RELIGIOUS INVOLVEMENT, ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP, AND PREFERENCES FOR ALTERNATIVE MENTAL HEALTH SETTINGS

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The undersigned, appointed by the Dean of the Graduate School, have examined the dissertation entitled

RELIGIOUS INVOLVEMENT, ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP, AND PREFERENCES FOR ALTERNATIVE MENTAL HEALTH SETTINGS

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A candidate for the degree of Doctor of Philosophy

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Abstract

Religion is an important diversity variable; however, it is an understudied area in psychology. The purpose of this study was to explore ways that religious factors interact with help-seeking attitudes as well as preferences for different help sources. Participants were 236 church members from 4 Christian groups. They completed religious measures, a help-seeking measure, and responses to mock brochures for traditional, nontraditional, and Christian mental health facilities. Both demographic and religious variables were found to predict help-seeking attitudes, although the relationships between help-seeking and religious predictors were less clear. Denominational differences were found in many of the religious variables. Several religious variables were related to the brochure responses, and the four denominations showed different patterns of preference for the brochures. Limitations and implications for practice and research are discussed.

Chapter 1 – Overview

Religion is a diversity-related construct that cuts across age, gender, race and ethnicity, education, and social class, and exerts profound effects on world view. Yet its effects on help-seeking attitudes and willingness to use mental health services have been understudied in the psychological literature. In this chapter, justification for a study of the relationships of the religious constructs of affiliation, commitment, belonging, and others to help-seeking attitudes and preferences for mental health services will be advanced. This justification reveals that religious factors have been underexamined, despite the great diversity of religion and its importance in the lives of many Americans. Research on religious constructs in mental health, coping, and psychotherapy will be reviewed briefly. The tendency of some religious individuals in distress to turn to resources other than mental health professionals will be highlighted. Finally, a rationale will be provided for the study of how religious constructs potentially are related to attitude toward psychological help-seeking and preference for different kinds of mental health services.

Religion as a Diversity Construct

According to the American Religion Data Archive (2000), which maintains a database of demographical, religious, social, and political data from a nationally representative sample, about 85% of people in the United States espouse some religious tradition. About 54% of these are Protestant, 24% are Catholic, 2% are Jewish, and 5% have some other religious affiliation. Wide variation exists between religious groups and among members of a given group on such dimensions as fundamentalism, values, and

degree of involvement in public and private religious activities. The differences in beliefs about these religious constructs underscore their potential influence on people's views of psychological help-seeking. They also make it clear that when studying religious constructs, it is necessary not only to examine people according to the religious group to which they belong, but also to explore the effects of variables such as level of religious commitment, affiliation with one's religious group, and level of religious activity.

Dearth of Research on Religion and Counseling and Psychotherapy

Counseling psychology has a long history of involvement with diversity issues in research, practice, and training. A growing body of scholarship has been advanced to improve therapists' knowledge and competence related to gender (e.g., Good & Brooks, 2005; Gilbert & Scher, 1998) and race and ethnicity (Ponterotto, Casas, Suzuki, & Alexander, 2001; Sue & Sue, 1999). Smaller bodies of research have begun to develop around other diversity issues including class, sexual orientation, disability, and religion. Religion, however, remains relatively underexamined by professionals in the social sciences. For example, the author's electronic search of the last 20 years in the Journal of Counseling Psychology and The Counseling Psychologist reveals 18 articles whose primary focus is religious constructs, five of these a major contribution and responses in a 1989 issue of The Counseling Psychologist (Bergin, 1989; Conway, 1989; Hendlin, 1989; McWhirter, 1989; Worthington, 1989). Much of what we know about religious constructs in mental health comes from studies in sociology, psychiatry, and clinical psychology. However, the literature in all these domains is limited when one searches for empirical research directly related to counseling and psychotherapy-related constructs.

Findings from Related Literature on Religion in Mental Health, Coping, and Psychotherapy

Literature in several areas can offer some insight into why religious constructs are important to help-seeking. Specifically, studies of how religion affects mental health, how people use religion to cope with stress and pain, and how religious constructs affect psychotherapy underscore the importance of giving attention to religious constructs in mental health fields. A number of studies (for a review, see Koenig, 1990) have examined the relationships between religious attitudes and behavior and various indicators of mental health. Although some findings have been equivocal, religious involvement tends to display a positive correlation with mental health. It is possible that religion provides a structure for making meaning in life and for dealing with physical and emotional pain (Koenig, 1990). Religious coping strategies such as prayer and attendance at religious services, in fact, are some individuals' primary means of coping with stressful events (Koenig, 1990; Pargament & Brant, 1998; Schnittker, 2001), although perceptions about the effectiveness of these strategies vary (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). Finally, many researchers and theorists (Bergin, 1980a, 1980b; Ellis, 1980; Walls, 1980) have engaged in study and debate about how religious values and attitudes affect psychotherapy. Some (Bergin, 1980a, 1980b, 1991; Griffith, 1982; Kelly & Strupp, 1992; Koenig, 1990) have argued that psychologists and other mental health professionals should give greater attention and respect to religious constructs that are relevant to their clients, whereas others (Ellis, 1980; Walls, 1980) have cautioned against accepting clients' religious values without careful examination of their effects on mental health. Some researchers (Bergin, 1991; Kelly & Strupp, 1992;

Shafranske & Gorsuch, 1984) have focused on a possible "gap" in religiosity between mental health professionals and client populations. Other studies (Kelly & Strupp, 1992; Shafranske & Gorsuch, 1984) have examined psychotherapy outcomes and their relationship to religious similarity or dissimilarity between client and provider.

Taken together, this body of research seems to indicate that religious constructs can have important effects on mental health, coping, and psychotherapy relationships, process, and outcome. Also essential to our understanding of religious constructs and psychology is the issue of how religious constructs affect help-seeking patterns. It is this literature that is of most relevance in the current research.

Religion and Help-Seeking Attitudes and Behaviors

If mental health professionals are to offer services appropriate to clients with different religious affiliation and involvement, a necessary step is to examine the attitudes of religious individuals toward mental health services and their willingness to seek professional help. It is also important to explore what types of services religious individuals prefer once they have decided to seek help from professionals. Research has shown that religious factors can have an effect on help-seeking patterns; the findings will be summarized here.

Some evidence exists to indicate that people from some religious groups may be less likely than others to seek help from mental health professionals in times of distress. Data from several studies (King, 1978; Neighbors, Musick, & Williams, 1998; Purdy, Simari, & Colon, 1983; Woods, 1977) suggest that for some church member populations, pastors rather than mental health professionals are often the first source of help. In these cases, the presence of clergy may reduce church members' perceived need for other

forms of help. A qualitative study conducted in Great Britain indicated that members of a church of evangelical Christians viewed mental health professionals as cold, impersonal, relatively ineffective, and neglecting or even rejecting of spiritual concerns (Mitchell & Baker, 2000). On the other hand, people in a Norwegian study who contacted priests for help were more willing to contact help in general, suggesting a pattern of general rather than source-specific help-seeking (Sørgaard, Sørensen, Sandanger, Ingebrigtsen, & Dalgard, 1996).

Among religious individuals who do seek out mental health services rather than the help of clergy, many look for professionals who espouse religious values similar to their own (Worthington, 1991). Sensitivity to religious issues may be a helpful factor in beginning and maintaining therapeutic relationships with these clients. "Integrating religious themes into psychotherapy…may be particularly helpful in maintaining patient interest and cooperation. This is particularly true for those who may be fearful of psychiatrists in general and reluctant to seek counseling" (Koenig, 1990, p. 44).

Rationale for the Current Study

Few studies have been concerned with religious constructs and psychological help-seeking attitudes and behavior. Of the studies currently in the literature, the results of some have focused mainly on expressed preference for or actual use of religious leaders as sources of help (Neighbors, Musick, & Williams, 1998; Purdy, Simari, & Colon, 1983; Woods, 1977). Others have compared attitudes of religious populations toward different help sources (Loewenthal et al., 2001; Mitchell & Baker, 2000) or compared help-seeking attitudes of different religious populations (Fischer & Cohen, 1972; Loewenthal et al., 2001). However, few have examined level of religious

commitment and belonging in relation to attitudes toward seeking professional help. Additionally, in the existing studies there is little consistency in measurement of religious or help-seeking constructs. A rigorous study of religious constructs as they relate to help-seeking attitudes could help to fill a gap in psychologists' understanding of factors that can encourage or discourage potential clients who consider seeking their help.

In addition to exploring religious involvement and help-seeking attitudes, it is necessary to determine whether different types of mental health services are more appealing to religious clients than others. Although we know that some religious clients seek out professionals with explicitly stated religious affiliation (Worthington, 1991), it would be helpful to know what preferences potential clients may have when presented with different types of mental health services including psychotherapy, coaching, and therapy designed to be sensitive to spiritual concerns. Learning more about potential clients' preferences for different kinds of services will enable the profession to better understand how much need exists for alternative approaches, and could assist mental health professionals in marketing their skills more effectively.

Purpose of the Study

Research on religious constructs and how they affect help-seeking attitudes in mental health settings is lacking in the psychology literature, despite the potential impact these relationships could have on utilization of mental health resources. Therefore, the current study had two purposes. First, the study examined psychological help-seeking attitudes and their relationships to several religious constructs in four Christian religious groups (Roman Catholic, Southern Baptist, United Methodist, and Mennonite Church USA). Religious constructs were tested as predictors of help-seeking attitudes, and the

four groups of participants were compared for denominational differences in religious constructs and help-seeking attitudes. Second, the study elicited ratings of descriptions of three different types of mental health facilities, and explored the relationships between religious constructs and participants' stated likelihood of using these facilities. Religious constructs were correlated to responses to each description, and the four groups of participants were compared for denominational differences in likelihood of using each facility.

Christian religious groups were chosen for several reasons. First, the variety of religious groups is too great to enable inclusion of all possible groups in the present study. Even within Christianity there is enough diversity among groups to make subgrouping desirable for purposes of sampling control. Second, it was necessary to limit the number of sampled religious groups in order to obtain a sufficient number of participants in each group to enable comparisons. Third, Christian groups were chosen because they are the most widely endorsed religious affiliations for U.S. residents (American Religion Data Archive, 2000), and thus provide results that are most representative of Americans. Finally, large populations of people affiliated with other religions (e.g., Jews, Muslims, Buddhists) would have been difficult to recruit in the Midwest, especially given that sampling was done in religious services.

Once the current research was narrowed to Christian groups, population statistics and personal interest were used to determine which specific groups within Christianity would be included. According to the Handbook of Denominations in the United States (Mead & Hill, 2001) and the American Religion Data Archive (2000), the largest specific denominations within Christianity in the U.S. are Roman Catholics, Southern Baptists,

and United Methodists. Hence, these three groups were included in the present study. Mennonites were added to the study because of their history of emphasis on community, separation from the world, self-sufficiency, a life centered around Biblical teachings, and involvement in mental health reform. Brief descriptions of each denomination as well as more information about the reasons for interest in Mennonites are discussed further in the literature review to follow.

In addition to religious affiliation with a denomination, several other religious constructs were examined in the current study as well. The choice of these constructs was complicated by the fact that measurement of religious constructs is characterized by lack of clear definitions, an abundance of attempts to identify dimensions of religion and religious involvement, a dearth of psychometrically sound measures, and reliance on single-item indicators. After examining the literature, it was determined that the following religious constructs would be included in the current study: religious commitment, religious belonging, organized religious activity, time in the religious body, acceptance of church teachings, self-perceived religiosity, perception of church conservatism/liberalism, and perception of church help-seeking attitudes. For definitions of these terms and a rationale for their inclusion, see the Literature Review which follows.

Research Questions and Hypotheses

Five questions were examined in the current study. These questions and hypotheses regarding the expected relationships are included in this section.

Question 1: What demographic variables predict attitudes toward seeking professional psychological help? The following demographics were included: age, gender,

race/ethnicity, urban/rural status, education, socioeconomic status, and previous help-seeking experiences.

Hypothesis 1: Demographic correlates of help-seeking attitudes will be similar to those found in previous studies; specifically, women, urban residence, greater education, higher SES, and previously seeking psychological help will be associated with more favorable attitudes toward seeking psychological assistance.

Question 2: What religious variables predict attitudes toward seeking professional psychological help?

Hypothesis 2: Religious commitment, religious belonging, and organized religious activity will all contribute to predicting attitudes toward psychological help-seeking.

Hypothesis 3: Perception of one's church as more conservative will be associated with less favorable help-seeking attitudes, and perception of one's church as more liberal will be associated with more favorable help-seeking attitudes.

Question 3: Are there denominational differences in the religious variables examined in this study? No hypothesis was offered for this question; it was purely exploratory.

Question 4: What religious variables are related to church members' responses when presented with descriptions of three different mental health facilities?

Hypothesis 4: Higher religious commitment, greater religious belonging, higher levels of organized religious activity, and/or stronger perception of one's church as conservative will be associated with higher likelihood ratings for a description of an explicitly Christian facility.

Question 5: Are there denominational differences in response when presented with descriptions of three different mental health facilities? No hypothesis was offered for this question; it was purely exploratory.

Chapter 2 – Literature Review

A large body of research investigates help-seeking attitudes and behavior, and help-seeking for psychological or emotional problems in particular. These attitudes and behaviors will be discussed as they relate to a number of different help sources; however, of particular interest to psychologists are patterns in seeking help from mental health professionals. In this review, studies on demographic, sociocultural, and personal factors in help-seeking will be briefly described, and religion will be identified as an understudied area of diversity. Research on religious factors in mental health, religious coping strategies, and religion and values in psychotherapy will be reviewed. Then studies on religious constructs in attitudes toward seeking psychological help will be examined in some detail. Research assessing consumer responses to different types of helping professionals and mental health settings will be reviewed as it pertains to religious issues in help-seeking. Issues in methodology and particularly measurement of religious constructs will be highlighted. Finally, the purpose and research questions for the current study will be described. Before the review can begin, however, it is necessary to define the help-seeking attitudes of interest.

Attitudes toward seeking professional psychological help have been defined as "tendency to seek or to resist professional aid during a personal crisis or following prolonged psychological discomfort" (Fischer & Turner, 1970, p. 79), and as "willingness to seek help from mental health professionals when one's personal-emotional state warrants it" (Fischer & Farina, 1995, p. 371). It is assumed that these attitudes are related to actual help-seeking behavior, and are thus important for

understanding how professionals can make their services accessible and attractive to consumers.

Demographic, Sociocultural, and Personal Factors in Help-Seeking

A number of demographic and sociocultural factors have been related to attitudes toward seeking psychological help. Researchers have found that women are more likely than men to seek help and to have favorable attitudes toward help-seeking (Fischer & Farina, 1995; Komiya, Good, & Sherrod, 2000; Neighbors, Musick, & Williams, 1998; Sørgaard et al., 1996). A strong sense of cultural affiliation has been associated with less favorable attitudes toward seeking mental health practitioners in some ethnic groups, including Asian Americans (Atkinson & Gim, 1989), American Indians (Price & McNeill, 1992), and Mexican Americans (Sanchez & Atkinson, 1983). Higher levels of education are positively correlated with favorable attitudes, and social science majors display more favorable attitudes than other students (Fischer & Cohen, 1972). People from lower social or economic classes are less likely to seek therapy (Tessler & Schwarts, 1972) and more likely to drop out prematurely (Imber, Nash, & Stone, 1955; Kandel, 1966). Contact with the mental health discipline, practitioners, or facilities is related to more favorable attitudes toward seeking psychological help (Fischer & Cohen, 1972; Fischer & Turner, 1970; Gelso & McKenzie, 1973; Murstein & Fontaine, 1993).

Some personal factors are also correlated with help-seeking attitudes. High authoritarianism and an external locus of control have been associated with more negative attitudes, whereas trust is related to more positive attitudes, particularly for men (Fischer & Turner, 1970). Emotional openness has been associated with more favorable help-seeking attitudes (Komiya, Good, & Sherrod, 2000). Greater psychological distress

is correlated with more favorable attitudes, while perception of stigma associated with seeking psychological help was related to more negative attitudes (Komiya, Good, & Sherrod, 2000).

It is clear that a wide variety of factors can affect the likelihood that a person will seek professional psychological help during times of stress, emotional upset, or crisis. One factor that has been understudied is religious affiliation and involvement. According to the American Religion Data Archive (2000), which maintains a database of demographical, religious, social, and political data from a national probability sample, about 85% of people in the United States espouse some religious tradition. About 54% of them are Protestant, 24% are Catholic, 2% are Jewish, and 5% have some other religious affiliation. Wide variation exists between groups and among members of groups on such constructs as fundamentalism, conservatism-liberalism, and degree of involvement. For example, in the population as a whole, attendance at religious services ranges from never (21%) or less than once per month (33%) to once a week or more (29%), with the rest of the population somewhere between. People also vary widely in the time spent in private religious activities such as prayer, study, and meditation. These differences underscore the great diversity of potential clients when viewed according to religious constructs. It also makes it clear that when studying religious constructs, it is necessary not only to examine people according to the religious group to which they belong, but also to explore the effects of level of affiliation with that group and level of public and private religious activity.

Because religion is a source of such diversity, it should be studied for its relationships with constructs related to mental health and counseling services. Several

general topics for research can be identified in the research, including religion and mental health, religion and coping, and religion and psychotherapy. These bodies of research will be summarized next.

Religious Factors in Mental Health

A great deal of scholarship has been dedicated to the issue of how religious attitudes and behavior are related to mental health. Koenig (1990) reviewed a number of studies on religious factors in later life, focusing on adults from the Judeo-Christian tradition. He concluded that although there are some equivocal findings, religious attitudes and behavior tend to display a positive correlation with indicators of mental health (e.g., well-being and life satisfaction), as well as functional status and satisfaction with health. These relationships were stronger for women, African Americans, and the very elderly. Koenig pointed out several limitations, including mixed findings about the strength of the relationship, a preponderance of studies conducted in the Midwest and South, geographical regions in which rates of participation in organized religious activities tend to be higher, and the possibility of studies with nonsignificant results failing to reach publication. Despite the limitations, he hypothesized that religion may offer a structure based in culture and worldview that provides meaning in life and allows older people to deal with issues of mortality, grief, and illness.

If religious involvement does indeed contribute to mental health, then a related question is how religion affects people who are experiencing psychological distress. Three major areas of research have been precipitated by this question: first, studies on religious coping strategies; second, research on how religious factors affect psychotherapy; and third, studies on how religion affects help-seeking behavior.

Although help-seeking attitudes are the focus of the current study, all three areas of research are relevant in examining help-seeking. For some people in psychological distress, religious coping strategies are the primary means of managing stress and emotional pain, and can therefore either supplement or take the place of any professional help the individual might receive (Corbett, 1998; Koenig, 1990). If individuals receive enough relief through religious coping strategies, they will not seek mental health services. Religious factors can also influence the course of therapy or counseling if people do choose to seek professional psychological help, and a number of scholars have explored how religious issues affect psychotherapy relationships, process, and outcomes (Griffith, 1982; Kelly & Strupp, 1992; Shafranske & Gorsuch, 1984). The literature on religious coping strategies and religion in psychotherapy will therefore be reviewed briefly here.

Religious Coping Strategies

Religious coping includes such strategies as faith, personal prayer, others' prayer, attending religious services, maintaining religious practices, and consultation with religious leaders. For some clients, these coping mechanisms are the primary means of managing stress and solving problems. Studies that assess the frequency with which people use these strategies found that religious coping is common among older adults in stressful situations (Koenig, 1990) and particularly among African American women (Corbett, 1998). However, studies that examine beliefs about religious coping produce more mixed results. Loewenthal and her colleagues (2001) conducted a study of British university students from a wide variety of religions and a no-religion group and found that religious coping, although rated as somewhat effective, was considered relatively

ineffective compared with social and cognitive coping methods. People who were members of some religion rated religious coping as more effective than people who claimed no religion; however, their ratings were still lower than their ratings of other coping strategies. Finally, studies that have explored relationships between religious coping and mental health constructs also show mixed results. Although Koenig (1990) reviewed studies showing that religious coping helped some people deal with emotional pain, Loewenthal et al. (2001) found that beliefs about coping methods were not related to the experience of depression. It seems, then, that religious coping can be helpful sometimes and ineffective or even harmful at other times.

Religion and Values Issues in Psychotherapy

The issue of values in psychotherapy has been subjected to lively debate and testing. Bergin (1980a) asserted that values were an "inevitable and pervasive" aspect of therapy (p. 97), and that values were part of the common or process factors that spread across theoretical orientations. He argued that pragmatic and humanistic values, while overlapping with religious values and offering much to psychotherapy, often excluded religious values from consideration and sometimes clashed with religious values. He saw these philosophies as a source of contrast between clinicians and many of their clients, and he called for greater consideration of religious values. Bergin also challenged professionals to acknowledge their value systems and make them explicit rather than implicit in therapy, while respecting the values of others. Moreover, he argued that all values should be subjected to evaluation and testing to determine their utility in therapy. Bergin's work drew some criticism, mainly from scholars who objected to his one-sided portrayal of humanism and who pointed out some harmful effects of absolutistic,

unexamined religious values (Ellis, 1980; Walls, 1980). In return, Bergin (1980b) reasserted that overlap existed, that points of difference could be important, and that therapists must be explicit about their values and test them carefully. He agreed that religion, because it is so diverse, can have both healthy and unhealthy effects, and he called for research to explore these effects further.

Several researchers have discussed a possible "gap" in religiosity between psychologists and the populations they serve. Shafranske and Gorsuch (1984) point out that psychology has rarely focused attention on spiritual or religious experience, suggesting that this neglect of spiritual issues may have resulted from psychology's attempts to earn credibility as a scientific field by distancing itself from philosophy. They found that clinical psychologists in California were less likely to belong to and participate in organized religious groups than the rest of the population, and that although they generally saw spirituality as relevant to their personal lives, they were more likely than the general population to espouse some kind of alternative spiritual path rather than traditional religions. It is unclear how much geographical or self-selection factors (their response rate was low) limited the applicability their findings. However, other researchers have had parallel results. Bergin (1991) found that when compared with the general population, a smaller proportion of mental health professionals claimed a Christian religious preference and/or said that their lives were based on their religious beliefs; and Kelly and Strupp (1992), when asking therapists and clients to rank order basic values, found that therapists ranked salvation lower than did clients.

Researchers have also explored how religious issues are addressed in therapy. Worthington (1988) hypothesized that individuals with high religious commitment would

resist counseling or prematurely terminate if they perceived counselor values as too different from their own. In contrast, Kelly and Strupp (1992) found that therapy outcomes were best when a balance of similar and dissimilar values was present between therapist and client. However in the same study, values placed on salvation (the only religious value tested) followed a slightly different pattern that was more compatible with Worthington's (1988) model. Values on salvation were usually perceived as either very important or very unimportant, and similarity between therapist and client on this variable was correlated with positive outcome as measured by independent observers. Shafranske and Gorsuch (1984) focused on the clinician's view rather than the client's and found that clinical psychologists were more likely to see spiritual issues as relevant to therapeutic work if they perceived spirituality as relevant in their personal lives. They commented that most had little to no training in working with spiritual/religious issues and argued that because of this lack of training, spiritual issues were likely to be understood through the clinician's personal framework rather than in the client's world view.

Expressing concern about the religious and values issues that can affect outcomes, some scholars have asserted the need for mental health professionals to be sensitive to religious issues in psychotherapy. Kelly and Strupp (1992), for example, commented that matching on religious values may not be as important as matching with therapists who can understand clients' religious values. In cases where worldviews are drastically different and misunderstanding is likely to occur, Griffith (1982) recommends the use of a "culture broker" to clarify differences in belief. Bergin (1991) and Koenig (1990) suggest that religious clients may benefit most from seeing professionals sympathetic to

their spiritual values. Bergin (1991) posits, "It would be unethical to trample on the values of clients, and it would be unwise to focus on value issues when other issues may be at the nucleus of the disorder…It is vital to be open about values but not coercive, to be a competent professional and not a missionary for a particular belief, and at the same time to be honest enough to recognize how one's value commitments may or may not promote health" (p. 399). Similarly, Koenig (1990) states, "Addressing religious issues in a sensitive and respectful manner may help the therapist to enter into a deeper therapeutic relationship with the religious older patient and engage them on the same level at which they are struggling with problems" (p. 40). He argues that the extent to which this should be done would depend on the professional's willingness, knowledge, and skill in this area, as well as ability to do so with respect, acceptance, and nonjudgment.

In general, the consensus among scholars in this area is that religious constructs do have important implications in therapy, and that thoughtful attention to these issues can result in better care for clients.

Religious Factors in Attitudes Toward Seeking Psychological Help

Some of the literature on religion and psychological help-seeking has focused on seeking help from a religious leader in times of distress. Other literature focuses on the attitudes of different religious groups and individuals toward help sources and toward professional help-seeking. Each of these areas will be examined in the following sections.

Help-seeking with religious leaders. Several studies (King, 1978; Neighbors, Musick, & Williams, 1998; Purdy, Simari, and Colon, 1983; Sørgaard, et al., 1996) focus

on the tendency of some groups to seek help from religious leaders rather than mental health professionals. King (1978) found that among evangelical Christians, a majority of those who sought help for psychological difficulties went to their pastors. They also found that pastors were spending increasing amounts of time in providing counseling or support for psychological and relationship difficulties. Purdy and her colleagues (1983) examined religiosity, knowledge of mental illness, and use of pastors for help in Puerto Rican and African American Pentecostal church members in the South Bronx area of New York City. They concluded that there were no significant differences within or between groups on the religiosity and knowledge dimensions. They also noted that when they provided a list of helpers and asked participants which helper they would consult for 19 specific problems, a pastor was the most commonly chosen source of help for 12 of the issues, despite the fact that some of them (e.g., feeling alone or sad, intrusive thoughts, suicidality) could be considered areas of expertise for mental health professionals.

As part of an effort to evaluate the results of decentralizing Norway's mental health system in 1983, Sørgaard et al. (1996) examined help-seeking patterns among 2,478 Norwegians in an urban and a rural area in 1983 and 1990. They included a wide range of help sources, from general practitioners to psychologists to priests. The researchers found that help-seeking increased in the rural area from 1983 to 1990; and that the urban and rural samples did not differ in their use of priests as a help source. Those who placed higher importance on religious beliefs, and those who had experienced a personal loss were slightly more likely than others to seek help from priests. People contacting priests were more willing to seek help in general. No differences in

satisfaction were found between those who sought help from priests and those who did not. The researchers concluded that there was no clear evidence for a "religiosity gap" between potential clients and mental health professionals.

Neighbors, Musick, and Williams (1998) used data collected as part of the National Survey of Black Americans to examine African American church members' use of ministers as help sources in times of crisis. Over 2000 African Americans chosen as representative of the African American population were surveyed in face-to-face interviews. They were asked to think of a "stressful episode" in their past and assessed for utilization of help sources in the context of that episode. The researchers found that most people reported no help-seeking. Of those who did seek help, most went to only one source, and ministers were the first source of help about one fourth of the time. People who went to ministers first were less likely than others to seek out any further help; the researchers speculated about whether this was because clergy did not make referrals, or whether the people received the help they needed. Of people who received help from only one source, people who had gone to ministers were more likely to return to the same help source or recommend it to others.

Neighbors, Musick, and Williams pointed out that informal support from ministers as part of a cohesive social network was important and helpful, and that ministers were uniquely qualified to offer primary psychological help and referrals because of their accessibility and respected status in the community, as well as their expertise around certain issues (e.g., death and grief). However, they asserted that most clergy receive either inadequate or no psychological training, and are therefore not as qualified as mental health practitioners to assist with their congregations' more serious

psychological problems. The researchers also expressed concern that support from ministers could have the unintended effect of reducing perceived need for other help such that people who needed specialized mental health services sometimes would not seek out those services. They called for improved communication between clergy and mental health professionals, and training for clergy in recognizing psychological problems that would merit referral to specialized services.

These studies highlight the tendency of some populations to seek out help from religious leaders, and the need for better communication between religious leaders and mental health professionals. However, methodological and sampling issues make generalization from their results very difficult. In the Purdy, Simari, and Colon (1983) study, all measures seem to have been brief sets of questions written by the researchers. No psychometric estimates or standardization were reported. No correlations or other statistical analyses are reported; conclusions seem to have been based on frequencies of high, medium, and low scores on their measures. Given these problems, it is difficult to assess whether the results are reliable or generalizable. Sørgaard et al. (1996) studied religious issues in Norway, where there is one national Lutheran church in which 90% of the population are members, but only 10% participate regularly in common religious activities. This limits the generalizability of their findings to U.S. populations, where religious affiliation is much more diverse and participation is higher. Neighbors, Musick, and Williams (1998) commented that the data was collected 20 years before the article was written (i.e., around 1977), and the response rate (67%) was low for face-to-face survey research. Their method of assessing problem severity and help sought depended heavily on participants' memories for events that may have happened years before. Also,

a few untestable assumptions were made: first, that the ministers consulted by participants were also African American; and second, that any help sought after the first help source was a result of referral by that help source.

From studies of clergy as help sources, researchers have concluded that some populations are likely to seek help from their religious leaders first, and thus, that educational and referral relationships between mental health professionals and religious leaders are important to serve the populations for whose needs they share responsibility. Other researchers have chosen to recruit participants representing various religious groups and assess their attitudes toward various types of help sources, both religious and secular. This literature is reviewed in the following section.

Attitudes of religious groups and individuals toward help sources. Two studies conducted in Great Britain have examined psychological help-seeking in a diverse sample of university students and a homogeneous group of highly committed Christians. Loewenthal et al. (2001) found that across a number of major religious traditions, medical and psychotherapeutic help strategies were seen as somewhat effective, but relatively ineffective compared to social and cognitive coping strategies. Belief in religious coping efficacy was positively related to intention to seek religious help and social help. Loewenthal and her colleagues commented that this data suggested an active coping style in which those who were willing to seek one kind of help were willing to consult multiple help sources.

Strikingly different results were obtained from a qualitative study by Mitchell and Baker (2000). They interviewed 14 members of a London church made up of "committed evangelical charismatic Christians" (p. 290) who had never experienced

therapy to explore their views and preferences about various sources of help. In the interviews, participants compared and contrasted Christian and non-Christian, professional and non-professional help sources and discussed factors that were important to them in choosing a helper. The researchers found four main themes that were common across participants. First, they believed in a spiritual dimension with good and evil influences, and they preferred helpers who shared this worldview (that is, Christian friends and Christian professionals such as clergy). Second, a sense of familiarity, trust, and safety was important to them, and these factors were assumed present in pre-existing relationships and the church community. Third, they respected secular professionals' training and ethic of confidentiality, but also viewed secular professionals as cold, impersonal, and neglecting or even rejecting of spiritual issues. Fourth, the participants wanted helpers with some degree of authority, and viewed prior relationships and church hierarchy as ways to earn the power needed to influence another person's life.

Although Mitchell and Baker (2000) had conceptualized their list of help sources as a 2X2 matrix with Christian/non-Christian and professional/non-professional dimensions, the participants seemed to evaluate the help sources by a different scheme. Any Christian help source, whether professional or not, was viewed as effective, warm, safe, and addressing spiritual concerns; any non-Christian, non-professional help source (e.g., astrologer, spiritualist healer) was viewed as dangerous and causing harm. Secular professionals were viewed with more ambivalence. Although valued for their professionalism and knowledge base, help from secular professionals was generally seen as limited, short-term, and superficial. Their small sample, "chosen for vivid illustration rather than for representativeness" (p. 299), presents obvious problems of

generalizability. The participants are likely to represent the highly religious end of the continuum, and their lack of contact with the mental health field may confound the results. However, the authors speculated that similar issues may be present in more subtle form for Christians generally. They concluded that for some clients, religious issues may be more salient than mental health professionals realize, and remarked "the present results suggest that the provision of services which are user-friendly for Christians may involve awareness of issues about which they may not openly speak, but which may affect their compliance" (p. 299). They suggested further research with more diverse religious groups.

Mitchell and Baker's (2000) results are congruent with other studies (King, 1978; Worthington, 1991) that have found evidence that religious populations desire congruity between their own values or religious affiliations and those of their helpers. Although some studies reviewed by Worthington (1991) suggested that similarity in religious values did not lead to improved outcome, Worthington posits that for some highly religious clients, lack of congruence between therapist and client affiliation or values may cause them not to begin therapy, or to terminate prematurely. Similarly, King (1978) found that among evangelical Christians, religious constructs were important considerations for their help-seeking patterns. Among those who sought professional counseling, most found counseling not to be a threat to their faith. Some participants, however, were dissatisfied with available services and cited concerns that their faith would be misunderstood or unappreciated as their primary criticism. Those who agreed strongly with church doctrine were less likely to seek professional counseling than those who did not agree strongly with church doctrine.

Findings about attitudes of religious groups toward different help sources have sometimes been contradictory, but most studies have found that religious populations may prefer helpers whose values are relatively compatible with their own, whether these helpers are professional mental health providers or not. A final body of research in the area of religious factors in help seeking focuses directly on religious populations' attitudes toward seeking help from mental health practitioners specifically. This area has been understudied; the research that has been completed on this topic is described below.

Attitudes of religious groups and individuals toward seeking professional help. Some studies have found evidence of differences among religious groups in their attitudes toward psychological help-seeking. For example, in several studies Jewish participants have displayed somewhat more favorable attitudes toward seeking psychological help than members of other groups; however this difference has not exhibited robust findings (Fischer & Cohen, 1972; Loewenthal et al., 2001).

The research reviewed here on help-seeking attitudes is very important for the understanding of how people think and feel about getting professional psychological help. It can also be applied to the study of behavioral decisions to obtain or not to obtain mental health services. However, attitude toward seeking psychological help is not the only factor that must be considered when help-seeking decisions are being studied. Once a person has decided to consider getting psychological help, it is important to understand how he or she will choose specific mental health services or providers. A construct that is relevant to this question is that of consumer responses to various help alternatives. A review of research on the ways that information about counseling service alternatives can affect one's choice of mental health services is included in the next section.

Consumer Responses to Different Kinds of Helping Professionals and Settings

There are a number of ways in which previous information about or contact with mental health services can affect people's attitudes toward and choice of providers or settings. Contact with the mental health discipline, practitioners, or facilities is related to more favorable attitudes toward seeking psychological help (Fischer & Cohen, 1972; Fischer & Turner, 1970; Gelso & McKenzie, 1973; Murstein & Fontaine, 1993). The provision of information about mental health services has also been associated with more positive help-seeking attitudes (Kaminetzky, 2001). Meanwhile, psychologists are recognizing the need to provide more culturally sensitive mental health services for diverse populations (Sue & Sue, 1999). Komiya, Good, and Sherrod (2000) recommended that psychologists attempt to reduce the barriers associated with psychological help-seeking by offering information to the public about the availability of mental health professionals who will work with clients and honor their desire to stay in control of what happens in therapy. They also suggest approaching barriers to help-seeking both by framing mental health services in terms of consultation, coaching, seminars, or classes, and by helping to educate the public about the value of self awareness.

Given evidence of some religious groups' preference for religious help sources and less favorable attitudes toward seeking professional psychological help, it seems reasonable to hypothesize that some religious groups would prefer alternative services similar to those described in a study by Robertson and Fitzgerald (1992). Their research was designed to address the issue of how mental health services can be presented most attractively to clients, and its methodology is parallel to the method intended for the

present research. The authors reviewed extensive research about men's underutilization of counseling services and reluctance to seek psychological help. They theorized that this hesitancy to seek counseling and psychotherapy may be related to male gender role socialization. They pointed out that traditional male gender role socialization teaches men to emphasize independence, competition, success, power, and rational thought. Yet traditional counseling and psychotherapy involves a process of seeking help, cooperation, revealing vulnerability, self-awareness, and emotional expression. While neither attitude is necessarily "wrong," the differences between them may explain why men are more reluctant than women to seek mental health services. In a study of 445 male students from a wide variety of backgrounds and interests, Robertson and Fitzgerald found support for this theory. Specifically, men with more adherence to traditional masculine norms displayed less favorable attitudes toward seeking professional psychological help, whereas men with less adherence to traditional norms displayed more favorable help-seeking attitudes.

Robertson and Fitzgerald (1992) also designed a procedure to examine whether negative attitudes toward help-seeking could be lessened by presenting mental health services in a way that was more consistent with traditional masculine interaction. They asked their participants to participate in a marketing study for campus services. They then presented each participant with one of two "advertising brochures" and asked them to offer their evaluations of the brochure. The two brochures contained the same graphics, style, and length. Both identified the same set of general issues that could be addressed at a center, and both contained parallel information about staff competence, costs, appointments, and waiting periods. However, different specific services were

included. One brochure described traditional college counseling center services; the other described alternative services such as classes, seminars, workshops, and a self-help library. The participants were given a list of common problems, and asked to rate their likelihood of seeking help at the center if they were experiencing each problem. It was hypothesized that men who displayed more adherence to traditional masculine norms and negative attitudes toward traditional help-seeking would be more positive toward the alternative services presented in the second brochure. The researchers found support for their hypothesis; among men who indicated positive attitudes toward traditional counseling, the brochures made almost no difference. However, men who scored higher on measures of masculinity and lower on help-seeking scales preferred the alternative brochure. They concluded that although men's preferences could not necessarily be assumed to predict actual use of alternative services, their findings offered reasonable support for the idea that some people who did not use traditional counseling would seek help in alternative settings.

Robertson and Fitzgerald's (1992) study highlighted the possibility that using different vocabulary and framing services in different ways may encourage people who have negative attitudes toward traditional counseling to use the mental health services available to them. They found that for some potential clients, programs that emphasized problem-solving and self-help approaches may be more attractive than insight oriented or emotionally focused therapy. In their view, their findings were consistent with counseling psychology's emphasis on the use of culturally sensitive formats for providing services.

The rationale and methodology described in Robertson and Fitzgerald (1992) provides a way to examine the possibility that different religious groups would respond differentially to alternative mental health services. A study of a religious sample could examine responses to traditional counseling services, more problem-solving oriented services, and services in a specifically religious setting. It is possible that religious constructs could predict preference for one or both alternative mental health settings over traditional counseling. The current study had two purposes: (1) to explore relationships between religious constructs and attitudes toward seeking professional psychological help; and (2) to examine religious constructs as they pertain to preferences for different mental health service formats.

Before a study of religious and help-seeking constructs could begin, however, several methodological issues needed to be addressed. The following section describes these issues and the solutions chosen for the current research.

Methodological Issues

This integrative review of previous literature on religion and help-seeking highlights numerous methodological flaws. If the question of how religious constructs affect help-seeking was to be explored and this area of research advanced, there were a number of sampling and measurement issues that needed to be addressed. The following section highlights these issues and outlines how the present study addressed them. First, problems in sampling are discussed, and the population chosen for the current research is described. Second, challenges in measuring religious constructs are addressed. Serious problems, including inconsistent use of religious constructs and lack of stable measures, are outlined; and the rationale for the measures chosen in the present research is included.

Problems in sampling. Much of the research on religious constructs in mental health, psychotherapy, and help-seeking is characterized by problems in sampling. Some studies (e.g., Loewenthal et al., 2001) have neglected to purposefully choose religious groups of interest; the result has often been that the participants are from such a wide variety of religious traditions that categorizing them into groups becomes difficult. Some religions are overrepresented, while others have too few participants to be analyzed as a discrete group. Other studies (e.g., Mitchell & Baker, 2000) have included overly specific religious groups from which to sample. When all or most participants have come from one or two congregations, it is difficult to make any generalizations about the factors under investigation. Results could be attributable to factors in the local congregation. This same problem is present to a lesser degree when all or most participants come from one religious denomination. A balance needed to be found between complete lack of control over participants' religious affiliation and sampling methods too narrow for any generalization of results.

Population chosen for the current study. For the current research, it was decided to focus on Christian religious groups only. This decision is consistent with findings that 78% of people in the U.S. identify themselves as either Catholic or Protestant (American Religion Data Archive, 2000), and limiting the sample to one major religion was thought to lend enough coherence to make the data more interpretable. It was decided to recruit participants from the three largest Christian denominations in the United States, which are the Roman Catholic Church, the Southern Baptist Convention, and the United Methodist Church, according to the Handbook of Denominations in the United States (11th ed.) (Mead and Hill, 2001) and the American Religion Data Archive (2000). A

fourth denomination, Mennonite Church USA, was included because it was of special interest to the researcher. A description of each denomination is found in the following sections. Unless otherwise indicated, information in these descriptions is drawn from Mead and Hill (2001).

Roman Catholic Church. The Roman Catholic Church is the largest Christian body worldwide, and the largest single religious body in the United States. Its U.S. membership is composed of over 62 million members in more than 19 thousand parishes. The Catholic Church defines its history as a continuous institution of faith since the time of the apostles, and much of its doctrine was established by Church Fathers in the 1st through the 8th centuries. The Protestant Reformation of the 15th-16th centuries brought great changes, including more clear definitions of doctrine and internal reform. The Roman Catholic Church is governed by a hierarchical structure of priests, bishops, archbishops, and cardinals, and headed by the pope. Religious orders composed of monks, friars, and nuns are responsible for much of its work in education, missions, social work, health care, and charitable institutions. Its doctrine and practices are founded on faith originated in Christ and sustained through the Bible and tradition. Historical emphases have included a sense of institution and loyalty, the Mass as the primary means of worship, the sacraments as a visible means of receiving God's grace, remembrance and veneration of saints, and Mary mother of Jesus as an intercessor for the faithful.

Southern Baptist Convention. Baptist churches grew out of English Puritanism in the early 17th century. They were influenced by Calvinist doctrine, as well as the Anabaptist/ Mennonite practice of "believer's baptism" (adult baptism on confession of

faith), emphasis on the authority of scripture, separation of church and state, and church discipline in family, business, and personal matters. Their doctrine also includes a strong evangelical emphasis, belief in the freedom of individuals to approach God, and emphasis on salvation and rebirth through faith. Baptist churches place a strong emphasis on the autonomy of the local congregation, but have organized into conventions for purposes of fellowship, education, and missions. The largest such body is the Southern Baptist Convention, which claims nearly 16 million members in over 41 thousand churches in the United States. It was established in 1845 because of a conflict over slaveholders' ability to serve in foreign missions; it adopted a resolution in 1995 to renounce and apologize for its racist beginnings. Southern Baptist churches tend to be more conservative in theology and more Calvinist than other Baptist churches, and to place a slightly greater emphasis on missions.

United Methodist Church. Methodist churches began as a Pietist movement within the Church of England in the 1730s, and they trace their leadership back to John and Charles Wesley, who preached a personal conversion experience and the holiness of life. The church in the United States split from its English roots during the American Revolution. It is governed primarily by conferences, with bishops appointing local clergy. Methodist churches tend to be respectful of history and liturgy, but give more of their attention to ministries for disadvantaged people and expression of faith through compassion, worship, love for others, personal piety, and evangelization. Their doctrine also includes individuals' free will, justification by faith, the scriptures' adequacy for salvation, baptism of both infants and adults, and church membership upon confession of faith. Congregations vary in liberal or conservative emphasis. The largest Methodist

denomination, the United Methodist Church, was founded in 1968 from the merging of the Methodist Church with the Evangelical United Brethren; its roots can be traced back to 1784. Its U.S. membership is composed of over 8 million people in more than 35 thousand congregations. It has adopted a Social Creed stressing human rights and ecological issues.

Mennonite Church USA. The Mennonite denominations originated in the Anabaptist movement beginning in the 1520s in Central Europe, and they were named for early leader Menno Simons. The Anabaptist movement was considered extremely radical by both Catholics and other Protestants because its members worked to model Biblical living and rejected the emphasis on proper theology, liturgy, and sacraments that characterized the "magisterial Reformation" of Luther and Calvin. Anabaptists were distinctive for emphasizing a personal relationship with God, practicing adult baptism as a public statement of faith, belief in separation of church and state, pacifism and nonresistance, and insistence on following Jesus' example as found in scripture, rather than church authority. The Mennonite church emphasizes lifestyle rather than public piety and calls for a life separate from the world. Until recently (still, in some groups), involvement in secular domains through such activity as bearing arms, voting, holding public office, or swearing oaths was frowned upon. Those who willfully sin are sometimes excluded from the church, and marriage within the faith is encouraged. Some have chosen to live in "intentional communities." Mennonite church governance is based primarily in local congregations, and denominations have varying emphases on theological and lifestyle issues, but the group as a whole is currently known for its emphases on discipleship, community, service, social justice, pacifism or nonresistance,

and a relatively simple lifestyle (Mennonite Church USA, 2003; Mennonite Media, 2003). It has a strong system of mutual aid and worldwide relief efforts. The Mennonites are a relatively small religious group; Mennonite World Conference (2000) estimates that there are about 1.2 million Mennonites worldwide, with about 444,000 living in the United States and Canada. The largest single denomination in this group is the Mennonite Church USA, which was formed in 2001 through a merging of the former Mennonite Church (founded in 1525) and General Conference Mennonite Church (founded in 1860), with a resultant membership of approximately 125,000. Like most Mennonite groups, its strongest membership is found in Pennsylvania and the Midwest.

The Mennonites are of interest in the current study for several reasons. First, this group is known for an emphasis on community, and many members have a strong sense of in-group loyalty (Just, 1954). Historically many of them have lived in relatively self-sufficient communities and rejected modern lifestyles that were considered too "worldly." Although living separate from mainstream society is now more an exception than the rule among Mennonites, it is possible that these historical values of community identity, self-sufficiency, and separateness will still be present in many church members' value systems and worldview. Second, the Mennonites' emphasis on following Jesus' example and attempting to make all decisions and behavior centered in Christ may result in a higher need than the general population to interpret their world using a religious value system. At least one study of Mennonite church members supports this conclusion (Thiessen, Wright, & Sisler, 1969). If this is true, Mennonites may be more concerned than others about possible values conflicts with a secular mental health system. These issues of values may result in the Mennonite population having more negative attitudes

toward professional psychological help and more preference for spiritually-based help sources than others. Third, despite possible sources of conflict with the mental health system, Mennonites have a historical connection to mental health services. Specifically, Mennonite and other "peace church" (i.e., Quaker, Brethren) workers assigned to state institutions for the mentally ill during World War II were appalled by the conditions they found there, and they were instrumental in bringing about the mental health care reform and patient advocacy movement of the post-war years. Many of these workers engaged in lifelong careers in clinical work, administration, and mental health education (Sareyan, 1994). Given their strong sense of community, tendency to interpret life using religious values, and historical connection to the mental health field, Mennonites may be a good population with whom to conduct research on making mental health resources more attractive and culturally sensitive for people with strong religious affiliation.

Measurement issues and problems. Religious attitudes and behavior are very complex, and it is difficult to find reliable ways of measuring the range of religious expression. In fact, it can be difficult to keep track of what researchers mean when they refer to "religion," "religiosity," "spirituality," or "religious involvement." The following section will attempt to clarify religious constructs or dimensions identified by past researchers and examine their utility for psychological research. The following section will explain the definitions that will be used in the current study and introduce the rationale for the variables chosen.

In some works on religious constructs, terms for religious constructs are used seemingly interchangeably; more specific religious concepts are included in other research. "The religious variable" or "religion" (King, 1967; King & Hunt, 1969, 1972,

1975) and "religious involvement" (Hilty, Morgan, & Burns, 1984) all seem to be used as general terms for an array of constructs including religious beliefs, attitudes, and behavior. "Religious orientation" was of interest to Allport and Ross (1967); they examined intrinsic and extrinsic reasons for people's participation in religious activity. They also called this construct "religious motivation," and this terminology was adopted by Hoge (1972). Worthington (1988) and his colleagues (Worthington et al., 2003) were most interested in "religious commitment," which is the degree to which a person's daily life is influenced by religious values, beliefs, and practices. In order to provide some clarity about the meanings of these terms, works of these theorists will be reviewed briefly in the following paragraphs.

Glock (1954) presented a theory of four dimensions of religion: Ideological (beliefs), Ritualistic (practices), Experiential (emotions), and Consequential (effects of applying other dimensions to one's lifestyle). Fukuyama (1961) found support for these four dimensions, but he also introduced an Intellectual element (knowledge). Glock incorporated this dimension into his original model (1962), resulting in a five dimensional model of religion that dominated the literature on religious constructs for some years. Some support for the five dimensional model was found by Faulkner and De Jong (1966) and Davidson (1975). In a later study, De Jong , Faulkner, and Warland (1976) identified six dimensions; they were similar to Glock's (1962) typology except that the Consequential dimension formed separate Moral and Social dimensions.

A different way of conceptualizing religious constructs came from the work of King (1967) and King and Hunt (1969, 1972, 1975), whose goal was to outline dimensions of "the religious variable," or "aspects of an individual's religious beliefs,

attitudes, and behaviors and of his involvement in a congregation" (1967, p. 173). They administered lengthy questionnaires to Methodists (1967, 1969) and four Christian denominations (1972) in the Dallas area, then conducted another study with a random national sample of Presbyterians. They developed religious dimensions based on the internal consistency of their items by using principle components analysis, item-scale analysis, and theoretical judgment. However, no internal consistency coefficients are reported, and some items are found in more than one dimension. With the exception of the first two studies, which were different analyses of the same data set, each study used a slightly different version of the questionnaire, with some items added and others removed. The result was variation in the number of dimensions (ranging from 9 to 15) as well as the specific dimensions discussed. The dimensions presented by King and Hunt include creedal assent, devotionalism, church attendance, financial support, religious knowledge, social ties, dogmatism, orientation to growth and striving, extrinsic orientation, behavioral and cognitive salience, purpose in life, and other factors.

King and Hunt's work was characterized by several limitations. Those most relevant to the present examination were related to generalizability and comprehensiveness. Their participants were white mainline Protestants, and they were cautious about applying their scales to other groups, even to other Protestants or Catholics (1972, 1975). They also noted (1972) that their scales were applicable mainly to constructs related to congregational life rather than the full spectrum of religious expression.

Hilty, Morgan, and Burns (1984) later returned to King and Hunt's work in an attempt to bring more clarity to the concept of religious involvement, a term that they

seem to equate with King and Hunt's "religious variable." They noted that some religious dimensions had been identified using a rational/theoretical method, while others used internal consistency. They criticized King and Hunt's use of both statistical and nonstatistical criteria to develop their scales, and stated an intention to retest King and Hunt's 1968 questionnaire (used in the 1969 publication) for dimensions based purely on latent variables in participants' responses. They administered the questionnaire to 758 Mennonite church members and drew out seven factors through principle axis factor analysis, then subjected these dimensions to a confirmatory factor analysis procedure. Two of their factors, Social Conscience and Knowledge of Religious History, were taken almost directly from the King and Hunt (1972) Tolerance-Prejudice and Religious Knowledge scales. The other five – Orthodoxy, Personal Faith, Church Involvement, Intolerance of Ambiguity: Revised, and Life Purpose – were composites of items from two or more King and Hunt scales. Hilty and his colleagues (1984) noted that their analyses did not provide a great deal of support for the King and Hunt dimensions.

The work of King (1967), King and Hunt (1969, 1972, 1975), and Hilty et al. (1984) highlights several issues around measuring religious constructs. First, it is clear that religious constructs have many dimensions, but these dimensions have changed substantially from study to study. Second, the studies described here include behavioral, cognitive, emotional, and social aspects of religion as well as spiritual aspects. These domains are often separated in psychological research; here they are mixed and overlapping. Third, both private and public aspects of religion are represented in the research, as well as some dimensions that encompass both the public and the private. Finally, many of their items are so strongly rooted in Christian doctrine and practice that

it is impossible to apply them to diverse religious populations. For example, items on the fourth version of King and Hunt's scales (1975) include, "I believe that God revealed Himself to man in Jesus Christ," and "How often have you taken Holy Communion during the past year?" The result of all these factors is that it is difficult to organize religious constructs into a scheme that is meaningful for counseling psychology research.

One scheme that seems more promising for the intended research is the concept of intrinsic versus extrinsic religious motivation (Allport & Ross, 1967; Hoge, 1972). Allport and Ross identified extrinsic motivation as "using" religion. They described it as an instrumental or utilitarian approach to religion, in which a person's religion is shaped to fit his or her own needs (e.g., security, comfort, social status, distraction, self justification). Intrinsic motivation, on the other hand, is identified as "living" religion. It is characterized by an approach in which faith is motivation in itself, and a person internalizes and follows his or her faith fully. His or her needs are shaped to religious faith as much as possible. Allport and Ross (1967) conceptualized extrinsic and intrinsic religious motivation as a continuum, but they also found that some individuals were "indiscriminately pro-religious," and endorsed both extrinsic and intrinsic items on their scale, even when the items seemed to be in opposition. Hoge (1972) expressed interest in the concepts of extrinsic/intrinsic religious motivation and developed a scale to measure intrinsic motivation. Hoge, like other theorists before him (Hilty et al., 1984; King & Hunt, 1967, 1969, 1972, 1975), focused on organized Christian participants. His respondents were identified by their ministers as either extrinsically motivated or intrinsically motivated. Hoge conducted two studies and used item-to-item and item-to-scale correlations, factor analysis, reliability coefficients, and correlations with ministers'

ratings to choose 10 items (of 30) which best measured intrinsic motivation. Strengths of his scale included strong correlations with older scales and better correlations with minister opinions than previous scales. The primary weakness of his scale was its possible susceptibility to social desirability effects, as Christian teachings criticize extrinsic motivation as an elevation of one's own needs above God.

A concept similar to intrinsic motivation that is found in more recent literature on religious factors is "religious commitment." Worthington (1988) introduced the concept of religious commitment, and he and his colleagues (2003) defined it as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (2003, p. 85). They comment that religious commitment has been measured in a variety of ways, including membership status, participation in religious activities, importance placed on religion, and belief in traditional doctrine. They criticize existing measures such as those of Glock and Stark (1966) and King and Hunt (1969, 1972, 1975) as Judeo-Christian centered, focused on traditional doctrine, and relatively lengthy. They address these problems in the development of the Religious Commitment Inventory–10, a refinement of earlier and longer versions of a scale designed to measure religious commitment. The scale has only 10 items; they are nonspecific in terms of religious tradition and do not include items about theology or doctrine. Although questions about organized religious activity are included, the emphasis is on personal participation; and private religious practices and attitudes are also included. More information on this scale can be found in the Method section.

Worthington (1988) developed a model to describe people with high levels of religious commitment. He theorized that highly religious people (those with high

religious commitment) would tend to evaluate the world in religious terms, based on religious values. He suggested that people identified with Western religions would evaluate the world based on three dimensions: the authority of scripture or sacred writings, the authority of religious leaders, and degree of identity with their religious group. He also hypothesized that religiously committed people would have "zones of toleration" for differences in these areas. This model seems similar to conceptions of intrinsic religious motivation in that the religiously committed person internalizes his or her faith and uses it to guide thought and behavior.

Given the variety of approaches and discrepancies in conceptualization when measuring religious constructs, it is not surprising that measurement has been a problem in much of the existing research. Some studies have simply classified participants into religious traditions (Loewenthal et al., 2001); others have used a one- or two-item measure of the religious variable by asking variations on questions such as "In general, how important are religious or spiritual beliefs in your day-to-day life?" and "How often do you attend religious services?" (Schnittker, 2001; Wong, 1997) or by including short sets of Likert-type items written by the researchers (Purdy, Simari, & Colon, 1983). Worthington (2003) has noted that a few behaviors and attitudes (e.g., participation in activities in one's organization, keeping informed and having influence in one's group, religious beliefs lying behind one's approach to life) have shown evidence of reliability as measures of religious commitment; he includes items for these behaviors in his scale. However, as Gorsuch (1984) argues, single-item measures have serious weaknesses. Using only one or two items offers only a superficial picture of religion. Given the wide variety of backgrounds, experiences, and personal involvement in religious life that can

be found in a given sample, such simple methods of examining religion are inadequate. None of the studies reviewed for the present research used any of the measures described in this section.

Even if one employs a more thorough method for measuring religion, accuracy can be somewhat poor. As Koenig (1990) observed, "different persons may express their religious faith differently from the way in which it is being measured, and the sincerest, most faithful individual may consequently score poorly on a conventional measure of religiousness" (p. 47). The result is that strong evidence of relationships between religious constructs and mental health constructs is relatively rare. Correlations are often weak or insignificant.

In examining relationships between religion and mental health or help-seeking constructs, it is also necessary to control for the effects of a number of other demographic and social factors. Differences in sex, age, race and ethnicity, general health, and functional status (i.e., mobility, ability to engage in physical activity) can confound the relationship between religion and mental health constructs, and researchers must take into account these factors before they can be reasonably certain that observed effects are actually attributable to the religious constructs of interest (Koenig, 1990). At the same time, controlling for these variables by restricting research to a homogeneous sample is not necessarily desirable. A diverse population with a wide range of involvement and activities is necessary in order to produce greater dispersion of scores and approximate a normal distribution in the constructs of interest (Koenig, 1990).

Definition of religious constructs and rationale for measures chosen for the current study. In the current research, the purpose was to examine religious constructs

broadly for their relationships to help-seeking and willingness to use different types of counseling resources. Consequently, several religious measures were used. The primary religious constructs included religious affiliation, religious commitment, and religious belonging. Several other constructs were of secondary interest and/or lack established measures; these were measured using one- to three-item sets and included organized religious activity, time in the religious body, acceptance of church teachings, self-perceived religiosity, perception of church conservatism/liberalism, and perception of church help-seeking attitudes. Definitions of the religious constructs are presented in this section, and a rationale for their inclusion in the study is offered.

1. Religious affiliation – the Denomination with which a participant is currently associated. This served as a sampling variable and allowed for control of what religious traditions were represented in the current study.
2. Religious commitment – "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (Worthington et al., 2003, p. 85). This variable was of interest because it seems to have potential as a measure of the degree of importance a person places on his or her religion, or the degree to which he or she interprets the world in religious terms, using religious values (see Worthington, 1988). Because counseling psychologists are concerned with world view and values of clients, such a measure seemed important in examining help-seeking attitudes and willingness to use different mental health services.
3. Religious belonging – the degree to which a person identifies with and feels he or she is part of a religious community. Given that members of religious populations

sometimes turn to their religious communities rather than mental health professionals to meet their psychological needs, it was reasonable to examine the relationship between religious belonging and help-seeking attitudes, as well as preference for different mental health services.

4. Organized religious activity – the frequency with which a person participates in or attends religious services or other organized religious activities. This variable has been used in much of the previous research and has shown some evidence of predictive validity (Loewenthal et al., 2001; Schnittker, 2001; Shafranske & Gorsuch, 1984; Worthington et al., 2003).
5. Time in the religious body – number of years that a person has been part of his or her denomination. It is possible that longtime church members have a greater sense of belonging or greater religious commitment than those who have joined the church recently.
6. Acceptance of church teachings – degree to which a person reports accepting the teachings of his or her church. Although orthodoxy and doctrine were not the primary variables of interest in the current investigation, acceptance of church teachings may be correlated with greater commitment and is likely to be a factor in determining clients' values. It therefore seemed reasonable to explore whether it was related to help-seeking constructs and preferences for mental health services. A more extensive measurement of this variable would probably have been more reliable; however, development of a single measure of acceptance of church teachings that would be applicable across four denominations would have been difficult, and not necessarily desirable given the diversity of doctrine among

Christian churches and the eventual goal of using these measures with still more diverse populations.

7. Self-perceived religiosity – degree to which a person sees him or herself as religious or spiritual, given participatory, transcendental, and moral definitions of religiosity and spirituality. This series of items was used because of its connection with Worthington and his colleagues' (2003) development of the Religious Commitment Inventory–10. They found that religious commitment was correlated with participatory and transcendental definitions but not with the moral definition; it was hoped that these results would be replicated in the current study.
8. Perception of church conservatism/liberalism – degree to which a person rates his or her congregation as valuing conservative Biblical interpretation, church tradition, and political ideology. It is possible that conservatism is associated with greater distrust of secular mental health services; however, this variable was included for purely exploratory reasons. No validated measure of religious conservatism is known.
9. Perception of church help-seeking attitudes – a person's perception of how much his or her church encourages members to seek psychological help from secular and Christian professionals and the church community. Some evidence (Clansy, 1998) shows that attitudes toward psychological help-seeking may be correlated with perception of family, friends, clergy, and the church as supportive of help-seeking. It was hoped that the current study would support the finding that a church environment that encourages help-seeking is associated with more positive help-seeking attitudes.

Purpose of the Study

The current study had two purposes. First, the study examined psychological help-seeking attitudes and their relationships to several religious constructs in Roman Catholic, Southern Baptist, United Methodist, and Mennonite samples. Religious constructs were tested as predictors of help-seeking attitudes, and the four groups of participants were compared for denominational differences in religious constructs and help-seeking attitudes. Second, the study elicited responses to descriptions of three different mental health facilities and explored the relationships between religious constructs and participants' stated likelihood of using these facilities. Religious constructs were correlated to responses to each description, and the four groups of participants were compared for denominational differences in likelihood of using each facility.

Chapter 3 – Method

This chapter will be divided into four subsections. First, the characteristics of the participants will be described. Second, a description of the development of informational materials about three forms of psychological help will be provided. Third, the psychometric properties of each instrument will be reviewed. More specifically, a Description Response Questionnaire, the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPH; Fischer & Turner, 1970), the Religious Commitment Inventory – 10 (RCI-10; Worthington et al., 2003), a modified version of the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992), a Religious Involvement Questionnaire, and a Demographic Questionnaire compose the set of measures to be used. Finally, an outline of procedures for recruiting participants and collecting data will be provided.

Participants

Participants included 236 church attendees, 79 men, 154 women, and 3 who did not disclose their gender. They ranged in age from 18 to 82, with a mean age of 47.93. Almost all participants were White (224), with 3 African American, 1 Latino/a, 1 Asian American, 3 multiracial, and 1 "other," as well as 3 people who did not disclose their racial background. Thirty-four of the participants were single, 12 were in serious relationships or cohabiting, 158 were married, and 28 were separated, divorced, or widowed, with four not responding. Most lived in Tennessee (157), Ohio (61), or Missouri (16), with 1 participant each from Massachusetts and Colorado. They showed variety in urban/rural residence, with 52 living in rural areas, 46 in small towns, 92 in

suburbs, and 46 in urban areas. There was also variation in education, with 30 people having high school education or less, 79 some college or associates degrees, 64 bachelors degrees, and 60 with graduate degrees (three did not answer). Finally, the participants varied in socioeconomic variables, with income ranges of less than $12,000 (24), $12-25,000 (28), $25-50,000 (85), $50-100,000 (65) and more than $100,000 (26), with 8 not disclosing their income.

Participants included members of four Christian religious denominations, specifically, the Roman Catholic (59 participants), Southern Baptist (55 participants), United Methodist (69 participants), and Mennonite Church USA (53 participants). The first three denominations were chosen because they are the largest Christian groups in the United States (American Religion Data Archive, 2000; Mead & Hill, 2001); the final group was chosen for their emphasis on community, separation, self-sufficiency, Biblical lifestyle, and mental health reform. Participants were recruited from a total of 16 congregations (four Catholic, four Baptist, five Methodist, and three Mennonite) whose leaders consented to have data collected in their churches. In each denomination, size of congregation, geographic location, and urban/rural location varied.

In addition to denomination, other information was collected about the participants' religious lives. They had been involved in their denominations for an average of 32.27 years, with a range of 1 to 82 years. A slight majority (140) attend religious services more than once per week, with 83 attending weekly and the remainder attending less than weekly. When asked about their degree of acceptance of church teachings, most answered "totally" (57), "mostly" (168), or "somewhat" (9).

Stimulus Materials

A help-seeking vignette with three descriptions of mental health services was provided as stimulus material for participants. In the questionnaire, the three descriptions are introduced with the following vignette:

> Imagine that you have been struggling with an issue in your life and have decided that it might be best to consult a professional for help. You search a local directory for resources, and you find three centers located in your community. You contact each center to get more information about their services, and brochures are sent to you through the mail. Upon examining the brochures, you find that each center
>
> 1) employs multidisciplinary teams of licensed professionals with expertise in a variety of problems;
> 2) offers services involving weekly meetings for a period of one to four months, although longer time periods can be arranged;
> 3) operates using a sliding fee scale (charges for services based on client income) to make services affordable to a wide variety of people;
> 4) has a waiting period of one to three weeks before the first appointment due to high demands for their services; and
> 5) can provide services on the same day in emergency situations.
>
> However, there are some differences in the descriptions of services offered by the centers. These descriptions are found below. Please read each description carefully and then respond to the questions below them.

To follow this vignette, three mock "brochures," or parallel descriptions of mental health services were developed. One description refers to traditional counseling services (i.e., one-on-one and group counseling services); another describes nontraditional, alternative services (e.g., classes, workshops, skill-building). The third describes traditional services at an explicitly Christian facility. All three descriptions specify identical general issues for which assistance can be found at the center, except that the Christian brochure includes spiritual issues among the problems. The brochures are similar in length and style and were counterbalanced to decrease the probability of order effects. For information about how these descriptions were developed, please see the Procedures section; for the descriptions themselves, see Appendix A.

Instruments

Description response questionnaire. Before the vignette and descriptions, participants read a series of items consisting of 17 common issues that people bring to counseling: making a career or academic choice, diet or weight issues, relationship difficulties, self-confidence problems, overuse of alcohol, personal worries, difficulty in sleeping, concerns about sexual issues, procrastination on the job or at school, difficulty concentrating, depression, fear of failure, improvement in self-understanding, relaxation training, anxiety about test or job performance, loneliness, and drug problems. This list was adapted from the list used in the Robertson and Fitzgerald (1992) study, and originally developed by Cash, Begley, McCown, and Weise (1975) for studies of college students. Some items were adapted to apply to a more general population; for example, "choosing a major" became "making a career or academic choice." Participants are

asked to rate the likelihood that they will face these problems in the future. Responses are indicated on a Likert scale ranging from 1 (very unlikely) to 6 (very likely).

After the three brochure descriptions, several questions are included as manipulation checks. They include the following: Which center most emphasized one-on-one counseling services with a secularly-trained therapist? Which center most emphasized skills-building and workshops? Which center most emphasized spiritual issues? These are presented in the form of multiple-choice questions, and participants are asked to choose one center that best represents each question.

The next set of items includes the same list of common problems as the items before the vignette. After reading each brochure, participants are instructed to imagine that they are struggling with each problem, even if they are not likely to have the problem in real life, and then to rate the likelihood that they would seek help for that problem in that center. The same items follow each brochure description. Responses are indicated on the following Likert scale: 1 = very unlikely, 2 = moderately unlikely, 3 = slightly unlikely, 4 = slightly likely, 5 = moderately likely, 6 = very likely. The questionnaires for each description are scored by finding the mean item response, resulting in a range of potential scores from 1 to 6 for each description. The Description Response Questionnaire (labeled *Service Questionnaire* in participants' copies) was used to measure stated likelihood of seeking help at each mental health facility. For a copy of the vignette, descriptions, and response questionnaire, see Appendix A.

Attitude Toward Seeking Professional Psychological Help Scale (ATSPPH). The ATSPPH (Fischer & Turner, 1970) was designed to measure "willingness to seek help from mental health professionals when one's personal-emotional state warrants it"

(Fischer & Farina, 1995, p. 371). The scale is composed of 29 items that are scored on a four-point Likert scale ranging from agree (3) to disagree (0). Approximately half the items are reverse-scored. The range of potential scores is from 0 to 87. High scores indicate more favorable attitudes toward seeking psychological help. Sample items include "I would want to get psychological help if I were worried or upset for a long period of time," and "A person should work out his or her own problems; getting psychological counseling would be a last resort."

The researchers reported good psychometric properties for the ATSPPH. The researchers' internal consistency estimate using the Tryon method was .83 in one sample and .86 in a second. Test-retest reliability over one month was .82. Four subscales were derived from factor analysis; these include recognition of personal need for help, tolerance of stigma, interpersonal openness about problems, and confidence in professionals. The subscales displayed internal consistency estimates ranging from .62 to .74, and correlation coefficients for the subscales ranged from .25 to .58. Although the authors recommended that the scale be used primarily as a unidimensional measure, it is of interest to the current study to conduct analyses using both the total scores and the subscale scores.

High scores on the ATSPPH, which indicate positive help-seeking attitudes, were correlated positively with social desirability, trust, and an internal locus of control, and negatively with authoritarianism and masculinity measures (Fischer & Turner, 1970). Psychology and social science majors scored higher than students in other majors ($\underline{p} < .03$ for women, $\underline{p} < .09$ for men). The ATSPPH was used in this study to measure the construct of "help-seeking attitudes."

Religious Commitment Inventory – 10 (RCI–10). The RCI-10 (Worthington et al., 2003) was designed to measure religious commitment, or "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (p. 85). The RCI-10 is based on earlier versions containing 62 items (Morrow, Worthington, & McCullough, 1993; for a review see Sandage, 1999), 20 items (McCullough & Worthington, 1995), and 17 items (RCI-17; McCullough, Worthington, Maxie, & Rachal, 1997). It includes 10 items that are scaled on a five-point Likert scale ranging from not at all true of me (1) to totally true of me (5). The range of potential scores is from 10 to 50, with higher scores indicating greater religious commitment. Example items include "Religious beliefs influence all my dealings in life" and "I enjoy working in the activities of my religious organization."

Two subscales were extracted by factor analysis: Intrapersonal Religious Commitment, which was largely cognitive; and Interpersonal Religious Commitment, which was largely behavioral. Some statistical evidence indicated that these two factors may measure different constructs: the Intrapersonal subscale displayed higher correlations with self-rated intensity of religious experience, while the Interpersonal subscale displayed higher correlations with attendance at religious services. Confirmatory factor analysis indicated that a two-factor model fit the data statistically better than a one-factor model. However, the subscales were themselves highly correlated ($r = .72$ to $.89$, $p < .001$). The authors therefore advocated using the instrument as a unidimensional measure rather than separating the subscale scores; this is how it will be used in the current study.

The reliability and validity of the RCI-10 were examined using six studies of college students, Christian church-attending married adults, undergraduates belonging to diverse religious or nonreligious groups, and clients and counselors at secular and Christian counseling agencies in diverse areas of the United States. Internal consistency reliability estimates using Cronbach's alpha range from .88 to .98 over the six studies. Three-week test-retest reliability was .87, and five-month test-retest reliability was .84. Higher scores were associated with ranking of salvation among the top 5 life values. RCI-10 scores were also significantly correlated with frequency of attendance at religious activities and with single-item self-ratings of religious commitment, intensity of religious experience, religiosity (defined as participation in organized religion) and spirituality (defined as participation in some transcendental realm). They were not correlated with scores on a morality scale or with a single-item self-rating of spirituality (defined as exemplary human characteristics such as honesty, hope, and compassion). Nonreligious participants scored lower than Christian, Protestant, Catholic, Muslim, Buddhist, and Hindu participants. Christian and Muslim groups scored higher than the Buddhist group. In a hypothetical robbery situation, scores predicted spontaneously reported religious activity, degree of empathy for the robber, and motivation to seek revenge.

Using data from almost 2,000 participants, the authors estimate that the normative mean RCI-10 score for a general sample of American adults is 26 with a standard deviation of 12. They suggest that someone who scores at least one standard deviation above the mean, or at least 38, could be classified as highly religious. They use a model by Worthington (1988) as a basis for concluding that a highly religious person "will evaluate the world through religious schema and thus will integrate his or her religion

into much of his or her life" (Worthington et al., 2003). In the current study, the RCI–10 was used to measure the construct of "religious commitment."

Multigroup Ethnic Identity Measure (MEIM). The MEIM (Phinney, 1992) was designed to measure ethnic identity, or "a sense of identification with, or belonging to, one's own group" (p. 158). Phinney posited that someone with a strong ethnic identity would have a sense of pride, feel good about his/her ethnic background, feel happy to be part of the group, and have a sense of belonging or attachment. She designed the scale in order to foster comparison of ethnic identity variables across diverse ethnic groups. The scale is composed of 20 items that are scaled on a four-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Scores are derived from reverse-scoring several items, summing across responses, and obtaining the mean. Thus, scores range from 1 to 4, with higher scores indicating stronger ethnic identity. Example items include "I have spent time trying to find out more about my own ethnic group, such as its history, traditions, and customs" and "I feel a strong attachment towards my own ethnic group."

The MEIM contains two separate scales as follows: 14 items measure aspects of ethnic identity, and 6 items measure other-group orientation. The ethnic identity items can be further subdivided into three subscales, including affirmation and belonging (5 items), ethnic identity achievement (7 items), and ethnic behaviors (2 items). Reliability coefficients using Cronbach's alpha indicated .81 and .90 in the ethnic identity scale for high school and college samples, respectively. Reliability estimates for the other-group orientation scale were .71 and .74 for high school and college samples, respectively. Reliability estimates for the three ethnic identity subscales were as follows: .75 and .86 for affirmation and belonging; .69 and .80 for ethnic identity achievement; and no

estimates for ethnic behaviors, since the subscale includes only two items. MEIM scores are correlated positively with self-esteem.

For the current study, a modified version of the MEIM (Phinney, 1992) was used to examine identity within a religious group. Items were changed such that "I have a strong sense of belonging to my own ethnic group" becomes "I have a strong sense of belonging to my own religious group." A precedent for this practice exists; Mohr and Rochlen (1999) used a modified version of the MEIM to measure group identity with people of differing sexual orientation. In the current study, scores on the modified MEIM were interpreted to indicate identification and attachment with one's religious group; thus, the MEIM was used to measure the construct of "religious belonging."

Religious Involvement Questionnaire. To provide additional data about the religious involvement of the participants, religious demographics and several single-item measures of religious constructs were included. Although single-item measures have significant weaknesses and are not considered adequate measures of religious involvement by themselves, a few have shown some evidence of predictive, concurrent, and construct validity as they have been used in previous research (Gorsuch, 1984). The Religious Involvement Questionnaire was constructed by the researcher using items that were included in previous studies of religious constructs, as well as a few items specific to the current study. The questionnaire includes the following:

1. Please indicate your current religious affiliation: Roman Catholic, Southern Baptist, United Methodist, Mennonite Church USA, and Other. This item was used to indicate "religious affiliation;" potential participants who marked the "other" response were not included in the study.

2. How often do you attend religious services or participate in other organized religious activities? 1 = never, 2 = once a year, 3 = a few times a year, 4 = once a month, 5 = once a week, 6 = more than once a week. This item or variations of it were used in several previous studies (Loewenthal et al., 2001; Schnittker, 2001; Shafranske & Gorsuch, 1984; Worthington et al., 2003). Here it was used to approximate the construct of "organized religious activity."
3. For how many years have you been a part of your denomination? This item was used to measure "time in the religious body."
4. How closely do your beliefs and values follow the teachings of your church? 1 = Not at all – I do not accept any of the teachings of my church. 2 = Mostly not – I accept very little of the teachings of my church. 3 = Somewhat – I accept some of the teachings of my church. 4 = Mostly – I accept most of the teachings of my church. 5 = Totally – I accept all of the teachings of my church. This item was used to measure the construct of "acceptance of church teachings."
5. The three questions used by Worthington et al. (2003) to measure self-perceived religiosity and spirituality. The first two questions were positively correlated with RCI-10 scores; the third was not. Each item is rated on a 5-point Likert scale from 1 = not at all to 5 = totally. The items include the following: (a) If religiosity is defined as participating with an organized religion, then to what degree do you consider yourself religious? (b) If spirituality is defined as a belief and participation in some transcendental realm, then to what degree do you consider yourself spiritual? (c) If spirituality is defined as qualities and characteristics of exemplary humanity (e.g., honesty, hope, compassion, love of

humanity, etc.), then to what degree do you consider yourself spiritual? These items were used to measure "self-perceived religiosity."

6. Three researcher-constructed items which, taken together, were used as an estimate of participants' perception of the conservatism or liberalism of their churches. Each item is rated on a 5-point Likert scale ranging from not at all characteristic of my church (1) to totally characteristic of my church (5). The items are as follows: (a) My church interprets the Bible literally. (b) My church closely follows denominational traditions. (c) My church espouses politically conservative teachings. These were used to measure the construct of "perception of church conservatism/liberalism."
7. Three researcher-constructed items which were used as an estimate of participants' perceptions of their churches' attitudes toward members receiving mental health services. Each item is rated on a 5-point Likert scale ranging from not at all characteristic of my church (1) to totally characteristic of my church (5). The items are as follows: (a) If a person has personal concerns, my church encourages members to seek assistance from secular mental health providers (e.g., counselors, psychologists). (b) If a person has personal concerns, my church encourages members to seek assistance from Christian mental health providers (e.g., counselors, psychologists). (c) If a person has personal concerns, my church encourages members to seek assistance from church leaders. These items were used to measure "perception of church help-seeking attitudes."

For a copy of the Religious Involvement Questionnaire, see Appendix B.

Demographic Questionnaire. Participants were asked to report their age, gender, race/ethnicity, relationship status, state of residence, urban/rural residence, education level, and annual income. They were also asked whether they or someone close to them have ever sought psychological help for a personal problem. For a copy of the Demographic Questionnaire, see Appendix C.

Procedure

The proposed study was submitted to the University of Missouri-Columbia Institutional Review Board for approval. When IRB approval was granted, the procedure described below was used to develop stimulus materials, recruit participants, and collect data.

Stimulus development. First, descriptions of three mental health facilities were developed for use in this study. The procedure for developing these descriptions was similar to the procedure described in Robertson and Fitzgerald's (1992) study of men's preferences for alternative forms of assistance. The introductory vignette and initial drafts of the three descriptions were written and submitted to two counseling psychologists, who assessed them for clarity, coverage of the content domain, and consistency with the rationale of the study. They were then given to twelve undergraduate students recruited from a class in human services. The undergraduate students used a 7-point Likert scale as well as written comment sheets to rate the vignette and brochures for clarity, comprehension, and attractiveness. Ratings of clarity ranged from 4 to 7, with means ranging from 6.22 to 6.91. Ratings of comprehension ranged from five to seven, with means ranging from 6.33 to 6.66. Ratings of attractiveness ranged from 1 to 7, with means ranging from 3.85 (for the vignette) to 5.33. This

information and their written comments were used to modify the format of the vignette and some wording in the brochures. The three validity questions were also included. All twelve students were able to distinguish which brochure emphasized spiritual issues. Eleven of twelve were correct in identifying the brochure that emphasized skills-building, and nine chose the correct brochure when asked which one emphasized counseling with a secular therapist. Variation in this last question was expected, as it was expected that some students would identify the "alternative," coaching and skills-based services with what they would expect from a counselor.

Next, six graduate students in counseling psychology were recruited via e-mail and invited to read and evaluate the vignette and descriptions. They used a 6-point Likert scale ranging from 1 (very well) to 6 (very poorly) to rate the degree to which each description matched nine statements about a helping environment. Three statements emphasized elements associated with traditional counseling, namely sharing personal concerns, expressing emotions, and gaining insight. Three emphasized elements associated with more nontraditional services, including skills mastery, a focus on behavior, and problem-solving. Three emphasized elements associated with a Christian facility, including focus on religion or spirituality, moral issues, and welcoming attitude to Christians. These ratings were then examined to determine whether the descriptions were consistent with the intended manipulation. In all cases, the expected differences were evident from means plots. Thus, items emphasizing traditional counseling were rated higher in the traditional and Christian brochures, and items emphasizing nontraditional counseling were rated higher in the nontraditional brochure. Finally, items emphasizing spirituality were rated higher in the Christian brochure. ANOVAs were

conducted to identify whether these differences were significant, and for all but two items, significance was reached despite the limited sample size.

Finally, a pilot study was conducted with 14 members of a local church to determine whether participants would respond differentially to the three descriptions. The participants in the pilot study completed all measures to be used in the final study, and analyses were then conducted to determine whether the participants preferred one or two brochures over the other(s). No one brochure was preferred by the group as a whole; however, analyses of each participant's responses showed that 10 of the 14 participants rated the three brochures significantly differently. It was therefore concluded that the materials were appropriate for the planned study.

Recruitment of participants. Participants were recruited from three to five congregations in each of the four religious denominations included. Wherever possible, the process was begun by seeking friends and colleagues' introductions to church leaders in the four denominations; when this was not possible, the researcher contacted clergy or appropriate church leaders in potential participating congregations via phone. The purpose and methodology of the proposed study was explained to each church leader, and permission was sought to collect data in his/her congregation. Each clergy member or church leader was also consulted about the best context in which to seek services, and their requests were respected. Thus, some clergy members or leaders made an announcement and distributed the questionnaires themselves, while others invited the researcher to visit a church service, Sunday school class, Bible study group, or other setting to recruit participants. In order for the recruitments of participants to be

consistent, a script for solicitation of participants was used by the researcher and given to any church leader who asked to make the announcement him or herself.

The request for participation was directed to all members of the congregation 18 years or older. Solicitation materials (a) indicated that the study was designed to explore variables that can assist human service professionals in offering services more suited to the populations they serve, (b) clearly stated that participation is voluntary and anonymous, (c) described what participation would entail and how long (20-25 minutes) it will take, (d) requested participation, (e) expressed appreciation for people's contributions, and (f) offered incentive for participation in the form of a $50 raffle for all participants who returned an entry slip separate from the data packet. In some cases, clergy members asked that the drawing not be offered since it was viewed as a gambling activity; in these cases the church leaders' wishes were respected. For scripts of the solicitation announcements, see Appendix D.

Data collection. Participants were given informed consent documents and the following research materials: the Description Response Questionnaire with vignette and three descriptions; the ATSPPH; the RCI-10; the MEIM; the Religious Involvement Questionnaire; and the Demographic Questionnaire. For a copy of the informed consent, see Appendix E; for copies of the other materials, see Appendices A-C. Participants were asked to complete the survey and return it to a drop box, large envelope, or the researcher, depending upon the context in which data was collected. Forms for entry in the $50 drawing were available with the drop box, envelope, or researcher's table.

When the study was finished, letters of appreciation were sent to the clergy or church leaders at each of the participating congregations. Brief summaries of the results

of the study were also sent, and updated information about how to contact the researcher with any questions or concerns were included.

Chapter 4 – Results

This chapter will describe statistical analyses and results obtained from the data. First, recoding of some data will be discussed. Then preliminary analyses will be described, including tests to compare the denominational groups, examine gender differences in help-seeking, and estimate reliability of the scales. Subsequently, results of analyses to address each research question will be presented.

Before analysis began, some adjustments were made in coding of demographic variables. Due to sample sizes and number of categories, variables were recoded as follows. In the urban/rural category, rural and small town residents were coded as 0, and suburban and urban residents were coded as 1. In relationship status, single, separated, divorced, and widowed people were coded as 0, while married and cohabiting people were coded as 1. Previous exposure to therapy was recoded as two separate 0-1 variables, namely, participants' personal experience of therapy, and experience of close friends or family members in therapy. Race was eliminated as a variable from all further analyses due to lack of variation in the population.

Preliminary Analyses

Before examining the research questions, several tests were conducted to determine whether the four denominational groups were reasonably equivalent in demographic variables such as age, gender, relationship status, urban/rural residence, education, and income. Although there were slight differences among the groups in mean age, relationship status, education, and income, none of these differences was determined to be sufficiently large to require adjustment or separate analyses.

Descriptive statistics were calculated for the variables included in the study and are displayed in Table 1. A correlation matrix for the variables is displayed in Table 2.

Table 1
Descriptive Statistics and Coefficient Alphas for Demographic, Religious, and Help-Seeking Variables

	Mean	*SD*	Min	Max	Alpha
ATSPPH	2.073	.445	.69	2.86	.891
RCI	4.155	.654	2.10	5.00	.875
MEIM	3.377	.329	2.05	4.00	.808
org. activity	5.506	.718	2.00	6.00	
time in body	32.270	18.839	1.00	82.00	
acceptance	4.205	.491	3.00	5.00	
religiosity1	4.568	.679	1.00	5.00	
religiosity3	4.575	.692	1.00	5.00	
conservatism1	3.667	1.294	1.00	5.00	
conservatism2	4.400	.791	1.00	5.00	
conservatism3	3.522	1.331	1.00	5.00	
church help1	3.158	1.335	1.00	5.00	
church help2	4.199	.930	1.00	5.00	
church help3	4.114	.998	1.00	5.00	
age	47.927	14.439	18.00	82.00	
urban/rural	.585	.494	0.00	1.00	
education	4.361	1.485	2.00	7.00	
income	3.180	1.122	1.00	5.00	
therapy1	.444	.498	0.00	1.00	
therapy2	.639	.481	0.00	1.00	
brochure1	3.378	1.223	1.00	6.00	
brochure2	3.349	1.248	1.00	6.00	
brochure3	3.850	1.283	1.00	6.00	

Note. ATSPPH = Attitude Toward Seeking Professional Psychological Help scale; RCI = Religious Commitment Inventory – 10; MEIM = Multigroup Ethnic Identity Measure (modified); org. activity = organized religious activity; time in body = time in religious body; acceptance = acceptance of church teachings; religiosity1 = self-perceived religiosity as participation in organized religion; religiosity3 = self-perceived religiosity as exemplary humanity (morality); conservatism1 = perception of church as interpreting the Bible literally; conservatism2 = perception of church as following denominational traditions; conservatism3 = perception of church as espousing politically conservative views; church help1 = perception of church as encouraging help-seeking with secular providers; church help2 = perception of church as encouraging help-seeking with Christian providers; church help3 = perception of church as encouraging help-seeking with church leaders; therapy1 = personal experience in therapy; therapy2 = close others' experience in therapy; brochure1 = traditional brochure response; brochure2 = nontraditional brochure response; brochure3 = Christian brochure response.

Table 2

Correlations Among Demographic, Religious, and Help-Seeking Variables

	A	B	C	D	E	F	G	H	I	J	K
A. ATSPPH	1										
B. RCI	.276***	1									
C. MEIM	.255***	.529***	1								
D. org. activity	.121	.446***	.226***	1							
E. time in body	.152*	.216**	.218**	-.047	1						
F. acceptance	-.031	.392***	.213**	.202**	.188**	1					
G. religiosity1	.085	.411***	.346***	.276***	.196**	.202**	1				
H. religiosity3	.122	.152*	.297***	.001	.146*	.170**	.147*	1			
I. conservatism1	-.065	.169**	-.037	.025	.034	.337***	.023	.066	1		
J. conservatism2	.043	.115	.186**	.041	.095	.187**	.161*	.134*	.218**	1	
K. conservatism3	-.007	.121	.042	-.011	.028	.318***	.073	.139*	.487***	.320***	1
L. church help1	.193**	-.083	.164*	-.055	.075	-.167*	-.016	.060	-.278***	.129	-.159*
M. church help2	.124	.239***	.166*	.154*	.049	.216**	.121	.101	.189**	.258***	.198**
N. church help3	.006	.142*	.166*	-.038	.047	.184**	.166*	.129	.192**	.278***	.288***
O. age	.217**	.222**	.049	-.037	.507***	.056	.122	.124	.073	.059	-.099
P. gender	.192**	.144*	.001	.059	.103	.016	.035	.098	.062	-.051	.008
Q. urban/rural	.198**	.044	.193**	.140*	-.196**	-.020	-.024	-.048	-.190**	.013	-.086
R. education	.056	.012	.096	-.031	-.086	-.087	.087	.009	-.307***	-.059	-.200**
S. income	.069	-.012	-.043	-.007	.069	.060	-.038	.014	-.008	-.003	-.030
T. therapy1	.440***	.231***	.161*	.210**	-.028	.036	.065	.067	-.125	.073	.039
U. therapy2	.155*	-.015	.036	.002	-.072	-.006	-.060	.071	-.104	.002	-.005
V. brochure1	.184**	-.080	.057	-.057	.064	-.227***	.009	.071	-.168*	-.102	-.089
W. brochure2	.123	-.099	-.041	-.109	.028	-.213**	.022	.106	-.152*	-.114	.019
X. brochure3	.171**	.190**	.020	.095	.030	.077	.144*	.109	.147*	-.020	.183**

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 2 (continued)

Correlations Among Demographic, Religious, and Help-Seeking Variables

	L	M	N	O	P	Q	R	S	T	U	V	W
L	1											
M	.187**	1										
N	.131*	.352***	1									
O	.135*	.040	-.043	1								
P	-.092	.022	-.021	.007	1							
Q	.161*	.099	.018	-.098	-.029	1						
R	.074	-.055	-.011	-.034	-.187**	.274***	1					
S	.060	-.044	-.116	.222**	-.122	.101	.332***	1				
T	.105	.182**	.036	-.015	.088	.236***	.192**	.076	1			
U	.105	-.038	-.003	-.025	.124	.164*	.156*	.150*	.135*	1		
V	.246***	-.020	.029	-.010	.057	.035	.095	-.089	.146*	.087	1	
W	.060	-.087	.017	-.040	.081	.076	.044	-.072	.063	.071	.708***	1
X	-.126	.116	.012	-.077	.157*	-.017	-.106	-.126	.229***	.046	.472***	.361***

Note.

A. ATSPPH = Attitude Toward Seeking Professional Psychological Help scale; B. RCI = Religious Commitment Inventory – 10; C. MEIM = Multigroup Ethnic Identity Measure (modified); D. org. activity = organized religious activity; E. time in body = time in religious body; F. acceptance = acceptance of church teachings; G. religiosity1 = self-perceived religiosity as participation in organized religion; H. religiosity3 = self-perceived religiosity as exemplary humanity (morality); I. conservatism1 = perception of church as interpreting the Bible literally; J. conservatism2 = perception of church as following denominational traditions; K. conservatism3 = perception of church as espousing politically conservative views; L. church help1 = perception of church as encouraging help-seeking with secular providers; M. church help2 = perception of church as encouraging help-seeking with Christian providers; N. church help3 = perception of church as encouraging help-seeking with church leaders; T. therapy1 = personal experience in therapy; U. therapy2 = close others' experience in therapy; V. brochure1 = traditional brochure response; W. brochure2 = nontraditional brochure response; X. brochure3 = Christian brochure response.

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

A preliminary analysis was also completed to find out whether the four denominations differed in their stated likelihood of experiencing the 17 problems included on the questionnaire. An ANOVA was conducted for mean problem likelihood, and found no significant differences, $F(3, 232) = .514$, $p = .673$. ANOVAs were also conducted for each problem individually, and differences were found in 2 of the 17 variables. In problem four, self-confidence problems, a significant result was found, $F(3, 228) = 2.863$, $p = .038$. A Tukey's post-hoc test showed that Baptists were more likely than Methodists to expect difficulties ($p = .023$). No other differences were found. In problem five, overuse of alcohol, a significant result was found, $F(3, 228) = 7.681$, $p < .001$. A Tukey's post-hoc test showed that Catholics were more likely than Baptists ($p = .003$) or Mennonites ($p < .001$) to expect problems. Based on these analyses, it was determined that the four groups were reasonably equivalent in their likelihood of experiencing the difficulties included for study.

In order to test a common result in previous studies, a t-test was completed to compare male and female respondents in ATSPPH scores. As in previous studies, it was expected that women would have higher scores than men. This difference was significant in the current study, $t(231) = -2.966$, $p = .003$.

Finally, analyses were completed to examine the reliability of the scales included in the current study. Cronbach's alphas were .891 for the ATSPPH, .875 for the RCI, and .808 for the MEIM. Alphas for the three 3-item scales were also tested and reported as follows: .316 for self-perceived religiosity, .611 for perception of church conservatism/liberalism, and .431 for perception of church help-seeking attitudes. Because these three values were so low, it was determined that the three sets of questions

should not be included as scales, but as separate variables in later analyses. Further examination also showed that the second self-perceived religiosity item (i.e., If spirituality is defined as a belief and participation in some transcendental realm, then to what degree do you consider yourself spiritual?) was questionable in its reliability. Responses were not consistent with the other two items, and some participants appeared to be unsure what "transcendental realm" meant. The item was therefore dropped from all further analyses.

Research questions 1 and 2 were investigated using multiple regression. The data analysis plan included an initial stepwise regression, followed by a backward regression. An additional stepwise regression would then be conducted with the best predictor removed in order to explore the contributions of other variables that might overlap with the best predictor

Question 1

To find what demographic variables predict help-seeking attitudes, a stepwise regression was conducted using the following variables as predictors of ATSPPH: age, gender, relationship status, urban/rural residence, education, income, previous personal therapy, and previous others' therapy. Four variables were added to the model, resulting in an R^2 of .281. The four variables included personal experience in therapy, age, gender, and urban/rural residence; all were related to ATSPPH in a positive direction, such that people who had had previous therapy, were older, were female, or who lived in more urban areas scored higher. Beta values for the model can be found in Table 3.

In accordance with the analysis plan, regression was also conducted using other methods. A backward regression ended with exactly the same model as was found in the

stepwise regression, and the order of predictors removed was as follows: education, income, relationship status, and previous others' therapy. Finally, a stepwise regression was conducted after removing the best predictor (previous personal therapy) from the list. Three variables were added to the model, resulting in an R^2 of .138. The variables included age, urban/rural residence, and gender. Thus, when personal therapy is removed, urban/rural residence becomes a more important predictor than gender. With this information taken into account, the original stepwise model seems to be the best fit.

Table 3
Summary of Stepwise Regression Analysis for Demographic Variables Predicting ATSPPH Scores (N = 236)

Variable	*B*	*SE B*	β	*p*
(Constant)	1.398	.105		.000
personal therapy	.355	.054	.392	.000
age	.007	.002	.229	.000
gender	.146	.054	.155	.008
urban/rural	.127	.054	.139	.021

Note. R^2 = .281.

Question 2

To find what religious variables predict help-seeking attitudes, a stepwise regression was conducted using the following variables as predictors of ATSPPH: RCI, MEIM, organized religious activity, time in religious body, acceptance of church teachings, two items on self-perceived religiosity, three items on perception of church conservatism or liberalism, and three items on perception of church help-seeking attitudes. Two variables were added to the model, resulting in an R^2 of .130. The two variables included RCI and perception of church help-seeking with secular providers. Both were related to ATSPPH in a positive direction, such that participants with higher

religious commitment scores or perception of their churches as encouraging help-seeking with secular providers scored higher in help-seeking.

When a backward regression was conducted, four variables remained in the model, resulting in an R^2 of .163. The four variables included RCI, time in religious body, acceptance of church teachings, and perception of church help-seeking with secular providers. RCI, time in religious body, and help-seeking with secular providers were related to ATSPPH in a positive direction, and acceptance of church teachings were related to ATSPPH in a negative direction, such that participants with higher religious commitment scores, more time in their religious body, less acceptance of church teachings, or perception of their churches as encouraging help-seeking with secular providers scored higher in help-seeking.

Finally, a stepwise regression was conducted after removing the best predictor (RCI) from the list. Three variables were added to the model, resulting in an R^2 of .105. The three variables included MEIM score, perception of church help-seeking with secular providers, and time in religious body. All three were related to ATSPPH in a positive direction, such that participants with higher MEIM scores, more time in their religious body, or perception of their churches as encouraging help-seeking with secular providers scored higher in help-seeking.

Given these results, it was unclear which model best fits the data. RCI and perception of church help-seeking with secular providers appeared consistently in the models, and time in religious body appeared in all except the stepwise model. MEIM and acceptance of church teachings each appeared in one model, but not the others. Of the models tested, the backward model accounted for the most variation. Beta values for the

stepwise and backward models as well as the model with RCI removed can be found in Table 4.

Table 4
Summary of Regression Analysis for Religious Variables Predicting ATSPPH Scores (N = 236)

Model/Variable	*B*	*SE B*	β	*p*
Model 1 (stepwise)				
(Constant)	.961	.205		.000
RCI	.212	.045	.303	.000
church help-seeking secular	.074	.022	.220	.001
Model 2 (backward)				
(Constant)	1.429	.289		.000
RCI	.236	.048	.338	.000
time in religious body	.003	.002	.137	.037
accept. of church teachings	-.151	.066	-.163	.023
church help-seeking secular	.061	.022	.179	.006
Model 3 (RCI removed)				
(Constant)	.854	.311		.007
MEIM	.284	.094	.202	.003
church help-seeking secular	.051	.022	.151	.023
time in religious body	.003	.002	.132	.047

Note. R^2 = .130 for model 1. R^2 = .163 for model 2. R^2 = .105 for model 3.

Additional Regression

It was decided to examine what religious variables would predict ATSPPH when demographic variables were accounted for. Consequently, a hierarchical regression was conducted using all demographic variables in the first block and religious variables in the second block, to be removed using a stepwise method. In step 1, the model was conducted with all eight demographic variables, resulting in an R^2 of .301. After step 2, the eight demographic variables and two religious variables were added to the model, resulting in an R^2 of .346 and a change in R^2 of .045. The two religious variables were

MEIM and acceptance of church teachings. MEIM was related to ATSPPH in a positive direction and acceptance of church teachings was related to ATSPPH in a negative direction, such that participants with higher MEIM scores and less agreement with church teachings scored higher on the ATSPPH. Beta values for the model with both demographic and religious predictors can be found in Table 5.

Table 5
Summary of Hierarchical Regression Analysis for Demographic and Religious Variables Predicting ATSPPH Scores (N = 236)

Variable	*B*	*SE B*	β	*p*
Step 1				
(Constant)	.970	.356		.007
age	.007	.002	.210	.001
gender	.134	.057	.141	.020
relationship status	.086	.062	.088	.164
urban/rural	.083	.058	.089	.154
education	-.021	.021	-.065	.316
income	-.003	.027	-.008	.904
personal therapy	.367	.055	.402	.000
others' therapy	.094	.056	.100	.097
Step 2				
MEIM	.301	.090	.210	.001
accept. of church teachings	-.129	.057	-.136	.024

Note. $R^2 = .346$.

Question 3

A series of ANOVAs was conducted to examine denominational differences in the RCI, MEIM, and the three single-item religious measures included in the study. Separate ANOVAs were used instead of a single MANOVA because the dependent variables were conceptually distinct (commitment versus belonging, attendance, time, and acceptance). Each ANOVA found significant differences, as follows: for the RCI,

$F(3, 232) = 7.191$, $p < .001$; for the MEIM, $F(3, 232) = 6.619$, $p < .001$; for organized religious activity, $F(3, 231) = 7.138$, $p < .001$; for time in religious body, $F(3, 229) = 3.558$, $p = .015$; for acceptance of church teachings, $F(3, 230) = 17.236$, $p < .001$. These results, as well as denominational means, are summarized in Table 6.

Table 6
Denominational Differences in Religious Variables

	Catholic (n = 59)		Baptist (n = 55)		Methodist (n = 69)		Mennonite (n = 53)				
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*df*	*F*	Tukey's
RCI	3.94	.08	4.46	.09	4.18	.08	4.04	.09	3, 232	7.191**	B > C, Mn
MEIM	3.52	.04	3.40	.04	3.33	.04	3.26	.04	3, 232	6.619**	C > Mt, Mn
Org act	5.49	.09	5.84	.09	5.47	.08	5.23	.10	3, 231	7.138**	B > C, Mt, Mn
Time	36.48	2.43	27.58	2.50	29.37	2.25	36.33	2.57	3, 229	3.558*	ns
Accept	4.10	.06	4.58	.06	4.06	.05	4.11	.06	3, 230	17.236**	B > C, Mt, Mn

Note. N = 236.
Degrees of freedom varied across tests due to missing data. All measures except time in religious body use Likert scales; ranges of possible scores are as follows: RCI (1-5), MEIM (1-4), org activity (1-6), acceptance (1-5). Time is measured in years.
* $p < .05$. ** $p < .01$.

Significant findings were followed with group comparisons using Tukey's post-hoc analysis and are shown in the last column of Table 6. For the RCI, Tukey's analysis showed that Baptists scored higher than Catholics ($p = .004$) or Mennonites ($p < .001$). For the MEIM, Catholics scored higher than Methodists ($p = .007$) or Mennonites ($p < .001$). For organized religious activity, Baptists scored higher than Catholics ($p = .041$), Methodists ($p = .020$), or Mennonites ($p < .001$). For time in religious body, Tukey's multiple comparisons were unable to detect any differences significant at the .05 level. The difference closest to obtaining significance was between Catholics and Baptists, such that the Catholics appeared to have been in their churches longer ($p = .055$). For

acceptance of church teachings, Baptists ranked this item higher than Catholics ($p <$ .001), Methodists ($p < .001$), or Mennonites ($p < .001$).

One-way MANOVAs with four levels of the independent variable (religious denomination) were conducted to examine differences in the three 3-item scales included in the study. Three separate MANOVAs were used instead of a single combined analysis because the clusters of dependent variables in each were conceptually distinct (self-perceived religiosity versus church conservatism versus church help-seeking). The MANOVA for self-perceived religiosity included the following two dependent variables: religiosity based on participation in organized religion and spirituality based on qualities of exemplary humanity. As noted in the preliminary analysis section, the second item was not included due to lack of reliability. The analysis found no significant differences, $F(6, 456) = 1.340$, $p = .238$.

The MANOVA for perception of church conservatism included the following three dependent variables: interpreting the Bible literally, following denominational traditions, and espousing politically conservative teachings. The results of the MANOVA suggested significant differences, $F(9, 545) = 19.346$, $p < .001$. Univariate follow-ups for all three items indicated significant differences. These analyses, denominational means, and results of Tukey's post-hoc comparisons are summarized in Table 7. In interpreting the Bible literally, Baptists ranked the item higher than Mennonites ($p = .001$), Methodists ($p < .001$), or Catholics ($p < .001$). Mennonites ranked the item higher than Methodists ($p = .002$) or Catholics ($p < .001$). In following denominational traditions, Mennonites ranked the item lower than Methodists ($p = .006$), Baptists ($p = .003$), or Catholics ($p = .002$). In political conservatism, Baptists ranked the

item higher than Catholics ($p < .001$), Mennonites ($p < .001$), or Methodists ($p < .001$). Catholics ranked the item higher than Methodists ($p = .009$), but neither differed from Mennonites.

Table 7
Denominational Differences in Perception of Church Conservatism

	Catholic (n = 59)		Baptist (n = 55)		Methodist (n = 69)		Mennonite (n = 53)			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(3, 226)	Tukey's
Bible	2.78	.14	4.77	.15	3.27	.13	3.98	.15	37.110**	B > Mn > Mt, C
Traditions	4.53	.10	4.53	.11	4.47	.09	4.00	.11	5.830**	C, B, Mt > Mn
Politics	3.53	.16	4.51	.16	2.85	.15	3.37	.17	19.472**	B > C, Mn, Mt C > Mt

Note. N = 236.
Results of multivariate analysis of variance (MANOVA) for this analysis were significant, $F(9, 545) = 19.346$, $p < .001$. All measures use Likert scales; range of possible scores for each is 1-5.
* $p < .05$. ** $p < .01$.

The MANOVA for perception of church help-seeking included the following three dependent variables: help-seeking with secular providers, Christian providers, and church leaders. The results of the MANOVA indicated significant differences, $F(9, 536) = 14.873$, $p < .001$. Univariate follow-ups for all three items indicated significant differences. These analyses, denominational means, and results of Tukey's post-hoc comparisons are summarized in Table 8. In help-seeking with secular professionals, Catholics ranked the item higher than Mennonites ($p < .001$) and Baptists ($p < .001$). Methodists also ranked the item higher than Mennonites ($p < .001$) and Baptists ($p < .001$). Catholics and Methodists did not differ, and Baptists and Mennonites did not differ. In Christian help-seeking, Mennonites ranked the item lower than Catholics ($p = .047$), Methodists ($p = .005$), or Baptists ($p < .001$). Baptists ranked the item higher than

Catholics (p = .045), but neither differed from Methodists. Finally, in help-seeking with church leaders, Baptists ranked the item higher than Methodists (p = .011) or Mennonites (p = .003).

Table 8
Denominational Differences in Perception of Church Help-Seeking

	Catholic (n = 59)		Baptist (n = 55)		Methodist (n = 69)		Mennonite (n = 53)			
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*(3, 222)	Tukey's
Secular	3.98	.15	2.17	.16	3.61	.14	2.70	.16	28.901**	C, Mt > Mn, B
Christian	4.16	.12	4.62	.12	4.27	.11	3.72	.12	9.163**	B, Mt, C > Mn B > C
Leaders	4.15	.13	4.52	.14	3.96	.12	3.85	.13	4.891**	B > Mt, Mn

Note. N = 236.
Results of multivariate analysis of variance (MANOVA) for this analysis were significant, $F(9, 536) = 14.873$, $p < .001$. All measures use Likert scales; range of possible scores for each is 1-5.
* $p < .05$. ** $p < .01$.

Question 4

To examine relationships between religious variables and preferences for the three brochures, correlations were completed. The correlations can be found in Table 9. No significant correlations were found between brochures and MEIM, organized religious activity, time in religious body, the third self-perceived religiosity item, following denominational traditions, or seeking help from Christian providers or church leaders. Weak positive correlations with the Christian brochure were found with RCI, the first self-perceived religiosity item (participation in organized religion), and political conservatism. Acceptance of church teachings showed weak negative correlations with the traditional and nontraditional brochures. Interpreting the Bible literally showed weak negative correlations with the traditional and nontraditional brochures and a weak

positive correlation with the Christian brochure. Perception of church help-seeking with secular professionals showed a weak positive correlation with the traditional brochure. It can also be noted that the three brochures were significantly positively correlated. The traditional and nontraditional secular brochures showed a strong correlation, while each was moderately correlated with the Christian brochure. These correlations can also be found in Table 9.

Table 9
Correlations Between Religious Variables and Brochures and Among Brochures

	Brochure A (traditional)	Brochure B (nontraditional)	Brochure C (Christian)
RCI	-.080	-.099	.190**
MEIM	.057	-.041	.020
organized religious activity	-.057	-.109	.095
time in religious body	.064	.028	.030
acceptance of church teachings	-.227**	-.213**	.077
self-perceived religiosity (organized)	.009	.022	.144*
self-perceived religiosity (moral)	.071	.106	.109
conservatism 1 (Bible interp. literally)	-.168*	-.152*	.147*
conservatism 2 (follow denom. traditions)	-.102	-.114	-.020
conservatism 3 (political conservatism)	-.089	.019	.183**
church help-seeking 1 (secular)	.246**	.060	-.126
church help-seeking 2 (Christian)	-.020	-.087	.116
church help-seeking 3 (church leader)	.029	.017	.012
brochure A		.708**	.472**
brochure B			.361**

* $p < .05$. ** $p < .01$ (2-tailed).

Question 5

A repeated measures ANOVA was used to compare the responses to the three brochures, and to test if responses differed by denomination. The interaction between denomination and brochure was significant, $F(6, 460) = 5.609$, $p < .001$. Therefore

additional repeated measures ANOVAs were conducted comparing brochure type in each denomination. Significant findings were followed with pairwise comparisons with a Bonferroni's correction. Results of these analyses as well as mean ratings for each brochure by denomination are found in Table 8, and a plot of these relationships is found in Figure 1.

Table 10
Denominational Mean Ratings for Mock Brochures

	Traditional Brochure		Nontraditional Brochure		Christian Brochure				pairwise comparisons
Denom	*M*	*SD*	*M*	*SD*	*M*	*SD*	*df*	*F*	w/ correction
Catholic	3.553	.149	3.590	.159	3.496	.152	2, 56	.221	ns
Baptist	3.075	.184	3.103	.191	4.236	.189	2, 53	12.934**	C > N, T
Methodist	3.485	.141	3.275	.133	3.792	.154	2, 67	6.981**	C > N
Mennonite	3.363	.166	3.451	.174	3.945	.164	2, 51	7.816**	C > N, T

Note. N = 236.
Degrees of freedom varied across tests due to different sample sizes in each denomination. All measures use Likert scales; range of possible scores for each is 1-6.
* $p < .05$. ** $p < .01$.

For Catholics, there was no significant difference among the brochures, $F(2, 56) = .221$, $p = .802$.

For Baptists, there was a significant difference among the brochures, $F(2, 53) = 12.934$, $p < .001$. For post-hoc tests, pairwise comparisons were made with a Bonferroni's correction, (e.g., $p < .05$ divided by 3 brochures results in an adjusted critical value of .017). Pairwise comparisons showed that the Christian brochure was rated more positively than either the traditional brochure ($p < .001$) or the nontraditional brochure ($p < .001$).

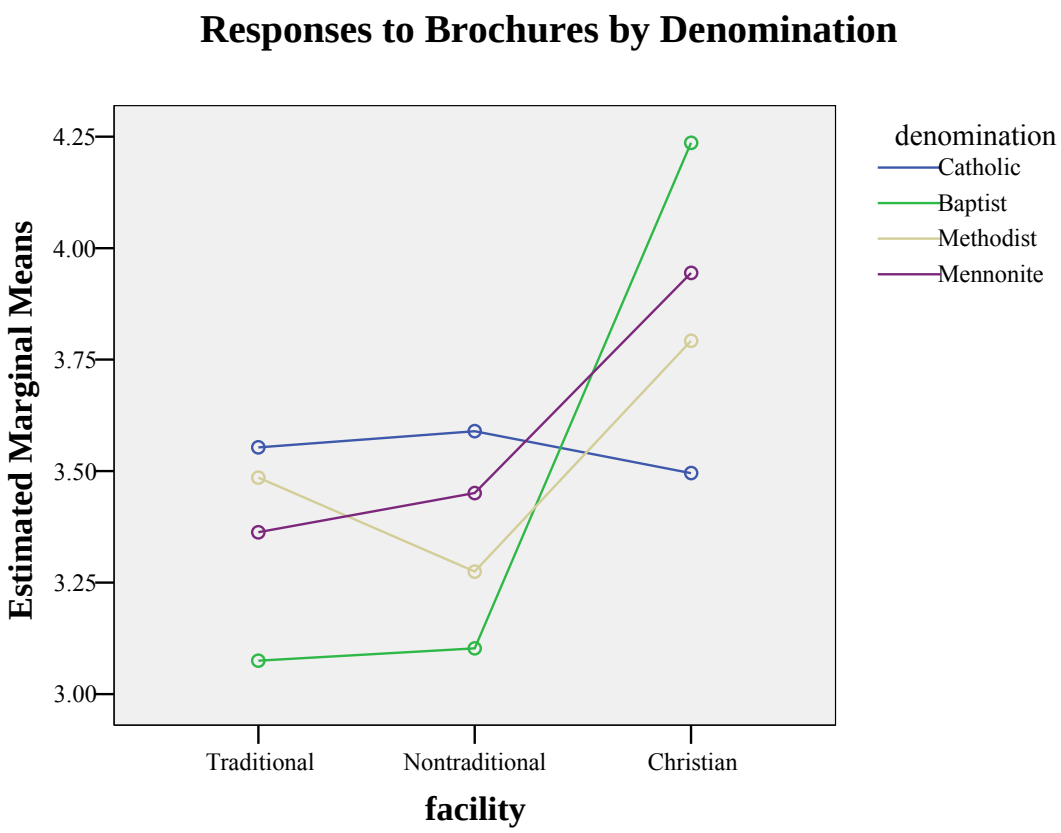
For Methodists, there was a significant difference among the brochures, $F(2, 67) = 6.981$, $p = .002$. For post-hoc tests, pairwise comparisons were made with a

Bonferroni's correction. Pairwise comparisons showed that the Christian brochure was rated more positively than either the traditional brochure ($p = .021$) or the nontraditional brochure ($p < .001$); however, the difference between the Christian and traditional brochure did not reach the Bonferroni adjusted critical value. The traditional brochure was rated slightly more positively than the nontraditional brochure ($p = .048$), but this difference was also insignificant under the Bonferroni adjustment.

For Mennonites, there was a significant difference among the brochures, $F(2, 51) = 7.816$, $p = .001$. For post-hoc tests, pairwise comparisons were conducted with a Bonferroni's correction. Pairwise comparisons showed that the Christian brochure was rated more positively than either the traditional brochure ($p < .001$) or the nontraditional brochure ($p = .001$).

Figure 1

Interaction Between Denomination and Brochure



Chapter 5 – Discussion

In this chapter, the results of the study will be examined, and contributions to the body of research on religious variables and help-seeking will be discussed. First, demographic and religious predictors of help-seeking attitudes will be explored, and then denominational differences in religious variables will be outlined. Religious variables' relationships to brochure responses, as well as denominational differences in brochure responses, will also be examined. Limitations of the study will be noted, and implications for research and practice will be discussed.

Demographic Predictors of Help-seeking Attitudes

It was hypothesized that the current study would provide further evidence to support the conclusions of previous research on demographic variables and help-seeking. Specifically, female gender, urban residence, greater education and income, and previous contact with mental health professionals were all expected to be related to more positive help-seeking attitudes. Support was found for some parts of this hypothesis; specifically, previous experiences with therapy, age, female gender, and urban residence were found to be the most significant demographic predictors of positive help-seeking attitudes. Education and income, however, were not related to help-seeking attitudes in this sample.

Results related to previous contact with mental health services are consistent with findings from several previous studies (Fischer & Cohen, 1972; Fischer & Turner, 1970; Gelso & McKenzie, 1973; Morgan, 1992; Murstein & Fontaine, 1993). However, the directionality of this relationship is unclear. It may be that help-seeking attitudes change in a more positive direction as a result of receiving needed help, or it may be that those

who have the most positive attitudes are likely to have sought help as a result. In either case, it appears that experiences in counseling were viewed positively among those participants who had sought help before. It is interesting to note that while personal therapy was associated with more favorable help-seeking attitudes, family and friends' experiences with therapy did not appear in the analyses. It seems that when these attitudes are formed, others' experiences are not as important as an individual's own experiences.

Female participants' higher help-seeking scores are also compatible with previous research (Fischer & Farina, 1995; Komiya, Good, & Sherrod, 2000; Neighbors, Musick, & Williams, 1998; Sørgaard et al., 1996). As Robertson and Fitzgerald (1992) argued, it may be that counseling's emphases on cooperation, vulnerability, self-awareness, and emotion are more compatible with female socialization than with male socialization.

Other findings were less expected, based on previous research. None of the studies included in the literature review addressed age and urban or rural residence as predictors of help-seeking, but both were significant predictors in the current study. Findings on urban or rural residence were as hypothesized; it seems logical that people may have more positive help-seeking attitudes when they live in areas where mental health services are more visible or readily available in their community. However, age was not expected to predict attitudes. In this population, there may be a generational or a developmental effect. That is, the older generations in the study may have developed more positive attitudes, or people may feel less invincible and better recognize the need for support and help as they age.

It is also interesting to note that some of the expected findings were not supported by the current research. In early studies, greater education (Fischer & Cohen, 1972) and higher SES (Tessler & Schwarts, 1972) were related to more positive help-seeking attitudes. In this sample, however, neither of these variables attained or even approached significance, despite the wide range of education and income levels among the participants. Reasons for these findings are unknown. It could be that in the past few decades, mental health services have become more visible and more accessible to people of varying social status, thereby increasing positive attitudes in a wider variety of populations.

Religious Predictors of Help-seeking Attitudes

This study examined relationships between religious variables and help-seeking, in hopes of building our understanding of variables that could lead to more positive attitudes among church members. It was hypothesized that religious commitment, religious belonging, and organized religious activity would have some predictive value. It was also hypothesized that perception of one's church as conservative would be associated with more negative attitudes, while perception of one's church as liberal would be associated with more positive ones. Limited support was found for the first of these hypotheses, and little to no support was found for the second. Specifically, regression models suggested that religious commitment and religious belonging were related to help-seeking attitudes, but church conservatism or liberalism did not appear in regression analyses. The findings are discussed below; however, it is important to note that they should be interpreted with caution, since the variables predicting help-seeking varied across different regression models.

In the current study, religious commitment appeared to have the strongest predictive value of the religious constructs, such that those who adhere more closely to religious beliefs and practices appeared to have more favorable attitudes about seeking help. Reasons for this relationship are unknown, but might be partially explained by correlations between religious commitment and demographic variables. In this sample, RCI scores showed weak positive correlations with previous therapy, age, and female gender. In other words, those who showed higher religious commitment were more likely to be older, female, and/or have previously sought mental health services. These interrelationships may be important to study further if the relationship between religious commitment and help-seeking attitudes is to be understood.

Two other religious variables appeared in more than one of the regression models described in the results section. Specifically, greater time in religious body and a perception that one's church would encourage help-seeking with secular providers both predicted more positive help-seeking attitudes. Those who had been involved with their churches for more time, and who presumably would be more established within their church communities, showed more positive attitudes. Reasons for this relationship are not clear. In contrast, the relationship between help-seeking attitudes and perception of church help-seeking seems to make sense intuitively. Churches that would encourage their members to seek help with secular providers would communicate the message that counseling and psychotherapy can be helpful whether or not the provider is Christian. Members who observed this attitude in their church communities might be more inclined to view mental health services in a positive light.

Finally, two other variables did not appear in a stepwise regression for religious predictors, but appeared in two alternative models. Specifically, religious belonging appeared when religious commitment was removed from the regression, and again in the hierarchical model when both demographics and religious constructs were included. This result, combined with the absence of religious commitment in the hierarchical model, lends support to the idea that the relationship between religious commitment and help-seeking was affected by demographic variables and previous help-seeking. It implies that when religious commitment is not considered, help-seeking may be more related to a sense of belonging within one's religious group. Acceptance of church teachings, in contrast, had a negative relationship with help-seeking attitudes. It appeared in the backward regression for religious variables and in the hierarchical model, and implies that those who report more acceptance of church teachings have more negative attitudes toward seeking help. This is consistent with King's (1978) finding that people who agreed strongly with church doctrine were less likely to seek professional help. One might conjecture that those who espouse total acceptance of what their churches teach might have negative reactions to the process of self-examination and questioning that is inherent in most counseling and psychotherapy.

Again, it is important to be cautious in interpreting the results for this part of the current study. The variability in regression models suggests that the relationships among religious constructs and between religious constructs and help-seeking are characterized by overlapping constructs and confounded by correlations with demographics. Further study is needed in order to understand the interrelationships among these variables.

Denominational Differences in Religious Constructs

The four denominations included in the current research were compared to find out whether there were any differences in religious variables. No hypotheses were offered to address this question; it was purely exploratory. No differences were found in self-perceived religiosity or time in religious body; significant differences were found in all of the other religious variables. These differences are reviewed here.

First, Baptists scored higher than Catholics or Mennonites in religious commitment and higher than all three other denominations in organized religious activity (attendance at religious services and events). It is possible that Baptists adhere more closely to religious beliefs and values, use them more in daily life, and attend religious events more often. However in this study, these differences are thought to be attributable to sampling error. As mentioned in the Method section, participants were recruited in times and settings preferred by each congregation's clergy or other leaders. In most congregations, this meant that participants were recruited during Sunday morning services. However, the two largest of the four Baptist groups requested that data be collected during Wednesday night activities. It is reasonable to assume that by recruiting participants on a day other than Sunday, the researchers would be gathering data from the most active and involved of the church members, resulting in some bias in the Baptist sample.

Baptists also scored higher than all three other denominations in three constructs related to religious conservatism, specifically, acceptance of church teachings, perception of the church as espousing literal interpretation of the Bible, and perception of the church as politically conservative. These differences may have been affected by the sampling

bias outlined above, but they are also compatible with the generally accepted view of the Southern Baptist Convention as a more fundamentalist or evangelical group than the other three denominations. Some differences also existed among the other three groups. In Bible interpretation, Mennonites perceived their churches as more literal than Catholics or Methodists (a result consistent with the Mennonite history of emphasis on scripture rather than church authority). In politics, Catholics perceived their churches as more conservative than Methodists.

An interesting difference was found in following church traditions, the third item related to church conservatism. Mennonites scored lower than all three other groups in answering this question. Given their history of living separate from the world, forming strong communities, and adopting simple lifestyles, it might have been expected that this group would report a strong sense of tradition. However, many of the surface distinctions that made Mennonites unique (e.g., agricultural lifestyle, plain clothing, simple church buildings, a capella singing) are disappearing, particularly in the Mennonite Church USA, which is the most mainstream of the Mennonite denominations. These changes within recent generations may result in a reduced sense of tradition within the denomination.

Significant results were also found when religious belonging was assessed. Catholics scored higher than Methodists or Mennonites in religious belonging, thereby suggesting that they identify more closely with their religious group than some Protestant denominations do. This may provide evidence for a strong sense of group identity among Catholic church members, and it is consistent with the strong sense of history, institution, and loyalty, hierarchical structure, worldwide organization, and strong involvement in education, health care, and charitable work for which the Catholic church is known. It is

also interesting that the Mennonite group did not score higher, given their history of living separate from the world, emphasis on community, and in-group loyalty (Just, 1954). However, the above-mentioned changes in the denomination may result in less cohesiveness than in the past.

It is very important to note that differences based on religious belonging should be interpreted with caution, since the term "religious group" was not specifically defined in the instructions for the MEIM. Some participants may have been assessing their relationship to their congregation, others to their denomination, and others to the Christian religion in general. An attempt was made to assess this by asking participants to specify their religious group before beginning the MEIM ("In terms of religious group, I consider myself to be ____."). In response to this question, 34 of the respondents answered Christian, and 124 specified their denomination (40 Catholic, 23 Baptist, 34 Methodist, and 27 Mennonite). The others either did not answer, listed multiple affiliations (e.g., both Christian and Catholic), or specified protestant, conservative/ liberal, or other identifiers. Clearly, differences in religious belonging may not be interpreted without considering individual differences in reference group.

Finally, differences were found among the four denominations in their perceptions of church help-seeking attitudes. With secular providers, Catholics and Methodists were more positive than Baptists or Mennonites. With Christian providers, Mennonites were less positive than all three other denominations, and Baptists were more positive than Catholics. With church leaders, Baptists were more positive than Methodists or Mennonites. Two patterns seem to be worthy of attention. First, Baptists were the highest scorers for both types of Christian help (professionals and church

leaders). This seems consistent with their higher level of involvement in church and greater acceptance of church teachings, and it may also have been related to the fact that two of the Baptist congregations had established counseling programs within their churches.

Second, it seems worth noting that Mennonites scored lowest on all three church help-seeking items. This may be a reflection of greater distrust for mental health resources or more reliance on ties with family and community. It may also be an issue of congregational size and resources. Several congregations within the other denominations were very large, urban, and provided a number of programs and services to their members. In contrast, the Mennonite congregations were small and tended to be in rural areas. It may be that members were not being encouraged to seek help because sources for mental health help were not as available within the organizations or communities.

Relationships Between Religious Constructs and Preferences for Alternative Mental Health Facilities

Relationships between the religious variables and participants' responses to the brochures may give insight into the factors that will affect Christian church members' choices, given options for seeking help. Several variables were positively related to Christian services, and several were negatively related to traditional and nontraditional services. One variable was positively related to secular help-seeking. These relationships, as well as interrelationships among the brochures, are outlined in this section.

First, it was hypothesized that higher religious commitment, higher belonging, more organized religious activity, and perception of one's church as conservative would

be related positively to the Christian brochure. Limited support was found for the first, third, and last parts of this hypothesis, as follows. Three variables were positively related to the Christian brochure, including religious commitment, perception of oneself as religious based on participation in organized religion, and perception of one's church as politically conservative. Thus, those who adhere more closely to religious beliefs, values, and practices in their daily lives, or who perceive themselves as highly involved in organized religion were more likely to seek services at a Christian facility. These findings are consistent with Worthington's (1991) assertion that potential clients often look for providers that hold similar values to their own and Mitchell and Baker's (2000) observation that highly committed Christians looked for helpers with a similar world view and had more positive views of Christian providers (professional or not) than secular providers. The finding that members of politically conservative churches were also more likely to seek services at a Christian facility also seems to make sense intuitively, given many conservative politicians' emphasis on religious values.

Two religious constructs were negatively related to the non-Christian (traditional and nontraditional) brochures. Those who espoused acceptance of church teachings and literal interpretation of the Bible were less likely to choose the traditional or nontraditional brochures. Given the assumed "gap" in religiosity between psychotherapists and the general population (Bergin, 1991; Kelly & Strupp, 1992; Shafranske & Gorsuch, 1984), these findings are very consistent with King's (1978) finding that those who agreed strongly with church doctrine were less likely to seek professional help. Although the current study did not offer clergy or church leaders as a helping alternative, these participants may also have been among those more likely to

consult clergy as their first help source, as did participants in several previous studies (King, 1978; Neighbors, Musick, & Williams, 1998; Purdy, Simari, & Colon, 1983; Woods, 1977).

One construct was positively related to responses to the traditional brochure, namely, perception that the church encourages members to seek help from secular providers. This result suggests a clear, logical relationship between church leaders' or congregations' attitudes and the help-seeking of individual members. It seems that members are more likely to seek help from a secular provider if their churches encourage them to do so.

Finally, the relationships among responses to the three brochures are noteworthy because of their relationship to previous findings. While all three brochures were positively correlated with each other, the Christian brochure was perceived as "more different" when compared to the traditional and nontraditional services. Previous research (Komiya, Good, & Sherrod, 2000; Robertson & Fitzgerald, 1992) suggested that potential clients (especially men with traditional gender roles) will respond differently if mental health services are reframed as consultation, coaching, seminars, or in other nontraditional terms. This may be true; however, when church populations are exposed to traditional language, nontraditional language, and Christian terms, the importance of traditional and nontraditional language fades in importance. Compatibility in values seems to be more salient to them, as suggested by King (1978), Mitchell and Baker (2000), and Worthington (1991).

Denominational Differences in Preferences for Alternative Mental Health Facilities

As a follow-up to an examination of how religious variables are related to preferences for the three mental health alternatives, the four denominations were compared for differences in brochure responses. Each denomination showed a different pattern in expressed likelihood of choosing among the brochures. These differences are discussed in this section.

First, Catholic respondents did not seem to have a preference for any brochure over the others. This group's pattern seems to fit with previous findings (Loewenthal et al., 2001; Sørgaard et al., 1996) that showed a nonspecific help-seeking pattern, such that those who were more likely to seek help from one source were more likely to seek help in general. It may be helpful to explore responses in this group further, in order to understand what makes them less likely to distinguish among different providers. If results of the current study hold in other samples, it may be that some element of Catholic religious life makes distinctions between secular and Christian providers less important.

In contrast, a strong preference was expressed for the Christian brochure by the Baptist participants, and no difference was perceived between the traditional and nontraditional brochures. In this group, which displayed higher religious commitment, more acceptance of church teachings, more literal interpretation of scripture, and more political conservatism, the religious variables appear to exert a strong influence on choices about mental health services. This group seems to exemplify the variables found to be most influential in other parts of the current study. Southern Baptists may thus be one good population with which to examine these relationships further.

Mean brochure rankings for Methodists and Mennonites were higher for the Christian brochure than for either the traditional or the nontraditional brochure. However, for Methodists the difference between the Christian and traditional brochures did not reach significance. The Methodists and Mennonites displayed the same basic patterns as the Baptist population, but the differences were much less intense. Presumably, this can be attributed to displaying less of the religious traits most associated with help-seeking attitudes. As these populations are generally viewed as less conservative and less evangelical, it may be less important to them to seek out Christian providers.

Limitations

Several limitations are evident in the present study. First, the population of respondents is not fully representative of the general population of church members. Participants were nearly all white and Midwestern or Southern, and they came from only four denominations among many. Thus findings may not be applied to non-white church members or to people living in different geographical regions. Neither may they be extended to other denominations or religious populations without extreme caution; religious and spiritual life in the U.S. is much too varied to assume that the results of this study can be applied to American Christians in general.

Second, there are limitations related to participant recruitment and sampling. As mentioned in the method section, the participants were asked to complete the questionnaires while they were in church services or activities. Asking people to participate while they were engaged in worship and fellowship may have produced an automatic tendency to view the questionnaire in religious terms and place greater

importance on religion. Participants may also have self-selected, such that the most involved members of the congregation might be more likely to volunteer for extra activities. One example of this may be the above-mentioned differences in religious commitment and attendance among Baptists, some of whom were recruited at Wednesday night services. It is unknown whether the results would have been as significant if people had been recruited at community events rather than church-related events, but it is likely that the sampling method reduced the possible dispersion of scores.

Finally, some limitations arise from the measurement issues discussed in the literature review. These limitations, as well as some improvements over previous studies, are reviewed in the following section.

Measurement Issues

Previous counseling and psychotherapy research with religious constructs have been plagued by measurement issues, including lack of consistency in definitions of religious variables and constructs, bias toward Christian religious beliefs and practices, reliance on one- or two-item measures or measures written specifically for one study, confounds with demographic variables, and lack of ability to account for the wide range of religious expression in American society. In several ways, the current study presents an improvement over previous research. In other ways, it is limited by the same problems.

First, the current study included a detailed review of attempts to measure "religion" or "the religious variable." As a result, religious constructs and measures that showed some evidence of reliability and/or predictive value, as well as compatibility with psychological research, were chosen. For example, the RCI-10 and MEIM have both

been used with success in psychological research, have good evidence of reliability and validity, and measure constructs judged to have implications for mental health (degree to which religious values affect daily life and decision-making, and degree of identification with or belonging in one's religious group, respectively). The current study provides further evidence of the good psychometric properties of these two measures; these choices also reduced the current study's reliance on single-item measures with untested psychometric properties.

Second, this study included a broader array of religious measures than many previous studies. Rather than relying solely group classification (Loewenthal et al., 2001), single-item measures (Schnittker, 2001; Wong, 1997), or brief sets of items (Purdy, Simari, & Colon, 1983), the current study used a combination of published measures, single items, brief Likert-type scales, and group classification. As a result, a broader view of religious variables in help-seeking was obtained, and relationships among religious variables can be further studied.

Some of the limitations of previous research remain. For example, although measures that seemed applicable to a wide variety of religious groups were chosen, no attempt was made to completely eliminate bias toward Christian groups. Since the study was focusing specifically on a Christian population, the occasional appearance of terms such as church and Bible were judged appropriate. Confounds with demographic variables may also have been present, as mentioned in the discussion of how religious commitment was correlated with previous help-seeking, age, and gender. Additionally, the full range of Christian religious expression could not be represented in a questionnaire.

Finally, although the primary religious variables to be examined (denomination, religious commitment, and religious belonging) were measured using established methods, the secondary religious variables were still measured using one- to three-item scales. These provide only a superficial view of the concepts, and their reliability and validity are largely untested. [A possible exception is organized religious activity or church participation, which Worthington (2003) noted has shown evidence of reliability.] In fact, although the significant relationships discovered in the current study lend evidence to support the utility of some items, the study also provided some evidence that the three-item scales were not internally consistent. Their coefficient alphas were low, and they needed to be split apart for the analyses. Included in these miniature scales were the three items Worthington and his colleagues (2003) used to develop the RCI-10. In the current sample, the item about transcendental definitions of spirituality appeared to be highly unreliable and was therefore eliminated from analysis. Any results associated with these single-item measures must therefore be interpreted with caution.

Implications for Practice and Directions for Further Research

The results of this research make it clear that religious variables are important in influencing help-seeking attitudes and choices among helpers. As noted previously, much support is leant to the idea that perceived similarity in values or at least respect for the importance of religion are important factors in determining whether highly involved Christians will seek help from a given provider. If these results can be generalized, it appears that many Christians, in particular Protestants, will prefer a Christian provider or facility over one in which religion is not emphasized. As Bergin (1991) and Koenig (1990) argued, potential clients will often search for a provider who is sympathetic to

spiritual concerns. Regardless of providers' spiritual beliefs and practices, they may be more likely to see religious clients if the information they give to the public conveys respect for spirituality and/or an openness to talking about spiritual concerns. Of course, congruence between advertising and actual practice is essential; not only is it important to convey respect for spirituality in advertising, but it is also important to convey respect in session and to understand clients' religious values and worldview, as Kelly and Strupp (1992) have argued.

Results also highlight the importance of messages about help-seeking that Christians hear in their religious groups. As noted above, a positive help-seeking attitude in the church (especially in regard to secular providers) may be associated with more positive help-seeking attitudes in its members. Involvement in religion may also have a subtle effect on help-seeking attitudes, as evidenced by the positive relationships with religious commitment and belonging. It may be that a positive experience in a religious community creates a more positive attitude toward seeking help when one needs it.

The study raises a number of questions for further research. First, relationships discovered in this population need to be tested in other populations, including widely varied Christian groups as well as groups from other religious traditions. Further improvements in measurement of religious involvement will be needed, particularly if research is to be extended outside the Christian tradition. In improving measurement, studies of the relationships among psychologically-relevant religious variables should be expanded, and connections better understood. It also seems appropriate to study further the responses of different religious groups to different information about mental health services. It would be useful to understand, for example, whether potential clients react

the same or differently to facilities that express respect for religion and spirituality in general, or one religious tradition in particular.

Religious constructs do seem to have an influence on Christians' help-seeking attitudes, as well as their preferences for alternative mental health settings. Further study is needed in order to examine and clarify these relationships, as well as to apply them to the practice and marketing of mental health services.

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Appendix A

Description Response Questionnaire

See the next seven pages for a copy of the Description Response Questionnaire, which was used to measure participants' stated likelihood of seeking help at each alternative mental health facility.

Service Questionnaire

The following is a list of common issues or problems that people encounter. For each issue, please rate the likelihood that you will face these problems in the future. Use the following scale:

1	2	3	4	5	6
very unlikely	moderately unlikely	slightly unlikely	slightly likely	moderately likely	very likely

1. making a career or academic choice	1	2	3	4	5	6
2. diet or weight issues	1	2	3	4	5	6
3. relationship difficulties	1	2	3	4	5	6
4. self-confidence problems	1	2	3	4	5	6
5. overuse of alcohol	1	2	3	4	5	6
6. personal worries	1	2	3	4	5	6
7. difficulty in sleeping	1	2	3	4	5	6
8. concerns about sexual issues	1	2	3	4	5	6
9. procrastination on the job or at school	1	2	3	4	5	6
10. difficulty concentrating	1	2	3	4	5	6
11. depression	1	2	3	4	5	6
12. fear of failure	1	2	3	4	5	6
13. improvement in self-understanding	1	2	3	4	5	6
14. relaxation training	1	2	3	4	5	6
15. anxiety about test or job performance	1	2	3	4	5	6
16. loneliness	1	2	3	4	5	6
17. drug problems	1	2	3	4	5	6

Please read the following description and answer the questions to follow.

Imagine that you have been struggling with an issue in your life and have decided that it might be best to consult a professional for help. You search a local directory for resources, and you find three centers located in your community. You contact each center to get more information about their services, and brochures are sent to you through the mail. Upon examining the brochures, you find that each center

1) employs multidisciplinary teams of licensed professionals with expertise in a variety of problems;

2) offers services involving weekly meetings for a period of one to four months, although longer time periods can be arranged;
3) operates using a sliding fee scale (charges for services based on client income) to make services affordable to a wide variety of people;
4) has a waiting period of one to three weeks before the first appointment due to high demands for their services; and
5) can provide services on the same day in emergency situations.

However, there are some differences in the descriptions of services offered by the centers. These descriptions are found below. Please read each description carefully and then respond to the questions below them.

Center A

Mission statement: [Center A] is a responsive and compassionate resource that is committed to fostering personal growth and mental health in members of our community. Our mission is to help individuals and families to reach their full potential at home, work, school, and leisure.

Services: We offer a full range of counseling services, including individual, couples, family, and group counseling, crisis intervention, psychiatric services, and referral.

- *Individual therapy*: You may use individual therapy to address concerns including but not limited to depression, anxiety, relationship issues, childhood trauma, and concerns about work or school.
- *Couples and family therapy*: Issues in couple and family relationships are best addressed by meeting together, with a therapist or pair of therapists who will help you to resolve conflicts, cope with problems, and develop closer relationships.
- *Group therapy*: When peer support is needed or interpersonal issues are involved, group therapy may be most useful. The center regularly offers groups for interpersonal concerns, survivors of sexual assault, people with bipolar disorder, and other concerns as needed.
- *Crisis intervention*: Immediate appointments are available in times of emergency. Simply walk into the center, and our on-call counselor will meet with you to address immediate concerns, provide support, and develop an action plan to resolve the crisis.
- *Psychiatric services*: For clients who may benefit from the use of medication, the center provides psychiatric services.
- *Referral*: If you have concerns that are not within the expertise of our staff, we will provide referral to other appropriate resources in our community.

Reasons for seeking help: We can be helpful in addressing a number of concerns. Here are some examples of reasons our clients come for help:
"I need to talk to someone"
"I'm depressed"
"I can't sleep"
"I'm having problems in my relationship"
"My eating is out of control"

"I hate my job"
"I was sexually assaulted"
"I want to be more assertive"

Now please imagine that you are struggling with each problem below, *even if you are not likely to have the problem in real life*. For each issue, please rate the likelihood that you would seek help for that problem in Center A. Use the following scale:

1	2	3	4	5	6
very unlikely	moderately unlikely	slightly unlikely	slightly likely	moderately likely	very likely

How likely would you be to seek help at Center A for each issue below?						
1. making a career or academic choice	1	2	3	4	5	6
2. diet or weight issues	1	2	3	4	5	6
3. relationship difficulties	1	2	3	4	5	6
4. self-confidence problems	1	2	3	4	5	6
5. overuse of alcohol	1	2	3	4	5	6
6. personal worries	1	2	3	4	5	6
7. difficulty in sleeping	1	2	3	4	5	6
8. concerns about sexual issues	1	2	3	4	5	6
9. procrastination on the job or at school	1	2	3	4	5	6
10. difficulty concentrating	1	2	3	4	5	6
11. depression	1	2	3	4	5	6
12. fear of failure	1	2	3	4	5	6
13. improvement in self-understanding	1	2	3	4	5	6
14. relaxation training	1	2	3	4	5	6
15. anxiety about test or job performance	1	2	3	4	5	6
16. loneliness	1	2	3	4	5	6
17. drug problems	1	2	3	4	5	6

Center B
Mission statement: [Center B] is an innovative, dynamic resource committed to helping you to achieve your optimum potential. Our mission is to help you develop your skills, overcome obstacles, and reach your goals!

Services: We provide a variety of services to our clients, including coaching, group skills workshops, stress management training, crisis management, psychiatric services, and referral.

- *Coaching*: You may meet individually with a professional in order to address current obstacles, develop your coping and interpersonal skills, and resolve conflicts related to your relationships, work or social life, or other areas.
- *Skills workshops*: The center regularly offers a number of 6-8 week workshops designed to improve your interpersonal skills and provide support. Workshop topics offered recently include assertiveness training, social skills, and coping skills for bipolar disorder. Other workshops are available as needed.
- *Stress management training*: We offer regular training on stress management, including workshops on breathing and other body relaxation, visualization techniques, cognitive strategies, and using artistic expression to cope.
- *Crisis management*: Immediate help is available in times of emergency. Simply walk into the center, and our on-call staff member will meet with you to address immediate concerns, provide support, and develop an action plan to resolve the crisis.
- *Psychiatric services*: For clients who may benefit from the use of medication, the center provides psychiatric services.
- *Referral*: If you have concerns that are not within the expertise of our staff, we will provide referral to other appropriate resources in our community.

Reasons for seeking help: We work with our clients to improve their skills in a wide variety of areas. Here are some examples of reasons our clients come:
"I'm not satisfied at work"
"I can't sleep"
"I want to learn to negotiate better"
"I could use some support"
"My dieting is causing difficulties"
"I've been feeling down"
"I want to improve my relationship"
"I am a rape survivor"

Now please imagine that you are struggling with each problem below, *even if you are not likely to have the problem in real life*. For each issue, please rate the likelihood that you would seek help for that problem in Center B. Use the following scale:

1	2	3	4	5	6
very unlikely	moderately unlikely	slightly unlikely	slightly likely	moderately likely	very likely

How likely would you be to seek help at Center B for each issue below?						
1. making a career or academic choice	1	2	3	4	5	6
2. diet or weight issues	1	2	3	4	5	6

3. relationship difficulties	1	2	3	4	5	6
4. self-confidence problems	1	2	3	4	5	6
5. overuse of alcohol	1	2	3	4	5	6
6. personal worries	1	2	3	4	5	6
7. difficulty in sleeping	1	2	3	4	5	6
8. concerns about sexual issues	1	2	3	4	5	6
9. procrastination on the job or at school	1	2	3	4	5	6
10. difficulty concentrating	1	2	3	4	5	6
11. depression	1	2	3	4	5	6
12. fear of failure	1	2	3	4	5	6
13. improvement in self-understanding	1	2	3	4	5	6
14. relaxation training	1	2	3	4	5	6
15. anxiety about test or job performance	1	2	3	4	5	6
16. loneliness	1	2	3	4	5	6
17. drug problems	1	2	3	4	5	6

Center C

Mission statement: [Center C] is a responsive and compassionate resource that is committed to fostering personal growth and mental health in a Christian setting. Our mission is to help individuals and families to reach their full potential at home, work, school, and leisure, as well as spiritually.

Services: We offer a full range of counseling services, including individual, couples, family, and group counseling, crisis intervention, psychiatric services, and referral.

- *Individual therapy*: You may use individual therapy to address concerns including but not limited to depression, anxiety, relationship issues, childhood trauma, and concerns about work or school. Our counselors are trained from a non-denominational Christian perspective and if you wish, will help you to explore spiritual dimensions of your concerns.
- *Couples and family therapy*: Issues in couple and family relationships are best addressed by meeting together, with a therapist or pair of therapists who will help you to resolve conflicts, cope with problems, and develop closer relationships within a Christian perspective.
- *Group therapy*: When peer support is needed or interpersonal issues are involved, group therapy may be most useful. The center regularly offers groups for interpersonal concerns, survivors of sexual assault, people with bipolar disorder, and other concerns as needed.
- *Crisis intervention*: Immediate appointments are available in times of emergency.

Simply walk into the center, and our on-call counselor will meet with you to address immediate concerns, provide support, and develop an action plan to resolve the crisis.

- *Psychiatric services*: For clients who may benefit from the use of medication, the center provides psychiatric services.
- *Referral*: If you have concerns that are not within the expertise of our staff, we will provide referral to other appropriate resources in our community.

Reasons for seeking help: We can be helpful in addressing a number of concerns. Here are some examples of reasons our clients come for help:
"I have concerns about a spiritual issue"
"I'm depressed"
"I can't sleep"
"I'm having problems in my relationship"
"My eating is out of control"
"I hate my job"
"I was sexually assaulted"
"I want to be more assertive"

Now please imagine that you are struggling with each problem below*, even if you are not likely to have the problem in real life*. For each issue, please rate the likelihood that you would seek help for that problem in Center C. Use the following scale:

1	2	3	4	5	6
very unlikely	moderately unlikely	slightly unlikely	slightly likely	moderately likely	very likely

How likely would you be to seek help at Center C for each issue below?						
1. making a career or academic choice	1	2	3	4	5	6
2. diet or weight issues	1	2	3	4	5	6
3. relationship difficulties	1	2	3	4	5	6
4. self-confidence problems	1	2	3	4	5	6
5. overuse of alcohol	1	2	3	4	5	6
6. personal worries	1	2	3	4	5	6
7. difficulty in sleeping	1	2	3	4	5	6
8. concerns about sexual issues	1	2	3	4	5	6
9. procrastination on the job or at school	1	2	3	4	5	6
10. difficulty concentrating	1	2	3	4	5	6
11. depression	1	2	3	4	5	6
12. fear of failure	1	2	3	4	5	6

13. improvement in self-understanding	1	2	3	4	5	6
14. relaxation training	1	2	3	4	5	6
15. anxiety about test or job performance	1	2	3	4	5	6
16. loneliness	1	2	3	4	5	6
17. drug problems	1	2	3	4	5	6

Which center most emphasized skills-building and workshops?

Center A Center B Center C

Which center most emphasized one-on-one counseling services with a secularly-trained therapist?

Center A Center B Center C

Which center most emphasized spiritual issues?

Center A Center B Center C

Appendix B

Religious Involvement Questionnaire

See the next two pages for a copy of the Religious Involvement Questionnaire, which was used to indicate denomination and measure organized religious activity, time in religious body, acceptance of church teachings, self-perceived religiosity, perception of church conservatism/liberalism, and perception of church help-seeking attitudes.

RIQ/DQ

Please answer the following questions about your religious involvement.

1. Please indicate your current religious affiliation:

   ____ Roman Catholic
   ____ Southern Baptist
   ____ United Methodist
   ____ Mennonite Church USA
   ____ Other (please specify: _____)

2. How often do you attend religious services or participate in other organized religious activities?

   ____ never
   ____ once a year
   ____ a few times a year
   ____ once a month
   ____ once a week
   ____ more than once a week

3. For how many years have you been a part of your denomination? _____

4. How closely do your beliefs and values follow the teachings of your church?

   ____ Not at all – I do not accept any of the teachings of my church
   ____ Mostly not – I accept very little of the teachings of my church
   ____ Somewhat – I accept some of the teachings of my church
   ____ Mostly – I accept most of the teachings of my church
   ____ Totally – I accept all of the teachings of my church.

5. Please answer the following by circling the number that best matches your response:

   a. If religiosity is defined as participating with an organized religion, then to what degree do you consider yourself religious?

      Not at all 1 2 3 4 5 Totally

   b. If spirituality is defined as a belief and participation in some transcendental realm, then to what degree do you consider yourself spiritual?

      Not at all 1 2 3 4 5 Totally

   c. If spirituality is defined as qualities and characteristics of exemplary humanity (e.g., honesty, hope, compassion, love of humanity, etc.), then to what degree do you consider yourself spiritual?

      Not at all 1 2 3 4 5 Totally

6. Please answer the following by circling the number that best matches your response:

   a. My church interprets the Bible literally.

      Not at all 1 2 3 4 5 Totally

   b. My church closely follows denominational traditions.

      Not at all 1 2 3 4 5 Totally

   c. My church espouses politically conservative teachings.

      Not at all 1 2 3 4 5 Totally

7. Please answer the following by circling the number that best matches your response:

   a. If a person has personal concerns, my church encourages members to seek assistance from secular mental health providers (e.g., counselors, psychologists).

      Not at all 1 2 3 4 5 Totally

   b. If a person has personal concerns, my church encourages members to seek assistance from Christian mental health providers (e.g., counselors, psychologists).

      Not at all 1 2 3 4 5 Totally

   c. If a person has personal concerns, my church encourages members to seek assistance from church leaders.

      Not at all 1 2 3 4 5 Totally

8. Have you or someone close to you ever sought professional psychological help for a personal problem? Please check all that apply:

   ____ yes, I have sought help from a mental health professional
   ____ yes, a family member has sought help from a mental health professional
   ____ yes, a close friend has sought help from a mental health professional
   ____ no, neither I nor someone close to me has sought help from a mental health professional

Appendix C

Demographic Questionnaire

See the next page for a copy of the Demographic Questionnaire, which was used to collect demographic information about the participants.

Demographic Sheet

Please answer the following questions about demographic variables:

1. Age: _____

2. Gender: ____ male ____ female

3. Race/ethnicity:

____ Caucasian/White
____ African American/Black
____ Hispanic/Latino/Latina
____ Asian American/Pacific Islander
____ Native American
____ Biracial/Multiracial
____ Other (please specify: _____)

4. Relationship status:

____ single
____ serious relationship
____ living with significant other
____ married
____ separated
____ divorced
____ widowed
____ other (please specify: _____)

5. Place of residence:

a. U.S. State: _____

b. Urban/rural: ____ rural ____ small town ____ suburban ____ urban

6. Highest level of education:

____ less than high school
____ high school diploma or GED
____ some college
____ associates or other professional degree
____ bachelors degree
____ masters degree
____ doctoral degree

7. Approximate annual income:

____ less than $12,000
____ $12,000 to $24,999
____ $25,000 to $49,999
____ $50,000 to $99,999
____ $100,000 to $1,000,000
____ greater than $1,000,000

Appendix D

Solicitation of Participants

The following three scripts were used to solicit participation in the study. Each is labeled for the condition in which it was to be used.

If the researchers made the announcement orally

Hi! My name is Stefani Hathaway, and I'm a doctoral student from the University of Missouri-Columbia. For my dissertation I'm conducting research about how members of various religious groups think about services provided by mental health professionals. My intent is to improve helping services and make them more useful to diverse religious groups. I'm here today to ask adults age 18 or older to participate in my research. If you agree to participate, you will fill out an anonymous written questionnaire, which should take approximately 20-25 minutes. You'll also have the option of entering a drawing for $50. If you are willing to be a part of my study, please stop by the table located in __. I'll be there after this service. And thank you in advance!

If a church leader made the announcement orally

Today a doctoral student from the University of Missouri-Columbia is visiting our church to request participation in her dissertation research. Her name is Stefani Hathaway, and she is conducting a study about how members of various religious groups think about services provided by mental health professionals. Her purpose is to improve helping services and make them more useful to diverse religious groups. She is asking adults age 18 or older to participate in the study. If you agree to participate, you will fill out an anonymous written questionnaire, which should take approximately 20-25 minutes.

You'll also have the option of entering a drawing for $50. If you are willing to be a part of the study, please stop by her table located in ____. She'll be there after this service. Thank you!

If the announcement was printed in a flyer or bulletin

Request for research participation: Today Stefani Hathaway, a doctoral student from the University of Missouri-Columbia, is visiting our church to request participation in her dissertation research. She is conducting a study about how members of various religious groups think about services provided by mental health professionals. Her purpose is to improve helping services and make them more useful to diverse religious groups. She is asking adults age 18 or older to participate in the study. If you agree to participate, you will fill out an anonymous written questionnaire, which should take approximately 20-25 minutes. You'll also have the option of entering a drawing for $50. If you are willing to be a part of the study, please stop by her table located in ____. She'll be there after this service. Thank you!

Appendix E

Informed Consent Form

See the next page for a copy of the Informed Consent form, which participants were asked to keep.

INFORMED CONSENT – RELIGION AND HELP-SEEKING

Stefani Hathaway, M.A.
Department of Educational, School, and Counseling Psychology
University of Missouri-Columbia

I am conducting a study that involves research. The purpose of this research project is to learn more about how mental health professionals can provide better services to people from diverse religious groups. Participation involves filling out a written questionnaire, and I expect the time required to be approximately 25-30 minutes. The survey includes questions about four areas: (1) your reactions to fictional mental health brochures; (2) your thoughts about seeking professional help; (3) your religious affiliation and involvement; and (4) basic demographic information.

1) Risks associated with participation in this project are minimal. However, the following is a reasonably foreseeable risk or discomfort: Although procedures have been put in place to protect your privacy, you may experience some discomfort in answering personal questions about yourself.

2) The benefits to you or to others that may reasonably be expected from the research are improvements in provision of mental health services and ability to effectively market them. You may also enter a raffle for a cash prize of $50. Simply take an entry form from the researcher's table, complete the contact information, and submit your entry in the "Cash prize" drop box. The researcher will contact you if you are the winner.

3) Confidentiality of records shall be maintained as follows: No identifying information will be written on your questionnaire. Although demographic information will be collected, it will not be specific enough to identify any individual participant. Your name will appear only on your entry form for the cash prize (which is optional), and at no time will your questionnaire and your entry form be connected. Entry forms will be shredded immediately after the drawing is completed; all other forms associated with this research project will be kept in a locked file cabinet for a period of up to 7 years, then shredded.

4) If you should have any questions about this research project, please feel free to contact me, Stefani Hathaway, at (865) 974-2196, or my advisor, Glenn Good, at (573) 882-3084. For additional information regarding human participation in research, please feel free to contact the UMC Campus Institutional Review Board Office at 573-882-9585.

5) Please understand that your participation is voluntary, your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue your participation at any time without penalty or loss of benefits. Also, you do not have to answer any questions that may be asked.

6) You may keep this informed consent form for your records.

If you have read and understand the above information, and are willing to participate in the study, then please read and complete the attached questionnaire. When you are finished, return the questionnaire packet to the "Questionnaire" drop box on the researcher's table, and keep this page. Then you may pick up your raffle form and submit it in the "Cash prize" drop box. If you do ***not*** *wish to participate, simply return your blank materials back to the researcher's table.*

VITA

Stefani Hathaway was born January 3, 1977 in Hannibal, Missouri. After attending public school in Missouri, she earned the following degrees: B.A. in Psychology from Westminster College in Fulton, Missouri (1999); M.A. in Counseling Psychology from the University of Missouri-Columbia (2002); Ph.D. in Counseling Psychology from the University of Missouri-Columbia (2005). She completed her internship at the Counseling Center at the University of Tennessee, and she is presently a staff therapist at the Counseling Center at Bowling Green State University, Bowling Green, Ohio.