Religiousness and Help Seeking:

Individual, Congregational, and Clergy Factors

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Abstract

Religious individuals are less likely to seek psychotherapy than nonreligious individuals, but few studies have looked at factors that may facilitate or hinder help seeking in these individuals. Using the Theory of Planned Behavior as a lens, we examined individual, congregational, and clergy factors related to help seeking among Christian individuals. Multi-level models using data from 239 participants from 14 randomly selected Christian congregations suggest that congregant religiousness and the frequency at which clergy spoke about mental health were related to help-seeking intentions and attitudes. Furthermore, the availability of mental health programming was related to a decrease in reported depression in the congregation. These results highlight the important role that clergy play in influencing their congregations' treatment seeking behaviors. Together, mental health advocates, psychotherapists, and clergy may work together to improve the mental health of their communities.

Keywords: Religion, Help Seeking, Theory of Planned Behavior, Congregation, Multi-level Modelling

Clinical Impact Statement: We asked, "why do religious individuals seek psychotherapy less often than non-religious individuals?" Data suggested that the way clergy discuss psychotherapy influenced congregants' attitudes and intentions toward seeking psychotherapy. Together, these findings suggest that therapists may effectively work with clergy to provide more accurate and encouraging information to their congregants about psychotherapy.

Religiousness and Help Seeking: Individual, Congregational, and Clergy Factors

Over half of the United States population reports that religion plays a "very important" role in their life (53%; Pew Research Center, 2015), and this religiousness appears to be generally health promoting for most people (Bonelli & Koenig, 2013). When religious individuals experience psychopathology, however, they are less likely to seek psychotherapy and experience fewer positive gains than non-religious individuals (Lefevor et al., 2018; Lukachko et al., 2015; Moreno et al., 2017). Among other factors, adverse experiences with secular providers, misattribution of psychiatric symptoms to punishment from God, and fear of stigma may feed this hesitancy to seek therapy and reduced gains (Nakash et al., 2018; Peteet, 2019).

The Theory of Planned Behavior (TOPB) offers axes to understand potential mechanisms that may perpetuate this disparity (Azjen, 1985). According to the TOPB, the decision to seek help can be understood through the interplay of several individual-level factors: attitudes, intentions, perceived efficacy, perceived behavioral control, and subjective norms around help seeking (Logsdon et al., 2013). Potentially then, religiousness may suppress any of these factors, ultimately leading to disparities in help seeking between religious and non-religious individuals.

Given that most individuals experience religiousness through congregational participation (Pew Research Center, 2015), group-level influences may be particularly important to consider in understanding how religiousness affects help seeking. Clergy's attitudes and practices, doctrines/policies of the congregation, and congregational norms may all uniquely influence congregants' likelihood to seek help (Lukachko et al., 2015; Peteet, 2019).

Research has suggested that religiousness influences help seeking (Lukachko et al., 2015; Peteet, 2019) and that both individual- and group-level variables may help explain this effect (Lefevor et al., 2020a). However, it is not clear how individual- and group-level variables may

(or may not) work together to explain help seeking. Grounded in the TOPB, the present study takes a multi-level perspective to examine how religiousness may influence help seeking vis-à-vis each of five TOPB constructs. This research offers the potential to educate both clergy and psychotherapists about the sources of help seeking disparities and offer guidelines to subsequently work to ameliorate such disparities.

A Multi-level Understanding of Religiousness

Religiousness is best understood as the search for the sacred in the context of established institutions (Pargament, 2013). Perhaps most commonly—at least among Judeo-Christian faiths—religiousness is assessed as a three-faceted construct involving organizational religiousness (e.g., service attendance), non-organizational religiousness (e.g., scripture study), and intrinsic religiousness (e.g. religious commitment; Koenig & Büssing 2010). Religiousness is most frequently assessed as an individual-differences variable, as individuals reliably vary from others in their service attendance, scripture study, and commitment (Lefevor et al., 2020b). Individual-differences research suggests that religiousness is linked to a variety of treatment-seeking outcomes including mental health (Bonelli & Koenig, 2013), response to psychotherapy (Razali et al., 1998), and ability to cope with traumatic stressors (Shaw et al., 2005).

Although religiousness is most often seen as an individual-differences phenomenon, it may also be studied as an aspect of social groups. Because religion is often experienced in social contexts, individuals are likely to be influenced by the norms, policies, and key figures of this larger group. Aspects of the congregation—such as its demographic makeup, religiousness, or exclusivity—may influence its congregants' views (Lefevor et al., 2019; Lefevor et al., 2020b). Attitudes held by clergy have been found to uniquely influence religious individuals as well, with congregants looking to clergy for guidance on political, social, and health-related issues (

Toni-Uebari & Inusa, 2009). As some religious individuals may seek help from clergy before psychotherapists, clergy may have an even greater influence over congregant attitudes in this area (Vermaas et al., 2017; Young et al., 2003).

Although clergy can be a helpful resource for religious individuals experiencing mental health issues—particularly as they generally have a better understanding of mental health than the general population—most lack the training to address the variety and intensity of symptoms presented by their congregants (Vermaas et al., 2017). Further, clergy in some faith traditions report viewing the etiology of depression as a spiritual/moral (rather than biological) issue (Payne, 2009). Nonetheless, clergy views can have a strong direct influence on both the beliefs and behaviors of their congregants (Toni-Uebari & Inusa, 2009). Given that biological or psychosocial views of the etiology of psychological disorders are more likely to result in help seeking (Van Voorhees et al., 2005), clergy's views on the etiology of these disorders may affect their congregants' treatment seeking. Congregants experiencing more intense depressive symptoms may thus deal not only with symptomatic barriers to seeking treatment, but also with negative attitudes regarding psychotherapy perpetuated by their faith community (Payne, 2009; Moreno et al., 2017).

The Theory of Planned Behavior

As religiousness is a multifaceted construct, it is important to understand *how* religiousness may influence treatment seeking. The TOPB postulates that whether and how often an individual engages in a behavior is governed by the individual's attitudes, intentions, perceived ability to engage in the behavior, and perceived efficacy of the behavior, as well as social norms that dictate the desirability of the behavior (Ajzen, 1985). We explore ways that religiousness may influence each of these aspects to lead to decreased treatment seeking.

Intentions. According to the TOPB, intention is the precursor to execution of the behavior and is affected by other components of the TOPB – attitudes, social norms, and perceived behavioral control (Azjen, 1985; Hammer et al., 2018). Help-seeking intentions may be affected by a number of factors including discrimination, perceived ability of accessing care, and social support (Bohon et al., 2016; Bilkins et al., 2016).

A religious congregation may influence an individual's intentions to seek help. It appears that when congregants feel supported by their congregation, they are less likely to seek help (Bilkins et al., 2016). However, if clergy endorse psychotherapy as a valid treatment for psychological disorders, it is more likely that the individual will feel supported in their intention to seek treatment, especially if the church itself has a mental health ministry (Williams et al., 2014). Thus, the support a congregation provides and the behavior the congregation encourages may influence a religious individual's intention to seek treatment.

Attitudes. Congregants' attitudes toward mental health can affect their intention to seek help, and thus, can impact their treatment-seeking behaviors. Previous research has found that attitudes toward mental health issues are indicative of beliefs of mental health treatment efficacy (Leong & Zachar, 1999). Negative attitudes toward mental health—typically characterized as fear, stigma, and rejection—have been associated with fewer intentions to seek treatment, and thus, less treatment-seeking behavior (Wrigley et al., 2005).

Religious individuals' attitudes toward help seeking may relate to their religious views and beliefs. On one hand, positive experiences with psychotherapy—including experiences where therapy facilitates spiritual growth—may increase the likelihood of seeking therapy (Isacco et al., 2014). Religious teachings and attitudes may also directly impact therapy seeking (e.g., beliefs about the caring for mind/body; Padela et al., 2016). On the other hand, negative

experiences or expectations that religious beliefs may not be respected or taken seriously in therapy may reduce the likelihood of seeking therapy (Bonelli et al., 2012).

Subjective Norms. Subjective norms—defined as the perceptions of a group's beliefs about engaging in a behavior (Azjen, 1985)—have a strong influence on whether an individual will seek help (Aldalaykeh et al., 2019). Subjective norms predict willingness to see a counselor (Kim & Park, 2009) and are strongly related to knowledge, anticipated benefits, public stigma, and intentions (Li et al., 2018).

The beliefs that clergy hold, as well as the values of the religion in general, may influence the development and enactment of social norms within a religious group, including those regarding help seeking. Religiously reinforced stigma towards mental health exists within congregations and may inhibit help seeking among congregants (Peteet, 2019). Fear of the reactions of clergy and fellow congregants may deter help seeking (Molock et al., 2007). In contrast, positive clergy attitudes toward mental health may encourage treatment seeking by creating positive perceived norms about help seeking (Peteet, 2019).

Perceived Behavioral Control. Perceived Behavioral Control is comprised of internal (e.g., time, information, skills, and abilities) and external factors (e.g., access to insurance, transportation, or competent providers). In general, the more an individual feels control of their behavior, the more likely they are to engage in it (Alalayken et al., 2019; Bohon et al., 2016).

Religious individuals' perceived control may be affected positively or negatively by both internal and external factors. Religious individuals tend to respond more positively and absorb more information if it is provided by a religious authority figure (Lakhan, 2018). Thus, if clergy discuss mental health, provide flyers or posters with mental health information, or host support groups, individuals may feel more informed and empowered to seek mental health services

(Payne, 2009). Places of worship may also provide concrete external support toward help seeking by hosting psychotherapists in their office space, providing transportation to therapy, or providing financial assistance to members in need of therapy.

Perceived Effectiveness. An individual's perception of the efficacy of psychotherapy can impact their likelihood of seeking treatment. Typically, the more someone believes an intervention to be beneficial, the more they engage in it (Mou, 2017); thus, the more an individual believes therapy will benefit them, the more likely they are to go to psychotherapy (Wrigley et al., 2005). Those who have had previous effective therapy or who have a more positive attitude toward help-seeking may view therapy as more effective (Bohon et al., 2016).

Religiousness may influence individuals' perceptions of the efficacy of therapy. In particular, if individuals see therapy as less effective than religious practices, they may be more likely to turn to practices rather than therapy in response to psychopathology (Aldalaykeh et al., 2019). Individuals may also hold negative attitudes toward mental health developed in their place of worship that may influence their likelihood to seek treatment (e.g., seeing mental disorders as a moral rather than medical issue; Leong & Zachar, 1999; Moreno et al., 2017).

Depression. Though not a part of the theory of planned behavior, religiousness has been shown to have a strong influence on mental health (Park & Slattery, 2003). Largely, religiousness appears to be negatively associated with symptoms of common psychological disorders such as depression or anxiety (Bonelli & Koenig, 2013). We also examine the influence of religiousness on depression to account for the possibility that religiousness mitigates the symptoms of depression, which creates less need for help seeking.

The Present Study

Our review of the literature suggested that religiousness influences treatment seeking in a variety of ways, on a variety of different levels. Previous work (Lefevor et al., 2020a, 2020b) has suggested that congregational factors may be more closely related to outcomes than individual factors, at least partially because individuals group themselves based on common characteristics. Further, previous work (Toni-Uebari & Inusa, 2009) has suggested that clergy may be particularly influential in congregants' views. Taken together, we suggest that individual, congregational, and clergy factors all relate to attitudes. However, we suspect that because most work has focused on individual-level factors, once congregation- and clergy-level factors are accounted for, the strength of the association between individual-level factors and outcomes will be mitigated.

Guided by the TOPB, we took a multi-level approach to better understand how religiousness may influence help seeking among Christian individuals and congregations. Overall, we predicted that congregation- and clergy-level factors will have stronger relationships with help seeking than individual-level factors (H1). At the individual level, we hypothesized that (H2) religiousness would be negatively related to TOPB constructs. At the congregational level, we expected (H3) that congregational resources (e.g., the availability of mental health programming, the awareness of a congregation about mental health) would facilitate help seeking. At the clergy level, we expected (H4) that clergy variables (e.g., less stigma, greater likelihood of referring congregants to providers, higher frequency of preaching on mental health issues) would be positively related to TOPB constructs. Finally, we expected that our results would confirm previous research that suggests that religiousness is negatively related to depression (H5).

Method

Sampling Procedure

Recent research suggests that multilevel models with a level-1 sample size of 5 to 40 participants nested within each of 10 to 30 level-2 units (i.e., congregations) can produce unbiased parameter estimates and minimal Type 1 error rate (Bell et al., 2014). To obtain this sample size, 91 Christian congregations were randomly selected from the White Pages of a city in the mid-south. IRB approval was obtained from the primary author's institution. Christian congregations were used because over 95% of places of worship in this city were Christian.

Places of worship were contacted via phone, Facebook, or in person before or after services by research assistants to obtain permission for data collection after a worship service. Team members visited places of worship twice, and if the place of worship did not grant permission during the second visit, they were categorized as uninterested because many places of worship kept saying, "I'll have to get back with you" without following up. Of the 91 churches selected, 28 would not provide a straightforward answer about participation after a follow up visit, 47 declined participation, and 16 consented to participate. Of the 16 places that consented, 2 were not included in the analysis, because they did not provide at least 4 congregants and 1 clergy response, leaving 14 final congregations. Of the 47 that declined participation, 16 reported not being interested in participating in research whether due to time commitments or lack of interest, 24 indicated that the content of the survey prohibited them from participating, and 7 did not specify a reason for declining participation. The present data were collected as part of a larger study examining attitudes toward same-sex sexuality; when congregations declined participation because of the content of the survey, they typically declined because of its focus on sexuality. Thus, the decision to participate may have been reflective of the socio-political climate of the church surrounding sexuality. Congregations were socio-politically and theologically

diverse, representing both “liberal” and “conservative” denominations including Church of God in Christ, Missionary Baptist, Southern Baptist, Presbyterian Church (USA), Disciples of Christ, and United Methodist.

Among participating congregations, three related surveys were collected. First, clergy filled out a survey either prior to or after services. Second, the clergy made an announcement stating that a research team member would be around after the service to administer a 10-minute survey. Congregants who were interested then approached a research assistant to fill out a survey using traditional paper and pen methods. Finally, a research assistant attended services the day of data collection and filled out an observation sheet (described below). Participants were not compensated. The survey responses were double entered and any disputes regarding the data entry were resolved by re-examination of the data to ensure that all data were accurate.

Participants

Congregants were largely middle-aged (M = 55.40, SD = 17.38), Black (68.4% Black; 30% White; 1.6% other), straight (97.4%; 2.6% sexual minority) women (73.3%; 26.7% men) who were religiously devout (on average, attended religious services weekly) . About a quarter of participants had a high school diploma or less (17.8%), another quarter had attended some college or vocational training (28.8%), another quarter had a bachelor’s degree (27.5%), and another quarter had a graduate degree (21.6%). Congregants reported positive attitudes, intentions, norms, perceived control, and perceived effectiveness toward help seeking, with most congregants responding between “somewhat agree” and “agree” on these questions.

Clergy demographics largely matched congregant demographics with the exception of gender and education. Clergy were primarily middle-aged (M = 55, SD = 20.37), Black (64.3%; 35.7% White), straight (100%) men (71.4%; 28.6% women). Two-thirds of clergy had a graduate

degree (64.3%) with about a sixth having a bachelor's degree (14.3%) and some college or vocational training (21.4%) respectively. Overall, clergy evidenced relatively little stigma toward help seeking, averaging "disagree" on items that assessed for stigma, and reported being between "likely" and "very likely" to refer a congregant in need of mental health services to a psychotherapist. Clergy varied in how often they discussed mental health in their preaching, but most indicated that they did so a few times a year but less than once a month. On average, congregations offered between 2 and 3 types of mental health programming.

Measures and Covariates

Three different versions of the survey were developed: a congregant, clergy, and research assistant (RA) version. Data for the congregant and clergy versions were collected using paper and pen surveys passed out by RAs after the end of service, which the RAs attended. The RA version of the survey was also a paper and pen survey that the RA filled out during the service. RAs received research ethics and compliance training prior to administering data collection.

Congregant Variables.

Religiousness. Religiousness was assessed through the Duke University Religiousness Index (DUREL; Koenig & Büssing, 2010). The DUREL is a 5-item measure that assesses organizational religious activity, non-organizational religious activity, and intrinsic religiousness, yielding a total score of 5 – 27, with higher scores indicating greater religiousness. The measure evidenced acceptable internal consistency in the present study ($\alpha = .75$).

Intentions to Seek Help. Help-seeking intentions were assessed using the 3-item Mental Help Seeking Intention Scale (MHSIS; Hammer & Spiker, 2018). Participants indicated their likelihood—on a 7-point Likert scale—of intending, trying, and planning to seek help from a mental health professional if they had a mental health concern, with higher scores indicating

greater intentions to seek help. The measure evidenced acceptable internal consistency in the present study (α = .95).

Attitudes towards Help Seeking. Help-seeking attitudes were assessed through the 9-item Mental Help Seeking Attitudes Scale (MHSAS; Hammer et al., 2018). The scale asks participants to indicate their attitudes toward seeking therapy by selecting between 9 different gradated (7-point Likert scale) pairs of dichotomous adjectives (e.g., useless vs. useful, good vs. bad), with higher scores indicating more positive attitudes toward help-seeking. The measure evidenced acceptable internal consistency in the present study (α = .88).

Subjective Norms. Subjective norms were assessed using three items following Ajzen's (2002) recommendations that have previously been used in treatment seeking research (Hammer et al., 2018): "The people in my life whose opinions I value would ___ of me going to see a mental health professional if I felt down", "It is expected of me that I see a mental health professional if I felt down", and "Most people who are important to me think that I ____ see a therapist if I felt down". Response were on a 7-point scale ranging from "not approve" to "approve", "very unlikely" to "very likely", and "should" to "should not", respectively. The scale demonstrated unacceptable internal consistency (α = .41), so was not used in analyses.

Perceived Behavioral Control. Perceived control of help seeking was assessed through three items following Ajzen's (2002) recommendations: "For me to seek therapy in the forthcoming month would be", "It is mostly up to me whether or not I seek therapy", and "If I really wanted to, I could attend therapy in the next year". Responses were on a 7-point scale ranging from "impossible" to "possible" (first item) and "strongly disagree" to "strongly agree" (other items). Higher scores indicated greater perceived control. The scale demonstrated acceptable internal consistency α = 76.

Perceived Effectiveness. The perceived effectiveness of psychotherapy was assessed through a single item: "If I had a mental health problem, working with a mental health professional would restore me to my normal level of functioning" on a 7-point scale ranging from "very unlikely" to "very likely" (Cooper-Patrick et al., 1997), with higher scores indicating greater perceived effectiveness.

Depression. Depression was assessed using the 9-item Patient Health Questionnaire (α = .84; PHQ-9; Kroenke et al., 2001). Example items included "little interest or pleasure in doing things" and "feeling tired or having little energy". Options were on a 4-point scale ranging from "not at all" to "nearly every day," with higher scores indicating more depression. The scale evidenced acceptable internal consistency (α = .82).

Clergy Variables

Clergy Stigma. Clergy stigma toward help seeking was measured using the 6-item perceived public stigma subscale of the Perceived Stigma and Barriers to Care of Psychological Problems measure (Britt et al., 2008). Each item asked clergy to rate the possible concerns affecting their decisions to seek treatment on a 6-point Likert scale such as "It would harm my reputation" or "I would be seen as weak", with higher scores indicating greater stigma. Internal consistency in the present study was .90.

Frequency of Discussions. Clergy were asked how often they preached about issues of mental health in a single item. Responses were recorded on a 5-point scale from "never" to "weekly," with higher scores indicating more frequent discussions about mental health.

Clergy Referral Likelihood. Clergy reported their likelihood of referring a congregant in need to a psychotherapist in a single item. Responses were on a 7-point Likert scale ranging from "very unlikely" to "very likely" with higher scores indicating greater likelihood of referral.

Congregational Variables

Congregation-Level Religiousness. Congregants' religiousness (as assessed through the DUREL) was aggregated on a congregational level. This variable represents the average religiousness of a congregation.

Mental Health Programming Available. Using items from the National Congregations Study (Chaves & Anderson, 2008), clergy indicated the availability of five types of mental health programs in their congregation: alcohol and substance use, marital counseling, sex education and counseling, domestic violence counseling, and sexual assault counseling. Though these may not represent all types of mental health programming a congregation could have, the total number of these five programs available was used to indicate the availability of programming.

Mental Health Awareness Indicators. Research assistants attended each congregation on the day of data collection to record the frequency with which they saw indicators of mental health awareness in both print and spoken word. A predetermined list was created including words such as depression, anxiety, mental illness, counseling, support group, and psychologist from which research assistants counted the number of references that were made in print (e.g., bulletins, bulletin boards) or the spoken word during services (see Appendix A for observation sheet). Scores indicate the number of words mentioned in services.

Analysis Plan

Multilevel modelling (MLM) was used to examine the unique influence of congregant and congregational factors on treatment seeking. MLMs were constructed in R version 3.6.0 (R Development Core Team, 2019) with maximum likelihood estimation using the "lme4" package (Bates et al., 2015). Categorical variables were dichotomized for analysis as follows: gender (1 = woman), ethnicity (1 = Person of Color). Because religiousness was examined at both

congregant and congregation levels, this variable was group mean centered at the congregant level to remove congregation-level variation and grand mean centered at the congregation level (Hox et al., 2017). Missing data were listwise deleted for relevant analyses. Models include a random effect for intercept and a fixed effect for slopes as variables were determined to be free to vary both between individuals and between congregations.

To inform our multilevel analyses, we first examined the relationships between key study variables. Religiousness and all help seeking variables were group centered to separate level-1 and level-2 variance, allowing *Table 1* to display the relationships between congregant-level variables with congregation-level variance removed. *Table 2* displays the relationships between congregation-level variables. *Table 3* displays the demographic characteristics of each of the 14 included congregations. These tables indicate that a) many level-1 and level-2 variables were related to help seeking and b) that many of these variables were interrelated, highlighting the possibility of overspecification and multicollinearity in our models.

We adopted a model building approach to test our main hypotheses. Theoretically, we were interested in the ability of a) demographic characteristics, b) congregant religiousness, c) congregation-level religiousness and other characteristics, and d) clergy characteristics to predict five help seeking dependent variables: intentions, attitudes, perceived control, perceived effectiveness, and depression. As such, we created five sets of MLMs, each set following the same basic procedure but focusing on a different dependent variable. In each set, we used a bottom-up model building approach that begins with a null model and then methodically adds predictors. Each model is compared to the previous model using the AIC and BIC to ensure that adding predictors explains more variation in outcomes, and only significant predictors are retained in subsequent models (Hox et al., 2017). Because of the potential for overspecification

and multicollinearity, at each step, we only included predictors that a) evidenced significant zero-order correlations with treatment seeking indicators ($p < .05$; see *Table 1* and *Table 2*) and b) did not increase the variance inflation factor (VIF) of any predictor beyond the commonly accepted value of 4 (Hair et al., 2010). VIFs were calculated using the vif.mer function (Robinson, 2019). Each set of models included up to five models with the following predictors added at each step: a) a null model, b) demographic predictors, c) congregant religiousness, d) congregation-level religiousness, and e) clergy characteristics.

Results

Help-Seeking Intentions

Correlational analyses indicated that only congregant religiousness was significantly associated with help-seeking intentions. As such, only a null model and a model including congregant religiousness were constructed. The null model indicated that 3% of the variation in Intentions could be attributed to congregation-level factors (AIC = 925.43; BIC = 935.72). The model with congregant religiousness indicated that congregant religiousness was significantly related to Intentions ($\gamma = 0.09$, $SE = .04$, $t(213) = 2.47$, $p < .05$) such that greater religiousness was related to increased Intentions. This model evidenced improved fit over the null model (AIC = 921.38; BIC = 935.09) and explained approximately 2% of the variation in Intentions. See table 4.

Help-Seeking Attitudes

Correlational analyses indicated that only the frequency with which clergy discussed mental health was significantly related with help-seeking attitudes. As such, only a null model and a model including Discussion Frequency were constructed. The null model indicated that 2% of the variation in Attitudes could be attributed to congregation-level factors (AIC = 701.30; BIC

= 711.39). The model with Discussion Frequency indicated that the more clergy discussed mental health, the more positive help-seeking attitudes congregants reported (γ = .29, *SE* = .11, $t(10) = 2.59$, $p < .05$). This model evidenced improved fit over the null model (AIC = 595.90; BIC = 608.75) and explained approximately 5% of the variation in Attitudes.

Perceived Behavioral Control

Correlational analyses indicated that Education, Gender, Discussion Frequency, and the presence of printed information about mental health in worship spaces (Mental Health Indicators) were related to Perceived Control. However, when all variables were entered together, the VIF for Mental Health Indicators was above the cut-off value of 2 (2.54), likely because Mental Health Indicators was substantially related to Discussion Frequency ($r = .74$, $p < .01$). Because Discussion Frequency evidenced a stronger zero-order correlation with Perceived Control, Discussion Frequency was retained in future models.

Three models were constructed for Perceived Control: a null model, a model with Education and Gender, and a model adding Discussion Frequency to Education and Gender. The null model indicated that 7% of the variation in Perceived Control could be attributed to congregation-level factors (AIC = 876.08; BIC = 886.32). The model including Education and Gender indicated that higher Education (γ = 0.30, *SE* = .11, $t(205) = 2.62$, $p < .01$) but not Gender (γ = 0.28, *SE* = .25, $t(205) = 1.12$, $p = .27$) was related to greater Perceived Control. This model evidenced improved fit over the null model (AIC = 860.96; BIC = 881.37), and thus Education was retained as a predictor in subsequent models. The model including Discussion Frequency indicated that both Education (γ = 0.24, *SE* = .11, $t(180) = 2.11$, $p < .05$) and Discussion Frequency (γ = 0.45, *SE* = .15, $t(10) = 3.07$, $p < .05$) were related to Perceived Control. This model evidenced improved fit over the previous model (AIC = 732.68; BIC =

749.00) and explained approximately 14% of the variation in Perceived Control. This model suggested that the more educated congregants were and the more frequently mental health issues were discussed, the more able they felt to seek mental health services.

Perceived Effectiveness

Zero-order correlations indicated that no variables were significantly related with the perceived effectiveness of psychotherapy. As such, only a null model was constructed. This model indicated that < 1% of the variation in Perceived Effectiveness could be explained by congregational factors (AIC = 907.67; BIC = 917.86).

Depression

Correlational analyses indicated that Education, Gender, Congregant Religiousness, and the availability of mental health programming in a congregation (Mental Health Programming) were significantly related with depression. As such, four models were constructed: a null model, a model including the two demographic variables, a model including Congregant Religiousness, and a model including Mental Health Programming.

The null model revealed that 10% of the variation in Depression could be accounted for by congregation-level predictors (AIC = 305.52; BIC = 315.92). The model including demographic predictors indicated that Education (γ = -.06, *SE* = .03, $t(217) = -2.20$, $p < .05$) but not Gender (γ = 0.02, *SE* = .06, $t(217) = 0.35$, $p = .72$) was related to Depression. This model evidenced improved fit over the null model (AIC = 282.15; BIC = 299.40), and as such Education was retained in subsequent models. The model including Congregant Religiousness indicated that neither Congregant Religiousness (γ = -.01, *SE* = .01, $t(218) = -1.31$, $p = .20$) nor Education (γ = -.05, *SE* = .03, $t(218) = -1.77$, $p = .08$) were related to Depression. However, this model did not evidence substantially improved model fit over the previous model (AIC = 280.87;

BIC = 298.15) and was not retained. The model including Mental Health Programming indicated that Mental Health Programming (γ = -.08, *SE* = .02, $t(11) = -3.39$, $p < .01$) but not Education (γ = -.05, *SE* = .03, $t(218) = -1.77$, $p = .08$) was related to Depression. This model evidenced improved fit over previous models (AIC = 266.88; BIC = 283.74) and explained approximately 11% of the variation in Depression. This model suggests that the more mental health programming congregants have available, the fewer depressive symptoms they report.

Discussion

Using 239 participants from 14 congregations, we examined the role that religiousness plays in help seeking at the individual, congregational, and clergy levels. Many of our hypotheses were supported partially. Our first hypothesis (H1) was partially supported as congregational- and clergy variables were sometimes but not always related to help seeking. We found that individual religiousness was related to help-seeking intentions; however, contrary to our second hypothesis (H2), we found that religiousness was *positively* related to help seeking. Contrary to our third hypothesis (H3), we failed to find evidence that congregational variables predicted help seeking; however, we found that the availability of mental health programming was related to reduced depression. In accord with our fourth hypothesis (H4) we found that the frequency with which clergy had mental health discussions was related to treatment seeking. Our final hypothesis (H5) was also supported as religiousness was negatively related to depression.

Congregations as a Level of Analysis

Our hypotheses were built on the assumption that individuals were meaningfully clustered into congregations and that consequently, congregational factors should be taken into account when interpreting our findings. Previous work has found congregational effects to be large, explaining nearly a 1/3 of the total variation (Lefevor et al., 2019; Lefevor et al, 2020a).

However, in the present study, congregations accounted for between 0% and 10% of the variation in outcomes, averaging 4.4%. Although this percentage is still substantial (small-to-medium by conventional effect size standards; Cohen, 1988), it is notably smaller than observed in other work. It is possible that congregational variables were not as influential in predicting help seeking because mental health is not explicitly discussed in the scripture, where other constructs assessed (i.e., attitudes toward same-sex sexuality) are more directly addressed; alternatively, the racial/ethnic, gender, and religious homogeneity of our sample may have understated the potential effects of congregations. Our results suggest that while congregations reliably vary in their help seeking, much more variation occurs between individuals than between congregations.

Religiousness and Help Seeking

Perhaps the most unexpected finding was that religiousness was not related to most indicators of help seeking and that, when it was, it was *positively* related. Particularly, we found that increased religiousness was related to increased help-seeking intentions, which may be the strongest predictor of behavior (Hammer et al., 2018; Li et al., 2018). Several explanations are possible for this trend. Perhaps the most direct explanation is that religiousness—when conceptualized as service attendance, scripture reading, and religious commitment—encourages mental health among its adherents (Bonelli & Koenig, 2013). Thus, those who are most engaged may be most likely to recognize the need to seek help when needed.

This explanation, does not fully address decades of research that have shown religiousness to be associated with stigma and reductions in treatment seeking (Lukachko et al., 2015; Molock et al., 2007), though it may suggest that religious individuals' attitudes toward help seeking have shifted over time. Additionally, we draw attention to the fact that our sample

was comprised primarily of middle-aged, Black women who attended services frequently. National data has suggested that Black individuals and women attend services more frequently than White individuals and men (Pew Research Center, 2015), and studies have suggested that religion may be more positively related to health for Black than White individuals (Lefevor, Smack & Giwa, 2019) and for those who are more religious compared to those who are less religious (Lefevor, Davis et al., 2021). Thus, it may be we sampled a group that was particularly positively disposed toward mental health treatment and that the relationships observed are attributable to the specific sample selected.

The Influence of Clergy on Help Seeking

We found that some clergy variables were related to congregant's likelihood of help seeking. In particular, the frequency with which clergy discussed mental health issues was related to an improved sense of control among congregants over their ability to seek help and to more positive attitudes toward seeking help. Although we interpret the significance of this relationship, we also note that clergy variables were not significantly related to other TOPB constructs including help-seeking intentions, or perceived effectiveness.

Because clergy have unique positions of power in their places of worship, and often also in their communities more broadly (Bilkins et al., 2016), they may act as "gatekeepers" of the community, effectively bridging the gap between the religious community and secular resources and providing congregants with the necessary tools and language to combat mental health issues. Gatekeepers have been identified as important assets for reaching underserved communities, as trusting relationships have already been established (Molock et al., 2007). This is particularly true for religious populations, as many religious individuals report seeking help from their religious community before utilizing any other resource (Aldalaykeh et al., 2019). Thus, clergy

may act as a powerful validating force in the lives of their congregants by speaking openly about psychotherapy, empowering their congregations to seek treatment by removing perceived barriers about the conflict between psychotherapy and religion.

Increased clergy discussion of mental health issues and resources was also related to more favorable attitudes of congregants toward help seeking. Negative attitudes toward mental health issues often manifest as fear, stigma, and rejection, which may be reduced through psychoeducation and exposure (Wrigley et al., 2005). Thus, clergy who use their platform to expose congregants to mental health issues and resources might naturally improve attitudes about the subject by normalizing and destigmatizing the idea of help seeking.

Previous work has demonstrated the influence of clergy on the attitudes and behaviors of congregants, with several studies specifically supporting their influence over physical and mental health-related issues (Toni-Uebari & Inusa, 2009; Vermaas et al., 2017; Young et al., 2003). The present study nuances this relationship by highlighting that discussion of mental health issues may be the operative factor in this relationship, at least among Christian clergy. Clergy stigma towards mental health issues and services was related to their likelihood of referring a congregant for psychotherapy, but neither variable was related to any help-seeking outcomes among congregants, suggesting that clergy's actions may be more impactful than their attitudes.

Religiousness and Depression

Consistent with prior evidence, in correlational analyses, religiousness was found to be generally related to fewer depressive symptoms among congregants (Bonelli et al., 2012). Several factors could contribute to this relationship, including social support within congregations, promotion of decision-making that reduces the risk for negative life events, help coping with stressful life events, and greater life satisfaction among religious individuals

(Bonelli et al., 2012). In the present study, religiousness was measured as frequency of attendance and scripture reading, and intrinsic religiousness. Service attendance and scripture reading may motivate increased engagement with the congregation, providing social support, that may buffer depressive symptoms. Further, intrinsic religiousness may predispose congregants to conceptualize their depression as an issue that requires the support of the congregation and their faith (Payne, 2009), further enabling social support.

Although the relationship between religiousness and health is well established (Park & Slattery, 2003), much less has been studied about the ways that clergy and congregational factors may impact their congregants' health. We found that congregants who worshipped in a congregation that provided access to mental health programming (e.g., support groups, alcoholics anonymous, marital counseling) evidenced less depression than congregants who worshipped in a congregation without as many resources. Providing explicit mental health resources in congregations may provide passive psychoeducation as well as access to resources.

Limitations

Our results are inevitably limited by several characteristics of the sample, sampling method, and measures used. Participants in this study were primarily Black, Christian women living in a mid-size city in the American South who self-selected to participate in this study. These demographics largely match the city from which they were sampled and also match national trends in service attendance (i.e., individuals who are female, Black, and Christian tend to attend services more than those who are not; Pew Research Center 2015). Nonetheless, future research should be done to enhance generalizability and ensure replicability. An ideal study would collect data from several cities (with varying degrees of urbanicity) across the United States and may purposively oversample individuals from nonChristian religions. Additionally,

clergy and religious individuals were approached for participation following a worship service at their place of worship, and thus our sample only represents those who attend religious services and those inclined to spend time filling out a survey about help seeking. It is possible that religion has differential effects on help-seeking behaviors of individuals who attend worship services less frequently or not at all.

There were additional limitations to the reliability and validity of the results. For example, all information was collected by a single research assistant on a single visit to each place of worship. A mixture of well-validated (e.g., MHSAS, MHSIS), newer (e.g., Mental Health Programming Available) and researcher-created (e.g., clergy referral likelihood, frequency of preaching about mental health) instruments were used in the survey. Further, some constructs (e.g., perceived effectiveness, frequency of discussions) were assessed by a single item, which are limited in their reliability and validity. Finally, we did not assess social desirability. Since religious individuals tend to be more socially desirable than nonreligious individuals (Kramer & Shariff, 2016), it is possible that participants may be underreported depressive symptoms and overreported help-seeking intentions and attitudes.

The survey presented to participants included questions regarding attitudes toward both mental health issues and homosexuality. Clergy were informed of the full content of the survey prior to allowing access to congregants, and thus it is possible that religious groups which declined participation hold ideologies which may influence their attitudes toward mental health issues and treatment. Finally, the subjective norms measure used in this study was not effective in measuring subjective norms. Although we followed recommendations used in previous literature (Hammer et al., 2018), our measure may have fallen short by having too few items. A 10-item measure of subjective norms that followed Ajzen's (2002) recommendations has

demonstrated adequate internal consistency (Hammer & Vogel, 2013), and should be used in future work.

Implications

Our results carry implications for research, therapy, and social justice advocacy. We found that congregational and clergy variables had discernible impacts on congregant's depression and likelihood of help seeking. Clergy may thus be an important community partner for psychotherapists in seeking to destigmatize treatment seeking. Although clergy have better mental health literacy than the general public, they have less mental health literacy than psychotherapists (Vermaas et al., 2017). Direct training with local clergy—including responsive listening and learning—may help effectively educate clergy about mental health and resources as well as educate psychotherapists about the unique religious needs of potential clients. Such conversations may encourage clergy to discuss mental health issues with their congregations as we found that such discussions were linked with help seeking.

Given that the availability of mental health programming was most strongly related to congregants' experiences of depression, psychotherapists and clergy may also work together to establish community-based mental health service models. For example, a psychotherapist in private practice may hold sessions at a local place of worship one day a week to increase access. Psychotherapists and clergy may also collaborate on the types of programming that may be most helpful for congregants. In this role, psychotherapists may contribute knowledge on the structure or format of such programming (e.g., support group, presentation), and the clergy may help promote and encourage congregants to participate. Clergy may be instrumental in directing those in need to psychotherapy, as religious individuals often respond more positively to advice given by religious leaders and turn to clergy first when mental health issues arise (Aldalaykeh et al.,

2019; Lakhan, 2018). Collaborations between psychotherapists and clergy may be helpful in improving attitudes and reducing stigma toward mental health issues and psychotherapy.

Conclusion

With a sample of 239 religious individuals nested within 14 congregations, we evaluated the effects of individual, congregational, and clergy variables on an individual's tendency to seek help. Specifically, we examined the effects of religiousness on each component of the Theory of Planned Behavior: intentions, attitudes, subjective norms, perceived behavioral control, and perceived effectiveness. Although some relationships were significant, we did not find overwhelming evidence that religiousness impacted constructs of the Theory of Planned Behavior. However, we found that individual religiousness uniquely affects both depressive symptoms and intentions to seek help, with more religious individuals demonstrating fewer depressive symptoms and greater intentions to seek help overall. We also found that the frequency with which clergy discusses mental health issues impacts both congregants' attitudes toward mental health and the amount of control they feel that they have over their ability to seek help if necessary. These results suggest a more nuanced relationship between religiousness and help seeking than previously recognized and emphasize the role that clergy may play in providing proper mental health resources to religious individuals.

Table 1. The relationship between demographics, group-centered religiousness, and treatment seeking.

	M	*SD*	Range	1	2	3	4	5	6	7	8	9
1. Age	55.40	17.38	18 – 93									
2. Ethnicity			0 – 1	-.10								
3. Gender			0 – 1	.10	.13							
4. Education	3.49	1.10	1 – 5	-.07	-.32	-.01						
5. Religiousness	23.03	3.67	5 – 27	.13	.02	.10	.23					
6. Intentions	5.68	1.83	1 – 7	.05	< .01	.08	.08	**.17**				
7. Attitudes	1.97	1.23	1 – 7	.04	.03	.08	.08	.06	.28			
8. Perceived Control	5.54	1.69	1 – 7	.04	-.05	**.17**	**.17**	.06	.25	.19		
9. Perceived Effectiveness	5.28	1.88	1 – 7	.08	-.01	.03	.03	.10	.72	.35	.31	
10. Depression	0.40	0.47	0 – 3	-.01	.02	**-.13**	**-.13**	**-.17**	-.10	-.10	.11	-.09

Note: Cut offs based on $n = 239$ congregants: $p < .01$ ($r > .16$); $p < .05$ ($r > .12$); relationships between IVs and DVs significant at the $p < .05$ level are bolded; Gender (1 = woman) and Ethnicity (1 = person of color) were dichotomized for analyses.

Table 2. The relationship between congregation- and leader-level variables and treatment seeking.

	M	*SD*	Range	1	2	3	4	5	6	7	8	9	10
1. Congregation-level Religiousness	23.26	1.46	19.82 – 24. 94										
2. Mental Health Programming Available	2.40	1.68	0 – 5	.23									
3. Mental Health Awareness Indicators	0.54	1.17	0 – 4	-.35	.41								
4. Leader Stigma	1.99	0.68	1 – 3	.26	.20	-.46							
5. Leader Referral Likelihood	1.62	1.08	1 – 4	-.46	-.35	.27	-.71						
6. Leader Frequency Mental Health Discussions	3.18	0.78	1 – 5	-.06	.46	.74	-.19	.24					
7. Intentions	5.70	0.55	4.77 – 6.71	-.49	-.11	.38	-.36	.73	.45				
8. Attitudes	6.07	0.34	5.07 – 6.60	.27	.38	.12	-.08	.19	**.66**	.13			
9. Perceived Control	5.63	0.54	4.38 – 6.75	-.36	.28	**.64**	-.36	.32	**.65**	.22	.48		
10. Perceived Effectiveness	5.30	0.47	4.50 – 6.67	-.07	.02	.11	-.25	.44	.36	.77	.33	-.05	
11. Depression	0.41	0.19	0.11 – 0.77	-.32	**-.72**	-.23	.11	.05	-.46	-.10	-.58	-.26	-.47

Note: The range is an indicator of the observed range and not scale endpoints; pairwise complete observations were included; Cut offs based on $n = 14$ congregations: $p < .01$ ($r > .66$); $p < .05$ ($r > .53$); relationships between IVs and DVs significant at the $p < .05$ level are bolded

Table 3. Demographic characteristics of the 14 included congregations.

Congregation Number	*n*	Percent Women	Percent People of Color	Percent with College Degree	Average Age	SD
1	13	61.53%	0.00%	46.15%	78.46	6.53
2	22	77.27%	100.00%	27.27%	57.05	15.46
3	13	69.23%	7.69%	84.62%	50.08	16.15
4	7	71.42%	100.00%	0.00%	63.33	8.62
5	16	68.75%	100.00%	56.25%	47.38	14.68
6	10	90.00%	100.00%	30.00%	68.10	12.30
7	26	80.77%	100.00%	36.00%	52.96	11.71
8	50	82.00%	100.00%	44.00%	58.53	14.78
9	9	66.67%	77.78%	55.56%	43.67	16.52
10	4	75.00%	100.00%	50.00%	38.75	12.31
11	22	65.00%	95.00%	25.00%	46.18	18.77
12	14	57.14%	7.14%	100.00%	60.21	12.80
13	13	61.53%	7.69%	46.15%	32.08	12.93
14	21	73.68%	10.00%	85.71%	63.45	14.92

Table 4. Multilevel models examining the effects of demographics, religiousness, and congregational mental health practices on congregant treatment seeking

	Intentions	**Attitudes**	**Perceived Behavioral Control**	**Perceived Effectiveness**	**Depression**
Fixed Part					
Intercept	5.70** (0.15)	6.04** (0.09)	5.61** (0.12)	5.30** (0.13)	0.41** (0.04)
Age					
Gender					
Ethnicity					
Education			0.24* (0.11)		
Individual Religiousness	0.09* (0.04)				
Congregation-level Religiousness					
Mental Health Programming Available					-.08** (.02)
Mental Health Awareness Indicators					
Leader Stigma					
Leader Referral Likelihood					
Leader Frequency Mental Health Discussions		.29* (0.11)	0.45* (0.14)		
Random Part					
$\sigma^2_{Initial}$	3.23	1.48	2.67	3.53	.19
$\tau_{00Initil}$	.09	.03	.20	< .01	.02
Intraclass Correlation	.03	.02	.07	0	.10
σ^2_{Final}	3.13	1.43	2.47	3.53	.19
$\tau_{00Final}$	.11	<.01	< .01	< .01	.01
R^2_{Total}	.02	.05	.14	0	.11
Model Fit					
AIC	921.38	595.90	732.68	907.67	266.81
BIC	935.09	608.75	749.00	917.86	280.31

Note. Only final models are presented in this table; σ^2 = Level 1 variance; τ_{00} = Level 2 variance; R^2_{Total} = Amount of total variance accounted for in the dependent variable by the model.$^{+}$ $p < .10$; * $p < .05$; ** $p < .01$

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