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The Relationship Between Religiosity and Mental Illness Stigma in the Abrahamic Religions

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THE RELATIONSHIP BETWEEN RELIGIOSITY AND MENTAL ILLNESS STIGMA IN THE ABRAHAMIC RELIGIONS

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APPROVAL OF DISSERTATION

We, the faculty supervising the work of Emma C. Bushong, affirm that the dissertation, *The Relationship Between Religiosity and Mental Illness Stigma in the Abrahamic Religions*, meets the high academic standards for original scholarship and creative work established by the Doctor of Psychology (Psy.D.) program and College of Liberal Arts. This work also conforms to the editorial standards of our discipline and the Graduate College of Marshall University. With our signatures, we approve the manuscript for publication.

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ABSTRACT

Numerous studies have established and examined the critical interplay between religion and mental health. A systematic review of existing literature found that the endorsement of religious beliefs and frequent attendance at religious services were routinely associated with greater physical and psychological well-being (Koenig, 2012; Tsaousis, Karademas, Kalatzi, 2013). Yet, history has shown that religion can be a source of conflict and prejudice and that individuals fostering negative religious perceptions can exhibit poorer mental health (Lee & Newberg, 2005; Pargament, 1997). Because religious and spiritual beliefs often guide perceptions and affect behavior toward others, the present study examines such influence as it pertains to the relationship between religiosity and mental illness stigma in the Abrahamic faiths. Three hundred and three participants provided general demographic information, information regarding degree of religious affiliation, and responses to the Centrality of Religiosity Scale -15 (Huber & Huber, 2012) and the Devaluation Discrimination Scale (Link, 1987). A regression analysis and one-way analysis of variance were completed to assess the relationship between levels of religiosity and levels of mental illness stigma and examine differences in stigma levels across faith communities. No significant results were found. Reasons and future research directions are explored.

CHAPTER 1

LITERATURE REVIEW

In his work *The Future of an Illusion*, Freud argues that religion is akin to a childhood neurosis, little more than a cultural expression of distress and means of wish-fulfillment (Freud, 1927, as cited in Pieper & van Uden, 2005). In reference to this particular assertion, Pieper and van Uden (2005) note that existing literature does not support so clear-cut a connection. Nevertheless, an extensive body of research now supports a link between religion and mental health (Hill & Pargament, 2003). Koenig's (2012) systematic review of existing literature found that the endorsement of religious beliefs and engagement in related practices were consistently linked to increased life satisfaction, happiness, positive affect, greater social support, and lower levels of depression; yet, individuals harboring negative religious perceptions can also demonstrate poorer mental health (Pargament, 1997). Williams and Sternthal (2007) note that religious communities can be "judgmental, alienating, and exclusive" (p.48). History has shown that religion can be a source of conflict, prejudice, and violence, leading to the ostracism of outsiders and justification of hatred (Lee & Newberg, 2005). Given that religion and mental health demonstrate such critical connections – specifically, the capacity for religious communities to both positively and adversely influence individuals – a more specific inspection of the relationship between religiosity and mental illness stigma in the Abrahamic faiths is warranted.

Parsing Religiosity and Spirituality

Despite years of research and considerable effort, there exists little consistency or consensus regarding the conceptualization and differentiation of 'religion' and 'spirituality' (Zinnbauer et al., 1997). Historically, disjunction was incited by a rise in secularism during the

mid-1900s; as a result of this movement, spirituality became divided from religion and began to evolve a unique significance (Ivtzan et al., 2013).

As a result of its association with and emphasis upon individual experiences of transcendence, spirituality has recently been afforded a particularly positive position (Spilka & McIntosh, 1996 as cited in Zinnbauer et al, 1997). Religion, rife with structure and formalities perceived as impediment to this genre of experience, has been perceived unfavorably (Turner et al., 1995 as cited in Zinnbauer et al., 1997). With respect to definition, the term spirituality is employed to describe a subjective, internal experience that prompts an interest in the meaning of life (Ellens, 2008 as cited in Ivtzan, Chan, Gardner, & Prashar, 2013). The term religion, conversely, describes beliefs, doctrines, creeds, and particular theologies subscribed to by members of a social group; these shared practices and ideals reflect a particular understanding of God and the world (Ellens, 2008 as cited in Ivtzan, Chan, Gardner, & Prashar, 2013; Miller & Thoresen, 2003).

King, Speck, and Thomas (2001) further parse the relationship, suggesting that religion "pertains to the outward practice of a spiritual understanding and / or the framework for a system of beliefs, values, codes of conduct and rituals" (p. 1015). There is, typically, an aspect of communal observance (King, Speck, & Thomas, 2001). In contrast, the term spiritual is described as a more general reference to an individual's belief in a power outside of their own presence. Spirituality is defined by a sense of connection to aforementioned power transcending present reality.

Religion and Wellbeing

Within the context of religion and belief, Pieper and van Uden (2005) note that there exists a wide variety of experiences and activities with therapeutic or formative functions. Both

participation in religious rituals (such as celebrations, confessions, exorcisms, pilgrimages, etc.) and intense religious experiences (such as conversion, speaking in tongues, and mystical encounters) are widely regarded as having curative and therapeutic effects. Religious socialization or upbringing can serve as a way to channel, reform, or remodel potentially problematic behaviors into more socially acceptable actions. For example, within religious families, education is frequently focused upon controlling or containing objectionable impulses and emotions such as aggression and anger.

Pieper and van Uden (2005) further note that, even beyond the family context, religious communities can influence and impress upon adherents. Such communities may exercise authority over individuals by denouncing or castigating undesirable behavior and, conversely, appreciating or endorsing good behavior. The more intimate or involved the community, the more radical the 'shaping' potential. In addition to such social pressures, the substance or content of beliefs (doctrines, dogma, etc.) can exert a regulatory effect. For example, 'good' Christians must observe the Ten Commandments and numerous other doctrines. In conjunction with notions of a punitive Creator, such adherence can have pronounced influence upon social behavior. This sort of 'shaping' can also arise through the imitation of religious models. That is, models found within the religious tradition and community (pastors, ministers, Biblical heroes, Jesus and his apostles, martyrs, saints, etc.) can exert a powerful influence.

In addition to the capacity for behavioral influence, Pieper and van Uden (2005) note that religious communities can act as shelters, offering sanctuary and support in the face of daily troubles and tensions. A belief in divine protection can alleviate feelings of insecurity while acceptance by and integration into a religious group can assuage fears of rejection and social isolation. Research examining individual attraction to/ investment in religion notes that pursuing

a relationship with God or a place in a congregation may reflect a more general desire for interpersonal connection and social support.

Positive effects have been repeatedly evidenced in research investigating the relationship between religion and mental health. In an attempt to assess this body of literature, Koenig (2012) conducted a systematic review of peer-reviewed studies published through mid-2010, hypothesizing that religious involvement would increase positive emotions and neutralize negative emotions. Religion and spirituality were found to enhance quality of life and serve as a coping resource. Both qualitative and quantitative research suggests that religion and spirituality aid in coping with external and internal adversity. Significant positive associations were found between religion and spirituality and an individual's general well-being, degree of hope, and sense of meaning and purpose.

Similarly, an analysis conducted by Pollner (1989) reports that "relations with a divine other are a significant correlate of well-being" (pg. 100), surpassing alternative predictors such as sex, income, age, race, church attendance, and marital status. Persons with strong religious faith report high levels of personal happiness, greater life satisfaction, and fewer negative psychosocial consequences in the face of traumatic life events (Ellison, 1991). Ellison and Levin (1998) outline and examine several potential explanatory mechanisms by or through which aspects of religious involvement may benefit adherents. Such mechanisms, which incorporate both psychosocial and behavioral constructs, include (but are not limited to) the provision of social and specific coping resources, lifestyle and health behavior regulation, and the cultivation of positive self-perceptions and emotions. Research by Levin (2001) provides evidence that loving and believing that one is loved by God positively influences perceptions of health. More

specifically, results indicate a strong, statistically significant link "between a loving relationship with God and positive ratings of self-health" (pg. 287).

One study assessed the significance of religious coping in general psychiatry institutions, forensic psychiatry institutions, and nursing homes (Pieper & van Uden, 2012). Specifically, investigators examined the extent to which patients utilized religious coping activities in dealing with their problems and the effects of such coping activities on well-being. Ultimately, for patients in all institutions, religion functioned as an important coping resource. Seventy-four percent of nursing home respondents, 54% of general psychiatric respondents, and 50% of forensic respondents reported positive influence. Conversely, 16% of general psychiatric respondents, eight percent of forensic respondents, and four percent of nursing home respondents reported a negative influence. Such positive influence appears to spur increased well-being in the form of decreased anxiety and enhances existential well-being; yet, when the negative influence of religion is considered in the model, it becomes apparent that such influence exerts a far more substantial influence upon well-being. It is noted that, in a majority of cases, religious emphasis upon humility / guilt negatively impacted individuals.

Wnuk and Marcinkowski (2014) posit that one way in which religiosity advantageously impacts psychological wellbeing is through enhancing hoping and providing meaning of life. To this end, a study was conducted assessing the relationships among spiritual experiences, meaning in life, hope, and psychological wellbeing (denoted as life satisfaction, positive / negative affect). Results indicate that meaning of life serves as a significant, mediating variable in the relationship between religious / spiritual aspects of functionality and an individual's quality of life. By finding religious meaning individuals can experience happiness, wellbeing, and life satisfaction. This relationship holds for populations of students, women, and Alcoholics Anonymous

representatives across both negative and positive assessments of well-being. Wnuk and Marcinkowski (2014), additionally, note that hope also served as a mediating variable in relationships between spiritual experiences and positive affect and spiritual experiences and life satisfaction. It is suggested that hope is enhanced by experiencing the presence of God as a source of peace, strength, joy, and balance, as experiencing God's guidance or love, as an acceptance of others or feeling of personal integrity, as identification with the good in the world and sense of selflessness. Hope is, similarly, reflected in positive goals, convictions, thoughts, and worldviews.

Van Cappellen, Toth-Gauthier, Saroglou, and Fredrickson (2016), explored the importance of positive emotions in the relationship between religiosity / spirituality and well-being. Two cross-sectional studies were completed. Results of study one, involving a population of European churchgoers, showed that the emotional effects of mass served as a mediating variable in the relationship between religion and well-being. More specifically, self-transcendent positive emotions such as peace, love, awe, and gratitude served as significant mediators (other positive emotions – such as amusement and pride – did not). The authors note that, in the complete model, neither social nor cognitive effects of mass served as significant mediators. Serving to extend study one, study two recreated that finding of study one with a population of U.S. university employees and a different measure of spirituality.

Although positive effects are widely evidenced, religion can also adversely influence mental health. Historically, religion has spawned conflict, produced prejudice, served as justification for violent behaviors, and been grounds for exclusion and ostracism (Lee & Newberg, 2005). Even today, religion can be "judgmental, alienating, and exclusive" (Williams & Sternthal, 2007, pg. 48). An inability or failure to conform to the norms of a particular

religious community may elicit criticism from the clergy / congregation members. Such criticism, combined with an individual's perception of having committed a religious transgression, can incite psychological and emotional distress that may manifest physically (Lee & Newberg, 2005).

Trenholm, Trent, and Compton (1998) note that cross-cultural evidence provides support for a "relationship between moral conflict and anxiety" (pg. 60). Particularly rigid or dogmatic religious and moral beliefs have been linked to anxiety incited by the possibility of punishment (Trenholm, Trent, & Compton, 1998). More specifically, perceptions of a vindictive God produce distress and fear of inevitable castigation. To this end, personal conflict regarding religious transgressions were shown to be a significant predictor of panic disorder. Pargament (2002) notes that feelings of rejection or abandonment from God may be particularly agonizing because they imply an absolute unlovabilty and ultimate culpability. Furthermore, questions regarding religious truth or God's omnipotent existence can incite internal instability, upturning an individual's world and way of life. Likewise, impressions of God as hostile or even powerless may destroy an individual's image or understanding of an altruistic and secure world. Injuries, insults, or threats aimed at or impinging upon the sacred may also be especially inimical as individuals are apt to resort to drastic measures to maintain those things they deem divine.

CHAPTER 2

LITERATURE REVIEW

The Abrahamic Religions

The 'Abrahamic faiths' or 'religions of Abraham' are conglomerate terms for Christianity, Judaism, and Islam, accentuating their common heritage and certain theological similarities (Dodds, 2009). Dodds (2009) discusses three increasingly complex levels of linguistic usage. The first, and most basic, is simply a useful designation for three religions that trace their lineage to the prophet and patriarch Abraham; it is a convenient, short-hand method of reference, more functional than theological. Second level usage is, in a sense, more specialized. Second level usage is intended to communicate theological and historical commonality. The extent of this commonality is, however, open and intricate, carrying an unspecified weight while still recognizing differences. Third level usage proclaims cohesion to the extent that the plural is removed – 'Abrahamic faith' as opposed to 'Abrahamic faiths' – speaking to a solidarity which involves a belief in the same God.

Christian, Jewish, and Islamic religions share the same roots. Pridmore and Pasha (2004) note that all trace their origins to the prophet Abraham and his wife Sarah who lived in Canaan (Palestine) and were long without child. As time passed and it appeared as if Abraham would have no heir, Sarah advised that he attempt to impregnate Hagar, her servant. Hagar bore a boy who was called Ishmael. Sarah soon became pregnant herself; she too bore a boy who was called Isaac. Sarah, concerned that the first-born Ishmael would displace her own son as the primary inheritor, pleaded with Abraham to send Hagar and her son away. Abraham acquiesced and Hagar and Ishmael journeyed to a location at or near the present Mecca. The descendants of Isaac formed the Hebrew tribes who became the Jews; the descendants of Ishmael became the

Muslims. Abraham himself is a prominent figure in the Christian Old Testament (Pridmore & Pasha, 2004).

Mojzes and Swidler (2002) note that, aside from such sacred lineage, the Abrahamic religions share numerous traits and tenets. Christianity, Judaism, and Islam are monotheistic religions; they believe that there is only one God who is the source and ultimate origin of all creation. God attends to and desires the well-being of all things. He is just and, according to his intentions, guides adherents down a path of goodness and righteousness. The Abrahamic faiths assert that human beings are the highest creatures walking the earth; God designed and delivered man with the potential for constant growth, both individually and collectively. Human beings, it is believed, have the capacity for both good and evil. Abrahamic adherents can exercise this ability in innumerable ways. Extending Mojzes and Swidler's explanations to the more specific issue of mental illness stigma, it is clear that one such opportunity comes in the form of either the acceptance or the rejection of stigmatizing beliefs. Adopting a belief in one God who is the creator of all things seems to presuppose an innate equality, an equality that 'goodness and righteousness' seem to dictate be observed by abandoning prejudice and embracing diversity.

The Abrahamic religions, Mojzes and Swidler (2002) further note, maintain that God and human beings can communicate. God is believed to communicate with people through revelations. The revelations of prophets are recorded in the Holy Scriptures of each religion. In such a way, God has provided man with guidelines or rules to live by.

For example, Mojzes and Swidler (2002) note that all three religions speak against murder or any arbitrary termination of innocent life. Likewise, God wants man to tell the truth, to leave others what is rightfully theirs, to respect the dignity of each person, and to care for those who are not able to care for themselves. God gifted man with a rational mind so as to

comprehend the everyday application of such rules. Men are to submit themselves to the will of God. Mojzes and Swidler note that all three faiths recognize a close relationship between religion and morality. Religiosity is expressed through a life of service and ethical behavior, by the demonstration of compassion and concern for the well-being of others. Once again extending Mojzes and Swidler's explanation to the more specific issue of mental illness stigma, such divine calls for ethicality and respect seem to demand compassion and empathy rather than degradation and distain for individuals afflicted with mental health issues.

Christianity

Brackney (2010) suggests that, throughout the years, the Christian community has achieved and espoused a relatively consistent set of values that address the essential questions and concerns of a religious tradition. However, for practicing Christians, it is not enough to adopt this perspective without behaving in accordance with its principles. Christians think of their presence in this world as an expression of God's existence in the earthly realm. Within the context of the Christian community, fulfillment or satisfaction amounts to a sense of oneness or peace with God, meaning that an individual can be released from anxiety about eternal destiny or ultimate value. This unity is accomplished through devotional acts such as prayer, reading Scripture, the sacraments, virtuous deeds, and the reinforcement of basic convictions by engaging in the larger community.

Christian theology, Brackney (2010) notes, is a product of the Old and New Testaments, shaped by centuries of interpretation, and authenticated by the practices of the community. The distinguishing theological characteristic of Christianity and Christian perceptions of God centers upon the person and the work of Jesus Christ. Jesus is acknowledged as both the son and a direct incarnation of God. In the final week of his earthly life, Jesus was wrongfully accused, tried, and

crucified by Jewish and Roman powers during the annual Passover Celebration. Christians believe that, three days later by the power of God, Jesus was resurrected and walked the earth for 40 days thereafter, providing proof of a post-Resurrection life. For Christians, Jesus's sacrifice becomes an opportunity for human salvation, recompense and reconciliation with God. Among Christians, Jesus is revered for his indiscriminate charity and benevolence. Building upon Brackney's characterization, it may be reasonably assumed that Christians intending to emulate such unconditional compassion would aid and embrace mentally ill individuals.

Brackney (2010) explains that early Christian followers also established an intricate understanding of a third manifestation of God, the Holy Spirit. Jesus taught that after he left earth, the spirit would remain and reside within communities of the faithful to guide understanding, provide necessary discipline, and authenticate experiences. These three manifestations – God (father), Jesus (son), and Holy Spirit –compose the doctrine of the Trinity. Other major doctrines in Christian theology include humanity, the church, sin, and salvation. These concepts are beyond the scope of this review. However, such beliefs may also play into mental illness stigma. For example, some Christians may view mental illness as a product of immoral or sinful behavior (Wesselmann & Graziano, 2010).

Despite common content and general theoretical consensus, there are divisions within the Christian community. Addressing the issue, Marty (1994) notes that there is nothing pertaining to the issue of denominations in the charters of Christianity. Between the fourth and 18th centuries, any sort of denominational demarcation would have been all but incomprehensible. The 18th century, however, brought about the disestablishment of the church in the British colonies. Such disestablishment made the previous adherent-dissenter paradigm relatively useless. In the 19th century, denominationalism became a formative force in American religion

that reigned well into the present century. The emergence of ecumenism, however, led many Christian leaders to acknowledge the importance of establishing and affirming the unity of the church. As the most conspicuous form of disjunction, denominations came under fire. Despite the clamor and calls for cohesion, 25,000 Christian denominations exist worldwide. Marty explains that each denomination appears divided within itself, unsure of how to justify beliefs or practices given that truth claims are disregarded or ignored by outsiders. While denominations are not dissolving, they are changing. Denominations are operating more in the fashion of extended families, with a shared history and sensibility. In light of Marty's description, it is reasonable to assume that Christians from different denominations may very well demonstrate different levels of mental illness stigma. However, an intensive examination of such heterogeneity is beyond the scope of this review.

Judaism

At present, the Jewish community appears more deeply divided than ever in regard to both the theory and the practice of their religion (De Lange, 2000). Solomon (1996) notes that this is, perhaps, not surprising as the question of Jewish identity is peculiarly new. That is, no one in the Middle Ages struggled with the issue. At that time, there appeared to be an understanding that Jews were 'the chosen people,' a 'special people' specifically selected by God to serve as the agents of His revelation. By the late Middle Ages, however, the Christian prophecy appeared to have been actualized and Christians had forcibly demoted the Jews to their previously prophesized state of social impoverishment.

In many ways, Solomon (1996) notes, Jews adopted and internalized their social condition, interpreting their strife and alienation in ancient Biblical terms. The Jews viewed themselves as a special and sacred people exiled from their land. Although the Christian and (to

a lesser degree) the Muslim community perceived God's punishment of the Jews as repudiation and ultimate abandonment, the Jews themselves thought their circumstances an assurance of their unique, 'chosen' status. Framing Solomon's work more objectively, the Jewish community became intensely stigmatized; its members were censured and ostracized. Rather than internalize such stigma, Jews cherished and found a special significance in their devalued position. Applied more generally, such a history of and ability to accept and appreciate difference may produce lower levels of mental illness stigma.

Addressing the religious aspects of Judaism, Solomon (1996) explains that spirituality, or godliness, can be established in and exercised through daily social relationships as well as learning, ascetic practices, and prayer. The lattermost of these, prayer, is of critical import in Judaism. Learning is also important. Both are an expression of spirituality and are understood as teshuva 'penitence,' a restoration of and return to God. Perhaps the most approachable form of spirituality is Torah (the first five books of the Hebrew Scriptures) study. Solomon notes that although it is common to come across the terms 'written law' and 'oral law,' law is an inaccurate translation of 'Torah,' which more correctly corresponds with 'instruction' or 'way.' The most meaningful thing about the laws or mitzvot is that they are to be abided and obeyed by the Jewish community because God commanded that they conduct themselves in this way. God does not need the mitzvot to be upheld, but the Jews do. The mitzvot allow individuals to become more like God in the sense that He does what is right and has provided the tools for earthly individuals to do so also. This emphasis on instruction and the demonstration of godliness highlighted in Solomon's work may spur further reductions in mental illness stigma within the Jewish community.

A common half-truth, Solomon (1996) suggests, is that Judaism is without religious orders. In actuality, there have been numerous trends and movements throughout the ages resulting in specific sects or branches of Jewish spirituality and devotion. Solomon attempts a concise consideration of some of today's central-most forms, beginning with Reform Judaism. Perhaps, these reformists argued, the old Biblical laws of the ancient Hebrew peoples were no longer appropriate within the context of a modern society in which newer, more applicable moral and spiritual values had been uncovered. Throughout the 19th century, this Reform understanding of Judaism adopted a mentality of progress and evolution.

In contrast, Solomon (1996) notes, Orthodox Judaism is a larger, more encompassing term for forms of traditional Judaism left behind Reform Judaism (and, subsequently, Conservative Judaism) movements. Contemporary orthodoxy consists of many different trends including Hasidic sects, mitnagdim (opponents of Hasidism), 'centrist' or 'modern' orthodoxy, and several 'regional' forms of Judaism. However, despite such divergence and heterogeneity, Orthodox leaders have tried to define Orthodoxy using terms such as 'Torah-true' or 'authentic' Judaism. In making such a distinction, Orthodox Jews emphasize their reverence and regard for halakha (Jewish law) and belief in Torah min haShamayim, the divine revelation of Torah at Sinai. Conservative Jews also acknowledge and appreciate the centrality of halakha, but are more flexible than the Orthodox, willing to adjust or adapt provisions in the face of evolving economic and social circumstance. Finally, in light of modern society and contemporary thought, Reconstructionist Jews call for a reassessment of Judaism, including such integral concepts as Israel, God, and the Torah. Considering Solomon's description, Jews from different branches or sects may very well demonstrate different levels of mental illness stigma. However, an intensive examination of such heterogeneity is beyond the scope of this review.

Islam

Derived from the Arabic root salaam meaning peace, the word Islam literally translates to English as "surrender." The word Muslim, denoting a follower of Islam, carries a similar sentiment, translating as "one who submits to the will of Allah" (Ali, Liu, & Humedian, 2004). Shepard (2009) notes that although many Muslims contend that there is a "true Islam" that is accurately attended to and properly upheld only by some, they often disagree as to what exactly this "true Islam" is.

For Muslims, Ali et al. (2004) explain, the word Allah refers to the God of all humanity. Muslims believe that the Islamic religion began in 7th century Arabia at the time when the first words of the Holy Qur'an were gifted to Muhammad ibn Abduallah. The Qur'an (Koran), literally translated as 'recitation,' is the holy book for Muslims. Shepard (2009) suggests that the Qur'an permeates and pervades Muslim culture even more extensively than the Bible in Western cultures. Pridmore and Pasha (2004) note that a fundamental theme is that deference, absolute submission to Allah, provides peace; the essential act of faith is to enable and actualize the will of Allah in both public and private life. The Qur'an instructs Muslims that responsibility to the Islamic community supersedes all national, ethnic, social, or tribal allegiances. Given Pridmore and Pasha's description of the Islamic emphasis on commitment and cohesion, it may very well be that any sort of individual difference becomes magnified and inspires castigation and disapproval. More traditional psychospiritual conceptualizations of mental illness may amplify this tendency, resulting in relatively radical devaluation.

The central teachings of the Qur'an, Shepard (2009) explains, pertain to Allah. Above all, it is firmly established that He is One, without partner or associate. Allah is both the creator and the sustainer of all things. He brought humans into being to glorify Him, to abide by His word

and His will. He guides them and, on the Last Day, he will destroy the universe and pass judgment upon mankind. The most severe or significant sin a human can commit is shirk, ascribing associates to Allah. Shirk can involve outright or obvious worship of gods other than Allah or, less conspicuously, it may be perpetrated in the form of affording anything – pleasure, career, wealth, nation, family – equal standing in one's life. Pridmore and Pasha (2004) note that Muslims also believe in David, Noah, Solomon, Adam, and John the Baptist. They believe in Heaven and Hell, angels, and the Day of Judgment. They believe in Mary and the Immaculate Conception. They believe the pregnancy was a miracle, but not that Jesus is the son of God. They believe Jesus will return to Jerusalem before the Day of Judgment. They believe in large portions of the Torah and the Old Testament.

Although there are significant differences in cultural practices and adherence to the many precepts of Islam, there exist five basic principles commonly accepted and identified as foundational by all Muslims (Esposito, 1998 as cited by Ali et al, 2004). Speaking in terms of 'pillars,' Ali et al. (2004) attempt a brief description. The first pillar of Islam is a belief in one God, Allah, and the conviction that Muhammad was His last and final prophet. The second pillar of Islam is prayer, prescribed five times per day, comprised of a sequence of prostrations and Arabic recitations performed while facing East. The third pillar of Islam is Zakat, the alms tax. Zakat is intended to remedy or repair social inequalities. The fourth pillar of Islam involves fasting (for followers who are physically and financially capable) and is intended to deepen and develop empathy for the poor and hungry. Finally, the fifth pillar of Islam, to be performed once in a lifetime, is the pilgrimage to Mecca. Ali et al.'s description suggests that embedded in many of these 'pillars,' particularly the third and fourth, is an ideal of empathy and altruism. Such

standards would suggest that mentally ill individuals might inspire compassion rather than censure.

CHAPTER 3

LITERATURE REVIEW

Stigma

Stigma has been previously defined in terms of an aspect or attribute that discredits or detracts from an individual, reducing him or her from a complete and conventional person to a diminished, discounted one (Goffman, 1963 as cited in Major & O'Brien, 2005). Stigmatization occurs when an individual possesses (or is believed to possess) some feature that communicates an identity that is depreciated in a specific social context (Crocker, Major, & Steele, 1998). Major and O'Brien (2005) note that all definitions of stigmatization assume that individuals who are stigmatized have (or are believed to have) a characteristic which distinguishes them and ultimately engenders social devaluation; such characteristics can be conspicuous or subtle, controllable or uncontrollable, visible or invisible, linked to behavior, group membership, or appearance. Stigma is context and relationship specific.

With no allusion to or implication of power, stigma swiftly becomes an overly expansive concept (Link & Phelan, 2001). Major and O'Brien (2005) explain that stigma occurs when negative stereotyping, labeling, low status, discrimination, and exclusion co-occur in a power situation which prompts, permits, or facilitates such processes. Although each of the aforementioned terms are often employed interchangeably with stigma, stigma is a more extensive and encompassing concept than any of these individual processes.

Corrigan, Roe, and Tsang (2011) note that, in order to better understand the stigma process, it is beneficial to differentiate between key concepts such as attitudes, stereotypes, prejudice, and discrimination. Briefly, attitudes are based upon ostensibly accurate impressions of the world and corresponding emotional responses. Stereotypes are beliefs about particular

individuals based upon their inclusion in a category or group. Prejudice implies a negative affective attitude regarding a specific group, indicating concurrence with offensive or uncomplimentary stereotypes. Discrimination is the behavioral product of stigma that takes place when individuals act upon their prejudices. By restricting access to critical life domains, discrimination influences the social status, physical health, and the psychological well-being of stigmatized individuals (Major & O'Brien, 2005).

Vogel, Wade, and Haake (2006) explain that the concept of stigma can be further divided into public and self stigma. Public stigma is a generalized impression or understanding within a society or group that an individual is socially undesirable, frequently prompting negative reactions toward them. To this end, Ciftci, Jones, & Corrigan (2012) note the public stigma, in the form of prejudice and discrimination, can impede access to education, employment, housing, and health care. Vogel et al. (2006) define self-stigma as a reduction in an individual's self-worth or self-esteem as a result of that individual self-labeling himself or herself as socially unacceptable. Corrigan, Larson, and Kuwabara (2007) note that, simply stated, self-stigma is the internalization of public stigma through a process of awareness, application, and harm. Had Corrigan et al. attended specifically to religious communities, it is reasonable to assume that negative perceptions of individuals with a mental illness would have been internalized by and adversely influenced affected adherents.

Contemporary stigma research, Major and O'Brien (2005) note, pays particular attention to the ways in which the effects of stigma are mediated by an individual's interpretations of social contexts, understanding of others' perceptions, and goals/motives. Stigma-induced identity threat occurs when an individual evaluates the demands of a stigma-relevant stressor as potentially damaging and in excess of present capacity to cope with such demands. Individuals

who consistently expect and are attentive to signs of discrimination may provoke the rejection they fear by unconsciously communicating such expectations to others. Major and O'Brien's explanations are likely applicable to members of religious communities dealing with mental health issues. That is, religious individuals are likely aware of and may be sensitive to the negative beliefs and biases of their fellow adherents. 'Attacks' upon an individual's social identity within a religious context - a setting previously perceived as a source of support and inclusion - may be particularly inimical.

Crocker and Major (1989) note that a review of research conducted across the last 20 years yields the contentious conclusion that prejudice aimed at stigmatized groups generally does not lead to reduced self-esteem for group members. However, it is asserted that such data do not mean that discrimination and prejudice are not psychologically harmful to victims in other ways. As compared to members of more highly esteemed or advantaged groups, members of stigmatized groups often differ on psychological dimensions such as performance expectancies, achievement motivation, task-specific self-confidence, and susceptibility to particular forms of physical and mental illness. It is reasonable to assume that stigmatized individuals within religious communities would exhibit differences and deficits similar to those identified by Crocker and Major.

One literature review examining the consequence of mental health stigma notes that, despite the pervasiveness of mental illness, an increasing number of individuals do not receive treatment (Sickel, Nabors, & Seacat, 2014). Current literature suggests that mental health stigma is a prevalent barrier with extensive implications for both mental and physical health. Mental health stigma appears directly related to variables such as race, ethnicity, age, illness severity, and treatment related variables. Sickel et al. comment that, while research supports a relationship

between mental health stigma and treatment seeking, the literature is relatively new and does not fully explain / elucidate the ways in which this influence takes place. The notion that mental health stigma could be differentially experienced by the social group in which it is measured is backed by social identity research.

Religion and Stigma

Religious and spiritual beliefs exert substantial influence upon the lives of many individuals (Wesselmann & Graziano, 2010). These beliefs guide perceptions in every day contexts and affect behaviors toward others. Because religion can act as such a dynamic social force, it is essential to account for it in the observation and study of various psychological processes and phenomena. Knowledge of specific beliefs about various groups is a key component in understanding the relationship between religion and stigmatization. One stigmatized group for which the link between religion and prejudice has been generally neglected is individuals with mental illnesses.

There exist relatively few studies that have empirically addressed this link. In the absence of work explicitly examining religious beliefs about mental illness, researchers have speculated on the basis of several clinical studies and personal observations (Wesselmann & Graziano, 2010). Wesselmann and Graziano (2010) conducted two studies to identify specific religious beliefs regarding mental illness in a Christian sample. They examined how those beliefs compared to scientifically established secular beliefs about mental illness. They found that religious beliefs about mental illness could be divided into two divergent but related dimensions: 1) beliefs about mental illness as a product of immoral or sinful behavior (for example, moral defect is the primary cause of mental illness) and 2) beliefs involving spiritually-oriented causes

and treatments - for example, individuals with a mental illness are being tortured by the devil (Wesselmann & Graziano, 2010).

In a 1967 publication, Allport and Ross assert that earlier research regarding the relationship between prejudicial attitudes and personal religious practices established three important facts: 1) On average, individuals who attend church are more prejudiced than those that do not. 2) This finding, by itself, conceals a curvilinear relationship. Most church attenders are more prejudiced than non-attenders; however, a significant minority of church attenders harbor less prejudice. 3) Irregular, fringe churchgoers typically harbor the most prejudice; their religious motivation is extrinsic in nature. Devout, internalized members typically demonstrate low levels of prejudice; their religious motivation is typically of the intrinsic variety.

Allport and Ross (1967) elaborate upon the relationship between extrinsic / intrinsic religious orientation and prejudice. In brief, they contend that individuals with an extrinsic religious orientation use their religious views to supply security, status, and social support. In and of itself, religion is of little value, rather, it supports other needs in a utilitarian manner. For these individuals, prejudice is also a convenient formation – similarly, it supplies security, status, and social support. An individual that relies upon a system of extrinsic religion is likely to rely upon a system of prejudice, hence the correlation between intolerance and extrinsic orientation. On the other hand, individuals with an intrinsic religious orientation do not utilize religion as an instrumental device; it is not merely a source of status or social support, rather, it is a commitment. Intrinsic religious orientation is an internalization of values such as compassion, humility, and love for thy neighbor. In the lives of these individuals, there is little place for disdain, disrespect, or rejection.

Research suggests that another dimension of religiosity, orthodoxy or fundamentalism, is an even stronger predictor of prejudice than orientation (extrinsic/intrinsic) constructs (Kirkpatrick, 1993). Kirkpatrick (1993) suggested that existing religion-prejudice literature generally avoids the question of whether orthodoxy and fundamentalism are discrete constructs or simply alternative labels referencing a single dimension. Kirkpatrick emphasizes the importance of distinguishing between the two in subsequent studies of religion and prejudice, finding that fundamentalism is more positively correlated than Christian orthodoxy with numerous measures of discriminatory attitudes.

Given the numerous ways in which religious beliefs can influence prejudice, and subsequently stigmatization, it can be reasonably assumed that religious communities can play a large role in the lives of families with mentally ill members (Rogers, Stanford, & Garland, 2012). Congregations are not always accepting of or supportive in issues related to mental health. Although recent evidence suggests that many people find aid and encouragement in their faith community, a significant number of individuals have been ostracized as a result of a mental health disorder (Stanford, 2007). Rogers et al. (2012) surveyed families with a mentally ill member that belonged to religious congregations. These families were less involved in faith practices, but wanted their faith community to provide support and assistance with mental health issues. The rest of the church community appeared to either discount or overlook this need. Help with depression and mental illness was ranked as the second priority of families with mental illness; it was ranked as the 42nd priority of control families (within respective congregations). These findings suggest that faith communities may not offer adequate support or assistance for individuals with mental health issues. In an environment where mental illness is often viewed as

a product of spiritual defect, individuals and their families may become unwilling to discuss mental health issues for fear of judgment or alienation.

Christianity and Stigma

To the extent that traditional Christianity accentuates sin as an origin of insanity, Dain (1992) notes, individuals with mental illness will be stigmatized. Many religious individuals and clergymen have long advocated a physician's view - although personal behavior can potentially produce or at least contribute to disorder/disease, such behavior does not embody an act against God and the illness itself is not sinful. However, religious individuals who employ a more literal interpretation of the Bible in their understanding of insanity are more likely to see any sort of disorder as the product of personal sin.

Kingston (2016), however, asserts that the tensions frequently noted between psychiatry and religion are not particularly pervasive in the American Christian Community. In the early 20th century, the Christian practice of "soul-care" was informed by psychiatry (Holifield, 1983 as cited in Kingston, 2016). Kingston (2016) suggests that the 1920s rise in clinical pastoral education strengthened this relationship. By midcentury, he informs, many clergy sought psychotherapeutic training to guide their pastoral work. The pastoral counseling campaign has prompted numerous movements important to and embedded in modern health care. For example, health care chaplains provide spiritual support in many settings.

Kingston (2016), additionally, elaborates upon the biblical counseling movement. During the 20th century, Protestant Christianity within the United States was distinctly divided between "liberal" and more "fundamentalist / evangelical" theologies. Biblical counseling began with Jay Adams, a pastor who rejected psychoanalytic teachings offered in seminary. Adams founded the "nouthetic counseling" movement. Nouthetic encompassed four primary tenets: 1) prominence

of personal responsibility (and personal sin as the central human issue), 2) belief that the Bible should take precedence as the primary pastoral counseling text, 3) distrust for psychology/psychiatry, and 4) pastors as primary counselors (as opposed to mental health workers). Biblical counseling asserts significant influence upon both clergy training and perceptions of mental illness with conservative Protestant congregations. Biblical counseling is, for example, the primary model of pastoral training within a number of Southern Baptist Convention seminaries. However, Kingston (2016) notes that biblical counseling is not the only approach within American Evangelical Christianity. Other Evangelicals, more willing to embrace psychological science, have developed programs/organizations referred to as "integrationist" (Ellens, 1997 as cited in Kingston, 2016).

Still, over the years, a number of prominent Christian authors have highlighted the unhealthy influence of the Christian community upon the mental health of its members (White et al., 2003). Aiming to explore this influence in the form of attitudes toward mentally ill members in the Christian church, Stanford (2007) found that a substantial percentage (approximately 30%) of mentally ill Christian congregation members who sought assistance from the Church had experiences or interactions counterproductive to treatment. These negative interactions were categorized into three subtypes: 1) abandonment by the church (60%), 2) mental illness ascribed to demonic possession (21%), and 3) mental illness attributed to personal sin or lack of faith (19%). In one study, Royal and Thompson (2012) found that although Protestant Christians frequently agreed that an individual unable to solve emotional problems on their own might benefit from professional help, they also, for the most part, believed that nearly all personal and emotional problems tend to work themselves out. Most of these individuals thought that the idea

of speaking with a psychologist about life problems was a poor way to resolve emotional conflicts.

Many Christian resources contain spiritually-based appraisals of mental illness (Webb, Stetz, & Hedden, 2008). Attempting to identify a broader Christian mentality with regard to mental illness, Webb et al. (2008) examined a collection of contemporary Christian self-help bestsellers, each containing material concentrated upon spiritual assessments of clinical depression. A large majority of the material emphasized strictly spiritual interpretations of the key assumptions, origins, elements, and treatment of depression. These best-selling texts propagated the belief that mental disorders, particularly depression, could be the result of demonic influences or personal sin. There was very little information on the stance and contributions of the professional psychological community. Etiological explanations of clinical depression differed markedly from those of mental health-professionals, accentuating the work of demonic forces. When demonic forces were not identified as the primary source of depression, focus was often shifted to the personal contributions of the depressed individual. Rather than highlighting the existence of and interplay between negative cognitions and emotions, it is suggested that these individuals are failing as Christians. These self-help texts often characterize emotions such as fear, sorrow, and anger as unacceptable; regardless of circumstances, these mental states are to be avoided or abstained from by the faithful adherent. It was suggested that an individual could exert significant control over the onset, course, and abatement of their disorder. Webb et al. (2008) conclude that this emphasis upon immediate, personal control may inadvertently lead Christian communities to believe that depressed persons are not only responsible, but also ultimately to blame, for their disorder.

Judaism and Stigma

In Judaism, Meyerstein (2004) notes, there is a blessing specifically crafted for encounters with those who have been created differently; it prompts appreciation for and wonderment at the exquisite diversity of God's creations. In Hebrew the word 'choleh' (ill) is similar to the word for hollowness or emptiness. Historically, mental illness was not understood as a moral flaw within Jewish communities; the objective has not been to deprive or disenfranchise afflicted individuals. However, mental illness has traditionally warranted exemption from the responsibilities of civil law and obligations of rituals (Spero, 1908 as cited in Meyerstein, 2004). The Talmud approaches mental illness from a legal stance, deeming it 'shtut' or mental incompetence (i.e., no capacity for / ability to reason or render judgments based in reality) (Meyerstein, 2004).

The Talmud does not appear to discourage or prohibit Jews from seeking help, stating ''a person can't heal himself, because a prisoner can't free himself from prison'' (Berakhot 56, as cited in Meyerstein, 2004, pg. 334). However, Meyerstein (2004) notes that because of attention to and anxiety about appearances in tightly knit Jewish communities, mental illness imparts a sense of stigma and shame. Particular practices and attitudes further complicate such matters; for example, 'shidduchin,' or arranged marriages, are far from uncommon in highly Orthodox communities. A mental illness or disability, even in a relative, can be problematic in match-making. Suicides are frequently concealed for the same reason, compounding the sense of segregation and suffering experienced by family members. Meyerstein argues that, over time, the idea of utilizing psychological services has become more acceptable; stigma has decreased as the overall Jewish community has made efforts to be more welcoming to and inclusive of persons with differences. In any case, Jews are both providers and consumers of mental health services.

Some research does, however, suggest an association between mental illness and low social status, particularly in Ultra-Orthodox Jews (Rosen, Greenberg, Schmeidler, & Shefler, 2008). Rosen et al. (2008) evaluated 38 referrals to a Community Mental Health Clinic located in a substantially Ultra-Orthodox neighborhood in North Jerusalem. Consistent with previous studies, findings suggested that a more religious upbringing was associated with higher levels of mental illness stigma. Religious upbringing emerged as a more dependable predictor of stigma level than current religious affiliation. Few Ultra-Orthodox individuals reported religious explanatory models; that is, most provided non-religious explanations of the origins and elements of their mental disorder/illness. Rosen et al. suggest that this explanatory model may reflect a gradual change in the general Jewish, and more specifically the Ultra-Orthodox, community away from primarily religiously-based interpretations of mental illness.

To this end, another study endeavored to establish and explore the influence of Jewish teaching upon orthodox Jewish beliefs about depression (Bayes & Loewenthal, 2013). Bayes and Loewenthal (2013) scoured rabbinic literature for teachings relevant to depression and selected ten strictly orthodox Jews to participate in a semi-structured interview pertaining to the beliefs about the origins of and treatment for depression. With respect to rabbinic literature, two groups of causal factors were identified. The first is sin (characterized as personal failure). However, it is noted that although depression may be perceived as a product of personal failure, it may also incite improvement and can – in and of itself- be perceived as a failure as it may impede the ability to serve God. The second causal factor identified is external events / stressors. Bayes and Loewenthal note that rabbinic sources endorse a variety of cognitive, behavioral, and emotional strategies to contend with or combat depression. Examples include religious study, prayer, increasing pleasant mood, practicing kindness, and adhering to the divine commandments.

Interviewees identified intrinsic causal factors such as character and biological predispositions (Bayes & Loewenthal, 2013). Extrinsic causes such as relationship difficulties, family pressure, trouble with children or at work, divorce, and serious physical illness, feelings of isolation and of being misunderstood, interviewees believed, could make aforementioned stressors more difficult to deal with. Some mentioned spiritual factors (e.g., not placing faith in God). In such instances, the opportunity for growth was often highlighted. With respect to treatment, interviewees identified various approaches, often highlighting underlying causes such as financial strain, relationship issues, and loneliness. Aiding others, being amiable, engaging in other activities (distraction), self-help books, and talk therapies (psychotherapy / counseling) were typically identified as more helpful than medication. In fact, several interviewees suggested that medication should be used only as a last resort. Interviewees also identified psalm recitation, prayer, rabbinic instruction, and community support. There was a general hesitance / disinclination to consult with psychiatrists because of risk for stigmatization. Most interviewees allowed that, for individuals afflicted with severe depression who evidence little insight or response to treatment, treatment might be given without consent in order to protect their life / health. To this end, Jewish teachings pertaining to the essentiality of preserving life and the significance of joyfully attending to the Divine – in both prayer and action – were emphasized (Bayes & Loewenthal, 20113).

Islam and Stigma

Historic Islamic understandings of mental illness, Bagasra and Mackinem (2014) suggest, can be divided into three categories: 1) theoretical notions advanced by Islamic scholars, religious leaders, and philosophers, 2) theological conceptualizations derived from the Qur'an and other prophetic traditions, and 3) lay beliefs spawning from individuals and groups in

Muslim society. These genres of understanding include definitions, causes, and predictors of mental illness as well as methods of symptom classification and proscribed treatments. A central tenet of Islam is that there exists only one God, Allah, and Allah is the origin of all things, including illnesses (Ciftci et al., 2012). Bagasra and Mackinem (2014) explain that, as a result of this belief in the omnipotence and intentionally of Allah, Muslims often think of psychological disorders as a test or form of punishment. "Disease of the Heart" or 'Sickness of the Heart" are common Islamic terms used to describe psycho-spiritual illnesses. The Islamic concept of the 'evil eye' demonstrates a comparable understanding of mental illness as the result of extrinsic, otherworldly influence.

Traditional Islamic psycho-spiritual conceptualizations of mental illness, Bagasra and Mackinem (2014) suggest, differ considerably from modern understandings of mental illness in Western texts. Contemporary research regarding mental illness in primarily Muslim countries evidences a multidimensional model of mental illness involving social, supernatural, and biological origins. Still, in the larger Muslim community, historic Islamic conceptualizations may take precedent. In a study exploring perceptions of and attitudes toward mental illness among both the general public and medical students in Oman, it was found that both groups believed mental illness to be caused by spirits, rejecting the notion of genetics as a significant factor; both groups endorsed popular stereotypes about individuals with mental illness and agreed that psychiatric facilities should be separated from the general community (Al-Adawi et al, 2002).

One study found significant differences in attitudes toward mental health help-seeking in a cohort of students containing Christian, Druze, and Muslim individuals (Al-Krenawi & Graham, 2011). Results indicate that, compared to individuals identifying as Muslim or Druze,

Christian participants had greater interpersonal openness, perceived the receipt of mental health services as less stigmatizing, and were less inclined to utilize traditional healing systems. Al-Krenawi and Graham (2011) note that most respondents were raised in Arab communities that may have had less access to and stigma surrounding mental health services. In accordance with previous research, the study confirms a positive relationship between age and years of post-secondary schooling with Arab respondents' positive perceptions of mental health services.

Al-Krenawi and Graham (2011) suggest that connections between Middle Eastern Christians and Western society facilitated less stigmatized views and greater utilization of mental health services. To this end, the authors posit that that differences between Christian and Druze / Muslim participants can be explained by concepts of cultural identity and acculturation. Western values – individualism, intellectualism, competition, success – may act as a barrier to informal support seeking for fear that it will be construed as a sign of weakness (Tzahr-Rubin, 2003 as cited in Al-Krenawi & Graham, 2011). Conversely, in most Eastern cultures, there is an emphasis upon the collective that facilitates reliance upon informal as opposed to stigmatized professional mental health services (Barakat, 1993 as cited in Al-Krenawi & Graham, 2011; Tzahr-Rubin, 2003 as cited in Al-Krenawi & Graham, 2011). Al-Krenawi and Graham (2011) note that, for Druze and Muslim respondents, the study revealed a high positive correlation between stigma and psychiatric therapy. This relationship was almost nonexistent among Christian respondents. Similarly, Druze and Muslim respondents – to a greater extent than Christian respondents – report belief in supernatural explanations of mental health and the efficacy of religious / traditional treatment approaches.

Even when Muslims are more accepting of and hold more positive attitudes toward psychological help-seeking, there is still significant social stigma (Ciftci et al., 2012). For

example, Tabassum, Macaskill, and Ahmad (2000) explored attitudes toward mental health issues among Pakistani families residing in the United Kingdom. Not a single subject reported that they would considering marrying an individual with mental illness. Only half of the subjects reported willingness to socialize with an individual with mental illness and fewer than one quarter would be willing to establish a close relationship.

Exploring the perspective of Muslim Americans, Bagasra and Mackinem (2014) observed general support for a Western view of mental illness tinged with more traditional religious beliefs. Like many immigrants, Muslims appear to have adopted many American beliefs and values. Muslim Americans acknowledge the environmental and biological factors influencing mental illness (e.g. life stresses, chemical imbalances, substance use). However, they may simultaneously endorse supernatural causes such as the evil eye and psycho-spiritual causes such as disobedience to or a test from God.

Within the larger Muslim community, being known to seek psychological services may have objectionable effects upon an individual's social reputation; that is, community members may view them as weak (Cinnirella & Loewenthal, 1999). In a study of religious and ethnic group influences on beliefs about mental illness, Cinnirella and Loewenthal (1999) found that Muslim respondents were most likely to agree that religion could help to treat schizophrenia (75% of subgroup) or depression (92% of subgroup). All Muslim respondents indicated that, if they were to seek professional help, they would prefer those professionals to be Muslims of the same race. They felt that Muslim professionals might help them by indicating particular religious practices or selecting holy passages. Should such methods fail, one participant suggested that the Qur'an could only guide and Allah could only protect good, practicing Muslims. This type of belief holds the dangerous implication that individuals with mental illness are not 'good

Muslims.' A perception of mentally ill individuals as 'bad Muslims' may be one of the primary causes of community stigma.

Still, for many Muslims, religion is integral to understanding and overcoming mental illmess. Eltaiba and Harries (2015) examined the ways in which individuals at the National Centre of Mental Health in Jordan understood the origins of their mental health issues, sought help, coped with their condition, and perceived recovery. All participants were raised in Muslim culture, identifying the Qu'ran and the Hadith as primary sources of understanding. All participants reported a high level of religiosity and all indicated that religion contributed to recovery. Despite such similarity, recovery was generally discussed as a dynamic and individualized process. All participants reported that the experience of mental illness made more salient their relationship with Allah. Participants reported deeper thinking and efforts to enhance their relationship with Allah. Of note, participants indicated that recovery involved acceptance of mental health issues as an aspect of Allah's will (Eltaiba & Harries, 2015).

Given that religion and psychological well-being demonstrate such critical connections – specifically, the capacity for religious communities to both positively and adversely influence mental health – a more specific inspection of the relationship between religiosity and the stigma surrounding mental illness is warranted. More specifically, a comparative examination of this relationship within the three Abrahamic religions is appropriate. Each community will be assessed in terms of degree of religiosity and level of mental illness stigmatization. It is hypothesized that 1) Higher levels of religiosity will predict higher levels of mental illness stigma. 2) The Muslim community will evidence the highest level of mental illness stigma across groups. 3) The Jewish community will evidence the lowest level of mental illness stigma across groups.

CHAPTER 4

METHOD

Participants

Amazon's Mechanical Turk (MTurk, www.MTurk.com) system was used to recruit 303 participants (49.5% male, 50.2% female; 34.3% Christian, 30.4% Jewish, 35.3% Muslim). Via Qualtrics, secure online survey software, participants completed an informed consent and were subsequently directed to an anonymous survey. Participants responded to demographic questions pertaining to age, sex, racial or ethnic identity, location (rural, suburban, urban), educational attainment, annual income, religious background and, when applicable, group or denomination. Participants were removed if they did not complete/provide data beyond demographics. A total of 17 participants (12 Jewish; 5 Muslim) were removed.

Instruments

Centrality of Religiosity Scale -15

The Centrality of Religiosity Scale (CRS) is a measure of the centrality, eminence, and importance of religious meaning (Huber & Huber, 2012). According to Huber and Huber (2012), the measure has been applied in more than 100 studies of the psychology and sociology of religion. The scale is presented in varying lengths – fifteen, ten, and five questions. The CRS-15 includes five core dimensions – private practice, public practice, religious experience, ideology, and an intellectual dimension – with three items each.

According to Huber and Huber (2012), the validity of the measure has been empirically confirmed with high correlations between the CRS and both self-reported salience of religious identity (0.83 is student sample, 0.73 in international Religion Monitor) and self-reports of the importance of religion in daily life (0.78 student sample, 0.67 international Religion Monitor).

Devaluation Discrimination Scale

The Devaluation Discrimination Scale was composed by Link in 1987 to aid in an evaluation of labeling effects upon mental disorders. The measure is composed of 12 items which assess the extent of rejection expectations – more specifically, the belief that most individuals will devalue or discriminate against a mental health patient. A six point Likert format – ranging from "strongly agree" to "strongly disagree" is employed. The measure shows an overall reliability of .78. It is noted that the validity of the measure is, largely, dependent upon the face validity of the individual items.

Procedure

Participants took part in an anonymous online survey through Amazon Mechanical Turk (MTurk). The informed consent and invitation to participate in the survey were posted on MTurk. From there, participants clicked on a link that directs them to the survey that is posted on the Qualtrics website. Participants completed the Centrality of Religiosity Scale-15 (Huber & Huber, 2012) and the Devaluation-Discrimination Scale (Link, 1987). The survey took approximately 10-20 minutes to complete. IP addresses were not recorded, so only the authors will have access to the informational data. The informational data was strictly anonymous. Participants were paid for their time ($0.10) at the completion of the survey. Participants' responses to the items on each instrument were summed and averaged to create composite variables.

RESULTS

Hypothesis 1) Higher Levels of Religiosity Will Predict Higher Levels of Mental Illness Stigma.

A regression analysis was used to assess the ability of religiosity to predict level of mental health stigma. Using a cutoff point of two standard deviations, 7 data points were removed from 'Religiosity' and 16 data points were removed from 'Stigma.' Normality was confirmed via the inspection of Q-Q plots.

The results of the regression indicate that religiosity accounted for approximately 0% of the variance, $F(1, 273) = 0.04$, p =NS, R squared = .00. The analysis showed that 0% of the variance is explained by the model. 'Religiosity' was not a significant predictor, $t = 0.20$, β = .01, p = NS. Therefore, there is no significant relationship between religiosity and level of mental health stigma.

Hypothesis 2) The Muslim Community Will Evidence the Highest Level of Mental Illness Stigma Across Groups.

A one-way analysis of variance was conducted to examine the difference in mental health stigma scores across faith communities. Because Levene's test for homogeneity of variance was violated, a Bonferroni correction was used to create a more stringent significance level of .025. There was no statistically significant difference in stigma scores across faith communities F (2, 279) = 2.13, p = .121.

In additional descriptive analysis intended to further explain and elaborate upon such findings, mean 'Stigma' scores were compared to determine the highest level of mental illness stigma across Abrahamic faith communities. The mean stigma score of the Christian group was 3.909; the mean stigma score of the Jewish group was 3.742; the mean stigma score of the Muslim group was 3.744.

Hypothesis 3) The Jewish Community Will Evidence the Lowest Level of Mental Illness Stigma Across Groups.

As described above (Hypothesis 2), a one-way analysis of variance was conducted to examine the difference in mental health stigma scores across faith communities. Because Levene's test for homogeneity of variance was violated, a Bonferroni correction was used to create a more stringent significance level of .025. There was no statistically significant difference in stigma scores across faith communities F (2, 279) = 2.13, p = .121.

Descriptive analysis revealed that the mean stigma score of the Christian group was 3.909; the mean stigma score of the Jewish group was 3.742; the mean stigma score of the Muslim group was 3.744.

CHAPTER 5

DISCUSSION

Hypothesis 1) Higher Levels of Religiosity Will Predict Higher Levels of Mental Illness Stigma.

Contrary to initial expectations, higher levels of religiosity did not predict higher levels of mental illness stigma. Further research, intended to explain and expound upon this finding, revealed a more intricate relationship than anticipated. More specifically, the relationship between religiosity and mental illness stigma may be mediated by factors such as degree of affiliation, spirituality, and acculturation. The following sections provide a brief discussion of such factors.

Degree of Affiliation

With respect to the present study, degree of affiliation was interpreted as a participant's frequency of attendance at and additional involvement with their faith community. As previously reviewed, faith communities can serve as a source of social support and shelter, providing comfort and relief in times of tension or trouble (Pieper & van Uden, 2005). As Pieper and van Uden (2005) note, religious communities have the power to influence or impress upon adherents. They feel the more intimate or involved an individual is with the community, the more 'radical' this shaping potential.

Research by Francis and Gibson (1993) underscores this shaping ability. The authors conducted a study of 11 to 12 and 15 to 16 year old students attending secondary school in Scotland. Students responded to a questionnaire, elaborating upon both personal and parental religious practice and attitudes. The data were used to examine overall influence upon different sex / age group combinations (11 to 12 year old girls, 11 to 12 year old boys, 15 to 16 year old

girls, 15 to 16 year old boys). Results indicate that, for all four adolescent samples, parental church attendance was an important predictor of attendance. Francis and Gibson note that variance was more strongly related to adolescent age (as opposed to sex). Both paternal and maternal attendance exerted highly significant influence. Such simultaneous influence, the authors note, is in accordance with the assertion that adolescents are most likely to attend church when the behavior is modeled by both parents. The findings of this study suggest that parental attitudes / practice impress more directly upon adolescents' public religious behavior than their private religious beliefs.

As different faiths and denominations have adopted different perspectives regarding and beliefs about mental illness (see sections titled 'Christianity and Stigma,' 'Judaism and Stigma,' 'Islam and Stigma'), it is reasonable to assume that differing degrees of affiliation will produce differing levels of mental illness stigma. However, further research in this area is necessary.

Spirituality

As previously noted, there exists little constancy or cohesion in the conceptualization or distinction of 'religion' and 'spirituality' (Zinnbauer et al., 1997). According to research by Zinnbauer et al. (1997), there is evidence to suggest that 'religiousness' and 'spirituality' describe at least partially different concepts. That is, the constructs evidence some different correlates. Religiousness was associated with higher levels of authoritarianism, parental religious attendance, religious orthodoxy, self-righteousness, church attendance, and intrinsic religiousness. In contrast, spirituality was associated with mystical experiences, higher income, New Age practices and beliefs, and the experience of being hurt by clergy. While spirituality was most typically characterized by personal or experiential items – such as a belief in or relationship with God or a higher power- descriptions of religiousness often included both personal and

institutional/organizational beliefs and practices such as church attendance, church membership, and adherence to the belief system of an organized religion or particular church.

Although 'religiousness' and 'spirituality' may be differentiated, they are not entirely autonomous (Zinnbauer et al., 1997). Self-rated spirituality and religiousness were found to be modestly but significantly correlated, with most participants indicating that they were both spiritual and religious. Both were associated with frequency of prayer and related to intrinsic religiosity, religious orthodoxy, and church attendance. Definitions did not show significant differences in the nature or characterization of the sacred. That is, both spirituality and religiousness included traditional conceptualizations of the sacred (e.g., references to God and the Church). Given both the complex relationship between and evidence for group differences with respect to these constructs, it can be reasonably assumed the spirituality of participants in the study could differentially influence 1) their adherence to or investment in a particular Abrahamic faith and 2) their perceptions of mental illness.

In another study, Ivtzan et al. (2013) divided participants from various religious affiliations / faith groups from a range of institutions across four groups: 1) high level of religious involvement and spirituality, 2) low level of religious involvement and high level of spirituality, 3) high level of religious involvement and low level of spirituality, 4) low level of religious involvement and spirituality. Group comparisons were made across three specific measures of psychological well-being: 1) personal growth initiative, 2) meaning in life, 3) levels of self-actualization. Results demonstrated that, with minor exceptions, groups one and two scored higher on all well-being measures. Of note, the authors found no significant relationship between religiosity or any measure of well-being. Similarly, no correlation was detected between spirituality and religiosity. Ivtzan et al. note that, as a whole, these results highlight the

significance of spirituality – regardless of association with religious participation – for psychological well-being.

Another study looked at the relationship between spirituality, religiosity, and mental health in a sample of Hindu, Muslim, and Christian participants (Ganga & Kutty, 2013). Among Christians, positive mental health scores were highest for individuals denying any link between spirituality and religion. For Hindus and Muslims, Ganga and Kutty (2013) note, the highest positive mental health scores were for the group stating that spirituality was not a positive trait. Interestingly, the lowest positive mental health scores in all three religions belonged to the group of individuals stating that they did not know what spirituality was. Such evidence further underscores the complexity of the relationship between religiosity and spirituality. Individual understandings or perceptions of spirituality, both in isolation from or in conjunction with religious belief or practice, may act as an important explanatory variable for mental health and perceptions of mental illness.

Acculturation

Extensive immigration from majority Muslim countries has restructured the religious backdrop of traditionally Christian, increasingly secularized societies (Gungor, Fleischmann, Phalet, & Maliepaard, 2013). According to Gungor et al. (2013), religiosity has been identified as an important aspect of cultural transmission and maintenance. It is often observed that religious communities provide a source of support and respectability for newcomers; yet, from the majority perspective, the religiosity of minorities is often an obstacle to or in conflict with mainstream integration and acculturation efforts (Foner & Alba, 2008).

In a meta-analysis of acculturation/enculturation and mental health, acculturation was negatively associated with negative mental health –for example, depression - and positively

associated with positive mental health – for example, self-esteem (Yoon et al., 2013). Yoon et. al (2013) found that enculturation was positively related to positive mental health and to anxiety. It is suggested that highly enculturated individuals may feel incompetent, unequal, or fearful outside of their ethnic surroundings. Such persons present with high enculturated behaviors or characteristics which serve to create an obvious 'otherness' and make them easy targets for discrimination. By confining interactions within their own ethnic group, these individuals may exacerbate such issues and further restrict social connections. Still, the more general, positive relationship between enculturation and positive mental health suggests that support from co-ethnics may be a critical component to coping with/resolving daily stresses and establishing a sense of security and groundedness. Considering the stigma associated with mental illness (see sections titled 'Stigma,' 'Religion and Stigma,' 'Christianity and Stigma,' 'Judaism and Stigma,' 'Islam and Stigma'), it may be reasonably assumed that individuals afflicted by mental illness do not derive the benefits of or are disconnected from the support of their peer groups – be they cultural, religious, or some amalgam of the two.

Hypothesis 2) The Muslim Community Will Evidence the Highest Level of Mental Illness Stigma Across Groups.

Contrary to initial expectations, the Muslim community did not evidence the highest levels of mental illness stigma. Mean stigma scores in the Muslim community were lower than those in the Christian community (which evidenced the highest levels of stigmatization) and only very marginally more than those of the Jewish community (which evidenced the lowest levels of stigmatization). As noted, there was no statistically significant difference in stigma scores across faith communities.

Further research suggests that such findings may, in fact, be at least partially attributable to the collectivism or non-Western culture at the root of Islam. Stigma, as Coker (2005) notes, is molded and modified by multiple determinants and cannot be comprehended outside or independently of social and cultural context. In a 2005 study, Coker presented 208 respondents (93% Muslim, living in Egypt) with vignettes aimed to elicit social distance judgments about and qualitative elaboration regarding depictions of alcohol abuse, depression, psychosis, and a 'possession state.' Ultimately, it is concluded that stigma or social distance in Egypt represents an amalgam of judgments regarding an individual's ability to fill an assigned or particular position, their moral fiber, and their place in and utility with respect to the social composition. Such judgments were relatively removed from or independent of mental health labels or other presupposed idea of mental illness. Interestingly, it was alcohol abuse – more so than the bizarre behaviors and verbalizations depicted in the psychotic vignette – that incited the most significant social distancing. Psychological distress or psychiatric diagnosis, however, were most often viewed as normal provided they were able to be understood in a social context.

Participants tended to assert and accentuate the moral necessity of extending aid to individuals afflicted with illness or experiencing difficulties (Coker, 2005). This necessity was, moreover, an essential element in the mediation of social distance. For example, during the interview portion of the study, the majority of the participants believed social support to be an effective method of treatment for the distress and the disorders illustrated in the vignettes. Such support was perceived as a shared responsibility belonging to friends, family, neighbors, and the community as a whole.

In the Western world, stigmas regarding mental illness are extensively endorsed by the public (Corrigan & Watson, 2002). Conversely, in the non-Western world, it is suggested that a

lack of discrimination/separation between non-psychiatric and psychiatric conditions results in significant stigma reduction; that is, although stigmatization of mental illness is quite possible in non-Western culture, it is more often assigned or attached to chronic illnesses which respond poorly to treatment (Fabrega, 1991 as cited in Corrigan & Watson, 2002).

Hypothesis 3) The Jewish Community Will Evidence the Lowest Level of Mental Illness Stigma Across Groups.

As initially hypothesized, the Jewish community evidenced the lowest level of mental illness stigma. Mean stigma scores in the Jewish community were lower than those of the Christian community (which evidenced the highest levels of stigmatization). However, such scores were only very marginally less than those of the Muslim community. As noted, there was no statistically significant difference in stigma scores across faith communities.

As previously reviewed, mental illness has not historically been perceived as a moral flaw within Jewish communities (Meyerstein, 2004). As Rietveld (2004) emphasizes, in the Jewish tradition, to act in the service of God means to emulate his love and justice. As such, it may be reasonably assumed that the Jewish communities' stigma scores reflect both moral obligations and the perception of mental illness within a communal context.

In one study examining community attitudes toward culture-influenced mental illness, a majority of Orthodox Jewish participants cited medical (e.g., genetic influence) and psychological (e.g., stress) explanatory models of mental illness; few endorsed social-religious explanations such as upbringing, moral flaws, or degree of religiosity, etc. (Pirutinsky, Rosmarin, & Pargament, 2009). Bayes and Loewenthal (2013) compare Rabbinic and community views on depression. In assessing the origins of depression, Rabbinic sources highlighted personal failure (sin) and external events (stressors). In contrast, community members emphasized intrinsic

factors – especially biological vulnerability. Most community members did not reference personal failure (sin) as a causal factor. With respect to help-seeking, normative Rabbinic view was similar to that of the community. That is, psychotherapy with a carefully selected and religiously approved individual could be of benefit.

Limitations

The present study has several limitations. First, it is possible that participants either intentionally or unknowingly misrepresented their religious beliefs / background. Similarly, it is possible that participants completed the survey multiple times. However, with respect to either complication, it is assumed that compensation was not so substantial as to motivate significant misrepresentation or to meaningfully distort data. Secondly, it is to be observed that the survey was offered only in English. Offering the survey only in English may have either limited or prohibited participation from non-native or secondary speakers. Offering the survey only in English may have also constrained acculturation ratings (that is, by limiting participation to English proficient individuals, the range/experience of acculturation may have been bounded). A final limitation pertains to the assumption of relative homogeneity within each individual faith system. Although data were collected for various Christian and Jewish denominations, further analysis and comparison of denominational differences was beyond the scope of the present study. It is, however, reasonable to assume that such differences would reflect aforementioned trends in spirituality, acculturation, and affiliation.

Future Research

As indicated by previous research, religiosity is a multifaceted concept affected by numerous forces and factors. Future research should aim to further explore and parse apart the influence of and interplay between variables such as degree of affiliation, spirituality, and

acculturation. By understanding the combined and individual influence of various factors, psychological services can be tailored to address the effects of religiosity upon mental health and mental health stigma.

Conclusions

Throughout the years, research has established and expounded upon critical connections between religion and mental health. This relationship has proven incredibly intricate - rife with interwoven aspects and overlapping variables. In analyzing and interacting with religion it is, perhaps, most important to be open and aware. As evidenced by the present study, there is rarely only one force at work. Religion, spirituality, acculturation, affiliation, and many influences beyond the scope of this study, work in tandem to create an experience that is unique to each culture and – likely – each individual.

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APPENDIX A: OFFICE OF RESEARCH INTEGRITY APPROVAL LETTER

MARSHALL UNIVERSITY
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Office of Research Integrity
Institutional Review Board
One John Marshall Drive
Huntington, WV 25755

FWA 00002704

IRB1 #00002205
IRB2 #00003206

July 20, 2015

Keith Beard, Psy.D.
Psychology Department

RE: IRBNet ID# 776334-1
At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Beard:

Protocol Title:	[776334-1] The Relationship Between Religiosity and Mental Illness Stigma in the Abrahamic Religions	
Expiration Date:	July 20, 2016	
Site Location:	MU	
Submission Type:	New Project	APPROVED
Review Type:	Exempt Review	

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee for the period of 12 months. The approval will expire July 20, 2016. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Emma Bushong.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral) Coordinator Bruce Day, ThD, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.