Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies Collection

11-26-2024

Religious Attitudes and Fear Toward Traditional Biomedical and Psychological Services Among People of the Christian Faith

Brennan Cackett
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

Part of the Social Psychology Commons

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Brennan Cackett

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Jody Dill, Committee Chairperson, Psychology Faculty
Dr. Susan Marcus, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

Religious Attitudes and Fear Toward Traditional Biomedical and Psychological Services Among People of the Christian Faith

by

Brennan Cackett

MS, Walden University, 2018

MA, California Baptist University, 2013

BS, California Baptist University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

November 2024

Abstract

Adults who identify as Christian often seek help within their religious communities for mental health issues. Research suggested that religious counseling services may discourage members from reporting mental health issues to traditional biomedical and psychological providers. The purpose of this quantitative study was to examine the extent to which people who identify as Christian in Southern California seek help outside of the Church and whether their help seeking is influenced by their religious attitudes and perceived fear of traditional psychological services. Southern California was chosen as it is where the Christian Counseling movement was started and has a large population of Christians. Heider's theory of attribution and Kelley's covariation model were used as the theoretical frameworks. A survey design was used to collect data from 128 adults using the Pathways Questionnaire to measure religious attitudes, the Thoughts About Psychotherapy Survey to measure perceived fear, and the Mental Help-Seeking Intention Scale to measure delay of mental illness reporting. The results of a Hayes PROCESS model 4 mediation analysis indicated the total effect of religious attitudes on delay of mental illness reporting mediated by perceived fear to be significant and negative, although the amount of variance accounted for was small. The indirect effect of perceived fear was negative and nonsignificant. Religious attitudes negatively predicted delay of mental illness reporting, and positively predicted perceived fear. The results may promote positive social change to encourage religious communities to support their parishioners to seek mental health services when experiencing distress and challenges.

Religious Attitudes and Fear Toward Traditional Biomedical and Psychological Services

Among People of the Christian Faith

by

Brennan Cackett

MS, Walden University, 2018

MA, California Baptist University, 2013

BS, California Baptist University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

Month 2024

Dedication

I wish to dedicate my dissertation to two individuals, John Avery Whittaker and my mother. My mother's dedication to my education and introducing me to the academic world early when I was growing up instilled in me a love of learning that has never left.

Acknowledgments

I would like to thank all of my friends and family who have supported me over the years; your kindness and listening ears have helped make this process easier. I would also like to specifically thank my mother, who first set me down the path of higher education by inspiring me to be the first member of my family to get a master's and then a PhD. I would also like to thank my committee, Dr. Jay Dill and Dr. Susan Marcus, for their time, mentorship, and commitment to helping me on this journey.

Table of Contents

Abstract ....

Dedication ....

Acknowledgment vii

List of Tables iv

List of Figures v

Chapter 1: Introduction to the Study 1

Background 1

Problem Statement 3

Purpose of the Study 6

Research Questions and Hypotheses 6

Theoretical Framework 7

Nature of the Study 8

Definitions 10

Assumptions 10

Scope and Delimitations 11

Limitations 11

Significance 12

Summary 13

Chapter 2: Literature Review 14

Literature Search Strategy 15

Theoretical Foundation 16

Literature Review....17

Fear of Traditional Biomedical and Psychological Services 17

Delay of Mental Illness Reporting 18

Choice of Service 21

Religious Attitudes.... 24

Summary 28

Chapter 3: Research Method....30

Research Design and Rationale 30

Methodology 33

Population 33

Sampling and Sampling Procedures 33

Sampling Size 33

Procedures for Recruitment, Participation, and Data Collection 33

Instrumentation and Operationalization of Constructs 36

Data Analysis Plan 39

Threats to Validity 40

Threats to Internal Validity 40

Threats to External Validity 41

Ethical Procedures 41

Summary 42

Chapter 4: Results....44

Data Collection 45

Demographics 46

Reliability Analysis..49

Results

Descriptive Statistics for Predictor and Outcome Variables................................ 49

Evaluation of Statistical Assumptions 52

Mediation Analysis 55

Summary 58

Chapter 5: Discussion, Conclusions, and Recommendations 60

Interpretation of the Findings...61

Relevance to Published Research 61

Relevance to Theoretical Framework 62

Limitations of the Study...63

Recommendations...64

Implications..64

Conclusion 65

References...67

Appendix A: Demographic Information Questionnaire 77

List of Tables

Table 1. Frequency Distributions of Demographic Characteristics 47

Table 2. Descriptive Statistics 51

Table 3. Correlation Matrix 51

Table 4. Results of Statistical Assumptions 53

Table 5. Model Summary 55

Table 6. Total Effect Model 55

Table 7. Model Summary 56

Table 8. Path Model 56

Table 9. Model Summary 56

Table 10. B Path and C Path Model 57

List of Figures

Figure 1. Scatterplot Dependent Variable Religious Attitudes.. 54

Figure 2. Mediation Model Results 58

Chapter 1: Introduction to the Study

The purpose of this quantitative study was to examine the relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear among adults who identify as Christian in Southern California religious communities and colleges, specifically adults who identify as Catholic or Protestant. This study addressed a gap in the literature regarding the role of religious counseling services in religious communities in Southern California potentially delaying its members from reporting mental health issues to traditional biomedical and psychological providers. There are potential implications for positive social change resulting from the findings of this study within the religious community regarding awareness of how it views mental health and professional biomedical and psychological services.

In this chapter, I provide background on the expanding nature of religious counseling services that compete with traditional biomedical and psychological services, as well the relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of traditional biomedical and psychological services. I also discuss the nature of the study, its research questions and hypotheses, theoretical framework, definitions of variables, scope, limitations, and significance.

Background

Ikwuka et al. (2016) studied pathways to mental health in South-Eastern Nigeria and the choice made between religious services and traditional biomedical and psychological services. Koenig (2012) provided information regarding patient care and religion as it relates to the spiritual needs of those seeking help, and also reviewed

research on religion/spirituality and mental health. Koenig (2012) also looked at behavioral outcomes such as depression and hope. Fox et al. (2020) examined religious commitment and spirituality and how they were directly related to attitudes toward psychological help seeking, with a focus on how these relationships were indirectly associated with spiritual bypass, which refers to a process by which an individual avoids painful psychological experiences by using spirituality as a defense (Basso et al., 2021). Fox et al. (2020) concluded that in practice, spiritual bypass can be an important patient quality to consider in relation to an individual’s attitudes toward and perhaps benefit from psychological help.

The role the church can and should play in mental health issues, which arise in the community, was discussed by Sanders et al. (2015) who recorded data on spirituality and psychotherapy; this research was relevant to the current study because it explained evidence-based practice regarding spirituality and psychology within the Christian community. Hodge et al. (2020) dealt with the overlapping subject matter of psychology and the church and how religious leaders expressed both positive and negative attitudes toward the use of psychologists in church ministry. Sutton et al. (2018) looked at how Christian psychotherapy is in high demand. However, Sutton et al. (2018) noted that in all but a few existing studies, outcomes from spiritually accommodated treatments did not outperform secular treatments on mental health outcomes.

A gap in the literature was identified regarding the role of religious counseling services in religious communities and their potential role in delaying its members from reporting mental health issues to traditional biomedical and psychological providers.

Oxhandler et al. (2018) addressed how religion and spirituality are interwoven into many individuals' cultures and are increasingly recognized as important constructs worth considering in the assessment and treatment of mental illness. The current study was needed because religious counseling is growing in popularity across Southern California as churches and religious communities seek to keep parishioners' issues and problems in-house to provide for their needs in a way that matches religious beliefs (see Knabb et al., 2019). With the increase in popularity of faith-based alternatives to psychological services, the current study was needed to understand the role of religious counseling services in religious communities and its potential role in delaying its members from reporting mental health issues to traditional biomedical and psychological providers.

Problem Statement

Over the last few years, religious communities have seen a growth in religious counseling services that compete with traditional biomedical and psychological services (Cuthbert et al., 2018). Ikwuka et al. (2016) addressed the significance of religious counseling and the effects it has on religious communities when individuals choose between religious counseling and professional biomedical and psychological options in Nigeria. Ikwuka et al. found that although religious services offered competition, people often chose traditional biomedical and psychological options. The issue of the intersection between religion and psychological treatment was also researched by Basso et al. (2021) regarding the handling of psychological cases in what was referred to as spiritual bypass, which denotes a process by which an individual avoids painful psychological experiences by using spirituality as a defense. The study found that

attitudes toward God were related to medical help-seeking attitudes. Likewise, these relationships were indirectly associated with spiritual bypass. The implications were that religious and spiritual variables relate to help-seeking attitudes. Although the general topic of mental health and religion had been researched for decades, the role of fear and religious attitudes toward traditional biomedical and psychological services on choosing counseling services was previously unknown in the Southern California region of the United States.

A meaningful gap in the literature existed regarding the role of religious counseling services in religious communities in potentially delaying its members from reporting mental health issues to traditional biomedical and psychological providers in the Southern California area of the United States. Turner and Llamas (2017) looked at the role fear of therapy and spirituality played in affecting access to mental health treatment among those of college age living in the state of Texas. Sutton et al. (2018) conducted a study into Christian psychotherapy and how in few existing studies, the outcome from spiritually accommodated treatments typically do not outperform secular treatments on mental health outcomes. Sutton et al. (2018) conducted two studies on adults who attended Christian psychotherapy to understand the relative contributions of patient factors to satisfaction with Christian psychotherapy and well-being. Ikwuka et al. (2016) conducted a study on the effects of faith-based counseling services on access to psychiatric care. Also, Winfrey and McMinn (1975) documented in many books the religious attitudes of the faith-based community toward non-church-based mental health care. These studies have shown this topic, at the intersection of spirituality, faith-based

counseling, and traditional mental health care, is important, and it also revealed a gap in this type of research in the Southern California area. According to the Center for Religion and Civic Culture (2020) located at the University of Southern California, the top three Christian religions (Roman Catholic, Nondenominational, and Southern Baptist) have almost 3,200 churches and almost 8 million adherents, which include 11 Christian universities, one of which is Biola University that houses one of the largest Christian psychology programs in the nation. Despite Southern California being a hub of Christianity and the biblical counseling movement, there was a gap on the topic that the current study addressed.

Mental health help seeking is important because of its potential impact on individuals and the church, and it can be a framework for a better understanding of the cultural context of the integration of church and psychology regarding help-seeking pathways (Hodge et al., 2020). Koenig (2012) mentioned that religions can play a role in an individual's decision to seek help or pursue other types of services because spirituality can be viewed as filling a need for attaining wholeness for the good of the community. The creation of the biblical counseling movement was due to the fear of traditional biomedical and psychological services that sprouted in churches and Christianity. Koenig argued that spirituality can be viewed as filling a need for attaining wholeness. Churches view psychology as being humanistic and secular, so there can be a fear of going to a psychologist. Mental illness might be treated in-house, which could delay reporting care to traditional biomedical and psychological providers. However, there was a gap in the literature regarding the role of fear and religious attitudes toward traditional biomedical

and psychological services in delaying care in the Southern California region of the United States where there are large numbers of Christians in various denominational communities.

Purpose of the Study

The purpose of this quantitative study was to examine the statistical relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of traditional biomedical and psychological services among adults who identify as Christian in Southern California religious communities and colleges. Specifically, the study addressed individuals who identify as either Catholic or Protestant. This population was selected because religious counseling is growing in popularity, and this target population is under researched. The current study assessed the relationship between religious attitudes toward traditional biomedical and psychological services and the choice of service for counseling. The study also examined the relationship between how choice of service for counseling may delay reporting of mental illness to traditional biomedical and psychological providers. The predictor variables were religious attitudes and perceived fear of traditional biomedical and psychological services, and the outcomes variables were choice of counseling service and delay of mental illness reporting.

Research Questions and Hypotheses

The following research questions and hypotheses guided the study:

RQ1: What is the relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults?

$H_0$1: There is no relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults.

$H_1$1: There is a relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults.

RQ2: What is the relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults?

$H_0$2: There is no relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults.

$H_1$2: There is a relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults.

RQ3: What is the relationship between choice of service for counseling and delay of mental illness reporting among Christian adults?

$H_0$3: There is no relationship between choice of service among Christian adults and delay of mental illness reporting.

$H_1$3: There is a relationship between choice of service among Christian adults and delay of mental illness reporting.

Theoretical Framework

The theoretical base for this study was Heider's (1958) theory of attribution and Kelley's (1973) covariation model. Heider's theory was selected because the theory of attribution addresses social perception and makes inferences regarding the reasons why people behave and view others in the ways they do. The theory helped me explain the reasons why members of religious communities may be partial to a particular viewpoint

when it comes to mental illness and the treatment thereof. The theory's use of types of attribution (internal versus external) and documentation of cultural bias was helpful in explaining members' religion-based attitudes, possible fear of biomedical and traditional psychological services, and embrace of religious services for mental illness issues.

Kelley's (1973) covariation model is a theory of attribution that is associated with social and self-perception regarding how and why people act the way they do in social and public situations. The model was appropriate for the current study because it helped me explain behavior over a period of time and attribute internal and external factors to see which of the two factors or combination of both is responsible. This was helpful in measuring the impact of religious attitudes on choice of services and it helped me explain the behavior of Christian adults and why they fear or embrace traditional or religious counseling services. Both theories' use of the documentation of cultural bias was helpful because churches and Christianity are a culture unto themselves in how they operate and the views they hold internally.

Nature of the Study

This study had a cross-sectional design using a survey method to obtain the data needed to answer the research questions. A positivist paradigm; a positivist approach was appropriate in this quantitative study to gather and analyze the data (Business Research Methodology, 2024. Positivism adheres to the view that factual knowledge is gained through observation and is trustworthy. In positivism, the role of the researcher involves data collection and analysis that is done in an objective way (Business Research Methodology, 2024). Quantitative methodology was chosen for the current study because

I sought to study the statistical relationships between variables and obtain quantifiable data on people's attitudes, perceptions, and behavior. Four variables were studied, including the religious attitudes of the participants, their fear of traditional biomedical and psychological services, their choice of counseling service, and delay of mental illness reporting.

The target population for this study was male and female Christian adults from various religious communities in Southern California that included churches, community centers, and universities. The research method was survey questionnaires administered in person and online due to the unpredictability of online ad conversions. The in-person facilitator who administered the questionnaires was provided with tables that were set up in churches, community centers, and universities. Electronic questionnaires were used to gather information online, and once this information was gathered, the data were analyzed using International Business Machines Statistical Package for the Social Sciences. I used linear regression to examine the possible statistical relationships between the variables. Online recruitment of participants included use of various forms of online ads such as Google and Facebook. The primary reason for this was to be able to gather as many different types of participants as possible. Using online ads to recruit participants also allowed me to reach a large number of participants and allowed the ads to be targeted. Gathering data in person also had its advantages including being able to recruit participants from a closed environment while also being able to offer rewards to take the surveys. The in-person method reached a smaller number of individuals; however, more of those individuals participated.

Definitions

Biomedical services: Services that use methods relating to biology and medicine to treat mental health issues (Deacon, 2013).

Choice of counseling service: An individual's act of selecting a type of service for counseling, including types such as religious counseling and traditional biomedical and psychological services (Ikwuka et al., 2016).

Christian: Individuals who follow the teachings of the Catholic, Protestant, or Evangelical branches of Christianity.

Delay of mental illness reporting: Individuals who delay seeking help for mental health issues (Dockery et al., 2015).

Fear of traditional biomedical and psychological services: The fear that religious individuals may have that comes from being influenced by the religions they follow (McMinn, 2012). This fear may be that traditional biomedical and psychological services will conflict with their religious ideals.

Psychological services: Services that use counseling or psychiatric methods to treat mental health issues (Barlow, 2004).

Religious attitudes: The attitudes that religion gives an individual that may inform their opinion regarding how they feel about biomedical and psychological services (Sharp, 1991).

Assumptions

An assumption in this study was that religious attitudes result in a delay in mental illness reporting, and that these attitudes inform Christian adults' decision regarding

choice of service. This choice could be explained by Heider's (1958) theory of attribution, which states that social perception and the inferences individuals make from them inform why people view others in the ways they do. I also assumed that all participants understood the questions being asked of them.

Scope and Delimitations

Religious communities have seen a growth in religious counseling services that have begun to compete with traditional biomedical and psychological services. This competition is possibly influencing the delayed reporting of mental illness due to religious attitudes. The current study focused on the large Christian population in Southern California and the religious choice of services in the region. There was a potential for generalizability with this study within the broader community of Christians outside Southern Californian because the results of this study could inform anyone who adheres to the basic tenets of Christianity.

Limitations

The first limitation was the need for extra resources to analyze the results of the study, which was due to having such a large pool of participants. Care needed to be taken regarding privacy issues with participants so as to not violate any ethical guidelines. One potential ethical issue was conducting the study on two university campuses where I had attended; however, this was not a major issue because my networking was minimal and did not impact this study. This research topic was chosen due to my observations of the religious counseling movement and its expansion in Southern California. I chose to focus on this region because it had not been studied before and it was home to millions of

religious followers. There was a potential for generalizability of results because the religious population was so large in this region. However, I did not see this as a concern because the religious population was large and comprised of various faith groups. To address limitations of survey instruments, I employed an anonymous survey, did not ask leading questions, and made sure my hypotheses were not visible to participants. Sampling and selection bias was avoided by the use of digital ads to target participants. This approach was random and did not allow me to select which people would participant aside from those of the Christian faith. Researcher bias was also avoided by not creating my own survey and using preapproved questionnaires.

Significance

This study supported potential contributions to social change because it examined how religious attitudes could influence Christian adults' perceptions of fear of traditional psychological and biomedical counseling services. Religion-based counseling services are growing, with many churches following one another to start counseling services for members of the community and their church base. This study provided findings to churches and traditional psychological and biomedical services regarding the role of fear in religious individuals' choice of service. This could impact how religious services are offered and to whom they are offered, making sure that fear is not being taken advantage of.

The study may effect positive social change through determining whether the choice of service for counseling among adults who identify as Christians is resulting in the delay of mental illness reporting to traditional biomedical and psychological

providers. The study may aid Christian adults by exposing religious attitudes and fear of traditional biomedical and psychological services. The findings could reveal the influence of religious attitudes or indicate that religious attitudes play no role in fear of traditional psychological and biomedical services. Either way, this study could help the religious community by giving them access to important information.

Summary

This study provided the opportunity to study a subject that had not been studied before in the greater Southern California region of the United States. By studying Christian individuals and gleaning data from this demographic, I sought to measure the variables and examine their relationships to answer the research questions. In Chapter 2, the researcher will review the theoretical framework and studies that have been conducted in this area.

Chapter 2: Literature Review

Religious institutions constitute an important help-seeking pathway for community members in need of mental health treatment. Mental health help seeking is important because of its potential impact on individuals and communities (Cauce et al., 2002). Religious attendance and religious community can be a beneficial aid to individuals dealing with mental health issues, including chronic psychosis (Wildman & McNamara, 2010). Griffith et al. (2016) discussed how church attendance is often highest in United States. States that have the least amount of financial resources in mental health funding and care, which could reinforce their religious communities, have an opportunity to aid individuals with mental health issues.

Research suggested that religious counseling services were potentially delaying members of religious communities from reporting mental health issues to traditional biomedical and psychological providers (Ikwuka et al., 2016). Fear may play a role in religious individuals' decision-making regarding whether they will seek traditional biomedical and psychological help or seek religious counseling services such as biblical counseling (Koenig, 2012). The creation of the biblical counseling movement was due to the fear of traditional biomedical and psychological services that emerged in churches and Christianity in the 1970s (Graham, 1984). Pastors and church leadership wanted to contribute to their own counseling methods in the Christian community (Graham, 1984). Koenig (2012) stated that religion can play a role in an individual's decision to seek help or pursue other types of services because spirituality can be viewed as filling a need for attaining wholeness for the good of the community. The current study considered the role

of religious attitudes and the fear that may or may not exist within religious communities, including how communities view biomedical and psychological help and whether their views of religion affect members' pursuit of help.

The purpose of this study was to examine the statistical relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of such services among adults who identify as Christian (Catholic, Protestant, or Evangelical) in Southern California religious communities and colleges. I selected this population because religious counseling is growing in popularity among Christians, particularly in Southern California (Griffith et al., 2016) yet was under researched. Ikwuka et al. (2016) indicated a need for more research on mental-health-seeking behavior.

This chapter includes a review of the literature and theoretical foundation for the current study. I synthesize research on the potential influence of religious counseling services in delaying the reporting of mental illness. I also review the research on fear of traditional biomedical and phycological services, delays in reporting, choice of services, and religious attitudes. The chapter concludes with a summary of what is known and the gap in the research and its impact on Christian communities.

Literature Search Strategy

Google Scholar, APA PsycARTICLES, PSYCBOOKS, PsycTESTS, and PsycINFO were used to search for the literature. The following search terms and combinations were used: *religion*, *religion and psychology*, *mental illness*, *religion* and *mental illness*, *biomedical services*, *counseling services*, *religious counseling services*,

religious counseling, *religious attitudes*, and *perceived fear*. The scope of this literature review was articles published in the last 7 years. However, I consulted research from as far back as 1947 as a means of finding additional studies and foundation material. The review focuses mostly on scholarly peer-reviewed journal articles that addressed mental illness, religion, and how counseling and Christian counseling may influence the reporting of mental illness. I also review books to identify other sources for information and research.

Theoretical Foundation

The theoretical base for this study was Heider's (1958) theory of attribution and Kelley's (1973) covariation model. I selected Heider's theory of attribution because it addresses social perceptions to explain why people behave and view others in the way they do. This theory helped me explain the reasons why members of religious communities were partial to a particular viewpoint when it comes to mental illness and the treatment thereof (see Ikwuka et al., 2016). This theory's inclusion of types of attribution (internal versus external) and documentation of cultural bias was helpful in explaining members' religion-based attitudes, possible fear of biomedical and traditional psychological services, and embrace of religious services for mental illness issues (see Ivtzan et al., 2013). An example of the former could be found in the study regarding LGBTQA members of the priesthood (Greene et al., 2017).

Kelley's (1973) covariation model is a theory of attribution associated with social and self-perception and explains how and why people act the way they do in social and public situations. Ivtzan et al. (2013) used the model to examine the link between religion

and psychological well-being and how this impacts self-actualization and personal growth. This model was appropriate for the current study because it helped me explain behavior over a period of time, including the possible influence of internal and external factors. This model was helpful in measuring the impact of religious attitudes on the choice of services. In addition, the model helped me explain the behavior of Christian adults and why they fear or embrace traditional or religious counseling services.

Both the theory of attribution and the covariation model's use of the documentation of cultural bias were helpful because Christian churches are a culture unto themselves in how they operate and the views they hold internally. Christian churches prefer to keep matters of self-betterment and religious matters within the confines of the Church community because the Christian church believes in verses such as "all Scripture is God-breathed and is useful for teaching, rebuking, correcting and training in righteousness, so that the servant of God may be thoroughly equipped for every good work" (New International Version Bible, 1973, 2 Timothy 3:16-17). This leads to a closed ecosystem of help; however, Griffith et al. (2016) examined ministries in churches, temples, mosques, and synagogues as a potential resource for individuals with chronic psychosis and other mental illness.

Literature Review

Fear of Traditional Biomedical and Psychological Services

Fear of traditional biomedical and psychological services was one of the variables in the current study. Individuals may be afraid of these services due to religious beliefs. Although it is somewhat controversial to discuss the crossroads of psychology and

spirituality, Gale et al. (2013) asked the question of how close spirituality is to psychosis. Gale et al.'s research was pertinent to my study because it focused on the clinical setting of individuals who are seeking help with psychological issues. Gale et al. asked whether individuals' spirituality is helping or hindering them in their psychological recovery.

This topic was also explored by Wig (2009) who examined the relationship between spirituality and mental health in India. Wig considered Hinduism, one of the dominant religions in India, and suggested that the Indian system does not follow the Western concepts of the mind and body dichotomy. Psychological and spiritual well-being in India is different from that in a Christian religious community in that the religious beliefs and ideas for self-betterment differ in many ways. Furthermore, mental illness diagnoses vary across cultures. However, Wig's research was pertinent to my study because it illustrated issues that transcend religion and how religious attitudes sometimes hinder clinical diagnosis. Despite religion being helpful to people's mental health, it can also be a hindrance if religious attitudes and cultural fear are present. Researchers such as Gale et al. (2013) have also considered the question of whether psychosis and other psychological issues stem from an individual's religious practices.

Delay of Mental Illness Reporting

The possible delay of mental illness reporting was a topic of interest when it comes to religious counseling. Griffith et al. (2016) looked at how community religious groups may aid in the recovery of individuals who are managing mental illness. Griffith et al. examined ministries in churches, temples, mosques, and synagogues as a potential resource for individuals with chronic psychosis and other mental illness. Griffith et al.

also looked at church attendance and how it was highest in states that had the least mental health funding, suggesting that there was a potential for community religious groups to help individuals dealing with a mental health crisis in a system that was underfunded.

This topic was also addressed by McLemore (1977) who looked at the diagnosis and treatment of an obsessive woman with a Christian Science background. The purpose of the study was to find out whether her religious beliefs caused the onset of her obsessive compulsions. McLemore critiqued an article that made the case of recognizing wider implications of the effect of changing a client's religious beliefs to cure a psychological problem. Although McLemore's study was dates, it offered an interesting position. The issues addressed by McLemore anticipate the idea of religious community aiding the mentally ill. This was also addressed by Griffith et al. (2016) who looked at how the American Psychiatric Association has been initiating efforts to grow relationships between religious groups and psychiatrists.

My literature review focused on the evidence that psychosocial community programs can help people dealing with mental illness. I also explored the positive impacts from collaborations between religious communities and traditional biomedical and psychological on low- and middle-income communities for mental health care. Despite its older publication date, McLemore's (1977) work was important to my study because it dealt with many of the same issues that my study addressed, such as examining the intersection of religious community programs regarding mental health and the intersection of traditional biomedical and psychological care. The idea of the religious community aiding in mental health care is interesting because McLemore discussed the

integration of religious beliefs with psychological problems. McLemore noted how to cure some of these problems and whether religion is the problem with the client.

The idea posited by Griffith et al. (2016) regarding the benefit of the religious community on mental health was not supported in a study by Greene et al. (2017). Greene et al. examined sexual identity and psychological distress among Roman Catholics, in particular priests. Greene et al. used an online survey to assess contributions to psychological distress, which involved sexuality, stress, social support, and fear of compassion from others. Greene et al. also addressed the differences in psychological distress across the spectrum of gender and sexual identity. The results indicated that psychological distress could be predicted by fear of compassion from others and stress.

Greene et al. (2017) found that priests who identified as LGBTQ were significantly more distressed when compared to priests who identified as heterosexual. Greene et al. concluded that priests who identified as gay had stress that was more related to cognitive dissidence, which resulted from social acceptance and the negative connotations that came from the Catholic Church's view of that community. Greene et al. found that gay priests all expressed profound satisfaction in their vocations but were unhappy with the stress and cognitive dissidence that came from the belief system of their vocation. This study was of use to me because the idea of sexual identity is important in the Christian counseling movement.

Fox et al. (2020) found that a process known as spiritual bypass was a way in which an individual could avoid painful psychological experiences by using spirituality as a defense. Fox et al. conducted a study of spiritual bypass by testing it with religious

commitment, spirituality and attitudes toward God, and psychological and medical help-seeking attitudes. The study found that spiritual bypass accounted for some of the relationship between religious and spiritual variables and help-seeking attitudes.

Choice of Service

An interesting facet of the intersection of religion and psychology is how individuals choose a counselor. Belaire and Young (2000) found that a participant's spirituality does not play a role in the counselor they choose and with the mental ailments they are suffering from. Davis and Hill (2005) explored clients who are seeking information about dreams they were experiencing. Davis and Hill found that incorporating spirituality into the counselor's dream interpretation helped clients decipher the dream and boosted their confidence toward getting the help that they were seeking from the counseling appointment. McCullough (1999) also explored the use of religious approaches with religious clients as a matter of client preference to provide the client with satisfaction and a sense of spiritual well-being.

The idea of integrating religion and psychological counseling is becoming more popular. Sanders et al. (2015) studied the various approaches that exist for how to incorporate psychotherapy into spirituality. This research took advantage of clients at private, religious, and university counseling centers. The clinicians integrated a variety of interventions of a spiritual nature with the use of interventions of a secular nature. The therapist recorded the clients' desire to discuss spirituality in sponsored sessions and was able to predict the frequency with which the spiritual interventions would be used with the clients. Sanders et al. found that the frequency and use of spiritual interventions was

not a predictor of a client's growth. Tomcsányi (2000) also looked at the integration of the two methods by looking at the role the church of Hungry played in the improvement of mental health. Tomcsányi discussed the post-Communist world of the nation of Hungry, the values in the notion the church of Hungry plays as a role in the treatment, and symptoms an individual faces in a crisis. Tomcsányi proposed training programs that help people specialize in narrowed fields of research and help pastors and religious leaders to be better trained in mental health so they have more means to help the people in their religious population.

Carrying on the thought of community and choice of service, and the relationship between negative and positive religious coping, Nolan et al. (2012) looked at the quality of life among individuals who suffer from mental illness. They found that cultural competence in treatment and community support regarding religious coping may in fact aid the outpatients and help them in their coping with their individual mental illness. This study is very interesting because it looks at some of the same factors as my dissertation and it deals with how individuals who are coping with mental illness view religious counsel. How does religious counseling help them cope with their disorders? Do they choose religious counseling over traditional biomedical and psychiatric help? Although the study that I conducted is not focused on schizophrenia itself, it still helped me in that it is looking at those who find religious counseling helpful in coping with their mental health issues. The results of the study did find that positive religious coping was related to a quality-of-life asset regarding the psychological health of these individuals, and the

study found that greater awareness regarding how religion and religious coping aided outpatients is needed.

Just as Tomcsányi (2000) looked at the idea of integration, Cuthbert et al. (2018) looked at the effectiveness of a spiritually integrated positive psychology intervention. The investigation examined the effect of an interactive positive psychology intervention (PPI) that was integrated with counseling of a spiritual nature. The point was to promote religious leaders to be humble and to have satisfaction when it came to their life. The study was conducted with 71 Christian pastors and lay leaders, self-selected to the waitlist-control ($n = 30$) or humility-PPI condition ($n = 41$). Humility-PPI participants completed a 16-exercise workbook with a partner. Intervention effectiveness was assessed using self and other-report measures.

The hypothesis for the study was not verified and the authors indicated that there was a need for more research in the genre of PPI integrated with spirituality. Overall, I found this study very interesting as it integrates well with Sander et al. (2015) and Tomcsányi (2000) research that religious individuals who are seeking counseling are seeking to better themselves. Tomcsányi's (2000) study is about humbleness and life satisfaction. In my study it is not necessarily those particular areas, but overall, they share overlap in the area of spiritual counseling and psychology.

Hook et al. (2019) conducted a study about the integration of psychology and the church. The researchers found that religious leaders expressed both a mixture of positive and negative attitudes toward psychological services and the church (Hook et al. 2019). Likewise, Kelley et al. (2018) conducted a study that looked into the high demand for

Christian psychotherapy. The researchers concluded that when patients and individuals' perspectives were looked at, spiritual factors added but an incremental value (Kelley et al. 2018).

Religious Attitudes

Religious beliefs and the practices of biomedical and psychological patients have long been studied and looked at by those in the psychiatric and psychological field. However, it has long been surmised that a patient's religion may in fact help them and be a resource to overcome the issues that they are facing (Koenig, 2008). Not only do the personal beliefs of these individuals come into play, but also community and groups, and some communities will also use spiritual interventions to get individuals to face a problem or issue (Sander et al., 2015).

These religious beliefs can and sometimes do help an individual deal with life circumstances and/or mental illness. Then again, it has also been found that psychiatrists in Europe and the United States do remain skeptical and some of them even prejudice against religion in the counseling space (Koenig, 2008). Religion in psychology have long gone hand-in-hand, with French neurologist Jean Charcot, and later his star pupil Sigmund Freud, both discussing and analyzing the role of religion with psychological problems and illness. It was from these views that a negative perspective of religion in psychology was born, as many people treated for mental illnesses were in fact people of religious belief (Koenig, 2008).

Fox et al. (2020) looked at the process by which an individual avoids painful psychological experiences by using spirituality as a possible defense. The study of

spiritual bypass by testing (a) its associations with religious commitment, spirituality, attitudes toward God, and (b) psychological as well as medical help-seeking attitudes. They found that spiritual bypass could be an important patient quality to consider in relation to an individual's attitudes toward and perhaps benefit from psychological help.

Ivtzan et al. (2011) dealt with the issues of religion and psychological well-being and confusion; debate and operational definitions are discussed and dissected. Using participants from different levels of religious communities, the authors compared their scores on psychological well-being and spirituality. This was an interesting study as it showcased the possible benefits of being a part of a religious community and how that can go together with possible psychological well-being. It delved into issues of self-actualization, the meaning of life, and personal growth initiatives. Their findings confirmed that there was a high level of importance given to spirituality on the psychological well-being of the participants (Ivtzan et al., 2011).

Koole et al. (2010) discussed why religious burdens move from religiosity to implicit self-regulation. The author discussed that to maintain religious standards, individuals must frequently injure adverse effects or the forsaking of pleasurable experiences. The authors speak about how religious individuals on average tend to display higher levels of well-being of an emotional nature compared to individuals and persons who are nonreligious. The study attempted to resolve the seeming conflict by suggesting that many forms of religion may in fact help to create a model of self-regulation within the individual that could in fact, be largely unconscious.

They hypothesized that religious individuals may also be aiming for high standards and may be able to maintain a high amount of emotional well-being. They concluded their study by finding that religious stimuli and practices did create an aura of self-regulation, mostly in individuals who internalize their religious experiences. The study concluded by finding that some aspects of religion may be rational and may have important benefits of a psychological nature on an individual regarding self-regulation. This particular article was very helpful for my study in that it delves into the idea of self-regulation in mental health; the very idea of religious counseling as held by religious institutions is, in fact, dealing with self-regulation. By using religious texts and religious teachings to solve psychological issues, they are relying on a model of belief implemented by the individual via the teachings from the Christian deity they believe in. This form of religious counseling is relying on the individual to regulate themselves and push for greater emotional and psychological healing by following the Biblical counseling steps.

Just as Koole et al. (2010) discussed the idea of self-regulation impacting attitude, Williams et al. (2014) discussed the successful collaboration between faith-based organizations and social workers within minority communities to improve the health and psychological outcomes for various medical conditions. The authors described how they used their program to implement mental health ministry committees within the community churches. These programs were designed to educate pastors and other church leaders, reduce stigma, and promote treatment for disorders and conditions such as depression.

The authors found that it is helpful to initially form partnerships with church staff prior to setting up the ministry committee and that it helped the programs to have greater flexibility and a committee-based participation success rate. This study was very helpful for my dissertation as it looks at the idea of mental health services within churches being set up to help members of the religious community of those churches. While this study did not inherently deal with fear and religious attitudes, it was helpful looking at the mix of counseling and religion, with how the religious community accepts or rejects this form of mental health aide to said individuals. Williams et al. (2014) discussed the mix of counseling and religion and how the religious community accepts or rejects this form of mental health aid to said individuals. Although psychology and religion deal with overlapping subject matter, the relationship between psychology and the church has come into conflict. Hodge et al. (2020) examined religious leaders' attitudes toward integrating psychological science into church ministry, which included the integration of psychology and church ministry.

It is La Barre et al.'s (1947) research that was useful to look at the history of the mixing of primitive psychotherapy with religion. Their research involved Native Americans and their use of peyote and confession. This specific study dealt with the peyote plant and how it was spread around the Native American tribes of the American plains. This study is fascinating because it dealt with a faction of a small number of individuals in a religious belief system that quickly spread. This study could be considered analogous to the Christian counseling movement; not to describe the Christian counseling movement as a faction, but it also started as a small movement that then

spread quickly to various churches in counseling centers all over the country. La Barre et al. (1947) looked at how Native Americans used peyote and confession as a means of "Counseling" to better themselves, mixing religious and counseling elements to self-actualize.

Summary

This present study filled a gap of whether or not the fear of biomedical and psychological counseling could delay reporting of psychological mental illness in the Christian community. It also filled the gap that existed for research to be done in the Southern California region of the United States; this area has a very large Christian population as well as a large and flourishing Christian counseling movement at local community Churches. The purpose of this study was to better understand the relationship between religious attitudes and the perceived fear that may exist of traditional biomedical and psychological services. It is hoped that this study extended knowledge in the social psychology and counseling psychology fields regarding how these services are being helped or harmed by Christian counseling. There is much that is known about the interception of religion and psychology, including Christianity; for example, it is known that religion and psychology and their intersection is very important to practitioners (McNamara et al., 2010), practitioners of both Christian counseling and psychological counseling are expanding into the same areas and communities (Ikwuka et al., 2016), and emotional well-being is an important part of both the Christian and the secular lifestyle (Koole et al., 2009). The American Psychiatric Association (2015) views religion as an important part of individuals lives and has been initiating new efforts to grow

relationships between religious groups and psychiatrists; yet, what was not known to a full extent is the role of Christian counseling and the fear of biomedical and psychological services on those communities.

This study provided the opportunity to quantitatively study a gap in the research that has not been studied before in the greater Southern California region of the United States. By surveying Christian individuals in this region, the statistical relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of such services and delay of mental illness reporting can be understood.

Chapter 3: Research Method

The purpose of this study was to examine the relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of such services among adults who identify as Christian (Catholic or Protestant) in Southern California religious communities and colleges. I selected this population because religious counseling is growing in popularity among Catholics and Protestants yet was under researched. I also looked at the relationship between religious attitudes toward traditional biomedical and psychological services and choice of service for counseling. Lastly, I examined the relationship between choice of service for counseling and potential delays in the reporting of mental illness due to traditional biomedical and psychological providers.

In this chapter, I discuss the research design, its rationale, and methodology. I define the variables of interest and the respective instruments that were used for their measurement. I also present the research questions and hypotheses and discuss ethical protections and the data analysis plan.

Research Design and Rationale

To answer the research questions, I used a quantitative cross-sectional design and the survey method. Quantitative research, with its underlying positivist philosophical foundation, was well suited for this study. Positivism adheres to the view that factual knowledge is gained through observation and is trustworthy (Business Research Methodology, 2024). In positivism, the role of the researcher involves data collection and analysis that is done in an objective way (Macionis et al., 2013). The reason quantitative

methodology was chosen for the current study instead of qualitative methodology was the large scope of the study, which included a population of many religious denominations, as well as the nature of the research questions and hypotheses. When quantifying a research problem, researchers use quantitative data because it allows them to examine the variables by looking at a large population of participants (Organizing Your Social Sciences Research Paper, n.d.). Quantitative research is more statistical than qualitative research, with the use of surveys research being one of the core aspects of this style of research. Quantitative researchers collect new or existing numerical data to examine relationships among variables (Organizing Your Social Sciences Research Paper, n.d.).

The problem addressed in the current study was that religious counseling services in religious communities may be delaying members from reporting mental health issues to traditional biomedical and psychological providers (see Ikwuka et al., 2016). Fear could play a role in in religious individuals' decision making regarding whether they will seek traditional biomedical and psychological help or seek biblical counseling alternatives. Mental health help seeking is important because of its potential impact on individuals and communities, and it can be a framework for a better understanding of the cultural context regarding help-seeking pathways (Cauce et al., 2002). Koenig (2012) mentioned that religions can play a role in an individual's decision to seek help or pursue other types of services because spirituality can be viewed as filling a need for attaining wholeness for the good of the community. The growth of the biblical counseling movement was due to the fear of traditional biomedical and psychological services

among American churches and the Christian community during the 1970s (Adams, 1986).

Participants in the current study came from the Christian populations in the Southern California area. I recruited individuals from various religious communities and colleges that are promoted as religious and Christian in nature. Existing survey instruments were used to measure the participants' religious attitudes and the perceived fear they had with a traditional service choice and the possible delay of mental illness reporting. The variables for this study were religious attitudes, fear of traditional biomedical and psychological services, choice of service, and delay of mental illness reporting.

I used a single questionnaire with several measures including online and physical copies, the latter of which I distributed in religious communities and colleges in the study area. I collected data from individual adult participants who identified as Christian from various churches and universities in Southern California. The survey instruments and questionnaires were used to gather data on participants' fears and whether their religious attitudes influence their choices of traditional biomedical and psychological counseling or traditional biblical counseling. There were no foreseeable time or resource constraints consistent with the design choice.

Methodology

Population

In this study, I surveyed male and female Christian individuals in the Southern California region of the United States. The target population was approximately 2 million individuals.

Sampling and Sampling Procedures

The sample population was adults from various religious communities in Southern California, which included churches, community centers, and universities. Criteria for inclusion in the study were that individuals identify as being a member of a Christian denomination or nondenominational institution, and that they reside somewhere in the Southern California area. Consistent with the definition of *resident* (Merriam-Webster, 2020), eligible participants were those living in this region rather than those visiting or vacationing there. This requirement was due to my focus on gathering data from Southern California natives or current residents within the Christian community in the state.

Sampling Size

Using this population's size of approximately 2 million individuals, I used G*Power (n.d.) to calculate the minimum sample size of 128 individuals.

Procedures for Recruitment, Participation, and Data Collection

For the questionnaire, I used SurveyMonkey (n.d.) to host the study materials. SurveyMonkey has built-in security so that a participant's privacy is not violated. SurveyMonkey also could be linked to advertisements, websites, emails, and social

media. Participants who used the online method to take the survey were provided with an informed consent form to digitally sign, and those who used the in-person method signed a physical version of this form. Online participants exited the study by clicking out of it after filling out the online questionnaire, and in-person participants placed the completed questionnaire into a case. There was no debriefing or exit interviews; anyone who wished to leave the study could simply click out of it or walk away from the table without completing the form without penalty. There were no ethical concerns regarding recruitment because participation was voluntary at the physical and digital locations.

I used survey questionnaires as the research method for this study. A self-administered questionnaire was used to gain demographic and personal information from prospective participants. The questionnaire included religious-oriented items and items concerning individual preferences for psychological or church counseling. I also included questions about whether participants had experience with either psychological or church counseling.

I administered the same questionnaires to in-person and online participants. The on-site person who was facilitating the survey was provided with tables that they set up in churches, community centers, or universities. These tables also were equipped with laptop computers that had access to the online questionnaire.

The second means of gathering the questionnaires from individuals was electronic in nature using SurveyMonkey. I posted the questionnaire online using Survey Monkey so anyone with the link could click on it and fill out the survey. Using an online version of the questionnaire allowed me to reach a larger number of individuals. through Google,

Facebook, and Twitter ads. The questionnaire was protected by site encryption. I stored downloaded data inside a password-protected document that I deleted according to university protocol. No data gathered were preserved in any form outside of the study itself.

The subjects whom I selected for this study were appropriate for this study because of the geographical location in which they resided and the religious beliefs that they shared; age was not important. The most important aspects of study eligibility pertained to geographical location (residence within the Southern California region) and religion (identification as Christian). Potential participants who met these criteria could complete the questionnaire. Potential in-person participants were free to decline study participation by not filling out the survey while those who clicked on the online survey link were free to click out of the survey at any time without penalty.

The on-site locations (Christian community centers, Christian universities, and community churches) were selected because they had large Christian populations, most of whom were Southern California residents. Another reason these locations were selected was due to the large amount of psychological and Christian counseling that takes place in these locations. Universities provide psychological counseling and Christian Counseling for students and faculty who attend and teach there. Students and faculty can choose which type of counseling they feel most comfortable with. Churches generally provide only Christian counseling; however, some churches employ a marriage and family therapist for their members. Christian community centers employ Christian

counselors for those who wish to seek help, but also provide information regarding psychological services for individuals who wish to take advantage of this option.

The individuals who attended these Christian locations were perfectly suited to answer the questionnaire that I presented to them for my study; all of them likely had some interaction with their institution's form of counseling. This did not mean that they had attended the counseling, but they likely knew of it, were familiar with it, and knew people who had taken advantage of it.

Instrumentation and Operationalization of Constructs

I provided a demographic questionnaire (see Appendix A) to gather data on the participants' gender, ethnicity, age, and religious affiliation. This questionnaire was administered in person and online depending on the location and availability of the participants.

Religious Attitude

The Pathways Questionnaire (Ikwuka et al., 2016) was used to measure the religious attitude variable. This instrument was used to elicit responses by starting with a few predetermined standard categories of spiritual, traditional, and biomedical pathways (Ikwuka et al., 2016). Each treatment preference was assigned to one of the three pathway categories with 18 items: seven under the traditional pathway, seven under the spiritual pathway, and four under the biomedical pathway.

Each of these items were converted into simple declarative statements assessed with a 4-point Likert response scale: *strongly agree*, *agree*, *disagree*, and *strongly disagree* (Ikwuka et al., 2016). I had permission to use this instrument from the author.

This instrument was appropriate for my study because even though it was developed in another country, it measures belief systems within the same religious faith. To refine the quantitative scale, the 18 items were subjected to principal component analysis and the validity was demonstrated with the inspection of the correlation matrix that revealed the presence of many coefficients at .3 and above in a population of students, nurses, and male and female adults (Ikwuka et al., 2016).

Choice of Service

The Beliefs about Psychological Services (BAPS) questionnaire (Ægisdóttir & Gerstein, 2009) was used to measure choice of service variable. The BAPS consists of 18 items rated on a 6-point Likert-type scale anchored with *strongly disagree* and *strongly agree*. There are 11 positively worded items and seven negatively worded items (Ægisdóttir & Gerstein, 2009). The negatively worded items (5, 8, 10, 11, 13, 15, and 17) need to be reverse scored before analyses. The BAPS has three subscales: Intent, Stigma Tolerance, and Expertness.

Scoring consists of adding values for each item on a subscale and dividing by the number of items. Scores range from 1 to 6 with higher scores reflecting a more positive view of psychologists and their services (Ægisdóttir & Gerstein, 2009). The BAPS also has been administered in the United States to people age 50 and older (Ægisdóttir & Gerstein, 2009). Internal consistency reliability of the BAPS subscales for this population was similar to reliability coefficients reported by Ægisdóttir and Gerstein (2009) for college students. Due to this instrument being used on both older and younger people,

this instrument was appropriate for my study. The BAPS can be used without permission, but the scale developers appreciate being informed regarding studies it is being used in.

Perceived Fear

The Thoughts About Psychotherapy Survey (Kushner & Sher, 1989) was used to measure preserved fear variable. This survey included 19 items that were each on a 5-point Likert-type scale ranging from *no concern* to *very concerned* (Kushner & Sher, 1989). This instrument does not require permission and can be used in noncommercial research and for educational purposes. A factor analysis of clinical and nonclinical subjects yielded three subscales: Therapist Responsiveness, Image Concerns, and Coercion Concerns. Subscale reliability was satisfactory (Carlton, 2000). This instrument was helpful to my study due to measurement of perceived fear of psychological services.

Delay of Mental Illness Reporting

The Mental Help-Seeking Intention Scale (MHSIS; Hammer & Spiker, 2018) was developed and created to measure one's intention to seek help from a mental health professional if the individual has a mental health concern. Internal consistency and convergent evidence of validity for the MHSIS score have been documented in the form of significant positive associations between intention and both attitudes and subjective norms around seeking professional psychological help (Hammer & Spiker, 2018). The data Hammer and Spiker (2018) collected was from a sample of community-dwelling adults currently dealing with a mental health concern. This scale could be used without permission. Internal consistency and convergent evidence of validity has been documented in the form of significant positive associations between intention and both

attitudes and subjective norms around seeking professional psychological help (Hammer & Vogel, 2013). In Hammer and Spiker (2018), data was collected from a sample of community-dwelling adults currently dealing with a mental health concern. Internal consistency, factor determinacy, and construct reliability with replicability, and predictive validity were also established (Hammer & Vogel, 2013). The MHSIS-3 total score demonstrated evidence of internal consistency (alpha = .94). The results indicated that the MHSIS-3 demonstrated a correct classification rate near 70%, thus evidence of predictive validity (Hammer, Spiker, 2018). This instrument was helpful to my study due to its measurement of delay of mental illness reporting**.**

Data Analysis Plan

To analyze the specific results in this research study, I used IBM SPSS software. A *t*-test will be used as it is widely considered to be an accurate way to measure Likert scales (De Winter et al., 2010). Linear regression will also be used to measure the possible relationship between the variables. The following research questions and hypotheses guided the proposed study.

RQ1: What is the relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults?

$H_0$1: There is no relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults.

$H_1$1: There is a relationship between religious attitudes and perceived fear of traditional biomedical and psychological services among Christian adults.

RQ2: What is the relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults?

$H_0$2: There is a relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults.

$H_1$2: There is no relationship between perceived fear of traditional biomedical and psychological services and choice of service for counseling among Christian adults.

RQ3: What is the relationship between choice of service for counseling and delay of mental illness reporting among Christian adults?

$H_0$3: There is a relationship between choice of service among Christian adults and delay of mental illness reporting.

$H_1$3: There is no relationship between choice of service among Christian adults and delay of mental illness reporting.

To be sure of the data's accuracy the following was checked. The data was double checked to be sure that it was entered accurately. Validity and reliability were looked at to make sure what is being measured is what is intended. Lastly the data's completeness was checked. (Mears et al 2022).

Threats to Validity

Threats to Internal Validity

Some threats that can occur would be changes within the subject grouping, as they would be aware they are test subjects, and this could affect the outcome; some of these effects could include the novelty effect or Hawthorn effect. There is not much to be done to combat this in an online group or even in person, as these reactions would likely be

internalized. A threat for those who took the survey online could include distractions from other persons or environment; this threat was combated by asking the participants to take the surveys in a quiet location. To combat this threat within person participants, the location was in a quiet room with booths set up for the participants to be able to concentrate. All data was collected anonymously and did not collect any self-identifying information. Self-report bias was combated by keeping the questions as short as possible, avoiding the use of complex or confusing concepts, and digital ads were run during times when participants were less stressed (e.g., the weekends or evenings).

Threats to External Validity

One of the threats that could be encountered is that of sampling bias; this bias could occur by sampling too many in too similar locations. The best way to combat this threat would be with the use of online surveying as this will allow sampling from a broad range of the targeted population. Situational effect could also act as a threat, as differing times of day, weather or location, could impact the findings; this threat was combated by asking the participants in the online survey to be mindful of where they take the survey and providing a controlled location for the in-person participants.

Ethical Procedures

I utilized digital advertising such as Google ads and Facebook ads. These forms of advertisements can be tailored for every need, so I discussed being able to target the exact type of participant that I am looking for in these advertisements. I used SurveyMonkey to gather my data and use its built-in protections.

All surveys were anonymous and did not ask for or gather any kind of personal identifying information. Informed consent was requested from the participants before they started the survey. IP address tracking was disabled to ensure that no personal information could be tracked to the individual. The data stored on SurveyMonkey's servers was protected by VPN, SSH, and other forms of internet security that require multi-factor authentication. I have access to the data that was collected from the participants and the information was protected by a password account on SurveyMonkey that only allowed me to access it.

The treatment of human participants was not of large concern for those whose data was gathered online because the participant had the freedom to terminate at any time by closing their web browser and they could choose to ignore the ad for the survey if they so choose. I discuss administering the study in person at various churches and universities. I discussed setting up chairs and tables that were equipped with several laptop computers that had access to the online questionnaire. Each of these laptops were spaced far enough apart so that the individuals had privacy. One possible ethical consideration was collecting surveys from my own church; however, I do not see this as being an issue as the church is very large with over 15,000 weekly attendances, which limited any potential conflict of interest.

Summary

The purpose of this study was to add to the body of research relating to the relationship between religious attitudes toward traditional biomedical and psychological services and perceived fear of traditional biomedical and psychological services. By

looking at how these attitudes may influence Christian's viewpoints towards psychological and biomedical services. This study used a quantitative cross-sectional design and the survey method. The primary participants and convenience sampling were from adults from various religious communities in Southern California, which included churches, community centers, and universities. I discussed using a survey questionnaire as the primary research method for this study. All surveys were anonymous and did not ask for or gather any kind of personal identifying information. for the questionnaire, SurveyMonkey was used to host the study materials, and target the participants using a mixture of digital ads and in-person canvassing (Pandemic allowing). To analyze the specific results, a *t*-test as well as linear regression to measure the possible statistical relationships between the variables was used. Chapter 4 presents the results of this study, including a description of the data collection process and its justification, tables and discussion of the results.

Chapter 4: Results

The purpose of this study was to examine the potential mediating effect of perceived fear on the relationship between religious attitudes and delay of mental illness reporting among Christian adults in the Southern California area of the United States. The study addressed the following research questions and hypotheses:

RQ: To what extent does fear of negative consequences associated with seeking help mediate the relationship between religious attitudes and delay of mental illness reporting?

H_0: Fear of negative consequences associated with seeking help does not mediate the relationship between religious attitudes and delay of mental illness reporting.

H_a: Fear of negative consequences associated with seeking help mediates the relationship between religious attitudes and delay of mental illness reporting.

Originally the study included three research questions; however, this was later reduced to one modified research question. Due to this change, one of the four variables and associated survey were dropped from the study. I originally planned to use linear regression and *t* tests to examine the possible relationship between the variables. This was altered to use a test of mediation to analyze the data. This chapter reports the study findings, including a description of the sample demographics, descriptive statistics, and statistical analysis. The data collection procedure and results are presented, followed by a summary of the chapter.

Data Collection

Data was collected over several weeks using an online survey hosted by FreeOnlineSurvey.com (now Shout.com). Participants were recruited from social media and Prolific.com, a professional online platform that administered surveys to participants who met all inclusion criteria. The criteria for inclusion were that participants identified as belonging to a Christian denomination or nondenominational church and that they resided in the Southern California region.

Data collection was originally planned to be conducted both in person (at churches and universities) and online. This plan was altered when I realized that data collection could be completed in a timelier manner using online resources to recruit participants. In Prolific, parameters were set up to find participants, and screeners were added, including age, location, and religious beliefs, to find participants who were Christian-identifying adults over the age of 18 who resided in Southern California. After the survey was created and submitted to Prolific, the site matched it to the database of users who met the criteria that were stipulated. These participants then clicked the survey to enter the study.

A total of 133 eligible participants received a link to the survey hosted by Prolific, and after clicking it they were taken to the consent form. The consent form, which followed the template constructed by the Walden University Institutional Review Board, contained the details of the study, my contact information, and possible risks. At the end of the consent form, the prospective participant was invited to give their consent by clicking to proceed to the next section, where they began the survey. An attempt was

made to recruit participants from social media groups and profiles; however, few were recruited using this method. People interested in the survey followed the link to the consent form. At the conclusion of the survey, participants were thanked for their time. No debriefing was required.

Demographics

A post-hoc power analysis was conducted using G*Power software to determine the statistical power achieved in the study. The analysis, based on the sample size (*N* = 128), alpha level (α = 0.05), and calculated effect size (d = 0.5), yielded an achieved power of 0.879 (87.9%). This result indicated sufficient power to reject the null hypothesis and reduced risk of Type II error.

In the sample's composition, over half of the participants were male (51.9%), 33% were under 29 years old, 48.1% were between 30 and 49 years old, and 28.6% were 50 or above. Demographic data also revealed that 58% held a bachelor's degree or higher, while the remainder had completed high school, earned associate's degrees, or had some college education. Most participants (97%) identified as Christian, with nearly a third (32%) identifying as Evangelical. A significant portion of the sample (78.9%) attended religious services in Southern California, and more than half (54%) reported moderate to high involvement in church activities (see Table 1).

Table 1

*Frequency Distributions of Demographic Characteristics (*N *= 133)*

Variable	**Category**	**Frequency**	**Percentage of total**
Gender	Female	64	48.1%
	Male	69	51.9%
Age	18–20	9	6.8%
	21–29	22	16.5%
	30–39	41	30.8%
	40–49	23	17.3%
	50–59	23	17.3%
	60 or older	15	11.3%
Education	Graduated high school	10	8%
	Some college, no degree	30	23%
	Associate's degree	13	10%
	Bachelor's degree	48	36%
	Graduate degree	29	22%

Identify as a Christian	Yes	129	97.0%
Christian denomination	Orthodox	1	1%
	Catholic	36	27%
	Protestant (general)	36	27%
	Evangelical	43	32%
	Other	17	13%
Reside in SoCal	Yes	128	96.2%
Attend religious services	Yes	105	78.9%
	No	28	21.1%
Involved in church activities	Not very involved	61	45.9%
	Moderately involved	53	39.8%
	Very involved	19	14.3%

Reliability Analysis

This study employed three scales, and internal consistency analysis was calculated. The Pathway Questionnaire (Ikwuka et al., 2016), which was used to measure religious attitudes, consisted of 16 items and demonstrated good internal consistency (α = .90). This suggests that the items in this scale reliably measure the intended construct. The Thoughts about Psychotherapy Survey (Kushner & Sher, 1989) comprising 19 items was used to measure perceived fear. For this sample, this measure showed excellent reliability (α = .93) indicating strong internal consistency among the items. Lastly, the Mental Help Seeking Intention Scale (Hammer & Spiker, 2018), which is a three-item measure used to measure delay of mental illness reporting, exhibited very strong internal consistency (α = .95). These results indicate all three scales demonstrated good to excellent internal consistency and were suitable for use in the current study.

Results

Descriptive Statistics for Predictor and Outcome Variables

Descriptive statistics for the measures used to test the hypotheses are presented in Table 2. Initially, religious attitudes demonstrated a significant positive skewness (skewness = 0.633, *SE* = 0.210), with a skewness *z* score of 3.2523. After I removed three outliers from this variable, the distribution of scores exhibited normality skewness of 0.339 (*SE* = 0.21), and the kurtosis value of -0.649 (SE = 0.422) suggested a normal distribution. With a mean score for religious attitudes of 2.24 (*SD* = 0.5), a skewness *z* score of 1.599, and a kurtosis *z* score of -1.5379, I concluded that there was no significant

skewness or kurtosis. The minimum value was 1.44, and the maximum value was 3.5. For perceived fear, the average mean score was 2.85 (*SD* = 0.81). The distribution demonstrated a normality skewness of -0.187 (*SE* = 0.210) with a kurtosis value of -0.150 (*SE* = 0.417), indicating a normal distribution. The skewness *z* score of -0.8904 and the kurtosis *z* score of -0.3597 indicated no significant presence of skewness or kurtosis. The minimum value was 0.8, and the maximum value was 1.00. The average mean score for the delay of mental illness reporting was 4.62 (*SD* = 1.54). The distribution exhibited a normality skewness of -0.384, (*SE* = 0.21) with a kurtosis value of -0.276 (*SE* = 0.417), suggesting a normal distribution. A *z* score of -1.8285 for skewness indicated normal distribution, and a kurtosis *z* score of -0.6618 was not significant. The minimum value was 1.5, and the maximum value was 1.00.

Table 2

Descriptive Statistics

Statistic	Religious attitudes	Perceived fear	Delay of mental illness reporting
N	130	130	130
M	2.25	2.85	4.63
SD	0.51	0.82	1.55
Min	1.44	1	1
Max	3.56	4.74	0.82
Skewness statistic	0.34	-0.19	-0.38
Skewness std. error	0.21	0.21	0.21
Kurtosis statistic	-0.65	-0.15	-0.28
Kurtosis std. error	0.42	0.42	0.42
Skewness *z* score	1.60	-0.89	-1.83
Kurtosis *z* score	-1.54	-0.36	-0.66

Table 3 presents the Pearson correlations of the variables for the hypothesis testing. This revealed that delay of mental illness reporting was significantly negatively correlated with religious attitudes ($r = -.240$, $p = .006$) but not significantly correlated with perceived fear ($r = -.114$, $p = .193$). Further, religious attitudes and perceived fear were significantly positively correlated ($r = .228$, $p = .009$). The risk of collinearity was low, as the correlations were relatively modest in magnitude.

Table 3

Correlation Matrix

Variable		Delay of mental illness reporting	Religious attitudes	Perceived fear
Delay of mental illness reporting	Pearson correlation	1	-.240**	-.114
	Sig. (2-tailed)		.006	.193
	N	133	130	133
Religious attitudes	Pearson correlation	-.240**	1	.228**
	Sig. (2-tailed)	.006		.009
	N	130	130	130
Perceived fear	Pearson correlation	-.114	.228**	1
	Sig. (2-tailed)	.193	.009	
	N	133	130	133

Evaluation of Statistical Assumptions

Prior to conducting the mediation analysis, I evaluated the data to determine whether they met the statistical assumptions. Table 4 and Figure 1 presents the results for the tests for multicollinearity, normality, and homoscedasticity.

Table 4

Results of Statistical Assumptions

Test	Religious attitudes	Perceived fear	Delay of mental illness reporting
Multicollinearity (VIF)	1.007	1.007	1.007
Durbin-Watson	1.6	1.6	1.6
Multivariate Normality (p-p plot)	Approximately normal	Approximately normal	Approximately normal
Linearity (scatterplot)	Approximately linear		
Shapiro-Wilk	0.97	0.97	0.95

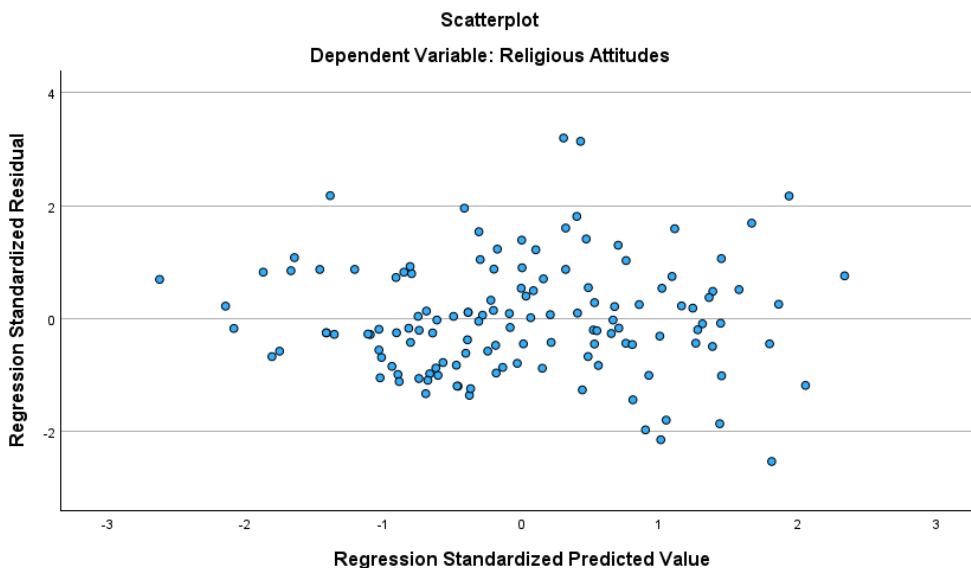
The best range for the variance inflation factor (VIF) is between 1 and 5 because this indicates no significant multicollinearity issues. A VIF score of 1.007 was found, which indicated no multicollinearity. The desired value of the Durbin-Watson is between 1 and 3. The Durbin-Watson statistic was calculated as 1.6, which was acceptable. The Shapiro-Wilk tests of normality revealed nonnormal results for the three variables: religious attitudes ($W(130) = 0.97$, $p = .005$), perceived fear ($W(130) = 0.97$, $p = .023$), and delay of mental illness reporting ($W(130) = 0.95$, $p = .001$). Although the Shapiro-Wilk test revealed nonnormal distributions for all three variables, in studies with large

samples (N = 130) the Shapiro-Wilk test can detect very small deviations from normality that would otherwise not be flagged as significant.

The scatterplot (see Figure 1) exhibited no pronounced pattern, with the data points distributed evenly around 0, indicating that the variance of the residuals remained relatively constant across all levels of the predictor variables. Although a fan pattern was observed, the Breusch-Pagan test did not detect significant heteroscedasticity, $\chi 2(2)$ = 1.04, p = .59. These findings could lend support to the assumption of homoscedasticity, which suggests that the variance of the residuals is sufficiently homogeneous across the range of predictor values. Thus, I concluded that the assumption of homoscedasticity had been met in this study.

Figure 1

Scatterplot Dependent Variable Religious Attitudes



Mediation Analysis

The total effect of Religious Attitudes (X) on Delay of Mental Illness Reporting (Y) was statistically significant (β = -0.722, t = -2.793, p = 0.006, R = 0.240, R^2 = 0.057).

Table 5

Model Summary

R	***R²***	***MSE***	***F***	***df*1**	***df*2**	***p***
0.240	0.057	2.221	7.799	1.000	128.000	0.006

Table 6

Total Effect Model

Model	**Coefficient**	***SE***	***t***	***p***	**LLCI**	**ULCI**
Constant	6.277	0.596	10.538	0.000	5.098	7.455
Religious attitudes	-0.722	0.259	-2.793	0.006	-1.233	-0.210

The R^2 value of 0.057 indicates that only 5.7% of the variance in Delay of Mental Illness Reporting is accounted for by Religious Attitudes. The effect of Religious Attitudes (X) on Perceived Fear (M) was statistically significant (β = 0.361, t = 2.645, p = 0.009, R = 0.228, R^2 = 0.052).

Table 7

Model Summary

R	***R^2***	***MSE***	***F***	***df*1**	***df*2**	***p***
0.228	0.052	0.619	6.996	1.000	128.000	0.009

Table 8

Path Model

Model	**Coefficient**	***SE***	***t***	***p***	**LLCI**	**ULCI**
Constant	2.027	0.315	6.444	0.000	1.404	2.649
Religious attitudes	0.361	0.137	2.645	0.009	0.091	0.631

The R^2 value of 0.052 indicates that 5.2% of the variance in Perceived Fear is accounted for by Religious Attitudes. The effect of Perceived Fear (M) on Delay of Mental Illness Reporting (Y), controlling for Religious Attitudes (X), was not statistically significant ($\beta = -0.062$, $t = -0.366$, $p = 0.715$). The direct effect of Religious Attitudes (X) on Delay of Mental Illness Reporting (Y), controlling for Perceived Fear (M), remained statistically significant ($\beta = -0.700$, $t = -2.627$, $p = 0.010$, $R = 0.242$, $R^2 = 0.058$).

Table 9

Model Summary

R	*R^2*	*MSE*	*F*	*df*1	*df*2	*p*
0.242	0.058	2.236	3.940	2.000	127.000	0.022

Table 10

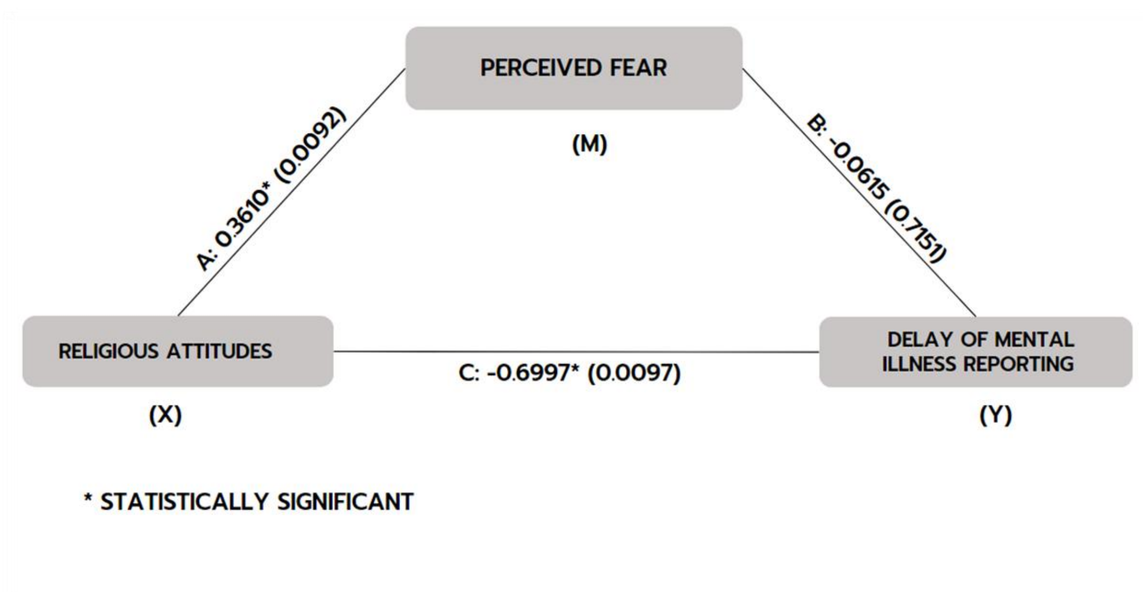
B Path and C Path Model

Stub heading	Coefficient	*SE*	*t*	*p*	LLCI	ULCI
Constant	6.401	0.688	9.307	0.000	5.040	7.762
Religious attitudes	-0.700	0.266	-2.627	0.010	-1.227	-0.173
Fear	-0.062	0.168	-0.366	0.715	-0.394	0.271

The R^2 value of 0.058 indicates that only 5.8% of the variance in Delay of Mental Illness Reporting is additively accounted for by Religious Attitudes and Perceived Fear. This small increase from the total effect model (5.7% to 5.8%) suggests that the addition of Perceived Fear adds very little explanatory power to the model. These results indicate that while Religious Attitudes significantly predict both Perceived Fear and Delay of Mental Illness Reporting, Perceived Fear does not significantly mediate the relationship between Religious Attitudes and Delay of Mental Illness Reporting. The small R^2 values across all models suggest that the model is not sufficiently specified, and future research should investigate the inclusion of other variables that can enhance the degree of variance accounted for.

Figure 2

Mediation Model Results



Summary

The study collected data by recruiting participants via Prolific.com who resided in the Southern California area of the United States. The study examined how religious attitudes might affect delays in reporting mental illness, with perceived fear as a potential mediator. The analysis revealed a significant positive association between religious attitudes and perceived fear indicating that higher levels of religious attitudes were correlated with increased perceived fear. However, the relationship between perceived fear and the delay of mental illness reporting was not statistically significant. Other findings suggests that religious attitudes directly contributed to a reduction in the delay of mental illness reporting, independent of the potential mediating role of perceived fear. In

Chapter 5, I summarize the results and interpret the findings and discuss implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

This purpose of this study was to examine the mediating effect of perceived fear on the predictive relationship between religious attitudes and delays of mental illness reporting among Christian adults in Southern California. The study was conducted in response to the gap in the literature regarding the role of religious attitudes in delaying parishioners from reporting mental health issues to traditional biomedical and psychological providers. Southern California was chosen as it is where the Christian Counseling movement was started and has a large population of Christians. A cross-sectional survey research method was used to collect data from 128 qualified adults. About 51% of the sample were male, and most were 30 or more years old. Almost 97% identified as Christian (32% were Evangelical Christian), most (78.9%) attended religious services, and more than half (54%) reported moderate to high involvement in church activities. Because of the convenience sample, the results are limited with respect to external validity.

The null hypothesis was tested using the Hayes PROCESS model 4 (Hayes, 2022) to study the direct and indirect relationships among the variables. The total effect of religious attitudes on delays of mental illness reporting with mediating perceived fear was found to be significant and negative (B = -.722, p = .006), although the amount of variance accounted for was small (R^2 = .058, p = .022). The indirect effect of perceived fear as the mediator was negative and nonsignificant (B = -.022), suggesting that perceived fear was not a useful mediator of this relationship. Rather, religious attitudes were a more important predictor of delays of mental illness reporting (ß = -.232) than

perceived fear (ß = -.0324) in this model. Of note, religious attitudes positively predicted perceived fear (R^2 = .052, p = .009; ß = .228).

Interpretation of the Findings

Relevance to Published Research

This study found that religious attitudes were linked with a delay in mental illness reporting in that that higher levels of religious attitudes contributed to delay of mental illness reporting. This is consistent with Wig's (2009) research illustrating how religious attitudes sometimes hinder clinical diagnosis. The finding of higher levels of religious attitudes contributing to delay of mental illness reporting is also supported by Greene et al. (2017). Fox et al. (2020) identified a process known as spiritual bypass, which demonstrates how individuals may use spirituality as a defense mechanism to avoid confronting painful psychological experiences. This process could explain the current study's findings in that those who use spiritual bypass to treat or avoid psychological experiences would be more likely to delay reporting mental illness. Koole et al. (2010) found that implicit affect regulation could help explain that higher religious attitudes were associated with reduced delays in mental illness reporting. The implicit affect regulation processes that are facilitated by religion could help religious individuals better manage the emotional aspects of acknowledging and seeking help for mental health issues.

The relationship between religious attitudes and delay of mental illness reporting did not explain a substantive amount of variance in the model (R^2 = .058). Recent literature identified other constructs that could increase the explanatory value of the

model. These include constructs such as beliefs about the causes of mental illness, stigma about mental health help seeking and social support, (Lloyd & Kotera, 2021; Lloyd & Waller, 2020; Lucchetti et al., 2021), and demographic characteristics such as age, gender, socioeconomic status, and geographical region.

Relevance to Theoretical Framework

Kelley's (1973) covariation model offered a valuable lens through which to interpret the findings of this study on religious attitudes, perceived fear, and delay in mental illness reporting. The significant positive association found between religious attitudes and perceived fear could be understood in terms of Kelley's model as potentially demonstrating high consensus, distinctiveness, and consistency. However, the key finding that religious attitudes directly contributed to a reduction in the delay of mental illness reporting, independent of perceived fear, presents a more complex picture. This relationship suggests high consistency because it remained stable even when controlling for perceived fear.

The lack of significant mediation by perceived fear indicates that, according to Kelley's model, observers are likely to attribute the reduced delay in reporting to religious attitudes directly, an internal cause, rather than to fear or other external factors. This interpretation aligns with Kelley's model by suggesting that the relationship between religious attitudes and prompt mental illness reporting might be viewed as primarily driven by individuals' beliefs rather than external influences, contributing to the understanding of how religious attitudes impact mental health behaviors in this population.

Heider's (1973) theory posited that individuals attempt to understand others' behavior by attributing causes to either internal (personal) or external (situational) factors. In the context of the current study, the significant negative relationship between religious attitudes and delay in mental illness reporting suggests that participants with stronger religious attitudes were more likely to report mental illness promptly. According to Heider's theory, observers might attribute this behavior to internal factors, such as personal religious beliefs or values, rather than external circumstances. This interpretation is further supported by the finding that perceived fear did not significantly mediate this relationship. The lack of mediation by perceived fear, a potential external factor, strengthens the case for internal attribution. Heider's (1973) theory would suggest that the reduced delay in mental illness reporting among more religious individuals is likely to be perceived because of their internal characteristics such as religious convictions or personal responsibility rather than external pressures or circumstances, providing insight into how religious attitudes may influence perceptions and behaviors related to mental health in this population.

Limitations of the Study

There were several limitations to the study. Regarding external validity, the participants who opted in were all found via the internet and a research-focused website. This recruitment process was typical of survey research that has the advantage of ease and efficiency of administration, but weak external validity (see Nardi, 2018). Regarding limitations to internal validity, the use of a cross-sectional design limits the ability to investigate the causal relationship that could exist between the variables. Further, this

kind of research incurs the risk of common method variance (Tehseen et al., 2017), which could result in inflation of the relationships between the variables that were used in the current study. However, this issue is unlikely given the null findings. The more important limitation is the potential lack of specificity of the model. The prediction of willingness to seek help is most likely influenced by other factors than the ones used in the study. Further study could investigate the other predictors that could influence and reveal more data. This does not address the limitations.

Recommendations

The study's results present interesting possibilities for further research in this area, particularly in identifying alternative mediating factors that may explain the relationship between religious attitudes and delay in mental illness reporting, given that perceived fear did not play this role. As suggested by Koole et al. (2010), a measure of emotional well-being is recommended to more fully flesh out this model. Other variables for consideration include social support and prior use of mental health services. Finally, to further expand this study's findings, future researchers could consider the use of a qualitative approach that allows for more direct engagement with members of the Southern California Christian community. This could allow for a more nuanced understanding of the motivations and influences of their beliefs on mental health help seeking.

Implications

The results of this study have implications for social change regarding how religious communities can encourage their parishioners to seek mental health services

when experiencing distress and challenges. If resources are not accessible, greater community outreach that is culturally sensitive to religious beliefs could be of benefit. This could also include involving pastors or church staff in mental health outreach programs. Larger religious communities can often support trained mental health professionals who have certification or accreditation with a religious affiliation, and parishioners may have less fear if the mental health provider is part of the community. Community-based participatory research that involves engaging leaders and members of the religious community in the research process could lead to more culturally sensitive and relevant outcomes involving religious attitudes and psychological services.

Conclusion

The relationship between religious attitudes and delays in reporting mental illness symptoms was important to investigate, and the insights gathered from this study addressed a topic that is often misunderstood. This study identified that religious attitudes and fear share a relationship, despite it not being the relationship that was predicted. The study was also able to show that fear does not cause delay of mental illness reporting among Christians in Southern California. The results from this study may provide opportunities for more research in the Christian community of Southern California, and more research may help to improve the mental health options for Christians and the communities of faith they inhabit. Christianity and psychology seek to improve the personal well-being of the person, and working in conjunction can further aid in bringing psychological services into the Christian faith-based communities. Involvement of community-based leaders and members of the religious community in the mental health

care process could lead to more culturally sensitive and positive results involving the religious attitudes of Christians and the psychological services they require.

References

Adams, J. E. (1986). *The Christian counselor's manual: The practice of nouthetic counseling*. Harper Collins.

Ægisdóttir, S., & Gerstein, L. H. (2009). Beliefs about psychological services [Database record]. PsycTESTS. https://doi.org/10.1037/t20529-000

American Psychological Association. (2015, June 30). *APA releases new resources on mental health for faith leaders*. https://www.psychiatry.org/newsroom/news-releases/apa-releases-new-resources-on-mental-health-for-faith-leaders

Anthropic. (2024). Claude (3 Sonnet version) [Large language model]. https://claude.ai/chats

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59*(9), 869–878. https://doi.org/10.1037/0003-066X.59.9.869

Basso, J. C., Satyal, M. K., & Rugh, R. (2021). Dance on the brain: enhancing intra-and inter-brain synchrony. *Frontiers in human neuroscience*, *14*, 584312. https://doi.org/10.3389/fnhum.2020.584312.

Belaire, C., & Young, J. S. (2000). Influences of spirituality on counselor selection. *Counseling and Values*, *44*(3), 189–197. https://doi.org/10.1002/j.2161-007X.2000.tb00171.x.

Business Research Methodology. (2024). *Positivism - Research Methodology*. Research-Methodology. https://research-methodology.net/research-philosophy/positivism/.

Carlton, P. A. (2000). Impact of attitudes and suicidal ideation on adolescents' intentions to seek professional psychological help. *Journal of Adolescence*, *23*(1), 35–45.

https://doi.org/10.1006/jado.1999.0299

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*(1), 4455. https://doi.org/10.1037/0022-006X.70.1.44

Cinnirella, M., & Loewenthal, K. M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *Psychology and Psychotherapy: Theory, Research and Practice*, *72*(4), 505–524. https://doi.org/10.1348/000711299160202

Corrigan, P., McCorkle, B., Schell, B., & Kidder, K. (2003). Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal*, *39*(6), 487–499. https://doi.org/10.1023/B:COMH.0000003010.44413.37

Cuthbert, A. D., Davis, E. B., Aten, J. D., Short, A., Yarborough, C. A., Lavelock, C. R., & Van Tongeren, D. R. (2018). Cultivating humility in religious leaders: The effectiveness of a spiritually integrated positive psychology intervention. *Spirituality in Clinical Practice*, *5*(4), 227. https://doi.org/10.1037/scp0000185

Davis, T. L., & Hill, C. E. (2005). Spiritual and nonspiritual approaches to dream work: Effects on clients' well-being. *Journal of Counseling & Development*, *83*(4), 492–503. https://doi.org/10.1002/j.1556-6678.2005.tb00371.x

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical psychology review*, *33*(7), 846-861. https://doi.org/10.1016/j.cpr.2012.09.007Get rights and

content

Dockery, L., Jeffery, D., Schauman, O., Williams, P., Farrelly, S., Bonnington, O., ... & MIRIAD Study Group. (2015). Stigma-and non-stigma-related treatment barriers to mental healthcare reported by service users and caregivers. *Psychiatry Research*, *228*(3), 612-619. https://doi.org/10.1016/j.psychres.2015.05.044

Fox, J., Picciotto, G., Cashwell, C. S., Worthington, E. L., Jr., Basso, M. J., Brow Corrigan, S., Toussaint, L., & Zeligman, M. (2020). Religious commitment, spirituality, and attitudes toward God as related to psychological and medical help-seeking: The role of spiritual bypass. *Spirituality in Clinical Practice*, *7*(3), 178–196. https://doi.org/10.1037/scp0000216

Gale, J., Robson, M., & Rapsomatioti, G. (Eds.). (2013). *Insanity and divinity: Studies in psychosis and spirituality*. Routledge.

G*Power. Universität Düsseldorf: G*Power. (n.d.). Retrieved February 9, 2023, from https://www.psychologie.hhu.de/arbeitsgruppen/allgemeine-psychologie-und-arbeitspsychologie/gpower

Graham, B. (1984). *Christian worker's handbook*. Baker Book House.

Griffith, J. L., Myers, N., & Compton, M. T. (2016). How can community religious groups aid recovery for individuals with psychotic illnesses? *Community Mental Health Journal*, *52*(7), 775–780. https://doi.org/10.1007/s10597-015-9974-1

Greene, D. C., Brennan, C., & Britton, P. J. (2017). Exploration of psychological distress in gay, bisexual, and heterosexual Roman Catholic priests. *Psychology of Religion and Spirituality*, *9*(4), 401. https://doi.org/10.1037/rel0000047

Hammer, J. H., & Spiker, D. A. (2018). *Mental Help-Seeking Intention Scale.* PsycTESTS. https://doi.org./10.1037/t66988-000

Heider, F. (1958). *The Psychology of Interpersonal Relations.* New York: John Wiley & Sons. http://dx.doi.org/10.1037/10628-000

Hodge, A. S., Hook, J. N., Davis, D. E., & McMinn, M. R. (2020). Attitudes of religious leaders toward integrating psychology and church ministry. *Spirituality in Clinical Practice*, *7*(1), 18–33. https://doi.org/10.1037/scp0000200

Ikwuka, U., Galbraith, N., Manktelow, K., Chen-Wilson, J., Oyebode, F., Muomah, R. C., & Igboaka, A. (2016). Pathways to mental healthcare in south-eastern Nigeria. *Transcultural Psychiatry*, *53*(5), 574–594. https://doi.org/10.1177/1363461516660903

Ivtzan, I., Chan, C. P., Gardner, H. E., & Prashar, K. (2013). Linking religion and spirituality with psychological well-being: Examining self-actualization, meaning in life, and personal growth initiative. Journal of religion and health, 52(3), 915-929. https://doi.org/10.1007/s10943-011-9540-2

Kelley, H. H. (1973). The processes of causal attribution. *American Psychologist, 28*(2), 107–128. https://doi.org/10.1037/h0034225

Koenig, H. G. (2012). *Religion, spirituality, and health: The research and clinical implications.* ISRN psychiatry. https://doi.org/10.5402/2012/278730

Koenig, H. G. (2008). Religion and mental health: What should psychiatrists do? *The Psychiatrist, 32*(6), 201–203. https://doi.org/10.1192/pb.bp.108.019430

Koole, S. L., McCullough, M. E., Kuhl, J., & Roelofsma, P. H. (2010). Why

religion'sburdens are light: From religiosity to implicit self-regulation. *Personality and Social Psychology Review, 14*(1), 95-107. https://doi.org/10.1177/1088868309351109

Knabb, J. J., Vazquez, V. E., Garzon, F. L., Ford, K. M., Wang, K. T., Conner, K. W., ... & Weston, D. M. (2020). Christian meditation for repetitive negative thinking: A multisite randomized trial examining the effects of a 4-week preventative program. *Spirituality in Clinical Practice, 7*(1), 34. https://doi.org/10.1037/scp0000206

Kushner, M. G., & Sher, K. J. (1989). *Thoughts about Psychotherapy Survey* [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t25960-000

La Barre, W. (1947). Primitive psychotherapy in native American cultures: Peyotism and confession. *The Journal of Abnormal and Social Psychology, 42*(3), 294. https://doi.org/10.1037/h0060765

Lloyd, C. E., & Kotera, Y. (2021). Mental Distress, Stigma and Help-Seeking in the Evangelical Christian Church: Study Protocol. *Journal of Concurrent Disorders*, *4*(1), 1.

Lloyd, C. E., & Waller, R. M. (2020). Demon? Disorder? Or none of the above? A survey of the attitudes and experiences of evangelical Christians with mental distress. *Mental Health, Religion & Culture, 23*(8), 679-690. https://doi.org/10.1080/13674676.2019.1675148

Lucchetti, G., Koenig, H. G., & Lucchetti, A. L. G. (2021). Spirituality, religiousness, and mental health: A review of the current scientific evidence. *World journal of*

clinical cases, 9(26), 7620. https://doi.org/10.12998/wjcc.v9.i26.7620

Macionis, J. J., Jansson, S. M., & Benoit, C. M. (2013). *Society: The basics (6th ed.).* Pearson Canada. Retrieved January 18, 2022, from https://exchange.pearson.com/products/9780134560830/revel-for-society-the-basics-sixth-canadian-edition-access-card?uuid=9b87305d-50f7-474f-ba92-c3bb9b3da8f3

Mears, K., Montelpare, W. J., Read, E., McComber, T., Mahar, A., & Ritchie, K. (n.d.). Data screening and cleaning. *Applied Statistics in Healthcare Research.* Retrieved January 18, 2022, from https://pressbooks.library.upei.ca/montelpare/chapter/data-screening-cleaning/

McBride, J. A., Lea, T., Hardman, R. K., & Barnes, D. V. (2015). Processes and outcomes of theistic spiritually oriented psychotherapy: A practice-based evidence investigation. *Spirituality in Clinical Practice, 2*(3), 180-190. https://doiorg.ezp.waldenulibrary.org/10.1037/scp0000083

McMinn, M. R. (2012). *Psychology, theology, and spirituality in Christian counseling*. Tyndale House Publishers, Inc.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Revie and meta-analysis. *Journal of counseling psychology, 46*(1), 92. https://doi.org/10.1037/0022-0167.46.1.92

McLemore, C. W. (1977). *Religion and psychotherapy: Ethics, civil liberties, and clinical savvy: A critique.* J H Court. https://doi.org/10.1037/0022-006X.45.6.1172

Nardi, P. M. (2018). *Doing survey research: A guide to quantitative methods*. Routledge. https://doi.org/10.4324/9781315172231

New International Version Bible. (1973). *2 Timothy 3:16-17*. Biblica.

Nolan, J. A., McEvoy, J. P., Koenig, H. G., Hooten, E. G., Whetten, K., & Pieper, C. F. (2012). Religious coping and quality of life among individuals living with schizophrenia. *Psychiatric Services, 63*(10), 1051-1054. https://doi.org/10.1176/appi.ps.201000208.

Organizing Your Social Sciences Research Paper: Quantitative Methods. (n.d.).Retrieved January 03, 2021, from https://libguides.usc.edu/writingguide/quantitative

Oxhandler, H. K., Narendorf, S. C., & Moffatt, K. M. (2018). Religion and spirituality among young adults with severe mental illness. *Spirituality in Clinical Practice, 5*(3), 188. https://doi.org/10.1037/scp0000164

Positivism Research Philosophy. (n.d.). Research-Methodology.Net. Retrieved November 15, 2020, from https://research-methodology.net/research-philosophy/positivism/#:~:text=As%20a%20philosophy%2C%20positivism%20adheres, interpretation%20in%20an%20objective%20way.

Peteet, J. R., Lu, F. G., & Narrow, W. E. (2011). *Religious and spiritual issues in psychiatric diagnosis: A research agenda for DSM-V*. American Psychiatric Pub.

Resident adjective. (n.d.). Https://Www.Merriam-Webster.Com/Dictionary/Resident. Retrieved November 15, 2020, from above.

Sample Size Calculator - Confidence Level, Confidence Interval, Sample Size, Population Size, Relevant Population - Creative Research Systems. (n.d.).

www.Surveysystem.Com. Retrieved November 15, 2020, from https://www.surveysystem.com/sscalc.htm

Sanders, P. W., Allen, G. K., Fischer, L., Richards, P. S., Morgan, D. T., & Potts, R. W. (2015). Intrinsic religiousness and spirituality as predictors of mental health and positive psychological functioning in Latter-day Saint adolescents and young adults. *Journal of religion and health, 54*, 871-887. https://doi.org/10.1007/s10943-015-0043-4

Sharp, G. (1991). The Role of Power in Nonviolent Action. In B. Martin (Ed.), Social Defence, Social Change (pp. 73-97). Retrieved November 4, 2024 https://www.bmartin.cc/pubs/peace/73Sharp/

Survey Monkey. (n.d.). Ensuring your data is secure and compliant is our top priority. Here's how we do it. Www.Surveymonkey.Com. Retrieved November 15, 2020, from https://www.surveymonkey.com/mp/data-security-and-compliance/

Sutton, G. W., Kelley, H. L., Griffin, B. J., Worthington Jr, E. L., & Dinwiddie, C. (2018). Satisfaction with Christian psychotherapy and well-being: Contributions of hope, personality, and spirituality. *Spirituality in Clinical Practice, 5*(1), 8. https://doi.org/10.1037/scp0000145

Tehseen, S., Ramayah, T., & Sajilan, S. (2017). Testing and controlling for common method variance: A review of available methods. *Journal of management sciences, 4*(2), 142-168.

Turner, E. A., & Llamas, J. D. (2017). The role of therapy fears, ethnic identity, and

spirituality on access to mental health treatment among Latino college students. *Psychological Services*, *14*(4), 524–530. https://doi.org/10.1037/ser0000146

Tomcsányi, T. (2000). Mental health promotion through the dialogue of different philosophies and professions. An interdisciplinary training in mental health. *Mental Health, Religion & Culture, 3*(2), 143-155. https://doi.org/10.1080/136746700750018221

Wig, N. N. (1999). Mental health and spiritual values. A view from the East. *International Review of Psychiatry, 11*(2-3), 92-96. https://doi.org/10.1080/09540269974230

Williams, L., Gorman, R., & Hankerson, S. (2014). Implementing a mental health ministry committee in faith-based organizations: The promoting emotional wellness and spirituality program. *Social work in health care, 53*(4), 414-434. https://doi.org/10.1080/00981389.2014.880391

Wildman, W. J., & McNamara, P. (2010). Evaluating reliance on narratives in the psychological study of religious experiences. *The International Journal for the Psychology of Religion, 20*(4), 223-254. https://doi.org/10.1080/10508619.2010.507666

Winfrey, D. W., & McMinn, J. G. (1975). Adams' theory of nouthetic counseling. Journal of Psychology and Theology, 3(3), 143-155. https://doi.org/10.1177/009164717500300301

Young, J. L., Griffith, E. E., & Williams, D. R. (2003). The integral role of pastoral counseling by African American clergy in community mental health. *Psychiatric*

Services, 54(5), 688- 692. https://doi.org/10.1176/appi.ps.54.5.688

Appendix A: Demographic Information Questionnaire

Please circle the answer that best describes your answer to the question.

Which category below includes your age?

- 18-20
- 21-29
- 30-39
- 40-49
- 50-59
- 60 or older

What is your gender?

- Female
- Male
- Other (specify) ___________

What is the highest level of college you have completed or the highest degree you have received?

- Some college but no degree
- Associate degree
- Bachelor’s degree
- Graduate degree

Do you identify as a Christian?

- Yes
- No

What denomination of Christianity do you identify with?

- Catholic
- Orthodox
- Protestant (General)
- Evangelical (Non-denomination)
- Other

Do you currently live in the Southern California area?

- Yes
- No

Do you attend religious services in the Southern California area?

- Yes
- No

How involved are you in your church? (ministries, volunteering)

- Not very involved
- Moderately involved
- Very involved