EXPLORING THE MEDIATING EFFECTS OF BELIEFS TOWARD MENTAL ILLNESS ON THE RELATIONSHIP BETWEEN RELIGIOSITY AND SELF-STIGMA OF SEEKING HELP

By

Grace Ann Gibby

Liberty University

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy

Liberty University April, 2024

EXPLORING THE MEDIATING EFFECTS OF BELIEFS TOWARD MENTAL ILLNESS ON THE RELATIONSHIP BETWEEN RELIGIOSITY AND SELF-STIGMA OF SEEKING HELP

By Grace Ann Gibby

A Dissertation Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy Liberty University, Lynchburg, VA

2024

APRROVED BY:

_____

Krista Kirk, Ph.D, Committee Chair

_____

Joy Mwendwa. Ph.D, Committee Member

_____

Jose Maldonaldo, Ph.D., Committee Member

ABSTRACT

It is well-known that mental health concerns are common worldwide. Despite the increased research and strategic programs designed to improve mental healthcare systems, there are still persistent gaps in the accessibility and utilization of these services globally. The struggle to improve mental healthcare is even more difficult in developing countries. As a developing country, Bahamian society has insufficiently addressed mental healthcare. Mental health concerns have been categorized as a number one priority for The Bahamas, and a strong effort for the detection, prevention, and treatment of mental health is highly recommended by the World Health Organization (WHO, 2017). Statistics show that 90% of The Bahamas attend a church, and the country is considered a Christian nation; however, the impact of religiosity on mental health is largely unexplored with this population. To date, no studies have been conducted on the beliefs toward mental illness and the self-stigma toward seeking help in religious Bahamians. This study sought to understand the attitudes and beliefs of the Bahamian people toward mental illness and the interaction of religiosity and self-stigma; it was the goal of this researcher that the study would provide insights into interventions and programs that could increase utilization of mental health services and decrease barriers such as stigma.

Keywords: self-stigma, beliefs toward mental illness, religiosity

Dedication

To my husband and children, you have been the best support system a working mother could have. To my parents, sister, and best friends—there was no way I could even conceive of this journey or complete it without the role each one of you played. To my country, thank you for the village and culture instilled in me. I hope to contribute to our country in the field of mental health.

Acknowledgements

The only way that this entire life goal was even possible was because of God. For your faithfulness, I will praise you. There were so many worries that came along with this journey, and critical times when I contemplated giving up or at the very least taking a semester off. I look back and wondered how did this all happen? To God be all the glory.

Dr. Kirk, you stayed with me for this entire journey. You met me with grace and compassion at times when I needed it most – Thank you. To Dr. Joy, and Dr. Maldonado – your encouragement during my proposal defense propelled me forward and I am forever grateful for your willingness to serve on the committee.

To the many classmates throughout the program, and individuals over time who have emerged as friends. I am privileged to have met so many outstanding counselors in one program. The kindness that all of you have shown to me during different classes has helped me to stay the course when there were many reasons to quit.

To several professors: Dr. Thomas, Dr. Deacon, Dr. Bohecker, Dr. Nivischi, and Dr. Volk. You have made an indelible impression in my academic journey, thank you for your faithfulness to my academic and professional development.

TABLE OF CONTENTS

Abstract ……. 3

Dedication ……. 4

Acknowledgements ……... 5

Table of Contents …….. 6

List of Tables ……10

List of Figures …….. 11

List of Abbreviations ……12

CHAPTER ONE: INTRODUCTION ……...13

Background to the Problem ……...14

Problem Statement……..18

Purpose of the study……19

Research Questions ……19

Definition of Terms ……20

Culture ……20

Acculturation ……..20

Mental Health ……20

Mental Illness ……20

Religiosity ……...21

Stigma ……21

Importance of the Study ……..21

Chapter Summary ……22

Organization of Remaining Chapters ……..22

CHAPTER TWO: LITERATURE REVIEW ……..23

Theoretical Conceptual Framework ……23

Person-Process-Context-Time (PPCT) ……24
Religious Theoretical Framework ……26
Current State of Global Mental Health and Mental Illness ……..28
Mental Health ……...28
Mental Health, Mental Illness and Stigma ……30
Mental Health.. ……..30
Mental Illness ……31
Mental Health Stigma ……...32
Self-Stigma ……33
Current State of Religiosity and Mental Health ……34
Religiosity ……..34
Religion and Mental Health ……...35
Culture and Mental Health ……36
Culture ……36
Culture and Mental Health ……..37
Acculturation and Maladaptation…….38
Cultural Beliefs, Religiosity, and Mental Health ……40
Bahamian People ……..41
History of The Bahamas ……41
Bahamian Development ……42
Economic Opportunities ……44
Culture and Lifestyle ……..46
Mental Health and The Bahamian Culture ……47
Bahamian Identity ……...49
Global Literature ……50
Accessibility to Mental Health ……52
Chapter Summary ……53
CHAPTER THREE: METHODS…….56

Research Questions ……. 56
Design ……..60
Participants and Settings ……..61
Instrumentation ……61
Procedures ……64
Data Processing and Analysis ……..64
Ethical Considerations ……65
Chapter Summary …… …66

CHAPTER FOUR: RESULTS …… 67
Restatement of the Purpose ……...67
Descriptive Statistics ……68
Participant Demographics ……68
Sample Descriptive Statistics ……70
Data Analysis ……71
Research Question One ……..72
Research Question Two ……73
Research Question Three ……...73
Research Question Four ……....74
Chapter Summary ……...75
CHAPTER FIVE: SUMMARY, LIMITATIONS, & RECOMMENDATIONS
…….....77
Summary of Findings ……78
Limitations of the Study……..83
Implications for Practice ……84
Suggestions for Future Research ……86
Conclusions…… ……88

REFERENCES ……..90

Appendix A: Beliefs Toward Mental Illness (BMI) ……...102

Appendix B: Religious Commitment Inventory (RCI) ……...104

Appendix C: Self-Stigma of Seeking Help Scale……..105

Appendix D: Recruitment Letter sent to Pastors ……..106

Appendix E: Informed Consent for Participants ……..107

List of Tables

Table 1: Participant Demographics …….. 69

Table 2: Descriptive Statistics ……71

Table 3: Results for the Mediation Model ……... 73

List of Figures

Figure 1: Proposed Conceptual Model …… 61

Figure 2: Mediation model with results ……... 75

List of Abbreviations

Beliefs toward mental illness (BMI)

Counsel for Accreditation of Counseling and Related Educational Programs (CACREP)

Diagnostic Statistical Manual (DSM)

Mental Health Literacy (MHL)

Mental Health Stigma (MHS)

Questionnaire for Social Desirability (KAS)

Religious Commitment Inventory (RCI)

Research Question (RQ)

Self-Stigma of Seeking Help (SSOSH)

World Health Organization (WHO)

CHAPTER ONE: INTRODUCTION

This chapter seeks to provide a clear understanding of the proposed study, which examined the relationships between religion, beliefs toward mental illness, and the self-stigma of help-seeking behaviors in Grand Bahama. Research demonstrates that religion has a strong influence on many areas of an individual's life, including well-being, distress tolerance, life satisfaction, and quality of life (Garssen et al., 2021). Oftentimes, religion is central to identity for many people and provides a framework to interpret problems; therefore, an individual's relationship with religion can serve as a valuable resource (Kirmayer et al., 2022).

Help-seeking behaviors are defined as attempts to obtain external assistance for dealing with mental health concerns (Rickwood et al., 2012). Studies show that individuals of all ages are reluctant to seek help; in a German study, only 41% of students diagnosed with depression or anxiety had ever received treatment, and only 34% of adults diagnosed with a mental illness had sought help (Gulliver et al., 2010). These statistics urge us to consider the factors that act as barriers to individuals who need psychological help. Understanding these barriers and facilitators to help-seeking behavior is fundamental for developing interventions and programs to support individuals with mental health concerns (Velasco et al., 2020).

Among the major barriers to seeking help, stigma is the most prominent (Corrigan et al., 2004Velasco et al., 2020; Vogel et al., 2006; Vogel et al., 2013; Vogel et al., 2017). There are four known types of stigmas: public stigma, self-stigma, professional stigma, and cultural stigma (Chatmon, 2020). Research has focused on public stigma for a long time (Dubreucq et al., 2021), but evidence of the negative effects of self-stigma is growing.

The intersectionality of religion, psychology, and stigma has been researched for many years, but due to the dearth of research in The Bahamas and the glaring increase in mental health

concerns worldwide, it is necessary to collect and understand data to improve the accessibility and utilization of mental health services. The interaction between these three constructs has a unique history, but the attitudes toward the mental health of religious individuals in developing countries such as The Bahamas is a commonly neglected domain (Choudry et al., 2016).

The historical influence of each construct is described and supported through the literature. In addition to providing the background and problem statement, this chapter addresses the research questions and the study's significance and provides an overview of the remaining chapters.

Background to the Problem

It is well-known that mental health concerns are common worldwide (Kilbourne et al., 2018; Vigo et al., 2016; Choudry et al., 2016). Despite the increased research and strategic programs designed to improve mental healthcare systems, there are still persistent gaps in the accessibility and utilization of these services globally (Kilbourne et al., 2018). Studies in America suggest that of the 51 million adults with a mental health illness, only 23 million seek out and receive psychological help (Moreno et al., 2022).

It is reported that 15% of all adults aged 60 and over suffer from a mental disorder (Gomez-Dantes et al., 2018). Half of all mental disorders begin during adolescence and often go untreated, constituting a larger percentage of the 20% affected (Patafio et al., 2021; Salamanca-Buentello et al., 2020). Nearly 80% of individuals with severe mental disorders live in low- and middle-income countries and do not receive treatment (Noorain et al., 2022). Millions do not seek help due to limited resources, lack of services, or stigma (Gomez-Dantes et al., 2018).

The relationship between mental health and economics is bi-directional and complex. In addition to the human suffering that they generate, mental disorders have a huge economic

impact; however, much is still unknown about all the economic effects (Gomez-Dantes et al., 2018; Knapp et al., 2020). Mental health concerns are growing rapidly and globally, with mental health costs estimated to rise to 6 trillion by 2030 (Bloom et al., 2012; Knapp et al., 2020).

The struggle to improve mental healthcare is even more difficult in developing countries. Despite the increasing global burden of mental illness, mental health systems are a low priority. The Bahamas are a developing country, and successful mental healthcare is currently lacking (Keva et al., 2014; Kwangu et al., 2017). Developing countries have vulnerabilities, including small size, remoteness, and susceptibility to climate change (Walker et al., 2022). Natural disasters such as earthquakes, tornadoes, and hurricanes increase mental and emotional health incidents, but limited resources are often diverted to areas other than mental health (Rathod et al., 2017). This is particularly important in The Bahamas and, specifically, the island of Grand Bahama, where the worst hurricane in the nation's history occurred on September 1, 2019. Hurricane Dorian destroyed several parts of the island, homes, and lives, and its effects on mental health have yet to be determined (Shultz et al., 2020).

While many previously mentioned barriers restrict accessibility or utilization of treatment for individuals suffering from mental health illnesses or disorders, three specific barriers are addressed in this present study: religiosity, self-stigma of help-seeking behavior, and beliefs toward mental illness.

The historical tension between religion and psychology has finally arrived at a current agreement where it is widely apparent that religiosity is strongly tied in both positive and negative ways to mental health (Rosmarin et al., 2020). When considering the disparities regarding the utilization of mental health services by religious individuals in other developing countries, such as the Latino/Hispanic communities, mental disorders are often perceived and

culturally defined as a spiritual problem (Caplan et al., 2019). Causal attributions include: sinful behavior of parents, lack of prayer, and demons (Caplan et al., 2019). In the Latino/Hispanic community, churches are a major social, educational, and cultural resource; thus, the faith-based community can serve as an important target for mental health literacy and anti-stigma interventions. Stigma and religious attributes of illness and belief systems pose significant deterrents to receiving treatment, and individuals often trust spiritual and faith healers more than therapeutic interventions (Rathod et al., 2017).

The second barrier in this study is self-stigma, which refers to a transformational process where a person's previous social identity, such as sister, brother, son, or employee, is progressively replaced with a devalued sense of self; the individual has moved beyond the mere awareness of the public stigma and has embraced it as their identity (Dubreucq et al., 2021). Several studies have deemed self-stigma as a potent force that may damage the lives of people with mental illness, causing effects such as low self-esteem and self-efficacy, feelings of shame, social anxiety and avoidance, hopelessness, depression, reluctance to seek help, and suicidal ideation (Chan et al., 2019; Chen et al., 2016; Park et al., 2019). The literature also shows that self-stigma is common in Europe and North America; however, the research on it in other geographical areas is sparse (Dubreucq et al., 2021). Such information supports the need for a study in The Bahamas to collect the necessary data for promoting increased accessibility and utilization of mental health treatment services.

Beliefs toward mental illness play a major role in the development of culturally-sensitive interventions and programs (Ocho et al., 2023; Sichimba et al., 2022). Research regarding attitudes and beliefs toward mental illness has come a long way, but there is much more to learn in general and especially regarding cross-cultural populations (Angermeyer et al., 2006).

Beliefs toward mental illness are further highlighted in a study that assessed the attitudes regarding mental health in Malaysian pharmaceutical students. Its findings suggest that a comprehensive understanding is crucial when working with diverse ethnic beliefs as healthcare professionals, as is the importance of beliefs and attitudes as a part of the mental health discourse (Bleibil et al., 2022; Jidong et al., 2022). Furthermore, a scoping review on beliefs about mental illness in Nigeria showed that individuals would seek traditional healers first rather than trained healthcare professionals (Labinjo et al., 2020) due to the illnesses being attributed to supernatural causes—possession of evil spirits, sorcery, witchcraft, and divine punishment.

A scoping review conducted in Canada to explore the impact of culture, religion, and spirituality on mental health in immigrants revealed four major themes: a) there are varying perceptions of mental health and mental illness when working with immigrants from different parts of the world; b) mental health practitioners need to be aware that spirituality and religion can be important dimensions of a client's reality and identity; c) stigma can also be a barrier for immigrants in seeking services; and d) mental health services need to be linguistically and culturally appropriate to meet the various needs of immigrants (Chaze et al., 2015).

Research supports the significant role of culture and its influence on mental health. Culture shapes how individuals understand their mental health, coping skills, and response to seeking help (Kotera et al., 2022; Putul et al., 2018). Systems and attitudes are strongly influenced by culture, in addition to the causation and etiology of illness (Gopalkrishnan et al., 2018). Western mental health models push to impose their methods and ways of determining causation, classification, and treatment of mental health disorders (Kopinak, 2015). However, what is normal and abnormal within a culture cannot be generalized globally (Yamada et al., 2013).

While this study does not measure the variable of culture specifically, the influence of culture is necessary to consider as the participants are Bahamian, and this population or an understanding of the cultural underpinnings needs inclusion and is not currently represented in the literature.

Problem Statement

Mental health issues are rising worldwide, with estimated costs rising to 6 trillion by 2030, as previously mentioned (Bloom et al., 2012). Less than half of the individuals struggling with mental illnesses or disorders are not receiving treatment. Developing countries are at an additional disadvantage due to limited resources, few trained practitioners, stigma, and additional barriers such as religiosity. Mental health concerns have been categorized as a number one priority for The Bahamas, and a strong effort for the detection, prevention, and treatment of mental health is highly recommended by the World Health Organization (WHO, 2017). Statistics show that 90% of The Bahamas attend a church, and the country is considered a Christian nation (Abernathy et al., 2019); however, the impact of religiosity on mental health is largely unexplored with this population. To date, no studies have been conducted on the beliefs toward mental illness and the self-stigma toward seeking help in religious Bahamians.

This study sought to understand the attitudes and beliefs of the Bahamian people toward mental illness and the interaction of religiosity and self-stigma; it was the goal of this researcher that the study would provide insights into interventions and programs that could increase utilization of mental health services and decrease barriers such as stigma.

Purpose of the study

This study aimed to examine the relationship between religiosity, beliefs toward mental illness, and the self-stigma of seeking help within the Bahamian population. The current literature supports that mental health issues are rising globally, and individuals are not receiving treatment (Choudry et al., 2016). While many studies have examined common barriers to receiving treatment and ways to increase the utilization and accessibility of mental health services in diverse countries, to date no studies have explored these constructs among the Bahamian people.

Mental health concerns have been categorized as a number one priority for The Bahamas, and a strong effort for the detection, prevention, and treatment of mental health illnesses is highly recommended by the World Health Organization (WHO, 2017). Mental health is further complicated when religiosity, stigma, and belief about mental illness interact in small developing countries. Therefore, this study's research questions address the Bahamian population's beliefs toward mental illness, how religiosity may also influence these beliefs, and ultimately their impact on help-seeking behavior. The study's significance is that it may inform clinical practitioners and key stakeholders of ways to increase an individual's desire to seek counseling services and overall access to mental health services.

Research Questions

RQ 1: What is the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues?

RQ 2: What is the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness in general?

RQ3: What is the relationship between a Bahamian person's attitudes and beliefs about mental illness and their self-stigma of seeking help for mental health issues?

RQ4: To what extent do a Bahamian person's attitudes and beliefs toward mental illness mediate the relationship between their level of religiosity and self-stigma of seeking help for mental health issues?

Definition of Terms

This section describes pertinent terms that will be used throughout the study.

Culture

A widely used definition of culture refers to beliefs, values, and rituals held by a particular ethnocultural group (Betancourt & Lopez, 1993)

Acculturation

Acculturation is the term given to describe the cultural and psychological change that individuals experience because of contact between two or more cultural groups (Berry, 2019). There is a range within the acculturation process where individuals can be categorized as having high acculturation or low acculturation.

Mental Health

WHO (2001b) has defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Mental Illness

Mental illness refers to conditions that affect cognition, emotion, and behavior (Manderscheid et al., 2010). It was developed by the medical profession (Weihofen, 1960). In the early 1960s and 70s, an individual with a mental illness was described solely by their diagnosis; however, a paradigm shift occurred, and individuals are now viewed with a more holistic approach regarding their mental health instead of only the diagnosis (Manderscheid et al., 2010).

Religiosity

For the purposes of this study, religion is defined as a set of traditional values and practices related to a certain group of people (Southard et al., 2020). Leading researchers Allport and Batson (1967) spent years defining religion and formulated two dimensions: extrinsic and intrinsic. Both dimensions serve to categorize the two poles of religion (Allport et al., 1967). Extrinsic orientation describes an individual who turns to God but without turning away from themselves. Intrinsic orientation describes an individual who embodies religious beliefs and prioritizes fully living them out.

Stigma

The term ‘stigma’ originated from the Greek language, referring to bodily signs that exposed something unusual and bad about the moral status of a person (Goffman, 1991). Currently, the term holds some of the original implications with an emphasis placed on the disgrace of an individual and not the bodily sign of it.

Importance of the Study

The significance of the present study is that the data collected could inform clinicians and policy stakeholders of barriers to mental health services and provide a better understanding of the relationships among beliefs toward mental illness, religiosity, and stigma. Additionally, there is a current need for research on mental health in small developing countries such as The Bahamas (WHO, 2011). With mental health concerns rising globally and associated costs estimated to rise to 6 billion (Choudry, 2016), ways to improve mental healthcare systems are critical to transformation. There is a paucity of research in The Bahamas, specifically Grand Bahama Island, and this study could bridge the gap between persons suffering from mental health issues and their access to supportive services.

Chapter Summary

This chapter discussed the needs for further research to understand the impact of beliefs toward mental illness and religiosity on the help-seeking behavior of Bahamians. Given that there is limited research conducted in the country and none in Grand Bahama Island, it is important to provide empirical findings which can inform practitioners and stakeholders of ways to increase the utilization of and accessibility to mental health services.

Organization of Remaining Chapters

This dissertation further includes chapters two through five. Chapter two provides a review of the literature, theoretical framework, RQs, and support for each research hypothesis. Chapter three provides the methodology that was used to answer the RQs. Chapter four provides the findings of the data analysis for the research study, specified to each RQ. Chapter five details conclusions from the research study and future research suggestions.

CHAPTER TWO: LITERATURE REVIEW

There is an increasing interest in studying factors that impact the beliefs toward mental health and mental health services. This study sought to examine the relationships among religiosity, stigma, and general beliefs about mental health. Governing bodies such as the World Health Organization (WHO) and Pan American Health Organization (PAHO) have emphasized that the economic costs of mental health will rise to 6 trillion by the year 2030 (Bloom et al., 2012). Such alarming numbers have placed these constructs at high priority on global research agendas. However, despite this new focused goal, developing countries such as The Bahamas are significantly behind in research. Much of what is known about mental health in Caribbean countries is derived from studies conducted in Jamaica, Guyana, and Trinidad.

This review aims to describe a conceptual framework that can be utilized to understand the impact of religion and beliefs toward mental illness on help-seeking behavior. Additionally, similar studies are reviewed that are based in a variety of countries to help understand possible outcomes and validate the methods of this present study.

Conceptual Framework

Mental Health is of growing popularity for diverse reasons. It has been discussed thus far in relation to its importance and interaction with religion and cultural influences. What is critical to further discourse is understanding a conceptual or theoretical framework that helps to provide insight on the accessibility to mental health services with respect to culture and religious beliefs. It is well-known that a lack of contextually effective approach results in an underutilization of mental health services (Tanhan et al., 2022). The need for a holistic perspective on mental health promotion and intervention has been highlighted in several international forums and public health services (Eriksson et al., 2018). This holistic approach deemed necessary is comprised of

social and biological determinants which require a targeted theory to understand the complex and multi-faceted pathways between these determinants and health (Eriksson et al., 2018).

An ecological approach embraces both the individual and systemic perspective simultaneously and the interdependent relations between the two systems (Eriksson et al., 2018). This is needed from a mental health perspective as ecological thinking considers broad contexts such as globalization, urbanization, and environmental change in relation to public health policies and its progress (Eriksson et al., 2018). Ecological theories emerge from a variety of disciplines, but research in public health arenas tends to be influenced by psychology (Eriksson et al., 2018). This section describes an ecological theory (PPCT) which provides a theoretical framework that can guide the understanding of how different components of an individual's world work in tandem to influence their mental health.

Person – Process – Context – Time (PPCT)

A major contributor to ecological thinking was Urie Bronfenbrenner—a developmental psychologist who was influenced by his mentor Kurt Lewin. Bronfenbrenner worked tirelessly until his death in 2005 refining and revising his emerging theory initially named an "ecological model of human development" and consequently throughout his life span ended with the name "Person-Process-Context-Time" (Eriksson et al., 2018). The term 'Ecology' was defined as a fit between the individual and his/her environment (Eriksson et al., 2018). Bronfenbrenner further described that if development was to occur between the individual and the environment rather than only survival, the fit between the two must be even closer (Eriksson et al., 2018). The ecological environment is comprised of many systems at four varied levels. The microsystem refers to relations that contain the individual and their immediate environment such as school, home, and work. The mesosystem is comprised of interrelations between major settings that

contain the individual; for example: home and school, and home and peer groups. The exosystem refers to major social institutions of society including the workforce, public agencies, and mass media. This level does not necessarily contain the individual but influences the immediate settings in which the person is found. The macrosystem, which is the final system in Bronfenbrenner's initial model, describes the laws and regulations of the society and the unspoken expectations and norms.

When seeking to understand a developmental outcome, it is critical to analyze the composition and interactions between these systems (Eriksson et al., 2018). Later developments on the model resulted in two new systems—chronosystem and biological. The biological component sought to include the interaction between an individual's genetic material and environmental experiences, emphasizing that genes were not finished traits but could be influenced by the environment. Chronosystem was formally included in this later version of the model to highlight changes that occurred over time within the individual and within the environments. For example, if a parent changes their job status from full-time to part-time, how does this affect parent-child communication and by extension how does this affect the child's development (Eriksson et al., 2018)? The latest revision to the theory, which resulted in the name – Process-Person-Context-Time (PPCT) model, focused on the development of "proximal processes" which Bronfenbrenner described as processes that involved reciprocal interaction between an individual and other persons, objects, and symbols in their immediate environment.

Mental health is experienced in a community and not in isolation (Cook, 2020). This is why the ecological theoretical framework fits the study of this interaction perfectly. Several studies have effectively utilized the Bronfenbrenner model (Campbell et al. 2002; Sreetheran et al., 2014; Tudge et al., 2003). Examining the influences on African American adolescent

academic achievement in low socioeconomic families (Campbell et al., 2002), discovering early factors that contributed to small children having a 'readiness' for school (Tudge et al., 2003), and exploring how neighborhoods impacted mental health (Sreetheran et al., 2014) all demonstrated that an ecological approach is necessary for a comprehensive understanding as opposed to factors considered as individual characteristics. The study discussed that there are social and cultural meanings that have originated from the communities in which children have been raised (Tudge et al., 2003). In developing countries such as The Bahamas, attitudes and perspectives are strongly influenced by all areas of an individual's life (McCartney, 2004). The ideas and concepts that are introduced and either accepted or rejected affect the individual within the ecosystem (Eriksson et al., 2018).

Religious Theoretical Framework

The history of religion and mental health has several interesting turns as it began in alignment, and through the work of Sigmund Freud was discounted as magical thinking or neurosis (Freud, 1927). However, the unwavering connection between the two constructs stood the test of time and many clinicians and scientists hold firm that whether the influence was malign or salutary, whatever an individual's beliefs about God or faith were, these ideas mattered (Levin, 2010). With this increased interest, many studies were conducted to collect empirical data; however, data alone does not increase understanding of a topic without a guiding theoretical framework. Several conceptual models are discussed here as perspectives to further explain and interpret the findings on religion and mental health (Levin, 2010).

Harvard Psychologist and philosopher James Watkins paved a more optimistic approach to the religion and mental health connection. Two types of religious expression are identified—religion of the healthy-minded and religion of the sick soul (James, 1994). The first category

describes a tendency which looks on all things and sees good; a temperament that is taught early on where an individual who is a child of God has infinite strength at hand to deal with any difficulty. This temperament allows the individual to take life more easily, and they will make the most out of life and in some ways minimize evil (James, 1994). The second category which refers to the religion of the sick soul addresses individuals who tend to maximize evil. For these individuals, as with healthy-minded individuals, there is a range of evil—for some it is a simple-mal-adjustment of life and somewhat temporary. However, there are some individuals for whom evil is a wrongness of their very nature and there is no remedy outside of a supernatural intervention. These perspectives can provide a framework for understanding how religion impacts individuals in different ways (James, 1994).

This section provides a theoretical framework to understand the relationships between culture and mental health and religion and mental health. The PPCT ecological theory is helpful specifically in collectivist cultures where there are high levels of interaction among the ecosystem, and the cultural norms infiltrate every level within the system. The family system is a strong entity and all individuals are expected to support the system; if a parent is ill, the child can be expected to miss school to provide care for the parent; should a school-aged high school student have a part-time job, their earnings can be expected to contribute to the monthly bills (Eriksson et al., 2018). If the adults believe in mental health and possess some literacy about the topic, the children are more open-minded to the topic. This influential process also exists within the churches; most of the time whatever concepts the church agrees to and supports, families will also blindly support, often without enough information (Fielding et al., 2019). These interactions are not indigenous to The Bahamas, but because they exist, Bronfenbrenner's model as an ecological theoretical framework helps to understand and clarify the varied levels of influence.

Considering the theoretical framework that James Watkins provides, views on religion are tied to an expression that is linked to learned behavior. The Bahamas is deemed a Christian nation with over 90% identifying as religious or churchgoers (Abernathy et al., 2019). This high percentage urges researchers to explore the views and perspectives of how religion is introduced and expressed within the community. For some islanders, God is the answer for everything and this idea is permeated throughout that household (Fielding et al., 2019; Taggart et al., 2019). For other islanders, they belive God has abandoned them and life is infinitely difficult. These polarized views are common on the island and James Watkins' perspectives on religious expression provide a framework to understand such views (Watkins, 1994).

Current State of Global Mental Health and Mental Illness

Mental Health

Mental Health issues are globally on the rise (Choudry et al., 2016), with research indicating that one in every three individuals struggle during their lifetime with mental illness (Vigo et al., 2016). The need for innovative ideas to promote good mental health and to prevent and treat mental health problems has never been greater (Wykes et al., 2021). There is growing communication and collaboration among international networks to advance the shared goals of early, accessible, and evidence-based care (Heinsenn et al., 2021).

While mental health issues constitute an increasing worldwide burden, there are still significant barriers such as stigma, lack of education, and cost (Drissi et al, 2020). The negative consequences of individuals who suffer with mental illness include temporary incapacity to fulfill their daily responsibilities, additional stress placed on the individuals' families, public stigma, shame, and personal self-loathing (McDaid et al., 2019). At times such individuals are in

danger of harming themselves, or others, which has resulted in authorities taking legal measures to restrict their access and rights (McDaid et al., 2019).

It is well known that half of all mental disorders begin by age 14 and 75% emerge before age 25 (Kessler et al., 2007; Patafio et al., 2021; Salamanca-Buentello et al., 2020). Such statistics urge researchers to consider what can be done during this critical developmental period. A new term, 'Mental Health Literacy' refers to the knowledge and beliefs individuals hold about mental health disorders. Adolescent individuals need educational information about positive mental health and the recognition of the signs and symptoms of mental illness ((Patafio et al., 2021). Poor mental health literacy results in delayed treatment-seeking, which in turn causes a negative impact on prognosis and recovery (Patafio et al., 2021).

There has been major medical knowledge advancement in psychological disorders, yet mental illness remains vastly untreated worldwide (Lee et al., 2020). Due to comorbidity with so many other conditions, mental illness has been underestimated in its true effects on individuals, families, and society. A new saying that there is "no health without mental health" highlights the significance of promoting mental health; do people really have good, general overall health if their mental health is struggling (Prince et al., 2007)? There are fundamental differences between mental and physical health, yet studies show that they strongly influence each other (Noorain et al., 2022). Most health professionals now agree that mental and physical health are inseparable (Moeti et al., 2022). Individuals who struggle with schizophrenia or bipolar disorder have higher morbidity and mortality rates of cardiovascular diseases than the general population. Research strongly supports that mental health is an important determinant of physical health (Ohrnberger et al., 2017)

It is estimated that 35-50% of individuals in developed countries and 76-85% in developing countries receive no treatment for mental health issues (Noorain et al., 2022). Failure to acknowledge this growing crisis could result in harm to individuals, societies, and economies worldwide (Noorain et al., 2022). While mental health difficulties are present in every age group, childhood mental health concerns are of critical importance due to strong association with later economic adversity in adulthood (Evensen et al., 2017). Unemployment is common in those who have mental health struggles and this creates additional financial burdens on the family (Wykes et al., 2021). Globally, the burden of mental illness exceeds the cost of non-communicable diseases including cardiovascular disease, cancer, and diabetes (McDaid et al., 2019). In 2010, costs associated with mental illness were estimated to be 2.5 trillion, and this is projected to increase to 6 trillion by 2030 (Bloom et al., 2012).

The way that people view mental health differs around the world (Moeti et al., 2022). Developing countries feel the same impact of mental health issues with limited resources to provide solutions (Rojas et al., 2019). Regardless of these new insights on the true burden of mental illness, developing countries still prioritize the control of infectious diseases, reproductive maternal issues, and child health issues (Prince et al., 2007).

Mental Health, Mental Illness, and Stigma

Mental Health

Discourse on the topic of Mental health faces the additional challenge of categorization and meanings of many terms that are sometimes used interchangeably. While researchers and experts are constantly striving to ensure that the meanings of terms are as accurate as possible, there has been an evolution of meanings. Mental health once referred to the absence of a disease or illness (WHO, 2001a). Although across cultures, mental health can mean different things;

there are core universal meanings so that mental health can be conceptualized without too many restrictions. Three central components utilized by the World Health Organization in defining mental health are: (a) mental health is an integral part of overall health, (b) mental health is not just the absence of disease or illness, and (c) mental health is closely related to physical health and behavior (WHO, 2004). One body of research discussed that there is significant agreement on subcomponents of mental health. Words such as autonomy, agency and control were commonly used in a survey given to experts in the mental health field and are factors relating to the individual's capacity and ability for choice in interacting with society (Manwell et al., 2015).

However, in current times the new definition is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001b). This state of well-being is not to be assumed as a constant state of positivity or only feeling positive emotions; it must be clearly understood that mental health also refers to feeling sad, angry, unhappy, and unwell (Galderisi et al., 2015). These emotions constitute a life that is lived well and has had a variety of experiences.

Mental Illness

Mental Illness was a term developed by the medical profession (Weihofen, 1960) and refers to conditions that affect cognition, emotion, and behavior (Manderscheid et al., 2010). In the 1960s and 70s, an individual with a mental illness was described by their diagnosis alone (Manderscheid et al., 2010). A major shift began in the 1980s and 90s, and perspectives towards individuals with a mental illness moved from a partial to a more holistic view, and from a diseased-focus model to a focus on health. These changes in perspectives have garnered an

approach that recognizes mental health is vital to overall health and focuses less on the stigma of mental illness (Manderscheid et al., 2010).

Mental Health Stigma

Stigma is a complex dynamic that requires a solid definition to provide a framework for discussions. The actual term ‘stigma’ originating from the Greek language referred to bodily signs that exposed something unusual and bad about the moral status of a person (Goffman, 1991). Currently, the term holds some of the original implications with an emphasis placed on the disgrace of an individual rather than an outward bodily expression. There are many aspects of human behavior that are governed by the fear of being stigmatized, which does not lead an individual to change the behavior but rather to hide it (Bharadwaj et al., 2017).

Mental Health Stigma (MHS) is a wide term that consists of public stigma, self-stigma, professional stigma, and cultural stigma (Chatmon, 2020). People with mental illnesses are generally considered by others to be responsible for causing their illness and they are usually on the receiving end of stigmatizing attitudes more often than people with physical disabilities (Rusch et al., 2005). People struggling with mental illnesses have a double problem—they are trying to deal with the symptoms of the disease itself and deal with the public perceptions. Oftentimes, employers discriminate against individuals with mental illnesses, which limits their ability to take care of themselves and feel empowered. The stigma experienced at times will cause these individuals to accept what is being said about them, which further reduces their self-esteem (Rusch et al., 2020).

Stigmatizing attitudes have increased over the last few decades. Studies show that stigmatizing perceptions and attitudes towards people with mental illness have substantially grown since 1950 (Parcesepe et al., 2013; Phelan et al., 1998; Phelan et al.; 2000; Rusch et al.,

2005). This stigmatization strongly affects the treatment for these individuals. Psychiatric symptoms and life disabilities can be greatly improved through medication and psychotherapy; however, people do not often seek out treatment, and if they do, they end it prematurely (Rusch et al., 2020).

Despite prevailing research on the importance of addressing mental health concerns, it is still common in many developing countries for people to experience stigma if they have a mental health disorder (Abuhammad et al., 2021). The stigma experienced in general settings tends to be amplified in religious settings, as oftentimes the conceptualization of an individual's psychological problems is primarily seen as spiritual or religious. Therefore, individuals often perceive seeking professional help as conflicting with their religious beliefs (Freire et al., 2016). Studies that have sought to examine the relationship between religion and stigma have discovered a positive relationship between the two, indicating that increased levels of religiosity are strongly associated with increased stigma (Adu et al., 2021). A common belief that explains this relationship is the idea that religious individuals should be able to overcome any personal challenges with faith. Therefore, individuals who suffer from mental illness are perceived to lack this quality; relatedly, mental illness is believed by many to be due to sinfulness and therefore the discomfort of the illness is viewed as punishment from the omnipotent (Adu et la., 2021).

Self-Stigma

Much of the literature on self-stigma originated with the groundbreaking work of Bruce Link, who sought to understand the effects of labeling (Tucker et al., 2013). This work supports the assertion that people develop conceptions of how others think of those with mental illness long before the mental illness even occurs (Link, 1987). Self-stigma, also called internalized

stigma, is defined as a three-step process: 1. An individual belongs to a stigmatized group, is aware of the public stigma, and legitimizes these negative attitudes, 2. The individual applies these attitudes to themselves, and 3. The individual experiences the negative consequences (Change et al., 2016). Leading researcher Corrigan and colleagues have suggested that self-stigma is often accompanied by a phenomenon called "Why try" in which individuals troubled by self-stigma are often discouraged from pursuing opportunities because of diminished self-esteem and self-efficacy (Corrigan et al., 2009). In other words, self-stigma has been found to play a forceful role in not seeking psychological services, the effectiveness of psychological treatment, and the recovery from mental illness (Corrigan et al., 2012).

Current State of Religiosity and Mental Health

Religiosity

Religiosity is a complex conceptual idea that is difficult to define, primarily because different disciplines approach religiosity from varied perspectives; theologians approach religiosity from a viewpoint of faith, psychologists see it as a dimensional concept including devotions and holiness, and sociologists view it through the lenses of church attendance and church membership (Holdcroft, 2006). Without an explicit definition from the aspect of religious education, religiosity tends to become synonymous with terms such as belief, faith, devotion, spirituality, piousness, and religiousness (Holdcroft, 2006). Social practices and doctrines that emanate from the search for the 'sacred' are often associated with religiosity (Chida et al., 2009). For the purposes of this study, religion is defined as a set of traditional values and practices related to a certain group of people (Southard et al., 2020).

Leading researchers Allport and Batson (1967) spent years defining religion and formulated two dimensions: extrinsic and intrinsic. Both dimensions serve to categorize the two

poles of religion (Allport et al., 1967). Extrinsic orientation describes an individual who turns to God, but without turning away from themselves. At this end of the continuum, individuals find religion to be useful as it provides security, solace, sociability, distraction, status, and self-justification (Allport et al., 1967). The religious beliefs are loosely held by this type of individual and particularly shaped to suit their primary needs (Allport et al., 1967). Intrinsic orientation describes an individual who embodies the religious beliefs and prioritizes fully living them out. These individuals are strongly motivated by religion and attend church to thank God and receive his guidance (Allport et al., 1967). In short, the extrinsically motivated individual uses his religion, and the intrinsically motivated individual lives his religion.

Religion and Mental Health

The relationship between religion and mental health is quite intricate (Moreno et al., 2022). In the age of antiquity, mental illness was seen as a gift that allowed Shamans to communicate with the spiritual world to heal physical illness (Larkin et al., 2020). In other belief systems during the Middle Ages, Christianity and Judaism viewed mental illness as the result of demonic possession. Religious groups oftentimes were the ones caring for the mentally ill in the early hospitals (Larkin et al., 2020). The European Age of reason in the seventeenth century brought a more medical view of mental health and as the scientific method emerged, tensions grew between the two entities (Larkin et al., 2020). Prominent neurologist Sigmund Fred perpetuated his belief that religion was an illusion motivated by wish fulfillment, a sign of neurosis in the early twentieth century (Cook, 2020; Larkin et al., 2020). This view was so widely held that it set psychiatry and religion in opposition to one another (Cook, 2020).

Late twentieth century, the tides began to shift as evidence demonstrated that Evangelical Christian psychiatrists were strongly influenced in their work by their religious beliefs, as many

thought that Bible readings and prayer were much more effective than medication (Cook, 2020). The discourse no longer surrounded religion and psychiatry but rather the boundary of good professional practice versus bad professional practice. Scientific research and evidence-based medicine practices demonstrated that religious influences represented resources for well-being and health (Koenig, 2009). These developments resulted in American College Training programs being mandated to provide at least one course in the curriculum on spirituality and religion (Koenig, 2009; Weber et al., 2014). Patient care changed toward a more holistic approach that integrated all parts of an individual, certainly not disregarding their spiritual realm to the patient's own peril (Sims, 1994). Simultaneously, in 1991 the United Kingdom raised attention to the importance of spirituality in psychiatric care when the patron to the Royal College of Psychiatrists, HRH Prince of Wales, highlighted that there was a spiritual task to attend to at the heart of mental healthcare (Cook, 2020).

This new perspective towards religion and mental health served as a catalyst to examine the outcomes of this relationship. Studies clearly showed that religion was generally associated with better mental health (Weber et al., 2014).

Culture and Mental Health

Culture

It is also important to address the intersectionality of culture and mental health. Firstly, the term 'culture' requires a definition. Nearly 50 years ago, culture had almost 125 definitions; currently, a widely-used definition of culture refers to beliefs, values, and rituals held by a particular ethnocultural group (Betancourt & Lopez, 1993). Culture is unique to specific groups, and any attempt to generalize the idea that what exists in one culture is experienced in another culture is trivial (Edgerton, 2010). Similarly, it is helpful to remember that within cultural norms

are different identities, and one cannot assume that two clients who share the same culture will be exactly the same (Hsiao-Wen et al., 2005).

Culture and Mental Health

Culture molds mental health in diverse ways—the allocation of resources, perspectives on symptomology, coping strategies, and the response to help-seeking behaviors (Kotera et al., 2022). The way people understand their mental health is influenced by culture, and this diversity is naturally carried directly to the services they may seek (Putul et al., 2018). The attitudes of the practitioners and mental health systems are significantly impacted by culture (Gopalkrishnan, 2018).

Evidence not only shows the significant role that culture plays in how a society understands its mental health, but also the role that culture plays in defining the causative beliefs or etiology of mental illness (Gopalkrishnan, 2018). Mental health clinicians need to be alert to what is culturally normal or deviant (Yamada et al., 2013). It is also important for clinicians to understand the degree to which the client is influenced by their cultural norms (Hsiao-Wen et al., 2005). If a cultural norm includes ancestral worship but this practice is not considered important by the client, then the counselor does not need to integrate this perspective as an intervention (Hsiao-Wen et al., 2005).

Depending on these beliefs that are inextricably tied to culture, clinicians will be able to effectively address these issues by understanding the different perceptions (Putul et al., 2018). Further research conducted among the Latino community discussed several paradigms. There were individuals who did not utilize mental health services if they believed the causes of mental illness were associated with religiosity or supernatural events (Moreno et al, 2017). There were also individuals more inclined to seek counseling services if the origin of mental illness appeared

biological or was considered serious (Moreno et al., 2017). Coping styles are modified by culture, and therefore mental health cannot be studied in a culture-free vacuum (Putul et al., 2018; Yamada et al., 2013). It is important to note that individuals who experience migration could be at great risk for maladjustment due to the possibility that the pressures of migration and acculturation exceed their coping resources (Yamada et al., 2013).

For the purposes of this regression design in this present study, it was necessary to review literature that focused on Caribbean countries or Small Island Developments (SIDS). The Bahamas, though technically not located in the Caribbean, is largely associated with the Caribbean countries. The WHO declared that despite the vacation-like appeal of these destinations, they were not exempt from mental health concerns (Setoya et al., 2018). It is undebatable that mental health concerns are growing globally; however, the assumption should not be made that descriptions about mental health issues developed in one culture are equally applicable to other cultures (Bass et al., 2007). The nature of emotions, behaviors, and thought patterns will likely vary from culture to culture.

Acculturation and Maladaptation

Acculturation is the term given to describe the cultural and psychological change that individuals experience as a result of contact between two or more cultural groups (Berry, 2019). There is a range within the acculturation process where individuals can be categorized as having high acculturation or low acculturation. A study conducted on Asian students who were studying in an American College reported that after they were residing in the host country and considered themselves American (indicating a high level of acculturation), they would seek treatment if they were experiencing mental health concerns (Han et al., 2015). Conversely, Asian students who wanted to remain totally devoted to their native culture (indicating a low level of acculturation),

would not seek treatment as it felt wrong and against their culture (Han et al., 2015). These findings were supported in similar research. A recent study conducted among Asian-American college students showed they experienced significantly higher rates of mental health concerns than Whie Americans in the same setting, and their psychological distress manifested in physical forms of pain, headaches, and other somatic ways (Kim et al., 2021). As avoidance of shame is a major catalyst for Asians, the loyalty to the family's honor must be maintained at all costs (Eng et al., 2020).

It has been previously described that culture serves as a foundational tenet in the shaping of attitudes toward psychological help. Everyone exists within a culture, and at times may immerse themselves in other cultures, e.g change of schools, community, or country; however, there is also a vast difference in global hemispheres. There are major differences between Eastern and Western Cultures—individuals from western cultures utilized treatment options more than eastern cultures (Krendl et al., 2020). Studies have demonstrated that despite an individual moving to a western culture and having access to the same treatment options, the prevailing Eastern Culture would usually prohibit the individual from seeking help and utilizing treatment (Krendl et al., 2020).

The mental health field utilizes the Diagnostic Statistical Manual of Mental Disorders (DSM) to define and understand the individual's presenting concerns. This collection of diagnoses is largely based in the American cultural context. However, research describes that normal and abnormal behavior are open to interpretation based on culture (Yamada et al., 2013). Thus, culture is a central component in understanding the etiology of mental disorders (Yamada et al., 2013).

Cultural Beliefs, Religiosity, and Mental Health

Cultural beliefs influence perceptions of mental health and practitioners should have cultural competence, which helps to distinguish culturally shared experiences from non-cultural experiences (Islam, 2016). In Arab nations, mental health symptoms are displayed through three main groups: somatic, emotional, and behavioral (Islam, 2016). Oftentimes somatic symptoms are seemingly related to physical health and are deemed more worthy of attention. However, emotional symptoms including anxiety and depression may be attributed culturally to a weak faith or weakness of personality (Islam, 2016). The last group of behavioral symptoms is often attributed to supernatural forces such as demons, evil spirits that are acting spontaneously to punish the client, e.g., engaging in culturally taboo behavior or lack of executing some familial duty (Islam, 2016). The interpretation of these groups is in the context of cultural influence in Arab nations. The symptoms themselves are perceived based on cultural beliefs, values, and traditions that are transgenerational (Islam, 2016). For example, a major life decision such as getting married can still be arranged in non-western cultures and arranged marriages can be common between cousins, resulting in genetic predispositions for mental health disorders (Islam, 2016). Literature shows that the prevalence of schizophrenia is much higher in this part of the world as opposed to western cultures who marry based on love, which limits genetic interaction (Islam, 2016).

This study seeks to understand the attitudes and perceptions towards mental health and psychological help in the developing country of The Bahamas and specifically Grand Bahama Island. It has been the intent of this review to lay the foundation for what has already been researched regarding perceptions and attitudes towards mental health globally, with a closer view

on developing countries. The present study collected data to inform stakeholders of the current climate of the Bahamian people in the critical area of mental health.

Bahamian People

History of The Bahamas

The Bahamas is an archipelago of around 700 islands and cays, 30 of which are inhabited (Palmer, 1994). First discovered by explorer Christopher Columbus in 1492, The Bahamas was considered the "New World." Prior to this discovery, however, the islands were not uninhabited. An indigenous tribe of individuals throughout the Caribbean called the Tainos, who were a branch of a people called the Lucayans, lived throughout the islands. This tribe were descendants of the Arawaks (Nevins et al., 2019). Nearly 25 years after Columbus discovered the islands, the Lucayans died out and The Bahamas islands came under the control of Spain (Nevins et al., 2019). Although under European control, The Bahamas remained uninhabited for more than a century. It was not until old religious issues surfaced in the new world in one of the British colonies called Bermuda that individuals sought another location to experience religious freedom in 1629. These adventurers were called Eleutheran Adventurers, guided by Captain William Sayle (Nevins et al., 2019). The Eleutheran Adventurers toiled hard and long to make a living through farming and fishing, but the soil was too thin and eventually the group left the islands and returned to Bermuda.

In 1671, King Charles II granted proprietorship to five men including the Duke of Albermarle. These men appointed a governor and left the island to their fate (Nevins et al., 2019). The neglect of the British proprietors left the islands open to corruption and piracy took over. Woodes Rogers was appointed to eradicate piracy in 1718 and by 1732 over two thousand pirates fled the islands. In 1729, the House of Assembly was organized by Woodes Rogers and

12 acts of parliament brought law and more orderly government to the islands of The Bahamas along with the beginning of commerce.

Post the American Revolutionary war, many settlers of former British Colonies moved to the Bahamas. They were called Loyalists, as they were strong supporters of the King. In the 1780s the population tripled with loyalists and their slaves who worked the cotton plantations. In 1807, the British abolished slavery and life in the Bahamas quieted down. The plantations did not fare well as a chenille bug killed off vegetation (Craton et al., 1992).

Many Bahamian families trace their ancestry to the colonizing Eleutheran Adventurers and the Loyalists. These groups of people brought their slaves, who eventually comprised most of the Bahamian population. While slavery was abolished in the British Empire in 1807, American states still utilized slaves from Africa and many ships bound for America were intercepted by the British Royal Navy; the people aboard were free and resettled in the Bahamas. Some seven thousand Africans came to the islands in this way. These people and their descendants became the backbone of the citizenry (Nevins et al., 2019).

Bahamian Development

The years 1808-1834 mark the transition period of formal slavery ending with the official slave act on September 27th, 1833. The slaves in Bahamas were described as healthy and seemingly content compared to those in other Caribbean countries such as Jamaica, Trinidad, and Antigua (Craton et al., 1992). There were four distinct classes of slaves: black seamen, domestics, slaves belonging to petty farmers, and plantation slaves. The seamen had the most freedom with collecting a percentage from their masters for their fresh catch; domestics and slaves of petty farmers were relatively on easy street as well, managing the home and selling fruits and vegetables at the Nassau local market. The plantation slaves had life harsher than the

other groups; however, treatment was not nearly as severe as in true West Indian Colonies. Plantation slaves had a three-hour meal break during the day, rarely worked after dark, and received time off during the holidays (Craton et al., 1992). There were considerable differences between the plantation colonies in The Bahamas and other British West Indian colonies. The slave trade was less severe than comparable colonies (Shepherd, 1993).

The original police force of 1802 was parochially-based and church wardens and vestries were appointed as honorary constables. As time passed, militia from different countries in the West Indies—Jamaica, Barbados, and Trinidad—were brought in for back-up militia support. As the islands started to progress as a developing colony with essentially three new groups of people—liberated African slaves, Blacks, and Whites—law and order became essential (Craton et al., 2000). By 1891 the police force was well-organized and an act had passed that required the force to have a commandant, inspector, sub inspector, sergeant, two corporals, and forty constables. The force consisted mostly of Barbadian soldiers who were brought in, trained, and lived in barracks on one compound (Craton et al., 2000). It was not until the 1960s and 70s that black nationalism emerged and the police force was Re-Bahamianized (Craton et al., 2000).

The Bahamian Education system was extremely weak and reflected the class and racial division that already existed. Money was in short supply and those in control saw it as a waste of finances to spend on ordinary blacks who were viewed as incapable of profiting from more than basic learning (Craton et al., 2000). Consistent throughout the British West Indies, the best education opportunities were reserved for those whose parents could afford to send them (Craton et al., 2000). Such segregated and selective opportunities for education left the responsibility of education to the churches (Craton et al., 2000). Though there were many toils and disagreements, a census taken in 1901 reflected that 37% of the population could read and write, and an

additional 11% could read but not write. These statistics showed great promise that churches were successful in providing some education if only at the primary level (Craton et al., 2000).

Economic Opportunities

Nassau, located on New Providence Island, began to experience a phase of unprecedented activity. The face of town changed from mostly being built of wood with shipbuilding features to one where new architectural designs inspired by the American Loyalists were constructed (Craton et al., 1992; McCartney, 2004). This new style of domestic design lasted for nearly a century with buildings such as the GreyCliff, Jacaranda, and Cascadilla, built between 1825-1850 and still standing today. The late 1800s highlighted the influence of the American Civil War as Blockade Running became a major boost for the economy between 1861-1865. Nassau served as a transshipment point, receiving cotton from the south in exchange for manufactured goods including guns, ammunition, and medicine from Europe (McCartney, 2004). The Bahamas also benefitted tremendously when Prohibition occurred. Such historical American events really allowed the Bahamian economy to thrive, until Prohibition was repealed (McCartney, 2004).

The role of laborer was exclusively monopolized by slaves and the term ‘tradesman’ referred to slave carpenters, boatbuilders, blacksmiths, masons, mechanics, basket makers, and seamstresses (Craton et al., 1992). The timeline of economic opportunities can be categorized as follows: slavery, apprenticeship, indentureship, sharecropping, labor tenancy, the credit and truck systems, and state-directed social control (Shepherd, 1993). The collapse of the cotton-based plantation system had worked in the favor of slaves as this dilemma reduced the need for slaves. Although Emancipation Day was the symbol to indicate freedom, it was found in subsequent years that slavery and freedom were not opposites (Shepherd, 1993). Merchants

created a coercive mode of labor as there were increases in staple production; essentially another form of servitude and wage labor was the order of the day (Johnson, 1988; Shepherd, 1993).

After Emancipation Day, ex-slaves had several adjustments to manage; one that is emphasized was the need to assume responsibility for their own maintenance during sickness and old age. These situations would have previously been attended to by the slave owners (Johnson, 1991). The strategy utilized by the former slaves for dealing collectively with this new responsibility was the organization of a "friendly society." The first friendly society was formed on Emancipation Day in 1834 and one year later two additional societies were formed in Eastern and Southern parts of Nassau. The goals of the society included provision through mutual assistance for periods of sickness, old age, and burial expenses, as well as rendering financial assistance to surviving family members. The rules for the group enforced that members who were sick and unable to work were entitled to a weekly allowance once they had a certificate from a "Medical Gentleman." Additionally, upon the death of a member of the society, twelve dollars were given to the friends of the deceased and twelve pounds were given to the widow (Johnson, 1991).

On January 10th, 1967, the Progressive Liberal Party won the election and for the first time in Bahamian history, most of the population were represented in government (Rommen, 1999). This marked a crucial period for the Black Bahamians, as the push was there to gain independence from Britain and begin the road to national identity (Rommen, 1999). The construction of the Bahamian nation did not end with the gaining of independence on July 10th, 1973. Settlements were formed around or near the best harbors to facilitate internal and external trade—lifelines for isolated communities. The geography of the islands encouraged a maritime culture and the sea became a vital component of the food culture and trade. This maritime

influence also allowed Bahamians to become well-known boat builders (Glinton-Meicholas, 2013).

Culture and Lifestyle

This historical understanding of how the Bahamas came to be a nation and its population constituted by Africans provides the framework for describing the culture of the Bahamian people. Friendly, warm, laidback, and relaxed are characteristics of African Bahamians (Storr, 2009). It is not uncommon for good conversations to happen between African Bahamians and total strangers. Another distinct quality of African Bahamians is their helpfulness. When visitors on the islands are noticeably lost, Bahamians will make every effort to assist them. This helpful nature is ubiquitous and aligns with the easy-going lifestyle that Bahamians particularly enjoy (Storr, 2009).

The picture of paradise that is often associated with the idea of The Bahamas consists of just the type of people one would find there: gregarious, genuinely charming, and kind (Storr, 2009). However, it is not to say that there are not any untoward people or experiences on the island. For example, Bahamians can flat out ignore rules and customs such as copyright laws and adultery (Storr, 2009). The word “sweet-hearting” is commonly used to describe adultery and is considered a national pastime. In the 1980s the very fiber of the country was worn down through illegal drug trafficking where government officials received kickbacks, for which no one was held accountable and the current government was reelected twice despite the corruption (Craton et al., 2000).

The inner workings of culture are quite intricate (Greetz,1973). A tradition that has helped in subsequent generations understanding the many different facets of culture is Folklore. Folklore represents a line that is tied to a vast network of values, meanings, and cognitions and

refers to story-telling, songs, myths, and legends that contain wisdom, problem-solving ideas, and reasoning skills (Goodenough, 1974). Although a dying tradition in The Bahamas, there is still valuable insight gained from storytelling. One of the most popular stories was of two famous characters called “B’Boukee and “B’Rabby” (Storr, 2009). It was common for people to sit around at family gatherings, usually at a grandmother’s feet, and listen to the tales. B’Boukee and B’Rabby were characters from Africa and were carried over through slavery; hence, these characters highlight the African heritage in The Bahamas (Storr, 2009). The tales are often about the cunning skills of B’Rabby to outsmart B’Boukee at every turn. B’Boukee was considered a bit dim-witted and B’Rabby used his intelligence to get ahead. How does this connect with Bahamian culture? B’Rabby is not just a mythical character; he represents a group of individuals seen in the culture repeatedly. The pirates, bootleggers, and drug dealers of yesteryear who have since turned into successful businessmen and politicians know the story well of using their skills to outwit every obstacle, escape every trap, and win every battle. Deep down there is a respect for using one’s wiles to win and forge ahead (Storr, 2009)

The Bahamas is a family based-society with strong Judeo-Christian values (Abernathy et al., 2019). About 95% of the population practices some form of Protestantism, Catholicism, or another Christian religion. With a strong sense of family, Bahamians enjoy getting together with the entire family including grandparents, and extended cousins to celebrate any occasion. Oftentimes, christenings, funerals, graduations, and birthdays are events that bring about gatherings.

Mental Health and the Bahamian Culture

To fully understand the current climate towards mental health in the Bahamas, it is critical to understand the components that underlie the context. Slavery and colonization have largely shaped the perspectives and generational trauma that exists today. Slavery increased the

rate of individuals who struggled with mental illness and insanity, which often resulted in suicide as a response (Hickling et al., 2013). Given the paucity of research for Grand Bahama Island, it is helpful to consider what countries with similar historical backgrounds have experienced. An anthropological study conducted by British social psychologist Madeline Kerr in Jamaica explored the relationship between personality and conflicts and provided historical perspectives on the cultural tensions that originated from the juxtaposition of African slavery and imposed British values (Rey, 1953). The main findings indicated that Jamaicans were lost, as they could not fall back on their African cultural roots neither could they fully adopt the Anglo-American standards (Rey, 1953).

Although The Bahamas is currently an independent nation, it continues to exhibit the influence of Britain. The British model for psychological and psychiatric treatment resulted in asylums and madhouses (Hickling et al., 2013). Prior to 1956 mental health patients were confined to a building like a prison that was nearby the hospital. It was a pastime for individuals to climb atop the hill and get a good view of the "crazies" banging their heads, shouting obscenities, and crying for help to be released. The first qualified psychiatrist to work in The Bahamas was a polish doctor—Dr. Henryk Podlewski. With great patience and concern he single-handedly transfered the 140 patients to a new compound located in the East of Nassau and called it Sandilands Rehabilitative Center. Intense public education and psychiatric trainings for nurses were well underway so that mental health patients could be viewed differently. Dr. Podlewski purported that these individuals could be cured and did not necessarily have to be locked away forever.

Bahamian Identity

An individual's national identity is a complex mix of shared values, memories, myths, and traditions (Smith, 1991). A strong sense of national identity is often considered a positive psychological trait (Long, 2021). The influence of colonial rule on national identity has left much unrest in its wake, with some white Bahamians still feeling a connection to the British Identity, in contrast to black Bahamians who feel a sense of freedom only since Independence in 1973 (Palmer, 1994). The necessary educational, legal, and political systems that a nation requires reinforce the British foundation and the struggle to reconcile the various parts of their identity is evident and demonstrated with the recurring question: what does being a Bahamian mean? (Palmer, 1994).

There are certain strategies that Bahamians have utilized to protect and preserve their identity. Specialty foods including the Queen Conch, festivals such as Junkanoo, language—the Bahamian dialect—and their own fabric print called Androsia (Ocloo, 2017) are unique cultural elements they have held onto. Often mothers are teaching their daughters how to prepare the food items that are symbolic of culture to keep the traditions alive (Ocloo, 2017). Tourism is the number one industry, and while there is a gratitude towards having this resource as a significant provider of income, in many ways there is a danger that tourism perpetuates the historical implanted identity (Palmer, 1994). There is a unique relationship between tourism, paradise, and colonization (Battle-Baptiste, 2017).

In further discourse the impact of culture on attitudes toward mental health concerns and services was explored. It is clearly understood that the national Bahamian culture is a composition of both British and African influences. The Britons contributed the English language, Protestantism, and European technology, while the African influences included

musical instruments and concepts, religious concepts, folk tales, and family patterns (Palmer, 1994).

Research purports that there is high shame in the British culture, and the prevailing attitude toward mental health suggested that mental illness was less of a medical problem and more of a moral or attitudinal problem that existed within the individual (Kotera, 2021; Wilson, 2021). A study conducted among U.K. business students who were experiencing mental health concerns reported there were high levels of shame towards mental health problems. This created a fear of seeking help as individuals worried they were violating some standard (Kotera, 2019).

The attitudes toward mental Illness in African countries are still heavily influenced by traditional beliefs that supernatural forces are the cause for mental illness (Gureje et al., 2015; Gureje et al., 2000). Oftentimes this belief system results in unhelpful responses towards seeking psychological services or stigmatization towards individuals who are suffering with a mental illness (Gureje et al., 2000). It is a commonly held view in many African countries that mental health concerns have spiritual issues at the root (Zeleke et al., 2019), and therefore spiritual interventions are sought as most patients frequently link mental health illnesses to cultural and ancestral roots (Nicholas et al., 2022).

Global Literature

Despite its gained traction in the last few decades, there are many significant gaps in understanding the role of religion in mental health. This study discovered that clients with religious beliefs viewed their problems as spiritual and not psychological; religious beliefs often provide contexts for suffering and a way to cope with the suffering with prayer as the antidote (Nakash et al., 2019). For example, although mainland China has 1.3 billion residents, (94% of whom have engaged in spiritual activities), almost no research has been conducted on the topic

of the effects of religious belief and practice on attitudes toward mental health there (Wang et al., 2019).

Despite the dearth of global literature on how religious beliefs might influence perspectives on mental health, few studies have explored this concept in developing countries. In one study conducted in Israel, religious clients conveyed their skepticism about the mental health care system and were concerned about the social stigma attached to treatment (Nakash et al., 2019). The religious beliefs hinder seeking treatment due to the belief in a higher entity (Nakash et al., 2019). Another analysis explored the history of Korea's cultural influences, such as the teaching of Confucian and how those teachings affected how Korean people handle mental illness (Choi, 2015). For example, in Confucianism there is a strong emphasis on behavioral and emotional control which results in harmonious living. Additionally, Confucianism focuses on a patriarchal hierarchy which led Korean culture to have a class-oriented system; the ruling class were oppressors of the lower class and therefore women were subservient to men. The effect of Confucianism was strengthened during the Japanese Colonial period and following the Korean War, many Koreans suffered unbearable pain, destruction, and loss (Choi, 2015). Such intense feelings of sorrow and pain were suppressed and Koreans silently suffered in order to live harmoniously with Confucius teachings. Consequently, Koreans suppressed their anger, held grudges, and became depressed. The influence of culture upon the dealings of help-seeking behaviors and mental illness is one that cannot be understated. These studies provide an idea of what has already been discovered, and more importantly highlighted, in at least three countries with this attitude of religious individuals toward stigmatizing mental health (Choi, 2015; Nakash et al., 2019).

Accessibility to Mental Health

There are growing concerns that a comprehensive understanding and intervention in mental health is needed everywhere—specifically, a deeper exploration of how to develop and implement counseling services that are culturally-appropriate in lower-middle income countries with little to non-existent mental health systems in place (Sacra et al., 2018). A major barrier also includes lack of trained practitioners within the developing country. This poses a problem because the few who are trained have received this training in other developed countries such as the United States of America or the United Kingdom. Practitioners are influenced by the dominant culture and must carefully integrate their training with culturally-sensitive strategies. This also encourages the discussion of countries training their own mental health counselors with the necessary combination of current culture and formal training (Sacra et al., 2018).

In developing countries, professional counseling services are still in a stage of infancy; a study conducted in Ethiopia describes how availability and accessibility of information on mental health issues are severely limited (Zeleke et al., 2019). While the western world views mental health from a biomedical perspective, previous studies conducted in Ethiopia found that religious beliefs were believed to be the cornerstone of causation. Mental health concerns were more attributed to evil-spirits and demonic possession. This resulted in people struggling with mental health issues seeking help from family, friends, religious leaders, traditional healers, and witches (Zeleke et al., 2019). In many cases, only severe mental health problems such as bipolar disorder or schizophrenia are recognized as needing formal intervention. This often is the last resort after exhausting religious and traditional healers. Lesser mental health concerns such as adjustment disorders are considered insignificant or not even identified, and consequently blamed on poverty, neglect, and abuse.

A quantitative study conducted in Trinidad among university students to measure their perceptions towards mental illness showed 32% of respondents felt mental health symptoms were caused by supernatural forces (evil spirits, demonic forces) and 77% of respondents felt that medical illness held a significant role (Ramkissoon et al., 2017). Similar attributions of supernatural forces as the cause for mental health disorders were also found in studies conducted in Nigeria (Labinjo et al., 2020).

Jamaica on the other hand has made significant progress in attitudes towards mental health. Recognizing that they needed to overcome the negative psychological impact of 500 years of colonialization, effects, and slavery, upon becoming independent in 1962 they dismantled the Bellevue hospital known for treating patients with mental health disorders (Lacy et al., 2016). An initiative to establish community mental health increased accessibility to services and largely reduced the strain on the general hospitals. Major training programs commenced through the University of The West Indies to increase the number of practitioners in the country (Lacy et al., 2016). The origins of conflict, anger, stress, and despair are attributed to the history of slavery and colonialism and considered to be characterizations of the post-colonial experience (Lacy et al., 2016).

Chapter Summary

Chapter two highlighted how there is a strong need to address mental health concerns and the barriers that exist towards help-seeking behavior in the Bahamian people. Research clearly shows that mental health issues are increasing at an alarming rate (Choudry et al., 2016; WHO, 2011), with costs believed to rise significantly by 2030 (Bloom et al., 2012). These problems are not specific to any country but rather are ubiquitous and require a multi-faceted international approach to solve the global dilemma (Heinsenn et al., 2021). The interaction of two main

constructs—religion and culture—with mental health are explored and theoretical frameworks are provided to guide the conceptualization (Eriksson et al., 2018; James, 1994). Further research states that developing countries have additional disadvantages due to minimal resources, fewer properly trained practitioners, lack of education, and stigma (Drissi et al., 2021).

The Bahamas is of interest in this study due to the researcher's origin and determination to implement ways that can help develop a better and healthier community. The history of The Bahamas, its development, effects of slavery and colonization, and current state of mental health have been discussed to establish a detailed perspective of how this small nation came to be (Craton et al., 1992; Craton et al, 2000; McCartney, 2004). As the Bahamas is deemed a Christian nation (Abernathy et al., 2019) the relationship between religion and mental health are of utmost importance and has been discussed at length to provide a strong foundation that illustrates the need for this present research. The construct of stigma and the significant role it plays in how a society understands, perceives, and copes with mental health was established (Gopalkrishnan, 2018). Research clearly demonstrates that practitioners must be mindful of what is culturally deviant or abnormal, therefore practicing cultural sensitivity when providing services to clients of diverse backgrounds (Yamada et al., 2013).

The literature review demonstrated similar needs and concerns of addressing mental health issues in diverse countries within the context of culture, stigma, and religion. Such studies confirmed the need for further research to be conducted, especially in developing countries, given the paucity of research. The primary focus of this present study was to examine the relationship between religiosity and self-stigma of seeking help and the mediating effect of beliefs toward mental illness in The Bahamas. Data collected could inform policy holders and clinical practitioners of ways to increase accessibility and utilization of mental health services

and provide support for allocation of resources. Chapter three outlines the research method used to address the identified RQs, exploring the relationship between internal stigma, help-seeking behaviors, and beliefs toward mental illness for the Bahamian people.

CHAPTER THREE: METHODS

This chapter presents the methodology used to explore the relationship between religiosity, self-stigma of seeking help, and the effect of beliefs toward mental illness within the Bahamian population. The research questions and hypotheses are discussed in addition to the research procedures, data analysis, and instrumentation. A conceptual model diagram is provided to illustrate the mediation model that was used in the study. The statistical tests are briefly described and a chapter summary is provided.

Research Questions

RQ 1: What is the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues?

Rationale

Despite prevailing research on the importance of addressing mental health concerns, it is still common in many developing countries to experience stigma if one has a mental health disorder (Abuhammad et al., 2021). The stigma experienced in general settings tends to be amplified in religious settings as oftentimes the conceptualization of an individual's psychological problems is primarily seen as spiritual or religious. Therefore, individuals perceive seeking professional help as conflicting with their religious beliefs (Freire et al., 2016). Studies that have sought to examine the relationship between religion and stigma have discovered similar findings of a positive relation between these constructs, indicating that increased levels of religiosity are strongly associated with increased stigma (Adu et al., 2021). Four types of stigmas have been identified and discussed in a prior chapter: public stigma, self-stigma, cultural stigma, and professional stigma. The most prominent barrier to seeking help is the self-stigma. In other words, self-stigma has been found to play a forceful role in seeking psychological services, the

effectiveness of psychological treatment, and the recovery from mental illness (Corrigan et al., 2012).

Hypothesis 1: The level of religiosity will have a statistically significant direct effect on an individual's level of self-stigma in seeking help.

Null Hypothesis**:** There is no relationship between religiosity and self-stigma of seeking help.

RQ 2: What is the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness in general?

Rationale

Beliefs toward mental illness play a major role in the development of culturally-sensitive interventions and programs (Ocho et al., 2023; Sichimba et al., 2022). Cultural biases shape how people think about mental health, and mental health professionals should have cultural skills that help them interpret culturally related experiences from their clients' non-culturally related experiences. (Islam, 2016). The diversity of how people understand their mental health is largely influenced by culture and is carried directly to the services they seek to utilize (Putul et al., 2018). There were individuals who did not utilize mental health services if the causes of mental illness were associated with religiosity or supernatural events (Moreno et al, 2017). There were also individuals more inclined to seek counseling services if the origin of mental illness appeared biological or considered serious (Moreno et al, 2017). Statistics show that 90% of people in The Bahamas attend a church, and the country is considered a Christian nation (Abernathy et al., 2019); however, the impact of religiosity on mental health is largely unexplored with this population.

Hypothesis 2**:** The level of religiosity will have a statistically significant direct effect on an individual's beliefs toward mental illness.

Null Hypothesis**:** There is no relationship between an individual's level of religiosity and their beliefs toward mental illness.

RQ3: What is the relationship between a Bahamian person's beliefs toward mental illness and a Bahamian person's self-stigma of seeking help for mental health issues?

Rationale

Slavery and colonization have largely shaped the perspectives and generational trauma that exist today in the Bahamian society. Slavery increased the rate of individuals who struggled with mental illness and insanity which often resulted in suicide as a response (Hickling et al., 2013). Research suggests that the national Bahamian culture is a combination of both British and African influences. The Bahamian language is a strong contribution of the Britons, along with Protestantism, and European technology. The African influences included musical instruments and concepts, religious concepts, folk tales, and family patterns. Research purports that there is high shame in the British culture, and the prevailing attitude toward mental health suggested that mental illness was less of a medical problem and more of a moral or attitudinal problem that existed within the individual (Kotera, 2021; Wilson, 2021). The attitudes toward mental illness in African countries are still heavily influenced by traditional beliefs that supernatural forces are the cause for mental illness (Gureje et al., 2015; Gureje et al., 2000). Such influences of shame and supernatural forces could contribute to the internalized feelings of self-stigma of seeking help.

Hypothesis 3: There is a statistically significant direct effect between an individual's beliefs toward mental illness and their levels of self-stigma in seeking help.

Null Hypothesis**:** There is no relationship between an individual's beliefs toward mental illness and their levels of self-stigma in seeking help.

RQ4: To what extent does a Bahamian person's attitudes and beliefs toward mental illness mediate the relationship between a Bahamian person's level of religiosity and self-stigma of seeking help for mental health issues?

Rationale

Beliefs about the causes of mental illness are largely influenced by personal experiences, education, broad cultural perspectives, and stigma (Stefanovics et al., 2016). These beliefs are then major determinants of behavior and have a broad influence on social behavior (Stefanovics et al., 2016). Literature supports the cross-cultural differences in beliefs; for example, in Australia mental illness is often viewed as a result of genetics, but in Japan mental illness is often viewed as a result of weakness in character (Nakane et al., 2005).

Oftentimes this belief system results in unhelpful responses towards seeking psychological services or stigmatization towards individuals who are suffering with a mental illness (Gureje et al., 2000). Many African countries share a common view that mental health concerns have spiritual issues at the root (Zeleke et al., 2019), and for this reason spiritual interventions are sought as most patients frequently link mental health illnesses to cultural and ancestral roots (Nicholas et al., 2022). The unique intersection of religion, psychology, and stigma has been researched for many years, but due to the lack of research in The Bahamas, it is necessary to collect and understand data regarding these three constructs. Such information could lead to an improvement in the accessibility and utilization of mental health services.

Hypothesis 4: An individual's attitudes and beliefs toward mental illness will mediate the relationship between person's level of religiosity and self-stigma in seeking help for mental health issues.

Null Hypothesis: There is no relationship between an individual's attitudes and beliefs toward mental illness, their level of religiosity, and their level of self-stigma in seeking help.

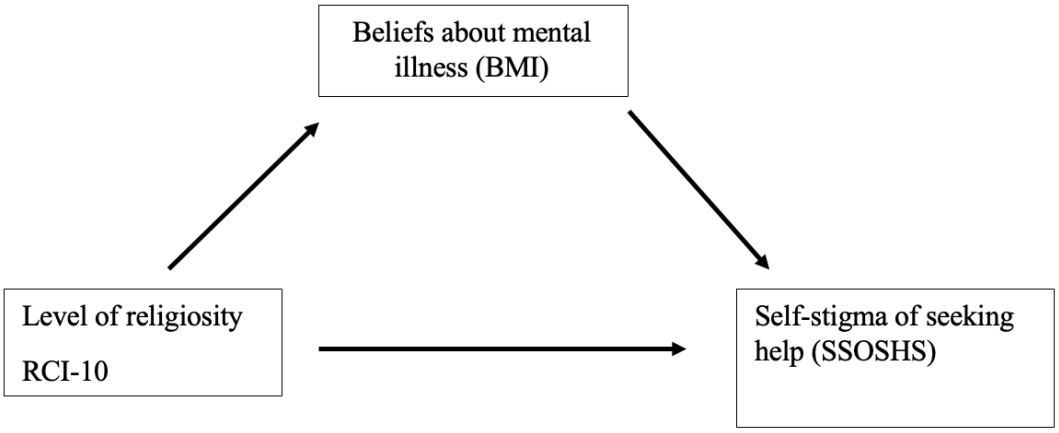
Design

The research design used for this study was a quantitative, non-experimental cross-sectional design. This design is used when two or more variables are not manipulated but the intent is to measure characteristics and then calculate the relationship between them (Curtis et al., 2016). Another study that sought to measure these beliefs toward mental illness, religiosity, and self-stigma has also utilized a non-experimental cross-sectional design (Ocho et al., 2023).

A mediation model was utilized, because in this study the researcher was seeking to determine the mediating effect of beliefs toward mental illness on the relationship between religiosity and self-stigma. The literature confirms that religiosity and self-stigma have an existing relationship, and the mediating variable of beliefs toward mental illness is predicted to impact that relationship.

Figure 1

Proposed conceptual model



Participants and Setting

The participants for the study included 300 adults (18 and over) who identified themselves as Christian and attended church services. All the churches were in Grand Bahama and were from different denominations: Anglican, Baptist, Presbyterian, Catholic, and Non-Denominational. The inclusion criteria of this study indicated that participants must be Bahamian citizens through birth or naturalization, acknowledge understanding the consent form, and be at least 18 years of age.

Instrumentation

The measures used in this study were the Self Stigma of Seeking Help Scale (Vogel et al., 2006), the Beliefs toward Mental Illness Scale (Hirai & Clum, 2000), the Religious Commitment-10 (Worthington et al., 2003), and The Social Desirability Scale (Drwal et al.,

1980), which was also included to add validity to the study. Demographic information was also collected.

Self-Stigma of Seeking Help Scale (SSOSH) is a 10 item measure that was derived from the original 28 question scale created by Vogel, Haake, and Wade (Vogel et al., 2006). The scale has an internal consistency of .91 and a unidimensional factor solution suggesting that it is measuring a single construct (Vogel et al., 2006). The SSOSH was designed to measure self – stigma, which research supports as the most cited reason why individuals refuse to seek treatment (Corrigan et al., 2004; Vogel et al., 2006; Vogel et al., 2013; Vogel et al., 2017). This scale has been widely used in many research studies, and specifically with cross-cultural studies, which was appropriate in the context of this Bahamian study (Nohr et al., 2021; Vogel et al., 2013). Questions on the survey include: "I would feel inadequate if I went to a therapist for psychological help," and "My self-confidence would not be threatened if I sought professional help." Participants responded using a 5-point Likert scale of 1 (strongly disagree) to 5 (strongly agree) (Adam et al., 2020).

Religious Commitment Scale – 10 (RCI-10). The RCI-10 is designed to assess the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living (Worthington et al., 2003). The reliability of the RCI-10 is .88. This scale is frequently used in research because other religious measures were developed for use with individuals in Judaic and Christian traditions and focused mostly on the degree to which a person believes in traditional doctrine (Worthington, 2003). Questions in this survey include: "My religious beliefs lie behind my whole approach to life," and "I spend time trying to grow in understanding of my faith."

Beliefs Toward Mental Illness (BMI). The BMI scale was developed in the United States in 2000 by Hirai and Clum. The scale was designed to measure the positive and negative beliefs of individuals with different cultural characteristics toward mental illness. The 21item survey uses a six-point Likert scale with responses ranging from "totally disagree" (0) to "totally agree" (5). There are three dimensions assessed on the BMI—dangerousness, poor social and interpersonal skills, and incurability. For the dimension of dangerousness, a sample question is: "A mentally ill person is more likely to harm others than a normal person"; for the dimension of poor social and interpersonal skills, a sample question is: "The 'term' psychological disorder' makes me feel embarrassed"; and for the dimension of incurability, a sample question is: "Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life." The validity and reliability have an alpha Cronbach's coefficient of 0.89. A high score on the BMI indicates a negative belief toward mental illness.

Questionnaire for Social Desirability Scale (KAS). The Social Desirability Scale is designed to measure the intensity of a person's desire to be accepted by other people, or how likely they are to behave in a way that is socially accepted (Drwal et al., 1980). Developed in the 1980s, the questionnaire has 29 items which describe behaviors indicating a clear social desirability or disapproval (Zarzycka et al., 2011). The alpha Cronbach's coefficient, which illustrates the reliability of the KAS scale, was 0.81. The KAS correlates positively with similar scales and other questionnaires, liable to the influence of social desirability: the Edwards SDS (r ¼ 0.38), the Marlowe and Crowne SDS (r ¼ 0.46), and the Delta Questionnaire (r ¼ 0.49) (Drwal, 1995). This scale provides validity to the present study as it was helpful to measure the level of need for social approval (Zarzycka et al., 2011).

Procedures

The pastor of each local church was contacted with a letter requesting permission for dissemination of information regarding the study. Pastors were provided with a letter that was read to the congregation explaining the study and what the data would be used for. Individuals were advised that their information would be kept anonymous. Once permission was secured, the researcher and pastor secured a date that the questionnaire would be emailed to church members. Individuals were emailed a link to participate in the online survey. Upon opening the email, individuals were required to read the informed consent, which outlined the purpose of the study, benefits and risks, inclusion criteria, and IRB approval along with contact information for the researcher if participants had questions or concerns. If individuals agreed to participate and met the criteria, they then responded to the scales provided. Participants were informed that they could withdraw from the study at any point by exiting the screen and answers would not be recorded.

Data Processing and Analysis

The data were collected and downloaded into SPSS and the Hayes PROCESS macro that correlates to model 4. The data were screened for normal distribution and any outliers. Further statistical analysis provided descriptive statistics, and regression analyses of the research questions and null hypotheses were performed. This section describes the data analysis for each research question. The researcher used IBM SPSS Statistics Version 29 with the PROCESS macro to analyze data from the cross-sectional design (Hayes, 2018).

RQ1: What is the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues?

Model 4 of Process Macro for SPSS (Hayes, 2018) was used to test the relationship between scores on the DUREL/Religious Commitment Scale and scores on the Self-Stigma of Seeking Help for mental health issues.

RQ 2: What is the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness in general?

Model 4 of Process Macro for SPSS (Hayes, 2018) was used to test the relationship between scores on the Religious Commitment Scale and the scores on the Beliefs Toward Mental Illness Scale.

RQ3: What is the relationship between a Bahamian person's beliefs toward mental illness and a Bahamian person's self-stigma of seeking help for mental health issues?

Model 4 of Process Macro for SPSS (Hayes, 2018) was used to test the relationship between scores on the Beliefs toward Mental Illness and the Self-Stigma of Seeking Help for Mental Health Issues.

RQ4: To what extent does a Bahamian person's attitudes and beliefs toward mental illness mediate the relationship between a Bahamian person's level of religiosity and self-stigma of seeking help for mental health issues?

Model 4 of Process Macro for SPSS (Hayes, 2018) was used to test the relationship between scores on the beliefs toward mental illness mediates the relationship between religiosity and self-stigma of seeking help.

Ethical Considerations

IRB approval was gained from the review board at Liberty University prior to conducting the survey. Participants were solicited through local churches on Grand Bahama through wide emails sent out from the pastors of each church to the church's email directory. The respondents

to the survey request were directed to a provided link that opened with an informed consent. Respondents did not have access to the survey until the informed consent was signed. After the informed consent was obtained, the participants were allowed to start the survey. The participants' risk was minimal because the study was non-experimental and there was no treatment given. However, should any participant experience any emotional distress, they were free to terminate the study at any time and information for counseling services was provided.

Chapter Summary

This chapter presented the proposed methodology by outlining the research design and procedures needed to conduct the study. The selection of participants, instrumentation, type of statistical analysis used, research questions, and hypotheses were discussed and a proposed conceptual diagram of the research model was provided.

CHAPTER FOUR: RESULTS

Chapter four provides the results for the study. First, the purpose of the study is restated; next, descriptive statistics are provided, each research question is described with the corresponding statistical test result, and a summary of the chapter is provided.

Restatement of the Purpose

This study aimed to examine the relationship between religiosity, beliefs toward mental illness, and the self-stigma of seeking help within the Bahamian population. The current literature supports that mental health issues are rising globally, and individuals are not receiving treatment (Choudry et al., 2016). Although many studies have examined these common barriers to receiving treatment and ways to increase the utilization and accessibility of mental health services in diverse countries, to date, no studies have explored these constructs among the Bahamian people.

Mental health concerns have been categorized as a number one priority for The Bahamas, and a strong effort for the detection, prevention, and treatment of mental illnesses is highly recommended by the World Health Organization (WHO, 2017). Mental health is further complicated when religiosity, stigma, and belief about mental illness interact in small developing countries. Therefore, this study's research questions addressed the Bahamian population's beliefs toward mental illness, how religiosity may also influence these beliefs, and ultimately their impact on help-seeking behaviour. The study's significance is that it may inform clinical practitioners and key stakeholders of ways to increase an individual's desire to seek counseling services and overall create better access to mental health services.

Descriptive Statistics (Data Screening, Preparation, and Description)

The survey was conducted through the SurveyMonkey platform. Once the targeted sample number was acquired, data were exported from SurveyMonkey into IBM's SPSS Statistics Version 28. A total of 114 participants started the study, with 14 participants who did not complete the questionnaire segment. Three participants said they were non-Bahamian which eliminated their data from the survey, and eight participants answered portions of demographic information but not completely. To ensure that data were cleaned and ready for analysis, any cases with missing data were eliminated. The number of completed surveys totaled 89 (n=89).

The variables were relabeled with shorter names, survey questions were changed to ordinal data rather than nominal, and survey questions were computed into the three scales required for the study. Once the scales were computed, the mediation analysis was conducted utilizing PROCESS by Hayes (2018) model 4.

Participant Demographics

To qualify for inclusion in the study, participants had to be 18 years of age or older and had to be Bahamian through birth or naturalization. Upon meeting the criteria, demographic data were collected and participants began assessments of beliefs toward mental illness, religious commitment, and the self-stigma of seeking help.

Demographics were collected for sex, race, religious affiliation, age, educational background, marital status, and annual income. The sample included 54 females (38.2%), 34 males (60.7%), and 1 individual who preferred to not say (1.1%). The ages ranged from 18 to over 55 with the largest percentage of 29.2% in the 45-54 age range (n=26), 28.1% in the over 55 range (n=25), 23.6% in the 35-44 age range (n=21), 18% in the 25-34 range (n=16), and 1.1% in the 18-24 age range (n=1). The religious affiliations were mostly 56.2% Non-Denominational (n

=50), 16.9% Other (n=15), 7.9% Baptist (n=7), 5.6% Presbyterian (n=5), 5.6% Pentecostal (n=5), 3.4% Brethren (n=3), and 2.2% for both Catholic (n=2) and Anglican (n=2). Participants were 93.3% Bahamian through birth (n=83) and 6.7% Bahamian through naturalization (n=6). 78.7% of participants were Black/African (n=70), 6.7% White/Caucasian (n=6), 1.1% Asian/Pacific Islander (n=1), and 13.5% were other (n=12). Marital status for participants included 73% married (n=65), 18% single (n=16), 4.5% separated (n=4), 3.4% divorced (n=3), and 1.1% widowed (n=1).

Table 4.1

Participant Demographics

Variable	N	%
Age		
18-24	1	1.1
25-34	16	18
35-44	21	23.6
45-54	26	29.2
0ver 55	25	28.1
Nationality		
Bahamian by birth	83	93.3
Bahamian by naturalization	6	6.7
Marital Status		
Single	16	18
Married	65	73
Separated	4	4.5
In a domestic partnership	0	0
Divorced	3	3.4
Widowed	1	1.1
Religious Denomination		
Baptist	7	7.9
Anglican	2	2.2
Presbyterian	5	5.6
Catholic	2	2.2
Brethren	3	3.4
Non-Denominational	50	56.2
Pentecostal	5	5.6
Other	15	16.9

Highest Level of Education		
Completed Primary School	1	1.1
Some High School	3	3.4
Graduated from High School	18	20.2
1 year of college	3	3.4
2 years of college	6	6.7
3 years of college	5	5.6
Graduated from College	38	42.7
Some Graduate School	1	1.1
Completed Graduate School	14	15.7
Annual Income		
Under $20,000.00	14	15.7
Between $20,000.00 and $50,000.00	43	48.3
Between $50,000.00 and $80,000.00	15	16.9
More than $80,000.00	6	6.7
Prefer not to say	11	12.4
Ethnicity		
White/Caucasian	6	6.7
Black/African American	70	78.7
Hispanic/Latino	0	0
Native American/American Indian	0	0
Asian/Pacific Islander	1	1.1
Other	12	13.5
Gender		
Male	34	38.2
Female	54	60.7
Prefer not to say	1	1.1

Sample Description Statistics for All Study Variables

The Descriptive Statistics are provided for the three study variables/scales: Self-stigma of Seeking Help, Beliefs about Mental Illness, and the Religious Commitment Inventory. The minimum and maximum scores are provided along with the mean and standard deviation. These results are in Table 4.2.

Table 4.2

Descriptive statistics of all measures used in this study.

Measure	N	Minimum	Maximum	*M*	*SD*
SSOSH	89	18	38	27.92	3.265
BMI	89	27	84	54.51	9.897
RCI	89	24	50	40.70	6.847

Data Analysis

To answer the research questions one statistical test had to be completed. Model 4 Process by Andrew Hayes allows one to perform a multiple linear regression and a mediation simultaneously. This analysis provided the results for the relationship between religiosity and beliefs toward mental illness, beliefs toward mental illness and the self-stigma of seeking help, and the direct and indirect effect of the relationship between religiosity and self-stigma of seeking help mediated by beliefs toward mental illness. When determining whether the effect that each variable has within the model was significant or not, the p-value cut-off for this study's significance was less than .05, and the confidence interval between the lower limits (LLCI) and the upper limits (ULCI) did not include zero. Results from the analysis are given in Table 4.3

Table 4.3

Results for the Mediation Model

					95% CI	
Source	*b*	*SE*	*t*	*p*	*LL*	*UL*
BMI: *R* = .0324, *R-sq* = .0010, *MSE* = 96.69, *F*(.0883), *dfl* (1), *df2* (84), *p* <.05						
Religious (RCI)	-.0463	.1557	-.2971	.7671	-.3560	.2634
SSOSH: *R* = .3188, *R-sq* = .1016, *MSE* = 23.67, *F* (4.69), *dfl* (2), *df2* (83), *p* < .05						
Religious (RCI)	-.0907	.0771	-1.1764	.2428	-.2440	.0627
Beliefs (BMI)	.1506	.0540	2.7895	.0065	.0432	.2580

RQ 1: What is the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues?

Hypothesis 1:

The level of religiosity will have a statistically direct effect on an individual's level of self-stigma of seeking help, meaning that as the level of religiosity increases, an individual's self-stigma increases.

This research question sought to establish the relationship between the two variables and to explore how much impact an individual's level of religiosity has on their self-stigma of seeking help. Model four of Hayes's (2018) PROCESS macro v4.2 in SPSS version 28 with 95% confidence intervals and 5000 bootstrap samples was used to test the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues. There appeared to be no direct relationship between a Bahamian person's level of

religiosity and self-stigma of seeking help (*b*= -.0907, SE = .0771, CI = [-.2440 to .0627]), and thus the hypothesis was not supported.

RQ 2: What is the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness in general?

Hypothesis 2

The level of religiosity will have a statistically significant impact on an individual's beliefs toward mental illness. This means that as an individual scores higher on their levels of religiosity, their beliefs toward mental illness will be more negative.

Model four of Hayes's (2018) PROCESS macro v4.2 in SPSS version 28 with 95% confidence intervals and 5000 bootstrap samples was used to test the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness. There was no statistical significance in the relationship between these two variables (r = .0324, r-sq = .0010, p = 0.7671). Results showed that a Bahamian person's level of religiosity was not a significant predictor of their beliefs about mental illness in general (*b*= -.0463, SE = .155, 95% CI [-.3560, .2634]), and the hypothesis was not supported.

RQ3: What is the relationship between a Bahamian person's beliefs toward mental illness and a Bahamian person's self-stigma of seeking help for mental health issues?

***Hypothesis 3*:**

There is a statistically significant relationship between an individual's beliefs toward mental illness and their levels of self-stigma of seeking help. This means that when an individual holds a negative view about mental illness, there will be an increase in self-stigma.

Model four of Hayes's (2018) PROCESS macro v4.2 in SPSS version 29 with 95% confidence intervals and 5000 bootstrap samples was used to test the relationship between a

Bahamian person's belief toward mental illness and their self-stigma of seeking help for mental health issues. Findings suggested a positive relationship between beliefs toward mental illness and self-stigma of seeking help (r=.3188, r-sq = .1016), and results showed that there was statistical significance as evidenced through the *p* value (p =.0065, *b*= .1506, SE = .0540, 95%CI = [-.0473, .0929]), and the hypothesis was supported.

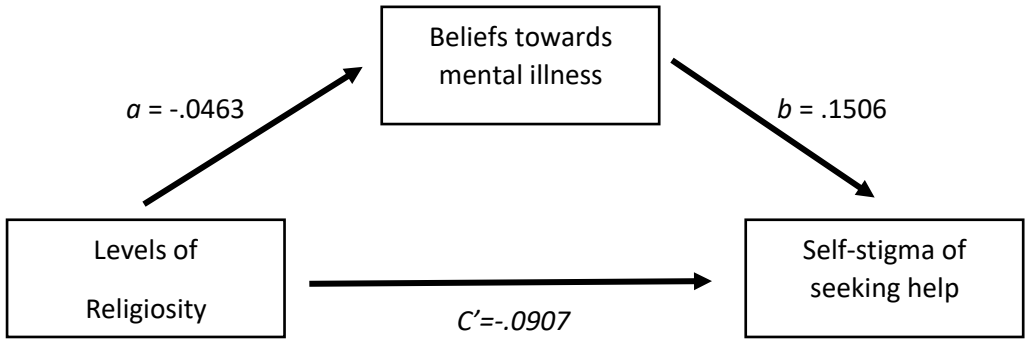
RQ4: To what extent does a Bahamian person's attitudes and beliefs toward mental illness mediate the relationship between a Bahamian person's level of religiosity and self-stigma of seeking help for mental health issues?

Hypothesis 4

An individual's attitudes and beliefs toward mental illness will mediate the relationship between person's level of religiosity and self-stigma of seeking help for mental health issues. This question sought to evaluate the mediating effect of beliefs toward mental illness, with the goal of obtaining a greater understanding of how beliefs toward mental illness can have an effect on self-stigma of seeking help. Model four of Hayes's (2018) PROCESS macro v4.2 in SPSS version 28 with 95% confidence intervals and 5000 bootstrap samples was used to test the extent to which a Bahamian person's beliefs toward mental illness mediate the relationship between a Bahamian person's level of religiosity and self-stigma of seeking help for mental health issues. The findings showed that the mediation was not significant (SE= .0070, 95% CI [-.0185, .0115], thus the proposed mediation model was not supported. The analysis on the proposed model is shown in Figure 1.

Figure 1

Mediation model



Chapter Summary

This chapter reported the results of this research study, which included demographic information and statistical analysis. The participants were recruited through pastors in local churches. The pastors received the electronic link to the survey on SurveyMonkey, with the first page being an informed consent. The data gleaned from the survey were entered into IBM's SPSS Version 28 (2023) and Hayes Process Macro (2018) for statistical analysis. Model 4 of Hayes Process Macro (2018) was used to analyze a mediation model.

Research Question One studied the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues. Hypothesis One stated that the level of religiosity is predictive of whether an individual has a higher level of self-stigma of seeking help. If an individual scores high on religiosity, then they would score high on self-stigma, indicating that they would seek out help less often. This was not found to be true, as no significant effect was found.

Research Question Two sought to determine the relationship between a Bahamian person's level of religiosity and their beliefs about mental illness in general. Hypothesis Two

stated that the level of religiosity is predictive of whether they have positive or negative beliefs about mental illness. The higher the level of religiosity, the more negative their belief about mental illness will be. This was not found to be true, as no significant effect was found.

Research Question Three examined the relationship between a Bahamian person's attitudes and beliefs about mental illness and a Bahamian person's self-stigma of seeking help for mental health issues. Hypothesis Three stated that if an individual has a negative belief about mental illness, they will have high scores on self-stigma of seeking help, indicating that they would seek out help less often. This was found to be true, as a significant effect was found.

Research Question Four sought to determine whether beliefs toward mental illness would mediate the relationship between levels of religiosity and self-stigma of seeking help. Findings suggest that beliefs toward mental illness did not mediate the relationship between levels of religiosity and self-stigma of seeking help.

The summary of the findings, limitations of the study, implications for clinical practice and research, and recommendations for further research are discussed in the next chapter.

CHAPTER FIVE: SUMMARY, LIMITATIONS, AND RECOMMENDATIONS

The current study sought to understand the relationship that self-stigma has with levels of religiosity and beliefs toward mental illness among the Bahamian population. Mental health concerns are growing at alarming rates globally (Choudry et al., 2016; Velasco et al., 2020). There are many individuals who struggle with mental health concerns but do not receive treatment (Gomez-Dantes et al., 2018; Noorain et al., 2022). This problem is magnified in developing countries such as The Bahamas (Keva et al., 2014; Kwangu et al., 2017). Developing countries have vulnerabilities, including small size, remoteness, and susceptibility to climate change (Walker et al., 2022). Such vulnerabilities lead to an increase in mental and emotional health incidents, but with limited resources that are often diverted to areas other than mental health (Rathod et al., 2017).

Literature highlights several barriers that exist for individuals when seeking help including stigma, financial struggles, and lack of sufficient and efficient services. The most prominent barrier is stigma (Velasco et al., 2020). Additionally, within the context of The Bahamas, religion plays an integral role in the daily lives of the average Bahamian, and the general beliefs about mental illness are largely unknown among this population. Among these three constructs, this researcher sought to explore the relationships and to test for mediation. There are ways in which these constructs interact; however, only one hypothesis of four had statistical significance. This effect was found between beliefs toward mental illness and self-stigma of seeking help.

This chapter explores the implications of this study's findings. Research questions one, two, and three are discussed and the mediating relationship of beliefs toward mental illness on the relationship between levels of religiosity and self-stigma of seeking help are explored. The

chapter describes 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 pastors of local churches with a letter requesting permission for dissemination of information regarding the study. Individuals were emailed a link to participate in the online survey. The survey was conducted through the SurveyMonkey platform. Once the targeted sample number was acquired, data were exported from SurveyMonkey into IBM's SPSS Statistics Version 28. A total of 114 participants began the study, there were 14 participants who did not complete the questionnaire segment. Three participants were eliminated as they responded as non-Bahamians, and 8 participants answered portions of demographic information but not completely. To ensure that data were cleaned and ready for analysis, any cases with missing data were eliminated. The total number of completed surveys totaled 89 (n=89).

Additionally, participants were also majority female (38.2%), the largest age range was 45-54 (29.2%), religious affiliations were mostly 56.2% Non-Denominational (n =50), and 78.7% of participants were Black/African (n=70). Analysis of the data was conducted through IBM's SPSS Statistics program utilizing Hayes's (2018) PROCESS macro. The cross-sectional data were analyzed with current statistical procedures and regression analysis. Each hypothesis was evaluated, examining relational effects of the different variables—levels of religiosity, beliefs toward mental illness, and self-stigma of seeking help.

RQ 1: What is the relationship between a Bahamian person's level of religiosity and their self-stigma of seeking help for mental health issues?

Hypothesis 1 The level of religiosity will have a statistically significant direct effect on an individual's level of self-stigma of seeking help.

This hypothesis was not supported through the results. There was no significant direct effect between the level of religiosity and an individual's level of self-stigma of seeking help. The literature review suggested that the stigma experienced in general settings tends to be amplified in religious settings, as oftentimes the conceptualization of an individual's psychological problems is primarily seen as spiritual or religious (Freire et al., 2016). Therefore, individuals perceive seeking professional help as conflicting with their religious beliefs (Freire et al., 2016). Studies that have sought to examine the relations between religion and stigma have discovered similar findings of a positive relation between these constructs indicating that increased levels of religiosity are strongly associated with increased stigma (Adu et al., 2021).

A positive relation was expected between the level of religiosity and an individual's level of self-stigma of seeking help based on previously mentioned studies. However, this was not the case in the present study. There may be a few explanations for why these findings were not consistent with the literature. One of the studies (Freire et al., 2016) utilized a mixed-methodology and one method of collecting data was through interviewing individuals in a focus group. These interviews may have allowed the researcher to create a richer picture of a person's religiosity as opposed to a scale, which limits answers to the range provided. The terminology in the previously-mentioned study was also interchangeable between 'religiosity' and 'spirituality.' This could indicate that individuals in the current study were more connected to the term 'spirituality' and therefore the term 'religiosity' did not capture their full perspective on level of religious commitment.

The study conducted in Ghana to explore the relationship between religiosity, stigma, and education about mental disorders utilized a sample size of 409 (Adu et al., 2021). The sample size was 89 after cases with excessive missing data were eliminated. This smaller sample size could have contributed to insignificant results.

RQ 2: What is the relationship between a Bahamian person's level of religiosity and their beliefs toward mental illness in general?

Hypothesis 2 The level of religiosity will have a statistically significant effect on an individual's beliefs toward mental illness.

This research question explored the relationship between a Bahamian person's level of religiosity and their beliefs toward mental illness. Although findings suggest that there is some impact, the effect was not statistically significant. One reason for this could be a lack of education. The Bahamian population is not familiar with the field of mental health and so the possibility exists that participants did not understand the Beliefs toward Mental Illness survey or terminology. Previous literature addresses that the relationship between religion and mental health is quite complex (Moreno et al., 2022). The pendulum has swung from religious groups caring for the mentally ill to the infamous words of Sigmund Freud that religion was an illusion, a sign of neurosis (Cook, 2020; Larkin et al., 2020). However, the most current view held in recent literature is that religion serves as a helpful resource for individuals struggling with mental health (Cook, 2020; Weber et al., 2014). In this study, the discrepancy in findings as compared to earlier research may be tied to the perspective that any understanding of mental illness is better explained by biological sources and therefore an individual's level of religiosity does not influence their beliefs toward mental illness, as the two variables are seen as separate.

RQ3: **What is the relationship between a Bahamian person's beliefs toward mental illness and a Bahamian person's self-stigma of seeking help for mental health issues?**

Hypothesis 3 : There is a statistically significant direct effect between an individual's beliefs toward mental illness and their levels of self-stigma of seeking help.

The relationship between a Bahamian person's beliefs toward mental illness and a Bahamian person's self-stigma of seeking help did show statistical significance (p =.0065, *b*= .1506, SE = .0540, 95%CI = [-.0473, .0929]), and therefore the hypothesis is supported. The result informs that if an individual holds a more negative view about their beliefs toward mental illness, their self-stigma would be high, which would indicate that they would seek out help less often. Earlier research states that people develop conceptions of what others think of mental patients long before they become patients (Link, 1987). This adds strength to the findings that if an individual holds a negative view of beliefs toward mental illness their self-stigma would be high as well.

This result provides critical insight regarding the variable that has an impact on self-stigma. It provides the researcher with guided direction towards the current mindset of the Bahamian population about beliefs toward mental illness. These findings suggest that if individuals can learn more about mental illness and have a better understanding, this would reduce their self-stigma and they would seek out treatment options more.

As previous research stated, self-stigma is often accompanied by a phenomenon "Why try" indicating that individuals troubled by self-stigma are often discouraged from pursuing the types of opportunities that are important to achieving goals in life because of diminished self-esteem and self-efficacy (Corrigan et al., 2009). In other words, self-stigma has been found to play a forceful role in seeking psychological services, the effectiveness of psychological

treatment and the recovery from mental illness (Corrigan et al., 2012). This study has provided insight into the possibilities of ways to help those struggling with high levels of self-stigma.

RQ4: **To what extent does a Bahamian person's attitudes and beliefs toward mental illness mediate the relationship between a Bahamian person's level of religiosity and self-stigma of seeking help for mental health issues?**

Hypothesis 4

An individual's attitudes and beliefs toward mental illness will mediate the relationship between a person's level of religiosity and self-stigma of seeking help for mental health issues.

Model 4 of Process Macro for SPSS (Hayes, 2018) was used to test the relationship of beliefs toward mental illness as the mediator between religiosity and self-stigma of seeking help. The results were not statistically significant and thus the hypothesis was not supported, meaning there was no mediation.

One explanation for why these findings were not consistent with the literature could be that the population is not familiar with mental illness, and this may have affected their comprehension of the surveys. Previous literature has shown that beliefs about the causes of mental illness are largely influenced by personal experiences, education, broad cultural perspectives, and stigma (Stefanovics et al., 2016), and that these beliefs are then major determinants of behavior (Stefanovics et al., 2016). Considering this literature, beliefs toward mental illness play an integral role, but perhaps not as a mediator between these two constructs.

Although the finding for beliefs toward mental illness as a mediator was not significant, future research may need to explore the impact of the same variables in different ways. Potential future research endeavors are outlined later in this chapter.

Limitations of the Study

There are several limitations identified in the study. The first limitation is the design of the study. While the design of a quantitative study allows for consistent data collection and analysis, a mixed-method approach could have added more depth and insight. This study had several variables that are difficult to measure exactly. Religiosity is such a vast idea that even though a well-constructed scale can measure a sense of religiosity, open-ended questions could allow participants to share a richer picture of their mindset if there were some components of an interview design within the study (Tenny, 2017).

Another limitation was the lack of addressing culture, which was difficult to observe and measure for the Bahamian population; however, through literature it is undebatable that the process of acculturation plays an integral part in the development of the Bahamian people. The influence of the British, American Loyalists, and African culture have all influenced the Bahamian culture. Thus, culture is a central component to understanding the etiology of mental disorders (Yamada et al., 2013); however, a new scale would need to be created specifically for the Bahamian population, because the culture is a combination of many other cultures and the time needed to explore and design that option was not available.

Lastly, another limitation of the study was the surveys used. Although the reliability and validity criteria for all scales were acceptable there were still risks of errors with the questions being misunderstood or not comprehended well. As stated before, to date there were no studies conducted in The Bahamas that measured these constructs. Additionally, studies on the topic of mental health are not common. Therefore, the population may not have been educated about the terms and constructs, but this is unknown due to the specificity of the scale. In other words, there was no space to state that a participant did not understand the question. Most scales would have a

neutral option to indicate the middle section of a likert rating, but not a response to indicate that they do not understand the question.

Clinical and Counselor Education Implications

This current study evaluated the relationships between level of religiosity, self-stigma, and beliefs toward mental illness among the Bahamian population. Specifically, this study sought to determine if beliefs toward mental illness transmitted an effect on the outcome variable self-stigma of seeking help. While most of the hypotheses were not supported statistically, there was significance in the relationship between beliefs toward mental illness and self-stigma of seeking help. Findings such as these could have implications for society at large, counselors, counselor educators, religious organizations, and future researchers.

Due to the rapid increase in mental health concerns (Choudry et al., 2016; Kilbourne et al., 2018; Vigo et al., 2016) and the large percentage of individuals that do not receive treatment especially in developing countries, The Bahamas can benefit from further understanding the factors which influence change in seeking help (Gomez-Dantes et al., 2018; Keva et al., 2014; Kwangu et al., 2017; Noorain et al., 2022).

One previous study showed that individuals of all ages are reluctant to seek help; in this German study, only 41% of students diagnosed with depression or anxiety had ever received treatment, and only 34% of adults diagnosed with a mental illness had sought help (Gulliver et al., 2010). These statistics urge researchers to consider the factors that act as barriers to individuals who need psychological help.

Among the major barriers to seeking help, stigma is the most prominent (Corrigan et al., 2004; Velasco et al., 2020; Vogel et al., 2006; Vogel et al., 2013; Vogel et al., 2017). Research has focused on public stigma for a long time (Dubreucq et al., 2021), but evidence of the

negative effects of self-stigma is growing. Findings from this current study showed that beliefs toward mental illness had an effect on self-stigma of seeking help. Such information can benefit counsellors who are seeking ways among the Bahamian population to lower self-stigma and increase utilization of mental health services. New interventions such as educational campaigns to inform the population about mental illness can be considered to ensure that accurate information is shared and understood about mental illness. Mental Health Literacy (Furnham & Swami, 2018) is an intervention program that encompasses knowledge about mental health disorders and is associated with their recognition, management, and prevention. With the information learned from the findings that beliefs toward mental illness had a statistically significant impact on self-stigma of seeking help, counsellors can specifically target areas that will reduce or eliminate the barrier of self-stigma.

Despite the other relationships in the study lacking statistical significance, such results are also helpful. The hypotheses that pertained to the effects of religiosity on beliefs toward mental illness and self stigma were not supported by the findings; this can inform counsellors that perhaps the cultural perception of religiosity as the driving force behind much change may not be the case. Religiosity of course is present, and counsellors must remain aware of this facet of an individual, but perhaps careful attention is given to its rightful context.

Counselor educators can gain insight from these findings, as they train the future counsellors. CACREP counselling curriculum (Cacrep Standards, 2024) outlines one of eight key areas as Social and Cultural Identities and Experiences:

> 2. The influence of heritage, cultural identities, attitudes, values, beliefs, understandings, within-group differences, and acculturative experiences on individuals' worldviews.

> 3. The influence of heritage, cultural identities, attitudes, values, beliefs, understandings, within-group differences, and acculturative experiences on help-seeking and coping behaviors (p. 13).

Counselor educators are directly meeting this requirement when a research study is carried out among diverse populations and the results are shared. This study heightens the importance of cultural sensitivity, which is a critical part of the counselling relationship and the importance of a counsellor educator. For example, the counsellor educator can articulate the challenges of developing countries and the consistent lack of accessibility and utilization of mental health services.

Supervision Implications

One of the roles as a counsellor educator is to provide supervision. Supervision is a multi-faceted process for cultivating counselling competencies, and quality client care (Swank et al., 2021). This may include working with individual, triadic or groups with trainees on personal growth, and skill development (Wester, 2019). In the ACA code of ethics (2014), Section F, and Section G outline some of the key areas that directly relate to the findings of this study: multicultural/diversity competence, and self-growth experiences.

The findings in this study had statistical significance between the relationship of beliefs toward mental illness and the self-stigma of seeking help. The literature review demonstrated that acculturation plays a major role in the cultural identity and belief system of Bahamians. The Bahamian culture has been informed about mental illness through the British influence, American Loyalists and the African slave trade. When we understand some of the contributing factors in developing beliefs toward mental illness, there is a platform to influence positive change and provide accurate information from which beliefs can be formulated. During the

supervision process, discussions around these findings can lead to a greater awareness of the negative impacts of heritage and how it can limit accessibility to seeking help especially among clients who are of the minority and diverse.

Additionally, a common area that requires development throughout the supervision process is helping supervisees gain self-awareness about their own stigma toward mental illness and how their spiritual beliefs impact their worldview (Swank et al., 2021). While levels of religiosity did not appear to have an impact on the relationship to self-stigma of seeking help in this study, exploring the spiritual belief system of supervisees can help them to understand the influence of their beliefs on their worldview. Activities that encourage self-reflection in these areas can help supervisees gain clarity and ensure that they are not perpetuating the stigma.

Suggestions for Future Research

Future research should continue exploring the experience of self-stigma and ways to reduce this barrier, thus increasing the desire to seek help. Often-times stigma is implicit, and participants may not be aware of their own bias towards admitting this. A qualitative design could capture this phenomenon so that a deeper probing of an individual's thoughts toward this topic could be explored.

Additionally, future research could utilize different surveys to measure the same constructs and compare the findings. It was expected that religiosity would influence self-stigma and beliefs toward mental illness, however this was not the case despite what previous literature indicated. This could be attributed to the use of scales and perhaps different scales could yield different findings such as increased variance that is accounted for, which could help researchers and clinicians better understand religiosity and its influence.

Since there was statistical significance in the relationship between beliefs toward mental illness and self-stigma of seeking help, this could be an area for future research. Studies could explore an experimental design of pre- and post-testing with groups that are provided psychoeducational training on mental illness, and through pre- and post-testing both groups could be compared; results could increase the knowledge of the population regarding beliefs toward mental illness.

Conclusions

Mental health concerns are growing rapidly and globally, with mental health costs estimated to rise to 6 trillion by 2030, as mentioned several times previously (Bloom et al., 2012; Knapp et al., 2020). Studies in America suggest that of the 51 million adults with a mental health illness, only 23 million seek out and receive psychological help (Moreno et al., 2022). Developing countries such as The Bahamas are at a significant risk for providing adequate services due to several barriers (Keva et al., 2014; Kwangu et al., 2017). While there are many barriers cited in literature, the barriers that were selected for this study were self-stigma, religiosity, and beliefs toward mental illness.

Due to the dearth of research conducted in The Bahamas and specifically the lack of studies conducted on these constructs, this study sought to explore these relationships and utilize findings to help clinicians and counselor educators, and to add information to the present body of knowledge. Out of four hypotheses, there was only one relationship that had statistical significance: beliefs toward mental illness and self-stigma of seeking help. Such findings can help researchers to understand more about the mindset of the Bahamian population towards these constructs. More education is needed to create a better understanding of mental illness among the culture and specifically the religious communities who were the sole participants. These findings

are important for clinicians to recognize how best to address the current barriers that exist for individuals struggling with mental health concerns.

References

Abuhammad, S., & Al-Natour, A. (2021). Mental health stigma: The effect of religiosity on the stigma perceptions of students in secondary school in Jordan toward people with mental illnesses. *Heliyon, 7*(5). https://doi.org/10.1016/j.heliyon.2021.eo6957

Adam C., Pace, J., & McGuire, M. (2020) The relationship of self-stigma of depression to evangelical beliefs and religious practices. *Mental Health, Religion & Culture*, *23*(9) 777-788. https://doi.org/10.1080/13674676.2020.1823348

Adu, P., Jurcik, T., & Grigoryev, D. (2021). Mental health literacy in ghana: Implications for religiosity, education and stigmatization. *Transcultural Psychiatry*, *58*(4), 516-531. https://doi.org/10.1177/13634615211022177

Allport, G.W., & Ross, J.M. (1967). Personal religious orientation and prejudice. *Journal of Personality & Social Psychology*, *5*(4), 432–443. https://doi.org/10.1037/h0021212

Bass, J.K., Bolton, P.A., & Murray, L.K. (2007). Do not forget culture when studying mental health. *The Lancet*, *370*(9591), 918-919.https://doi.org/10.1016/S0140-6736(07)61426-3

Battle-Baptiste, W. (2017). Cruise ships, community, and collective memory at millars plantation, eleuthera, bahamas. *Historical Archaeology*, *51*(1), 60-70. https://doi.org/10.1007/s41636-017-0008-4

Berry. J.W. (2019). *Acculturation: A personal journey across cultures*. Cambridge University Press.

Blebil, A., Dujaili, J., Shuang, A.T., & Ying, T.P. (2022). Malaysian pharmacy students' knowledge, attitudes and perceptions on mental health: A cross-sectional study. *International Journal of Mental Health & Addiction, 20*(5), 2851–2864. https://doi.org/10.1007/s11469-021-00553-8

Campbell, F.A., Pungello, E.P., & Miller-Johnson, S. (2002). The development of perceived scholastic competence and global self-worth in african american adolescents from low-income families: The roles of family factors, early educational intervention, and academic experience. *Journal of Adolescent Research*, *17*(3), 277-302. https://doi.org/10.1177/0743558402173004

Chandra, A.L., Mehta, U.M., Asnaani, A., & Radhakrishnan, R. (2016). Asian Indians in America: The influence of values and culture on mental health. *Asian Journal of Psychiatry*, *22*, 202–209. https://doi.org/10.1016/j.ajp.2015.09.011

Chaze, F., Thomson, M.S., George, U., & Guruge, S. (2015). Role of cultural beliefs, religion, and spirituality in mental health and/or service utilization among immigrants in Canada: A scoping review. *Canadian Journal of Community Mental Health, 34*(3), 87–101. https://doi.org/10.7870/cjcmh-2015-015

Chen, E.S., Chang, W.C., Hui, C.L., Chan, S.K., Lee, E.H.M., & Chen, E.Y. (2016). Self-stigma and affiliate stigma in first-episode psychosis patients and their caregivers. *Social Psychiatry and Psychiatric Epidemiology, 51*, 1225-1231.https://doi.org/10.1007/s00127-016-1221-8

Corrigan, P.W., Rafacz, J., & Rüsch, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research*, *189*(3), 339-343. https://doi.org/10.1016/j.psychres.2011.05.024

Cook, C.C.H. (2020). Spirituality, religion & mental health: Exploring the boundaries. *Mental Health, Religion & Culture*, *23*(5), 363-374. https://doi.org/10.1080/13674676.2020.1774525

Curtis, E.A., Comiskey, C., & Dempsey, O. (2016). Importance and use of correlational research. *Nurse Researcher, 23*(6), 20-25. https://doi.org/10.7748/nr.2016.e1382

Drwal, R.Ł., & Wilczyńska, J.T. (1980). Opracowanie kwestionariusza aprobaty społecznej = Elaboration of the social desirability questionnaire. *Przegląd Psychologiczny, 23*(3), 569–583.

Eng, D.K., & TenElshof, J.K. (2020). Addressing the stigma associated with seeking help for mental health among asian americans. *Journal of Psychology and Christianity*, *39*(2), 125-133.https://www.proquest.com/scholarly-journals/addressing-stigma-associated-with-seeking-help/docview/2449675136/se-2

Fischer, E.H., & Turner, J.I. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, *35*(1, Pt.1), 79–90. https://doi.org/10.1037/h0029636

Fischer, E.H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36*(4), 368–373.

Freire, J., Moleiro, C. & Rosmarin, D. (2016). Calling for awareness and knowledge: Perspectives on religiosity, spirituality and mental health in a religious sample from Portugal (a mixed-methods study). *Open Theology, 2*(1). 682-699. https://doi.org/10.1515/opth-2016-0053

Furnham, A., & Swami, V. (2018). Mental health literacy: A review of what it is and why it matters. *International Perspectives in Psychology : Research, Practice, Consultation, 7*(4), 240-257. https://doi.org/10.1037/ipp0000094

Galderisi, S., Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry, 14*(2), 231-233. https://doi.org/10.1002/wps.20231

Garssen, B., Visser, A., & Pool, G. (2021). Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. *The International Journal for the Psychology of Religion*, *31*(1), 4-20. https://doi.org.10.1080/10508619.2020.1729570

Gorsuch, R.L., & McPherson, S.E. (1989). Intrinsic/extrinsic measurement: I/E-revised and single-item scales. *Journal for the Scientific Study of Religion*, *28*(3), 348–354. https://doi.org/10.2307/1386745

Gibson, R.C., Abel, W.D., White, S., & Hickling, F.W. (2008). Internalizing stigma associated with mental illness: Findings from a general population survey in Jamaica. *Revista Panamericana De Salud Pública, 23*(1), 26-33. https://doi.org/10.1590/S1020-49892008000100004

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health, 6*, 179 https://doi.org/10.3389/fpubh.2018.00179

Gopalkrishnan, N., & Babacan, H. (2015). Cultural diversity and mental health. *Australasian Psychiatry*, *23*(6), 6-8. https://doi.org/10.1177/1039856215609769

Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *Bulletin of the World Health Organization*, *78*(4), Article 475.https://doi.org/10.1590/S0042-96862000000400009

Gureje, O., Abdulmalik, J., Kola, L., Musa, E., Yasamy, M.T., & Adebayo, K. (2015). Integrating mental health into primary care in Nigeria: Report of a demonstration project

using the mental health gap action programme intervention guide. *BMC Health Services Research, 15*(1), 1-8. https://doi.org/10.1186/s12913-015-0911-3

Hall, D.E., Meador, K.G., & Koenig, H.G. (2008). Measuring religiousness in health research: Review and critique. *Journal of Religion and Health, 47*, 134-163. https://doi.org/10.1007/S10943-008-9165-2

Halter, M.J. (2004). Stigma & help seeking related to depression: A study of nursing students. *Journal of Psychosocial Nursing & Mental Health Services, 42*(2), 42-51.https://doi.org/10.3928/02793695-20040201-07

Herrman, H., Saxena, S., Moodie, R., & Walker, L. (2005). Introduction: promoting mental health as a public health priority. *Promoting mental health: concepts, emerging evidence, practice. Geneva, World Health Organization(http://www. who. int/mental_health/evidence/MH_ Promotion_Book. pdf, accessed 17 January 2013)*, *2*.

Hickling, F.W., Gibson, R.C., Hutchinson, G. (2013). Current research on transcultural psychiatry in the Anglophone Caribbean: Epistemological, public policy, and epidemiological challenges. *Transcultural Psychiatry, 50*(6), 858-875. https://doi.org/10.1177/1363461513508806

Hickling, F.W. (2020). Owning our madness: Contributions of jamaican psychiatry to decolonizing global mental health. *Transcultural Psychiatry, 57*(1), 19-31. https://doi.org/10.1177/1363461519893142

James, W. (1994). *The varieties of religious experience: A study in human nature*. The Floating Press.

Kao, L.E., Peteet, J.R., & Cook, Christopher C.H. (2020) Spirituality and mental health. *Journal for the Study of Spirituality*, *10*(1), 42-54. https://doi.org/10.1080/20440243.2020.1726048

Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustün, T.B. (2007). Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Kim, J. M., Kim, S. J., Hsi, J. H., Shin, G. H. R., Lee, C. S., He, W., & Yang, N. (2021). The "let's talk!" Conference: A culture-specific community intervention for Asian and Asian American student mental health. *Community Mental Health Journal*, *57*, 1001-1009. https://doi.org/10.1007/s10597-020-00715-3

Knapp, M., & Wong, G. (2020). Economics and mental health: the current scenario. *World Psychiatry*, *19*(1), 3-14. https://doi.org/10.1002/wps.20692

Koenig, H.G. (2009). *Research on religion, spirituality, and mental health: A review*. Sage Publications. https://doi.org/10.1177/070674370905400502

Koenig, H.G., & Büssing, A. (2010). The duke university religion index (DUREL): A five-item measure for use in epidemological studies. *Religions, 1*(1), 78-85. https://doi.org/10.3390/rel1010078

Kirmayer, L.J., Andermann, L., Fung, K., Guzder, J., & Jarvis, G.E. (2022). The importance of religion and spirituality in cultural psychiatry: Reply to Drs Persad and Oyewumi. *Canadian Journal of Psychiatry*, *67*(8), 661-661. https://doi.org/10.1177/07067437221087939

Kotera, Y., Conway, E., & Van Gordon, W. (2019). Mental health of UK university business students: Relationship with shame, motivation and self-compassion. *Journal of Education for Business, 94*(1), 11-20. https://doi.org/10.1080/08832323.2018.1496898

Kotera, Y., Sheffield, D., Green, P., Asano, K. (2021). Cross-cultural comparison of mental health shame: Negative attitudes and external, internal, and reflected shame about mental health in Japanese and UK workers. In C.H. Mayer, E. Vanderheiden, & P.T.P. Wong, (Eds.) *Shame 4.0.* Springer, Cham. https://doi.org/10.1007/978-3-030-59527-2_3

Labinjo, T., Serrant, L., Ashmore, R., & Turner, J. (2020). Perceptions, attitudes and cultural understandings of mental health in nigeria: A scoping review of published literature. *Mental Health, Religion & Culture, 23*(7), 606-624. https://doi.org/10.1080/13674676.2020.1726883

Lacey, K.K., Powell Sears, K., Crawford, T.V., Matusko, N., & Jackson, J.S. (2016). Relationship of social and economic factors to mental disorders among population-based samples of jamaicans and guyanese. *BMJ Open, 6*(12), e012870-e012870. https://doi.org/10.1136/bmjopen-2016-012870

Levin, J. (2010). Religion and mental health: Theory and research. *International Journal of Applied Psychoanalytic Studies, 7*(2), 102-115. https://doi.org/10.1002/aps.240

Long, Y., Quan, F., & Zheng, Y. (2021). Effects of bicultural identity integration and national identity on COVID-19-related anxiety among ethnic minority college students: The mediation role of power values. *Psychology Research and Behavior Management, 14*, 239-249. https://doi.org/10.2147/PRBM.S294547

Manderscheid, R.W., Ryff,C.D., Freeman, E.J., McKnight – Eily, L.R., Dhingra,S., & Strine, T. W. (2010). Evolving definitions of mental illness and wellness. *Preventing chronic disease, 7*(1), Article 19. http://www.cdc.gov/pcd/issues/2010/jan/09_0124.htm

Manwell, L.A., Barbic, S.P., Roberts, K., Durisko, Z., Lee, C., Ware, E., & McKenzie, K. (2015). What is mental health? Evidence towards a new definition from a mixed methods multidisciplinary international survey. *BMJ Open 5(6),*e007079-e007079. https://doi.org/10.1136/bmjopen-2014-007079

Mechanic, D. (1999). Mental health and mental illness: Definitions and perspectives. In A.V. Horwitz & T.L. Scheid (Eds.), *A handbook for the study of mental health: Social contexts, theories, and systems* (pp. 12–28). Cambridge University.

McCartney, D.M. (2004). *Bahamian culture and factors which impact upon it: A compilation of two essays*. Dorrance Publishing Co., Inc.

Milner, K., Crawford, P., Edgley, A., Hare-Duke, L., & Slade, M. (2019). The experiences of spirituality among adults with mental health difficulties: A qualitative systematic review. *Epidemiology and Psychiatric Sciences, 29,* e34 https://doi.org/10.1017/S2045796019000234

Nicholas, A., Joshua, O., & Elizabeth, O. (2022). Accessing mental health services in Africa: Current state, efforts, challenges and recommendation. *Annals of Medicine and Surgery 81*, Article 104421. https://doi.org/10.1016/j.amsu.2022.104421

Nohr, L., Lorenzo-Ruiz, A., Sandoval-Ferrer, J.E., & Buhlmann, U. (2021). Mental health stigma and professional help-seeking attitudes a comparison between Cuba and Germany. *PloS One, 16*(2), e0246501. https://doi.org/10.1371/journal.pone.024650

Ocho, O.N., Moorley, C., Richardson, S.C., Caesar-Greasley, L.A., & Hardy, S. (2023). Cultural influences on mental health provision in the Caribbean: How do contemporary perceptions and beliefs about persons with mental illness inform workforce transformation? *Journal of Transcultural Nursing*, *34*(1), 14-23. https://doi.org/10.1177/10436596221121329

Ocloo, X. (2017). Capturing the Bahamian National Identity. *Inquiry in Aces*, *3*(1), 35-39.

Parcesepe, A.M., & Cabassa, L.J. (2013). Public stigma of mental illness in the united states: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research*, *40*(5), 384-399. https://doi.org/10.1007/s10488-012-0430-z

Palmer, M. (2003). *Freud and Jung on religion*. Routledge.

Palmer, C.A. (1994). Tourism and colonialism: The experience of the Bahamas. *Annals of tourism research*, *21*(4), 792-811. https://doi.org/10.1016/0160-7383 (94)90084-1

Park, K., MinHwa, L., & Seo, M. (2019). The impact of self-stigma on self-esteem among persons with different mental disorders. *International Journal of Social Psychiatry*, *65*(7-8), 558-565. https://doi.org/10.1177/0020764019867352

Phelan, J., & Link, B. (1998). The growing belief that people with mental illnesses are violent: the role of the dangerousness criterion for civil commitment. *Psychiatry Epidemiology*, *33* (1), S7–S12. https://doi.org/10.1007/s001270050204

Phelan, J.C., Link, B.G., Stueve, A., & Pescosolido, B.A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared?. *Journal of Health and Social Behavior 41*(2),188-207. https://doi.org/10.2307/2676305

Picco, L., Abdin, E., Chong, S.A., Pang, S., Shafie, S., Chua, B.Y., Vaingankar, J.A., Ong, L.P., Tay, J., & Subramaniam, M. (2016). Attitudes toward seeking professional psychological

help: Factor structure and socio-demographic predictors. *Frontiers in Psychology, 7*, Article 547. https://doi.org/10.3389/fpsyg.2016.00547

Ramkissoon, A.K., Donald, C., & Hutchinson, G. (2017). Supernatural versus medical: Responses to mental illness from undergraduate university students in Trinidad. *International Journal of Social Psychiatry*, *63*(4), 330-338. https://doi.org/10.1177/0020764017702412

Rey, T.H. (1953). Madeleine Kerr: Personality and conflict in Jamaica (book review). *The International Journal of Psycho-Analysis, 34*, Article 345. https://go.openathens.net/redirector/liberty.edu?url=https://www.proquest.com/scholarly-journals/madeleine-kerr-personality-conflict-jamaica-book/docview/1298181227/se-2

Rippentrop, E.A., Altmaier, E.M., Chen, J.J., Found, E.M., & Keffala, V.J. (2005). The relationship between religion/spirituality and physical health, mental health, and pain in a chronic pain population. *Pain (Amsterdam), 116*(3), 311-321. https://doi.org/10.1016/j.pain.2005.05.008

Ruiz, J.M., Sbarra, D., & Steffen, P.R. (2018). Hispanic ethnicity, stress psychophysiology and paradoxical health outcomes: A review with conceptual considerations and a call for research. *International Journal of Psychophysiology*, *131*, 24-29. https://doi.org/10.1016/j.ijpsycho.2018.04.001

Rüsch, N., Angermeyer, M., & Corrigan, P. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, *20*(8), 529-539. https://doi.org/10.1016/j.eurpsy.2005.04.004

Sacra, M.M., & Nichols, L.M. (2018). Globalization and internationalization: The implications on the mental health field in bhutan. *International Journal for the Advancement of Counselling*, *40*(4), 443-454. https://doi.org/10.1007/s10447-018-9336-0

Setoya, Y., & Kestel, D. (2018). WHO mental health gap action programme implementation in the small island development states: Experience from the pacific and english-speaking caribbean countries. *BJPsych International*, *15*(2), 27-30. https://doi.org/10.1192/bji.2017.16

Sims, A. (1994). 'Psyche'–spirit as well as mind? *The British Journal of Psychiatry*, *165*(4), 441-446. https://doi.org/10.1192/bjp.165.4.441

Smith, A. D. (1991). *National identity* (Vol. 11). Reno: University of Nevada press.

Sreetheran, M., van den Bosch, Cecil C. Konijnendijk, & Sveriges lantbruksuniversitet. (2014). A socio-ecological exploration of fear of crime in urban green spaces – A systematic review. *Urban Forestry & Urban Greening*, 13(1), 1-18. https://doi.org/10.1016/j.ufug.2013.11.006

Swank, J. M., & Barrio, M. C. A. (Eds.). (2021). *Critical incidents in counselor education : Teaching, supervision, scholarship, leadership, and advocacy*. American Counseling Association.

Taggart, T., Powell, W., Gottfredson, N., Ennett, S., Eng, E., & Chatters, L.M. (2019). A person-centered approach to the study of black adolescent religiosity, racial identity, and sexual initiation. *Journal of Research on Adolescence*, *29*(2), 402-413. https: doi.org/10.1111.jora.12445

Tenny, S., Brannan, J.M., & Brannan, G.D. (2017). Qualitative study.In:statpearls. StatPearls Publishing, Treasure Island (Fl); (2023).

Tudge, J.R.H., Odero, D.A., Hogan, D.M., & Etz, K.E. (2003). Relations between the everyday activities of preschoolers and their teachers' perceptions of their competence in the first years of school. *Early Childhood Research Quarterly, 18*(1), 42-64. https://doi.org/10.1016/S0885-2006(03)00005-X

Vogel, D.L., Wade, N.G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*(3), 325-337. https://doi.org/10.1037/0022-0167.53.3.325

Weber, S.R., & Pargament, K.I. (2014). The role of religion and spirituality in mental health. *Current opinion in psychiatry, 27*(5), 358-363.https://doi.org/10.1097/YCO.0000000000000080

Weihofen, H. (1960). The definition of mental illness. *Ohio St. Law Journal, 21*(1).

Wilson. N. (2021). Minding your noggin: A comparative analysis of mental health care law in the U.S., U.K., and China. *Transnational Law & Contemporary Problems, 30*(1), 157-181.https://link.gale.com/apps/doc/A674841728/GB1B?u=vic_liberty&sid=summon&xid=d0e84Zaf

World Health Organization. (2004). *Promoting mental health: Concepts, emerging evidence, practice: Summary report*. World Health Organization.

Worthington, E.L., Wade, N.G., Hight, T.L., Ripley, J.S., McCullough, M.E., Berry, J.W., Schmitt, M.M., Berry, J.T., Bursley, K.H., & O'Connor, L. (2003). The religious commitment inventory-10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*(1), 84-96. https://doi.org/10.1037/0022-0167.50.1.84

Zarzycka, B., & Rydz, E. (2011). The selective relationship between religious dimensions and social desirability among Polish students. *Mental Health, Religion & Culture, 14*(5), 411-422.https://doi.org/10.1080/13674671003739170

Zeleke, W.A., Nichols, L.M., & Wondie, Y. (2019). Mental health in Ethiopia: An exploratory study of counseling alignment with culture. *International Journal for the Advancement of Counselling, 41*(2), 214-229. https://doi.org/10.1007/s10447-018-9368-5

APPENDIX A

Beliefs Toward Mental Illness Scale (BMI)

Rating Scale

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

1. A mentally ill person is more likely to harm others than a normal person.

2. Mental disorders would require a much longer period of time to be cured than would other general diseases.

3. It may be a good idea to stay away from people who have a psychological disorder because their behavior is dangerous.

4. The term “psychological disorder” makes me feel embarrassed.

5. A person with a psychological disorder should have a job with minor responsibilities.

6. Mentally ill people are more likely to be criminals than nonmentally ill people.

7. Psychological disorders are recurrent.

8. I am afraid of what my boss, friends, and others would think if I were diagnosed as having a psychological disorder.

9. Individuals diagnosed as mentally ill will suffer from its symptoms throughout their life.

10. People who have once received psychological treatment are likely to need further treatment in the future.

11. It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.

12. I would be embarrassed if people knew that I dated a person who once received psychological treatment.

13. I am afraid of people who are suffering from psychological disorders because they may harm me.

14. A person with a psychological disorder is less likely to function well as a parent.

15. I would be embarrassed if a person in my family became mentally ill.

16. I do not believe that psychological disorders are ever completely cured.

17. Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.

18. Most people would not knowingly be friends with a mentally ill person.

19. The behavior of people who have psychological disorders is unpredictable.

20. Psychological disorders are unlikely to be cured regardless of treatment.

21. I would not trust the work of a mentally ill person assigned to my work team.

APPENDIX B

Religious Commitment Inventory—10

Each item is rated as 1 = not at all true of me , 2 = somewhat true of me , 3 = moderately true of me , 4 = mostly true of me , or 5 = totally true of me .

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious organization.
10. I keep well informed about my local religious group and have some influence in its decisions.

APPENDIX C

Self-Stigma of Seeking Help Scale (SSOSH)

1. I would feel inadequate if I went to a therapist for psychological help.

2. My self-confidence would NOT be threatened if I sought professional help.

3. Seeking psychological help would make me feel less intelligent.

4. My self-esteem would increase if I talked to a therapist.

5. My view of myself would not change just because I made the choice to see a therapist.

6. It would make me feel inferior to ask a therapist for help.

7. I would feel okay about myself if I made the choice to seek professional help.

8. If I went to a therapist, I would be less satisfied with myself.

9. My self-confidence would remain the same if I sought help for a problem I could not solve.

10. I would feel worse about myself if I could not solve my own problems.

APPENDIX D

Recruitment Letter sent to Pastors

July 14th, 2023

Dear Local Pastor
Senior Pastor
Freeport Bible Church
Norma Headley Highway
Freeport, Grand Bahama
Bahamas

Dear Pastor,

As a graduate student in the at Liberty University, the title of my research project is Exploring the mediating effects of beliefs toward mental illness on the relationship between religiosity and self-stigma and the purpose of my research is to better understand ways to increase accessibility and utilization of mental health services among the Bahamian population.

I am writing to request your permission to utilize your membership list to recruit participants for my research.

Participants will be asked to complete the attached survey. Participants will be presented with informed consent information prior to participating. Taking part in this study is completely voluntary, and participants are welcome to discontinue participation at any time.

Thank you for considering my request. If you choose to grant permission, respond by email. A permission letter document is attached for your convenience.

Sincerely,

Doctoral Candidate (CES)

APPENDIX E

Informed Consent

Title of the Project: Exploring the Mediating Effects of Beliefs Toward Mental Illness on the Relationship between Religiosity and Self-Stigma of Seeking Help

Principal Investigator: Grace-Ann Gibby, Doctoral Candidate, Department of Counselor Education and Family Studies, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years of age or older and a Bahamian Citizen. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to examine the relationship between religiosity, beliefs toward mental illness, and the self-stigma of seeking help within the Bahamian population. Data collected will inform researchers to better understand the utilization of mental health services in the Bahamas and potential barriers that people face in seeking help.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Complete a brief demographic questionnaire (<1 minute)
2. Complete a brief social desirability questionnaire (<5 minutes)
3. Complete three assessments that measure variables related to religiosity, beliefs toward mental illness, and self-stigma of seeking help (25-35 minutes).

How could you or others benefit from this study?

There are no direct benefits participants should expect to receive from taking part in this study. However, benefits to the Bahamian society include providing data that clinicians and

stakeholders might use to better understand the effects of beliefs toward mental illness, religiosity and self-stigma of seeking help.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The potential risk is a change in emotion, while it is unlikely that you would experience distress during this study, if you would need assistance with any type of distress, please contact the Bahamas Resilience Center or the Rand Memorial Hospital.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses to the online survey will be anonymous.
- Data will be stored on a password-locked computer. After three years, all electronic records will be deleted.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with your church or pastor. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

What should you do if you decide 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.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Grace Ann Gibby, Counselor Education and Supervision doctoral student at Liberty University. You may ask any questions you have now.

Whom do you contact if you have questions about your rights as a research participant?

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 IRB. Our physical address is Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

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

_____

Printed Subject Name

_____

Signature & Date