

Religious Beliefs, Attitudes towards Mental Health Treatment, and Mental Health  
Utilization among Southern Rural African Americans

by

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*Praise the LORD! Give thanks to the LORD, for he is good! His faithful love endures forever. Psalms 106:1*

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## **Chapter I**

### **Introduction**

According to the Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General (DHHS, 1999; 2001) formal mental health services are underused by all Americans. Ethnic minorities, however, are less likely to utilize mental health services, specifically outpatient services, than White Americans (DHHS, 2001). Historically, research has documented that among Americans with perceived or actual clinical needs, White Americans were more likely to be receiving active treatment than both Hispanic Americans and African Americans (Wells, Klap, Koike, and Sherbourne, 2001; Williams, 2007). This disparity in treatment utilization has become a focus of mental health policy and research.

The federal government has focused on transforming the mental health delivery system by investigating and ultimately eliminating the barriers that currently discourage minorities from utilizing mental health care. In 2001, President Bush signed the New Freedom Initiative, which seeks to promote access to community life for people with disabilities. As a part of this initiative, the New Freedom Commission on Mental Health was formed to assess the current mental health system and suggest changes that will positively affect mental health outcomes. Based on their findings, the commission emphasized the importance of understanding underlying factors, both structural factors (i.e. accessibility and availability of services) and attitudes, which may affect utilization



among minorities. (The President's New Freedom Commission on Mental Health, 2003; Rost & Fortney, 2002; National Advisory Committee on Rural Health, 2002).

### *Rural America and Mental Health*

Understanding mental health needs among rural Americans has become a recent focus of federal policy (NFR, 2003). However, federal policy makers have yet to agree upon a single definition of rural. Some definitions, such as the U.S. Census Bureau's definition, use population density as the main indicator of rurality. The U.S. Census Bureau defines rural as any area that is not considered an urbanized area (an urban nucleus of 50,000 or more people) or an urban cluster (contains an UA and a population density of 1,000 persons per square mile) (U.S. Census, 2000). Other definitions of rural add an additional component of proximity to urban communities. The Office of Management and Budget (OMB) defines rural areas in terms of nonmetro counties. Nonmetro counties are counties that fall outside the boundaries of metro areas. There are two types of nonmetro areas; 1) micropolitan, areas are any nonmetro county with an urban cluster of at least 10,000 persons or more; and 2) noncore county. Researchers who discuss rurality consider both micropolitan and noncore counties as rural (OMB, 2000). For the purposes of this paper, we will be using the U.S. Census Bureau definition.

### *Rural African Americans: An Understudied Population*

Although, the Black population is extremely diverse, psychological research related to mental health utilization tends to focus on African Americans from urban areas, leaving a significant portion of the Black community unstudied. Current estimates indicate approximately fifteen percent of African Americans live in rural areas (U.S. Census,

2000). Historically, a region in the southeastern United States termed the Southern Black Belt (Washington, 1901) contains a significant portion of the rural African American population. This region is characterized by high levels of poverty, inadequate education, poor health, and high mortality (Wimberley & Morris, 1997). These current substandard conditions are worsened due to recent shifts in the economic environment. Specifically, as rural areas have transitioned from primarily agriculture-based economy to a manufacturing based economy; many rural communities have become more susceptible to job loss during the recession (Hoyt, 1995). The recession has disproportionately affected the rural African American community, leaving a significant portion of African Americans unemployed or underemployed (Wimberley & Morris, 1997). These increases in economic stresses may have caused African Americans to become more vulnerable to increased mental illness and in need of mental health treatment.

However, despite the greater environmental stressors and likely concomitant increases in psychiatric risk among rural Americans, there has not been a significant increase in mental health service usage in this population. In fact, recent examinations found significant rates of under usage in rural areas. Approximately 4% of African Americans with a diagnosable mental illness receive specialty mental health care (New Freedom Report, 2003, Angold, 2002). This limited usage of services despite need should renew the emphasis on understanding factors that influence utilization of services in rural African Americans.

Research in rural communities has focused primarily on structural barriers that discourage utilization including accessibility and availability of services. While disparities in treatment utilization can be explained by lack of accessibility to services,

underlying factors that drive utilization of mental health treatment, particularly the role that religious beliefs play in the decision to seek treatment, have yet to be fully explored in this population.

### *African Americans, Religion, and Utilization*

African Americans have a unique history that has been characterized by extreme adversity that continues to affect their social standing. However, the resiliency that African Americans exhibit in the face of social disadvantage has become the focus of recent psychological research. For example, Williams and colleagues' analysis of the National Survey of American Life data (NSAL) have found that African Americans report lower lifetime rates of major depressive disorder in comparison to White Americans. Similarly Breslau and colleagues' (2005) analysis of the National CoMorbidity Survey-Replication data (NCS-R) finds that in comparison to White Americans, African Americans have lower risk for several psychiatric disorders, including depression, generalized anxiety, social phobia, panic disorder, substance use disorders and impulse control disorders. Further, the pattern of racial differences in psychiatric risk indicates the presence of protective factors that originate early in life and generalize to mental health (see Breslau, et al., 2005). One such protective factor that Breslau implicates in his explanation of decreased psychiatric risk is religion, which has become an important focus in utilization research.

Religious beliefs have been found to be important in the lives of African Americans with 85% of African Americans reporting being fairly or very religious (Taylor and Chatters, 1991). More specifically, African Americans demonstrate high

levels of both public and private religious behaviors including religious participation (i.e. church attendance), spiritual readings and prayer (Taylor 2004; Chatters, 1999, Bearon, 1990). Previous research has established the protective role that religion plays in the lives of Americans, particularly minorities (Pargament, Koenig, and Perez, 2000; Koenig, 2001). Specifically, religious beliefs and behaviors are associated with lower rates of several mental disorders, including depression; better physical health, and reduced levels of mortality (Pargament, 2000; Koenig, 2001).

Another closely related, but distinct concept is religious coping. Religious coping, or the use of religious beliefs to adapt to stressful situations, also acts as a protective factor in the lives of African Americans. When using religious beliefs to cope with the many stressors that African Americans encounter, African Americans experience lower levels of mental health problems including lower levels of depressive symptoms (Paragment, 2000, Taylor, Chatters, and Levin, 2004). Interestingly, religious coping has also been shown to partially explain disparities in service utilization. A recent examination of the relationship between religious coping and mental health utilization found that African American college students who more frequently utilized religious coping methods were less likely to utilize mental health services when experiencing significant depressive symptoms (Haynes, Kohn-Wood, & Hammond-Powell, under review). These findings indicate that, although religious coping acts an important source of strength when facing stress it can also act as a barrier to utilizing mental health services for those who could possibly benefit from such services.

*Focus of present studies*

Previous research has suggested that the use of religious beliefs as a mechanism to cope with distress is related to the likelihood of seeking help from professional mental health sources (Haynes et al., under review). This association has not been thoroughly examined among African Americans living in rural areas, where religion arguably plays its greatest role due to the reliance upon religious institutions in the absence of other resources (Taylor, Chatters, and Levine, 2004).

To better understand the influence of religion on the decision of rural African Americans to utilize or not utilize mental health treatment, this mixed method study was designed to elucidate the relationship between religious coping, religious beliefs, religious attitudes and mental health utilization behavior and beliefs. The Theory of Reasoned Action (Ajzen & Fishbein, 1980; 2005) will be used as a theoretical framework for understanding the association between attitudes, behaviors, subjective norms and behavioral intentions. In this framework, it is hypothesized that the best predictor of future behavior or distal outcomes is behavioral intentions, and behavioral intentions are directly associated with attitudes and subjective norms of a given group for a specific phenomenon. In the proposed study ‘intent to use mental health services’ is conceptualized as behavioral intent and religious coping strategies are conceptualized as a current behavior that may mediate or moderate the association between identified attitudes and subjective norms on the intent to utilize mental health services.

Following Ajzen and Fishbein’s (2005) methods for conducting Theory of Reasoned Action studies, methods of qualitative inquiry will be used to first elicit service attitudes followed by quantitative methods to confirm the relationship. Specifically, qualitative methods will be used to identify beliefs and attitudes related to the mental

health service system, previous or intended use of services, and to investigate how these attitudes and beliefs are influenced by religious beliefs and coping behaviors from rural African Americans' perspective. Quantitative methods will be used to assess systemic ways that religiosity and religious coping are related to the intent to utilize mental health services.

Understanding the association between the influence of religious behavior and attitudes and mental health service utilization is important for three reasons; 1) this association may inform observed patterns of underutilization of mental health services among rural African Americans, 2) this association may, in part, explain the evidence for mental health resilience among African Americans (Breslau et al., 2005; Williams, et al., 2007) and 3) this association could help to inform interventions designed to increase appropriate utilization of mental health services among hard to reach groups, such as African Americans in rural areas.

## **Chapter II**

### **Literature Review**

#### **Mental Health Service Use among African Americans**

African Americans show different patterns of mental health service use in comparison to others. African Americans are less likely to utilize outpatient mental health services, and are more likely than any other ethnic group to rely on emergency psychiatric services, (Neighbors, Caldwell, Williams, Nesse, Taylor, Bullard, Torres & Jackson, 2007; Wells, Klap, Koike, and Sherbourne, 2001; Snowden, 1999).

Epidemiological research has shown that African Americans have lower lifetime rates of psychiatric disorders, which may suggest that overall African Americans have a lessened need for mental health services. However, only 16% of African Americans with diagnosable disorder have sought any mental health services (Breslau, 2005, DHHS, 2001). More specifically, Williams et al (2007), found that only 2.8% of African Americans with a diagnosable mood disorder received services from a specialized mental health specialist. Alarming, in these data as the severity of symptoms increased, mental health utilization rates did not increase significantly. Taken together, these data indicate that the overwhelming majority of African Americans in need of mental health treatment are not receiving adequate treatment even when experiencing severe impairment. This decreased usage of specialty outpatient mental health services is especially disturbing because clinical trials have consistently shown that treatment outcomes are significantly

better when individuals receive treatment that includes weekly visits to a trained mental health specialist (Katon, Von Korff, & Lin, 1995, Fortney, Rost, Zhang, and Pyne, 2001). Decreased usage of mental health services coupled with the severe functional impairment potential untreated mental illness among African Americans, underscores the importance of understanding how to increase appropriate utilization non-emergency outpatient treatment among African Americans.

### *Rural Americans and Mental Health*

Previously, researchers and policy makers theorized that mental illness was less common in rural communities (Diala, 2003). However, with the recent economic changes (i.e. the shift from an agriculturally based economy to a manufacturing based economy) and increases in unemployment rates, researchers are beginning to find higher levels of distress are being reported in rural communities (Diala, 2003). Specifically, comparisons of mental illness in rural communities versus of urban communities have found either higher or comparable rates of major depression or other psychiatric illnesses among residents of rural communities (Diala, 2003; Kessler, 1994, Wagenfield, 1994). Further investigation found that in rural communities, lower income has been associated with higher risk for psychiatric illness, particularly among rural men (Diala, 2003).

Similar to research examining rates of mental illness in urban communities, African Americans in rural communities tended to report lower rates of psychiatric illness than their White counterparts (Diala, 2003). However, there are many critiques of the epidemiological rates of psychiatric illness among rural African Americans. One such critique is that African Americans are usually overrepresented in high need populations, such as the homeless and incarcerated, that are not sampled in larger prevalence studies



(Snowden, 1999) thereby leading to inaccurate estimates of actual prevalence rates. Sampling difficulties are especially apparent in rural communities where finding a representative sample is made more difficult due to small sample sizes, geographical barriers, and poor funding (Strong, Del Grosso, Burwick, Jethwani, & Ponza, 2005; National Rural Health Association, 1998). Therefore, it is possible that the current studies reporting similar or lower prevalence rates of psychiatric illness for rural African Americans may be an underestimate.

However, even when taking the limitations of the aforementioned studies into account, there is still a notable proportion of the rural African American population in need of mental health care. Barry et al (1997) found similar rates of individuals with serious mental illnesses are served by rural community health centers when compared to urban community mental health centers, with serious mental illnesses being defined as a diagnosable psychiatric disorder resulting in significant impairment, disability or disadvantage (SAMHSA, 2002). Research also documents that African Americans are disproportionately represented in samples of individuals with serious mental illness regardless of geographic region. This coupled with the aforementioned research indicating that African Americans who experience mental illness often experience higher rates of severity and higher rates of functional impairment compared to White Americans (Williams, 2007), indicate that African Americans constitute a significant proportion of individuals at increased risk for psychiatric illness and severe impairment in rural communities.

Despite the increased risks of untreated mental illness in rural African Americans, usage of mental health services is significantly lower among African Americans living in

rural areas, with estimates of mental health utilization falling well below the national average (New Freedom Commission, 2003). Specifically, only 4% of African Americans with identified clinical needs are receiving mental health services (Angold, 2002). Additionally, individuals living in rural communities often reach higher thresholds of distress before perceiving need for treatment (Rost, 2002), leading rural residents to enter treatment at a later point in the course of the disorder, which usually results in more disabling and persistent symptoms (New Freedom, 2003). These findings indicate that factors associated with underutilization of mental health services are an important issue to investigate in rural African American communities.

#### Barriers to Care: Quality and Availability of Services

Several barriers to utilization of services have been examined in the literature with particular focus on disparities in the availability and accessibility of services. One factor that may contribute to underutilization of mental health services among African Americans is the quality of service options available. African Americans seeking mental health care are more likely to receive an incorrect diagnosis and more likely to receive substandard care in comparison to their White counterparts (Neighbors, et al, 2007; DHHS, 2001; Snowden, 2001). Furthermore, African Americans are less likely to receive services from African American clinicians. Among clinically trained mental health professionals, only 2 percent of psychiatrists, 2 percent of psychologists, and 4 percent of social workers said they were African American in a previous survey (Holzer et al., 1998). While therapist client ethnic match is not necessarily related to better treatment outcomes for African Americans, it does seem to be related to the length of treatment for African Americans (Takeuchi, Sue, and Yeh, 1995).

The availability of mental health services is highly related to where one lives. In rural areas, proximity to mental health care is a serious issue. Evidence indicates that mental health professionals are concentrated in urban areas and are less likely to be available in rural areas (Holzer et al., 1998), where a significant proportion of African Americans reside. Specifically, of the approximately 1600 designated mental health professional shortage areas, more than 85% of those are in rural communities (New Freedom Report, 2003, Rost, 2002). This shortage places a large portion of the responsibility for the diagnosis and treatment of mental health disorders on primary care physicians, who may be ill prepared to provide adequate mental health care (New Freedom, 2003). Mental health problems are most often undiagnosed or misdiagnosed in primary care settings, with approximately half of symptomatic clients seen in primary care settings going undiagnosed (Wells, Schoenbaum, Unutzer, Lagnomasino, 2000; Schoenbaum, 2000). If mental illness is detected, without targeted training in the delivery of mental health services, primary care providers are often uncomfortable and feel unprepared to deliver such services leading to inadequate treatment of mental health issues (Samet, Friedmann, & Saitz, 2001; McCabe, 2000; McCabe & Grover, 1999; Shell, Smith, & Moody, 1998). The paucity of adequate services in rural areas leaves rural African Americans in need of services without appropriate care.

#### *Barriers to Care: Access to Services*

In addition to decreased availability of services, poverty, lack of adequate insurance coverage, and barriers such as lack of transportation and time constraints may make it difficult to access formal mental health services (DHHS, 2001). Access barriers are especially apparent in rural communities. Rural Americans are uninsured at a rate

20% higher than that of their urban counterparts (National Rural Health Association (NRHA), 1998) and suffer from high poverty rates, yet only 25% of rural individuals qualify for federal Medicaid, compared to 43% of individuals in urban settings (DHHS, 2000). Economic and geographic factors create practical issues such as the need to travel longer distances to mental health care centers without adequate transportation and economic resources thereby making services inaccessible to rural communities ( U. S. Surgeon General, 1999 ).

Problems with economic inaccessibility are especially acute for rural African Americans because nearly one-fourth of African Americans are uninsured (Brown et al., 2000), a percentage 1.5 times greater than the rate for White Americans. In the United States, health insurance is typically provided as an employment benefit. Because rural African Americans are often employed in marginal jobs, the rate of employer-based coverage among employed African Americans is substantially lower than the rate among employed whites (53% versus 73%) (Hall et al., 1999)

As an increasing number of African American families are entering the middle class sector (U.S. Census, 2000; DHHS, 2001); however, accessibility disparities have lessened. Nonetheless, middle class African Americans continue to utilize formal outpatient mental health services less often than White Americans, even when insurance levels are comparable, and in some cases less than poor African Americans (Padgett, Patrick, Burns & Schlesinger, 1994; Snowden, 2001; Thomas and Snowden, 2001). Since availability and accessibility barriers do not fully explain the problem of mental health service underutilization among African Americans, other explanatory factors have been investigated.

## Symptom Attribution and Utilization

In addition to structural barriers to care, some researchers have theorized that cognitive-affective variables such symptom attribution, may explain low utilization patterns in African Americans. Symptom attribution represents one's beliefs about the possible causes of the symptoms. Kirmayer, Young, and Robbins (1994) have argued that when people face emotional symptoms, they tend to label problems as psychological or physiological. Those who attribute symptoms to a medical condition are likely to focus on physiological sensations leading them to seek help from medical professionals, (Kolk, Hanewald, Schagen, 2002). In contrast, attributing symptoms to a mental illness increase the likelihood of utilizing mental health professionals. Research indicates that African Americans' tendency to report somatic symptoms (i.e., physical causes) in comparison to White Americans (Das et al., 2006), may help account for disparities of mental health services. The evidence from research examining the relationship between cognitive-affective variables and utilization; however, indicates that these variables do not account for group differences in treatment seeking (Ayalon et al., 2005). Therefore, additional factors should explain utilization differences by race.

## Informal Help-Seeking and Utilization

Along with the structural barriers to care created by lack of accessibility and availability and a tendency to report somatic complaints, some researchers have theorized that African Americans turn to alternative sources for mental health care. Research has shown that African Americans often rely on group-centered activities for coping with stressful situations (Utsey, 2000). A sizable body of literature indicates that African Americans receive considerable informal supports such as church-based networks (Boyd-

Franklin, 2009; Mattis, 2000; Neighbors, 1984; Taylor, 2007; Taylor & Chatters, 1991; Taylor, Chatters & Levin, 2004) when experiencing distress. In fact, Neighbors (1998) found that approximately one-third of African Americans would recommend speaking to a minister or relative when facing mental health issues. However, despite a willingness to recommend relying on informal networks to others, when personally faced with mental illness, African Americans are actually less likely to turn to informal support systems (Snowden, 1998). Further, African Americans are less likely than White Americans to seek help from informal sources and when help from informal sources is used, it is as a complement to rather than a substitute for formal mental health services (Snowden, 1998; Neighbors & Jackson, 1984).

#### Attitudes towards Mental Health services among African Americans

With structural barriers and use of informal supports not fully explaining disparities in utilization, researchers have examined how common perceptions and attitudes regarding mental health care influence the likelihood of utilizing mental health care. Mental health service attitudes are defined as personal beliefs about the positive or negative consequences of utilizing mental health services. Early research investigating such attitudes indicates that African Americans are more likely to report mistrust and fear when considering utilizing mental health care. Sussman et al. (1987) found that African Americans with moderate levels of mental illness were more likely to cite fears of hospitalization and of treatment as reasons for not seeking mental health treatment. Specifically, approximately half of the African American sample reported being afraid of mental health treatment. By contrast, only 20 percent of Whites in the same study cited

such fears. At more severe levels of distress, however, group differences were not observed.

In comparison to other groups, African Americans also report higher levels of embarrassment or stigma surrounding the use of mental health services. This stigma is based on the belief that seeking psychological help was a sign of weakness, but again, group differences are found only for moderate levels of severity (Sussman & Robins, 1987; Cooper-Patrick, 1997, Sanders-Thompson et al, 2004). For rural African Americans, fear of stigma may be related to the perception that anonymity and confidentiality will be threatened due to the size and closeness of the community. Rural communities have been likened to a “fishbowl” where people attending a mental health program are easily noticed. Therefore, greater concern may exist regarding how others will perceive an individual in mental healthcare (Smith, 2003).

Concerns regarding being perceived negatively due to seeking mental health services seem to be closely related to beliefs that seeking mental health care indicates a personal weakness. Previous research indicates that African Americans have expectations that life will be difficult but that they possess and should leverage inner strengths in their effort to effectively cope with stressful situations (Sanders-Thompson, Bazile, & Akbar, 2004). Specifically, research has indicated that African Americans participate in a range of coping mechanisms, but show preferences for specific types of coping that can fall into general categories. One such category is Cognitive/Emotional Debriefing (Utsey, 2000), which represents an adaptive reaction by African Americans in their efforts to manage environmental stressors. This category is usually characterized by distracting behaviors, such as hoping that the problem will change. However, African Americans balance this

coping response with the desire to actively confront a problem and overcome the stressful situations (Snowden, 1999), thereby leading to the perceptions that difficulties will arise but that the individual should be able to personally overcome such difficulties. Hence, decisions to utilize formal mental health services might be perceived by African Americans as a failure of strength and a lack of culturally expected coping skills.

Additional factors that contribute to African Americans' underutilization of services are perceptions and beliefs regarding the quality and usefulness of mental health care. African Americans fear that psychologists, specifically White American psychologists, lack an understanding of Black American culture and will make quick judgments that could lead to misdiagnoses and labeling (Cooper-Patrick, 1997, Sanders-Thomson, et al., 2004, Whaley, 2001). Collectively these perceptions of the mental health system may dissuade African Americans from seeking treatment. However, Diala (2000) found that African Americans who had not previously used mental health services had similar if not more positive attitudes (e.g., likelihood of seeking care) regarding mental health services compared to White Americans. Conversely, African Americans who reported using mental health services were more likely than Whites to hold negative attitudes about their care, were less likely to return for additional services, and were less positive about their friends knowing they had sought help (Diala, 2000). Therefore, at least in terms of initial contacts with mental health services, race disparities in seeking and utilizing treatment, while not totally accounted for by African Americans' perceptions of the mental health system, is indeed impacted by such attitudes.



## Religion and Mental Health Service Utilization

As attitudes regarding mental health care may impact the decision to utilize mental health services, understanding how these attitudes develop is an important step in further understanding utilization patterns among African Americans, particularly rural African Americans. One possible predictor of mental health service attitudes is cultural beliefs. Culture can be defined as “a dynamic process involving world views and ways of living in a physical and social environment shared by groups which are passed from generation to generation and may be modified by contact between cultures in a particular social, historical or political context” (Whaley & Davis, 2007).

Researchers have documented that culture establishes not only what constitutes an illness, but also acceptable responses to such illnesses (Kleinman, 1987). Therefore, a person’s perception of mental health problems, and related attitudes about the utilization of mental health care, is greatly influenced by cultural and traditional norms, values and beliefs. One such cultural factor that is an important thread in African American culture is religion.

Historically, the African American church has fulfilled several important roles for African Americans. These roles include providing refuge from oppression as well as providing for both the social and economic welfare of the African American individual (Taylor et al, 2004). The significance of the African American church in rural communities is especially pronounced due to the paucity of social and economic resources in these communities. In fact, the Black Belt is often characterized by increased levels of religious commitment and involvement when compared to other regions (Sherkat & Ellison, 1999). Further, religious beliefs have been found to be very important

in the lives of African Americans. In fact, 85% of African Americans report being fairly or very religious (Taylor & Chatters, 1991). In general, national survey data indicates that African Americans demonstrate high levels of religious behaviors with 70% of African Americans attending services and 80% reporting daily prayer (Taylor 2004; Chatters, 1999, Bearon, 1990). When examining the relationship between religious beliefs and mental health outcomes, aspects of religion (e.g., denomination, service attendance) are associated with lower rates of several mental disorders, including depression; better physical health, and reduced levels of mortality (Pargament, 2000; Koenig et al., 2001).

Among African Americans religion plays an additional role as a context for identifying one's mental health or psychological problem and as an influence in terms of the selection of how one seeks help. More specifically, religious beliefs have been found to be an important factor in how African Americans perceive emotional distress. African Americans were more likely than other groups to conceptualize personal distress using a religious framework with up to 60% of African Americans endorsing that that use of faith was the most successful method in treating depressive symptoms (Neighbors, 1998). Framing distresses using a religious framework coupled with increased importance of religion in African American communities indicate that religion may have important associations with mental health service attitudes.

*Definitions of religious variables.*

Religion is a larger umbrella term that is defined as a “formal set of rituals, beliefs, and practices that expresses an internal belief in God or another higher power” (Dancy & Wynn-Dancy, 1994). However, the complexity of religion cannot be captured in one simple definition. A criticism of previous research regarding religion is that

researchers tend to conflate separate religious expressions into a one-dimensional representation of religion, thereby glossing over the intricacies of the construct. Therefore, it is important to conceptualize religion as a multidimensional construct that is characterized by several closely related, yet distinct variables, particularly religious involvement, spirituality, God Image, and religious coping.

Perhaps the most commonly studied expression of religion is religious involvement. Previously, religious involvement has been defined as church attendance. However, over the past several years, religious involvement has been conceptualized as more multidimensional in character including organizational, non-organizational, and subjective aspects. Organizational religious participation refers to behaviors that take place within a religious setting, such as church attendance and membership in auxiliary organizations (Levin, Chatters, & Taylor, 1995). Non-organizational religious participation refers to behaviors that take place outside of a religious setting such as private prayers (Levin et al., 1995). Subjective religiosity is defined as the centrality of religion to an individual (Ellison and Levin 1998; Idler and George 1998; Koenig, Larson, and McCullough 2001; Idler et al. 2003).

Despite overall high levels of religious involvement among African Americans (Taylor, et al, 2004), there is evidence for sociodemographic differences in the patterns of religious involvement, such that both female gender and advanced age are positively related to increased levels of religious involvement (Chatters, 1999). Additionally, urbanicity has been associated with differing levels of religious involvement. Analyses of urban vs. rural differences in religious involvement found no differences in non-organizational and subjective religiosity dimensions (Chatters, 1999). Rural residents;

however, are more likely to report being a member of a church (Taylor, Chatters, and Levin, 1995) and attend services more frequently than urban African Americans when taking service frequency into account (Taylor, Chatters, Levin, 2004).

In contrast to the externality and thereby increased visibility of religious involvement, spirituality is often less visible and a more internal process. Spirituality is defined as a personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred (Koenig, McCullough, and Larson, 2001). Although empirical research regarding African American spirituality is sparse, quantitative assessments of spirituality underscore the importance of spirituality in the lives of African Americans. For example, eight out of 10 African Americans report that spirituality is very important in their lives and four out of 10 characterize themselves as very spiritual (Taylor, 2009). Although specific analyses of associations between urbancity and spirituality by race are not available, there is a significant dispersion of African Americans in Southern rural communities, where research has indicated there are higher levels of spirituality in comparison to other regions of the country (Taylor et al., 2004). Additional research indicates that African Americans conceptualize spirituality as the “internalization and consistent expression of positive values” and the effort to live a life that expresses the internalization of such values (Mattis, 2000). Additionally, when asked, African Americans were also more likely to define spirituality in terms of a personal relationship with God (Mattis, 2000).

Building upon the importance of relationships in the definition of spirituality, research has moved towards a conceptualization of religion using a relational framework that emphasizes the role that religion and spirituality has in African American

relationships (Mattis and Jagers, 2001). Utilizing a relational framework, underscores the importance of understanding how one relates with God. Therefore, the concept of ‘God image’ has emerged as important facet of religion. God image is defined as “a psychological working internal model of the sort of person that the individual imagines God to be”, which is thought to be distinct from one’s God Concept, which is defined as an “intellectual, mental-dictionary definition of the word God” (Rizzuto, 1979, p. 54). Although an image of God is often developed through a relational process with one’s parents or authority figures, the church also acts as a symbolic representation that affects the development of a God image, such that how one experiences and relates to members of their church act as representations as to how to experience and relate to God (Hoffman, 2005). Quantitative assessments of God Image have focused on three dimensions or questions: 1) Is God there for me (presence)? ; 2) Does God want me to grow (challenge)?; and 3) Am I good enough for him to love (acceptance)? These dimensions are important factors in the measurement of one’s God image. Initial findings have shown that positive images of God are related to higher self-esteem and lower rates of mental illness (Lawrence, 1999). Although underrepresented in research regarding God Image, African Americans tend to score higher than other ethnic groups in experiencing God as being present for them (Lawrence,1999).

It is not only important to understand how one relates to God, but how one conceptualizes God’s role in dealing with stressful situations, also described as religious coping. Religious Coping is defined as “the extent to which persons use their religious beliefs and practices to help them to adapt to difficult life situations and stressful life events” (Koenig, 2001 pg 502). Religious coping may manifest in a wide-range of

behaviors and activities, including the use of prayers, reading of religious materials, and watching religious television programs (Pargament, 1990). In addition to these problem-solving behaviors, researchers have identified distinct religious problem solving styles. More specifically, Pargament (1988) conceptualized three different dimensions of religious coping including ‘Collaborative Religious Problem Solving, Deferring Religious Problem Solving, and Self-Directed Religious Problem Solving.’ Collaborative Religious Problem Solving is defined as the individual and God working together to solve problems, whereas Deferring Religious Problem Solving is defined as the individual relying more heavily on God to solve the problem. Self-Directing Religious Coping is defined as the individual taking responsibility for solving the problem without any direct intercession from God. Research that differentiates between the different styles of religious coping has found mixed results. Generally, the use of collaborative religious problem solving has shown to be related to more positive outcomes while the use of deferring religious problem has been shown to be related to more negative mental health outcomes including increased depressive symptoms (Pargament, 1997). Research specifically focused on religious coping indicates that African Americans report increased use of religious resources and engagement as coping techniques in comparison to White Americans (Kohn-Wood, et al., 2010), Taylor, 2004; Pargament, 1997). African Americans with higher levels of education, however, were less likely to endorse use of religious coping strategies to cope with problems (Taylor, Chatters, Levin, et al., 2008).

## Religious Factors and Mental Health Utilization

Researchers have theorized that religion may lead to decreased use of mental health services through two processes. First, high levels of religious involvement may lead African Americans to seek help for mental health problems from informal religious sources, such as clergy, rather than formal mental health services. However, recent research examining the relationship between religious involvement and help-seeking behaviors found that even highly religiously involved participants do not seek help from clergy members (Ayalon & Young, 2005). The second common hypothesis is that religious coping may explain decreased mental health utilization by helping individual's frame stressful problems as less stressful, thereby decreasing the perceived need for secular treatment (Pargament, 1997, Taylor et al, 2004). A recent examination of the relationship between religious coping and mental health utilization found that African American college students who more frequently utilized religious coping methods were less likely to utilize mental health services when experiencing subclinical levels of depressive symptoms, however, when experiencing clinically significant levels of depressive symptoms, religious coping was no longer a significant predictor of mental health utilization (Haynes, Kohn-Wood, Hammond-Powell, 2010) indicating that the relationship between religious coping and usage is more complex than previously hypothesized.

A third potential hypothesis, however, has yet to be examined in the literature. It is possible that various aspects of religion are mediated by mental health service attitudes, meaning that religion impacts the utilization of mental health services by directly influencing attitudes related to mental health service use. Therefore, the current study

extends the literature by empirically examining the paths by which religion explains utilization, with a specific emphasis in understanding the relationship between religion and mental health service attitudes. Further, research about mental health service attitudes that focuses on rural African Americans is generally non-existent. The research that does exist has yet to examine the how religion explains utilization patterns in rural African American communities, for which religion arguably plays its biggest role (Taylor, Chatters, and Levine, 2004). Therefore, this project will increase our understanding of the role of religion and utilization patterns in rural communities by elucidating this relationship in an understudied population.

*Theoretical Framework: Theory of Reasoned Action*

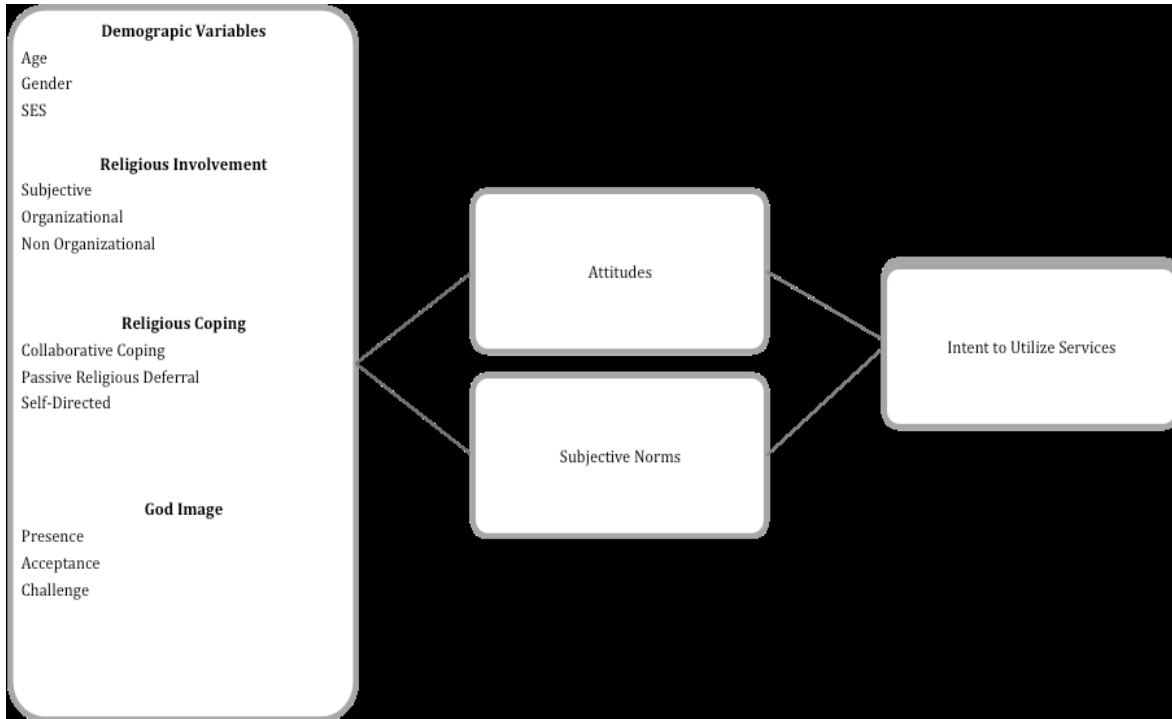
The current study investigates the possibility that various expressions of religion contribute to reduced psychological service use among African Americans by influencing attitudes about service utilization. To understand the many factors that may influence mental health utilization it is helpful to employ a health behavior theoretical model, such as the theory of Reasoned Action. The Theory of Reasoned Action (TRA) proposes that a person's voluntary behavior is best predicted by attitudes about the behavior coupled with perceptions of how others would view them if they performed the behavior (Ajzen & Fishbein, 1980). An attitude consists of personal beliefs about the positive or negative consequences of performing the behavior. Subjective norm refers to a person's positive or negative views associated with a behavior. Subjective norms often depend on whether or not the behavior is accepted by important or relevant individuals such as family members or friends. A person's attitude, combined with subjective norms, form



behavioral intention; and behavioral intention measures a person's relative strength of intention to perform a behavior.

Despite widespread use of this model to predict utilization of health behaviors, this model does not adequately assess the impact of cultural variables on the creation of subjective norms and attitudes. Mollock (2009) proposed an extension of the TRA model that not only assesses subjective norms and attitudes, but also examines how cultural variables, such as expression of religion, influence subjective norms and attitudes regarding the use of mental health services. Therefore, the current study will employ Mollock's extended TRA model by conceptualizing the relationship between the intention to utilize mental health services and expressions of religion, specifically religious coping, religious involvement, and God Image as aspects of rural African American culture, as mediated by mental health service attitudes (Fig. 1.1)

Figure 1.1. Theoretical Model



## Research Questions

The proposed study seeks to better identify and understand how various expressions of religion explain the intent to utilize to mental health services through the following specific research questions:

1. *What factors explain the intent to utilize services among rural African Americans?*

Ajzen and Fishbien (1980) suggest that researchers first elicit commonly held attitudes and beliefs from within the community before testing the model. Therefore, both quantitative and qualitative methods will be employed to understand factors associated with decreased levels of intent to utilize services. Qualitative methods will be utilized to understand how rural African Americans construct mental health service attitudes and

how expressions of religion impact the construction of such attitudes. Survey methods will complement qualitative results by quantitatively assessing relationships between:

- a. Demographic variables and the intent to utilize mental health services
- b. Religious indices (religious involvement, religious coping, and God Image) and the intent to utilize mental health services
- c. Mental health service attitudes and the intent to utilize mental health services
- d. Subjective norms and the intent to utilize mental health services.

Based on previous research, it is hypothesized that mental health service attitudes and subjective norms will be positively related to the intent to utilize mental health services.

## *2. What factors directly influence mental health service attitudes?*

Survey methods will be used to examine relationships between:

- a. Demographic variables and mental health service attitudes
- b. Religious indices (Religious involvement, religious coping, and God Image) and mental health service attitudes

Based on previous research, it is hypothesized that increased reliance on religious coping strategies, increased perceived importance of religion, and increased frequency of both private and public religious activities will be negatively associated with mental health service attitudes.

*3. Is the relationship between religious indices and intent to utilize mediated by mental health service attitudes?*

Survey methods will be used to test mediational models containing religious indices (religious involvement, religious coping, and God Image) mental health service attitudes, and the intent to utilize mental health services. It is hypothesized that mental health attitudes will mediate the relationship between religious indices and intent, whereby religious indices indirectly influence intent to utilize through mental health attitudes.

## **Chapter III**

### **Qualitative Method**

#### *Participants*

Four focus groups were conducted with a total of 20 rural African American participants. Focus groups have been described as a useful method in eliciting a multiplicity of views, attitudes and beliefs that are representative of community held attitudes and beliefs (Morgan, 1993) and therefore deemed appropriate for this study. Rural location was defined using the Census Bureau definition that states, “a rural community has 2,500 or fewer residents” (United States Census Bureau, 2000). The sample consisted of predominantly female participants (18 female and 2 male). Each group included four to six participants. The age of participants ranged from 18-45 years (M= 29) Most reported growing up in a predominately African American household with an annual income of \$32,000-\$62,000 (35%). Most participants (90%) reported being a church member and the majority (75%) reported attending church at least once weekly (Table 3.1).

#### *Procedure*

Following approval obtained from the researcher’s university Institutional Review Board, participants were recruited from universities and religious institutions in two Southern, rural communities; Thomson, Georgia and Colt, Arkansas. These particular sites were chosen as samples of convenience, as members of the research team

had personal connections to both communities. Both communities are situated within the rural Black Belt. According to census reports, Thomson has a population of 2,345 residents with 56.3% of residents identifying as African American. The median age of Thomson residents is 33 years and the majority of residents report a yearly income of \$10,000 or less (U.S Census Bureau, 2000). Colt has a population of 368 residents with 5.4% of residents within the official boundaries of the community identifying as African American (U.S. Census Bureau, 2000). It is important to note, however, that the majority of African Americans in the Colt community live outside of the official boundaries, excluding them from census profiles. Therefore, the census estimate of the African American population within and surrounding Colt is likely an underestimate. The median age of Colt residents is 37.8 years and the majority of residents report a yearly income of \$25,000 to \$35,000 (U.S Census Bureau, 2000). Approximately, 25% of the sample (n=5) was from Colt, and 75% (n=15) was from Thomson.

In both communities participants were recruited using newspaper advertisements and fliers. In addition, Pastors of local religious institutions in Colt and Thomson were approached, told about the study, and agreed to forward the research team's email to church congregants. Interested individuals contacted researchers, the majority of whom were through email contact. Individuals were asked to participate in a focus group that took approximately 90 minutes to complete. Each participant read and signed an informed consent document before joining the group.

The research team included two trained moderators, both African American women from each of the targeted communities. Training for the moderators included 1) reading about focus group methodology, 2) observing experienced researchers conduct

focus groups with African American college and community participants, 3) and co-facilitating focus groups with African American college and community participants with supervised feedback. One moderator conducted each focus group and participants received lunch and a \$10.00 giftcard as compensation for completing the group.

In an attempt to learn as much about the participants' opinions as well as their responses to a priori questions, moderators used the "funnel approach" to questioning (Morgan, 1997). That is, each moderator was responsible for getting a small, specific battery of core questions into the discussion. Once the key questions were asked, moderators allowed the group members take the discussion in other directions if the participants were interested in other issues. In all of the focus groups, the moderators made their way through the entire protocol of key questions. The moderators also attempted to try to bring all participants into the discussion without exerting undue pressure for any one individual participant to contribute, by inviting each member to share their thoughts, monitoring the flow of discussion and intervening if any one participant or smaller subset of the group appeared to dominate the discussion.

Each focus group met with the moderators in a small conference room setting. The group was provided with a light meal and each participant was asked to choose their own pseudonym as an ice-breaker. Participants' pseudonyms were also used to refer to one another during the discussion and were utilized in focus group transcriptions as confidential identifiers. In order to open the discussion in a non-threatening manner, and also based on previous researchers recommended approach for understanding religion and spirituality among African Americans (Boyd-Franklin & Lockwood, 2009) the moderator asked the opening question of the interview: "What do you think are the main

issues facing the Black community today?” The moderator guided the conversation to issues of psychological or emotional problems, and asked the participants how they thought African Americans should deal with these problems. After a broader conversation about psychological problems such as depression, the moderator presented participants with three sets of questions (modules) that represented barriers, attitudes, and subjective norms that may influence one’s decision to seek help for psychological distress. For the complete focus group protocol of questions see Appendix B.

*Module 1: Perceived Need for Mental Health Care.* The first module of the focus group was devoted to a discussion of specific psychological or emotional problems that warrant professional psychological intervention and how their religious beliefs and coping behaviors influence their perceptions of a serious psychological problem in need of psychological help. Sample questions from this module included: “What types of problems require treatment?” “When should someone rely on faith to deal with problems?”

*Module 2: Religious Beliefs and Help-Seeking.* The second module of the focus group asked participants to discuss their personal perceptions of help-seeking behaviors as well as the perceptions of help-seeking by others in their community, particularly among rural African Americans of faith. Specifically, participants were asked questions such as “Does going to a psychologist mean that you don’t have faith in God?”

*Module 3: Perceptions of Mental Health Professionals.* The third module asked questions regarding participants’ perceptions of mental health professionals and the perceived helpfulness of professionals in assisting with emotional or psychological problems faced by rural African Americans. Questions posed to participants included



“Do you believe seeing a psychologist would be less helpful, as helpful or more helpful than praying or using your faith to solve problems?”

At the end of the focus group, participants were given an opportunity to ask questions of the researchers. They were verbally debriefed as to the nature of the study and given a packet of information about mental health resources. Tapes from the focus groups were transcribed by a trained undergraduate research assistant, and then analyzed using close readings by researchers. In order to develop codes for the data, a grounded theory approach was used (Strauss & Corbin, 1990). This approach allows for the development of themes from the data without using a priori codes. The research team read through the transcripts multiple times for emergent themes and recurrent comments to create a second set of codes. The data were then coded by two members of the research team by grouping comments and segments of conversation thematically. Finally, the research team checked back with the original transcript to ensure that the context warranted the categorization. (Henwood & Pidgeon, 2003). This process enables participants’ experiences to be reflected within themes as much as possible by the researcher (Strauss & Corbin, 1990). In the chapter that details the qualitative results, excerpts from the focus groups are presented using the group number and participant gender to protect their confidentiality.

## **Chapter IV**

### **Quantitative Method**

#### *Participants*

The sample of participants who completed the quantitative survey portion of the study consisted of 94 (11 male and 83 female) self-identified rural African American adults. Again, rurality was defined using the definition utilized by the Census Bureau (2000) that states, “ a rural community has 2,500 or fewer residents” and this definition was included as part of a set of questions at the outset of the survey for participants to state the approximate size of their communities. Only those indicating they resided in communities that fit the definition of rural were included in the sample (United States Census Bureau, 2000). Ages ranged from 18-45 years (M=30.29 years). Most (29.3%) reported completing some college with an annual income of \$32,000-\$62,000 (37.8%). The majority of the sample reported being an official member of a church (61%) and attending services at least once a week (66.2%). Full demographic characteristics of the sample are listed in Table 6.1.

#### *Procedure*

Participants were recruited through flier advertisements, email advertisements, and direct contact. Specifically, leaders of local religious institutions were contacted via phone and email and asked to forward information regarding the study to their congregants.

Interested participants contacted the researcher and were emailed a link to the online

survey. Once emailed the link, participants were able to complete a series of survey questionnaires using online survey software. Completion of the survey took approximately 40 minutes. For the purposes of the research questions, measures included religious coping styles, willingness to seek help, and depressive symptoms. After completing the survey, participants received compensation for completion (\$10.00 gift e-card), debriefing information, and a list of community and school based agencies that offer mental health services.

### *Measures*

#### Psychological Distress

*Brief Symptom Inventory (BSI)* (Derogatis, 2000). To control for the possibility that distress may explain a significant amount of variance in the intent to utilize services, the BSI was used to assess symptoms of psychological distress as a control variable in the analyses thereby allowing for the unique explanatory contribution of religious variables on utilization to be elucidated. The BSI consists of 18 items measuring severity of psychological distress in three areas, depression, anxiety, and somatization. Participants are asked to indicate how much they have been bothered by psychological symptoms in the past week. Responses on the BSI were measured on a 5-point scale ranging from (1) “Not at All” to (5) “Extremely”, with a midpoint of (3) “Moderately”. Sample items include: “Feeling no interest in things” (BSI-depression), “Feeling tense or keyed up” (BSI-anxiety), “Numbness or tingling parts of your body” (BSI-somatization), In this sample, the BSI was found to have good internal consistency ( $\alpha = .92$ ) and scores were

summed to create a total composite score<sup>1</sup> of general distress that was used in the analyses.

### Religious Participation

*Multidimensional Measure of Religious Involvement* (MMBI). Each item is scored on a 5 point Likert scale and responses ranged from 1-not at all important to 5-very important. The MMBI consists of three subscales that measure the distinct factors of the multidimensional model of religious involvement--- Subjective Religiosity, Organizational Religiosity, and Non-organizational Religiosity (Levin, Taylor, and Chatters, 1995). Subjective Religiosity was measured using the Subjective Religiosity Scale of the MMBI—a three-item subscale assessing the extent to which the individual sees religion as being important in their lives. Representative items from this subscale include “How religious are you?” and “How important is religion in your life today?” In this sample, this subscale was found to have adequate internal consistency ( $\alpha=.81$ ). Organizational religiosity or public, institutional forms of religious involvement, was assessed using the Organizational Religiosity scale. A representative item from this subscale is “Are you an official member of a church?” The subscale was not internally consistent ( $\alpha=.41$ ) in this sample and therefore was not included in the analyses. The Non-organizational Religiosity subscale assesses private or informal types of religious involvement. Representative items from this subscale is, “How often do you read religious material” and “How often do you pray?” This subscale was found to have moderate internal consistency in this sample, with an alpha level of .70.

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<sup>1</sup> Total composite scores of 13 or above are considered clinically significant.

## Religious Coping

*Pargament's Religious Problem Solving Scale (RPS)*. Each item is scored on a 4 point Likert scale and responses ranged from 1-not at all to 4-a great deal. The RPS consists of three subscales that measure Pargament's conceptualizations of different dimensions of religious problem solving—Collaborative, Deferring, and Self-directed (Pargament, 1988). Collaborative Religious Coping was measured using the Collaborative Religious Coping Scale of the RPS—a three-item subscale assessing the extent to which the individual worked collaboratively with God or a higher power to solve the problem. Representative items of this subscale include “Did my best then turned the situation over to God (or Higher Power)” and “Took control over what I could, and gave the rest up to God (or Higher Power). In this sample, the 3-item subscale was found to have good internal consistency ( $\alpha=.90$ ). Passive religious deferral (PRD), or the extent to which the individual completely depends on God or a Higher Power to solve the problem, was assessed by the three-item Passive Religious Deferral subscale. A representative item of this subscale is, “Didn't do much, just expected God (Higher Power) to solve my problems for me.” In this sample, the 3-item PRD subscale, was found to be internally consistent ( $\alpha=.88$ ). Self Directed Religious Coping (SRC) subscale is a three-item subscale assessing the extent to which the individual assumes personal responsibility for life's problems without explicit reliance on God. Representative items from this subscale include, “Tried to make sense of the situation without relying on God (or a Higher Power)”. This 3-item subscale was found to be internally consistent in this sample with an alpha of .90.

## God Image

*God Image Scale (GIS)*. Each item is scored on a 4-point Likert Scale and responses ranged from 1-Strongly Disagree to 4- Strongly Agree. The GIS consists of 6 subscales that measure possible psychological representations of God. However, previous research has established the validity for a shorter form that utilizes three subscales (Hoffman, 2005). Therefore, for the purposes of this study, the shorter GIS measure was used.

Presence, or the extent to which one feels that God is there, was measured by the 12-item Presence God Image subscale. Representative items from this subscale includes, “I can talk to God on an intimate basis.” This subscale was found to be internally consistent in this sample ( $\alpha = .83$ ). The Challenge God Image subscale measured the extent that one feels that God desires the individual’s personal growth (challenge). Representative items from this subscale include, “God takes pleasure in my achievements.” This 3-item subscale was found to have low but acceptable internal consistency in this sample with an alpha level of .62. The Acceptance God Image Subscales measured the extent to which one feels that they are good enough to be loved by God (acceptance). Representative items from this subscale include, “I am confident of God’s love for me.” This subscale was found to have adequate internal consistency in this sample ( $\alpha = .89$ ).

## Mental Health Service Attitudes

Mental Health Service Attitudes were measured with a series of questions that assessed perceived need for treatment, level of perceived usefulness of services, and perceived benefit of utilizing services. These questions were created by the research team using guidelines outlined by Ajzen and Fishbien (1980) to directly elicit beliefs regarding health behaviors. Responses ranged from 1- not at all confident/strongly disagree to 4-

very confident/strongly agree. Representative items from this scale are, “How confident are you that seeing a mental health professional for an emotional problem would be helpful?” The scale was found to be internally consistent in this sample ( $\alpha=.81$ ). Items that were worded negatively were reverse coded, so that higher scores indicated more favorable attitudes towards treatment seeking. Item scores were averaged to create a composite mental health service attitude score that was used in the analyses.

#### Mental Health Service Subjective Norms

Subjective Norms regarding mental health utilization were measured using a series of questions that assessed both important others, or individuals whose opinions are important to the individual, and the level of importance of those opinions. In order to create a single indicator of subjective norms, scores on items that assessed ‘important others’ were multiplied by the level of importance. Responses ranged from 1- not at all embarrassed to 4- very embarrassed, so that higher scores indicated higher importance of subjective norms. Representative items from this scale include, “How embarrassed would you be if your church members knew that you were seeing a mental health professional?” The scale was found to have acceptable internal consistency ( $\alpha=.66$ ). Items were averaged to create a composite subjective norm score that was used in the analyses.

#### Intent to Utilize Services

Participants intent to utilize services was assessed by a single question; “If you had a serious emotional problem, would you definitely, probably, probably not, or definitely not, go for help. Responses were scored using a 4-point Likert scale so that higher scores indicated increased willingness to utilize services when distressed.

## Demographic Variables

Gender, parental education, and age were used as control variables in the analyses. Maternal education was used as a proxy for SES due to evidence that reported income is often a more unstable measure of SES (Shavers, 2007). Maternal education was measured categorically including “some high school,” “high school diploma,” “some college,” and “college diploma.” Age of respondent was measured continuously in years.

## *Analytic Strategy*

Data was examined for statistical outliers and missing data. Outliers more than 2 standard deviations above and below the means were eliminated from analyses resulting in a final sample size of 92. In an effort to maintain sufficient power, missing data discovered within the sample was imputed using the variable mean. As a preliminary analysis, correlations and univariate analyses (ANOVA) were conducted among the individual factors (i.e. religious coping, mental health service attitudes, and subjective norms) and outcome variables. Non-significant ANOVA models were excluded from further analyses.

Hierarchical linear regression analyses were used to address research question 1, which examined the relationship between mental health service attitudes, subjective norms, and intent to utilize mental health services. . It was hypothesized that (1) mental health service attitudes would be inversely associated with intent to utilize mental health services, and (2) subjective norms would be inversely associated with intent to utilize. Two hierarchical regression models were used to analyze the relationships of both attitudes and norms to intent to utilize. The background variables for age, and mother’s education were entered at the first step of each model in order to control for demographic



effects that might contribute to the variance in intent<sup>2</sup>. In both models, general psychological distress was entered at the second step after controlling for demographics. Mental health service attitudes and subjective norms were entered during the third step.

To address the second research question, that religious factors (i.e. religious participations, religious coping, etc) are related to mental health service attitudes, ANOVAs and regression models were used. Initial ANOVAs were used to examine associations between individual factors and mental health service attitudes. Factors that were significantly related to attitudes were entered into regression models to ascertain the unique contribution of the religious factors to mental health service attitudes. Demographic variables (age and mother's education) were entered in first step and psychological distress was entered in the second step of each model. The individual factor was entered in the final step of each model.

To test for a possible mediating relationship, bootstrapping methods were utilized. Although Baron and Kenny's (1986) has long been the statistical test of choice for analyzing mediating relationships, recent research indicates that examining indirect effects through the use of bootstrapping is far superior (Preacher and Hays, 2007). Therefore, following recommendations by Hayes (Hayes, 2009), 5000 bootstrap resamples were generated in the current study. This procedure yields an inference about the size of the indirect effect (mean of  $ab$  across the 5000 resamples), a standard error estimate (mean of the standard deviation across the 5000 resamples), and 95% confidence intervals based on the distribution of the 5000 samples. If the confidence interval does not include zero, the indirect effect (i.e., mediation) is considered significant.

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<sup>2</sup> Gender variables were excluded from analyses due to the low numbers of male respondents in this sample.

## **Chapter V**

### **Qualitative Results**

Four themes emerged during the discussion of perceptions of mental health service utilization in rural African American communities (Table 5.1). Consistent with previous research, participants across all groups indicated initial positive attitudes towards utilizing mental health services when distressed. However, as the discussion continued, despite positive attitudes regarding the use of professional mental health services, participants also identified several factors that would likely decrease the likelihood of actual utilization.

The first theme related to participants' willingness and perceived need for professional mental health care. Despite positive support for professional mental health care, participants indicated that when experiencing their own emotional or psychological distress, they were unsure when it is appropriate to seek professional services for specific problems. There seemed to be a varying and ill-defined litmus test for when and for what professional services would be useful, which could then act as a barrier to treatment seeking.

The second theme relates to the perceived usefulness of professional psychological help. Despite overall positive attitudes toward service use, participants tended to question the usefulness of utilizing services. In particular, participants reported doubts that mental health care, particularly talk therapy, would be useful and that mental health professionals could offer help that couldn't be gained through other sources.

The third theme related to the role of religious coping in deciding to seek mental health services. Participants indicated that although seeking professional help did not directly conflict with their religious beliefs, when confronted with distressful situations the way that they utilize their faith to cope with such issues might act as a deterrent to professional mental health utilization. More collaborative conceptualizations of how one utilizes faith to solve problems may be more amenable to professional services in comparison to those who felt that God explicitly directed their lives.

Finally, the fourth theme relates to the subjective norms in religious communities regarding mental health service use. More specifically, participants anticipated that they would encounter stigma from their religious community at greater levels than they would expect in the larger community. This perception was heightened by the fears of a lack of anonymity and confidentiality in rural communities

*Theme 1: Perceived Need for Mental Health Services*

The first theme relates to initial willingness to and perceived need to utilize professional psychological services. Preliminary discussions of willingness to utilize services were positive, with the majority of participants indicating that they would be supportive of utilizing professional mental health care resources. However, as the discussions continued, many participants included a caveat that the services needed to be necessary before they would consider using them personally.

“I don’t see anything wrong with seeing a psychologist, if you need to” (RG1, Male)

“Yeah, I’d go to the psychologist if I needed to” (RG2, Female)

Determining when psychological services were necessary proved to be less clear. When asked about specific disorders that warranted mental health intervention, there was a consensus among most participants that disorders such as Schizophrenia and Bipolar Disorder warranted psychological intervention. However, there were many discrepant views regarding the need to seek help for other disorders, particularly depressive disorders. While some participants indicated that depression could be treated without professional intervention, others disagreed. Those who endorsed the belief that depression should be handled personally often utilized religious coping mechanisms such as prayer and daily scripture reading.

“We may tend to pray or seek counsel from our religious leaders uh, and what they give us along with what we do as a studying through God’s work, we may get an answer for our situation and those that may have a reoccurring depressive state they, they may not, it’s like a medical condition where they need to seek medical assistance.” (RG1, Male)

“I know from my own experience that there is health, encouragement, peace of mind, comfort and strength in reading and studying the Holy Bible along with prayer and fasting. So our faith can handle most of those little things that we face on a day to day basis.” (RG3, Female)

Participants who endorsed the view that depression was a mental illness that warranted professional intervention, made clear distinctions that symptoms needed to be both persistent and severe to necessitate treatment.

“I mean it’s getting to be, you know, it’s beyond a few moments or it’s beyond just today, this is beginning to be my normal routine, I gotta get some help.” (RG4, female)

Most participants agreed that severe and persistent symptoms needed professional intervention, but many indicated not knowing *how* severe or *how* persistent symptoms must be seeking help is acceptable.

“I guess I just don’t know what actual depression is compared to regular ol’ feeling down, so I wouldn’t know what I had and if I should continue doing what I normally do or try something else like a um counselor I guess.”

Discussions during this module highlighted the complexities of the decision to utilize services. Participants seemed to consider professional mental services as a possible resource, but mostly for more severe cases of psychopathology such as Schizophrenia. However, when facing other forms of mental illness, such as depression, participants were less likely to perceive the need for mental health intervention, unless the symptoms were both severe and persistent. Furthermore, participants indicated some uncertainty in their ability to assess the level of severity necessary to warrant treatment, thereby acting as a barrier to seeking mental health care.

### *Theme 2: Perceived Usefulness of Mental Health Services*

Along with difficulties determining what level of distress warrants treatment, participants also report negative perceptions of the usefulness of mental health services. Some participants indicated doubts that mental health services would be useful in solving problems or relieving their level of distress. The majority of participants were unclear as to the variety of services offered by mental health professionals and were more likely to believe that the primary type of mental health intervention was talk therapy. Many wondered if talking with a psychologist would be as helpful or more helpful than personal coping strategies such as prayer, reading scriptures, or talking with friends.

“What are we going to do, sit on a couch a talk about my problems? I can sit at home a talk to the master for free.” (RG1, female)

“When I think about psychologists I think about couches and I just wonder how does laying on the couch help the problem?”

“Can they really help me? What can they tell me, to help me get through it. “

Some participants did not question the helpfulness of the actual talking itself, but more questioned the fitness of the mental health professional. Specifically, participants reported beliefs that psychologists were more likely to suffer from their own mental illness thereby making them ineffective to help others. For example, participants endorsed beliefs that the “stories” that psychologists listened to daily would eventually cause them to have “nervous breakdowns” themselves.

“When you think about the things they [mental health professionals] have to listen to, I am sure they go crazy themselves.”

“You know they say that psychologists be the one’s who are really crazy, that’s why they work with crazy folks.”

The perception that mental health professionals suffered from comparable or higher levels of mental illness when compared to the community, led participants to question the ability to helpful to them when they are distressed.

“Just like ‘Why Did I Get Married, Too?, when Janet Jackson’s character went crazy. I think that’s common for a lot of psychologists. How they gon be helpful if they just as crazy?”

“ Shoot, if they can’t help themselves, they sho’ll can’t help me”

Other participants focused on how possible mismatches in belief systems could influence the helpfulness of mental health treatment. In particular, there were assumptions that the psychologist would not share their beliefs and wouldn’t be able to relate to participant’s use of faith. For participants who indicated that religion was an important aspect of their identity, the inability to understand their faith would limit the psychologist’s helpfulness.

“Professional psychologists sometimes don’t have the same fear of God that I do and I don’t know if they could really understand me if they don’t understand my faith.”

“ I think I would be able to better identify with a Christian psychologist, cuz at least they would know what I was talkin’ about when I say things about my beliefs. And just me, but I think that it would be less useful if I got to be spending time explainin’ things to them about my faith.”

This module began with discussions of perceptions regarding mental health treatment and professionals including the beliefs that mental health treatment consists solely of talk therapy and mental health professionals are more likely to have mental illness. For participants, these perceptions impacted perceptions of helpfulness thereby decreasing the likelihood of seeking mental health treatment. However, as the conversation continued, emphasis was placed on how unique aspects of life in the rural African American community, such as the importance of religion, also impacted perceptions of the usefulness of mental health treatment. Participants indicated that seeking treatment from a mental professional who does not share their own religious would also limit the mental health professionals ability to connect with the individual, especially when religion was an important aspect of their personal identity.

*Theme 3: Religion and Mental Health Utilization*

Discussion from the previous module led to a more in-depth discussion of how religion affects the decision to seek mental health treatment. Many participants agreed that utilizing mental health services is not contradictory to religious beliefs. In fact, most participants believe that psychological services can complement the use of faith.

“I think that you can do both. You can talk to the Lord and seek counsel from spiritual leaders and you can also seek counsel from professional psychologists. ”

(RG1, Male)

“It’s not against the Christian beliefs or ideology and teachings of the bible, but it’s a personal thing of whether you just pray about it or if you get help and pray. It’s all about how you interpret your faith.” (RG4, female)



“Matter of fact, you pray about it before hand. Ask God to please help the psychologist to help me” (RG2, Female)

As the discussion, progressed participants began to discuss the complexities of making sense of seeking mental health treatment when taking their faith into account. Some participants made sense of the potential conflict by first acknowledging God’s sovereignty and ability to heal mental illness. In addition to acknowledging God’s ability to fix the situation, they also acknowledged that His help could come to them in many different venues, one of which could be a mental health professional. Therefore, mental health treatment was constructed as a manifestation of God’s power to heal.

“God is the only one who can truly heal or fix situations, but I feel that the professional is a good person to talk to”

“I seek God's help first but I also know that healing comes through psychologists or people.”

“My religious views strongly guide me to take those issues to God, but I think that God uses the professional to assist in those problems”

“I still would put God before any man (doctor) but would still seek help professionally. The two together equals a greater prognosis.”

Further, as participants discussed how they personally utilize their faith to cope with stressful situations, individuals who tended to see themselves as partners with God in solving a problem (Collaborative Religious Problem Solving) were more likely to endorse the aforementioned view mental health care and thereby indicated an increased willingness to utilize mental health care from a professional.

“I am a firm believer that God helps those who help themselves. Who’s to say that God is not using a psychologist to bless you.”

However, participants who endorsed the view that mental health care could be a resource that God was using to help them indicated that their willingness to actually utilize services were contingent on 1) receiving clear direction from the God to seek such services and 2) the implementation of their faith into the treatment that is being offered. First, participants believed that if God were to use the mental health professional to help them, he would provide an indication that would direct them to seek mental health care.

“Professional help is very good if the spirit leads me in that direction.”

Further, they would continue to look for confirmation that the services are indeed in line with God, by assessing whether or not the professional incorporates their faith into the therapeutic work.

“ I think that God can use a psychologist to help, but if I go to the psychologist and he ain't talking about God, I know then that this wasn't sent from God.”

Conversely, some participants found it more difficult to integrate mental health treatment with their faith. For some participants, mental health treatment was not believed to conflict with religious beliefs, but felt that God or an explicit religious source should be utilized for help when distressed. These participants were less likely to endorse willingness to utilize professional mental health services and more likely to support total dependence on God during times of distress.

“God should be our only source of help”

“.....I was always taught that God could solve your problems and that He was the only one you needed to talk to regarding your problems.”

“We are taught to bring our problems to God or men of God.”

In line with total dependence on God, participants who endorsed the belief that God should be the only source of help, tended to discuss religious coping techniques that fostered reliance on God by giving him total control of the problem (Passive Religious Deferral). For these participants, prayer and other religious coping strategies were used with the express purpose of surrendering the problem to God.

“Prayer is the KEY and my faith opens the door.”

“You have to give all problems over to God in prayer”

“ God is God all by himself and I believe that if you pray about, God will take your problems away”

“I keep saying to myself “This too shall pass”, you know, it’s goin’ be alright.”

When probed as to why a religious source would be more appropriate than a non-religious source, participants indicated that relying on a non-religious source might threaten the sovereignty of God. Participants expressed beliefs that by seeking help outside of their religion, the mental professional would be seen as the source of help rather than God. This would lead to possible dependence or reliance on the mental health professional to the exclusion of one’s faith.

“Sometimes we tend to lose sight of God when we rely solely on professional help.”

“I would not want to get caught up in the professional or person being the healer or fixer of my problems.

“Personally, I think that some individuals become dependent upon professional help”.

In this module, participants were able to discuss how their religious beliefs influenced the views of mental health utilization. Although seeking help from a mental health source is not expressly in conflict with personal religious beliefs, different interpretations of faith can impact the use of mental health services. For some, mental health services are considered a manifestation of God’s hand in solving their problems; others viewed the use mental health services as denial of God’s power to solve the problem. Each view was related to differing religious coping techniques and levels of willingness to utilize services with those who see mental health services as being a God ordained source of help being more agreeable to utilizing services.

#### *Theme 4: Church Based Stigma*

Towards the end of the discussion, participants began to focus on the impact that negative perceptions from community members would have if they chose to seek professional mental health care. First, there was a general consensus that there was a great deal of stigma in the African American community surrounding seeking mental health care.

“And that’s the, that’s the theory and the image that people have if you go to speak to a mental health professional, you must be losing your mind and that’s not always the issue”

Some participants believed that the stigma surrounding seeking mental health care is greater for Christians. Many participants believed that their fellow church members would perceive them negatively if they were to seek mental health care, or more specifically, they would think that they did not have enough faith in God to solve their problems.

“Depending on who the church members are, like those who wear stockings and those big church hats, those will tear you down, ‘Why you gon do that, talk to the pastor.....’”

“Sometimes because many folk think that when you are professing to be saved you need to let God help you.”

“I think it’s increased because we teach in the church, um, to depend on God and not man.”

“It’s not brought up in the church necessarily, but I think the belief is that we [Christians] should not use mental health uh, providers for emotional issues.”

“You are taught to have faith and let God work things out.”

“I think many Christians are very quick to jump to "you should be praying your way out." and that is not always the answer.”

As the discussion of church based stigma continued, participants also indicated that the perceived lack of anonymity and confidentiality in rural communities played a big role in

fostering stigma. Specifically, participants strongly believed that “their business would get out” and then church members would “tear them down” or possibly use it against them if it were discovered that they were talking to a psychologist.

“So, I think that sometimes because we’re such a small community, that we think our business will get out.”

“I think that people think that if they talk to you that you gone tell somebody that they know, or tell somebody else their business.”

After acknowledging the risk for increased stigma from church peers however, participants did not indicate a decreased willingness to utilize services. In fact, participants indicated that they would simply deal with the stigma if mental health treatment were necessary.

“I think I would [use mental health services] but I, you have to know that that stigma may come along with it. People will see you differently.”

Some participants, while understanding that their “business” will most likely be shared with others, expressed taking precautions to limit the stigma by controlling the flow of information as much as possible, usually by not discussing psychological issues with fellow church members.

“Let’s be honest, you just don’t bring that type of talk in the church, even though people say that ‘oh you can talk to your church family about

anything, we all know that is not true. So no one is gonna come up in church and talk about ‘oh I need help, I need therapy,’ that just ain’t gonna happen.

When discussing stigma surrounding use of mental health services, participants believed that individuals who utilized mental health services would be likely to encounter negative perceptions from fellow community members in general, but especially fellow church members. However, for these participants, the risk of negative perceptions, were not enough to deter individuals from utilizing services if deemed necessary.

#### Summary of Qualitative Results

Initially, participants expressed positive attitudes towards mental health service utilization, with most participants reporting that they would definitely seek mental health treatment if necessary. However, as the discussion deepened, a more complex story began to unfold. First, when deciding to seek help, rural African Americans must decide if their level of distress is severe or persistent enough to warrant treatment. This proved to be difficult as many participants lacked knowledge regarding signs and symptoms of mental illness. Therefore, many are forced to make decisions regarding the need for treatment based on subjective assessments of the severity of symptoms thereby increasing the possibility of over- or under- estimating the seriousness of distress levels.

Then, participants must decide if the mental health provider offer services that will be useful in solving the problem. Again, because many participants are unaware of the services offered by mental health professionals, perceptions of the mental health treatment were based on the assumption that mental health treatment is primarily talk therapy. Most participants doubted the usefulness of talk therapy particularly when compared to personal coping strategies such as prayer or talking with friends.



But perhaps most importantly, individuals must integrate seeking help with their personal religious beliefs indicating that religious beliefs influence attitudes towards mental health treatment. For some, utilizing mental health care was seen as healing source that was sent by God and therefore seen as a compliment to coping with religion. Endorsing this view of mental health treatment led to increased willingness to utilize services in conjunction with religious coping strategies. For others, utilizing mental health care was constructed as a deviation from their beliefs and thereby threatening the role of God as the sole healer of psychological illness. Endorsing this view of mental health treatment led to decreased willingness to utilize services instead choosing to rely solely on religious coping strategies.

Finally, rural African Americans must weigh the cost of the increased church based stigma against the benefit of receiving treatment. Many individuals downplayed the role that perceptions of their peers, with most participants be willing to endure the stigma if distressed. Participants also discussed ways to navigate possible negative perceptions including by either preparing for the stigma or attempting to control the flow of information by not discussing such problems with church members.

Themes discovered in the qualitative portion of the study identified important mental service attitudes and important subjective norms from within the rural African American community that can be examined quantitatively. Therefore, these findings provide important context for understanding the relationship between religious factors, mental health service attitudes, subjective norms, and intent to utilize services.

**Table 5.1 Characteristics of Qualitative Sample**

Total Sample	(N=20)	
Variable	n	%
Age at the time of survey (years)		
18-22	15	75%
23-30	0	0%
31-45	5	25%
Gender		
Male	2	10%
Female	18	90%
Family Income per Year		
\$200,000+	1	5%
\$62,000- 200,000	5	25%
\$32,000- 62,000	7	35%
\$15,000-32,000	6	30%
\$14,000 or less	1	5%
Highest Level of Education Obtained		
Some High School	0	0%
High School Graduate	3	15%
Some College	15	75%
Associate, two-year degree	0	0%
Four year college degree	1	5%
Postgraduate degree started	0	0%
Postgraduate degree completed	1	5%
Religious Affiliation		
No Affiliation	1	5%
Baptist	17	85%
Church of God in Christ	1	5%

Non-Denominational	1	5%
<b>Church Memberships</b>		
Yes	18	90%
No	2	10%
<b>Church Attendance</b>		
4 or more times a week	0	0%
1-3 times a week	15	75%
1-3 times a month	5	20%
Few times a year	0	0%
Less than once a year	0	0%

**Table 5.2 Summary of Qualitative Themes**

When should one consider seeking professional mental health services?		
Theme	Definition	Example
Persistence	Defining mental illness using the persistence of psychological distress symptoms as the primary criterion	“I mean it’s getting to be, you know, it’s beyond a few moments or it’s beyond just today, this is beginning to be my normal routine, I gotta get some help.” (RG4, female)
Severity	Defining mental illness using severity of symptoms as the major criterion	It’s time to get help when it affects their daily life in a negative way.”
<b>Mental Health Service Attitudes</b>		
Helpfulness:		
Limited helpfulness of psychotherapy techniques	Perceiving professional mental health service utilization as unhelpful due to techniques utilized	“What are we going to do, sit on a couch a talk about my problems? I can sit at home a talk to the master for free.” (RG1, female)
Limited helpfulness of psychologists	Perceptions that mental health professionals are incapable of	“You know they say that psychologists be the one’s who are really crazy, that’s why they work with crazy folks.”
Limited helpfulness due to lack of integration of religious beliefs.	Perceptions that mental health treatment is unhelpful due to mismatches in belief systems which limit the helpfulness ability of the psychologist to relate to the individual	“Professional psychologists sometimes don’t have the same fear of God that I do and I don’t know if they could really understand me if they don’t understand my faith.”
<b>Religion and Treatment Utilization</b>		
Treatment as a compliment	Perceptions that psychological treatment complements use of religion to cope.	“I think that you can do both. You can talk to the Lord and seek counsel from spiritual leaders and you can also seek counsel from professional psychologists.”

Treatment as manifestation of God	Perceptions of treatment as a source of God's divine healing	"God is the only one who can truly heal or fix situations, but I feel that the professional is a good person to talk to"
Treatment vs. God's ability to heal	Perceptions that seeking professional mental health treatment conflicts with beliefs in God's divine healing	".....I was always taught that God could solve your problems and that He was the only one you needed to talk to regarding your problems."
Subjective Norms regarding treatment utilization		
Community based stigma	Negative perceptions of psychological treatment seeking from community members.	"And that's the, that's the theory and the image that people have if you go to speak to a mental health professional, you must be losing your mind and that's not always the issue"
Church based stigma	Increased levels of stigma from religious community	"Depending on who the church members are, like those who wear stockings and those big church hats, those will tear you down, 'Why you gon do that, talk to the pastor.....'"

## Chapter VI

### Quantitative Results

Demographic and mental health characteristics of the participants are shown in Table 6.1 and means, standard deviations, and correlations of all study variables are shown in Table 6.2. The sample reported a mean 21.85 on the psychological distress measure, which is more than 2 SD above the documented clinical cutoff of 13 (Zabora, 2001). However, only 29.9% (n=28) reported that they had a problem that was serious enough to seek help. Among the sample, 2.1% (N=2) reported having had previous experience with a mental health professional, which was defined as psychiatrist, psychologist, social worker, or campus mental health center. Approximately 44% reported that they would probably seek help from a professional mental health source if they were experiencing a serious emotional problem.

On the religious coping subscales participants reported more frequent use of Collaborative Religious Problem-Solving (M=2.90, SD=.86) than Self-Directed (M=1.34, SD=.53) and Passive Religious Deferral (M=2.56, SD=.79) religious coping styles. Participants reported that religion was “quite important” (M=4.46, SD=3.33). Participants also reported weekly participation in public (M= 2.41. SD=.76) and private religious activities (M=2.41, SD=.89)

Initial bivariate analyses (Pearson correlations) found no significant relationships between any of the religious expression subscales and intent to

utilize mental health services. Mental health service attitudes were significantly associated with intent ( $r=.45$ ,  $p\leq.00$ ), but subjective norms were not ( $r\leq-.028$ ,  $p=.80$ ). Further, preliminary ANOVA models indicate significant relationships between attitudes and intent ( $F(16)=2.86$ ,  $p\leq.00$ ) and psychological distress and intent ( $F(20)= 1.74$ ,  $p\leq.05$ ) Therefore, subsequent analyses tested a single model examining the relationship between mental health service attitudes and intent to utilize services.

Research Question 1: What factors explain intent to utilize mental health services in rural African Americans?

*Mental Health Service Attitudes and Intent to Utilize Services*

The results of the hierarchical regression examining the relationship between mental health service attitudes and intent to utilize services are presented in Table 6.3. The first block of this model (demographic factors) was not significant ( $R^2= .054$ ,  $F=2.21$ ,  $p\leq.12$ ). However, mother's education trended toward significance ( $\beta=-.20$ ,  $p\leq.08$ ) indicating that as mother's education increased by one unit, intent to utilize decreased.

Adding the composite BSI scores did not significantly increase the fit of the model ( $R^2= .056$ ,  $F=1.52$ ,  $p\leq.22$ ). In the third step, adding mental health service attitudes increased the overall fit of the model ( $R^2=.24$ ,  $F=6.11$ ,  $p\leq.00$ ) and was significantly related to intent ( $\beta=.44$ ,  $p\leq.00$ ), indicating that participants who held more favorable mental health service attitudes were more likely to indicate intent to utilize services when distressed. Based on these findings, the hypothesis that mental health service attitudes would be positively related to intent was partially confirmed.

Research Question 2: What factors are related to mental health service attitudes?

Preliminary univariate analyses (ANOVA) found significant relationships between psychological distress and mental health service attitudes ( $F(21)=1.83, p \leq .03$ ), collaborative religious coping and attitudes ( $F(16)=1.86, p \leq .04$ ), and Acceptance and attitudes ( $F(19)=1.90, p \leq .03$ ). Therefore, subsequent analyses tested two models; one examining the relationship between collaborative religious coping and attitudes and one examining the relationship between acceptance and attitudes.

#### *Collaborative Religious Coping and Mental Health Service Attitudes*

Scatterplots provide evidence for the presence of a non-linear relationship between collaborative religious coping and mental health service. Additionally, focus group results indicate that the relationship between religious coping and mental health attitudes may be more nuanced, so that the relationship may not be fully captured by a linear regression; therefore, nonlinear regression models were also tested.

The linear regression model examining the relationship between Collaborative Religious Coping and Mental Health Service Attitudes (Appendix A) produced an overall non-significant model ( $R^2=.001, p \leq .76$ ). However, the quadratic regression model yielded an overall significant model ( $R^2=.07, p \leq .03$ ). Collaborative Religious Coping ( $\beta=1.51, p \leq .00$ ) and the squared Collaborative Religious Coping Term ( $\beta - 1.57, p \leq .01$ ), were significantly related to mental health service attitudes, indicating that as the frequency of collaborative religious coping utilization increases, the likelihood of endorsing favorable mental health service attitudes increases. However, as utilization of collaborative religious coping increases past moderate levels, the likelihood of endorsing



favorable mental health service attitudes begins to decrease so that participants who report the highest levels of collaborative religious coping are less likely to endorse favorable mental health service attitudes.

#### *Acceptance and Mental Health Service Attitudes*

Again, both linear and nonlinear regression models were utilized to examine the relationship between God Image Acceptance and mental health service attitudes. Neither the linear regression model ( $R^2=.09$ ,  $F(1)=.78$ ,  $p\leq.38$ ) nor the nonlinear regression ( $R^2=.029$ ,  $F(2)=1.33$ ,  $p\leq.27$ ) yielded significant models.

Research Question 3: Mediating relationship between religious indices and intent to utilize mental health services

Initial univariate analyses (ANOVA) found no significant relationships between religious variables and intent, thereby lending additional support for the use of bootstrapping methods that do not require a direct effect in order to test for mediating effects. Because of significant univariate relationships between collaborative religious coping and acceptance with attitudes, two models were tested--- one with collaborative religious coping as the independent variable and one with acceptance as the independent variable. Both models examined the role of attitudes as a mediating factor. In order to test for a mediating relationship where changes in religious indices would yield a change in intent via the effect on attitudes, bootstrapping methods were utilized. After 5000 resamples, confidence intervals for both collaborative religious coping (-.11 to .08) and acceptance (-.16 to .03) contained 0, indicating non-significant results.

To summarize, a significant relationship was found linking mental health service attitudes with intent to utilize services. Further, findings indicate that the use of collaborative religious coping can both increase and decrease the likelihood of endorsing favorable mental health service attitudes, such that low levels of collaborative religious coping and high levels of collaborative religious coping are associated with less favorable mental health service attitudes. Finally, analyses of a meditational model were non-significant.

Table 6.1 Characteristics of Quantitative Sample

Variable	Total Sample (N=94) n	Cumulative %
Age at the time of survey (years)		
18-22	14	14.9%
23-30	55	38.3%
31-45	7	35.1%
Missing	18	11.7%
Gender		
Male	9	11.0%
Female	73	89.9%
Family Income per Year		
\$200,000+	2	2.1%
\$62,000- 200,000	11	11.7%
\$32,000- 62,000	36	38.2%
\$15,000-32,000	24	26.0%
\$14,000 or less	20	21.3%
Highest Level of Education Obtained		
Some High School	3	3.7%
High School Graduate	15	18.3%
Some College	24	29.3%
Associate, two-year degree	9	11.0%
Four year college degree	15	18.3%
Postgraduate degree started	5	6.1%
Postgraduate degree completed	11	13.4%
Mother's Highest Level of Education Obtained		

Elementary school or less	8	9.8%
Some High School	12	14.6%
High School Graduate	23	28.0%
Some College	14	17.1%
Associate, two-year degree	8	9.8%
Four year college degree	5	6.1%
Postgraduate degree started	2	2.4%
Postgraduate degree completed	10	12.2%
 Brief Symptom Inventory		
0-18	32	34.1%
19-35	61	63.9%
36+	2	2.2%
 Religious Affiliation		
No Affiliation	2	3.0%
Baptist	47	71.2%
Church of God in Christ	7	10.6%
Non-Denominational	6	9.1%
Other	4	4.3%
 Church Memberships		
Yes	66	98.5%
No	1	1.5%
 Church Attendance		
4 or more times a week	1	1.5%
1-3 times a week	45	66.2%
1-3 times a month	17	18.1%
Few times a year	3	4.4%
Less than once a year	2	2.9%

Religious Coping <sup>a</sup>

Collaborative Religious Coping

1	10	10.7%
2	49	52.3%
3	23	35.3%
4	12	12.8%

Deferred Religious Coping

1	13	13.9%
2	58	61.7%
3	19	20.2%
4	4	4.3%

Self-Directed Religious Coping

1	86	91.5%
2	7	7.5%
3	0	0 %
4	1	1.1%

Subjective Religiosity

Not at all Important	1	1.1%
A little Important	1	1.1%
Somewhat Important	7	7.4%
Quite Important	62	65.9%
Very Important	23	24.5%

God Image <sup>b</sup>

Acceptance

1	0	0%
2	3	4.5%
3	19	21.0%
4	63	74.5%

Challenge		
1	0	0%
2	0	0%
3	29	43.4%
4	38	56.6%
Presence		
1	0	0%
2	0	0%
3	22	27.9%
4	46	67.6%
Mental Health Service Attitudes <sup>c</sup>		
1	52	55.2%
2	38	40.4%
3	4	4.3%
4	0	0%
Intent to Utilize Services		
Definitely go for help	28	34.6%
Probably go for help	41	50.6%
Probably not go for help	10	12.3%
Definitely not go for help	2	2.5%

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a- 1= Not Often- 4=Very Often

b- 1= Strongly Disagree – 4= Strongly Agree

c- 1= Very Favorable- 4= Not at all Favorable

Table 6.2. Means, Standard Deviations, and Correlations of study variables.

	1	2	3	4	5	6	7	9	10	11	12	13	14
Mean	30.45	1.89	23.19	1.95	15.33	43.63	44.09	4.46	2.90	2.56	1.34	21.85	1.83
SD	7.74	.32	10.91	.58	1.76	5.35	3.26	.56	.74	.67	.46	7.71	.74
1. Age	---	-.16	.10	.08	-.21	-.01	-.14	.12	.03	-.09	.03	.11	.12
2. Gender		---	-.06	.05	.01	-.08	.06	-.02	-.03	.12	-.08	.08	-.03
3. Subjective Norms			---	-.08	.182	.23*	.18	.21*	.10	-.10	.09	-.09	-.03
4. Attitudes				---	-.02	.09	-.10	.08	-.03	.15	.03	-.11	.45**
5. God Image Challenge					---	.57**	.20	.14	.13	-.00	.26*	-.19	-.05
6. God Image Acceptance						---	.29**	.21*	.13	-.03	.13	-.24*	.06
7. God Image Presence							---	.45**	.24*	-.09	.22*	-.25*	-.10
9. Subjective Religiosity								---	.41**	-.05	.50**	-.06	.13
10. RCOPE Arc									---	-.14	.58**	-.24*	.10
11. BSI_COMP										---	-.16	.17	-.03
12. RCOPE PRD											---	-.25*	.14
13. RCOPE_SD												---	-.14
14. Intent to Utilize													---

\*- p < .05      \* = p < .05      \*\* = p < .01

Table 6.3 Linear Regression Model: Mental Health Service Attitudes and Intent

Variable Entered	$R^2$	$R^2\Delta$	$\beta$
Step 1:	.054	.054	
Age			.011
Mother's education			-.20 <sup>t</sup>
Step 2:	.056	.002	
Psychological Distress			-.05
Step 3:	.243	.187	
Mental Health Service Attitudes			.44 <sup>**</sup>

t= p<.10      \*=p<.05      \*\*= p<.01



Table 6.4 Regression Model: Collaborative Religious Coping and MHS Attitudes

Variable Entered	$R^2$	$R^2\Delta$	$\beta$
Step 1:	.014	.014	
Age			.076
Mother's education			-.084
Step 2:	.034	.010	
Psychological Distress			.145
Step 3:	.035	.001	
Mental Health Service Attitudes			-.021

t= p<.10      \*=p<.05      \*\*= p<.01

Table 6.5 Quadratic Regression: Collaborative Religious Coping and MHS Attitudes.

Variable Entered	$R^2$	$\beta$
Step 1		
Collaborative Religious Coping	.073	1.51**
Step 2:		
Collaborative Religious Coping Squared	.073	-1.57**
t= p<.10      *=p<.05      **= p<.01		

Table 6.6 Bootstrapping Results: Mental Health Service Attitudes as a mediator of the relationship between Collaborative Religious Coping and Intent

	Data	boot	Bias	SE	Lower	Upper
TOTAL	-.0083	-.0106	-.0023	.0478	-.1097	.0824
Attitude	-.0083	-.0106	-.0023	.0478	-.1097	.0824

Table 6.7 Bootstrapping Results: Mental Health Service Attitudes as a mediator of the relationship between Acceptance and Intent

	Data	boot	Bias	SE	Lower	Upper
TOTAL	-.0083	-.0106	-.0023	.0478	-.1632	.0324
Attitude	-.0083	-.0106	-.0023	.0478	-.1632	.0324

## **Chapter VII**

### **Discussion**

The underutilization of formal mental health services by African Americans has been well documented in the literature (DHHS, 2001; Snowden, 1999), particularly in rural African American communities (New Freedom Report, 2003). Understanding the underuse of services is particularly important due to research indicating that African Americans with untreated mental illness tend to experience higher levels of functional impairment (Williams, 2007). Further, once in treatment African Americans make significant gains (Breland, 2006; Brown et al., 1998), thereby underscoring the importance of understanding reasons that may discourage use of mental health treatment. The present study examined the influence of religious factors on the construction of mental health service attitudes in a previously understudied community, rural African Americans. The overall findings suggest that mental health service attitudes are an important factor in self-reported intent to utilize among this population. Findings also suggest that mental health service attitudes are influenced by religious factors, specifically collaborative religious coping.

#### **Qualitative Discussion of Intent to Utilize Mental Health Services**

In the present study religion was utilized as a framework for focus group discussions of mental health service utilization. Results suggest a connection between how the rural African Americans in this sample evaluated treatment utilization and their beliefs about

God and divine healing. Although participants denied the influence of religious beliefs on their perceptions of mental health treatment, their responses during the discussion suggest that religion influences views on the acceptability of mental health treatment to a certain extent.

Conversational choices revealed the process by which rural African Americans constructed views regarding the acceptability of mental health treatment. When discussing mental health treatment, conversations typically began by first minimizing the influence of religion. Or more specifically, participants downplay the influence of the explicit ritualized and dogmatic features of religion while emphasizing the influence of more internalized views of God's role in the problem solving process in their construction of mental health service attitudes. These results provide context to previous findings that did not find associations between religious beliefs and treatment utilization (Ayalon, 2005), possibly because internal representations of God, not organizational aspects of religion influence patterns in utilization. This is further corroborated by findings that intrinsic aspects of religion, such as spirituality have been found to directly influence attitudes regarding treatment for depressive symptoms (Cooper, 2003).

Participants asserted that God is in control and able to provide healing from emotional distress. However, participants juxtaposed this view of a sovereign healer with their perceptions of personal agency. Analysis of conversational choices revealed that participants struggled to strike a delicate balance so that God retained the dominant role, while maintaining a lesser yet active role in the process. Therefore, the extent to which participants viewed themselves as an active participant in the process varied. Some participants preferred to *actively* give the problem to God through prayer and other

methods, while leaving the actual healing and/or solving to God alone without further action on their part. In fact, performing actions other than giving the problem to God, including seeking mental health treatment, was viewed overstepping bounds and possibly irreverent to God thereby leading to more negative beliefs regarding the necessity and usefulness of mental health treatment. In contrast, others both *actively* gave the problem to God, and also *actively* worked with God to decrease the distress. This view led to more favorable attitudes towards treatment utilization as a compliment to and possible source of God's healing.

While previous research indicates that individuals tend to use more active coping strategies when faced with situations in which they have more perceived control (Pargament, 1997). However, in this sample, participants did not indicate varying levels of active religious coping when faced with specific problems, but rather indicated that the process of actively coping with distress in this sample seems to be more related to their perception of God and less to external stressors. Therefore, these results suggest that intrinsic representations of God are indirectly associated with intent to utilize by directly influencing mental health service attitudes. Therefore, assessing and understanding how individuals view God's role in solving problems is important in explaining possible disparities in treatment utilization in this community.

Further, results suggest individuals with favorable views towards treatment conduct a litmus test of sorts to determine if God ordains the proposed treatment. These individuals would consider a lack of integration between their religious needs and psychological needs as a sign of this treatment not being in line with God's will. These results may provide further understanding for previous findings that African Americans

have more negative attitudes towards mental health treatment following actual utilization (Diala, 2000).

It is also important to note that this sample reported a lack of knowledge regarding symptoms of psychological illness and services offered by professional mental health providers. Specifically, participants reported uncertainty as to when symptoms are at a level that warrants psychological care. This is particularly important because many participants use severity and persistence as key indicators of a need for professional services. Therefore, a lack of knowledge about the mental health care system can lead to confusion about need for and appropriateness of care. Although not surprising, this unawareness of the utility of mental health care influenced attitudes regarding mental health services indicating a need to target public psychoeducation efforts to rural communities.

#### Quantitative

Consistent with previous research (Diala, 2000), our sample reported favorable attitudes towards mental health treatment utilization. However, despite indicating clinically significant psychological distress symptoms, very few 1) perceived the problem as serious enough to warrant help and 2) actually utilized professional mental health services. Studies of religious coping and mental health outcomes have found relationships between religious coping and positive mental health outcomes (Pargament, 1997) therefore; one would expect *lower* levels of psychological distress in this sample especially with the increased levels of religious coping and involvement in this sample. However, not only did the sample on average report higher levels of psychological distress, psychological distress was not associated with religious coping or involvement



measures. Given the current economic situation, it is possible that the increased levels of psychological distress are in part related to increased stress resulting from economic distress. Additionally, because African Americans tend to report higher levels of somatic symptoms of psychological distress (DHHS, 2001, Brown, 1996); it is possible that our measure, which includes several questions that assess physiological symptomatology, may serve as an overestimate of actual psychological distress. Another possibility is that for this sample increased religious involvement and coping does not necessarily decrease symptoms of psychological distress, but rather lessens the perceived need for professional help. Therefore, these results lend some support to the possibility that religion is playing a protective role in this population.

Revisiting our theoretical model, we would expect to see increased utilization of mental health services in this sample given the positive attitudes towards service utilization, however, in this sample; actual utilization is still low *despite* favorable attitudes and psychological distress. It is possible that for this population, the relationship between mental health attitudes and actual utilization is impacted by structural barriers that were not assessed in this study. Therefore, future studies may need to include measures of perceived accessibility and availability of services in order to fully understand the process by which service utilization takes place.

#### *Attitudes, Subjective Norms, and Intent to Utilize Services*

Our first hypothesis that mental health service attitudes and subjective norms would be associated with intent was partially supported. Mental health service attitudes were significantly and positively related to intent to utilize. This positive relationship is consistent with previous literature that show attitudes direct influence intent to utilize.

However, subjective norms were not significantly related to intent in bivariate or univariate analyses and were not further pursued. Given this study's qualitative findings regarding the minimal impact of subjective norms on intent to utilize, the lack of quantitative findings linking subjective norms to the intent to utilize in this sample is somewhat less surprising. Yet these null results are in contrast to findings from other studies associating subjective norms to intent. Overall, these results suggest that when experiencing personal distress, individuals will rely on their personal evaluations of treatment options rather than perceived acceptability of treatment options by their community.

*Factors that influence mental health service attitudes.*

The second hypothesis, that individual religious indices would be related to mental health service attitudes, was also partially supported. Collaborative religious coping was related to service attitudes; however the direction of this relationship was unexpected. Instead of the negative relationship that we hypothesized, there was a curvilinear relationship between the variables such that both high levels of collaborative religious coping and low levels of collaborative religious coping are associated with less favorable attitudes. During focus groups, participants indicated that reliance on Collaborative Religious Coping was related to more positive attitudes regarding utilization of mental health services and use of Passive Religious Deferral was related to less favorable attitudes regarding utilization of mental health services. Using these qualitative results as context, it is possible that as reliance on collaborative religious coping techniques decrease, reliance on more passive religious coping increases thereby leading to less favorable mental health service attitudes. In contrast, as reliance on

collaborative religious coping increases to higher levels, reliance on self-directed religious coping increases, again leading to less favorable mental health service attitudes. Although suggestive, these results indicate the possibility of a religious coping spectrum, meaning that religious coping may be more dimensional than categorical in this sample.

Focus group participants also signified the importance of internal representations of God in the construction of mental health service attitudes. Preliminary quantitative analyses found significant relationships between mental health service attitudes and two God Image subscales-- acceptance and presence. However, further analyses did not confirm a relationship between God image and attitudes. Our measure of God Image assessed internal views of God, but not necessarily their view of God during times of distress, which qualitative analyses illustrate as an important factor in the construction of service attitudes.

#### *Mediating relationship between Religious factors and intent*

Despite indications from previous literature (Barksdale and Molock, 2009) and qualitative results that mental health service attitudes mediated the relationship between religious indices and intent to utilize, the quantitative results do not support this hypothesis. One possible explanation for the non-significant results may be due to measurement issues. Qualitative results show that it's the *internal beliefs* regarding their level of control in times of emotional distress. And although religious coping can be considered behavioral manifestations of these internal beliefs, it is possible that the religious coping measures used do not fully capture the underlying belief that may be instrumental in understanding this relationship. Again, these results are corroborated by Patrick's (2003) recent findings that show relationships between intrinsic indices of

spirituality are important in the evaluation of treatment. Therefore, assessing latent beliefs regarding God's control and perceived personal agency may be more indicative of the hypothesized mediation relationship.

### *Clinical Implications*

As mental health service attitudes have been found to relate to the intent to utilize services and religious coping is related to mental health service attitudes, the results from these data speak to the need for collaboration between religious organizations and mental health professionals in developing public education programs that encourage the use of mental health services by targeting mental health service attitudes. Working with religious leaders will provide invaluable insight as to how the mental health profession can create and implement public education programs and modify available service options so that they accommodate and complement religious coping beliefs and techniques utilized in this population. Hopefully, by modifying services and increasing visibility of such services through public education campaigns, intent to utilize will also increase. Further, formal mental health service providers should make targeted efforts to provide psychoeducation to the community with a particular focus on mental illness and symptoms that warrant professional help.

The findings also suggest that when working with African American clients, clinicians should assess not just religious participation, but specific forms of religious coping. Understanding the role that religion plays in the life of the client will allow clinicians to tailor treatments to the client. For example, when working with clients who use collaborative religious coping strategies, clinicians should develop methods to include God and religious content as elements in the therapeutic process and in a manner

that is consistent with the client's understanding of this relationship (e.g., collaborative, deferring). Further, clinicians should be aware that clients might be assessing if the treatment is in line with current beliefs. Therefore, being open to discuss religion and incorporate it in treatment may be very important in developing initial rapport and decrease the rate of early termination among African American clients.

### *Limitations*

Some limitations should be taken into account when interpreting this data. The first limitation is the temporal differences between the measures. The BSI asks about symptoms that occurred in the last week, while the religious coping measures ask participants to think about coping strategies used during a distressing event that could have occurred at anytime during their life. The self-report format of the mental health service attitudes measure may have led to an over-estimate of actual services attitudes held by participants, particularly given that focus group participants also initially indicated positive attitudes until probed further. Furthermore, participants were asked to self-identify as rural residents; however, there were not external measures to verify if participants were actually residing in rural areas. Therefore, it is possible that some participants were not rural residents.

Further, participants for this study were recruited from religious institutions located in rural Southern communities thereby creating a select sample that predominately consisted of females from Baptist churches. While results from some epidemiological studies indicate that the demographic characteristics of this sample may be representative of the rural African American church going population (ref), it limits the generalizability of these results to other populations particularly rural African

American males, rural African Americans from other religious affiliations, and rural African Americans from other geographical regions (i.e. African Americans from rural communities located in the North). Therefore, future research should examine the relationship between mental health service attitudes and religious coping among rural African Americans from various regions and denominations and especially among rural African American males given the increased risk for functional impairment when. Additionally, this sample also reported higher levels of education and income than would be expected based on census data in the communities in which they reside, indicating higher levels of associated cognitive and financial resources, which limits the generalizability of these results to other rural communities. Finally, due to the cross sectional nature of these data causality cannot be inferred.

#### *Future Directions*

The present study provides some evidence regarding the relationship between the mental health services attitudes and religious indices, thereby shedding some light into possible explanations for the underutilization of services. However, further research should examine this relationship among a variety of samples (e.g. different neighborhood compositions, levels of education, geographic location, and religious affiliations). It will be especially important to examine these associations among rural African Americans from other denominations as denominational differences may influence one's construction of God and the perception of mental illness. Again, it will also be important to target rural African American males for future research. Future studies may need to target places outside of church where African American males are more likely to frequently such as community centers, barber shops, etc to increase the inclusion of male

participants. Also, future research should examine, both quantitatively and qualitatively, the relationship between religious coping and perceived helpfulness with the goal of devising clinical interventions that can better serve this population. Prospective studies of coping in relation to different types of problems are also indicated as important next steps.

This study contributes to the literature by extending current research examining a variety of religious variables, service attitudes, and subjective norms as indicators of patterns of mental health service utilization in the rural African American population. Understanding this relationship between religious variables and utilization can inform the development of targeted public education efforts that may increase utilization of outpatient mental health sources among rural African Americans. The goal of increasing appropriate utilization of mental health services among African Americans in general is of critical importance given the persistent racial disparities in care.

## Appendix A

### Informed Consent

The purpose of this study is to examine how the use of religious coping techniques affect the decision to seek help from a formal mental health source. Previous research has discovered that the use of religious coping techniques is related to a decreased likelihood of seeking help from a formal mental health source. This study seeks to further examine this relationship in hopes of developing more appropriate mental health resources.

As part of this study, you will be asked to complete a series of questionnaires related to the aforementioned topics. At no time during this study will you be asked to discuss any personal experiences you may have had or the experiences of others. This study is only interested in opinions you may have about the aforementioned topics. After completion of this survey, you will be given a \$10 I Tunes gift card.

This survey will take approximately 45 minutes to complete. You must be 18 years of age. Your participation in this study is voluntary and you can decide to withdraw at any time without penalty. There is little risk to you for participating in this study; however, some questions may ask you to think about experiences, which could cause discomfort. If you find that some questions are too difficult to answer, you may refuse to answer those questions or withdraw from the study at any time. This study offers no direct benefit to you other than helping increase our understanding of the connection between religious coping and mental health service use.

Any information collected in this study will remain confidential. However, the Institutional Review Board or university officials responsible for monitoring this study may inspect these records. If you report any child abuse, or an intention to harm yourself or someone else, that information must be reported to the campus office of public safety. Only the members of this research team will have access to the information you provide during this study. The records kept for this project will not include any personal information about you that could allow others to identify you. Anonymous data obtained maybe presented in manuscripts, published research reports, and/or academic meetings and conferences.

One copy of this document will be kept together with the research records of this study. If you have additional questions, would like to have a copy of this form for your personal records, or if you are interested in obtaining copies of reports based on study findings, you may contact the principal investigator, Tiffany Haynes 530 Church Street, 2257 East Hall, Ann Arbor, MI 48109, [thaynesz@umich.edu](mailto:thaynesz@umich.edu).



Should you have questions or concerns regarding your rights as a research participant, please contact the Institutional Review Board, 540 E. Liberty Street, Suite 202, Ann Arbor, MI 48104-2210, 734-936-0933, [irbhsbs@umich.edu](mailto:irbhsbs@umich.edu).

I have read and understand the information provided in this consent form and I hereby consent to participate in the study.

- Yes I consent to participate in this study
- No, I do not consent to participate in this study

## Appendix B

### Focus Group Protocol

Instructions: Ask each participant to choose an alias (pick a name) that will be used for the recording. Before beginning the lead-in ask each participant to clearly state his or her alias/name for a tape recorder operations check.

(Suggestion for a lead-in): Today we want to talk with you about problem/issues that young Black people face in today's society. This is a very informal group discussion, so please feel free to say what you really think. The only ground rule is that you allow each other to finish speaking before you jump in.

#### Module 1: Perceived Need for Mental Health Services

PRECEDE DISCUSSION WITH REMINDER THAT WE ARE NOT ASKING FOR PERSONAL EXPERIENCES:

Instructions: Use participant-generated words/descriptions to probe questions

**What do you think are some of the biggest issues facing young Blacks in their communities today?**

**Some people believe that experiencing the issues you mentioned above (name the issues that they mention) can affect the emotional health of young Blacks. Do you agree that emotional problems are a concern for young Blacks?**

**Some people define emotional problems differently based on their individual values and experiences, what do you think is an example of an emotional issue?**

**What types of emotional issues would you consider serious?**

Alternate: Would you say that problems such as depression are serious emotional issues? What about anxiety? Schizophrenia?

**When someone is experiencing an emotional problem, when should psychotherapy be considered?**

Alternate: What types of problems require psychotherapy?

**When someone is experiencing an emotional problem, when should they just deal with the problem using their religious faith?**

Alternate: What types of problems can be handled just using religious faith?

## **Module 2: Perceptions of Help Seeking**

PRECEDE DISCUSSION WITH REMINDER THAT WE ARE NOT ASKING FOR PERSONAL EXPERIENCES:

We've discussed what types of problems warrant professional help, now we are going to switch to discussing how you feel about seeking help.

**How do you cope with emotional problems?**

**(If mentioned): I see that some of you mentioned seeing a psychologist. Do you think that it is ok for a Christian to see a psychologist?**

**(If not mentioned): Do you think that Christians should see psychologists?**

Do you think that Christians that see psychologists have a lack of faith in God?

**What messages have you heard in church about seeking help from a mental health professional?**

Do these messages affect your likelihood of seeking help if you need it?

**How does your religious faith affect your likelihood of seeking help if you need it?**

**How do you think fellow church members would react if they found out that you were seeing a psychologist?**

## ***Module 3: Perceptions of Mental Health Professionals***

Now that we've discussed problems that should be handled by a psychologist and how we feel about seeing a psychologist, let's discuss how you view psychologists.

**What is your image of psychologists or other mental health professionals?**

What messages or experiences have you had that influenced your current impressions of mental health professionals?

**Do you think that it is important for Christians to see a psychologist of the same faith?**

**Would you accept advice from a non-believing psychologist?**

## CLOSURE

Instructions:

Thank students for talking freely.

Ask them if they have any follow-up questions.

**IMPORTANT:** Ask them to fill out demographic questionnaire using alias/fake name they chose at the beginning.

Handout Demographic Questionnaire.

Briefly review questionnaire for missing information when they hand it back.

Give them a handout with names, phone numbers of mental health resources in the community so if they want to talk more or ever need help they know where to go.

## Appendix C

### Demographic Questionnaire

1. Which of the following best represents your ethnicity?  
 African American  
 Afro-Brazilian  
 Afro-Caribbean, specify country \_\_\_\_\_  
 African, specify country \_\_\_\_\_  
 Other, please specify \_\_\_\_\_
  
2. Please select your gender.  
 Male  
 Female  
 Other (Please specify)  
\_\_\_\_\_
  
3. What is the highest level of formal education you have obtained?  
 Elementary School or less  
 Some high school  
 High School graduate  
 Some college  
 Associate, two-year degree  
 Four year college degree  
 Postgraduate degree started  
 Postgraduate degree completed
  
4. What is the highest level of formal education obtained by your mother  
 Elementary School or less  
 Some high school  
 High School graduate  
 Some college  
 Associate, two-year degree  
 Four year college degree  
 Postgraduate degree started  
 Postgraduate degree completed
  
5. What is the highest level of formal education obtained by your father  
 Elementary School or less

- Some high school
- High School graduate
- Some college
- Associate, two-year degree
- Four year college degree
- Postgraduate degree started
- Postgraduate degree completed

6. Which of the following best describes your family income per year?

- \$200,000 +
- \$62,000-200,000
- \$32,000-62,000
- \$15,000-32,000
- \$14,000 or less

7. Which of the following categories best describes where you live

- City of 100,000+
- Town of 50,000 to 100,000
- Town of 25,000 to 50,000
- Town of 10,000 to 25,000
- Town of 2,500 to 10,000
- Town of 2,500 or below

8. What is your current marital status?

- Married
- Widowed
- Divorced
- Separated
- Never Married

## Appendix D

### BRIEF SYMPTOM INVENTORY

The following is a list of problems people sometimes have. Please read each one carefully, and chose the answer that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING **THE PAST 7 DAYS INCLUDING TODAY**. Choose one answer for each item.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
<b>How much were you distress or bothered by:</b>					
1. Nervousness or shakiness inside	0	1	2	3	4
2. Faintness or dizziness	0	1	2	3	4
3. Pains in heart or chest	0	1	2	3	4
4. Thoughts of ending your life	0	1	2	3	4
5. Poor appetite	0	1	2	3	4
6. Feeling lonely	0	1	2	3	4
7. Feeling no interest in things	0	1	2	3	4
8. Nausea or upset stomach	0	1	2	3	4
9. Trouble falling asleep	0	1	2	3	4
10. Trouble catching your breath	0	1	2	3	4
11. Hot or cold spells	0	1	2	3	4
12. Numbness or tingling in parts of your body	0	1	2	3	4
13. Feeling hopeless about your future	0	1	2	3	4
14. Trouble concentrating	0	1	2	3	4
15. Feeling weak in parts of your body	0	1	2	3	4
16. Feelings of worthlessness	0	1	2	3	4

## Appendix E

### Attitudes and Norms regarding Mental Health Service Attitudes

If you had a serious emotional problem, would you

- I would definitely go for help
- I would probably go for help
- I would probably not go for help
- I would definitely not go for help

If you were distressed due to an emotional problem, seeking help from a professional would be:

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Beneficial	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pleasant for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worthless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How comfortable would you be talking about personal problems with a professional?

- Very Comfortable
- Somewhat Comfortable
- Not very comfortable
- Not at all comfortable

How embarrassed would you be if your friends knew you were getting professional help for an emotional problem?

- Very embarrassed
- Somewhat embarrassed
- Not very embarrassed



- Not at all embarrassed

How embarrassed would you be if your church members knew you were getting professional help for an emotional problem?

- Very embarrassed
- Somewhat embarrassed
- Not very embarrassed
- Not at all embarrassed

If I had an emotional problem, most people in my church would want me to get help from a professional

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

If I had an emotional problem, people in my church would pressure me to get help from a professional

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

If I had an emotional problem, most people in my church would expect me to get help from a professional

- Strongly Agree
- Agree
- Disagree
- Strongly Disagree

When it comes to seeking professional help for an emotional problem, how important is your family's approval?

- Very Important
- Somewhat Important
- Neither Important nor Unimportant
- Not very important
- Not at all Important

When it comes to seeking professional help for an emotional problem, how important is your friends' approval?

- Very Important
- Somewhat Important
- Neither Important nor Unimportant
- Not very important
- Not at all Important

When it comes to seeking professional help for an emotional problem, how important is your church's approval?

- Very Important
- Somewhat Important
- Neither Important no Unimportant
- Not very important
- Not at all Important

How confident are you that talking to a professional about an emotional problem would be helpful?

- Very Confident
- Somewhat confident
- Not very confident
- Not at all confident

## Appendix F

### Help-Seeking Scale

1. Problems often come up in life. Sometimes they are personal problems. When problems like this have come up, has there ever been a time when you felt you were about at the point of a nervous breakdown?

- Yes GO TO Question 4  
 No

2. Has there ever been a time when you had a personal problem where you felt so nervous you couldn't do much of anything?

- Yes GO TO Question 4  
 No

3. Has there ever been a time when you felt down and depressed, so low that you felt like you just couldn't get going?

- Yes GO TO Question 4  
 No GO TO

4. Thinking about the last time that you felt that way, what was the problem about?

- No Serious Problem  
 Academic Problems  
 Romantic Relationship Problems  
 Family Problems  
 Occupational Problems  
 Financial Problems  
 Other (Please Specify) \_\_\_\_\_

5. Did you seek help for this problem

- Yes

No GO TO Question 7

6. The next few questions ask about other people you may have gone to for help with your problem. Please tell me all of the people on this list you talked to about your problem. Then rate whether you found your interaction helpful

Did you talk to a Psychiatrist

Yes

No

If yes, Did you find it helpful?

yes

No

Did you talk to an other Mental Health Professional (Psychologist, Social Worker, Campus Mental Health Center)

Yes

No

If yes, Did you find it helpful?

Yes

No

Did you talk to a Spiritual Advisor  
(Pastor, Minister, etc)

Yes

No

If yes, Did you find it helpful?

Yes

No

Did you talk to any other healer like a faith healer?

Yes

No

If yes, Did you find it helpful?

Yes

No

Did you attend a self-help group, mutual help group, or support group?

Yes

No

If yes, Did you find it helpful?

yes

No

Did you talk to any other professional  
(Please SPECIFY) \_\_\_\_\_

Yes

No

7. Here are some reasons that people have for not seeking professional help even though they think they need it. Please indicate if one or more of these statements apply to why you did not see a professional.

Problem went away by itself and I didn't really need help

Thought that the problem would go away by itself

Wanted to solve the problem on my own

Wanted to solve the problem through my faith

Didn't know where to go for help

The problem didn't bother me that much

Didn't think it would help

Couldn't afford it

Was embarrassed to talk about the problem

Was worried about what others would think

## Appendix G

### Religious Problem Solving Scale

Think about how you try to deal with and understand major problems in your life. To what extent is each involved in the way that you cope. (Please Circle your response)

R1. After I've gone through a rough time, I try to make sense of it without relying on God

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R2. When I have difficulty, I decide what it means by myself without help from God

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R3. When faced with trouble, I deal with my feelings without God's help.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R4. When deciding on a solution, I make a choice independent of God's input

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R5. When thinking about a difficulty, I try to come up with possible solutions without God's help

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R6. I act to solve my problems without God's help

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R7. Rather than trying to come up with the right solution to a problem myself, I let God decide how to deal with it.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R8. In carrying out solutions to my problems, I wait for God to take control and know somehow He'll work it out.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R9. I do not think about different solutions to my problems because God provides them for me.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R10. When a troublesome issue arises, I leave it up to God to decide what it means for me

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R11. When a situation makes me anxious, I wait for God to take those feelings away

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R12. I don't spend much time thinking about troubles I've had; God makes sense of them for me.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R13. When it comes to deciding how to solve a problem, God and I work together as partners

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R14. When considering a difficult situation, God and I work together to think of possible solutions.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R15. Together, God and I put my plans into action.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R16. When I feel nervous or anxious about a problem, I work together with God to find a way to relive my worries

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

R17. After solving a problem, I work with God to make sense of it

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal



R18. When I have a problem, I talk to God about it and together we decide what it means.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4
Not at all	Somewhat	Quite a bit	A Great Deal

## Appendix H

### Multidimensional Religious Involvement Scale

S1. How religious are you?

- Not at all religious
- A little religious
- Somewhat religious
- Quite religious
- Very religious

S2. How important is religion in your life today?

- Not at all
- A little important
- Somewhat important
- Quite important
- Very important

S3. How important is it for African Americans to take their children to church?

- Not at all important
- A little important
- Somewhat important
- Quite important
- Very important

S4. What is your current religious affiliation?

- No Religious Affiliation
- Baptist
- Church of God in Christ
- Pentecostal
- Non-Denominational
- Other (Please Specify)

S6. Other than for weddings and funerals, have you attended services at a church or other place of worship since you were 18 years old?

- Yes
- No

S7. How often do you usually attend religious services?

- Nearly everyday or 4 or more times a week
- At least once a week or 1 to 3 times a week
- A few times a month or 1 to 3 times a month
- A few times a year
- Less than once a year

S8. On a typical (Sunday/Saturday) how many hours are you at your church or place of worship?

- 0-1 Hours
- 1-3 Hours
- 3-5 Hours
- 6 or more Hours

S9. Are you an official member of a church or other place of worship?

- Yes
- No

S10. Not including religious services how many hours per week are you at your place of worship?

- 0-1 Hours
- 1-3 Hours
- 3-5 Hours

- 6 or more Hours

S11. How often do you see, write, or talk on the telephone with members of your church (place of worship)?

- Nearly every day
- At least once a week
- A few times a month
- At least once a month
- A few times a year
- Never

S12. How often do people in your church (place of worship) help you out?

- Very often
- Fairly often
- Not too often
- Never
- Never needed help

S13. How often do you help out people in your church (place of worship)?

- Very often
- Fairly often
- Not too often
- Never
- Never needed help

S14. How close are you to the people in your church?

- Very close
- Fairly close
- Not too close
- Not close at all

**S15. How often do you**

	Nearly every day	At least once a week	A few times a month	At least once a month	A few times a year	Never
... read religious books or other religious materials?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... watch religious programs on tv?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... listen to religious programs on the radio?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... pray?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
... ask someone to pray for you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**How important have the following things been to you?**

	Very important	Fairly important	Not too important	Not at all important
How important was religion in your home while you were growing up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is it for parents to send or take their children to religious services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is religion in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How important is spirituality in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How important is prayer when you deal with stressful situations?

## Appendix I

### God Image Scale

G1. God does not answer when I call

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G2. I can feel God deep inside of me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G3. I can talk to God on an intimate basis

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G4. God doesn't feel very personal to me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G5. God nurtures me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G6. I get no feeling of closeness to God, even in prayer

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G7. God is always there for me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G8. I sometimes feel cradled in Gods arms.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G9. God feels distant to me.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G10. I rarely feel that God is with me

- Strongly Disagree
- Disagree



- Agree
- Strongly Agree

G11. I feel the presence of God when I pray

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G12. God never reaches out to me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G13. I am sometimes anxious about whether God still loves me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G14. I am confident of God's love for me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G15. I know that I am not perfect, but God loves me anyway

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G16. God's love for me has no strings attached

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G17. Even when I do bad things, I know that God still loves me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G18. God loves me only when I perform perfectly

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G19. God loves me regardless

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G20. I often worry about whether God can love me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G21. God's love for me is unconditional

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G22. I am not good enough for God to love

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G23. I sometimes think that not even God could love me

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G24. God never challenges me to grow

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G25. Thinking too much could endanger my faith

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G26. God takes pleasure in my achievements

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

G27. God keeps asking me to try harder

- Strongly Disagree
- Disagree

- Agree
- Strongly Agree

## Appendix J

### Brief Satisfaction with Life Scale

L1. In most ways, my life is close to my ideal

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neither Agree nor Disagree
- Slightly Agree
- Agree
- Strongly Agree

L2. The conditions of my life are excellent

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neither Agree nor Disagree
- Slightly Agree
- Agree
- Strongly Agree

L3. I am completely satisfied with my life

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neither Agree nor Disagree
- Slightly Agree
- Agree

Strongly Agree

L4. So far I have gotten the most important things in my life

Strongly Disagree

Disagree

Slightly Disagree

Neither Agree nor Disagree

Slightly Agree

Agree

Strongly Agree

L5. If I could live my life over, I would change nothing

Strongly Disagree

Disagree

Slightly Disagree

Neither Agree nor Disagree

Slightly Agree

Agree

Strongly Agree

Appendix K  
ANOVA Tables

Anova Table for the Intent Variable

Variable	df	<i>F</i>	<i>P</i>
Attitudes	14	2.858	.002**
Subjective Norms	27	.947	.550
Psychological Distress	20	1.743	0.051
Self Directed Religious Coping	13	.848	.609
Passive Religious Coping	19	.615	.880
Collaborative Religious Coping	16	.698	.786
Subjective Religiosity	9	.523	.854
God Image Presence	15	.472	.946
God Image Acceptance	19	.683	.821
God Image Challenge	8	.849	.563

\* =  $p < .05$     \*\* =  $p < .01$

Anova Table for the Attitude Variable

Variable	df	<i>F</i>	<i>P</i>
Collaborative Religious Coping	16	1.857	.038*
Psychological Distress	21	1.826	.032*
Subjective Religiosity	9	1.239	.283
God Image Presence	15	1.686	.071
God Image Acceptance	19	1.895	.027*
God Image Challenge	8	.945	.484

\*= p<.05

\*\*=p<.01



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