# Influence of Religiosity and Fundamentalism on Attitudes Toward Psychotherapy: Religion Related Barriers to Mental Health Services Utilization

# Influence of Religiosity and Fundamentalism on Attitudes toward Psychotherapy: Religion Related Barriers to Mental Health Services Utilization

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## Abstract

While the level of mental illness in the U.S. population increases year after year, the utilization of professional mental health services is still lagging (SAMHSA, 2017). Influence of some demographic factors (gender, age, race/ethnicity, and education level) on mental health services utilization has been researched. However, research on influence of one important demographic factor, religion, is rather sparse.

A person's religion influences many aspects of his or her decision making process, and some research suggests that it may also influence how an individual views mental illness and whether and where he or she will seek help for their psychological distress. This research aimed to evaluate whether a person's religion influences his/her willingness to seek professional mental health treatment and to determine specific elements of religion and religiosity that might influence an individual's psychological help-seeking behaviors.

This research indicates that some aspects of religiosity, such as level of fundamentalism or conservatism of one's beliefs, perception of antagonism between psychology and religion, and value-disconnect between mental health professionals and religious people correlate negatively with attitudes toward psychotherapy and willingness to seek professional mental health help. It also showed that a person's preference for seeking help for his/her emotional and mental distress from their religious leaders correlates negatively with attitudes toward professional psychotherapy. This may motivate a religious person to seek help only from religious leaders, who are not always adequately prepared to offer such help. This research suggests that psychology and

mental health professionals need to be aware of religious beliefs when designing outreach programs in order to help conservatively religious people be more comfortable in seeking and receiving professional mental health treatment.

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# Chapter I

## Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2017) survey estimated that, in 2016, 44.7 million adults in the United States (18.3% of U.S. adults) had some type of mental illness, and 10.4 million of them had severe mental illness. The U.S. National Comorbidity Survey Replication conducted in 2004, the latest nation-wide survey that looked at mental illness life-time prevalence, estimated that the lifetime prevalence of any-type mental illness among U.S. adults is 57.4 percent (Harvard Medical School, 2005). The SAMHSA (2017) report shows increase in mental illness numbers through the years, indicating that life-time prevalence of mental illness is probably higher now than 15 years ago.

Conversely, the percentage of people receiving help for their mental health problems is still rather low, with only about 36.5% of those with non-serious mental illness and 64.8% of those with serious mental illness receiving some kind of mental health treatment in 2016 (SAMHSA, 2017). In the same SAMHSA (2017) report it was estimated that about 11.77 million people perceived they had mental health needs that weren't fully met and about 5.5 million of adults needing mental health care did not receive any treatment.

Several demographic factors, such as gender, age, ethnicity/race, and education level seem to have an effect on mental health services utilization (SAMHSA, 2017). Gender appears to be the most consistent factor in predicting likelihood of seeking help

for mental health issues (Pattyn, Verhaeghe, & Bracke, 2015; Rhodesa, Goering, Tod, & Williams, 2002). In 2016 women were more likely to report having some type of mental illness (61.6% of people with any-type mental illness and 65.4% of those with serious mental illness were women). However women were also more likely to seek treatment, with 48.6% of women vs. 33.7% of men with any-type mental illness and 83.6% of women vs. 29.2% of men with serious mental illness seeking some kind of mental health help (SAMHSA, 2017).

The picture is not so clear for other demographic factors. It seems that older age groups are more likely to seek help, but the difference between groups is not that pronounced. In SAMHSA (2017) survey 46.62% of 50+ year olds, 42.96% of 26-49 year olds, and 34.98% 18-25 year olds with any-type mental illness had some kind of help. Caucasians seem to be more likely to seek help than people of other racial/ethnic groups. Among people with some type of mental illness 48.48% of Caucasians, 37.13% of those with mixed racial background, 30.86% of Hispanics, 29.32% of African Americans, and 21.54% of Asian Americans used some type of mental health services in 2016 (SAMHSA, 2017). However, these are self-reported results and not measures of actual utilization.

The influence of educational level on mental health services utilization was not presented in the SAMHSA report and good empirical research on the influence of this demographic factor is sparse. There were few studies done on the influence of education on attitudes toward professional mental health help. One study found that attitudes toward seeking help from mental health professionals are more negative in people with a high school education or less than in those with a college education (Picco, et al., 2016).

However, research by Fischer and Cohen (1972) indicates that only college graduates with social and biological science majors had more positive attitudes about professional mental health treatment than those with high school degree or less. College graduates with natural sciences college majors had more negative attitude than those with lower education levels.

One demographic category that is usually not included in nationwide surveys on mental health is the level of religiosity and religious affiliation of survey participants. Religion has a strong foothold in U.S. society with 87% of people declaring they believe in God, 51% claiming religion is very important in their lives (Gallup Inc., 2017), and 33% declaring they use religion as a main source of ethical guidance (Pew Research Center, 2015). Therefore, to fully and clearly understand what can motivate and what can prevent people from seeking mental health help they might need, the influence of religion must be taken into consideration.

Psychologists view religion as an integral part of a person's self-schema (McIntosh, 1995) and as a significant part of an identity formation (Erikson, 1950). Religion provides the most fundamental framework for interpreting reality, shapes how individuals view themselves and the world around them, and influences decisions in a person's daily life (Cadwallader, 1991). In recent years there has been a noticeable increase in research, published articles, and books dealing with positive influences of religion and religious practices on mental health (Koenig, 2015; Luhrmann, 2013; Moreira-Almeida, Neto, & Koenig, 2006) and improving care for religious clients (Barnett & Johnson, 2011; Cashwell, Young, Cashwell, & Belaire, 2001; Lukoff, Lu, & Turner, 1992; Milstein, Manierre, Susman, & Bruce, 2008). However, there is a scarcity

of quality empirical research to give a clear picture of how religion influences professional mental health care seeking behaviors among religious individuals and their views of psychology and psychotherapy.

The American Psychological Association's (APA) (2017) latest Code of Ethics states that religion of the patient is one of the important individual characteristics that have to be considered and respected in the process of diagnosing and treating mental health issues. Lack of research into the influence of religion on professional mental health treatment utilization and barriers religious people might have in getting appropriate mental health care makes it difficult to address in a culturally appropriate manner the issues and needs religious people might face when seeking help for their mental health problems.

## Definition of Terms

Terms relevant for this research are used with following definitions in mind.

Religion: a set of beliefs and practices related to some Higher Power with rules to guide human behavior on earth and doctrines about life after death, often organized as a community of believers (Koenig, 2015).

Religiosity: in the context of this research, the measure of religious devotion to prescribed forms of religious practices and expressions, often measured in terms of variables such as frequency of religious service attendance, private devotional activities, and religious experience (Abe-Kim, Gong, & Takeuchi, 2004).

Intrinsic and Extrinsic Religiosity: constructs proposed by Allport and Ross (1967) to divide items in measures of religiosity into two subgroups which measure two

different poles of religious motivation. Extrinsic motivation describes the use of religion to satisfy more primary needs with religious creeds being embraced lightly to suit those needs. Intrinsic religious orientation describes a primary motive to live in accordance with religious beliefs while other needs are regarded as less significant.

Abrahamic Religions: a unified term that refers to three monotheistic religions, Judaism, Christianity, and Islam, which claim Prophet Abraham as a common forefather of their faith (Hughes & Bernstein, 2015). About 75% of the total U.S. population and 95% of those who declare themselves to be religious associate themselves with one of these religions (Gallup Inc., 2017), and they will be a target population for this research.

Devoutly religious: those persons strongly committed to their religion or to religious duties.

Conservative religions: for the purpose of this research, religious belief systems that favor tradition (in a sense of morality, values, and religious practices) in the face of external forces of change. They are more likely to believe in scriptural literalism, consider the word of God as an important source of guidance in life, and reject moral relativism and social progressivism.

Fundamentalism: a term originally related to Christianity, described a movement to identify essential, nonnegotiable Christian doctrines in order to prevent their erosion by more liberal forces within Christianity. The term was later adopted by the social sciences to refer to any religious movement that fights against modernization of religious beliefs and advocates for stricter adherence to basic religious ideas and practices (Liht, Conway, Savage, White, & O'Neill, 2011). The level of fundamentalism was used as a measure of religious conservatism in this research.

Barriers: obstacles that may prevent a person from seeking and accessing professional mental health services. For the purpose of this research barriers will be classified as suggested by Leong and Lau (2001) as:

- Physical Barriers – including the inability to find an appropriate therapy practitioner or to afford therapy;
- Cognitive Barriers - involving culturally informed concepts of mental illness, especially regarding the nature, causes, and cures of mental illness;
- Affective Barriers - culturally based emotive responses that may act as a deterrent to seeking psychological treatment, usually manifested a stigma of admitting to having mental illness and not being strong enough to solve your own problems, or fear of what the treatment might entail; and
- Value Orientation Barriers: involve cultural values that govern norms for emotional management and communication.

## Religion, Religiosity and Psychological Help Seeking

The first problem in assessing the influence of religiosity on psychotherapy utilization is the lack of questions about participant's religion and religious observance in national surveys on mental health services utilization. The search for studies on influence of religion on mental health services utilization yielded only two relevant peer-reviewed papers. Harris, Edlund, and Larson (2006) used data from 2001–2003 National Surveys on Drug Use and Health to investigate the influence of different religious factors on mental health service utilization. The analysis of that data showed that the frequency of attendance at religious services had a positive association with treatment utilization

regardless of the level of mental distress. However, there was negative relationship between outpatient service use and the level of importance of religious belief in person's life in a group of people with moderate level of distress and negative correlation between mental health service use and the influence of religious belief on decision making in people with severe level of distress (Harris, Edlund, & Larson, 2006). Survey data for 4,684 school attending adolescents ages 12–18 showed that the participants' level of religiosity was inversely related to the probability of seeking mental health services help, after controlling for depression severity, demographic characteristic, insurance status, and family context (Quinn & Utz, 2015).

Some research suggests that assessing attitudes toward professional mental health help may serve as a good predictor of seeking therapy when the need arises. Data analysis of the National Comorbidity Survey from 1990–1992 and its follow-up from 2001–2003 shows that willingness to seek professional help for serious emotional problems and feeling comfortable talking about one's emotional problems with professionals predicted future help seeking and treatment utilization (Mojtabai, Evans-Lacko, Schomerus, & Thornicroft, 2016). Other studies assessing associations between treatment attitudes and actual treatment use also show statistically significant positive associations in samples of college students (Cohen, 1999; Fischer & Farina, 1995; Mackenzie, Knox, Gekoski, & Macaulay, 2004), local community residents (Mackenzie et al., 2004), and the general population (Lin & Parikh, 1999).

Studies on attitudes toward professional mental health treatment are somewhat more available than actual treatment utilization studies and are often used to assess future likelihood of professional mental health treatment use. They also seem to suggest that a

higher level of religiosity correlates with more negative attitudes toward psychotherapy and professional mental health help. However, many of those studies on the influence of religiosity on attitudes toward professional mental health treatment have severe limitations. Some studies concentrate primarily on the influence of religiosity on treatment seeking among one ethnic minority, such as African Americans (Rogers, 2007; Smith, 2013) without addressing ethnicity as a cofounding variable. Most studies concentrated only on one specific subset of the religious population, thus do not provide a clear picture of whether it is the level of religiosity or the type of religious belief that matters (Carpenter, 1998; Lillios, 2010; Roberts, 1994).

A majority of the research on attitudes toward seeking professional mental help and treatment utilization was conducted on Jewish populations. Jewish populations seem to be disproportionately over-represented in terms of positive attitudes toward help-seeking as well as actual help-seeking behavior, almost equal in both aspects to non-religious populations and significantly better than Protestant and Catholic populations (Fischer & Cohen, 1972; Greenley & Mechanic, 1976). Nevertheless, several studies suggests that attitudes toward professional mental health help and treatment utilization of very conservative Jewish subgroups are significantly more negative than for more religiously liberal and moderate Jewish subgroups (Greenberg & Witztum, 2001; Schnall, 2004). About 73.9% of surveyed Orthodox mental health professionals (Feinberg & Feinberg, 1985) and 82% of surveyed Orthodox rabbis in New York City (Feinberg & Feinberg, 1986) felt that mental health needs of Orthodox Jewish populations are underserved compared to the general population, especially in Ultra-Orthodox and Hasidic communities. Landsberg and Rosenblum's (as cited in Feinberg & Feinberg,

1986) survey of Orthodox and Hasidic Jewish communities in the Boro Park suburb of New York City also notes underserved mental health needs of that population and their reluctance to seek psychotherapy. However, Kaminetzky and Stricker (2000) compared Orthodox, Conservative, and Reformed Jewish groups and didn't find any statistical differences in their attitudes toward seeking professional mental health help, although the groups' levels of religious observance and self-declared levels of religiosity differed significantly.

Members of other Abrahamic religions seem to show trends similar to Orthodox Jews in their attitudes toward psychological help treatment. A LifeWay Research (2014) survey of the relationship between different aspects of mental illness and Christian faith indicated that Protestant Christians were more likely to take psycho-pharmaceuticals than utilize psychotherapy and consider medications more effective than therapy. A survey of senior Baptist pastors showed that for a wide array of mental disorders they thought that medications were the most effective treatment method and significantly more effective than psychotherapy (Stanford & Philpott, 2011). Comparing psychotherapy to other types of therapy this same group of Baptist pastors considered psychotherapy less effective than pastoral care but significantly more effective than spiritual deliverance treatment (Stanford & Philpott, 2011). In a survey, 95% of U.S. imams reported that they actively counsel members of their congregation across a wide range of problems but feel that there is an increase in psychological needs in their community with which they need professional help (Ali, Milstein, & Marzuk, 2005). A sample of 166 African-American university students in the Mid-Atlantic region showed that those who scored higher on aggregation of religiosity measures had more negative attitudes toward seeking

professional mental health help (Smith, 2013). Rogers' (2007) study among African-American church goers of different Protestant denominations found that higher level of religiosity correlated with a higher level of stigma toward mental illness and a lower willingness to seek professional mental health treatment. Across faith traditions, when conservative and devoutly religious persons consider psychotherapy, they expressed strong preference for counselors being of the same or similar religious faith and were reluctant to seek help from secular therapists (Guinee & Tracey, 1997; Stanford & Philpott, 2011).

One element that might influence attitudes toward mental health help seeking is the type of religiosity. Using Allport and Ross' (1967) division of religiosity into its intrinsic and extrinsic components, Thompson (2009) examined the influence of different types of religiosity on attitudes toward seeking professional mental health help in a group of church goers of diverse Protestant denominations. He found a small but significant negative relationship between intrinsic religiosity and attitudes toward seeking professional psychological help, as well as belief about mental illness, while extrinsic religious orientation had a significant positive correlation with belief about mental illness. McGowan and Midlarsky (2012) show that older adults who scored higher in intrinsic religiosity reported less favorable attitudes toward mental health, including a lower stigma tolerance and interpersonal openness than those who scored lower in religiosity.

Another element to look at might be the level of a religious person's integration into mainstream society. Many conservatively religious people in the United States view with apprehension the increasing divergence of the modern world values from the traditional moral values they cherish (Dreher, 2017). This has led many of the

conservatively religious to feel like a persecuted and discriminated minority, holding true not only for minority conservative religious groups (Ali, Milstein, & Marzuk, 2005; Ostrov, 1976), but also for those religious groups that make up a majority of the U.S. population (Dreher, 2017). Comparison of attitudes toward professional mental help seeking among several Orthodox Jewish subgroups showed that stricter religious observance and less openness to secular culture and education resulted in significantly lower willingness to seek mental health treatment from professional therapists but a higher likelihood to turn toward their rabbi for counsel or insist that the mental health professional be Orthodox (Bronstein, 2004). Brody's (1994) study of college students found that traditional ideological factors, defined as a set of beliefs that are more conventional, conservative or historically older, had strong negative relationships with attitudes toward seeking help and far better predicted attitudes toward psychotherapy and treatment use than demographics, stress, and depression factors. Other research showed that Biblical literalism (taking Bible as the literal word of God), which is key indicator of conservative Protestant belief, was strongly associated with considering clergy as the primary source for seeking help for mental issues (Ellison, Vaaler, Flannelly, & J.Weaver, 2006).

One suggestion that emerges from multiple studies is that maybe religious people don't differ that much from the general population in the level of help seeking but rather in the source from which they seek that help. Many Americans struggling with psychological distress think that the clergy is a viable option for help with mental health issues and prefer getting help from clergy over mental health professionals (Farrell & Goebert, 2008; Kaminetzky & Stricker, 2000). Wang, Berglund and Kessler's (2003)

analysis of the 2001–2003 National Comorbidity Survey data suggests that about a quarter (23.5%) of people turned first to religious providers for help with their emotional and mental problems while only 16.7% turned first to mental health professionals. Among those with serious mental illness 8.7% reported that a religious provider was the sole source of care. The SAMHSA (2014) in its mental health survey estimated that 14.5% of those who sought help for major depression received it from religious or spiritual advisors. Surveys of different religious populations seem to indicate that for millions of religious Americans clergy are frontline mental health counselors and more likely to be contacted for help by persons with a psychiatric diagnosis than psychologists and psychiatrists combined (Chalfant, et al., 1990; Oppenheimer, Flannelly, & Weaver, 2004). This opinion that help from clergy is preferable to help from mental health professionals is particularly pronounced among conservative Protestants (Bornsheuer, Henriksen, & Irby, 2012; Ellison et al., 2006) and Muslims (Dawood, 2010). While getting some kind of help is better than not getting help, seeking help only from clergy with the exclusion of professional mental health services often doesn't give religious people the appropriate, evidence-based treatment they need. Members of clergy themselves feel that they are not sufficiently prepared to deal with serious mental illness (Farrell & Goebert, 2008; Hunter & Stanford, 2014; LifeWay Research, 2014; Virkler, 1979), and multiple studies shows that clergy don't do well in diagnosing serious mental issues that require professional help (Domino, 1985, 1990; Holmes & Howard, 1980; Weaver, 1992).

As the abovementioned studies indicate, highly religious people, especially those from more conservative religious denominations, seem to have more negative attitudes

toward seeking help from mental health professionals than the general population. When they seek help they seem more prone to seek help from their religious leaders and may never get the appropriate mental health care they need.

## Barriers to Accessing Mental Health Services

According to the SAMHSA (2014) report, among the general U.S. population the most prominent obstacles to better utilization of mental health services are physical barriers, such as the inability to afford mental health care and not knowing where to turn for help. Other prominent barriers include thinking that one can handle the problem without professional help and fear of negative community opinion (SAMHSA, 2014).

Empirical studies into barriers to mental health care access specific to religious populations are rare. The few that exist suggests that main issues that may discourage religious people from accessing professional mental health treatment are ascribing religious etiology to mental illnesses (Feinberg & Feinberg, 1985; Mollica, Streets, Boscarino, & Redlich, 1986; Stanford & Philpott, 2011), stigma (Feinberg & Feinberg, 1986; McGowan & Midlarsky, 2012), perceived value differences between psychology and religion, and fears about how those differences will play out during psychotherapy (Sell & Goldsmith, 1989; Woollcott, 1969; Worthington, 1986; Worthington & Scott, 1983).

Considering that many conservatively religious people feel like a cultural minority in a modern, secular world, it might be expected that some of the barriers noticed in minority populations, such as distrust of intrusion, stigma within the group, and feeling that a relationship with a therapist is difficult because of cultural differences

(Leong & Lau, 2001; Schnittker, Freese, & Powell, 2000) might also apply to religious people. Leong and Lau (2001) in their assessment of barriers to mental health services utilization for Asian Americans organized those barriers into following categories: physical barriers, cognitive barriers, affective barriers, and value orientation barriers. As one's religion and culture have a similar level of influence on an individual's life and formation of the world-view (Astor, Burchardt, & Griera, 2017; Wuthnow, 1991), for the purpose of this research using the categories introduced by Leong and Lau (2001) proved useful in presenting religion-specific barriers religious people may face in their access to professional mental health services.

### Religion Related Physical Barriers

It is to be expected that religious people will have similar physical barriers to accessing mental health as the general U.S. population. What might be unique for this population is that often they might turn first to their church for help to find those services but that is where their search ends (Bornsheuer et al., 2012). Religious people desire more guidance from their churches on where to find appropriate help and more advertising of already available church-sponsored or community resources, but feel that churches do not talk enough about mental health and mental health services (Bornsheuer et al., 2012; LifeWay Research, 2014). Although members of the clergy seem to recognize that they often don't have enough knowledge or time to properly address the mental health needs of their congregates, many also seem rather reluctant to refer them to mental health professionals (Linebaugh & DeVivo, 1981; Mannon & Crawford, 1996; McMinn, Runner, Fairchild, Lefler, & Suntay, 2005; Stanford & Philpott, 2011), and in

some instances the referral rate is as low as 10% (Mollica et al., 1986; Virkler, 1979). Some of the reasons given by religious leaders for their reluctance to refer their congregates to mental health professionals are: concern that clinicians may not be sensitive to the values of their congregates or may hold negative views toward religion (Ali & Milstein, 2012; Bobgan & Bobgan, 1987; Feinberg & Feinberg, 1986), fear that mental health professional not of their faith would negatively affect religious values of the faithful (Klein, 1979; Mannon & Crawford, 1996; Rumberger & Rogers, 1982; Spero, 1986; Thurston, 2000), or feeling of religious duty to be involved in helping their congregates in distress and often not being able to find therapists who are willing to keep them involved (Ali & Milstein, 2012; Farrell & Goebert, 2008; Milstein et al., 2008).

### Religion Related Cognitive Barriers

Differences in opinion on the etiology of mental illness and at times very strong philosophical antagonism between theological and psychological views of human nature may present significant cognitive barriers for the conservatively religious when it comes to seeking psychotherapy.

Central to the beliefs of all three Abrahamic religions is the existence of an everlasting human soul which is the source of guidance that governs human behavior and the determinant of human personality and character (Haque, 2004). Therefore, it is understandable that erratic behavior, emotional suffering, and mental illness were often equated with a damaged soul. That damage may be caused by sinful behavior, defined as diverging from God's prescribed laws and practices through lack of faith or willful disobedience (Feinberg & Feinberg, 1985), demonic oppression or possession that needs

to be cast out by the power of faith (Farrell & Goebert, 2008), or God's punishment for sinful behavior that is intended to cause guilt and pain as a motivator for repentance and a return to holiness (Greenberg & Witztum, 2001). Espousing this etiological view may lead devout religious persons to think that emotional pain, fear, and guilt are just manifestations of their conscience that will lead to reconciliation with God and should not be medicated away (Baasher, 2001; Esau, 1998; Klostreich, 2001) nor should they even be treated by secular psychotherapist who is not knowledgeable of God's laws (Greenberg & Witztum, 2001). As a matter of fact, if religious individuals believe that their religion has the power to heal and that all answers can be found in their doctrine, they may feel that outside counseling is not necessary (Hunt & Blacker, 1968; Koltko, 1992; Moench, 1985).

As the nature of the attributed cause for a problem is found to be related to views about what sources of help are appropriate for that problem (Cheung, Lee, & Chan, 1983; Fosu, 1995), it is to be expected that a belief in etiology of mental disease may have an effect on utilization of mental services. Schnittker and colleagues (2000) found that the more study participants subscribed to biological or family upbringing etiology the more likely they were to recommend professional help, while those who endorsed God's will as a cause of mental illness were more likely to reject treatment, regardless of race. It has been suggested that African Americans ascribing more spiritual etiology to mental health issues than Caucasians may be a reason they underutilize mental health services (Millet, Sullivan, Schwebel, & Myers, 1996) and why African American clergy tends to place greater emphasis than their Caucasian colleagues on using religious practices as a method for treating emotional problems (Mollica et al., 1986). Conservative Protestant pastors'

opinion that schizophrenia and bipolar disorder most likely have biological etiology while depression, anxiety, and ADHD have stronger psychosocial and spiritual components (Stanford & Philpott, 2011) might suggest why members of that group have a stronger preference for mental health professionals over clergy for schizophrenia but not so for depression and substance abuse (Ellison et al., 2006). Although the etiology beliefs gap between religion and psychology is narrowing, the clergy of more conservative religions are still more likely to believe that disorders such as depression, suicidal ideations, anxiety, or ADHD have a strong spiritual or weakness of personality component (Ali & Milstein, 2012; Domino, 1985; Hall & Tucker, 1985; Milstein, Midlarsky, Link, Raue, & Bruce, 2000; Payne, 2009).

Throughout history, religion and psychology have not often seen eye to eye. It is a well-known fact that many of the fathers of psychology have considered religion as primitive thinking and neurotic illusion (Freud, 1961), a stance that is counterproductive to emotional and psychological health and in some ways equal to mental disturbance (Ellis, 1983, 1988), or an infringement on development and a happy life (Wagenaar, 1975). Indeed, research shows that there is a 'religiosity gap' that separates psychotherapists from much of the U.S. population, with psychiatrists more likely than the general population to be non-religious or Jewish and less likely to be Protestant or Catholic (Curlin, et al., 2007; Giglio, 1993; Franzblau, 1975; Ragan, Malony, & Beit-Hallahmi, 1980). This 'religiosity gap' might be a reason why mental health professionals are considered by most people to be more liberal, secular, and against religion (Bergin, 1980). Opinions about psychotherapy among Protestants are as varied as their denominations. More liberal branches support psychotherapy or promote pastoral

counseling programs, attempting to provide the faithful with trained mental health professionals who also can serve as guardians of their souls (Beck & Banks, 1992). However, more conservative groups promote alternative biblical counseling models of care for mental illness (Adams, 1970; Welch, 1998) or claim that Christianity and psychology are completely incompatible (Bobgan & Bobgan, 1979; Hunt & McMahon, 1987). About 40% of surveyed Orthodox Jewish rabbis consider the belief that religion and psychology are in conflict as possible reasons for underutilization of mental health services among Orthodox Jewish population (Feinberg & Feinberg, 1986). Despite the continued mistrusts, there were recently some positive movements toward encouraging psychotherapy by top leadership among some religions such as Catholic Church (Farley, 2017; Sherwood & Giuffrida, 2017) and The Church of Jesus Christ of Latter-day Saints (Holland, 2013; West, 2016).

### Religion Related Affective Barriers

One of most salient affective barriers to utilizing professional mental health services is the fear of treatment. Kushner and Sheer (1989) conceptualized mental health seeking as an approach-avoidance conflict where the level of one's distress and desire to relieve it compete with multiple fears of treatment such as: fear of differences in essential values, fear of embarrassment by sharing deeply personal struggles, fear of incompetence or malicious intents of the therapists, and fear associated with negative previous treatment experiences. Vogel, Wester, and Larson (2007) further classify those avoidance factors into seven categories: social stigma, social norms, treatment fear, anticipated

utility and risk, fear of emotion, self-disclosure, and self-esteem. Some of these fears seem to be particularly relevant in shaping the religious person's view of therapy.

Stigma toward mental illness and having professional mental health treatment is the barrier that has received the most attention and has been often identified as one of the primary motives for treatment avoidance (Fischer & Turner, 1970; Kushner & Sher, 1989; Stefl & Posperi, 1985). Stigma of viewing one seeking help for psychological problems as weak, defective, or crazy is present among people of different ethnicities and cultural backgrounds (Wikler, 1986). It is not, therefore, surprising that this barrier is also noticeable in religious populations. About 90% of surveyed Orthodox Jewish rabbis (Feinberg & Feinberg, 1986) and 58% of Orthodox Jewish mental health professionals (Feinberg & Feinberg, 1985) identified stigma as one of the primary reasons why they think Orthodox Jews are reluctant to seek mental health help. Social norms or implicit standards of those close to the individual in need of psychological help are closely related to the concept of stigma. People reported greater intent to seek professional help when they believed they have approval of that treatment by important people in their lives (Bayer & Peay, 1997; Vogel, Wester, Wei, & Boysen, 2005) or when they had somebody they trust recommend seeking therapy (Dew, Bromet, Schulberg, Parkinson, & Curtis, 1991). For a devoutly religious person their church community represents a significant social network, and the lack of open discussion about mental health issues and appropriate places to seek help (LifeWay Research, 2014) may pose a significant barrier.

Considering the 'religiosity gap' between therapists and the general population, other fears are worth considering: the fear of misunderstanding of religious beliefs, the fear of change of religious beliefs or malicious intents and coercion by a therapist, and

the fear of religious beliefs being misdiagnosed as pathology. Those fears might be even more pronounced in minority religious populations. Surveyed imams reported that the main reasons they don't refer members of their congregations to mental health professionals is the concern of Muslims that their religious values and requirements may be misunderstood or unwittingly transgressed upon (Ali & Milstein, 2012). About 56% of Orthodox Jewish rabbis stated that general mistrust of mental health services is a main reason for underutilization of mental health services among their congregates (Feinberg & Feinberg, 1986). Among Orthodox Jews the studies have noticed particular fear of people with lack of rabbinic authority exercising malicious influence over a clients' value system and undermining their beliefs (Klein, 1979; Spero, 1986), with a push to sexual decadency being one of the biggest concerns (Greenberg & Witztum, 2001). The problem of misdiagnosis may be more noticeable when the culture of the ethnic/cultural minority client doesn't match the well-established cultural norms of the society (Leong & Lau, 2001; O'Connor & Vandenberg, 2005, 2010).

### Religion Related Value Orientation Barriers

If a patient thinks that his or her values will be in conflict with values promoted by mental health researchers and practitioners they may be reluctant to seek help from such sources (Bergin, 1980). Psychologists transfer their values to patients even when they are reluctant to openly engage with clients' religion during therapy (Bergin, 1988). Patterson (1989) was of the opinion that there has been a gradual although slow recognition that the possibility of value-free counseling is a myth and that therapists' values can affect therapy outcomes. The more people feel apart from a secular world it is

to be expected the more they will feel 'value gap' between psychology and religion. Religious people largely feel more comfortable with having a counselor who shares or at least understands their values, and the most important factor in clergy-mental health professional referral patterns is shared values between the two individuals (Farrell & Goebert, 2008; McMinn et al., 2005; Stanford & Philpott, 2011).

Existing research has done some exploration into what might prevent religious people from having better attitudes toward psychotherapy and better access to professional mental health help. However, there is a limited amount of direct surveys of religious people on topics of interaction between attitudes toward professional mental health treatment and their religious beliefs, and good quantitative studies are even harder to find. When it comes to the relationship between religion and mental health treatment seeking there are still many unanswered questions. In this research we aimed to answer few of them: Does the level of religiosity influence attitudes toward psychotherapy? What matters more, level of religiosity or type of religious belief? What are some of the major religion specific barriers that might keep the devoutly religious from accessing help they need?

This research aimed to get quality data by directly surveying religious people of various religious orientations, rather than relying on surveys of clergy or opinions about possible barriers by psychologists who claim to have understanding of particular religious beliefs. The intent was to determine the level to which religion influences people's mental health help seeking behaviors and the most dominant obstacles conservatively religious people may face in getting appropriate professional mental health therapy.

Based on the previous research presented here, the following two-fold hypothesis was postulated for this research

1. It is expect that people with higher religiosity will have more negative attitudes toward professional mental health services, but the level of conservatism will actually have a greater influence than merely the level of religiosity.

2. It is expect that most dominant religion-specific barriers will be value barriers and treatment fears, especially fears that are in close connection with a perceived 'value gap' between psychology and religion.

The hope is that this research will provide a better understanding of how to make professional psychotherapy more appealing to a significant segment of the U.S. population – the devoutly religious.

# Chapter II

## Method

This study was conducted using on-line survey open to United States residents 18 years and older. The survey was advertised via e-mails and on-line platforms, Reddit and Facebook. The aim was to collect data from as wide variety of people as possible, taking in consideration time and financial limits of this study. Participation in the survey was completely voluntary and the data was collected without any personally identifiable information.

### Participants

The target population of this study was adult United States residents affiliating themselves with one of the Abrahamic religions. The data for those who declare themselves non-religious or associate with non-Abrahamic religion was also collected and included in calculations of the influence of demographic factors, including the self-declared level of religiosity, on attitudes toward professional mental help, treatment fears, ability to recognize mental illness, and opinions on etiologies of presented conditions.

### Instruments

This research measured several constructs: attitudes toward seeking professional psychological help, treatment fears, level of religiosity, level of fundamentalism, opinions of religious people about certain aspects of psychology and their relation to the world in

general, ability to recognize symptoms of mental illness, and beliefs about the etiology of mental illness.

Demographic data collected in this survey included gender, age group, race/ethnicity, education level, and, if they declared themselves religious, information about the religious denomination with which survey participants associate themselves.

One of the most established instruments for measuring attitudes toward mental health treatment is the *Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH)* (Fischer & Turner, 1970). This research used a modernized version of that instrument, the *Attitudes Toward Seeking Professional Psychological Help Scale – Short Form (ATSPPH-SF)* (Fischer & Farina, 1995). The instrument is a 10-item 1–4 Likert-type scale that measures participants' agreement with different aspects of professional mental health treatment, with 1 representing 'disagree' and 4 representing 'agree'. Values of all the items are added up (items 2, 4, 8, 9, and 10 are reverse scored) to create ATSPPH-score with range of 10-40. Higher score indicates more positive attitude towards seeking professional psychological help. This scale has been found to have good internal consistency reliability (.84) (Fischer & Farina, 1995), and good reliability (.82) among different subject populations (Vogel et al., 2005).

Three questions to assess participants' previous potential experience with psychotherapy were added at the end of ATTSPPH-SF. If the participant had psychotherapy before they were asked to rate on a scale of 1-5 how positive was their experience and how successful they found psychotherapy for their specific problem. Those two ratings were added together to create PT-score in a range of 2-10, with higher number indicating better experience with psychotherapy.

For assessing level of religiosity, in addition to participants' self-declared religiosity level, this study also used Gorsuch and McPherson (1989) variation of the *Religious Orientation Scale (ROS)*, which is a short-form of the original Allport and Ross (1967) scale with adjustment by Gorsuch and Venable (1983) for the purpose of language simplification. This *Intrinsic/Extrinsic Religiosity Revised Scale* is a 14-item 1–5 Likert-type scale with 1 representing 'strongly disagree' and 5 representing 'strongly agree'. Items 1, 3, 4, 5, 7, 10, 12, and 14 (items 3, 10, and 14 are reverse scored) measure intrinsic religiosity and remaining items measure extrinsic religiosity. The score for extrinsic religiosity is in the range of 6-30 and for intrinsic religiosity in the range of 8-40, with higher score indicating higher level of religiosity. Confidence of reliability of intrinsic items is .83 and for extrinsic items is .65 (Gorsuch & McPherson, 1989).

Level of fundamentalism was measured using the *Religious Fundamentalism Scale* (Altemeyer & Hunsberger, 2004) which measures attitudes about a person's religious beliefs and can be used to capture fundamentalism in many faiths, but is especially suitable for assessing Abrahamic religions. The original instrument is a 12-item 9 point scale (from -4 to +4) that measures the level of agreement of participants with the presented statement from 'very strongly disagree' to 'very strongly agree'. It also allows for the cumulative agreement level for different parts of the statements in case the level of agreement differs for different parts of the statement. To make the survey more mobile-platform friendly, for this research the scale was reduced to a 5 point scale by removing two moderate levels of agreement and two moderate levels of disagreement. This changed the range of the score from -48 to 48 into the range of -24 to 24. This might have reduced somewhat the sensitivity of this scale, but it was still sensitive enough to

give a good insight into the participants' level of fundamentalism. The higher number here indicates a higher level of fundamentalism.

For measuring possible fears and concerns participants might have about psychotherapy and psychotherapists this research used the *Thoughts about Psychotherapy Survey (TAPS)* (Kushner & Sher, 1989). The TAPS consists of 19 statements with participants rating their concern about an item on a 1–5 Likert-type scale with 1 indicating 'not being concerned at all' about the item and 5 indicating 'very high concern' with the item. The TAPS-score range is from 19 to 95, with the higher number indicating more fearfulness. This scale has 3 subscales: therapist responsiveness (items 2, 3, 4, 6, 8, and 14), image concerns (items 7, 9, 10, 11, 12, 13, and 19), and coercion concerns (items 15, 16, 17, and 18). The subscales have all been found to have good internal consistency and satisfactory reliability, with Cronbach's alpha for the subscales range from 0.92 to 0.87 (Deane & Todd, 1996; Kushner & Sher, 1989). For religious people value difference might also be of significant concern and the answer to question 5 was used to look into that therapy fear, which in further text is referred to as value concern.

To examine some concerns and views about psychotherapy specific to religious population, a mixed group of Likert-type questions was created specifically for this research. All questions in this group are on a scale of 1-5 with 1 representing 'strongly disagree' and 5 representing 'strongly agree'. Items 1, 5, 10 and 14 of that question group examined religious people's perception of antagonism between psychology and religion. This Psychology-Religion Antagonism score range is 4-20 with a higher number indicating greater perception of antagonism between the two disciplines. Items 3, 6, 8,

11, and 16 assess general feeling of being apart from the secular world. This Separateness from the World score range is 5-25, with a higher number indicating that the participant feels more apart from the modern, secular world. Items 2, 7, 9, 13, and 17 (9 and 17 are reverse scored) measure preference for seeking help for emotional or mental problems from a religious person. This Preference for Religious Help score ranges from 5-25, with a higher number indicating greater preference for getting help from religious leaders over professional mental health specialists. Items 4, 12, and 15 assess how much participants feel that their religious leaders address mental health issues.

Talking about all aspects of religion and psychotherapy can be uncomfortable for some. To mitigate potential distress some questions might cause to some participants, all questions had an option of 'I don't know/I don't want to answer'. This allowed people to skip the question they didn't feel comfortable to answer, while still ensuring that participants didn't skip any question.

The last portion of the questionnaire assessed the participants' ability to distinguish between mental illness and regular life problems, to recognize what type of help would be more appropriate for the problem, and investigated participants' beliefs about the etiology of presented scenarios. Participants were presented with four vignettes describing fictitious persons' problems and then asked about their opinion on the causes and solutions for the problem. The vignettes and two of the questions were taken from research done by Link and colleagues (1999). First vignette (scenario 1) presented a person having some life troubles, but not meeting criteria for mental illness diagnosis. Three vignettes presented mental health problems: schizophrenia (scenario 2), alcohol dependency (scenario 3), and depression (scenario 4). For the purpose of this research,

we have removed race/ethnicity identification of the person in the vignette and have changed names and genders of some of the people presented in the stories to remove gender or racial bias the participants might have. We have also added six additional questions for each vignette. For the etiology portion of questions we added as options causes that might be more in line with how conservative religious people might think about the etiology of mental distress and life problems, as discussed previously.

## Procedure

An electronic survey designed in Qualtrics was distributed through online platform Reddit and through snowball distribution via e-mail and Facebook. The survey was anonymous and no personally identifiable data was collected. Participants were informed about the purpose of the survey, assured about anonymity and confidentiality of data, and asked to give electronic consent to data collection before taking the survey. To increase the response rate, participants were given the option to provide their e-mail to be entered into an random drawing for one of five $20 Amazon gift cards. The survey took on average 15-20 minutes to complete.

Several tests were run on the collected data. One-way ANOVA was run across different demographic factors to determine if there are significant differences between groups on different psychological and religious measures. Pearson correlation tests were run between different measures to determine relation of variables with each other. Linear regression was run only on variable pairs that showed significant correlation. Repeated measure ANOVA was run on etiology measures between different case scenarios to see if there were differences in the likelihood of a particular etiology assigned to different

presented conditions. Of particular interest were religion-related etiologies, such as lack of faith, God's will, or weak personality.

# Chapter III

## Results

In total 178 people responded to the survey. As the survey was completely anonymous and didn't track social platform or e-mail identifiers of the participants, it is impossible to say which collection method had the best response rate. After data check for completeness 131 of those entries were selected for further analysis.

### Population Statistics

The sample was predominately female, with 96 (73.3%) of participants identifying themselves as female and 35 (26.7%) as male. A significant majority of the sample identified as Caucasian (111 or 84.7%). Race/ethnicity of other participants was 3 (2.3%) African American, 6 (4.8%) Hispanic, 5 (3.8%) Asian American, 2 (1.5%) Native American/Pacific Islander, and 4 (3.1%) other. The participants in this sample were rather well educated, with 57 (43.5%) having at least some post-graduate studies, 33 (25.2%) having a Bachelor's degree, 36 (27.5%) having at least some college credits, and only 5 (3.8%) having High School diploma or less. The majority of the sample was 45 years or younger, with 22 (16,8%) age 18-25, 30 (22.9%) age 26-35, 41 (31.3%) age 36-45, 15 (11.5%) age 46-55, 9 (6.9%) age 56-64, and 14 (10.7%) age 65 and older.

The survey also collected the participants' self-declared level of religiosity and, for those who declared themselves religious, the type of religion they practice. This sample had a good spread of participants across religiosity levels, with 33 (25.2%) being

not religious at all, 15 (11.5%) being a little bit religious, 23 (17.6%) being moderately religious, and 60 (45.8%) being very religious. Out of 98 people who declared themselves to be religious 21 (16.0%) associated with one of Protestant denominations, 12 (9.2%) were Catholics, 4 (3.1%) were Jewish, 55 (42.0%) were members of The Church of Jesus Christ of Latter-day Saints (CJC-LDS in further text), and 7 (4.6%) declared themselves as some other religion that did not fall into any of Abrahamic religion groups. This sample did not have any members of Eastern Orthodox denominations nor Muslims.

The full demographic cross-category summary is given in Appendix A Table A1.

## Measures of Religiosity Statistics

To test how well self-declared religious level correlates with other measures of religiosity used in this survey One-Way ANOVA was run to compare means of Extrinsic Religiosity, Intrinsic Religiosity, Fundamentalism, Perceived Religion-Psychology Antagonism, Separateness from the World, Preference for Religious Help, and Clergy Openness to Discussing Mental Health.

Table 1 summarizes all ANOVA tests comparing means for all collected religiously measures between different levels of Self-declared Religiosity.

Only measures of Extrinsic Religiosity didn't show any significant difference between means for different Self-declared Religiosity groups. For all other measures of religiosity the very religious group scored significantly higher than those who declared to be either a little or moderately religious.

Table 2 summarizes all ANOVA tests comparing means for all collected religiously measures between different religious groups.

Table 1

One-Way ANOVA of Religiosity Measures between Self-Declared Religiosity Groups

| **Self-Declar. Religiosity** | One-way ANOVA | Group 2 Little Religious | | | Group 3 Moderately Religious | | | Group 4 Very Religious | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Religiosity Measures** | F | Mean (N) | $p_{2-3}$ | $p_{2-4}$ | Mean (N) | $p_{3-2}$ | $p_{3-4}$ | Mean (N) | $p_{4-2}$ | $p_{4-3}$ |
| Extrinsic Religiosity | 0.13 | 16.53 (15) | .99 | .91 | 16.68 (22) | 0.99 | 0.931 | 17.8 (59) | 0.91 | 0.93 |
| Intrinsic Religiosity | 91.38 | 19.20 (15) | <.001 | <.001 | 29.23 (22) | <.001 | <.001 | 35.31 (59) | <.001 | <.001 |
| Fundament. | 21.56 | -15.87 (15) | .001 | <.001 | -3.41 (22) | .001 | .04 | 2.85 (59) | <.001 | .04 |
| Psy.-Relig. Antagonism | 7.86 | 7.00 (14) | .92 | .006 | 7.43 (21) | .92 | .007 | 9.94 (51) | .006 | .007 |
| Separat. from World | 33.80 | 11.14 (14) | .001 | <.001 | 14.86 (22) | <.001 | <.001 | 18.23 (53) | <.001 | .001 |
| Pref. for Relig. Help | 11.54 | 7.00 (15) | .35 | <.001 | 8.28 (21) | .35 | .007 | 10.47 (53) | <.001 | .007 |
| Rel. Leaders Address MH | 8.92 | 10.00 (12) | .19 | <.001 | 11.40 (20) | .19 | .05 | 12.75 (51) | <.001 | .05 |
| *Statistically significant if p-value < .05; Statistically highly significant if p-value < .005* | | | | | | | | | | |

Table 2

One-Way ANOVA of Religiosity Measures between Different Religious Groups

| **Self-Declar. Religiosity** | Group 1 Protest. | Group 2 Catholic | Group 3 Jewish | Group 4 CJC-LDS | Group 7 Other | One-way ANOVA | | Significant Between Group Differences |
|---|---|---|---|---|---|---|---|---|
| **Religiosity Measures** | Mean (N) | Mean (N) | Mean (N) | Mean (N) | Mean (N) | F | p-val | |
| Extrinsic Religiosity | 15.52 (21) | 13.09 (11) | 16.25 (4) | 18.27 (55) | 16.60 (5) | 4.44 | .003 | $p_{6-2}$=.003 |
| Intrinsic Religiosity | 28.00 (21) | 29.18 (11) | 29.75 (4) | 33.76 (55) | 25.80 (5) | 4.27 | .003 | $p_{6-1}$=.01 |
| Fundament. | -6.00 (21) | -6.64 (11) | -10.25 (4) | 3.76 (54) | -18.00 (6) | 10.04 | <.001 | $p_{6-1}$=.003, $p_{6-2}$=.02, $p_{6-7}$<.001 |
| Psy.-Relig. Antagonism | 6.06 (17) | 8.18 (11) | 6.75 (4) | 10.23 (48) | 8.33 (6) | 7.16 | <.001 | p6-1<.001 |
| Separat. from World | 13.71 (17) | 14.36 (11) | 13.25 (4) | 18.24 (51) | 12.50 (6) | 10.68 | <.001 | $p_{6-1}$<.001, $p_{6-2}$=.006, $p_{6-4}$=.04, $p_{6-7}$=.001 |
| Pref. for Relig. Help | 8.83 (18) | 9.09 (11) | 7.25 (4) | 10.00 (51) | 7.20 (5) | 16.95 | .12 | |
| Rel. Leaders Address MH | 11.50 (16) | 12.00 (10) | 10.50 (4) | 12.53 (49) | 9.50 (4) | 2.48 | .05 | |
| *Statistically significant if p-value < .05; Statistically highly significant if p-value < .005* | | | | | | | | |

The only religious group that seems to be significantly different from other groups are members of CJC-LDS. They scored highest on both extrinsic and intrinsic religiosity scale, scoring significantly higher than Catholics in extrinsic religiosity, and significantly higher than Protestants in intrinsic religiosity. Statistically members of CJC-LDS also scored significantly higher than all other groups on feelings of separateness from the world. On fundamentalism scale they score significantly higher than most groups. The difference on fundamentalism between members of CJC-LDS and Jewish faith did not reach statistical significance, though that might be due to the small number of participants in the Jewish group. Members of CJC-LDS also score highest on perceived antagonism between religion and psychology, though that difference is only statistically significant between them and Protestants. There was no significant difference between the groups in preference for religious help and religious leaders addressing mental illness, though members of CJC-LDS also scored highest on both of those measures.

## ATSPPH and TAPS One-Way ANOVA

One-way ANOVA was run for ATSPPH-score and TAPS-score between different demographic groups. Because this sample was predominately Caucasian, running statistical tests separately for all different racial/ethnic groups was meaningless. Therefore, all non-Caucasian race/ethnic groups were combined together and compared against Caucasian participants.

The only statistically significant difference in means for ATSPPH-score is between males (30.20) and females (33.95), with $p < .001$. Although females showed less

therapy fear than males (TAPS mean 42.96 vs. 44.80), that difference did not reach statistical significance. Other demographic categories did not show any statistically significant differences between groups for ATSPPH-score. For TAPS-score only comparison between groups with different levels of self-declared religiosity was statistically significant (p=.03).

Looking at means for different race/ethnicity groups shows that in this sample Asian Americans had most negative attitude toward psychotherapy (28.00), but the most therapy fear was reported by Native Americans/Pacific Islanders group (49.50) and Hispanic group (46.33). The age group 46-55 showed the most negative attitude toward psychotherapy (30.67) and those in the 18-25 age group had most the positive attitude (34.23). However, the 46-55 age group showed the least fear of therapy (38.27), while the most fearful group was ages 26-35 (47.33). Means for both measures based on education levels are very similar to each other with those with some college having the most positive attitude (33.75) and the least amount of fear (41.78) about psychological therapy. In this sample the very religious had the most negative attitude (32.10) and the most therapy related fear (46.32). Among the different religious groups members of CJC-LDS had most negative attitude (31.87) and the most therapy fear (44.80).

When looking at expressed willingness to engage in psychotherapy in the future gender again showed that females were significantly more likely to do so than males ($Mean_F$=3.51, $Mean_M$=2.86, p<.001). The difference between people of different level of self-declared religiosity was borderline significant (p=.05) with willingness to seek psychotherapy decreasing with increasing level of religiosity. There was also significant statistical difference between different religious groups, with members of CJC-LDS

expressing lowest willingness to seek therapy in the future and Jewish participants expressing the highest level of willingness to seek therapy in the future.

A full summary of the results of the One-Way ANOVA between different demographic groups for ATSPPH-score, TAPS-score, and willingness to seek therapy in the future is presented in Appendix A Table A2.

## Correlations

The population of interest was members of Abrahamic Religions. Therefore, for following analyses, those associating themselves with other types of religion were removed from religious sub-samples. For those who declared that they are not at all religious the survey didn't assess any of the religiosity parameters, therefore they were automatically excluded from the analysis of influence of religious factors on ATSPPH-score and TAPS-score. Members of CJC-LDS were significantly different from other religious groups on many of religiosity parameters and they also make the largest proportion of this religious sample, therefore it was considered interesting to examine them as a separate group. Correlations were examined for multiple combinations of parameters on three different sample sub-sets: all Abrahamic religion members (sub-sample 1), all Abrahamic religion except members of CJC-LDS (sub-sample 2), and members of CJC-LDS only (sub-sample 3).

Extrinsic religiosity showed no significant correlation with any of the other religiosity measures in sub-sample1 and sub-sample 3, but in sub-sample 2 it had significant negative correlation with measures of fundamentalism ($R=-0.45$, $p=.006$) and separateness from the world ($R=-0.36$, $p=.045$). Other measures of religiosity mainly

showed a significant correlation between each other in all sub-samples. However there are a few exceptions to this that are worth mentioning. In sub-sample 2, the psychology-religion antagonism measure didn't show significant correlation to preference for religious help and in sub-sample 3 fundamentalism and intrinsic religiosity measures didn't significantly correlate with psychology-religion antagonism or religious help preference measures.

In sub-sample 2 leaders talking about mental health and promoting mental health therapy didn't significantly correlate with any of other religiosity measures. In sub-sample 3 leaders talking about mental health had significant positive correlation with intrinsic religiosity ($R=0.54$, $p<.001$) and separateness from the world ($R=0.40$, $p=.004$) measures, while leaders promoting professional mental help services correlated positively with fundamentalism ($R=0.40$, $p=.005$) and negatively with perceived psychology-religion antagonism ($R=-0.29$, $p=.04$).

The full list of all correlations between religious measures is shown in Appendix A Table A3 and Table A4. In light of these results it does not seem that for our sample religiosity measures can be treated as independent predictor variables. Therefore, running multivariable regression was not useful.

Looking at two measures of opinions about psychotherapy, ATSPPH-score and TAPS-score, there is significant weak negative correlation between two measures for the entire sample ($R=-0.22$, $p=.01$) and sub-sample1 ($R=-0.23$, $p=.03$), but not for other two sub-samples. TAPS subscales that show significant correlation with ATSPPH-score for the entire sample is coercion concern ($R=-0.32$, $p<.001$) and image concern ($R=-0.27$, $p=.002$). Those two subscales also have significant weak correlation within sub-sample 1

(coercion concern R=-0.31, p=.002; image concern R=-0.28, p=.006), but those correlations are not significant for the other two sub-samples.

Results of correlation between different ATSPPH, TAPS, and different religiosity measures are presented in Table 3.

For sub-sample1 and sub-sample 3 measures of fundamentalism, extrinsic religiosity, and intrinsic religiosity showed no significant correlation with either ATSPPH-score or TAPS-score. However, for the sub-sample 2 fundamentalism showed significant weak negative correlation with ATSPPH-score and measure of extrinsic religiosity showed significant a positive correlation with ATSPPH-score.

Some measures for specific characteristics of conservative religions, such as perception of psychology-religion antagonism and feeling separateness from the secular world, showed significant weak negative correlation with attitudes toward psychological help in sub-sample 1 and sub-sample 3. However, they showed no significant correlation with ATSPPH-score for sub-sample 2. Preference for religious help measure showed significant moderate negative correlation with ATSPPH-score for all sub-samples.

For sub-sample 3 church leaders promoting getting professional help had significant positive correlation with ATSPHH-score. That correlation for sub-sample 2 is not significant and it is actually negative. Correlation between leaders just talking about mental illness and ATSPHH-score is not significant for all sub-samples.

Table 3

Correlations between ATSPPH, TAPS, Willingness to Seek Psychotherapy, and Religiosity Measures

| | | ATSPPH Correlation [R (p-value)] | TAPS Correlation [R (p-value)] | Will Seek PT Correlation [R (p-value)] |
|---|---|---|---|---|
| All Abrahamic Religions (sub-sample 1) | Fundamentalism | -0.12 (.26) | 0.04 (.69) | -0.28* (.007) |
| | Extrinsic Religiosity | 0.15 (.15) | -0.12 (.25) | 0.06 (.60) |
| | Intrinsic Religiosity | -0.17 (.11) | 0.03 (.81) | -0.27* (.009) |
| | Psy.-Rel. Antagonism | -0.37** (.001) | 0.39** (<.001) | -0.45** (<.001) |
| | Separat. from World | -0.36** (.001) | 0.18 (.11) | -0.39** (<.001) |
| | Pref. for Religious Help | -0.54** (<.001) | 0.04 (.71) | -0.52** (<.001) |
| | Rel. Leaders Addr. MH | -0.04 (.73) | 0.06 (.56) | -0.16 (.16) |
| | Rel. Leaders Prom. PT | 0.15 (.18) | -0.08 (.44) | -0.05 (.66) |
| | TAPS/ATSPPH | -0.23* (.03) | -0.22* (.03) | 0.02 (.83) |
| CJC-LDS excluded (sub-sample 2) | Fundamentalism | -0.36* (.03) | 0.14 (.42) | -0.56** (<.001) |
| | Extrinsic Religiosity | 0.40* (.02) | -0.29 (.09) | 0.20 (.25) |
| | Intrinsic Religiosity | -0.22 (.20) | -0.02 (.90) | -0.31 (.07) |
| | Psy.-Rel. Antagonism | -0.02 (.92) | 0.38* (.03) | -0.18 (.32) |
| | Separat. from World | -0.27 (.14) | 0.01 (.94) | -0.38* (.03) |
| | Pref. for Religious Help | -0.53** (.002) | -0.18 (.33) | -0.61** (<.001) |
| | Rel. Leaders Addr. MH | 0.06 (.73) | -0.15 (.40) | -0.05 (.77) |
| | Rel. Leaders Prom. PT | -0.23 (.22) | -0.11 (.56) | -0.18 (.20) |
| | TAPS/ATSPPH | -0.32 (.06) | -0.32 (.06) | 0.08 (.66) |
| CJC-LDS alone (sub-sample 3) | Fundamentalism | 0.26 (.06) | -0.11 (.45) | 0.14 (.31) |
| | Extrinsic Religiosity | 0.20 (.15) | -0.11 (.44) | 0.21 (.12) |
| | Intrinsic Religiosity | -0.01 (.95) | 0.01 (.95) | -0.10 (.49) |
| | Psy.-Rel. Antagonism | -0.39** (.006) | 0.44** (.002) | -0.41** (.003) |
| | Separat. from World | -0.29* (.04) | 0.27 (.06) | -0.21 (.02) |
| | Pref. for Religious Help | -0.52** (<.001) | 0.13 (.38) | -0.42** (.002) |
| | Rel. Leaders Addr. MH | 0.04 (.81) | 0.13 (.38) | -0.06 (.70) |
| | Rel. Leaders Prom. PT | 0.38* (.007) | -0.12 (.40) | 0.09 (.56) |
| | TAPS/ATSPPH | -0.17 (.22) | -0.17 (.22) | 0.05 (.72) |

* p-value < 0.05; ** p-value < 0.005

Only perception of psychology-religion antagonism showed significant weak positive correlation with TAPS-score. Psychology-religion antagonism correlates

significantly with therapist concern, image concern, and coercion concern subscales only for sub-sample 1 ($R_{TC}$=0.26, $p_{TC}$=.02; $R_{IC}$=0.33, $p_{IC}$=.003; $R_{CC}$=0.41, $p_{CC}$<.001) and sub-sample 3 ($R_{TC}$=0.39, $p_{TC}$=.006; $R_{IC}$=0.34, $p_{IC}$=.02; $R_{CC}$=0.47, $p_{CC}$=.001). Separateness from the world measure positively correlates with therapy concern subscale for sub-sample 3 (R=0.28, p=.05) and with coercion concern subscale for sub-sample1 (R=0.28, p=.01) and sub-sample 3 (R=0.28, p=.04). Value concern subscale correlates significantly with psychology-religion antagonism for all sub-samples ($R_{s1}$=0.34, $p_{s1}$=.002; $R_{s2}$=0.35, $p_{s2}$=.048; $R_{s3}$=0.39, $p_{s3}$=.005). For sub-sample 3 the value concern subscale also has significant correlations with intrinsic religiosity scale (R=0.28, p=.04), separateness from the world measure (R=0.36, p=.009), preference for religious help measure (R=0.33, p=.02), and leaders talking about psychotherapy measure (R=0.35, p=.01).

Looking at willingness to engage in psychotherapy in the future it can be noticed that it correlates negatively with many religious measures, but that correlation is different for different sub-samples. In sub-sample1 it has significant negative correlation with intrinsic religiosity (R=-0.27, p=.009), fundamentalism (R=-0.28, p=.007), psychology-religion antagonism (R=-0.45, p<.001), separateness from the world (R=-0.39, p<.001), and preference for religious help (R=-0.51, p<.001). Sub-sample 2 shows significant negative correlation with fundamentalism (R=-0.56, p<.001), separateness from the world (R=-0.38, p=.03), and preference for religious help (R=-0.61, p<.001). Sub-sample3 has significant correlation only with psychology-religion antagonism (R=-0.41, p=.003) and preference for religious help (R=-0.42, p=.002).

## Previous Experience with Therapy Influence

Another element the survey measured was previous experience with therapy. In this sample 95 people had previously participated in some form of psychological therapy and 34 had not, with 2 participants choosing not to answer. There is significant difference ($p<.001$) in ATSPPH-score between those who had previous experience with psychological therapy and those who had not. On average those who had therapy previously had more positive attitudes about therapy than those who had not had therapy before (ATSPPH-score mean of 34.14 vs. 29.65 respectively). There was almost no difference in fear of therapy between two groups (TAPS-score means of 43.75 vs. 43.50 for those who had therapy vs. those who did not). The distribution of those who had therapy among different levels of religiosity and different religious groups is shown in Table 4.

Table 4

Previous Psychotherapy Experience in Different Religiosity Levels and Religious Groups

| Groups | N | Within group % | PT-score mean | One-way ANOVA |
|---|---|---|---|---|
| 1 - Not Religious | 28 | 84.80% | 7.64 | F= 2.69 |
| 2- Little Religious | 14 | 93.30% | 8.64 | p= .05 |
| 3- Moderately Religious | 16 | 69.60% | 8.69 | |
| 4 - Very Religious | 37 | 61.70% | 7.38 | |
| 1 - Protestant | 17 | 81% | 8.12 | F= 1.33 |
| 2 - Catholic | 9 | 75% | 7.78 | p= .27 |
| 4 - Jewish | 4 | 100% | 9.75 | |
| 6 - CJC-LDS | 32 | 58.20% | 7.56 | |
| 7 - Other | 5 | 83.30% | 8.60 | |

On average previous experience with therapy was more positive than negative, with PT-score mean of 7.85. The very religious group had the most negative experience

with therapy, followed closely by the Non-Religious group. Statistically there was no significant difference of PT-score means between different self-declared levels of religiosity groups. Members of CJC-LDS had most negative experience with psychological therapy and Jewish participants had the best experience.

One measure that had a consistent significant moderate positive correlation with ATSPPH-score on the entire sample and all sub-samples was the PT-score (all sample: $R=0.53$, $p<.001$; sub-sample 1: $R=0.68$, $p<.001$; sub-sample 2: $R=0.64$, $p<.001$; sub-sample 3: $R=0.70$, $p<.001$).

PT-scores had significant weak negative correlation with TAPS-score only for the entire sample ($R=-0.26$, $p=.01$). The only TAPS subscale that shows significant correlation is the coercion concern subscale ($R=-0.37$, $p<.001$). That subscale also shows significant correlation for sub-sample 1 ($R=-0.37$, $p=.004$) and sub-sample 2 ($R=-0.51$, $p=.004$), but not for sub-sample 3.

The PT-score also had significant weak positive correlation with expressed willingness to seek psychotherapy in the future for full sample ($R=0.23$, $p=.02$), sub-sample 1 ($R=0.30$, $p=.02$), and sub-sample 2 ($R=0.38$, $p=.04$), but not for sub-sample 3.

For sub-sample 1 the PT-score had a significant negative correlation with fundamentalism ($R=-0.32$, $p=.01$), psychology-religion antagonism ($R=-0.32$, $p=.02$), separateness from the world ($R=-0.33$, $p=.01$), and preference for religious help ($R=-0.40$, $p=.002$). The PT-score for sub-sample 2 showed significant correlation only with psychology-religion antagonism ($R=-0.52$, $p=.004$) and preference for religious help ($R=-0.43$, $p=.02$). Sub-sample 3 had no significant correlation between PT-score and any of religiosity measures.

## Mental Illness Recognition and Etiology

Participants of this survey were quite effective in differentiating between scenarios that classify as mental illness and those scenarios which do not. Most participants recognized that case 1 scenario represented normal troubles of life and is most likely not mental illness while case 2 scenario, representing person with schizophrenia, is the most severe disease. One-way ANOVA was used to determine if there are any significant differences between participants with different levels of religiosity and between different religious groups. The only significant differences were noted for the case 1 scenario. In this case the Little Religious (Mean = 3.62) group thought that the scenario was just the regular troubles of life more so than either the Non-Religious group (Mean=2.82, p=.05) or the Moderately Religious group (Mean=2.73; p=0.03). The Non-Religious group (Mean=3.55) thought it significantly more likely (p=.04) that talking to somebody will help in this case than did the Very Religious group (Mean=3.08). A full summary of results for this survey section are given in Appendix A Table A5 and Table A6.

Comparison of the group differences for the etiology of problems presented in case scenarios yielded several significant results. The Very Religious group (Mean=1.37) was significantly more likely (p=.004) than the Non-Religious group (Mean=1) to think that problems were due to lack of faith in a case scenario representing emotionally troubled person. The Very Religious group (Mean=1.24) was also significantly more likely (p=.007) than the Non-Religious group (Mean=1) to think that problems described in depression case might be caused by lack of faith. In the cases of substance abuse disorder, the Very Religious group (Mean=1.37) was significantly more likely to ascribe

lack of faith as a likely cause for the problems the person was experiencing than Non-Religious (Mean=1, p<.001), Little Religious (Mean=1, p=.01), and Moderately Religious (Mean=1.15, p=.02) groups.

In assessing differences between religious groups the only significant difference (p=.02) was that Catholics (Mean=1.80) were more likely than Protestants (Mean=1.06) to think that a person's problems in a case of schizophrenia were due to bad influence. A full summary of results for Etiology section of the survey are given in Appendix A Table A7 and Table A8.

Repeated measures ANOVA compared differences between etiologies assigned to different scenarios/conditions. Full sample results, including between scenario differences are presented in Table 5.

Of special interest for this study are religion influenced etiologies: bad influence, weak personality, lack of faith, and God's will. It seems that substance abuse disorder is significantly more likely than all other conditions to be ascribed the etiologies of lack of faith, bad influence, and weak personality. Repeated measures ANOVA on different sub-samples showed that lack of faith etiology difference between substance abuse disorder scenario and other scenarios is only significant in sub-sample of members of CJC-LDS (F=377.81, p<.001), but not in other sub-samples. For religious sub-sample substance use disorder was significantly more likely to be ascribed weak personality etiology than all other scenarios (F=22.20, p<.001), which was not a case for the sub-sample of those who declared themselves not religious (F=3.62, p=.07).

Table 5

Repeated Measure ANOVA Results for Etiology Measures

| Group (N) | Case Scenario | Mean | F (p-value) | Between Group significance | | | |
|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 |
| Genetic (N=104) | Scenario 1 | 2.09 | 84.98 (<.001**) | | <.001** | <.001** | <.001** |
| | Scenario 2 | 3.42 | | <.001** | | .001** | <.001** |
| | Scenario 3 | 3.05 | | <.001** | .001** | | 1.00 |
| | Scenario 4 | 2.98 | | <.001** | <.001** | 1.00 | |
| Chemical (N=105) | Scenario 1 | 2.06 | 141.74 (<.001**) | | <.001** | <.001** | <.001** |
| | Scenario 2 | 3.84 | | <.001** | | <.001** | <.001** |
| | Scenario 3 | 2.65 | | <.001** | <.001** | | <.001** |
| | Scenario 4 | 3.45 | | <.001** | <.001** | <.001** | |
| Life Stress (N=108) | Scenario 1 | 3.06 | 5.29 (.002**) | | .74 | .34 | 1.00 |
| | Scenario 2 | 2.88 | | .74 | | .001** | .014* |
| | Scenario | 3.25 | | .34 | .001** | | 1.00 |
| | Scenario 4 | 3.16 | | 1.00 | .014* | 1.00 | |
| Family Upbringing (N=102) | Scenario 1 | 2.18 | 47.42 (<.001**) | | .000** | .77 | <.001** |
| | Scenario 2 | 1.42 | | <.001** | | <.001** | <.001** |
| | Scenario 3 | 2.32 | | .72 | <.001** | | <.001** |
| | Scenario 4 | 1.79 | | <.001** | <.001** | <.001** | |
| Bad Influence (N=105) | Scenario 1 | 1.86 | 52.10 (<.001**) | | <.001** | . <.001** | .01* |
| | Scenario 2 | 1.38 | | <.001** | | . <.001** | .005* |
| | Scenario 3 | 2.38 | | <.001** | <.001** | | <.001** |
| | Scenario 4 | 1.60 | | .01* | .005* | <.001** | |
| Weak Personality (N=111) | Scenario 1 | 1.16 | 15.57 (<.001**) | | .04* | <.001** | 1.00 |
| | Scenario 2 | 1.07 | | .04* | | <.001** | .04* |
| | Scenario 3 | 1.65 | | <.001** | <.001** | | <.001** |
| | Scenario 4 | 1.16 | | 1.00 | .04* | <.001** | |
| Lack of Faith (N=109) | Scenario 1 | 1.19 | 11.32 (<.001**) | | .005* | .26 | .35 |
| | Scenario 2 | 1.05 | | .005* | | <.001** | .07 |
| | Scenario 3 | 1.32 | | .26 | <.001** | | .001** |
| | Scenario 4 | 1.12 | | .35 | .07 | .001** | |
| God's Will (N=106) | Scenario 1 | 1.11 | 3.18 (.037*) | | 1.00 | .66 | 1.00 |
| | Scenario 2 | 1.15 | | 1.00 | | .11 | 1.00 |
| | Scenario 3 | 1.06 | | .66 | .11 | | .12 |
| | Scenario 4 | 1.13 | | 1.00 | 1.00 | .12 | |

Scenario 1 – Regular Life Troubles; Scenario 2 – Schizophrenia;
Scenario 3 – Substance Abuse Disorder; Scenario 4 – Depression;
* p-value <.05; ** p-value<.005

# Chapter IV

## Discussion

This sample was predominantly female, less ethnically diverse (Caucasians overrepresented; African Americans, Asians and Hispanics underrepresented), younger, and better educated than the average U.S. population (U.S. Census Bureau, 2019). Considering that social media and snow-ball distribution were used to collect data it is not surprising that survey participants were younger and more educated, as those groups feel more comfortable with taking electronic on-line surveys. Also, snow-ball collection, where participants forward survey link to their friends and family, makes it more likely that the sample would be demographically and religiously similar.

There were no participants who declared affiliation to Eastern Orthodox or Muslim religions among those who declared their religious preference. There were only four Jewish participants who predominantly associated themselves with Conservative Judaism. A very few Protestants declared belonging to one of the more theologically conservative Protestant denominations.

A low survey response rate was the major hindrance found in common with many previous attempts to survey conservatively religious populations is (see Ali et al., 2005; Bronstein, 2004) especially among those who are suspicious of psychology. Moderators of several conservatively religious sub-Reddits were unwilling to post the survey invitation to the community they moderate.

The most numerous and the most conservative religious group in this sample are members of The Church of Jesus Christ of Letter-day Saints. They scored higher than other religious groups, in many cases significantly higher, on extrinsic religiosity, intrinsic religiosity and fundamentalism scales. Members of CJC-LDS were significantly more likely than all other surveyed religious groups to feel separateness from the secular world. They also seem to perceive more existence of antagonism between psychology and religion than members of other faiths, though that difference was only significant between them and the Protestant group. Considering the religious persecution this Church community experienced in the past and their minority, non-main stream status in the U.S. religious milieu, that distrust might be understandable. Members of CJC-LDS also showed stronger preference than other groups to seeking help from religious leaders, but that difference was not statistically significant. Notably, they were also most likely to report that their church leadership addressed mental illness and encouraged members to seek psychological help when needed. Indeed, examination of the official Church web-site shows the existence of specific sites addressing mental illness and how to obtain help (The Church of Jesus Christ of LDS, 2018), as well as top Church leaders addressing in public their experiences of dealing with depression and encouraging members to seek professional help (Holland, 2013).

This public promotion of seeking professional mental health help might make CJC-LDS members different in their views of mental illness and psychotherapy than other conservatively religious groups. However in many other beliefs and world views, CJC-LDS members seem to be very similar to Evangelical Protestants, Muslims and

Orthodox Jews (Gallup Inc., 2017), and in this research they are considered a representative group of conservatively and devoutly religious.

## Demographic Influences

The first question this research aimed to answer was whether religion should be taken into consideration as one of the demographic factors that should be surveyed and used when looking at mental health services utilization.

Of all the demographic factors only gender showed significant influence on ATSPPH-score in this sample. Females had significantly more positive attitudes toward psychotherapy than males. That aligns with other research where females seem to be more likely to utilize mental health services than males (Pattyn et al., 2015; Rhodesa et al.,2002; SAMHSA, 2017). Although women had somewhat lower mean levels of therapy fear than men, that difference didn't reach statistical significance.

Other demographic variables did not show any significant differences between groups. Some demographic factors in this sample actually behaved differently than the national survey on mental health might suggest. In this sample those under 25 and those over 56 had comparable ATSPPH-scores and the highest among age groups. The middle aged group (ages 46-55) had the most negative attitude toward psychotherapy. However, younger age groups reported more treatment fear than older ones. As SAMHSA (2017) survey reports that older age groups are more likely to actually seek help for their problem, in this case it seems that treatment fear measure (TAPS-score), might be a better predictor of actually seeking therapy, than the attitude people have about psychotherapy.

It was difficult to get some useful statistical analysis with this heavily Caucasian sample. The Asian Americans revealed the most negative attitudes about psychotherapy. Those who identified as Native American/Pacific Islander revealed the most therapy fear, followed by Hispanic participants. However, differences between the groups were not so great as to explain why there is such a large mental health utilization difference in the SAMHSA (2017) report between Caucasians and people of most other racial/ethnic backgrounds. It is quite possible that some other factors, such as access to services and availability of appropriate mental health specialists trained to address racial and ethnical differences in therapy, might have stronger influence on services utilization than do racial/ethnic attitudes toward psychotherapy and therapy fears.

Because participants in this survey were very highly educated (all but 5 had at least some college) it is not possible to determine with any degree of accuracy how education influences either attitudes or therapy fears. In our sample there was no difference between different education groups.

When looking at the actual willingness to engage in psychotherapy in the future, gender, again, was the most prominent demographic variable. However, differences in level of religiosity and the type of religion also predicted willingness to seek therapy, if needed. This seems to confirm previous research that the level of religiosity affects the likelihood that somebody will seek needed professional mental health services (Harris, Edlund, & Larson, 2006; Quinn & Utz, 2015)

Although self-declared level of religiosity was not predictive of attitudes toward psychotherapy or therapy fear scores, it was related to actual willingness to engage in therapy in the future. The results do seem to support the premise of this research that

religion does influence the utilization of mental health services and closer examination is warranted.

## Influence of Religiosity and Fundamentalism

The first hypothesis in this research was that the level of religiosity and the level of conservatism would influence attitudes toward psychotherapy and a willingness to seek therapy, with the level of conservatism having a stronger influence than level of religiosity.

Self-declared level of religiosity was related to ATSPPH-scores, with the Very Religious having the lowest scores, indicating the most negative attitude toward psychotherapy, though in this sample that score was very similar to the score of those who declared themselves non-religious, and was not significantly different from scores of other self-declared levels of religiosity. The Very Religious also had the highest average level of therapy fear, which was significantly higher than the therapy fear score of Moderately Religious, who on average showed the least fear of therapy.

Although, in this sample, the number of Jewish participants was limited they expressed the most positive attitudes about psychotherapy, reported the lowest therapy fear, and expressed the highest willingness to engage in therapy in the future. This fits well with other research into treatment utilization where those of the Jewish faith consistently showed better attitudes toward and higher utilization of psychotherapy (Fischer & Cohen, 1972; Greenley & Mechanic, 1976). This sample, however, did not have any declared Orthodox Jews. Therefore we do not know if those of the Jewish faith with higher level of religious orthodoxy would have had more negative views of

psychotherapy, as some previous research suggested (Greenberg & Witztum, 2001; Schnall, 2004).

CJC-LDS members had most negative attitudes toward psychotherapy and reported the highest level of therapy fear and lowest willingness to seek therapy in the future; though no between-group difference reached statistical significance. As mentioned previously, this group is considered conservatively religious and the results seem to support the premise that those more conservative in their beliefs are less likely to seek professional help in the mental health services.

For the Abrahamic religions sub-sample, the level of fundamentalism and intrinsic religiosity had weak negative correlations with ATSPPH score, while extrinsic religiosity had weak positive correlation with attitudes toward therapy. However, those correlations were not statistically significant. When the CJC-LDS group was excluded from calculations the influence of fundamentalism and extrinsic religiosity became significant, with fundamentalism showing a weak negative correlation with ATSPPH score and extrinsic religiosity manifesting weak positive correlation with attitudes toward therapy, which supports previous research by Thompson (2009) into attitudes and types of religiosity, where extrinsic religiosity was positively correlated with attitudes toward psychotherapy and only some aspects of intrinsic religiosity correlated negatively with ATSPPH score.

Analysis of the group of only CJC-LDS members showed quite a different picture. For this group the higher level of fundamentalism actually had very weak and non-significant but positive correlation with attitudes toward psychotherapy. Considering that participants from this religious group were significantly more likely to hear their

leaders talk about mental illness and more likely to hear their religious leaders promote professional mental health than members of other religions in this sample, it might be that this inverse correlation between fundamentalism and ATSPPH score is present only in this particular conservative religious group and might not translate to other conservatively religious groups. The higher level of information about mental illness and professional mental health treatment members of CJC-LDS received from their religious leaders might also explain why in this sub-sample there is negative, though not significantly so, correlation between level of fundamentalism and perception of psychology-religion antagonism, while for the sub-sample of other religious group that correlation is significantly positive.

In the full religious sample and in all sub-samples the measure that had the strongest and most significant correlation with attitudes about psychotherapy was a measure of preference for religious help, thus supporting our previous assumption that religious people might not utilize professional mental health services because they prefer to seek that help from their religious sources (Chalfant, et al., 1990; Oppenheimer, Flannelly, & Weaver, 2004; Wang et al., 2003). In the sub-sample with only CJC-LDS members two other characteristics of religious conservatism, perception of antagonism between psychology and religion and feeling of separateness from the secular world, also showed significant weak negative correlation with attitudes toward psychotherapy, thus possibly indicating that certain aspects of conservatism might influence how people feel about psychotherapy more than others. It is possible that these two measures tap into feeling of mistrust toward psychology as a secular science.

A perception of antagonism between psychology and religion seems to be the only religiosity factor that has significant and positive correlation with TAPS-score for all examined groups. This finding is not surprising as it is understandable that if one thinks that he or she is viewed with antagonism one is likely to experience more fear when confronted with such a situation.

The real goal of this research was to determine if people would actually be willing to seek professional mental help if they need it. Therefore, probably the most interesting measure to evaluate is the answer to that particular question of ATSPPH scale. Across different groups the strongest correlation was between willingness to seek psychotherapy in the future and preference for religious help. That correlation is understandably negative, as it is to be expected that those who prefer religious help would be more likely to turn to their religious leaders for help first. This also seems to be in line with several previous findings that many religious people would first seek the counsel of their religious leaders if they felt distressed (Bornsheuer et al., 2012; Dawood, 2010; Ellison et al., 2006). For the sub-sample excluding CJC-LDS members, fundamentalism and feelings of separateness from the world also had a significant negative correlation with expressed willingness to seek professional help. In the sub-sample of only CJC-LDS members those who perceived more antagonism between psychology and religion also seemed to be significantly less willing to seek therapy in the future.

These results seem to partially confirm the first point of the initial hypothesis of this research. In the very conservative sample, certain aspects of fundamentalism, although not the fundamentalism measure itself, have more influence on attitudes toward psychotherapy than the level of religiosity. Fundamentalism and certain hallmark factors

of strong religious conservatism also seem to significantly correlate with the willingness to seek therapy in the future, while the level of religiosity alone does not.

## Religion Related Barriers to Professional Mental Health Treatment Use

The second point of the hypothesis was that among the barriers that religious people specifically might face in seeking professional psychological help, the most prominent ones will be perception of "value gap" between psychology and religion and fear of value disconnect between them and psychotherapist. The measures used to access that element of barriers were feelings of separateness from the secular world and value concern subscale of TAPS scale.

The results here are mixed. Value concern itself didn't show any significant correlation with attitudes toward psychotherapy nor willingness to seek psychotherapy in the future. However, feeling more separated from secular world values and world-views showed significant negative correlation with attitudes toward psychotherapy in the Abrahamic religions sub-sample and in the CJC-LDS only sub-sample. For the sub-sample without the CJC-LDS group there was negative correlation between this factor and attitudes but that correlation wasn't statistically significant. If the sub-sample was larger perhaps the relationship would have reached statistical significance.

For the Abrahamic religion sub-sample and the sub-sample excluding CJC-LDS members the separateness from the world measure had significant negative correlation with willingness to engage in psychotherapy in the future. For the CJC-LDS sample correlation between separateness from the world and actual declared willingness to engage in psychotherapy in the future is also negative but not significant.

Although the perception of antagonism between psychology and religion was in the initial barrier classification labeled as cognitive barrier, there is really no sharp delineation between this particular barrier and value orientation barrier. It is especially so with the measure used for psychology-religion antagonism in this research. The majority of questions assessing psychology-religion antagonism actually question the perception of value difference between the science of psychology and the religious values of participants. Therefore, psychology-religion antagonism measure could also be considered useful for assessing the influence of "value-gap" barrier. With a second look at the questions it can be concluded that the separateness from the world measure assesses more "value-gap" between religious people values and secular world values, while the psychology-religion antagonism measure actually looks at "value-gap" between religious value and values the religious perceive that psychology espouses.

In our sample psychology-religion antagonism measure significantly and positively correlated with both value concern subscale of TAPS and separateness from the world measure. The perceived antagonism measure had significant positive correlation with therapy fear measure for all sub-samples, and significant negative correlation with attitudes toward psychotherapy and the willingness to seek psychotherapy in the future for Abrahamic religions sub-sample and CJC-LDS only sub-sample.

Participants of this survey seem to be adept in distinguishing between mental illness and regular life troubles, assessing severity of mental illness, and recommending appropriate level of treatment. Predominant etiologies selected for the schizophrenia case were chemical imbalance and genetics, for substance-use disorder were life stress and

genetic, and for depression case were chemical imbalance and life stress. Religiously specific etiologies of bad influence, lack of faith and God's will were given low likelihood by all groups and for all cases. Participants in this survey actually did better in mental illness recognition and recognition of etiology of different cases than was shown by clergy members surveyed in other research assessing beliefs about etiology of mental illness (Ali & Milstein, 2012; Domino, 1990; Payne, 2009). Participants of this survey were predominately very highly educated and it is possible that they were better informed about mental illness than the average person.

It is worth noting that the very religious were significantly more likely than other groups to ascribe the lack of faith as a cause of the disorder in both the substance-abuse case and the depression case, albeit the highest suggested likelihood for that etiology was still very low. However, it would be interesting to see if, in a less educated very religious population, lack of faith would be viewed as a more prominent cause of substance abuse and depression. The members of CJC-LDS were the only ones who ascribed to substance abuse disorder the lack of faith cause significantly more than to other presented scenarios. This might be understandable, because this religion teaches total avoidance of alcohol, tobacco, and other addictive substances as a part of their belief system. Engaging in any use of these substances may prevent members of CJC-LDS from participating in certain religious ordinances or practices and, therefore, while substance abuse is recognized as an illness it is also considered a crisis of one's faith (Lyon, 2013). Although there was no statistically significant difference for people of religions other than CJC-LDS, they still ascribed lack of faith as a cause to substance use disorder more than to other scenarios.

Weak personality was also considered by all religious sub-samples a significantly more likely cause for substance abuse disorder than for other conditions.

This demonstrates that particular belief system has to be taken into consideration when approaching treatment of different disorders, and that some disorders may carry with them more stigmas for a religious individual than others. In previous studies surveyed clergy were more likely to ascribed spiritual etiology to disorders such as ADHD and anxiety than to schizophrenia and bipolar disorder, or consider that depression was sign of spiritual problems and weak personality (Ali & Milstein, 2012; Stanford & Philpott, 2011). That was especially evident with pastors of more conservative and evangelical religions (Payne, 2009). This study supports the concept that the type of disorder may influence to what degree people will ascribe spiritual causes to the disorder and thus can influence the level to which they will seek professional mental health help for that disorder (Schnittker et al., 2000)

As in previous religious samples, it seems that people have little ambiguity about psychopathology or psychological etiology of severe mental illnesses, but depression and especially substance use disorder may sometimes be viewed as stemming from some personal weakness (Ellison et al., 2006; Stanford & Philpott, 2011).

If we look at the perceived antagonism measure as a "value-gap" measure, then we can say that the second part of the hypothesis is satisfied. Value orientation barrier seems to have more influence over attitudes toward psychotherapy and a willingness to seek psychotherapy in the future than any other barriers examined in this research.

## Conclusion

In summary, the level of fundamentalism seems to have stronger influence on attitudes toward psychotherapy than just level of religiosity, suggesting that those following more conservative religious teachings may be more reluctant to seek professional mental health care. The most prominent barrier among the ones examined seems to be a feeling that psychology may not understand, may look down on, or even go against person's religious values. This "value-gap" barrier seems to be more pronounced the more a person feels that there is disconnect between his or her religious values and secular world values, confirming what was previously found by Bronstein (2004) in Orthodox Jewish group and Brody (1994) in student populations.

It is shown here that more conservatively religious people have certain barriers to utilizing professional psychotherapy that need to be addressed for any mental health promotion program to be successful.

Having had previous experience with therapy seems to make people more likely to seek therapy in the future. Positive previous experience with therapy seems to correlate with more positive attitude toward psychotherapy. Therapy experience seems to also correlate positively with willingness to engage in therapy in the future for sub-sample of all religions excluding members of CJC-LDS, but not for CJC-LDS only sub-sample. It is also interesting to notice that members of CJC-LD also had on average the worst experiences with previous therapy. This research didn't follow up with interviews to fully assess what particular elements of therapy were problematic for members of this conservatively religious group. Some previous research had shown that trained and licensed therapists when presented with certain core beliefs of different religions were

more likely to diagnose as delusional beliefs of less mainstream religions (O'Connor & Vandenberg, 2005). After being informed that particular scenarios actually represent religious beliefs, the level of delusion diagnosis was reduced noticeably for scenarios presenting mainline Protestant and Catholic beliefs but significantly less so for scenarios presenting beliefs of members of CJC-LDS and Nation of Islam (O'Connor & Vandenberg, 2005). Taking this into consideration the more negative experience with therapy of members of CJC-LDS might be understandable, though more research needs to be conducted before any definitive claims can be made.

The mitigating factor for the conservatively religious might be promotion of professional mental health by religious leaders. For CJC-LDS members the leaders promoting professional psychological help had significant positive correlation with attitudes toward psychotherapy. Interestingly, just hearing leaders talk about mental health had no significant correlation with attitude toward psychotherapy, but it had significant positive correlation with value concern subscale of TAPS, indicating that those who heard their leaders talk more about mental illness at the same time also had more fear that psychotherapy may conflict with their values. As this is only correlation, it cannot be claimed that what leaders say increases that fear. It just might be that those who are more religious and concerned about keeping up their value system are also more likely to listen to their church leaders and hear them speak about mental health. Indeed, for the sub-sample of members of CJC-LDS, hearing leaders talk about mental illness also significantly correlated with the level of intrinsic religiosity. Just by definition of intrinsic religiosity, those who score higher on that scale care more about their religious values (Allport & Ross, 1967).

The biggest task the psychology community has when it comes to mental health services promotion among conservatively religious would most likely be overcoming the mutual mistrust. Religious communities probably could profit from learning more about mental illness. However, it might be hard for the devoutly religious to feel that psychology is not against religion without widespread and publicly noticeable denouncement by psychologists of aforementioned anti-religious pronouncements by fathers of psychology (Freud, 1961; Ellis, 1983, 1988).

This sample was highly educated, yet, as it seems from results presented here, they still might not be aware of the latest positive movements in how psychology views religion and its possible positive effects on mental health. Considering the influence of the antagonism factor on the willingness to seek psychotherapy, education of religious people on the new psychological research into positive aspects of religion on mental health may start to dispel their perception that psychology is the enemy of religion and thus dispel fear that mental health professionals will look down on religious beliefs or disparage their religious values.

Conversely, some studies suggest that mental health professionals are also not sufficiently educated about religion (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Furman, Benson, & Canda, 2008) and may not feel fully equipped to approach the question of religious beliefs in therapy or to incorporate positive religious aspects into therapy (Knight, 2010). Therefore, education needs to go both ways.

As it seems that the type of religion matters and as mental health professionals cannot be well-versed in all the different religious beliefs, approaching religious leaders of the devoutly religious person in order to better understand where their client comes

from has been suggested as a good way to better serve devoutly religious clients (Milstein et al., 2008). However mental health professionals might be reluctant to initiate such an approach (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). For the conservatively religious it seems that the promotion of mental health services by their religious leaders can correlate with more willingness to seek professional mental health help, therefore establishing cooperation between religious leaders and psychologists might be a good starting point.

Dealing with mistrust between religion and psychology needs to go both ways. It is unlikely that conservatively religious will become more trusting of good intentions of mental health professionals, if mental health professionals do not learn to trust religious people and not shy away from openly addressing and understanding religious beliefs of their clients.

Further research including more diverse populations and interviews may help us better understand what specific elements of psychology make religious people feel that psychology teachings are antagonistic to religious people and their beliefs and what type of intervention may ameliorate the antagonism. Further investigation of the therapy experiences of religious conservatives might prove useful in evaluating the efficacy of therapeutic elements and determining elements which proved most problematic.

Appendix A

Results Summary Tables

Table A1

Demographics Cross-Category Summary

| | Total | Gender | | Age group | | | | | | Ethnicity | | | | | | Education | | | | Religious SD | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N= 131 | M | F | 1 | 2 | 3 | 4 | 5 | 6 | AfA | C | H | A | NA | O | HS< | SC | BS | >BS | NR | LR | MR | VR |
| **Male** | 35 (26.7%) | | | 6 | 8 | 12 | 4 | 2 | 3 | 1 | 27 | 2 | 3 | 2 | 0 | 1 | 10 | 11 | 13 | 7 | 4 | 7 | 17 |
| **Female** | 96 (73.3%) | | | 16 | 22 | 29 | 11 | 7 | 11 | 2 | 84 | 4 | 2 | 0 | 4 | 4 | 26 | 22 | 44 | 26 | 11 | 16 | 43 |
| **18-25** | 22 (16.8 %) | 6 | 16 | | | | | | | 1 | 19 | 0 | 2 | 0 | 0 | 3 | 13 | 4 | 2 | 9 | 6 | 3 | 4 |
| **26-35** | 30 (22.9%) | 8 | 22 | | | | | | | 0 | 25 | 3 | 0 | 1 | 1 | 1 | 9 | 9 | 11 | 13 | 3 | 7 | 7 |
| **36-45** | 41 (31.3%) | 12 | 29 | | | | | | | 1 | 32 | 3 | 3 | 0 | 2 | 1 | 8 | 11 | 21 | 9 | 3 | 5 | 24 |
| **46-55** | 15 (11.5%) | 4 | 11 | | | | | | | 0 | 15 | 0 | 0 | 0 | 0 | 0 | 5 | 4 | 6 | 0 | 1 | 4 | 10 |
| **56-64** | 9 (6.9%) | 2 | 7 | | | | | | | 1 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 7 | 2 | 0 | 1 | 6 |
| **65+** | 14 (10.7%) | 3 | 11 | | | | | | | 0 | 12 | 0 | 0 | 1 | 1 | 0 | 1 | 3 | 10 | 0 | 2 | 3 | 9 |
| **Afr. Am.** | 3 (2.3%) | 1 | 2 | 1 | 0 | 1 | 0 | 1 | 0 | | | | | | | 0 | 2 | 0 | 1 | 2 | 1 | 0 | 0 |
| **Caucasian** | 111 (84.7%) | 27 | 84 | 19 | 25 | 32 | 15 | 8 | 12 | | | | | | | 4 | 31 | 26 | 50 | 24 | 12 | 20 | 55 |
| **Hispanic** | 6 (4.6%) | 2 | 4 | 0 | 3 | 3 | 0 | 0 | 0 | | | | | | | 0 | 0 | 3 | 3 | 1 | 1 | 3 | 1 |
| **Asian** | 5 (3.8%) | 3 | 2 | 2 | 0 | 3 | 0 | 0 | 0 | | | | | | | 1 | 1 | 2 | 1 | 3 | 0 | 0 | 2 |
| **NA/PI** | 2 (1.5%) | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | | | | | | | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 |
| **Other** | 4 (3.1%) | 0 | 4 | 0 | 1 | 2 | 0 | 0 | 1 | | | | | | | 0 | 1 | 2 | 1 | 3 | 0 | 0 | 1 |
| **HS or <** | 5 (3.8%) | 1 | 4 | 3 | 1 | 1 | 0 | 0 | 0 | 0 | 4 | 0 | 1 | 0 | 0 | | | | | 4 | 1 | 0 | 0 |
| **Som Col.** | 36 (27.5%) | 10 | 26 | 13 | 9 | 8 | 5 | 0 | 1 | 2 | 31 | 0 | 1 | 1 | 1 | | | | | 11 | 6 | 8 | 11 |
| **BS** | 33 (25.2%) | 11 | 22 | 4 | 9 | 11 | 4 | 2 | 3 | 0 | 26 | 3 | 2 | 0 | 2 | | | | | 9 | 2 | 5 | 17 |
| **>BS** | 57 (43.5%) | 13 | 44 | 2 | 11 | 21 | 6 | 7 | 10 | 1 | 50 | 3 | 1 | 1 | 1 | | | | | 9 | 6 | 10 | 32 |
| **Not Rel.** | 33 (25.2%) | 7 | 26 | 9 | 13 | 9 | 0 | 2 | 0 | 2 | 24 | 1 | 3 | 0 | 3 | 4 | 1 | 9 | 9 | | | | |
| **Little Rel.** | 15 (11.5%) | 4 | 11 | 6 | 3 | 3 | 1 | 0 | 2 | 1 | 12 | 1 | 0 | 1 | 0 | 1 | 6 | 2 | 6 | | | | |
| **Mod. Rel.** | 23 (17.6%) | 7 | 16 | 3 | 7 | 5 | 4 | 1 | 3 | 0 | 20 | 3 | 0 | 0 | 0 | 0 | 8 | 5 | 10 | | | | |
| **Very Rel.** | 60 (45.8%) | 17 | 43 | 4 | 7 | 24 | 10 | 6 | 9 | 0 | 55 | 1 | 2 | 1 | 1 | 0 | 11 | 17 | 32 | | | | |

Table A2

One-Way ANOVA on ATSPPH, TAPS, and Willigness to Seek Psychotherapy between Demographic Groups

| | | ATSPPH (Total Mean = 32.95) | | | TAPS (Total Mean = 43.45) | | | Will Seek PT (Total Mean = 3.34) | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Mean | F | p-val | Mean | F | p-val | Mean | F | p-val |
| Gender | Male | 30.20 | 15.76 | <.001 | 44.80 | 0.40 | .53 | 2.66 | 13.54 | <.001 |
| | Female | 33.95 | | | 42.96 | | | 3.16 | | |
| Age | 18-25 | 34.23 | 1.07 | .38 | 43.45 | 1.49 | .20 | 3.64 | 2.18 | .06 |
| | 26-35 | 32.97 | | | 47.33 | | | 3.63 | | |
| | 36-45 | 32.61 | | | 45.22 | | | 3.2 | | |
| | 46-55 | 30.67 | | | 38.27 | | | 2.87 | | |
| | 56-64 | 34.00 | | | 40.89 | | | 3.11 | | |
| | 65+ | 33.64 | | | 37.14 | | | 3.29 | | |
| Race/ Ethnicity | Caucasian | 32.92 | | .18 | 42.67 | | .98 | 4.00 | | .14 |
| | Afr. Am. | 37.00 | All Non-Caucasian vs. Caucasian: Mean 33.1 p-val. .88 F 0.02 | | 43.35 | All Non-Caucasian vs. Caucasian: Mean 44 p-val. .86 F 0.03 | | 3.33 | All Non-Caucasian vs. Caucasian: Mean 3.35 p-val. .94 F 0.01 | |
| | Hispanic | 34.17 | | | 46.33 | | | 3.33 | | |
| | Asian | 28.00 | | | 42.80 | | | 2.40 | | |
| | NA/PI | 33.50 | | | 49.50 | | | 4.00 | | |
| | Other | 34.75 | | | 40.25 | | | 3.75 | | |
| Education | HS or < | 32.20 | 0.44 | 0.73 | 43.80 | 0.43 | .73 | 3.20 | 0.72 | 0.54 |
| | Some Col. | 33.75 | | | 41.78 | | | 3.53 | | |
| | BS | 32.55 | | | 45.79 | | | 3.30 | | |
| | >BS | 32.74 | | | 43.12 | | | 3.25 | | |
| Self-Declared Religiosity | Not Rel. | 32.97 | 1.44 | .23 | 42.70 | 3.17 | .03 | 3.55 | 2.62 | .05 |
| | Little Rel. | 34.27 | | | 45.60 | | | 3.73 | | |
| | Mod. Rel. | 34.26 | | | 35.65 | | | 3.35 | | |
| | Very Rel. | 32.10 | | | 46.32 | | | 3.12 | | |
| Religion Type | Protestant | 33.67 | 1.67 | .16 | 41.95 | 0.20 | .94 | 3.52 | 2.957 | .02 |
| | Catholic | 34.33 | | | 42.50 | | | 3.75 | | |
| | Jewish | 36.75 | | | 40.50 | | | 4.00 | | |
| | CJC-LDS | 31.87 | | | 44.80 | | | 3.00 | | |
| | Other | 34.83 | | | 44.33 | | | 3.33 | | |

Table A3

Correlations between Religiosity Measures for All Abrahamic Religions (sub-sample 1)

| All Abrahamic Religion (sub-sample 1) | | Extrin. Relig. | Intris. Relig. | Fund. | Psy.-Rel. Anta. | Sep. from World | Pref. Rel. Help | Rel. Lead. Talk MH | Rel. Lead. Prom. PT |
|---|---|---|---|---|---|---|---|---|---|
| Extrinsic Religiosity | R | 1 | .05 | -.01 | -.01 | .05 | -.05 | .14 | .15 |
| | p-value | | .63 | .92 | .95 | .64 | .65 | .20 | .19 |
| | N | 91 | 91 | 90 | 80 | 83 | 84 | 83 | 79 |
| Intrinsic Religiosity | R | .05 | 1 | .69** | .27* | .74** | .40** | .45** | .31** |
| | p-value | .63 | | <.001 | 0.02 | <.001 | <.001 | <.001 | .006 |
| | N | 91 | 91 | 90 | 80 | 83 | 84 | 83 | 79 |
| Fundament. | R | -.01 | .69** | 1 | .27* | .71** | .38** | .26* | .37** |
| | p-value | .92 | <.001 | | .02 | <.001 | <.001 | .018 | .001 |
| | N | 90 | 90 | 90 | 79 | 82 | 83 | 82 | 78 |
| Psy.-Relig. Antagonism | R | -.01 | .27* | .27* | 1 | .55** | .37** | .22 | -.10 |
| | p-value | .95 | .02 | .02 | | <.001 | .001 | .05 | .40 |
| | N | 80 | 80 | 79 | 80 | 80 | 80 | 79 | 77 |
| Separat. from World | R | .05 | .74** | .71** | .55** | 1 | .53** | .41** | .25* |
| | p-value | .64 | <.001 | 0 | 0 | | 0 | 0 | .03 |
| | N | 83 | 83 | 82 | 80 | 83 | 83 | 82 | 79 |
| Pref. for Relig. Help | R | -.05 | .40** | .38** | .37** | .53** | 1 | .21 | .04 |
| | p-value | .65 | <.001 | <.001 | .001 | 0 | | .05 | .75 |
| | N | 84 | 84 | 83 | 80 | 83 | 84 | 83 | 79 |
| Rel. Lead. Talk about Mental Health | R | .14 | .45** | .26* | .22 | .41** | .21 | 1 | .35** |
| | p-value | .20 | <.001 | .02 | .052 | 0 | .053 | | .002 |
| | N | 83 | 83 | 82 | 79 | 82 | 83 | 83 | 78 |
| Rel. Lead. Promote Prof. Mental Help | R | .15 | .31** | .37** | -.10 | .25* | .04 | .35** | 1 |
| | p-value | .20 | .006 | .001 | .40 | .03 | .75 | .002 | |
| | N | 79 | 79 | 78 | 77 | 79 | 79 | 78 | 79 |

** Significant with p-value < .05; ** Significant with p-value < .005;*

Table A4

Correlations between Religiosity Measures for CJC-LDS Only (sub-sample 3)

| CJC-LDS only (sub-sample 3) | | Extrin. Relig. | Intrin. Relig. | Fund. | Psy.-Rel. Anta. | Sep. from World | Pref. Rel. Help | Rel. Lead. Talk MH | Rel. Lead. Prom. PT |
|---|---|---|---|---|---|---|---|---|---|
| Extrinsic Religiosity | R | 1 | -.003 | -.01 | -.18 | -.01 | -.05 | -.03 | .05 |
| | p-value | | .98 | .92 | 023 | .93 | .73 | .83 | .73 |
| | N | 55 | 55 | 54 | 48 | 51 | 51 | 50 | 49 |
| Intrinsic Religiosity | R | -.003 | 1 | .58** | -.08 | .59** | .21 | .54** | .21 |
| | p-value | .98 | | <.001 | .59 | <.001 | .13 | <.001 | .16 |
| | N | 55 | 55 | 54 | 48 | 51 | 51 | 50 | 49 |
| Fundament. | R | -.01 | .58** | 1 | -.25 | .43** | .10 | .11 | .40** |
| | p-value | .92 | <.001 | | .09 | .002 | .47 | .44 | .005 |
| | N | 54 | 54 | 54 | 47 | 50 | 50 | 49 | 48 |
| Psy.-Relig. Antagonism | R | -.18 | -.08 | -.25 | 1 | .39** | .47** | .09 | -.29* |
| | p-value | .23 | .59 | .09 | | .007 | .001 | .54 | .049 |
| | N | 48 | 48 | 47 | 48 | 48 | 48 | 47 | 47 |
| Separat. from World | R | -.01 | .59** | .43** | .39** | 1 | .49** | .40** | .06 |
| | p-value | .93 | 0 | .002 | .007 | | <.001 | .004 | .66 |
| | N | 51 | 51 | 50 | 48 | 51 | 51 | 50 | 49 |
| Pref. for Relig. Help | R | -.05 | .21 | .10 | .47** | .49** | 1 | .16 | -.18 |
| | p-value | .73 | .13 | .47 | .001 | <.001 | | .27 | .22 |
| | N | 51 | 51 | 50 | 48 | 51 | 51 | 50 | 49 |
| Rel. Lead. Talk about Mental Health | R | -.03 | .54** | .11 | .09 | .40** | .16 | 1 | .32* |
| | p-value | .83 | <.001 | .44 | .54 | .004 | .27 | | .03 |
| | N | 50 | 50 | 49 | 47 | 50 | 50 | 50 | 48 |
| Rel. Lead. Promote Prof. Mental Help | R | .05 | .22 | .40** | -.29* | .06 | -.18 | .32* | 1 |
| | p-value | .73 | .16 | .005 | .049 | .66 | .22 | .03 | |
| | N | 49 | 49 | 48 | 47 | 49 | 49 | 48 | 49 |

** Significant with p-value < .05; ** Significant with p-value < .005;*

Table A5

Case Scenarios Recognition of Mental Illness: Means and One-Way ANOVA p-values for Self-Declared Religiosity Levels

| | | Not Relig. | Little Relig. | Mod. Relig. | Very Relig. | Total | p-value | p-value BTW groups |
|---|---|---|---|---|---|---|---|---|
| Case 1: Emotionally Troubled Person | Mental Illness | 1.75 | 1.38 | 1.95 | 1.82 | 1.78 | .20 | Regular Life Troubles: p1-2=.048, p2-3=.03; Talking to Others Helps: p1-4=.04 |
| | Regular Life Troubles | 2.82 | 3.62 | 2.73 | 3.26 | 3.09 | .007** | |
| | Self-Treatment will Help | 2.29 | 2.25 | 2.40 | 2.63 | 2.46 | .17 | |
| | Talking to Others will Help | 3.55 | 3.23 | 3.45 | 3.08 | 3.28 | .04* | |
| | Medication will Help | 1.65 | 1.25 | 1.61 | 1.34 | 1.46 | .12 | |
| | MHP Treatment will Help | 2.29 | 2.25 | 2.05 | 2.02 | 2.12 | .54 | |
| | PCP Treatment will Help | 2.00 | 1.42 | 2.00 | 1.87 | 1.88 | .24 | |
| Case2: Person with Schizophrenia | Mental Illness | 3.93 | 4.00 | 4.00 | 3.91 | 3.94 | .58 | |
| | Regular Life Troubles | 1.10 | 1.08 | 1.00 | 1.09 | 1.08 | .72 | |
| | Self-Treatment will Help | 1.03 | 1.00 | 1.00 | 1.04 | 1.03 | .73 | |
| | Talking to Others will Help | 3.93 | 3.92 | 3.86 | 3.81 | 3.86 | .74 | |
| | Medication will Help | 3.86 | 3.58 | 3.75 | 3.59 | 3.69 | .24 | |
| | MHP Treatment will Help | 3.83 | 4.00 | 4.00 | 3.85 | 3.89 | .39 | |
| | PCP Treatment will Help | 3.03 | 3.54 | 3.41 | 3.25 | 3.26 | .36 | |
| Case 3: Person with Substance Use Disorder | Mental Illness | 3.28 | 3.00 | 3.25 | 2.77 | 3.01 | .10 | |
| | Regular Life Troubles | 1.55 | 1.69 | 1.48 | 1.56 | 1.56 | .90 | |
| | Self-Treatment will Help | 1.28 | 1.31 | 1.27 | 1.15 | 1.22 | .59 | |
| | Talking to Others will Help | 3.72 | 4.00 | 3.86 | 3.87 | 3.85 | .35 | |
| | Medication will Help | 2.19 | 2.00 | 2.37 | 2.35 | 2.27 | .63 | |
| | MHP Treatment will Help | 3.57 | 3.92 | 3.48 | 3.52 | 3.57 | .27 | |
| | PCP Treatment will Help | 3.04 | 3.62 | 3.50 | 3.46 | 3.38 | .11 | |
| Case 4: Person with Depression | Mental Illness | 3.76 | 3.67 | 3.67 | 3.55 | 3.64 | .61 | |
| | Regular Life Troubles | 1.46 | 1.58 | 1.76 | 1.64 | 1.61 | .64 | |
| | Self-Treatment will Help | 1.39 | 1.31 | 1.33 | 1.29 | 1.32 | .89 | |
| | Talking to Others will Help | 3.79 | 4.00 | 4.00 | 3.85 | 3.88 | .22 | |
| | Medication will Help | 3.17 | 3.17 | 3.25 | 3.06 | 3.14 | .87 | |
| | MHP Treatment will Help | 3.89 | 3.77 | 3.86 | 3.74 | 3.81 | .56 | |
| | PCP Treatment will Help | 3.07 | 3.46 | 3.38 | 3.19 | 3.23 | .53 | |

** Significant with p-value < .05; ** Significant with p-value < .005;*

Table A6

Case Scenarios Recognition of Mental Illness: Means and One-Way ANOVA p-values for Different Religious Groups

| | | Protest. | Cath. | Jewish | CJC-LDS | Other | Total |
|---|---|---|---|---|---|---|---|
| Case 1: Emotionally Troubled Person | Mental Illness | 1.40 | 1.91 | 1.25 | 1.92 | 1.80 | 1.79 |
| | Regular Life Troubles | 3.24 | 3.27 | 3.75 | 3.14 | 2.80 | 3.18 |
| | Self-Treatment will Help | 2.38 | 2.18 | 2.67 | 2.67 | 2.20 | 2.52 |
| | Talking to Others will Help | 3.19 | 3.55 | 3.25 | 3.12 | 3.20 | 3.20 |
| | Medication will Help | 1.31 | 1.20 | 2.00 | 1.44 | 1.25 | 1.39 |
| | MHP Treatment will Help | 2.13 | 1.80 | 2.33 | 2.04 | 2.25 | 2.06 |
| | PCP Treatment will Help | 1.60 | 1.67 | 2.33 | 1.90 | 2.00 | 1.84 |
| Case2: Person with Schizophrenia | Mental Illness | 4.00 | 4.00 | 4.00 | 3.90 | 4.00 | 3.94 |
| | Regular Life Troubles | 1.06 | 1.00 | 1.00 | 1.00 | 1.10 | 1.07 |
| | Self-Treatment will Help | 1.00 | 1.00 | 1.00 | 1.04 | 1.00 | 1.00 |
| | Talking to Others will Help | 3.88 | 3.91 | 4.00 | 3.78 | 4.00 | 3.84 |
| | Medication will Help | 3.71 | 3.30 | 4.00 | 3.66 | 3.50 | 3.63 |
| | MHP Treatment will Help | 4.00 | 4.00 | 4.00 | 3.84 | 4.00 | 3.91 |
| | PCP Treatment will Help | 3.59 | 3.00 | 4.00 | 3.29 | 3.00 | 3.33 |
| Case 3: Person with Substance Use Disorder | Mental Illness | 3.13 | 3.00 | 2.33 | 2.84 | 3.20 | 2.92 |
| | Regular Life Troubles | 1.47 | 1.45 | 1.00 | 1.67 | 1.40 | 1.56 |
| | Self-Treatment will Help | 1.18 | 1.55 | 1.25 | 1.16 | 1.00 | 1.20 |
| | Talking to Others will Help | 4.00 | 3.91 | 4.00 | 3.82 | 4.00 | 3.89 |
| | Medication will Help | 2.19 | 1.70 | 2.00 | 2.48 | 2.40 | 2.30 |
| | MHP Treatment will Help | 3.71 | 3.40 | 3.50 | 3.52 | 4.00 | 3.57 |
| | PCP Treatment will Help | 3.41 | 3.30 | 3.50 | 3.59 | 3.20 | 3.49 |
| Case 4: Person with Depression | Mental Illness | 3.75 | 3.73 | 3.33 | 3.49 | 4.00 | 3.60 |
| | Regular Life Troubles | 1.53 | 1.36 | 1.67 | 1.82 | 1.20 | 1.66 |
| | Self-Treatment will Help | 1.29 | 1.27 | 2.00 | 1.27 | 1.20 | 1.30 |
| | Talking to Others will Help | 4.00 | 3.82 | 4.00 | 3.88 | 4.00 | 3.91 |
| | Medication will Help | 3.07 | 2.90 | 3.00 | 3.20 | 3.20 | 3.13 |
| | MHP Treatment will Help | 3.94 | 3.82 | 3.50 | 3.71 | 4.00 | 3.78 |
| | PCP Treatment Helps | 3.47 | 2.70 | 3.50 | 3.29 | 3.75 | 3.28 |
| *There is no statistically significant ANOVA between group differences* | | | | | | | |

Table A7

Case Scenarios Etiology: Means and One-Way ANOVA p-values for Self-Declared Religiosity Levels

| | | Not Relig. | Little Relig. | Mod. Relig. | Very Relig. | Total | p-value | p-values BTW group |
|---|---|---|---|---|---|---|---|---|
| Case 1: Emotionally Troubled Person | Weak Personality | 1.17 | 1.08 | 1.10 | 1.22 | 1.17 | .55 | Lack of Faith: $p_{1\text{-}4}$=.005 |
| | Chemical | 2.30 | 1.69 | 2.00 | 2.02 | 2.05 | .13 | |
| | Life Stress | 3.18 | 3.08 | 2.95 | 2.94 | 3.02 | .66 | |
| | Genetic | 2.12 | 2.17 | 2.05 | 2.06 | 2.08 | .96 | |
| | Family Upbringing | 2.22 | 2.08 | 2.15 | 2.17 | 2.17 | .96 | |
| | Bad Influence | 1.89 | 1.83 | 1.70 | 1.92 | 1.86 | .69 | |
| | Lack of Faith | 1.00 | 1.00 | 1.20 | 1.37 | 1.20 | .004** | |
| | God's Will | 1.03 | 1.00 | 1.05 | 1.22 | 1.11 | .05 | |
| Case2: Person with Schizophrenia | Weak Personality | 1.07 | 1.00 | 1.05 | 1.10 | 1.07 | .73 | |
| | Chemical | 3.90 | 4.00 | 3.77 | 3.73 | 3.81 | .24 | |
| | Life Stress | 2.86 | 3.17 | 2.90 | 2.82 | 2.88 | .68 | |
| | Genetic | 3.46 | 3.67 | 3.35 | 3.34 | 3.41 | .50 | |
| | Family Upbringing | 1.41 | 1.50 | 1.38 | 1.40 | 1.41 | .96 | |
| | Bad Influence | 1.28 | 1.25 | 1.38 | 1.42 | 1.36 | .67 | |
| | Lack of Faith | 1.00 | 1.00 | 1.05 | 1.08 | 1.04 | .52 | |
| | God's Will | 1.07 | 1.00 | 1.05 | 1.27 | 1.15 | .16 | |
| Case 3: Person with Substance Use Disorder | Weak Personality. | 1.54 | 1.33 | 1.57 | 1.79 | 1.64 | .34 | Lack of Faith: $p_{1\text{-}4}$<.001, $p_{2\text{-}4}$=.01, $p_{3\text{-}4}$=.02 |
| | Chemical | 2.41 | 2.42 | 2.65 | 2.88 | 2.67 | .18 | |
| | Life Stress | 3.29 | 3.46 | 3.14 | 3.13 | 3.21 | .55 | |
| | Genetic | 3.00 | 3.42 | 2.90 | 3.04 | 3.05 | .38 | |
| | Family Upbringing | 2.37 | 2.33 | 2.38 | 2.26 | 2.32 | .94 | |
| | Bad Influence | 2.37 | 2.33 | 2.43 | 2.35 | 2.37 | .99 | |
| | Lack of Faith | 1.00 | 1.00 | 1.15 | 1.63 | 1.31 | <.001** | |
| | God's Will | 1.07 | 1.00 | 1.00 | 1.08 | 1.06 | .67 | |
| Case 4: Person with Depression | Weak Personality. | 1.13 | 1.08 | 1.19 | 1.18 | 1.16 | .84 | Lack of Faith: $p_{1\text{-}4}$=.01 |
| | Chemical | 3.70 | 3.58 | 3.32 | 3.29 | 3.43 | .12 | |
| | Life Stress | 3.32 | 3.33 | 3.19 | 2.96 | 3.13 | .20 | |
| | Genetic | 3.14 | 2.92 | 2.86 | 2.94 | 2.97 | .59 | |
| | Family Upbringing | 1.82 | 1.83 | 2.15 | 1.57 | 1.78 | .05 | |
| | Bad Influence | 1.52 | 1.92 | 1.52 | 1.58 | 1.59 | .43 | |
| | Lack of Faith | 1.00 | 1.00 | 1.05 | 1.24 | 1.12 | .007* | |
| | God's Will | 1.07 | 1.00 | 1.05 | 1.23 | 1.13 | .17 | |

** Significant with p-value < .05; ** Significant with p-value < .005;*

Table A8

Case Scenarios Etiology: Means and One-Way ANOVA p-values for Different Religious Groups

| | | Prot | Cath. | Jew. | CJC-LDS | Oth. | Total | p-val. | p-val. BTW groups |
|---|---|---|---|---|---|---|---|---|---|
| Case 1: Emotionally Troubled Person | Weak Personality | 1.06 | 1.18 | 1.00 | 1.22 | 1.00 | 1.16 | .49 | |
| | Chemical | 1.80 | 1.80 | 1.75 | 2.08 | 1.80 | 1.96 | .54 | |
| | Life Stress | 3.00 | 3.18 | 2.25 | 2.96 | 3.00 | 2.97 | .44 | |
| | Genetic | 2.13 | 2.11 | 2.33 | 2.04 | 2.00 | 2.08 | .93 | |
| | Family Upbringing | 2.33 | 2.33 | 2.00 | 2.10 | 1.80 | 2.15 | .52 | |
| | Bad Influence | 1.60 | 2.11 | 2.33 | 1.85 | 1.80 | 1.85 | .33 | |
| | Lack of Faith | 1.12 | 1.27 | 1.00 | 1.37 | 1.00 | 1.27 | .34 | |
| | God's Will | 1.06 | 1.27 | 1.00 | 1.16 | 1.00 | 1.14 | .58 | |
| Case2: Person with Schizophrenia | Weak Personality | 1.00 | 1.09 | 1.00 | 1.10 | 1.00 | 1.07 | .61 | Bad Influen: $p_{1\text{-}2}$=.02 |
| | Chemical | 4.00 | 3.80 | 4.00 | 3.70 | 3.60 | 3.78 | .29 | |
| | Life Stress | 3.00 | 2.90 | 2.00 | 2.84 | 3.60 | 2.89 | .13 | |
| | Genetic | 3.56 | 3.00 | 3.67 | 3.39 | 3.40 | 3.39 | .43 | |
| | Family Upbringing | 1.25 | 1.80 | 1.67 | 1.37 | 1.40 | 1.41 | .17 | |
| | Bad Influence | 1.06 | 1.80 | 1.33 | 1.39 | 1.60 | 1.39 | .04* | |
| | Lack of Faith | 1.00 | 1.09 | 1.00 | 1.08 | 1.00 | 1.06 | .84 | |
| | God's Will | 1.12 | 1.09 | 1.00 | 1.23 | 1.00 | 1.17 | .81 | |
| Case 3: Person with Substance Use Disorder | Weak Personality | 1.65 | 1.73 | 1.33 | 1.76 | 1.00 | 1.67 | .48 | |
| | Chemical | 2.50 | 2.70 | 2.67 | 2.86 | 2.80 | 2.76 | .79 | |
| | Life Stress | 3.18 | 3.27 | 2.75 | 3.18 | 3.40 | 3.18 | .79 | |
| | Genetic | 3.29 | 2.89 | 2.67 | 3.04 | 3.00 | 3.06 | .61 | |
| | Family Upbringing | 2.13 | 2.56 | 3.33 | 2.23 | 2.40 | 2.3 | .27 | |
| | Bad Influence | 2.07 | 2.70 | 3.33 | 2.33 | 2.40 | 2.37 | .28 | |
| | Lack of Faith | 1.18 | 1.18 | 1.33 | 1.60 | 1.00 | 1.42 | .13 | |
| | God's Will | 1.00 | 1.09 | 1.00 | 1.07 | 1.00 | 1.05 | .89 | |
| Case 4: Person with Depression | Weak Personality | 1.06 | 1.18 | 1.00 | 1.23 | 1.00 | 1.16 | .50 | Bad Influen: $p_{1\text{-}7}$=.05 |
| | Chemical | 3.29 | 3.55 | 3.00 | 3.35 | 3.20 | 3.34 | .84 | |
| | Life Stress | 3.07 | 3.09 | 3.33 | 2.98 | 3.80 | 3.07 | .28 | |
| | Genetic | 2.94 | 2.89 | 3.00 | 2.90 | 3.00 | 2.91 | .99 | |
| | Family Upbringing | 1.63 | 2.11 | 2.67 | 1.65 | 2.00 | 1.76 | .11 | |
| | Bad Influence | 1.38 | 2.11 | 1.67 | 1.52 | 2.40 | 1.62 | .02* | |
| | Lack of Faith | 1.00 | 1.09 | 1.00 | 1.26 | 1.00 | 1.16 | .13 | |
| | God's Will | 1.12 | 1.09 | 1.00 | 1.20 | 1.00 | 1.15 | .84 | |

** Significant with p-value < .05; ** Significant with p-value < .005;*

Appendix B

The Study Questionnaire

Demographics Questions:

Gender: ○ Male; ○ Female

Age: ○18-25; ○26-35; ○36-45; ○46-55; ○56-64; ○ 65 +

Race/Ethnicity:

○ Black (non-Hispanic);
○ White (non-Hispanic);
○ Hispanic;
○ Asian;
○ Native American/Pacific Islander;
○ Other

Education Level:

○ Less than High school;
○ High school diploma;
○ Some college/2 year degree;
○ Bachelor's degree;
○ Post-graduate studies/degrees

Do you consider yourself religious?

○ Not at all; ○ Little bit Religious; ○ Moderately Religious; ○ Very Religious

Religion:

○ Protestant (please specify);
○ Catholic;
○ Eastern Orthodox (please specify);
○ Jewish (please specify);
○ Muslim;
○ Church of Jesus Christ of Latter-day Saints;
○ Other

Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-SF)

Please read each statement carefully and check a box that indicates how much you agree or disagree with a given statement.

| Questions | 1<br>Disagree | 2<br>Somewhat Disagree | 3<br>Somewhat Agree | 4<br>Agree |
|---|---|---|---|---|
| If I believed I was having a mental breakdown, my first inclination would be to get professional attention | ○ | ○ | ○ | ○ |
| The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts | ○ | ○ | ○ | ○ |
| 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 | ○ | ○ | ○ | ○ |
| 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 | ○ | ○ | ○ | ○ |
| I would want to get psychological help if I were worried or upset for a long period of time | ○ | ○ | ○ | ○ |
| I might want to have psychological counseling in the future | ○ | ○ | ○ | ○ |
| A person with an emotional problem is not likely to solve it alone, he or she is likely to solve it with professional help | ○ | ○ | ○ | ○ |
| Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me | ○ | ○ | ○ | ○ |
| A person should work out his or her own problems; getting psychological counseling would be a last resort | ○ | ○ | ○ | ○ |
| Personal and emotional troubles, like many things, tend to work out by themselves | ○ | ○ | ○ | ○ |

Did you have any previous experience with psychological therapy? ○ Yes; ○ No

How would you rate that experience?

○ Very Good; ○ Good; ○ Neither Good nor Bad; ○ Bad; ○ Very Bad;
○ Prefer not to answer

How successful you feel that experience was?

○ Very Successful; ○ Somewhat Successful; ○ Neutral; ○ Somewhat Unsuccessful;
○ Very Unsuccessful; ○ Prefer not to answer

Treatment Fear (Thoughts About Psychotherapy Survey – TAPS)

In filling out the following survey, we would like you to imagine that you have decided to see a therapist for a personal problem. Please answer the following questions to indicate what will be your level of concern or worry about following aspects of participating in psychological treatment.

| Statements | 1<br>Not at all Concerned | 2<br>Mildly Concerned | 3<br>Moderately Concerned | 4<br>Rather Concerned | 5<br>Very Concerned |
|---|---|---|---|---|---|
| Is psychotherapy what I need to help me with my problems? | ○ | ○ | ○ | ○ | ○ |
| Will I be treated more as a case than as a person in psychotherapy? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist be honest with me? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist take my problems seriously? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist share my values? | ○ | ○ | ○ | ○ | ○ |
| Will everything I say in psychotherapy be kept confidential? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist think I'm a bad person if I talk about everything I have been thinking and feeling? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist understand my problem? | ○ | ○ | ○ | ○ | ○ |
| Will my friends think I'm abnormal or weird for coming? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist think I'm more disturbed than I am? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist find out things I don't want him/her to know about me and my life? | ○ | ○ | ○ | ○ | ○ |
| Will I learn things about myself I don't really want to know? | ○ | ○ | ○ | ○ | ○ |
| Will I lose control of my emotions while in psychotherapy? | ○ | ○ | ○ | ○ | ○ |
| Will the therapist be competent to address my problem? | ○ | ○ | ○ | ○ | ○ |
| Will I be pressured to do things in psychotherapy I don't want to do? | ○ | ○ | ○ | ○ | ○ |
| Will I be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now? | ○ | ○ | ○ | ○ | ○ |
| Will I be pressured into talking about things that I don't want to? | ○ | ○ | ○ | ○ | ○ |
| Will I end up changing the way I think or feel about things or the world in general? | ○ | ○ | ○ | ○ | ○ |
| The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general. | ○ | ○ | ○ | ○ | ○ |

Extrinsic/Intrinsic Religiosity Revised Scale

Please rate your level of agreement with each of following statements about your religious views and practices.

| Questions | 1<br>Strongly Disagree | 2<br>Somewhat Disagree | 3<br>Neither Agree nor Disagree | 4<br>Somewhat Agree | 5<br>Strongly Agree |
|---|---|---|---|---|---|
| I enjoy reading about my religion. | ○ | ○ | ○ | ○ | ○ |
| I go to church because it helps me to make friends. | ○ | ○ | ○ | ○ | ○ |
| It doesn't much matter what I believe so long as I am good. | ○ | ○ | ○ | ○ | ○ |
| It is important to me to spend time in private thought and prayer. | ○ | ○ | ○ | ○ | ○ |
| I have often had a strong sense of God's presence. | ○ | ○ | ○ | ○ | ○ |
| I pray mainly to gain relief and protection. | ○ | ○ | ○ | ○ | ○ |
| I try hard to live all my life according to my religious beliefs. | ○ | ○ | ○ | ○ | ○ |
| What religion offers me most is comfort in times of trouble and sorrow. | ○ | ○ | ○ | ○ | ○ |
| Prayer is for peace and happiness. | ○ | ○ | ○ | ○ | ○ |
| Although I am religious, I don't let it affect my daily life. | ○ | ○ | ○ | ○ | ○ |
| I go to church mostly to spend time with my friends. | ○ | ○ | ○ | ○ | ○ |
| My whole approach to life is based on my religion | ○ | ○ | ○ | ○ | ○ |
| I go to church mainly because I enjoy seeing people I know there. | ○ | ○ | ○ | ○ | ○ |
| Although I believe in my religion, many other things are more important in life. | ○ | ○ | ○ | ○ | ○ |

A Revised Religious Fundamentalism Scale

Please read each statement carefully and check a box that indicates how much you agree or disagree with a given statement.

| Statements | -2<br>Strongly Disagree | -1<br>Somewhat Disagree | 0<br>Neither Agree nor Disagree | +1<br>Somewhat Agree | +2<br>Strongly Agree |
|---|---|---|---|---|---|
| God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed. | ○ | ○ | ○ | ○ | ○ |
| No single book of religious teachings contains all the intrinsic, fundamental truths about life | ○ | ○ | ○ | ○ | ○ |
| The basic cause of evil in this world is Satan, who is still constantly and ferociously fighting against God. | ○ | ○ | ○ | ○ | ○ |
| It is more important to be a good person than to believe in God and the right religion. | ○ | ○ | ○ | ○ | ○ |
| There is a particular set of religious teachings in this world that are so true, you can't go any "deeper" because they are the basic, bedrock message that God has given humanity. | ○ | ○ | ○ | ○ | ○ |
| When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God; and the rest, who will not. | ○ | ○ | ○ | ○ | ○ |
| Scriptures may contain general truths, but they should NOT be considered completely, literally true from beginning to end | ○ | ○ | ○ | ○ | ○ |
| To lead the best, most meaningful life, one must belong to the one, fundamentally true religion. | ○ | ○ | ○ | ○ | ○ |
| "Satan" is just the name people give to their own bad impulses. There really is no such thing as a diabolical "Prince of Darkness" who tempts us. | ○ | ○ | ○ | ○ | ○ |
| Whenever science and sacred scripture conflict, science is probably right | ○ | ○ | ○ | ○ | ○ |
| The fundamentals of God's religion should never be tampered with, or compromised with others' beliefs. | ○ | ○ | ○ | ○ | ○ |
| All of the religions in the world have flaws and wrong teachings. There is no perfectly true, right religion | ○ | ○ | ○ | ○ | ○ |

Opinions of Religious People about Psychology and Psychotherapy

In this section we are interested about your opinions and feelings about these statements; there is no right or wrong answer. Please rate your level of agreement or disagreement with each of the following statements.

| Statements | 1<br>Strongly Disagree | 2<br>Somewhat Disagree | 3<br>Neither Agree nor Disagree | 4<br>Somewhat Agree | 5<br>Strongly Agree |
|---|---|---|---|---|---|
| I think psychology looks down on religion and religious people | ○ | ○ | ○ | ○ | ○ |
| If I see psychotherapist he/she has to be of same or similar religious belief as I am | ○ | ○ | ○ | ○ | ○ |
| My faith should be enough to help me deal with all my emotional and psychological problems | ○ | ○ | ○ | ○ | ○ |
| I have heard my religious leaders talk about mental illness | ○ | ○ | ○ | ○ | ○ |
| Psychotherapist not of my faith or similar religion will not be respectful of my beliefs | ○ | ○ | ○ | ○ | ○ |
| Live in the world but don't be part of the world (worldly values) | ○ | ○ | ○ | ○ | ○ |
| I think that my religious leaders can help with all emotional and psychological problems I might have | ○ | ○ | ○ | ○ | ○ |
| I believe that one can be healed through faith/miracle/prayer | ○ | ○ | ○ | ○ | ○ |
| I would see psychotherapist if I feel I need one | ○ | ○ | ○ | ○ | ○ |
| I feel that teachings of psychology go against my religious values | ○ | ○ | ○ | ○ | ○ |
| I feel like religious people are becoming minority in a modern world | ○ | ○ | ○ | ○ | ○ |
| My religious leaders encourage people to seek professional psychological help if they need it | ○ | ○ | ○ | ○ | ○ |
| I will rather talk with my religious leader about my problems than with psychotherapist. | ○ | ○ | ○ | ○ | ○ |
| Psychology teachings and religious teachings are not very compatible | ○ | ○ | ○ | ○ | ○ |
| I will see psychotherapist if my religious leader recommended me to see one | ○ | ○ | ○ | ○ | ○ |
| The world is becoming less friendly and accepting of religious people and religious values | ○ | ○ | ○ | ○ | ○ |
| Sometimes talking to religious leader (pastor, priest, rabbi, imam) is not enough and one has to turn to mental health professional for help. | ○ | ○ | ○ | ○ | ○ |

Etiology of Mental Illness

In the following 4 sections you will be presented with stories of 4 different people. Please read each story carefully and then answer questions presented to you. There is no right or wrong answers; we are interested in your opinions about questions we ask.

Case Scenario 1: Regular Life Trouble

Sarah's Story: Up until a year ago, life was pretty okay for Sarah. While nothing much was going wrong in Sarah's life she sometimes feels worried, a little sad, or has trouble sleeping at night. Sarah feels that at times things bother her more than they bother other people and that when things go wrong, she sometimes gets nervous or annoyed. Otherwise Sarah is getting along pretty well. She enjoys being with other people and although Sarah sometimes argues with her family, Sarah has been getting along pretty well with her family.

Case Scenario 2: Schizophrenia

Dave's Story: Up until a year ago, life was pretty okay for Dave. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. Dave was convinced that people were spying on him and that they could hear what he was thinking. Dave lost his drive to participate in his usual work and family activities and retreated to his home, eventually spending most of his day in his room. Dave was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.

Case Scenario 3: Substance Abuse Disorder

John's Story: During the last month John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he became very agitated, sweaty and he couldn't sleep, so he took another drink. His family has complained that he is often hungover, and has become unreliable-making plans one day, and canceling them the next.

Case Scenario 4: Depression

Jane's story: For the past two weeks Jane has been feeling really down. She wakes up in the morning with a flat heavy feeling that sticks with her all day long. She isn't enjoying things the way she normally would. In fact nothing gives her pleasure. Even when good things happen, they don't seem to make Jane happy. She pushes on through her days, but it is really hard. The smallest tasks are difficult to accomplish. She finds it hard to concentrate on anything. She feels out of energy and out of steam. And even though Jane feels tired, when night comes she can't go to sleep. Jane feels pretty worthless and very discouraged. Jane's family has noticed that she hasn't been herself for about the last month and that she has pulled away from them. Jane just doesn't feel like talking.

Following questions were asked after each scenario is presented

In your opinion, how likely it is that following statements are true for *[Name]* situation

| Statements | Not at all likely | Somewhat likely | Moderately likely | Very likely |
|---|---|---|---|---|
| *[Name]* is experiencing "mental Illness" | ○ | ○ | ○ | ○ |
| *[Name]* is just experiencing regular troubles of life | ○ | ○ | ○ | ○ |
| *[Name]* will resolve his problems without help of others | ○ | ○ | ○ | ○ |
| *[Name]* would benefit from talking to somebody about his problems | ○ | ○ | ○ | ○ |
| *[Name]* needs some kind of medication | ○ | ○ | ○ | ○ |
| *[Name]* needs help from mental health professional | ○ | ○ | ○ | ○ |
| *[Name]* needs help from his primary health care doctor | ○ | ○ | ○ | ○ |

In your opinion, how likely it is that *[Name]* situation might be caused by a following?

| Etiology | Not at all likely | Somewhat likely | Moderately likely | Very likely |
|---|---|---|---|---|
| Weak personality or his own bad character | ○ | ○ | ○ | ○ |
| Chemical imbalance in the brain or some other physical problem | ○ | ○ | ○ | ○ |
| Stressful circumstances in the person's life | ○ | ○ | ○ | ○ |
| Genetic or inherited problem | ○ | ○ | ○ | ○ |
| Way person was raised | ○ | ○ | ○ | ○ |
| Bad influence from friends or family or environment | ○ | ○ | ○ | ○ |
| Not following God's laws or Lack of faith in God | ○ | ○ | ○ | ○ |
| God's will | ○ | ○ | ○ | ○ |

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