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Religious Views and Coping in the Black Community

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The African American community is oftentimes overlooked, misunderstood, and underserved in society. Typically, these injustices are due to adverse institutionalized and systemic pressures historically placed upon the community by others outside of the community, but when it comes to the stigma of mental illness, African Americans become self-sufficient in placing their own barriers upon themselves. African Americans are particularly apt to acknowledge the physical bonds that chained them years ago, but many refuse the mental ones that plague them today. The tendency of the community at large to place emphasis on physical strength and determination as the sole "cure" to any illness clearly indicates the deep roots of modern day mental illness stigma. These negative attitudes and faulty belief systems about mental illness are damaging, and, when upheld, only aid in preventing individuals from getting actual help. The present study will evaluate how various factors have shaped the African American experience when dealing with mental illness, specifically trust, multiple stigma, coping, and religion.

There is a strong feeling of mistrust in the African American community when it comes to dealing with mental illness (Cheng & Robinson, 2013). The patient-professional relationship can be a fragile one, as many African Americans believe that they will not receive proper medical attention due to discriminatory factors such as skin tone and socioeconomic status (Cheng & Robinson, 2013). Henderson's (2015) cross sectional study attempted to find a relationship between the diagnosis of schizophrenia, patient mistrust, and unfair treatment from health professionals. His findings indicated that health professionals did not choose to treat their patients unfairly due to their diagnosis of schizophrenia. Instead, the lack of acknowledgement of

pain was correlated to the fact that many of the health professionals were discriminatory towards their Black and Mixed-race patients more often than their White counterparts (Henderson, 2015).

Given that the majority of health professionals are White men, many African American patients become defensive and lose trust in their care providers because they cannot identify with them (Alvidrez, Snowden, & Kaiser, 2008). If African Americans are able to self-identify with their care providers more often, their levels of mistrust lower and likelihood of seeking help increase (Alvidrez, Snowden, & Kaiser, 2008). Unfortunately, identification with the health care provider is only the first step towards getting African Americans to seek help, as once they face their emotional barriers of mistrust, they are subjected to other physical and mental stressors that also prevent them from acknowledging their mental illness and seeking help.

African Americans are also subjected to racial and environmental stressors that negatively affect their mental health. Oftentimes African Americans live in underserved, urban areas, and they are often without the financial means to travel to nor access a mental health facility (Cheng & Robinson, 2013). These stressors mediate a sense of isolation and reluctance to seek help. A sense of isolation can especially be seen amongst minority students, in particular African American students, who attend Predominantly White Institutions (PWIs). A study was conducted at PWIs measuring the cultural and environmental factors that would impact a person's viewpoint towards their encounters with others (McClain et al., 2016). The results indicated a positive relationship between ethnic identity and mental health, as individuals who positively identified with their ethnic group also had better mental health than those who did not (McClain et al., 2016). The data supports the idea that how one views their minority status can negatively influence their mental health stability (McClain et al., 2016). Connor et. al (2010)

support these findings in a study where African American attitudes and beliefs about depression were analyzed.

The concept of multiple stigma is also useful in explaining the negative effects of how one perceives their minority status. Multiple stigma is having more than one stigma in society, such as suffering from a physical disability and mental illness. African Americans are impacted greatly by this concept, believing they are defined by only one stigma, that of being a racial minority. They refuse to accept another stigma, such as mental illness (Connor et al., 2010). This belief explains a general ignorance encircling the African American community when it comes to acknowledging mental illness. This ultimately leads African Americans to suppress their mental illness through the practice of faulty coping mechanisms.

African Americans use multiple self-administered coping mechanisms to suppress the effects of mental illness, which prevents them from seeking the help of a licensed health professional. Connnor et, al explored in a qualitative interview two of those typically used by African Americans (2010). The first labeled ,"frontin," described the manner in which African American would suppress and hide their symptoms of mental illness from others (Connor et al., 2010). For example, if a person was suffering from depression, instead of isolating themselves inside of their homes, they would be out and about socializing with their peers in order to keep up the persona of nothing being wrong with them. This type of self-concealment is more common amongst African American men than their European counterparts **(**Masuda, Anderson & Edmonds, 2012). Connor et. al (2010) also identified "denial," where the individual suffering would lie to others and eventually themselves and associate their symptoms of mental illness as another unrelated issue. This can be seen commonly, when an individual is confronted by their family members or peers about noticing possible signs of mental illness, and, instead of

admitting to it, they would deflect the question and attribute their mental illness to "just being a bad day."

Began, Etowa, and Bernard observed a third kind of coping, the "Let go and let God" approach which is most commonly used by African American women (2012). As many African American women tend to be religious, they believe they are going through trials and tribulations by the Lord in order to reach a higher level of self (Beagan et. al, 2012). This approach is the most commonly used in the community, as religion plays a central role in the lives of African Americans. Many within the community believe that prayer and devotion to the Lord is the best medicine to deal with loads of microaggressions that weigh on their self perception (Beagan et. al 2012). Accordingly, the term "depression" was so stigmatized amongst members in the Black community, that the women would use phrases such as "feeling down and out" or "feeling sad" in its stead (Beagan et. al, 2012). Many older women especially had issues with the word "depression" and the medication that was associated with it (Beagan et. al, 2012). This fully translates into the cultivation of the strong Black woman archetype. Black women believe that they need to be strong all of the time and are the martyrs of their race because they believe that they cannot afford to have any physical ailments. Many Black women attribute their strength to their spirituality. Black women's involvement within the church— as youth leaders, choir teachers, Sunday school teachers, and beyond (Lee et. al, 2012)- —renders them pillars of the Black church. This means that instead of seeking out a physician for their mental illness, they leave it in the hands of their savior. This misplaced faith subjects Black women to dealing with their mental illness in silence. Black women's reliance upon God for all their mental and physical ailments instead of a health professional becomes a negative coping mechanism.

Unfortunately, all three of these forms of coping that African Americans believe relieved their pain actually made it worse and lessened their perceived wellness (Alvidrez, Snowden, & Kaiser, 2008). Fortunately, there is evidence that suggests collaboration between religious groups and health professionals provides useful mechanisms to help the patient cope in healthy ways (Leavey, Loewenthal, & King, 2016). When patients are granted a duality of techniques that aid them both spiritually and mentally they receive the best of both worlds (Walsh, 2011). Walsh (2011) explains these alternative techniques as "therapeutic lifestyle changes" (TLCs), that when properly utilized can enhance the individual's physical and mental health. Unfortunately, there is not yet much evidence to support this claim, and there are conflicting views of such collaboration (Leavey, Loewenthal, & King, 2016). Nevertheless, Leavey, Loewenthal and King's works suggests one way stigma against mental health could be lessened and African Americans could be more effective in acquiring better coping strategies.

Similarly, a study conducted on first year college students to evaluate their perceptions towards mental illness showed that stigma towards seeking help was greater in individuals who showed symptoms of depression than those who did not. Talebi et. al (2016) offered a possible solution which involved changing how mental illness is framed. They suggested that if the framing of stigma was changed from psychological to biological it could be more effective for sufferers to cope, as people tend to be more accepting of physical illness resulting from traceable biological means (Talebi et. al, 2016). This could be one way to change the negative attitudes toward help-seeinng of African American men observed by Masuda, Anderson and Edmonds in their evaluation of mental health stigma and self concealment **(**Masuda, Anderson & Edmonds, 2012). Once individuals feel less stigmatized about their mental illness, they become more receptive towards seeking other methods of aid.

African American men might also take advantage of more mental health services if they had more social support (Lindsey, Joe, & Nebbitt, 2010). In particular, familial social support was found to be more effective, as opposed to professional and peer support (Lindsey et. al, 2010). When the African American male youth has support from his central family unit, signs of illness are more likely to be spotted earlier on.

Ultimately, it is important to recognize that mental illness is not a choice. Nor is it a learned behavior, but suppression is (Beagan et. al, 2012). I hypothesize that African Americans who have belief systems centered around religion are more likely to develop negative coping mechanisms when dealing with mental illness. The African American community's disregard for the issues at hand have resulted in collectively teaching youth supposedly self-sufficient coping mechanisms, with the basis of treatment often being one's faith in their religion. This is a problem that must be dealt with. The community cannot allow professional mistrust, environmental and racial stressors to hinder the acknowledgement of illness and awareness of the necessity to get help.

Method

Participants

Participants included 20 students, male and female, from Xavier University of Louisiana. All participants were recruited by the Psychology department subject pool and by word of mouth. The students' class year ranged from freshman to junior. All of the participants were African American.

Materials

To measure belief systems centered around religion I used the Centrality of Religiosity Scale (CRS) (Huber & Huber, 2012). The scale measured the importance of religion to an

individual using five core-dimensions. The five core-dimensions were that of public practice, private practice, religious experience, ideology, and intellectual dimensions (Huber & Huber, 2012). The five core-dimensions are the basis of evaluating how religion defines how an individual chooses to live their life. An example question from the measure states, " Do you try to connect to the divine spontaneously when inspired by daily situations?" (Huber & Huber, 2012, p. 717). The questions were measured using a 5-point Likert-Scale with the range from 1 = strongly disagree to 5 = strongly agree. Higher scores mean that the individual has a higher sense of religiosity.

To measure negative coping mechanisms I used the COPE Inventory Scale (Carver, Scheier, &, Weintraub, 1989). The scale measured how well an individual coped when confronted with stressful situations in their life. An example question from the measure states, "I admit to myself that I cannot deal with it, and quit trying" (Carver, Scheier, &, Weintraub, 1989). The question was measured using a 4-point Likert-Scale with the range from 1 = I usually don't do this at all to 4 = I usually do this a lot. Higher scores indicate that an individual uses a lot of that coping mechanism.

Procedure

I conducted a non-experimental, correlational study measuring the relationship between religious belief or lack thereof and negative coping mechanisms. First, all participants were required to sign a consent form. If the participant felt as though the study would affect them negatively or did not particularly align with their beliefs, they could leave. Then, the survey packet was handed out to each participant. There was enough time allotted to complete the survey. Once the survey was completed by all participants I collected them. All confidentiality was maintained because the participant's name only appeared on the consent form. The consent

form was collected separately from the data to keep the participant's identity anonymous. Once all the surveys were collected, I debriefed the participants on the true purpose and nature of the study.

Results

To test my hypothesis, I conducted a Pearson's r test. Statistically significant results that had a negative correlation were found between Ideology & Behavioral Disengagement $r(19) = -.182$, $p = .021$, Public Practice & Substance Abuse $r(19)= -.455$, $p = .050$, Private Practice & Substance Abuse $r(19)= -.535$, $p = .018$, and Religiosity Total & Substance Abuse $r(19)= -.474$, $p = .040$. This indicates that the more religious an individual is, the less likely they are to participate in these methods of negative coping.

Discussion

I hypothesized that African Americans who have belief systems centered around religion are more likely to develop negative coping mechanisms when dealing with mental illness. Although my data collected was significant, my hypothesis was not supported. Instead, my data was the opposite of what I hypothesized. This means my data supports the idea that individuals who have belief systems centered around religion are less likely to develop negative coping mechanisms, instead of more likely to do so. It is interesting to note that it seems as though the more aligned an individual was with some sort of spirituality, the more they seem to look internally for positive measures to solve solutions and the less likely they were to use negative ones, such as substance abuse. This was most likely due to coping only being mentioned generally, instead of coping being specifically measured with regard to mental illness.

There were two theoretical implications important to this study. The first of which is that it is important to evaluate how religious views can help and hinder an individual when

processing how to cope (Beagan, Etona, & Bernard, 2012). If the individual's religious views are known, then that information can be used to see how that influences their coping methods. The second theoretical implication is that all three forms of coping ("frontin," "denial," and "Let go and let God") that African Americans believed relieved their pain in turn actually made it worse and lessened their perceived wellness (Alvidrez, Snowden, & Kaiser, 2008). It would be the assumption that those of whom who use the "Let go and let God" approach, meaning they have belief centers centered around religion, would have worse perceived wellness than their nonreligious counterparts. My data shows that it is possible for individuals who use the "Let go and let God" approach can actually partake in more positive coping mechanisms than their nonreligious counterparts. However, I did not directly ask about coping with mental illness.

The practical implications of my findings address how to improve positive coping skills. Positive coping can be obtained by practicing active coping, seeking familial social support, learning how to accept circumstances, writing out the pros and the cons of the situation, or using meditation in order to find inner peace. When society practices positive coping skills, it allows for individuals to experience better overall wellness, as they are more likely to look for solutions to their specific situation, instead of dwelling on the difficulty of the problem.

There were a few limitations to this study. The data could have been affected by self-report bias, especially in the COPE Inventory. The way the questions were posed, without specific regard to mental illness, could have caused more participants to identify with positive coping outside of the scope of mental illness. Participants were susceptible to selective memory by recalling only how often they used measures of positive coping, but not recalling how often they use negative measures of coping. Cultural bias seemed to be relevant in the Centrality of Religiosity Scale (CRS). Out of the 20 participants 19 identified as Christian. All participants

were students of Xavier University of Louisiana, which is the only Catholic affiliated HBCU. Therefore, a large number of individuals who attend the school are more likely to be religious than not, and identify as Christian, which could explain the higher scores on the religiosity scale.

Future ideas for research would include repeating the same design, but instead getting a sample from a population of college students at an institution that is not a Catholic or Jesuit college affiliate. Another idea for future research would be to measure the African American's perspective on the concept of mental illness and religion. My study only measured religiosity and coping. Thus, a better measurement would have been religiosity and coping with respect to mental illness, as coping in general is vague and can be misinterpreted without specific context. In order to get a more well-rounded perspective on African Americans, mental health stigma, and coping, another study should include a scale that measures "African Americans perspective" on the importance of mental health in the Black community, the CRS, and COPE Inventory Scale to get more conclusive results on the significance of the correlation between those three variables.

In conclusion, my study showed that religious individuals practice more coping mechanisms. Those who place their faith within their religion are also more likely to seek out other positive resources to help aid them when coping with mental illness. More research is needed in regards to evaluating how alternative methods of faith-based medicine can resolve matters of multiple stigma and help-seeking reluctance within the African American community.

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