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RELIGIOSITY, BELIEFS ABOUT MENTAL ILLNESS, AND ATTITUDES
TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP AMONG
PROTESTANT CHRISTIANS

By

Juan Michael Thompson
B.A., Warner Southern College, 1992
M.A.Ed., Western Kentucky University, 1996

A Dissertation
Submitted to the Faculty of the
Graduate School of the University of Louisville
in Partial Fulfillment of the Requirements
for the Degree of

Doctor of Philosophy

Department of Education and Counseling Psychology
University of Louisville
Louisville, Kentucky

December 2009

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A Dissertation Approved on

November 30, 2009

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DEDICATION

This dissertation is dedicated to the memory of my father, Jo Don Thompson, and to the future of my daughter, Brooklyn Thompson. I will forever cherish the life and love of both of these wonderful and inspirational individuals.

ACKNOWLEDGEMENTS

I would like to express my heartfelt thanks to my dissertation chair, Dr. Sam Stringfield, for his guidance, leadership, and especially patience. I would also like to thank the other members of my committee, Dr. Kathleen Kirby, Dr. Jeffrey L. Hicks, Dr. Joe Talley, and Dr. Kandi Walker for their direction and encouragement. I would like to mention Dr. Jason Rinaldo and Dr. Paul Williamson, without both of whom I could have never moved forward. Dr. Amy Hirschy provided valuable encouragement and editing. I am also grateful to Dr. Rob Geist and Dr. Al Sprinkle for their direction and encouragement.

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ABSTRACT

RELIGIOSITY, BELIEFS ABOUT MENTAL ILLNESS, AND ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP AMONG PROTESTANT CHRISTIANS

Juan M. Thompson

November 30, 2009

Researchers have long been interested in the relationship among the separate fields of psychology and religion. This dissertation seeks to explore the differences in the way protestant Christians with various religious orientations view mental illness and how these views relate to their attitudes toward seeking professional psychological help.

A total of 540 individuals from church congregations representing ten different denominations completed measures of religiosity, beliefs about mental illness, and attitudes toward seeking professional psychological help. Scores on these measures were analyzed to observe group differences between religious orientations and correlations among the orientations and dependent variables of belief about mental illness and attitudes toward seeking professional psychological help.

Analyses revealed significant group differences between extrinsic religiosity and all other religious orientations as it pertained to stereotypical beliefs about mental illness. Also, results showed a small but significant negative correlation between intrinsic religiosity and belief about mental illness, a significant positive correlation between extrinsic religiosity and belief about mental illness, and weak but significant negative

correlation between intrinsic religiosity and attitudes toward seeking professional psychological help. Finally, hierarchical regression analysis showed a weak but significant predictor model with religious orientation and belief about mental illness as valid predictors of attitudes toward seeking professional psychological help.

In the final chapter, results are discussed along with study limitations.

Implications for practice and future research are presented.

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CHAPTER 1

Introduction

For many years researchers have attempted to investigate correlations between constructs in the separate fields of religion and psychology. One of the topics of interest to psychology has been help-seeking behavior (Wills & Depaulo, 1991). Unfortunately, the study of help-seeking behavior of a specific population of Protestant Christians seems to be lacking in the psychological literature. This study addresses that gap by studying religious orientation and help-seeking for mental/emotional problems among individuals who identify themselves as Christian from the following range of Protestant denominations: , Assembly of God, Southern Baptist, Christian (Disciples of Christ), Church of Christ, Church of God (Anderson), Church of God (Cleveland), Church of God of Prophecy, Episcopal, Independent Non-Denominational, and United Methodist.

Larson, Donahue, Lyons, and Benson (1989) indicated that relative to general population demographics, religious individuals were underrepresented both in psychiatric research and use of services. Worthington, Kurusu, McCullough, and Sandage (1996) conducted a review of research from 1984 through 1994 which included 148 empirical articles dealing with the subjects of religion and counseling. Kurusu et al. reported that although “religious counseling by religious counselors of religious clients has recently assumed an increased prominence, (p. 449)” people who hold strong religious beliefs and values still tend to underutilize professional secular mental health counseling services.

There could be several variables which contribute to this phenomenon. The variables of interest for this present study were religious orientation, views about mental illness, and willingness to seek professional psychological help.

Statement of the Problem

Various studies have found that a relatively small percentage of individuals who could potentially benefit from mental health counseling actually seek it (Ogletree, 1993; Wills & Depaulo, 1991). Further, religious individuals are underrepresented among the total population of people who do seek mental health counseling (Larson et al., 1989; Worthington et al., 1996). People often view counseling as a last resort and only utilize it after all other avenues of help have been exhausted (Hinson & Swanson, 1993; Lin, 2002; Maniar, Curry, Sommers-Flanagan & Walsh, 2001). Several factors inhibit individuals from seeking psychological help from a professional. Some of these factors include fear of treatment (Kushner & Sher, 1989, 1991; Pipes, Schwarz, & Crouch, 1985), desire to avoid discussing distressing information (Cepeda-Benito & Short, 1998; Cramer, 1999, Kelly & Achter, 1995; Vogel & Wester, 2003), desire to avoid experiencing painful feelings (Komiya, Good, & Sherrod, 2000), and desire to avoid social stigma or negative judgments from others (Deane & Chamberlain, 1994). A person's attitude toward seeking help is a strong predictor of help-seeking behavior (Halgin, Weaver, Edell & Spencer, 1987; McCarthy & Holliday, 2004; Vogel, Wester, Wei & Boysen, 2005).

What those studies failed to investigate were the relationships among religious orientation and help-seeking attitudes and behaviors. In one early study researchers found religious orientation to be related to attitudes toward seeking help (McLatchie & Draguns, 1984). McLatchie and Draguns found that participants tended to view help-

seeking from a professional and help-seeking from a higher power (e.g., God) as mutually exclusive. This early research would indicate that some individuals view mental/emotional problems as spiritual in nature and require help from someone other than a psychological professional. A later study by Miller and Eells (1998) examined relationships among religiosity and attitudes toward seeking professional counseling; however, that study did not include a discussion of the beliefs of Christians concerning mental illness. Attitudes about help seeking and belief about mental illness may be one reason that religiously-oriented clients are underrepresented in mental health counseling.

Purpose

The purpose of the present study was to explore differences in the way Protestant Christians with various religious orientations view mental illness, and how these views relate to their help-seeking attitudes and behaviors. Given the lack of research investigating the relationships among religious orientation, belief about mental illness, and willingness to seek help, it would be valuable to determine if Protestant Christians in general have negative beliefs about mental illness, and if this is related to religious orientation. This information would allow the psychological community to better understand and serve religiously-oriented individuals with mental illness and also better understand the role of religious orientation as a possible hindering factor in seeking help for psychological problems.

Value of this Study

The current study investigated and described how religious orientation based upon the fourfold typology (intrinsic, extrinsic, indiscriminately pro-religious, indiscriminately nonreligious) relates to belief about mental illness and help-seeking practices in a

Protestant Christian sample. This study is relevant due to the lack of current research that examines these variables together. Komiya et al. (2000) suggested that a better understanding of people's motivations to seek or not to seek counseling would allow the profession to more effectively reach out to those who need services. The results of the present study may be used to better understand some of the differences between various Christians of different religious orientations. This understanding could then equip the mental health community to further engage and provide services for a specific portion of the general public. Because this study examines religiosity exclusively among a Protestant Christian population, the term "religious" will refer specifically to Protestant Christians.

Previous research indicates that Christians differ from each other in respect to religious orientation. Allport and Ross (1967) noted important differences between individuals which they labeled as intrinsically (I) oriented or extrinsically (E) oriented. They described intrinsically religious individuals as those who live their faith regardless of social pressure. Conversely, they described extrinsically religious individuals as those who use their faith for social or personal gain. Other researchers have also examined the distinctiveness of intrinsic and extrinsic orientations (Donahue, 1985; Genia, 1996, 1993; Gorsuch & Venable, 1983; Gorsuch & McPherson, 1989; Hood, 1978, 1971; Kahoe, 1974; Kirkpatrick, 1989; Kirkpatrick & Hood, 1990; Watson, Morris, & Hood, 1990). Based upon results from a decade of research, Worthington et al. (1996) reported that intrinsically and extrinsically religious people experience and express life differently. One example of this difference of expression was found when Hood, Morris, and Watson (1990) conducted a study on college students in intrinsically religious students described

sensory experiences in religious terms under all circumstances; however, extrinsically religious students did not use religious terms even when prompted. The present study attempted to examine more of the differences between these two groups and how these differences relate to views about mental illness and willingness to seek professional psychological help.

Initially, intrinsic and extrinsic religious orientations were considered to be two ends of a bipolar continuum (Allport & Ross, 1967; Donahue, 1985). However, as test subjects agreed with items on measures of both intrinsic and extrinsic religiosity, Allport and Ross (1967) expanded the original two-dimensional approach into a fourfold typology: (a) intrinsic (high intrinsic and low extrinsic), (b) extrinsic (high extrinsic and low intrinsic), (c) indiscriminately pro-religious (high intrinsic and high extrinsic), and (d) indiscriminately nonreligious (low intrinsic and low extrinsic). Researchers have varied in their opinions on whether assessments of religiosity and related variables should use the two dimensions of intrinsic and extrinsic religiosity or the fourfold typology using the dimensions listed above (Allport & Ross, 1967; Kirkpatrick & Hood, 1990; Watson et al., 1990). Many investigators report the use of all four categories of orientation in their research as beneficial (Hood, 1978; Hood et al., 1990; Markstrom-Adams & Smith, 1996). In his 1985 meta-analysis, Donahue encouraged the use of the fourfold typology as a guide to measure religious orientation. This study will use the fourfold typology.

Definition of Terms

Fourfold Typology

This typology is the expanded intrinsic-extrinsic approach for classifying religiosity proposed by Allport and Ross (1967). Research using the fourfold typology is

very limited and some researchers have criticized its use (Kahoe, 1976; Kirkpatrick & Hood, 1990). In early research, Kahoe (1976) was critical due to the fact that there was no available published data to support interactions among the four typologies. Later, Kirkpatrick and Hood (1990) also voiced criticism due to poor delineation of the construct of religious orientation. Due to the fact that research using the fourfold typology is limited, information on correlations between variables and the indiscriminately pro-religious and indiscriminately nonreligious categories is scant. Donahue (1985) suggested that researchers should consider using the fourfold typology, but only after the relationship between intrinsic and extrinsic orientation is examined for possible curvilinearity.

Religiosity

Described in context of the following four orientations:

Intrinsic Orientation. In 1967, Allport and Ross suggested that individuals who express an intrinsic religious orientation live out their faith rather than using their faith to achieve social support and status. It is an orientation wherein an individual experiences religion as an internalized, master motive in his/her life. It is frequently associated with positive psychological adjustment and lower psychological distress (Genia, 1993, 1996; Hackney & Sanders, 2003; Ventis, 1995). Several researchers have found that an intrinsic orientation serves as a stress buffer and is negatively correlated to a depressive reaction to negative life events (Hettler & Cohen, 1998; Kendler, Gardner, & Prescott, 1997; Park, Cohen, & Herb, 1990). In this study intrinsic religiosity was measured using the I/E-R Scale (Appendix B, items 24, 26, 27, 28, 30, 33, 35, & 37; Gorsuch &

McPherson, 1989). The I/E-R Scale is a 14-item Likert-type measure of religious orientation.

Extrinsic Orientation. Allport and Ross (1967) reported that extrinsically religious individuals are those who use their religion for social support and status. Extrinsic religious orientation has been frequently associated with psychological maladjustment and psychological distress (Genia, 1996; Hackney & Sanders, 2003; Markstrom-Adams & Smith, 1996; Park & Murgatroyd, 1998; Ventis, 1995). Kirkpatrick (1989) reanalyzed several studies using measures of intrinsic and extrinsic religiosity and concluded that the extrinsic scale subdivides into categories of personally oriented extrinsic items (Ep) and socially oriented extrinsic items (Es). Gorsuch and McPherson (1989) confirmed these findings both factor analytically and by the low correlation between Ep and Es. Genia (1993) described Ep as use of religion for personal benefits and Es as use of religion for social reward. Extrinsic religiosity was also measured using the I/E-R Scale (Appendix B, Ep items 29, 31, 32; Es items 25, 34, & 36; Gorsuch & McPherson, 1989).

Indiscriminately pro-religious orientation. The indiscriminately pro-religious orientation is indicated when a person scores high on both measures of intrinsic and extrinsic religiosity (Allport & Ross, 1967; Donahue, 1985). Indiscriminately pro-religious individuals are likely to be sensitive to pressure to appear religious (Hood, Morris, & Watson, 1990). Further research on this topic is scant. This category was measured using median splits on the I/E-R Scale (Gorsuch & McPherson, 1989).

Indiscriminately nonreligious orientation. The indiscriminately nonreligious orientation is indicated when a person scores low on both measures of intrinsic and

extrinsic religiosity (Allport & Ross, 1967; Donahue, 1985). Research describing this category is minimal. It has mostly been described in relation to extrinsic and intrinsic orientations. When measured using religious dependent variables such as beliefs and values, indiscriminately nonreligious individuals are more similar to extrinsically religious individuals. In contrast, when measured using nonreligious dependent variables such as prejudice and dogmatism, indiscriminately nonreligious individuals are more similar to intrinsically religious individuals (Donahue, 1985). This category was measured using median splits on the I/E-R Scale (Gorsuch and McPherson, 1989).

Belief About Mental Illness

Several studies have examined the stigma associated with mental illness (Hirai & Clum, 2000; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Pescosolido, Monahan, Link, Stueve & Kikuzawa, 1999; Phelan & Link, 1998; Van Dorn, Swanson, Elbogen & Swartz, 2005). Each of the studies listed above specifically addressed the view of the general public that mentally ill individuals are dangerous. Phelan and Link (1998) attribute the idea of mentally ill individuals being dangerous to the fact that danger to self or others is generally a criterion for commitment to mental institutions. Although there is a paucity of research concerning beliefs of Christians about mental illness, some researchers (McLatchie & Draguns, 1984; Mitchell & Baker, 2000) have found that Christians basically view emotional problems as spiritual in nature and that these problems require spiritual rather than psychological help. Belief about mental illness was measured by the Belief Toward Mental Illness Scale (BMI; Appendix B, items 38-58, Hirai & Clum, 2000). The Belief Toward Mental Illness Scale is a 21-item Likert-type measure of stereotypical perceptions of mental illness.

Willingness to seek help

The topic of help seeking is complex. Wills and Depaulo (1991) found that people seek help in a pyramid fashion, with most not seeking help at all, fewer seeking help from family and friends, even fewer seeking help from medical professionals and clergy, and the fewest seeking help from mental health professionals. Willingness to seek help as examined in this study is the tendency to either seek or resist mental health counseling services from mental health professionals during times of mental, emotional, or relational problems. This was measured by the Attitudes Toward Seeking Professional Psychological Help (ASPPH; Appendix B, items 14-23; Fischer & Farina, 1995).

Research Questions

As stated above, the purpose of this study was to add to the present knowledge base about the relationship among religious orientations of Christians, beliefs about mental illness, and willingness to seek help. More specifically, this study examined the following questions:

1. Do Protestant Christians with various types of religious orientations differ in their views about the dangerousness, poor social and interpersonal skills, and incurability of persons with mental illness?
2. Do Protestant Christians with various types of religious orientations differ in their attitudes toward seeking professional psychological help?
3. Is religious orientation significantly correlated with stereotypical beliefs (dangerousness, poor social and interpersonal skills, and incurability) about mental illness?

4. Is religious orientation significantly correlated with attitudes toward seeking professional psychological help?
5. Are religious orientation and stereotypical beliefs about mental illness significant predictors of attitudes toward seeking professional psychological help?

Hypotheses

1. Religious orientations will differ significantly from each other in respect to stereotypical beliefs about mental illness.
2. Religious orientations will differ significantly from each other in respect to attitudes toward seeking professional psychological help.
3. Religiosity will correlate with scores on a measure of stereotypical beliefs about mental illness:
 - a. Intrinsic and indiscriminately nonreligious religiosity will be negatively correlated with scores on stereotypical beliefs about mental illness.
 - b. Extrinsic and indiscriminately pro-religious religiosity will be positively correlated with higher scores on stereotypical beliefs about mental illness.
4. Religiosity will correlate with scores on a measure of attitudes toward seeking professional psychological help:

- a. Intrinsic and indiscriminately nonreligious orientations will be positively correlated with more positive attitudes toward seeking professional psychological help.
 - b. Extrinsic and indiscriminately pro-religious orientations will be negatively correlated with more positive attitudes toward seeking professional psychological help.
5. Scores on measures of religiosity and beliefs about mental illness will be significant predictors of attitudes toward seeking psychological help.

Summary

Although psychology and how it relates to religion has been studied for a long period of time, knowledge is incomplete specifically as it relates to help-seeking behaviors of Christian individuals for mental/emotional problems. This study investigated the potential relationships among religious orientation, belief about mental illness, and willingness to seek help. The benefits of learning more about Protestant Christians' help-seeking attitudes and behaviors are (a) an increased understanding of the role of religious orientation as a motivating factor in seeking help for psychological problems and (b) the ability of the psychological community to maximize their ability to serve Protestant Christians with mental illness.

CHAPTER 2 – LITERATURE REVIEW

Introduction

Although interest in religion and how it relates to psychological constructs has increased in recent years, there remains a paucity of research in many areas. Though bodies of literature exist examining religion/religiosity, attitudes/beliefs about mental illness, and willingness to seek help for psychological or emotional difficulties, there is a shortage of focused study on how these variables interact. In this review, studies on religious orientations will be examined and discussed. Research on beliefs and attitudes about mental illness will be reviewed first from a general population perspective and then from a Protestant Christian perspective. Then studies on willingness to seek professional psychological help will be examined in a similar fashion, first from a general population perspective and then from a Christian perspective. Finally, the research questions and hypotheses derived from this review of research that shape this dissertation will be presented.

Religious Orientations

Religion can have a significant impact on people's lives (Koenig, McCullough, & Larson, 2001; Miller & Thoresen, 2003; Salsman & Carlson, 2005; Shreve-Neiger & Edelstein, 2004). Nationally representative surveys reveal that almost 80 percent of adults in the United States report a formal religious affiliation to Christianity, and almost 40 percent of adults report attending religious services once a month or more, 52 percent of which report to be Protestant (Pew Forum, 2008). Studies of the health effects of

religion and/or spirituality have linked it to reduced depression and anxiety, increased longevity, and other physical and psychological health benefits (Curlin et al, 2007, Koenig et al., 2001).

In 2003, Hackney and Sanders published a meta-analysis of 35 studies concerned with religion and psychological adjustment in which they identified three general categories of religiousness: ideological religion, institutional religion, and personal devotion. Ideological religion emphasized beliefs involved in religious activity (e.g., attitudes, belief salience, and fundamentalism). Institutional religion focused on social and behavioral aspects of religion (e.g., extrinsic religiousness: attendance at religious services, participation in church activities, or habitual prayer). Personal devotion was characterized by aspects of internalized, personal dedication (e.g., intrinsic religiousness: emotional attachment to God and devotional intensity).

Hackney and Sanders' (2003) description of institutional religiousness is similar to what Allport and Ross (1967) described as extrinsic religiosity. What Hackney and Sanders (2003) identified as personal devotion was similar to Allport and Ross' (1967) concept of intrinsic religiosity. Allport (1967) stated that individuals who score high on measures of extrinsic religiosity "use their religion," and individuals who score high on measures of intrinsic religiosity "live their religion." Hood (1971) associated the institutional characteristics of religion to the extrinsic orientation and the personal experiential characteristics of religion to the intrinsic orientation. Similarly, Donahue (1985) reported that extrinsically religious people are highly religious in their behaviors (i.e., regular church attendance and strict adherence to church dogma), whereas

intrinsically religious people may not adhere to any particular religion, but are deeply committed to their spiritual faith and values.

Early research by Allport and Ross (1967) focused on intrinsic and extrinsic religiosity as two ends of a single dimension. However, when not all subjects fit neatly onto one dimension, Allport and Ross began looking at individuals in perspective of a fourfold typology. In this typology, an individual may be: (a) intrinsic (high intrinsic and low extrinsic), (b) extrinsic (high extrinsic and low intrinsic), (c) indiscriminately pro-religious (high intrinsic and high extrinsic), and (d) indiscriminately nonreligious (low intrinsic and low extrinsic). Because this typology is key to this dissertation, a detailed discussion of the empirical literature concerning the intrinsic, extrinsic, indiscriminately pro-religious (high intrinsic and high extrinsic) and indiscriminately nonreligious (low intrinsic and low extrinsic) categories and their relationship to various psychological variables follows.

Intrinsic Orientation

In 1967, Allport suggested that individuals who express an intrinsic religious orientation live out their faith rather than using their faith to achieve social support and status. Various researchers have found correlations with intrinsic religiosity and variables of interest to mental health professionals, such as psychological adjustment, stress moderation, and dogmatism. Following is a discussion of each of these concepts in detail.

Psychological adjustment. In 2005, Salsman and Carlson reported results of an investigation of religious orientation and psychological distress. Subjects included 251 students enrolled at the University of Kentucky. Each subject completed the

Intrinsic/Extrinsic-Revised Scale (I/E-R; Gorsuch & McPherson, 1989), the Quest Scale (Batson & Schoenrade, 1991), the Faith Maturity Scale (Benson, Donahue, & Erickson, 1993) and the Symptom Checklist-90-R (Derogatis, 1992). Their analyses revealed that intrinsic religiousness was inversely associated with hostility ($r = -0.16$, $p < 0.01$) and paranoid ideation ($r = -0.18$, $p < 0.01$). Salsman and Carlson concluded that internalized religious or spiritual commitment was inversely related to depression, paranoia, hostility and overall psychological distress. This finding is comparable to that of Hackney and Sanders (2003), who conducted a meta-analysis of 35 studies which examined the relationship between religiosity and psychological adjustment. In their analysis, Hackney and Sanders defined negative aspects of mental health such as depression and anxiety as psychological distress. Alternatively, they identified positive aspects of mental health such as self-esteem, happiness, identity integration, existential well-being, and similar variables as psychological adjustment. The results of Hackney and Sanders' analysis indicated that personal devotion (i.e., intrinsic religiosity) was associated with lower levels of psychological distress. In contrast, the results revealed a positive correlation between personal devotion and psychological adjustment.

In a study which examined relationships between religious orientation and depression, Genia (1993) sampled 309 subjects across groups of various faiths, such as Christian Protestant, Catholic, Jewish, and Unitarian. Each participant completed a Beck Depression Inventory (BDI) and an Allport-Ross Religious Orientation Scale (ROS). Among Christians, there was a positive correlation between intrinsic religiosity and positive mood, as well as a negative correlation between intrinsicness and depression. In a 1996 study, Genia found similar results which gave credence to her earlier finding that

intrinsic religiosity was negatively associated with depression. In a study that produced similar results Park and Murgatroyd (1998) found a strong negative correlation between depression and intrinsic religiosity among Korean-Americans. They sampled 95 Korean Americans from four churches in Louisiana. Ninety-one of the study subjects were Protestant Christians and four were Catholic. Subjects were given the Allport-Ross ROS and the BDI. They stated that their most important finding was the strength of the correlation coefficient ($r = -0.68, p < 0.001$) between intrinsic religiosity and depression. Koenig, George, and Titus (2004) also found a negative correlation between depression and intrinsic religiosity among elderly medically ill hospital patients. In their sample of 838 study participants at Duke University Medical Center, ages 50 and older, 97.6 % were religiously affiliated. Of those individuals, all but 5% were Protestant. Results of the study revealed significant correlations between intrinsic religiosity and depression ($\beta = -0.10, p < 0.01$), and intrinsic religiosity and social support ($\beta = 0.16, p < 0.0001$).

Fear and anxiety surrounding beliefs about death have long been variables of interest related to psychological adjustment (Donahue, 1985; Lester 1967; Templer, Lavoie, Chalgujian, and Thomas-Dobson, 1990). Ardel and Koenig (2007) found in a qualitative study involving hospice patients that an intrinsic orientation to religion is related to purpose in life and therefore creates subjective well-being even in the face of death. They stated this was not so of the extrinsically oriented individuals in their study. In a study published in 2000, Maltby and Day administered the Death Obsession Scale and the Age Universal I-E Scale-12 to 156 undergraduate students at Sheffield Hallam University. Their findings indicated a significant negative correlation between intrinsic religiosity and death obsession ($r = -.35, p < .01$). Maltby and Day stated that their

findings are consistent with previous findings which generally showed that an intrinsic orientation toward religion is accompanied by less death distress. In a meta-analytic review of 67 studies measuring I-E, Donahue (1985) also reported that intrinsic religiosity was negatively correlated with fear of death and trait anxiety.

Stress buffer. Some researchers have found that an intrinsic orientation serves as a stress buffer and is negatively correlated to a depressive reaction to negative life events (Hettler & Cohen, 1998; Park, Cohen, & Herb, 1990). In 1998, Hettler and Cohen reported results from a study of intrinsic religiosity as a stress-moderator for adult Protestant churchgoers. Their study included 124 White individuals ranging from ages 22 to 82 from 12 churches in Delaware and Pennsylvania from five different denominations (Baptist, Lutheran, Presbyterian Church of America, United Methodist, and Evangelical). Although they found a difference in significance among denominations, intrinsic religiosity played an important role in the coping process for the more “liberal denominations” (p.606).

Hettler and Cohen’s (1998) study lends partial support to the findings of Park, Cohen, and Herb (1990), who, in two separate studies of undergraduate students in an introductory psychology class at the University of Delaware, investigated the stress-moderating effect of intrinsic religiosity. For the Protestant subsample, they reported that intrinsic religiosity served as a stress-buffer for negative life events.

Dogmatism. In 1996, Markstrom-Adams and Smith conducted two separate studies to examine identity status and religious orientation. Study 1 was conducted among 38 Mormon and 47 non-Mormon high school students living in a predominantly Mormon Utah community. Study 2 was conducted using 102 Jewish high school

students living in Ontario, Canada. Although these populations are different than the population of interest in the proposed study, the constructs of religiosity are similar and the use of the fourfold typology of religious orientation in data analysis makes the study relevant to observe. In both studies the authors found that individuals in the intrinsic categories scored higher on measures of ego-identity that are more associated with healthier psychological adjustment and less associated with prejudice and dogmatism. Intrinsic individuals also scored significantly lower on measures of ego-identity that are most associated with prejudice, dogmatism, and rigid and closed thinking patterns. Markstrom-Adams and Smith stated that prejudice and dogmatism suggest a close-minded pattern of thinking and therefore would be resistant to change. The findings of Markstrom-Adams and Smith lend partial support to those of Kahoe (1974) where individuals in the intrinsic and indiscriminately nonreligious categories were least associated with dogmatism.

Extrinsic Orientation

In 1967, Allport suggested that individuals who express an extrinsic religious orientation use their faith for social or personal gain. Further, researchers have concluded that the extrinsic orientation actually subdivides into categories of personally oriented extrinsicness (Ep) and social oriented extrinsicness (Es) (Genia, 1993; Gorsuch & McPherson, 1989; Kirkpatrick, 1989). Genia (1993) described Ep as use of religion for personal benefits and Es as use of religion for social reward. In 1985, Donahue opined that, "Extrinsic religiousness ... does a good job of measuring the sort of religion that gives religion a bad name (p. 416)." Various researchers have found correlations with

extrinsic religiosity and variables of interest to mental health professionals, such as psychological maladjustment, prejudice, and dogmatism.

Psychological maladjustment. Some researchers have found extrinsic religiosity to be positively associated with depression, trait anxiety, and fear of death. In the same meta-analysis mentioned above, Hackney and Sanders (2003) found that institutional religion (i.e., extrinsic religiosity) was associated with increased psychological distress, with a Pearson correlation coefficient of $r = -0.03$, $p < 0.001$ significance level. The authors reported that scores on measures of distress were reverse-coded, such that high scores represented low distress, and low scores were indicative of increased stress. In their meta-analysis, Hackney and Sanders used definitions of psychological adjustment that focused on “unhappy aspects” of mental health such as depression and anxiety to describe psychological distress (p. 49).

In a study investigating the relationship between intrinsic-extrinsic religious orientation and depressive symptoms, Park and Murgatroyd (1998) surveyed 95 Korean-Americans who were members of four Korean Christian churches in a southeastern state. Their subjects were between the ages of 30 and 53. They each completed the Korean version of the Allport-Ross Religious Orientation Scale and the Beck Depression Inventory. The results showed that depressive symptoms were positively related to extrinsic religious orientation ($r = 0.47$, $p < 0.01$).

In 1996, Genia conducted a study of 211 college students at an urban university to examine how social desirability and religious fundamentalism may moderate relationships between religious orientation and measures of psychological and spiritual health. Genia reported that Ep predicted greater psychological distress. Ep was also

associated with a satisfying relationship with God, but unrelated to a sense of purpose and meaning of life. According to Genia, except for a weak association with worship attendance, Es failed to correlate with any of the religious or psychological variables.

In 1993, Genia conducted a study using a large data set from a previous study (Genia and Shaw, 1991). The purpose of the 1993 study was twofold: 1) to determine the replicability of three distinct measures of religious orientation, i.e., I, Ep, and Es in a highly religiously diverse sample, and, 2) to examine the relationship between religious orientation and depression. Of 309 subjects examined, 97 were Catholic, 39 Jewish, 77 evangelical Protestant, 51 theologically liberal Protestant, and 45 Unitarian-Universalist. All participants completed the Allport-Ross Religious Orientation Scale and the Beck Depression Inventory. Genia reported that for all subjects, Es was unrelated to depression, whereas Ep was associated with higher depression.

In 1991 Genia and Shaw conducted the original study with the 309 subjects listed above to examine relationships between religious orientation and depression. In this study, Genia and Shaw separated subjects into four categories; 1) intrinsic, 2) extrinsic, 3) indiscriminately non-religious, and 4) indiscriminately pro-religious. Extrinsic religiosity was found to be significantly correlated to depression ($r = .24, p < 0.001$).

Along with being positively correlated with depression, extrinsic religiosity has also been found to be positively correlated to death anxiety and trait anxiety. In 2000, Maltby and Day administered the Death Obsession Scale (Abdel-Khalek, 1998) and the Age Universal I/E Scale-12 (Maltby, 1999) to 156 undergraduate students at Sheffield Hallam University. The authors reported a positive significant relationship between death obsession and an extrinsic-personal orientation toward religion ($r = .28, p < .01$),

and a positive significant relationship between death obsession and an extrinsic-social orientation toward religion ($r = .38, p < .01$). Maltby and Day reported that the sample population was Christian; this is relevant to the present study because the population of interest is Christian also. As referenced above, Donahue (1985) completed a meta-analysis of 67 studies measuring I-E religious orientations and their relationships to various psychological and religious constructs. He reported that in seven of the studies which measured death anxiety or fear of death, extrinsic religiosity was positively correlated with a Pearson r of .28. In 1982, Baker and Gorsuch reported a positive correlation between extrinsic religiosity and trait anxiety.

Prejudice. In addition to being positively correlated to constructs of psychological maladjustment, researchers have found extrinsic religiosity to be positively correlated to prejudice. As early as 1967, Allport and Ross stated that all religiosity appeared to be related to prejudice. They theorized, however, that extrinsic religiosity would be more positively associated with prejudice than intrinsic religiosity. Their conclusions supported their theory and they found a positive correlation between E and prejudice. As previously stated, Donahue (1985) conducted a meta-analysis of studies that examined the intrinsic and extrinsic orientations and their relationships to various psychological constructs. He reported that several studies had also found positive correlations between E and prejudice ($r = .34$), though these correlations appeared weaker than what Allport and Ross had previously found. Since 1985, several researches have examined the relationship between E and prejudice with somewhat mixed results. In 2004, Rowatt and Franklin surveyed a diverse sample ($N = 158$) of undergraduate psychology students at Baylor University. When they measured the relationship between

religious orientation and implicit racial prejudice they found no significant correlation between intrinsic ($r = .06$) or extrinsic (Es: $r = .07$, Ep: $r = .06$) religiosity and prejudice.

In yet another study, Duck and Hunsberger (1999) observed the role of religious proscription in relationship to prejudice. They measured the attitudes of 363 Catholic and Protestant, Canadian college students. Results of their study showed that racism was usually seen as a religiously proscribed (prohibited) prejudice, while harboring negative attitudes toward homosexuals was viewed as nonproscribed (acceptable). Prohibited prejudice was negatively related to intrinsic religiosity and positively related to extrinsic religiosity. On the other hand, when prejudice was seen as acceptable, it was positively related to an intrinsic orientation and negatively related to an extrinsic orientation.

In 1989, Morris, Hood, and Watson surveyed 379 undergraduate students in introductory psychology courses in order to measure self-reports of racial intolerance. They found that whereas an intrinsic orientation was not related to prejudice ($r = -.06$), an extrinsic orientation was significantly indicative of prejudice ($r = .20, p < .01$). The results of this study are counter to the results found by Griffin, Gorsuch, and Davis (1987) where a sample of 191 Seventh-Day Adventists showed no correlation between the extrinsic orientation and prejudice toward Rastafarians, and a significant positive correlation between an intrinsic orientation and prejudice. The authors stated that the relationship between I and prejudice can be explained by the church's norms were perceived to supportive of prejudicial attitudes towards Rastafarians in the culture they studied. This would be similar to Duck and Hunsberger's (1999) results where nonproscribed (acceptable) prejudice was related to I and proscribed (prohibited)

prejudice was related to E. Griffin et al (1987) conclude that there is no singular relationship between religious orientation and prejudice.

Dogmatism. Markstrom-Adams and Smith stated in 1996 that, "Prejudice and dogmatism suggest closed-mindedness that might be reflected in conformity (p. 249)." They also stated that internal locus of control is associated with an open pattern of thinking whereas external locus of controls suggests limited and constrained thinking. Not surprisingly, internal locus of control has been associated with intrinsic religiosity (Donahue, 1985; Kahoe 1974) and external locus of control has been linked with extrinsic religiosity (Kahoe, 1974). Donahue (1985) found in the five studies in his meta-analysis dealing with religious orientation and dogmatism, the correlation between intrinsic religiosity ranged between $r = .22$ and $r = .04$, with an average of $r = .06$. In those same studies, the correlation between extrinsic religiosity and dogmatism ranged from between $r = .66$ and $r = .08$, with the average being $r = .36$. These findings indicated that while intrinsic religiosity was basically uncorrelated with dogmatism, a positive relationship is generally found between extrinsic religiosity and the measure.

Indiscriminately Pro-religious and Nonreligious

Initially, Allport and Ross (1967) set out to measure two concepts on a single continuum, expecting individuals to endorse either one or the other, to be either intrinsically or extrinsically motivated. However, when some subjects scored either high or low on both scales, they stated that these subjects were, "provokingly inconsistent (p.437)." This provocative inconsistency led them to suggest a four-fold classification system which would include the dimensions of indiscriminately pro-religious and

indiscriminately nonreligious orientations. Though literature concerning these two orientations is limited, a discussion of both will follow.

As part of his meta-analysis Donahue (1985) examined studies which used the four-fold religious classification system. He reported that in those studies using religious variables such as belief, practice, and religious experience, the intrinsic and indiscriminate categories were very similar, and both categories scored higher on measures than did extrinsic or indiscriminately nonreligious. However, when measuring nonreligious variables such as prejudice and dogmatism, the tendency was for those in the intrinsic orientation to score similarly to those in the indiscriminately nonreligious orientation, and for both of these groups to score lower than those in the extrinsic and indiscriminately pro-religious orientations.

In two studies in 1996, Markstrom-Adams and Smith utilized the four-fold typology to examine relationships between identity status and religious orientation in Mormon and Jewish high school students. Identity status subscales included diffusion, foreclosure, moratorium, and achievement. The authors suggested that diffusion is indicative of the least healthy of the four identities, with foreclosure being more mature, moratorium even more mature, and finally achievement as the most mature scale of identity as defined in their studies. In their first study, as expected, with the nonreligious variable of identity status, those with an indiscriminately pro-religious orientation scored similarly to extrinsics on all four maturity scales. This lends support to earlier findings by Donahue (1985) that with nonreligious variables, the extrinsic and indiscriminately pro-religious categories parallel each other. Similar patterns were found in study two among these two orientations. However, the authors' prediction that the intrinsic and

indiscriminately nonreligious categories would parallel each other did not hold true in either study. Markstrom-Adams and Smith explained this contradiction in expectation by stating that the sample was comprised strongly of religiously affiliated individuals, thus, the nonreligious individuals who were still part of the religious population could have been affected by the norms of their particular group culture.

In 1990, Hood, Morris and Watson conducted a study in which 78 introductory psychology students from the University of Tennessee at Chattanooga were given a measure of intrinsic/extrinsic religiosity as part of regular course proceedings. Participants were then subjected to an isolation tank and then read items from the Mysticism Scale (Hood, 1975) by the experimenter. The purpose of the study was to measure report of religious experience among the various religious orientations. Of the study participants, five were deemed to be in the indiscriminately nonreligious category and therefore removed from the study. The remaining 73 participants were divided into religious types based on median splits of their intrinsic and extrinsic scores. This procedure resulted in 25 indiscriminately proreligious, 20 intrinsic, and 28 extrinsic individuals. Given that a religious variable was measured against religiosity, the expectation was that the indiscriminately pro-religious individuals would most resemble intrinsics rather than extrinsics. As predicted, intrinsics scored higher on religious interpretation of the Mysticism Scale, with a mean score of 4.63, followed closely by pro-religious individuals, with a mean score of 4.00, and then extrinsics with a mean score of 2.27. Hood et al. stated this supports the notion that indiscriminately pro-religious individuals have a generalized pro-religious mindset, or the propensity to be hyper aware of anything religious.

Although the literature is scant concerning these two religious orientations, those studies reviewed above show the findings of Donahue to be accurate in that, when measuring nonreligious variables, intrinsic and indiscriminately nonreligious orientations score similarly, and extrinsic and indiscriminately pro-religious orientations score similarly. The opposite appears to be true for studies using religious issues as their dependent variables.

Summary. Religious attitudes and behaviors are complex and the wide variety of ways in which researchers have measured religion/religiosity/spirituality has shown how difficult it is for researchers to agree on this concept. The work of Allport and Ross (1967) has been used for years as a measure of religious orientation or motivation. Several researchers since have followed up on measuring religiosity using orientation scales (Donahue, 1985; Genia, 1993, Gorsuch & McPherson, 1989; Gorsuch & Venable, 1983; Hood, 1978; Kirkpatrick & Hood, 1990; Watson, Morris, & Hood, 1990). Research has revealed the distinctiveness and the value of looking at religiosity from an intrinsic/extrinsic orientation point of view. As the above review of literature has shown, individuals within these various orientations experience and express their lives differently.

Beliefs about mental illness

How an individual thinks about an issue influences their behavior. Therefore, it would follow that the perspective from which an individual perceives mental illness affects their resulting help-seeking behavior. Consequently, in order to understand Christians' help-seeking behaviors for mental illness, their belief system about mental

illness should be explored. The following is a discussion about the beliefs about mental illness among the public in general, and then Christians in particular.

Beliefs among the general public. Social stigma and beliefs about those experiencing mental illness have long been studied in the behavioral sciences (Link et al., 1999; Van Dorn et al., 2005; Vogel, Wade, & Haake, 2006). Research shows that current attitudes toward mental illness are mostly negative. Multiple researchers studying perceptions of those with mental illness have indicated a strong stereotype for dangerousness and desire for social distance (Link et al., 1999; Van Dorn et al., 2005). Those individuals who are diagnosed with a mental illness are viewed by society as less desirable, dirty, insincere, slow, and weak (Van Dorn et al., 2005; Walker & Read, 2002). Vogel et al (2006) stated, the “stigma associated with seeking mental health services ... is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable” (p.325). In addition, Ben-Porath (2002) produced data which indicated that a person who sought help for a psychological problem was viewed more negatively and as more unstable than an individual not seeking help for the same problem. Often, even the family members of the person experiencing mental health problems experience social rejection and strained relationships as a result (Van Dorn et al., 2005).

In 2005, Van Dorn et al. reported results of a study that investigated the difference in views held by mental health stakeholder groups and the general public. Structured interviews were conducted in person with consumers of mental health services, family members of consumers, and the general public. Self-administered questionnaires were completed by mental health clinicians. The consumer group consisted of individuals

adults diagnosed with schizophrenia and related disorders who lived in a designated area of north-central North Carolina. A total of 104 individuals were included in the final sample of this group. The family group was made up of individuals related to those from the consumer group. In total, 83 members of the family group were included in the study. The clinician sample (n = 85) was selected from staff rosters of area mental health providers who were identified as primary providers for persons with schizophrenia and related disorders. Finally, the general public group consisted of 59 individuals who were recruited through a list of research volunteers maintained through Duke University Medical Center. Researchers administered measures to assess participants' perception of the dangerousness of people with mental illness, their desire for social distance from persons with mental illness, and their beliefs about the causes of mental illness. The results of this study revealed insignificant differences in the way stakeholder groups and the general public stigmatize individuals with mental illness. The researchers found that 63% of consumers, 46% of family members, and 30% of clinicians perceived it somewhat or very likely that a person with schizophrenia would be violent toward others. This is in comparison with 50% of the general public holding these same perceptions. The only significant difference in those results was between consumers and clinicians. Findings regarding the desire for social distance from individuals with mental illness were similar. Thirty-three percent of consumers, 35% of family members, and 36% of clinicians were either somewhat or very likely to desire social distance from mentally ill individuals, in comparison to a reported 44% of the general public with the same beliefs. There were no significant between group differences reported in those results.

Segal, Coolidge, Mincic, and O'Riley (2005) examined differences in younger and older adults' beliefs about mental illness and willingness to seek help. The younger adults group consisted of 96 undergraduate students recruited from psychology classes. The older adults group was made up of 79 community-dwelling individuals recruited from senior housing facilities which included independent and assisted living facilities. Individuals in each group were given two questionnaires to fill out: the Beliefs Toward Mental Illness Scale (Hirai & Clum, 2000) and the Willingness to Seek Help Questionnaire (Cohen, 1999). The results revealed similarities among both groups concerning beliefs about mental illness with one exception: older adults perceived mentally ill individuals as more lacking in social and interpersonal skills and were "patently embarrassing and untrustworthy" (p. 366). There were insignificant differences in beliefs among the groups concerning the dangerousness and incurability of the mentally ill. Results also indicated that more negative attitudes toward mental illness were associated with a lower willingness to seek psychological help. This held true for both groups.

Ben-Porath (2002) conducted a study to investigate the extent to which stigma applies to persons who seek psychological help. Four hundred and two undergraduate students in an introductory psychology course completed a questionnaire after reading a randomly assigned vignette. After eliminating 22 protocols due to errors, results were reported from a sample population of 380 subjects. Data revealed that individuals suffering from depression were viewed more negatively than those suffering from a physical illness. Subjects rated depressed individuals as more emotionally unstable ($p < .001$), less interpersonally interesting ($p < .001$), less competent ($p < .001$) and less

confident ($p < .001$) than those with a physical problem. What's more, there was also a more negative perception of individuals seeking help for their problem. Those who sought help for their depression were viewed as less competent and more unstable than those who did not seek help.

In 1999, Pescosolido et al. reported results of data on the public's evaluation of the ability of persons with a wide range of mental health problems to function on a daily basis and their likelihood of engaging in violence toward themselves or others. Researchers used the 1996 General Social Survey, a face-to-face survey involving a nationwide representative sample of adults ($n = 1444$) in non-institutionalized settings which used a cluster sampling design. Respondents were given vignettes based on diagnostic criteria for schizophrenia, major depression, alcohol or drug dependence, or a control case referred to as, "troubled" (p. 1340). Four areas of competence were examined: an individual's ability to make treatment decisions, an individual's ability to make money management decisions, an individual's likelihood of violence toward others, and an individual's likelihood of violence toward himself. Results from their data revealed that the nature and severity of an individual's problem was the most important factor in shaping the public's opinion. However, even when controlling for nature of problem and case severity, respondents reported perceived less competence and increased expectation of violence if the person in the vignette was labeled as having a mental illness. Ninety-three percent of respondents viewed the "troubled" person as capable of managing treatment decisions. Almost two thirds (63.7%) believed persons with major depression were able to do the same. In contrast, only 27.9% believed persons with drug

dependence were able to manage treatment, and only 25.7% who believed persons with schizophrenia were capable.

In looking at ability to make money management decisions, Pescosolido et al. (1999) reported similar results to the treatment decision question in all categories. The highest perception of dysfunction was shown when 92% of respondents reported the belief that individuals with drug dependence were either not very able or not able at all to make decisions concerning money.

In reporting danger of violence to self or others, Pescosolido et al. (1999) found that even concern for “troubled” persons was high, with 16.8% reporting the belief that this person would be very likely or somewhat likely to commit violence toward others. The numbers rose when considering individuals with depression (33.3%) and individuals with schizophrenia (60.9%). An overwhelming majority of individuals believe that persons with alcohol (70.9%) or drug (87.3%) would be either very or somewhat likely to commit violence toward others.

When dangerousness to oneself was considered, the numbers for the “troubled” person were similar, with 25.9% reporting the belief that this individual would be either very or somewhat likely to do something violent to himself. However, the numbers for the person with major depression increased drastically to 74.9% of respondents stating this individual is very or somewhat likely to commit harm to self. The majority of subjects believed that persons with alcohol dependence (82.1%), schizophrenia (86.5%), and drug dependence (92.2%) are at risk for violence to self. The overall findings of this study show the belief that individuals with mental illnesses or alcohol and/or other drug

dependence are less capable and have a greater propensity toward violence to self or others than the rest of society (Pescosolido et al., 1999).

Using the same data set as Pescosolido et al. (1999) referenced above, Link et al. (1999) reported on the public's recognition of mental illnesses, beliefs about the causes of mental illnesses, beliefs about how dangerous individuals with mental illnesses are, and the amount of social distance desired from individuals with mental illnesses. The findings of interest to this dissertation proposal are those which dealt with dangerousness and desire for social distance. Results were the same as the Pescosolido et al. (1999) study concerning the public perception of dangerousness of those with mental illness. Concerning social distance, respondents were asked how willing they would be to move next door to a mentally ill person, spend an evening socializing with the person, make friends with the person, start working closely with the person, and have the person marry into their family. Respondents desired most social distance from individuals who experienced drug dependence (90%), followed by alcohol dependence (70%), schizophrenia (63%), major depression (47%), and the troubled person (29%). Assuming that desired social distance was related to perceived dangerousness, Link et al. calculated the correlation between perceptions of violence and social distance and found it to be 0.432 ($P < .001$). This lends support to the association between the belief that a person is likely to be violent and the desire to be socially distant from that person.

Beliefs among Christians. Research has shown that there exists a stigma among the general public toward mental illness. But what about the relationship between religiosity and belief about mental illness? Specifically, do Christians hold the same views as the general public about the dangerousness and desire for social distance from

those who are mentally ill? In the 1960's and 70's, the move among some Christian leaders was generally away from psychiatry (Adams, 1970; Mowrer, 1961). This movement propagated the belief that causes of mental illness are spiritual in nature and result from personal sin or a lack of faith. Based upon that supposition, those leaders called for spiritual answers to spiritual problems. Since that time, inroads have been made among religious leaders and the mental health professionals. Psychologists in general are becoming more aware of and open to religious issues and spiritual issues (McMinn, Aikins, & Lish, 2003), and Christian leaders have become more educated on psychological on the biosocial causes and treatments of mental health problems (Lafuze, Perkins, & Avirappattu, 2002). Following is a discussion of the present literature which examines the beliefs about mental illness among Christians.

In a study reported in 2007, Stanford examined common attitudes toward mentally ill congregants in the Christian church. The study consisted of 293 self-identified Christians who completed an online survey. Participants were recruited from ongoing mental health discussion groups and had interaction with the church due to their own mental illness (57.7%) or a family member's mental illness (child, 12.6%; spouse 4.8%; other family member 24.9%). A wide range of psychiatric disorders was represented in the sample, including mood disorders (39.9%), schizophrenia and psychotic disorders (30.4%), anxiety disorders (15.7%), substance use disorders (6.8%), eating disorders (4.1%), and other (3.1%). Results revealed that, of the 293 respondents, 31.4 % stated that the church made them feel their mental illness was the result of personal sin. When asked if the church had denied that the participant even had a mental illness, although a professional had already diagnosed it, 32.4% responded yes. When

asked about psychiatric medication, 18.4% reported that it was discouraged and 2.7% stated that it was forbidden. Almost 40% of respondents stated their condition had not changed as a result of the church's involvement, and 25.9% stated it had worsened.

Although the sampling method used in this study had many methodological limitations, the results were consistent with those of previous studies (Trice & Bjork, 2006).

In a study examining Pentecostals' perspectives of the causes of and treatment for depression, Trice and Bjork (2006) sampled 230 students at a nondenominational, post-high school, Charismatic Bible training school located in the Mid-Atlantic region of the United States. A survey was given eliciting responses regarding demographics, students' religious beliefs, their views regarding the causes for and treatment of depression, and their own experiences of depressive symptoms. Potential causes for depression were rated with 32 items taken from relevant literature. Before rating these items, participants were given a definition of depression in hopes of strengthening inter-rater reliability. Seven Cause scales were then created from the 32 items: Victimization, Death Issues, Social-Relational, Finances, Loss of Personal Control, Biology, and Spiritual Failure. Results of a univariate analyses indicated that participants agreed most strongly that depression is caused by Victimization and Death Issues ($p < .001$), then Social Relations, then Finances, then Lack of Personal Control, and finally Biology and Spiritual Failure. The authors noted surprise that the Pentecostal sample did not endorse Spiritual Failure higher as a cause of depression. All of the causes on the scale, however, were significantly rated as potential causes for depression. Interestingly, one of the faith-related items of the survey (demonic oppression/possession) loaded on the Victimization scale rather than the Spiritual Failure scale and received the fourth highest mean item

rating ($M = 6.43$, $SD = 0.88$) across all 32 causal items (after rape, suffering abuse, and loss of spouse).

Study participants views of effective treatment for depression were assessed with 25 items taken from relevant literature. Factor analyses produced seven factors. These seven factors, in order of endorsement frequency, were as follows: Spiritual Discipline, Faith Practices, Rest, Support, Health, Psychology/Psychiatry, and Intensive Medical Procedures. These results, though limited, indicate that this group of Christians hold in higher value faith practices (including Scripture memorization, confessing sin, fasting, prayer with laying on of hands, deliverance/exorcism, individual prayer, and the avoidance of Yoga meditation) rather than psychologically based treatments (including psychotherapy and medication). This view revealed a proclivity toward a spiritual answer to any problem, whether or not the cause of the problem is seen as spiritual (Trice & Bjork, 2006).

Gray (2001) administered a questionnaire designed to examine attitudes to mental illness to an evangelical Anglican congregation in the United Kingdom. The same questionnaire had been given to a sample from the general population of England by Crisp, Gelder, Rix, Meltzer, and Rowlands (2000). Sixty-eight adult members of the church congregation completed and returned the questionnaire. Results revealed that for this limited sample, the church group expressed less stigmatizing attitudes than the national figures. However, both groups saw people with schizophrenia as dangerous and unpredictable. The church group was less likely to blame individuals for alcoholism and drug addiction than was the general population comparison group. Gray reported no

evidence for the hypothesis that mental illness is seen as a divine judgment or a result of moral weakness.

In 1984, McLatchie and Draguns reported results of a study intended to assess the relationship between the hypothesized mistrust of mental health providers by evangelical Christians. The researchers investigated whether or not evangelicals distrust of secular mental health providers prevented them from seeking their help, whether or not evangelicals were concerned that therapists espoused their same beliefs, whether or not they believed emotional problems to be spiritual problems requiring spiritual answers, and whether or not evangelicals have characteristic ideas concerning mental illness. A sample of 152 subjects was recruited from various churches in Pennsylvania and students in a psychology course at Penn State University. Participants completed a survey measuring religious orthodoxy and overall modernity as independent variables, and attitudes toward seeking mental health services, opinions about mental illness, and tendencies to view mental health problems as spiritual served as dependent variables. Results indicated that although persons high in theological conservatism were not “disinclined” (p. 156) to seek professional help for emotional problems, they did see these problems as spiritual and in need of spiritual help. Further investigation into the survey revealed that conservatives tended to seek out spiritual counselors. They wished to know what the professional service provider believed about God and their ethical values. Results from this study also revealed the tendency for participants to accept demon possession as a possible etiology for mental illness.

Summary. Although research is fairly limited regarding specific perceptions of Christians concerning mental illness, it is clear that some stigmatization of the mentally

ill person still exists within this population. Given the existence of stereotypical views of the mentally ill, i.e., dangerousness, lack of social skills, and overall undesirability, coupled with the possibility that the Christian may view mental/emotional problems as spiritual in nature and needing spiritual answers, it is quite fathomable that some Christian individuals may turn to prayer, reading of scripture, and other forms of religious coping rather than formal mental health treatment when experiencing difficulties (Koenig et al., 2001). It is, therefore, quite likely that a person's religious orientation and their view concerning mental illness would affect their willingness to seek professional psychological help.

Help Seeking

Attitudes toward seeking professional psychological help have long been studied. As early as 1970, Fischer and Turner developed a scale to measure attitudes about help-seeking. They defined help-seeking attitudes as "the tendency to seek or to resist professional aid during a personal crisis or following prolonged psychological discomfort" (p.79). Years later, Fisher and Farina (1995) went on to describe it as the "willingness to seek help from mental health professionals when one's personal-emotional state warrants it" (p.371).

Many factors are involved in a person's decision to seek help. Padgett and Brodsky (1992) proposed that individuals seek help in stages: recognition (stage one), the decision to seek help (stage two), and the choice of a helper (stage 3). Wills and Dapaulo (1991) suggested a pyramid pattern in help-seeking whereby a person would first go to family and friend for a minor problem, second go to medical and religious professionals

for persistent problems, and third go to mental health professionals for persistent problems.

According to Corrigan (2004), many people who are experiencing psychological and interpersonal concerns never actually pursue treatment. Vogel, Wade, and Hackler (2007) stated, "According to some estimates, within a given year, only 11% of those experiencing a diagnosable problem seek psychological services" (p. 40). The most often cited reason for a person avoiding seeking help for an emotional/mental problem is stigma associated both with mental illness and seeking help for mental illness (Corrigan, 2004). As has been stated earlier, Ben-Porath (2002) found those who sought help for their depression were viewed as less competent and more unstable than those who did not seek help. This is consistent with the 1999 surgeon general's report which stated the fear of stigmatization deterred individuals from acknowledging their illness, seeking help, and remaining in treatment, therefore, enduring unnecessary suffering.

Of interest to this dissertation are the help-seeking practices of those who identify themselves as Christian. Hence, this section will include a discussion of the relevant literature concerning help-seeking practices of the public in general, and then the help-seeking practices of Christians.

Help-seeking in general. Vogel, Wester, and Larson (2007) conducted a review of literature concerning psychological factors which inhibit help-seeking. They divided their discussion of the literature into two parts: avoidance factors and demographic and situational influences. They reported that the literature contains five factors of avoidance: social stigma, treatment fears, fear of emotion, anticipated utility and risk, self-disclosure, and social norms. The authors also stated that social norms and self

esteem are avoidance factors, but these factors have not been discussed as much as others in the literature on help-seeking. Also included in the review of help-seeking literature by Vogel et al. was a discussion on demographic and situational influences on client avoidance. They included sections on gender, race and ethnicity, setting and problem type, and finally, age. Each of these topics show effects on the salience of different avoidance factors and create further issues for consideration when making the decision to seek help.

In 2003, Vogel and Wester examined a general model of help seeking. Their stated goal was to determine the degree to which avoidance factors predict an individual's likelihood of seeking psychological help. In two separate studies with different samples, they examined the relationships among variables such as comfort with self-disclosing distressing information and the perceived outcomes of such self-disclosure. In their first study, they sampled 209 college students recruited from psychology classes at a large Midwestern university. Students completed measures of distress disclosure, emotional disclosure, perceived risks and utility of disclosing emotions, and attitudes toward counseling. Five predictors of help-seeking attitudes included tendency to self-disclose distressing information, perceived risk in self-disclosing emotional material to a counselor, perceived utility of such self-disclosure, gender, and previous counseling. An overall regression equation was significant (adj. $r^2 = .39$, $p < .001$), explaining a large amount of variance. Further, Vogel and Wester reported that one's comfort with self-disclosing distressing information ($\beta = .29$), one's anticipated utility of self-disclosing to a counselor ($\beta = .24$), and one's anticipated risk of

self-disclosing to a counselor ($\beta = -.18$) were each significant predictors of individual's attitudes toward seeking help.

In their second study, Vogel and Wester (2003) used a sample of 268 college students from psychology courses at a large Midwestern university. Participants completed measures of distress disclosure, self-concealment, anticipated risks and utility of disclosing emotions, psychological distress, social support, and attitudes toward counseling. A regression equation was analyzed and found to be significant (adj. $r^2=.32$, $p<.001$). Each factor accounted for a unique amount of variance. Distress disclosures ($\beta = .19$), Anticipated utility ($\beta = .29$), anticipated risk ($\beta = -.18$), self-concealment ($\beta = -.17$), and previous use of therapy ($\beta = -.18$) each accounted for a unique amount of the variance. The results of both Study 1 and Study 2 showed that several avoidance factors, including comfort with self-disclosing distressing information and the perceived outcomes of such self-disclosure, predict a significant amount of the variance associated with a person's help-seeking attitudes and intentions. The authors concluded that an individual's decision whether or not to seek professional help is strongly associated with their comfort with self-disclosing information.

Building on the previous work of Vogel and Wester (2003), Vogel et al. (2007) examined the mediating effects of self-stigma associated with attitudes toward seeking counseling and willingness to seek counseling. They used a structured equation model (SEM) to evaluate data from 676 undergraduates recruited from psychology classes at a large Midwestern university. Participants completed measures of perceived public stigma, self-stigma, attitudes toward seeking professional psychological help, and willingness to seek counseling for psychological and interpersonal concerns. Results of

SEM analyses indicated that perceptions of the public stigma associated with mental illness predicted the self-stigma associated with seeking counseling, which, in turn predicted attitudes toward seeking help, and finally, willingness to seek counseling for psychological problems. The authors' hypotheses that perceived public stigma is related to self-stigma, that self-stigma is negatively associated with attitudes toward counseling, and attitudes are positively associated with willingness to seek help for psychological problems were confirmed. In short, the data suggest that one of the primary predictors of willingness to seek help is an individual's attitude toward counseling, and these attitudes are greatly affected by the degree of public and self-stigma experienced.

Komiya et al. (2000) investigated the effects of emotional openness, gender (male), perception of stigma, discomfort with emotions, and lower psychological distress on attitudes toward seeking psychological help. The authors surveyed 311 undergraduate students enrolled in introductory psychology courses at a large Midwestern university on measures of emotional style, stigma for receiving psychological help, levels of psychological distress, and attitudes toward receiving professional psychological help. Predictor variables were entered into a simultaneous regression model predicting help-seeking attitudes. Results indicated that the model was significant $F(4, 305)=25.88$, $p<.001$, and accounted for 25% of the variance in attitude scores (adj. $r^2=.24$). Gender ($\beta = -.22$), stigma ($\beta = -.30$), emotional openness ($\beta = .13$), and distress ($\beta = .11$) were each found to be significant unique predictors of attitudes toward help-seeking.

Help-seeking among Christians. Clearly, there are many variables which impede an individual's decision to seek professional psychological help, including several avoidance factors and demographic and situational influence (Vogel et al, 2007). One

understudied factor that influences help-seeking behavior is religious affiliation and involvement. Of particular interest to this dissertation is how religiosity affects help-seeking among Christians. Following is a discussion of literature concerning these topics.

Among a Christian groups it is quite likely that a person experiencing psychological distress would seek help from religious leaders rather than any other professional help-giver, that is, if they sought help at all (Chalfant, Heller, Roberts, Briones, Aguirre-Hochbaum, & Farr, 1990). This could be due to many factors, including availability of clergy, ease of access to clergy, trust for religious leaders, and counselor preference (Clemens, Corradi, & Wasman, 1978; Oppenheimer, Flannelly, & Weaver, 2004; Worthington et al., 1996). What are the help-seeking practices of Christians? What factors are significant in their decisions whether to seek help at all, and from whom to seek that assistance?

Mayers, Leavey, Villianatou, and Barker (2007) reported data from a qualitative study in the United Kingdom designed to explore how clients with religious/spiritual beliefs conceptualized their psychological problems, and how their beliefs influenced the help they sought. Participants included individuals who were currently receiving or had recently finished therapy. Ten clients were interviewed (seven women and three men) with a mean age of 42 (range: 32-52). The study was conceptualized with the framework of Interpretive Phenomenological Analysis (IPA), a systematic method for qualitative research in health psychology and related fields. A semi-structured interview was conducted to explore people's experiences of seeking and receiving help and how their religious/spiritual beliefs affected the process. Themes emerging from the interviews

were grouped in two domains: (1) spiritual and secular help seeking; and (2) receiving secular help. The authors found that participants' preconceptions about therapy as antagonistic to religious/spiritual beliefs may impede, but not deter help-seeking from secular therapy. One explanation for this is the participants in this study had previously received therapy. The authors of the study noted that participants realized their religious or spiritual beliefs did not have to be concealed or diminished in therapy, but could be used complimentary, depending on the ability/willingness of the therapist. Obviously, this study is limited due to its restricted sample, however; the results are similar to those found by Guinee and Tracey (1997) and Worthington et al. (1996) which conclude that although religious/spiritual individuals may have apprehensions about secular therapy, it does not mean that these individuals would believe a secular therapist could not offer them help.

In a study examining the help-seeking practices of older adults, Pickard (2006) used data from the Naturally Occurring Retirement Community (NORC) Demonstration Project. The NORC is an area of St. Louis County, Missouri and is comprised of single-family homes, apartment buildings, condominiums, town homes, and senior congregate housing. Approximately 1337 of the 4370 people living within this area were 65 years-of-age or older. A sample was obtained through advertising, mailings, door-to-door canvassing, presentations at organizations serving older adults, community events, and word of mouth. Participants were compensated \$20 for completing study. A total of 326 respondents completed usable interviews. Each subject was measured on mental health service use, predisposing factors (age, gender, marital status, religious affiliation, and religiosity), enabling factors (education, income, and social support), and need factors

(depression, self-rated stress, alcohol abuse, and physical health). Central tendencies and distributions of all study variables were examined. Binary logistic regression was used to test the hypothesis that religiosity is associated with mental health service use. Results of logistic regression analysis revealed that time spent in religious activities and intrinsic religiosity were both related to the use of mental health services. Participants who spent more time in private religious activities were more likely to have sought some form of mental health service than those who spent less time in private religious activities. Also, the same held through for religiosity. Study participants who scored higher in levels of intrinsic religiosity were more likely to have sought some form of mental health service than those with lower levels of intrinsic religiosity. Pickard asserted the possibility that those with higher levels of intrinsic religiosity have more trust in their higher power, and this trust causes them to have less of the stigma that is associated with seeking professional psychological help.

Miller and Eells (1998) conducted a study of the effects of degree of religiosity on attitudes toward seeking professional counseling. Study participants included 463 undergraduate students from private Christian colleges in the upper Midwest region of the United States. Each subject was administered a questionnaire on demographic information, religiosity, and willingness to seek professional psychological help. Religiosity was measured using Gorsuch and McPherson's (1989) Intrinsic-Extrinsic/Revised Religious Orientation Scale (I/E-R). Help-seeking attitudes were measured using an updated version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) originally developed by Fischer and Turner (1970) and revised by Fischer and Farina (1995). Students were given the questionnaire during

the last fifteen minutes of a required general education class. Questionnaires were completed anonymously and on a volunteer basis. Relationships between students' degree of religiosity and their help-seeking attitudes were initially analyzed using Pearson's product-moment correlation. Significant strong positive correlations were reported between both the intrinsic and extrinsic subscales of the religiosity measure and the Need, Stigma, and Openness subscales of the ATSPPH. Strong positive correlations were also reported between the I/E-R subscales and the ATSPPH total score. As follow up analyses, respondents were divided into high and low religiosity levels according to their scores on the Intrinsic subscales on the I/E-R. The authors used a median split to divide the participants into two groups. The Extrinsic subscales were not used in this analysis due to the low reliability of the scales (Es, $r=.52$; Ep, $r=.51$). A multivariate analysis was computed with the Need, Stigma, Openness, and Confidence subscale scores of the ATSPPH serving as the dependent covariables. This analysis resulted in a significant religiosity effect, $F(4,455)=7.31, p<.001$. Subsequent univariate analyses for the religiosity effect resulted in significance for two of the four variables: Stigma, ($p<.01$); and Openness, ($p<.001$). These results provide evidence that individual attitudes toward seeking professional psychological help among Christians are directly related to level of intrinsic religiosity. Also found in this study was evidence of a positive correlation between gender and attitudes toward seeking professional psychological help; however, the authors were careful to point out that, "the more positive attitudes related to degree of intrinsic religiosity were not a function of gender" (p. 254). Participants in this study who displayed high levels of intrinsic religiosity showed a higher level of tolerance for the stigma associated with seeking professional psychological help and also showed

greater openness with regard to their own difficulties. They did not, however, display greater propensity to recognize personal need for psychological help or more confidence in the ability of mental health professionals. Miller and Eells stated that these results could be because individuals who express intrinsic religiosity are more aware of their own internal processes and are more likely to be open to potential difficulties.

As the above review of research reveals, there are many facets involved in the help-seeking process. Because so few people who need professional psychological help actually seek help, it is important for psychologists to understand any issue which might impede individuals from making the decision, and then taking the necessary steps, to obtain help (Worthington, 1996, Vogel et al., 2007). These impedances quite likely exist in specific communities, i.e, the Christian community, as well as the general population (Morgan, 1982; Worthington, 1996, Vogel et al., 2007).

Summary

The topic of help-seeking is a complex one. Research suggests there are many factors involved in the stages that take a person from the recognition of a problem, the decision as to whether or not to seek help, and then the choice of a helper. As would be expected, several variables influence this process. The purpose of this study was to examine the relationships between religious orientation, views about mental illness, and willingness to seek professional psychological help. Do Christians have stereotypical views of mental illness, or do they simply view it as a spiritual problem needing a spiritual answer? Does religious orientation affect views about mental illness and willingness to seek help? Does belief about mental illness alone have a greater effect on willingness to seek psychological help than religious orientation? Although research has

looked at religious orientation, views about mental illness, and willingness to seek professional psychological help individually, there is no research examining all of these variables together. It was the intent of this study to do so and thereby add to the psychological literature, thus producing a better understanding of a specific population's attitudes and behavior concerning these psychological constructs.

CHAPTER 3

Methods

Introduction

The purpose of this study was to explore differences in the way Christians from a range of Protestant denominations with various religious orientations view mental illness and how these views relate to their help-seeking attitudes. Given the lack of research investigating the relationships among religious orientation, belief about mental illness, and willingness to seek help, it would be valuable to determine if, in fact, Protestant Christians in general have negative beliefs about individuals with mental illness, if this belief is related to religious orientation, and how each of these factors relate to attitudes toward seeking professional psychological help.

Sample

The participants in this study included 540 adults (age 18 and over) who identified themselves as Christian and who attended services held by several different Protestant denominations. These churches were from a range of different protestant denominations, including Assembly of God, Southern Baptist, Christian (Disciples of Christ), Church of Christ, Church of God (Anderson), Church of God (Cleveland), Church of God of Prophecy, Episcopal, Independent Non-Denominational, and United Methodist. Participating churches were located in North Carolina, Tennessee, and Alabama, with the majority from Alabama. All churches in this sample were located in the south-eastern United States. Subjects completed a survey that was distributed to them

at a regularly scheduled congregational meeting determined by the examiner and the senior pastor of each individual church.

Instrumentation

The measures used in this study were as follows: the Intrinsic/Extrinsic-Revised Scales; the Beliefs Toward Mental Illness Scale; and the Attitudes Toward Seeking Professional Psychological Help Scale. Demographic information will also be gathered. Each measure is described below.

Intrinsic/Extrinsic-Revised (I/E-R) Scales. The I/E-R Scales was developed by Gorsuch and McPherson (1989) as a revision of the Age Universal I/E Scales developed by Gorsuch and Venable (1983). The I/E-R Scales are used to measure intrinsic (I) and extrinsic (E) religiosity. Both the Age Universal I/E and the I/E-R scales were developed from the work of Allport and Ross (1967), who worked extensively in operationalizing the concepts of intrinsic and extrinsic religiosity. In 1985, Donahue reported that over 70 published studies had used Allport's Religious Orientation Scale (ROS).

Although Allport's ROS had been widely used with adults to measure I and E orientations, its use with children and adolescents was not suitable because of the reading level required. This prompted Gorsuch and Venable (1983) to develop a measure that could be used by both children and adults. This measure was titled "Age Universal I/E Scale." In 1989, Gorsuch and McPherson revised the Age Universal I/E Scale to become the I/E-R Scale.

The I/E-R Scale is a 14-item Likert-type measure of religious orientation (Appendix B). It produces intrinsic and extrinsic subscales with higher scores indicating greater affiliation with each respective orientation. The extrinsic subscale consists of

extrinsic-personal (Ep) and extrinsic-social (Es) orientations. Each item on the instrument is a statement that is scored on a 5-point scale ranging from (0) strongly disagree to (4) strongly agree. The I scale consists of 8 items, the Ep scale consists of 3 items, and the Es scale consists of 3 items. The three subscales show a low correlation with each other: a correlation between the I scale and the Ep scale of .07; a correlation between the I scale and the Es scale of -.12; and a correlation between the Ep scale and the Es scale of .41. In their original creation of the I/E-R Scale, Gorsuch and McPherson (1989) found Cronbach's alpha scores as follows: I=.83, Ep=.57; Es=.58; and Ep/Es=.65. They stated that although the reliability numbers for Ep, Es, and E combined are low, if the number of respondents is sufficiently high, significance tests would be powerful enough that the lower reliabilities would be adequate. Using the Spearman-Brown prophecy formula to double the total number of items for the Ep and Es subscale would increase the alpha coefficients to .73 and .73 respectively (Brown, 1996). In a recent study of religious orientation, mature faith, and psychological distress, Salsman and Carlson (2005) used the I/E-R Scales, and they report Cronbach's alphas for their study as follows: I=.83; Ep=.72; Es=.68, and Ep/Es=.71.

Beliefs Toward Mental Illness Scale (BMI). The BMI scale was designed by Hirai and Clum (2000) to assess negative stereotypical views of mental illness. Primary validity studies were completed using Asian and American students. Participants in the study were recruited from a large state university in southwest Virginia. Email was sent to Asian students who were on the international student list obtained from an International Student Center at the university. A total of 216 students were used in the

study. One hundred and fourteen international students were born in Asia and held student visas.

The BMI scale (Appendix B) is a 21 item, 6 point Likert-type response format questionnaire presented first in the *Journal of Psychopathology and Behavioral Assessment* by Hirai and Clum (2000). Responses to each item range from “completely disagree” (0) to “completely agree” (5) with higher scores indicating more negative beliefs. A series of exploratory factor analyses examining construct validity revealed three subscales which identify subjects’ beliefs about mental illnesses. These subscales are as follows: dangerousness, poor social and interpersonal skills, and incurability. Inter-factor correlations were obtained ranging from .51 to .66 ($p < .01$). The authors report that identified factors and item distributions were found to be consistent with expectations and mirror beliefs toward mental illness discussed in the literature. Examination of the reliability estimates for each factor revealed that Cronbach’s alpha for the overall scale for American students was reported to be .89. For the three subscales, Cronbach’s alpha for American students was reported as follows: dangerousness = .77; poor social skills = .74; incurability = .85. The BMI was used recently in a study by Segal et al. (2005) examining the views of younger and older adults concerning beliefs about mental illness and willingness to seek help. They reported the following internal reliabilities of the BMI for younger and older adults: younger adults BMI total score $\alpha = 0.89$ and older adults BMI total score $\alpha = 0.91$.

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH). The ATSPPH was developed by Fischer and Farina (1995) as a brief scale measuring attitude toward seeking professional counseling for psychological problems. It was adapted from

the earlier work of Fischer and Turner (1970). Fischer and Turner's original scale consisted of 29 items and was multidimensional, yielding subscales of (1) recognition of need for help, (2) stigma tolerance, (3) interpersonal openness, and (4) confidence in mental health practitioners. However, the subscales used to measure those dimensions lacked internal consistency. Because of this, the authors suggested that researchers use the total scale scores rather than subscale scores (Fischer & Turner, 1970). Subsequently, Fischer and Farina (1995) sought to create a shorter, easier to use instrument that would yield a single unitary measure of attitudes toward seeking professional help.

The ATSPPH is a 10-item self-report measure that uses Likert-type responses ranging from "disagree" (0) to "agree" (3) for statements about seeking professional psychological help. Total scores range from 0 to 30. It was developed from two studies using students enrolled in an introductory psychology course at the University of Connecticut. In the first study, 389 participants completed the survey. The purpose of the second study was to determine the stability, over time, of scores obtained from the scale. Students from the same university who had not been in the first study were asked to sign up for two testing sessions spaced apart by one month. Sixty-two students volunteered to be a part of the second study (Fischer & Farina, 1995).

High scores on the ATSPPH indicate more positive attitudes toward seeking professional counseling. Fischer and Farina (1995) reported an internal consistency estimate (Cronbach's alpha) of .84. Test-retest revealed reliability estimates of $r = .80$ over one month. The authors reported an adequate concurrent validity estimate of $r = .39$ in comparison of ATSPPH scale scores and whether or not individuals sought professional help when experiencing serious emotional or personal problems.

Procedures

Permission to conduct the study was obtained from the senior pastor of each local church identified to participate. Once permission was secured, the examiner and the pastor selected a date for the study and, on that date, distributed packets with questionnaires to each adult present at the church service. The number of questionnaires given to each church corresponded to 120% of the average number of adults attending services as provided to the examiner by each church's senior pastor. The senior pastor was provided with a study protocol explaining how the packets were to be distributed and completed. The survey consisted of 50 questions and took approximately 15 minutes to complete by each participant. Upon completion, all questionnaires were returned to the individual packet envelope and collected by the senior pastor and returned to the examiner. After data analysis is completed each pastor will be furnished with study results pertaining to his/her congregation and the over-all sample. As incentive to participate, each church received one dollar for each survey completed at that church.

Data Analysis

Questionnaire responses were entered into an item-level, computerized data base, and items will be combined into scales as indicated by previous research. Each respondent was categorized as to religious orientation (intrinsic, indiscriminately nonreligious, indiscriminately pro-religious, extrinsic) based upon responses to the I-E/R Scales (Gorsuch and McPherson, 1989). Categories were divided based upon median splits of the measures of religiosity. Once criterion groups were determined, statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS).

Hypotheses and Specific Analyses Undertaken

The following hypotheses were tested:

1. Religious orientations of church goers will differ significantly in respect to stereotypical beliefs about mental illness. A one-way analysis of variance (ANOVA) was performed to test for significant between group differences with religious orientation (intrinsic, extrinsic, indiscriminately pro-religious, indiscriminately non-religious) as the independent variable and scores on the BMI scale as the dependent variable. Post hoc analyses using Scheffé (Keppel, 1991) was completed to examine significance.
2. Religious orientations of church goers will differ significantly from each other in respect to attitudes toward seeking professional psychological help. A one-way ANOVA was performed to test for significant between group differences with religious orientation (intrinsic, extrinsic, indiscriminately pro-religious, indiscriminately non-religious) as the independent variable and scores on the ATSPPH as the dependent variable. Post hoc analyses using Scheffé (Keppel, 1991) was completed to examine significance.
3. Religiosity will correlate with scores on a measure of stereotypical beliefs about mental illness:
 - a. Intrinsic and indiscriminately nonreligious religiosity will be negatively correlated with scores on stereotypical beliefs about mental illness. A Pearson product moment correlation was performed comparing scores on the I/E-R Scale measuring intrinsic and indiscriminately nonreligious religiosity and scores on the BMI scale

which measures stereotypical beliefs about mental illness. See means plot for first ANOVA.

- b. Extrinsic and indiscriminately pro-religious religiosity will be positively correlated with scores on stereotypical beliefs about mental illness. A Pearson product moment correlation was performed comparing scores on the I/E-R Scales measuring extrinsic and indiscriminately pro-religious religiosity and scores on the BMI scale.
4. Religiosity will correlate with scores on a measure of attitudes toward seeking professional psychological help:
- a. Intrinsic and indiscriminately nonreligious orientations will be positively correlated with more positive attitudes toward seeking professional psychological help. A Pearson product moment correlation was performed comparing scores on the I/E-R Scales measuring intrinsic and indiscriminately nonreligious religiosity and scores on the ATSPPH which measures attitudes toward seeking professional psychological help.
 - b. Extrinsic and indiscriminately pro-religious orientations will be negatively correlated with more positive attitudes toward seeking professional psychological help. A Pearson product moment correlation was performed comparing scores on the I/E-R Scales measuring extrinsic and indiscriminately pro-religious religiosity and scores on the BMI scale.

5. Scores on measures of religiosity (I/E-R Scales) and beliefs about mental illness (BMI Scale) will be significant predictors of attitudes toward seeking psychological help (ATSPPH Scale). Scores on the I/E-R Scales (independent variables) were entered into a regression equation, followed by scores on the BMI Scale (independent variable), and then scores on the ATSPPH Scale (dependent variable).

CHAPTER 4

Results

This chapter reports and summarizes statistical analyses used to evaluate the research questions and hypotheses. Descriptive statistics of the sample are followed by the hypotheses driven analyses and exploratory analyses. All data analyses were performed using SPSS version 17.0.

Data from the current study were gathered from surveys handed out to 10 different churches from various protestant Christian denominations. A total of 950 surveys were distributed to churches based upon the number of surveys requested by participating pastors. Of the total returned, 36 had entire sections left incomplete and were therefore excluded from the study. Of the remaining 540 surveys, 57 had four or less missing items. These items were scored based on the mean score for the missing item. This resulted in an overall N of 540. The number of surveys given and returned from individual churches are as follows (number given/number returned completed): Assembly of God (60/31); Southern Baptist (70/27); Christian (Disciples of Christ)(50/22); Church of Christ (50/28); Church of God (Anderson)(300/231); Church of God (Cleveland)(50/27); Church of God of Prophecy (50/18); Episcopal (50/27); Independent Non-Denominational (200/86); and United Methodist (70/43).

Participants included 216 males and 324 females. The majority of participants reported being married (393), followed by those reporting being single (69), those reporting being separated/divorced (51), and finally, those reporting being widowed (27).

A total of 114 participants were in the 18-30 age range, 273 were in the 31-55 age range, 114 were in the 56-70 age range, and 39 were over 70 years of age. In responding to whether or not they believed emotional/mental/relationship problems such as depression, anxiety, intense grief, loneliness, thoughts of self-harm or substance abuse are solely religious/spiritual in nature, 102 participants responded “yes,” whereas 438 participants responded “no.” When asked whether or not those problems require only a religious/spiritual answer, 97 participants responded “yes,” and 443 participants responded, “no.”

Scale measurements.

I/E-R Scales. In order to measure religiosity, the *I/E-R Scales* was used to place participants into categories of intrinsic, extrinsic, indiscriminately pro-religious, and indiscriminately nonreligious religiosity. The *I/E-R Scales* consist of a scale measuring intrinsic religiousness and a scale measuring extrinsic religiousness. Higher scores on each scale indicate greater affiliation with the respective religious orientation. The intrinsic scale consists of 8 items and revealed a reliability coefficient of .72. The extrinsic scale consists of 6 items and revealed a reliability coefficient of .66. Although reliability numbers are slightly low, the number of respondents was sufficiently high enough that significance test showed adequate power.

For the intrinsic scale, the range of scores was from 10 to 32 with a mean score of 26.36, a standard deviation of 3.928 and a median of 27. For the extrinsic scale, scores ranged from 0 to 22 with a mean score of 9.87, a standard deviation of 3.895 and a median of 10.

In order to create the categories of indiscriminately pro-religious and indiscriminately nonreligious religiosity, data was coded so that individuals scoring below the median on the intrinsic scale were given a value of 0, and individuals scoring above the median were given a value of 1. Similarly, individuals scoring below the median on the extrinsic scale were given a value of 0, and individuals scoring above the median were given a value of 1, thus creating categories of “high” and “low” on each scale. Scores then created a variable called “religious orientation” wherein a person who scored low on both categories would be determined “indiscriminately nonreligious” (Intrinsic-0, Extrinsic-0), “intrinsic” (Intrinsic-1, Extrinsic-0), “extrinsic” (Intrinsic-0, Extrinsic-1), and “indiscriminately pro-religious” (Intrinsic-1, Extrinsic-1). The religious orientation category was then coded 0, 1, 2, or 3, depending upon the participant’s particular orientation. The above procedure resulted in 159 participants classified as intrinsic, 144 as extrinsic, 132 as indiscriminately pro-religious, and 105 as indiscriminately nonreligious.

BMI Scales. The Beliefs Toward Mental Illness scale was used to assess an individual’s negative stereotypical views of mental illness. The scale consists of 21 items scored on a 6 point Likert-type response format with higher scores indicating more negative beliefs. A reliability coefficient of .89 was obtained for this study. A mean score of 40.48 was obtained, with a standard deviation of 14.19 and a median of 41.

ATSPPH Scale. The Attitudes Toward Seeking Professional Help Scale was used to assess an individuals attitude toward seeking professional counseling for emotional/mental/relationship problems. The scale consists of 10 items scored on a 4 point Likert-type response format with higher scores indicating more positive attitudes

toward seeking professional psychological help. A reliability coefficient of .82 was obtained for this study. The mean score for this measure was 17.73 with a standard deviation of 6.27 and a median of 18.

Statistical Analyses.

In order to test hypotheses one and two, a one-way ANOVA was performed to examine between group differences with religiosity as the independent variable and scores on the BMI scale and the ATSPPH scale as the respective dependent variables. Post hoc tests were performed using Scheffé to examine significance. Hypotheses 3 and 4 were tested using Pearson Product Moment correlations. Finally, hypothesis 5 was tested using a hierarchical regression equation.

Religious Orientation and Beliefs About Mental Illness. Hypothesis One was as follows: “Religious orientations of protestant Christian church goers will differ significantly in respect to stereotypical beliefs about mental illness.” This hypothesis was supported as one-way Anova revealed significant between group differences as related to scores on the BMI scale, $F(3, 336) = 14.068, p = 0.00$ (see Table 1).

Table 1.

Analysis of Variance for Religious Orientation and Beliefs About Mental Illness

	df	SS	MS	F-value
Between groups	3	7926.23	2642.08	14.07***
Within groups	536	100666.46	187.81	
Total	539	108592.69		

*** = $p \leq 0.001$

Post hoc analyses using the Scheffé criterion for significance indicated that the extrinsic religious orientation differed significantly from all other religious orientations. As can be seen in Table 2, none of the other orientations differed significantly from each other.

Table 2.

Scheffé Post-Hoc Test Comparison of Religious Orientations

Dependent Variable: BMI							
	(I) ReligiousOrientation	(J) ReligiousOrientation	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Scheffe	IndiscriminatelyNonreligious	ExtrinsicallyReligious	-9.240*	1.759	.000	-14.17	-4.31
		IntrinsicallyReligious	-.168	1.723	1.000	-5.00	4.66
		IndiscriminatelyProreligious	-4.522	1.792	.096	-9.55	.50
	ExtrinsicallyReligious	IndiscriminatelyNonreligious	9.240*	1.759	.000	4.31	14.17
		IntrinsicallyReligious	9.072*	1.577	.000	4.65	13.49
		IndiscriminatelyProreligious	4.718*	1.651	.044	.09	9.35
	IntrinsicallyReligious	IndiscriminatelyNonreligious	.168	1.723	1.000	-4.66	5.00
		ExtrinsicallyReligious	-9.072*	1.577	.000	-13.49	-4.65
		IndiscriminatelyProreligious	-4.354	1.614	.065	-8.88	.17
IndiscriminatelyProreligious	IndiscriminatelyNonreligious	4.522	1.792	.096	-.50	9.55	
	ExtrinsicallyReligious	-4.718*	1.651	.044	-9.35	-.09	
	IntrinsicallyReligious	4.354	1.614	.065	-.17	8.88	

*. The mean difference is significant at the 0.05 level.

Religious Orientation and Attitudes Toward Seeking Professional Psychological

Help. Hypothesis Two was as follows: “Religious orientations of protestant Christian church goers will differ significantly from each other in respect to attitudes toward seeking professional psychological help.” This hypothesis was not supported as was revealed by one-way ANOVA, $F(3, 336) = .89, p = .44$. No significant between group

interaction was found. Table 3 illustrates the means and descriptive statistics for comparisons of religious orientations as they relate to scores on the Attitude Toward Seeking Professional Psychological Help Scale. As can be seen, means from each group were quite similar.

Table 3.

Descriptive statistics of religious orientation means and standard deviations of scores on the Attitude Toward Seeking Professional Psychological Help Scale

	N	Mean	SD
Indiscriminately Nonreligious	105	17.43	6.27
Extrinsically Religious	144	18.46	5.71
Intrinsically Religious	159	17.43	6.63
Indiscriminately Pro-religious	132	17.53	6.41
Total	540	17.73	6.27

Correlations between Religious Orientations and Beliefs About Mental Illness.

Hypothesis Three-A was as follows: “Intrinsic and indiscriminately nonreligious religiosity will be negatively correlated with scores on beliefs about mental illness.” This hypothesis was supported as revealed by results of a Pearson product-moment correlation. There was a significant negative correlation found between intrinsic religiosity and scores on the BMI, $r = -0.097$, $N = 540$, $p = 0.012$ (see Table 4).

Table 4.

Correlation between Religious Orientation and Beliefs About Mental Illness and Attitudes Toward Professional Psychological Help

	Beliefs About Mental Illness			Attitudes Toward Psych Help		
	N	r	p-value	N	r	p-value
Intrinsic Religiosity	540	-0.097	0.012*	540	-0.083	0.026*
Extrinsic Religiosity	540	0.222	0.000**	540	0.051	0.117

*Significance is at the 0.05 level (1-tailed).

**Significance is at the 0.001 level (1-tailed).

Hypothesis Three-B was as follows: “Extrinsic and indiscriminately pro-religious religiosity will be positively correlated to scores on stereotypical beliefs about mental illness.” This hypothesis was supported as revealed by results of a Pearson product-moment correlation. There was a significant positive relationship found between extrinsic religiosity and scores on the BMI, $r = 0.22$, $N = 540$, $p = 0.000$ (see Table 4).

Correlations Between Religiosity and Attitudes Toward Seeking Professional Psychological Help. Hypothesis Four-A was as follows: “Intrinsic and indiscriminately nonreligious orientations will be positively correlated with more positive attitudes toward seeking professional psychological help.” This hypothesis was not supported.

Conversely, a Pearson product-moment correlation revealed a weak, yet significant negative relationship between intrinsic religiosity and scores on the ATSPPH, $r = -0.083$, $N = 540$, $p = .026$ (see Table 4).

Hypothesis Four-B was as follows: “Extrinsic and indiscriminately pro-religious orientations will be negatively correlated with more positive attitudes toward seeking

professional psychological help.” This hypothesis was not supported. A Pearson product-moment correlation showed no significant relationship between extrinsic religiosity and scores on the ATSPPH, $r = 0.051$, $N = 540$, $p = 0.117$ (see Table 4).

Predictive Validity of Religiosity, Beliefs About Mental Illness, and Attitudes Toward Seeking Professional Psychological Help. Hypothesis Five was as follows: “Scores on measures of religiosity (I/E-R Scales) and beliefs about mental illness (BMI Scale) will be significant predictors of attitudes toward seeking professional psychological help (ATSPPH Scale).” This hypothesis was supported by the overall model, however with a weak but significant predictor relationship among intrinsic and extrinsic religiosity, and belief about mental illness. In the first step of the regression model, intrinsic/extrinsic religiosity was entered as a predictor variable, which revealed a small and insignificant level of explanation for change ($p = 0.103$). In step two of the equation, religiosity was held constant and BMI was entered, revealing a significant change ($p = 0.001$), albeit very small, only explaining about 3% of change in variability (see Table 4). The overall model showed significant predictor validity of the model, $F(3, 536) = 5.371$, $p = 0.001$.

Table 5.

Hierarchical Regression Model for Variables Predicting Attitudes Toward Professional Psychological Help

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.092 ^a	.008	.005	6.258	.008	2.287	2	537	.103
2	.171 ^b	.029	.024	6.198	.021	11.451	1	536	.001

a. Predictors: (Constant), IntrinsicallyReligious, ExtrinsicallyReligious

b. Predictors: (Constant), IntrinsicallyReligious, ExtrinsicallyReligious/NegativeMIBeliefs

CHAPTER 5

Discussion

The purpose of this study was to examine the relationship between religious orientation, beliefs about mental illness, and attitudes toward seeking professional psychological help among a protestant Christian population. Religious orientation was broken down into four categories based upon the work of Allport and Ross (1967). The four categories included intrinsic, extrinsic, indiscriminately pro-religious, and indiscriminately nonreligious orientations of religiosity. These religious orientations were measured and analyzed to see if their relationships to beliefs about mental illness and attitudes toward seeking professional psychological help were statistically significant.

Research question one asked how religious orientations differ in relation to stereotypical beliefs about mental illness. Results showed significant differences between the extrinsic orientation and all three other religious orientations. As expected, the intrinsic and indiscriminately nonreligious categories looked most alike when observing a non-religious dependent variable; however, there were still significant differences observed between extrinsic and indiscriminately pro-religious orientations, which was not expected (Donahue, 1985). These results lend further support to earlier findings which state that intrinsically and extrinsically religious people experience and express life differently (Hood, Morris, & Watson 1990; Worthington et al., 1996).

Similarly to question one, the second research question sought to investigate between group differences among the religious orientations in relation to attitudes toward seeking professional psychological help. The results showed no significant differences among any of the groups as they related to this dependent variable.

The third research question sought to observe any correlations among religious orientation and beliefs about mental illness. The results showed that intrinsic religiosity had a weak, but albeit significant negative relationship with stereotypical beliefs about mental illness, and extrinsic religiosity had a significant positive relationship with stereotypical beliefs about mental illness. These results lend support to earlier findings which show no significant relationship between intrinsic religiosity and prejudice and dogmatism, but a positive correlation between extrinsic religiosity and prejudice and dogmatism (Duck & Hunsberger, 1999; Kahoe, 1974; Morris, Hood, & Watson, 1989). Also, Markstrom-Adams and Smith (1996) found significant associations with variables related to open mindedness and external locus of control and intrinsic religiosity. With research showing the public stigma associated with mental illness (Link, et al., 1999; Van Dorn et al., 2005; Vogel et al., 2006; Walker & Read, 2002), it would follow that an individual with significant relationships associated to prejudice and dogmatism would also show a correlation to a negative view of individuals with mental illness. Conversely, the findings of Rowatt and Franklin (2004) showed no significant relationship between intrinsic or extrinsic religiosity and prejudice. One difference in the Rowatt and Franklin study was that the sample was from psychology students at a major southwestern university, where one would expect students to be more open minded when considering issues of prejudice, dogmatism, and mental illness.

The fourth research question investigated the possible association between religious orientation and attitudes toward seeking professional psychological help. Results revealed a weak, but significant negative correlation between intrinsic religiosity and attitudes toward seeking professional psychological help, and no significant relationship between extrinsic religiosity and attitudes toward seeking professional psychological help. This finding is contrary to earlier findings of Miller and Eells (1998) who reported that individual attitudes toward seeking professional psychological help was significantly positively related to intrinsic religiosity. Differences in these findings may be due again to the different populations that were sampled. Whereas Miller and Eells participants were college students from three different private Christian colleges in the upper Midwest United States with the majority of participants being freshmen, the participants in the present study were from local churches and may or may not have been students past or present. Also, the majority of participants in the present study were in the 31 to 55 age range. Although previous results of the present study indicate less negative views of the mentally ill among individuals with an intrinsic orientation, there still may be a lack of confidence in the efficacy of therapy, or less awareness of the personal need for psychological services.

The fifth question examined the predictive validity of religious orientation and stereotypical beliefs about mental illness as they relate to attitudes toward seeking professional psychological help. Results indicate that the combination of religious orientation and belief about mental illness is a weak but albeit significant predictor of attitudes toward seeking professional psychological help. Religious orientation uniquely accounted for less than one percent of variance in attitudes toward professional

psychological help. That proportion of variance was not significant on its own and had to be combined with beliefs about mental illness to obtain a significant result. Although significant at the $p < 0.001$ level, the overall model only explained approximately three percent of the total variance. This result suggests that religious orientation may have a relatively small relationship to one's inclination toward seeking psychological help from a mental health professional.

Implications for Practice and Future Research. The results of this study underscore previous research that shows the complexity of religiosity and how it relates to any given topic, and in particular how it relates to beliefs about mental illness and attitudes toward seeking professional psychological help. Practitioners can better serve clients by being aware of a client's religious beliefs and how those beliefs might affect the client's perceptions about their symptoms, the system from which they might or might not seek help, and appropriate causes and treatment modalities. As this study shows, individuals who report an extrinsic orientation to religiosity are more likely to view mental illness in a more negative light than others. Knowing this would help the mental health practitioner work with a client to lessen the cognitive dissonance that the client might feel due to their experience of mental illness despite their religious views.

The psychological community must be aware of the need to continue to combat the stigma of mental illness in every segment of the population and not ignore the religious community. This can be done by confronting stereotypes, both among religious individuals about the mental health community and among practitioners about the religious community. The religious community, especially leaders of denominations and leaders of individual congregations, must help de-stigmatize mental illness by letting

Christians know that even “good people” experience mental illness, and though sometimes episodes of mental illness may be related to lifestyle choices considered by the Christian community as sinful, this is not always the case. Sometimes the experience of mental illness is due to biology, genetics, life circumstances, or environment. Whatever the cause, the religious and psychological communities should work together to alleviate pain and suffering.

There must be an increased importance placed upon educating the religious community about the benefits of therapy and psychological study. Religious leaders can educate themselves about the benefits offered by the mental health community and then pass on that information through lectures, seminars, and building relationships with those in the psychological community. After relationships are built, religious leaders can use their influence in their community to make appropriate referrals for their followers to qualified mental health providers. Finally, psychologists, social workers, and mental health counselors can work with religious leaders to confront, combat, and lessen stigma associated with individuals diagnosed with mental illnesses.

The current study has implications for further research. Findings of this study showed agreement with some earlier research, and disagreement with others. This inconsistency seems to be consistent with the fact that there is inconsistency among research concerning religious orientation. The implication, therefore, is that research using religious variables needs clarity and sophistication in measurement and research design in order to better understand the relationship between religion and mental health. A similar study with a different sample would be beneficial to test whether the results of this study can be replicated. Studies should be conducted to examine the differences

between views of various denominations, particularly comparing the views of theologically conservative and theologically liberal groups. Although many studies have been conducted using samples of students or others located on university campuses, it would be valuable to conduct a replication study at various seminaries. These seminaries are where current and future religious leaders are being trained. Finally, a mixed-method study could further our understanding of how religious orientation affects views of mental illness and attitudes toward seeking professional psychological help.

Study Limitations. The limitations of this study include sample composition and survey design. The sample used in this study could be described as homogeneous in several ways, including fact that all participants were church attendees in the southeast United States. Also, the environment for all surveys to be completed was the same. All study participants were assumed to be protestant Christian given their attendance at a protestant church to complete the survey. Research focused on a Christian population may not generalize to individuals from other religious communities. Finally, there was an unequal number of participants from each group represented, and only one group from each represented denomination, which limits generalizability to any particular denomination.

The self-report nature of the study represents a limitation in that it relies on respondents' reports of their beliefs and attitudes and is subject to response bias, possibly reducing accuracy of responses. Another limitation of the study is that it used a sample of convenience and lacked randomization of choice of denomination and congregation, thereby limiting the ability to generalize results to the general population, or even to the protestant Christian population.

Summary and Conclusions. Despite the above mentioned limitations, this study suggests that beliefs about mental illness and attitudes toward seeking professional psychological help vary depending upon categories of religious orientation. Stigma exists concerning mental illness among protestant Christians, and there is a relationship between type of religiosity and belief about mental illness. It is clear that more research is needed to better understand previous inconsistent findings concerning religious variables and mental health issues, thus enabling both the religious and psychological community to interact in helpful and appropriate ways.

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IRB# 09.0360

Religiosity, Beliefs About Mental Illness, and Attitudes Toward Seeking Professional Psychological Help in a Protestant Christian Population

Date: 7/30/09

Dear Sir or Madame:

You are being invited to participate in a research study by answering the attached survey about *religiosity, beliefs about mental illness, and attitudes toward seeking professional psychological help*. There are no known risks for your participation in this research study. The information collected may not benefit you directly. The information learned in this study may be helpful to others. The information you provide will *be used for educational purposes*. Your completed survey will be stored at *an office located in Hartselle, Alabama, in a locked file cabinet*. The survey will take approximately *15 minutes* to complete.

Individuals from the Department of Educational Counseling and Psychology, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Taking part in this study is voluntary and completely anonymous. There will be no personal identifying information on the survey. By completing this survey you agree to take part in this research study. You do not have to answer any questions that make you uncomfortable. You may choose not to take part at all. If you decide to be in this study you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

If you have any questions, concerns, or complaints about the research study, please contact: *Sam Stringfield, PhD, at (502) 862-0615*. If you have any questions about your rights as a research subject, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a research subject, in private, with a member of the Institutional Review Board (IRB). You may also call this number if you have other questions about the research, and you cannot reach the research staff, or want to talk to someone else. The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has reviewed this research

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study. If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

Sincerely,

Sam Stringfield, Ph.D.

Mike Thompson, MAEd.

Questionnaire

Thank you in advance for completing this survey. All of the following questions are important to the study. Please read each question and all the possible answers carefully before selecting your response. Your entire questionnaire is anonymous. Nothing you write on this questionnaire can be used to identify you.

*Please complete questions 1 through 5 by circling **ONE** answer that describes you best.*

1. What is your age?

- a. 18-30
- b. 31-55
- c. 56-70
- d. 70-Over

2. What is your sex?

- a. Male
- b. Female

3. What is your marital status?

- a. Single
- b. Married
- c. Separated/Divorced
- d. Widow/Widower

4. Do you believe emotional/mental/relationship problems such as depression, anxiety, intense grief, loneliness, thoughts of self-harm or substance abuse problems are solely religious/spiritual in nature?

- a. Yes
- b. No

5. If so, do those problems require only a religious/spiritual answer?

- a. Yes
- b. No

Appendix B

Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and circle the number that relates to your agreement, partial agreement, partial disagreement, or disagreement. Please express your frank opinion in relating the statements. There are no "wrong" answers, and the only ones are whatever you honestly feel or believe. It is important that you answer every item.

For each question, circle the number that best relates to your opinion...		Disagree	Partly Disagree	Partly Agree	Agree
6.	If I believed that I was having a mental breakdown, my first inclination would be to get professional attention.				
7.	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
8.	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				
9.	There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.				
10.	I would want to get psychological help if I were worried or upset for a long period of time.				
11.	I might want to have psychological counseling in the future.				
12.	A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.				
13.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.				
14.	A person should work out his or her own problems; getting psychological counseling would be a last resort.				
15.	Personal and emotional troubles, like many things, tend to work out by themselves.				

Please read the following statements carefully and indicate with an "X" the response that you identify with most.		SD (strongly disagree)	D disagree	N (don't know)	A (agree)	SD Strongly disagree
16.	I enjoy reading about my religion.					
17.	I go to church because it helps me to make friends.					
18.	It doesn't much matter what I believe so long as I am good.					
19.	It is important to me to spend time in private thought and prayer.					
20.	I have often had a strong sense of God's presence.					
21.	I pray mainly to gain relief and protection.					
22.	I try hard to live all my life according to my religious beliefs.					
23.	What religion offers me most is comfort in times of trouble and sorrow.					
24.	Prayer is for peace and happiness.					
25.	Although I am religious, I don't let it affect my daily life.					
26.	I go to church mostly to spend time with my friends.					
27.	My whole approach to life is based on my religion.					
28.	I go to church mainly because I enjoy seeing people I know there.					
29.	Although I believe in my religion, many other things are more important in life.					

Appendix B

On the statements below, indicate with an "X" the response that you identify with most.		CD (completely disagree)	D (dis-agree)	SWD (somewhat disagree)	SWA (somewhat agree)	A agree	CA Completely agree
30.	A mentally ill person is more likely to harm others than a normal person.						
31.	Mental disorders would require a much longer period of time to be cured than would other general diseases.						
32.	It may be a good idea to stay away from people who have psychological disorders because their behavior is dangerous						
33.	The term "psychological disorder" makes me feel embarrassed.						
34.	A person with a psychological disorder should have a job with minor responsibilities.						
35.	Mentally ill people are more likely to be criminals.						
36.	Psychological disorders are recurrent.						
37.	I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder.						
38.	Individuals diagnosed as mentally ill will suffer from its symptoms throughout their lives.						
39.	People who have once received psychological treatment are likely to need further treatment in the future.						
40.	It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.						
41.	I would be embarrassed if people knew that I dated a person who once received psychological treatment.						
42.	I am afraid of people who are suffering from psychological disorders because they may harm me.						
43.	A person with a psychological disorder is less likely to function well as a parent.						
44.	I would be embarrassed if a person in my family became mentally ill.						
45.	I do not believe that a psychological disorder is ever completely cured.						
46.	Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.						
47.	Most people would not knowingly be friends with a mentally ill person.						
48.	The behavior of people who have psychological disorders is unpredictable.						
49.	Psychological disorders are unlikely to be cured regardless of treatment.						
50.	I would not trust the work of a mentally ill person assigned to my work team.						

CURRICULUM VITAE

Juan Michael Thompson

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EDUCATION

University of Louisville, Louisville, KY – December 2009

- Ph.D. , Counseling Psychology

Western Kentucky University, Bowling Green, KY - December 1996

- Master of Arts in Education in Mental Health Counseling
- Specialization: Marriage and Family Therapy

Warner Southern College, Lake Wales, FL - December 1992

- Bachelor of Arts in Organizational Management
- Honors: Academic Honors

OTHER EDUCATIONAL EXPERIENCES

INTERNATIONAL SERVICE LEARNING PROGRAM

Belize, Central America, Mar. 8-16, '02

- Visited communities, gained exposure to the culture, and explored medical/mental health facilities
- Consulted with medical personnel in developing plans for mental health referrals and service delivery

TEACHING EXPERIENCE

Part-time Instructor, Western Kentucky University – 1998 - 2002

Served as instructor of graduate and undergraduate courses in the Consumer and Family Sciences (CFS) Department and the Department of Counseling and Student Affairs (CNS), Counseling Program. Classes taught include:

- CFS 311 Family Relations
- CFS 494 Parenting Strategies
- CNS 590 Counseling Practicum
- CNS 567 Lifespan Mental Health Counseling (DSM IV)

RESEARCH EXPERIENCE

UNIVERSITY OF LOUISVILLE

A Study of Middle School Bullying Using a Framework for Violence Prevention, Aug. '00 to April '02

- Reviewed professional literature concerning bullying behaviors, surveyed middle school students, analyzed data, advocated for implementation of supported strategies
- Completed certification on the Protection of Human Research Subjects

PROFESSIONAL AFFILIATIONS AND CERTIFICATIONS

- Former Kentucky Certified Alcohol and Drug Counselor, Certification #0664
- American Psychological Association, Student Affiliate
- University of Louisville College of Education and Human Development Doctoral Student Organization, Executive Committee '01-'02
- Member Kentucky Domestic Violence Association '97-'99, former Level 1 Certified Domestic Violence Counselor

HONORS AND AWARDS

- NAMI of Morgan County, AL - Service Excellence Award 2007
- Mental Health Counseling Graduate Student of the Year – '96-97
- Service Award – Audubon Area Headstart Association – 1998
- United Way Venture Grant: \$10,000 to study the effectiveness of bullying prevention programs – Owensboro, KY – 1998

WORK EXPERIENCE

08/04 – 07/08 *Senior Therapist/Program Director, Decatur General Hospital – West*
Supervised all clinical aspects of inpatient psychiatric program, including development and implementation of programming for child, adolescent, and adult psychiatric populations; supervised therapists, caseworkers, school personnel, and interns; provided group and individual therapy; provided psychiatric consultations for community court systems to determine appropriateness of patients for admission into psychiatric hospital.

08/03 – 08/04 *Psychology Intern – APA Accredited Internship, United States Department of Justice, Federal Bureau of Prisons, Federal Medical Center, Lexington, Kentucky*

Provided psychological services for federal prison inmates housed in the Federal Medical Center in Lexington, Kentucky. Responsibilities included providing therapy, developing treatment plans, leading process and psycho-educational groups, mental health checks for specialized populations, and a specialized rotation in the residential drug and alcohol program. Outplacement experience one day per week in the University of Kentucky Counseling and Testing Center where responsibilities included initial intakes and diagnostic impressions, continuing therapy, and crisis counseling for graduate and undergraduate students and their families. All internship experiences were supervised by licensed psychologists.

04/03 – 08/03 *Therapist, Decatur General Hospital – West*

Provided therapy for inpatient psychiatric population; developed treatment plans and reviewed discharge criteria for patients; provided psychiatric consultations for community to determine appropriateness of patients for admission into psychiatric hospital.

06/00 – 12/02 *Targeted Assessment Specialist, University of Kentucky Institute on Women and Substance Abuse*

Conducted thorough assessments on clients of the Kentucky Cabinet for Families and Children targeting the areas of mental health, substance abuse, domestic violence, and learning problems. Provided short-term therapy and facilitated referrals and follow-up for clients.

02/00 – 05/00 *Therapist, Mental Health Center of North Central Alabama*

Conducted intake, provided diagnostic impressions, created treatment plans and conducted therapy for adults and children.

01/97 – 12/99 *Child Development Coordinator, OASIS Family Self-Sufficiency Campus – Substance Abuse Treatment Center and Spouse Abuse Shelter*

Coordinated all functions of children's department including supervising counselors, caseworkers, and childcare workers. Developed program materials for children in families who were homeless because of domestic violence or drugs and alcohol.

09/94 – 06/97 *Senior Pastor, Family Worship Center, Owensboro, KY*

Responsibilities included visionary planning and forecasting for church growth and expansion, supervision of budget plans and operations, supervision of small part-time paid and volunteer staff, counseling, and public speaking.

08/93 – 09/94 *Senior Pastor, New Bayview Church of God, Bonifay, FL*

Same responsibilities of senior pastor as listed above

8/88 – 8/93 *State Youth and Pastoral Care Department Director, Florida Church of God of Prophecy*

Coordinated all functions of each department including seminars and retreats for training and personal development. Directed volunteer youth camp staff of 25. Served as program facilitator for 125 churches

8/86 – 8/88 *State Evangelist, Florida Church of God of Prophecy*

Represented department in speaking engagements throughout the state of Florida, and in seven other states and Canada.

SUPERVISED PRACTICUM EXPERIENCE

*Cardinal Treatment Center – Department of Juvenile Justice – Louisville, Kentucky
Practicum Student, Jan. '01 – May '02: Total of 491 hours.*

- Completed one assessment practicum and two advanced therapy practicums.

- Completed full psychological assessments for residents.
- Led various treatment groups, including drug and alcohol and grief and loss.
- Conducted individual client therapy with several residents.

OASIS Family Self-Sufficiency Campus – Substance Abuse Treatment Center and Spouse Abuse Shelter – Owensboro, Kentucky
Practicum Student, Jan. '96 to Dec. '96: Total of 795 hours.

- Provided clinical services to clients and children, including group and individual therapy, court advocacy, and public presentations.

PRESENTATIONS AND GUEST LECTURES

May 2008 – Decatur General West Hospital, Decatur, Alabama. “Choice Theory and How it Relates to Reality Therapy in an Inpatient Psychiatric Population.”

June 2007 – Hill Crest Hospital, Birmingham, Alabama. “How to Communicate Well with the Psychiatric Patient.”

September 2006 – American Electrology Association National Convention, Newark, New Jersey. “How to Create (or Sabotage!) A Healthy Work Environment.”

June 2005 – Louisiana Association of Professional Electrologists State Convention, Baltimore Maryland. “Biopsychosocialspiritual Effects of Stress in Everyday Life.”

May 2003 – Maryland Association of Professional Electrologists State Convention, Baltimore, Maryland. “Biopsychosocialspiritual Effects of Stress in Everyday Life.”

April 2003 – University of Louisville, Louisville, KY. “Peace Begins with Me: Youth Forum for Peace.” Forum jointly sponsored by the University of Louisville, the Muhammad Ali Institute for Peacemaking and Conflict Resolution, and the Center for Safe Urban School Communities. Co-led groups of youth from Louisville schools identifying ways to promote peace in their homes, schools, and communities.

March 2003 - Poster Session – American Counseling Association National Convention, San Francisco, CA. “A Comprehensive Approach to Addressing Violence in the Middle School Environment.”

October 2002 – American Electrology Association National Convention, Las Vegas, NV. “Biopsychosocialspiritual Effects of Stress in Everyday Life.”

September 2002 – University of Louisville, Louisville, KY. “Moving Together Toward Peace,” part of “Louisville Remembers,” the city-county 9/11/02 remembrance jointly sponsored by the University of Louisville (Muhammad Ali Institute for Peacemaking and Conflict Resolution and the Center for Safe Urban School Communities) and the Muhammad Ali Center.” Co-led groups of youth from Louisville schools to reflect on the events of 9/11/01 and to identify personal power in creating peaceful environments.

April 2002 – Spring Research Conference, Universities of Cincinnati, Kentucky, and Louisville, Cincinnati, OH. “Contributors to Bullying Behavior and Victimization Among 6th-8th Grade Students in Private Urban Elementary Schools.”

March 2002 – Belize Mental Health Association, Dangriga/Belize City, Central America. “New Initiatives in Mental Health Referrals: Dealing with Dual Diagnosis.”

March 1999 – Kentucky Domestic Violence Association, Frankfort, KY. Kentucky Domestic Violence Association Certification Training: “Crisis and Suicide Intervention.”

September 1998 - Kentucky Domestic Violence Association, Frankfort, KY. Kentucky Domestic Violence Association Certification Training: “Crisis and Suicide Intervention.”