WHEN PRAYER IS NOT ENOUGH: THE MEDIATING ROLE OF MENTAL HEALTH LITERACY AND STIGMA FOR RELIGIOUS INDIVIDUALS' HELP-SEEKING ATTITUDES

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ABSTRACT

WHEN PRAYER IS NOT ENOUGH: THE MEDIATING ROLE OF MENTAL HEALTH LITERACY AND SELF-STIGMA ON RELIGIOUS INDIVUALS' HELP-SEEKING ATTITUDES

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Many individuals who suffer from psychological distress and mental illness experience barriers to seeking help, including an individual's level of mental health literacy and self-stigma of seeking help. Religious individuals have been observed to hold more negative attitudes towards seeking help, yet there is limited research exploring how mental health literacy (MHL) and self-stigma of seeking help as possible may explain this relationship. This study is aimed to investigate the relationship between religiosity and attitudes towards seeking professional psychological help, specifically addressing mental health literacy and self-stigma of seeking help in a serial mediation effects model. A cross-sectional study was conducted involving 278 adults (mean age = 27.47). Participants completed surveys assessing their religiosity, attitudes towards receiving professional psychological services, MHL, and self-stigma of seeking help. Findings revealed a significant negative direct effect of religiosity onto attitudes towards seeking professional psychological help (β = -0.10, *SE* = .04, $p < .05$, 95% CI [-0.18, -0.02]). However, findings also show a positive significant indirect effect of religiosity on attitudes towards seeking professional psychological assistance through the mediators of MHL and self-stigma (β = .04, Bootstrap*SE* = .01,

Bootstrap95% CI [0.01, 0.06]). Whereas individuals reported being more religious were more likely to have more mental health literacy and thus less self-stigma of seeking help. In turn, participants were more likely to have positive attitudes towards seeking professional psychological help. The results of this study highlight the intricate relationships between religiosity and attitudes towards seeking professional psychological assistance. Mental health providers should focus on the importance of MHL and self-stigma in their effects of religious individuals' attitudes towards seeking professional psychological help. Adapting approaches to religious individuals through way of increasing MHL and finding similarities or supplemental benefits of mental health practices in religious individuals' lives.

Introduction

An estimated 14.1 million adults (5.5% of U.S. adults) live with a serious mental illness, which severely impairs daily functions and limits one or more of their major life activities. Fortunately, psychological services can provide these individuals with a safe space to learn coping behaviors, collaboratively work through the troubles that they face, and find relief from their distress. However, there are many barriers to seeking psychological services in the U.S., both real and perceived. Among these barriers include stigmatizing beliefs and beliefs held by various religious groups that can downplay mental illness. Stigma and religious beliefs both have internal and external facets that can also impact an individual's daily experience. These examples can promote ineffective forms of relief and the discouragement to seek professional psychological assistance. Furthermore, religious groups might create barriers to seeking professional psychological assistance because of their lack of knowledge about mental health (i.e., poor mental health literacy). In the current research, we will explore the attitudes of religious individuals towards professional psychological assistance, and the role that mental health literacy, stigma, and age have explaining these attitudes.

Help-Seeking Behaviors

In 2021, an estimated 57.8 million adults live with a mental illness (Substance Abuse and Mental Health Services Administration, 2022). This makes up roughly 22.8% of the U.S. adult population. Unfortunately, only 44.6% of adults ages 18-25 years with any mental illness, 48.1% of those ages 26-49, and 47.4% of those ages 50+ received help via mental health services (Substance Abuse and Mental Health Services Administration, 2022).

Several individual differences can contribute to the increased likelihood that someone will not seek professional psychological assistance. For example, the degree of severity one

experiences can negatively influence the intentions to seek out mental health services, such that increased severity decreases the likelihood of seeking help. Additionally, for younger individuals, having a history of anxiety, increasing depressive symptoms, and feelings of hopelessness were found to be associated with lower intentions to seek professional psychological assistance (Calear et al., 2021; Wilson & Deane, 2010). For those who experience suicidal ideation, even at a subclinical level, intentions to seek help for their suicidal ideation was lower than those who reported no suicidal thoughts (Wilson & Deane, 2010). However, even though the number and severity of symptoms may hinder help seeking, help seeking behaviors are increased when these symptoms begin to impede other areas of their life. In a three-year longitudinal study, functional impairment showed to be the strongest predictor of help-seeking behavior among middle adulthood individuals living with mental illness (Doll et al., 2021). Though professional mental health services serve to provide relief from struggles experienced, it seems to be as individual's severity of mental health problems increase, they are less likely to reach out to mental health services until having noticeable difficulties in other important aspects of their daily life.

Along with an individual's level of functioning, there are many other barriers to seeking treatment that one can experience. In interviews with younger individuals, Eigenhuis and colleagues (2021) identified that limited accessibility to services can also inhibit them from seeking help for their mental distress. In addition to the practicality of being able to access mental health services, they also found that individuals with reduced insight and understanding of the signs of mental distress impeded them from seeking help. Finally, many individuals reported attitudes and stigmatizing beliefs held by their community to be major barriers to them seeking assistance. This includes both attitudes held by themselves (e.g., shame for seeking help,

personal attitudes towards treatment) and perceived attitudes held by those around them (i.e., fear of being pitied or bullied, others not understanding their experiences). One significant body that might stigmatize mental health and create barriers to help seeking is religious communities.

Religiosity and Help-Seeking

Religion plays an integral part in constructing both individual and cultural beliefs; therefore, religious beliefs may contribute to attitudes of mental health seeking and possibly limit religious individual’s formal help seeking behaviors. However, understanding religion has proven to be a troubling matter for historians, anthropologists, and psychologists alike, in that religion encompasses a global array of multifaceted beliefs and attitudes. Religion can include the supernatural, various forms of beliefs in God/gods, finite and infinite number of supernatural deities and entities, and a set practices, beliefs and rituals that totally defy any single definition (Hood et al., 2018). Furthermore, religion encompasses joining communities and contexts that might impact these shared beliefs. At a societal level, religion can be seen as communities that base non-falsifiable beliefs on traditions that are authoritatively transmitted from generation to generation (Cox, 2009). This covers how these culturally based beliefs are shared between individuals and are often non-disputable. On a personal level, Pargament (2002) defines religion as the search for significance via various pathways that are all somehow related to the sacred. The sacred can include ideas of a higher power, God, the divine, or a sense of transcendence. This definition also includes the many pathways that individuals can take to come to find significance, including beliefs, behaviors, relationships with others, and personal feelings. However, the term religiosity specifically indicates the intensity, importance of, commitment to, or intensity in which the individual holds these religious beliefs (Huber & Huber, 2012).

This search for significance and finding communities that share beliefs is a goal for many individuals across the world, especially in the United States. According to a 2020 census conducted by the Public Religion Research Institute (2021), about 7 in every 10 Americans identify as a Christian. To be noted many of the theories and frames of thinking on religion throughout this study is steeped in Western religious bodies, primarily Judeo-Christian ideologies. These ideologies dominate the religious disciplines of the U.S. and provide a basis for many societal frameworks in the Western world. Religion is an integral part in the culture of the U.S., being woven into political, moral, and interpersonal identities. In addition to these shared belief systems and individual identity, religion can link an individual to a community and sociocultural context, e.g., a group of believers or a church/synagogue/mosque. Religion and spirituality provide a structured guide to life through established practices, beliefs and attitudes, goals, and values (Dein, 2013). Furthermore, religion and spirituality can dictate how individuals cope with difficult life circumstances, such as mental health difficulties.

Religion can provide a structured guide to help the user attain meaning and direction through difficult life circumstances. And these religious coping strategies, like spiritual support and appraisals of life events (Dein, 2013), might be used by religious individuals in lieu of professional psychological assistance. Religious coping strategies have further been divided into both positive and negative styles of coping, that can have varying effects on one’s mental health. Positive coping styles reflect those that are based on a secure relationship with God or what the individual deems as sacred (Pargament et al., 2011). Conversely, negative religious coping strategies are steeped in tension, conflict, and struggles with the sacred/God (Pargament et al., 2011).

Pargament (1997) elaborated that there are 5 main functions that religious coping serves, which might further explain this unlikelihood that religious individuals will seek professional psychological assistance. These include: finding meaning, gaining control, gaining comfort from God, finding intimate relationships with others, and catalyzing life transformations. Control and responsibility over life is a major aspect that is entwined in one's relationship with God. Three styles of responsibility-taking have been observed. The self-directing approach puts responsibility on the individual to cope with difficulties. The collaborative approach has the individual assume responsibility while also having expectations that God will be a partner in the coping process. The final approach is the deferring approach, in which the individual puts all expectations on God to intervene and achieve coping (Pargament, 1997). All 5 of these religious coping styles create expectations for the individual to not seek formal mental health assistance; however, religious individuals who use the deferral coping approach are even less likely to seek professional psychological assistance (Wamser et al., 2011).

Furthermore, individuals who are religious may tend to 'spiritualize' their psychological distress, which might also lead to less formal mental health help seeking. This deferral coping strategy may lead to them leaving their troubles to God or feel the need to increase their religious practice (e.g., pray more, raise church attendance, change behaviors). This is done to reconcile with God so that they may find relief from their psychological distress rather than reach out for professional psychological assistance (Lloyd et al., 2022). Spiritualizing distress is highlighted by a process known as the 'Spiritual Bypass' (Welwood, 1986). This process is characterized by avoiding difficult emotions, developmental tasks, and psychological issues by spiritual/religious means or practices. Those who are reported as having a higher sense of religiosity have shown to more frequently engage in spiritual bypassing (Fox et al., 2020). Religiosity, when using

negative religious coping strategies and the process of spiritual bypass, has been observed to have a role in religious individuals' attitudes and preferences towards seeking help from professional psychological services for their distress.

There is a seemingly complex relationship between religion and individuals' mental health outcomes. Religiosity has shown to have profound effects in the lives of those experiencing difficulties and those with mental illness. Through these religious coping strategies those with mental disorders like depression or those living with substance abuse have been observed to find relief from their frustrations and symptoms (Smith et al., 2003; Koenig & Larson, 2001; Tepper et al., 2001). In fact, out of 87 patients diagnosed with depression, those who reported having more religiosity were significantly more likely to have a faster remission of their depressive symptoms (Koenig et al., 1998). Though we see these improvements in quality of life and life satisfaction (Koenig & Larson, 2001; Stroppa et al., 2018), these improvements are marked by the use of positive religious coping strategies. Specifically, it has been observed that those who are more religious may be more likely to perceive support from God, in turn this may have individuals be more likely to experience less psychological distress (Lloyd & Reid, 2022). Also, religiosity and religious involvement has been seen to be significantly associated with having more social support (Koenig & Larson, 2001). These intricacies of the relationship between religiosity and mental health are seemingly to be tied to the types of religious coping strategies that the individual takes. While we see more positive outcomes for those who are religious, these better outcomes seem to be underscored by the use of positive religious coping strategies. Whereas those who report practicing more positive religious coping strategies have been observed to have better outcomes in their physical, mental and social health, as well as environmental security (Stroppa et al., 2018). Conversely, individuals who perform negative

religious coping strategies have reported higher rates of depressive symptoms, and worse outcomes for their mental health (Harrison et al., 2001; Stroppa et al., 2018). These negative coping strategies are often associated with an avoidance of the psychological distress (i.e., the spiritual bypass), which could be an explanation for why these styles of coping are associated with less help seeking from psychological assistance (Wamser et al., 2011). The outcomes and need for additional support are seemingly tied to the relationship that one holds with their religion and the styles of coping that an individual takes. There are also influences of the group and individual beliefs that one holds that could further augment these relationships.

Religious individuals' beliefs may also lead to further spiritualizing mental health in ways that apply to the causes and treatments of mental illness. Dietz and Lorona (2023) have found that in a college sample of religious individuals, those reporting more religiosity were more likely to hold beliefs that mental illness (e.g., anxiety) were the result of sin or immorality. They also observed that these religious individuals were more likely to attribute a spiritual cause to mental illness and favor spiritual treatment. In turn, the belief in spiritual causes and treatment were also associated with an increase in stigma towards having to seek help from a mental health provider, and they were less likely to be willing to seek psychological treatment. In addition, religious fundamentalism, the practice of applying literal interpretations of religious teachings to key aspects of life (Razaghi et al., 2020), has been associated with higher intentions to seek religious assistance rather than professional psychological assistance (Wamser et al., 2011). An example of scripture that can been interpreted to discredit the science of psychology reads, "O Timothy, keep that which is committed to thy trust, avoiding profane and vain babblings, and oppositions of science falsely so called" (King James Version Bible, 1959, I Timothy 6:20). Using literal interpretations of this scripture can generate an understanding that psychologists'

expert knowledge of science is nothing more than a rebuttal against the teachings of faith imbued in sin (Powlison, 1993). This interpretation can then lead to the belief that prayer, repentance, and faith are more viable means to alleviate distress and discredit modern understandings of mental health troubles in favor of a 'spiritualized' way of understanding (Sullivan et al., 2014). Thus, individuals may seek religious assistance to facilitate divine intervention rather than seeking out professional psychological assistance for their distress (Wamser et al., 2011).

Furthermore, different religious affiliations might also predict less professional psychological help seeking. Research has shown that those who identify as Protestant Christians have shown to have an increased tendency to engage in religious belief-based attributions of psychological distress and deferral methods, emphasizing a preference for informal or religious based interventions. Individuals reporting Protestant affiliation often had a delay in treatment for symptoms of psychosis when compared to those who identified as unaffiliated (Moss et al., 2006), possibly due to increased rate of deferral of health outcomes to divine power. Hayward and colleagues (2017) observed that Evangelical Protestants were observed to report an increased engagement in divine health deferral, the perception that God is ultimately in control of health outcomes and passively awaiting intervention, as well as the belief in miraculous healing events when compared to other religious orientations. Specifically, Evangelical Protestants showed to have a higher rate of these deferral style coping strategies when compared to other denominations of Christianity, religious groups not defined under Christianity, and those that reported no religious affiliation. These findings also noted that divine health deferral was reported most among White, Evangelical Christians, whereas, Black individuals of all religious affiliations reported more divine health deferral. While the existing research theorizes potential reasons why religious individuals seek less professional psychological assistance (i.e., low

socioeconomic status, less knowledge), there is a dearth of research that has directly examined why and how this connection exists.

Mental Health Literacy as a Mediator

As noted earlier, research has indicated that poor mental health literacy (MHL) generally is a barrier to seeking formal psychological help (e.g., Eigenhuis et al., 2021); thus, MHL might also explain why religious individuals seek less formal psychological help. Jorm and colleagues (1997) defined MHL as having a broad understanding of mental health, including: being able to recognize the symptoms of mental disorders, understanding how to seek information regarding psychological distress and the experience of mental disorders, understanding risks and causes of mental illness, how to personally manage mental disorders, knowledge of available professional psychological assistance and how to seek it out, and having a set of attitudes that emphasize the recognition of mental illness and appropriate help-seeking behaviors. And existing research generally shows that poor MHL explains less professional mental health help-seeking.

In particular, Thorne and Ebener (2020) compared how rural adults with poor MHL and high religiosity independently predicted professional mental help seeking. They found that rural adults' knowledge about mental illness showed to be the only significant predictor of willingness to seek psychological help for emotional distress, such that rural adults with lower MHL were less willing to seek psychological help. Although they found that MHL predicted willingness to seek professional help more than religiosity in rural adults, researchers did not examine the indirect effects of religiosity through the mechanism of MHL on professional psychological assistance. This work suggests that past experience, an understanding of mental health and the therapeutic process can increase an individual's propensity to seek professional psychological

services. And this experience and knowledge can alleviate the ambiguity surrounding counseling, therapy, and psychology.

Furthermore, individuals who have previously experienced psychological counseling and rated their counseling experience as helpful have shown to hold more positive attitudes towards mental health help-seeking (Kakhnovets, 2011). This is highlighted in a meta-analysis of 18 previous studies of psychosocial variables and help-seeking intentions among college students. Researchers found that having a positive attitude towards seeking professional psychological assistance, as well as the belief that psychological services are useful were associated with a greater help-seeking intention (Wenjing et al., 2014). In addition to the attitudes and beliefs of potential clients, mental health staff have noted a misunderstanding of services provided by mental health professionals to be a barrier to seeking mental health support (Pullman et al., 2010).

Along with the general adult population, when research has examined the MHL of religious individuals, specifically religious leaders, many religious officials have been shown to have little MHL and an increased likelihood to recommend spiritual alternatives to relief. Interviewed clergy members reported feeling unprepared in the recognition and treatment of mental illness, yet most had the tendency to provide counseling for problems presented to them (Farrell & Goebert, 2008). Moreover, Gouniai and colleagues (2022) found that though many clergy members rated their MHL as ‘good’ or higher, nearly two thirds of their sample did not correctly identify obsessive compulsive disorder (OCD) when studying a vignette presenting OCD-specific symptoms. Additionally, while most of the clergy in the sample correctly attributed the symptoms presented as clearly a mental health condition, a majority indicated that pastoral/biblical counseling as the most effective option for treatment. Thus, clergy may be more

likely to misinform their practitioners and misdirect them to seek pastoral/biblical counseling in lieu of professional psychological assistance, further explaining the low levels of professional psychological help seeking. This misinformation and the recommendation of spiritual relief could aid in the development of misleading beliefs regarding seeking professional psychological assistance.

Stigma as a Mediator

In addition to poor MHL and general lack of knowledge, erroneous knowledge, beliefs, and attitudes might also contribute to the failure to seek professional psychological assistance and explain religious individuals' hesitancy in seeking professional psychological assistance. Public stigma are various negative beliefs, stereotypes, and attitudes associated with a certain group that are commonly endorsed throughout one's own culture and society (Zuckerman et al., 2018; Pescosolido et al., 2013). If an individual within this group is exposed to these beliefs often enough, they may begin to apply such stereotypes and beliefs to themselves, as they begin to fear and anticipate stigmatizing responses from others (Barney et al., 2010). This can then lead to the individual developing an increased self-stigma, an internal process in which the individual believes that these culturally spread beliefs are then applicable to themselves and direct these judgments from society towards themselves. (Pearl et al., 2017; Overton & Medina, 2008).

Public and self-stigma can be applied to groups with mental health concerns and for those who seek mental health services. Public stigma for receiving psychological services has often been reported by adults to be a barrier to seeking mental health services (Topkaya, 2015; Pullman et al., 2010). Furthermore, public stigma of mental illness can lead to an internalization of these beliefs, which might result in self-stigma of seeking professional psychological assistance. It has been observed that those who have an increased self-stigma of seeking

psychological assistance hold more negative views on themselves when seeking professional treatment (Vogel et al., 2006; Rojas-Viches et al., 2011). Having this increased self-stigma can predict negative attitudes towards seeking professional psychological assistance and a willingness to seek services for psychological concerns in the future (Vogel et al., 2007). This is seen in that those who have more negative attitudes toward mental illness, and beliefs that mental illness cannot be treated, hold more negative attitudes towards seeking mental health services (Rojas-Viches et al., 2011).

These negative beliefs could be tied to having increasing religiosity. Those who align with Christian Fundamentalists ideas reported higher stigma towards mental illness, often reporting that mental illnesses were a result of immoral or sinful behavior (Wesselmann & Graziano, 2010). Crosby & Bossley (2012) found that for individuals who reported high religiosity, they tended to show preference for seeking support from religious bodies (i.e., clergy) for their psychological distress. Individuals with high religiosity also showed more negative attitudes towards seeking help from professional psychological services. By being part of a religious community that also holds these inaccurate views of mental health, religious individuals also would repeatedly hear of and interact with individuals that hold beliefs that stigmatize individuals with mental illness. They can then begin to internalize these beliefs, increasing their self-stigma. Which can then lead to the individual to also having reservations about seeking help for their personal psychological struggles, and possibly be more apt to seek help from informal sources of assistance (i.e., religious leaders).

Furthermore, stigma might help explain why individuals with decreased MHL have fewer psychological help seeking behaviors. Such that individuals who know less of mental health or have inaccurate views of mental health might be more fearful and/or have inaccurate perceptions

of individuals with mental illness. Subsequently, this could increase stigma and negative beliefs/stereotypes of these individuals. Whereas those with higher levels of MHL have shown to have a more positive attitude toward seeking professional psychological assistance and perceive less stigma in their immediate environment (Doğan et al., 2021). Thus, religious individuals, with lower MHL, might experience increased stigma, and as a result be less likely to seek professional psychological assistance.

Age Effects

Furthermore, the relation between religiosity, MHL, stigma, and professional psychological help-seeking might also be impacted by age. Extant research has shown that age has been observed to influence the attitudes and intentions of seeking professional psychological assistance. Older adults' public stigma perceptions were more likely to be associated with self-stigma of seeking professional psychological assistance. This, in turn, was more likely to be associated with negative attitudes towards seeking professional assistance for older adults (Mackenzie et al., 2019).

Meanwhile, emerging adults have been observed to hold more positive attitudes towards seeking mental health services when compared to older individuals (Farrer et al., 2008). In an international study of treatment contact for mental illness, younger individuals were found to have a higher probability for treatment contact in many countries for anxiety disorders, mood disorders, and substance use disorders (Wang et al., 2007). Younger generations seem to hold more positive, accepting views of individuals with mental illness which may be why they have fewer stigmatizing beliefs surrounding mental health treatment. When compared to their parents, young adults reported those with mental illness to be less dangerous. They also believed that mental illnesses were more treatable, perceived less stigma attached to both mental illness and

help-seeking behaviors, and were significantly more willing to pursue professional psychological assistance (Rojas-Viches et al., 2011).

Thus, emerging adults have also shown a shift in religiosity as there has been a decline in religious attendance in recent decades, giving way to more spiritual practices (e.g., meditation; Smith & Snell, 2009). Though this increase in unaffiliated status regarding religion has been observed across all age groups in America, it has been the most substantial for young adults. In 1986, 10% of adults between ages 18-29 identified themselves as religiously unaffiliated. This number hit its peak in 2016 at 38% yet has slightly slowed as of 2020 (36%; Public Religion Research Institute, 2021). This decrease in religiosity within younger generations may be why there is a higher acceptance of secular explanations of mental health and seeking professional psychological assistance in this population.

In addition to less religiosity, emerging adults also might have increased MHL, which may explain their increased likelihood of seeking professional psychological assistance. College students with higher scores of MHL were likely to have better attitudes toward help-seeking which enhanced their intentions to seek professional assistance (Kim et al., 2020). In a sample of Korean adults living in South Korea, Lee and colleagues (2017) showed that overall health literacy was negatively associated with age. Individuals 65 and over had less MHL than those ages 40-64, and those ages 40-64 had lower MHL than those ages 20-40.

Although there are fewer emerging adults who are religious, because they are in a generation of individuals who have increased MHL and mental help seeking, the few religious emerging adults might not conform to the model of formal mental help seeking. The younger religious individuals might experience less of these personal and public stigmas associated with mental health and thus have increased MHL and formal psychological help seeking. Therefore,

the models examining the effects of religiosity on formal psychological help seeking, indirectly through MHL, should include a comparison of emerging adults and older adults.

Current Study

While research has established that religious individuals are less likely to seek professional psychological assistance, there is a paucity of research examining how and why religiosity affects psychological help seeking. Thus, the current study uses a cross-sectional online survey regarding participants' attitudes towards seeking professional psychological help, their religiosity, level of MHL, and self-stigma regarding professional psychological seeking help. In addition, due to research suggesting that religious affiliation/religious fundamentalism, age, and gender might also generate differences in help seeking, these are included as covariates. On the basis of religiosity affecting individuals help-seeking attitudes and behaviors, Hypothesis 1 predicts that individuals who have increased religiosity will have decreased MHL. Having decreased MHL will then be associated with decreased help seeking intentions for professional psychological assistance. Furthermore, considering the relationship that MHL has on individuals' attitudes towards seeking professional psychological assistance, Hypothesis 2 predicts that decreased MHL will predict increased self-stigma toward mental health services, because less knowledge about mental health would allow inaccurate beliefs to appear. And since self-stigma is associated with poorer intentions to seek professional assistance, Hypothesis 3 predicts a serial-effects model, such that self-stigma will also act as a mediator of MHL. Such that religious individuals will have decreased MHL, and thus increased self-stigma, as a result, will lead individuals to be less likely to seek professional psychological assistance. Regarding age effects, Hypothesis 4 predicts that in contrast to the model for older adults (i.e., 60+ years old), younger adults (i.e., <60 years old) who are religious will have increased MHL and have less self-stigma

regarding mental health help-seeking and have more positive attitudes towards seeking professional psychological assistance. (See Figure 1).

Methods

Participants

Participants (*N* = 344) were recruited through various means, including the SONA system at Western Carolina University, posting to social media (Reddit, Facebook, Personal account postings), personal contacts, flyers placed at community centers (e.g., Churches, Local libraries, etc.). Postings to social media included public groups focused on psychology, research recruitment, and religious groups (e.g., r/Psych_religion, r/SciencePlusReligions, r/psychology, r/SampleSize). Participants were asked to complete a collection of online surveys regarding demographic information, religiosity, attitudes towards help seeking, self-stigma and MHL through Qualtrics. Participants provided demographic information pertaining to the study including age, race, gender, ethnicity, education level, income level, and religious affiliation. After excluding those that had missing data and those that identified as unaffiliated, the final sample consisted of 278 adults (mean age = 27; men = 132, women = 138, 2 transgender, 4 non-binary, 2 chose not to respond). Of these 278 adults the majority were white (*n* = 206, 74.1%), lived in an urban community (*n* = 207, 74.5%), and had completed some college (*n* = 93, 33.5%). Participants were also given the opportunity to provide their religious affiliation, in which the majority of participants were Catholic (Catholic = 79, 28.4%; Protestant Christian = 75, 27%; Muslim = 33, 11.9%, Buddhist = 32, 11.5%; Jehovah's Witness = 21, 7.6%; Jewish = 10, 3.6%; Mormon = 10, 3.6%; Other = 10, 3.6%; Hindu = 8, 2.9%). Participants who reported as another religious affiliation that was not listed were given the opportunity to write-in their religious affiliation identification. Responses that were deemed as having no religious beliefs or more

spiritual practices were removed. For example, those that were included in the final analysis included those that identified as pagan, belonging to the Church of Latter-day Saints, and those that wrote in Christian affiliation. For the purposes of this study, those that had self-identified as Jewish were included as this pertained to their faith, rather than their ethnic identity. Upon completion, participants were able to enter a drawing for one of four $25 dollar Amazon gift cards. See Appendix A for demographic questionnaire.

Materials

Professional Psychological Help-Seeking. The Attitudes Toward Seeking Professional Psychological Help short form (ATSPPH-SF; Fischer & Farina, 1995) is a 10-item measure of individuals attitudes towards seeking professional assistance when experiencing psychological troubles (see Appendix B). The measure was shortened and revised from its original 29-item length (Fischer & Turner, 1970) for sake of brevity yet retains the psychometric features of the original scale. Items are scored on a 4-point Likert scale with final scores ranging from 0, indicating more negative attitudes towards seeking professional psychological assistance, to 30, indicating more positive attitudes towards seeking help. Example items include: “I would want to get psychological help if I were worried or upset for a long period of time”, and “A person should work out his or her own problems; getting psychological counseling would be a last resort”. Original factor structure conducted by Fischer and Farina (1975) concluded that the 10 items supported a univariate structure. Cronbach’s α ranging from .76 to .84 (Fischer & Farina, 1975; Elhai et al., 2008; Thorne & Ebener, 2020; Doğan et al., 2021). For the current study, Cronbach’s α is .70.

Religiosity. The Santa Clara Strength of Religious Faith Questionnaire (SCSORF; Plante & Boccaccini, 1997) is a 10-item measure used to observe reported strength of religious faith,

regardless of denomination (See Appendix C). Items are scored on a 4-point Likert scale format. Scores range from 10 to 40, where scores of 10 denote an individual holding low faith and 40 denote an individual holding high faith. Example items from the SCSORF include: “My religious faith is extremely important to me”, and “My faith impacts many of my decisions”. The SCSORF has shown excellent internal consistency reliability within both young adults and older adults (Cronbach’s α = .95-.96; Storch et al., 2004; Cummings et al., 2015). Research has also indicated that the SCSORF supports a univariate factor structure measuring religious faith (Freiheit et al., 2006). For the current study, Cronbach’s α is .94.

Mental Health Literacy. Mental health literacy was measured using the Mental Health Literacy Scale (MHLS; O’Conner & Casey, 2015) (see Appendix D). The MHLS is a 35-item measure used to observe knowledge in mental health and the attitudes that individuals hold toward mental health and help-seeking. Items are formatted on either a 4- or 5-point Likert scale, and scores can range from 35 (low MHL) to 160 (High MHL). These items aim to measure 6 attributes of MHL, such as the ability to recognize specific disorders, knowledge of risk factors and causes of mental disorders, and knowledge of how to seek out information regarding mental health (O’Conner & Casey, 2015). Items include: “To what extent do you think that it is likely that the diagnosis Agoraphobia includes anxiety about situations where escape may be difficult or embarrassing”, “To what extent do you think it would be helpful for someone to avoid all activities or situations that made them feel anxious if they were having difficulties managing their emotions”. Authors of the scale have noted that the MHLS supports a univariate structure, and the 35-items have good internal reliability (α = .87; O’Conner & Casey, 2015). The MHLS has also been shown to have good internal consistency when observing both young adult students and older adults with Cronbach’s alphas ranging from .85 to .86, respectively (Digal & Gagnon,

2020). The MHLS will be slightly revised in that the original questionnaire refers to Australia, whereas the current study will be used in an American sample. For the current study, Cronbach's α is .90.

Self-Stigma. Self-stigma was assessed using the Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) (see Appendix E). The SSOSH is a 10-item measure of individuals self-stigma associated with seeking professional psychological assistance, scored using a 5-point Likert scale (strongly disagree, disagree, agree & disagree equally, agree, strongly agree). Example of an item include "I would feel inadequate if I went to a therapist for psychological help." Robust developmental studies of the SSOSH determined that the measure displayed strong reliability with Cronbach's alphas ranging from .89 to .91. The SSOSH has also shown strong reliability within both younger adults (α = .84; Lannin et al., 2023) and older adults (α = .83; Mackenzie et al., 2019). For the current study, Cronbach's α is .81.

Statistical Procedure

To observe the effects that religiosity, MHL, and stigma have on attitudes towards professional psychological help seeking, a serial mediation analysis was performed. This is appropriate as we will be able to observe mutually exclusive effects while controlling for covariate variables, and thus estimate direct and indirect effects. Using multiple linear regression in IBM SPSS Statistics (v.28.0.1.0; 2021) with the PROCESS add-on (v.4.3; Hayes, 2022), we examined changes in variance explained with professional psychological help seeking as the outcome, using a serial mediation analyses to assess the indirect effects of MHL and self-stigma on the relationship between religiosity and attitudes towards seeking professional psychological services. Because the current study hypothesized differences in the model by age, the model was separately run for emerging adults and older adults.

Results

Descriptive statistics of the sample are presented in Table 1. All variables in these analyses were normally distributed with skew and kurtosis less than 5.0. Next, we then completed preliminary correlational analyses for attitudes towards seeking help, religiosity, MHL, and self-stigma of seeking help (see Table 2). Religiosity and attitudes towards seeking help were not significantly correlated, $r = .06$, $p = .36$. Thus, participants' levels of religiosity have no relationship with their attitudes towards seeking help for mental health difficulties when including the possible effects of participants MHL and self-stigma of seeking help. However, religiosity was significantly correlated with MHL and self-stigma of seeking help in directions opposite of what were predicted. Religiosity and MHL were significantly and positively correlated ($r = .16$, $p < .01$). Religiosity and Self-Stigma for seeking help were also significantly and negatively correlated ($r = -.26$, $p < .001$). These results suggest that participants who have more religiosity also reported having higher MHL and lower self-stigma towards seeking help.

Focal Analyses

A bootstrapping method was performed using model 6 of the SPSS Process Macro to test the serial mediation where religiosity predicts attitudes towards seeking help from a mental health provider, mediated through MHL and self-stigma of seeking help. We report the indirect effect for the mediation model, specifically the effect of indirect pathway three which indicates the mediated pathway through MHL, and self-stigma described in the model. We report unstandardized β coefficients and 95% confidence intervals for the effects. 95% CI of the indirect effects were obtained using 5,000 bootstrap samples, and CI levels indicate that an indirect effect is significant if zero does not fall within this range. The PROCESS macro also

allows for covariate variables to be controlled for when running analyses. For the purposes of this study, the controlled covariates include age and gender.

Path coefficients for the tests of mediation are presented in Table 3 and Figure 1. All pathways of the model (religiosity to MHL; MHL to self-stigma of seeking help; MHL to attitudes towards seeking help; self-stigma of seeking help to attitudes towards seeking help; religiosity to attitudes towards seeking help) were significant. Religiosity showed a significant direct effect when controlling for participants MHL and self-stigma that supported the current model, such that reporting a higher level of religiosity predicted having more negative attitudes towards seeking help, $c' = -0.10$, $SE = 0.04$, $t(272) = -2.49$, $p < .05$, 95% CI [-0.18, -0.02]. However, in contrast to the direction of Hypothesis 1, the results of the regression analysis indicated that individuals with more religiosity predicted increased MHL, $a_1 = 0.53$, $SE = 0.16$, $t(274) = 3.31$, $p < .01$, 95% CI [0.21, 0.85]. Next, MHL was a significant predictor self-stigma of seeking help, $d_{21} = -0.17$, $SE = 0.02$, $t(273) = -7.71$, $p < .001$, 95% CI [-0.21, -0.13]. Third, self-stigma of seeking help, and MHL were significant predictors of attitudes towards seeking help. In support of our hypothesized pathways, those participants who reported higher MHL predicted more positive attitudes towards seeking help, $b_1 = 0.07$, $SE = 0.02$, $t(272) = 4.23$, $p < .001$, 95% CI [0.04, 0.10]. Also, in support of predicted pathways, those participants who reported more self-stigma of seeking help predicted more negative attitudes towards seeking help, $b_2 = -0.40$, $SE = 0.04$, $t(271) = -9.96$, $p < .001$, 95% CI [-0.47, -0.32].

The results of the indirect effect based on 5,000 bootstrap samples indicated religiosity indirectly predicted attitudes towards seeking help serially through MHL and self-stigma of seeking help. In contrast to the hypothesized directions of these pathways, results indicated a significant positive indirect relationship between religiosity and attitudes towards seeking help,

mediated by MHL and self-stigma, $a_1 d_{21} b_2$ = .04, Bootstrap *SE* = .01, Bootstrap 95% CI [0.01, 0.06]. This could also possibly explain the nonsignificant correlational associations between religiosity and attitudes towards seeking professional psychological help. Whereas as positive significant indirect effect through the mediators of MHL and self-stigma was observed in contrast to a significant negative direct effect of religiosity onto attitudes towards seeking help, thus suppressing the total effect and correlation between the two variables (MacKinnon et al., 2000). The findings of the analysis therefore supported a serial mediation of the effect of religiosity to attitudes towards seeking help through MHL and self-stigma of seeking help. However, the direction of this effect was opposite of what was predicted, such that participants with increased religiosity predicted more MHL and less self-stigma, which predicted better attitudes towards seeking help from a mental health provider.

Discussion

While other studies have sought to establish the link between religiosity and mental help seeking, our study was the first to examine the mechanisms that might explain this relationship. The results were significant, but not in the direction we originally hypothesized. Participants with more religiosity were associated with having increased mental health literacy and decreased self-stigma. Thus, these findings do not support Hypothesis 1 and are in contrast to previous research. Thorne and Ebener (2020) had found that religiosity was associated with individuals having less MHL. However, their sample examined participants who resided primarily in rural areas. The present study possibly found these contrasting associations due to a majority of our participants residing in urban areas in which a higher access to care could be available. It is possible that individuals who live in urban areas have increased MHL and acceptance of seeking mental health services and this is strengthened by their religiosity.

In support of Hypothesis 2 and 3, participants with increased mental health literacy and decreased self-stigma were more likely to report having more positive attitudes towards seeking help. This supported and was in the direction of the current hypotheses and is in accordance with previous research (Vogel et al., 2007). Furthermore, results showed a significant indirect effect of mental health literacy and self-stigma partially explaining the relationship between religiosity and mental help seeking. Thus, individuals who are more religious are more likely to have more MHL and less self-stigma, which then predicts more positive attitudes towards mental help seeking. While the indirect effect of religiosity significantly predicted mental health help seeking, it was in the opposite direction of predicted effects. These results clearly portray a very complex picture of the relation between religiosity, mental health literacy, self-stigma, and professional mental help seeking.

Unfortunately, we were unable to address hypothesis 4 and complete the analysis of this model when comparing emerging adults to older adults due to a limited number of older adults who participated in this study. While we controlled for age in our model, age was not a significant predictor of attitudes towards seeking professional mental health. The opposite direction of our findings thus could be attributed to our younger adult demographic (mean age of our sample was 27.47, although the range was from 18-81 years old). In a sample of Korean adults, younger adults displayed increased MHL compared to older adults (Lee et al., 2017). Young religious individuals' personal preferences, attitudes, and intentions to seek out mental health providers may be high due to generational differences in mental health acceptance and increased mental health literacy and reduced self-stigma of mental help seeking. Yet when considering previous research, their samples might have only included older generations that fit

the directions of our hypotheses. Due to our sample, the current model shows significant relationships yet differs from what was expected.

Limitations and Future Directions

Conclusions of this research should be considered within the following limitations. As a result of too few older participants responding to this study, analyzing this model comparing older to younger adults was unable to be completed. When recruiting our study, we recognized that older old adults might not be as likely to respond to online questionnaires or be a part of the online community for recruitment. We tried to encourage this population to participate by providing paper and pencil surveys distributed directly by known individuals; however, this recruitment strategy ultimately provided limited responses. The lack of older old participants and less internet savvy participants could also explain why results showed such associations between religiosity, MHL, and self-stigma of seeking help. For future research directions, it would be beneficial to address these beliefs in an older adult population using paper-pencil recruitment strategies in rural areas to observe the hypothesized direction of effects and age effects on the model.

Additionally, a large portion of our sample identified as either Catholic or Protestant Christian. The beliefs and attitudes towards seeking help discussed could be concentrated to only specific subgroups within these religious affiliations. Specifically, fundamentalists could be a subgroup of Christian faith where these relationships exist, as they hold more extreme negative attitudes towards professional help of any kind outside of their religion (Wasmer et al., 2011). For future research, it would be beneficial to observe the differences in beliefs between these religious affiliations and specifically attempt to recruit participants from fundamentalist or groups considered more extreme. While we only analyzed the level of mental health literacy that

these individuals hold, there could be other held beliefs within their identified religions that could also change the observed relationships. These religious individuals may hold beliefs that pertain to a spiritualization of mental health, whereas they may believe that the sources of psychological distress are of spiritual origin – possibly explaining the direct negative relationship found between religiosity and attitudes towards seeking psychological help (Dietz & Lorona, 2023). Individuals' specific beliefs regarding mental illness, it's causes and forms of treatment, and perceived support from their faith could also be further analyzed to find any moderating effects on the relationship between religiosity and attitudes towards seeking professional psychological help.

It also is observed that there is a complex relationship between religiosity, mental health outcomes, styles of coping, and willingness to receive psychological services. The present research focused primarily on the commitment or intensity in which people believe in their practiced religion. First, there have been clear observations in which religiosity has been associated with more positive outcomes in life regarding life satisfaction, and less psychological distress (Smith et al., 2003; Koenig & Larson, 2001; Tepper et al., 2001). While there has been an observed relationship between religiosity and the spiritualization of mental health (Lloyd et al., 2022; Fox et al., 2020), it seems that the ways in which individuals interact with their religion in regard to their mental health has differing outcomes. Whereas those that practice more positive religious coping mechanisms may be more likely to interact with their mental health in a beneficial way albeit through spiritual means (Stroppa et al., 2018). Furthermore, the specific negative religious coping strategies like the spiritual bypass and the deferral approach of religious coping may be the biggest attributor to more negative attitudes towards receiving psychological services. This relationship could be due to the focus on avoidance of psychological

distress and a lack of personal responsibility taken in regard to managing psychological distress. In future research, it would be beneficial to further observe religious individuals' styles of coping with their psychological distress as a potential moderator of the relationships observed in the present research. There is a possibility that by analyzing the ways in which religious individuals cope with their psychological distress could present contrasting relationships to those that were observed. Whereas those individuals practicing self-directing or collaborative styles of religious coping would have more positive attitudes towards receiving psychological services as they would see it as their personal duty to seek assistance to manage their psychological distress.

The included analyses also do not include individuals that identify as unaffiliated with a religion. The Public Religion Institute (2021) identified that religiously unaffiliated has become the majority group for religious affiliations, at 24%, within the United States. Similarly, 19% of participants that responded to the current study also identified as unaffiliated. It would be beneficial in future research to compare differences in MHL, self-stigma, and attitudes towards seeking help within this population and those that identify with a religious affiliation.

Furthermore, this data is cross-sectional and only observes these individuals' beliefs, attitudes, and knowledge at one time-point, which does not allow us to examine developmental changes in these attitudes and beliefs. By observing individuals' attitudes towards seeking help and self-stigma of seeking help over a longer period of time, we might better determine how beliefs and attitudes could shift over time accounting for individual differences and better explore the impact of age on these relationships.

Conclusions

The present study is one of the first attempts to explain the relationship between religiosity and attitudes towards seeking professional mental help by examining a serial

mediation model that included the indirect effects of mental health literacy and self-stigma. This study contributes to the growing body of research that addresses the intersection of religion and mental health services and attempts to clarify our understanding of the barriers that many of these individuals face. The findings of this study can further assist to improve mental health providers in their outreach to religious individuals and incorporate the importance of religiosity into their practices: (a) participants high religiosity predicted a higher MHL; (b) having a higher MHL predicted less self-stigma; (c) having a high MHL and low self-stigma predicted more positive attitudes of seeking help; (d) individuals who are more religious are more likely to have more MHL and less self-stigma, which thus predicts more positive attitudes towards mental help seeking. Mental health providers should work to show the similarities and additional benefits of secular practices of mental healthcare. Additionally, the current data can encourage mental health providers to find ways to incorporate religious/spiritual practice within their work for religious individuals to foster more positive attitudes towards seeking a mental health provider. Overall, the current study highlights the importance for mental health providers to recognize the impacts that religiosity has on attitudes towards seeking help and to adapt their approaches accordingly to these populations.

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Table 1. *Sample Sociodemographic & Variable Characteristics*

Variable	Value
Mean (*SD*) age, range	27.47 (8.87), 18-81
Gender (%)	
Male	132 (47.5%)
Female	138 (49.6%)
Trans	2 (0.7%)
Non-binary	4 (1.4%)
Education (%)	
Some high school	10 (3.6%)
High school or GED	60 (21.6%)
Some college	93 (33.5%)
Associate degree	33 (11.9%)
Bachelor’s degree	60 (21.6%)
Master’s degree	19 (6.8%)
Doctorate	3 (1.1%)
Race (%)	
Native American or Alaska Native	44 (15.8%)
Asian	7 (2.5%)
Black or African American	13 (4.7%)
Multi-racial	3 (1.1%)
Native Hawaiian or Pacific Islander	3 (1.1%)
White	206 (74.1%)
Other	1 (0.4%)
Type of community (%)	

Urban	207 (74.5%)
Rural	70 (25.2%)
Religious Affiliation (%)	
Buddhist	32 (11.5%)
Catholic	79 (28.4%)
Hindu	8 (2.9%)
Jehovah's Witness	21 (7.6%)
Jewish	10 (3.6%)
Mormon	10 (3.6%)
Muslim	33 (11.9%)
Protestant Christian	75 (27%)
Other	10 (3.6%)
Mean (*SD*) Religiosity (SCSRFQ)	29.64 (5.79)
Mean (*SD*) MHL (MHLS)	107.96 (15.91)
Mean (*SD*) Self-stigma (SSOSHS)	26.32 (6.37)
Mean (*SD*) Attitudes towards seeking help (ATTSPH-SF)	26.50 (4.73)

Table 2. *Descriptives and Correlations of Focal Variables.*

	Mean	*SD*	Correlations			
			1	2	3	4
1. Attitudes towards help seeking	26.50	8.87	--			
2. Religiosity	29.64	4.73	.06	--		
3. MHL	107.96	5.79	.44†	.16**	--	
4. Self-stigma	26.32	15.91	-.60†	-.26†	-.46†	--
5. Age	27.47	6.37	.04	.06	-.16**	.07
6. Gender	1.59	2.90	.11	-.13*	.17**	-.09

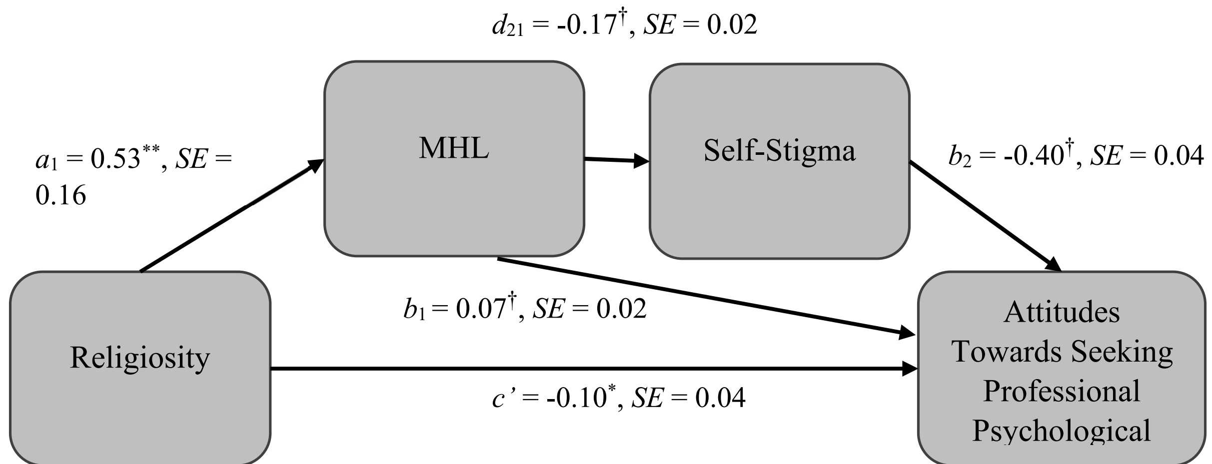
* $p < .05$, ** $p < .01$, † $p < .001$

Table 3. *Direct and Indirect Effects of Religiosity, MHL, and Self-Stigma on Attitudes Towards Seeking Help.*

Relationship	Effect	*SE*	*t*	*p*	95% CI	
					Lower	Upper
Direct Effects						
Religiosity→ATTSPH[1]	-0.10^{*}	.04	-2.49	.01	-0.18	-0.02
Religiosity→MHL[2]	0.53^{**}	.16	3.31	.00	0.22	0.86
Religiosity→Self-stigma	$-0.21^{\dagger}$	.06	-3.59	.00	-0.33	-0.10
MHL→Self-stigma	$-0.17^{\dagger}$	.02	-7.71	.00	-0.21	-0.13
MHL→ATTSPH	$0.07^{\dagger}$	.02	4.23	.00	.04	.10
Self-stigma→ATTSPH	$-0.40^{\dagger}$	.04	-9.96	.00	-0.47	-0.32
Indirect effects						
Religiosity→MHL→ATTSPH	0.04	.02			0.00	0.08
Religiosity→Self-stigma→ATTSPH	0.08	.03			0.02	0.15
Religiosity→MHL→Self-stigma→ATTSPH	0.04	.01			0.01	0.06

$^{*}p < .05$, $^{**}p < .01$, $^{\dagger}p < .001$, [1]Attitudes towards seeking professional help, [2]Mental Health Literacy

Figure 1. *Relationship & serial mediation model for Religiosity, MHL, Self-Stigma, and Attitudes Towards Professional Mental Health Services.*



c' = -0.10, *SE* = 0.04, $t(272) = -2.49$, $p < .05$, 95% CI [-0.18, -0.02]

a_1 = 0.53, *SE* = 0.16, $t(274) = 3.31$, $p < .01$, 95% CI [0.22, 0.86]

b_1 = 0.07, *SE* = 0.02, $t(272) = 4.23$, $p < .001$, 95% CI [0.04, 0.10]

b_2 = -0.40, *SE* = 0.04, $t(272) = -9.96$, $p < .001$, 95% CI [-0.47, -0.32]

d_{21} = -0.17, *SE* = 0.02, $t(273) = -7.71$, $p < .001$, 95% CI [-0.21, -0.13]

Indirect pathway 3

$a_1d_{21}b_2$ = 0.04, Bootstrap*SE* = 0.01, Bootstrap95% CI [0.01, 0.06]

Appendix A

Demographic Questionnaire

1. What is your gender?

   ___ Man

   ___ Woman

   ___ Trans

   ___ Non-Binary

   ___ Other, Please specify: ____________________

2. What is your age? ____________________

3. What is your race?

   ___ American Indian or Alaska Native

   ___ Asian

   ___ Black or African-American

   ___ Multi-racial

   ___ Native Hawaiian or Other Pacific Islander

   ___ White

   ___ Other, Please Specify: ____________________

4. What is your ethnicity?

   ___ Hispanic or Latino

   ___ Not Hispanic or Latino

   ___ Other, Please specify: ____________________

5. What is your current marital status?

   ___ Single (never married)

___ Married

___ In a partnership

___ Divorced

___ Widowed

6. What is your highest level of education?

___ High school or GED

___ Associate degree

___ Bachelor’s Degree

___ Master’s Degree

___ Doctorate

___ Other, Please specify: ____________________

7. What is your current employment status?

___ Full-time employment (40+ hours a week)

___ Part-time employment (Less than 40 hours a week)

___ Unemployed

___ Student

___ Retired

___ Self-employed

8. What is your current yearly income level?

___ Less than $10,000

___ $10,000 to $19,000

___ $20,000 to $29,000

___ $30,000 to $39,000

___ $40,000 to $49,000

___ $50,000 to $59,000

___ $60,000 to $69,000

___ $70,000 to $79,000

___ $80,000 to $89,000

___ $90,000 to $99,000

___ $100,000 to $149,999

___ $150,000+

9. What is your religious affiliation?

___ Buddhist

___ Catholic

___ Hindu

___ Jehovah's Witness

___ Jewish

___ Mormon

___ Muslim

___ Protestant Christian (e.g., Baptist, Lutheran, Methodist, Pentecostal, etc.)

___ Unaffiliated

___Other, Please Specify: ____________________

Appendix B

Attitudes Toward Seeking Professional Psychological Help – Short Form

Please rate to what degree you agree or disagree with each statement using the scale below.

0 = disagree

1 = partly disagree

2 = partly agree

3 = agree

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

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

Appendix C

Santa Clara Strength of Religious Faith Questionnaires

Please answer the following questions about religious faith using the scale below.

Indicate the level of agreement (or disagreement) for each statement.

1 = strongly disagrees

2 = disagree

3 = agree

4 = strongly agree

1. My religious faith is extremely important to me.
2. I pray daily.
3. I took my faith as a source of inspiration.
4. I took to my faith as providing meaning and purpose in my life.
5. I consider myself active in my faith or church.
6. My faith is an important part of who I am as a person.
7. My relationship with God is extremely important to me.
8. I enjoy being around others who share my faith.
9. I took to my faith as a source of comfort.
10. My faith impacts many of my decisions.

Appendix D

Mental Health Literacy Scale

The purpose of these questions is to gain an understanding of your knowledge of various aspects to do with mental health. When responding, we are interested in your degree of knowledge. Therefore, when choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

1. If someone became extremely nervous or anxious in one or more situations with other people (e.g., a party) or performance situations (e.g., presenting at a meeting) in which they were afraid of being evaluated by others and that they would act in a way that was humiliating or feel embarrassed, then to what extent do you think it is likely they have **Social Phobia**
2. If someone experienced excessive worry about a number of events or activities where this level of concern was not warranted, had difficulty controlling this worry and had physical symptoms such as having tense muscles and feeling fatigued then to what extent do you think it is likely they have **Generalized Anxiety Disorder**
3. If someone experienced a low mood for two or more weeks, had a loss of pleasure or interest in their normal activities and experienced changes in their appetite and sleep then to what extent do you think it is likely they have **Major Depressive Disorder**
4. To what extent do you think it is likely that **Personality Disorders** are a category of mental illness.

5. To what extent do you think it is likely that **Dysthymia** is a disorder.
6. To what extent do you think it is likely that the diagnosis of **Agoraphobia** includes anxiety about situations where escape may be difficult or embarrassing.
7. To what extent do you think it is likely that the diagnosis of **Bipolar Disorder** includes experiencing periods of elevated (i.e., high) and periods of depressed (i.e., low) mood.
8. To what extent do you think it is likely that the diagnosis of **Drug Dependence** includes physical and psychological tolerance of the drug (i.e., require more of the drug to get the same effect)
9. To what extent do you think it is likely that in general, in the United States, **women are MORE likely to experience a mental illness of any kind compared to men.**
10. To what extent do you think it is likely that in general, in the United States, **men are MORE likely to experience an anxiety disorder compared to women.**

When choosing your response, consider that:

Very Unhelpful = I am certain that it is NOT helpful

Unhelpful = I think it is unhelpful but am not certain

Helpful = I think it is helpful but am not certain

Very Helpful = I am certain that it IS very helpful

11. To what extent do you think it would be helpful for someone to **improve their quality of sleep** if they were having difficulties managing their emotions (e.g., becoming very anxious or depressed)
12. To what extent do you think it would be helpful for someone to **avoid all activities or situations that made them feel anxious** if they were having difficulties managing their emotions.

When choosing your response, consider that:

Very unlikely = I am certain that it is NOT likely

Unlikely = I think it is unlikely but am not certain

Likely = I think it is likely but am not certain

Very Likely = I am certain that it IS very likely

13. To what extent do you think it is likely that **Cognitive Behavior Therapy (CBT)** is a therapy based on challenging negative thoughts and increasing helpful behaviors.
14. Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

    To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**: *If you are at immediate risk of harm to yourself or others.*
15. Mental health professionals are bound by confidentiality; however, there are certain conditions under which this does not apply.

    To what extent do you think it is likely that the following is a condition that would allow a mental health professional to **break confidentiality**: *If your problem is not life-threatening and they want to assist others to better support you.*

Please indicate to what extent you agree with the following statements:

Strongly Disagree

Disagree

Neither agree nor disagree

Agree

Strongly Agree

16. I am confident that I know where to seek information about mental illness.
17. I am confident using the computer or telephone to seek information about mental illness.
18. I am confident attending face to face appointments to seek information about mental illness.
19. I am confident I have access to resources (e.g., internet, friends) that I can use to seek information about mental illness.
20. People with a mental illness could snap out if it if they wanted.
21. A mental illness is a sign of personal weakness.
22. A mental illness is not a real medical illness.
23. People with a mental illness are dangerous.
24. It is best to avoid people with a mental illness so that you don't develop this problem.
25. If I had a mental illness, I would not tell anyone.
26. Seeing a mental health professional means you are not strong enough to manage your own difficulties.
27. If I had a mental illness, I would not seek help from a mental health professional.
28. I believe treatment for a mental illness, provided by a mental health professional, would not be effective.

Please indicate to what extent you agree with the following statements:

Definitely unwilling

Probably unwilling

Neither unwilling nor willing

Probably willing

Definitely willing

29. How willing would you be to move next door to someone with a mental illness?
30. How willing would you be to spend an evening socializing with someone with a mental illness?
31. How willing would you be to make friends with someone with a mental illness?
32. How willing would you be to have someone with a mental illness start working closely with you on a job?
33. How willing would you be to have someone with a mental illness marry into your family?
34. How willing would you be to vote for a politician if you knew they had suffered a mental illness?
35. How willing would you be to employ someone if you knew they had a mental illness?

Appendix E

Self-stigma of Seeking Help (SSOSH) scale

People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

Strongly disagree

Disagree

Agree & disagree equally

Agree

Strongly agree

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