The Influence of Individual and Congregational Religiousness on Seeking Psychotherapy: A Multi-Level Analysis

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Clinical Impact Statement: Our research suggests that characteristics of congregations may relate to the likelihood that their congregants seek psychotherapy. We encourage researchers, therapists, and advocates to consider congregations as useful sites of intervention to address mental health concerns.

Abstract

Religious individuals are less likely to seek treatment than their nonreligious counterparts; however, what accounts for this disparity remains unclear. Some have suggested that variation between congregations may explain this effect; yet, few studies have examined these factors due to the difficulty of conducting congregation-level research. Using a sample of 298 participants recruited from 20 congregations across three major religions (Islam, Christianity, Judaism), we used multilevel modelling to examine how individual and congregational factors effect psychotherapy seeking behavior. Guided by Azjen's Theory of Planned Behavior, we examined treatment seeking and two related outcomes: attitudes to seeking treatment and subjective norms around treatment seeking. We found individuals' scripture reading and service attendance unrelated to either attitudes or subjective norms. When scripture reading and service attendance were aggregated as congregation-level variables, they proved negatively related to attitudes and treatment visits, though these effects disappeared after accounting for race/ethnicity. Congregational efforts to destigmatize mental illness were unrelated to attitudes, subjective norms, or treatment visits. Intraclass correlations indicate that congregation-level factors account for a small-to-medium percentage of variation in treatment seeking indicators. Taken together, our results indicate that congregational factors may play a role in treatment seeking; however, the relationship may be mediated by demographic features of the congregation. We encourage therapists and advocates to utilize congregations as loci of intervention to encourage treatment seeking.

Keywords: Theory of Planned Behavior, Religion, Treatment Seeking, Congregation, Mental Health

The influence of individual and congregational religiousness on psychotherapy seeking: A multilevel analysis

Despite the growing accessibility of psychotherapy, many who could benefit from psychotherapy fail to seek it, leading to unnecessary suffering. Several explanations have emerged for why this disconnect may exist, including societal stigma around mental health (Lannin, Vogel, Brenner, & Tucker, 2015; Vogel & Hammer, 2010), individuals' self-stigmatizing beliefs (Lannin et al., 2015; Vogel & Hammer, 2010), and structural barriers to treatment seeking (Ward & Besson, 2012). Perhaps the most comprehensive framework to be proposed to explain this disconnect is the Theory of Planned Behavior (Azjen, 1985; Hammer, Parent, & Spiker, 2018). This theory asserts that treatment seeking behavior is most likely when an individual holds positive attitudes toward treatment seeking, is part of a group that has positive subjective norms around treatment seeking, and perceives themselves as able to seek treatment. The Theory of Planned Behavior has been applied with some success to understanding disparities in treatment seeking across gender (Chandrasekara, 2016), race/ethnicity (Woods, 2013), education (Zorrilla et al., 2019), and age (Damghanian & Alijanzadeh, 2018).

Recent scholarship suggests that religion and religiousness may also play an important role in influencing psychotherapy seeking. Meta-analyses consistently indicate that religiousness (i.e., religious affect, behavior, and cognition; Salsman et al., 2015) has a small but positive relationship with mental health (Salsman et al., 2015; Smith, McCullough, & Poll, 2003); however, religious individuals appear to be less likely to seek out psychotherapy when experiencing distress than non-religious individuals (Moreno, Nelson, & Cardemil, 2017; Wamser, Vandenberg, & Hibberd, 2011). This reticence to seek treatment may be based in perceived group norms around psychotherapy seeking (Weatherhead & Daiches, 2009) and

perceptions of how successful seeking treatment may be in reducing distress (Mirza et al., 2019). Although religious individuals may successfully cope with some degree of distress in other ways (e.g., religious coping, prayer, speaking with a religious leader; Breland-Noble, Wong, Childers, Hankerson, & Sotomayor, 2015), not seeking treatment for severe mental illness likely perpetuates suffering that could be alleviated through therapy or medication.

Like other attitudes (e.g., attitudes toward same-sex sexuality; Lefevor, Sorrell et al., 2019; Whitehead, 2013), attitudes toward psychotherapy seeking may by formed and reinforced in religious congregations. As such, an individual's attitudes and behaviors may be influenced not only by their own attitudes but by the attitudes and behavior of their fellow congregants (Lefevor, Paiz et al., in press). Leaders of congregations may particularly influence individuals' attitudes toward psychotherapy seeking, as they may provide adequate psychoeducation around mental health and encourage congregants to seek psychotherapy as needed. However, due at least in part to the difficulty of conducting congregation-level research, these relationships have yet to be examined.

To fill this gap, in the present study, we examine how religiousness relates to psychotherapy seeking using nested data gathered from congregants at 20 randomly selected places of worship in a city in the southern United States. Guided by the Theory of Planned Behavior (Azjen, 1985; Hammer et al., 2018), we focus particularly on the role of individual and congregational factors on individuals' attitudes toward treatment seeking, stigma around psychotherapy, and psychotherapy visits in the last year. We also examine how various demographic factors (i.e., age, gender, education, race/ethnicity) may relate to psychotherapy seeking to add to the growing literature examining the Theory of Planned Behavior.

The Theory of Planned Behavior

An understanding of how religiousness or other demographic factors may influence treatment seeking must be based on a broader understanding of why individuals who need psychotherapy fail to seek treatment, even when they have ample opportunities and resources. The Theory of Planned Behavior (Azjen, 1985), addresses this question by asserting that behaviors result from a complex interplay of beliefs, attitudes, intentions, and control over behavior. Individuals' intentions are thought to be shaped by their attitudes toward a behavior, as well as the attitudes of the groups of which they are a part (i.e., subjective norms). When positive intentions are coupled with both perceived and actual behavioral control, the target behavior is more likely to emerge. Thus, an individual's likelihood to seek treatment can be anticipated by three predictors: an individual's attitudes toward seeking treatment, the subjective norms around seeking treatment of the groups to which the individual belongs, and the degree to which the individual feels capable of seeking treatment. This theory is sufficiently broad to account for various factors noted to inhibit treatment seeking, including societal stigma (conceptualized as subjective norms; Chen, Romero & Karver, 2016; Lannin et al., 2015), self-stigma (conceptualized as attitudes toward treatment seeking; Choi & Miller, 2018; Kaplan, Vogel, Gentile, & Wade, 2012), and structural barriers, such as inadequate time to seek treatment for racial and ethnic minorities, difficulty attaining psychotherapy in rural areas, and more distance from and less knowledge of resources amongst African American populations (conceptualized as perceived behavioral control; Miranda, Soffer, Polanco-Roman, Wheeler, & Moore, 2015; Murry, Helfinger, Suiter, & Brody, 2011; Thurston & Phares, 2008).

Attitudes and Norms across Demographic Variables

According to the Theory of Planned Behavior (Azjen, 1985), demographic characteristics do not exert a direct influence on behavior but may influence the individual's attitudes, form the

individual's subjective norms, or affect perceived behavioral control, which in turn may influence behavior. To set the stage for the discussion of the potential relationship between religiousness and psychotherapy seeking, we discuss research examining the relationship between various demographic characteristics and psychotherapy seeking.

Education. Education may influence individuals' attitudes, subjective norms, and perceived ability to access psychotherapy. Generally, those who have more formal education are more likely to have positive attitudes toward psychotherapy (Al-Darmaki, 2003; Kikuzawa et al., 2019), to have more positive group norms about psychological disorders (Corrigan & Watson, 2007), to be more likely to seek treatment from a mental health provider (Evans-Lacko et al., 2017; Parslow & Jorm, 2000), and to be more likely to comply with treatment recommendations (Jones, Cook, & Wang, 2011) than those with little or no formal education. Education is closely related to income and socioeconomic status, which may in turn impact individuals' perceived ability to seek psychotherapy, through factors such as insurance coverage, access to transportation, time to attend treatment, and money to pay for treatment (Ward & Besson, 2012).

Age. Age has also been found to influence treatment seeking, with older individuals seeming to be more likely to seek treatment than younger individuals (Mackenzie et al., 2019; Mackenzie, Gekoski, & Knox, 2007; Rickwood et al., 2007). Although there is some disagreement (e.g., Jang, Chiriboga, & Okazaki, 2008; Mojtabai, 2007), older adults appear to have more positive attitudes toward psychotherapy seeking (Mackenzie et al., 2007) and to perceive less stigma toward seeking psychotherapy (Mackenzie et al., 2019) than younger adults. Additionally, as individuals age, they may experience a greater sense of behavioral control—given increased autonomy and access to resources—which may further facilitate treatment seeking.

Race/Ethnicity. Race/ethnicity may affect psychotherapy seeking both directly and indirectly. Individuals' attitudes toward and subjective norms around psychotherapy seeking are influenced in large part by their racial/ethnic identity (Allen, Kim, Smith & Hafoka, 2016; Heath, Vogel, & Al-Darmaki, 2016; Owen, Thomas, & Rodolfa, 2013). Because race/ethnicity is related to socioeconomic status (Williams, Priest & Anderson, 2016) and many People of Color report negative experiences in therapy due to cultural conflicts (Lynch, Vansteenkiste, Deci, & Ryan, 2011), race/ethnicity may also relate to perceived behavioral control. Overall, People of Color are less likely to seek treatment than are White individuals (Masuda et al., 2009), even though they may experience more distress (Lefevor, Janis, Franklin, & Stone, 2019).

Gender. Generally, women are more likely to seek psychotherapy than men (Booth, McDermott, Cheng & Borgogna 2019; Hammer & Vogel 2010; McDermott, Cheng, Wong, Booth, Jones & Sevig 2017). Although women may experience more distress than men due to systemic oppression (Lefevor, Boyd-Rogers, Sprague, & Janis, 2019), which may lead them to seek treatment more readily, women also report more favorable attitudes (Allen et al., 2016; Vogel, Heimerdinger-Edwards, Hammer & Hubbard 2011) and less perceived stigma (Salsman et al., 2015; Owen & Rodolfa 2013) toward psychotherapy than men. These favorable attitudes and decreased stigma may also empower women to have a greater sense of perceived control over accessing treatment.

The Role of Religiousness in Treatment Seeking

Religiousness may function like other demographic characteristics in relation to treatment seeking. In general, individuals who are religious are less likely to seek treatment (Moreno et al., 2017; Wamser et al., 2011) than nonreligious individuals and report negative experiences in therapy, potentially due to cultural mismatch (Lefevor, Janis, & Park, 2018). Religiousness likely

shapes psychotherapy seeking through its influence on attitudes, subjective norms, and perceived behavioral control.

Religiousness has been associated with ambivalent attitudes toward psychotherapy seeking (Moreno et al., 2017). This association may stem from supernatural understandings of the origin of mental illness espoused by some religious individuals (Mirza et al., 2019). Conceptualized thus, mental illness may reflect sin, punishment from a Higher Power, or bad fate, which modern psychotherapy would be seen as unable to address. Some research has pointed to religious individuals' preference for help from religious leaders over therapists for psychological distress (Wamser et al., 2011).

Religious communities have their own subjective norms, which may also impact psychotherapy seeking. In some religious communities, those who seek treatment may be criticized or ostracized because they are seen as less faithful (Breland-Noble et al., 2015). Treatment seeking may thus represent a lack of faith that God will take care of them (Wamser et al., 2011). Regardless of why religious communities develop subjective norms that do not favor treatment seeking, the existence of these norms discourages treatment seeking (Weatherhead & Daiches, 2010).

It is much less clear how religiousness may affect one's perceptions of control of behavior. Leaders of congregations are often apprehensive of referring congregants to mental health professionals, which could weaken congregants' sense of control over their ability to seek treatment (Allen, Davey, & Davey, 2010). Further, congregations typically do not offer their own mental health programming or have strong ties to outside mental health services (Blank, Mahmood, Fox, & Gutterbock, 2002), which may make it more difficult for congregants to seek mental health services.

The Present Study

The Theory of Planned Behavior (Azjen, 1985) suggests that religiousness may influence psychotherapy seeking through its relationship with attitudes toward psychotherapy seeking, subjective norms about seeking treatment, and perceived behavioral control of seeking treatment. It further suggests that intervention by congregation leaders toward destigmatizing mental illness or providing resources may encourage psychotherapy seeking behavior. The present study examines how well the Theory of Planned Behavior may explain the relationship between religiousness and psychotherapy seeking. From our literature review, we hypothesize:

H1: Religiousness will be negatively related to psychotherapy seeking.

H2: Religiousness will be negatively related to individuals' attitudes toward psychotherapy seeking

H3: Religiousness will be positively related to perceptions of stigma (i.e., subjective norms)

H4: Efforts by religious leaders to destigmatize psychotherapy seeking and enhance perceptions of behavioral control will be related to increased psychotherapy seeking

H5: Gender, age, ethnicity, and education will be related to psychotherapy seeking in the directions indicated from the literature review

Method

Sampling Procedures

Multilevel models require a sufficient sample size at all levels of analysis. Recent guidelines suggest that a level 1 sample size of 5 to 40 units per cluster and a level 2 sample size of 10 to 30 units yields acceptable estimates when examining main effects (Bell, Morgan,

Schoeneberger, Kromrey, & Ferron, 2014). To attain this sample size, we first conducted an initial search of the White Pages to locate all the places of worship in a southeastern city (1493 churches, 11 mosques, and 10 synagogues). From this results list, we randomly selected 78 places of worship using stratified random sampling to ensure inclusion of a variety of religious traditions in the sample (68 churches, 5 synagogues, 5 mosques) to ensure the participation of at least 10 to 30 congregations.

Prior to engaging in data collection, IRB approval was obtained from the Rhodes College IRB. Research assistants followed a protocol to contact all places of worship. They began by attempting to contact via a phone call. Where leaders did not return phone calls or a number was unavailable, the research team visited the place of worship to ask for permission to collect data following worship services. Of the 78 places of worship, we were unable to contact 18 (numbers disconnected, addresses no longer in use), 40 declined participation (either before or after learning about the content of the survey)[1], and 20 agreed to data collection. Common reasons for declining participation included leaders of congregations feeling uncomfortable with survey aims or questions and leaders' disinterest in or suspicion of psychological research. Some synagogues declined participation because congregants do not write or use electronics on the day of their worship services.

Research team members asked leaders of consenting congregations to make an announcement that team members would be administering a 10-minute survey to those interested following services. Participants were informed that they would be completing a survey regarding religious belief, practice and attitudes, and provided informed consent prior to completing the

[1] The present study was part of a larger project that examined attitudes toward homosexuality (Lefevor, Sorrell et al., 2019). Some of the congregations who declined participation did so due to discomfort with those aims of the survey.

survey. All survey responses were double coded, and disputes were resolved by team discussion. Participants were not compensated for participation.

Participant Characteristics

Participants were eligible for inclusion if they (a) were 18 years of age or older, (b) were at the place of worship the day of data collection, and (c) completed survey items related to study variables. The final sample consisted of 298 participants from 20 congregations (16 churches, 3 mosques, 1 synagogue) with an average of approximately 17 participants per congregation. Congregations belonged to a variety of religious denominations, including Sunni Islam (n = 3), Reform Judaism (n = 1), Baptist (n = 7), Seventh Day Adventist (n = 1), Pentecostal (n = 2), Episcopal (n = 2), Catholic (n = 1), and non-denominational Christian (n = 3).

Similar to the city from which the data were collected, the majority of the sample was Black (75%), with an average age of 50.32 (SD = 15.86) and were relatively split between having no college degree (48.3%) and having either a bachelor's degree (27.5%) or a graduate degree (25.2%). Almost all participants (95.3%) identified as heterosexual/straight. Over half (67.1%) identified as women, and only one participant identified as transgender or genderqueer. Our sample reported attending worship services on average between "nearly every week" and "every week" (SD = 1.24) and reading scripture on average "nearly every week" (SD = 2.20). The average congregation had discussed approximately 2 mental health issues in the past year (SD = 1.65) and had 1.5 programs related to mental health issues (SD = 1.45).

Measures

Service Attendance and Scripture Reading. Frequency of religious service attendance and scripture reading were assessed using the organizational religious activity and non-organizational religious activity subscales of the Duke University Religiousness Index (Koenig

& Büssing, 2010). These items ask participants to report how often they attend church or other religious meetings and how often they read sacred texts on a 9-point Likert scale from "never" (1) to "several times a week" (9) with higher scores indicating more frequent attendance.

Congregational Resources. Frequency of discussion of mental health topics was determined using an item that assessed whether the congregation had dealt with any of the following six topics in the past 12 months: depression, delusion or paranoia, dementia or Alzheimer's disease, nervous breakdown, suicide, or other mental health problems. Each was assessed as a dichotomous variable, and a summed score (0-6) was attained for frequency of discussion. The availability of mental health programs offered by the congregation was similarly assessed by asking participants if their congregation offered programming related to any of the following five concerns: alcohol and substance abuse, marital counseling, sex education and counseling, domestic violence counseling, and sexual assault counseling. Each was assessed as a dichotomous variable, and a summed score (0-5) was attained for availability of programming.

Treatment Seeking. Psychotherapy seeking stigma was measured using the perceived public stigma subscale of the Perceived Stigma and Barriers to Care of Psychological Problems measure (Britt et al., 2008). The scale consists of six questions which require the participant to rate the possible concerns that would affect participants' decision to seek treatment for a psychological problem from "strongly disagree" (0) to "strongly agree" (5). Treatment seeking attitudes were measured using the question, "Overall, what is your current attitude toward seeking treatment from a mental health professional were you to develop a problem?" The participants rated their answer from "very negative" to "very positive." Participants also reported the number of psychotherapy visits they made in the past 12 months.

Data Preparation and Analysis Plan

We employed multilevel modelling (MLM) to examine the unique influence of individual- (level 1) and congregation-level (level 2) variables on outcomes. Data were analyzed in R (version 3.6.0; R Development Core Team, 2019) using maximum likelihood estimation with the "lme4" package (Bates, Maechler, Bolker, & Walker, 2015). Grand mean centering was performed on non-dichotomous variables to facilitate interpretation of effects. Dichotomous variables were coded as follows: gender (1 = woman), ethnicity (1 = Person of Color). Missing data were handled using listwise deletion. All models included a random effect for intercept, a fixed effect for slopes, and a random effect for slopes of level 1 variables[2].

We tested our hypotheses by examining three independent MLMs with treatment seeking attitudes, stigma, and psychotherapy visits as the corresponding dependent variables. In each, we used a model building approach where, beginning with a null model (Model 0), a set of theoretically-related parameters were sequentially added to a model and models were compared to the previous model using the AIC and the BIC (Hox et al., 2017). Where the AIC and BIC provided conflicting indicators of model fit, a likelihood ratio test was conducted to provide additional information about model fit (Hox et al., 2017). Where predictors were significant, they were retained and subsequent models were compared against the original model with significant predictors.

Five sequential multilevel models were created. The null model (Model 0) was estimated without any explanatory variables to enable the calculation of the intraclass correlation. Model 1 was comprised of individual-level demographic predictors (age, gender, education, and ethnicity). Model 2 included individual-level religiousness predictors (scripture reading, service

[2] A random effect for slope was not included for variables in Model 1 of the mental health treatment visits model due to failure to converge, which was likely due to the inclusion of so many random effects aiming to explain so little level-2 variation.

attendance) in addition to any significant demographic predictors. Model 3 added congregation-level religiousness predictors (congregation-level scripture reading and service attendance). Model 4 included congregation-level mental health resource variables (availability of programming and frequency of discussion). We calculated a final model including only significant predictors, standardizing the coefficients for ease of interpretation. Because psychotherapy visits were positively skewed (skewness = 6.42), treatment visits were log transformed for analyses adding a constant (1) because of the existence of "0" values.

Results

Before conducting analyses, we examined the relationships between variables as well as the descriptive statistics of variables of interest (see Table 1). On average, participants held a "positive" view toward seeking psychotherapy (SD = 1.31) and largely "disagreed" that stigma would prevent them from seeking treatment (SD = 0.80). The average participant had 1.24 psychotherapy visits in the past 12 months (SD = 4.71), though 80.2% of participants had not sought psychotherapy at all.

Attitudes toward Treatment Seeking

The results of five nested MLMs and the final model for attitudes toward treatment seeking are shown in Table 2. The null model indicated a significant intercept ($\gamma_0 = 5.92$, $p < .01$), justifying the inclusion of an intercept in future models. Results from the null model indicate that the individual-level variance was .0004 and the congregation-level variance was 1.7452. The estimated intraclass correlation was .0002, indicating that 0.02% of variation in attitudes toward treatment seeking was attributable to differences in congregations. Though the variation at the congregation-level was not substantial, we included predictors at both levels to account for the nested nature of the data and to evaluate our hypotheses.

Model 1 indicated that being a woman (γ_{gender} = .64, p < .01) and having more formal education ($\gamma_{education}$ = .18, p < .01) were related to more positive attitudes toward psychotherapy. Model 1 did not significantly improve model fit over the null model, as evidenced by increases in both the AIC and BIC (see Table 2). Nonetheless, gender and education were retained as predictors in subsequent models.

Model 2 indicated that neither individual-level service attendance nor scripture reading was related to attitudes toward psychotherapy. Because neither predictor was significant, and the BIC increased from the null model to Model 2, no new predictors were retained for subsequent models.

Model 3 indicated neither congregational-level service attendance nor scripture reading was related to attitudes toward psychotherapy. Because predictors were not significant, and the BIC increased the null Model to Model 3, no new predictors were retained.

Model 4 indicated that neither the frequency of discussion of mental health issues nor the availability of programming around mental health issues was related to attitudes toward psychotherapy. Because neither predictor was significant, and the BIC increased from the null model to Model 4, no new predictors were retained for the final model.

The final model included only gender and education. Both gender ($\gamma_{genderstandardized}$ = .16, p < .01) and education ($\gamma_{educationstandardized}$ = .20, p < .01) were significantly related to attitudes toward psychotherapy. Although the AIC showed a significant reduction relative to the null model, the BIC evidenced an increase, indicating unclear goodness of fit. As such, a likelihood ratio test was conducted to compare the null model to the final model. The results of this test indicated that the final was preferred (likelihood ratio = 25.58, p < .01), indicating the goodness of fit of the final model.

Stigma

The results of five nested MLMs and the final model for stigma are shown in Table 3. The null model indicated a significant intercept ($\gamma_0 = 2.01$, $p < .01$), justifying the inclusion of an intercept in future models. Results from the null model indicate that the individual-level variance was .6118 and the congregation-level variance was .0184. The estimated intraclass correlation was .0291, indicating that 2.91% of variation in stigma was attributable to differences in congregations. Though the variation at the congregation-level was small, it was substantial (Cohen, 1988), so we included predictors at both levels.

Model 1 indicated that older age ($\gamma_{age} = .01$, $p < .01$) and being a man ($\gamma_{gender} = -.44$, $p < .01$) were related to more stigma. Model 1 significantly improved model fit over the null model as evidenced by decreases in both the AIC and BIC (see Table 3). As such, both age and gender were retained as predictors in subsequent models.

Model 2 indicated that neither individual-level service attendance nor scripture reading was related to stigma. Because neither predictor was significant, and both the AIC and BIC increased from Model 1 to Model 2, no new predictors were retained for subsequent models.

Model 3 indicated neither congregational-level service attendance nor scripture reading was related to stigma. Because neither predictor was significant, and both the AIC and BIC increased Model 1 to Model 3, no new predictors were retained.

Model 4 indicated that neither the frequency of discussion of mental health issues nor the availability of programming around mental health issues was related to stigma. Because neither predictor was significant, and both the AIC and BIC increased Model 1 to Model 4, no new predictors were retained for the final model.

The final model included only age and gender. Both age ($\gamma_{agestandardized}$ = .12, p < .01) and gender ($\gamma_{genderstandardized}$ = -.26, p < .01) were significantly related to stigma. Both the AIC and BIC show significant reductions relative to the null model and Model 1, indicating the goodness of fit of the final model.

Psychotherapy Visits

The results of five nested MLMs and the final model for psychotherapy visits are shown in Table 4. The null model indicated a significant intercept (γ_0 = .28, p < .01), justifying the inclusion of an intercept in future models. Results from the null model indicate that the individual-level variance was .0062 and the congregation-level variance was .5323. The estimated intraclass correlation was .0115, indicating that 1.15% of variation in psychotherapy visits was attributable to differences in congregations. Though the variation at the congregation-level was not substantial, we included predictors at both levels to account for the nested nature of the data.

Model 1 indicated that being older (γ_{age} = -.01, p < .05) and being a Person of Color ($\gamma_{ethnicity}$ = -.24, p < .05) were related to fewer psychotherapy visits. Although the AIC evidenced a decrease from the null model to Model 1, the BIC evidenced an increase (see Table 4). As such, a likelihood ratio test was conducted, which confirmed that Model 1 significantly improved model fit (likelihood ratio = 10.63, p < .05), and both age and ethnicity were retained as predictors in subsequent models.

Model 2 indicated that neither individual-level service attendance nor scripture reading was related to psychotherapy visits. Because neither predictor was significant, and both the AIC and BIC increased from Model 1 to Model 2, no new predictors were retained for subsequent models.

Model 3 indicated neither congregational-level service attendance nor scripture reading was related to psychotherapy visits. Although the AIC and BIC suggested improved model fit over Model 1, no new predictors were retained because the new predictors tested were not significant.

Model 4 indicated that neither the frequency of discussion of mental health issues nor the availability of programming around mental health issues was related to psychotherapy visits. Because neither predictor was significant, and the AIC and BIC increased from Model 1 to Model 4, no new predictors were retained for the final model.

The final model included only age and ethnicity. Both age ($\gamma_{agestandardized}$ = -.13, $p < .05$) and ethnicity ($\gamma_{ethnicitystandardized}$ = -.13, $p < .05$) were significantly related to psychotherapy visits. Although neither the AIC nor the BIC showed a reduction relative to Model 1, the final model was retained as the final model because it included all of the significant predictors of Model 1, which evidenced greater model fit over the null model.

Discussion

Religiousness and the Theory of Planned Behavior

Our first three hypotheses predicted a relationship between individual-level religiousness (i.e., scripture reading and service attendance) and indicators of psychotherapy seeking suggested by the Theory of Planned Behavior (Azjen, 1985). We failed to find a relationship between individual-level religiousness and attitudes, stigma, or treatment visits in either zero-order correlations or multi-level models. These findings run contrary to predictions in the literature suggesting that religiousness is negatively related to treatment seeking (Lukachko, Meyer & Hankerson, 2015; Ng et al., 2011; Wamser et al., 2011), as well as findings suggesting that

religiousness is related to stigma and negative attitudes toward treatment seeking (Moreno et al., 2017).

This discrepancy may be best attributed to the characteristics of the current sample. On average, participants read sacred texts weekly, attended religious services weekly or nearly every week, held a positive view toward seeking psychotherapy and reported little stigma that would prevent them from seeking treatment. The lack of variability and restricted range in measures of both religiousness and treatment seeking may have made it more difficult to detect a relationship between the variables. Given that religiousness has been linked with reduced treatment seeking in the general population (Wamser et al., 2011), it is possible that religiousness exerts a categorical influence on treatment seeking, with the largest difference being between those who are or who are not religious, which would not have been detected in this study.

The Congregation as a Level of Analysis

Our fourth hypothesis concerned the relationship between congregation-level variables and psychotherapy seeking. We found that congregations accounted for a small to medium percentage of the variation in two of the three treatment seeking indicators (Cohen, 1988), suggesting that congregational effects should be considered when studying treatment seeking. Previous literature has examined the impact of congregations on attitude formation (Lefevor, Sorrell et al., 2019; Whitehead, 2013), but this is the first study to our knowledge that uses a multi-level approach to examine the influence congregations may have on treatment seeking.

We failed to find a substantial relationship between treatment seeking and congregational variables related to treatment seeking, specifically the frequency with which leaders discussed mental health concerns and the availability of mental health programming in the congregation. On one hand, this trend may represent a true finding that suggests that leaders' actions are, at

best, distally related to congregants' attitudes, perceptions, and behaviors. Should this interpretation be accurate, it would fall in line with other social psychology research finding only minimal correlations between leadership characteristics and employee outcomes and would suggest that researchers search for other congregation-level variables that could explain the variation in treatment seeking. On the other hand, this lack of relationship may relate to measurement issues in the present study. In the study, congregants reported their *perceptions* of the availability of programming and the frequency with which leaders spoke of mental health concerns, which may have introduced an additional reporting bias into the study. However, asking leaders directly or having researchers observe congregations directly may yield more reliable data that could find a relationship between these predictors and treatment seeking.

Although we did not observe a relationship between congregation variables related to treatment seeking, correlational analyses indicated that scripture reading and service attendance—when understood as congregation-level variables (i.e., differences between *congregations* in frequency of scripture reading or service attendance)—were related to treatment seeking indicators. Specifically, congregations with members who attend services and study scriptures more frequently, had more negative attitudes toward seeking treatment and sought treatment less frequently. That these trends are evident on a congregational level appears to indicate that being part of a specific type of congregation—in this case, one in which members are more religious—may influence individuals' treatment seeking indicators above and beyond an individual's religiousness.

The relationships between scripture reading or service attendance and treatment seeking, however, were non-significant in any of the multi-level models, suggesting that other variables likely accounted for the relationship seen in the correlational analysis. This apparent

contradiction is likely due to the relationship between race/ethnicity and service attendance (r = .27) and scripture reading (r = .31) and the fact that congregations were highly segregated, with congregations averaging 90% of congregants from the same racial/ethnic background (Lefevor, Paiz et al., in press). Thus, because our MLMs were structured in a way to account first for race/ethnicity and second for religiousness, it is likely that the relationship between religiousness on a congregational level and treatment seeking is mediated by race/ethnicity.

Taken together, our results examining the contributions of congregation-level variation on treatment seeking suggest that congregation-level factors may be important to consider when examining psychotherapy seeking, though it is unclear which factors may be most strongly related to treatment seeking. We encourage additional research examining the specific practices of leaders of congregations around mental health (Smith et al., 2018).

Demographic Characteristics and the Theory of Planned Behavior

Our final hypothesis concerned the relationship between demographic characteristics and treatment seeking indicators as predicted by the Theory of Planned Behavior (Azjen, 1985). In concordance with previous literature, we found that being a woman, being younger, having more formal education, and being White were positively associated with treatment seeking indicators (Forbes et al. 2017; Gonzalez 2011; Hays, 2015; Ofonedu et al., 2017; Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011; Ojeda 2008; Sarkin, 2015). It is likely that these group differences reflect differences in attitudes, norms, or perceived control of action across gender, age, education, and race/ethnicity.

In addition to broadly replicating previous findings, the results from our study further nuance how various demographic characteristics may relate to treatment seeking, as not all demographic characteristics predicted treatment seeking across indicators of treatment seeking.

In particular, we found that gender was associated with attitudes toward treatment seeking and subjective norms but did not influence the actual number of psychotherapy visits made. We found that age predicted the number of psychotherapy visits made and subjective norms around treatment seeking but was not related to attitudes toward treatment seeking. Education was related only to attitudes toward treatment seeking, and race/ethnicity was related only to the number of psychotherapy visits made.

It is possible that these trends reflect true differences. In this lens, our results suggest that older adults may not seek treatment due to concerns around stigma rather than due to poor views of treatment (Mackenzie et al., 2008). They may also suggest that factors other than subjective norms and attitudes—such as perceived control of behavior or structural stigma (Allen et al., 2016; Cheng, Kwan & Sevig, 2013; Heath et al., 2016; Owen et al., 2013)—are responsible for disparities in treatment seeking based on race/ethnicity. Our results may also indicate that although being a woman and having formal education may be associated with more positive attitudes toward treatment seeking, having positive attitudes is not sufficient to produce increased rates of seeking treatment (Hammer & Vogel, 2013).

Implications for Practice

Our findings have implications for psychologists as both therapists and mental health activists. Given that various treatment seeking indicators appeared to vary by congregation, we encourage therapists to consider clients' congregational affiliations as a potentially important factor in their treatment. Particularly as we found stigma to vary by congregation, therapists may inquire about how supportive clients' congregational community is of their presence in therapy and the interventions proposed (Breland-Noble et al., 2015).

We also found that certain types of clients are less likely to seek treatment than others, particularly racial/ethnic minorities and older adults. These findings suggest potential structural and stigma-related barriers that these clients may experience that others do not (Lefevor, Janis, Franklin, & Stone, 2019). Given the decreased frequency of treatment seeking in these groups, therapists may benefit from being more attuned to the needs of these clients and following up more intensely if clients stop attending therapy than therapists may otherwise be inclined to do.

Therapists may also apply the results of this study to their work as mental health activists. The Theory of Planned Behavior (Azjen, 1985) suggests that individuals are likely to reach out for mental health services if they have positive attitudes, group norms that facilitate treatment seeking, and perceived control over their behavior. We found that congregations play a role in perpetuating stigma among religious individuals. Many congregations, however, may do so out of ignorance or lack of education (Smith et al., 2018). Therapists may thus play an important role in providing psychoeducation or support to congregations to reduce stigma around mental health.

Limitations

Despite efforts to enhance generalizability, our study is necessarily limited by characteristics of the sample, sampling procedure, and analytic methods. Our sample primarily consisted of Black, Christian women in a single mid-southern city. Although these participant demographics largely match the city from which they were sampled, it is unclear if these findings would be replicated in other contexts. Religiously, our sample was diverse; however, it did not cover the range of denominational possibilities (e.g., no Mormon or Seventh Day Adventist congregations participated) nor did it successful assess interdenominational variation (e.g., Sunni vs. Shia Muslims). Because of the small sample size on a congregational level, analyses were not able to be done between denominations, and future work should explore

whether such differences exist. Finally, all participants were approached at their place of worship, and thus our sample represents only religious individuals who attend worship services. It is possible that religiousness relates differently to treatment seeking for those who do not attend worship services or who attend less frequently. Future work should be done to examine these possibilities.

Conclusions

With a sample of 298 participants from 20 congregations representing 3 world religions, we found that stigma toward psychotherapy seeking and the number of psychotherapy visits made varied substantially between congregations, indicating the potential for interventions targeting religious congregations to reduce stigma and encourage treatment seeking. We also found that treatment seeking was related to various demographic factors, including age, education, race/ethnicity, and gender. We encourage therapists working with religious clients to understand the role that clients' congregational communities may play in supporting their treatment. We also encourage therapists as activists to consider engaging with local faith organizations to provide accurate information about psychological disorders and mental health that may serve to improve attitudes toward seeking treatment, reduce stigma, and ultimately help those in need of treatment feel capable of getting it.

Table 1

Descriptive statistics and correlations of variables of interest

Variable	*M*	*SD*	Range	1	2	3	4	5	6	7	8	9	10	11	12
1. L1 Age	50.32	15.86	18-84	1.00											
2. L1 Gender	.67	0.47	0-1	-.01	1.00										
3. L1 Education	4.23	1.45	1-6	-.07	.04	1.00									
4. L1 Ethnicity	.75	0.43	0-1	-.12*	.02	-.15*	1.00								
5. L1 Service Attend	7.72	1.24	1-9	.07	-.04	-.08	.27**	1.00							
6. L1 Scripture Read	7.07	2.20	1-9	.18**	.05	-.05	.31**	.52**	1.00						
7. L2 Service Attend	7.68	0.50	6.33-8.5							1.00					
8. L2 Scripture Read	7.07	1.02	5.17-8.89							.84**	1.00				
9. L2 MH Discussion	1.86	1.65	0-6							.07	.02	1.00			
10. L2 MH Program	1.50	1.45	1-5							.06	.03	.36**	1.00		
11. Treatment Attitudes	5.92	1.31	1-7	.08	.20**	.21**	-.04	-.05	-.03	-.14*	-.09	.03	.10	1.00	
12. Treatment Stigma	2.01	0.80	1-5	.14*	-.23**	-.07	.04	-.04	-.03	-.01	< .01	-.02	.01	-.25**	1.00
13. Treatment Visits	1.24	4.71	0-52	.01	-.02	.08	-.16**	-.04	-.09	-.18**	-.17**	-.08	<.01	.07	-.12*

Note. MH = mental health; $^{*}p < .05$, $^{**}p < .01$

Table 2

The influence of individual- and congregation-level variables on treatment seeking attitudes

Model	**Model$_0$** Unstd. (*SE*)		**Model$_1$** Unstd. (*SE*)		**Model$_2$** Unstd. (*SE*)		**Model$_3$** Unstd. (*SE*)		**Model$_4$** Unstd. (*SE*)		**Model$_{Final}$** Stand.
Fixed Part											
Intercept	5.92**	(0.08)	5.27**	(0.12)	5.41**	(0.17)	7.92**	(1.45)	5.28**	(0.34)	
L1 Age			0.01	(0.01)	-	-	-	-	-	-	
L1 Gender			0.64**	(0.01)	0.67**	(0.20)	0.61**	(0.19)	0.61**	(0.18)	.16**
L1 Education			0.18**	(0.07)	0.16**	(0.06)	0.15*	(0.06)	0.16**	(0.06)	.20**
L1 Ethnicity			0.19	(0.23)	-	-	-	-	-	-	
L1 Service Attendance					0.01	(0.08)	-	-	-	-	
L1 Scripture Reading					-.01	(0.04)	-	-	-	-	
L2 Service Attendance							-.42	(0.29)	-	-	
L2 Scripture Reading							0.12	(0.15)	-	-	
L2 Mental Health Discuss									-.07	(0.16)	
L2 Mental Health Programs									0.24	(0.23)	
Random Part											
σ^2	1.75		1.46		1.48		1.53		1.54		1.53
τ_{00}	<.01		< .01		< .01		< .01		< .01		< .01
Model Fit											
AIC	949.80		952.07		949.80		939.67		941.41		938.23
BIC	960.69		1028.25		1033.59		983.20		984.94		974.50

Note. Model 2 was retained as the final model. Unstd. = Unstandardized coefficients; Stand. = Standardized coefficients; L1 = level 1 variable; L2 = level 2 variable; σ^2 = Level 1 variance; τ_{00} = Level 2 variance; * $p < .05$; ** $p < .01$

Table 3

The influence of individual- and congregation-level variables on psychotherapy seeking stigma.

Model	**Model$_0$**		**Model$_1$**		**Model$_2$**		**Model$_3$**		**Model$_4$**		**Model$_{Final}$**
	Unstd.	(*SE*)	Unstd.	(*SE*)	Unstd.	(*SE*)	Unstd.	(*SE*)	Unstd.	(*SE*)	Stand.
Fixed Part											
Intercept	2.01**	(0.07)	2.15**	(0.12)	2.29**	(0.09)	2.43**	(0.93)	2.59**	(0.20)	
L1 Age			0.01**	(< .01)	0.01*	(< .01)	0.01*	(< .01)	0.01	(< .01)	.12*
L1 Gender			-.44**	(0.10)	-.43**	(0.10)	-.43**	(0.10)	-.40**	(0.10)	-.26**
L1 Education			0.18	(0.12)	-	-	-	-	-	-	
L1 Ethnicity			-.03	(0.04)	-	-	-	-	-	-	
L1 Service Attendance					-.01	(0.02)	-	-	-	-	
L1 Scripture Reading					-.03	(0.05)	-	-	-	-	
L2 Service Attendance							-.11	(0.18)	-	-	
L2 Scripture Reading							-.11	(0.09)	-	-	
L2 Mental Health Discuss									-.06	(0.09)	
L2 Mental Health Programs									-.13	(0.14)	
Random Part											
σ^2	.61		.52		.53		.55		.55		.56
τ_{00}	.02		.02		.02		.01		.01		.01
Model Fit											
AIC	749.96		677.58		680.12		666.28		665.05		663.98
BIC	761.20		754.07		756.60		709.98		708.75		700.40

Note. Model 2 was retained as the final model. Unstd. = Unstandardized coefficients; Stand. = Standardized coefficients; L1 = level 1 variable; L2 = level 2 variable; σ^2 = Level 1 variance; τ_{00} = Level 2 variance; * $p < .05$; ** $p < .01$

Table 4

The influence of individual- and congregation-level variables on log transformed psychotherapy visits

Model	**Model$_0$** Unstd. (*SE*)		**Model$_1$** Unstd. (*SE*)		**Model$_2$** Unstd. (*SE*)		**Model$_3$** Unstd. (*SE*)		**Model$_4$** Unstd. (*SE*)		**Model$_{Final}$** Stand.
Fixed Part											
Intercept	0.28**	(0.05)	0.51**	(0.11)	0.72**	(0.18)	2.10**	(0.87)	0.83**	(0.26)	
L1 Age			-.01*	(< .01)	-.01	(< .01)	-.01*	(< .01)	-.01*	(< .01)	-.13*
L1 Gender			-.08	(.09)	-	-	-	-	-	-	
L1 Education			0.02	(0.03)	-	-	-	-	-	-	
L1 Ethnicity			-.24*	(0.10)	-.23*	(0.11)	-.09	(0.14)	-.26*	(0.10)	-.13*
L1 Service Attendance					0.02	(0.04)	-	-	-	-	
L1 Scripture Reading					-.03	(0.02)	-	-	-	-	
L2 Service Attendance							-.15	(0.16)	-	-	
L2 Scripture Reading							-.04	(0.08)	-	-	
L2 Mental Health Discuss									< .01	(0.08)	
L2 Mental Health Programs									-.03	(0.12)	
Random Part											
σ^2	.53		.52		.52		.52		.52		.52
τ_{00}	.01		.01		< .01		< .01		< .01		< .01
Model Fit											
AIC	633.69		631.06		640.79		628.16		636.36		631.89
BIC	644.63		656.58		684.53		653.68		661.88		657.41

Note. Model 2 was retained as the final model. Unstd. = Unstandardized coefficients; Stand. = Standardized coefficients; L1 = level 1 variable; L2 = level 2 variable; σ^2 = Level 1 variance; τ_{00} = Level 2 variance; * $p < .05$; ** $p < .01$

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