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# **Does Religious Belief Affect Attitudes Towards Mental Illness?**

An Honors Thesis submitted in partial fulfillment of the requirements for Honors in  
Nursing

By  
Robert Conway

Under the mentorship of Jeffrey Harris MSN

## **Abstract**

There has been an increase in recent years in the effort to raise awareness of mental health issues, particularly suicide. However, awareness does not equate to understanding and there has been little in the way of public education. One of the biggest obstacles faced by those suffering from a mental illness is the public stigma associated with it. Given the high percentage of the population in the South who identify as being religious, this study looked at the relationship between religiosity and public stigma towards mental illness. Two hundred forty-two university students drawn from undergraduate biology and nursing classes completed a questionnaire which comprised two established surveys on religiosity and attitudes towards mental illness respectively. The intention was to follow the survey with educational presentations to audiences who identified as very religious to measure whether increased understanding resulted in a decrease in negative attitudes. Of the 31 places of worship approached – in writing, by telephone, by referral and in person – none agreed to participate. A subsequent educational intervention with a group of university students revealed an unexpected confound in that the evaluation questionnaire was found to be ambiguous.

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## **Introduction**

The incidence and prevalence of mental illness has been increasing at an alarming rate in the United States. The National Alliance on Mental Illness publishes a wealth of statistics on the subject: 1 in 5 U.S. adults experienced a mental illness in 2018; 1 in 25 adults experience a serious mental illness each year; 50% of all lifetime mental illness begins by age 14, and 75% by age 24; suicide is the second leading cause of death among people aged 10-34. (NAMI n.d.) Most people are aware that rates are even higher for populations such as veterans, those identifying as LGBT and older white males. (American Foundation for Suicide Prevention 2017).

There has been a considerable push in recent years to reduce the stigma associated with people suffering from mental illness. Quite apart from the altruistic aim of removing the blame from those suffering from a debilitating disease public stigma acts as a powerful hindrance to seeking help for those affected. (Corrigan, 2014). Phrased another way, the attitudes of the healthy are preventing the treatment of the sick. Much of the effort to reduce this stigma has been in the domain of public health education. As discussed below, this has had a positive effect on the overall public perception and opinions regarding mental illness. As the sophistication of the public awareness campaign increases it is becoming clear that understanding the nature and sources of the stigma is crucial to tailoring education to combat it.

Stigma towards mental illness is of particular concern to the nursing profession. Stigma is a barrier to health promotion, one of the most important roles for nursing. Understanding the basis and extent of the problem is crucial to enabling nurses to recognize address and overcome the societal hurdles the mentally ill face.

An important distinction to note is the difference between perceived stigma versus personal stigma. Perceived stigma says, "Because I am mentally ill, people won't like me." Personal stigma says, "I don't like people who have a mental illness". The purpose of this paper is to focus on personal stigma. Unless societal attitudes become more accepting of those who are mentally ill, the impact of outreach efforts towards those suffering will be limited.

Most of the studies related to religiosity and attitudes towards mental illness concern themselves with the perceived stigma associated with seeking out mental health services. African Americans and Latinos were specifically addressed because those groups have a higher instance of religiosity than many others. The literature addressing personal stigma towards mental illness is not nearly as homogenous in its scope.

The literature concerning racial differences in attitudes is fairly consistent in its findings. One of the earlier studies found that, compared to whites, African-Americans were more likely to attribute mental illness to a chemical imbalance than to a genetic

cause. At the same time, African-Americans were more likely to reject explanations for mental illness that were linked to family circumstances than they were a linkage to stress relating to life generally. (Schnittker, 2000).

Anglin (2008) specifically concurred with Schnittker and found that African Americans were more likely than whites to believe that the mentally ill could get help from mental health professionals such as psychiatrists or psychologists. Diala (2000) agreed and further found that African-Americans were more comfortable talking about emotional problems with health professionals than whites were.

Anglin (2006) agrees with this and says, "...even though African Americans were more likely than Caucasians to believe individuals with mental illness would be violent, they were less likely to believe these individuals should be blamed and punished if they were violent. African Americans were more lenient and less punishing in their views on how people with mental illness should be treated..." (p.860).

There are also broadly similar findings from studies of Hispanic subjects. "[O]ur findings showed that Hispanic patients attributed the causes of depression to social pressures and life circumstances rather than to internal mechanisms related to biological, genetic or chemical factors." (Cabassa, 2007 p.13). "We did not find support for our hypothesis that Latinos and African Americans would report more negative attitudes towards mental health treatment." (Gonzales, 2005 p.8).

There is very little in the literature related to religion and stigma towards mental illness. Most of the research that has been undertaken is related to perceived stigma and the role of religious faith in self-care. For example, Stanford (2008), a British study, found that 30% of mentally ill Christians had a negative experience with their local church. In some cases, participants were told by the spiritual leaders that they did not have a mental illness or that its cause was spiritual in nature. An Australian study, Hartog (2005), discovered that 38.2% and 37.9% of the Protestant Christian subject group believed that major depression and schizophrenia respectively had a demonic etiology. Wesselmann (2010) found a similar high correlation between religiosity and beliefs that mental illness has a spiritual cause or is the result of sinful behavior. Unlike Adams (2018), this study found a positive correlation between stigma and Christian orthodoxy as well as with religious fundamentalism.

The two articles below specifically speak to the issue of social stigma by the very religious. “Higher religious fundamentalism was associated with greater preference for religious rather than psychological assistance ... This also speaks to the unique importance of religious factors in research with religious populations. In future studies with religious populations, it is then likely important to assess levels of fundamentalism for treatment-seeking preferences.” (Wamser, 2011 p.234). Adams (2018) found that religious fundamentalism generally, rather than Christian orthodoxy specifically, was correlated with more negative attitudes towards mental health.

Koenig (2001) makes the statement that “[r]eligious beliefs and practices are consistently related to greater life satisfaction, happiness, positive affect, morale and other indicators of well-being.” (p.99). Hill (2003) agrees and says “[t]here is now a substantial literature that connects religion and spirituality to physical health.” (p.64). In accord with these assertions, Moreno (2018) said “...Mexican immigrants had lower lifetime prevalence rates of depressive disorders, anxiety disorders and substance use disorders compared with US-born Mexican-Americans. [W]e also found that Mexican immigrants reported higher levels of religious attendance... “ (p.13). This is also consistent with Wamser (2011). A year earlier, the same researcher observed that “[a]lthough religiosity is significantly and negatively related to attitudes towards professional mental health services, it is not through these coping strategies that we see this relationship among a Latino/a sample. Further research is needed to continue to investigate other possible mediators that explain the significant and negative relationship between religiosity and attitudes towards professional mental health services.” (Moreno, 2017 p.634).

By contrast, a British study found that “...religious coping was seen by the sample as a whole as relatively ineffective, although in absolute terms, it was somewhat effective.” (Lowenthal, 2001 p.8). Among emerging adults in the United States, one study found that “[I]ndividuals who were *religious and spiritual* fared the best in terms of psychosocial outcomes. Individuals who were *spiritual but not religious* and *neither*

*religious nor spiritual* tended to have better outcomes than did those who were *religious but not spiritual.*" (Nadal, 2018 p.30). Again, it is worth noting that this study focused on self-care.

In general terms, Corrigan (2009) stated that "[P]eople labeled with drug addiction are viewed more blameworthy and dangerous compared to individuals labeled with mental illness who, in turn, are viewed more harshly than those with physical disabilities." (p.139).

Anglin (2006) found that "younger and more conservative respondents were more likely to believe that individuals with mental illness should be blamed and punished for violent behavior. In addition, Protestants were more likely than people of other religions to blame mentally ill individuals for becoming violent...". (p.860). A British study, Papadopoulos (2002), agreed and said that "[t]he most consistent predictor of stigma is knowledge level. Thus, higher knowledge scores correlate with decreased stigma." (p.432). The study found that its subjects "regard their religious faith as one of the most important indicators of their society." (p.433). The subjects of this study were Greek-Cypriots living in a Anglo-Saxon British society. Hartog (2005) found that "overall, religious beliefs and counseling/psychology knowledge accounted to significant amounts of variance in levels of cognitive dissonance." (p.270).



As with most things, familiarity with mental illness leads to greater acceptance. “Research suggests that members of the general public who are familiar with mental illness – those who have some contact with persons who have psychiatric disabilities – are less likely to endorse stigmatizing attitudes. Conversely, individuals who perpetuate stigma are likely to socially distance themselves from persons with mental illness, social distance may manifest itself in such discriminatory practices as not renting to or not hiring people who have psychiatric disabilities.” (Corrigan, 2001 p.953). “Research with adults has consistently shown that stigma is reduced through contact with people affected by mental disorders...” (Jorm, 2008 p.147). Griffiths (2008) was another Australian study which reached a similar conclusion.

It has only been in the past decade or so that efforts have been made to understand the relationship between religious beliefs and attitudes towards mental illness. Given the rising prevalence of mental illness and the greater prominence of strong Christian beliefs in many parts of the United States, the lack of knowledge and understanding about mental illness is troubling. By increasing public knowledge and awareness, improvements in the ability to address the needs of this vulnerable population can be made for the betterment of society generally.

Given the prominence of religious conservatism in Southeast Georgia, this study examined the relationship between religious beliefs and attitudes towards mental illness among college students from a regional university. Although individual

demographic as to origin was not collected on an individual basis, publicly available statistics on enrolment demonstrate that slightly more than 90% of students come the same five counties in Southeast Georgia. (Georgia Southern University 2018).

Participants were asked about the strength of their religious beliefs and their attitudes towards people suffering from depression.

## **Methods**

### ***Participants***

Using convenience sampling 242 undergraduate students were recruited from the Armstrong Campus of Georgia Southern University. Of these 154 were first and second year students from the biology department with the balance being first year nursing students who had not yet taken a mental health course. The only demographic information collected was gender. Six responses were excluded because of missing data points. Of the remaining 236 participants, 35 were male, 183 were female and 18 chose not to identify their gender.

### ***Procedure***

This study was approved by the Georgia Southern University Institutional Review Board. The study questionnaire (Appendix A) was distributed in a classroom setting with the assistance of the course instructors. Students were told the nature and the purpose of the study and told that participation in the study was completely voluntarily. No extra credit or other incentive was provided in exchange for participation. Informed

consent in the form approved by the IRB was obtained (Appendix B). Students completed the questionnaire in approximately 5-10 minutes.

### ***Measures***

The questionnaire consisted of a single demographic question related to gender, the five questions of the brief version of the Santa Clara Strength of Religious Faith Questionnaire (“SCSRFQ”) (Plante 2002) and the twelve questions of the Revised Perceived Devaluation Discrimination Scale – Depression (“RPDSCD”) (Brown, 2010).

The SCSRFQ is a tool used to assess the strength of an individual’s religious beliefs. It is not directed towards a specific religion, but rather towards religiosity generally. For example, the first question, “I pray daily”, can refer equally to God, Allah, Yahweh or Buddha. Much of the existing research into the relationship between religious beliefs and attitudes towards mental illness looks at it in the context of Christian orthodoxy. While this is certainly useful, it is at the same time limiting. In the United States between 2009 and 2019, the population identifying as Christian fell by 12% while the number identifying as atheist, agnostic or “nothing in particular” rose by nearly the same percentage. (Pew Research Center, 2019). Accordingly, it was felt that questions that were not specifically directed towards practicing Christians was a more realistic measure.

Many existing studies looked at attitudes towards mental illnesses such as schizophrenia. While “schizophrenia” is a word that is recognized by most of the

population, the disease is not well understood and provokes fear in many. (Thibodeau, 2019). The same is likely true for bipolar disorder and other major mental illnesses. For this reason, depression was chosen as the mental illness for this study as it was thought less likely to produce an automatic negative reaction. Brown (2010) developed the RPDSCD for exactly this reason believing that “views about severe mental illnesses and depression might differ”. (p.5). The RPDSCD was administered to participants in its entirety. However, in addition to the questions on public stigma which concern this study, it contains questions related to perceived stigma and treatment. Responses to the latter questions were collected but not analyzed.

The 17 questions comprising both questionnaires were assessed on a 4-point Likert scale (strongly disagree – strongly agree) with the individual questions determining which end of the scale indicated the greatest stigma.

## **RESULTS**

In the initial analysis, responses to the first five questions comprising the SCSRFQ were averaged to provide a number to indicate religiosity. Participants with a score of <2.5 were classified as “Not Religious” (n=44), those with scores between 2.5 and 3.5 as “Moderately Religious” (n=118) and those with scores >3.5 as “Very Religious” (n=80).

After grouping participants together, their responses to the following questions related to public stigma were measured:

8. Most people believe that a person who has been hospitalized for depression is just as intelligent as the average person. (1 = greatest stigma)
10. Most people would accept a person who has fully recovered from depression as a teacher of young children in a public school. (1 = greatest stigma)
14. Most employers will hire someone who has had depression if he or she is qualified for the job. (1 = greatest stigma)
15. Most employers will pass over the application of someone who has had depression in favor of another applicant. (4 = greatest stigma)
16. Most people in my community would treat someone who has had depression just as they would treat anyone else. (1 = greatest stigma)
18. Once they know that a person was in a mental hospital for depression, most people will take his or her opinion less seriously. (4 = greatest stigma)

In order to make the results more easily understood by a lay person, the resulting average scores for each question were converted to a 10-point scale using the formula from IBM (2010) with 10 representing the greatest level of public stigma. The results were as follows:

|                      | Question |     |     |     |     |     |
|----------------------|----------|-----|-----|-----|-----|-----|
|                      | 8        | 10  | 14  | 15  | 16  | 18  |
| Very Religious       | 7.0      | 6.9 | 7.0 | 5.4 | 6.7 | 6.3 |
| Moderately Religious | 6.6      | 6.9 | 7.1 | 5.2 | 6.8 | 5.3 |
| Not Religious        | 6.8      | 6.8 | 6.7 | 5.2 | 7.1 | 5.2 |

With the surprising exception of question 16, the results were in line with expectations and prior studies and revealed a higher level of public stigma towards depression among the moderately and very religious.

## **DISCUSSION**

Given the overall purposes of this project, the data was not analyzed with the same rigor as would be the case with a scientific paper or published journal article. The participants were all university students who would be expected to have more liberal and accepting attitudes than the public at large. This is particularly true in the South where religious conservatism is prominent. Although participants were not asked about their religious affiliation it can be assumed that most if not all are Christian. Pew Research Center (2019) found that 77% of the U.S. population identified as Christian, compared with 82% of the participants.

Despite these limitations, the survey results were clear in correlating religiosity with higher levels of public stigma towards those suffering from depression.

Corrigan (2014) discusses at length the dramatic inverse correlation between knowledge and stigma regarding mental health, in terms of both public and perceived stigma. Neely-Fairbanks (2018) demonstrated a similar finding. Buizza (2017) found that higher knowledge and education, and also personal contact with mental illness, resulted in significantly lower levels of prejudice towards the mentally ill.

### ***The First Intervention***

Given the importance of knowledge and education in improving public attitudes towards mental illness, an education intervention was prepared to be presented to a

group of participants who self-identified as very religious. Slides relating specifically to the causes and nature of mental illness were extracted from an existing public presentation on suicide prevention (Anderson, 2007). The larger presentation was originally intended for an audience of church leaders and was very suitable for the present purpose. A copy of these slides appears as Appendix C.

Thirty-one places of worship in the Savannah area were approached over several weeks and asked if this presentation could be given to a gathering of churchgoers such as a bible study group or youth club. Requests were made to the spiritual leaders of a wide range of denominations: African Methodist Episcopal (n=2), Baptist (n=9), Catholic (n=1), Episcopal (n=4), Methodist (n=1), Non-affiliated Christian (n=13) and Unitarian (n=1). Requests were made in person (n=4), by telephone (n=2), by the request of a congregation member (n=5) and in writing (n=20).

Not one agreed to participate.

Although several did say that the project seemed worthy and expressed hope for its success, the overwhelming majority did not reply. This lack of response in itself is very indicative of the prejudices and daily difficulties faced by the mentally ill in this community. The problem is compounded by the relative importance placed on religion and religious participation in Southeast Georgia generally.

**The Second Intervention**

An instructor in the biology department at Georgia Southern University Armstrong Campus agreed to allow her anatomy and physiology lab group to participate. This consisted of 22 participants: 3 males, 16 females and 3 who chose not to identify their gender. Five were classified as Very Religious, 10 as Moderately Religious and 7 as Not Religious.

Participants were given the same questionnaire at the outset of the intervention and asked to complete it. An educational presentation using the slides at Appendix C lasting approximately 20 minutes was given and the participants were asked to complete the questionnaire again. The results appear below:

Before Presentation

|                      | Question |     |     |     |     |     |
|----------------------|----------|-----|-----|-----|-----|-----|
|                      | 8        | 10  | 14  | 15  | 16  | 18  |
| Very Religious       | 7.0      | 7.0 | 8.2 | 6.0 | 7.7 | 7.2 |
| Moderately Religious | 7.3      | 6.7 | 8.5 | 6.3 | 7.3 | 5.4 |
| Not Religious        | 8.3      | 7.9 | 8.3 | 5.6 | 8.7 | 6.9 |

After Presentation

|                      | Question |     |     |     |     |     |
|----------------------|----------|-----|-----|-----|-----|-----|
|                      | 8        | 10  | 14  | 15  | 16  | 18  |
| Very Religious       | 4.6      | 5.8 | 9.4 | 6.0 | 8.8 | 4.8 |
| Moderately Religious | 7.6      | 7.3 | 7.6 | 5.1 | 6.7 | 6.3 |
| Not Religious        | 5.3      | 5.7 | 5.7 | 6.4 | 6.6 | 6.0 |



Although stigma appears to have been reduced generally following the educational presentation about mental illness, this is not the case with every question. The inconsistent results arise in part because of the ambiguity of the RPDSCD questionnaire when used in these circumstances. During discussions which took place after completion of the second survey, some participants said that their responses reflected the negative attitudes that were highlighted during the educational presentation. As an example, after they had been told that the mentally ill faced discrimination in the workplace, they responded to question 14 – “Most employers will pass over the application of someone who has had depression in favor of another candidate” – as “Strongly Agree” when they had chosen a different response on the first questionnaire. When combined with the small sample size, the unsuitability of the survey tool renders the measurement of the success of this intervention unmeaningful.

## **CONCLUSION**

The surprising difficulties encountered when undertaking this project illustrate perfectly the difficulties faced in dealing with mental illness in the greater community. The importance of religion, religious belief and religious participation in the community is a factor of life in the South and is unavoidable for some. For people dealing with mental health issues, their problems are compounded many times over by a fear of ostracization from this community as well as an inability to seek help from it.

The failure to be secure an opportunity to educate a religious population is the most significant finding from this project. There are a number of possibilities for future work which immediately suggest themselves. An outreach to spiritual leaders to educate them about the issue of mental health seems an important step, and enlisting a leader with local, regional or national prominence would be ideal. Identifying opportunities outside of the place of worship to educate the religious is another possibility. Medical offices and religiously operated medical clinics are good choices for this.

The second intervention illustrated the unsuitability of the questionnaire used in this study. Although it was useful to measure the relationship between religiosity and attitudes towards mental illness, it was unsuitable to measure the success of the educational intervention. Published and validated survey tools were used for this project. A future effort to look at the relationship between religiosity and mental illness would likely require far more work and the design of a suitable measurement tool.

The purpose of this project was to identify a nursing problem and a possible solution to that problem. Although the problem was identified with considerable success, the success of the intervention was not capable of measurement to a strict academic standard. Anecdotally however, this was not the case and the small sample audience indicated that the educational presentation improved their views of mental illness.

For these reasons, the nursing profession is the best placed to provide the education and advocacy that this vulnerable population so desperately needs. Although the direct contact with the mentally ill is during the access to care, it is the interaction with the greater public that offers the most opportunity to bring about meaningful and lasting change to public attitudes. Although many of the mentally ill are homeless and/or lead solitary and lonely existences, all of them are or once were somebody's child, parent, spouse or friend. Had that person recognized the signs of mental illness and offered support, the outcome would likely be very different. Nursing is a profession that is universally respected and trusted. Incorporating mental health into all patient education is something every nurse can do to dramatically affect the overall perception of mental illness in this country. By doing so, nurses will be able to exponentially care for and help more of those who need it.

## REFERENCES

- Adams, K. S., Tost, J. R., Whatley, M. A., Brown, M. C., Dochney, B. J., Taylor, J. M., & Neal, M. H. (2018). Relationship of Christian beliefs to attitudes toward people with mental illness. *American Journal of Psychotherapy, 71*(3), 104–109. doi: 10.1176/appi.psychotherapy.20180022.
- American Foundation for Suicide Prevention (2017). Retrieved from <https://afsp.org/suicide-statistics/>
- Anderson, E. (2007). Saving lives: Understanding depression and suicide in our communities – a training for clergy and church leaders. Retrieved from <http://www.ohiospf.org/files/2Clergy%20gatekeeper%20training%20handout%20R5-07.ppt>.
- Anglin, D. M., Alberti, P. M., Link, B. G., & Phelan, J. C. (2008). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *American Journal of Community Psychology, 42*(1/2), 17–24. doi:10.1007/s10464-008-9189-5.
- Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial Differences in Stigmatizing attitudes toward people with mental illness. *Psychiatric Services, 57*(6), 857–862. doi: 10.1176/ps.2006.57.6.857.
- Brown, C., Conner, K. O., Copeland, V. C., Grote, N., Beach, S., Battista, D., & Reynolds, C. F. (2010). Depression stigma, race, and treatment seeking behavior and attitudes. *Journal of Community Psychology, 38*(3), 350–368. doi: 10.1002/jcop.20368.
- Buizza, C., Ghilardi, A., & Ferrari, C. (2017). Beliefs and prejudices versus knowledge and awareness: How to cope stigma against mental illness. A college staff e-survey. *Community Mental Health Journal, 53*(5), 589–597. doi: 10.1007/s10597-017-0116-9.
- Cabassa, L. J., Lester, R., & Zayas, L. H. (2007). "It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *Journal of Immigrant and Minority Health, 9*(1), 1–16. doi:10.1007/s10903-006-9010-1.
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest, 15*(2), 37–70. doi: 10.1177/1529100614531398.
- Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services, 52*(7), 953–958. doi: 10.1176/appi.ps.52.7.953.
- Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work, 9*(2), 139–147. doi:10.1177/1468017308101818.

- Diala, C., Muntaner, C., Walrath, C., Nickerson, K. J., LaVeist, T. A., & Leaf, P. J. (2000). Racial differences in attitudes toward professional mental health care and in the use of services. *American Journal of Orthopsychiatry*, 70(4), 455–464. doi:10.1037/h0087736.
- Georgia Southern University (2018) Retrieved from [https://em.georgiasouthern.edu/ir/wp-content/uploads/sites/5/GS\\_Fall2018FastFacts.pdf](https://em.georgiasouthern.edu/ir/wp-content/uploads/sites/5/GS_Fall2018FastFacts.pdf)
- Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology*, 33(5), 611–629. doi: 10.1002/jcop.20071.
- Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Predictors of depression stigma. *BMC Psychiatry*, 8, 1–12. doi:10.1186/1471-244X-8-25.
- Hartog, K., & Gow, K. M. (2005). Religious attributions pertaining to the causes and cures of mental illness. *Mental Health, Religion & Culture*, 8(4), 263–276. doi: 10.1080/13674670412331304339.
- Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, 58(1), 64–74. doi:10.1037/0003-066X.58.1.64.
- IBM (2010, August 23). Retrieved from <https://www.ibm.com/support/pages/transforming-different-likert-scales-common-scale>.
- Jorm, A. F., & Wright, A. (2008). Influences on young peoples' stigmatising attitudes towards peers with mental disorders: National survey of young Australians and their parents. *British Journal of Psychiatry*, 192(2), 144–149. doi: 10.1192/bjp.bp.107.039404.
- Koenig, H. G. (2001). Religion and medicine II: Religion, mental health, and related behaviors. *The International Journal of Psychiatry in Medicine*, 31(1), 97–109. doi:10.2190/BK1B-18TR-X1NN-36GG.
- Loewenthal, K. M., Cinnirella, M., Evdoka, G., & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK. *British Journal of Medical Psychology*, 74(3), 293–303. doi: 10.1348/000711201160993.
- Moreno, O., Nelson, T., & Cardemil, E. (2017). Religiosity and attitudes towards professional mental health services: Analysing religious coping as a mediator among Mexican origin Latinas/os in the southwest United States. *Mental Health, Religion & Culture*, 20(7), 626–637. doi:10.1080/13674676.2017.1372735.
- Moreno, O., & Cardemil, E. (2018). The role of religious attendance on mental health among mexican populations: A contribution toward the discussion of the immigrant health paradox. *American Journal of Orthopsychiatry*, 88(1), 10–15. doi: 10.1037/ort0000214.
- Nadal, A. R. C., Hardy, S. A., & Barry, C. M. (2018). Understanding the roles of religiosity and spirituality in emerging adults in the United States. *Psychology of Religion and Spirituality*, 10(1), 30–43. doi:10.1037/rel0000104

- NAMI. (n.d.). Retrieved from <https://www.nami.org/learn.more/mental-health-by-the-numbers>
- Neely-Fairbanks, S. Y., Rojas-Guyler, L., Nabors, L., & Banjo, O. (2018). Mental illness knowledge, stigma, help-seeking behaviors, spirituality and the African American Church. *American Journal of Health Studies, 33*(4), 162–174.
- Papadopoulos, C., Leavey, G., & Vincent, C. (2002). Factors influencing stigma: A comparison of Greek-Cypriot and English attitudes towards mental illness in North London. *Social Psychiatry and Psychiatric Epidemiology, 37*(9), 430. doi:10.1007/s00127-002-0560-9.
- Pew Research Center (2019, October 17). “In U.S., Decline of Christianity Continues at Rapid Pace”.
- Plante, T.G., Vallaey, C.L., Sherman, A.C., & Wallston, K.A. (2002). The development of a brief version of the Santa Clara strength of religious faith questionnaire. *Pastoral Psychology, 50*(5), 369-367.
- Stanford, M.S., Mcalister, K.A. (2008). “Perceptions of Serious Mental Illness in the Local Church.” *Journal of Religion, Disability & Health, 12*(2), 144–153., doi:10.1080/15228960802160654.
- Thibodeau, R., & Principino, H. M. (2019). Keep your distance: People sit farther away from a man with schizophrenia versus diabetes. *Stigma and Health, 4*(4), 429–432. doi: 10.1037/sah0000156.
- Wamser, R., Vandenberg, B., Hibberd, R. (2011). Religious fundamentalism, religious coping, and preference for psychological and religious treatment. *International Journal for the Psychology of Religion, 21*(3), 228–236. doi: 10.1080/10508619.2011.581582.
- Wesselmann, E. D., & Graziano, W. G. (2010). Sinful and/or Possessed? Religious Beliefs and Mental Illness Stigma. *Journal of Social and Clinical Psychology, 29*(4), 402–437. doi: 10.1521/jscp.2010.29.4.402.

## APPENDIX A

This survey is designed to look at the relationship between faith and attitudes towards depression. Your responses are completely anonymous and will be combined with the answers of all other respondents. Please consider each question individually and remember that there is no “right” or “wrong” answer.

I am (circle one):      Male                  Female                  Prefer not to say

1.      I pray daily.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

2.      I look to my faith as providing meaning and purpose in my life.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

3.      I consider myself active in my faith or church.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

4.      I enjoy being around others who share my faith.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

5.      My faith impacts many of my decisions.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

6.      Have you or anyone close to you ever experienced depression to the point where you sought help? (circle one)

Yes                  No

7.      Most people would accept a person who has had depression as a friend.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

8.      Most people believe that a person who has been hospitalized for depression is just as intelligent as the average person.

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
| 4                     | 3            | 2               | 1                        |

9.      Most people believe that a person who has had depression is just as trustworthy as the average citizen

|                       |              |                 |                          |
|-----------------------|--------------|-----------------|--------------------------|
| <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|-----------------------|--------------|-----------------|--------------------------|

- |  | 4                     | 3            | 2               | 1                        |
|--|-----------------------|--------------|-----------------|--------------------------|
| 10. Most people would accept a person who has fully recovered from depression as a teacher of young children in a public school              |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 11. Most people believe that entering a mental hospital is a sign of person failure.   |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 12. Most people would not hire someone who has had depression to take care of their children, even if he or she had been well for some time. |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 13. Most people think less of a person who has been in a mental hospital for depression.   |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 14. Most employers will hire someone who has had depression if he or she is qualified for the job.   |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 15. Most employers will pass over the application of someone who has had depression in favor of another applicant.                           |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 16. Most people in my community would treat someone who has had depression just as they would treat anyone else.                             |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 17. Most young women would be reluctant to date a man who has been hospitalized for depression.  |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |
| 18. Once they know that a person was in a mental hospital for depression, most people will take his or her opinion less seriously.           |                       |              |                 |                          |
|  | <i>Strongly Agree</i> | <i>Agree</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|  | 4                     | 3            | 2               | 1                        |



## APPENDIX B



### **WATERS COLLEGE OF HEALTH PROFESSIONS**

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### **DEPARTMENT OF NURSING**

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#### **Informed Consent**

#### **Does Religious Belief Affect Attitudes Towards Mental Illness?**

1. I am an undergraduate student at Georgia Southern University and am undertaking this research as part of my Honors Project.
2. Purpose of the Study: The purpose of this research is to study the relationship between a person's religious faith and his/her attitudes towards depression in others.
3. Procedures to be followed: Participation in this research will include completion of an anonymous survey
4. Discomforts and Risks: There is a possibility that some participants may feel uncomfortable discussing their personal beliefs.
5. Benefits:
  - a. The benefits to participants include helping to discover new ways to improve access to treatment for people suffering from mental illness.
  - b. The benefits to society include improved understanding of societal views towards mental illness and improved access to care for those affected.
6. Duration/Time required from the participant: 5-10 minutes
7. Statement of Confidentiality: All data collected will be maintained for a period of three (3) years.
8. Future use of data: Deidentified or coded data from this study may be placed in a publically available repository for study validation and further research. You will not be identified by name in the data set or any reports using information obtained from this study, and your confidentiality as a participant in this study will remain secure. Subsequent uses of records and data will be subject to standard data use policies which protect the anonymity of individuals and institutions.

9. Right to Ask Questions: Participants have the right to ask questions and have those questions answered. If you have questions about this study, please contact the researcher named above or the researcher's faculty advisor, whose contact information is located at the end of the informed consent. For questions concerning your rights as a research participant, contact Georgia Southern University Institutional Review Board at 912-478-5465.
  
10. Voluntary Participation: Participation in this survey is entirely optional. You may end your participation at any time by simply destroying the survey form. Even if you do choose to participate, you are not obliged to answer any question you do not wish to.
  
11. Penalty: There is no penalty for deciding not to participate in the study.
  
12. You must be 18 years of age or older to consent to participate in this research study. By completing this survey you acknowledge that you have consented to participate.

You will be given a copy of this consent form to keep for your records. This project has been reviewed and approved by the GSU Institutional Review Board under tracking number H20146.

Title of Project: Does Religious Belief Affect Attitudes Towards Mental Illness?

Principal Investigator: Robert Conway, [rc15039@georgiasouthern.edu](mailto:rc15039@georgiasouthern.edu), (212) 742-0874

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## APPENDIX C

# SAVING LIVES:

## Understanding Depression And Suicide In Our Communities - A Training for Clergy and Church Leaders

Sponsored By The Ohio Suicide Prevention  
Foundation

*Developed By Ellen Anderson, Ph.D.,  
LPCC, 2003-2007*

## Mental Illness and Stigma

- ▶ Historical beliefs about mental illness color the way we approach it even now, and offer us a way to understand why the stigma against mental illness is so powerful
- ▶ For most of our history, depression and other mental disorders were viewed as demon possession
- ▶ Afflicted people were “outside the gates”, unclean, causing people to fear of the mentally ill
- ▶ Lack of understanding of illness in general led

## What Is Mental Illness?

- ▶ We called it mental illness because we wanted to stop saying things like “lunacy”, “madness”, “bats in her belfry”, “nuttier than a fruitcake”, “rowing with one oar in the water”, “insane”, “ga ga”, “wacko”, “fruit loop”, “sicko”, “crazy”
- ▶ Is it any wonder people avoid acknowledging mental illness?
- ▶ Of all the diseases we have public awareness of, mental illness is the most misunderstood
- ▶ Any 5 year-old knows the symptoms of the common cold, but few people know the symptoms of the most common

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## What Is Mental Illness?

- ▶ We understand that something like Parkinson's damages the brain and creates behavioral changes
- ▶ Even diabetes is recognized as creating emotional changes as blood sugar rises and falls
- ▶ Stigma about illnesses like depression, schizophrenia and Bi-Polar disorder seems to keep us from seeing them as brain disorders that create changes in mood, behavior and thinking

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## How Are the Religious Affected by Depression?

- ▶ Depends on religious beliefs
- ▶ Experiencing depression is perhaps more stigmatized among believers than even in the general public
- ▶ Depression is often viewed as a failure of faith rather than as an illness
- ▶ The concept of depression as a spiritual failure may lead people to avoid acknowledging depressed thoughts

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## How Are the Religious Affected by Depression?

- ▶ Lack of knowledge about the symptoms of this illness may mean that people are unaware they are suffering a physical illness
  - ▶ The negative thinking endemic to depression means depressed people blame themselves, their lack of faith, or view themselves as unacceptable to God
  - ▶ Religious people may avoid seeking medical/ psychotherapeutic help for a medical issue if they view it as a spiritual shame
- (Kennedy, 2000; WHO article, 2002)
- ▶ See the book Why Do Christians Shoot Their Wounded by Dwight Carlson, MD

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## Impact Of Depression On Religious Beliefs

- ▶ Most find comfort associated with their faith
- ▶ But depression is associated with feelings of alienation from God
- ▶ Suicidality can be associated with religious fear and guilt, particularly with belief in having committed an unforgivable sin for simply thinking of suicide
- ▶ This religious strain is associated with greater depression and suicidality, regardless of religiosity levels or the degree of comfort found in religion

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## Factors That May Conflict With Church Attendance

- ▶ Persons who are depressed are less likely to leave their homes, want to be in groups, or to enjoy attending church, synagogue, mosque, temple, circle, etc. Also, those with social anxiety tend to avoid groups
- ▶ Homosexuals have a higher suicide rate as a group and are unlikely to attend church because of the degree of rejection they perceive they will find there
- ▶ Attendance at religious services potentially gives individuals access to a support network - those without a support network are more likely to commit suicide

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## Depression Is An Illness

- ▶ Suicide has been viewed for countless generations as:
  - ▶ a moral failing, a spiritual weakness
  - ▶ an inability to cope with life
  - ▶ “the coward’s way out”
  - ▶ A character flaw
- ▶ Our cultural view of suicide is wrong - invalidated by our current understanding of brain chemistry and it’s interaction with



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- ▶ The research evidence is overwhelming - depression is far more than a sad mood. It includes:
  1. **Weight gain/loss**
  2. **Sleep problems**
  3. **Sense of tiredness, exhaustion**
  4. **Sad or angry mood**
  5. **Loss of interest in pleasurable things, lack of motivation**
  6. **Irritability**
  7. **Confusion, loss of concentration, poor memory**
  8. **Negative thinking**
  9. **Withdrawal from friends and family**
  10. **Sometimes. suicidal thoughts**



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(DSMIVR, 2002)

- 20 years of brain research teaches that these symptoms are the **behavioral** result of
  - **Internal changes in the physical structure of the brain**
  - **Damage to brain cells in the hippocampus, amygdala and limbic system (5HPA axis)**
- As Diabetes is the result of low insulin production by the pancreas, depressed people suffer from a physical illness - what we might consider “faulty wiring”

(Braun, 2000; Surgeon General's Call To Action, 1999, Stoff &

## Faulty Wiring?

- ▶ Literally, damage to certain nerve cells in our brains - the result of too many stress hormones - cortisol, adrenaline and testosterone - hormones activated by our Autonomic Nervous System to protect us in times of danger
- ▶ Chronic stress causes a change in the functioning of the ANS, so that high levels of activation occur easily
- ▶ Constant activation of the ANS causes changes in muscle tension and imbalances in blood flow patterns leading to certain illnesses such as asthma, IBS and depression



## Faulty Wiring?

- ▶ Without a way to detach and go back to a baseline of rest, hormones accumulate in the brain, doing damage to brain cells
- ▶ Stress alone is not the problem, but how we interpret the event, thought or feeling
- ▶ People with **genetic predispositions**, placed in a highly **stressful environment** will experience damage to brain cells from stress hormones

## Possible Sources Of Depression

- ▶ **Genetic:** a predisposition to this problem may be present, and depressive diseases seem to run in families
- ▶ **Predisposing factors:** Childhood traumas, car accidents, brain injuries, abuse and domestic violence, poor parenting, growing up in an alcoholic home, chemotherapy
- ▶ **Immediate factors:** violent attack, illness, sudden loss or grief, loss of a relationship, any severe shock to the system

## Why Don't We Seek Treatment?

- ▶ We don't know we are experiencing a brain disorder - we don't recognize the symptoms
- ▶ When we talk to doctors, we are vague about symptoms
- ▶ Until recently, Doctors were as unlikely as the rest of the population to attend to depression symptoms
- ▶ We believe the things we are thinking and feeling are our fault, our failure, our weakness, not an illness
- ▶ We fear being stigmatized at work, at church,

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## What Happens If We Don't Treat Depression?

- ▶ Significant risk of increased alcohol and drug use
- ▶ Significant relationship problems
- ▶ Lost work days, lost productivity
- ▶ High risk for suicidal thoughts, attempts, and possibly death

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- ▶ Depression is a medical illness that will likely affect the person later in life, even after the initial episode improves
- ▶ Youth who experience a major depressive episode have a 70% chance of having a second major depressive episode within five years
- ▶ Many of the same problems that occurred with the first episode are likely to return, and may worsen

## Reduce Stigma

- ▶ Stigma about having mental health problems keeps people from seeking help or even acknowledging their problem
- ▶ Reducing the fear and shame we carry about having such “shameful” problems is critical
- ▶ People must learn that depression is truly a disorder that can be treated - not something to be ashamed of, not a weakness
- ▶ Learning about suicide makes it possible for us to overcome our fears about asking the “C” question

## Final Suggestions For Helping Your Congregation

- ▶ How many members of your congregation experience depression?
- ▶ Are they comfortable telling you about this vulnerable place in their life?
- ▶ Openness and discussion by church leaders about depression and suicidal thinking can free people to talk about their own situations
- ▶ Help your congregation to understand that depression is not a “loss of faith” or a spiritual failure
- ▶ Help people emerge from the stigma our culture has placed on this and other mental health problems
- ▶ Consider setting up depression/anxiety awareness and support groups

(Anderson, 1999)