of fundamentally religious individuals' experiences with religiosity, stigma, mental health, and help-seeking, paying attention to any consistent patterns of relationship or connections between these concepts. Within the existing literature, a separate construct of a uniquely "religious stigma" is not addressed nor established as a self-contained construct or theory, but what *is* present in the lean amount of current studies focuses on how religious people treat mental health issues when they arise, with some discussion of the ways religious individuals may spiritualize psychological issues. As qualitative studies are concerned with exploring individual experiences and phenomena (Robson & McCartan 2016, p.20), it is well-suited to investigating a previously unexplored area of experience. With its focus on an individual's unique, lived experience and perspective, it was a good fit for studying if religious individuals have any particular experiences with stigma, whether arising from themselves and/or their religious communities, family, friends, and leaders.

Consensual Qualitative Research (CQR) emphasizes the importance of the participant's lived experience, with the researcher's role bringing influence into the data collection process through the use of probes to help participants share more fully (Hill et al., 2005). Its creators deem it ideal when studying the inner experiences of individuals,

which is befitting of stigma. Furthermore, CQR was appropriate for this study, as using a team of data analysts provided multiple viewpoints, helpful in avoiding bias. Given the principal investigator's past close association with multiple religious groups, incorporating other perspectives was crucial in analyzing the data without bias. Notably, the foundation of CQR places high value on multiple perspectives, as it posits that complex issues automatically reflect multiple and varied perspectives, opinions, and ideas (Hill, Thompson, & Williams, 1997) that can best be understood with several people. Thus, CQR requires a team that analyzes the data and reaches agreement, or consensus, on the material and how it should be coded and themed, and incorporates an auditor who reviews the raw data and emerging themes and provides feedback to the team (Hill et al., 1997).

Participants

A literature review conducted for this study explored religious attitudes toward mental health issues, discovering some references that Christian fundamentalist-oriented people tend to have more negative views of mental illness and spiritualize psychological problems. Therefore, participants were selected from a Christian, Protestant fundamentalist pool. Inclusion criteria centered on possessing fundamentalist-type beliefs, not membership in an exclusively fundamentalist church or denomination.

Participants were selected from an adult population in the Midwest, aged 18+, with no preference for gender or race. This study sought to establish homogeneity of fundamentalist, religious views and experience as the common denominator, not age,

race, or gender. Thus, patterns or themes emerging in the data may speak to religious stigma as an entity apart from race, age, or gender being primary variables.

Nine participants were recruited and provided in-depth, in-person interviews. The participant pool included six females and three males, ranging in age from 23 to 76, with a mean age of 40.6. Five participants were married, and four were single. Seven identified as White/Caucasian, one as African-American, and one as biracial (Native American and Caucasian). All participants verbally affirmed adhering to a conservative, fundamental religious belief system, with some identifying from a range of Christian denominations including Assemblies of God, Methodism, Lutheran Brethren, and Apostolic Pentecostal. Some participants did not identify belonging to a specific denomination, rather identifying themselves as "non-denominational," "born-again Christian," or simply "Christian." Participants were coded with random pseudonyms for purposes of anonymity regarding inclusion of specific quotes in the Results section; they are listed in Table 1.

Table 1. Participant Pseudonyms.

Name	Age	Religious affiliation
Betty	54	Assemblies of God
Mary	30	None specific; identifies as "Christian"
Kim	25	Non-denominational
Sue	76	Methodist
Hannah	23	Pentecostal
Laurie	27	Evangelical Free
Tom	33	None specific; identifies as "born-again Christian"
William	38	Non-denominational; identifies as "Christian"
Steve	60	Lutheran

Participant Recruitment

Participants were recruited via phone calls and emails to churches most closely fitting fundamentalist Christianity, with a brief explanation of the project provided, "Research study planned where we are interested in understanding ways religious views or beliefs may influence or shape attitudes and thoughts around mental health." Further, flyers with the study's information were distributed on the PI's university campus and in local merchants' shops, especially those associated with a fundamental religious organization. Participant requirements advertised included ages 18 or older; attend church regularly; identify as a Protestant Christian with fundamental beliefs; and agree to up to 2 one-hour interview sessions, if necessary. This description meant those individuals who adhered to a literal interpretation of the Bible and considered God to be their ultimate authority. Examples of these include the Assemblies of God, Southern Baptist, and Lutheran-Missouri Synod. Each of these denominations' websites list tenets of faith/doctrine, and all indicated the above criteria (Assemblies of God USA, 2016; Southern Baptist Convention, 2017; Lutheran Church-Missouri Synod, 2017). Given the reality that beliefs vary somewhat by individual, recruited participants labeled themselves fundamentalist or otherwise, with the first interview question asking them to describe their religious views. Churches in the Grand Forks area were targeted for the sake of proximity. A $20 gift card to a local merchant was given as a thank-you to each participant.

During the recruitment phone call, the PI gave a general description of the study and asked if an announcement calling for participants could be placed in the church's bulletin, newsletter, or email blasts. For those who responded, a five-minute phone call screening was conducted, asking what church they were affiliated with and confirming they identified as someone holding fundamentalist religious beliefs and views. Among the participants, several identified with a specific denominational church, with two participants attending churches established independent of a particular denomination.

Snowball sampling was utilized to identify additional participants. This type of sampling is appropriate when a population is hidden or the topic is sensitive (Hendricks & Blanken, 1992); the topics of mental health and religion may carry some social stigma, especially given the project's focus, and may be difficult for participants to acknowledge. Asking individuals to refer someone who fits the study should more readily identify appropriate participants. Informed consent was obtained in person prior to the interviews, with each participant giving written consent prior to interviewing. Signed IC forms were stored in a locked file box in the PI's office at the University of North Dakota.

With consideration for the mental health aspects addressed in the interviews and that discussion of these topics may create psychological discomfort for the participants, a list of local counseling resources was provided to all participants, with faith-based services included. The list bore the following instructions, "This list is not inclusive of all available services, and no endorsement is implied in the selection of this sampling."

To determine when enough participants had been recruited, the principle of saturation, salient in qualitative research, was followed. Saturation refers to the point

reached where no new domains or core ideas are emerging from the data (Saunders et al., 2017). In this project, it was evident after 6-7 participants that interviewees were describing similar views and beliefs, despite gender, age, or specific religious affiliation. Given Hill et al.'s (2005) recommendation that 8-15 participants are generally desirable for CQR studies, more participants were sought to reach this suggested range. After the resultant 9 participant interviews concluded, data analysis revealed the last 2-3 interviewees' information fit into the emerging domains and core ideas, with no new themes emerging. Therefore, 9 participants reflected saturation and no new interviews were conducted.

Data collection

Data was collected via semi-structured private interviews conducted by the principal investigator. Interviews took place on campus in a private office or at a location of the interviewee's choice. Interviews were recorded electronically using a password-protected smartphone belonging to the PI, then transferred to and stored on a password-protected hard drive, with back-ups stored on a password-protected jump drive. Transcriptions were recorded and stored in this manner as well.

With qualitative research, emphasis is on the individual's perspective and subjective experience, hearing their story and paying attention to what they deem is important. Questions were open-ended and designed to explore the participant's unique experience and viewpoint, included as Appendix A. All follow-up prompts or probes were short and exploratory in nature as well, consisting of "Can you tell me more about that?" type questions, designed to more deeply explore but not lead the participant to

what the researcher might deem more salient. To obtain sufficient consistency in the process from interview to interview, the same protocol was followed for all queries (Hill, Thompson, & Williams, 1997). Analysis of data included a team of three graduate student researchers and an auditor, in accordance with CQR (Hill et al., 2005), thereby providing a consensus on themes and avoiding bias. In accordance with Hill et al. (2005) recommendations, the auditor was part of reviewing the interviews.

The team was comprised of graduate students in the UND counseling psychology department, including two counseling psychology doctoral students and one school counseling master's student, and a licensed practicing psychologist as the auditor. CQR is built upon the premise that all voices in the analytic process are valuable and contribute to the end product; therefore, a discussion was held during training regarding equality and power, highlighting the importance and validity of all viewpoints, regardless of level of education or experience. Specifically, in an effort to further level power in the group, open dialogue was encouraged regarding any questions or concerns individual members may have held regarding their own qualifications.

CQR involves three overarching steps in the data analysis process: first, reviewing raw data and outlining it into domains and core ideas, second, interpreting the data, and third, conducting a cross analysis of all interviews (Hill et al., 1997). In accordance with CQR, team members developed a list of domains, guided by the literature, and independently read transcripts and assigned blocks of text to the appropriate domains. From here, core ideas were developed individually by each team member, then brought to the whole group for the purpose of reaching consensus. As CQR is an iterative process,

after the auditor reviewed the data, it was returned to the team to analyze further, with this process repeated until final consensus was reached (Hill et al., 1997). During cross analysis, the team examined domains and core ideas across all cases to see what similarities existed and to cluster the information into categories.

As each step in the process requires specific tasks to be fulfilled, prior to analysis the team members were briefed and trained on CQR domain construction, coding, and interpreting. Training included reading Hill et al.'s 1997 original article detailing CQR, Hill et al. 2005 follow-up study, and Juntunen et al.'s 2001 research demonstrating use of the CQR method in a study exploring American Indians and career perspectives.

Based on related topics discovered in the literature review regarding religiosity, mental health attitudes, and prejudice, it was expected that individuals who identify as fundamentalist Christians would describe stigma that is in some way uniquely religious; ie, believing that mental illness and/or mental health concerns are spiritually based, not psychologically related, and reflect spiritual deficits such as lack of faith, leading to either receiving or projecting negative attitudes (stigma). Further, it was suspected that this religious stigma hampers individuals from seeking out psychological help designed to address the problem in question (anxiety, depression, schizophrenia).

Researcher Bias Disclosure

An important step in conducting a qualitative study is understanding the researchers' bias and preconceived ideas. To that end, the following bias is disclosed:

The principal investigator has intimate familiarity with religious communities, having belonged to and actively participated in a church community for 35 years. Those

churches all adhered to a literalist, fundamental view of Christianity and the Bible. In addition, the PI attended a conservative Christian college for undergraduate psychology, completed a master's degree in theology at a conservative Christian seminary, and a master's degree in counseling psychology at a Catholic university. Additionally, the PI worked or volunteered at several Christian organizations over a period of 25 years. During these years of church involvement, she held to a majority of the doctrine.

Contrasting the above experiences, the PI's religious beliefs evolved over the period of the past 8 years to embrace more general spiritual views, disavowing a literal, fundamentalist approach to Christianity or spirituality. Additionally, her cultural religious identity is spiritual not religious; in other words, she no longer identifies as a fundamentalist, literalist Christian.

To address and reduce potential bias among the data analysis team, during training the PI encouraged each team member to think about their religious experiences, if any, and led discussions on how those events have contributed to their identity and viewpoints on religiosity, mental health, and stigma. Team members presented from an array of religious backgrounds, including fundamental Christian, Catholic, Muslim, and Lutheran. Of these, only the Lutheran member was actively involved in a faith community. The Christian and Catholic members described moving away from those beliefs, with the formerly Catholic individual identifying as more Buddhist. The Muslim-identified member described being in an exploratory place with their faith. During analysis meetings of the transcripts, the PI conducted regular check-ins designed to encourage team members to internally consider and confront any bias they detected. All

team members were receptive and reported paying close attention to their thought processes and reactions.

CHAPTER III

RESULTS

Preliminary Analysis

All participants described themselves as holding fundamentalist Christian beliefs in some way, and expressed similar views regarding their religious identity, such as God's authority and the Bible's central importance, including a firm belief in its guidance and ultimate source of truth, and a tendency to take the Bible literally. These views qualified them as fundamentalist and therefore were included in the study. These beliefs were expressed in a variety of ways: "I recognize the divinity of Jesus Christ" reflected one participant's view, with others speaking to the authority of the Bible in their lives: "It looks like obedience to the word of God, which is the Holy Bible." Regarding "God" and "Bible," these terms were capitalized according to standard grammatical rules of proper nouns. Capitalization was not meant to reflect any of the PI's or team's views of these religious concepts.

Main Analyses

Five themes/domains arose from the interview data transcripts: Religion provides guidance and greater purpose; faith alleviates mental health concerns; perceived support from religious "family"/community; perceived stigma; and religious identities guide help-seeking behaviors (see Table 2). In accordance with CQR standards and practices,

all domains reflected either general (all participants) or typical (five to seven participants) frequency. This demonstrated strong representation of the domains across the interviews.

Table 2. List of Domains and Frequency.

Domain	Frequency	Core ideas
Religion provides guidance and greater purpose.	General	God as foundational. The Bible is truth. God does for humanity what humanity cannot do alone. Seeking help from God through prayer.
Faith alleviates mental health concerns	General	Necessity of faith. Faith heals.
Perceived support from religious community /"family"	General	Helping other faith followers become better followers and overcome challenges. Church community is family. Preference for religious-based support.
Perceived stigma	Typical	Internalized stigma. Personal and religious community's beliefs regarding stigma. Religious community's perception of stigma from the professional mental health community. Religious community's stigma towards mental health providers.
Religious identities guide help-seeking behaviors	Typical	Obedience to God guides behavior. Choosing religious interventions. Acceptance of Christian or non-Christian counselor.

General=All cases; Typical=5 to 8 cases.

Domain 1: Religion Provides Guidance and Greater Purpose

The ideas emerging in Domain 1 encompassed the participants' views of religion's function and role in their lives, with a General level of frequency shown across interviews. In identifying God as a source of guidance and greater purpose, participants spoke to the role of God in infusing purpose into one's life. This sense of purpose was led by the guidance provided by God, serving as a foundation for actions and decisions. Core ideas forming this domain included four concepts: God is the higher power, the

Bible is truth, seeking God's help through prayer, and the belief that God acts in life in ways humanity cannot alone.

God as foundational.

All of the participants in some way described the role of God as foundational in their lives. This core idea expressed a key aspect of the participants' relationship with God and their reliance on God to provide guidance and support. One participant, a 60 year old male named "Steve," offered that his religious faith functions as the foundation of his entire life, explaining:

> My faith, it gives every part of me meaning. Decisions I make daily are all based upon my foundation in life, and my base, my foundation is my beliefs in Christ, and my faith informs every decision that I make, all the way up to the daily tasks that I do each day. And so my faith informs every area of my life.

Hannah, a 23 year old female, characterized God and God's role in her life as, "God is my foundation, he's my rock. And with him I know I can keep going forward, and I know I can keep being happy…"Another idea reflecting God as a higher power involved the concept of humans putting God first. 38 year old William described God's sovereignty in his life this way:

> I trust in the plans God has for me. That the things that happen in life, or the things that are happening…there's always a greater purpose. There's always a greater plan for it… I often think that it's good to know that there's someone, that God is up there, and that there's someone who has a greater plan and a greater

design than we understand.

Similarly, Hannah stated, "…God is our foundation, he's our center." Laurie, a 27 year old female, shared about a personal struggle and looking to God for help, explaining, "…It's something that's ongoing where I've asked, 'Lord, will you just take this away so I never have to struggle with this again?' But that's not how he's wired me. It drives me to Jesus…"

The Bible is truth.

The core idea involving the Bible pointed to participants' belief that the Bible is truth and can be useful in obtaining God's guidance. Further, participants linked the Bible and its teachings as important in living a positive life. Mary expressed simply, "I believe in what the Bible says, what is true." Another participant described the Bible as part of trust and faith, and following it leads to positive well-being:

> …If you believe what the Bible says, if you believe the things that are being talked about every Sunday in church or the songs that you're singing in church or the things that you're reading in the Bible or the things that you're praying about, when you have that trust and that faith in Jesus, it contributes to your overall well-being, because you just understand that there is a greater purpose, that there is someone who has a hand in what is happening in your life.

William echoed similar ideas about the Bible:

> The reason that when you look at the Bible or you look at what it says, or what I believe are sort of the truths, and the designs that God has in there for life, He

> gives us to those so that we can have life and have it more abundantly. I think the things that are a part of that [the Bible] is the design that He gives us for the best way that we can live.

Hannah shared that following the Bible is following truth, stating, "…the Bible is full of truth. Just because you follow religion, doesn't mean you're going to be in full truth. You have to make sure you're following what the Bible says."

Seeking God's help through prayer.

Some referenced prayer as instrumental in obtaining help or guidance from God, a way of communicating with and discerning God's purpose and plans. Tom, a 33 year old male, stated "…the most important person to go to is to go to God in prayer." Steve explained how God gives him direction through prayer:

> But that's the gift of prayer, and the beauty of prayer, is that we can take it [difficult things] to a God that knows what's going on with us. He knows the number of the hairs we have on our head, He knows even before a word is formed in our mouth that it's gonna come. He's all-knowing, He knows all that kind of stuff, and he cares about what we care about. He loves us, and so He invites us to take that to Him in prayer.

God does for humanity what humanity cannot do alone.

Relatedly, God doing for humanity what humanity cannot do alone emerged as a core idea under Domain 1. Kim, a 25 year old woman who normally attends a nondenominational church, offered depression as an example of where God helps humans, stating, "Depression I guess in our church is a sense of…when you're depressed

you go to God because he's your strength and he's your joy." Tom described Jesus as helping fix issues, "[The Bible] has at least one or more verses where it says about how in order to go to God, you have to go through Jesus first. That's why Jesus is the answer. Besides, Jesus can help you with anything." Steve, who identifies as Lutheran, expressed:

> We're all born in the image of God, we're all created in His image, we all function in pretty much the same way. He's created us just in a very special way to survive, he created us with minds, it says in Deuteronomy, to create wealth, and so he gives us talents and skills and abilities…

Betty shared how God does for her what she says she cannot do: "With the faith, I recognize I'm incapable of fixing myself because I'm only human. God does the fixing. I just have to do some of the work and let him work in me." Mary explained, "I don't do anything in my own strength. Anything that I conquer, anything that ... any growth that I have is through the presence of God…"

Domain 2: Faith Alleviates Mental Health Concerns

The second domain represented core ideas related to the role one's religious faith plays in addressing mental health challenges, with a General level of frequency shown across interviews. Two primary ideas made up this domain—the necessity of being full of faith and that faith heals. Under this domain, participants spoke of religious faith—faith in God—as important to treating and finding relief from mental health concerns. For some, faith played a critical, central role in treatment, and in a sense was the treatment.

Necessity of faith.

This core idea encompassed the participants' view that religious faith is not just preferred, but necessary to living well. Sue, a 76 year old woman who identified as Methodist in her Christian affiliation, shared about her physical illnesses and pain she has lived with since her twenties, and pointed to her religious faith as vital to coping. She explained, "It's really my faith that has helped me to compensate and not dwell on the physical…it's my faith that keeps me going." Betty, a 54 year old female who identified as a member of the Assemblies of God, shared:

> If I'm contrasting to people that are outside faith, who, when they're faced with difficulty, have nowhere to turn but secular authority or other people and so life is often being battered by circumstances and feeling that this is all there is ... to try to fight through this and yes, they may have the supportive agencies or family, but not having that long view of, God is always with us, God will help us through it. We may go through this, but we're not alone in it.

Tom, who identified as a born-again Christian, spoke about the pervasive nature of faith in his life and its tangible effects:

> …how important it is to have faith that God's there or God is with us, God can help us, Jesus is the answer. We have faith in that, it says in the Bible about how you can't please God without faith, and how God can provide. God can help you. When you're going through whatever experience, whether the thing's good or bad, having faith can go a long way. That faith can really make a difference for your life to be great, because you have that faith…Faith is when you not only believe

> something, but you take action to go through life, believing that God will be there no matter what you're going through, no matter what.

Faith heals.

In addition to faith's necessary role in having positive wellbeing, participants shared their beliefs that having religious faith is part of healing or treating mental health issues. They emphasized faith in God as a source of help and support in difficult times or circumstances. Betty shared further about her own challenges recovering from mental health issues. She talked about the centrality of her religious faith in facing these concerns:

> When I went to the spiritual [treatment group], where they join the 12 steps and the faith together, that is when I started to find healing for my emotional and mental difficulties, so ... having the faith and having the faith bring me to that has made all the difference in my life and my life has just made a complete turn-around, in the last three years for that.

Tom expounded on his views, reiterating faith's positive effects:

> No matter how tough things are, you have faith that God is with you, that God will make sure things are all right no matter what, and how your life can be so much different mentally and physically and all around because of that faith.

For all participants, faith in God was tangible and important in living through challenges; Mary shared that God helps her with emotional experiences such as anger and jealousy:

> But people call it [faith in God] a crutch, but it's not a crutch. It's just ... it's how I live because God is my God and I know he's real. He actually helps, it's true. It's

> not like some self-medicated type of thing. I don't do anything in my own strength. Anything that I conquer, anything that ... any growth that I have is through the presence of God…

In discussing faith's role as a support in someone's mental health, Sue described it as:

> The perspective that faith provides is that there is a constant help or a constant ... I'm probably going to use the word support. I am going to use the word support here. There is a constant support to each of us individually and personally and within us, if we seek it to support whatever it is, whether it be our mental or our physical aspects, or our emotional.

William, another participant identifying primarily as a Christian without a specific denominational identity, talked about how his faith relates to his overall well-being, stating, "Just when you think of all the ups and downs of life and all the things that come at you, I don't know how people who don't have faith in Christ, how they get through a lot of the things that happen." Steve offered a simple response: "My faith incorporates everything that I am, including my mental health" Finally, Kim offered a related perspective, speaking to God's pervasive presence and faith interacting with all aspects of human wellbeing:

> I know that it [faith] is intertwined, it's the same how I believe that there are medical interventions but there's God overseeing all of those things. God is in all of it, God is in your spiritual, your physical, your mental wellbeing.

Domain 3: Perceived Support from Religious Community /"Family"

The third domain and its core ideas coming from the data reflected the role participants' religious community plays in their life, namely that they perceived receiving support from these communities, for some to the extent that their religious group was considered "family." Again, a General level of frequency occurred across the data. This support was considered beneficial in strengthening each other's religious faith, helping others adhere closely to the faith's teachings, and providing emotional and spiritual support in facing life's challenges. Importantly, this domain also reflected a preference for support that is religiously-based.

Church community is family.

Steve, a member of a Lutheran faith community, used "family" when referencing how his community might support its members with mental health concerns, explaining, "You would hope that they would feel a part of that family enough to reach out. And others would reach out to them, if they see them struggling." Betty spoke similarly, describing the minister at her church as "…the head of the family. The church here, very much they believe in that we are family." Laurie, a single woman, also described her church relationships as family, explaining:

> I see kind of the grandpas in the church. Some of them just consider me like their grandkid. I have a family that considers me totally their family. I go out to their house whenever I want to. They have a lot of children, and it's really fun to just be like an older sister.

Helping other faith followers become better followers and overcome challenges.

Beyond acting as family, some participants shared their views of the role their faith community provides, or should provide, in helping and supporting mental health concerns. This core idea consisted of viewpoints around a religious community's role in Christian believers' lives, namely being a help and support in these believers' spiritual lives and in overcoming difficulty, whether spiritual in nature or practical. Laurie shared how other women of her faith provide personal support:

> I look for guidance from mentors and role models in my life. I have a lot of Christian older women, like I mentioned, that kind of mentor me, take me under their wing, teach me what they've learned through their struggles. I'm a single 27 year old, and sometimes people are questioning, "Why aren't you married you yet?" I know what I'm looking for, and I know what I'm not looking for. There's a lot of not looking for out there.

As noted previously, Betty found support for addiction issues through her congregation's spiritual support group. Tom shared his view that churches should do more to treat mental health, "I don't think that really gets talked about enough, honestly, when it comes to church and mental health. I think, I really believe that church should deal with mental health a lot more, way more than they do."

Preference for religious-based support.

This core idea focused on participants' preferred means of support: ones that are spiritually based and line up with and affirm their Christian faith. Tom expanded on his thoughts about churches providing mental health support, views that included the belief that those who identify as Christian should get religious help:

> For one, not enough people go to the church for that. They don't think of it as an option… However, they also rely too much on regular therapists or help from the outside. As Christians, we should be relying on more toward the church for that kind of help and less on things outside of church. Then, the church [is] not providing it most of the time.

In responding to how she would address a mental health concern, Hannah emphasized reaching out to God, then trusted family members who would connect her to her pastor, if necessary:

> So honestly at first, I would probably try to handle it myself. And just pray to God, and eventually, like I said before, I would probably, if it got bad, like if I was really desperate, I would probably go to my boyfriend, and possibly even my older brother. And they would probably have to help me get to my pastor to talk about it.

Domain 4: Perceived Stigma

The concept of stigma that arose from the participants was captured by the team as perceived stigma, referring to negative attitudes, impressions, or actions they had encountered personally, observed, or feared could manifest. Typical frequency was demonstrated across the expressed views. Four core ideas comprised this domain: internalized stigma; personal and religious community's beliefs regarding stigma; the religious community's perception of stigma from the professional mental health community; and the religious community's stigma towards mental health providers.

Internalized stigma.

Some participants shared their personal sense of negative attitudes they held toward themselves, reflecting a stigma emerging from their self-perceptions of mental health challenges. In describing her own experiences with mental health issues and needing help, Hannah offered:

> I guess I was probably embarrassed, and full of shame, and guilt. I didn't want to go see someone, I was stubborn, and I guess prideful would be too. I didn't think anything was wrong with me. Was there? I don't know for sure.

Mary disclosed she had recently sought help for depression, but noted it took some time; she explained, “It's embarrassing for me to seek help on it. And to even talk about it or admit it.” In a follow-up question delving deeper into her experience with mental health stigma, she offered thoughts that suggested her self-imposed stigma was possibly influenced by her Christian community’s negative views of people with mental health concerns:

> Yeah, I'm not sure if the stigma was from the church exactly, but from all the people that I grew up around, and they were all very "Christian.” In our community which is just our family & stuff, and our friends, depression was just a person either being lazy or a person not trying hard enough. You know, the other mental disorders like schizophrenia or bipolar or anything like that, I didn't hear anyone talk about those. The depression was one ... I don't know where I got this idea, but I thought that's ... you can't admit to that or something. It's just you being, or it's just a person being lazy or something. I don't know where I got that idea, but it's strong. It's hard to break.

Personal and religious community's beliefs regarding stigma.

Participants talked openly about ways they perceived stigma's presence in their church or religious community and what they believed fueled that stigma. Some participants likened what they observed in their religious communities as being similar to stigma that occurs in society in general. For some participants, they held opinions that generational differences could have an influence on how mental health is perceived or talked about. Regarding her religious community's beliefs regarding stigma, Laurie shared that she observed a potential age difference, explaining, "I think there is some stigma in the church. I wouldn't say with people I spend time with, but my church has a variety of generations. There are quite a few people who are older." In a follow-up question, she explained further:

> I do think that some of it depends on the generation. For us, I feel like my generation talks about mental health a lot more than other generations. I think that that helps for us to realize there's some things that we don't have control over, and medication is the best course of action.

Steve offered this observation, when asked what he thought about stigma and help-seeking:

> They're afraid. They're afraid of what people might think of them. Maybe see it as a weakness. Maybe they're concerned about insurance, you know, "If I go and get help for this, counseling or medication, it's gonna cost me." Maybe concerned about what the cost will be. But I think mostly societal. Just pressure.

He included Christians from his faith community as well, further explaining:

> No doubt, it would apply to all human beings, whether they have a faith or not. It would be everybody. Definitely. I think it would be easier for the person of faith, because they're in a community of believers already. You would hope that they would feel a part of that family enough to reach out. And others would reach out to them, if they see them struggling.

Speaking in reference to his nondenominational congregation, William described his perception of stigma among his faith community, likening it the public stigmatized perception of mental health issues held by society as a whole:

> I think, generally, the church ... Not necessarily because it's the message from the church, but I think the church has the same issue as society as a whole, where we don't really deal with ... Mental health has such a bad stigma to it that people don't want to put out there that they're struggling with those things…I guess maybe what I meant by that is obviously, in our society as a whole, we don't want to show mental health. There's been a lot of talk about it, about how we need to do more for mental health. You hear it talked about when there's shootings. You hear about it all the time, talked about. I don't feel like in the church, people come in there and they're like, "Okay, I'm in a church so I can just talk about my mental health now and everything's cool." Stigma gets in the way. I can tell people that I've got this, this, and this struggle. I don't think the church is different that way. I don't think people always view it as a safe place to do it. I don't think it's necessarily because of something that my church, in general, is doing. I just think it's society that sometimes we carry those same weights no matter where we go.

> Even in what should be a safe place, like a church. Sometimes, I don't think there's that belief that, "I can just be open that I'm struggling with this."

Laurie shared a different experience regarding feeling or experiencing stigma, explaining she has felt free to share her MH concerns, even with other Christians:

> I do think that some of it depends on the generation. For us, I feel like my generation talks about mental health a lot more than other generations. I think that that helps for us to realize there's some things that we don't have control over, and medication is the best course of action… I do think the strong Christians I surround myself with too are just more open. It's okay. In the Bible, it talks about when we are weak, he is strong. I don't think we have to be scared to say, "Hey, I'm really struggling with this right now," or there are issues in my life… There's freedom, I feel like, when we're vulnerable and say, "Hey, I really need prayer for this," or, "I don't understand how this is going to work out for me. I have a lot of uncertainty about my future."

Religious community's perception of stigma from the professional mental health community.

Participants also talked about experiencing stigma related to their faith coming from mental health providers. This core idea captured participants' concerns that their religious faith and identity would be negatively viewed, misunderstood, or overlooked by professionals in the mental health treatment community. Mary shared feeling uncertain about how her faith would be perceived by providers, explaining:

> That [how I would be perceived] I don't know and that's probably why I'm a little leery to go to somebody who doesn't believe in God. Because I don't think ... I

> really don't think anyone who doesn't believe in God can grasp my mind or what I'm going through really.

Steve offered that the perception of his identity as a religious person could be positive or negative:

> If they're coming from a non-faith background, and I think you used the word, you mentioned it, stigma. They would have a stigma of me and this community, the faith community, that would be in a negative way. That's just the culture we're living in right now, today's world. Christianity is viewed in a negative sense, in many ways. The word Christian has some connotation to it. I'd rather use a follower of Christ, instead of Christian. I'm not saying Christian's wrong, but I think a person of faith, a follower of Christ, a believer. I think the professional mental health community would view me and the faith community in two ways. And that all depends on what kind of education do they have? Where did they go to school? What kind of teaching did they receive? What kind of church background do they have? What kind of spiritual journey are they on? So they're gonna view me based upon their presuppositions.

Laurie wondered that mental health providers would hold a negative view, stating, “They probably see me as ignorant or someone that is kind of narrow-minded, but I don't believe that that's true.” Hannah held the opinion that Christians would be held to higher expectations:

> I feel like some of them have high expectations for people of faith. Because they hear things, and if they read the Bible, they know, oh that's a good Christian life. I mean we are, but I feel like they maybe put higher standards on us sometimes.

Religious community's stigma towards mental health providers.

This core idea arose reflecting negative attitudes or views religious individuals may hold toward mental health providers, with these views appearing to be fueled by perceptions that the MH community would contradict their faith. In some respects, those outside of the fundamentalist faith may be perceived as "ungodly," or even dangerous to a person's faith by introducing ideas and concepts that appear to contradict, or fail to reinforce, a particular religious view or belief system. Thus, fundamentalist believers may hold negative, inaccurate, incomplete, or biased opinions of MH providers, particularly those who do not explicitly identify themselves or their treatment as Christian. In describing what she deemed important in a counselor, Laurie stated:

> You want a perspective that is godly. If you're just hearing a perspective from someone that doesn't see Christ, they might tell you a bunch of stuff that is not in line with God's word.

Tom expressed that for those who identify as Christian, seeking out secular, or non-religious, helps could be detrimental:

> I would say that someone is a Christian, then I would agree with they should only go to pastoral and not regular therapy. For anyone who becomes Christian, that should be what they just do, because that [going to regular therapy] could bring about confusion. You depend on the world, and the world's views, there's a lot of

> similarities, but there's a lot of differences and mixed in ideas that aren't exactly the ways of God with the stuff that could be putting God's ways plus the world ways together. That's not so good.

Domain 5: Religious Identities Guide Help-Seeking Behaviors

The fifth and final domain, religious identities guide help-seeking behaviors, demonstrated the culmination of what participants would practically *do* regarding getting help for a MH issue; this was represented with Typical frequency. As shown in previous domains, their faith, their identity as a religious person, was the catalyst influencing their behaviors. This domain encompassed three core ideas: obedience to God as the determinant of behavior; choosing religious interventions, and acceptance of Christian or non–Christian counselors.

Obedience to God guides behavior.

Participants shared a perspective that obedience to God and Christ was a salient determinant in how they live their lives, and how they behave. Hannah stated:

> We seek things to please, just like if you have a spouse, or some significant other, you want to please them, you want to make them happy, just like God. I want to please him, I want to make him happy, so I want to be obedient. He's the king of kings so yes we obey by like the law of man, like our governors, our President, et cetera like that, but God is the ruler of everything. He's our creator, so he's the one that we should obey the most.

Steve explained that faith guides his actions, "Decisions I make daily are all based upon my foundation in life, and my base, my foundation is my beliefs in Christ, and my faith

informs every decision that I make, all the way up to the daily tasks that I do each day." Mary included the Bible as a guidepost for action, stating, "I put Jesus as Lord of my life and King of my life…Basically, it looks like obedience to the word of God, which is the Holy Bible."

Choosing religious interventions.

In responding to a question regarding how they would address a mental health concern, several participants referenced faith-based interventions, with some participants talking about being open to both faith-based and secular strategies in addressing their mental health and wellbeing. Kim stated, "I would pray about it first. Then I would ask God to bring me wisdom." Tom also espoused turning to God in prayer first to address a mental health concern. He stated:

> I guess unless it was really serious, go to God and Jesus in prayer. Then even if it is serious, the best thing to do is go to God and Jesus in prayer. Then do the best to rely on God with whatever should happen, because you could say, call a crisis number, or talk to a therapist, or a pastoral counselor, which all could be good, even though, like I said, I recommend pastoral counselor if the person is a Christian.

Sue talked about being open to counseling to address mental health concerns, but also added an important caveat for her would be the inclusion of spirituality. She stated, "…I would have to have a counselor who was open to a mix of spirituality and counseling theory, counseling practice…I know counseling does not impose but if the person were

not open to a spiritual orientation, then I would seek a different counselor." Similarly, Steve offered he would turn to spiritual sources:

> Yeah. If I needed some professional help, I would definitely call the [Name] Christian Counseling. They have a biblical worldview on how counseling works, whether it be addiction or depression, just struggles of any kind. And so I would go to [Name] right away. I know those people… [Z] is the director, I know him. I'd go to [Z] directly. If he wouldn't be able to help with their counseling center, then he would steer me in the right direction, with somebody else, if it was something else that I needed help with. So that would be my plan of attack, go to family and friends first, and then professionally, go to [Name], to seek other help if I needed it.

Laurie explained she would turn to others, including her pastor, whom she expected would provide a spiritual intervention: "Probably friends, a couple close friends. Depending on how severe it was, I might go to my pastor and just ask him to pray." However, she also expressed openness to a variety of treatment methods beyond overtly spiritual:

> I know that for me, when I'm really struggling, it helps to go exercise. I remember learning in a psychology class, exercise is more effective than medication sometimes. It's long-term, and you don't get addicted to the medications. I think there's a variety of ways to cope with mental health issues, but I definitely think that sometimes medication does help the most. It really depends on the person.

Acceptance of Christian or non-Christian counselors.

This core idea encompassed participants' thoughts regarding their choice of counselor, given they ever decided to seek out counseling, and if they would choose either a Christian or non-Christian provider. In following up regarding next steps after praying about a concern, Kim expounded on the importance of counseling:

> Honestly, I think it's good to talk to a counselor. I think it's good to be aware of your mental health and your mental state. Talking to a counselor, yeah absolutely. Not a religious counselor but actually a regular counselor, that I have no problems with.

Laurie endorsed the idea of counseling and that she has sought counseling, but specified it was a person of faith who included spiritual practice in session:

> Yeah, but she is, it's a Christian practice. That was one nice thing is that she's able to pray with me at the beginning, and at the end of our session. She just sees things from the Bible's perspective. She's able to say, "Yeah, that would frustrate me too if this was a different situation, but if this person is not a person of integrity and doesn't follow through, I can understand why you're frustrated, but we also want to love him like Jesus does."

Hannah was also clear in her acceptance of a Christian counselor:

> If me, or if someone I knew, I just personally I believe that if I was ever to get to that state [of needing help], then I would want a Christian. Because they're going to more than likely, not saying that others wouldn't, but since they're Christian I know they're going to center around God.

CHAPTER IV

DISCUSSION & IMPLICATIONS

This project focused on exploring and understanding fundamentally religious individuals' perceptions and experiences with mental health, stigma, and help-seeking. Five domains emerged from the participants' interviews, covering a range of viewpoints including religion and religious beliefs' roles in providing guidance and purpose, alleviating mental health concerns, and guiding participants' help-seeking preferences and behavior. Further, key themes arose regarding the role religious communities play in supporting one's religious beliefs and how they might contribute to the presence and experience of mental health stigma, and the lived experience some participants have had with stigma. The findings highlighted ways that participants' religious beliefs and viewpoints intersected with their mental health and wellbeing, ultimately providing guidelines for seeking out supports for their mental health.

Roles of Faith and Religious Belief

Domain 1 captured participants' views on ways their religious beliefs provide them guidance and purpose in life. Their responses clearly revealed a reliance on God as a higher power, a being capable of providing strength and support to people in their struggles. Part of recognizing God as sovereign was the belief that God should be included in every aspect of life, and not only included, but viewed as the authority in prescribing rules and guidelines for living. This authority was perceived as emanating

from the Bible, a text considered by participants to contain truth and *be* truth. Therefore, the Bible was considered useful in discerning God's will and intentions for those who follow God. This reliance on God for direction and wisdom laid the foundation for how participants thought about mental health and wellbeing, and what they decided to do when they faced a struggle.

Importantly, relying on God also reflected the idea that God does for people what they cannot do alone. Various participants asserted a position that though they can, and do, act in their own lives, this agency was perceived as limited, with a belief that ultimately, God was the one able to fix, heal, or transform. Such views seem reflective of different styles of problem-solving that incorporate God as an agent, explored previously in literature examining how those who hold religious beliefs include God in the problem-solving process (Pargament et al., 1988). This study demonstrated different ways individuals tackle life issues and the role religion plays; these approaches were then analyzed and ultimately led to the description of three main styles: Self-Directing, Deferring, and Collaborative. As the names hint, a Self-directing style takes the stance that the individual has the resources within to address challenges, with the belief God granted those abilities to solve one's problems. Alternatively, those with a Deferring approach look to and wait for God to provide solutions, thus viewing God as the generator of answers. The Collaborative stance blends these two polar styles, reflecting

the belief that both the individual and God are active in problem-solving, with the sense of the individual being strengthened by God.

Fox. Blanton, and Morris (1998) conducted a follow-up study that tested these problem-solving approaches on a group of male clergy members and their spouses. Results substantiated Pargament et al's previous findings, and highlighted the potential utility in understanding unique challenges clergy couples and families may face and how their approaches to handling life's stressors may influence their constituents. Within the present study, participants offered descriptions or examples of how they approach personal issues that appeared consistent with the Deferring and Collaborative approaches, demonstrating that important distinctions exist between believers, even when they hold to similar doctrine. Understanding religious individuals' personal approaches to and methods of solving problems holds potentially significant implications for providing mental health treatment to fundamentalist believers. Recognizing how a client includes God in solving problems may provide helpful insight and guidance to practitioners in implementing religiously-sensitive interventions and approaches.

One spiritual exercise, prayer, was perceived as a vital means of communicating with God and getting God's support and guidance. Therefore, it fits accordingly that prayer would be utilized as a tool, or means, for treating one's mental health concerns. This has been demonstrated in previous literature that highlighted Christians' use of prayer to alleviate mood concerns such as depression and anxiety (Boelens et al., 2009;

Trice & Bjorck, 2006). Interestingly, one participant, Kim, specifically named depression as something God provides remedy for; from her vantage point, when one is depressed, turning to God provides joy and strength.

Johnson (2018) wrote an overview outlining the many forms of prayer engaged in for centuries and the positive effect it can have on depression. He points out prayer as a practice that engages a person holistically—mind, body, and spirit—and therefore may provide unique benefits not found in traditional treatments such as medication. In one of its more ancient forms, prayer can have a centering, meditative quality that is reminiscent of mindfulness; Knabb (2012), drew comparisons between mindfulness-based cognitive therapy, a treatment inclusive of mindful meditation and relating differently to one's thoughts, emotions, and physical sensations, and centering prayer, a religious practice emphasizing connecting with God in the present moment and relating differently to one's thoughts. In this way, prayer, a religious expression, and cognitive therapy, a psychological theory, may find a partnership. Therefore, mental health treatments inclusive of meditation or prayer practices would likely be more appealing and trusted by individuals who look to God as a key, vital source of truth, strength and support.

Closely related to Domain 1 was Domain 2, where participants expressed the critical role faith plays for them in alleviating mental health concerns. They offered that faith was a necessity for their lives, undergirding and encompassing all aspects. What participants shared about their faith had a pervasive quality to it, with faith being

expressed beyond the spiritual compartments of life, and finding influence in physical health, decision-making, emotional concerns, and overall sense of well-being. A strong sense of faith being positive, supportive, and providing strength for life came through, as opposed to alternative attitudes some participants imagined others might hold, that faith is a crutch or somehow intangible. Rather, participants held a view their faith impacted their lives in real, tangible ways.

Past literature has repeatedly shown that faith and religious practice can be linked with positive well-being; for example, positive forms of prayer such as thanksgiving and adoration have been correlated with subjective constructs of well-being such as optimism, self-esteem, and life satisfaction (Whittington & Scher, 2010). One study drew upon the 9-11 terrorism crisis to measure the effects of prayer and spiritual support on coping; their outcomes showed prayer was used as a coping mechanism for negative emotional reactions, correlating with less distress, and that spiritual support (defined as an intimate relationship with a deity figure) and positive attitude mediated the effects of prayer on distress (Ai, Tice, Peterson, & Huang, 2005). Individuals holding high levels of intrinsic faith, or faith in and reliance upon a deity, have been shown to experience significantly lower levels of anxiety and depression (Laurencelle, Abell, & Schwartz, 2002). More specifically to believers who hold fundamentalist religious views like the participants, Evangelical Protestant individuals have demonstrated higher levels of religious

commitment, which in turn predicted lower depression, hostility, and experiencing greater meaning in life (Tix, Dik, Johnson, & Steger, 2013).

Taken together, these studies offer an overall picture of faith's impact on psychological health and well-being, paralleling the lived experiences and views of this study's participants. For them, faith appeared to go beyond mental assent to doctrine or religious opinion, but offered real relief, real help, real support. It is not surprising, then, that participants did not separate their faith from their struggles, or suggest that God would shield them from hardship, but expected their faith, their connection to God, to heal, change, or transform them in a positive way. In this case, participants readily acknowledged hardship, challenges, struggles, and pain, but met those circumstances with a belief that God was present, *is* present. This seemed to produce a sense of resilience in the respondents, as reflected in Sue's view of taking "the long view of life" and persevering in God's strength. For mental health providers who may encounter clients with these religious identities, qualities such as an abiding faith and hopeful expectation in God's help could be highlighted as strengths or protective factors, and provide a wealth of motivation, meaning, and commitment to the therapeutic process.

However, for someone looking to God as holding the answers to a mental health challenge, reliance on God could negatively impact the HS process. As previously discussed, those holding more fundamental beliefs typically view God as an authority and possessing truth. If solutions offered are purely psychological or devoid of religious

content, help in this form could be viewed as ineffective or less desirable for lacking an explicit inclusion of spiritual interventions. A 2002 study with Protestant Christian adults in the southern region of the U.S. found that those considered "highly conservatively religious" held expectations that counseling would include religious practices such as prayer and scripture reading, and use of religious language (Belaire & Young, 2002). This may present a challenge for non-religious practitioners unfamiliar or uncomfortable with religious belief or practice; by extension, this challenge could impact training programs that seek to be multiculturally sensitive. One question to possibly address this gap between religious clients' expectations and practitioners' methods is, how do programs best prepare trainees to provide this level of culturally-derived intervention? This will receive further consideration in the Clinical Implications section.

Under Domain 3, participants expressed that part of sustaining and strengthening their religious beliefs and practices was their connection to a religious community, with several interviewees choosing familial language to describe those relationships. One participant's characterization of her church's minister as the "head of the family" pointed to a deeper level of connection, intimacy, and familiarity between that church's members. Other characterizations from the interviews reflected similar connections and a sense of expectancy that one's fellow community members stand in roles that family would typically fill, such as relationship advice or love and acceptance. From the descriptions provided for this study, participants saw those relationships as overwhelmingly positive,

helpful, and nurturing. Their collective answers spoke to a sense of trust in their faith communities—trust in their guidance, their shared wisdom, and perhaps most importantly, their ability to provide help when someone is struggling, including mental health-related issues.

Unsurprisingly, this trust and commitment resulted in reflecting a preference for religiously-based support and help. Given the trust and commitment participants felt within their particular faith communities, it made sense that when help was needed, this group would turn first to that community. Although some participants expressed in later domains they would be open, at some point, to non-religious sources of treatment, a clear pattern emerged from the data regarding first steps and preferences: first, seek out God personally and directly; second, turn to your Christian community and leaders for help and/or guidance; and finally, if the situation warrants further attention, access safe (religious) counseling. This pattern is congruent with the research offered in the literature review that demonstrated those adhering to more a fundamental, conservative religiosity hold high views of religious authority and submitting to it (Blogowska & Saroglou, 2013). Further, as Wamser, Vandenberg, & Hibberd (2011) pointed out, this population of religious followers often views their MH struggles as spiritually-based, not psychological. Therefore, it follows they would seek spiritual answers first, if not exclusively. Interestingly, some participants offered that the Christian church as a whole should provide specific help for mental health or life issues, in essence bringing together

the spiritual and psychological. Steve's description of reaching out for MH needs pointedly included seeking services at a local Christian, "biblically based" counseling center. A perusal of that organization's services via their website revealed commitments to both Christian teaching and professional counseling, summed up in a mission statement as:

> …believes that God, through the Lord Jesus Christ, has all power to guide and carry people through the hurt, uncertainty, and pain of their lives. In the process of counseling, and within the context of a caring community of believers, each individual client is offered healing, restoration, strength, love, and comfort.

For these participants and other individuals valuing inclusion of their faith with their MH treatment, centers offering explicit "Christian counseling" may fill the gap between faith and secular psychological services. However, not every community may offer such specific services, particularly in highly rural areas, leaving individuals to rely on simply what is available, religious or otherwise. Further, expanding religious fundamentalism to non-Christian faiths such as Islam or Judaism, religious adherents of those religions may also prefer that their specific beliefs be central in their MH treatment experience. Addressing these religious populations is beyond the scope of this study, but could warrant future consideration in delivering culturally-sensitive services to these groups.

Given the body of research conducted on religious fundamentalism's stance on the origin of mental health issues being somehow sinful, the apparent openness and desire

to share their struggles, on some level, with their faith communities ran counter to a sense of needing to confess sin or wrongdoing, a desire to cover up an issue, or a hesitancy in being forthright. Instead, participants viewed those sources positively and as offering assistance, not judgment. Though seeking help from a pastor or church leader does not equal seeking professional services, it illustrates a willingness to one, recognize when outside help may be warranted, and two, an opportunity for the individual to get connected to helpful treatment, whether through the leader, a Christian organization, or another community entity.

Stigma and Help-seeking Behaviors

Experiencing and/or perceiving stigma related to mental health was expressed by several participants. Some spoke about internalized stigma, ways they perceived their own experiences with mental health issues; others talked about stigma from a public or social perspective, including faith communities. Various personal factors seemed to have an impact, including generational status and personal encounters with MH concerns.

Internalized/self-stigma. When talking about internalized stigma, those who experienced it shared feeling guilty, ashamed, or embarrassed for their issue(s). For one participant, Mary, she considered her self-stigma as being influenced by the Christian community she grew up around, sharing that they held negative views of people with mental health concerns. From her perspective, those concerns reflected a character or moral flaw. Mary's lived experience correlates with Vogel's theory regarding self-stigma

as the process of internalizing society's negative view on an issue (Vogel et al., 2006; Vogel, Bitman, Hammer, & Wade, 2013). Further, her community's negative attitude toward those with MH concerns (Mary cited depression, specifically) has been demonstrated in studies looking at Christian religiosity and attitudes toward mental illness (Adams et al., 2018; Stanford, 2007), and stands as an example of public stigma (Vogel, Corrigan 2002). To be precise, both Adams et al.'s and Stanford's studies used serious mental illness, i.e. schizophrenia, in their methodologies; other studies cited in this project included mood disorders (depression) or substance use to measure attitudes of stigma (Ben-Porath, 2002; Link et al., 1999). Across these studies, individuals with MH concerns or illness experienced stigma in some way.

Importantly, it should be noted that some participants did not perceive their religious community as contributing to a personal sense of feeling stigmatized. For Laurie, she perceived that older members of her community were uncomfortable with discussing mental health concerns, but was explicit in pointing out that her generation (she is 26) talks much more about mental health, leading to her feeling freer in discussing it with others. In Betty's situation, her congregation provided religiously-oriented treatment as part of their core teachings and programming; further, she expressed receiving understanding, care, and support for her concerns and did not report feeling stigmatized by her religious community. Fully exploring what contributed to a lack of perceived stigma is beyond the scope of this project, but Crisp and Turner's (2009)

project, mentioned earlier, demonstrated that having positive imagined contact with a member of a outgroup reduced negative perceptions of that outgroup. Comparing this outcome with Betty's experience, it is possible her church community's inclusion of MH programming helped reduce negative perception of individuals with MH concerns. Further research could lend valuable insights into this process within religious settings or organizations.

Public/social stigma. Other participants, though denying experiencing stigma personally, shared observations that mental health stigma is an issue and had been observed in society as a whole and in their respective churches. In two instances, participants believed stigma was present in their congregation's members, despite the church being perceived as a place one ought to be able to feel safe enough to share any concerns. However, the participants held fairly divergent views on whether or not people *did* feel safe, i.e. non-stigmatized, in sharing their struggles. One interviewee hoped that given the nature of church being a welcoming, accepting place, his fellow members would seek help from others in the church, though he suspected some would fear being perceived as weak (self-stigma). A second interviewee held no such illusions; from his perspective, church is simply a reflection of the society around it—if society is leery to talk about MH struggles, then all those in the local society who come to church bring with them those same hesitations, resulting in people not feeling comfortable talking about MH. His response did not provide a clear sense of whether public or self-stigma

was more prevalent, but part of his comments focused on how MH takes center stage whenever violence, such as a mass shooting, is reported in the news.

His observance conjured a common stereotype attached to mental illness, that those with MH concerns act more violently (Corrigan, 2004; Corrigan et al., 2010), and is a prime example of public stigma at work. Under Corrigan's (2002) public stigma model, stereotypes, or beliefs held about a certain group, are a key component of stigma, along with prejudice and discrimination. When a stereotype is held, it leads to agreement with the belief (prejudice), and finally, acting in accordance with the belief (discrimination). In general society, those discriminatory actions have barred individuals from jobs or housing; in a church or religious community, discrimination may take the form of social exclusion (Adams et al., 2018) or being counseled to stop taking psychiatric medication (Stanford, 2007). Ultimately, one of the most concerning outcomes of stigma and discrimination is failing to reach out for help from available sources, whether spiritual or psychological in nature. As already discussed, far too often stigma prevents individuals from connecting to what they need.

Conversely, another participant who felt free to share MH struggles with her close Christian friends and church members, did not experience internalized stigma, nor voiced being influenced by public or social stigma. In that instance, because her valued social circle of influence, her faith community, normalized struggles and encouraged sharing, public stigma did not seem present and therefore, the individual could seemingly accept

and face her struggles as well. This participant contributed her lack of feeling stigmatized in part to generational differences, explaining that she believes her generation talks more openly about MH than previous generations.

Understanding why some individuals don't experience mental health stigma may be just as helpful as teasing out what causes it. In the cases of Steve and William, they reported strong observations of public stigma, but did not endorse self-stigma. This was not surprising, given neither of them affirmed experiencing a MH concern personally. Of note was their perception that public stigma exists, has negative impacts on individuals, and that stigma should be reduced, despite their lack of personal struggle with a MH issue. It was not clear what factors contributed to these men's abilities to not hold stigmatizing attitudes themselves, but past research has shown that exposure to or contact with a stigmatized group can reduce negative perceptions (Conner et al., 2018; Crisp & Turner, 2009). Steve and William both disclosed they held leadership positions in their congregations, putting them in contact with a wide variety of congregants. Their contact with these individuals may have alerted them to the presence of MH issues, and the accompanying stigma, thereby counteracting any negative views they may have held.

Another angle on stigma came through the interview data, involving the perception participants had that the professional MH community held stigmatized attitudes toward religious folk, and that in turn, religious individuals might have negative perceptions of MH professionals. For some participants, uneasiness was expressed that a

secular or non-religious provider would view faith negatively; one individual used "crutch" as a metaphor, and others were concerned their faith would simply be ignored or overlooked. Based on the demonstrated importance faith held for this group, influences seen as harmful or dismissive would be one, viewed negatively (unhelpful, undermining of faith) and two, avoided in favor of spiritually-based interventions. Past research confirms these concerns, demonstrating that highly religious individuals held more negative expectations of secular counselors, i.e. they ignore or misunderstand spiritual concerns, offer solutions contrary to their faith or moral standards, or doubt the utility of God's influence (Keating & Fretz, 1990; Worthington & Scott, 1983). These concerns could speak to the presence of a religiously-oriented type of stigma, where someone's religious or faith identity is negatively perceived or is feared to be seen as negative, resulting in a person of faith not seeking out available MH resources. Further studies exploring how MH providers view religious clients or address personal bias around religion could be instrumental in teasing out stigma and its effects on this population.

Impact on help-seeking. From the nine individuals' input in this study, public or self-stigma as conceptualized in Vogel and Corrigan's models did not appear to be the primary barrier to or influence upon their help-seeking behavior; rather, their concerns about their identities as Christians and their religious beliefs being negatively viewed shaped *where* they sought help and from *whom*. When participants discussed specifics regarding what they would do if facing a MH concern, three primary faith-related

components came forth from the data—acting in line with/obeying what God would say, using spiritual practices such as prayer, and choosing counseling if offered by a Christian or religiously-oriented provider. These items are explicit in their religious orientation, overwhelmingly highlighting just how intertwined these participants' faith and Christian identities are with their decision-making around help-seeking. Even for a participant like Kim, who was open to a "regular" counselor vs Christian, her first inclination in addressing a concern was prayer and asking God for wisdom. Laurie demonstrated a similar openness to secular interventions such as medication or exercise, but again, initially sought out spiritual sources. Seeking out religious leaders for MH help is not uncommon for religious individuals; in fact, studies have shown that clergy often act as front-line providers of MH care in recognizing and treating psychological distress (Weaver, Flannelly, Flannelly, & Oppenheimer, 2003; Wang, Berglund, & Kessler, 2003). Therefore, opportunity exists to partner with clergy in reaching and educating faith populations about mental health, with the hoped-for outcome of reduced stigma between these groups and increased psychological help-seeking.

This preference for Christian-based care reflected a pattern of who participants believed they could trust, starting with who they trusted to confide in and provide guidance or next steps to take for treating their MH. Well-established in the counseling literature is the importance of trust in the therapeutic relationship and its impact on positive treatment outcomes (Rogers,1957a; Kirschenbaum & Jordan, 2005; Quinn,

2011); for deeply religious individuals, the ability to trust must include their faith identity being recognized, affirmed, and/or valued in some way. For practitioners, the field's ethics codes directly address the vital importance of fidelity and respect for clients' rights and dignity, a principle designed to recognize and respect elements of diversity and multicultural differences, including religion (APA Code of Ethics, 2010; ACA Code of Ethics, 2018). Despite clear ethical guidelines regarding respect for and engagement of client spirituality and religion as part of multicultural competence, this area of multicultural competence has received less attention than more salient factors such as race and sexual orientation. Ways counselor training programs can address this disparity is addressed under Clinical Implications.

One question to consider is, what might explain this continuum of care, from those believers only comfortable with strictly Christian-oriented treatment, to those open to secular sources? Research has shown that those with higher amounts of religiosity, both internal (personal belief) and external (religious practice) tend to prefer religiously-oriented help (Crosby & Bosley, 2012; Belaire & Young, 2002). Given this, clinicians' awareness of how individuals may differ in spiritual identity, how strongly they hold their beliefs, and what practical implications their faith may have, can assist in providing more effective treatment and interventions for those religious clients who do opt to seek out professional counseling.

Clinical Implications

Clinical practice. First and foremost, participants' experiences with their faith, mental health concerns, and professional psychology carry potential positive impacts for the delivery of culturally-competent and effective mental healthcare to fundamentalist Christians, beginning with designing outreach to provide education on the benefits of MH treatment. Given the hesitancy this population may have in approaching professional treatment, working with clergy and local churches in the community can provide avenues of connection and mutually exchanged information, resulting in reduction of stigma and increased understanding of the other group's perspective. A 2012 study performed a review of all published literature focused on MH established outreach programs designed to reach clergy and congregants (Singh, Shah, Gupta, Coverdale, & Harris, 2012). Some of the prominent elements of the reviewed programs included support groups for families with mentally ill members, where educational pamphlets and a hotline service were featured; half-day workshops provided by MH professionals at local churches; and the fostering of relationships between clergy members and community psychologists, resulting in referral services where continuity of care for the individual's psychological and spiritual needs received attention (Milstein, Manierre, Susman, & Bruce, 2008). Evaluation of the outreach and support efforts showed positive scores for increased

knowledge of MH and satisfaction with the group. Unfortunately, none of the studies specifically measured impact on clients or clergy attitudes; this represents opportunity for future research.

As referenced earlier, some participants were open to counseling for treatment, but expressed reservations about non-religious providers, citing feeling misunderstood in some way as a barrier. For religious clients who do venture into counseling, knowing their beliefs will be acknowledged and respected could be vital in creating connection with them and contributing to an overall positive view of professional MH care by religious communities. Practitioners could accomplish this and build trust by offering explicit affirmation of the client's religious identity. A parallel process could be found in gay affirmation therapy (GAT) (Alessi, 2014), a technique of sorts whereby the clinician offers explicit affirmation of the client's sexual orientation, as opposed to taking a neutral stance (Medley, 2018). GAT focuses on reducing minority stress for those outside of the dominant culture, creating a safe, accepting environment. Although Christians belong to the dominant religious majority in the U.S., within the confines of the mental health profession, these religious individuals may experience similar stress, of being stereotyped, misunderstood, or discriminated against, as these participants expressed. By offering explicit affirmation, any attitudinal barriers between client and clinician may begin to dissolve.

Training Programs. Multicultural competence has taken a prominent role in counseling training programs, with emphasis on producing clinicians who are culturally sensitive to all aspects of clients' identities, including race, ethnicity, gender identity,

sexual orientation, religion, socioeconomic status, age, and disability status. A review of the *Journal of Counseling Psychology* literature from 1963 to 2015 found the studies in multiculturalism replete with examples focused on racial/ethnic identity and sexual minority status (Oh, Stewart, & Phelps, 2017), but little attention, if any, on religious identity. Rightfully so, counseling psychology (CP) as a discipline has recognized the inequity and gaps in service with marginalized groups, and sought to promote social justice and culturally-appropriate care for all; these objectives and values are at the core of CP training programs (Scheel, Stabb, Cohn, Duan, & Sauer, 2018).

Although Christianity is the dominant religious group in the U.S., as a religion it encompasses a widely varying set of groups, denominations, and congregations. Those expressing fundamentalist views and beliefs make up only one part of the dominant group, and in some settings such as urban cities, may actually hold minority status. Further, fundamentalist-oriented individuals from other religions such as Islam and Judaism may desire faith-infused treatment, and experience similar trepidations in approaching secular counseling. Sublette and Trappler (2000) highlighted cultural issues that arose in the inpatient treatment of Orthodox Jews with major psychiatric illnesses, including differences in values such as modesty and social contact between genders, necessity to separate from secular culture, and restrictions on appropriate topics for discussion with others. The department of psychiatry at this study's hospital sought to increase staff's awareness and sensitivity to these issues by adding specific religious and spiritually-oriented trainings, resulting in more effective treatment for this population.

This study stands as an example of the numerous religiously diverse presentations that can be encountered within the MH field, and points out the need for tailored trainings.

For counseling training programs, insuring and evaluating students' multicultural competency is a key task and central to the delivery of ethical treatment (Scheel et al., 2018). Researchers interested in the specific inclusion of spirituality and religion have looked at measuring trainees' spiritual competence (Robertson, 2010). This study aimed at developing a scale measuring spiritual competency in counseling trainees, with items such as "coping strategies are influenced by religious beliefs;" "a client's perception of God or a higher power can be a resource in counseling;" and "clients' use of spiritual language is something for a counselor to be aware of." The scale was tested with 701 counseling trainees from 18 secular and 10 religious-based universities, and across the board, trainees yielded scores below competency, particularly on the Cultural and Worldview subscale. This demonstrated a specific knowledge gap around treating individuals with strong religious beliefs and addressing issues related to spirituality. By increasing spiritual competency, trainees are better equipped to engage those clients, resulting in more culturally appropriate care (Leighton, 2016), which in turn, can reduce stigma for religiously-oriented individuals in need of treatment.

Regarding Pargament's (1988) religious decision-making model using Collaborative, Deferring, and Self-directing styles to describe the interplay between one's faith and making choices, incorporating academic discussion points centered on how religious clients make choices would provide a fruitful occasion to expand trainees' abilities to conceptualize around multicultural issues. Considering religious beliefs'

influence on decision-making would be an excellent opportunity for trainees to link their conceptualizations around religious identity to treatment, in tangible ways that lift theoretical knowledge above mere mental exercises and academic discussions, to a level where real application is possible and demonstrated.

Another critical aspect for trainees' cultural competency is understanding their own identities, including their belief system, spiritual or otherwise, and how those identities impact interactions with clients and the therapeutic process. The body of counseling literature is replete with studies that demonstrate how a counselor's self-identity and their awareness of those identity pieces makes a significant impact on their clients and the therapeutic relationship and process (Collins, Arthur, & Wong-Wylie, 2010; APA, 2002; Constantine, Juby, & Liang, 2001). The concept of *cultural auditing*, where clinicians engage in self-reflection surrounding their intersecting identities, offers rich opportunity for counselors to reflect on self, the client, and the therapeutic alliance, and bring that knowledge directly into session. Collins, Arthur, and Wong-Wylie (2010) propose a comprehensive step-by-step audit process with detailed questions/areas of reflection that guide the MH provider in considering how culture identity is impacting the work. Topics encompassed in the audit include the ways culture might influence initial intakes or appointments; how cultural identity shapes the clinician's conceptualization of the client's concerns; how cultural identity of both client and therapist might affect clinical goals; and how evaluation of progress made in treatment may be influenced by culture. Including a counselor's religious or spiritual identity, or lack of this identity, would make for a fuller, more comprehensive understanding of how beliefs held may

manifest in the therapy relationship. Ultimately, clients with spiritual identities will be better served when all aspects of their identity receive careful and thoughtful attention.

Given the trepidation and uneasiness expressed by some participants in this study, building trust with fundamentally-religious clients takes on a deeper meaning and higher priority. In addition to counselors reflecting on their own identities and increasing their spiritual competency, considering ways the therapy environment reflects the clinician's values that may differ from their clients, is a worthy task to undertake and provides another excellent opportunity to engage in self-reflection around one's cultural competence and ways culture influences the therapeutic process. Clinicians who choose to display a Bible or other religious writings, for example, likely communicate, intentionally or not, that they embrace certain values or hold particular beliefs. Of course, clients will perceive that through their own cultural lenses, and may cast that therapist in a certain light. The same principle can be applied to a host of expressions used in a clinician's office—photos, books, decorations, favorite quotes.

For both trainees and experienced clinicians, even considering how clients might be affected by office spaces can spark ways the field can express welcoming, open, and nonjudgmental attitudes to clients from a myriad of backgrounds and beliefs. Efforts have been made in recent years to communicate counseling centers as safe for LGBTQ clients via providing training to counselors and trainees on how to create safe space for this population, and then using simple door placards that advertise the office as safe (Finkel, Storaasli, Bandele, & Schaefer, 2003); similar programs aimed at student veterans have risen up in efforts to better support the needs of this group (Dillard & Yu, 2016). These

efforts can reap tremendous benefits in connecting with many minority or cultural groups by fostering inclusionary attitudes and explicit practices that communicate warmth and acceptance, even before words are exchanged in session.

As practitioners engage in these reflective processes, they will inevitably find that their values differ from some or many clients, or that clients identify in ways that for some individuals, represent values and beliefs at odds with each other. A notable example involves clients who identify as a sexual minority and also as Christian, at times fundamentally Christian. Within many fundamentalist-based communities, identifying as LGBTQ has been considered wrong, sinful, or at odds with religious beliefs. Oftentimes, LGBTQ individuals have encountered judgment or resistance. For a population that has faced considerable discrimination and mistreatment, it is imperative that clinicians provide sensitive and ethically-sound treatment, or they risk doing harm (APA, 2002). For clinicians who find themselves holding personal, including religious, beliefs at odds with their professional values and ethics, a self-reflective process of their own identities and how it impacts clients must include a plan for how that therapist will manage that discrepancy, including supervision and input and guidance, beginning at the initial stages of training. As the GAT model demonstrates, LGBTQ clients often benefit from clinicians offering overt affirmation of their sexual identity, rather than neutrality (Alessi, 2014). In cases where a clinician has difficulty affirming a client's identity, sexual or otherwise, due to personally held beliefs, it is vital they seek out ways to resolve that conflict in order to best serve the client. That resolution begins with a firm foundation of

multicultural sensitivity and competency, fostered and developed in training environments that embrace and teach diversity and inclusion.

Limitations and Directions for Future Research

One inherent limitation in conducting qualitative studies is their emphasis on the lived experiences of a narrow pool of people; in this study, nine participants were interviewed, offering a limited perspective. Therefore, drawing generalizations from these nine interviews to apply to the wider population of fundamentalist Christian believers is not desirable or appropriate. It should be noted that understanding common themes and similar experiences is helpful and holds great utility for working with this population, but those commonalities serve only as a framework for understanding; attention must always be paid to individual differences. As discussed earlier, great variation exists among religious groups, and even those belonging to the same congregation or denomination may differ in their beliefs, experiences, and level of religiosity. This variation presented as a second limitation, in that isolating religion's influence on participants' experiences of stigma, mental health, and help-seeking could not be narrowed down to a set of specific, core fundamentalist doctrines or beliefs to help explain their experiences. As qualitative studies do not seek to establish causal links between ideas or constructs, this project did not serve to demonstrate any definite, measurable religious influence on mental health stigma. Again, the described experiences serve to highlight themes, similar ideas, and patterns that may be useful to understanding this population.

Given this study's focus on fundamental Christian religiosity, an abundance of future research opportunities exist to explore the experiences of other religious groups such as Orthodox Judaism or Islam. More globally, the need for religion and spirituality to occupy a more prominent space in multicultural research, specific to cultural competency in counseling, provides significant opportunity to better address these identity factors when working with clients. A future research avenue to consider would involve exploring mental health providers' attitudes regarding religious faith and working with clients who identify as highly religious. A project of this nature would lend potentially valuable insights into any bias or stereotypes held by MH providers of this client population, providing data to help shape training around spiritual competence. Finally, expanding the current research on stigma to include measuring outcomes on the effectiveness of targeted outreach to religious communities would yield potentially rich data useful to reducing stigma and improving delivery of services. By advancing the research in these key areas, rather than reflecting suspicion and fear, future interactions between people of faith and the professional mental health community can be characterized by mutual respect and collaboration.

APPENDIX

APPENDIX A

Research Questions

1. How would you describe your Christianity or Christian beliefs? More specifically, what is your view or image of God? What is your view/image of your pastor/minister? Finally, what is your view/image of your religious community?
2. Can you describe how your faith/religious beliefs relate to your overall wellbeing? How does your faith play out in your life?
3. How do your peers in your faith community view wellbeing?
4. How does your church/religious community view mental health concerns?
5. What, if any, teaching, counsel, or instruction have you received within your church/religious community regarding mental health and wellbeing? Specifically, the nature or origins of mental health concerns?
6. What, if any, teaching, counsel, or instruction have you received from your religious leaders (i.e., pastor, Bible study leader)?
7. Do you have friends or family within your religious community/church who have experienced a mental health issue(s)? If so, what kind? What did you perceive as the nature or origin of that issue(s)?
8. If you experienced a mental health concern, who would you share that with, if anyone?

9. If you experienced a mental health concern, how would you go about addressing it?
10. From a different perspective, how do you think the professional mental health community perceives you as a person of faith or religious person?

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