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Mental Distress, Stigma and Help-Seeking in the Evangelical Christian Church: Study Protocol

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Abstract: *Background:* A large body of research supports the central importance of religious and spiritual belief systems for personal wellbeing. Many religious communities hold beliefs about the causes and suitable treatments for mental health conditions, which can influence how an individual experiences their mental health, as well as the likelihood of seeking professional or religious help for their psychological difficulties. Research suggests that this is especially the case for evangelical Christians, who are more likely to view mental illness as caused by demons, sin, diminished faith, or generational curses. Whilst recent qualitative evidence suggests that such beliefs can hold negative effects for evangelical Christians, there is little research exploring quantitative pathways. *Objective:* This study protocol paper presents a pilot study, which aims to explore how beliefs about the causes of mental illness, religious fundamentalism, help-seeking, stigma and mental health are related in evangelical Christian communities. Whilst there is some existing research exploring this area, most is drawn from a US context. The findings of the present study, therefore, will uniquely apply to a UK context. *Study Design:* A quantitative design is proposed, which will involve statistical analyses such as correlation, regression, moderation and path analysis, to explore associations between these variables. Ethical considerations and dissemination plans are discussed, with awareness of characteristics of our target sample.

Keywords: Protocol; Christianity; religious beliefs; stigma; mental health; help-seeking; evangelical

Background

Decades of research has shown that religion and spirituality are associated with many positive health outcomes, being referred to in the literature as a "buffer" against a range of illnesses (Koenig, 2012). Indeed, a substantial body of literature points to the positive effects of religious beliefs for both physical and psychological well-being (Pargament, 1997). In their large scale, systematic evidence based-review, Bonelli & Koenig (2013) reported the helpful effects of religious involvement upon mental wellbeing in areas such as depression, substance abuse and suicide; with some evidence for stress-related disorders and dementia.

Religious beliefs and related practices, however, can also have a negative impact upon mental health. An important variable in predicting whether religion supports wellbeing is the specific theological and religious beliefs held about mental distress, including aetiological factors, possible treatment options and beliefs regarding recovery (Hartog & Gow, 2005; Laythe et al., 2002; Leavey, 2010; Lloyd & Waller, 2020). The extent and strength of these aetiological beliefs across religious traditions is variable, however there is growing evidence to suggest that Christian communities—evangelical denominations in particular—may hold beliefs about mental illness that can have negative consequences for wellbeing (Lloyd & Waller, 2020). In theological terms, Christian communities commonly view emotional and mental health as vertically representative, in that the psychological health of the individual is understood as embodying the inner spiritual life (Cook & Hamley, 2020; Scrutton, 2020; Webb, 2017). This is especially true for evangelical Christianity, which is defined as a transdenominational movement stressing personal conversion experience, the absolute authority of the Bible (interpreted literally), a focus on Jesus's death and resurrection, and the importance of Evangelism for all Christians (Bebbington, 2003).

Current research suggests that religious attitudes are positively associated to stigmatising beliefs about mental distress (Wesselmann & Graziano, 2010). Examples of stigmatising beliefs may include associating mental illness exclusively as a result of sin, moral or spiritual failure, or that it can be cured with prayer or other spiritual intervention in isolation. In a recent large-scale qualitative study, Lloyd and Hutchinson (in press) examined the experiences of 293 evangelical Christians with mental distress. A prominent theme included Christians experiencing stigma and relational disconnection from their religious community in relation to their mental health. Furthermore, in a more recent phenomenological analysis of interview data with evangelical Christians with mental distress, participants discussed a range of unhelpful experiences from their faith community in relation to their mental health (Lloyd, 2021). These included the imposed belief from their church community that their mental illness was the result of spiritual forces, which was distinct from participants own sense-making. Lloyd (2021, p.18) refers to this negative aspect as "spiritual reductionism",

the belief that all forms of mental illness can be explained with reference to spiritual entities. Whilst these qualitative studies have explored negative experiences from faith communities in relation to mental health, little quantitative research attention has explored variables associated with such experiences in a UK context.

The impact of religious beliefs about mental illness may also have other ramifications. Some evidence suggests that religious beliefs can influence the social support individuals may receive from their church, as well as their likelihood of seeking professional help for their mental illness from outside the church context (Rogers et al., 2012; Stanford, 2007). Both of these are likely to directly affect psychological wellbeing, yet the potential theoretical pathways for this link have not been fully elucidated. Stigma is one factor that is understood to be influential (Mathison, 2016), and has been associated with negative psychological and physical health outcomes. However, while stigma about mental illness in Christian communities has been widely recognised in the United States (Weaver, 2014), little is known about this in the UK context, which has vastly different theological dimensions than the US. For example, it is widely acknowledged that religious belief in the UK tend to be more liberal than in the US (Lloyd & Waller, 2020).

Most empirical research on mental illness, help-seeking behaviours and stigma has concentrated on the general population, without examining factors that may be specific to religious groups or subcultures. While stigma may influence the degree to which the general population accesses professional mental health services (e.g., Kotera et al., 2020a), evidence suggests that those in religious communities may underutilise them even more (Mayers et al., 2007; Trice & Bjorck, 2006). Considering the negative impact of self-stigma for both physical and psychological functioning, this study will make a timely contribution to the literature.

Aims and Objectives

This study attempts to collect new data to investigate religious stigma and mental distress (namely anxiety and depression), in the Evangelical Christian population of the UK. This will include ascertaining whether religious beliefs about the causes and cures of mental illness, religious commitment, fundamentalism, attitudes towards professional help seeking, and perceived experiences of social support from the church, might predict religious mental health stigma and anxiety and depression, in UK-based Evangelical Christians.

Method

Study Design

A cross-sectional study design, utilising online quantitative questionnaires will be used. The data analysis will be conducted using

correlation analysis, to evaluate whether variables are significantly related to each other, and regression analysis, to identify which variables are significant predictors for the dependent variables.

Recruitment and Participants

A-priori g*power analysis shows that at least 119 participants will be needed (effect size f2=0.15, α=0.05, Power=0.95). Online survey posters will be disseminated virtually via open access social media groups, such as Evangelical Christians UK.

Recruitment will take place using convenience sampling by having participants click on a link to the questionnaires created on Qualtrics Software (© 2020 Qualtrics®). Whilst convenience sampling carries a number of drawbacks, including the risk of gathering a biased sample, for this study, recruitment will be undertaken specifically within a specialised network of religious circles. The resultant sample will, therefore, be more generalisable to a population of concern, than the general public.

Eligibility Criteria

To be eligible for inclusion, participants need to self-identify as both Christian and Evangelical, be aged 18 years of age or older and be a resident of the UK.

Questionnaires

Participants will be asked to complete seven questionnaires in a randomised order following initial demographic items. Randomisation of the questionnaires will be implemented to mitigate against participant responses being influenced by the particular ordering, or presentation of the questionnaires (e.g., order effects).

Participants will initially be asked to report their age, gender, religious/spiritual affiliation, and frequency of attendance to religious/spiritual meetings, services, or events.

(Independent Variable 1) ***Religious Beliefs about Mental Illness***. We will use an established measure of religious beliefs about mental illness (Wesselmann & Graziano, 2010). This measure assesses the Morality/Sin (9 items, e.g., "Moral weakness is the main cause of mental illness.") and Spiritually-Oriented Causes/Treatments belief factors (7 items, e.g., "Prayer is the only way to truly fix a mental illness."). Participants indicate their agreement with each statement (9-point rating scale; 1 = strongly disagree, 9 = strongly agree). This scale demonstrates high validity and reliability (r = .55, p < .01; α = .77-.88).

(Independent Variable 2) ***The Religious Commitment Inventory-10***. This inventory is a brief screening assessment of religious commitment (Worthington, 2003). This 10-item inventory measures religious commitment in religious and nonreligious communities and in various religious traditions such as Christianity, Islam, and Buddhism. This scale has high validity and reliability (r = .57, p < .001; α = .95).

(Independent Variable 3) ***The Christian Fundamentalist Belief Scale*** (CFBS; Gibson & Francis, 1996) is a 12-item scale. Respondents are required to rate each item on a 5-point Likert scale, ranging from disagree strongly to agree strongly (1-5). The scale measures a single unidimensional construct – fundamentalism, within Christians traditions. The validity and reliability of CFBS are high (r =.44-50, $p < .01$; $\alpha = .92$).

(Independent Variable 4) ***Inventory of Attitudes Toward Seeking Mental Health Services*** (IASMHS; Mackenzie et al., 2004). The IASMHS was developed in 2004 by Mackenzie, Knox, Gekoski, and MaCaulay as an adaptation of and an extension of the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS). The IASMHS is a 24 question, 5-point Likert scaled inventory with responses which range from disagree (0) to agree (4). Fifteen of the items require reverse coding. It has three subscales: psychological openness, help-seeking propensity, and indifference to stigma. Higher scores indicate that the respondent has a more positive attitude toward seeking professional help. IASMHS has demonstrated high validity and reliability (r = .47-65 $p < .001$; Pc = .70-77).

(Independent Variable 5) ***The Religious Support Scale*** (Fiala, Bjorck, & Gorsuch, 2002) is a 21-item measure loading on 3 factors: congregational support (7 items), God support (7 items), and church leader support (7 items), with a 5-point rating scale (1 = strongly disagree, 5 = strongly agree). It is developed to assess perceived support from respondents' congregation, church leaders, and God. This scale has high validity and reliability (r = .12-73 $p < .05$; α = .75-91).

(Dependent Variable 1) ***Religious Mental Health Stigma Scale*** (Mathison, 2016) is a 11-item measure with strong psychometric support. It incorporates theory on public stigma and self-stigma of mental illness and help-seeking. This scale demonstrates high validity and reliability (r = .54, $p < .01$; α = .83).

(Dependent Variable 2) ***The Patient Health Questionnaire-4*** (PHQ-4; Kroenke, Spitzer, Williams, & Löwe, 2009) is a 4-item inventory rated on a 4-point Likert-type scale. Its items are drawn from the first two items of the 'Generalized Anxiety Disorder–7 scale' (GAD–7) and the 'Patient Health Questionnaire-8' (PHQ-8). Its purpose is to allow for a very brief and accurate measurement of depression and anxiety. This scale has high validity and reliability (r = .80, $p < .01$; α = .83).

Ethical Considerations

Informed Consent

A consent form will be provided to the participant through 'Qualtrics' (© 2020 Qualtrics®).

Participants must tick all boxes prior to answering the questionnaires, to confirm that they have read and understood the participant information sheet, that they are participating voluntarily, that

they understand the withdrawal process and to confirm that they are satisfied with the procedures which are in place to protect their personal information. These procedures include:

- The researchers will not seek more information than what is essential for the study.
- Participants' anonymity will be protected using ID codes.
- Data will be gathered during the study will be used only for the purposes of the study and for any relevant publications that arise from it.
- Data will be stored in password protected databases for no longer than is necessary (7 years) and will be safely destroyed after such time has passed.

Debriefing

The debriefing of participants will consist of providing them with the 'Debrief Form' once questionnaires have been completed. Through the debrief form, participants will be thanked for their participation, the objectives of the study will be re-defined, and participants will be reminded of their right to withdraw from the study, up to one week following survey completion. Participants will also be provided with support contacts, should any of the participants experience any distress, during or after the completion of the questionnaires. The debrief form will also provide a reminder of our ethical and legal requirements in collecting and storing their data so they are fully aware of the guidelines in place.

Risk Assessment

The survey will be disseminated to the Christian community broadly and does not specifically seek the views of those considered clinically vulnerable. Distress is not considered likely to arise from participation in the study. Nevertheless, as the absence of distress can never be guaranteed, all participants will be provided with full details of relevant mental health agencies following their completion of the survey.

Remuneration

No incentive or reward will be offered for taking part in the study.

Data Protection

All consent forms and procedures will be in line with the British Psychological Society (BPS) Code of Human Research Ethics (2014). No personally identifiable information will be collected from participants. All collection and storage of data will be in line with the General Data Protection Regulations (Carey, 2018) and stored securely with the University of Derby server. This will only be available to the researchers.

Confidentiality and Deception

Each participant will be asked to provide a unique identifier, which will consist of the last three letters of their surname and the last three numbers of their mobile number. At the end of the survey, all data within

Qualtrics will be downloaded onto the secure network of the University of Derby, after which data within Qualtrics will be destroyed.

Outcomes and Dissemination

The findings of this study will be published in peer reviewed academic journal articles that sit at the interface between the domains of mental health, psychology, and religion. The work is anticipated to be of interest to Christian communities, academics working in the field of psychology, psychotherapy, theology, and other interdisciplinary subjects.

- Peer reviewed journals
- Academic scholars
- Christian mental health charities, such as, the Mind and Soul Foundation (n.d.) and, Think Twice (n.d.).

The findings from this study will help to:

- Increase understanding of variables which might contribute to religious mental health stigma.
- Increase understanding of pathways to mental health help-seeking behaviours amongst evangelical Christians and what might influence this.
- Provide insight for psychotherapeutic practitioners regarding developing culturally and religiously sensitive mental health interventions.
- Act as a wider psychoeducational resource for religious communities interested in developing mental health literacy in their congregations.

Study Limitations

The main limitation is that the data collected will be cross-sectional in nature and hence will prevent causal relationships being determined. The use of self-report measures also carries the risk of response biases (Kotera et al., 2020b). However, it is anticipated that the findings of the present study will act as a foundation for further studies in this area, including those with stronger statistical design and power, including longitudinal projects capable of exploring beliefs and experiences over different time periods.

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