

RELIGIOUS ADVISORS' MENTAL ILLNESS STIGMA:
PENTECOSTAL ATTRIBUTIONS

by

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Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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Abstract

Some individuals, who subscribe to religious beliefs, often prefer to seek help from religious advisors when addressing mental health issues rather than seek help from mental health professionals. Although these religious advisors do not believe they have received adequate training to support individuals with these issues, they will still attempt to counsel them without the help of mental health professionals. One particular issue both types of practitioner face is the increase of the addictive qualities associated with problematic pornography use. The representation of the addictive qualities in problematic pornography use is a widespread concern, especially in religious communities, and mental health professionals report an increase in cases of problematic unwanted sexual behavior including pornography use. Simultaneously, some religious communities not only identify mental health as a diabolical issue, but for those who approach religious advisors for help with problematic pornography use, little is known in how this mental illness stigma might influence assessment and subsequent treatment of the congregant. This study examined the relationship between mental illness stigma and religious advisors' propensity to refer congregants to mental health professionals when mediated by diabolical attribution. This study also examined the moderation of the mediated model by the perceived level of threat in a comorbid mental disorder. It was hypothesized that religious advisors' stigma would predict whether referrals would be made through diabolical attribution of mental illness and that a level of threat in a disorder would then change these relationships. The results suggested no relationship between religious advisors' mental illness stigma and their propensity to refer congregants to a mental health professional; diabolical attribution of mental illness associated with PPU also did not mediate the relationships. However, the results suggested a diabolical attribution predicted the likelihood that a religious advisor would refer to a

mental health professional. Additionally, specifically in the vignettes that reflected psychosis, there was a lower diabolical attribution than in the depression and anxiety vignettes, and the likelihood of referral was higher in the vignettes that reflected psychosis than in the depression and anxiety vignettes. Implications, limitations, and ideas for future research are discussed.

Keywords: pornography, problematic pornography, integration, mental illness, mental illness stigma, religious advisor, clergy, Christian, hypersexual disorder, counseling, referral, mental health professional

Dedication

This manuscript is dedicated to my husband, Robert. You have earned this right alongside me.

Acknowledgments

I want to thank Dr. Fred Volk for his mentorship and insight not only throughout this dissertation process, but through this entire doctoral program. Your principle number one has influenced both my professional and personal life, and I am so grateful to God that He graced you into my life. Thank you for all you invested.

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List of Abbreviations

American Counseling Association (ACA)

Day's Mental Illness Stigma Scale (DMISS)

Problematic Pornography Use (PPU)

CHAPTER ONE: INTRODUCTION

Religion and psychology have often contended with each other (Ellis, 1955; Freud, 1961; Skinner, 1953); however, over the last few decades, research has indicated the inclusion of religion into psychotherapy may have several benefiting factors. Religion can be a protective factor when coping with distress (Buser, Buser, & Rutt, 2017; Krause, Ironson, Pargament, & Hill, 2017), specifically protecting against self-harm (Buser et al., 2017), enhancing positive caregiving of persons with illness (Pearce, Medoff, Lawrence, & Dixon, 2016), and alleviating depressive symptoms (Areba, Duckett, Robertson, & Savik, 2017; Breland-Noble, Wong, Childers, Hankerson, & Sotomayor, 2015; Rathier, Davis, Papandonatos, Grover, & Tremont, 2013). Clinicians have continued to utilize integrative factors of religion in therapy. However, religious individuals have not seemed to reciprocate. Research has suggested religious communities still possess a stigmatic view of mental illness.

Among these religious communities, mental illness is often attributed to personal choice (Crosby & Bossley, 2012; Hartog & Gow, 2005; Judd & Vanderberg, 2014; McGowan & Midlarsky, 2012) and believed to be perpetuated by a moral weakness (Hartog & Gow, 2005; Trice & Bjorck, 2006). With religious individuals approaching religious advisors for help with mental illness issues (Crosby & Bossley, 2012; Farrell, & Goebert, 2008; Leavey, 2010; Montesano, Layton, Johnson, & Kranke, 2011; Veroff, Douvan, & Kulka, 1981), typically, treatments of mental health issues are only addressed using religious practices, and referral to a mental health professional has been unlikely (Farrell and Goebert, 2008).

Mental illness stigma within religious communities has affected the attribution of different disorders. Disorders that reflect a perceived threat to the advisor (e.g., Schizophrenia) are attributed to physiological issues, while disorders that are not perceived as threatening (e.g.,

Depression) are often attributed to a lack of social support, and individuals who experience symptoms are seen more responsible for onset (Angermeyer & Matschinger, 2003; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Jorm et al., 1997a; Khan, Hassali, Tahir, & Khan, 2011; Marie & Miles, 2008). Religious advisors are generally ill-equipped to address psychopathological issues (Friesen, 1988; Gottlieb & Olfson, 1987; Weaver, 1995), yet they have reported that they still engaged with these individuals, offering to counsel without an additional referral (Farrell & Goebert, 2008).

One particular area seen by religious advisors is pornography use (MacInnis & Hodson, 2014). Problematic pornography use has risen among religious individuals, and negative consequences, due to the shame associated with use, is emerging (Grubbs, Sessoms, Wheeler, & Volk, 2010; Nelson, Padilla-Walker, & Carroll, 2010; Patterson & Price, 2012). When religious communities explicitly have conveyed the idea that pornography is addictive (e.g., Chester, 2010; Driscoll, 2009) and have condemned its effects upon one's religion and spirituality, potential religious struggles have then affected an individual's psychological and physical well-being (Exline, 2013; Rosmarin, Bigda-Peyton, Öngur, Pargament, & Björgvinsson, 2013; Pirutinsky, Rosmarin, Pargament, & Midlarsky, 2011).

Little research has explored the roles of religious advisors in the psychological treatment of those who approach them for help. With the rise of pornography and its widespread accessibility, the growing knowledge of its compulsive tendencies has suggested religious advisors are ill-equipped to treat these individuals alone. Yet religious advisors may still treat individuals who do not seem to have a threatening disorder such as Depression or Problematic Pornography Use. Mental illness stigma in a religious advisor may affect his or her decision to refer to a mental health professional; yet, no study to date has addressed this growing problem.

Background of the Problem

Historically, conflict has plagued religion and mental health (Bergin, 1980), and prominent psychologists have considered religiosity as a form of neurosis and emotional disturbance (Freud, 1961; Skinner, 1953). In 1930, Freud had written in his *Future of an Illusion* that religion results in, “depressing the value of life and distorting the picture of the real world in a delusional manner—which presupposes an intimidation of intelligence” (p. 18). Although some psychologists have had a positive view of psychology (Jung, 1969), others like Albert Ellis (1955) have considered religiosity to be equivalent to irrational thinking and believed solutions came from becoming unreligious. However, previous ideas regarding religiosity and mental health were not based on empirical research and were mostly concluded from clinical cases and opinions.

Over the last 20 years, integration research of psychology and religion has emerged, suggesting religion and spirituality may actually have a positive impact on mental health. Spirituality and religion are seen as positive indicators of emotional coping in a variety of emotional trials such as cancer (Ginsburg, Quirt, Ginsburg, & MacKillop, 1995), depression (Russinova, Wewiorski, & Cash, 2002), death of a loved one (Trevino, Archambault, Schuster, Richardson, & Moye, 2012), and even substance abuse (Shorey, Gawrysiak, Anderson, & Stuart, 2015). With the positive impact of spiritual and religious integration, counselors are encouraged to utilize spirituality within treatment practices (Koenig, 2010; Steglitz, Ng, Mosha, & Kershaw, 2012).

As researchers have begun to integrate spiritual practices in research, religious advisors have not appeared to be reciprocating. Recent studies have suggested a negative view of mental

health has continued to exist in religious communities, often attributing illness to personal choice (Crosby & Bossley, 2012; Hartog & Gow, 2005; Judd & Vanderberg, 2014; McGowan & Midlarsky, 2012). Not all religious traditions have continued to endorse negative perceptions of mental health. However, evangelicals have often attributed causes of mental illness to moral weakness (Hartog & Gow, 2005; Trice & Bjorck, 2006) and the result of ongoing sin in the individual's life (Rabinowitz, 2014). Religious beliefs may have a large effect on attitudes and perceptions of mental illness and may even be seen as the cause of problems (Hartog & Gow, 2005).

Varying definitions of "religious" exist; however, Baumsteiger and Chenneville (2015) define religiosity as a term that mostly includes "behavior/actions," "God," "follow," and "believe." This study has primarily focused on the Christian religion, which functions upon the Bible, focusing on individuals who follow its teachings. Not all Christian individuals hold the same beliefs about mental illness, yet more conservative, Pentecostal, and fundamentalist congregations tend to view prayer, reading the Bible, and healing ministries as appropriate treatments (Crosby & Bossley, 2012; Leavey, 2010). Pentecostal pastors, in particular, may lean more toward a diabolical model (suggesting any mental health problem is due to spiritual sin in one's life) for mental health rather than an integrative biomedical perspective (Asamoah, Osafo, & Agyapong, 2014).

For some, religious advisors provide support, guidance, and comfort, and may even be considered unofficial representatives of a mental health professional (Kovess-Masfety et al., 2009); therefore, some individuals who subscribe to religious beliefs often prefer to seek help from a religious advisor when addressing mental health issues rather than seek help from a mental health professional (Hartog & Gow, 2005). It is suggested that these highly religious

individuals are actually less likely to seek out mental health treatment at all (McGowan & Midlarsky, 2012). They fear another's differing perspective could weaken their faith (Altemeyer, 1988; Mayers, Leavey, Vallianatou, & Barker, 2007).

Although religiosity's impact on mental health has been widely studied, mental illness stigma in religious communities and its influence upon help-seeking behaviors has only begun to emerge in research. A Surgeon General report has cited mental illness stigma as, "the most formidable obstacle to future progress in the arena of mental illness and health" (U.S. Department of Health and Human Services, 1999). Mental illness stigma may impact an individual's desire to seek treatment from a mental health professional (Mojtabai et al., 2011), and when mental illness is considered a moral weakness, religious individuals may only seek a religious advisor's help (Crosby & Bossley, 2012; Leavey, 2010). Furthermore, access to a religious advisor is free of charge and does not require a referral; therefore, the concerns regarding the quality of care given by religious advisors is warranted because research is suggesting mental health training for religious advisors seems somewhat insufficient. Studies have described the inability of religious advisors to identify mental health problems and their estimation of severity (Taylor, Ellison, Chatters, Leving, & Lincoln, 2000). Even so, religious advisors have continued to report frequent contact with people who suffer from mental health problems and feel inadequate in treating such problems (Farrell & Goebert, 2008; Montesano et al., 2011).

One specific area of interest, as is seen in the Christian church, is in the realm of sexuality. Due to the many biblical passages that warn against sexual immorality (e.g. 2 Corinthians 12:21, Ephesians 5:3, Galatians 5:19, Hebrews 13:34), sexuality is seen as a taboo topic, and anything discussed beyond procreation is considered to be forbidden (Yarhouse &

Tan, 2014). Hollinger (2009) has discussed the history of asceticism in Christianity and how there has been a “higher” way of living through chastity and obedience. A large body of research has existed on faith and sexuality, pointing to protective benefits toward sexual behavior. Faith is related to decreased rates of teenage sexual behavior (Mueller et al., 2009), delayed sexual onset (Boonstra, 2010), and a decrease in sexual partners (Kalina et al., 2009). Although this literature of the protective benefits toward sexual behavior has existed, criticisms of these same faith communities and how these communities negatively impact sexual behavior have existed as well. Women who were raised in conservative Christian households were more likely to participate in risky sexual practices, and young men were less likely to use contraception (Manlove, Ikramullah, & Terry-Humen, 2008). With these conflicting narratives, little research has explored the influence of Christianity on varying dimensions of sexual behavior.

Most literature in this domain has concerned itself with the ongoing problem of sexual abuse within the Catholic church (e.g., Keenan, 2011), and yet very little has examined hypersexual behavior in the Christian church and how it is addressed (see Edger, 2012). Hypersexual behavior refers to the inability to control a sexual behavior or desire, even when it generates negative life outcomes (Womack, Hook, Ramos, Davis, & Penberty, 2013). When this “out-of-control” sexual activity causes harm to an individual’s emotional and physical health, it can be arguably considered compulsive and addictive (Kor, Fogel, Reid, & Potenza, 2013). Although the decision was ultimately made to not include hypersexual disorder in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association, 2013), links in similar brain activity in those considered addicted to different substances and those who reported compulsive sexual behavior have emerged in the research

(Hilton & Watts, 2011; Voon et al., 2014). Recently, clinicians have recognized the need for appropriate treatments of this compulsive behavior and have suggested frameworks that are used with substance abuse addiction such as Acceptance and Commitment Therapy (Twohig & Crosby, 2010; Hayes, Strosahl, & Wilson, 1999) and Cognitive Behavioral Therapy (Beck, 1967; Minarcik, 2016) in order to help alleviate these negative effects.

Interestingly, problematic pornography use (PPU) was reported as the most prominent issue in 81% of the patients assessed for the potential criteria for hypersexual disorder (Reid et al., 2012a). With the growth of PPU, its conceptualization as compulsive sexual behavior has become increasingly embraced (Grant et al., 2014; Hilton & Watts, 2011; Kafka, 2010; Potenza, 2017). Although there are conflicting opinions about whether PPU has constituted an addiction (Giugliano, 2011; Hall, 2014; Moser, 2013), a widespread idea that the compulsive nature of problematic pornography use has existed, focusing on the subjective experience of the individual (Davies, 2003; Grubbs, Volk, Exline, & Pargament, 2014; Reay, Attwood, & Gooder, 2013; White & Kimball, 2009). Compulsive sexuality can be seen as an uncontrollable behavior, evoking negative consequences that affect an individual's life (Young, 2007), and many individuals who report their use have described it as "impulsive" and "addictive" (Bancroft & Vukadinovic, 2004). The perceived addiction can be connected with anxiety (Grubbs et al., 2014), loneliness (Patterson & Price, 2012), and depression (Bradley, Grubbs, Uzdavines, Exline, & Pargament, 2016; McBride, Reece, & Sanders, 2008; Patterson & Price, 2012; Reid, Carpenter, & Hook, 2016). Furthermore, mental health professionals have reported that pornography use is a consistent concern among those seen in treatment (Ayres & Haddock, 2009; Wood, 2011).

In addition to mental health professionals seeing a rise in clients with PPU, personal

beliefs have appeared to be linked with perceived addiction. Religious individuals have reported greater rates of addiction to Internet pornography (Grubbs et al., 2014, attributing perceived addiction with their religious beliefs, interpersonal struggles, and the idea that they have failed morally (Grubbs, Exline, Pargament, Volk, & Lindberg, 2017). Popular religious books have often discussed the addictive nature of pornography use and its negative effects on spiritual well-being (e.g., Chester, 2010; Driscoll, 2009), adding to the idea of this heightened sense of addiction.

Given the mental health ramifications related to problematic pornography use and the facilitation of this use by increasing online activity, mental health professionals have been more likely to see individuals who struggle with PPU and the accompanying mental health issues. Consequently, when religious individuals have perceived themselves as addicted to pornography (Grubbs et al., 2014) and preferred to seek help from religious advisors (Hartog & Gow, 2005), more than likely, they have sought out religious advisors for help with PPU. To date, no study has explored the religious advisors' approach to addressing PPU and how their approach is affected by their positive or negative view of mental health.

Spiritual well-being has been a known predictor of positive mental health (Pargament, Koenig, Tarakeshwar, & Hahn, 2004), and PPU is associated with a variety of mental illnesses (Bradley et al., 2016; Grubbs et al., 2014; Patterson & Price, 2012; McBride, Reece, & Sanders, 2007; Patterson & Price, 2012; Reid et al., 2016); therefore, it is important to explore the attitudes of religious advisors toward PPU (along with other mental illnesses) and how these attitudes may affect an individual's overall treatment. One sole study has suggested seminary students would be willing to refer individuals to a mental health professional only when attitudes toward mental health included an acceptance of psychological factors (Stegeman, 2008). Further

exploration is warranted to understand how religious advisors view problematic pornography use, along with other common disorders, and their willingness to refer to a mental health professional to address negative mental health consequences.

Statement of the Problem

Religious advisors are often approached by people who are suffering from mental health problems and lack adequate training to support these individuals (Farrell & Goebert, 2008; Montesano et al., 2011). With problematic pornography use rising (Davies, 2003; Grubbs et al., 2014; Reay et al., 2013; White & Kimball, 2009; Young, 2007) and its compulsive nature emerging (Kor et al., 2013), religious advisors will be approached even more by people who seek help in alleviating the negative consequences of the problematic use. Issues arise when religious advisors conceptualize PPU as only a moral weakness (Hartog & Gow, 2005), and compulsivity may often go overlooked as a psychological problem. PPU often leads to anxiety (Grubbs et al., 2014), loneliness (Patterson & Price, 2012), and depression (Bradley et al., 2016; McBride, Reece, & Sanders, 2007; Patterson & Price, 2012; Reid et al., 2016); therefore, in addition to integrating spiritual needs, individuals should also be referred to a mental health professional for adequate treatment. Minimal research explores how those in religious authority address problematic pornography use when approached for help.

Purpose of the Study

The purpose of this study was to investigate how religious advisors' attitudes toward mental health affect how they may address individuals with mental health disorders in the presence of co-occurring problematic pornography use. In this, the goal was to illuminate the Christian church's role in addressing this growing issue and bridge the gap in the literature in how the mental health community can support religious advisors in recognizing this pervasive

issue.

Research Questions

The first research question sought to find any relationship between mental illness stigma and the propensity for a religious advisor to refer to a mental health professional. Since religious advisors often associate mental health as a moral weakness (Hartog & Gow, 2005; Trice & Bjorck, 2006), the hypothesis was that the higher an advisor scored on Day's Mental Illness Stigma Scale (DMISS) (Day, Edgren, & Eshleman, 2007), the more likely he or she would attempt to treat the individual with religious practices alone and not refer to a mental health professional.

The second research question sought to find any relationship between the sole diabolical attribution of problematic pornography use and the propensity to refer to a mental health professional. This was important because no research exploring the growing use of pornography in the evangelical church and the mental health implications of this use has existed to date. Since several Bible verses warn against sexual immorality and Pentecostal pastors tend to associate mental illness with moral weakness (Hartog & Gow, 2005), making them less likely to refer to a mental health professional (Stegeman, 2008), it was hypothesized that religious advisors would attempt to treat the individual without a mental health professional's help.

A third research question was exploratory in nature. It sought the influence of the perceived level of threat in a comorbid mental illness upon the relationship between mental illness stigma and the sole diabolical attribution of PPU. In the general population, it was suggested that mental health stigma was higher for disorders that posed a danger or a threat, such as schizophrenia, rather than a lower posing threat such as depression or anxiety (Hasan & Musleh, 2017; Norman, Windell, & Manchanda, 2012; Wood, Birtel, Alsawy, Pyle, & Morrison,

2014); therefore, the hypothesis was that the relationship between the level of mental illness stigma and the sole diabolical attribution for PPU would be moderated by the perceived level of threat in a comorbid disorder. Simply, the higher the perceived threat of the disorder, the less likely PPU would be given a sole diabolical attribution; however, in conditions with a low level of mental illness stigma, the relationship would not be influenced.

A fourth research question was also exploratory in nature. It sought the influence of the perceived level of threat of comorbid mental illness upon the relationship between a sole diabolical attribution for PPU and the propensity to refer to a mental health professional. It was hypothesized that the relationship between sole diabolical attribution of PPU and the propensity to refer to a mental health professional would be moderated by the perceived level of threat in a disorder. In other words, the higher the perceived level of threat in a disorder, the more likely a referral would be made; yet in conditions of a strong diabolical attribution, the relationship would not be as strong as conditions with those with a low diabolical attribution of PPU.

The fifth research question was exploratory seeking the influence of perceived level of threat of comorbid mental illness upon the relationship between mental illness stigma and the propensity to refer to a mental health professional. It was hypothesized that the higher the perceived threat of the mental illness, the more likely a referral would be made; however, in conditions of high mental illness stigma, the relationship would not be as strong as conditions of low mental illness stigma.

Assumptions and Limitations

The Christian church consists of three large divisions: Evangelical Protestantism, Protestantism, and Catholicism. Pew Research Center (2015) estimated that 25.4% of the U.S. population subscribed to Evangelical Protestant churches, and this study focused upon 3.6% of

the Evangelical church. With over 300 million individuals in the United States, this study only focused on a small number of religious subscribers in comparison. An assumption of this study was that participants recruited were representative of the broader population of the Pentecostal church. Although this was a limitation on the generalizability of the findings to all religious individuals, this small percentage of the population still represented almost 11 million people and can have a significant impact upon the nature of how the church addresses a growing mental health issue. Another limitation was associated with the measures used. Measurements were in the form of case vignettes, and the analysis of answers were coded by the researchers, which may have had some degree of error. Lastly, other measurements were self-reported by participants, which may also have had some degree of error due to social desirability.

Definition of Terms

Religious advisor may have many different definitions represented in the church. They may take on titles such as a parishioner, pastor, minister, or elder within the Christian church. In the context of the Bible, a religious advisor is considered an overseer of the church, one who is a decision maker, manager of church affairs, and a leader (Acts 20:28; 1 Peter 5:2). These individuals must meet scriptural qualifications (1 Timothy 3:1–7; Titus 1:5–9), which includes marital fidelity, mature Christianity, and reputable demeanor. For the purposes of this study, a religious advisor represents a minister or pastor of the Christian faith.

A Mental health professional can vary with different job titles and specialties dependent upon the state. The National Alliance on Mental Illness (2017) has described a mental health professional as one who “can help you achieve your recovery goals . . . work[ing] in inpatient facilities . . . and outpatient facilities. Therapists can help someone better understand and cope with thoughts, feelings, and behaviors [they] may also help assess and diagnose mental health

conditions” (para. 4). A mental health professional has completed a minimum of a master’s degree and also completed residency clinical hours per the requirement of the state of residence (Mental Health America, 2017).

Mental illness stigma is “the most formidable obstacle to future progress in the arena of mental illness and health” (U.S. Department of Health and Human Services, 1999) and can have an unfortunate impact upon help-seeking behaviors (Clement et al., 2015; Eisenberg, Downs, Golberstein, & Zivin, 2009; Henderson, Evans-Lacko, & Thornicroft, 2013; Mojtabai et al., 2011). Mental illness stigma is often used broadly, but it can take on some distinct features. *Public stigma* is defined as a negative view and prejudice regarding mental illness held by those in society or a community while *self-stigma* is what people with the disorder do when they internalize the disorder (Corrigan, 2005). Public stigma includes stereotypes against mental illnesses such as dangerousness (people with unpredictable and violent behaviors), blameworthiness (lack of character), and incompetence (people with mental illness are not capable of real work) (Jones et al., 1984; Rabiner, Wells, Stuenkel, & Schmeidler, 1983). For the purposes of this study, mental illness stigma refers to public stigma.

Pornography research has lacked a common definition, and in many instances, researchers have used the subjective definitions and perspectives of the participant (Tylka, 2015; Wright, 2013a). This can cause problems when attempting to compare results across studies (Short, Black, Smith, Wetterneck, & Wells, 2012); however, Busby, Chiu, Olsen, and Willoughby (2017) recently suggested that pornography has multiple dimensions. These dimensions include pornography as different types of media (image, video, film, and writing), posing suggestively, and explicit intercourse. Varying studies have utilized the self-defined model and approaches (Yu, 2013; D’Abreu & Krahe, 2014; Wright, Tokunaga, & Bae, 2014);

for the purposes of this study, pornography is confined to the definition as set by Hald (2006) and Busby et al. (2017) as material that (1) aims at enhancing sexual feelings or thoughts through explicit exposure, (2) contains descriptions of genitals, and (3) contains explicit sexual acts.

Problematic pornography use was the most common issue that was reported when considering hypersexual disorder for the DSM-5 (Reid et al., 2012a); however, several individuals who engaged in pornographic activities were able to discontinue the behavior when necessary or were able to view pornography without ramifications. Therefore, problematic pornography use appears when the shared features of other addictive behaviors emerge such as compulsivity in gambling and substance use (Brand et al., 2012; Carnes & Wilson, 2002). Behaviors characterized by poor impulse control that lead to diminished self-control over pornographic engagement and the use of pornography to avoid negative emotions while impairing life functioning are considered problematic (Kor et al., 2013; Schreiber, Odlaug, & Grant, 2012).

Negative outcomes, due to problematic pornography use, have been reflective of the same negative outcomes due to other addictive behaviors (Brand et al., 2011; Carnes & Wilson, 2002). For the purposes of this study, negative outcomes due to problematic pornography use are characterized by “legal consequences, (decreased) job productivity, guilt, shame, spiritual/religious incongruence, and social/interpersonal relationship” (Twohig et al. 2012, p. 261).

Diabolical attribution is when a participant establishes a basis for his or her view about the cause of mental illness upon the idea that the one suffering has a demonic intrusion (Asamoah et al., 2014). Although many individuals may not necessarily endorse the view that demonic possession is the reason for those suffering from mental illness, there are still

widespread views among lay Christians that mental illness is caused by a separation from God (Dain, 1994; Hartog & Gow, 2005; Loewenthal, 1996). For the purposes of this study, the term diabolical is used as a representation of the view that mental illness is caused by ongoing sin in one's life and is a consequence of separation from God.

Integrative therapy can be defined both implicitly and explicitly. Tan (1996) has referred to explicit integration as the systematic dealings of scripture, prayer, and sacred texts within therapy, while implicit integration is a more covert approach, basing therapeutic values on theistic principles, but not necessarily initiating a discussion of religious issues. Integrative therapy has not only utilized implicit and explicit dealings of religion, but it also has utilized professional mental health services (Tan, 1996). For the purposes of this study, integrative therapy represents both implicit and explicit modes of integration to enlighten the discourse of the importance of holistic treatment.

Significance of the Study

This study is anticipated to further the dialogue of mental illness stigma in religious communities, identify areas in which stigma might be highest, and describe how this stigma may influence potential treatment of individuals who seek help for differing mental disorders. Since there is no research to date that explores how a religious advisor's stigma might influence an individual's treatment, this study is likely helpful for integrative initiatives for both the evangelical church and the mental health field. For the evangelical church, this research may help in the understanding of the psychological impact of mental health disorders and problematic pornography use, and how an integrative outlook can be beneficial for holistic treatment. For the mental health field, this research may serve as a foundation and argument for the positive factors that result from integrative therapy for mental health disorders and problematic pornography use.

Additionally, this study can also support mental health professionals who are a part of the evangelical church to create collaborative initiatives to heighten awareness of the need for holistic treatment.

Organization of Remaining Chapters

The second chapter explores an in-depth investigation into the extant literature on the topics discussed. This focuses on (1) the historical tension between psychology and the Christian religion, (2) mental health and the Christian church's reciprocation of influence, (3) sexuality in the Christian church, (4) the growth and influence of problematic pornography use in the general population, and (5) the growth and influence of problematic pornography use among religious users. The third chapter describes the research method. This includes the method of data collection, measurements that will be utilized in the study, and the data analysis procedures. The fourth chapter explicates the results of the study, involving how each hypothesis was tested and the data that was obtained through statistical analysis. Any unexpected analyses that arise are detailed in this section. Lastly, the fifth chapter describes the findings through a summary of the results, an interpretation of the results, and how these findings influence the field. In this chapter, limitations are identified as well as implications for future research.

Chapter Summary

Some individuals who subscribe to religious beliefs often prefer to seek help from a religious advisor when addressing mental health issues rather than seeking help from a mental health professional. Although these religious advisors do not feel they have received adequate training to support individuals with these issues, they will still attempt to counsel the individuals on their own. One particular area of interest is the growth in accessibility for online pornography. Research has begun to identify the negative ramifications for those with

compulsive use. The representation of the addictive qualities in problematic pornography use has become a widespread concern, and mental health professionals have seen an increase in cases with this problem. Simultaneously, some religious communities are identifying mental health as a diabolical issue and for those who approach religious advisors for help with problematic pornography use, little is known in how this mental illness stigma might influence treatment. Stigma toward mental illness in religious communities has become an important topic to research because the compulsive nature of problematic pornography use may be left untreated causing a perpetuation of symptoms. This study sought the relationship of religious advisors' mental health stigma with their potential treatment of individuals who approach them with different mental disorders and problematic pornography use. The next chapter reviews the literature regarding mental illness stigma in religious communities and research related to problematic pornography use.

CHAPTER TWO: REVIEW OF THE LITERATURE

The purpose of this study is to explore the relationship between mental illness stigma in religious communities, mental illness disorders, and problematic pornography use. Specifically, the first research question will examine any relationship between the religious advisors' level of mental illness stigma and their propensity to refer to a mental health professional. The second research question is a mediation model to identify whether the relationship between mental illness stigma and the propensity to refer to a mental health professional is mediated by the diabolical attribution of PPU. It is hypothesized that mental illness stigma is predictive of diabolical attributions of PPU, which in turn will affect the propensity to refer to a mental health professional. Since mental illness stigma continues to emerge in religious communities, and problematic pornography use has reflected compulsive implications, it is important to identify the avenue in which religious advisors are supporting these individuals. A conceptualization in the use of integrative counseling is identified throughout these constructs. The third, fourth, and fifth research questions are exploratory in nature, seeking to identify the influence of the perceived level of threat upon each of these relationships. That is, the questions seek to find under what levels of a perceived threatening mental illness the proposed mediation model strengthened or attenuated.

This chapter will begin with an overview of the historical tensions between psychology and religion, and how the reconciliation of psychology and religion involves beneficial integrative therapy. Next, a historical view of these tensions within religious communities is reviewed and how this has fostered a mental illness stigma among religious subscribers. Then extant research on sexuality and hypersexuality will be detailed, with their relation to problematic pornography use. This will include research reflecting the compulsive nature of

pornography use. Mental health implications for such use will be detailed.

Historical Tensions Between Psychology and Religion

In the mid-twentieth century, well-known psychologists argued that religiosity was a form of neurosis and emotional disturbance (Freud, 1961; Skinner, 1953); however, as research progressed, psychologists began to contract these previously held notions. This section will begin by defining the term *religious* and the overarching themes it reflects. Then, a description of the work these prominently-known psychologists and their conclusions of religiosity is highlighted.

Religious Pathways

While Baumstieger and Chenneville (2015) defined religiosity as a term that mostly includes “behavior/actions,” “God,” “follow,” and “believe,” Pargament (1997) similarly defined religion as, “a search for significance in ways related to the sacred” (p. 32). Both these definitions relied on the assumption that all individuals are goal-directed, seeking what is considered significant. Pargament & Mahoney (2002) argued this concept was based on an acceptance that there is a higher power and this goal-directed activity must include sanctified objects seen in material things (wine, crucifix), psychology (self, meaning), sociality (compassion, community), roles (marriage, work), culture (music, literature), people (leaders), and events (birth, death).

This definition encompassed a wide range of religious pathways. It included ways people might think and behave, how they relate to others, and how they feel in the midst of the sacred. To know God, experiencing the divine, and living in accord with the values consistent with the divine is usually at the core of most religious traditions. These values are the process through which people discover the sacred (Pargament & Mahoney, 2002). This definition also helped

explain both the “noble as well as the nefarious” of religion (Zinnbauer, Pargament, & Scott, 1999, p. 908). It defines the destructive ways people attempt to discover the sacred through acts of violence in the name of God. Either way, it explains the desire for spiritual growth.

Psychology’s Contention with Religion

It remains clear that few people are neutral when it comes to religion. As the study of psychology continued to expand, well-known psychologists often delineated between science and religion. Freud (1961), in particular, is one of the most prominently known psychologists who termed religion as, “depressing the value of life and distorting the picture of the real world in a delusional manner—which presupposes an intimidation of intelligence” (p. 18). Freud’s view of helplessness in the individual was rooted in needing to face the powerful forces of nature. In order to overcome a feeling of despair, one must fight against nature to survive its cruelty (LaMothe, 2014). Freud saw religion as an excuse to band together against nature, and the future would no longer be in need of religious systems because scientific reasoning could convince people to renounce their faith. He (1930) wrote, “If the sole reason why you must not kill your neighbor is because God has forbidden it . . . when you learn that there is no God . . . you will certainly kill your neighbor without hesitation” (p. 39). Freud defined the helplessness of human beings in relation to the inescapable power of nature. He went on to argue that the belief in the character of God was an infantile need for a powerful father figure and would therefore help restrain violent impulses. When this character of God was recognized as facetious, Freud argued the illusion of religion was no longer needed to maintain humanity, but that human beings would need to band together out of inevitable necessity to survive. He argued science would serve well in this task.

In the midst of Freudian influences, Albert Ellis developed Rational Emotive Behavior

Therapy (REBT) (1955), an action-oriented approach to cognitive, emotional, and behavioral disturbances. He argued it was the individual's thinking that led to emotional and behavioral problems and REBT helped the individual challenge his or her unhelpful thinking and self-defeating behaviors. In this, he believed that there was no absolute Truth and people held illogical "absolutistic musts and shoulds" (p. xvi). He recognized that religion, in particular, philosophized one must believe in a central idea of faith and any deviation from that faith was considered condemning. He wrote, "I clearly (and strongly) began to realize the primacy of people's Jehovian musts and saw how they usually underlay their other dysfunctional beliefs" (p. xvii). He argued Christians believed humans were innately sinful. And it was a philosophy that was often created and maintained by self-talk. Ellis viewed this as oppressive, and until the individual was unconditionally self-accepting, change could not occur.

Similarly, B. F. Skinner (1953), one of the founders of the behaviorist school, also saw religion as punitive. He argued the individual longed to find meaning and blame for unfortunate events that occurred outside of one's control. In this longing, the individual then sought to establish a range of control over this bad or good luck through religious agency, attributing these events to a supernatural order. The punitive nature of religion was then reinforced through the members of the religious group. He rejected the premise of having a will, and Christianity is often reliant on the basis of free will. The school of behaviorism explained prayer as superstitious, and Skinner believed that the reinforcement schedule would cause the individual to see things prayed for, making the religious believe that prayer worked (1953). Religion could also be exploitative, according to Skinner (1987), "At times, (the religious) have helped people behavior well . . . but the claimed power to intervene in supernatural rewards and punishment is the kind of power that corrupts, and it is no accident that religion today is so often associated

with terrorism and repression” (para. 6).

These psychologists, among others (see Wulff, 1997), continued to argue their stance against religion and its harrowing effects on the individual; however, these premises were often concluded by individual cases. Little empirical research was conducted for these conclusions, and the theories of religion were called into question throughout the turn of the century. Until recently, research in this arena has been in relatively short supply. Perhaps this has been because psychologists are often less religious than the general public (Delaney, Miller, & Bisono, 2007) and tend to overlook religiosity in research. Consequently, the question of whether religion was helpful or harmful depended on circumstance and context (Pargament, 2002).

Reconciliation of Psychology with Religion

Although religion was negatively defined throughout the early twentieth century, other widely known names in the psychological arena supported it. James (1902) considered religion a way to reach one’s highest potential, Jung (1969) saw it as a balance of harmony and wholeness, and Erikson (1950) termed religion as the basis of wisdom and maturity. In contrast to Freud’s contention with religion’s premise, these psychologists concluded religion no longer needed to be perceived as guilt-ridden repressions but as a natural dimension of psychological activity. For Jung, “God’s reality is that of the archetypal father of the collective unconscious. God, so conceived, is an irreducible and inescapable psychic reality, experienced by the individual in the deepest level of his being” (as quoted in Palmer, 1997, p. 114).

More recently, a renewed interest in the integration of religion and psychology has emerged. The term *integration* is used to specify interdisciplinary efforts among psychologists and theologians and is often used throughout literature, becoming the foundation for a number of journal publications (i.e., *Journal of Psychology and Theology*, *Journal of Psychology and*

Christianity, Psychology of Religion and Spirituality). With multicultural theory emerging, psychologists have continued to call for treatments that are culturally sensitive and relevant to the client (Walker, Gorsuch, & Siang-Yang, 2004). The next few sections will detail some of the most definitive themes emerging in research on integration.

Explicit and Implicit Integration

Approaching integration can vary dependent upon the therapist and needs of the client. Tan (1996) detailed both explicit and implicit integration, urging the therapist to be sensitive to the desire of the client. He explained explicit integration as an overt approach that directly dealt with spiritual and religious issues. It used spiritual resources such as prayer, scripture, lay counselors, and other religious practices. In this explicit approach, both the therapist's and client's spirituality played a role, and this spirituality determined the direction of counseling. Tan (1996) continued to explain that in implicit integration, approaches were less overt, were not initiated in the discussion of religious issues, and did not systematically use spiritual resources in therapy. This covert approach would instead base therapeutic principles on an organized religion. This type of integration may be the preferred method of licensed counselors who may not be trained in the explicit nature of the religion. A meta-analysis from almost 15 years ago discovered that most education and training did not include religious integration (Walker et al., 2004); however, recent changes have been made with the American Counseling Association's *Code of Ethics* (2014) creating guidelines for all counselors. This training is not only considered, but the multicultural components of counseling have become a standard for most counseling programs.

Religion in Psychotherapy

Over the course of the past century, a number of studies were conducted, seeking to

identify religion's role in coping with distress (Buser et al., 2017; Krause et al., 2017). A person's internalized cultural beliefs may affect the appraisal of stressors, causing different responses with different coping strategies (Chun, Moos, & Cronkite, 2006; Lam & Zane, 2004; Lazarus & Folkman, 1984). Despite the specificity of values, religion has had protective influences that moderate the impact of negative life events on physical and mental health (Ano & Vasconcelles, 2005; Berzengi, Berzenji, Kadim, Mustafa, & Jobson, 2017; Bryant-Davis & Wong, 2013; Krause, 1998; Matthews et al., 1998; Smith, McCullough, & Poll, 2003). Belief in a just and benevolent God, the experience of this God as a supporter in coping, and the involvement in rituals have led to healthier mental health (Pargament et al., 2004). More specifically, spiritual and religious coping is identified as a protective factor against self-harm (Buser et al., 2017), has played an important role for positive caregiving of persons with illness (Pearce et al., 2016), is associated with better mental health for disadvantaged populations (Olson, Trevino, Geske, & Vanderpool, 2012), has enhanced outcomes for survivors of domestic violence (Abu-Raiya, Sasson, Palachy, & Tourgeman, 2016), and is utilized to alleviate depressive symptoms (Areba et al., 2017; Breland-Noble et al., 2015; Rathier et al., 2013) and anxiety (Areba et al., 2017; Ng, Mohamed, Sulaiman, & Zainal, 2016).

Integrative factors of religiously-oriented therapy have continued to be utilized by clinicians and thousands of studies have emerged, indicating the positive outcomes resulting from these integrative factors. This current study focuses on the benefits of a specific religion, Christianity, and how the interaction of religion may affect these potential positive outcomes. It can be argued that psychology has accepted the need to address religion and spirituality in counseling, as evidenced by the many studies that reflect the benefits; however, literature still suggests that the Christian church may not be reciprocating such sentiments. Some studies have

shown that a Christian's view of mental health has reflected a sinful nature, and therefore any struggles with mental health are seen as a result of a personal choice (Crosby & Bossley, 2012; Hartog & Gow, 2005; Judd & Vanderberg, 2014; McGowan & Midlarsky, 2012).

Mental Health and Christianity

With the focus of this study addressing the religion of Christianity and a Christian religious advisor's propensity to refer to a mental health professional, this section highlights the foundational concepts of Christianity and how those who subscribe to Christianity often view mental health as a result of an ongoing sin issue. Additionally, the literature is reviewed on the role of religious advisors in addressing mental illness in their congregations and how specific mental illnesses may cause differing treatment and perceptions.

Foundational Concepts of Christianity

The widely renowned Italian philosopher Giovanni Reale (1987) argued that Socrates (469 B.C. – 399 B.C.) radically influenced the anthropological scene of his time. He emphasized the link between the body and soul, asserting a unique ideology for moral goodness for the primacy within the soul. Socrates argued that the soul's integrity should supersede the needs of the body, in which Reale (2003) translated as care for the soul, or otherwise known as *soul care*. MacIntyre (1984) described how the Greeks placed great emphasis on ethics, virtue, and education, as seen in Aristotle's *Nicomachean Ethics*, "Ethics is the science which is to enable men to understand how they make the transition from the former state to the latter . . . reason instructs us both as to what our true end is and as to how to reach it" (pp. 52–53). Christianity has adopted these Aristotelian principles, adding the concept of sin to the Aristotelian concept of error.

In addition to this central belief of sin, Christians believe that one must have faith in God

as the creator of heaven and earth (Genesis 1), that the fall of man caused separation from that Creator (Genesis 3), then the incarnation of the Creator was in Jesus Christ (Philippians 2:6–8), and His death on the cross gives eternal life to those who have faith (John 3:16). The addition of this concept of sin is one of the central Christian beliefs, profoundly changing the Greek's view of man. First Corinthians 1:2–23 proclaimed, “For Jews demand signs and Greeks look for wisdom, but we proclaim Christ crucified, a stumbling block to Jew and foolishness to Gentiles.” Furthermore, this has given suffering new meaning for the Christian, where it became a mystery, only solved through Christ's work of salvation (Colossians 1:24; Luke 9:23). Consequently, Christians generally have sought the counsel of wise men who then become religious advisors.

Christianity's Contention with Mental Health

Christian clients have preferred to consult with religious advisors regarding their mental health rather than with a mental health professional (Dobson, 1990; Gass, 1984; Kovess-Masfety et al., 2010), yet these Christian communities have tended to foster stereotypical beliefs about mental health professionals, which in turn, influenced their non-use of clinical care (Nickerson, Helms & Terrell, 1994). Christianity has differed from other distinctive sets of beliefs and has defined mental health in its own particular way (Gass, 1984). To understand the development of this skepticism by Christians, an explanation of the origin of Christian beliefs about mental illness is warranted.

Prior to the eighteenth century, religious sanctions required the mentally ill to be isolated and treated with fear and neglect. Mental health stigma has existed still in some developing countries, mimicking these effects, where religious and cultural beliefs view the mentally ill as “lunatics” and “insane” (see Dain, 1994; Gureje & Alem, 2000). Although many Protestant Christians have renounced their beliefs in the demonic etiology of mental illness, a qualitative

study conducted by Loewenthal (1996) suggested lay Christian advisors may still view mental illness as the result of a separation from God or demonic possession (Dain, 1994; Loewenthal, 1996). Similarly, Favazza (1982) investigated techniques used by modern Christian advisors when dealing with mental illness, revealing prayer, scripture reading, and participating in the Christian community, as most common to mimic the healing that Jesus performed in the Bible. Key elements of biblical Christianity reflected the healing of both physical and mental illnesses through religious practice.

The traditional belief among Christians that insanity was often a punishment by God on the sinner dominated American society throughout the seventeenth century (Neaman, 1975). Those who stressed the Bible as the source of understanding for “insanity” were more likely to see the disorder as a consequence of sin (Dain, 1994). After all, those who were considered insane did at times curse God and commit sins against the Ten Commandments (Exodus 20), perpetuating this conclusion. Dain (1994) explained that this traditional view was then reinforced after the Protestant Reformation, when both the Protestant and Catholics would compete to show their abilities to cure these “possessed” individuals, and those who were “successful” in these curing practices would certify as the “true” Christianity. With this origin of mental health in Christianity, there was a continual stigma among those with mental illness in Christian communities (Hartog & Gow, 2005; Rabinowitz, 2014; Trice & Bjorck, 2006). Studies have revealed that the less individuals were knowledgeable of psychology, the more unlikely they would attribute mental illness problems to pathology (Hartog & Gow, 2005; Stegeman, 2008). This is critical in understanding the disposition of the religious advisors who religious subscribers seek help from because advisors are likely ill-equipped to treat the need fully.

Several studies have focused on cultural and religious definitions of the prevalent mental

disorders Schizophrenia and Major Depression. These two disorders represent two classifications in the DSM-5 (APA, 2013), and one is often seen more pathological than the other in religious communities (Furnham, 1988). A study done almost thirty years ago piloted this focus when Furnham and Henley (cited in Furnham, 1988) looked at the perceptions of schizophrenia and depression, identifying perceptions of the disorder and how this affected the biological attribution for onset. In this study, religious individuals stressed a physical basis for only schizophrenia and often attributed depression to a lack of social support. Even in the general population, this premise was consistent over the last few decades where several studies indicated that individuals often associated depression with less danger, reflecting more of a personal responsibility for onset (Angermeyer & Matschinger, 2003; Crisp et al., 2000; Jorm et al., 1997a; Khan et al., 2011; Marie & Miles, 2008). Due to this, personal blame for one's illness has been quite higher for those who do not reflect any sort of psychosis (Wood et al., 2014).

The distinction between different mental disorders in relation to perceptual blame is consistently seen throughout religious communities and has had an impact upon help-seeking behaviors (Chadda, Agarwal, Singh, & Raheja, 2001; Cinnirella & Loewenthal, 1999; Hartog & Gow, 2005; Judd & Vandenberg, 2014). Christians have tended to believe stressful life events, loss of sleep, and the weather were main causes of less-threatening disorders (such as depression and anxiety) and the main coping strategy for these disorders have been an increase of religious practices (Cinnirella & Loewenthal, 1999). Moreover, the higher the Christians measured on religiosity, the higher mental illness stigma they reflected (Altemeyer, 1988; McGowan & Midlarsky, 2012). These individuals then tended to adhere to their ideologies and were more fearful of people or perspectives that posed a perceived threat to their beliefs (Altemeyer, 1988). Additionally, Lovinger (1984) reported those he worked with were often afraid to see mental

health professionals because the professionals would make them “look bad,” thus embarrassing themselves, their family, and the church. This is an important function to note in Christian communities because it suggests that devout Christians see psychotherapy as an antithetic pathway for healing. Unfortunately, little research has been done in this area.

Religious Advisors and Treatment

A long tradition of faith-based initiatives and faith-based communities has been a concern for health and well-being (Gilkes, 1980; Levin, 1984; Olson, Reis, Murphy, & Gem, 1988). For some, religious advisors provide support, guidance, and comfort, and may even be considered unofficial representatives of a mental health professional (Kovess-Masfety et al., 2009); because of this, some individuals who subscribe to religious beliefs have preferred to seek help from a religious advisor when addressing mental health issues rather than seek help from a mental health professional (Hartog & Gow, 2005). As a matter of fact, 39% of Americans have sought help from a religious advisor when facing a serious personal problem, well surpassing rates for help from psychiatrists, psychologists, doctors, counselors, and social workers (Veroff et al., 1981). Religious advisors are consulted on a variety of psychological issues (Farrell & Goebert, 2008; Montesano et al., 2011), suggesting both advantages and disadvantages for the community. The Veroff et al. (1981) study identified that the cost of treatment was a significant barrier in seeking help from a mental health professional; therefore, assistance from a clergy member was more appealing because they did not charge fees for services. Specifically, fundamentalist and Pentecostal denominations have used clergy extensively for mental health needs (Crosby & Bossley, 2012; Leavey, 2010; Veroff et al., 1981) and were less likely to contact a professional after meeting with the religious advisor (Neighbors, Musick, & Williams, 1998).

Much of the literature on clergy mental health training was published in the 1970s and

1980s, and it remains unknown whether there has been an increase in systems training for religious advisors. However, it is clear that religious advisors frequently functioned as gatekeepers to the mental health services system (Veroff et al., 1981), and past research suggested specialized training in counseling was minimal for religious advisors, even among those who had pursued postgraduate education (Friesen, 1988; Weaver, 1995). Although unfamiliar with various forms of psychopathology, religious advisors are still frequently asked to address mental health issues and emotional distress (Gottlieb & Olfson, 1987). Farrell and Goebert (2008) surveyed 98 religious advisors, revealing most (71%) reported feeling inadequately trained to recognize mental illness. Interestingly, even though these advisors reported feeling inadequately trained, they stated that they would still provide counseling instead of a referral. Minimal studies have researched this conundrum between religious advisors' training and subsequent referrals, even though these advisors were usually the frontline for mental illness issues in the church.

Sexuality and the Christian Church

One specific area of mental health the Christian church deals with is sexuality. Scripture verses in the Bible warn against sexual immorality (e.g., 2 Corinthians 12:21; Ephesians 5:3; Galatians 5:19; Hebrews 13:34), and sexuality/sexual disorders often go undiscussed in Christian communities because they are seen as a taboo topic (Yarhouse & Tan, 2014). The unflattering history of sexual ethics in the Christian tradition began in medieval times where asceticism was upheld as the preferred way to be. Hollinger (2009) explained this history, "Sexual intimacy and even marriage are obstacles to the soul's truest quest . . . sex and marriage are rejected altogether, while moderate types, sex is problematic and legalized by . . . bringing children into the world" (p. 36). Although these exact sentiments have not resonated across all Christian

believers, research has still suggested sexual constructs are often avoided in these communities (Ahrold, Farmer, Trapnell, & Meston, 2011; Kamitsuka, 2010).

With these beliefs ruminating in Christian communities, conflicting evidence regarding religion's effects on sexual behavior has existed. Faith has been associated with a decrease in teenage sexual behavior (Mueller et al., 2009), a delayed onset for sexual activity (Boonstra, 2010), and a decrease in sexual partners (Kalina et al., 2009). However, it has been argued that many of the studies done on religiosity and sexuality have been inconsistent (Landor, Simons, Simons, Brody, & Gibbons, 2011). Some studies have suggested a relationship among general sexual involvement, safe sex-practices, and religiosity (Landor & Simons, 2014; Neymotin & Downing-Matibag, 2011), but contradictory evidence has suggested faith may actually have negative influences of upon sexual behaviors. Women raised in conservative Christian households were more likely to participate in risky sexual practices and men less likely to use contraceptives (Manlove et al., 2008). Additionally, those who supported the Love Waits purity pledge by LifeWay in 1993 had only a slight delay of the onset of sexual activity (by 12 to 18 months), had a reduction in use of contraception, had an increase in unwanted pregnancy, and had a significant increase in shame and self-loathing (Charles, 2011). These conflicting narratives urge researchers to explore the influences of Christianity on varying dimensions of sexual behavior.

Hypersexual Behavior

Hypersexual behavior refers to the inability to control sexual behavior or desire, despite the negative life outcomes it generates (Womack et al., 2013). It has also been called sexual addiction, compulsive sexual behavior, and sexual impulsivity (Kafka, 2010; Womack et al., 2013). Conceptually, hypersexual behavior, or sexual addiction, is a chronic disorder

characterized by recurrent sexual urges, thoughts, and behaviors that cause significant distress, including impairment to relationships, occupational functioning, and even physical health (Gold & Heffner, 1998; Levine, 2010). It is marked by unsuccessful attempts to reduce sexual thoughts or compulsions (Gold & Heffner, 1998; Schaeffer, 2009; Schneider, 1994).

Although the DSM-5 (American Psychiatric Association, 2013) committee ultimately decided to not include Hypersexual Disorder in its publication, a greater awareness of hypersexual behavior in both clinical and non-clinical populations has led to an increase in research, revealing that it also has significant negative mental health consequences. Hypersexual behavior is associated with depression, anxiety, substance abuse, intimacy difficulties, and relationship problems (Bancroft & Vukadinovic, 2004; Dodge, Reese, Cole, & Sandfort, 2004; Reid, Carpenter, Draper, & Manning, 2010; Reid, Dhuffar, Parhami, & Fong, 2012b). It has been argued that hypersexual behavior may constitute a behavioral addiction (Schreiber et al., 2012).

The term *addiction* was not originally linked to substance abuse behaviors, but research for the DSM-III (American Psychiatric Association, 1980) revealed the term to reflect compulsivity. Similarly, *addiction* is not yet a term universally accepted for hypersexual behavior; however, studies are suggesting similarities in pathological hypersexuality and compulsive drug use (Hilton & Watts, 2011; Voon et al., 2014). The poorly controlled and habitual patterns of sexual behavior reflected in hypersexual behavior (Schreiber, Odlaug, & Grant, 2012) are considered legal, yet the risks associated can lead to impairment (Kafka, 2010). One report noted that 72% of patients with hypersexual behavior also reported mood disorders, 38% reported anxiety disorders, and 40% reported substance abuse (Kafka & Hennen, 2002). Recently, clinicians recognized the need for appropriate treatments of this compulsive behavior

and suggest frameworks that are used with substance abuse addiction, such as ACT (Twohig & Crosby, 2010; Hayes et al., 1999) and Cognitive Behavioral Therapy (Beck, 1967; Minarcik, 2016) to help alleviate these negative effects.

In efforts to include Hypersexual Disorder in the DSM-5 (APA, 2013), Reid et al. (2012a) discovered that problematic pornography use was reported as the most prominent issue in potential criteria. The role of pornography in hypersexual behavior is in need of attention as 87% of young men and 31% of young women report use on a weekly basis (Carroll et al., 2008); however, the conceptualization of problematic pornography use is still being discussed in the literature.

Pornography

Along with the rise in research focused on hypersexuality in recent years, there has also been an increase in attention toward pornography use (Griffiths, 2012; Twohig & Crosby, 2010; Twohig, Crosby, & Cox, 2009). Problematic pornography use was reported as the most prominent issue in 81% of patients assessed for potential criteria for hypersexual disorder (Reid et al., 2012), and with many Americans viewing pornography regularly (Wright, 2013b; Wright, Bae, & Funk, 2013), some estimates placed it as 13% of total Internet traffic (Ogas & Gaddam, 2011). Although some academics have argued against the addictive nature of pornography use (Giugliano, 2011; Hall, 2014; Moser, 2013), there has been the widespread idea that PPU encompasses a compulsivity (Davies, 2003; Grubbs et al., 2014; Reay et al., 2013; White & Kimball, 2009), and mental health professionals have reported that pornography use was a consistent concern among those seen in treatment (Ayres & Haddock, 2009; Wood, 2011). These individuals who report using pornography described their use as “impulsive” (Bancroft & Vukadinovic, 2004) and stated that they were unable to control their behavior (Young, 2007).

More simply, a number of pornography users have reported a perceived addiction to sexual media (Grubbs, Exline, Pargament, Hook, & Carlisle, 2015), even without an official diagnosis.

Much of the research fully relies on individuals self-reporting perceptions of their sexual behaviors (see Hook, Hook, Davis, Worthington, & Penberthy, 2010). Consequently, perceived addiction to pornography is defined as individuals labeling themselves addicted to pornography (Grubbs et al., 2014). Due to this, it can be argued that the literature has only measured perceived addiction rather than actual addiction or dependence; therefore, further research for the inclusion of Hypersexual Disorder from the DSM-5 is warranted. Even so, perceived addiction is still linked to a number of negative consequences. Specifically, problematic pornography use is associated with occupational problems (Shapira et al., 2003; Young, 2007), legal consequences (de Almeida Neto, Eyland, Ware, Galouzis, & Kevin, 2013), anxiety (Grubbs et al., 2015), neuroticism (Egan & Parmar, 2013), hopelessness (Cavaglioni, 2009), and overall psychological distress (Bradley et al., 2016; McBride, Reece, & Sanders, 2008; Patterson & Price, 2012; Reid, Carpenter, & Hook, 2016).

PPU in Religious Communities

Within academic communities, psychosocial benefits and costs of pornography use are generally focused upon (Malamuth, Hald, & Koss, 2012); however, by contrast, in the popular media, these debates have had a moral component to them. When compared to non-religious individuals, religious people have tended to have more conservative sexual values (Ahrold et al., 2011) and tended to disapprove of pornography use in general (Wright, 2013a). In fact, many religious books have been explicit in the idea that pornography is addictive, emphasizing the addiction's effects upon one's religion and spirituality (e.g., Chester, 2010; Driscoll, 2009). Even so, religious individuals frequently use pornography (MacInnis & Hodson, 2014). Among

these religious users, negative consequences have emerged, where less happiness is reported (Nelson et al., 2010; Patterson & Price, 2012) and shame over use has been explicit (Grubbs et al., 2010). Additionally, these religious users have attributed their perceived addictions to their lack of religious beliefs, interpersonal struggles, and the idea that they have failed morally (Grubbs et al., 2017).

With the emphasis of PPU's impact upon religion and spirituality, it is important to note the growing body of research documenting the impact of these religious and spiritual struggles upon an individual's psychological and physical well-being. Recent studies have suggested these struggles were predictive of poor mental health, including anxiety and depression symptoms (Exline, 2013), suicidal tendencies, (Rosmarin et al., 2013), and poor coping with trauma (Pirutinsky et al., 2011). PPU can be regarded as an act of lust and sin, and with the incongruence with one's religion, more examination is needed to determine how these social variables may perpetuate and impact religious users.

Research Questions, Hypotheses, and Theoretical Model to be Tested

With the review of the extant literature, research questions and hypotheses were developed. The first hypothesis (H1) was that the level of mental illness stigma was predictive of the propensity for a religious advisor to refer an individual to a mental health professional when approached with mental illness issues. Since religious advisors are approached with a variety of psychological issues yet tend to view mental illness as a personal choice, often attributing it to moral weakness and ongoing sin in one's life, this study proposed that religious advisors would attempt to treat individuals without the support of mental health professionals.

Secondly, it was hypothesized (H2) that religious advisors who measured higher on mental illness stigma would view PPU as only a diabolical issue and not a compulsive mental

health issue, therefore, assuming treatment for the individual rather than referring to a mental health professional. Pornography use in religious communities is considered an act of lust and sin, therefore, aiding in the shame over its use. When religious advisors are uneducated of the growing research determining its additional compulsive tendencies, it was hypothesized that the sole diabolical attribution for PPU would mediate the relationship between mental illness stigma and the propensity to refer to a mental health professional. Simply, religious advisors with high mental illness stigma would view PPU as only a diabolical issue and would attempt to use spiritual practices alone to support this individual.

A third, fourth, and fifth research questions recognized not all religious traditions continue to endorse negative perceptions of mental health, yet a misguided distinction between illnesses has remained. Illnesses that include some sort of psychosis (i.e., Schizophrenia) are often attributed to physical dysregulation; however, illnesses that reflect less threatening symptomology (i.e., Depression) are considered a result of the individual's lack of social support. These questions were exploratory in nature, hypothesizing that the perceived level of threat in the comorbid disorder would moderate all three of these relationships.

Specifically, (H3) in conditions where there was higher mental illness stigma, it was hypothesized that the advisor was less likely to give a sole diabolical attribution for PPU when there was a moderation of a high perceived threat in the comorbid disorder. In conditions where there was low mental illness stigma, it was hypothesized the relationship would not be influenced. (H4) It was hypothesized that the relationship between the sole diabolical attribution of PPU and the propensity to refer to a mental health professional would be moderated by the perceived level of threat in a disorder, in that, conditions where advisors gave a sole diabolical attribution for PPU it was more likely a referral would be made, if there is a higher perceived

level of threat in the comorbid disorder; however, in conditions of strong diabolical attribution, the relationship would not be as strong as conditions with those with low diabolical attribution of PPU. Lastly, (H5) the relationship between mental illness stigma and the propensity to refer to a mental health professional was moderated by the perceived level of threat in the disorder in that the higher the perceived threat of the mental illness, the more likely a referral would be made; however, in conditions of high mental illness stigma the relationship would not be as strong as conditions in low mental illness stigma (see Figure 2.1).

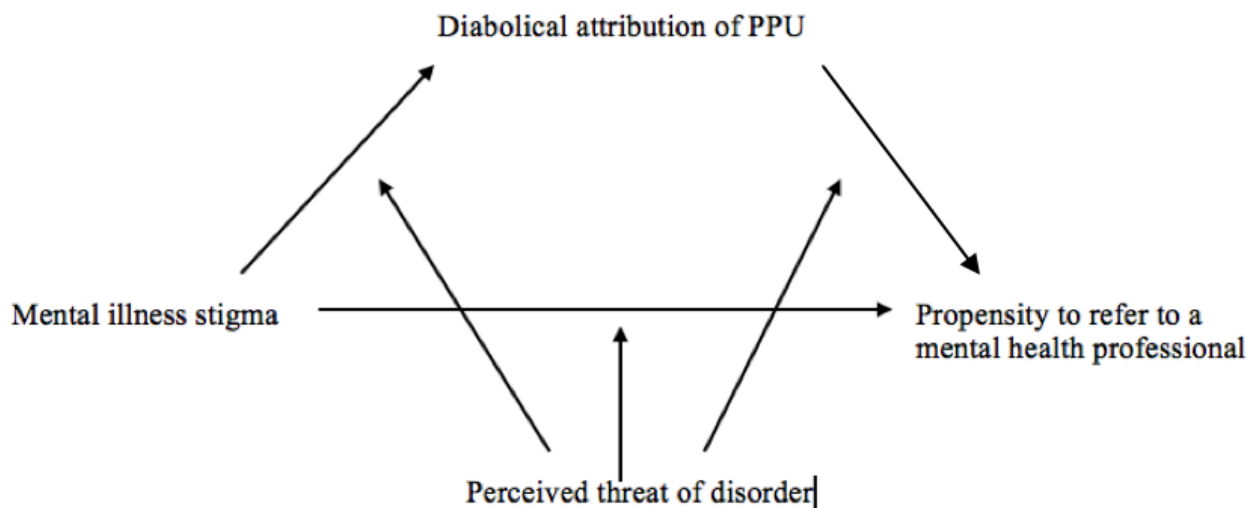


Figure 2.1. Proposed conceptual model of research questions

Chapter Summary

The tension between psychology and religion is both long established and well researched. Although psychology once rejected the notion of religion, researchers have recently recognized the positive factors associated with its impact on mental health. This integration of religion might now be embraced in psychology; however, some religious institutions still hold

stereotypical views of mental illness, reflecting stigmatic perceptions. Mental illness is often attributed to sinful living among the religious, and the belief is commonly held that religious practices alone can cure such illnesses. With this belief held, the notion that religious advisors frequently function as the gatekeepers to the mental health services system may become problematic. Deficits in training for religious advisors regarding psychopathology could potentially be impacting their ability to competently counsel individuals who approach them with mental health problems.

Specifically, the mental health of those reflecting problematic pornography use and the compulsive tendencies that accompany use can have a wide array of negative mental health consequences, including symptoms of depression, anxiety, and hopelessness. Specifically, pornography users, who are religious, also have the added weight of feeling shamed for using and will typically seek out a religious advisor's help to stop or meaningfully reduce their compulsive use. To date, there is no research on how a religious advisor's stigma toward mental illness impacts this phenomenon. Additionally, with the rise of problematic pornography use, religious advisors are approached even more frequently with this compulsive issue. This study sought to bridge the gap in the literature and proposes several hypotheses. The next section of this paper focuses on the methodology of the proposed study.

CHAPTER THREE: METHODS

This chapter focuses on the methodology used to explore the relationship between a religious advisor's mental illness stigma and his or her propensity to refer to a mental health professional, how this stigma elicits a diabolical attribution for PPU, and in turn changes whether a referral will be made, as well as whether the perceived level of threat changes these relationships. This chapter briefly reviews the purpose of the study, the research questions, and hypotheses. Next, the process by which participants were obtained is detailed, along with an explanation of the measures that were utilized in the study. Lastly, the research procedures are described along with the statistical tests used to analyze the data.

Research Purpose

The purpose of this research was to explore how religious advisors' level of mental illness stigma may affect how they address individuals with differing mental health disorders. Additionally, the relationship between religious advisors' mental illness stigma and their diabolical perception of problematic pornography use was explored, particularly as it affected their propensity to refer to a mental health professional. The hope of this study was to gain insight into how religious communities address mental health disorders, and more specifically, problematic pornography use, and how such insight may support the notion of integrative treatment.

Research Questions and Hypotheses

Research Question 1: What is the relationship between a religious advisor's mental illness stigma and his or her propensity to refer to a mental health professional when approached with mental health issues?

Hypothesis 1: The level of mental illness stigma is predictive of whether the religious

advisor will refer to a mental health professional when approached with mental health issues in that the higher the level of mental illness stigma, the less likely the religious advisor will refer to a mental health professional.

Null hypothesis: There is no relationship between mental illness stigma and a propensity to refer to a mental health professional.

Research Question 2: Is the relationship between a religious advisor's mental illness stigma and the propensity to refer to a mental health professional mediated by the sole diabolical perception of PPU?

Hypothesis 2: A higher level of mental illness stigma is predictive of whether the religious advisor views PPU as a sole diabolical issue; therefore, the religious advisor will not refer to a mental health professional.

Null hypothesis: There is no relationship between mental illness stigma, the religious advisor's diabolical attribution of PPU, and the propensity to refer to a mental health professional.

Research Question 3: What influence does the perceived level of threat in a mental illness have on the relationship between mental illness stigma and the sole diabolical perception of PPU?

Hypothesis 3: The relationship between the level of mental illness stigma and the diabolical attribution for PPU is moderated by the perceived level of threat in a disorder, in that those who have higher mental illness stigma will then be less likely to give a sole diabolical attribution for PPU when there is an interaction of a high perceived threat; however, in those who have low mental illness stigma, the relationship will not be influenced.

Null hypothesis: There is no interaction of the perceived level of threat on the

relationship between mental illness stigma and the sole diabolical attribution of PPU.

Research Question 4: What influence does the perceived level of threat in a mental illness have on the relationship between sole diabolical attribution to PPU and the propensity to refer to a mental health professional?

Hypothesis 4: The relationship between sole diabolical attribution of PPU and the propensity to refer to a mental health professional is moderated by the perceived level of threat in a disorder, in that those who give a diabolical attribution for PPU are more likely to refer to a mental health professional if there is a higher perceived level of threat in the disorder; however, in conditions of strong diabolical attribution, the relationship will not be as strong as conditions with those with low diabolical attribution of PPU.

Null hypothesis: There is no interaction among mental illness stigma, the level of perceived threat in mental health disorders, and the propensity to refer to a mental health professional.

Research Question 5: What influence does the perceived threat in a mental illness have on the relationship between mental illness stigma and the propensity to refer to a mental health professional?

Hypothesis 5: The relationship between mental illness stigma and a propensity to refer is moderated by the perceived level of threat in a disorder, in that, the higher the perceived threat of the mental illness, the more likely a referral will be made; however, in conditions of high mental illness stigma, the relationship will not be as strong as conditions in low mental illness stigma.

Null hypothesis: There is no interaction between mental illness stigma and the propensity to refer to a mental health professional as moderated by the perceived threat in the disorder.

Research Design

This study used a nonexperimental cross-sectional design. This design was chosen because there was no intervention used and participants were reporting on their dispositional tendencies. Since there was no longitudinal data, there was caution in the interpretation of causal inferences.

Participants were recruited through a Network email of the New York Assemblies of God. Benefits of utilizing this Network included the guarantee that all those who received the email were credential holders with the Assemblies of God. E-communication allowed sampling on a large scale with relatively low costs (Hackworth & Kunz, 2010). It was also the ideal situation that was free of intimidation and social desirability due to its total anonymity in responses (Cresswell, 2007). Additionally, e-communication increased response rate (Brondani, MacEntee, & O'Conner, 2011), which in turn, increased response overall.

In the email, the participants were informed of the purpose of the study before being asked to click on a provided link that sent the participant to an informed consent for participation (see Appendix A). After consent was given, those who wished to participate were asked to click on the link which directed them to a Liberty University Qualtrics server, where the survey was hosted. The order of measures was as follows: demographic items, case vignettes, then Day's Mental Illness Stigma Scale. After participants completed the surveys, the data was coded as needed and was downloaded in IBM SPSS Statistics. Data analysis procedures are described in more detail below.

Selection of Participants

Participants were recruited through a network email of a Pentecostal denomination. Adult participants (age 18 or older) who have been credentialed or ordained by the Assemblies

of God were recruited. Inclusion criteria included being over the age of 18, acceptance of consent for study, and those who were credentialed or ordained as a religious advisor.

Research Instruments

Demographic information. Demographic questions used in this study included participants' gender, age, ethnicity, level of education, religious affiliation, relationship status, marital status, prior participation in counseling, formal training in counseling, and number of years ordained/credentialed. This information is listed in Appendix B.

Day's Mental Illness Stigma Scale (DMISS). Mental illness stigma was assessed using Day's Mental Illness Stigma Scale (Day et al., 2007). The 28-item measure is composed of seven subscales. These subscales include Anxiety, which measures feelings of nervousness and danger around those with mental illness; Hygiene, referring to the respondent's beliefs about an individual's ability to care for personal needs; Relationship Disruption, focusing on the respondent's beliefs about whether someone with mental illness is capable of having a healthy relationship with another person; Visibility, measuring whether the respondent believes he or she can identify a person with mental illness; Treatability, assessing the respondent's beliefs of whether mental illness can be treated; Efficacy, exploring the respondent's beliefs that mental health professionals can effectively treat mental illness; and Recovery, measuring the respondent's beliefs regarding whether a person can recover from a mental illness. Participants responded to statements using a 7-point Likert scale from 1 (completely disagree) to 7 (completely agree). Sample items for this scale were, "It would be difficult to have a close meaningful relationship with someone with a mental illness," and "Psychiatrists and psychologists have the knowledge and skills needed to effectively treat mental illness." Mean scores were computed for each subscale; these subscales have demonstrated adequate internal

consistencies (Day et al., 2007; Stone & Merlo, 2011) and test-retest reliability (Day et al., 2007). To calculate the subscales, items 8 (treatability), 9 (visibility), 11 (treatability), 13 (recovery), and 20 (recovery) were reversed coded and scored. Then the means of each subscale were calculated. This information is listed in Appendix C.

Case vignettes. Vignettes were well-suited to assess the quality of care in clinical practices (Peabody, Fimka, Munoz, Nordyke, & Luck, 2004). Peabody et al. (2004) developed clinical case vignettes with algorithmically scored open-ended responses to assess the clinical performance of physicians. Participants were asked to list as few or as many responses as necessary, to rank their responses from most likely to least likely, to indicate any combination of answers, and to be as specific as possible. Huffman et al. (2010) utilized this model by integrating psychopathological symptoms into the vignettes to assess a clinician's management of schizophrenia. Both studies revealed that a clinician's ability to recognize symptoms within the vignettes was consistent across all diseases and was independent of case complexity.

This study used a vignette approach to elicit deep attitudes and specific actions from participants that might not surface in direct surveys. The present study gave vignettes of persons with problematic pornography use along with different symptoms of Major Depression, Schizophrenia, Generalized Anxiety Disorder, Schizoaffective Disorder (two low threat and two high threat). The symptoms of each disorder were consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) (American Psychiatric Association, 2013). Important to note that not all criteria were visible within the vignettes; however, enough criteria for adequate referral were implied. These vignettes were derived from previous studies that utilized the vignette model (Jorm et al., 1997b; Peabody et al., 2004; McEvoy, Schooler, Friedman, Steingard, & Allen, 1993; Tanaka, Inadomi, Kikuchi, & Ohta, 2005); however, they

were adapted to fit vignettes that would be understandable to a religious advisor and to additionally contain the component of PPU (as defined by Kor et al., 2014). After the participants read through the vignette, they were asked to explain what they believed may have attributed to the problem and what they would do to help. Following this question, the participants were asked to indicate what percentage of the problem they believed was attributed to a Personal Sin issue and what percentage was attributed to a Mental Health issue.

Research Procedures

Prior to collecting data, approval was obtained from the Institutional Review Board. After approval of research was given, the case vignettes and measurements were created in Qualtrics, and an email was sent to all credential and/or ordained pastors who were within the New York Ministry Network of the Assemblies of God. In the body of the email, participants were told the purposes of the study with minimal information regarding the measurement of stigma to reduce the potential for social desirability. If participants desired participation, they were asked to click on a link provided. Before engaging in the survey, the participants were given an informed consent and were asked if they agree or disagree. Participants who agreed to the informed consent were directed to the measurements. After completion of survey, participants were entered into a raffle for an Apple iPad.

Data Processing and Analysis

Data was coded and downloaded into IBM SPSS Statistics version 23 with the PROCESS macro for SPSS (Hayes, 2013). Any missing data were excluded from analysis, and case vignettes were transformed accordingly. Preliminary data screening was utilized to determine if scores were normally distributed and if any assumptions were violated. The data was also screened for outliers. Sample means, standard deviations, and minimum and maximum scores

are detailed in Table 4.2.

The first step taken was to answer the first and second research question. The first research question asked about the relationship between the DMISS subscales and the propensity to refer to a mental health professional. The second research question involved a mediation model in which DMISS subscales were the predictors, propensity to refer to a mental health professional was the outcome variable, and diabolical attribution of PPU was the mediator. This model was tested through PROCESS (Hayes, 2013), which is a macro for SPSS that allows for testing of conditional process models. Non-normal distribution of variables was identified; therefore, bootstrapping was used (Hayes, 2013). The coefficients, standard error, R square, and *p*-value are displayed Table 4.3. A figure demonstrating the conceptual and statistical diagram of the model can be found in Figures 4.1 and 4.2.

To answer the third, fourth, and fifth research questions, a moderation model was tested through the use of ANCOVAs. To test the hypotheses, ANCOVAs were performed for each condition (vignette). Diabolical attribution of PPU scores were taken from each vignette, and the ANCOVAs examined the relationship between the DMISS subscales and the propensity to refer to a mental health professional when diabolical attribution scores were used as the dependent measure. Reports of coefficients, standard error, and *p* values of the relationships in the model can be found in Tables 4.4 and 4.5. Lastly, additional findings within the conditions were identified through a paired-samples *t*-test. Reports of means, standard deviations, *t* value, degrees of freedom, and significance can be found in Tables 4.6 and 4.7.

Ethical Consideration

Approval from the institutional review board was obtained before any data was collected. Additionally, participants read an informed consent which gave a description of the study. If

participants agreed to the terms of the informed consent, they were directed to engage in the survey instruments. If the participants did not agree to the informed consent, they were not permitted to engage in the study.

It was not anticipated that participants would have any adverse risks. Since this study was not implementing a treatment, nor were there any experimental conditions, participants were at minimal risk. In the event that any participant may have experienced emotional distress after reading the case vignettes or any other part of the study, information for counseling was provided.

Chapter Summary

This chapter first explained the research questions and the research hypotheses. Then the research designed for this cross-sectional study was detailed. The selection of participants was described ,and the measures that were used in this study were described and evaluated. Lastly, data screening, data analysis, and the display of results were discussed. This concludes the chapter about research methods.

CHAPTER FOUR: RESULTS

The purpose of this study was to investigate how a religious advisor's attitude toward mental health affects how they may address individuals with mental health disorders and problematic pornography use. This research was designed to explore how the relationship between religious advisors' mental illness stigma and their diabolical attribution of problematic pornography use might affect their propensity to refer to a mental health professional. The study proposed a model that incorporated five hypotheses regarding the relationships between these variables. The first hypothesis asserted that the level of mental illness stigma would be predictive of whether the religious advisor would refer to a mental health professional when approached with mental health issues, while the second hypothesis asserted that this relationship contained a mediator in the diabolical attribution of PPU. The third, fourth, and fifth hypotheses explored the influence of the perceived level of threat in a disorder upon each of these relationships within the mediation model.

This study used a sample of 162 adults who were credentialed or ordained with the New York Assemblies of God Network. Participants were given demographic items including questions regarding their personal use of professional mental health counseling and whether they have been licensed as a professional mental health counselor. Participants responded to questions following four vignettes and questions which assessed their mental illness stigma. This chapter describes data analysis used to examine whether the hypotheses were supported by the data. A summary of the findings is presented here.

Data Screening

The criterion for people to participate in this study was that they must have been credentialed with the New York Assemblies of God Ministry Network. Participants were not

able to continue with the survey if they did not respond “Yes” to this first question. A sample of 162 participants was obtained during data collection in February and March of 2018. Several methods were employed to screen data. First, cases were deleted where participants began the survey but then did not complete the survey. There were 15 cases deleted. Secondly, in cases where participants were licensed as mental health counselors, their responses were removed to ensure the utilization of responses that were provided by only those who would be considered formally uneducated regarding mental health. There were five cases that were deleted at this step. Lastly, participants who did not complete the open-ended questions after each vignette were deleted. Since these participants did not give a response for whether they would refer to a mental health professional, this data would not be able to be coded for analysis. There were 22 cases removed from the analysis. Participants who completed the open-ended questions were then coded regarding their answers. Participants who mentioned referring to a professional mental health counselor were given a score of one, while participants who did not mention referral were given a score of zero. Additionally, the data were examined for outliers. A histogram was created for the total scores on the DMISS; no outliers were observed.

Altogether, 120 cases were retained. To explore whether the data were normally distributed, skew and kurtosis were calculated on the DMISS subscales. A moderate positive skew was observed on the Anxiety subscale, the Treatability and Recovery subscales were observed as highly negatively skewed, and the Professional Efficacy subscale was observed with a moderate negative skew. Other scales were observed with a normal distribution. Although this violated the assumptions of regression (Warner, 2012), having a normal distribution was not necessary for regression analysis (Hayes, 2017). Hayes (2017) asserted that Likert-type scales do not produce continuous distributions; it was appropriate to use ordinary least squares

regression.

Participant Demographics

Of the 120 participants who were included in the analysis ($N = 120$), 65.9% were male, and 22.2% were female. Participants ranged from age 21 to 77 years ($M = 51.4$, $SD = 13.3$) with 17 participants not disclosing their age. The mean age of females was 54.4 years ($SD = 13.70$), and the mean age of males was 50.3 years ($SD = 13.14$). Most of the participants identified as Caucasian (70.4%), with 3% identifying as African American; 3% as Asian; 8% as Hispanic, Latino, or of Spanish origin; and 7% identifying as “other.” Seventeen participants did not disclose their race. The majority of participants had earned either a bachelor’s degree (29.6%) or a master’s degree (21.5%), with 20% completing some college. High school diplomas were earned by 3.7% of participants while 8.2% earned a professional degree or doctorate. Fifteen participants did not disclose their highest level of education. Most participants were married or had a life partner (77%). Other responses to relationship status included, “single and have never been in a serious relationship” (3.7%), “single and are not currently in a serious relationship, but have been in the past” (1.5%), “monogamous dating relationship” (.7%), “divorced” (1.5%), and “widowed” (3%). Participants were asked how long they had been credentialed/ordained with the Assemblies of God. 27.4% of respondents identified as being credentialed/ordained for 1–5 years, 21.5% for 6–10 years, 8.9% for 11–15 years, 5.9% for 16–20 years, 7.4% for 21–25 years, and 17% for 25+ years. Sixteen did not respond to how long they had been credentialed. Lastly, participants were asked if they had ever received personal counseling from a licensed mental health professional, and 37% answered “yes” while 51.1% answered “no.” Sixteen participants did not respond to this question. See Table 4.1.

Table 4.1

Participant Demographics

	<i>N</i> or Range	% or <i>M</i>
Overall Age	21–77	51.38
Age (Male)	21–75	50.43
Age (Female)	23–77	54.43
Missing	17	
Gender		
Male	88	73.3
Female	30	25
Missing	2	1.67
Racial Identity		
Caucasian/White	95	70.4
African American	4	3.0
Asian	4	3.0
Hispanic	8	5.9
Other	7	5.2
Missing	17	12.6
Educational Background		
Less Than High School	1	0.7
High School Diploma or Equivalent (e.g., GED)	5	3.7
College Freshman	5	3.7
College Sophomore	9	6.7
College Junior	10	7.4
College Senior	3	2.2
Trade, Technical, or Vocational Training	7	5.2
Bachelor's Degree	40	29.6
Master's Degree	29	21.5
Professional Degree	4	3.0
Doctorate	7	5.2
Missing	15	11.1
Length of Credentials/Ordination		
1–5 years	37	27.4
6–10 years	29	21.5
11–15 years	12	8.9
16–20 years	8	5.9
21–25 years	10	7.4
25+ years	23	17.0

Missing	16	11.9
Current Relationship Status		
Currently Single – Never in a Relationship	5	3.7
Single – Not Currently in a Relationship	2	1.5
Monogamous Dating Relationship	1	.7
Married/With a Life Partner	104	77.0
Divorced	2	1.5
Widowed	4	3.0
Missing	17	12.6
Received Counseling From a Licensed Mental Health Professional		
Yes	50	37.0
No	69	51.1
Missing	16	11.9

Sample Means

The minimum score, maximum score, mean, and standard deviation were calculated for all of the measures used. These results are displayed in Table 4.2.

Table 4.2

Descriptive Statistics of All Measures Used in This Study

Measure	Minimum Score	Maximum Score	<i>M</i>	<i>SD</i>
DMISS Treatability	9	21	18.61	2.78
DMISS Rel Disr	6	40	18.53	7.01
DMISS Hygiene	4	26	11.49	4.78
DMISS Recovery	5	14	12.43	2.02
DMISS Anxiety	7	49	18.32	8.49
DMISS Visibility	7	27	16.90	3.82
DMISS Professional Efficacy	2	14	10.67	2.80
Refer- Depression	0	1	.3167	.467
Refer- Schizophrenia	0	1	.7500	.435
Refer- Anxiety	0	1	.3417	.476
Refer- Schizoaffective	0	1	.775	.419
Diabolical Attrib- Depression	0	100	58.741	21.757
Diabolical Attrib- Schizophrenia	0	100	18.265	19.841
Diabolical Attrib- Anxiety	0	100	54.751	27.461
Diabolical Attrib- Schizoaffective	0	100	21.075	22.131
Total Refer	0	4	2.18	1.26
Total Diabolical Attribution	0	400	152.83	62.04

Note. DMISS = Day's Mental Illness Stigma Scale

Data Analysis

Data analysis was performed using IBM SPSS Statistics Version 25 and with PROCESS macro for SPSS (Hayes, 2017). Participants who did not answer the open-ended questions regarding referral were excluded from analysis. Answers to open-ended questions were coded 0 (no referral) and 1 (referral). Four ANCOVAs were performed to determine in which conditions (moderations) the relationships between DMISS subscales, diabolical attribution for PPU, and propensity to refer differed. Additionally, using PROCESS 3 macro for SPSS (Hayes, 2017), the mediation model was tested. The remainder of this chapter will define the results of these analyses. An exploratory paired-samples t-test examined the group mean differences between the Diabolical Attribution of PPU in psychosis (higher threat) and Depression/Anxiety (lower threat); a second paired-samples t-test examined the group mean differences of Propensity to Refer for psychosis (higher threat) and Depression/Anxiety (lower threat).

Model Testing

The first research question asked about the relationship between a religious advisor's mental illness stigma and his or her propensity to refer to a mental health professional when approached with mental health issues. The second research question asked about the relationship between a religious advisor's mental illness stigma and the propensity to refer to a mental health professional mediated by the diabolical attribution of PPU. To test the mediation model, Hayes' (2013) Conditional Process Analysis PROCESS 3 macro for SPSS was used. Model four used the Total Propensity to Refer as the outcome variable, the DMISS subscales as predictor variables, and Total Diabolical Attribution as the mediator. A pictorial representation of this conceptual model is presented in Figure 4.1, and Figure 4.2 presents the statistical model. Bootstrapping resampling using 5,000 bootstrap samples was used.

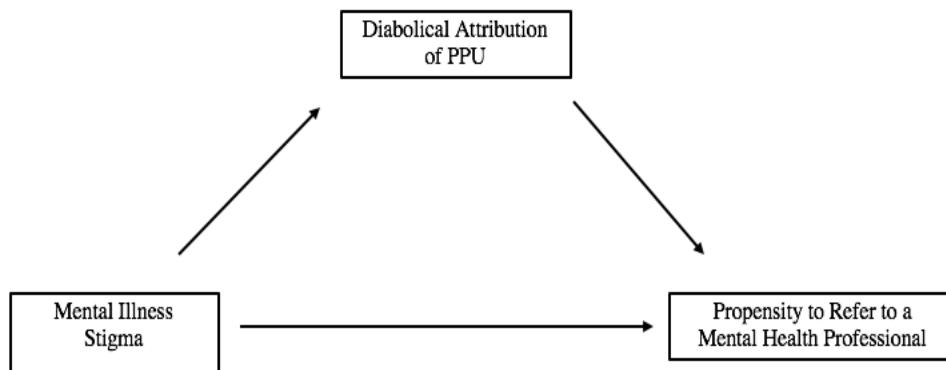
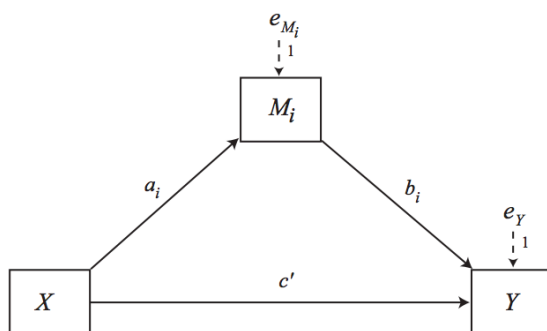


Figure 4.1 Hypothesized conceptual model



Indirect effect of X on Y through $M_i = a_i b_i$
 Direct effect of X on Y = c'

Figure 4.2 Hypothesized statistical mediation model

The overall mediation model did not show any statistical significance. The total, direct, and indirect effect of the DMISS subscales on Propensity to Refer through Diabolical Attribution did not reveal any significant relationships; however, the analysis suggested total diabolical attribution was predictive of the total propensity to refer to a mental health professional ($t = -4.19, p = .0001$). These results suggest the more diabolical attribution of PPU given, the less likely one will refer to a mental health professional. Results from the PROCESS mediation model can be found in Table 4.3

Table 4.3

Process Analysis Results for Mediation Model

<i>Source</i>	<i>b</i>	<i>se</i>	<i>t</i>	<i>p</i>	<i>LLCI</i>	<i>ULCI</i>
Diabolical Attribution: $R = .2664$, $R^2 = .0710$, $MSE = 3798.83$, $F(7, 112) = 1.222$, $p = .2965$						
Treatability	2.9417	2.4204	1.2154	.2268	-1.853	7.737
Hygiene	.8641	1.8705	.4620	.6450	-2.841	4.570
Recovery	-4.0758	2.9868	-1.3646	.1751	-9.994	1.842
Anxiety	.8636	.8652	.9981	.3204	-.851	2.578
Visibility	.6074	1.5921	.3815	.7035	-2.547	3.761
Professional Efficacy	2.8225	2.2008	1.2825	.2023	-1.538	7.183
Relationship Disruption	-1.1866	1.2971	-.9141	.3627	-3.755	1.384
Refer Total: $R = .4883$, $R^2 = .2384$, $MSE = 1.2896$, $F(8, 111) = 4.3440$, $p = 0001$						
Treatability	.0719	.0449	1.6026	.1119	-.0170	.1609
Total Diabol. Attrib.	-.0073	.0017	-4.1939	.0001***	-.0108	-.0039
Hygiene	.0151	.0345	.4390	.6615	-.0532	.0835
Recovery	-.0256	.0555	-.4618	.6451	-1.1356	.0843
Anxiety	.0147	.0160	.9168	.3612	-.0170	.0464
Visibility	.0418	.0294	1.4256	.1568	-.0163	.1000
Professional Efficacy	-.1210	.0408	-2.9623	.0037	-.2019	-.0401
Relat Disruption	-.0490	.0240	-2.0420	.0435	-.0965	-.0014
Refer Total: $R = .3432$, $R^2 = .1178$, $MSE = 1.4806$, $F(7,112) = 2.1356$, $p = 0455$						
Treatability	.0505	.0478	1.056	.2932	-.0442	.1451
Hygiene	.0088	.0369	.2392	.8114	-.0643	.0820
Recovery	.0041	.0590	.0701	.9442	-.1127	.1210
Anxiety	.0084	.0171	.4903	.6249	-.0255	.0422
Visibility	.0374	.0314	1.190	.2365	-.0249	.0997
Professional Efficacy	-0.403	.0256	-1.575	.1181	-.0911	.0104

Moderation Testing

The proposed model hypothesized that dependent upon the conditions stated, the mediation model may vary. To test this hypothesis, ANCOVAs were performed for each

condition (vignette).

Depression and Anxiety: DMISS subscales and Propensity to Refer. The diabolical attribution scores were taken from the Depression a vignette, ANCOVAs were performed to examine the relationship between the DMISS subscales (Treatability, Relationship Disruption, Hygiene, Recovery, Anxiety, Visibility, and Professional Efficacy) and the Propensity to Refer to a mental health professional when the Diabolical Attribution scores (within Depression) were used as the dependent measure. The analysis suggests no relationship between any of the DMISS subscales, diabolical attribution, and a propensity to refer with the condition of the Depression vignette. Additionally, the same analysis suggests no relationship between any of the DMISS subscales, diabolical attribution, and propensity to refer with the condition of the Anxiety vignette.

Schizophrenia: DMISS subscales and Propensity to Refer. As with the Depression and Anxiety vignettes, the diabolical attribution scores were taken from the Schizophrenia vignette, and ANCOVAs were performed to examine the relationship between the DMISS subscales (Treatability, Relationship Disruption, Hygiene, Recovery, Anxiety, Visibility, and Professional Efficacy), and the Propensity to Refer to a mental health professional when the Diabolical Attribution scores (within Schizophrenia) were used as the dependent measure. See Table 4.4 for ANCOVA results and significance levels. With each ANCOVA performed, age was a significant covariate identified ($p < .05$), suggesting that age and Diabolical Attribution of PPU within the Schizophrenia vignette, are linearly related. Additionally, a significant relationship was seen between the Diabolical Attribution of PPU and Propensity to Refer to a mental health professional ($F= 4, 117, p < .001$). The relationship suggests the less diabolical attribution of PPU in the Schizophrenia vignette the more likely a referral will be made.

Table 4.4

ANCOVA Results for Diabolical Att. of Schizophrenia

<i>Source</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig. (2-Tailed)</i>
Age	1	1750.536	5.192	.025
Referral given	1	4538.488	13.462	<.001

Schizoaffective: DMISS subscales and Propensity to Refer. The diabolical attribution scores were taken from the Schizoaffective vignette and ANCOVAs were performed to examine the relationship between DMISS subscales (Treatability, Relationship Disruption, Hygiene, Recovery, Anxiety, Visibility, and Professional Efficacy) and the Propensity to Refer to a mental health professional when Diabolical Attribution scores (within Schizoaffective) were used as the dependent measure. See Table 4.5 for ANCOVA results and significance levels. With each ANCOVA performed, age was a significant covariate identified ($p < .05$), suggesting that age and a Diabolical Attribution of PPU within the Schizoaffective vignette, are linearly related. The analysis suggested a relationship between Diabolical Attribution of PPU in Schizoaffective and Propensity to Refer to a mental health professional $\{F(4,117) = 63.357, p < .001\}$. The relationship suggests that the more diabolical attribution given, the less likely a referral will be made.

Table 4.5

ANCOVA Results for Propensity to Refer in Schizoaffective

<i>Source</i>	<i>df</i>	<i>Mean Square</i>	<i>F</i>	<i>Sig. (2-Tailed)</i>
Age	1	1656.854	4.780	.031*
Referral given	1	4290.165	12.376	.001*

Note. * $p < .05$

Paired-Samples T-Test

Diabolical Attribution. A paired-samples t-test examined the differences of Diabolical Attribution of PPU within each level of the accompanying perceived threatening disorder (Depression and Anxiety versus Schizophrenia and Schizoaffective). See Table 4.6 for t-test results and significance levels. The analysis suggests a significant difference between group means ($t = 16.92, p = .000$). The relationship suggests that participants were more likely to give a diabolical attribution of PPU to those vignettes with an accompanying lower-perceived threat (Depression and Anxiety) than those with a higher-perceived threat (Schizophrenia and Schizoaffective).

Table 4.6

Paired-Samples T-Test Results for Diabolical Attrib of PPU

<i>Pair</i>	<i>Mean</i>	<i>Std.Dev</i>	<i>t</i>	<i>df</i>	<i>Sig. (2-Tailed)</i>
Dep/Anx vs. Schizo/Schizoaff	74.153	47.99	16.923	119	< .001*

Note. * $p < .001$

Propensity to Refer. A paired-samples t-test examined the differences of Propensity to Refer within each level of the accompanying perceived threatening disorder (Depression and Anxiety versus Schizophrenia and Schizoaffective). See Table 4.7 for t-test results and significance levels. The analysis suggests a significant difference between group means ($t = 11.737, p = .000$). The relationship suggests participants were more likely to refer to a mental health professional when approached with a higher-perceived threatening disorder (Schizophrenia and Schizoaffective) than a lower-perceived threatening disorder (Depression and Anxiety).

Table 4.7

<i>Paired-Samples T-Test Results for Referral</i>						
<i>Pair</i>	<i>Mean</i>	<i>Std.Dev</i>	<i>t</i>	<i>df</i>	<i>Sig. (2-Tailed)</i>	
Dep/Anx vs. Schizo/Schizoaff	.86667	.08891	11.747	119	< .001*	

Note. * $p < .001$

Chapter Summary

This chapter highlighted the results of this study. First, data screening procedures were detailed, and the deleted cases were explicated. Then, the participant demographics were presented, along with the sample of means of each measure used. Lastly, the data analysis of the mediation model and the moderation of the mediation model were detailed along with their suggestions. The next chapter will discuss the implications of these results.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study explored five theoretical models in response to the extant literature. First, research indicates religious individuals prefer to consult with a religious advisor regarding their mental health rather than a mental health professional (Dobson, 1990; Gass, 1984; Kovess-Masfety et al., 2010), yet the higher these advisors measure on religiosity, the higher they measure on mental illness stigma (Altemeyer, 1988; McGowan & Midlarsky, 2012). In light of these stigmatized beliefs about mental health, religious advisors may refrain from utilizing clinical care (Nickerson et al., 1994). Consistent with stigmatizing frameworks, religious counselors frequently attempt to treat individuals with exclusively religious interventions (e.g., prayer and scripture reading) (Favazza, 1982).

Secondly, these stigmatic beliefs increase the likelihood that religious advisors will attribute mental illness to ongoing sin in one's life (Rabinowitz, 2014) and, sometimes, to demonic influences (Dain, 1994; Loewenthal, 1996). Additionally, with mental illness being attributed to sin, many religious individuals fear that seeing a mental health professional would embarrass the one seeking help, the individual's family, and the church (Lovinger, 1984). These feelings of embarrassment are important to note because they suggest that devout Christians see psychotherapy as an antithetic pathway for healing.

Specifically, a mental illness that has been observed in religious communities is hypersexual behavior and PPU (MacInnis & Hodson, 2014). The distress resulting from hypersexual behavior and PPU is suggesting compulsivity (Hilton & Watts, 2011; Voon et al., 2014), and the stigmatic beliefs of mental health are perpetuating in diabolical attributions of mental illness and of PPU (Ahrold et al., 2011; MacInnis & Hodson, 2014; Wright, 2013a). Since religious advisors will likely attribute PPU to sin, it is also unlikely that a referral to a

mental health professional will be made (Hartog & Gow, 2005).

The last three theoretical models explored the religious definitions of different mental disorders. Mental disorders that exhibit more threatening behaviors, such as schizophrenia, are often considered more pathological than those with less threatening behaviors, such as depression (Angermeyer & Matschinger, 2003; Crisp et al., 2000; Furnham, 1988; Khan et al., 2011). The perceptual personal blame is consistently seen throughout religious communities (Hartog & Gow, 2005) where disorders with less-threatening behaviors are a result of the weather, loss of sleep, and stressful life events (Cinnirella & Loewenthal, 1999). The influence of the level of threat in a disorder upon PPU was explored in this present study.

This chapter will explore the implications of this study's findings. Research questions one and two will be discussed, and the moderating relationships of the perceived level of threat will be explored. The chapter will describe the implications for clinical practice and counselor education, limitations that exist, and suggestions for future research.

Summary of Findings and Implications

The participants were recruited through a Network-wide email associated with a Pentecostal denomination. Participants, 162 in all, completed five measures and four open-ended questions that included responses to four case vignettes and the DMISS. Participants were between the ages of 21 and 77 ($M = 51.4$, $SD = 13.3$), mostly male (65.9%), married (77%), Caucasian (70.4%), having earned either a bachelor's degree (29.6%) or a master's degree (21.5%). 27.4% were credentialed/ordained with the Assemblies of God for 1–5 years, 21.5% 6–10 years, 8.9% for 11–15 years, 5.9% for 16–20 years, 7.4% for 21–25 years, and 17% for more than 25 years.

Research Question One

Question one explored the relationship between mental illness stigma and the propensity to refer to a mental health professional. Research indicates that religious clients often prefer to consult with religious advisors regarding their mental health rather than a mental health professional (Dobson, 1990; Gass, 1984; Kovess-Masfety et al., 2009); however, advisors' stigmatic beliefs of mental health influence whether they use additional clinical care (Nickerson et al., 1994). Since religious advisors tend to treat individuals without the help of clinical professionals, the hypothesis stated that mental illness stigma would predict whether the advisor would refer to a mental health professional. The seven subscales of the DMISS (treatability, relationship disruption, hygiene, recovery, anxiety, visibility, and professional efficacy) each revealed that there was no relationship between a religious advisor's mental illness stigma and his or her propensity to refer to a mental health professional.

There may be a few explanations for why these findings were not consistent with the literature. The design of the study asked participants to write open-ended answers to describe how they would support the individual in the vignette. Although the answers were coded according to whether a referral was mentioned, there were several answers that stated a referral would be made if the advisor's efforts were not first successful. For example, one advisor stated, "(I would) introduce biblical tools that can strengthen him in mind and spirit while properly placing his trust in God. . . . If after time he makes little to no progress, I would recommend him to professional counseling." Many of these answers mentioned a referral; however, the referral was conditional on the religious advisor's interventions being ineffective. Consistent with Stegeman's (2008) study examining seminary students, a trend was also identified in the present study among religious advisors. Both the seminary students measured by Stegeman and the

religious advisors in the present study were willing to refer individuals to a mental health professional only after determining symptoms were not diabolical but psychological. This means religious advisors will first examine symptoms and determine if the cause is because of personal sin before considering any psychological influences. With religious advisors having minimal training in psychology (Taylor et al., 2000), this could potentially result in mental illness going undetected, and in turn, not treated competently.

Research Question Two

Question two explored if religious advisors would attribute problematic pornography use to sin or mental health. Although some academics have argued against the addictive nature of pornography use (Giugliano, 2011; Hall, 2014; Moser, 2013), there has been the widespread idea that PPU encompasses compulsivity (Davies, 2003; Grubbs et al., 2014; Reay et al., 2013; White & Kimball, 2009), and mental health professionals have reported that pornography use has been a consistent concern among those seen in treatment (Ayres & Haddock, 2009; Wood, 2011). Specifically, in religious circles, problematic pornography use is commonly referred to as an addiction and can be treated by dealing with the sin in one's life (e.g., Chester, 2010; Driscoll, 2009). Consequently, among these religious users, research indicates negative outcomes emerge, less happiness is reported (Nelson et al., 2010; Patterson & Price, 2012), and shame over use is explicit (Grubbs et al., 2010). With the idea that religious individuals attribute PPU to a lack of religious beliefs, interpersonal struggles, and a sense of having failed morally (Grubbs et al., 2017), the hypothesis stated that the diabolical attribution of PPU would mediate the relationship between mental illness stigma and the propensity to refer to a mental health professional. Interestingly, in addition to no direct relationship between stigma and propensity to refer, the mediation model also revealed that there was no indirect effect with the diabolical attribution of

PPU. In other words, stigma did not have any influence on whether a religious advisor would refer to a mental health professional when approached with mental health issues, but stigma also did not influence whether there was an overall diabolical attribution of PPU.

There may be a few explanations for the lack of results. The results may have been influenced by how diabolical attribution was actually being measured. Since the symptoms of PPU were comorbid with mental disorders in the vignettes, it is unknown whether the advisor was attributing sin to the mental disorder, to PPU, or to both. Additionally, several of the answers to the open-ended questions were clear that a referral to a mental health professional would not have been made for PPU, but a referral would have been made for the other symptomology. For example, one answer stated, “Bobby sounds like his reality is wrapped up in TV . . . I would pray with Bobby, suggest he stop watching TV, especially porn and suggest he sees a licensed counselor.” This infers religious advisors could potentially be seeing pornography as a spiritual issue and the other symptoms related to mental health. With these types of answers, it may be beneficial to have PPU as a separate vignette rather than with comorbid disorders so as to help specifically identify the diabolical attribution.

Although the model did not reveal a mediated relationship, the analysis suggests that the total diabolical attribution of PPU is predictive of the total propensity to refer to a mental health professional. These findings further the dialogue of Farrell and Goebert’s (2008) assertion that the more a disorder is attributed to sin, the more likely religious advisors will attempt to treat the symptoms without the help of a professional. From these results, it can be argued that religious advisors identify PPU as solely a sin issue and the treatment of its negative effects are within the scope of the advisors’ expertise. However, with research indicating depression, anxiety (Exline, 2013), and even suicidal tendencies (Rosmarin et al., 2013) as negative consequences for

pornography use among religious users, an advisor's assumption of competence can gravely impact the individual's well-being.

Research Questions Three, Four, and Five

Questions three, four, and five explored how a perceived level of threat in the comorbid disorder moderates the relationships in the mediation model. Several studies have focused on the cultural definitions of two prevalent disorders, schizophrenia and depression, indicating that individuals often associate depression with less danger, and a lower threat, than compared to schizophrenia. Furthermore, in religious communities, schizophrenia is often seen as more pathological than depression (Furnham, 1988). In these religious communities, it is consistently seen that there is a distinction between different mental disorders in relation to perceptual blame, and this distinction can have an impact upon help-seeking behaviors (Chadda et al., 2001; Cinnirella & Loewenthal, 1999; Hartog & Gow, 2005; Judd & Vandenberg, 2014). This perceptual blame could also be impacting the shame that religious individuals feel, perpetuating the notion that personal sin is the reason for mental illness. Furthermore, Christians tend to believe stressful life events, loss of sleep, and the weather are main causes of less-threatening disorders (such as depression and anxiety) and the main coping strategy for these disorders should be an increase of religious practices (Cinnirella & Loewenthal, 1999). With perceptual blame increasing as threatening behaviors decrease, the hypothesis stated that the perceived level of threat would moderate the relationship between DMISS and propensity to refer, DMISS and diabolical attribution, and diabolical attribution and propensity to refer.

The perceived level of threat was only influential upon the relationship between diabolical attribution and propensity to refer. Dependent upon the condition (i.e., the disorder in the vignette), the advisors were either more or less likely to attribute symptoms to sin, thereby

changing whether they would refer to a mental health professional. In the depression and anxiety vignettes, there was no relationship between diabolical attribution and whether one would refer; however, in the schizophrenia and schizoaffective vignettes, less diabolical attribution was given, the more likely a referral was made. This could explain how advisors are more likely to attribute psychotic symptoms to physiological influences, yet with depression and anxiety, the symptoms were considered self-inflicted. Because of this, religious individuals who feel depression and anxiety could potentially feel shamed, and it would be unlikely for them to seek out help in general.

Additionally, in the Schizophrenia vignette, age and diabolical attribution were linearly related, revealing that the older the advisor, the more diabolical attribution was given. Considering the traditional view of mental illness resulting from separation from God (Loewenthal, 1996), a hypothesis regarding this linear relationship is that it may be generational. More contemporary views of mental illness have been impacted by movements to end mental illness stigma, such as the National Alliance on Mental Illness (2017) psychoeducational forums. These movements may also have contributed to younger advisors recognizing the pathological nature of symptoms (Hartog & Gow, 2005; Stegeman, 2008).

Additional Findings

Diabolical attribution. Exploratory analyses sought to identify differences between diabolical attributions within the higher-threatening disorders compared to the lower-threatening disorders. In a pilot study almost 30 years ago, Furnham and Henley (cited in Furnham, 1988) suggested religious individuals stressed a physical basis for only Schizophrenia and often attributed depression to a lack of social support. Even in the general population, this premise has been consistent over the last few decades; several studies have indicated that individuals often

associate depression with less danger, reflecting more of a personal responsibility for onset (Angermeyer & Matschinger, 2003; Crisp et al., 2000; Jorm et al., 1997a; Khan et al., 2011; Marie & Miles, 2008). Due to this perception that depression is associated with less danger, personal blame has been quite high for those who do not reflect any sort of psychosis (Wood et al., 2014). The present study was consistent with the literature where the two higher-threatening disorders, schizophrenia and schizoaffective, were given significantly less diabolical attributions for PPU than the two lower-threatening disorders, depression and anxiety. These findings suggest religious advisors attribute personal sin is to blame for pornography use in the depression and anxiety vignettes yet were more lenient for pornography use in the psychosis vignettes. It can be argued that these religious advisors were more willing to identify the PPU as a result of psychotic symptoms, while depression and anxiety symptoms did not justify PPU. This is important to note as the distinction between different mental disorders in relation to perceptual blame seen in religious communities can have an impact on help-seeking behaviors.

Propensity to Refer. Religious advisors are used extensively for mental health needs (Crosby & Bossley, 2012; Leavey, 2010; Veroff et al., 1981), and religious individuals are less likely to contact a professional after meeting with their religious advisor (Neighbors et al., 1998). Since religious advisors are likely only to refer to a professional when psychological factors are more apparent (Stegman, 2008), exploratory analyses sought to identify differences between a religious advisor's propensity to refer for the higher-threatening disorder compared to the lower-threatening disorders.

The two higher-threat disorders, schizophrenia and schizoaffective, had significantly higher rates of being referred in comparison to the lower-threatening disorders, depression and anxiety. The difference in the group means appears to support the current literature that there is

a higher acceptance for physiological influences on psychosis (Wood et al., 2014) and more personal responsibility for lower-threatening disorders (Angermeyer & Matschinger, 2003; Crisp et al., 2000; Jorm et al., 1997a; Khan et al., 2011; Marie & Miles, 2008). Furthermore, these findings support the research that asserts religious advisors are unable to identify mental health problems and their estimation of severity (Taylor et al., 2000). This perpetuation of the belief among Christians that mental illness is a consequence of sin suggests there is a need for researchers to explore and identify the mental health training (or lack thereof) that religious advisors receive. When religious advisors are approached with mental illness issues, they may not fully understand the extent to which they are dealing with mental health rather than sin. This could heavily impact the well-being of those who approach advisors for support. Since advisors are often the gatekeepers to the mental health community, it calls to question if individuals who are seeking the advisors' help may be suffering from perpetual shaming.

Limitations of the Study

There are several limitations identified in the study. The first limitation is by the way the predictor variable, mental illness stigma, was measured. The DMISS uses individual subscales that measure different aspects of explicit mental illness stigma; however, O'Driscoll, Heary, Hennessy, and McKeague (2012) have reported that often times stigma can be more implicit than explicit. In other words, those who have mental illness stigma may not outright admit or discuss stigmatic perceptions but may still reflect feelings of stigma. A self-report measure may not have fully captured the extent to which stigmatic perceptions exist as maybe a qualitative study.

Additionally, in the open-ended questions, religious advisors would report that they believed sin was the foundational issue with the case vignettes, yet many times their answers on the DMISS scale would reflect non-stigmatic perceptions. The reason for the contradictory

answers is unknown; however, social desirability could have been a factor. Social desirability has been identified as a consistent trait seen when measuring mental illness stigma, where participants attempt to reflect psychoeducational understanding (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012). A social desirability scale was not incorporated into the list of measures; therefore, it was not possible to determine the degree in which this may have occurred within the sample.

Another limitation is within the design of the study. The vignettes were created to have comorbid disorders alongside problematic pornography use. Although the goal was to understand the differences between diabolical attribution of PPU through a disorder's perceived level of threat, the comorbidity in the vignettes prevented the researcher from specifically identifying the diabolical attributions that were given. The open-ended questions were unclear in how the religious advisor was attributing the individual's problems and resulted in an incomplete understanding of their perspective. It may be beneficial to utilize PPU as a completely separate vignette to specifically identify perceptions of the use.

Lastly, another limitation of the study is how the individuals were described in the vignettes. The vignettes were all male cases, and almost all the female participants referred the individuals to a mental health professional. In this sample, female participants may have felt reluctant to address the client's sexual behaviors, which may have resulted in making these referrals. Research suggests that female therapists can be hesitant to work with male clients due to sexual attraction, lack of emotional connections, and concerns about physical aggression (Fitzpatrick, 2000). Potentially, there could have been different results if the female participants were given vignettes about females.

Suggestions for Future Research

Future research should continue exploring the experience of religious advisors and their treatment of those who approach them with mental health issues. Since social desirability is a consistent trait seen in participants when measuring mental illness stigma (Henderson et al., 2012), including additional measures of social desirability is important so that future research is able to have a more holistic picture of the experience. Furthermore, a qualitative study that attempts to understand the internal experiences of religious advisors when treating mental illness can help researchers and clinicians identify the more implicit nature of mental illness stigma without social desirability potentially influencing answers.

Additionally, future research should split the vignettes into completely separate disorders along with their different symptomology. It was difficult to determine whether the advisor was attributing sin to PPU or whether it was attributed to the comorbid disorder. Having separate disorders along with comorbid disorders would help delineate between the perspectives of each. This might increase the variance that is accounted for, which could help researchers and clinicians better understand the stigma associated with different disorders.

Since age was a significant covariate identified in the analyses, a narrower age differential could impact the generational perspectives of mental illness in future research. Those who hold a more traditional view of mental illness may be attributing symptoms to sin (Dain, 1994) while the younger generations have been exposed to spontaneous protests to initiate change in mental illness stigma (Kaplan & Haenlein, 2010). Social media may have also had a significant impact on these generational differences (Betton, Borschmann, Docherty, & Coleman, 2015), and age's influence should be considered in future studies.

Lastly, in the present study, out of 30 women, 26 referred to a mental health professional in every vignette. The reasoning behind these referrals could be multifaceted; however, studies

indicate women therapists have hesitations in counseling men (Fitzpatrick, 2000). Combining this hesitation with the minimal psychological training received as a religious advisor (Farrell & Goebert, 2008; Gottlieb & Olfson, 1987), women religious advisors are unlikely to treat the men who approach them for help. Assigning gender specific vignettes to women and men could create more variance in results because woman religious advisors may be more inclined only to treat women.

Clinical and Counselor Education Implications

The *ACA Code of Ethics* (American Counseling Association, 2014) discusses the ethical responsibilities of the counselor and ranges from ethics in practice to training, advocacy, and research. Counselors are expected to adhere to this code and to refer to it whenever needed. One particular area of interest is the counseling relationship. To facilitate growth and development in clients, the Code of Ethics requires counselors to:

“actively attempt to understand the diverse cultural background . . . (and) to recognize that support networks hold various meanings in the lives of clients and (to) consider enlisting the support, understanding and involvement of others (e.g., religious/spiritual/community leaders, family, friends) as positive resources, when appropriate, with client consent” (p. 4).

Mental health professionals are expected to not only integrate and recognize the values of the clients but are also expected to actively seek out religious and spiritual leaders’ support in the development of clients. Religious coping is identified as a protective factor in mental health (Areba et al., 2017; Buser et al., 2017; Ng et al., 2016; Pargament et al., 2004, and as a part of advocacy efforts, counselors and counselor educators must recognize the significant impact that religious advisors may have with clients. Furthering integrative initiatives is required to provide

holistic treatment.

Additionally, a part of these advocacy efforts should also include psychoeducational forums for religious advisors because religious advisors are frequently approached with mental health issues (Farrell & Goebert, 2008) and they often feel inadequately trained in treating mental health problems (Montesano et al., 2011). Advisors describe their inability to estimate the severity of symptoms (Taylor et al., 2000), yet with advocacy efforts of counselors, the well-being of clients requires educating those whom they feel most comfortable within their social network (American Counseling Association, 2014).

Summary of the Study

Religious advisors are frequently approached with mental health issues and can be considered unofficial representatives of a mental health professional (Kovess-Masfety et al., 2009). Simultaneously, these same religious advisors are reportedly feeling inadequately trained to support those who approach them yet will still provide counseling despite their lack of training (Farrell & Goebert, 2008). This phenomenon puts in question the well-being of those who approach religious advisors for help, especially since the higher an advisor scores on religiosity, the more mental illness stigma he or she reflects (Altemeyer, 1988; McGowan & Midlarsky, 2012). With the prevalence of mental illness stigma in religious communities (Dain, 1994; Hartog & Gow, 2005), religious advisors are giving diabolical attributions for mental disorders (Hartog & Gow, 2005), and the advisors' stigma is heavily impacting help-seeking behaviors (Crosby & Bossley, 2012; Leavey, 2010). One specific area of mental health that religious advisors often see is problematic pornography use (MacInnis & Hodson, 2014) and the accompanying negative psychological consequences (Grubbs et al., 2010; Grubbs et al., 2017; Nelson et al., 2010; Patterson & Price, 2012). With PPU rising (Davies, 2003; Grubbs et al.,

2014; Reay et al., 2013; White & Kimball, 2009; Young, 2007) and its compulsive nature emerging (Kor et al., 2013), religious advisors will be approached even more often by people who seek help in alleviating the negative consequences of the problematic use of pornography.

This study recruited 162 participants through a Network-wide email associated with a Pentecostal denomination. To examine mental illness stigma and treatment, 120 participants were selected for analysis. Mental illness stigma was not predictive of the diabolical attribution of PPU nor whether one will refer to a mental health professional; however, there were significant relationships between a diabolical attribution and whether a referral was made. Additionally, significant differences were observed between diabolical attributions and a propensity to refer to a mental health professional dependent upon the perceived level of threat in the disorder. These findings, along with other associated factors of mental illness stigma, are important for clinicians to recognize as integrative initiatives are formed to holistically treat those with religious values.

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Appendix A: Informed Consent

Mental Illness and the Church
Krista Kirk
Liberty University
Counselor Education and Family Studies

You are invited to be in a research study on how mental illness is handled among leaders in the Christian church. You were selected as a possible participant because you are a credentialed or ordained minister with the NY Assemblies of God and because you are over the age of 18. Please read this form and ask any questions you may have before agreeing to be in the study.

Krista Kirk, a doctoral candidate in the Department of Counselor Education and Family Studies at Liberty University, is conducting this study.

Background Information: The purpose of this study is to identify the ways in which pastoral leaders engage those in their churches who reflect mental illness.

Procedures: If you agree to be in this study, I would ask you to do the following things:

1. Complete the demographics questionnaire (1 minute)
2. Complete a survey that will ask questions regarding your ideas and perceptions of mental illness (3-5 minutes)
3. Read through four vignettes that describe a fictitious individual in your church and answer questions regarding your perceptions of the individual (5-10 minutes)

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. If any adverse psychological stress occurs, please contact Bedrock Ministries at (315) 652-0000 to obtain counseling.

Benefits: Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include: For the evangelical church, this research may help in the understanding of the psychological impact of mental illness and how an integrative outlook can be beneficial for holistic treatment. For the mental health field, this research may serve as a foundation and argument for the positive factors that result from integrative spiritual therapy for mental illness. Additionally, this study can also support mental health professionals who are a part of the evangelical church to create collaborative initiatives to heighten awareness of the need for holistic treatment.

Compensation: Participants will be asked to provide their email address upon the completion of the surveys in order to be entered into a raffle for an Apple iPad and Amazon gift cards. Five participants will be randomly selected to receive a \$20 Amazon gift card and one participant will be randomly selected to receive an Apple iPad.

Confidentiality: The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records. No identifying information will be gathered and all data will be stored on a password locked computer. This data may be used in future presentations and will be deleted after three years. In the case where participants discuss their experiences with this study, I cannot assure that these discussions remain confidential.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University or the NY Ministry Network. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Study:

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

Contacts and Questions: The researcher conducting this study is Krista Kirk. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at (315) 427-6065 and/or kristaekirk@gmail.com. You may also contact the researcher's faculty advisor, Fred Volk, PhD at fvolk@liberty.edu.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 1887, Lynchburg, VA 24515 or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)

Signature of Participant

Date

Signature of Investigator

Date

Appendix B: Demographics Survey

1. Gender

Female
Male
Other

2. Age _____

3. Race

Caucasian/White African American
American Indian or Alaska Native
Asian
Native Hawaiian or other Pacific Islander
Hispanic, Latino, or of Spanish Origin
Other

4. What is your highest completed educational level?

No schooling completed
Less than high school
High school diploma or equivalent (e.g. GED)
College Freshman
College Sophomore
College Junior
College Senior
Trade/technical/vocational training
Bachelor's degree
Master's degree
Professional degree
Doctorate Degree

5. How long have you been married to your current spouse? (leave blank if never married).

0-5 years
6-10 years
11-15 years
16-20 years
More than 20 years

6. Current relationship status

Single (I have never been in a serious relationship)
 Single (I am not currently in a serious relationship, but have been in the past)
 Non-committed dating relationship
 Monogamous dating relationship
 Married/Life Partner
 Married, but legally separated
 Divorced
 Widowed

7. In terms of denomination, how would you describe yourself? Choose one of the following answers:

Methodist
 Baptist
 Pentecostal
 Anglican
 Catholic
 Other

8. How often do you attend religious services?

Less than one time per month
 One time per month
 Two times per month
 Three or more times per month
 I don't attend religious services

9. Please choose the answer that best describes your belief in God.

I believe there is a God.
 I sometimes believe there is a God.
 I used to believe there was a God but do not anymore.
 I do not believe there is a God and I cannot say that I have never believed in a God.

10. Are you a credentialed/ordained pastor with the Assemblies of God?

Yes
 No

If yes, how long have you been credentialed/ordained with the Assemblies of God?

1-5 years
 6-10 years
 11-15 years
 16-20 years

21-25 years
More than 25 years

11. Have you ever seen a licensed mental health professional for personal counseling?

Yes
No

12. Has a state licensed you to practice as a mental health professional?

Yes
No

Appendix C: Day's Mental Illness Stigma Scale

The Day's Mental Illness Stigma Scale (Day, Edgren, & Eshleman, 2007) was removed due to copyright. The scale can be found in the *Journal of Applied Social Psychology* or by visiting <https://onlinelibrary.wiley.com/doi/10.1111/j.1559-1816.2007.00255.x>.

Appendix D: Case Vignettes

All vignettes will begin with the following explanation:

You will be given 4 case vignettes that describe an individual in your church who has approached you for counseling. After reading the vignette, please describe what you think may have attributed to these issues and then explain how you might help this individual. Reminder: there is no correct answer; please just give some steps that you might follow, or things you might say, to support this individual. Then, please indicate what percentage of the individual's problem you would attribute to a Personal Sin issue and what percentage of the individual's problem you would attribute to a Mental Health issue. Your total percent must add up to 100%.

NOTE: Although we recognize that all brokenness is a result of the fall, when referring to Personal Sin, we are specifically trying to address the idea of a person's day-to-day psychological/spiritual/behavioral existence.

Case Vignette One (PPU and Depressive Symptoms)

Paul, a 46-year-old male who has attended your church for over twenty years, has approached you for counseling due to his pornography use. Paul has been a leader for his small group for several years and has even supported the church through transitions of church plants and satellite campuses. He has come to you for help because he is recognizing this pornography use may have developed into an addiction, revealing that he cannot stop the urge to watch, even when he wants to. Paul tells you that he began watching pornography in his early 20s when he and his wife were first married and has been able to refrain from using it until about a year ago. He says he will find himself watching pornography every day for at least 3 hours a day, and often finds himself on pornographic websites while at work too. He tells you that he was caught one time viewing pornography at work and was “written up” with a warning, and the next time it happens his position with the company will be terminated. He mentions that he just recently communicated this to his wife, and she is extremely distraught and is too embarrassed to attend counseling with him; she is threatening to leave him.

Over the past six months Paul finds himself viewing pornography more often, and because of it, has been feeling extreme shame. He says that some days he cannot get himself out of bed and will remain there all day, for 14-17 hours a day, which is also affecting his job. He states that he cannot find as much satisfaction in the activities he used to enjoy and has recurrent feelings of hopelessness, but says he does not have a plan to hurt himself. He is just seeking your help to “feel better” and to “stop using pornography.”

Explain what you think may have attributed to Paul’s problem and what you might do to help Paul.

Please indicate what percentage of Paul’s problem you would attribute to a Personal Sin issue and what percentage of Paul’s problem you would attribute to a Mental Health issue. Your total percent must add up to 100%.

NOTE: Although, we recognize that all brokenness is a result of the fall, when referring to Personal Sin, we are specifically trying to address the idea of a person’s day-to-day psychological/spiritual/behavioral existence.

Mental Health Issue	<input type="text" value="0"/>	%
Personal Sin Issue	<input type="text" value="0"/>	%
Total	<input type="text" value="0"/>	%

Case Vignette 2 (PPU and Schizophrenia symptoms)

Sally, the mother of Bobby, has come to your office with Bobby asking for your support with her son. Bobby is a 22-year-old, unmarried, Caucasian man who does not attend your church; however, you have seen Sally in attendance on occasion. Sally states her concerns about Bobby since he moved home recently. She says he will lock himself in his room and will watch TV for several hours. Bobby is open with you and explains he spends most of his time in the house and will no longer go out at night alone. He says he does not feel safe to do so and to calm his nerves he will watch TV, mostly pornography, all day long.

He previously lived independently until a few months ago when he moved back in with his mother, Sally. He tells you that he made an error on his taxes and is convinced the Internal Revenue Service (IRS) hired detectives to gather information about his whereabouts. He states that since his mistake he uncovered an essential flaw in the taxation algorithm, which may expose the underpinnings of the IRS, and is convinced they hired assassins disguised as bikers. After moving in with his mom, he did not see the bikers, but they are trying to trace his “mental activity,” so he tries to flood his mind with the pornography and TV watching. He also hears them outside of his house talking about how they will kill him; he reported the problem to the police and FBI and is seeking your help to “vouch” for him to the IRS.

Explain what you think may have attributed to Bobby’s problem and what you might do to help Sally and Bobby.

Please indicate what percentage of Bobby’s problem you would attribute to a Personal Sin issue and what percentage of

Bobby’s problem you would attribute to a Mental Health issue. Your total percent must add up to 100%.

NOTE: Although, we recognize that all brokenness is a result of the fall, when referring to Personal Sin, we are specifically trying to address the idea of a person’s day-to-day psychological/spiritual/behavioral existence.

Mental Health Issue	<input type="text" value="0"/> %
Personal Sin Issue	<input type="text" value="0"/> %
Total	<input type="text" value="0"/> %

Case Vignette 3 (PPU and Anxiety Symptoms)

Martin is a 55-year-old widower who has just started attending your church over the past six months and has come to you for counseling. He is a Chinese man and recently lost his wife three years ago to leukemia. He tells you that he has really struggled with the death of his wife and finds himself having difficulty in several areas of his life. He has trouble sleeping, where nights are almost never restful, and he feels tired all throughout the day. He often worries about the rest of his family and whether they will also be diagnosed with some sort of terminal illness. He admits to you that he is a natural “worry wart” and has been this way for as long as he can remember.

Upon giving you his life story, he tells you that he has struggled with his spirituality because he cannot seem to trust that God “has everything in the bag.” He states that he was in and out of prison during his 20s and early 30s for robbery and paying for prostitution. After he was released from prison, he would watch pornography to satisfy his sexual desires because he did not want to go back into prison. He met his wife when he was 37 years old and was married to her only six months after meeting. They began attending a local church shortly after marrying and he says he was “freed from all the bondage” he’s felt his entire life. Since his wife’s death, however, he has felt overwhelmed with worry, stating, “She was the one who kept me in line.” He says he even feels tightness in his chest and is short of breath at times when he thinks about returning to his old life. He admits that in order to alleviate these feelings, he will lay awake at night for several hours and will watch pornography. He says he feels very ashamed because he believed he “had this under control,” and yet says, “But I figure it’s better than going back to my days in prostitution.” He is seeking your help.

Explain what you think may have attributed to Martin’s problem and what you might do to help Martin.

Please indicate what percentage of Martin’s problem you would attribute to a Personal Sin issue and what percentage of

Martin’s problem you would attribute to a Mental Health issue. Your total percent must add up to 100%.

NOTE: Although, we recognize that all brokenness is a result of the fall, when referring to Personal Sin, we are specifically trying to address the idea of a person’s day-to-day psychological/spiritual/behavioral existence.

Mental Health Issue

0 %

Personal Sin Issue

0 %

Total

0 %

Case Vignette 4 (PPU and Schizoaffective symptoms)

Eli is a 26-year-old male who was brought into your office by another church attender, Mary. Mary is the liaison to the local Rescue Mission and leads the ministry that provides the Rescue Mission with service in different areas. Mary says she met Eli about three months ago during a dinner session at the Rescue Mission, and she believes you might be able to help him.

Eli is dressed in a cape and snow face mask, yet greets you upon arrival. When you ask him to tell his story, he divulges that he has family in the area but that last week they kicked him out of the house because he “cannot keep a job.” Over the last six months he stopped seeing his friends and began locking himself in his bedroom, refusing to eat or bathe. He had a TV in his bedroom and would only watch *I Love Lucy* and pornography for hours throughout the day. He says if he watched anything else, “the TV would talk to him and tell him to go hurt people.” His family knew what he was watching and would threaten to kick him out of the house if he did not stop; however, he said he could not get himself to turn it off.

He says he is feeling very down lately and does not seem to think there is much hope for him to keep a job and return to his family. He says he has been at the Rescue Mission shelter for the past week and will just sleep all day. He explains he is afraid that if he leaves the shelter he will hear the voices telling him to hurt people on the street. Mary is hoping you can help him gain more confidence and control.

Explain what you think may have attributed to Eli’s problem and what you might do to help Eli.

Please indicate what percentage of Eli’s problem you would attribute to a Personal Sin issue and what percentage of Eli’s problem you would attribute to a Mental Health issue. Your total percent must add up to 100%.

NOTE: Although, we recognize that all brokenness is a result of the fall, when referring to Personal Sin, we are specifically trying to address the idea of a person’s day-to-day psychological/spiritual/behavioral existence.

Mental Health Issue	<input type="text" value="0"/>	%
Personal Sin Issue	<input type="text" value="0"/>	%
Total	<input type="text" value="0"/>	%