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# Ambivalence Over Emotion Expression and the Effects of Religious Coping in African American Christians

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Abstract

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Abstract

African Americans are 10% more likely than non-Hispanic Whites to report having serious mental health issues from psychological stressors. Mental health concerns, such as depression and anxiety, that arise from psychological stressors, are more than likely to go untreated in African Americans. African Americans are more likely to turn to religion- their church, their pastors, and fellow parishioners to address these concerns. Religion and religious coping has influenced African Americans' attitudes regarding help-seeking and mental health treatment, with the "Black Church" historically being a source of many things, including mental health care. Pargament's theory of religious coping served as a theoretical framework to look at how religion and religious coping affected help-seeking attitudes as well as symptoms of depression and anxiety in African American Christians. How ambivalence over emotion expression (AEE) interacted with and moderated the relationship between religious coping and symptoms of depression and anxiety was also analyzed. Multivariate multiple regression was used to analyze the relationship between the variables positive religious coping, negative religious coping, AEE, help-seeking attitudes, and symptoms of anxiety and depression in African Americans. Positive religious coping had no significant interaction with help-seeking, symptoms of anxiety, or symptoms of depression. Negative religious coping was significant in predicting symptoms of anxiety and symptoms of depression, but not help-seeking attitudes. AEE moderated the relationship between positive religious coping and symptoms of anxiety and depression. Potential implications for social change from this research could be an increase in cultural competency for practitioners and help close the gap on the disparities between African Americans and non-Hispanic Whites in relation to mental health.

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# Dedication

My Christian background is one of the things that prompted this research, and I would be amiss not to thank God for the success of it before anything, and my mother, Savannah Williams for always having me in church and always believing in me, praying for me, and supporting whatever task I chose to take on. I would also like to acknowledge and dedicate this work to my grandfather who is no longer here physically but is forever with us. He always stressed the importance of education and laid the foundation for the success of his family in all areas, along with my grandmother who never stopped saying how proud she was of me during my very extensive journey through higher education. Thank you to my siblings-- Natalie, Lakito, Gwenshaunjala, and Kordaryl-- who were nothing but supportive and my biggest and proudest fans.

Thank you to my Golden Girls- Shakena, Karon, Shannon- who remained available to listen to me vent and continued to push me to completion. Thanks for all times you read sections I was unsure about, and the help and feedback you provided. I am most thankful for the encouragement and prayers.

For all the times that I was unmotivated and stagnant, I am grateful for the push from my big brother Dr. Tyson. Completing this was no small or easy feat for me, and resulted in a lot of my own stress, so I would like to acknowledge and thank Monica McNeil who continuously reminded me that I was more than capable of doing this while also stressing the importance of self-care.

For those who took the time to break with me and engage in whatever form of self-care needed, thank you. To everyone else who played a part in this success, whether big or small, prayers, thoughts, motivation, celebration- I am forever grateful. You all are my people!

I would also like to express my gratitude to my chair, Dr. Susan Rarick for all of the feedback and constructive criticism and patience. And to Dr. Alethia Baker, thank for your knowledgeable feedback before and during the dissertation process. The time and guidance you both provided me are greatly appreciated!

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# Chapter 1: Introduction to the Study

## Introduction

According to the U.S. Department of Health and Human Services Office of Minority Health (2017), African Americans are 10% more likely than non-Hispanic Whites to report having serious mental health issues due to psychological stressors. This number increases for those African Americans living below poverty, as they are three times more likely to make these reports. Factors such as social, economic, and physical health in the African American community greatly influence mental health; individuals who are more disadvantaged in society are more likely to experience distress than individuals who are more advantaged (Jang & Johnson, 2004). Stress from disadvantaged status and experiences with discrimination cause African Americans to be more distressed and increase their vulnerability to mental health disorders (Avent et al., 2015; Jang & Johnson, 2004). Moreover, because of stressors related to racism and economic disadvantage, African Americans are more distressed than other groups, especially non-Hispanic Whites (Jang & Johnson, 2004).

Compared to other groups, African Americans also have the greatest severity of mental illness that is not treated professionally (Cook et al., 2014). Stressors and other experiences of African Americans can result in symptoms of depression and anxiety. Despite the experiences with anxiety, depression, and other mental health disorders, most African Americans do not seek help from professional mental health services (Neighbors et al., 2007; Obasi & Leong, 2008). Numerous factors contribute to the disparities in mental health and mental health treatment among African Americans and non-Hispanic

Whites. Attitudes among African Americans about mental health and seeking treatment contribute to these disparities, specifically related to the avoidance of treatment (Alvidrez et al., 2008; Holden et al., 2012; Ward et al., 2009; Ward & Heidrick, 2009). Cultural barriers have shown to be a significant contributor to the attitudes and behaviors surrounding help-seeking among African Americans (Alvidrez et al., 2008; Thompson et al., 2004). Religion and religious coping are a major cultural factor within the African American community that may contribute to attitudes regarding help-seeking.

The Black Church has historically been a source of many things for African Americans, specifically where they go seeking mental health care. For years, African Americans have relied on religious and spiritual coping to address concerns related to depression, anxiety, and other mental health stressors (Chapman & Steger, 2010; Jang & Johnson, 2004). The Church has been beneficial for many African Americans in providing solace and promoting well-being, but it has also been a scapegoat for many African Americans to avoid professional treatment (Chapman & Steger, 2010; Holden et al., 2012; Ward et al., 2009; Ward & Heidrich, 2009). Although research has shown the positive effects of using the Black Church and its resources for emotional support and a sense of refuge, the research is insufficient regarding the effects of negative religious coping among this group and the effects of religious coping as a barrier to seeking professional treatment. In my study, I look specifically at how both negative and positive religious coping affects ambivalence over emotion expression (AEE) and anxiety that results from it.

## Background

Coping is making a conscious effort to solve personal and interpersonal problems while minimizing stress and conflict and increasing one's ability to cope with them. Religious coping is the same idea but understanding and dealing with life stressors in a way related to the sacred. Religious coping might include prayer, support of church members, pastoral care, and faith. Many people rely on religion as a way of understanding and dealing with difficult times that they may experience, as religion provides numerous psychological functions (Bryan et al., 2016; Singh & Madan, 2017). African Americans are well-known for relying on religion to help them cope with life stressors (Chapman & Steger, 2010; Jang & Johnson, 2004). Dempsey et al. (2016) pointed out that African Americans are more likely to rely on church officials than to seek out professionals for their mental health needs. There is the possibility of maladaptive consequences on one's mental health when an individual relies strictly on religious coping to respond to their stress and other mental health needs. Magyar-Russel and Griffith (2016) asserted, "Religion and spirituality can simultaneously be part of the solution to problems, part of the problem, and also the problem in and of itself" (p. 160). One problem that might result from religion and religious coping is emotion suppression or, more specifically, AEE.

AEE is defined as "An approach-avoidance conflict between the desire to show certain positive or negative emotions and the fear of negative consequences resulting from the expression of these emotions" (Trachsel et al., 2010, p. 142). According to Trachsel et al., the avoidance of expressing or experiencing emotion can deny some the

benefit from certain functions of emotions, such as being able to adjust to certain situations; therefore, ambivalence as it relates to expressing emotions has shown to be negatively related to mental health and contribute to social problems. The research on AEE as it relates to religion, however, is limited.

Bryan et al. (2016) investigated whether religious coping changes the interaction between AEE and symptoms of depression and anxiety. The researchers found a positive relationship between AEE and symptoms of depression and anxiety. In addition, they found that those who have higher levels of AEE and who are also more reliant on religious coping may experience more symptoms of depression and anxiety, as higher religious coping was shown to exacerbate the relationship between AEE and symptoms of distress (Bryan et al., 2016). Ahles et al. (2015) examined whether positive and negative religious coping would moderate the relationship between stress and depressive symptoms in young adults. The researchers found that negative religious coping did moderate the relationship between stress and symptoms of depression, specifically in those who reported high religious commitment. Positive religious coping was not found to be a buffer against the effects that stress has on symptoms of depression (Ahles et al., 2015). Chapman and Steger (2008) also found that positive religious coping served no protective role in reference to anxiety symptoms among African Americans.

My study fills a gap in research on the relationship of religious coping and mental health among African Americans. My study also fills a gap in research related to the effects of religious coping on anxiety and depression as a result of AEE. Hays and Lincoln (2017) pointed out the need to further study how religion acts as a resource

and/or a barrier to improving mental health among African Americans. My study addresses an underresearched area in religious coping among an underresearched population- African Americans (Xu, 2015). The results of the study provide insight into the relationship between religious coping and culture related to African Americans. The results also provide insight into the effects of religious coping on a population that relies highly on the method and reports higher rates of mental illness (Alegría et al., 2008). These insights may help to increase cultural competency among practitioners. The results could also lead to improved intervention strategies to attract African Americans to mental health services and close the gap on the disparities between African Americans and non-Hispanic Whites, while also facilitating positive social change.

## Problem Statement

African Americans have historically relied on the Black Church for several aspects of life, including mental health care. This reliance on religious and spiritual coping has been shown to provide a sense of solace and increased well-being (Chapman & Steger, 2010; Jang & Johnson, 2004). However, this reliance also highlights the tendency for African Americans to avoid professional mental health treatment in favor of the emotional refuge they receive from the Black Church (Holden et al., 2012; Ward et al., 2009; Ward & Heidrich, 2009). While research has shown the benefit of using the Black church as a source of emotional support and refuge, much of the research is lacking regarding the effects of negative religious coping, especially related to AEE and subsequent anxiety and/or depression. Research is also lacking in addressing the effects of religious coping as a barrier to seeking professional treatment.

Although religious beliefs can help an individual to understand and work through stressful situations, those same beliefs can also inhibit the coping process (Krok, 2015). According to Paragament et al. (2005), those beliefs can also be a source of stress. Magyar-Russell and Griffith (2016) pointed out that religiousness and spirituality can be a solution to problems but also part of the problem or the problem itself. According to Xu (2016), research has not been conducted to adequately address the relationship between religious coping and culture. Therefore, the problem is that despite knowledge of the importance of and benefits of positive religious coping on mental health, information is lacking on the effects of negative religious coping and its potential to exacerbate the effects of AEE on anxiety and depression among African Americans. In addition, knowledge is lacking on the extent of the effects of religious coping creating a barrier to treatment for African Americans and also potentially exacerbating symptoms of anxiety and depression.

## Purpose of the Study

The purpose of my study was to use quantitative methods to analyze the relationship between positive religious coping, negative religious coping, AEE, help-seeking attitudes, and symptoms of anxiety and depression among African American Christians. My intent was to determine whether positive and/or negative religious coping predict symptoms of anxiety, symptoms of depression, and help-seeking attitudes. I also intended to determine whether there were differences in these predictions with the addition of AEE. The specific variables of the study were positive religious coping, negative religious coping, AEE, symptoms of anxiety, symptoms of depression, and help-

seeking attitudes. With the prevalence of African Americans using religion as a means of coping, there is a need to determine the extent to which religion may keep African Americans from seeking treatment and whether religion also contributes to symptoms of anxiety and depression and the need for treatment among this population.

## Research Questions and Hypotheses

RQ1: Does positive religious coping predict help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$1: There is no significant relationship between positive religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$1: There is a significant relationship between positive religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

RQ2: Does negative religious coping predict help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$2: There is no significant relationship between negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$2: There is a significant relationship between negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

RQ3: Does AEE moderate the relationship between positive and/or negative religious coping and help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$3: AEE does not moderate the relationship between positive or negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$3: AEE does moderate the relationship between positive or negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

## Theoretical Foundation

The theoretical framework I used in this study was Pargament's (1997) religious coping model. Pargament described how religion can act within the coping process. Previous research has shown that "religiosity can be seen as an element of coping, a contributor to coping, and a product of coping" (James & Wells, 2003, p. 364); Pargament looked at the role of religion in each of these facets. Pargament's theory is impartial in that it looks at both the helpful roles of religion and the possible impediments of religion to the coping process. Pargament suggested that religion will differ in its advantages and disadvantages for people depending on their situation, including their resources, personal needs, and preferences (James & Wells, 2003).

Pargament (1997) suggested two types of religious coping: positive religious coping and negative religious coping. Pargament explained that positive religious coping are the things that show that an individual has a secure relationship with God, such as

praying, seeking God as a supportive partner, and forgiveness. Pargament explained negative religious coping as those things that show an individual has an insecure relationship with God, such as perceiving stressors to be punishment from God, trying to handle things on one's own, not seeking spiritual support, or passively waiting for God to remove a stressor from one's life. This theory on religious coping guided my research because of its use in explaining the positive and the negative forms of religious coping and how each may help or harm one's experiences with mental health issues.

## Nature of the Study

I used the quantitative method to test my hypotheses. I used multivariate multiple regression to examine the relationship between positive religious coping, negative religious coping, AEE, symptoms of anxiety, symptoms of depression, and help-seeking attitudes among African Americans Christians. Data were collected using the Brief RCOPE (Pargament, 1997), the Ambivalence over Emotional Expression Questionnaire (AEQ; King & Emmons, 1990), the Mental Help Seeking Attitudes Scale (MHSAS; Hammer et al., 2018), and the Patient Healthcare Questionnaire Anxiety-Depression Scale (PHQ-ADS; Kroenke et al., 2016).

## Operational Definitions

*African American*: A person having origins in any of the Black racial groups of Africa (Centers for Disease Control and Prevention, 2014).

*Ambivalence over emotion expression (AEE)*: The conflict that arises due to a desire to express emotions while simultaneously having a fear or struggle with doing so; AEE also refers to the regret of having expressed an emotion (King & Emmons, 1990).

*Anxiety (symptoms)*: Defined by the American Psychiatric Association (APA, 2013) as the "anticipation of future threat" (p. 189). The APA differentiates anxiety from fear in that one may experience muscle tension and vigilance as they prepare for a possible future danger, while demonstrating cautious and/or avoidant behaviors.

*The Black Church*: The "sociological and theological shorthand reference" to the variety of Black Christian churches in the United States typically controlled completely by African Americans (Lincoln & Mamiya, 1990, p. 1).

*Depression (symptoms)*: Defined by a persistent inability to foresee happiness or pleasure often accompanied by feelings of worthlessness and self-loathing. Depression is often associated with self-criticism and pessimistic ruminations (APA, 2013).

*Religion*: "A system of beliefs in a divine or superhuman power, and practices of worship or other rituals directed towards such a power" (Argyle & Beit-Hallahmi, 1975, p.1).

*Religious coping*: The use of religion to understand and deal with stress and critical life events. Religious coping is the religiously based cognitive, emotional, and behavioral response to stress, looking to God for strength and guidance (Pargament, 1997).

*Negative religious coping*: Religious coping strategies that demonstrate an insecure relationship with God and possible conflict with members of one's religious establishment. Negative religious coping includes not being content with one's religion, punishing God reappraisals, and demonic reappraisals (Pargament et al., 1998).

*Positive religious coping*: Religious coping that demonstrates a secure relationship in God and a spiritual connection with others. This includes such strategies as benevolent reappraisals, praying, and seeking spiritual support or guidance from the members of one's religious establishment, especially clergy (Pargament et al., 1998

## Assumptions

There were many assumptions made when completing this study. The first assumption was that everyone would be honest regarding their experience with anxiety and depression symptoms. I also assumed that everyone would be honest regarding their use of religious coping to work through these symptoms and how their use of religious coping may or may not prevent them from seeking professional mental health care. There was also the assumption that religious coping could be harmful (Pargament et al., 2013).

## Scope and Delimitations

African Americans are an underresearched population. My decision to focus on African American Christians in this research was due to a personal observation related to African Americans and the stigma of seeking professional mental health care and the lack of research on the role that religion plays with this stigma. All participants had to be at least 18 years old and identify as African American and Christian. Participants were recruited using social media. I only looked at African American Christians and not Christians from other ethnic groups. Due to the cultural aspect of the study as it relates to coping, sociocultural theory could have been used to guide the research as it proposes that the way in which one thinks about and interprets the world is shaped by social experiences (Jaramillo, 1996). However, because I was focused on specific forms of

religious coping within a certain group and less on how this group thinks about and interprets the world, Pargament's religious coping theory was used instead.

The key variables of the study were positive religious coping, negative religious coping, which were the independent variables; and anxiety symptoms, depression symptoms, help-seeking attitudes and AEE, which were the dependent variables. Questionnaires were used to collect data, which were analyzed using multivariate multiple regression to determine the relationship between religious coping and anxiety symptoms, depression symptoms, and AEE.

## Limitations

As with any research, there are some limitations that need to be addressed in this study. Although there were comparisons made to other ethnic groups, African Americans were the only group included in the study; there is no group in the study to make a comparison to. Other limitations were the grouping of several different denominations. I did not differentiate between the different denominations associated with the Black church and how this might affect beliefs, views, specific coping styles, and attitudes about mental health help-seeking.

This study was prompted by a personal observation growing up in the Black church, so there were potential biases that could influence the outcome of the study. One bias was my personal belief that African Americans do not seek professional mental health care because the Black church encourages African Americans to go to God for everything: "Tell God all about your problems; let go, let God; if God can't do it, it can't be done; PUSH- pray until something happens," and so many other cliché's that promote

seeking help only from God and the Church.. To address these potential biases, I relied specifically on research in the field related to religion and help seeking among African Americans. Each belief or bias I have about the Black church that may have come up during the study was addressed using research.

## Significance of the Study

My study attempted to fill a gap in research on the relationship of religious coping and culture. My study also attempted to fill a gap in research related to the effects of negative religious coping on anxiety and depression as a result of AEE. This project addressed an underresearched area in religious coping among an underresearched group: African Americans (Xu, 2015). The results of the study may provide insight into the relationship between religious coping and culture related to African Americans. The results also may provide insight into the effects of religious coping on a population that reports having higher rates of mental illness than non-Hispanic Whites, yet relies heavily on this method to address mental health needs (Alegría et al., 2008). These insights may help increase cultural competency among practitioners, may lead to improved intervention strategies to attract African Americans to mental health services, and may close the gap in mental health between African Americans and non-Hispanic Whites and facilitate positive social change.

## Summary

African Americans are likely to report having mental health issues and are also likely to turn to religious coping to respond to these mental health issues. Helping professionals must be aware of effective responses to their mental health needs, and

African Americans need to know how to effectively respond to their mental health needs and obtain professional care if necessary. Knowing whether religious coping is beneficial to a statistically significant degree is important and can contribute to cultural competency when it comes to treating African American patients. I sought to reach a better understanding of the relationship between religious coping and mental health among African American Christians by answering questions related to AEE and whether religious coping changes the relationship between AEE and anxiety and depression symptoms.

# Chapter 2: Literature Review

## Introduction

African Americans have historically relied on the Black church for various aspects of life, including mental health care. This reliance on religious and spiritual coping has been shown to provide a sense of solace and increased well-being (Chapman & Steger, 2010; Jang & Johnson, 2004), but it also highlights the tendency for African Americans to avoid professional mental health treatment in favor of the emotional refuge they receive at or from the Black church (Holden et al., 2012; Ward et la., 2009; Ward & Heidrich, 2009). While research shows the benefit of using the Black church as a source of emotional support and refuge, much of the research is lacking when it comes to the effects of negative religious coping, especially related to AEE and subsequent anxiety and/or depression. Research is also lacking in addressing the effects of religious coping as a barrier to seeking professional treatment.

This chapter consists of a discussion of the research that has been conducted to explore the issues of mental health in the African American Christian community, depression and anxiety symptoms in this community, AEE, and the use of religious coping as a preferred method of treatment for mental health concerns. The research discussed was conducted to look at the relationship between these variables and the need for further exploration to identify the interactions among them. Pargament's (1997) theory of religious coping is also discussed in this chapter, as it will be used to guide the research.

## Literature Search Strategy

To review the literature for this study, I conducted online searches using Walden University and South University libraries. The databases used were PsychINFO, PsychARTICLES, SocINDEX, ERIC, ProQuest, EBSCO, and JSTOR. Google Scholar was also used during the search. Some of the key words and terms used for the searches included: *religion, religious coping, spiritual coping, the Black Church, Christianity, depression, anxiety, mental health, help-seeking, coping, ambivalence over emotion expression, emotion suppression, mental health disparities,* and *RCOPE*. Other keywords/key phrases were *theory of religious coping* and *sociocultural theory*. The initial searches were limited to peer-reviewed articles published from 2008–2019; due to limited amounts of research in certain areas, the search was extended to articles published 2005–2008 as well.

## Theoretical Framework

Pargament's (1997) religious coping model explains the relationship of religion within the coping process. According to Pargament, the beliefs a person holds within their specific religion can be adapted into forms of coping. Pargament addressed religion as an element of coping, a contribution to coping, and a product of coping (James & Wells, 2003). Religious coping is a diverse and complex concept defined as a way that a person understands and manages negative life events and stressors related to the sacred (Pargament & Raiya, 2007).

African Americans have an extensive history of coping with life's stressors within the confines of the Black church due to many things such as stigma related to seeking

mental health care and distrust of the health care system (Hays, 2015; Obasi & Leong, 2009). The use of religious coping can prove helpful or harmful to African American Christians living with anxiety and/or depression. Pargament's theory is impartial- used to look at both the helpful roles of religion and also noting the possibility of religion impeding the coping process. Pargament suggested that religion will differ in its advantages and disadvantages for people depending on their particular situation, including their resources, personal needs, and preferences (James & Wells, 2003). The idea of religious coping being helpful or harmful is further explained in the assumptions discussed below.

**Assumptions of Religious Coping Theory**

There are seven assumptions on which Pargament's theory of religion and coping is based. For the purpose of this research, only four are relevant: "religious coping does not operate in a vacuum; religious coping has spiritual, psychological, social, and physical implications; religious coping can be both helpful and harmful; and religion can be more fully interwoven into efforts to help people" (Pargament & Raiya, 2007, pp. 743–745). With the first assumption, Pargament and Raiya pointed out that religious coping does not occur in seclusion, but rather, it often encompasses every part of a person's life. People use their attitudes, beliefs, goals, values, and practices to identify religious solutions to everyday problems and stressors, especially problems and stressors that go beyond what individuals can address using their everyday personal and social resources. This assumption of the theory also addresses the importance of religious

coping among different cultures. In these varying cultures, religious coping is used for many things.

According to Pargament and Raiya (2007), because religion is multifunctional and serves many purposes, religious coping is implicated in spiritual, social, physical, and psychological domains. This makes religious coping important in the helping process. Religion has been linked to a number of psychological goals, such as a search for meaning, development of self, self-control, and reducing anxiety. Despite its link to psychological benefits, religious coping can also be harmful, which is another assumption of the religious coping theory.

Pargament and Raiya (2007) pointed out that coping via religion can be "constructive or destructive, or helpful or harmful" (p. 744); nonetheless, this method continues to be an important means of coping for many. There are no easy answers about the value of religious coping in mental health, so it is important to look at the extent to which individuals integrate religious coping into their situations, including needs, socialization, and goals. This assumption is very important in the current research that looked looked specifically at African Americans suffering from depression and/or anxiety to see how using religion to cope with these illnesses may affect their mental health either positively or negatively. Because of its importance within culture and the tendency of many to use this method of coping, religion is a measure that can and should be included in measures used to help, despite its potential to harm. This is the focal point of the following assumption.

Pargament and Raiya (2007) believed that beliefs, attitudes, and behaviors based in religion are fundamental parts of an individual's day-to-day functions. They stated that helping professionals should automatically assume that individuals who seek help have religious coping resources; therefore, these coping methods should be joined with other interventions. Pargament and Raiya also encouraged helping professionals to develop comfort in discussing religion and religious practices used for coping with their clients, pointing out how many helping professionals become uncomfortable and defer when it comes to religion and religious coping practices. For a while, religion was simply treated like a personality trait (Newton & McIntosh, 2010), but with Pargament's (1997) theory of religion and coping, this changed. Pargament's theory of religion and coping shifted the focus from religion being treated as unchanging to further investigating how people use their religion and spirituality to deal with crisis situations and other stressors (Pargament et al., 1998). Religion is something that cannot be explained away, as some helping professionals might like to do (Pargament et al., 1998). Unfortunately, not everyone who uses religious coping does so in a matter that is helpful for them. There is positive religious coping and negative religious coping.

**Two Types of Religious Coping**

According to Pargament (1997), religious coping can be positive religious coping and negative religious coping. Positive religious coping can be described as those things that demonstrate an individual has a secure relationship with God. Individuals who engage in positive religious coping believe there is greater meaning and seek it out while maintaining spiritual connections with others (Pargament et al., 1998). Positive religious

coping consists of activities or strategies such as praying, treating God as a partner, and seeking God for support and love, seeking support from clergy and other members of the congregation, and forgiveness (Pargament, 1997). On the other hand, negative religious coping can be described as those things that demonstrate an individual has an insecure relationship with God that consists of a religious struggle to find and maintain significance in life; therefore, those who use negative religious coping see the world portentously (Pargament et al., 1998). Negative religious coping consists of behaviors such as viewing stressors as punishment from God, trying to deal with things without God, or passively waiting for God to remove a stressor (Pargament, 1997). To test these methods and be able to measure religious coping in relation to physical and mental health, Pargament developed a measure called the RCOPE.

Pargament et al. (2000) developed the RCOPE to give researchers a tool to use to measure the different ways religious coping is expressed and to also assist helping professionals with incorporating religious and spiritual factors into the treatment process. A large sample of college students were used to test the RCOPE. This sample was used to examine and determine the level of "internal consistency and factor-analytic support for the subscales" (Pargament et al., 2000, p. 525). The researchers looked at the intercorrelations between the RCOPE and different measures such as physical and mental health, spiritual outcomes, and stress-related growth. Pargament et al. also tested the RCOPE using a sample of older adults in a hospital with serious medical illnesses and compared their scores to the college students' scores.

The factor analysis of the items from the RCOPE from the study using the college sample presented factors consistent with the concepts and construction of the subscales of the RCOPE. The scale was found to be internally consistent aside from a few of the subscales that were skewed. The RCOPE was also proven to have incremental validity. Most importantly, the RCOPE was proven to be applicable to different populations of people of different ages, with different problems, and having different levels of religiousness. The results of these studies imply that the RCOPE is a useful tool in assessing religious coping and for incorporating into the counseling process. The findings also suggested the importance of assessing for the possibility of religious coping being harmful as well as helpful (Pargament et al., 2000). The RCOPE consisted of 105 items, but to make the measure more assessable and practical in different settings, an abbreviated version called the Brief RCOPE was developed.

In this study, positive and negative religious coping were explored and the theory of religious coping was used to guide the research; the Brief RCOPE was a measurement instrument used to collect data in the study. Previous researchers have used this theory in a similar sense. For instance, Braam et al. (2010) used Pargament's (1997) theory to guide their study on how positive and negative religious coping affect depressive symptoms in ethnic groups from the Netherlands. Pargament's theory has also been used to guide research on health outcomes; religious coping has been linked to desirable health outcomes. For instance, Cummings and Pargament (2010) addressed the number of studies conducted to investigate religious coping in people who have medical conditions.

In the current study, I explore how negative and positive religious coping might affect depressive symptoms, anxiety symptoms, and AEE in African American Christians.

## Literature Review

### African Americans and Mental Health

According to the U.S. Department Health and Human Services Office of Minority Health (2017), African Americans are 10% more likely to report having serious psychological distress compared to non-Hispanic Whites. This number increases for African Americans living below poverty, as they are three times more likely to report psychological distress. Individuals who are more disadvantaged in society are more likely to experience distress than individuals who are more advantaged (Jang & Johnson, 2004). Factors such as social, economic, and physical health in the African American community all greatly influence mental health.

Stress from disadvantaged status and experiences with discrimination cause African Americans to be more distressed and increase their vulnerability to mental health disorders (Avent & Cashwell, 2015; Jang & Johnson, 2004). Jang and Johnson infer that because of stressors related to racism and economic disadvantage, African Americans are more distressed than other groups, especially non-Hispanic Whites. Compared to other groups, African Americans also have the greatest severity of mental illness that is not treated professionally (Cook et al., 2014). These stressors and other experiences of African Americans sometimes result in symptoms of depression and anxiety. Despite experiences with anxiety, depression, and other mental health disorders, most African Americans do not seek help from professional mental health services (Neighbors et al.,

2007; Obasi & Leong, 2008). Below, these mental health concerns, as well as the aforementioned disparities, and avoidance of mental health services are discussed.

### *Anxiety and Depression in African Americans*

Anxiety disorders—panic disorder, specific phobias, social anxiety disorder, generalized anxiety disorder, posttraumatic stress disorder, and obsessive-compulsive disorder—have been identified as the most prevalent group of mental illnesses (Hunter & Schmidt, 2010). As with other disorders, culture is an influential factor in anxiety disorders. An individual's social and cultural values, beliefs, and attitudes are likely to influence their beliefs and attitudes about potential anxiety-causing stimuli. (Hunter & Schmidt, 2010). Context or an individual's situation influences fears, how stress is interpreted, and beliefs about how to access help (Hunter & Schmidt, 2010). Despite the importance of understanding race-ethnic differences in anxiety disorders, research on the nature and prevalence of anxiety disorders in different racial and ethnic subpopulations has been limited (Himle et al., 2009).

Research has shown that African Americans face greater stressors in elevated rates of unemployment, exposure to crime, lower socioeconomic status, and discrimination and/or racism (Jackson et al., 2004; Turner & Lloyd, 2004; Wimberley, 2015). These stressors are expected to cause or at least contribute to an increase in anxiety symptoms, but some researchers have found lower rates of anxiety disorders in African Americans than in non-Hispanic Whites (Breslau et al., 2006; Himle et al., 2009). Hunger and Schmidt (2010) suggested that due to the stigma of mental illness among African Americans, they avoid research and treatment resulting in fewer reports of the

disorder. Hunter and Schmidt also discussed the possibility of anxiety symptoms presenting differently in African Americans than in non-Hispanic Whites, resulting in misdiagnosis. Bell et al. (2015) further discussed misdiagnoses and pointed out how African Americans are diagnosed with schizophrenia more often than with mood disorders, even when presenting with the same symptoms as non-Hispanic Whites. Although overall rates of anxiety disorders in African Americans were lower than in non-Hispanic Whites, Himle et al. (2009) found that posttraumatic stress disorder was more prevalent among African Americans than non-Hispanic whites, which is likely related to being exposed to high-trauma environments and race-related stressors. Research on African Americans and depression show similar findings when it comes to influences, rates, presentation, and accuracy of depression (Watkins & Johnson, 2018).

Depression is another very prevalent mental illness, affecting more than 18 million people in the United States (National Institute of Mental Health, 2011). Like anxiety, the rate of depression in African Americans is lower than that of non-Hispanic Whites (Watkins & Johnson, 2018). Also like anxiety, although the rates are lower in African Americans, the severity and chronicity are reportedly higher (Anthony, Johnson, & Schafer, 2015). African Americans with major depressive disorder (MDD) tend to rate the severity of their disorder as very severe and disabling in comparison to non-Hispanic Whites (Williams et al., 2007). Contributing to the severity and disabling effects of depression among African Americans is the high likelihood of a comorbid disorder (Hankerson et al., 2011).

Many of the same challenges and stressors faced by African Americans resulting in and/or contributing to anxiety are the same as those resulting in and/or contributing to depression: low SES, access to services, and racism and/or discrimination. Earl, Williams, and Anglade (2011) pointed out that these things along with living in an oppressive environment, living in high crime areas, experiencing injustice, and having limited access to goods and other services result in feelings of unhappiness and dissatisfaction with one's life leaving African Americans more vulnerable to the stressors that trigger depression. Despite the many stressors African Americans face that potentially result in depression, depression is still viewed by many in the African American community as a sign of weakness (Bailey et al., 2011; Conner et al., 2010). This attitude about depression along with other contributing factors result in racial disparities related to treatment.

**Mental Health Disparities**

There are a number of disparities in mental health care between African Americans and non-Hispanic Whites. Unfortunately, as Earl et al., (2011) point out, these disparities are not simple or straightforward. Research has shown that African Americans who seek mental health care do not receive the same quality of care as non-Hispanic Whites who seek mental health care. According to McGuire and Mirand (2008), African Americans who receive mental health care receive poor quality of care and do not receive the best available treatments. For instance, evidence-based medication therapy or psychotherapy is less likely to be offered to African Americans compared to other ethnic groups (Wang et al., 2000). Hankerson et al. (2011) found that African Americans with

MDD are less likely to be prescribed medication as a treatment, even with medication being a major support in treating major depression. A 2001 U.S. Surgeon General's report also found that African Americans are not as likely to receive guideline-consistent care (APA, 2017). Important to also note here is the likelihood of misdiagnosis of disorders in African Americans, which would also affect the quality of care received. For example, African Americans are more likely to be diagnosed with schizophrenia than a mood disorder compared to non-Hispanic Whites with the same symptoms (Bailey et al., 2011; Bell et al., 2015). Given the difference in the quality of care as well as other factors related to African Americans who seek mental health treatment, one would expect there to be some disparity in the epidemiology of mental illness among African Americans compared to non-Hispanic Whites.

Although most research shows there is no significant difference in the prevalence of anxiety and depression among African Americans and non-Hispanic Whites, the course of anxiety and depression in African Americans is more chronic than in non-Hispanic Whites (Breslau et al., 2005). Breslau et al. found a lower prevalence of psychiatric disorder among African Americans when compared to non-Hispanic Whites, but also found that African Americans experience more severe, persistent, and debilitating episodes when there is a psychiatric disorder. In a study of the prevalence and persistence of MDD in African Americans, Caribbean Blacks, and non-Hispanic Whites, Williams et al., (2007) found that the severity of the disorder was higher in both African Americans and Caribbean Blacks. Himle et al. (2009) found that African Americans who met criteria for an anxiety disorder experienced higher levels of impairment in

functioning as well as overall mental illness severity. Other disparities, such as economic disparities and disparities in access may explain the disparity related to chronicity.

As mentioned above, one's economic situation as well as access to services may affect the persistence and severity of mental illnesses. Hunter and Schmidt (2010) assert that the higher chronicity of anxiety and depression in African Americans is directly related to economic disparities and disparities in access to services. In the 2001 Surgeon General's report, the United States Department of Health and Human Services found that African Americans are less likely to access mental health services and receive quality care when compared to non-Hispanic Whites (Hunter & Schmidt, 2010). According to the American Psychiatric Association (APA), (2017), this continues to be the case. The APA (2017) reports, only one out of three African Americans who need mental health services receive them. Some of the reasons for the underutilization of services among African Americans are the lack of access, lack of or inadequate insurance, and lack of trust for healthcare providers. This list of reasons is not exhaustive, as other reasons will be later discussed, as underutilization among African Americans continues to be an issue of concern (McGuire & Miranda, 2008).

Research clearly shows utilization of mental health services among African Americans is much lower than that of non-Hispanic Whites. There are many factors that have come up in research relating to the underutilization of services among African Americans such as those mentioned above- lack of insurance, inadequate insurance, access, and mistrust. These factors are considered barriers to treatment. Among these are also institutional racism, discrimination, stigma surrounding mental health (Obasi &

Leong, 2009), and what research seems to have overlooked as a barrier- religion- especially among African Americans who are considered highly religious (Hays, 2015).

**Religious Coping**

Religious coping simply defined is the attempt to make sense of and deal with life stressors and negative events in a way that recognizes the sacred and includes prayer, member support, pastoral counseling, church involvement, and one's overall faith (Pargament 1997; Singh & Madan, 2017). Although not coined religious coping, Smith (2003) suggested American religion encourages different beliefs and practices that help believers to cope with stress from different emotions, process the feelings that evolve from the stress, and work through interpersonal conflicts, therefore enhancing overall well-being. Despite the positive connotation associated with the word coping, it can be either positive or negative according to Singh and Madan. This is also the case for religious coping. Xu (2016) used the phrase "double-edged sword" when discussing religious coping, pointing out the importance of looking at religious coping from an impartial perspective and not a biased one as religious coping can be beneficial, but can also result in harmful outcomes. The type of religious coping one chooses to use can either empower and help one to feel more capable of handling stress that may be detrimental to one's physical and/or mental health, or it may exacerbate the situation leading to more stress and possible decreased well-being and/or mental health (Brelsford et al., 2015)

For years, psychologists have been in disagreement when it comes to the debate on whether religion and religious coping is salutary or deleterious, with psychologists on

either side of the argument. Well-known psychologists such as Skinner, Freud, Erikson, and Ellis are among many who have expressed their support of or criticism of religion in reference to mental health (Pargament, 2002). Pargament stated that the key to benefiting from religion is having a secure relationship with God and seeing Him as supportive, loving, and kind. On the other hand, if God is seen as punitive and one's relationship with Him is lacking, then according to Pargament, this causes the potential for harmful effects. These are the basis of positive and negative religious coping respectively. Positive religious coping is a reflection of a secure relationship with a loving and kind God, believing there is meaning in life, and having a sense of spiritual connection with others. Negative religious coping, also considered spiritual/religious struggle, is a reflection of a more insecure relationship with God, seeing Him as punitive, acknowledging demonic involvement, religious interpersonal problems, and struggles with oneself and the divine (Pargament et al., 2005; Singh & Madan, 2017).

***Positive Religious Coping***

One's belief about and view of God is an important factor in religious coping and the subsequent effect of such coping. What one believes about God can determine whether coping is considered positive or negative religions coping. Research has shown that it helps to seek God as a partner and to search for comfort in or from Him when faced with challenging events or stressors (Brelsford et al., 2015). In a study using 1426 adults from a 2010 Baylor Religion Survey, Silton et al., (2014) found that believing God to be benevolent was negatively associated with social anxiety, paranoia, obsession, and compulsion. Even as it relates to suffering, if the belief is that the God is still benevolent

in suffering, the results were positive. This means that those who were more likely to believe God to be benevolent were less likely to experience social anxiety, paranoia, obsession, and compulsion. In a study using a sample of 3083 undergraduate students and a sample of 1047 U.S. adults, Wilt et al., (2016) found that when individuals attributed a benevolent role to God in their suffering, it was linked to better well-being.

Much of the research on religious coping and mental health focuses on the positive effect of religious coping on mental health and even physical health. Some studies combine both physical and mental health as they relate to religious coping. Freitas et al.'s (2015) study, for instance, researched the influence of religious coping on depression and anxiety associated with inflammatory bowel disease, treatment adherence, and health-related quality of life. They found that patients with inflammatory bowel disease used religious coping to help them adjust to stressors they faced due to their disease, and the coping was associated with less psychological distress and more satisfaction with mental health and overall health-related quality of life. Aflakseir and Mahdiyar (2015) also researched the effects of religious coping as it relates to the relationship between a physical ailment and mental health. In their study of 72 women with fertility problems, they found that active religious coping was a predictor of reduced depression. The researchers found that when using religious coping specifically for stressful situations, women were less likely to experience depression as a result of the stressful situations.

Unfortunately, not every person who uses religious coping engages in the positive form. Some individuals may question God, engage in demonic reappraisals, and struggle

spiritually. Although much of the research on religious coping and mental and/or physical health focuses on positive religious coping and the advantageous effects thereof, there can be adverse effects from religious coping, usually from the use of the negative religious coping style.

### *Negative Religious Coping*

The effects of religion and religious coping on individuals are not always positive or beneficial. Some of the beliefs endorsed about one's religion can often lead to adverse effects. Silton et al. (2014) and Wilt et al. (2016) both found that believing God to be punitive or non-benevolent resulted in adverse effects. Silton et al. found that believing God to be punitive was positively associated with social anxiety, paranoia, obsession, and compulsion resulting in a harmful effect. Wilt et al. found that those who believed suffering was caused by a nonbenevolent God was linked to more divine struggle, lower levels of well-being, and higher distress. Other beliefs that are sometimes endorsed within one's religion have the potential to cause harmful effects also. Ellison, Burdette, and Hill (2009) found that having strong beliefs that sin is widespread was linked to anxiety. While religion may be a source of support for some, it may sometimes be the cause of or the reason for an increase in anxiety for others, potentially causing problems with social supports and interpersonal relationships (Exline, 2002).

Negative religious coping has also been linked to depression. In a study of 198 individuals with HIV/AIDS, Lee et al., (2014) used multiple hierarchical analyses to determine that negative religious coping is significantly associated with higher levels of depression and a lower quality of life. In other cases related to physical ailments, Trevino

et al., (2014) found that negative religious coping was associated with an increase in risk for suicidal ideation. Despite the majority of research on negative religious coping suggesting it leads to adverse or harmful outcomes, there is still no consensus within the literature (Brelsford et al., 2015) and remains paucity within this area of research.

**Barriers to Treatment**

Religious coping can be seen as a negative form of coping when it keeps individuals from seeking out potentially needed, formal mental health treatment. Some individuals who consider themselves religious may believe that mental health disorders can be overcome with religious striving. Such religious beliefs can keep patients from reaching out to mental health professionals (Ayvaci, 2016). Having a relationship with one's clergy can also lead to avoiding mental health services due to respecting the clergy's perception of mental health, which often attributes depression to not trusting God (Ayvaci, 2016; Payne, 2009).

Although mental illness and an increase in the need for mental health care is very prevalent, there still remains the failure of many individuals with mental health issues to receive the proper treatment due to stigma and misunderstandings (Almanzar, 2017). One's religious beliefs can often be the source of those stigmas and misunderstandings. Some of the religious beliefs related to mental health are mental illness being the work of demons and mental illness being the result of one's sin (Standford, 2007). When mental illness is believed to have religious causes, outside sources are avoided, as the cure is often believed to be found within religion. For example, in a 2013 study by LifeWay Research using 1,001 Americans, they found that a third of the respondents believed that

prayer and Bible study were the only way to rid oneself of serious mental illness. Almanzar concluded from his study that many Christians believe mental illness to be the result of sin and the only way to get relief from one's mental illness is to repent and "get right" with God.

Although sparse, research on religion and spirituality suggests there may be some importance in looking at these factors in relation to African Americans and health and well-being. As will be seen later, African Americans are a highly religious group and rely heavily on their religion for many things, including mental health concerns (Avent & Cashwell, 2015; Dempsey et al., 2016; Hays, 2015; Nguyen, 2018). This group is also less likely to seek out mental health treatment as will be further discussed later in relation to their religious practices.

**The Black Church**

Research shows that religion and spirituality are very important to African Americans when it comes to addressing, treating, and understanding the cause of their mental health concerns (Payne, 2008). Research shows that many African Americans rely on the Black Church as a source of strength, support, and resilience. According to the Pew Research Center (2009), almost 80% of African Americans expressed the importance of religion in their life, with a large majority of them identifying as Christian. The Black Church provides African Americans with a family, community, and spiritual experience. So, it is no surprise that religion and faith come up in reference to African Americans and their mental and physical health. Given the challenges and life stressors that African Americans face, it may be a surprise to some that they are more

psychologically well and better adjusted than expected and predicted by some experts. According to Mouzon (2017), African Americans sometimes demonstrate better mental health outcomes than non-Hispanic Whites, despite the disparity in treatment. Some think that religion and spirituality may explain this phenomenon (Bell-Tolliver & Wilkerson, 2011).

***History***

To understand the role and importance of The Black Church as it relates to African Americans and mental health, one must have some knowledge of its development. The term, "The Black Church," per scholarly literature and a lot of the general public, simply refers to the variety of black Christian churches in the United States, typically ones that are historically and completely controlled by African Americans (Lincoln & Mamiya, 1990). Lincoln and Mamiya describe it as a "sociological and theological shorthand reference" (p. 1). The Black Church began as an informal, secretive group of slaves who were afraid to assemble to worship together due to the rule against more than five slaves gathering at a time without an overseer. With the discontent of worshipping with slave masters and their families, a desire to evoke change, and a desire to avoid discrimination on Sundays and have their own place of worship, slave gatherings became less secretive, and slaves began the foundation of what is currently known as the Black Church. Over time, this institution would become the core of the community for slaves, a site for education, and a place of fellowship (Avent & Cashwell, 2015). The Black Church during slavery was the first form of mental health services, as it provided a sense of therapeutic relief and refuge from the stress, pressure,

and cruelty that came with the slave experience; it was sometimes the only place where slaves could express their feelings related to living in a hostile and racially oppressive society (Avent & Cashwell, 2015; Hays, 2015).

The Black Church would continue to be an essential institution for African Americans during emancipation, the Civil Rights era, and through today (Avent & Cashwell, 2015; Hays 2015). One aspect of the Black Church during the Civil Rights era was its growth related to financial independence and the development of its self-help doctrine. During this time, African Americans learned to rely on each other for financial, mental, emotional, and social support as a survival mechanism (Littlefield, 2005). This is important to note, as Avent and Cashwell point out that this perspective may be still held by African Americans today, causing them to seek out support from professional mental health care less than other ethnic groups.

***Cultural Importance Today***

Avent and Cashwell (2015) considered the initial function of the Black Church as a "historical precedent" (p. 83), meaning the counseling, mental health, and social service view of the church has been maintained through this day. The Black church has always been a source of support, offering community, family, and social resources, role models, food services, education, financial support, counseling and other methods for coping to its members. Religion and spirituality are connected to all parts of life for African Americans, including their beliefs about (mental) health. The Black Church has always been and continues to be of great importance to the African American experience by maintaining and promoting core goals, values, and objectives at every level of the

African American experience- individual, leaders, and organizational (Hays, 2015). It has been the strongest resource for African Americans in overcoming adversity, and it continues to serve as the preferred source of help for African Americans, mainly because of the trust already established with the institution. Even in cases where the Black Church may not have the capacity to effectively address a certain mental health concern, it will continue to be relied upon as the most trusted institution within the African American community. When discussing health disparities in the African American community, it is imperative that the role of the Black Church is considered (Hays, 2015) as it has been a significant and consistent resource, offering several means of coping during times of stress and adversity.

***Forms of Coping Within the Black Church***

Because the Black Church has a deep and extensive history of support for African Americans, many recognize it as a significant tool for coping. Acts such as prayer, singing, outward praise, pastoral counsel, and other church activities are considered therapeutic outlets and forms of religious coping among African Americans (Dempsey et al., 2016). For many African Americans, God is the main part of coping. In a study of demographic predictors about attitudes regarding religious coping, Chatters, Taylor, Jackson, and Lincoln (2008) found that religious coping was more highly endorsed among African Americans, specifically those in the south. African Americans are more likely than non-Hispanic Whites to proactively confront situations of distress based on religious beliefs and their relationship with God, who they view as their guide and partner in addressing these situations (Jang & Johnson, 2004).

Although Africa Americans have been shown to be open to seeking mental health services, religious coping is the preferred means for addressing mental health concerns (Ward et al., 2013). In a study of individuals who were recovering from sexual assault, Ahrens et al., (2009) found that African Americans use more religious coping, both positive and negative, compared to the other ethnic groups who participated in the study. Taylors et al., (2004) found that an estimated 9 out of 10 African Americans report using prayer and looking to God for strength, support, and guidance, as an important means of coping with stress, all of which are positive forms of religious coping.

**Positive Religious Coping Among African Americans**. Positive religious coping has been shown to benefit African Americans at different ages and for different situations. Park et al. (2017) examined the effects of religious coping on overall well-being of African American adults over a two and half year period. For well-being, they looked at depressive symptoms, positive and negative affect, self-esteem, and meaning of life. The researchers found that positive religious coping at the start of the study (baseline) were a positive and consistent predictor of well-being after the two and a half years. In another study on well-being, specifically looking at anxiety symptoms, Chapman and Steger (2010) found that African Americans were more likely to use positive religious coping than were non-Hispanic Whites, and as a result, experienced fewer symptoms of anxiety.

Although positive coping among African Americans has been shown to be beneficial in dealing with mental health concerns, Park et al., (2017) point out that it is not certain if this is the case when also taking negative religious coping-demonic

religious reappraisals, spiritual discontent, and punitive religious reappraisals- into account. A tendency toward negative coping can have an adverse effect, and the tendency to choose religious coping over seeking professional mental health care may prevent African Americans from getting the care needed to truly address their mental health needs. Because of negative coping and avoiding treatment, one may question rather religious coping is really a resource for African Americans in treating their mental health illnesses or if it is a barrier.

Religion for African Americans has often been found to be a protective factor, yet research has also found an association between high levels of religiosity and lower levels of mental health help-seeking. Despite the positive effects of religion on mental health, religion has the potential to keep individuals from seeking out professional mental health treatment. Matthews et al., (2006) found that African Americans who are religious feel that they learn to use God as their means of coping resulting in them being less likely to get professional help for mental health concerns. Religion has the potential to cause a person to engage in escapist coping instead of actively addressing their problems directly (Jang & Johnson, 2004). This and the potential to avoid treatment are especially true among African Americans. The National Survey of American Life found that most African Americans who are depressed do not seek help, and those that do, do so when their symptoms have become very severe and then will typically seek help from non-health care professionals such as clergy (Williams et al., 2007), who many not always have the best perspective of mental health disorders or belief about mental health disorders.

Some of the beliefs promoted by clergy and endorsed within the Black Church may give rise to African Americans' tendency to avoid therapy and other professional mental health services. For instance, in a qualitative study completed by Payne (2008), many of the pastors in the study viewed depression as a weakness and any experiences with it should be addressed with the "Prince of Peace" (i.e., God, Jesus). The overall message in most sermons in the Black Church encourages listeners (African Americans) to rely on Jesus, rather than mental health professionals, as an answer to their mental health concerns (Payne, 2008). Some pastors in Black Churches also endorse the message of suffering in this lifetime, awaiting the promise of Heaven and no suffering after death (Avent & Cashwell, 2015), perhaps leading some to believe that their mental health issue is part of divine order or that it will "be okay afterwhile" or "over yonder" (in Heaven), preventing them from seeking any help. According to Avent and Cashwell, this message creates a sense of acceptance for present adversity as it is only temporary, and the eternal promise will be worth it, and those who believe this message may be less inclined to seek professional care.

For those who do seek professional care, they may be less likely to accept a mental health diagnosis such as major depression because of other messages promoted in the Black Church such as "where's your faith" or "who's report will you believe?", meaning despite what the doctor says, God says otherwise. For instance, in a study of depression among African Americans by Wittink et al., (2008), African Americans viewed depression as a loss of faith (not believing God), quoting other Black Church clichés like "God can do anything but fail." The individuals in the study who did accept

that a person could be clinically depressed believed that faith alone was the cure for it, therefore creating another barrier to treatment. For some, religious coping may be a resource, but religious coping also has the potential to be a barrier for those struggling with mental health needs. In most cases, it seems the use of negative religious coping is the cause.

**Negative Religious Coping Among African Americans**. There are many forms of medical and psychological treatment that are beneficial that also have the potential to have an adverse effect on one's mental health; religion is one of these. Although these adverse effects may not be as frequent as some of the beneficial effects, religion does have the potential to affect mental health treatment negatively (Reeves et al., 2011). These adverse effects are usually due to negative forms of religious coping. Negative religious coping is defined as a weak or strained relationship with God, a fearful view of the world, and an internal struggle to find meaning and purpose in one's life (Bjorck & Thurman, 2007). These include God's punishment reappraisals or viewing things as punishment from God and seeing God as angry and punitive; demonic reappraisals or blaming the devil for one's stresses or acknowledging demon involvement in one's situation; self-directing religious coping or trying to control or do things on one's own without help from God; spiritual discontent or dissatisfaction and an insecure relationship with God and having an internal struggle with oneself and the divine; and interpersonal religious discontent or dissatisfaction with clergy and other members (Pargament et al. 1998).

Negative religious coping is not always the first response to stress or other difficult situations. McCleary and Miller (2018) point out that when faced with situations such as prejudice, African Americans will first utilize positive religious coping but resort to negative religious coping with changing their view of God after realizing that prejudice is a continuous stressor that affects other parts of their life. They express that the stressor might initially be seen as a possible benefit, but as it continues, it may later be seen as a punishment from God. McCleary and Miller's findings that negative religious coping and the experience of prejudice among African Americans were significantly related is in contrast to previous studies that show African Americans tend to turn to positive religious coping methods such as prayer when faced with stressors in life. Negative religious coping has also been found to mediate the relationship between abuse and posttraumatic stress as a result of the abuse in African American women. The women who used negative religious coping as a response to their abuse experienced greater levels of stress (Bradley et al., 2005).

Negative religious coping often leads to negative emotions that result in elevated distress in clients. This has been recognized by mental health providers (Reeves et al., 2011). Park et al., (2017) found that negative religious coping was a consistent, strong negative predictor of well-being after two and a half years, meaning well-being decreased with the use of negative religious coping more than it increased with the use of positive religious coping. They also found that negative religious coping was a strong predictor of negative well-being traits such as depressive symptoms. In another study of African American veterans, Witvliet et al., (2004) also found negative religious coping to be

related to depression symptom severity, as well as anxiety and posttraumatic stress symptom severity. Some of the negative emotions caused by negative religious coping may be difficult for African American Christians to express or cause ambivalence. For instance, feeling angry at God as a result of religious discontent, is one feeling that Schnorr (2013) points out Christians have difficulty admitting or expressing.

Being able to process and express emotions is important for one's mental health. According to Stanton et al., (2000), the processing and expressing of emotions has been causally related to positive outcomes, including enhancing psychological and physical health. According to Ben-Ari and Lavee (2011), it is not simply the expressing of emotion itself that improves one's well-being though, but rather how one feels about that expression. Therefore, one's propensity toward negative religious coping may cause the ambivalence that one might experience related to emotion expression and have an opposite outcome in relation to psychological and physical health.

**Ambivalence Over Emotion Expression**

AEE is defined as conflict that arises due to a desire to express emotions but having a fear or struggle with doing so; it also refers to the regret of having expressed an emotion (King & Emmons, 1990). AEE is related to the conflict one experiences about his/her style of emotional expression, whether it is the desire to express emotion and the fear that comes with doing so or expressing emotion and later regretting it (Brockmeyer et al., 2013). It is a variable of emotional regulation that quantifies the level of comfort an individual has in how they expresses emotion (Awada et al., 2014).

The research on the role of AEE as it relates to mental health is very limited and inconsistent, but AEE has been linked to negative life satisfaction and psychological distress, to include depression and anxiety (Chen et al., 2012; Trachsel et al., 2010). Brockmeyer et al., (2013) analyzed AEE in 76 individuals with MDD compared to 77 non-depressed individuals and found that AEE was positively correlated to levels of depression in the individuals with MDD. In a 2004 study on suicidal ideation and hopelessness in depressed adults, Lynch et al., (2004) found that AEE resulted in the increased presence of suicidal predictors. Lynch et al.'s findings suggest the importance of improving the inhibition of emotions in suicide prevention methods. The research on AEE and mental health is scarce. The paucity is even greater on the relationship between AEE and religion or religious coping as it relates to mental health.

One specific study that looked at the relationship between religious coping, AEE, and anxiety and depression was completed by Bryan et al. in 2016. Bryan and his colleagues' study investigated whether religious coping would moderate the relationship between AEE and anxiety and depressive symptoms. They wanted to determine whether their prediction that religious coping weakens the relationship between AEE and anxiety and depressive symptoms would be correct. They actually found that religious coping made the relationship between AEE and anxiety and depressive symptoms worse suggesting that religious coping may not be the best coping mechanism for individuals who experience high levels of AEE. Bryan et al. suggested further researching the role of AEE when it comes to religious coping.

## Summary and Conclusion

Mental health is important to a person's overall well-being, so when seeking help for concerns such as depression and anxiety, it is important that the method chosen, is actually beneficial. For African American Christians, that method is often religious coping by means such as seeking pastoral counseling, praying, fellowshipping with others, questioning God's love, questioning whether God is there, or blaming the devil (Chatters et al., 2008; Jang & Johnson, 2010; Payne, 2008). Although religious coping has been linked to mental health benefits for some (Olson et al., 2012; Pargament & Raiya, 2007; Yendork & Somhlaba, 2017), the propensity of African Americans to avoid formal mental health care and turn to religious coping is a concern (Hays, 2017). Does the tendency to rely on religious coping make African Americans ambivalent about expressing their emotions, therefore resulting in exacerbated or increased experiences of depression and anxiety? Based on the research discussed above, there is a need to look deeper into the use of religious coping as it relates to depression, anxiety, and AEE to answer this question. In this study, I intend to further explore the role of religion in coping among African American Christians who experience depression and anxiety.

# Chapter 3 Research Method

## Introduction

The purpose of this quantitative, nonexperimental, correlational research study was to explore whether positive religious coping or negative religious coping predict help-seeking attitudes and symptoms of anxiety and depression in African American Christians. With the prevalence of African Americans' use of religion as a means of coping, the purpose of my study was to determine whether this use of coping predicts a change in help seeking, symptoms of anxiety, and symptoms of depression among this group. I also intended to determine whether there was a change in the relationship between positive religious coping or negative religious coping and help seeking, symptoms of anxiety, and symptoms of depression when AEE is present; AEE has been shown to be related to an increase in anxiety and depression symptoms (Brockmeyer et al., 2013; King & Emmons, 1990).

This chapter begins with a description and details of the selected research design and the rationale for choosing the design. I also provide detail on the population chosen and the sampling procedures used. I give explanation of the power analysis used to determine the needed sample size for the study. The procedures for recruitment, participation, and data collection will also be discussed in this chapter. Detailed explanations of each instrument used will also be included in this chapter. The last part of the chapter will include a discussion of any threats to validity and ethical procedures.

## Research Design and Rationale

The procedure of inquiry and the specific means for collecting and analyzing data and interpreting results and the philosophical views of the researcher should match the selected research design (Creswell, 2014). I used a quantitative research design because it was most appropriate for the research questions. Quantitative research is used to explain phenomena using mathematically based methods to analyze collected numerical data (Creswell, 2018). Quantitative research is especially useful in testing hypotheses to help explain relationships between different variables (Muijs, 2010). The independent variables in this study were positive religious coping, negative religious coping, and AEE. The dependent variables were symptoms of anxiety, symptoms of depression, and help-seeking attitudes. AEE was expected to be a moderating variable. The quantitative research design helped me to answer the research questions about the relationships among these variables.

The research was focused on positive and negative religious coping among African American Christians and whether either predict symptoms of anxiety, symptoms of depression, and help-seeking attitudes. The research also focused on determining whether AEE moderates the relationship between religious coping and symptoms of anxiety and religious coping and symptoms of depression in African American Christians. The data collected were analyzed using multivariate multiple regression.

Multivariate multiple regression is similar to multivariate analysis of variance, or MANOVA, but differs when it comes to independent variables. Multivariate multiple regression analysis may be used when a study has more than one independent variable

and more than one dependent variable. This method is used to assess the relationship between these variables (Hidalgo & Goodman, 2013). Because my study used continuous independent variables and not categorical variables and my study had multiple dependent variables, it was necessary and appropriate to use multivariate multiple regression analysis.

## Methodology

### Population

Because religion is important in the lives of African Americans, it is important to better understand the role that religion plays in the lives of African Americans as it relates to mental health (Hays & Lincoln, 2017). According to Pew Research Center (2014), nearly 80% African Americans identify as Christian; therefore, the population for my research was African American Christians at least 18 years old.

### Sampling and Sampling Procedures

The sampling method used for my research was convenience sampling. I intended to use churches I have connections to and request participation, but due to the COVID-19 pandemic, this was not possible. This form of sampling was originally chosen due to the connections I have with certain churches in my area and their willingness to participate and knowing people who attend other Black churches who would have also extended invitations to their members. Instead of this method of gaining participants, I used social media for my convenience sampling. To participate in the research, individuals had to identify as African American, Christian, and be at least 18 years of age.

To find sample size, a researcher must first determine the statistical power, alpha level, and effect size. Statistical power is the probability that a test will report a statistically significant treatment effect or relationship between the variables being tested (Baugley, 2004). Choosing a high statistical power helps to ensure there is a real treatment effect, while also improving chances that the findings are not simply because of chance (Baugley, 2004). The accepted value for power is .80 (Cohen, 1992), which simply means that a test will detect a real treatment effect or relationship 80% of the time. The alpha level is chosen by the researcher; larger alpha values result in more power than smaller values as larger alpha values expand the rejection region (Baugley, 2004). Setting the alpha level at .05 is standard and translates to a 5% chance that the research conclusion is wrong or a 95% chance the conclusion is correct. The effect size lets a researcher know how strong the relationship is among the variables. The larger the effect, the fewer people needed to see the effect. Prior research can be used to calculate or estimate the effect size (Baugley, 2004; Cohen, 1992).

Although .80 is the accepted value for power, for my study, the statistical power was set at .90 to increase the possibility of ensuring a real relationship between the variables being analyzed and that the null hypotheses could be correctly rejected. The alpha level chosen for my study was .05 to also ensure a greater chance at making the correct conclusion. Due to the lack of evidence for using a medium or large effect size in previous research, a smaller effect size of .2 was used. To determine the sample size, these values were imputed into G*Power. G*Power uses five different types of analysis: a priori, compromise, criterion, post-hoc, and sensitivity. In this case, I used a priori,

which indicates the sample size needed based on the power, alpha level, and effect size (Prajapati et al., 2010). With an effect size of .2, an alpha level of .05, and a power of .9, using G*Power, the sample size required was 70.

**Procedures for Recruitment, Participation, and Data Collection**

Upon approval from the Walden University Institutional Review Board (IRB), I intended to reach out to ministry leaders at different churches providing them with information on my study to obtain permission to reach out to request participation from parishioners. Due to the closing of churches because of the pandemic, I was unable to do this. I posted an advertisement requesting participation from those who met the participation criteria on Facebook. There was a link provided that gave them access to the questionnaire. I used Survey Monkey to create and distribute the questionnaire. Each participant was asked to complete demographic information, such as age, sex, gender, and ethnicity. Each participant was asked to complete an informed consent form, which was provided with the link and before the questionnaire. This form included information about the purpose of the study. The names of the participants were not requested to ensure anonymity and confidentiality. The consent form contained any potential risks associated with participating in the study, the fact that the study was voluntary, the approximate time it would take to complete the questionnaire, along with contact information for myself should there be any questions for the participants. Because the study was looking at depression symptoms, the consent also included suicide hotline contact information and information for finding a therapist if needed.

Data were collected through questionnaires completed by African American Christians via SurveyMonkey. There was no procedure for exiting the study. Each participant was thanked for participating and informed to simply hit submit when they were done or exit out of the survey at their discretion. Each participant was informed of the voluntary nature but was encouraged to complete the questionnaire in its entirety. There was no need to follow-up with any of the participants after they completed the survey.

**Instrumentation and Operationalization of Constructs**

The questionnaire used for the study was compiled using the Brief RCOPE (Pargament, 1998), the AEQ (King & Emmons, 1990), the MHSAS (Hammer et al., 2018), and the PHQ-ADS (Kroenke et al., 2016). The Brief RCOPE is a 14-item measure developed from the RCOPE by Pargament et al. (1998) as a short version of the RCOPE to measure positive and negative patterns of methods for religious coping. The scale was developed using a sample of college students who were experiencing stressors. Researchers were able to determine the scale had good reliability—an alpha of .92. The researchers also found that the scale demonstrated good concurrent validity. This scale was used in a study completed by Mohammadzadeh and Najafi (2017) to examine the factor analysis and validation of the scale. The researchers used the scale in a study among Iranian students and determined that the Brief RCOPE is beneficial in using to screen larger samples sized in studies on religion (Mohammadzadeh & Najafi, 2017). Test-retest was .90, split-half reliability was .75, and the Cronbach's alpha score was .79

for the positive factors and .71 for the negative factors (Mohammadzadeh & Najafi, 2017).

The purpose of the Brief RCOPE was to give researchers and practitioners a way to measure religious coping. The 14 items of the Brief RCOPE are broken down into two subscales: positive religious coping and negative religious coping. Each item is rated on a 4-point scale (Pargament et al., 2011). To score the Brief RCOPE, one would add all the positive items to obtain the subscale score and then sum all the negative items for that subscale score. There are no scaled scores for the Brief RCOPE.

The AEQ (Kings & Emmons, 1990) is a 28-item questionnaire that measures AEE. Kings and Emmons determined the scale to have a good reliability, with alpha of .89. Test-retest reliability was .78. Exploratory factor analysis was used to determine the reliability of the measure. To determine convergent validity, Kings and Emmons computed correlations between the scores on the AEQ and the Raulin Intense Ambivalence scale. They found that the AEQ was significantly correlated with the already established Raulin scale ($r = .35$, $p < .001$). The AEQ was used in a study by Awada, Bergeron, Steben, Hainault, McDuff (2014) in which they examined the examined AEE couples where the woman had provoked vestibulodynia to determine if this was associated with women's pain and psychological, sexual, and relational functioning among the couples. They found that the study had good reliability using test-retest as well as internal consistency.

The Mental Help Seeking Attitude Scale was developed by Hammer, Parent, and Spiker (2018) to measure an individual's evaluation of their seeking help from a mental

health professional. The researchers used exploratory factor analysis, confirmatory factor analysis, and item response theory analysis to ensure the items demonstrated internal consistency with an alpha value of 0.93. They completed multiple studies to determine test-retest reliability, but they also determined the construct reliability to be .94. This scale was used in a study by Ibrahim et al. (2019) to examine what factors are associated with students' mental help-seeking attitudes. The researchers were able to establish good reliability with Cronbach alpha value .884

The Patient Health Questionnaire 9-item depression scale (PHQ-9) and the 7-item Generalized Anxiety Disorder scale (GAD-7) are two of the best validated and most commonly used measures of depression and anxiety. These two scales were combined to create the PHQ-ADS as a composite measure of depression and anxiety (Kroenke et al. 2016). This scale is an appropriate measure for this research to determine the level of anxiety and depression experienced by the participants. Kroenke et al. (2016) found the PHQ-ADS to have very good internal reliability with a Cronbach's alpha of 0.80-0.90. The scale also demonstrated strong convergent and construct validity, ranging from .89 to .95 in its trials. To determine the reliability and validity of the PHQ-ADS, Kroenke et al. tested the measure on 896 patients within two primary-care based trials of chronic pain and one trial of depression and pain from an oncology-practice. The measure was also used in a study on the effectiveness of cognitive-behavioral therapy for treating distress in dialysis patients. The researchers used confirmatory factor analysis to evaluate structural validity (Chilcot et al., 2018).

## Threats to Validity

### External Validity

External validity is the ability to use one's study to generalize beyond the study's participants to a wider population. Threats to external validity happen when a researcher makes incorrect inferences from the research data and applies it to other populations or situations (Creswell, 2018). One possible threat to external validity is that of the interaction between history and treatment. According to Creswell, the result of the research will be limited by time; therefore it is not possible to generalize the results to any past or possible future situations as the treatment effect may change over time. For my study, an example of this was what seems to be a current change in the attitude of those who seek treatment but are still Christian and still using the same coping methods. Although at some point, their means of coping may have kept them from seeking professional mental health care, this may not continue to be the case over time. To address this particular threat, Creswell recommended repeating the study at a later time. Because this method is not possible, another way to address this was to ask about previous methods of coping to assess for change.

Another threat to external validity was the interaction between selection and treatment. This threat refers to the inability to generalize to individuals who do not share the same characteristics as the participants (Creswell, 2018). In the case of this research, I was not able to generalize my results to African Americans who identified with a religious affiliation other than Christian. To address this threat, Creswell recommended restricting claims about other groups to which the research cannot be generalized. So, this

was addressed in the study's limitations, and it was recommended that future research look at the coping patterns of African Americans who are not Christian. Researchers must also be aware of threats to internal validity.

### Threats to Internal Validity

Internal validity refers to the ability to demonstrate a causal relationship between the study's variables. Threats to internal validity refer to any treatment, experiences of the participants, and any experimental procedures that might threaten the researcher's ability to draw inferences from the data about the population within the study (Creswell, 2018). One threat to internal validity was the use of self-administered questionnaires. Each participant was expected to answer honestly, but there was the possibility that some participants may have wanted to portray a different version of their actual selves and attitudes. This was addressed with the assurance that their information was completely confidential and that the questionnaire did not require or request the use of any of their names.

## Ethical Procedures

I requested permission from Walden University's IRB to gain access to the participants needed for my study before attempting to collect any data. The risk to participants was expected to be minimal, but it was still important to ensure ethical guidelines were followed during the study. There was no treatment or intervention done with the participants. The participants were not considered a vulnerable population nor was the study considered a sensitive topic.

Each participant was provided a consent form explaining the focus of the study, their rights, researcher's contact information and contact to a Walden representative, and the right to refuse participation at any time without penalty. Participants were informed of their anonymity as the researcher did collect any personal identifying data. Upon agreement to the consent form, participants were provided with the research questionnaire. To address the possible refusal of participation or early withdrawal from the study, I used more participants than necessary.

I used SurveyMonkey to generate the questionnaire and gather data. According to SurveyMonkey (2018), data submitted to their website are kept on an external drive which is encrypted and password protected. The data are typically destroyed after 5 years. Other than SurveyMonkey, I was the only person with access to the data.

## Summary

The purpose of this quantitative, nonexperimental, correlational research study was to analyze the relationship between religious coping, AEE, help-seeking attitudes, and symptoms of anxiety and depression in African American Christians. Due to the use of multiple independent variables and multiple dependent variables, I employed the use of a multivariate multiple regression analysis.

This chapter addressed the methodology and research design that was used to conduct the study. This chapter also described the means for obtaining participants and the data collection method along with the instruments that were employed. This chapter also reviewed the research questions and any response implications and how the data from the responses were analyzed.

# Chapter 4: Results

## Introduction

The purpose of the study was to analyze the relationship between positive and negative religious coping and AEE, help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians. The variables were measured using the Brief RCOPE (Pargament, 1998), the AEQ (King & Emmons, 1990), the PHQ-ADS (Kroenke et al., 2016), and the MHSAS (Hammer et al., 2018). I examined the relationship between positive religious coping and negative religious coping from the Brief RCOPE and variables AEE using the AEQ, help-seeking attitudes from the MHSAS, and symptoms of anxiety and depression using the PHQ-ADS. In this chapter, I describe the recruiting and data collection process as well as the statistical analysis procedures and report of the findings.

The research questions and hypotheses for this study are as follows:

RQ1: Does positive religious coping predict help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$1: There is no significant relationship between positive religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$1: There is a significant relationship between positive religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

RQ2: Does negative religious coping predict help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$2: There is no significant relationship between negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$2: There is a significant relationship between negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

RQ3: Does AEE moderate the relationship between positive and/or negative religious coping and help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians?

$H_0$3: AEE does not moderate the relationship between positive or negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

$H_1$3: AEE does moderate the relationship between positive or negative religious coping and help-seeking attitudes, symptoms of depression, and symptoms of anxiety in African American Christians.

## Data Collection

### Recruitment

To recruit participants for this study, a link was posted on my personal Facebook profile and within Facebook groups that were specifically geared toward the targeted group: African American Christians. The link with the study information was posted in

groups upon approval from the group administrators. The information provided in the posting was the purpose of the research, participant criteria, possible time commitment, and my contact information for any questions or concerns. I intended to also use Walden University's participant pool and reach out to church leaders in the area as stated in Chapter 3, but the Facebook recruitment was sufficient and provided the sample size needed.

The data collection took approximately two weeks to complete. There were 116 individuals to respond to the survey with an 85% completion rate. All the participants were African American. There were both male and female participants. The sample was representative of the population of interest—African American Christians—in that everyone identified as African American and Christian or of a Christian denomination. There was missing data for one participant.

## Results

### Descriptive and Demographic Characteristics of Sample

A summary of the sample's descriptive statistics is provided in Table 1. Per participation criteria of the survey, 100% of the sample identified as African American and Christian, though denominations varied with the majority of the sample identifying as simply *Christian*. An overwhelming majority of the respondents identified as female (89.1%). The ages of respondents ranged from 18–50+ with most respondents being between 35 and 44 (52.6%).

**Table 1**

*Frequencies and Percentages of Demographics, N = 116*

| Variable | Frequency | Percentage |
|---|---|---|
| Age | | |
| 18–24 | 3 | 2.6 |
| 25–34 | 38 | 32.8 |
| 35–44 | 61 | 52.6 |
| 45–54 | 10 | 8.6 |
| Over 55 | 3 | 2.6 |
| Missing | 1 | 0.9 |
| Gender | | |
| Male | 11 | 9.5 |
| Female | 104 | 89.1 |
| Missing | 1 | 0.9 |
| Ethnicity | | |
| Black/African American | 115 | 99.1 |
| Missing | 1 | 0.9 |
| Religion | | |
| Other | 1 | 0.9 |
| Protestant | 5 | 4.3 |
| Catholic | 1 | 0.9 |
| Christian | 91 | 78.4 |
| Inter/Nondenomination | 14 | 12.1 |
| No religion | 3 | 2.6 |
| Missing | 1 | 0.9 |

## Multivariate Multiple Regression Assumptions

Data were analyzed to test for linearity, multicollinearity, independent observations, homoscedasticity, and normality, and that there were no outliers that would bias the model. Linearity was assessed with the use of scatterplots, which suggested the data were linear. Multicollinearity was assessed by examining and ensuring the variance inflation factor scores were below 10 and tolerance scores above 0.2. Durbin-Watson scores were used to determine that the values of the residuals were independent. Scatterplots were also used to test homoscedasticity, which was met. P-P plot was used to

test that the values of the residuals were normally distributed. The results showed that this assumption may be violated and the results should be interpreted with caution. Finally, Cook's distance values were assessed and were all under 1, which suggested the individual cases were not unduly influencing the model and there were no outliers.

**Findings of Statistical Analysis**

The research questions aimed to explore the relationship between the independent variables—positive religious coping and negative religious coping—and the dependent variables—help-seeking attitudes, symptoms of anxiety, and symptoms of depression. The research questions also aimed to determine whether AEE moderated the relationship between these variables. Multivariate multiple regression was used to test each hypothesis associated with each of the research questions. The first research question asked whether positive religious coping predicted help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians. Positive religious coping was not a statistically significant predictor of help-seeking attitudes, symptoms of anxiety, or symptoms of depression, $F = .998$, $p = .485$; Wilk's $\Lambda = 0.559$.

**Table 2**

*Multivariate Tests*[a]

| Effect | | Value | F | Hypothesis df | Error df | Sig. |
|---|---|---|---|---|---|---|
| Intercept | Pillai's trace | .968 | 787.147[b] | 3.000 | 79.000 | .000 |
| | Wilks' lambda | .032 | 787.147[b] | 3.000 | 79.000 | .000 |
| | Hotelling's trace | 29.892 | 787.147[b] | 3.000 | 79.000 | .000 |
| | Roy's largest root | 29.892 | 787.147[b] | 3.000 | 79.000 | .000 |
| PosRel Coping | Pillai's trace | .522 | 1.005 | 51.000 | 243.000 | .472 |
| | Wilks' lambda | .559 | .998 | 51.000 | 236.001 | .485 |
| | Hotelling's trace | .651 | .991 | 51.000 | 233.000 | .498 |
| | Roy's largest root | .339 | 1.616[c] | 17.000 | 81.000 | .079 |

*Note*. a. Design: Intercept + PositiveRelCoping; b. Exact statistic; c. The statistic is an upper bound on F that yields a lower bound on the significance level.

The second research question asked whether negative religious coping predicted help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians. Negative religious coping was a statistically significant predictor of help-seeking attitudes, symptoms of anxiety, and symptoms of depression $F = 2.42$, $p =< .05$ ; Wilk's $\Lambda = 0.266$ (see Table 2); however, follow-up tests were done to determine how the dependent variables differ from the independent variable. This was done using tests of between-subjects effects (Table 3). From this, I determined that negative religious coping does not significantly predict help-seeking attitudes, $F= 1.47$, $p =.126$; however, negative religious coping does significantly predict symptoms of anxiety $F=5.33$, $p < .05$ and symptoms of depression $F= 3.23$, $p < .05$. The results are displayed in Table 3.

**Table 3**

*Multivariate Tests*[a]

| Effect | | Value | F | Hypothesis df | Error df | Sig. |
|---|---|---|---|---|---|---|
| Intercept | Pillai's trace | .959 | 609.765[b] | 3.000 | 78.000 | .000 |
| | Wilks' lambda | .041 | 609.765[b] | 3.000 | 78.000 | .000 |
| | Hotelling's trace | 23.453 | 609.765[b] | 3.000 | 78.000 | .000 |
| | Roy's largest root | 23.453 | 609.765[b] | 3.000 | 78.000 | .000 |
| NegRel | Pillai's trace | 1.007 | 2.247 | 54.000 | 240.000 | .000 |
| Coping | Wilks' lambda | .266 | 2.418 | 54.000 | 233.226 | .000 |
| | Hotelling's trace | 1.840 | 2.613 | 54.000 | 230.000 | .000 |
| | Roy's largest root | 1.259 | 5.595[c] | 18.000 | 80.000 | .000 |

*Note*. a. Design: Intercept + PositiveRelCoping; b. Exact statistic; c. The statistic is an upper bound on F that yields a lower bound on the significance level.

**Table 4**

*Tests of Between-Subjects Effects*

| Source | Dependent variable | Type III sum of squares | df | Mean square | F | Sig. |
|---|---|---|---|---|---|---|
| Corrected model | HelpSeekingScore | 8.388[a] | 18 | .466 | 1.465 | .126 |
| | SymptomsOfAnx | 35.058[b] | 18 | 1.948 | 5.333 | .000 |
| | SymptomsOfDep | 17.895[c] | 18 | .994 | 3.225 | .000 |
| Intercept | HelpSeekingScore | 425.691 | 1 | 425.691 | 1338.027 | .000 |
| | SymptomsOfAnx | 224.568 | 1 | 224.568 | 614.876 | .000 |
| | SymptomsOfDep | 176.730 | 1 | 176.730 | 573.225 | .000 |
| Negative RelCoping | HelpSeekingScore | 8.388 | 18 | .466 | 1.465 | .126 |
| | SymptomsOfAnx | 35.058 | 18 | 1.948 | 5.333 | .000 |
| | SymptomsOfDep | 17.895 | 18 | .994 | 3.225 | .000 |
| Error | HelpSeekingScore | 25.452 | 80 | .318 | | |
| | SymptomsOfAnx | 29.218 | 80 | .365 | | |
| | SymptomsOfDep | 24.665 | 80 | .308 | | |
| Total | HelpSeekingScore | 1216.062 | 99 | | | |
| | SymptomsOfAnx | 437.563 | 99 | | | |
| | SymptomsOfDep | 373.682 | 99 | | | |
| Corrected total | HelpSeekingScore | 33.839 | 98 | | | |
| | SymptomsOfAnx | 64.276 | 98 | | | |
| | SymptomsOfDep | 42.560 | 98 | | | |

*Note.* a. R squared = .248 (adjusted R squared = .079); b. R squared = .545 (adjusted R squared = .443); c. R squared = .420 (adjusted R squared =.290).

The third and final research question asked whether AEE moderates the relationship between positive and/or negative religious coping and help-seeking attitudes, symptoms of anxiety, and symptoms of depression in African American Christians. To test the hypotheses, two new variables were developed: one for the interaction between AEE and positive religious coping and one for the interaction between AEE and negative religious coping. The results showed that AEE does moderate the relationship between positive religious coping and help-seeking attitudes, symptoms of anxiety, and symptoms of depression, $F= 4.18$, $p < .05$., Wilk's $\Lambda= .000$.

**Table 5**

*Multivariate Tests*[a]

| Effect | | Value | F | Hypothesis df | Error df | Sig. |
|---|---|---|---|---|---|---|
| Intercept | Pillai's trace | 1.000 | 4807.487[b] | 3.000 | 5.000 | .000 |
| | Wilks' lambda | .000 | 4807.487[b] | 3.000 | 5.000 | .000 |
| | Hotelling's trace | 2884.492 | 4807.487[b] | 3.000 | 5.000 | .000 |
| | Roy's largest root | 2884.492 | 4807.487[b] | 3.000 | 5.000 | .000 |
| Ambivalence Positive Interaction | Pillai's trace | 2.924 | 3.045 | 267.000 | 21.000 | .002 |
| | Wilks' lambda | .000 | 4.180 | 267.000 | 15.958 | .001 |
| | Hotelling's trace | 440.794 | 6.053 | 267.000 | 11.000 | .001 |
| | Roy's largest root | 373.602 | 29.384c | 89.000 | 7.000 | .000 |

*Note*. a. Design: Intercept + PositiveRelCoping; b. Exact statistic; c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Because there was a significant relationship, tests of between-subject effects were again used to look at the specific relationship between the independent and dependent variables. AEE does not moderate the relationship between positive religious coping and help seeking. AEE does moderate the relationship between positive religious coping and symptoms of anxiety, $F= 5.45$, $p< .05$ and symptoms of depression, $F= 3.76$, $p< .05$.

**Table 6**

*Tests of Between-Subjects Effects*

| Source | Dependent variable | Type III sum of squares | df | Mean square | F | Sig. |
|---|---|---|---|---|---|---|
| Corrected model | HelpSeekingScore | 30.774[a] | 89 | .346 | 1.607 | .264 |
| | SymptomsOfAnx | 60.090[b] | 89 | .675 | 5.449 | .012 |
| | SymptomsOfDep | 39.830[c] | 89 | .448 | 3.759 | .035 |
| Intercept | HelpSeekingScore | 1130.982 | 1 | 1130.982 | 5256.285 | .000 |
| | SymptomsOfAnx | 353.276 | 1 | 353.276 | 2851.145 | .000 |
| | SymptomsOfDep | 314.316 | 1 | 314.316 | 2640.256 | .000 |
| AEEPos Interaction | HelpSeekingScore | 30.774 | 89 | .346 | 1.607 | .264 |
| | SymptomsOfAnx | 60.090 | 89 | .675 | 5.449 | .012 |
| | SymptomsOfDep | 39.830 | 89 | .448 | 3.759 | .035 |
| Error | HelpSeekingScore | 1.506 | 7 | .215 | | |
| | SymptomsOfAnx | .867 | 7 | .124 | | |
| | SymptomsOfDep | .833 | 7 | .119 | | |
| Total | HelpSeekingScore | 1194.617 | 97 | | | |
| | SymptomsOfAnx | 424.313 | 97 | | | |
| | SymptomsOfDep | 362.225 | 97 | | | |
| Corrected total | HelpSeekingScore | 32.280 | 96 | | | |
| | SymptomsOfAnx | 60.957 | 96 | | | |
| | SymptomsOfDep | 40.664 | 96 | | | |

*Note.* a. R squared = .953 (adjusted R squared = .360); b. R squared = .986 (adjusted R squared = .805); c. R squared = .980 (adjusted R squared =.719).

The second part of the third research questions looks to determine whether AEE also moderates the relationship between negative religious coping and help-seeking attitudes, symptoms of anxiety, and symptoms of depression. AEE does not moderate the relationship between negative religious coping and help-seeking attitudes, symptoms of anxiety and symptoms of depression $F= 1.93$, $p = .087$, Wilk's $\Lambda= .00$.

**Table 7**

*Multivariate Tests*[a]

| Effect | | Value | F | Hypothesis df | Error df | Sig. |
|---|---|---|---|---|---|---|
| Intercept | Pillai's trace | .999 | 1162.766[b] | 3.000 | 4.000 | .000 |
| | Wilks' lambda | .001 | 1162.766[b] | 3.000 | 4.000 | .000 |
| | Hotelling's trace | 872.074 | 1162.766[b] | 3.000 | 4.000 | .000 |
| | Roy's largest root | 872.074 | 1162.766[b] | 3.000 | 4.000 | .000 |
| Ambivalence Negative Interaction | Pillai's trace | 2.916 | 2.316 | 270.000 | 18.000 | .020 |
| | Wilks' lambda | .000 | 1.934 | 270.000 | 12.960 | .087 |
| | Hotelling's trace | 140.284 | 1.386 | 270.000 | 8.000 | .328 |
| | Roy's largest root | 80.756 | 5.384[c] | 90.000 | 6.000 | .020 |

*Note*. a. Design: Intercept + PositiveRelCoping; b. Exact statistic; c. The statistic is an upper bound on F that yields a lower bound on the significance level.

## Summary

Findings from the data analysis revealed that for the first research question, the null hypothesis is accepted and positive religious coping does not predict help-seeking attitudes, symptoms of anxiety or symptoms of depression; however, the findings revealed that the null hypothesis should be rejected in the second research question, as negative religious coping was a significant predictor of symptoms of anxiety and symptoms of depression, although not a significant predictor of help-seeking attitudes. Lastly, the findings from the data revealed that the null hypothesis is rejected for the last research questions as AEE was shown to moderate the relationship between positive religious coping and symptoms of depression and symptoms of anxiety. AEE on the other hand, did not moderate the relationship between negative religious coping and these variables.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of the study was to examine the relationship between positive and negative religious coping and African American Christians' help-seeking attitudes, symptoms of anxiety, and symptoms of depression and to determine whether any of those relationships would be moderated by AEE. The reason for conducting this study was due to the historical concern that African American Christians tend to rely on the Black church to address their mental health needs. Although there has been research conducted on the relationship between religious coping and some mental health symptoms, there has been inadequate research into the relationship of religious coping within the Black church and whether it results in exacerbated mental health symptoms and avoidance of professional mental health care.

In the current study, I found that positive religious coping had no significant interaction with help-seeking, symptoms of anxiety, or symptoms of depression until AEE was added as a moderator variable. When AEE was added, the relationship between positive religious coping and symptoms of anxiety and symptoms of depression changed, making positive religious coping a predictor for both symptoms. AEE did not change the relationship between positive religious coping and help seeking. Negative religious coping proved to be significant in predicting symptoms of anxiety and symptoms of depression, but not a significant predictor of help seeking. AEE did not moderate the relationship between negative religious coping and help seeking, symptoms of anxiety, or

symptoms of depression. This chapter will include a discussion of these findings, implications and limitations of the study, and recommendations for further research.

## Interpretation of Findings

This study provided further insight into the effects of religious coping on mental health, specifically in African American Christians. The findings of this study both confirmed and disconfirmed some of the research findings reported in Chapter 2. Although Krok (2015) and Pargament et al. (2005) found that religious beliefs could hinder the coping process and even contribute to stress level, the current study showed no significant relationship between positive religious coping and symptoms of anxiety or symptoms of depression until the moderator variable AEE was added. Bryant et al., (2016) determined that when an individual has higher levels of AEE coupled with higher religious coping, they experience greater distress, indicating these individuals may experience more anxiety and depression symptoms than others.

Negative religious coping did predict symptoms of anxiety and symptoms of depression for African American Christians, which confirms previous findings (Siltan et al., 2014). Siltan et al. found that negative religious coping was associated with social anxiety and other adverse effects, such as lower levels of well-being and higher levels of distress. The current study's findings also confirm previous findings from Lee et al., (2014) who found that negative religious coping was significantly associated with higher levels of depression.

This study did not confirm Ayvaci's (2016) and Payne's (2009) findings that having a relationship with clergy can lead to avoiding mental health services. This

study's findings revealed no significant relationship between negative or positive religious coping and seeking mental health care. Based on Pargament's (1997) religious coping model, I expected to find a relationship between religious coping, especially negative religious coping, and help seeking, symptoms of anxiety, and symptoms of depression. Pargament's theory points out the potential for religious coping to be harmful to the coping process. Pargament addressed the significance of each individual's situation, resources, needs, and preferences in determining whether religious coping would be advantageous or disadvantageous. Based on the theory, I expected that positive religious coping would have an adverse effect on help seeking and result in decreased symptoms of anxiety and depression. In the current study, there was no significant relationship between positive religious coping and help seeking, symptoms of anxiety, or symptoms of depression in African American Christians. This means for individuals who had a secure relationship with God in which they engaged in activities such as praying, treating God as a partner, seeking Him for support and love, and seeking the support of clergy and other members, there was no significant relationship with help seeking, symptoms of anxiety, or symptoms of depression. This relationship changed when AEE was added. This means that for those individuals who had higher levels of AEE, positive religious coping was a predictor of symptoms of anxiety and depression.

According to Pargament's (1997) theory, negative religious coping was expected to have an adverse effect on symptoms of anxiety and symptoms of depression, which was the case in this study. Negative religious coping predicted symptoms of both anxiety and depression. This means that individuals who struggle with their relationship with

God, see their stress as punishment from God, try to deal with things without God, or try to wait for God to remove their stressor while they do nothing will have increased symptoms of anxiety and depression. The results of this study, like previous studies, suggest there is importance in examining the relationship between religious coping and mental health, especially in groups who do not have a positive history of professional mental health care, but there are other factors that may affect the results of the study or provide further insight that were not addressed in the current study. These limitations are discussed in the following section.

## Limitations of the Study

There are a number of limitations to note for this study. The first limitation is related to recruitment and the use of convenience sampling, which was solely through social media using Facebook groups and posts. The plan was to initially recruit at local churches in addition to Facebook, but because of church closures due to the COVID-19 pandemic, this was no longer an option. Through social media recruitment, there was no way to vet the participants, so I relied solely on the word of the participants. This also poses a limitation to reliability. The data were all from self-reports; therefore, there is no way to know whether each participant answered the questions completely honestly.

Another limitation for this study is related to generalizability. Because I focused only on African Americans, the results of may not be generalizable for other racial and ethnic groups. The sample also consisted largely of women (97.5%), which means the results also may not be generalizable to men. The sample size of the study may also be a limitation. The sample consisted of 115 participants. Despite this being a sufficient

sample size based on power analysis, this sample may not be representative of this group as a whole. Because of the limitations of the current study, there are some recommendations for further research.

## Recommendations

In the current study, I focused on religious coping in African American Christians. The results of the study indicate a significant relationship between negative religious coping and symptoms of anxiety and symptoms of depression among this group. In future studies, researchers should explore whether this is also the case among other racial and ethnic groups. In future studies, researchers might also want to look at whether this differs among specific denominations under Christianity.

Future researchers should also explore other factors that may result in decreased help seeking among this group; the current research showed no significant relationship between help seeking and either type of religious coping, although previous research has shown that religion is a barrier to treatment (Almanzar, 2017; Ayvaci, 2016; Payne, 2009). Based on previous research, there may be other religious variables resulting in decreased help seeking, which is important to study. For example, there is the relationship some individuals may have with clergy who are dismissive of mental health issues or clergy who see mental health as a punishment from God or as the result of demonic possession.

My study also found that there was a change in the relationship between positive religious coping and symptoms of depression and anxiety when AEE was added. I recommend that future research look closer at the relationship between AEE and religious

coping in this population and other populations. Previous research has shown that religious coping changed the relationship between AEE and anxiety and depressive symptoms by worsening symptoms, (Bryan et al., 2016), but there is a lack of research that looks specifically at how religion and religious coping effects one's ability to express their emotions.

## Implications

This study contributes to the reduction of the gap related to how religious coping affects mental health among African Americans as well as the gap of the effects of religious coping on anxiety and depression resulting from AEE. The study also provides further research in an underresearched area and an underresearched group—religious coping and African Americans, respectively.

Based on the results of the study, viewing stressors as punishment from God, trying to deal with things without God, or passively waiting for God to remove a stressor, also known as negative religious coping, is a predictor of anxiety and depression symptoms in African American Christians. These results provide important information for mental health professionals as well as clergy working with African Americans who are experiencing symptoms of anxiety and depression. The study suggests the importance of addressing the religious background and use of religion when coping with symptoms, when identifying treatment goals, and subsequently providing treatment to African American Christians. It is important for therapists to know what contributes to a client's symptoms, and religious coping has previously been overlooked as a possible contributing factor to one's mental health symptoms. The client might also overlook or

not understand or recognize how employing the use of negative religious coping could result in some of the symptoms they are seeking help for. By knowing and understanding the research in this area, therapists can now address these things in treatment, potentially enhancing the overall experience and efficacy of therapy for African American Christians.

The results also suggest the importance of assessing AEE when working with this group, as this was an important factor that changed the relationship between positive religious coping and anxiety and depression symptoms. This means that it is important for therapists to know that although activities such as praying, treating God as a partner and seeking him for support and love, seeking support from one's church, and forgiveness may be advantageous when addressing anxiety and depression symptoms, this changes when the client also experiences conflict with wanting to express emotions but fear with doing so or has regret after expressing emotions. This implies that it is important for therapists to address any conflict, fear, or regret clients may have related to expressing how they feel.

Historically African American Christians have relied on the Black Church and have had difficulty admitting or expressing certain feelings, especially those related to God and the Church. Understanding this connection between AEE and African American Christians' mental health will also increase treatment efficacy by allowing for a healthy outlet for Christians to express their emotions and also process the conflict, fear, or regret they may experience as a result of it. For example, if an African American seeks out therapy for symptoms of anxiety and depression and mentions the importance of their

Christian faith, results from this study can be used to prepare the therapist for potential religion-related concerns and the client's potential difficulty with discussing those concerns due to ambivalence. The results of this study can also give the client a new perspective on their symptoms and how to better address them with their therapist.

The findings of the study can be used in discussing and addressing mental disparities among African Americans and other groups, such as non-Hispanic Whites, which may impact positive social change at an organizational and societal level. Research has shown that African Americans are less likely to seek mental health care (Hays, 2015; Neighbors et al., 2007; Obasi & Leong, 2008). Increasing understanding of cultural factors, such as the use of religious coping among African Americans, has the potential to enhance services and address religion as a potential barrier to help-seeking, therefore contributing to increased multicultural competency.

This study also has the potential to be socially impactful to individuals, families, and the group African American Christians in helping them to understand not only the benefits of religion and religious coping, but also the potential harm of it. The knowledge from this study can be presented in therapy and/or discussed with one's clergy. The knowledge gained from this study potentially provides more insight into experiences with symptoms of anxiety and symptoms of depression among African American Christians. When not used as a healthy and supplementary form of coping, the study shows that religious coping, specifically negative religious coping, can contribute to unwanted mental health symptoms of anxiety and depression. The study can contribute to a better understanding about these experiences and lead individuals to actively address their

mental health instead of blaming the devil for it or seeing it as a punishment from God and waiting on Him to fix it, therefore increasing the rates of help-seeking among this group and subsequently adequate treatment.

## Conclusion

Religions and the Black Church has been a staple in the African American community for many things and many years. Historically, one of the main functions of the Black Church is counsel from clergy for mental health concerns. Although works have focused on this role of the Black Church, the effect of the individual choice of religious coping has been neglected among this group. Beyond counsel from clergy, there is the individual use of both negative and positive religious coping in African Americans. The purpose of this study was to determine the relationship between positive religious coping, negative religious coping, help-seeking attitudes, symptoms of anxiety and depression and a moderator variable—AEE—in African American Christians. This study showed that positive religious coping, when moderated by AEE, predicts both anxiety and depression symptoms. It also showed that negative religious coping alone was a predictor of both anxiety and depression symptoms. The lack of significance in the relationship between both positive and negative religious coping and help seeking was a surprise as the researcher was under the impression that relying on one's religion would result in lesser propensity to seek help from a formal mental health provider. This researcher is hopeful that what the study did not show, its limitations, implications and further recommendations provided will be a catalyst for other researchers to further

investigate and develop greater knowledge into the relationship between African American Christian beliefs and coping and their mental health.

The results of the study can be shared among staff within the Black Church as well as its parishioners to modify the Black Church experience and enhance the benefits thereof. Also of importance, these results can and should also be shared among mental health practitioners as the results provide knowledge and insight into improving treatment among this group. According to Ward et al. (2009) and Hunter and Schmidt (2010), African Americans are more likely to be misdiagnosed due to a misunderstanding of how symptoms are presented and other issues of cultural competence. The results of this study can be used to enhance knowledge and therefore cultural competency of therapists when working with African American Christians. Previous studies have also shown that African Americans who receive mental health care receive poor quality of care and do not receive the best available treatments (McGuire & Mirand, 2008). With the knowledge and insight gained from this study, practitioners can provide better and more informed treatment for this group.

Ultimately, the researcher hopes this study will begin to close the gap between African American's view of Christianity and professional mental health care. The hope is that some clergy will stop seeing mental health care as a distrust in God. With the knowledge and insight from the study, a partnership between clergy and professional mental health providers to address the mental health needs of African American Christians is not too farfetched. The goal is to understand the barriers to treatment, address those barriers, and provide the best treatment available, and for an African

American Christian, that very well may be through the church and a therapist. The Black Church has always been and seems that it will remain a staple in this area, but per this study's implications, the benefits of using religious coping can be enhanced through professional mental health care.

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Appendix A: Brief RCOPE Permission

**Re: Brief RCOPE permission**

Kenneth I Pargament <kpargam@bgsu.edu>
Sat 5/9/2020 9:38 AM
**To:** Anya Dobbs <anya.dobbs@waldenu.edu>

2 attachments (523 KB)
Brief RCOPE and Manualdoc mixed + - items.doc; Pargament 2011 Brief RCOPE Religions.pdf;

Dear Anya:

You have my permission to use the Brief RCOPE. I'm attaching information about the use of the scale and a fairly recent article. Please keep me posted on your findings.

Best regards,
Ken

Kenneth I. Pargament, Ph. D.
Professor
Department of Psychology
Bowling Green State University
Bowling Green, OH 43403

Author, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred*, Guilford Press, 2007
Editor-in-Chief, *APA Handbook of Psychology, Religion, and Spirituality* (Vols. 1 and 2), APA Press, 2013

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**From:** Anya Dobbs <anya.dobbs@waldenu.edu>
**Sent:** Thursday, May 7, 2020 9:41 PM
**To:** Kenneth I Pargament <kpargam@bgsu.edu>
**Subject:** [EXTERNAL] Brief RCOPE permission

Hi Dr. Pargament,

I am currently a PhD student in the dissertation process. I would like to use the Brief RCOPE in my research. Would you please provide me with permission to do so and information on how to access the questionnaire with its scoring information.

# Appendix B: Brief RCOPE

Brief RCOPE

The following items deal with ways you coped with the negative event in your life. There are many ways to try to deal with problems. These items ask what you did to cope with this negative event. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something about a particular way of coping. We want to know to what extent you did what the item says. *How much or how frequently.* Don't answer on the basis of what worked or not – just whether or not you did it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can. Circle the answer that best applies to you.

1 – not at all
2 – somewhat
3 – quite a bit
4 – a great deal

| | | | | | |
|---|---|---|---|---|---|
| (+) l. Looked for a stronger connection with God. | | 1 | 2 | 3 | 4 |
| (-) 2. Wondered whether God had abandoned me. | | 1 | 2 | 3 | 4 |
| (-) 3. Felt punished by God for my lack of devotion. | 1 | 2 | 3 | 4 | |
| (+) 4. Sought God's love and care. | | 1 | 2 | 3 | 4 |
| (+) 5. Sought help from God in letting go of my anger. | | 1 | 2 | 3 | 4 |
| (-) 6. Decided the devil made this happen. | | 1 | 2 | 3 | 4 |
| (+) 7. Tried to put my plans into action together with God. | | 1 | 2 | 3 | 4 |
| (-) 8. Questioned the power of God. | | 1 | 2 | 3 | 4 |
| (+) 9. Tried to see how God might be trying to strengthen me in this situation. | 1 | 2 | 3 | 4 | |
| (-) 10. Wondered what I did for God to punish me. | | 1 | 2 | 3 | 4 |
| (-) 11. Questioned God's love for me. | | 1 | 2 | 3 | 4 |
| (+)12. Asked forgiveness for my sins. | | 1 | 2 | 3 | 4 |
| (+)13. Focused on religion to stop worrying about my problems. | 1 | 2 | 3 | 4 | |
| (-)14. Wondered whether my church had abandoned me. | | 1 | 2 | 3 | 4 |

_____
(+) Positive religious coping item
(-) Negative religious coping item

# Appendix C: AEQ Permission

PsycTESTS®

**Ambivalence Over Emotional Expressiveness Questionnaire**

PsycTESTS Citation:
King, L. A., & Emmons, R. A. (1990). Ambivalence Over Emotional Expressiveness Questionnaire [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t00699-000

Instrument Type:
Inventory/Questionnaire

Test Format:
The rating scale for the Ambivalence Over Emotional Expressiveness Questionnaire (AEQ) ranged from 1 to 5, with 1 indicating that the respondent never feels what the statement suggests and 5 indicating that the respondent frequently feels that way. It may be noted that no items on the AEQ are negatively worded.

Source:
King, Laura A., & Emmons, Robert A. (1990). Conflict over emotional expression: Psychological and physical correlates. Journal of Personality and Social Psychology, Vol 58(5), 864-877. doi: https://dx.doi.org/10.1037/0022-3514.58.5.864

# Appendix D: AEQ

PsycTESTS®

doi: 10.1037/t00699-000

**Ambivalence Over Emotional Expressiveness Questionnaire**
**AEQ**

Items

24. It is hard to find the right words to indicate to others what I am really feeling.
25. I worry that if I express negative emotions such as fear and anger, other people will not approve of me.
1. I want to express my emotions honestly but I am afraid that it may cause me embarrassment or hurt.
27. I often cannot bring myself to express what I am really feeling.
11. I'd like to talk about my problems with others, but at times I just can't.
18. I want to tell someone when I love them, but it is difficult to find the right words.
19. I would like to express my disappointment when things don't go as well as planned, but I don't want to appear vulnerable.
8. Often I'd like to show others how I feel, but something seems to be holding me back.
21. I try to hide my negative feelings around others, even though I am not being fair to those close to me.
17. Often I find that I am not able to tell others how much they really mean to me.
10. I try to keep my deepest fears and feelings hidden, but at times I'd like to open up to others.
22. I would like to be more spontaneous in my emotional reactions but I just can't seem to do it.
20. I can recall a time when I wish that I had told someone how much I really cared about them.
26. I feel guilty after I have expressed anger to someone.
6. I would like to express my affection more physically but I am afraid others will get the wrong impression.
23. I try to suppress my anger, but I would like other people to know how I feel.
15. I try to apologize when I have done something wrong but I worry that I will be perceived as incompetent.
28. After I express anger at someone, it bothers me for a long time.
14. I try to show people I love them, although at times I am afraid that it may make me appear weak or too sensitive.
9. I strive to keep a smile on my face in order to convince others I am happier than I really am.
12. When someone bothers me, I try to appear indifferent even though I'd like to tell them how I feel.
4. I try to avoid sulking even when I feel like it.
5. When I am really proud of something I accomplish I want to tell someone, but I fear I will be thought of as conceited.
13. I try to refrain from getting angry at my parents even though I want to at times.
7. I try not to worry others, even though sometimes they should know the truth.
2. I try to control my jealousy concerning my boyfriend/girlfriend even though I want to let them know I'm hurting.
16. I think about acting when I am angry but I try not to.
3. I make an effort to control my temper at all times even though I'd like to act on these feelings at times.

Appendix E: MHSAS Permission

# Hammer Instrument Permission Form

Congratulations! You hereby have permission to use Dr. Hammer's instrument(s) for the study/application you described.

You can download a copy of the instrument(s) from their pages (see http://drjosephhammer.com/research/) on Dr. Hammer's website.

Please note that you will need to fill out this permission form again to use the instrument(s) in future studies/applications.

Edit your response

Submit another response

# Appendix F: MHSAS



**Mental Help Seeking Attitudes Scale (MHSAS)**

INSTRUCTIONS: For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression).

Please mark the circle that best represents your opinion. For example, if you feel that your seeking help would be extremely useless, you would mark the circle closest to "useless." If you are undecided, you would mark the "0" circle. If you feel that your seeking help would be slightly useful, you would mark the "1" circle that is closer to "useful."

**If I had a mental health concern, seeking help from a mental health professional would be...**

| | 3 | 2 | 1 | 0 | 1 | 2 | 3 | |
|---|---|---|---|---|---|---|---|---|
| Useless | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Useful |
| Important | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Unimportant |
| Unhealthy | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Healthy |
| Ineffective | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Effective |
| Good | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Bad |
| Healing | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Hurting |
| Disempowering | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Empowering |
| Satisfying | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Unsatisfying |
| Desirable | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Undesirable |

**Scoring Key**

The MHSAS contains nine items which produce a single mean score. The MHSAS uses a seven-point semantic differential scale. Please note that the scale labels (3, 2, 1, 0, 1, 2, 3) are only provided to assist participants, and are not to be used in scoring the MHSAS. To counteract possible response sets, the valence of the item anchors was counterbalanced across the nine items. For example, the "useless – useful" item had the positively-valenced term (i.e., useful) on the right side of the scale, whereas the "important – unimportant" item had the positively-valenced term (i.e., important) on the left side of the scale. In order to properly calculate the MHSAS mean score, where a higher mean score indicates more favorable attitudes, it is necessary to reverse-code items 2, 5, 6, 8, and 9. After reverse coding, a score of "1" (the circle to the farthest left of the seven-point scale) on a given item should indicate an unfavorable attitude, a score of "4" (the middle circle of the seven-point scale) on a given item should indicate a neutral attitude, and a score of "7" (the circle to the farthest right side of the seven-point scale) on a given item should indicate a favorable attitude. Once reverse-coding is complete, calculate the MHSAS mean score by adding the item scores together and dividing by the total number of answered items. The resulting mean score should range from a low of 1 to a high of 7. For example, if someone answers 9 of the 9 items, the mean score is produced by adding together the 9 answered items and dividing by 9. Likewise, if someone answers 8 of the 9 items, the total score is produced by adding together the 8 answered items and dividing by 8. Per Parent's 20% recommendation (2014; DOI: 10.1177/0011000012445176), a mean score should only be calculated for those respondents who answered at least 8 of the items. For more information about the MHSAS, please visit: http://DrJosephHammer.com

*Please visit http://drjosephhammer.com/research/mental-help-seeking-attitudes-scale-mhsas/ for information on how to administer, score, interpret, discuss the reliability and validity of, consider the limitations of, and obtain permission to use the MHSAS.

# Appendix G: PHQ-ADS (PHQ9 and GAD-7)

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING 0 + _____ + _____ + _____

**=Total Score:** _____

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

| **Not difficult at all** | **Somewhat difficult** | **Very difficult** | **Extremely difficult** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

# GAD-7

| Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| **2.** Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| **3.** Worrying too much about different things | 0 | 1 | 2 | 3 |
| **4.** Trouble relaxing | 0 | 1 | 2 | 3 |
| **5.** Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| **6.** Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| **7.** Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**(*For office coding: Total Score T____ = ____ + ____ + ____ )***