FACTORS RELATED TO MENTAL HEALTH STIGMA AMONG CHURCH-AFFILIATED AFRICAN AMERICANS

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FACTORS RELATED TO MENTAL HEALTH STIGMA AMONG CHURCH-AFFILIATED AFRICAN AMERICANS

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ABSTRACT

African Americans make up 13% of the U.S. population, yet represent nearly 20% of persons diagnosed with a mental illness. Studies suggest African Americans experience higher levels of mental health related stigma (MHS) than whites. In addition, African Americans have the highest rate of church attendance compared to all other racial/ethnic groups, and they are more likely to seek counsel from religious leaders. Although there is a growing body of research on MHS with African Americans, few studies have explored MHS predictors among church-affiliated African Americans – a population that may be important to examine given studies have shown that African American churches have great influence on health behaviors and beliefs among their members. This study used the Health Stigma and Discrimination Framework's key constructs (e.g., domains, facilitators, stigma marking, manifestations) to guide examination of predictors (e.g., mental health fear, awareness, and social support, cultural and social norms, access to mental health services, demographics, mental health conditions, and mental health-related stigma beliefs) of MHS among an African American church-affiliated population. Baseline survey data from the religiously-tailored

Healthy Actions to Impact Mind and Soul (Healthy AIMS) pilot intervention study, which focused on mental health screening and linkage to care services and took place in four African American churches (N=200 participants) in Kansas City, MO, was used to determine potential predictors of mental health stigma for examination. Most participants were female (79.5%), church members (78.5%) and an average age of 53 (SD = 17). Participants endorsed moderate to high levels of MHS (M = 39.03; SD = 6.8; range 11-55). Results indicated that social support (support from others and beliefs), collaborative and self-directive religious coping, and engaging in religious activities (e.g., thinking of God, meditating, praying) were significantly related to MHS. Linear regression analysis indicated that self-directive religious coping was a positive predictor of MHS. African Americans may engage in self-directive religious coping due to negative beliefs about the connection between having a mental illness and religiosity/spirituality. Future interventions may consider addressing MHS through providing tailored education and offering screening in a trusted setting, such as African American churches.

The faculty listed below, appointed by the Dean of the College of Arts and Sciences have examined a thesis titles “Factors Related to Mental Health Stigma Among Church-Affiliated African Americans,” presented by Tacia R. Burgin, candidate for the Master of Arts degree, and certify that in their opinion it is worthy of acceptance.

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CHAPTER 1

INTRODUCTION

Mental health issues are among the most prevalent health conditions in the United States (U.S.; CDC, 2018) and have risen by 13% in the past decade (WHO, 2020). According to the CDC (2018), 50% of adult Americans will be diagnosed with a mental illness in their lifetime. Between 2017 and 2018, mental illness diagnoses increased by over 1.5 million Americans and increased again between 2019 and 2020 (CDC, 2020; Mental Health America [MHA], 2020; National Institute of Mental Health [NIMH], 2021). The most prevalent mental illnesses include depressive disorders (affecting approximately 7% of the U.S. population) and anxiety disorders (affecting approximately 19% of the U.S. population; National Alliance on Mental Illness [NAMI], 2019). Major depressive disorder (MDD) – a mood disorder characterized by sad, empty or irritable mood and physical and/or mental changes that impair a person's ability to function on a daily basis, is a leading cause of disability worldwide (NIMH, 2019; WHO, 2020). MDD affects over 250 million people and is a contributor to the great global burden of chronic disease (NIMH, 2019; WHO, 2020). In the U.S., MDD affects nearly 7% of Americans each year (NIMH, 2019). Furthermore, suicide continues to represent the 10th leading cause of death in the U.S., and rates have continued to grow, especially in racial/ethnic minority populations (National Institute of Health [NIH], 2020). Over $193.2 billion is spent on serious mental illness costs each year (any mental disorder resulting in functional impairment substantially interfering with one's everyday life), and nearly $300 billion is spent on untreated mental illness costs per year (CDC, 2018; NAMI, 2017). Since

2011, reports have indicated that over 20% of Americans report an unmet need for mental health treatment (MHA, 2020).

The SARS-CoV-2 (COVID-19) pandemic has had a significant impact on mental health. An online COVID-19 survey with U.S. adult respondents found that 41% of participants reported at least one mental or behavioral health condition (i.e., anxiety/depressive disorder, trauma-and-stressor related disorder, increased substance use; Czeisler et al., 2020). Studies indicate that the COVID-19 impact on mental health could be due to several reasons, including social isolation and loneliness from shut down orders and quarantines, and/or increased worry and stress (Panchal et al., 2021). The Common Wealth Fund (2020) conducted a study and found that the majority of individuals with mental health concerns during the early months of this pandemic were Latinos (40%) and African Americans (39%) compared to whites (29%). Recent reports on suicidal ideation during the COVID-19 pandemic indicated that nearly 11% of U.S. adult respondents reported contemplating suicide 30 days before completing the survey in June 2020; 19% of these respondents were of Hispanic origin, and 15% were non-Hispanic black respondents (Czeisler et al., 2020).

Mental Health and African Americans

African Americans represent 13.3% of the population and 16% of U.S. adults affected by mental illness (MHA, 2020). African Americans have been more likely to experience chronic stress compared to whites in their lifetime (Rodriquez et al., 2018). Studies indicate 10% of African American adults have been diagnosed with MDD compared to 18% whites in their lifetime. However, African Americans are

particularly burdened by MDD in the long-term, with 56% of chronic cases among African Americans and 39% among whites (Bailey et al., 2019; Watkins et al., 2015). Major depressive episodes have also increased by up to 3% in African Americans aged 12-49 between 2015 and 2018 (from 9-10% for ages 12-17, 6-9% for ages 18-25, 6-7% for ages 26-49; MHA, 2020). Other more prevalent mental health illness disparities experienced by African Americans are described below and indicate a need to increase African Americans' access to professional mental health services.

Depression

Although the lifetime prevalence of depression is lower in African Americans compared to whites, some studies indicate that depression may be greatly underdiagnosed among African Americans even when they seek treatment. Sauceda and colleagues (2021) have found mixed results in their studies focused on Latinx and African American participants' somatization of depression and have reported that presentation of somatic symptoms instead of classic psychological symptoms among African Americans may contribute to misdiagnosis and underdiagnoses of depression. Furthermore, African Americans living with depression often have more difficulties with other health conditions (e.g., hypertension, cardiovascular disease, liver disease, arthritis, obesity; Hankerson et al., 2011; Watkins et al., 2015) that disproportionately affect African Americans (American Heart Association, 2009; Chapman et al., 2005; Hankerson at el., 2011), which can contribute to depression. This is possibly due to limited social and medical support related to managing chronic health conditions and lack of self-care due to having a mental illness (Assari, 2014). Studies have also reported that African Americans with MDD often show more somatic symptoms,

such as insomnia, restlessness, and early morning awakening, compared to their white counterparts (Hankerson at al., 2011).

Anxiety

Around 31% of American adults experience an anxiety disorder in their lifetime (NIMH, 2017). Anxiety symptoms have more than tripled for African Americans, from 8% to 34%, since 2019 (Fowers & Wan, 2020). A separate study found varying rates across anxiety disorder types in African Americans (social anxiety: 9%; generalized anxiety: 5%; panic: 4%; PTSD: 9%; The Recovery Village, 2020). Similar to other mental illnesses, anxiety disorders in African Americans is often underdiagnosed. However, African Americans tend to have increased exposure to social issues (e.g., victimization, oppression) that can contribute to symptoms or risk factors for anxiety (Himle et al. 2009). There is also a lack of screening (MHA, 2020), research and knowledge about anxiety among African American populations (Williams et al., 2013). Research has found that discrimination, homelessness, and exposure to violence are among various social factors that also contribute to increasing rates of anxiety among African Americans or that hinders them from seeking treatment (Anxiety and Depression Association of America [ADAA], 2020; Williams, 2018).

PTSD

Post-traumatic stress disorder is most common among African Americans with a lifetime prevalence of around 9% compared to whites at around 7% (Roberts et al., 2011, The Recovery Village, 2020). Much like other anxiety disorders, exposure to violence is highly related to PTSD, and African Americans tend to be more

chronically exposed to community violence (Sheats et al., 2018). Research has found that hearing about, witnessing, and being a direct victim of violence are predictors of PTSD (Gollub et al., 2019). In particular, African American youth are at a greater risk for PTSD compared to other races by over 25% due to high exposure to community violence (ADAA, 2020). In a study with nearly 310 million participants, African Americans and other non-whites, uninsured individuals, and those living in low income areas were less likely to seek trauma care for PTSD compared to others (Carr et al., 2017).

Substance Use

The 2018 National Survey on Drug Use and Health found that over 7% of African Americans have a substance use disorder, which is similar to 7% in the general U.S. population (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). They also found that, compared to 3% of the total population, almost 4% of African Americans have an illicit drug use disorder. Moreover, a separate national study found that over 13% of African Americans were engaged in illicit drug use compared to whites at 12% in 2018 (Kaliszewski, 2020). A similar prevalence of misuse of opioids and other prescription drugs has been reported among African Americans when compared to the general U.S. population at the rate of 4% (National Institute of Mental Health (NIMH), 2020). Over one million African Americans misused prescription pain relievers in 2019 (SAMHSA, 2020). Furthermore, substance and illicit drug use are more prevalent among African American individuals with mental health issues compared to those without mental health issues (MHA, 2020). Although studies have reported that whites are the

majority users of illicit drugs in the U.S. (SAMHSA, 2020), African Americans are less likely to be prescribed opioids for pain compared to whites. Research also suggests that African Americans are less likely to have access to medication-assisted treatment compared to whites (SAMHSA, 2020).

Suicide

In 2018, the number of deaths due to suicide among African Americans of all ages was over 15 per 100,000 people compared to whites at 37 per 100,000 people (The Office of Minority Health, 2021). African Americans have reported high levels of both risk and protective factors for suicide. Studies have shown that risk factors for suicide among African Americans include substance use, racism and discrimination, mood and anxiety disorders, and prior suicide attempts (Suicide Prevention Resource Center, 2018). Also, African Americans who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ+) tend to be at a greater risk for suicidal behavior. For example, Price-Feeney and colleagues (2020) found that 44% of African American LGBTQ+ youth participants considered suicide and 18% attempted suicide in 2019. Additionally, African Americans living at or below the poverty level are twice as likely to report serious psychological distress which may result in suicide (The Office of Minority Health, 2021). Reports on protective factors against suicide with African American populations include religiosity, social support, contacts with caregivers, and effective mental health care (Suicide Prevention Resource Center, 2018).

Despite the disproportionate rates of several mental illnesses among African Americans compared to other races/ethnicities (e.g., chronic MDD, PTSD, substance

use disorder, suicide among special African American populations), African Americans are still less likely to seek professional treatment compared to others (Broman, 2012). In 2018, over 58% of young adult African Americans (aged 18-25) and over 50% of African American adults (aged 26-49) who could have benefitted from professional mental health services had not received them (MHA, 2020).

Factors Contributing to Mental Health Inequities Including Limited Mental Health Service Seeking Among African Americans

Studies have reported that several individual, social, and structural factors contribute to mental health disparities that burden African Americans. Multilevel factors including age, limited mental health treatment seeking, medical mistrust, underdiagnoses, limited access to mental health information and services, and mental health stigma are discussed below.

Age

SAMHSA's 2018 national survey on drug use and mental health reported that a difference in depression rates existed across African American age groups, with the highest rates found in adolescence (ages 12-17 at 10%, 18-25 at 9%, and 26-49 at 6%; MHA, 2020). Heary and colleagues (2017) found that children's beliefs and attitudes towards others with mental illnesses, such as attention deficit hyperactivity disorder (ADHD) or depression, may be shaped by implicit messages provided from their family and community. More specifically, African American adolescents have reported being more likely to distance themselves from peers with a mental illness (Dupont-Reyes et al., 2019). Although research has reported that depression is more prevalent among adolescents, depression in older adults is less likely to be identified

and treated (Conner et al., 2010). Still, Conner and colleagues (2010) found that many older African American adults with mental illnesses in their study would not seek help because of their personal beliefs, such as being too old for treatment to work and treatment should be used for young adults who can benefit more, and/or have expressed limited faith in mental health treatment, medical mistrust, and limited access to treatment.

Medical Mistrust

Distrust in professional mental health care providers is another barrier that has been associated with a lack of mental health treatment seeking among African Americans (Hankerson & Weissman, 2012). For example, Conner and colleagues (2010) found that African American participants had many apprehensions about being treated for a mental illness, including concerns about treatment approaches and difficulties trusting a provider of a different race and ethnicity. Past research has suggested that African Americans have more trust in and prefer health care professionals of the same race and ethnicity (Goode-Cross & Grim, 2014). Studies have reported that having a provider of the same race and ethnicity may decrease the level of discrimination, racism, and bias a person may experience in receiving health care services (Huerto, 2020). However, African American mental health care providers are in limited supply (NIMH, 2020). The majority of professional mental health care providers are non-Hispanic whites (76% of all psychiatrists, 95% of all psychologists, 80% of all counselors, and 90% of all psychiatric nurses; Buche et al., 2017). Therefore, finding an African American provider may be challenging. To address these issues, the NIMH has created a strategic plan to address diversity and

inclusion of mental health professions. The goal of this plan, NIH Neuroscience Development for Advancing the Careers of a Diverse Research Workforce (R25), is to encourage individuals from underrepresented communities to pursue studies or careers in neuroscience, and biomedical/behavioral science research (NIMH, 2020), and to help to address concerns about having more representation and more selection of preferred mental health providers among underserved populations, such as African Americans.

Limited Access to Mental Health Information and Services

Studies have also shown that racial/ethnic minorities are at risk for low health literacy (e.g., ability to find, or enable individuals to find, understand, and use information and services to inform health related decisions for themselves and others; CDC, 2021), which may impair their access to mental health services. Fifty-eight percent of African American adults in a 2003 National Assessment of Adult Literacy were found to have basic or low health literacy (Muvuka et al., 2020). A separate study found that African Americans and their families were less likely to recognize mental health symptoms (Alegría et al., 2012). Discriminatory practices and systemic factors (e.g., limited educational opportunities, racism, health system mistrust, lack of culturally tailored health information) are some of the social issues that have created barriers to accessing general health information and care (Muvuka et al., 2020). In addition, African Americans- a population that tends to have lower monthly incomes than whites (e.g., African Americans earning an average of $41,361 compared to whites at $70,642 in 2018; Long & Dam, 2020)- have limited access to professional

mental health care due to the cost of mental health services (Kawaii-Bogue et al., 2017).

The average cost of care for annual health insurance for single coverage was $7,188 and $20,576 for family coverage in 2019 (Kaiser Family Foundation, 2019; Leonhardt, 2019). The median annual household income among African Americans was around $42,000 compared to whites at nearly $68,000 in 2018; thereby, health insurance costs could potentially consume up to half of the African American household income (U.S. Census Bureau, 2021). Additionally, most health insurance plans cover only a percentage of the costs of mental health services (Miner, 2020). For example, a 2019 Kaiser Family Foundation (KFF) survey found that employers paid an average of 82% of health insurance for single coverage and 70% for family coverage (KFF, 2020), which could leave a significant financial burden for the uncovered coverage. Transportation is another barrier that may impede access to mental health services for many African Americans (Kawaii-Bogue et al., 2017). Sharma and colleagues (2017) conducted a study on geographic access to professional mental health providers in California. They found that mental health care facilities were more likely to be placed in high-income areas highly populated by whites compared to low-income racial minority areas, suggesting racial minorities and/or those living in lower-income areas may have difficulty in accessing a professional mental health provider due to the need to travel longer distances to receive services.

Underdiagnoses When Treatment is Sought

Studies have shown that underdiagnoses of mental health illnesses among African Americans could be due to a number of factors, including clinician bias, cultural differences in presentation of mental illness symptoms, and misdiagnosis (Bailey et al., 2019). For example, Gara and colleagues (2019) examined electronic medical records (N=1,657 total; 36% African American) from a community behavioral health clinic. Findings indicated that 19% of African Americans who screened positive for MDD were given a diagnosis of schizophrenia at a significantly higher rate (three percent) compared to whites. Although primary care physicians have guidelines to screen for various mental health issues more routinely during visits, African Americans have been half as likely to be screened for depression compared to whites (Akincigil & Matthews, 2017).

Mental Health Stigma

Past research has indicated that stigma is also a prominent contributor to mental health inequities and service seeking among African Americans (Hankerson & Weissman, 2012; Heath, 2017; Phelan et al., 2019). Studies suggest that, among African Americans, stigma related to mental health is considered to be a barrier in seeking mental health treatment (Conner et al., 2010; Hankerson & Weissman, 2012; Williams et al., 2014). Yet, few studies have examined predictive factors contributing to mental health stigma among African Americans or persons of African descent (e.g., DeFreitas et al., 2018; Matthews et al., 2006). Fewer of these studies have been guided by theoretical or conceptual models (e.g., Taylor & Kuo, 2019) that could help guide the design of culturally-appropriate interventions to reduce mental health

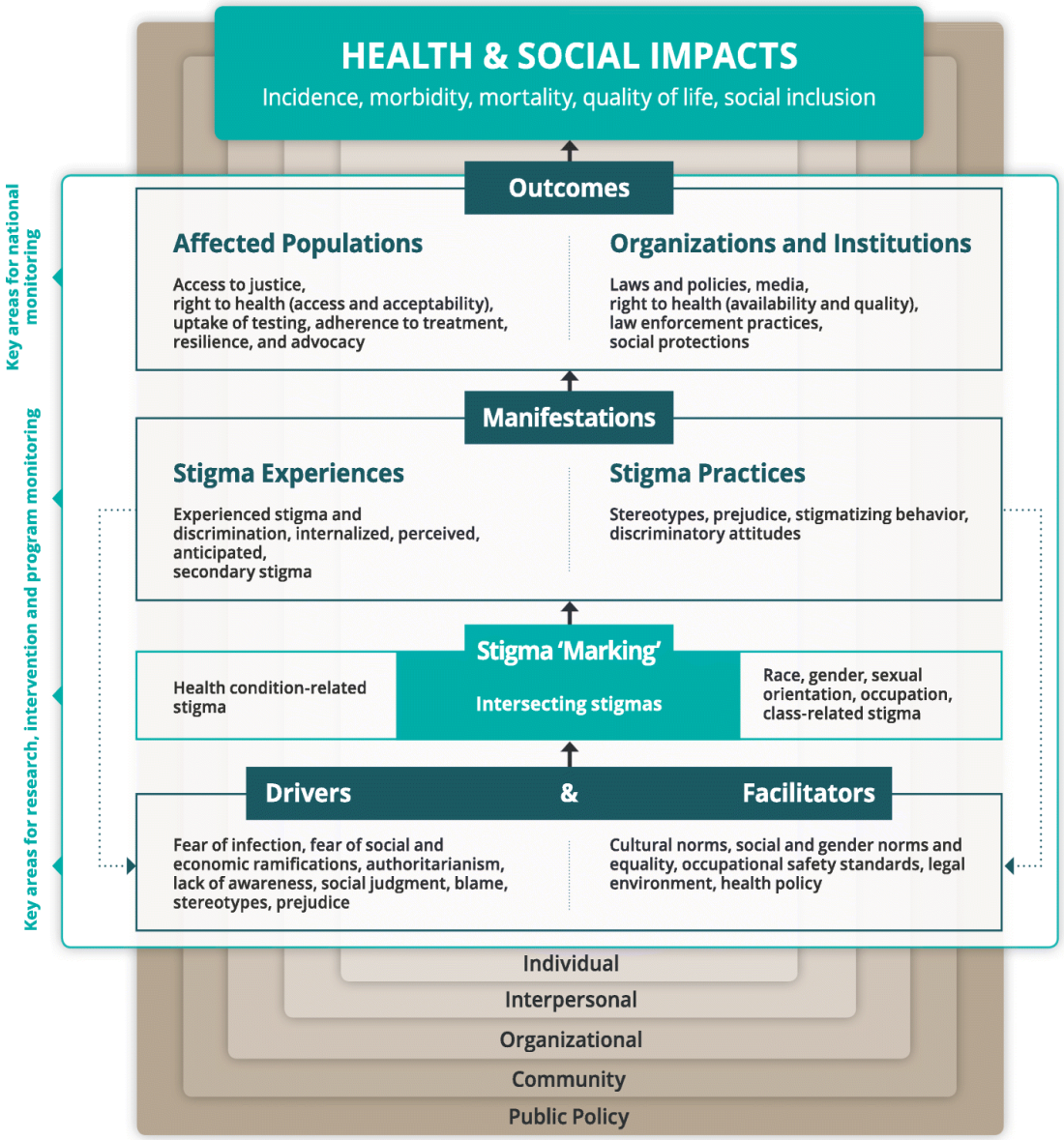
stigma as a barrier of mental health service use among African Americans, and ultimately could be a contributing strategy to reducing mental health inequities. The Health Stigma and Discrimination Framework (Stangl et al., 2019) is a potential model to help expand the understanding of stigma and mental health among African American populations and increase use of mental health services.

The Health Stigma and Discrimination Framework

Stigma has been defined as "an attribute that is deeply discrediting" and declines someone "from a whole and usual person to a tainted, discounted one" (Goffman, 1963). Health-related stigma, in particular has been found to be enacted in two forms: self-stigmatizing beliefs - or perceived stigma (internalizing attitudes that one will be discriminated against based on their mental illness), and public stigma (either being stigmatized because of mental illness from others or stigmatizing others because of their mental illness; Corrigan & Rao, 2012). Studies have shown that persons with a mental illness are among the most stigmatized groups in society (Stuart, 2008; WHO, 2001). Being a member of a highly stigmatized group, such as people living with disabilities, being a member of a race/ethnic minority group, and persons living with HIV is a risk factor for the development of mental health problems (Dinos, 2014; Parker & Aggleton, 2003). Although past research has found that mental health-related stigma has decreased from 2007 to 2017 (from 64% to 46% perceived and 11% to 6% personal; American Psychiatric Association, 2018), mental health stigma still remains a key barrier to seeking professional treatment for most, and particularly among ethnic minority populations (APA, 2017).

The Health Stigma and Discrimination Framework (Stangl et al., 2019) was developed to help guide the design of health-related stigmatization reduction interventions, including those focused on mental health. According to this framework, there are four domains in the stigmatization process: drivers and facilitators, stigma "marking", stigma manifestations, and outcomes. *Drivers* are explained as negative health-related thoughts and behaviors that range from fear of infection from contact with someone living with a communicable disease to beliefs that people with mental health issues are dangerous, responsible for their problem, and should be ashamed. *Facilitators* are explained as both positive and negative external influences on behaviors (e.g., cultural/social/gender norms, occupational safety standards, health policy). This framework states that the drivers and facilitators determine whether *Stigma Marking* - applying stigma to people or groups according to their differences (e.g., health conditions, race, occupation) - occurs. *Stigma manifestations* are described as stigma experiences and practices (i.e., experienced discrimination, experienced stigma, internalized/self-stigma, perceived stigma, and secondary/associative stigma) due to stigma marking. These experiences and practices lead to health-related outcomes, such as lack of treatment seeking, low self-efficacy, low self-esteem, and poor quality of life.

Figure 1. The Health and Discrimination Framework



(Stangl et al., 2019)

The Health Stigma and Discrimination Framework: A Guide to Examine Mental Health Stigma Among African Americans

The Health Stigma and Discrimination Framework was created to be used globally and across various health conditions that are commonly stigmatized,

including HIV, cancer, and mental health. This framework can be used to examine predictors contributing to mental health stigma particularly when adapted for populations with a history of poor mental health outcomes (e.g., LBGTQ+ community; Banerjee & Nair, 2020). Stangl and colleagues (2019) have reported that there can be differences in mental health-related stigma marking based on race (e.g., greater embarrassment for Somalian participants compared to African American participants with mental illness) and gender (e.g., men experiencing increased stress when speaking about mental illness compared to women, specific mental illnesses are seen as feminine such as eating disorders). They have also reported differences in drivers based on fear (e.g., fear of persons with mental illness providing childcare or marrying into their family). The table below describes how the framework's four domains can be adapted to examine mental health-related stigmatization among African Americans, particularly in the church context.

Table 1

Adapted Framework Domains for Mental Health-Related Stigmatization among African Americans

Drivers	**Facilitators**	**Stigma Marking: Intersecting Stigmas**	**Manifestations (Stigmatizing Practices)**
Fears (Mental health issues) Awareness (Mental health) Social support (support from others and social beliefs)	Cultural norms (Religious activities) Social norms (Discrimination) Access to mental health services	Demographics Age Gender Sexual orientation SES (education; health insurance) Mental health conditions	Mental health-related stigma beliefs (Stereotypes and prejudices)

Drivers

Fears About Mental Health Issues

Past studies have reported that many African Americans withhold information regarding mental illness for various reasons. Some of these reasons include concern of hurting the family, ruining their career, having people think they are "crazy", not wanting to appear weak, shame, and fear (Neely-Fairbanks et al., 2018). In their review, Pescosolido & Martin (2015) found that many African Americans have the fear that people with mental illnesses are dangerous, prefer to distance themselves from others with mental illness and wish to not be labeled as someone with a mental illness. Another study focused on African American's perception of mental illness and treatment seeking found that one of the main barriers for treatment seeking was fear of shame from others and unwanted feelings of vulnerability (Avent Harris et al., 2020). Studies have also suggested that African Americans tend to commonly have fears that mental illness is an extremely severe health condition, and therefore, for someone to seek help, they have to undergo extremely severe treatment (e.g., need for inpatient hospitalization; DeFreitas et al., 2018).

Other fears about mental health expressed by African Americans have also focused on issues regarding use of mental health services. For example, African Americans with previous experiences with mental health professionals have been found to be less likely to seek professional mental healthcare for current needs (Alang, 2019; Broman, 2012). Studies have suggested that this may be due to fears that they will be discriminated against in the mental healthcare system, similar to how they feel discriminated against in the general healthcare system and that they may

have difficulty in navigating the system (e.g., Alang, 2019; Haynes et al., 2017). Furthermore, research has suggested that African Americans are less trusting of psychiatric medications due to known or perceived side effects, efficacy, and the belief that some treatments may be addictive (Hankerson et al., 2011; Watkins et al., 2015).

Awareness About Mental Health

As stated previously, a majority of African Americans have been found to have average to below average health literacy (Muvuka et al., 2020). Studies with African Americans have found that they tend to be less likely to recognize mental health symptoms (e.g., Alegría et al., 2012). For example, Ward and colleagues (2013) examined awareness of mental health illness symptoms among African American men and women. They found that majority of participants could identify hostility, suicidal ideation, becoming suddenly scared for no known reason, experiencing panic or terror episodes, and desiring to bring harm to others as symptoms of mental illness. Participants were less likely to identify heart or chest pain, nausea and upset stomach, hot and cold flashes, and sudden weakness in specific body parts as symptoms of mental illness. A separate study examining mental health literacy and treatment seeking attitudes found that African Americans were less likely to recognize symptoms of generalized anxiety compared to Latino/a and white Americans. They also stated that mental health literacy was a predictor of mental health service seeking (Cheng et al., 2018).

Social Support and other Beliefs About Mental Health Services

Studies have found that African Americans are likely to report that social support and encouragement from key peers is highly valued when seeking mental health services (Hankerson & Weissman, 2012; Lukachko et al., 2015). For example, a study examining African American men's attitudes and beliefs toward mental health screening found that participants felt more comfortable getting screened when support from friends, family, and community members was received (Bauer, 2020). Participants in this study also believed that there was no guarantee that professional mental health care providers could help them if they were experiencing a mental illness, because most mental health providers did not have the same ethnic/racial background or social life experiences as they had. Lee et al. (2021) compared African American's and Asian American's beliefs about mental health screening for various mental health illnesses and found that African Americans believed alcohol and drug use were the most important mental health problems and were less likely to endorse importance of screening for suicide, possibly due to their own personal judgements on the level of social severity of these conditions in their community.

Facilitators

Cultural Norms (Religious Beliefs and Behaviors)

Studies have indicated that various cultural beliefs and norms in the African American community regarding mental health exist – and that most are grounded in religious beliefs. Religiosity's positive impact on mental health has been found to be instrumental in improving ability to cope with stressful situations and in providing support from the faith community (Pargament et al., 2000; Ward & Brown, 2015;

Ward et al., 2013). Studies have found that African Americans tend to be highly religious and engage in religious coping at higher rates than other racial/ethnic minorities (Ward et al., 2013), which may be due to their high rates of participation in religious activities (e.g., church attendance, prayer; Watkins et al., 2015; Pew Research Center, 2008). Studies suggest that African Americans are highly likely to cope with mental illness through different religious coping strategies (e.g., prayer, reading holy scriptures; Ward et al., 2013). Studies on religious coping with African Americans conducted by Pargament et al. (2000) have found that positive religious coping (e.g., religious purification/forgiveness and religious direction/conversion) was predictive of stress-related growth, positive outcomes established from stressful events, and improved cognitive functioning.

Other studies have also found that religiosity may serve as a protective factor against mental disorders (Lukachko et al., 2015) by providing a sense of hope (Starnino, 2016), social support, and a supportive belief system (Chatters et al., 2011), especially for persons affiliated with African American churches. Furthermore, several studies have also shown that African Americans tend to prefer receipt of counseling from religious leaders (Christensen et al., 2017), primarily due to increased trust in the church or clergy members and faith that God will heal them (Neely-Fairbanks et al., 2018). Breland-Noble et al. (2015) conducted a qualitative study examining religious coping in African American youth (aged 11-17) with depression and found that religious coping is important to African American adolescents and may aid in increased professional mental health treatment seeking. However, religiosity may also be damaging to mental health, especially in

considering some studies have found that some African Americans may believe having a mental illness is spiritual problem (e.g., believing the illness is an act of the devil or a punishment from God) that can be alleviated through religious acts (e.g., prayer, fasting; Weber & Pargament, 2014).

Social Norms (Discrimination)

Racial discrimination may be a leading contributor to differences in symptomology, and thereby limited service seeking and limited treatment of depression cases among African Americans (DeFreitas et al., 2018; Dinos, 2014; Hankerson et al., 2011). This may be due to a person experiencing discrimination and attaching the discrimination to their social identity (Kilk et al., 2019), which has been found to negatively affect professional mental health treatment seeking (Clement et al., 2015). Research has identified that negative interaction with family members and daily racial/ethnic discrimination are risk factors for professional mental health treatment seeking (Taylor & Chatters, 2020). Mental health problems found to be associated with discrimination and social exclusion include PTSD, psychosis, attempted suicide, and drug dependence (Dinos, 2014). Williams (2018) reported that African Americans who have experienced racially motivated verbal abuse or physical assault have a two- and three-fold increase in the risk of common mental illnesses and psychosis.

Inequality and Access to Mental Health Services

Past research has reported that African Americans tend to have limited access to professional mental health services due to multiple factors, such as lack of access to general health information, cost of care, traveling distance to mental health

services, and limited transportation (Kawaii-Bogue et al., 2017; Muvuka et al., 2020; Sharma et al., 2017; U.S. Census Bureau, 2021). It is estimated that a large proportion of African Americans need mental health services and only one in three receive them (American Psychiatric Association (APA), 2017). Older African Americans are significantly less likely to seek mental health treatment and are more likely to use other forms of coping strategies (Conner et al., 2010; Kim et al., 2020). Additionally, African American's use of mental health services may be low due to poorer quality of mental health care, higher rates of attrition from mental health treatment programs, and non-culturally tailored mental health treatment (Ward & Brown, 2015). Being uninsured, in or under the poverty level, and living in low socioeconomic areas are additional barriers among African Americans seeking mental health treatment. There are significantly less mental health resources in these areas, as well as, lack of mental health professionals of color preferred by African Americans (Buche et al., 2017).

Additionally, studies have reported that African Americans tend to seek out mental health services from clergy and other religious leaders. For example, Lukachko and colleagues (2015) found that 25% of African Americans received counseling from clergy members compared to 17% seeking professional help from psychiatrists or medical doctors. Berkley-Patton et al. (2018) reported in a health needs assessment study with African American churches that nearly half of African American church members reported seeking mental health services from their religious leaders.

Stigma Marking: Intersecting Stigmas

Demographics

Gender

Research has suggested that there may be gender differences regarding beliefs and attitudes about mental health. For example, Ward and colleagues (2013) examined African American men and women's attitudes concerning mental health and mental health stigma. They found that women often believed mental illness could be caused by stress, trauma, drug use, alcohol use, heredity, family problems, and work stress. The men agreed that mental illness could be caused by stress, trauma, drug use, alcohol use, and family problems, but not heredity and work stress. Women were also found to believe that although mental illness is chronic and cyclic, with negative consequences, they also believed it can be controlled. Both men and women reported being neutral to understanding mental illness and being affected emotionally by it. Lastly, they found that African American women appeared to be significantly more willing to seek mental health services compared to men.

Age

Middle aged men and women are more inclined to use professional help, informal support, and religious coping, compared to older adults when dealing with mental health (Ward et al., 2013). One study found that African American college students' perception of their ability to identify persons with mental illness was related to increased perceived mental health stigma (DeFreitas et al., 2018). They explained this relation by stating that the stigma may be due to perceived severity of the mental illness. Lastly, DuPont-Reyes et al. (2019) examined differences in mental health

stigma in 6th graders and found that non-Latino/black boys and girls wanted more separation from peers with mental illness compared to non-Latina white girls in particular.

SES

Higher education is associated with greater use of mental health services for whites but not for African Americans. Past research has found that previous experience with mental health treatment is associated with lower current receipt of services among African Americans likely due to medical and mental health stigma (Broman, 2012). Less education may also be a risk factor to mental health stigma and a barrier to accessing general mental health resources due to its association with life expectancy, health literacy, and quality of care received (Bound et al., 2015). Less education is also related to lower paying jobs with less benefits, such as health insurance, which studies have shown to be a barrier to accessing mental health services (Hodgkinson et al., 2017).

Sexual Orientation

Individuals who are both African American and members of the LGBTQ+ community are often exposed to multiple stigmas that intersect with mental health stigma, including poverty, homelessness, increased violence, police brutality, and discrimination (Holmes et al., 2021). Price-Feeney et al. (2020) found that 35% of African American LBGTQ+ youth 13 to 24 years old have experienced homelessness, 17% physical threats, and 52% discrimination. This study also found that 55% of African American LGBTQ+ youth reported symptoms of generalized anxiety disorder (GAD) and 63% MDD. These GAD and MDD statistics increased to 70%

and 71%, respectively, for African American transgender and nonbinary youth. A review of the literature by Williams (2018) reported that most research on mental health shows a higher prevalence of mental health problems and related issues, including mental health stigma, among African American, minority ethnic, and LGBTQ+ groups.

Mental Health Conditions and Chronic Disease Related Stigma

Many culturally tailored mental health interventions purposely restrict use of terms such as depression. Researchers have reported limited use of this term because of the stigma associated with the word among African Americans (Hankerson et al., 2018; Mynatt et al., 2008). Budhwani & De (2019) conducted a study on perceived stigma in health care settings and physical/mental health among people of color and found that perceived stigma was significantly associated with higher odds of a depression diagnosis. Moreover, a qualitative study conducted on African American men found that many of the participants did not seek treatment for depressive symptoms due to the stigma that needing treatment may threaten their masculine appearance and the desire for a space for discussion in nonjudgmental support groups (Hudson et al., 2016). Other participants endorsed complete disbelief in their depression diagnoses (Hudson et al., 2016). Villines (2020) conducted a review examining anxiety among African Americans and found that many of their participants endorsed stigmatized beliefs that anxiety is a choice or personal problem, African Americans don't experience anxiety due to biological differences across races, and African American youth do not have mental health issues. Other research has found that ethnic identity and mental health stigma were associated with anxiety

among African Americans and may result in unwillingness to report symptoms or seek professional treatment (Hopkins & Shook, 2017).

Moreover, African Americans are disproportionately affected by chronic diseases that are highly stigmatized, such as HIV/AIDS – a chronic disease that is strongly associated with HIV related stigma. For example, Berkley-Patton and colleagues (2010) found that African American church populations were highly knowledgeable about HIV but found that 42% of participants were afraid of people with HIV and over half were concerned about discrimination and experiencing stigma from others if found positive for HIV. As another example, African Americans, especially men, have the highest rates of lung cancer in the U.S. (CDC, 2020), primarily due to cigarette smoking. Lathan and Colleagues (2015) examined African American's knowledge and perspectives on lung cancer and found that their participants expressed experiencing stigma from others, which lead them to hide their lung cancer diagnoses and engage in less professional treatment seeking. These participants also believed that lung cancer gets less attention compared to other chronic diseases in African American communities.

Manifestations

Mental Health-Related Stigma Beliefs

Past research has found that many African Americans believe that depression in the African American community is more stigmatizing than in other communities (Conner et al., 2010). Some studies found that African Americans tend to believe that depression is a form of weakness – or a personal problem that can heal itself (Ward et al., 2013). Additionally, Neely-Fairbanks and colleagues (2018) found that majority

of African Americans in their study reported that their belief and reliance (70%) on God would keep them healthy both physically and mentally. Yet, other research has found African Americans are open or comfortable about disclosure regarding depression and with seeking mental health treatment (Anglin et al., 2008; Diala et al., 2001; Ward et al., 2013). However, mental illness stigma may be a factor that may keep many African Americans from seeking help and normalizing conversations about mental health (Conner et al., 2010; Hankerson et al., 2011; Ward et al., 2013).

Furthermore, research has found that African American's perceived mental health stigma can result in negative attitudes regarding treatment (DeFreitas et al., 2018). White (2019) has suggested that these negative attitudes and stigmas may originate from the case that African Americans have historically been resilient and may believe that no one has authority to suggest they have an illness, especially when considering the systemic racism and feelings exploitation by the U.S. government that many African Americans have experienced. Fripp and Carlson (2017) conducted a study on attitudes and mental health stigma among African American and Latino/a populations and found an inverse correlation between help-seeking attitudes and mental health stigma and that attitudes toward seeking help can predict participation in use of professional mental health services. Given the many fears and limited awareness that potentially drive and facilitate mental health stigma among many African Americans, and in turn may limit their access to professional mental health services, consideration should be given to accessible, trusted settings that have potential to increase reach of these services with African American populations. The African American church can serve as a positive environment for opportunities to

decrease mental health stigma beliefs and practices and increase linkage to mental health services with the populations they serve.

The Black Church: A Setting to Address Mental Health Stigma Among African Americans

The African American church has great potential to increase reach of mental health stigma reduction interventions with church-affiliated populations. Many African Americans trust the church and clergy members to provide guidance, safety, and comfort – which may position the church the ability to address drivers and facilitators related to mental health stigma (Hankerson & Weissman, 2012; Williams et al., 2014). African Americans have the highest rate of church attendance compared to all other racial/ethnic groups (Taylor et al., 2016; Pew Research Center, 2020). A study conducted with 3,570 African Americans found that 84% of respondents reported being "fairly" or "very religious," and 60% had high levels of church attendance (e.g., attending a few times a month or more; Lukachko et al., 2015). Studies have also found that African Americans with high levels of religiosity and high church attendance were less likely to seek professional mental health services. Neely-Fairbanks and colleagues (2018) found that nearly all of their church-affiliated participants stated that there should be more engagement of the church in addressing mental health literacy and linkage to care, and most expressed interest in using mental health services provided by the church.

These studies suggest that the church could greatly increase reach and influence with African American church and community members to address mental health stigma. A growing number of faith-based mental health interventions have

been tested in African American church settings (Campbell et al., 2007; Hankerson & Weissman, 2012; Mynatt et al., 2008; Pargament et al., 2000; Ward & Brown, 2015; Weissman et al., 2015; Williams et al., 2014) and have found that religious tailoring (e.g., use of community partnered participatory research [CPPR], pastoral involvement; Hankerson et al., 2018) and increasing access to services have shown promise in increasing access to mental health screening and supportive services (e.g., counseling, support groups; Pickett-Schenk, 2002), and in some cases improved mental health outcomes (e.g., substance use, MDD, anxiety; Marcus et al., 2004; Mynatt et al., 2008; Ward & Brown, 2015). Only one study could be found that addressed stigmatizing beliefs (i.e., HIV stigma) with African American church populations. Derose and colleagues (2016) conducted a church-based HIV stigma reduction intervention with African Americans and Latinos/as church members. This intervention included HIV workshops (e.g., raise awareness and knowledge about HIV and HIV testing), peer leader workshops (e.g., developing skills to discuss HIV stigma), HIV sermons (e.., the pastor gave a sermon or homily focused on HIV with the congregation), and HIV testing events. This intervention led to significant reductions in HIV stigma and increased rates of HIV testing. Yet, no church-based intervention has been designed and implemented to address mental health stigma with African American church populations or has been assessed to understand how addressing mental health stigma could potentially improve mental health outcomes and treatment seeking. Considering the reach and influence of African American churches, examining mental health stigma in the African American church context could greatly expand the literature in understanding factors that contribute to mental

health stigma and ways to culturally tailor mental health-related stigma reduction interventions for African American church settings.

Study Rationale and Hypotheses

There is a growing body of research on mental health among African Americans. However, more research is needed on the predictive factors of mental health stigma in the African American church context to fill gaps in the literature that could further address increasing access to professional mental health services among African Americans. The present study's goal was to expand the literature on predictive factors of mental health stigma with an African American church-affiliated population.

This study used the Health Stigma and Discrimination Framework (Stangl et al., 2019) as a guide to examine potential predictors of mental health stigma among African American church members along with community members using church outreach services (e.g., food and clothing pantries, social services, recovery programs, prison ministries, day cares). Specific domains examined from the framework included *drivers* (e.g., fears, awareness about mental health, social support), *facilitators* (e.g., cultural norms, social norms, access to mental health services), *stigma marking* (e.g., demographics, mental health conditions), and *manifestations* (e.g., mental health-related stigma beliefs). Of note, the framework has been adapted for the church context. Variables for consideration as predictors primarily have been tailored to assess key drivers, facilitators, stigma marking, and manifestations that align with examining mental health stigma with the church as the setting of interest instead of the broader African American community. Therefore, non-church context

related variables (e.g., occupational safety standards, legal environment) were not included in the current study. Also, for the current study, discriminatory attitudes were categorized as a predictor of mental health stigma due to differences in race/ethnicity being a driving factor of mental health disparities among African Americans. Additionally, this study examined stigma practices as the dependent variable due to mental health stigma attitudes or beliefs affecting the use of professional mental health treatment seeking.

Based on the literature and the Health Stigma and Discrimination framework, it was hypothesized that among the African American church-affiliated population in the current study, higher levels of mental health stigma will be associated with increased endorsement of :

(1) fears, awareness and social support for mental health issues and services;

(2) cultural norms (e.g., engagement in religious activities);

(3) social norms (e.g., experienced discrimination); and

(4) age.

It was also hypothesized that higher levels of mental health stigma will be associated with lower levels of :

(5) access to mental health services (e.g., therapy); and

(6) gender (e.g., male).

Lastly, a linear regression analysis was conducted as an exploratory hypothesis to examine predictors of mental health stigma.

CHAPTER 2

METHOD

Setting, Participants and Procedures

This study used baseline data collected from Healthy Actions to Impact Mind and Soul (AIMS). Healthy AIMS is a clustered, randomized religiously-tailored pilot study implemented to increase mental health screening and provide linkage to care services using faith community-engaged approaches with Kansas City, Missouri African American churches over the course of six months. Participants were recruited from four churches, and each church was randomly assigned to the intervention or comparison group. Eligibility criteria for each church included a) having a minimum of 100 African American church members, b) a pastor willing to assist in study delivery activities, c) ongoing outreach services (i.e., daycares, food/clothing programs, social services) to a minimum of 50 adult community members, and d) a commitment of two or three volunteers to deliver mental health information in their church. The churches were compensated $1500 for assisting in study delivery and recruitment-retention activities.

Participants were recruited during church services and ongoing outreach ministries (e.g., daycares, food/clothing programs, social services). Interested individuals were screened for eligibility and completed informed consent within the church setting. Eligibility to participate in the study included: a) being aged 18 and older, b) being willing to participate in two surveys administered during and after church services, c) being willing to provide contact information (i.e., two phone numbers, mailing/email address, phone numbers for two people with whom they have

ongoing contact), and d) regularly attending church (at least once a month) or using outreach services (at least four times a year). Participants were compensated $20 for completing the baseline survey and $20 for completing a posttest survey at six months. Each survey took about 30-45 minutes to complete and were administered during or immediately after a designated Sunday church service or community outreach activity at their respective churches. Study procedures were approved by the University of Missouri-Kansas City Institutional Review Board.

Survey Measures

Drivers

Fears About Mental Health

Mental health fears were assessed using one question asking, "*Are there any reasons you would not take advantage of church-based mental health screening?*". Only four of the nine options were used for this project to align with the construct of fear in the framework. Summed scores range from 1 to 4 with higher scores indicating higher levels of fear.

Awareness About Mental Health

Mental health awareness was assessed with 2 questions. These questions include "*In your opinion, how serious is mental health in your community*" and "*In the last 12 months, how many people at this church/church center or at an event sponsored by this church did you talk to about any topics related to mental health*" (1 = not at all serious to 4 = very serious and 1 = none to 6 = 20 or more people).

Social Support

Social support for mental health was assessed with two questions. These questions asked the extent of belief in statements such as "*If I found out I had a mental health condition, I could get connected to resources (e.g., counseling) or receive medications for treatment*" (social beliefs) and "*My friends would support me in getting a mental health screening*" (social support from others; 0 = not at all to 6 = very likely; 0 = not at all to 6 = very much so). Summed scores range from 0 to 30 and 0 to 36 respectively with higher scores indicating more positive social support.

Facilitators

Cultural Norms

Cultural norms were assessed using measures on religiosity. These measures included participant affiliation with the church (e.g.., *church or community member*). Also, six questions inquired about engagement in various religious activities (e.g., *thoughts of God, prayer, meditation, attended a worship service, read scriptures/holy writings, had direct experiences with God*) in the past 12 months with response categories ranging from 1 = never to 8 = more than once a day. Summed scores range from 6 to 48, with higher scores indicating engagement in religious activities/coping. Religious/spiritual coping was assessed using the RCOPE (Pargament, 1999). The RCOPE is a comprehensive measure that assesses both positive and negative methods of religious/spiritual coping. Nine RCOPE questions examined Collaborative Religious Coping (e*.g., I try to make sense of the situation with God*), Self-directing Religious Coping (*e.g., I try to deal with my feelings without God's help)*, and Passive Religious Deferral coping (*e.g., I don't try to cope; only expect God to take my*

worries away) with response categories ranging from 1 = not at all to 4 = a great deal. Internal consistency for each scale is: collaborative religious coping (Cronbach's α = .84), self-directive religious coping (Cronbach's α = .74), and passive religious coping (Cronbach's α = .79). Subscale items were summed to create three measures for each of the coping styles and scores ranged from 0 to 9 each, with higher scores indicating more religious coping.

Social Norms

Two questions were asked regarding discrimination and harassment (1 = yes, 0 = no; e.g., *Have you experienced discrimination because of your race or skin color during a healthcare visit in the past year; Have you experienced harassment because of your race or skin color by police in the past year;* Henning-Smith et al. 2013). Summed scores range from 0 to 2; higher scores indicate more experiences of discrimination and/or harassment.

Access to Mental Health Services

The survey assessed help seeking behaviors by asking about visits with a mental health professional (0 = no, 1 = yes), medications for mental health concerns in their lifetime (0 = no, 1 = yes), and counseling from a religious leader (0 = no, 1 = yes).

Stigma Marking/Intersecting Stigmas

Demographic Information

Demographic measures included age, gender at birth, race/ethnicity, sexual orientation, average monthly income and insurance coverage.

Mental Health Conditions

Mental health issues or mental illnesses (e.g., depression, anxiety and other stress related factors) were assessed. Depression was assessed using the Patient Health Questionnaire (PHQ)-9 (*Cronbach's alpha* = .81; Kroenke et al., 2001). This measure consisted of nine questions ranging from 1 = not at all to 4 = nearly every day (e.g., little interest or pleasure in doing things, feeling tired or having little energy). Summed scores range from 9 to 32, with higher scores indicating more severe depression.

Anxiety was assessed using the Generalized Anxiety Disorder (GAD)- 7 (*Cronbach's alpha* = .89; Spitzer et al., 2006). This scale consists of seven questions (1 = not at all sure to 4 = nearly every day; e.g., feeling nervous, anxious or on edge, trouble relaxing). Summed scores range from 7 to 28, with higher scores indicating increased anxiety.

Stress factors were assessed using the Perceived Stress Scale (*Cronbach's alpha* = .82; Cohen et al., 1983). This measure consisted of 10 questions (1 = never to 5 = very often; *e.g., in the last week, how often have you been upset because of something that happened unexpectedly?*). The four positively stated items will be reversed (e.g., 1 = 5, 2 = 4, 3 = 3, 4 = 2 & 5 = 1) and then summed across all scale items to obtain scores. Four additional questions were included in this scale (1 = never to 5 = very often; *In the last week have you… dealt successfully with irritating life hassles; felt that you were effectively coping with important changes that were occurring in your life?).* Summed scores range from 14 to 64 and higher scores indicate increased levels of stress and greater vulnerability to stressful life events.

Manifestations

Mental Health-related Stigma Beliefs

Mental health stigma was assessed using the scale created by 19 Mental Illness Stigma Panel members (MISPM) consisting of individuals from SAMHSA and the Division of Adult and Community Health, CDC members, and other academic and consumer partners, examining attitudes towards people with mental illness (Kobau et al., 2010). This scale was created after the panel researched previous mental health stigma measures and considered their limitations (e.g., including vignettes, focusing on a specific disorder). The panel used items from the British Omnibus National Survey (ONS) to measure mental illness stigma. This measure consists of 11 questions regarding attitudes about mental health (1 = strongly disagree to 5 = strongly agree; e.g., *I believe a person with mental illness is a danger to others; I believe a person with mental illness can eventually recover*). The seven positively stated items will be reversed (e.g., 1= 5, 2 = 4, 3 = 3, 4 = 2 & 5 = 1) then summed across all scale items to obtain scores. Two additional questions were included in this scale. Asking participants their level of agreement with each statement (1 = strongly disagree to 5 = strongly agree*; e.g., people with mental health conditions are responsible for having their illness; scientists and doctors can be trusted to tell the truth about mental health conditions*). Summed scores range from 11 to 55, with higher scores indicate increased mental health stigma.

Data Analysis

Participant characteristics were examined with descriptive statistics. Frequencies and proportions were examined for categorical variables (e.g., gender)

and means and standard deviations were examined for continuous variables (e.g., religious activities [cultural norms], age, mental health stigma). The mental health stigma score, with a range of 11 to 55, was first examined as a continuous variable to identify the prevalence of mental health stigma among our sample. For use as the dependent variable of interest and to appropriately run independent t-tests, the mental health stigma score was dichotomized by the mean to create a low (below 35.93) and high (above 35.93) mental health stigma variable. Chi-square analyses were conducted to examine the differences between level of mental health stigma and categorical variables (e.g., awareness about mental health, access to mental health services) and mental health stigma. *T*-tests were used to determine significant differences in means among the continuous variables (e.g., fear, social support, religious activities [cultural norms], age, income, mental health conditions) and mental health stigma. A p-value of ≤ 0.1 was used to identify predictors from the bivariate analyses to include in the linear regression analysis. Linear regression analyses were conducted to explain the association between the potential predictive factors and mental health stigma. Data will be analyzed using IBM SPSS Statistics (Version 26) predictive analysis software.

CHAPTER 3

RESULTS

Among participants (N= 200), 78.5% were church members and 21.5% were guests or community members who used the church's outreach services (e.g., food pantry, clothing, daycare, school programs). Most participants (mean age = 53; *SD* = 17l range 18 – 88) were African American (95.5%, n = 191), female (79.5%, *n* = 159), and heterosexual (97%, n = 194), as shown in Table 2. Among participants, 55% (*n* = 110) had a monthly income of more than $2501.

Seventy-three percent (*n* =146) of participants reported that mental health was a very serious issue within their community and 50.5% (n = 101) had not talked to anyone at their church or church events about mental health related topics. Fifty-nine percent of participants had never visited a mental health professional (n = 117), and 18.5% (n = 37) reported taking medication for mental health concerns. Many participants endorsed never receiving counseling from a pastor or religious leader (44.5%, n = 89). On average, participants reported high levels of participation in religious activities (M = 38.9; SD = 7.1; range = 6 to 48), high levels of collaborative religious coping (M = 10.2; SD = 2.3; range = 3 to 12), moderate levels of self-directive religious coping (M = 6.5; SD = 3.0; range = 3 to 12), and low to moderate levels of passive religious coping (M = 5.4; SD = 2.6; range = 3 to 12). Participants also endorsed moderate to high levels of mental health stigma (M = 35.93; SD = 6.8; range = 11 to 55).

Preliminary Analysis

Preliminary analyses were first conducted to determine associations between each continuous and categorical variable and levels of mental health stigma (*p*–value of < 0.1) to include in the linear regression. Chi-square analyses were conducted with categorical variables (i.e., gender, race, sexual orientation, income, awareness of mental health issues, access to mental health services, and insurance) and level of mental health stigma. As illustrated in Table 3., there were no significant relationships between each of the categorical variables and levels of mental health stigma. Independent t-test analyses were conducted with continuous variables (i.e., age, perceived stress, depression, anxiety, fear, religious coping, religious activities, discrimination, social support and beliefs) and levels of mental health stigma. As indicated in Table 4, there were significant differences among several continuous variables and mental health stigma. Higher levels of mental health stigma were found among those who reported more frequent: receipt of social support from others (t (81.67) = -1.99, p = .05), experiences of discrimination (social norms) (t (187) = -2.67, p = .008), engagement in religious activities (cultural norms) (t (126.03) = -2.05, p = .04), collaborative religious coping (t (138.77) = -2.09, p =.04), and self-directive religious coping (t (181.09) = -2.22, p = .03). There were no significant differences between the other continuous variables and levels of mental health stigma.

Table 2

Participants Characteristics (Frequencies, Means and Standard Deviations).

Participant Characteristic	% (n)
Church association	

Participant Characteristic	% (n)
Member	78.5 (157)
Non-member	21.5 (43)
Race	
African American	95.5 (191)
Other	4.5 (9)
Gender	
Male	20.5 (41)
Female	79.5 (159)
Sexual orientation	
Heterosexual	97 (194)
Not heterosexual	3 (6)
Education	
Low (8th grade - some college)	55.2 (110)
High (Associates degree - grad school)	44.8 (89)
Income	
0- 2500	32.5 (65)
2501+	55 (110)
Health Insurance	
Yes	93 (186)
No	14.5 (29)
Marital Status	
Married	35 (70)
Not married	65 (130)
Mental health is a serious issue (awareness)	
Yes (somewhat- very serious)	91 (182)
No (not at all- not too serious)	9 (18)
Talk about mental health topics (awareness)	
Yes	48 (96)
No	50.5 (101)
Visited a mental health professional	
Yes	41 (82)
No	58.5 (117)
Counseling from religious leader	
Yes	38.5 (77)
No	44.5 (89)
Medication for mental health	
Yes	18.5 (37)

Participant Characteristic	% (n)
No	80.5 (161)

[a] Unless otherwise indicated, values are numbers (percentages). Percentages may total less than 100 because of rounding or missing responses.

Table 3

Differences Across Categorical Variables and Levels of Mental Health Stigma (Chi-square Analyses)

			Low Mental health stigma		High Mental health stigma		Test statistic	*P*-value
	N	%	N	%	N	%	$\chi 2$	*P*
Mental health stigma								
Low	81	42%						
High	112	58%						
Gender (Stigma marking)								
Male	41	21%	17	9%	24	12%	.01	.94
Female	64	33%	64	33%	88	46%		
Race (Stigma marking)								
Other	7	4%	2	1%	5	3%	.529	.47
African American	184	96%	78	41%	106	55%		
Sexual orientation (Stigma marking)								
Not Heterosexual	2	1%	0	0%	2	1%	1.45	.23
Heterosexual	187	99%	79	42%	108	57%		
Income								
0-2500	61	36%	21	12%	40	24%	1.09	.29
2501+	108	64%	46	27%	62	37%		

Mental health is a serious issue (Awareness)								
No	15	8%	8	4%	7	4%	.86	.42
Yes	178	92%	73	38%	105	54%		
Talk about mental health topics (Awareness)								
No	156	82%	65	34%	91	48%	.14	.85
Yes	34	18%	13	7%	21	11%		
Visited a mental health professional (Access)								
No	113	59%	48	25%	65	34%	.07	.79
Yes	79	41%	32	17%	47	24%		
Counseling from religious leader (Access)								
No	119	62%	48	25%	71	40%	.23	.63
Yes	73	38%	32	17%	41	21%		
Medication for mental health (Access)								
No	155	81%	61	32%	94	49%	2.16	.14
Yes	36	19%	19	10%	17	9%		
Insurance								
No	29	15%	14	7%	15	8%	.56	.46
Yes	164	85%	67	35%	97	50%		

[a] Unless otherwise indicated, values are numbers (percentages). Percentages may total less than 100 because of rounding or missing responses.
* $p < .05$ ** $p < .01$ *** $p < .001$

Table 4

Differences Across Continuous Variables and Levels of Mental Health Stigma (Means; T-test Analyses)

Demographic factor	Overall mean	Low mental health stigma	High mental health stigma	Test statistic	*P*-value
	M (SD)	*M (SD)*	*M (SD)*	*t*	*p*
Mental health stigma	35.9 (6.8)	*30.1 (6.0)*	*40.1 (3.4)*	-	-
Age	53 (17)	53.1 (16.9)	51.5 (17.2)	.66	.51
Perceived Stress	39.03 (11)	37.4 (11.7)	39.9 (10.5)	-1.44	.15
Depression	11.9 (4.3)	11.9 (4.9)	11.9 (4.0)	-.05	.96
Anxiety	10.4 (5)	10.3 (5.2)	10.5 (5.0)	-.26	.79
Reasons to not get mental health screening at your church (Fear)	.28 (.57)	.26 (.65)	.29 (.53)	-.31	.76
Collaborative religious coping (Cultural norms)	10.2 (2.3)	9.7 (2.7)	10.5 (2.0)	-2.09	.04*
Self-directive religious coping (Cultural norms)	6.5 (3.0)	4.9 (2.2)	5.7 (2.9)	-2.22	.03*
Passive religious coping (Cultural norms)	5.4 (2.6)	6.3 (3.0)	6.5 (3.1)	-.43	.67
Religious activities (Cultural norms)	38.9 (7.1)	37.5 (8.2)	39.8 (6.2)	-2.05	.04*

Discrimination (Social norms)	.49 (.75)	.43 (.72)	.55 (.77)	-1.07	.29
Social support from others (Social support)	22.9 (9.9)	20.6 (11.6)	24.6 (8.61)	-1.99	.05*
Social beliefs (Social support)	22.7 (9.2)	20.8 (9.3)	24.2 (8.7)	-2.7	.008**

[a] Unless otherwise indicated, values are numbers (percentages). Percentages may total less than 100 because of rounding or missing responses.
*$p < .05$ ** p <.01 *** $p < .001$

Linear Regression

A linear regression was conducted to indicate predictors of mental health stigma using social support (support from others and social beliefs), religious activities (cultural norms), collaborative religious coping, and self-directive religious coping, as indicated by the independent t-test. As shown in Table 5., self-directive religious coping (B = .292, SE = .017, p = .004) was found to be a predictor of mental health stigma.

Table 5

Predictors of Mental Health Stigma (B, Significance Values)

			95% CI		
Effect	*B*	S.E.	LL	UL	*p*
Social support from others (Social support)	-.021	.006	-.013	.011	.86
Social beliefs (Social support)	.16	.006	-.004	.021	.19
Religious activities (Cultural norms)	.128	.007	-.006	.022	.25

Collaborative religious coping (Cultural norms)	.128	.022	-.019	.069	.262
Self-Directive religious coping (Cultural norms)	.292	.017	.017	.086	.004**

[a] Unless otherwise indicated, values are numbers (percentages). Percentages may total less than 100 because of rounding or missing responses.

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

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit.

CHAPTER 4

DISCUSSION

Past research has shown that mental health stigma may be a leading factor in the lack of professional mental health service seeking among African Americans (Conner et al., 2010; Hankerson et al., 2011; Ward et al., 2013). However, no studies have examined predictors of mental health stigma in the African American church population. This is important because health promotion interventions conducted among the African American church population have been found to increase the reach of health information and improve overall health outcomes in underserved African Americans (Berkley-Patton et al., 2018; Berkley-Patton et al., 2020; Hankerson et al., 2018; Lasater et al., 1986; Neely-Fairbanks et al, 2018). The current study aimed to address this gap by examining predictive factors of mental health stigma among African American church-affiliated populations. Unique to this study's population was its inclusion of community members who used church outreach ministries, such as food pantries, social services, and recovery programs. Studies have found that church-going African Americans' engagement in religious practices (e.g., prayer, attending services) can protect against mental illness (Farrer et al., 2008, Lukachko et al., 2015). However, community members may be less likely to attend church regularly and have been found to be less engaged in other religious practices (Berkley-Patton et al., 2010), and thereby may not benefit from having religiosity as a protective factor against mental illness. Nonetheless, the African American church continues to be a representation of African American culture and experience and is a place where religious and non-religious African Americans go for support (Hays,

2015). Due to their ongoing contact with community members through outreach ministries, African American churches may be well-positioned to address mental health stigma with this church-affiliated population while also supporting their mental health. Additionally, this study showed that the church is not only a prime setting to examine mental health issues among church members but can also be a prime location for implementing mental health research with its surrounding community. Further research is needed on how African American churches can partner with health organizations to disseminate mental health information to community members.

The majority of participants reported moderate to high levels of mental health stigma, which is somewhat consistent with other studies. For example, Defreitas and colleagues (2018) found high levels of perceived stigma among African Americans while overall mental health stigma levels among African American and Latinx participants were low. Similarly, Dempster and colleagues (2015) found that African American parents of children between the ages of three and eight had elevated perceptions of public stigma towards their children and themselves. Past research has suggested that possible reasons for this level of stigma among African Americans may be grounded in culturally and socially driven beliefs, such as mental illness is a weakness or personal problem (Ward et al., 2013), God will keep them healthy (Neely-Fairbanks et al., 2018), and previous mistrust for mental health professionals (White, 2019). These beliefs may further exacerbate mental health stigma and may drive decisions to not seek mental health services and to engage in unhealthy behaviors used to cope with mental illness (DeFreitas et al., 2018; Fripp & Carlson, 2017). Although this study examined many potential factors related to mental health

stigma among African Americans, there remains a need to understand additional drivers (e.g., lack of awareness, blame, stereotypes, fear of ramifications; Stangl et al., 2019) that may be related or predictive of mental health stigma especially considering mental stigma may be a barrier to seeking mental health services for many African Americans experiencing mental illnesses.

Participants in this study reported low levels of anxiety and depression and moderate levels of perceived stress. These findings are fairly consistent with studies that have reported that African Americans tend to have a lower prevalence of depression (Himle et al., 2009). However, past studies have also suggested that African Americans have been underdiagnosed for depression and anxiety (Sauceda et al., 2021). These underdiagnoses could be due to differences in presentation of somatic symptoms, lack of screening, misdiagnosis, and clinician bias which may lead to limited professional mental health service seeking (Bailey et al, 2019, Himle et al., 2009, Sauceda et al., 2021). Additionally, past research has also reported that African Americans have high rates of PTSD and perceived stress (Roberts et al., 2011, The Recovery Village, 2020). The current study's participants may have lower levels of PTSD and stress because of religion potentially acting as a protective factor against mental illness in African Americans (Lukachko et al., 2015). Furthermore, some African American populations may be more likely to have mental illness, such as depression, compared to others. For example, national studies have shown that older African American adults are less likely than other African American age groups (e.g., adolescents) to be diagnosed with mental illnesses, such as depression (SAMHSA, 2018). Depression in older African Americans may not be identified due

to their personal stigma-related beliefs (e.g., perceptions that they are too old for treatment preventing them from seeking help; Conner et al., 2010). Mental health professionals may also underdiagnose mental illness due to the presentation of other, more pronounced, health issues (e.g., dementia, chronic diseases; Assari, 2014). The population of this study was over-represented by older African Americans. Therefore, additional examination should be given to the effect of mental health stigma and treatment seeking in different age groups among the African American population. Considerations should also be given to increasing understanding on mental health stigma in relationship to other chronic diseases prevalent among African Americans.

Consistent with past studies regarding service seeking among African Americans, the majority of participants reported never visiting a mental health professional. Yet, they believed that mental health was a serious issue in their community. The lack of service seeking could be a result of concerns and disbelief of the efficacy of treatment (e.g., medication; Hankerson et al., 2011; Watkins et al., 2015), decreased ability to access mental health services due to transportation and cost (Kawaii-Bogue et al., 2017), and mental health stigma (Conner et al., 2010; Hankerson & Weissman, 2012; Williams et al., 2014). Other possible reasons may include the preference for same race providers, poor representation of African American mental health professionals and African Americans' preference to receive counsel from religious leaders. Older African Americans are among the highest religious populations and have been found to prefer using religious counsel and coping for general and mental health concerns (Christensen et al., 2017; Ward et al., 2013). Mental health services provided by religious leaders may mitigate mental

health concerns by providing services in easily accessible and trusted settings such as the African American church. Because of the high church attendance among older African American adults, collaborations between behavioral health organizations and African American churches could have great potential to reach African American populations with mental health screening and other health services by tapping the strengths of faith-based settings (e.g., high attendance rates from African Americans, support from clergy and church members; Taylor et al., 2016; Pew Research Center, 2020).

Linear regression results indicated that self-directive religious coping (e.g., coping without the help of God) was a positive predictor of mental health stigma. Self-directive religious coping could be considered as "negative" religious coping and may have the opposite effect of "positive" religious coping (e.g., religious purification/forgiveness and religious direction/conversion), which could lead to reduced stress (Pargament, Koenig and Perez, 2000). Bivariate findings indicated that in higher levels of mental health stigma were significantly associated with increased collaborative religious coping (e.g., working alongside with God). Research on religiosity and use of religious coping for mental health and mental health stigma varies. Past research has found religiosity to have a positive impact on mental health and one's ability to cope with stressful situations due to the support from the faith community (Pargament et al., 2000; Ward & Brown, 2015; Ward et al., 2013). Other research has found that many religious African Americans may have negative beliefs regarding mental illness (e.g., believing the illness is an act of the devil or a punishment from God; Weber & Pargament, 2014). Research should examine how

natural religious functions of the church (e.g., testimonials, responsive readings, sermons) can be used for mental health education on causes, symptoms, availability of services, and coping with mental illness. Health promotion interventions that have included these religious functions have found shifts in beliefs and improvement of use of health services (Berkley-Patton et al., 2020).

Although not significant in the regression analysis, higher levels of mental health stigma and were significantly associated with increased engagement in religious activities (e.g., prayer, attending worship services, reading scriptures) in the bivariate analysis, as hypothesized. Contrary to the hypothesis, there was no significant difference between mental health stigma and fears, awareness, social norms, age, access to mental healthcare, and gender. One explanation for these results could be that our sample was majority women with access to health insurance and higher income. Past studies have found that women are more open to mental health treatment (Ward et al., 2013), and having health insurance and higher incomes may be protective factors against mental health stigma (Hodgkinson et al., 2017, Kawaii-Bogue et al., 2017). Additionally, only one measure was used to assess fear. This measure asked about fear in relation to being screened for mental illness in a church setting and was not specific to fear regarding having a mental illness or mental health stigma and is a possible explanation to why there was no difference between fear and mental health stigma. Future studies should examine other fear variables regarding mental illness symptoms, repercussions of having a mental illness, self-stigma and judgment from others among African Americans. These fear variables are particularly important for African American church-populations where mental health stigma

levels may be elevated. Prioritizing male participants and those who have low income should also be considered in future mental health stigma studies because of their limited access to mental health treatment and the lack of representation in the current literature.

There was also a significant difference between levels of social support (support from others and social beliefs) and mental health stigma. The African American church has a history of being a main source of social support for church members and the surrounding community. Past research with African Americans has found social support to be a valuable strategy to address mental health concerns (Hankerson & Weissman, 2012; Lukachko et al., 2015), but little is known about how social support can negatively (or positively) impact mental health stigma in faith-based settings. Studies are needed that examine the effect of faith-based intervention strategies, such as how social support (e.g., support groups) and engagement in religious activities (e.g., prayer, attending worship services, reading scriptures) can be creatively used to assist in decreasing mental health stigma and increasing professional mental health service seeking.

Several interventions have focused on mental health in the African American church population. One intervention, Oh Happy Day Class (OHDC), focused on increasing treatment retention and satisfaction and decreasing MDD symptoms with cognitive behavioral interventions among African Americans (Ward & Brown, 2015). They found a significant decrease in depressive symptoms as well as a positive change in quality of life scores. However, differences weren't found in mental health attitudes or stigma. Additionally, Williams and colleagues (2014) examined a church-

based intervention (Promoting Emotional Wellness and Spirituality [PEWS]) to reduce stigma on depression, educate about depressive symptoms and the importance of spirituality during treatment, promote treatment seeking, and provide linkage to care information for mental health services. Their results indicated that partnerships between mental health organizations and churches that employ a community-based participatory research approach for heightened community engagement were important intervention approaches for achieving impactful mental health ministries. However, this intervention did not examine knowledge of mental illness symptoms, mental health treatment seeking, or changes in mental health stigma. These church-based mental health interventions could examine educating African American church leaders and members on the importance of providing social support and encouraging members to combine seeking mental health services and engaging in religious activities (cultural norms). These activities may help determine the effectiveness of incorporating African American faith leaders in increasing professional mental health treatment seeking and decreasing mental health stigma.

Limitations

There are some limitations to consider when examining the results from the present study. As stated previously, and consistent with other church-based research (Berkley-Patton et al., 2018; Hankerson & Weissman, 2012), the majority of the sample for this study were women. Women may be more willing to seek mental health services (Ward et al., 2013), which may have affected the lower levels of mental health stigma reported. The majority of the sample were also older adults. The general mental health stigma score for this study may have been affected by older age

due to older individual's potential to believe they are too old for treatment, distrust in mental health treatment (Conner et al., 2010), and belief that having a mental illness is a weakness or shameful (Neely-Fairbanks et al., 2018). Age may also be associated with the amount and regularity of participation in religious activities and coping, which often acts as protective factors against mental illnesses (Farrer et al., 2008, Lukachko e al., 2015), causing an increase in social support and a decrease in reported mental illness and mental health stigma. Lastly, because the study was conducted among highly religious African Americans in the Midwest, an area considered to be included in the "Bible Belt" (Brunn et al, 2011), generalizability of the findings may be limited to faith-based populations in this region.

Conclusion

Mental health stigma is a contributor to mental health inequities and decreased service seeking among African Americans (Hankerson & Weissman, 2012; Heath, 2017; Phelan et al., 2019). In order decrease mental health stigma among African Americans, research should consider understanding predictive factors of mental health stigma. As guided by the Health Stigma and Discrimination Framework (Stangl et al., 2019), results from this study indicate that self-directive religious coping is a predictor of mental health stigma. Results also indicated that there was a significant difference between levels of mental health stigma and social support (support from others and beliefs) and religious activities (cultural norms). Research has shown that culturally and religiously tailored interventions for the African American church population tend to be more effective than non-tailored interventions (Hays & Aranda, 2016; Lee-Tauler et al., 2018). Future research should prioritize

culturally tailoring mental health interventions based upon type of religious coping and social support as well as addressing mental health stigma among older, church-affiliated African Americans in a trusted setting such as the African American church.

APPENDIX

Drivers (Fear)

1. 21b. **Are there any reasons you would <u>not</u> take advantage of church-based mental health screening**? (*Check all that apply*)

□ You are concerned people will make judgments or start rumors about being screened.

□ You do not feel comfortable being screened for mental health concerns in a church or church-related setting.

□ You are not sure your screening results will be kept private.

□ You do not want to know your mental health status at this time.

Drivers (Awareness)

2. In your opinion, how serious is mental health in your community? *(Check one)*

□ Not at all serious □ Not too serious □ Somewhat serious □ Very serious

3. In the last 12 months, how many people at this church/church center or at an event sponsored by this church did you talk to about any topics related to mental health? *(Check one)*

□ None
□ 1-2 people
□ 3-5 people
□ 6-9 people
□ 10-19 people
□ 20 or more people

Drivers (Social Support)

4. How likely would the following people support you in getting screened for mental health concerns? *(Circle one number for each statement below. Mark circle under "Don't Know" if you don't know.)*

Support for getting a mental health screening	*Not at all likely*						*Very Likely*	*Don't Know*
My friends would support me in getting a mental health screening.	0	1	2	3	4	5	6	0
My partner/spouse would support my getting a mental health screening.	0	1	2	3	4	5	6	0
My church members would support my getting a mental health screening.	0	1	2	3	4	5	6	0
My pastor would support my getting a mental health screening.	0	1	2	3	4	5	6	0
My doctor would support my getting a mental health screening.	0	1	2	3	4	5	6	0

5. To what extent do you believe the following statements? *(Circle one number for each statement below)*

I believe:	*Not at all*						*Very much so*
a. I can receive mental health screening at my church.	0	1	2	3	4	5	6
b. I can receive mental health screening at a local clinic/doctor's office.	0	1	2	3	4	5	6
c. The cost of a mental health screening a clinic or doctor's office is affordable or free.	0	1	2	3	4	5	6
d. If I received a mental health screening at church, my results would be kept confidential.	0	1	2	3	4	5	6

I believe:	*Not at all*						*Very much so*
e. If others thought I had a mental health condition, I could be treated differently or badly.	0	1	2	3	4	5	6
f. If I found out I had a mental health condition, I could get connected to resources (e.g., counseling) or receive medications for treatment.	0	1	2	3	4	5	6

Facilitators (Cultural Norms)

6. How are you connected to <u>this</u> church? *(Check all that apply)*

□ Member
□ Guest
□ Person who received food services
□ Person who received health screening or participated in a health fair
□ Person who received drug rehab services
□ Person who received clothing
□ Parent of a child in church daycare, summer school, after-school program, or mentoring program
□ Other (please list): _____

7. For the <u>past 12 months</u>, how often have you done each of the following activities? (*Mark one circle for each activity)*

Activities	*Never*	*Rarely*	*Once a month*	*Twice a month*	*Once a week*	*Twice a week*	*Almost daily*	*More than once a day*
a. Thought of God	0	0	0	0	0	0	0	0
b. Prayed	0	0	0	0	0	0	0	0
c. Meditated	0	0	0	0	0	0	0	0
d. Attended a worship service	0	0	0	0	0	0	0	0

Activities	*Never*	*Rarely*	*Once a month*	*Twice a month*	*Once a week*	*Twice a week*	*Almost daily*	*More than once a day*
e. Read scriptures or holy writings	0	0	0	0	0	0	0	0
f. Had direct experiences with God	0	0	0	0	0	0	0	0

8. The following questions are specifically about religious or spiritual ways you might cope with mental health concerns. Indicate how much you use each of the following methods to cope with mood or mental health concerns. When the items refer to God, please think of this as referring to your Higher Power.

Health topics and screenings	*Not at all*	*A little*	*A medium amount*	*A great deal*
a. I don't do much; just expect God to solve my problems for me.	0	0	0	0
b. I work together with God as partners.	0	0	0	0
c. I try to put my plans into action together with God.	0	0	0	0
d. I try to make sense of the situation with God.	0	0	0	0
e. I try to deal with my feelings without God's help.	0	0	0	0
f. I don't try much of anything; simply expect God to take control.	0	0	0	0
g. I make decisions about what to do without God's help.	0	0	0	0
h. I don't try to cope; only expect God to take my worries away.	0	0	0	0
i. I try to make sense of the situation without relying on God.	0	0	0	0

Facilitators (Social Norms)

9. Have you experienced discrimination because of your race or skin color during a healthcare visit in the past year?

□ Yes □ No

10. Have you experienced discrimination because of your race or skin color at work in the past year?

□ Yes □ No

Facilitators (Access to mental health care)

11. Have you ever visited a mental health professional, such as a therapist, counselor, or psychologist?
(*Check One)*
□ Yes
□ No
□ Don't know
□ Refuse to answer

12. Have you ever received counseling services from your pastor or religious leader?

□ Yes
□ No
□ Don't know
□ Refuse to answer

13. Have you ever taken medications for mental health concerns?

□ Yes
□ No
□ Don't know
□ Refuse to answer

Stigma Marking: Intersecting Stigmas (Demographics)

14. How old are you? _____Years Old

15. Are you: *(Check one)* □ Male □ Female

16. What is your race or ethnicity? *(Check one)*

□ Black or African American
□ White or Caucasian

□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ More than one race
□ Unknown
□ Refuse to answer
□ Other race: (please specify): _____

17. How do you identify yourself? *(Check one)*

□ Heterosexual (straight)
□ Homosexual (gay/lesbian)
□ Bi-sexual (attracted to both men and women)
□ Other
□ Choose not to answer

18. What is your highest level of education you have completed? *(If you attended school outside the U.S., mark the U. S. equivalent) (Check one)*

□ 8th grade or below
□ 9-11th grade
□ High school graduate or GED
□ Post high school technical training
□ Some college (but no degree)

19. Do you have health insurance or coverage that helps pay for part of your medical bills? *(Check all that apply)*
□ Yes, Medicare
□ Yes, Medicaid
□ Yes, Private Insurance (Such as Blue Cross/ Blue Shield, Kaiser, etc.)
□ No, I do not have health insurance
□ Yes, Some other insurance (please list):_____

20. For the past 12 months, please estimate the average monthly income of your household. Take into account all the sources of income from the members of your household. *(Check One)*

□ $0 - $1,000
□ $1,001 - $2,000
□ $2,001 - $2,500
□ $2,501 - $3,000
□ More than $3,000
□ Don't know

Stigma Marking: Intersecting Stigmas (Mental Health Conditions)

21. Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	*Several days*	*Over half the days*	*Nearly everyday*
a. Feeling nervous, anxious, or on edge.	0	0	0	0
b. Not being able to stop or control worrying.	0	0	0	0
c. Worrying too much about different things.	0	0	0	0
d. Trouble relaxing.	0	0	0	0
e. Being so restless that it is hard to sit still.	0	0	0	0
f. Being easily annoyed or irritable.	0	0	0	0
g. Feeling afraid as if something awful might happen.	0	0	0	0

22. Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	*Several days*	*More than half the days*	*Nearly every day*
a. Little interest or pleasure in doing things.	0	0	0	0
b. Feeling down, depressed, or hopeless.	0	0	0	0
c. Trouble falling or staying asleep, or sleeping too much.	0	0	0	0
d. Feeling tired or having little energy.	0	0	0	0
e. Poor appetite or overeating.	0	0	0	0
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	0	0	0
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	0	0	0
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	0	0	0
i. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	0	0	0

23. The following questions will ask you about your feelings and thoughts over the last 7 days. In each case, you will be asked to indicate how often you felt a certain way. Some of the questions may sound similar, but please treat each question separately. Try to answer each question fairly quickly – do not try to count up the number of times you felt a particular way, but rather provide your best guess.

In the last week how often have you…	*Never*	*Almost never*	*Sometimes*	*Fairly often*	*Very often*
a. Been upset because of something that happened unexpectedly?	0	0	0	0	0
b. Felt that you were unable to control the important things in your life?	0	0	0	0	0
c. Felt nervous or "stressed"?	0	0	0	0	0
d. Dealt successfully with irritating life hassles.	0	0	0	0	0
e. Felt that you were effectively coping with important changes that were occurring in your life?	0	0	0	0	0
f. Felt confident about your ability to handle your personal problems?	0	0	0	0	0
g. Felt that things were going your way?	0	0	0	0	0
h. Found that you could not cope with all the things that you had to do?	0	0	0	0	0
i. Been able to control irritations in your life?	0	0	0	0	0
j. Felt that you were on top of things?	0	0	0	0	0
k. Been angered because of things that happened that were outside of your control?	0	0	0	0	0
l. Found yourself thinking about things that you have to accomplish?	0	0	0	0	0
m. Been able to control the way you spend your time?	0	0	0	0	0
n. Felt that difficulties were filing up so high that you could not overcome them?	0	0	0	0	0

Manifestations (Mental health stigma)

24. Please mark the response that best represents your answer to each of the following questions.
(Mark one circle for each statement below)

Attitudes about Mental Health	*Strongly Disagree*	*Somewhat Disagree*	*Uncertain*	*Somewhat Agree*	*Strongly Agree*
a. I believe a person with mental illness is a danger to others.	0	0	0	0	0
b. I believe a person with mental illness is unpredictable	0	0	0	0	0
c. I believe a person with mental illness is unpredictable	0	0	0	0	0
d. I believe a person with mental illness has only himself/herself to blame for his/her condition.	0	0	0	0	0
e. I believe a person with mental illness would improve if given treatment or support.	0	0	0	0	0
f. I believe a person with mental illness feels the way we all do at times.	0	0	0	0	0
g. I believe a person with mental illness could pull himself/herself together if he/she wanted.	0	0	0	0	0
h. I believe a person with mental illness can eventually recover.	0	0	0	0	0

Attitudes about Mental Health	*Strongly Disagree*	*Somewhat Disagree*	*Uncertain*	*Somewhat Agree*	*Strongly Agree*
i. I believe a person with mental illness can be as successful at work as others.	0	0	0	0	0
j. Treatment can help people with mental illness lead normal lives.	0	0	0	0	0
k. People are generally caring and sympathetic to people with mental illness.	0	0	0	0	0

25. Please mark the response that best represents your answer on how strongly you agree or disagree with each statement. *(Mark one circle only for each statement)*

Opinions	*Strongly Disagree*	*Somewhat Disagree*	*Uncertain*	*Somewhat Agree*	*Strongly Agree*
a. People with mental health conditions are responsible for having their illness?	0	0	0	0	0
b. Scientists and doctors can be trusted to tell the truth about mental health conditions?	0	0	0	0	0

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