Relationship of Christian Beliefs to Attitudes Toward People With Mental Illness

Katharine S. Adams, Ph.D., Jeremy R. Tost, Ph.D., Mark A. Whatley, Ph.D., Meghan C. Brown, M.S., Brendan J. Dochney, M.S., Jessica M. Taylor, M.S., Mary H. Neal, M.S.

This study assessed the influence of Christian beliefs on attitudes toward people with mental illness. Participants (N=204) provided demographic information and completed the Christian Orthodoxy Scale, the Religious Fundamentalism Scale, and the Attitudes to Mental Illness Questionnaire. Participants read vignettes of a person with a mental illness (schizophrenia), a general medical illness (diabetes), and a control condition (practicing Christian) and rated them on five criteria representing stigmatizing attitudes. The data were analyzed by sequential multiple regression. Religious fundamentalism, but not Christian orthodoxy, was a significant predictor of stigmatizing attitudes toward a person with mental illness. Consistent with past research, neither religious fundamentalism nor Christian orthodoxy were significant predictors of stigmatizing attitudes toward a general medical illness. As predicted, both religious fundamentalism and Christian orthodoxy were significant predictors of positive attitudes toward a practicing Christian. Sensitivity and discourse regarding stigmatization and deeply held fundamental religious beliefs are needed among mental health professionals, religious leaders, and laypersons.

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More than 80% of people residing in the United States report belief in God (1), and 77% identify with a Christian religion (2). Researchers have sought to describe how religious beliefs influence attitudes toward others, subjective interpretations of life experiences, and individual problem-solving strategies (3). Relationships between religious beliefs and social stigmas toward specified groups, such as women, racial and ethnic minorities, and homosexuals, have been established (4–9). Less attention, however, has been focused on the relationship between religious beliefs and attitudes toward those with mental illness, another well-documented socially stigmatized group (10, 11).

Several paradigms can be used to understand the construct of social stigma (12). According to Goffman's (13) writings on social identity, stigma refers to any long-lasting individual or group trait that is considered deviant and may evoke negative or punitive responses from others. Distinctions also have been made between general awareness of public stigma and self-stigma, an internalized negative societal judgment leading to self-doubt and decreased self-esteem (14, 15).

Several studies have investigated social stigma toward people with mental illness (15–19). Stigmatization is based on perceived blemishes of individual character (13) and is associated with beliefs that those with mental illness are dangerous and responsible for their conditions (16). Discrimination toward people with mental illness results in decreased opportunities for employment, housing, health care, and social interaction (11, 20).

Fewer studies have investigated social stigma toward people with mental illness as influenced by deeply held religious beliefs. A small body of research supports the relationship between Christian beliefs, causal attributions, and negative social interactions between those who hold Christian beliefs and those with mental illness. Stanford (21) investigated common attitudes toward mental illness held by the Christian church. Results indicated that approximately 30% of mentally ill male and female Christian participants had experienced a negative interaction with the Christian church (22). For example, participants who solicited help from the church were told that they did not have a mental illness (22) and that the cause of their problem was spiritual (e.g., a result of personal sin or demonic involvement).

Wesselmann and Graziano (3) investigated the relationship between religious beliefs about mental illness and negative secular beliefs about mental illness. Their study suggests that religious beliefs about mental illness include beliefs that mental illness is a result of sinful behavior and has spiritually oriented causes and/or treatments. These two beliefs were related to negative secular beliefs about mental illness, such as fear/danger, anger, and responsibility. Additionally, spirituality-oriented causes of mental illness were positively associated with both religious fundamentalism and Christian orthodoxy. Attributions related to sin and

responsibility, however, were associated with religious fundamentalism only (3). Finally, increased familiarity with someone with a mental illness resulted in decreased religious beliefs regarding sin and spiritually oriented causes of mental illness (3).

Theoretical and empirical research suggests that Christian orthodoxy and religious fundamentalism are distinct constructs (6). Christian orthodoxy is defined as acceptance of doctrine central to the Christian faith (e.g., Jesus Christ was the divine son of God) and is common among Catholics and Protestants (23, 24). Religious fundamentalism is an approach to a religious system characterized by beliefs that one's religion is infallible, unchangeable, and the only true religious path (4, 25). Not all who hold orthodox beliefs are fundamentalists, in that it is possible to believe in Christian tenets while acknowledging the validity of other people's beliefs (25). Fundamentalism, not Christian orthodoxy, has most often been associated with prejudice and hostility toward various stigmatized groups (4, 6, 26).

Until recently, the relationship between religious beliefs and stigmatizing attitudes toward people with mental illness has been largely ignored. This literature gap is unfortunate given the prevalence of Christianity in the United States (2) and the level of stigmatization faced by those with mental illness (20). By better understanding the relationship between these two social forces, efforts can be made to promote understanding and compassion for those living with mental illness and to work against the stigmatizing attitudes that devalue this population.

Given the well-documented influence of religious beliefs on social stigmatization (e.g., 3, 21, 22), we examined the extent to which Christian orthodoxy and religious fundamentalism were associated with participant attitudes toward individuals with a mental illness (schizophrenia), with a general medical illness (diabetes), and with no illness (with a practicing Christian as the control condition) among college students residing in the southeastern United States and largely self-identifying as Christian.

METHODS

Participants

Of 225 postsecondary students who were recruited from a regional university in Georgia and responded to the survey packet, 21 were excluded due to one or more missing data points. The resulting sample consisted of 204 students (50 men and 154 women). Participants ranged in age from 18 to 47 (mean ±SD=22.81±5.56). Of the participants, 7% (N=14) were freshmen, 29% (N=60) were sophomores, 42% (N=85) were juniors, 20% (N=41) were seniors, 2% (N=3) were graduate students, and <1% (N=1) self-identified as other. Additionally, 64% (N=130) were European-American, 32% (N=65) were African-American, 1% (N=2) were Asian American, and 3% (N=7) self-identified as other. Of the participants, 70% (N=142) were members of a church or other organized religious group. Participant-disclosed religious affiliation indicated that 44% (N=90) identified as Baptist, 13% (N=26) Methodist, 6% (N=12) Pentecostal, 5% (N=11) Catholic, 5% (N=10) Episcopal, 1% (N=2) Church of Christ, 1% (N=2) Presbyterian, and <1% (N=1) Lutheran, and 15% indicated they were (N=30) non-denominational, 9% (N=19) other, or 0.5% (N=1) did not indicate.

Procedure

This study was approved by the Valdosta State University Institutional Review Board. Students were recruited from undergraduate courses with assistance from individual course instructors. In obtaining informed consent, we described the nature and purpose of the study and emphasized that participation in the research was voluntary. Extra credit for participation in the study or alternate assignments (e.g., research article review) was given at the discretion of the course instructors. We distributed survey packets to groups of students in a classroom setting. Students completed the survey packets in approximately 20–30 minutes. After students completed the survey packets, we discussed the study with them and answered questions pertaining to the research.

Materials

Research survey packets were counterbalanced using the Latin square technique and included a questionnaire assessing demographic characteristics, the Christian Orthodoxy Scale (23, 27), the Religious Fundamentalism Scale (4), and the Attitudes to Mental Illness Questionnaire (28). The questionnaire on demographic characteristics assessed age, gender, race-ethnicity, religious affiliation, frequency of church attendance, and previous experience with mental health services.

The Christian Orthodoxy Scale (23, 27) assessed the degree to which individuals adhered to the foundational tenets of Christianity (e.g., "God exists as Father, Son, and Holy Spirit," "Jesus Christ was the divine son of God," "Jesus was crucified, died, and was buried, but on the third day he rose from the dead"). Participants answered the 24 items on a 9-point Likert scale (–4, strongly disagree, to 4, strongly agree). We prepared the data for analysis by rescaling responses so that all questions were assessed using the same scale (1, strongly disagree, to 9, strongly agree) and reverse-keying 12 items worded in the contrary direction, with higher scores indicating a more orthodox response. We then summed the scale items to yield an overall score for Christian orthodoxy (range 24–216), with higher scores indicating more orthodox beliefs. The Christian Orthodoxy Scale is a well-validated measure with adequate psychometric properties (25). Cronbach's alpha within our sample was 0.97.

The Religious Fundamentalism Scale (4) assesses participants' level of agreement with conservative religious tenets (e.g., "different religions and philosophies have different versions of the truth and may be equally right in their own way," "to lead the best, most meaningful life, one must

TABLE 1. Prediction of attitudes toward people with a mental illness (schizophrenia) among those adhering to religious fundamentalism and Christian orthodoxy (N=204)[a]

Variable	M	SD	R	B	β	sr^2
Religious fundamentalism	34.68	21.84	−.14	−.17*	−.14	.01
Christian orthodoxy	74.65	31.46	−.08	.00	.04	.00
Stigma toward people with schizophrenia (dependent variable)	−5.36	2.65				

[a] R^2=.02, adjusted R^2=.01, R=.14.
*p<.05

belong to the one, true religion," and "there are only two kinds of people in the world: the righteous, who will be rewarded by God, and the rest, who will not"). Participants answered these 20 items by responding on a 9-point scale (–4, strongly disagree, to 4, strongly agree). We prepared the data for analysis by rescaling responses (1, strongly disagree, to 9, strongly agree) and by reverse-keying 10 items worded in the opposite direction, with higher scores indicating a more fundamentalist response. We then summed the scale items to yield an overall score for religious fundamentalism (range 20–180), with higher scores indicating more fundamental belief. The Religious Fundamentalism Scale is a well-validated measure with adequate psychometric properties (25). Cronbach's alpha within the sample was 0.92.

To determine the relationship between Christian beliefs and stigmatizing attitudes, we chose three vignette selections from the Attitudes to Mental Illness Questionnaire (28), which assesses stigmatizing attitudes toward people with and without mental illness. Luty et al. (28) based their questionnaire on Cunningham et al.'s (29) research measuring the effects of substance types (alcohol, tobacco, and cocaine) and labels on stigma, but adapted the questionnaire to include example vignettes from people with a mental illness (schizophrenia), a physical illness (diabetes), and a control subject (a practicing Christian). Luty et al. found the specific vignettes to have construct validity as well as test-retest reliability (28).

Respondents read three short hypothetical vignettes gleaned from the Attitudes to Mental Illness Questionnaire (28). The first vignette describes an individual with diabetes who needs to inject insulin every day and has a special diet. The second vignette describes an individual with schizophrenia who needs an injection of medication every two weeks and has a history of hospitalization due to hearing voices and belief in special powers. The third vignette describes an individual who attends church every Sunday and attempts to lead a Christian life [control]. Respondents answered two behavioral questions for each vignette (e.g., "I would be comfortable with Michael as my colleague at work" and "I would be comfortable about inviting John to a dinner party") and three opinion questions (e.g., "how likely do you think it would be for Michael's wife to leave him," "do you think that this would damage Michael's career," and "how likely do you think it would be for Michael to get in trouble with the law?"). Participants responded on a 5-point scale (1, strongly disagree/very unlikely, to 5, strongly agree/very likely). Following the scoring procedure used by Luty et al. (28), we found that scores ranged from –10 to 10, with negative scores indicating greater stigmatizing attitudes. Reliability (internal consistency) for the specific vignettes was as follows: diabetes (0.78), schizophrenia (0.76), and Christian (0.76).

RESULTS

We conducted a series of sequential multiple regression analyses to predict attitudes toward people with a mental illness (schizophrenia), a medical illness (diabetes), and a control condition (Christian) for comparison. The medical illness vignette was included in the analysis as a basis of comparison for mental illness, because some research indicates that attributions for mental illness tend to be more stigmatizing than those for medical illness (16, 17). Religious fundamentalism was entered first into the regression as a predictor variable in step 1, as past research documents a relationship between religious fundamentalism and prejudice toward various stigmatized groups (4, 6, 26). Christian orthodoxy was entered into the regression as a predictor variable in step 2.

Tables containing mean±SD for the predictors and criterion, correlation between each predictor and criterion, unstandardized regression coefficients (B), standardized regression coefficients (β), semipartial correlations (sr^2), R^2, adjusted R^2, and R are included.

Predicting Attitudes Toward Schizophrenia

With both predictors, religious fundamentalism and Christian orthodoxy, in the equation, R=0.14, F=2.13, df=1 and 201, p=0.122. After step 1, with religious fundamentalism in the equation, R=0.02, F_{inc}=4.14, df=1 and 202, and p=0.043. After step 2, with Christian orthodoxy added to the prediction of attitudes toward schizophrenia, R^2=0.02, F_{inc}=0.14, df=1 and 201, and p=0.712. As expected, the addition of Christian orthodoxy to the model did not improve R^2 (Table 1).

Predicting Attitudes Toward Diabetes

With both predictors, religious fundamentalism and Christian orthodoxy, in the equation, R=0.04, F=0.18, df=1 and 201, and p=0.834. After step 1, with religious fundamentalism in the equation, R^2=0.00, F_{inc}=0.01, df=1 and 202, and p=0.944. After step 2, with Christian orthodoxy added to the prediction of attitudes toward diabetes, R^2=0.00, F_{inc}=0.36, df=1 and 201, and p=0.550. As expected, neither predictor added to the equation improved R^2 (Table 2).

Predicting Attitudes Toward Practicing Christians

With both predictors, religious fundamentalism and Christian orthodoxy, in the equation, R=0.34, F=13.43, df=1

TABLE 2. Prediction of attitudes toward people with a general medical illness (diabetes) among those adhering to religious fundamentalism and Christian orthodoxy (N=204)[a]

Variable	M	SD	R	B	β	sr^2
Religious fundamentalism	34.68	21.84	.01	.01	.05	.00
Christian orthodoxy	74.65	31.46	−.03	−.01	−.06	.00
Stigma toward people with schizophrenia (dependent variable)	4.83	5.96				

[a] R^2=.00, adjusted R^2=−.01, R=.04.

TABLE 3. Prediction of attitudes toward people with the control condition (a practicing Christian) among those adhering to religious fundamentalism and Christian orthodoxy (N=204)[a]

Variable	M	SD	R	B	β	sr^2
Religious fundamentalism	34.68	21.84	.32	.05	.18*	.02
Christian orthodoxy	74.65	31.46	.32	.04	.19*	.02
Stigma toward people with schizophrenia (dependent variable)	4.79	5.90				

[a] R^2=.12 (unique variability=.08; shared variability=.04), adjusted R^2=.11, R=.34.
*p<.05

and 201, and p<0.001. After step 1, with religious fundamentalism in the equation, R^2=0.10, F_{inc}=22.19, df=1 and 202, and p<0.001. After step 2, with Christian orthodoxy added to the prediction of attitudes toward practicing Christians, R^2=0.12, F_{inc}=4.31, df=1 and 201, and p=0.039. The addition of Christian orthodoxy to the equation resulted in a significant increase in R^2 (Table 3). Stronger adherence to religious tenets, as assessed by religious fundamentalism and Christian Orthodoxy scales, was associated with more favorable attitudes toward the practicing Christian (control condition).

DISCUSSION

Social stigma surrounding individuals with mental illness is well documented (10, 11, 16, 17), as are relationships between religious beliefs and stigmatized minority groups (4–9). Few studies, however, have specifically tied the contribution of deeply held religious beliefs to social stigma toward people with mental illness (3, 21, 22). Findings from this study contribute to the small body of literature devoted to understanding relationships between Christian beliefs in the United States (2) and stigmatizing attitudes commonly faced by those with mental illness (20).

We conducted a series of sequential multiple regression analyses to determine relationships between religious beliefs and attitudes toward a mental illness (schizophrenia), a common medical illness (diabetes), and a control condition (practicing Christian). A small but predicted relationship was observed between religious fundamentalism and attitudes toward mental illness (schizophrenia). Consistent with research on other stigmatized groups (3, 4, 6, 21, 22, 26), religious fundamentalism was associated with more negative attitudes toward individuals with mental illness. The small effect size was expected given the myriad of factors affecting stigma toward those with mental illness, including knowledge about mental illness, severity of symptomatology, gender (30), age, familiarity with mental illness (18), personal contact, media exposure (31), counseling experience (3, 22), and attribution style (3, 16, 32). Although the purpose of this study was to determine whether significant relationships exist between religious beliefs and stigma toward people with mental illness, future research could add additional variables to the regression model to bolster the overall predictive power.

In past research, adherence to Christian orthodoxy predicted prejudice toward those holding different religious beliefs (6, 33, 34), yet was associated with tolerance and compassion toward stigmatized racial groups (4, 8, 26). In our study, no significant relationships were found between Christian orthodoxy and attitudes toward people with mental illness. Additionally, neither fundamentalism nor Christian orthodoxy influenced participant attitudes toward individuals with a medical illness (diabetes). These findings were expected, because past research indicates that mental illness tends to be more stigmatizing than medical illness (16, 17). Finally, religious beliefs, including fundamentalism and Christian orthodoxy contributed to positive participant attitudes toward the control condition of a practicing Christian. Again, these findings were expected given the largely Christian sample with characteristics similar to those of the control vignette.

Grounded in Goffman's (13) social identity theory, mental illness may be perceived as a long-lasting blemish of individual character that evokes negative attributions of dangerousness, responsibility (16), or sin (3). Our findings suggest that the social stigma surrounding mental illness may be greater from participants with more fundamental religious beliefs.

Knowledge of ideological and/or organizational characteristics common to religious fundamentalism (35) may provide some insight into the mechanism by which fundamentalist beliefs have an impact on the social stigma surrounding mental illness. For example, those with fundamentalist beliefs may be selective about which aspects of modernity they accept (35), which may influence their explanations as to the cause of mental illness. Additionally, fundamentalist groups are often regarded as authoritarian, with an emphasis on group conformity (35). A desire to be part of a group and tendencies toward making "us versus them" or "in-group versus out-group" judgments may facilitate prejudices (25).

Mental health professionals may find the results of this research useful. Fear of being judged as deviant may negatively affect a person's attitudes toward counseling and willingness to seek treatment (15, 20, 36–39). Both mental illness and the act of seeking professional help may be stigmatized (32, 40). Counselors should be sensitive to client

concerns related to stigmatization and cognizant that such concerns may arise from deeply held fundamental religious beliefs. In doing so, counselors may work with clients to reduce perceived stigma, encourage help-seeking behavior, increase treatment compliance, and improve treatment outcomes.

Additionally, religious leaders and laypersons should consider initiating dialogue within faith-based communities about any underlying social stigmas associated with mental illness. Providing education about mental illness and its varied causes (3), developing familiarity among persons with and without mental illness (41), and promoting positive social interactions (21) may help debunk harmful attributions held by group members (3, 22). By working to change "us versus them" attitudes, we can promote understanding, compassion, and inclusion for people with mental illness and work against the stigmatizing attitudes that devalue people living with these illnesses.

This study was limited by its sample and the region in which the study was conducted. Participants were predominantly female Christian college students from the southeastern United States. Although our resources did not allow for a large, representative sample, there are benefits to our focus on college students. Only a fraction (18%) of college students with mental health problems seek treatment (42), compared with one-third of other individuals with mental health issues (43, 44). Efforts must be made to understand the factors related to the stigmatization of mental illness among college students.

Additionally, of the sample, 90% (N=184) reported being of a Christian faith. The religious demographic characteristics of the sample were not surprising, given that 77% of people living in the United States identify with a Christian religion (2) and the southeastern region is more religious than other parts of the country (45, 46). Therefore, this work cannot be used to determine whether such patterns of results might be consistent with other regions or faiths and cannot be generalized to society as a whole.

Disproportionate gender representation also limits interpretation and generalization. We hope to extend this research in the future to include further analysis of gender differences. Across racial and ethnic groups, women tend to be more religious than men (47), and previous researchers have found gender differences regarding attitudes, self-stigma, help-seeking behavior, and interactions with the church (16, 21, 30, 38, 48).

Finally, this study was limited by the use of specific vignettes to measure attitudes toward mental illness. The study focused exclusively on schizophrenia as representative of mental illness. Past research, however, indicates that psychotic disorders such as schizophrenia are generally more stigmatizing than less severe types of mental illnesses (17, 49, 50). In future studies, researchers may wish to incorporate a larger number of vignettes describing more common or less severe (e.g., anxiety or depression) mental illness or perhaps use a larger number of items referring to mental illness in general rather than to specific diagnoses to improve generalizability.

CONCLUSIONS

Findings from this study contribute to our understanding of the relationships between Christian beliefs in the United States (2) and stigmatizing attitudes commonly faced by those with mental illness (20). Consistent with research on other stigmatized groups (3, 4, 6, 21, 22, 26), religious fundamentalism, and not Christian orthodoxy, was associated with more negative attitudes toward individuals with mental illness. Mental health professionals, religious leaders, and laypersons should be sensitive to underlying social stigmas related to mental illness, cognizant of the association between stigmatization and fundamental religious beliefs, work against attitudes that devalue people living with mental illnesses, and actively promote help-seeking behaviors.

AUTHOR AND ARTICLE INFORMATION

Department of Psychology, Counseling, and Family Therapy, Valdosta State University, Valdosta, GA (all authors).

Send correspondence to Dr. Adams (ksadams@valdosta.edu).

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