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Perception of Mental Illness in the African American Church Culture

Original Research

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Abstract

Introduction: The purpose of this study was to assess the need for mental health education with several African American churches within a major Midwestern city.
Methods: Researchers examined participant knowledge of disease causality and familiarity. Additionally, researchers examined relationships between demographic variables on responses to four stigma items.
Results: Analyses indicated higher education and income was associated with higher stigma. Females were less likely to report higher stigma levels. Results showed as age increases for females, stigma levels decrease.
Conclusions: Study findings indicate the need for future study replication within larger populations, and additional mental health education within the African American faith-based community.

Key Words: Mental-Health Stigma, African Americans, Faith-based, Spirituality, Church

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Introduction

Each year, 43.8 million (1 in 5) adult Americans experience a mental illness.[26] Within the U.S., anxiety followed by depression, bipolar disorder and schizophrenia are the most predominant diagnoses.[26] Minorities as a whole, make up the majority of persons living with a mental illness.[26] More specifically, African Americans (18.6%) represent the 3rd highest racial/ethnic group to be diagnosed with a mental illness, preceded only by Caucasians (19.3%) and American Indian/Alaska Natives (28.3%). Most common mental health diagnoses amongst African Americans include major depression, attention deficit hyperactivity disorder, and posttraumatic stress disorder.[27]

Moreover, minorities are least likely to access mental health treatment services, and more likely to experience poor quality of care and experience higher levels of stigma.[26] In 2015, only 31% % of African Americans accessed mental health services within the past year in comparison to 48% of White Americans.[3] African Americans indicated associated costs, structural barriers (e.g. transportation, lack of qualified health care providers) & prejudice and discrimination as the top three reasons for not using mental health services.[36] Additionally, African Americans reported

experiencing heightened levels of culturally-incompetent treatment practices (racism, micro-aggressions, misdiagnosis, overmedicated, and dismissive behavior) by mental healthcare professionals.[41, 6]

These prejudices in combination with mental illness, have a compounding effect, resulting in double stigma for minorities.[17] For African Americans this is extremely salient, as they have been a historically marginalized group.[24] Because of these prejudices, African Americans may be less apt to seek mental-health treatment services.[1,11, 35]

Concerning African American views on mental illness and help seeking behaviors, past research has shown conflicting results. Some scholars report that African Americans regard mental illness as a sign of weakness and highly stigmatizing and are less likely to connect to mental health treatment services because of their beliefs.[10, 17] While other studies have reported that African Americans in comparison to Caucasians were more likely to believe that mental health professionals could help individuals with mental illness.[4, 14] However, African Americans were less likely to use mental health services and more likely to believe that mental illnesses would improve on its own. [4, 14]

Concerning coping mechanisms, research has shown African Americans are more likely to attribute mental illness to supernatural/spiritual causes in comparison to other racial/ethnic groups.[5] As such, African Americans may be more likely to engage in religious coping (church support, prayer, etc.) instead of professional treatment services in times of mental health crises.[7,40] The "church", may provide support more in line with African American cultural norms, which helps to facilitate familial trust and understanding.[19]

Moreover, the church is the hub/apex within the African American community. In times of calamity, whether it be financial, emotional or physical trauma, the church is typically "the first response". [8, 19, 23, 30, 37]

Currently, there is a lack of research on how the church influences congregants' beliefs/attitudes on the use of mental health treatment services. Plunkett[32] postulated that there are two overarching views within the church that influence connection to services: (1) prevailing belief that the cure for mental illness comes from direct divine intervention from God; and (2) prevailing belief that God will send someone (i.e. mental health professional) to intervene on behalf of the person experience sickness. Depending upon which ideology is endorsed, seeking professional mental health services could be viewed as a lack of faith in God. To increase comfortability with professional mental health help seeking behaviors in the African American faith-based community, mental health professional must take care to integrate core beliefs into clinical treatment practices. [13, 32]

After careful review of the literature, findings highlighted the need for further exploration of mental health stigma levels among African Americans. There is limited research on demographic (gender, age, income, education) influencers of mental health stigma in African American populations.[40] More specifically, less is known about demographic influencers of mental health stigma in African American faith-based populations. [29]

To fill these literary gaps, this study assessed the perception of mental health stigma amongst African Americans church attendees within the Greater Cincinnati Area. Specifically, we examined participant knowledge of disease etiology (disease causation) and familiarity with the most common mental health diagnoses (e.g. depression, anxiety). Additionally, we examined the relationship between demographic factors and mental health stigma levels.

Scientific Methods

Participants

Study participants were African Americans, aged 18 and older (N=47) with a mean age of 42 ± .64 SD, attending predominately African American places of worship within a major Midwestern city. Place of worship were selected if: (1) they were located within predominately African American neighborhoods, based on 2017 United States Census Data; (2) had a neighborhood family median income of $15,833 ± $10,000; (3) neighborhoods located within specific zip code area, specified by study criteria. Participant recruitment was conducted by the first author as part of her non-for profit. Participants were informed of the voluntary nature of the survey and were able to discontinue survey completion at any time.

Review by IRB was not required, as this was deemed as a quality improvement study, per U.S. Department of Health and Human Services guideline 45CRF.46.102(d).

Protocol

Surveys were administered to participants on Sunday mornings after church service. Prior to survey administration, participants were informed of the study purpose, the voluntary nature of the survey and the importance of answering honestly. Once surveys were completed, participants were instructed to place surveys in an envelope which was given to an Apple of His Eye Inc. staff member. Data collection spanned a total of two months (August 2017 through September 2017).

Participants completed The Apple of His Eye Mental Health Stigma Survey*, which* is a 32-item questionnaire. Survey stigma questions were adapted from the, Perceived Devaluation Discrimination Scale. The Perceived Devaluation Discrimination Scale was found to have an overall internal consistency of alpha =.76.[22] The survey contained three items asking participants about the potential causes for mental illness (sample item: Please indicate how strongly you agree or disagree with genetics as the cause of mental illness) and nine items asking about mental illness familiarity (sample item: Please indicate how strongly you agree or disagree Depression is a type of mental illness). The survey also includes four stigma items assessing bias and myths about mental health: (1) People with mental illness are just like everyone else; (2) Most people in my community would treat a person with a mental illness just as they would treat anyone else; (3) Most people looked down on people with mental illness; (4) Most people believe having a mental illness is a sign of weakness. Participants also completed demographic questions assessing their race, gender, age, income level, highest level of education and religious denomination. Previous research has indicated the need for further exploration of African American mental health stigma levels on the basis of gender and age differences.[40]

Statistical Analysis

Descriptive statistics were used to summarize demographic data (gender, age, race, yearly- income, denomination) and survey responses. Similarly with previous studies, *Neither Agree* nor *Disagree* and *Don't Know* response choices were grouped into an *Uncertain* category; *Agree* and *Disagree* answer choices were kept as distinct categories, sub-categories { *slightly agree* or *slightly disagree* } were merged with distinct categories. [20, 33, 34]

To understand the relationship between demographic factors and responses to stigma items, multivariate regression analyses were performed. Specifically, we examined the impact of age, gender, income and education on responses to stigma items. Next, we examined possible moderated relationships (interaction effects) between multiple predictors (gender and age; gender and education; gender, age and income) and responses to stigma items utilizing multiple regression. All analyses were conducted in SPSS version 24 or Mplus version 8 (to normalize survey data distribution, log transformations were performed in Mplus version 8). [21, 25] Two additional methodological techniques warrant mention. First, 5000 bootstrap replications were performed for all analyses to obtain observed rather than estimated standard errors. Second, to better meet the assumption of a normally distributed response variable, the Likert-scale stigma response variables were log-transformed prior to analysis. [15, 31]

Results

Participants

A total of 47 African American churchgoers throughout the Greater Cincinnati Area completed surveys. The survey sample was predominately female (61.7%). The majority of participants indicated not having a mental illness (87%). The survey sample primarily consisted of persons aged 50 and older (67%). Approximately half (53.2%) of the participants had college experience. Income varied widely across study sample. Income ranged from less than $12,000 to $50,000 and up. Participants were primarily from a Christian-Baptist denomination (Table 1).

Concerning disease etiology, the majority of participants indicated they believed mental illness was caused by genetics (80%) and environmental factors (71.1%). Approximately half (42.2%) of participants indicated they were unsure if mental illness was caused by fate/destiny. With respect to familiarity with mental health diagnoses, the majority of participants indicated depression (93.5%) schizophrenia (83.3%), anxiety (78.2%), ADHD (69.8%) drug addiction (66%), stress (63%) grief (56.8%), and autism (50%), and were all examples of mental illnesses; 39.5% of participants believed down-syndrome was not a mental illness (Table 2).

Relationship Between Demographics & Stigma

There were no significant associations for questions one and two, results not shown. For question 3 (Most people look down on people with mental illness?), results indicated participants reporting higher incomes were significantly more

likely to agree that "most people look down on people with mental illness" (p =.05). For question 4 (Most people believe having a mental illness is a sign of weakness?), results showed females were significantly less likely to report that "most people believe having a mental illness is a sign of weakness", in comparison to males (p =.048).

Interactions Between Demographics & Stigma

There were no significant associations for questions one and two, results not shown. For question 3 (Most people look down on people with mental illness?), results indicated that as age increases for females, females were significantly less likely to report that "most people look down on people with mental illness" (p =.037). No association was found for males. For question 4 (Most people believe having a mental illness is a sign of weakness?), when interaction terms were included in the model, gender was no longer significant, and education became a significant predictor of stigma. Results showed that as education levels increased participants reported significantly lower agreement that "Most people believe having a mental illness is a sign of weakness" (p =.037).

TABLE 1: DEMOGRAPHICS AND BACKGROUND CHARACTERISTICS

Items	N	%
Race/Ethnicity	47	100
Sex		
Female	29	61.7
Male	18	38.3
Age		
18-35	4	8.7
36-49	11	23.9
50 and Up	31	67.4
Education		
Less than High school	4	8.5
High school diploma	18	38.3
College	25	53.2
Income		
Less than $12,000	11	23.9
$12,000 to $19,999	6	13
$20,001 to $34,999	8	17.4
$35,000 to $49,999	11	23.9
$50,000 and Up	10	21.7
Denomination		
Baptist	31	66
Apostolic/Pentecostal	0	0
Non-denominational	8	17
Other Christian Denomination	7	14.9
Other Religion	1	2.1

Percents denote valid percents; Missing values excluded

TABLE 2: KNOWLEDGE BASE QUESTIONS

Items: Knowledge Base Causation (Disease Etiology)	Agree N (%)	UNCERTAIN N (%)	DISAGREE N (%)
How strongly do you agree or disagree with the following factors as a cause for mental illness?			
Genetics	36 (80)	9 (20)	0
Fate/Destiny	11 (24.4)	19 (42.2)	15 (33.3)
Environment	32 (71.1)	11 (24.5)	2 (4.4)
Items: Knowledge Base Causation (Disease Familiarity)			
How strongly do you agree or disagree each condition is a type of mental illness?			
Depression	43 (93.5)	2 (4.3)	1 (2.2)
Down Syndrome	15 (34.9)	11 (25.6)	17 (39.5)
Drug Addiction	29 (66)	5 (11.4)	10 (22.7)
Grief	25 (56.8)	4 (9.1)	15 (34.1)
Schizophrenia	35 (83.3)	2 (4.8)	5 (11.9)
ADHD	30 (69.8)	8 (18.6)	5 (11.6)
Anxiety Disorder	36 (78.2)	5 (10.9)	5 (10.9)
Autism	22 (50)	12 (27.3)	10 (22.8)
Stress	29 (63)	7 (15.2)	10 (21.7)

Percents denote valid percents; Missing values exclude

TABLE 3: REGRESSION ANALYSES FOR STIGMA QUESTIONS 3 AND 4

Model Results: Question 3	Estimate	S.E	EST. /S.E.	Two-Tailed P-Value
Most people looked down on people with mental illness?				
Gender				
Age	-.137	.146	-.936	.349
Education	.084	.114	.733	.463
Income	-.048	.119	-.401	.689
	.102	.052	1.956	.050
Model Results: Question 4				
Most people believe having a mental illness is a sign of weakness?				
Gender	-.270	.136	-1.981	.048
Age	.125	.100	1.248	.212
Education	-.091	.094	-.986	.333
Income	.036	.040	.895	.371

TABLE 4: REGRESSION ANALYSES FOR STIGMA QUESTIONS 3 AND 4

Model Results: Question 3	Estimate	S.E	EST. /S.E.	Two-Tailed P-Value
Most people looked down on people with mental illness?				
Gender	.602	.824	.731	.465
Age	.245	.161	1.524	.128
Education	-.115	.179	-.640	.522
Income	.099	.069	1.448	.148
(Age*Gender)	-.491	.235	-2.091	.037
(Education*Gender)	.234	.257	.908	.364
(Income*Gender)	.019	.115	-.168	.867
Model Results: Question 4				
Most people believe having a mental illness is a sign of weakness?				
Gender	-1.268	.749	-1.692	.091
Age	.103	.118	.872	.383
Education	-.221	.106	-2.082	.037
Income	.008	.045	.178	.859
(Age*Gender)	.045	.299	.198	.843
(Education*Gender)	.281	.228	1.232	.218
(Income*Gender)	.060	.114	.527	.598

Discussion

Study results showed that most participants believed mental health conditions are caused by genetic predisposition and environmental factors. These results support prevailing literature, which purports mental illness is caused by both genetic and environmental influences.[28, 2] Concerning disease familiarity, majority of participants were able to correctly identify the six out of the six examples of mental illnesses/mental health disorders (i.e. depression, schizophrenia, anxiety, ADHD, drug addiction, and autism) listed on survey. Participants incorrectly identified grief and stress as examples of mental health disorders. Study findings are consistent with previous research, in that the majority of participants showcased a general knowledge of mental health disorders.[29]

Study results indicated higher income was associated with increased awareness of mental health stigma. In contrast to current study findings, previous research has indicated that lower income is associated with increased stigma.[42] Higher income and education are extremely correlated.[16] Higher income is typically associated with greater access to resources, such as housing, nutrition and education.[42] As result, people may be more informed about mental illness, and less likely to hold negative views towards persons with mental health conditions.

Study results also indicated that higher education was associated with perceptions that most people would not view mental illness as a weakness. Prior research has shown that higher education is associated with decreased stigma.[12] Advanced education provides individuals with access to accurate information on an array of topics, which may help to thwart stigma and future misconceptions.

This study also found that females were significantly less likely to report that "most people believe having a mental illness is a sign of weakness", in comparison to males. Consistent with previous findings, females tend to exhibit lower levels of stigma in comparison to their male counter parts. Corrigan & Watson[12] found that women were less likely to endorse stigmatizing beliefs/behaviors in comparison to men. Women expressed greater levels of empathy and were less likely to avoid persons with a mental illness. As a result, women may be more apt to show grace to persons experiencing a mental illness. Toussaint, L. & Webb[39] reported women in general tend to express greater levels of empathy in comparison to males. Gonzalez, Alegria, Prihoda[18] also found that men were more likely than women to report feelings of shame/embarrassment if people knew they were seeking professional help for a mental illness.

Results also indicated that as age increases for females, females were significantly less likely to report that "most people look down on people with mental illness". This is consistent with previous research indicating that younger individuals may be more susceptible to public scrutiny and the negative media portrayal of persons with mental illness. [18] As such, young adults (18 to 25) may be more likely to embrace mental health stereotypes more in line with mainstream society.[38] (However, study results did not indicate a significant gender interaction for males. It may be that these males embraced a more conservative (emotionally strong, self-reliant) societal role so admittance of a mental health issue of any kind is seen as a sign of weakness.[18] Future studies with larger samples are needed to replicate this finding and to help understand how perceptions of individuals with mental disorders may change with age.

Study limitations should be noted. The sample only included members of churches in one area within the community. In addition, the sample size was small limiting the generalizability of results. Further, the study only used self-report measures which may have overestimated or underestimated respondent's actual behavior. Finally, completing measures at a place of worship may have impacted participants' responses in that they may have felt pressured to respond in a more socially desirable manner.

Conclusions

Findings from this study add to the literature by providing a more in-depth look into African American churchgoers' attitudes/stigma levels towards persons with mental illness based on demographic influencers. Additionally, study results validate the need for additional mental health education within the African American faith-based community. Findings from this pilot study also highlight the necessity for further exploration of African American faith-based populations' mental-health stigma levels towards individuals with mental illness. [9,29]

Conflict of Interest and Source of Funding
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