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Religion and Help-Seeking: Theological Conservatism and Preferences for Mental Health Assistance

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Abstract: Religious affiliation and attendance have been shown to affect various facets of mental health, including the willingness to seek mental health assistance; however, little is known about how theological beliefs influence people's assessments of religious and secular mental health assistance options. Prior research using theological conservatism (beliefs about scripture, sin, and salvation) has conceptualized this perspective as being a schema in which the dimensions operate in tandem. Nonetheless, given the personalized nature of mental health, this study has conceptualized this perspective as three interrelated, but distinctly different dimensions of a religious belief system. Using data from the NORC General Social Survey's (GSS) 2006 and 2018 waves (N = 2563), this study enlists a fruitful but underutilized approach to gauging perceptions of mental health assistance through the use of situational vignettes that prompt survey respondent appraisals of different sets of circumstances and various possible solutions. This study finds some support for the hypothesis that predicted theological conservatism would be associated with a more favorable view of religious support for mental health as opposed to secular sources of assistance; there was also considerable support for the hypothesis that the salvation dimension of this worldview would exhibit an influence apart from the scripture and sin dimensions. This investigation sheds light on an understudied facet of religion in relation to receptivity toward distinctive forms of mental health treatment and highlights potential directions for future research.

Keywords: religion; theological conservatism; scripture; Bible; sin; salvation; mental health; therapy; counseling; clergy

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1. Introduction

In the United States, issues regarding mental health have become increasingly prevalent in public discourse and people's lives. A mental illness is an emotional, behavioral, or mental health disorder that impacts an individual, and a serious mental illness is a disorder that causes severe functional impairment and negatively interferes with one's life (National Institute of Mental Health 2021). The Substance Abuse and Mental Health Services Administration (2020) estimated that in 2019, there were 51.5 million adults within the United States that experienced a mental illness; this figure represents nearly 20.6% of the adult population age eighteen and older. Evaluating the prevalence of some common mental illnesses illustrates just how pervasive these conditions are. In 2019, 7.8% of U.S. adults had a minimum of one major depressive episode, with 5.3% of adults having a major depressive episode involving serious impairment (Substance Abuse and Mental Health Services Administration 2020). In that same year, 5.3% of individuals 12 years old and older had an alcohol use disorder and 3% of this same population had at least one illicit drug use disorder (Substance Abuse and Mental Health Services Administration 2020). However, of those estimated 51.5 million adults suffering from any mental illness, it was reported that only 23 million of them sought out and received a form of professional treatment (i.e., inpatient/outpatient counseling, prescription medication) for their problem;

this value represents only 44.8% of the total number of people experiencing any mental illness (Substance Abuse and Mental Health Services Administration 2020). With less than half of the people living with these psychological conditions seeking professional help for their problem, it is crucial for researchers to continue investigating the barriers that limit access to, or acceptance of, professional mental health treatments. While barriers to mental health assistance include a fear of mental health stigma and general distrust of healthcare systems, conflicting worldviews and the possibility of contradictory messages concerning the appropriate ways to address mental illnesses are of great concern to many religious people (Nakash et al. 2019).

As an important aspect of one's cultural identity, religion and religious beliefs play a significant role in defining mental illnesses and appraising suitable courses of action to address them, particularly in conservative religious communities. Recent data indicate that a large proportion of the United States' population is religious, with about 45% of Americans reporting that they attend religious services every month or more (Pew Research Center 2019). Additionally, 76.5% of U.S. adults identify with a Christian or non-Christian faith (Pew Research Center 2015), indicating that religion is still prominent. Furthermore, 43% of all U.S. adults identify as Protestant (Pew Research Center 2019). Of immense interest to this research, over half (59%) of these Protestant adults report that they were "born-again" or "evangelical" Christians (Pew Research Center 2019). The beliefs of Conservative Protestants are important research considerations given that some religious sources indicate mental illnesses are the result of one's personal sins or the manifestation of demonic forces and, in turn, may influence one's attitudes and preferences for sources of mental health assistance (Webb 2012; Webb et al. 2008). However, while denominational affiliation, religious service attendance, and global religiosity have been evaluated and linked with preferences for varying sources of mental health assistance, to date the fundamental beliefs of these religious people have yet to be evaluated with preferences for different sources of mental health assistance. Studies using an indicator of biblical literalism (i.e., the belief that the Bible is the literal word of God) to assess the preference for mental health assistance are the closest evaluations of one's personal religious beliefs; however, this approach is limited given that the single indicator of biblical literalism is reductionistic of an entire worldview. Therefore, this research will expand upon these prior investigations by using a more comprehensive conceptualization of theological conservatism to evaluate this phenomenon. While denominational affiliation has the potential to erroneously assume personal religious beliefs from claims of organizational affiliation, theological conservatism as conceptualized in this research directly addresses and evaluates one's religious beliefs at the individual level. Theological conservatism is comprised of fundamental beliefs about biblical scripture, human sin, and salvation to more thoroughly evaluate a theologically conservative worldview (Hempel and Bartkowski 2008). By focusing on these core religious beliefs held by individuals, this study will permit researchers to better understand how these views potentially influence religious people's attitudes towards mental health services.

2. Literature Review, Theory, and Hypotheses

The relationship between religious beliefs and perceptions of mental illness are quite complex. There is a sizable scholarly literature illustrating a rather negative influence of religious beliefs on perceptions of strategies for addressing mental illnesses. When living with a mental illness, many religious people struggle to make sense of their condition (Milner et al. 2019). There is a well-documented tension between those with conservative religious outlooks and mental illnesses, and while many religious people hope to obtain support and guidance from their religious community during times of distress, not all do (Stanford and McAlister 2008). In a study by Stanford (2007), approximately one-third of Christians who sought religious counsel for their mental illness indicated their interaction was negative, and in a subsequent investigation by Stanford and McAlister (2008), 41.2% of respondents indicated that their church suggested they did not have a mental illness,

even though they had been professionally diagnosed with one. Of these respondents who reported this denial of mental illness from their church, many expressed that their church was conservative with doctrine and scriptural interpretations (Stanford and McAlister 2008). In another study by Lloyd and Waller (2020), 34% of a sample of self-identified evangelical Christians expressed that their church framed mental disorders as the result of demons or spirits, and 31% of these Christians said their church proposed that recovery from a mental illness depended on prayer and deliverance alone. When mental illnesses are discussed as the work of Satan, the product of demons, or the result of personal sin (Stanford 2007), it becomes easy to attach a stigma to the individual and attribute all blame to their own wrongdoings or their lack of spiritual fortitude (Webb et al. 2008; Wesselmann and Graziano 2010).

Furthermore, prior research has indicated that those who are theologically conservative do not endorse professional psychological treatments for mental illnesses and tend to hold more stigma towards mental illnesses. Conservative Protestants[1] place immense value on religious teachings, and research has shown that those who score higher on levels of religious fundamentalism show a greater preference for religious help-seeking than psychological help-seeking (Wamser et al. 2011). In addition, when comparing denominational affiliations, Protestant and non-denominational Christians endorse spiritually oriented causes and treatments of mental illnesses more than Catholics (Wesselmann and Graziano 2010). This preference for religious sources of help may emerge out of tension between those who believe in the Bible as divinely inspired and those who do not (Nakash et al. 2019). Alternatively, this preference may result from concerns that secular service providers may dismiss spiritual experiences and explanations of mental illnesses (Milner et al. 2019). A third possibility for this preference may be the religious clients' perceived discrepancy between their own belief system and that of a secular therapist (Crosby and Bossley 2012).

Generally, stigma acts as a deterrent to seeking mental healthcare (Brenner et al. 2018; Crosby and Bossley 2012) and research has illustrated that stigma of mental illness may vary among religious denominations. It is documented that self-stigma of seeking help is related to negative attitudes towards professional psychological help for mental illnesses (Brenner et al. 2018). In evaluating self-stigma among religious groups, it has been shown that Christians hold a greater self-stigma of depression than non-Christians (McGuire and Pace 2018), while Evangelicals hold a greater self-stigma toward depression than both non-evangelical Christians and non-Christians (McGuire and Pace 2018). Since stigma is associated with less favorable attitudes toward seeking professional help, and theologically conservative groups hold greater self-stigma, this study will account for the stigma of mental illness.

Prior research has highlighted the substantial role of religious leaders as providers of mental health assistance among those who are religious. Clergy are often seen as valuable sources of advice and guidance and are commonly regarded as having formidable interpersonal communication skills (Ellison et al. 2006; Wang et al. 2003). Furthermore, clergy are frequently viewed as a familiar, trusting, easily accessible, and "free" (economical) source of mental health guidance (Payne and Hays 2016; Pickard and Guo 2008). In one study, it was indicated that clergy were contacted at a higher rate than psychiatrists and general medical doctors, and almost one-quarter of all people who sought mental health treatment of any kind also sought help from clergy (Wang et al. 2003). Additionally, in 1996, approximately one-third of U.S. adults viewed clergy as the first or second choice of assistance for a variety of mental health issues (Ellison et al. 2006), and, in evaluating trends from 1996 to 2006, there was a noteworthy increase (from 22% in 1996 to 42% in 2006) in the endorsement of spiritual healers as being an appropriate source of help for those with depression (Blumner and Marcus 2009).

Furthermore, while research has indicated that religious affiliation, attendance at religious services, and global religiosity influence one's preference for mental health assistance from religious leaders, none of these studies have provided a comprehensive evaluation of religious beliefs on preferred types of assistance. Among religious denominations,

Conservative Protestants were shown to be more favorable disposed to selecting clergy as a primary or secondary source of mental health assistance, followed by moderate Protestants, then liberal Protestants, and then Catholics (Ellison et al. 2006). In addition, frequent attendance at religious services is positively associated with a preference for clergy as a mental health support (Pickard and Guo 2008), with one study indicating that a majority (56%) of regular church attenders regard religious leaders as a first or second choice for assistance (Ellison et al. 2006). Moreover, some have indicated that global religiosity is a robust predictor of seeking help from religious sources, perhaps even being more important than attendance at religious services (Crosby and Bossley 2012). Those with high intrinsic religiosity are more willing to seek assistance from clergy (Pickard and Guo 2008) and having a greater preference for religious help-seeking for mental health issues was associated with a decreased preference for seeking secular assistance (Crosby and Bossley 2012).

Additionally, biblical literalism has been evaluated as a predictor of one's preference for mental health assistance from religious leaders; however, this single measure alone does not provide a complete evaluation of a multidimensional religious worldview on preferred assistance. Biblical literalism is the belief that the Bible is the literal word of God (Ellison et al. 2006; Hempel and Bartkowski 2008). Biblical literalists are more likely to endorse religious leaders as an appropriate source of help than non-biblical literalists (Stanfield 2002), and in some studies, biblical literalists are more inclined to select clergy as a first or second source of help than non-biblical literalists (Ellison et al. 2006). Interestingly, though, a study by Stanfield (2002) revealed that biblical literalists were just as likely as non-biblical literalists to suggest that psychiatrists, psychologists, and other secular professionals were appropriate sources of mental health assistance. While these investigations are insightful, they neglect to address the reductionist nature of this singular item.

It becomes evident in reviewing the scholarly literature that religious beliefs have been largely overlooked as a predictor of one's preference for mental health assistance. Indeed, biblical literalism alone has been studied; however, only evaluating one's interpretation of the Bible is an overly simplistic approach to analyzing an entire religious worldview (Hempel and Bartkowski 2008). This study rectifies the lack of attention given the relationship between theological conservatism and preferences for mental health assistance.

The present study evaluates the concepts of schemas and theological conservatism in relation to preferences for various sources of assistance with mental illnesses. A schema is a cognitive framework that allows an individual to perceive and comprehend the world and determine appropriate action for different circumstances (Bartkowski et al. 2012; McIntosh 1995). Schemas give people a mental structure to perceive, process, and conceptually understand a situation (McIntosh 1995). They help us to accomplish the sense-making tasks we are faced with daily. Schemas are built through interactions with one's environment, and while they have a potential to undergo modification, they are often quite stable (McIntosh 1995). In other words, we often adjust the external stimuli to fit our established schema rather than revise the schema itself. Additionally, these mental frameworks are generalizable to the extent that a well-developed schema can be applied to new situations as they occur (Sewell 1992). Religious schemas emerge as an interconnected system of theological principles that allow an individual to reach morally justified conclusions (Bartkowski et al. 2012). Schemas are then a constellation of beliefs that are activated on a routine basis. In addition, research has indicated that some religiously conservative groups (in particular, those who are members of Conservative Protestant denominations) generally hold negative attitudes towards science (Ellison and Musick 1995). Therefore, those with a mature religious schema of this sort would arguably be skeptical of secular interventions for mental illnesses, thus preferring religious options (e.g., clergy) as a source of assistance for mental illnesses (Taylor 2001).

Theological conservatism can be understood as a religious schema because it is a cognitive framework through which people interact with the world. Hempel and Bartkowski (2008) contend that theological conservatism provides a more thorough understanding of the complexities associated with a Conservative Protestant faith tradition and the norms

that prevail in this tradition. They argue that specific beliefs about scripture, sin, and salvation are the central tenets of a theologically conservative worldview. Rooted in ethnographic research, the construct of theological conservatism encompasses a set of collectively shared understandings through which people practice, and live, their theological beliefs. Thus, it is not concerned with academic debates about theology, but rather focuses on how adherents apply doctrinal principles in their everyday lives. With scripture, theological conservatives believe that the Bible is the "literal word of God." Thus, the epistemology of theological conservatism privileges religious sources of truth (especially the Bible) over secular ways of knowing (e.g., science) (Bartkowski 2001). Concerning sin, theological conservatives believe that humans are innately sinful and that God has created a world in which justice demands people being punished for their transgressions. The ontology of theological conservatism, then, is centrally focused on sin and punishment (Bartkowski 2001). Somewhat tautologically, this perspective on the inherent corruption of human nature (ontology) is grounded in a particular reading of scripture (epistemology) that elevates passages which emphasize people's penchant for disobedience to God's laws. Finally, salvation beliefs are the domain of soteriology, that is, what must one do to be "saved" (Bartkowski 2001). Among theologically Conservative Protestants, it is believed that salvation entails the imperative for an individual to accept Jesus Christ as his or her "personal savior." Altogether, the combination of these three distinct positions on scripture, sin, and salvation constitute theological conservatism as a shared hermeneutic posture that creates an interpretive community among those who hold these views. With a reliance on three axes, rather than a single component alone (e.g., biblical literalism only), this more holistic approach to theological conservatism can shed additional light on a multifaceted set of beliefs that make conservative faith traditions unique.

How, then, would theological conservatism as a schema be expected to influence preferences for different sources of mental health assistance? As noted, theological conservatives believe that scripture is the literal word of God (Hempel and Bartkowski 2008). Those who hold this commitment to scripture would be expected to use the Bible as a key resource throughout a mental illness recovery process as it and God are seen as providing authoritative guidance. For instance, within Biblical Counseling, a form of counseling common among Conservative Protestants, emphasis is often placed on scripture for the duration of this therapy (Kinghorn 2016; Peteet 2019). With this scriptural focus, frequent Bible-reading as well as continual recall of God's authority and will are understood as an appropriate response to mental illness.

In addition, through this theologically conservative worldview, mental illnesses may be viewed as the result of personal sin. Mental illnesses could be seen as punishment for one's transgressions (sinful behaviors) or a product of spiritual weakness such as a lack of faith or trust in God (Webb 2012). In some cases, mental illnesses are thought to be the product of being a failed or "bad" Christian (Webb et al. 2008). If this perception is held, then the appropriate response to address a mental illness would involve taking personal responsibility for and confessing one's sins, engaging in religious practices such as prayer, and trusting in God or Jesus Christ to save the wayward person from this condition (Webb et al. 2008).

Moreover, theological conservatism indicates that the salvation of one's soul is only accomplished by accepting Jesus Christ as his or her savior (Hempel and Bartkowski 2008). Consequently, if one views mental illness as a burden on the soul, salvation may be the key to releasing the burden and becoming renewed (Sontag 1984). Similarly, if the illness is viewed as being the result of demonic works or influences, an appropriate response to address the ailment may be to turn to Christ for restoration (Webb et al. 2008).

Understanding these key components of theological conservatism, and how they might influence one's evaluation of mental health, it becomes possible to speculate how someone might evaluate various avenues of mental health assistance in accord with this worldview. Religious approaches such as reading the Bible, confession of personal sin, prayer, and trust in God are encouraged among Conservative Protestants. It could be inferred that if

these individuals were willing to seek assistance for mental issues, they would most likely encourage seeking assistance from others who share their similar faith and understanding, including clergy and other religious leaders. Furthermore, those with this theology might value assistance from religious leaders as more beneficial than assistance from external, secular sources that do not share their theology such as psychiatrists and other secular mental health professionals.

When treated as a schema, the tenets of theological conservatism are perceived as operating in combination with one another; scripture, sin, and salvation would be expected to function together. While this constellation approach has been useful in evaluating more general social ideas such as support of gender traditionalism (Bartkowski and Hempel 2009) or one's inclination to exhibit generalized trust in others (Hempel et al. 2012), it is possible that when presented with personal issues of mental health, a single dimension of theological conservatism would exhibit greater influence than the others.

In particular, the salvation dimension of theological conservatism may be elevated in influence over scripture and sin given the perceived need for "inner change" for which salvation could be perceived as the quintessential solution. Moreover, our study uses a methodology that prioritizes the personalized nature of mental illness, and salvation is a understood an acceptance of Jesus Christ as one's personal savior. In this investigation, vignettes depicting an individual with a mental health disorder are presented to respondents for assessment. Vignettes are often used in research to simulate and evaluate participants' decision-making process with various phenomena (Evans et al. 2015), and the mental health vignettes in this study provide an opportunity to see how respondents interact with and interpret highly personalized mental health scenarios. Furthermore, research investigating secular social services and faith-based initiatives have highlighted the role of personal transformation as a key facet of many faith-based approaches to social problems (Bartkowski and Grettenberger 2018). This personal transformation requires an individual to initiate change from within (Bartkowski and Grettenberger 2018). In essence, the inner change only begins once one accepts God or Jesus Christ as their savior. Therefore, this individualized approach to salvation may be emphasized among those who are theologically conservative when presented with personalized mental health vignettes. Understanding this possibility, this study is taking a slightly different approach to utilizing theological conservatism. Rather than analyzing the three components of theological conservatism in tandem, this study individually evaluates each dimension to assess its independent influence.

Overall, making use of how theological conservatism can be analyzed from the perspective of epistemology (scripture), ontology (sin), and soteriology (salvation), this research comprehensively assesses how those holding this set of beliefs make interpretations about sources of help for mental illnesses. If religious approaches to coping with mental illness such as reading the Bible, confessing sin, and accepting Christ are encouraged among people of faith, these individuals would perhaps be more willing to seek assistance for mental health issues from others who share their faith, including clergy and other religious leaders. Therefore, this research study proposes the following hypothesis.

Hypotheses 1 (H1). *Theological conservatism will be positively associated with a preference for mental health assistance from a minister, priest, rabbi, or other religious leader for a mental disorder, net of confounding factors.*

Furthermore, those who embrace conservative theology might perceive assistance from religious leaders as more beneficial than assistance from external, secular sources, given that many secular professionals may not share their religious worldview. For that reason, our investigation proposes the following hypothesis.

Hypotheses 2 (H2). *Theological conservatism will be negatively associated with a preference for mental health assistance from secular sources of help for a mental disorder, net of confounding factors.*

Finally, given that the salvation dimension of theological conservatism is closely aligned with personalized issues of mental health and individual transformation, we propose the following hypothesis.

Hypotheses 3 (H3). *Among the theological conservatism predictors, the associations between salvation beliefs and preferences for mental health assistance from various sources of help will be more consistently predictive than scripture and sin beliefs.*

These hypotheses are explored in what follows with attention to all three elements of theological conservatism, namely, scripture, sin, and salvation, where possible (General Social Survey [GSS] 2006); however, in some circumstances, data limitations lead us to drop one element of this tripartite construct, such that only the associations with scripture and salvation are explored (GSS 2018). In this latter series of analyses, the sin component needed to be dropped due to its status as a missing variable without an adequate proxy in the 2018 wave of GSS data. In addition, this move is justified by the GSS 2006 evidence of limited influence for the sin component of theological conservatism.

3. Materials and Methods

General Social Survey (GSS) data from the 2006 and 2018 waves are used to conduct this study. The GSS is a cross-sectional probability sample of the United States population (NORC 2020; Smith et al. 2019). This nationally representative sample is comprised of English- and Spanish-speaking non-institutionalized adults eighteen years of age and older. For the 2006 wave of data collection, a total of 4510 interviews were conducted with a response rate of 71.2% (Smith et al. 2019); however, only a portion of the respondents completed both the religious and mental health questions of interest (specifically, GSS 2006 Ballots A, B, and C). Therefore, the analytical sample size for this research is N = 1444 (unweighted). For the 2018 wave of data collection, a total of 2348 interviews were conducted with a response rate of 59.5% (Smith et al. 2019). Though 1173 respondents completed the National Stigma Studies–Replication II (NSS-RII) module, 1119 (unweighted N) respondents who completed both the religious and mental health questions are included in the present study. Thus, the total unweighted sample size is 2563 (for more information on the GSS, please visit NORC at: https://gss.norc.org/ accessed on 13 July 2021).

The 2006 and 2018 GSS featured a mental health module with various vignettes depicting an individual with either a mental illness or not (see Appendix A for vignette wording). Vignettes are an appropriate tool to utilize in this study because they prompt respondents with a task in which their interpretive cognitive framework can be evaluated. Vignettes are considered to have sound validity in research if they can realistically portray a scenario (construct validity), prompt a realistic response (internal validity), and produce results that can be generalized to an appropriate extent in the real world (external validity) (Evans et al. 2015). In this research, these mental health vignettes are a tool to render the results (selection from a menu of options) associated with the respondent's interpretation of the presented scenario. These vignettes serve as a sense-making task in which the respondent's cognitive framework (i.e., their schema) is put into action. They present highly personalized information to the respondent and then provide them with an opportunity to interpret the situation and make judgements about the individual in the vignette.

Three cases met diagnostic criteria for a psychiatric condition of alcohol dependence, major depression, or schizophrenia, and one case served as a control (full vignette wording is available in Appendix A). This control case depicted an individual with usual troubles and distress that did not constitute any mental health disorder. Furthermore, the individual in each vignette varied by educational attainment (up to 8th grade, high school, or college), race/ethnicity (white, African American, or Hispanic), sex (male or female), and name (John/Juan for males and Mary/Maria for females). Respondents were randomly assigned to a vignette with a single condition (alcohol dependence, depression, schizophrenia, or the control). After the respondents were presented with the vignette, they were asked a variety of questions about the individual as well as their condition.

3.1. Dependent Variables

The dependent variables for this research are the respondents' answers to an assortment of questions about a variety of mental health assistance options. The respondents were asked, "Should (the person) do any of the following..." with response categories including (1) "talk to a minister, priest, rabbi or other religious leader," (2) "go to a general medical doctor for help," (3) "go to a psychiatrist for help," (4) "go to a therapist, or counselor, like a psychologist, social worker, or other mental health professional for help," (5) "take prescription medication," and (6) "check into a mental hospital."[2] Given that these questions were presented in a dichotomized "yes" or "no" format, these items were dummy-coded with 1 = yes or 0 = no. These items serve as the dependent variables in this study by assessing the respondent's preference for various sources of mental health support.

3.2. Independent Variable

The key independent variable in this research is theological conservatism (Hempel and Bartkowski 2008), which has three distinct dimensions representing (1) specific beliefs about biblical scripture, (2) human sin, and (3) the promise of salvation. Therefore, the GSS variables BIBLE, PUNSIN, REBORN, and SAVESOUL were selected as they were the most relevant and appropriate GSS variables that addressed the three crucial dimensions of theological conservatism. The GSS item BIBLE asked respondents, "Which of these statements comes closest to describing your feelings about the Bible?" with response categories, "the Bible is the actual word of God and is to be taken literally, word for word," "the Bible is the inspired word of God but not everything in it should be taken literally, word for word," and "the Bible is an ancient book of fables, legends, history, and moral precepts recorded by men." This item was dummy-coded to gauge the respondent's literal interpretation of the Bible with 1 = literal word of God, or 0 = all others. The item PUNSIN stated, "Those who violate God's rules must be punished," with responses ranging from 1 = agree strongly to 4 = disagree strongly. This item was dummy-coded to measure a stronger commitment to the belief that sinners should be punished with 1 = agree or 0 = others. The REBORN item asked respondents, "Would you say you have been 'born again' or have had a 'born again' experience—that is, a turning point in your life when you committed yourself to Christ?" This item was presented in a dichotomized "yes" or "no" format and was dummy-coded with 1 = yes or 0 = no. The last item, SAVESOUL, asked respondents, "Have you ever tried to encourage someone to believe in Jesus Christ or to accept Jesus Christ as his or her savior?" This item was also presented in a dichotomized "yes" or "no" format and was dummy-coded with 1 = yes or 0 = no.

The GSS items used to create the independent variable of theological conservatism roughly approximate the measures proposed by Hempel and Bartkowski (2008) and, as such, are quite suitable for this study. The GSS measure for scriptural interpretation (BIBLE) is not identical to that recommended by Hempel and Bartkowski (2008); however, it is routinely used in research employing GSS data to address one's view of biblical scripture, and effectively identifies biblical literalists as opposed to those who believe the Bible is merely inspired by God but may contain errors or others who believe God has nothing to do with the Bible. In addition, the measures for salvation (REBORN and SAVESOUL) do not measure one's belief about salvation, but rather measure one's experience of salvation for themselves and others (Hempel and Bartkowski 2008). These indicators evaluating one's experiences arguably assess an especially strong belief structure. Further, the measure for beliefs about human sin (PUNSIN) asks about the punishment of those who violate God's rules, which can be reasonably seen as on par with an item that asks about beliefs concerning God's punishment of sinners (Hempel and Bartkowski 2008). Slight wording differentiation aside, this measure is still sound. Overall, all four measures have strong face validity.

3.3. Statistical Controls

This study controls for a wide array of possible confounding factors. The vignette types were dummy-coded with the control condition (i.e., "no problem") serving as the reference. Additionally, the stigma of mental illness was included as a statistical control (McGuire and Pace 2018) which was assessed using two measures of the vignette individual's perceived competence. Respondents were asked how able the vignette characters were to make their own decisions about the treatment that they should receive and how able they were to make their own decisions about managing money. Responses were recorded on a 4-point scale, ranging from 1 = very able to 4 = not able at all with greater values indicating increased stigma of mental illness.

Furthermore, this study included religious denominational affiliation to account for religious variations in preference for mental illness assistance (Ellison et al. 2006; Wesselmann and Graziano 2010). More specifically, religious denominational affiliation was dummy-coded into Conservative Protestant, Mainline Protestant, Catholic, and other Christians (Smith 1990) with no religious preference serving as the reference group. Non-Christian faith traditions were omitted from the analysis. In addition, responses to a global religiosity item that asked respondents to what extent they considered themselves a religious person were reverse-coded so that 1 = not religious and 4 = very religious (Crosby and Bossley 2012). Attendance at religious services was utilized to control for how regularly respondents practiced within their faith (Ellison et al. 2006; Pickard and Guo 2008).

In regard to sociodemographic characteristics, respondent age as a continuous measure was controlled, since some research has indicated that older individuals more often endorse clergy as an appropriate mental health resource (Ellison et al. 2006). Moreover, gender was included and dummy-coded with 1 = female or 0 = male, given that men tend to endorse more religiously based beliefs of mental illnesses and their appropriate treatments than women, and men tend to view professional mental health services more negatively than women (Brenner et al. 2018; Crosby and Bossley 2012; Wesselmann and Graziano 2010). Respondent's educational attainment, measured in highest year of schooling achieved, was controlled since some research has proposed that lower levels of educational attainment are associated with greater preference for religious help-seeking for mental illnesses (Ellison et al. 2006; Wang et al. 2003). In addition, marital status was controlled with 1 = ever married or 0 = never married, as some research illustrates that married individuals seek help from clergy more so than unmarried individuals (Wang et al. 2003). Race was controlled as a dummy variable with white serving as the reference, given that some research indicates that blacks are less likely to endorse professional sources of help for mental illnesses than whites (Schnittker et al. 2000). Region of interview was dummy-coded into Northeast, Midwest, South, and West, with South serving as the reference, as some literature has proposed that those in the South are likely to contact clergy for mental health assistance (Wang et al. 2003). Lastly, respondent's family income in constant dollars was log transformed and statistically controlled to account for the perception that clergy are perhaps a "free" mental health resource (VanderWaal et al. 2012).[3]

3.4. Analytic Procedures

IBM SPSS 28 was used for data management and statistical analysis. Unless stated otherwise weights were used for data analysis such that all results are nationally representative. As noted previously, this study is centered around religious respondents who belong to various Christian denominations (i.e., Conservative Protestants, Mainline Protestants, Catholics, and other Christians), therefore, those with non-Christian religious affiliations were omitted from this study (i.e., other religions in 2006 GSS = 185; other religions in 2018 GSS = 301). The following variables had missing data in the combined GSS dataset: biblical literalism (n = 41), sinners punished (n = 94), reborn experience (n = 32), save soul (n = 9), talk to religious leader (n = 192), go to general medical doctor (n = 167), go to psychiatrist (n = 191), go to other mental health professional (n = 178), take prescription medication (n = 225), check into a mental hospital (n = 252), attendance at religious services

(n = 12), general religiosity (n = 18), decide own treatment (n = 183), decide managing money (n = 202), age (n = 5), education (n = 3), and log transformed income (n = 281). Missing data were imputed on all independent and dependent variables using the iterative Markov chain Monte Carlo (MCMC) method in SPSS (Johnson and Young 2011; Rezvan et al. 2015). Five imputation datasets were generated and used. Multicollinearity statistics were generated and inspected. These tests did not reveal any problems (e.g., none of the variance inflation factors [VIF] exceeded 2.3, which is well within the threshold that indicates no threat of multicollinearity).

Following preliminary univariate and bivariate analyses, a series of binary logistic regression models were estimated to assess the multifaceted associations between theological conservatism and preference for sources of mental health assistance while controlling for other factors. Although structural equation modeling was used in prior investigations involving theological conservatism (Bartkowski and Hempel 2009; Hempel and Bartkowski 2008; Hempel et al. 2012), binary logistic regression was utilized in the current study to evaluate the independent effects of each dimension of theological conservatism on the sources of mental health assistance separately.[4] Moreover, due to the personalized nature of this vignette-based research in which the mental health issues varied across the GSS respondents, the components of theological conservatism might operate differently than a schema (which presumes a coordinated influence). As such, the dependent variables of interest (i.e., the different sources of mental health assistance) were assessed individually to allow for appropriate comparison across different sources of mental health assistance.

As exhibited in the regression tables, the 2006 GSS dataset was analyzed separately. The first model (Model 1) is an unadjusted model in which the primary independent variables for theological conservatism (BIBLE, PUNSIN, REBORN, and SAVESOUL) were included without statistical controls. The next model (Model 2) included the vignette condition controls, the two measures of mental health stigma, and all the sociodemographic control variables (age, gender, education, marital status, race, region, and income). The last model (Model 3) introduced the religious service attendance variable, the general religiosity variable, and the control for denominational affiliation to account for the strength of the GSS respondents' religious commitment and religiosity. Next, the combined 2006 and 2018 GSS dataset was analyzed in a similar fashion. In the regression analysis, PUNSIN was omitted given that the 2018 GSS wave did not contain this specific variable. All the regression models followed the same sequence as delineated above for the 2006 GSS dataset. Since all the regression results were juxtaposed for comparison purposes, the regression models were labeled as Model 4, Model 5, and Model 6.

4. Results

The sample characteristics are presented in Table 1. The 2006 GSS sample is predominantly White (72.54%), female (54.7%), middle aged (M_{age} = 44.7), and located in the South (40%). In addition, 34.4% of respondents are biblical literalists, 47.1% of respondents agree that violators of God's rules must be punished, 37.2% of respondents have identified that they have been "born again" or have had a "born again" experience, and 44.9% of respondents have tried to encourage someone to believe in/accept Jesus Christ as his or her savior. The combined 2006 and 2018 GSS sample is also predominantly White (72.1%), female (53.4%), middle aged (M_{age} = 45.6), and located in the South (39.9%). In addition, 32.2% of respondents are biblical literalists, 38.9% of respondents have identified that they have been "born again" or have had a "born again" experience, and 44.6% of respondents have tried to encourage someone to believe in/accept Jesus Christ as his or her savior.

Table 1. Sample characteristics (weighted).

	GSS 2006		GSS 2006 and 2018	
	n	**Percent**	**n**	**Percent**
Dependent Variables				
Religious Clergy: Yes vs. No	1244	86.6	2228	86.9
General Medical Doctor: Yes vs. No	1230	85.6	2217	86.5
Psychiatrist: Yes vs. No	1145	79.7	2116	82.6
Other Professional: Yes vs. No	1241	86.4	2308	90.
Prescription: Yes vs. No	1040	72.4	1741	67.9
Mental Hospital: Yes vs. No	500	34.8	974	38
Independent Variables				
Biblical Literalism: Word of God	495	34.5	825	32.2
Reborn Experience	535	37.2	999	39
Save Soul	645	44.9	1142	44.6
Sinners Punished	678	47.2	-	-
Control Variables				
Religious Service Attendance [a]	3.51	2.8	3.34	2.8
General Religiosity [a]	2.69	0.9	2.59	1
Conservative Protestant	392	27.3	633	24.7
Mainline Protestant	241	16.8	394	15.4
Catholic	385	26.8	626	24.4
Other Christians	114	8	260	10.1
No Affiliation (reference)	305	21.2	650	25.4
Decide Treatment [a]	2.28	1	2.26	0.9
Decide Money [a]	2.29	1	2.29	1
Vignette Alcohol: Yes vs. No/Other	358	25	593	23.1
Vignette Depression: Yes vs. No/Other	383	26.7	640	25
Vignette Schizophrenia: Yes vs. No/ Other	345	24	571	22.3
Female	787	54.8	1370	53.5
Non-white	409	28.5	714	27.9
Age [a]	44.78	16.7	45.60	17.2
Education [a]	13.31	3.1	13.56	3.1
Ever-married	1077	75	1863	72.7
Logged Income [a]	10.09	1	10.07	1.1
Northeast	230	16	411	16
Midwest	311	21.6	552	21.5
West	321	22.3	577	22.5
South (reference)	575	40	1023	39.9
GSS 2018	-	-	1126	43.9
GSS 2006 (reference)	-	-	1437	56.1

[a]: Mean and standard deviation.

4.1. Religious Sources of Assistance

The results of the binary logistic regressions to predict the likelihood of approving religious sources of mental health assistance are displayed in Table 2. As shown in the table, net of other theological conservatism indicators, socioeconomic characteristics, and other religious factors, having had a "born again" experience significantly and uniformly increased the odds of approving a religious leader as a source of mental health assistance, irrespective of the GSS data sources. These results are statistically significant at the 0.001 level. As such, Hypothesis 1 is partially supported as not all the theological conservatism variables are statistically significant. Moreover, as hypothesized, having ever tried to encourage someone to believe in/accept Jesus Christ as his or her savior also significantly increased ($p < 0.01$ in Model 4 and $p < 0.05$ in Model 5) the odds of approving a religious leader as a source of mental health assistance in the combined GSS 2006 and 2018 dataset. However, the positive association between the salvation belief such as "save soul" and approval of a religious leader as a source of mental health assistance is no longer statistically significant in Model 6 as other religious variables were statistically controlled. Taken together, these results lend credence to Hypothesis 3 which predicted that the associations between salvation beliefs

and preferences for mental health assistance from various sources of help will be more consistent than scripture and sin beliefs (e.g., statistically insignificant).

Table 2. Odds ratios predicting beliefs about religious sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.82		1.04		0.79		1.11		1.22		0.94	
Reborn Experience	5.08	***	4.59	***	2.82	***	3.54	***	3.31	***	2.32	***
Save Soul	1.25		1.21		0.67		1.76	**	1.67	*	1.16	
Sinners Punished	1.21		1.28		1.01							
Decide Treatment			1.11		1.08				0.99		1.02	
Decide Money			0.94		0.93				1.14		1.12	
Vignette Alcohol: Yes			1.89		1.98	*			1.32		1.35	
Vignette Depression: Yes			1.4		1.53				1.22		1.3	
Vignette Schizophrenia: Yes			1.26		1.34				0.81		0.81	
Female			0.82		0.69				0.87		0.79	
Non-white			0.74		0.71				0.95		0.92	
Age			1.00		0.99				1.01		1.00	
Education			1.08	*	1.08	*			1.04		1.02	
Ever-married			1.74	*	1.6	*			1.38		1.33	
Logged Income			1.09		0.95				1.22	**	1.16	*
Northeast			0.63		0.68				0.50	***	0.53	**
Midwest			0.55	**	0.51	**			0.51	***	0.51	***
West			0.93		1.17				0.60	**	0.68	*
2018									0.89		1.03	
Conservative Protestant					1.53						1.13	
Mainline Protestant					2.15	*					1.53	
Catholic					0.64						0.85	
Other Christians					3.28	*					1.75	
Religious Service Attendance					1.27	***					1.21	***
General Religiosity					1.45	**					1.23	*
Constant	3.93	***	0.37		0.99		3.86	***	0.26		0.32	
Model Chi-square	78.19	***	133.59	***	215.87	***	138.83	***	214.51	***	289.48	***
n	1437		1437		1437		2563		2563		2563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.2. General Medical Doctor

Next, to test Hypothesis 2, we turn to an examination of secular sources of mental health assistance. The results of the binary logistic regressions to predict the likelihood of approving mental health assistance from a general medical doctor, the first of the secular sources of mental health assistance, are reported in Table 3. As anticipated, net of all control variables, having had a reborn experience significantly and uniformly lowered the odds of approving a general medical doctor as a source of mental health assistance. Though the significance level fluctuated between $p < 0.05$ and $p < 0.01$, the association remained significant cutting across all the regression models (Models 1–6) and the GSS datasets. It is worth noting that scripture and sin indicators continue to be statistically irrelevant throughout the regression models. These results provide partial support for Hypothesis 2 but pronounced support for Hypothesis 3.

Table 3. Odds ratios predicting beliefs about general medical doctors as sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.91		1.05		1.07		1.05		1.12		1.07	
Reborn Experience	0.58	*	0.48	**	0.51	**	0.71	*	0.66	**	0.62	**
Save Soul	1.50		1.37		1.38		1.11		1.05		0.98	
Sinners Punished	1.11		1.20		1.15							
Decide Treatment			1.10		1.08				1.19		1.19	
Decide Money			1.20		1.20				1.15		1.14	
Vignette Alcohol: Yes			2.25	**	2.24	**			2.23	***	2.22	***
Vignette Depression: Yes			3.55	***	3.59	***			3.14	***	3.17	***
Vignette Schizophrenia: Yes			1.79		1.82				2.32	***	2.36	***
Female			1.62	*	1.62	*			1.58	***	1.56	***
Non-white			0.64	*	0.65	*			0.73	*	0.73	*
Age			1.00		1.00				1.00		1.00	
Education			1.03		1.03				0.98		0.97	
Ever-married			1.45		1.45				1.13		1.12	
Logged Income			1.14		1.15				1.18	**	1.16	*
Northeast			0.65		0.63				0.98		0.97	
Midwest			0.75		0.74				0.81		0.81	
West			1.17		1.15				0.91		0.93	
2018									1.37	*	1.43	**
Conservative Protestant					0.70						0.89	
Mainline Protestant					1.06						1.42	
Catholic					0.87						1.00	
Other Christians					0.65						0.89	
Religious Service Attendance					0.99						1.04	
General Religiosity					1.11						1.07	
Constant	6.13	***	0.26		0.25		6.93	***	0.35		0.40	
Model Chi-square	11.54	*	105.81	***	110.93	***	6.36		151.85	***	162.52	***
n	1437		1437		1437		2563		2563		2563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.3. Psychiatrist

The results of the binary logistic regressions to predict the likelihood of approving mental health assistance from a psychiatrist are displayed in Table 4. Consistent with the regression results shown in Table 3, having had a "born again" experience significantly and uniformly lowered the odds of approving a psychiatrist as a source of mental health assistance, net of all the religious and sociodemographic control variables. This observed negative association between "born again" experience and approving mental health assistance from a psychiatrist was statistically significant at least at the 0.01 level across all the regression models and the GSS datasets, thus partially supporting Hypothesis 1. Interestingly, in the combined GSS 2006 and 2018 dataset, there was a significant and negative association between biblical literalism and approval of mental health assistance from a psychiatrist; that is, net of other theological conservatism indicators, being a biblical literalist lowered the odds of approving a psychiatrist as a source of mental health assistance. However, this statistically significant ($p < 0.05$) finding from Model 4 became insignificant in Models 5–6 after controlling for additional sociodemographic and religious variables. This lackluster result provides limited support for Hypothesis 2. Once again, the pattern that emerged from Table 4 lends strong support for Hypothesis 3 as the salvation indicator (i.e., having a "born again" experience) was significant in all regression models, whereas the biblical literalism indicators were largely insignificant with the exception of Model 4.

Table 4. Odds ratios predicting beliefs about psychiatrists as sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.88		0.85		0.88		0.78	*	0.82		0.86	
Reborn Experience	0.56	**	0.51	**	0.51	**	0.66	**	0.56	***	0.57	**
Save Soul	1.19		1.13		1.11		1.19		1.26		1.28	
Sinners Punished	0.95		0.97		0.92							
Decide Treatment			1.19		1.18				1.17		1.17	
Decide Money			1.35	*	1.36	*			1.39	***	1.39	***
Vignette Alcohol: Yes			1.94	**	1.91	**			2.03	***	2.02	***
Vignette Depression: Yes			4.63	***	4.63	***			3.92	***	3.87	***
Vignette Schizophrenia: Yes			5.73	***	5.77	***			5.82	***	5.84	***
Female			1.23		1.22				1.00		1.00	
Non-white			0.75		0.78				0.87		0.92	
Age			0.99	*	0.99	**			0.99	***	0.98	***
Education			0.99		0.98				1.01		1.01	
Ever-married			0.79		0.78				0.85		0.85	
Logged Income			0.95		0.95				1.01		1.01	
Northeast			0.94		0.94				1.00		1.02	
Midwest			0.85		0.87				0.82		0.81	
West			1.76	*	1.79	*			0.98		0.98	
2018									2.00	***	2.01	***
Conservative Protestant					0.86						0.88	
Mainline Protestant					1.73						1.69	*
Catholic					0.96						0.93	
Other Christians					0.95						1.04	
Religious Service Attendance					0.98						0.96	
General Religiosity					1.15						1.11	
Constant	4.92	***	3.35		3.17		5.67	***	1.41		1.33	
Model Chi-square	18.79	*	226.18	***	237.88	***	20.53	***	334.48	***	351.63	***
n	1437		1437		1437		2563		2563		563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.4. Other Mental Health Professional

The results of the binary logistic regressions to predict the likelihood of approving mental health assistance from a secular therapist, counselor, or other mental health professional are shown in Table 5. In stark contrast to the previous findings, all regression models suggest that being a biblical literalist systematically lowered the odds of approving mental health assistance from a therapist, counselor, or other mental health professional, net of the religious and sociodemographic control variables. The significance level ranged from $p < 0.05$ to $p < 0.001$. While these results provide some support for Hypothesis 2, no statistical evidence surfaced from these regression models to support Hypothesis 3.

Table 5. Odds ratios predicting beliefs about other mental health professionals as sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.57	**	0.57	**	0.57	*	0.54	***	0.58	*	0.62	*
Reborn Experience	0.91		0.92		0.91		0.96		0.87		0.96	
Save Soul	1.33		1.19		1.16		1.18		1.17		1.24	
Sinners Punished	0.95		1.06		1.09							
Decide Treatment			1.16		1.16				1.19		1.17	
Decide Money			1.45	*	1.45	*			1.34	*	1.34	*
Vignette Alcohol: Yes			1.89	**	1.84	*			2.41	***	2.43	***
Vignette Depression: Yes			2.53	***	2.52	***			3.24	***	3.25	***
Vignette Schizophrenia: Yes			1.41		1.37				2.04	**	2.07	**
Female			2.16	***	2.18	***			2.07	***	2.10	***
Non-white			0.69		0.74				0.79		0.81	
Age			0.99		0.99				0.99	*	0.99	*
Education			1.03		1.03				1.03		1.03	
Ever-married			0.85		0.85				0.91		0.93	
Logged Income			0.92		0.93				0.92		0.93	
Northeast			1.27		1.27				1.42		1.38	
Midwest			0.96		0.96				0.95		0.93	
West			1.63	*	1.53				1.57	*	1.44	
2018									3.10	***	2.98	***
Conservative Protestant					0.72						0.61	*
Mainline Protestant					1.02						0.83	
Catholic					0.72						0.79	
Other Christians					1.50						0.82	
Religious Service Attendance					0.97						0.96	
General Religiosity					1.10						1.06	
Constant	7.38	***	3.21		3.05		10.73	***	3.13		3.10	
Model Chi-square	12.89	*	117.57	***	125.68	***	18.88	***	216.92	***	224.79	***
n	1437		1437		1437		2563		2563		2563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.5. Prescription Medication

The results of the binary logistic regressions to predict the likelihood of accepting prescription medication as a form of mental health assistance are reported in Table 6. A careful examination of the table suggests a significant ($p < 0.05$ in Model 1) and negative association between biblical literalism and acceptance of prescription medication as a form of mental health assistance in the GSS 2006 dataset, but this significant association was washed away by other control variables included in Models 2–3. Moreover, Models 5-6 from the combined GSS 2006 and 2018 data demonstrate a stronger association after controlling for both sociodemographic and additional religious variables. These results lend modest support for Hypothesis 2. Since none of the salvation indicators are statistically significant, there is no support for Hypothesis 3.

Table 6. Odds ratios predicting beliefs about prescription medications as sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.72	*	0.76		0.78		0.82		0.74	**	0.76	*
Reborn Experience	0.85		0.79		0.90		0.86		0.89		0.96	
Save Soul	1.02		0.95		0.96		1.14		1.09		1.10	
Sinners Punished	1.23		1.15		1.08							
Decide Treatment			1.22		1.20				0.97		0.97	
Decide Money			0.97		0.98				1.03		1.03	
Vignette Alcohol: Yes			0.51	***	0.50	***			0.95		0.95	
Vignette Depression: Yes			2.42	***	2.47	***			3.14	***	3.16	***
Vignette Schizophrenia: Yes			3.59	***	3.73	***			5.33	***	5.42	***
Female			1.41	*	1.37	*			1.13		1.13	
Non-white			0.81		0.78				0.74	**	0.74	*
Age			1.00		1.00				1.01	*	1.01	*
Education			1.04		1.04				1.00		1.00	
Ever-married			1.19		1.21				0.97		0.97	
Logged Income			0.97		0.97				0.93		0.93	
Northeast			0.69		0.62	*			0.98		0.92	
Midwest			0.66	*	0.64	*			0.86		0.85	
West			1.13		1.07				0.99		0.95	
2018									0.62	***	0.63	***
Conservative Protestant					0.64						0.73	*
Mainline Protestant					0.84						0.99	
Catholic					1.18						1.08	
Other Christians					0.61						0.76	
Religious Service Attendance					0.98						0.98	
General Religiosity					1.20						1.12	
Constant	2.83	***	0.99		0.79	***	2.27	***	2.58		2.31	
Model Chi-square	11.30	*	191.58	***	208.73	***	8.07	*	316.95	***	329.88	***
n	1437		1437		1437		2563		2563		2563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.6. Check into a Mental Hospital

The results of the binary logistic regressions to predict the likelihood of approving mental health assistance from a mental hospital are included in Table 7. As exhibited in Models 5–6, having ever tried to encourage someone to believe in/accept Jesus Christ as his or her savior increased the odds of approving a mental hospital as a source of mental health assistance, net of the religious and sociodemographic controls. This effect is statistically significant at the 0.05 level in Model 5 and the 0.001 level in Model 6, thus providing modest support for Hypothesis 3. It is important to note that the positive association between Save Soul and mental health hospital assistance is the opposite of what would normally be expected, barring the use of a mental hospital with possible religious ties.

Table 7. Odds ratios predicting beliefs about mental hospitals as sources of assistance.

	GSS 2006						GSS 2006 and 2018					
	Model 1		**Model 2**		**Model 3**		**Model 4**		**Model 5**		**Model 6**	
Biblical Literalism	0.88		0.79		0.90		0.98		0.87		0.96	
Reborn Experience	0.97		0.95		1.09		0.91		0.86		0.96	
Save Soul	1.23		1.19		1.40		1.20		1.29	*	1.45	**
Sinners Punished	0.87		0.75		0.76							
Decide Treatment			1.13		1.13				1.08		1.08	
Decide Money			1.30	*	1.31	*			1.61	***	1.60	***
Vignette Alcohol: Yes			1.79	***	1.77	*			1.31		1.31	
Vignette Depression: Yes			2.14	***	2.09	***			1.50	**	1.48	**
Vignette Schizophrenia: Yes			9.07	***	9.25	***			7.11	***	7.21	***
Female			1.19		1.20				1.13		1.15	
Non-white			1.02		1.06				0.94		0.97	
Age			1.00		1.00				1.00		1.00	
Education			1.00		1.00				0.99		1.00	
Ever-married			1.05		1.08				1.12		1.14	
Logged Income			0.98		0.98				0.90	*	0.91	
Northeast			0.83		0.84				0.97		0.96	
Midwest			0.71		0.74				0.88		0.88	
West			0.76		0.76				0.73	*	0.73	*
2018									1.68	***	1.68	***
Conservative Protestant					1.18						1.13	
Mainline Protestant					1.94	**					1.49	*
Catholic					1.56	*					1.37	*
Other Christians					1.10						1.02	
Religious Service Attendance					0.97						0.95	
General Religiosity					0.83						0.91	
Constant	0.55	***	0.15	*	0.15	*	0.59	***	0.27	*	0.26	*
Model Chi-square	4.88		301.47	***	318.31	***	3.78		586.50	***	602.00	***
n	1437		1437		1437		2563		2563		563	

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

4.7. Results of Bivariate Analysis

Since the results of the main models presented in the previous sections indicated that these three dimensions of theological conservatism perhaps operate independently, rather than in tandem, additional bivariate analyses were completed. Overall, the bivariate results were consistent with the multivariate findings presented previously.

In the bivariate analyses of the GSS 2006 dataset (see Table 8), all of the theological conservatism indicators were positively associated with the likelihood of approving mental health assistance from a religious source. However, in the multivariate analyses previously presented, when controlling for other factors, only having had a "born again" experience significantly and uniformly increased the odds of approving a religious leader as a source of mental health assistance. Furthermore, bivariate analysis indicated that having a "born again" experience was negatively associated with approving mental health assistance from a general medical doctor. When controlling for other factors in the multivariate analyses, this observation is seen again. In addition, being a biblical literalist and having a "born again" experience was negatively associated with approving a psychiatrist. In the multivariate analyses, only having had a "born again" experience significantly decreased the odds of approving psychiatrists. In the bivariate analysis, being a biblical literalist was negatively associated with approving other mental health professionals and prescription medications. This observation held in the multivariate analysis, in that being a biblical literalist lowered the odds of approving mental health assistance from a therapist, counselor, or other mental health professional. With prescription medication, however, the negative association between biblical literalism and acceptance of prescription medication as a form of mental health assistance was initially seen, but then was attenuated once other control variables were added. Finally, in the bivariate analysis, none of the theological conservatism

indicators were associated with approving mental health assistance from a mental hospital (this observation held in the multivariate analysis).

Table 8. Bivariate correlations: GSS 2006.

	Biblical Literalism	**Reborn Experience**	**Save Soul**	**Sinners Punished**
Religious Sources of Assistance	0.07	0.21	0.14	0.07
Sig. (2-tailed)	0.022	<0.001	<0.001	0.01
N	1437	1437	1437	1437
General Medical Doctors as Sources of Assistance	−0.02	−0.06	0.02	0.01
Sig. (2-tailed)	0.447	0.047	0.565	0.65
N	1437	1437	1437	1437
Psychiatrists as Sources of Assistance	−0.06	−0.11	−0.04	−0.03
Sig. (2-tailed)	0.027	<0.001	0.224	0.308
N	1437	1437	1437	1437
Other Mental Health Professionals as Sources of Assistance	−0.09	−0.03	0.00	−0.03
Sig. (2-tailed)	0.002	0.33	0.993	0.34
N	1437	1437	1437	1437
Prescription Medications as Sources of Assistance	−0.07	−0.05	−0.03	0.02
Sig. (2-tailed)	0.02	0.091	0.361	0.492
N	1437	1437	1437	1437
Mental Hospitals as Sources of Assistance	−0.02	0.00	0.02	−0.03
Sig. (2-tailed)	0.429	0.993	0.402	0.327
N	1437	1437	1437	1437

In the bivariate analyses of the combined GSS 2006 and 2018 dataset (see Table 9), all of the theological conservatism indicators were again positively associated with the likelihood of approving mental health assistance from a religious source. In the multivariate analyses presented above, only two indicators were significant. First, having ever tried to encourage someone to believe in/accept Jesus Christ as his or her savior significantly increased the odds of approving a religious leader as a source of mental health assistance. This relationship was attenuated once all control variables were entered into the full model. Second, having had a "born again" experience significantly and uniformly increased the odds of approving a religious leader as a source of mental health assistance. In addition, having a "born again" experience was negatively associated with approving mental health assistance from a general medical doctor. When controlling for other factors in the multivariate analyses, this pattern is again observed. In addition, being a biblical literalist and having a "born again" experience was negatively associated with approving a psychiatrist. In the multivariate analyses, only having had a "born again" experience significantly decreased the odds of approving psychiatrists (the association for biblical literalists disappeared once all control variables were added). Further, being a biblical literalist was negatively associated with approving other mental health professionals and prescription medications. This observation held in the multivariate analysis, in that being a biblical literalist lowered the odds of approving mental health assistance from a therapist, counselor, or other mental health professional. With prescription medication, the negative association between biblical literalism and acceptance of prescription medication as a form of mental health assistance did not appear until other control variables were added. Similar to the GSS 2006 dataset, in the bivariate analysis of the combined GSS 2006 and 2018 dataset, none of the theological conservatism indicators were associated with approving mental health assistance from a mental hospital (again this observation held in the multivariate analysis).

Table 9. Bivariate correlations: GSS 2006 & 2018.

	Biblical Literalism	**Reborn Experience**	**Save Soul**
Religious Sources of Assistance	0.1	0.2	0.17
Sig. (2-tailed)	0.001	0	<0.001
N	2563	2563	2563
General Medical Doctors as Sources of Assistance	−0.01	−0.05	−0.01
Sig. (2-tailed)	0.728	0.027	0.649
N	2563	2563	2563
Psychiatrists as Sources of Assistance	−0.06	−0.08	−0.02
Sig. (2-tailed)	0.002	0.002	0.27
N	2563	2563	2563
Other Mental Health Professionals as Sources of Assistance	−0.08	−0.03	−0.01
Sig. (2-tailed)	<0.001	0.259	0.585
N	2563	2563	2563
Prescription Medications as Sources of Assistance	−0.05	−0.04	−0.01
Sig. (2-tailed)	0.029	0.077	0.806
N	2563	2563	2563
Mental Hospitals as Sources of Assistance	0.00	0.00	0.03
Sig. (2-tailed)	0.915	0.942	0.165
N	2563	2563	2563

Overall, the bivariate results are consistent with the multivariate results. These results lend greater support to the argument that the dimensions of theological conservatism operate independently from one another.

To summarize, when evaluating the various sources of religious and secular mental health assistance, there is modest, albeit inconsistent, evidence to support Hypotheses 1 and 2. Very generally, having a reborn experience as an indicator of theological conservatism is (1) significantly and positively associated with a preference for mental health assistance from religious sources, and both having a reborn experience and being a biblical literalist are (2) significantly and negatively associated with a preference for mental health assistance from secular sources, net of confounding factors. On the other hand, "saving soul" and "punishing sinner" as additional indicators of theological conservatism are either insignificantly or inconsistently associated with a preference for mental health assistance.

5. Discussion

Previous research has evaluated how various religious dimensions are associated with preferences for different sources of mental health assistance. This study has expanded on these prior investigations by using theological conservatism (Hempel and Bartkowski 2008) to evaluate this complex phenomenon. Theological conservatism is complex due to its multidimensional character (scripture, sin, and salvation), and because of its inherently interpretive elements (questions about valid knowledge, the nature of human beings and the world they inhabit, and what is required for people to achieve salvation). Accounting for the three core beliefs about biblical scripture, human sin, and salvation, and thus assessing how these beliefs are internalized at the individual level, our study has investigated how this constellation of views influences attitudes towards mental health services. Additionally, we have tested how theological conservatism does not always operate as a coherent or singular schema. The three dimensions of theological conservatism are not routinely activated in tandem as the schema approach proposes, but rather act as individual facets of a multifaceted theologically conservative worldview. Hence, the results of this study do not provide strong support for the influence of theological conservatism as a schema on vignette-prompted preferences for various sources of mental health assistance.

Overall, our study hypotheses received mixed support. Theological conservatism was only modestly associated with a preference for mental health assistance from a minister, priest, rabbi, or other religious leader for a mental disorder, net of confounding factors. In several models, those who have been "born again" were more likely to support seeking

mental health assistance from a religious leader. Thus, there was weak support for Hypothesis 1. Furthermore, theological conservatism was not negatively associated with a preference for mental health assistance from secular sources of help for a mental disorder, net of confounding factors. Specifically, when assessed as individual indicators, those who have been "born again" were less likely to support seeking mental health assistance from a psychiatrist or medical doctor, and biblical literalists were less likely to accept prescription medication as a form of assistance. With regard to seeking assistance from another mental health professional, those who were biblical literalists were less accepting of these professionals' help. Interestingly, in some cases, the individual indicators displayed results that were in direct opposition with Hypothesis 2. There was only a direct (and counterintuitive) association between one of the salvation indicators of theological conservatism and approving of a mental hospital as a source of mental health assistance. Taking these observations into consideration, there was only modest support for Hypothesis 2.

Nevertheless, this study has investigated how the salvation dimension of theological conservatism is closely aligned with personalized issues of mental health, and the results did provide strong support for Hypothesis 3. Among the theological conservatism predictors, the associations between salvation beliefs and preferences for mental health assistance from various sources were more consistently significant than the associations between scripture and sin beliefs and preferences for assistance. Indeed, the "born again" and "encourage someone to believe in/accept Jesus Christ as his or her savior" (i.e., "save soul") indicators were significant net of other indicators in numerous models. Arguably, these results emerged given the personal nature of the mental health vignettes and individualized approach to salvation. When presented with a personalized mental health problem and possible solutions to help alleviate the problem, those who are theologically conservative are perhaps more inclined to rely on their understanding of personal, inner transformation that begins with salvation through Jesus Christ. Moreover, the results of this study illustrate that this dimension of theological conservatism was not applied universally among the two salvation indicators. While the "save soul" indicator was associated with a greater preference for mental health hospitals and more support for religious leaders, the "born again" indicator demonstrated less support for psychiatrists and medical doctors and more support for religious leaders. These indicators for salvation did not operate in the same manner, and arguably, the reborn measure performs as its own component within this context. When respondents are presented with a personalized mental health problem, this measure of salvation overshadows the other indicators of theological conservatism. Perhaps this pattern is observed because this conception of salvation taps into the idea that mental health adversities are personal issues, and thus solutions to help alleviate these psychological states are achieved through personal change in whatever form it may be available (religious or secular).

Given that many indicators of theological conservatism were not significantly associated with preference for mental health assistance from secular sources, one might speculate that perhaps some aspects of mental health have become accepted by those with conservative religious beliefs. There is a well-documented convergence of secular and faith-based services to help address numerous mental health ailments (Bartkowski and Grettenberger 2018). Perhaps the acceptance of the medicalization of mental health has reached religious communities, thus blurring the boundaries of spirituality and science. Furthermore, greater acceptance of secular interventions may indicate some destigmatization of seeking professional help for mental illnesses.

Key insights from this research investigation rest on the complexity and specificity of both theological conservatism and research on mental health and mental health assistance. There is complexity with theological conservatism in that the tenets of this perspective are not activated and expressed in a uniform way, not just between each dimension, but within each as well (i.e., the variations between the two salvation components). Moreover, there is complexity with the indicators for various sources of mental health assistance. As the results showed, none of the secular sources of assistance were evaluated in the same

way. Thus, specificity is needed with both theological conservatism and mental health research. While the schema approach to theological conservatism has been suitable for prior research using this concept (Bartkowski and Hempel 2009; Hempel and Bartkowski 2008; Hempel et al. 2012), the personalized nature of mental health considered here necessitates a more precise, distinct indicator approach. Further, the vignette method utilized in this study targets specificity in a novel way. Rather than asking general questions about mental health or mental health disorders in this country, the vignettes provided respondents with a detailed account of an individual's personal issue. Prior studies have used a similar vignette method to better understand the relationship between religious beliefs and assistance (e.g., Noort et al. 2012). To our knowledge, however, ours is the first study to use vignettes in this way to examine preferences for sources of assistance among those with a theologically conservative worldview.

Altogether, this examination produces a few implications for future research. First, while there is value in understanding theological conservatism as a schema and evaluating it in quantitative research as such (i.e., using structural equation modeling), there is also room for this concept to be addressed as having three dimensions that operate independently, rather than in tandem, depending on the context in which they are used. Hempel and Bartkowski (2008) contended that this schema approach would allow for a more thorough understanding of the Conservative Protestant faith tradition. While this blended method has been useful with more general social issues (see Bartkowski and Hempel 2009; Hempel et al. 2012), future research should consider the capacity for the dimensions to operate in an independent fashion and consider separating the indicators used. Additionally, in some cases, certain dimensions of theological conservatism may be elevated in their influence over others, again depending on the context. Therefore, although beliefs about scripture, sin, and salvation could be viewed as interrelated ideas, attention should be paid to the uniqueness of each component. Next, given the noteworthy observations seen with the reborn ("born again") measure of salvation, it is recommended that future research investigating the influence of Christian religious beliefs on other social topics should consider incorporating this measure into its study design. Furthermore, while this research has only evaluated the influence of a literalist interpretation of the Bible (as proposed by Hempel and Bartkowski 2008), future research can be conducted to consider how different theologically conservative gradations (e.g., the influence of inspired, rather than literal, views of the Bible) might present similar or different evaluations of sources of mental health assistance. We explored this prospect but found absolutely no evidence that inspired views of the Bible affect appraisals of religious versus secular sources of mental health assistance (results available by request). (By far, an inspired view of the Bible is the largest response category in the GSS for this item.) It is possible, however, that other aspects of mental health may be associated with inspired views of the Bible. We leave it to other researchers to consider this possibility. Finally, the use of vignettes in this investigation allowed this study to assess how respondents interact with highly personalized scenarios depicting cases of mental illness and their possible sources of assistance. These vignettes are then a unique way to access respondent's attitudes on social issues that tend to be quite personal. Thus, future research should consider expanding the use of vignettes within attitudinal research.

As with all research, this study has some limitations. Given that the GSS has a cross-sectional design and only two waves of the GSS were used in this investigation, this study is limited in its ability to draw causal inferences. While the two waves of the GSS provided the most comprehensive analysis of relevant indicators, partial reusing of this dataset (i.e., using the 2006 GSS dataset twice) does prove to be a limitation. Moreover, this study's theoretical casual ordering could pose some limitations. While this study has interpreted that one's conservative theological beliefs occur prior to one's interpretation of these mental illness vignettes, the possibility remains that prior exposure to mental illnesses could influence one's conservative theological worldview. Furthermore, while this study has attempted to evaluate internal heterogeneity (e.g., literalist vs. inspired views

of scripture), there are a series of external linkages that our investigation does not take into consideration. For instance, changing societal views of mental health, subcultural distinctions between theological conservatives and mainstream culture, and larger political and religious dynamics (demonization of public spaces, religious deprivatization, etc.) may influence theological conservatives' views of mental health assistance (cf. Taylor et al. 2012; Casanova 1994). Moreover, while the mental health assistance response options in this study provide a vast assortment of secular mental health options, these items did not account for psychologists or mental health professionals who are potentially religiously based (e.g., Christian counselors) or religious themselves. In addition, the ballot design of the GSS left us lacking predictor variables across some models. This limitation was quite evident with the lack of a sin indicator (e.g., PUNSIN) for the 2018 wave. As such, our ability to operationalize theological conservatism consistently was limited. Perhaps future waves of the GSS could incorporate additional items that better feature the three components of theological conservatism, as well as include more sources of assistance into this module that tap into this secular/religious overlap. Additionally, while our focus is on theological conservatives, our study did not account for various subgroups of theological conservatives. As such, future researchers are encouraged to evaluate preference for sources of mental health assistance among fundamentalists versus other conservative religious groups such as evangelicals and Pentecostals (Unsworth and Ecklund 2021). For instance, as a subgroup of theological conservatives, fundamentalists are distinguished by their opposition to modernity, which can include the use of psychological science to treat mental health conditions. While not the sum total of all theological conservatives, analysis of these subgroups would be beneficial to further understand the complexity of a theologically conservative worldview when evaluating mental health sources of assistance. Finally, we acknowledge the possibility that empirical observations can be spurious. We were unable to consider some important measures that could influences one's interpretation of mental illnesses, such as having a family member or close friend with a mental illness. Despite these limitations, however, our study has advanced prior research into preferences for different sources for mental health assistance among those who are conservative in their religious beliefs.

6. Conclusions

Understanding the multidimensional role that conservative religious beliefs play in mental illnesses is important. Believing that a person has total control over their mental illness can lead one to attribute all blame to the individual living with the mental illness (Webb et al. 2008) and propose that they turn to faith to overcome their hardship. Therefore, religious individuals tend to prefer healthcare providers that have a similar philosophical outlook on life as themselves (Nakash et al. 2019), and there is an increasing understanding that mental health includes both the physical and spiritual needs of people (McGuire and Pace 2018). As movements have promoted the integration of religious and spiritual factors into medical care for mental illnesses (Milner et al. 2019; Turner et al. 2019), continued research into how religious beliefs and ideas translate into preferences for various sources of mental health assistance are vital; however, until that research is conducted, this study has contributed to the growing literature on sources of assistance for mental health ailments. Furthermore, this research has shown that some dimensions of a complex and multifaceted theologically conservative worldview are influential in fostering approval for religious sources of assistance and disapproval for many secular sources of assistance.

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Appendix A. Vignette Wording

Alcohol dependence:

> *[John/Juan/Mary/Maria] is a [white/African American/Hispanic] [man/woman] with an [eighth grade/high school/college] education. During the last month [John/Juan/Mary/Maria] has started to drink more than his/her usual amount of alcohol. In fact, he/she has noticed that he/she needs to drink twice as much as he/she used to get the same effect. Several times, he/she has tried to cut down, or stop drinking, but he/she can't. Each time he/she has tried to cut down, he/she became very agitated, sweaty and he/she couldn't sleep, so he/she took another drink. His/Her family has complained that he/she is often hungover, and has become unreliable—making plans one day, and canceling them the next.*

Major depression:

> *[John/Juan/Mary/Maria] is a [white/African American/Hispanic] [man/woman] with an [eighth grade/high school/college] education. For the past two weeks [John/Juan/Mary/Maria] has been feeling really down. He/She wakes up in the morning with a flat heavy feeling that sticks with him/her all day long. He/She isn't enjoying things the way he/she normally would. In fact nothing gives him/her pleasure. Even when good things happen, they don't seem to make [John/Juan/Mary/Maria] happy. He/She pushes on through his/her days, but it is really hard. The smallest tasks are difficult to accomplish. He/She finds it hard to concentrate on anything. He/She feels out of energy and out of steam. And even though [John/Juan/Mary/Maria] feels tired, when night comes he/she can't go to sleep. [John/Juan/Mary/Maria] feels pretty worthless, and very discouraged. [John's/Juan's/Mary's/Maria's] family has noticed that he/she hasn't been himself/herself for about the last month and that he/she has pulled away from them. [John/Juan/Mary/Maria] just doesn't feel like talking.*

Schizophrenia:

> *[John/Juan/Mary/Maria] is a [white/African American/Hispanic] [man/woman] with an [eighth grade/high school/college] education. Up until a year ago, life was pretty okay for [John/Juan/Mary/Maria]. But then, things started to change. He/She thought that people around him/her were making disapproving comments, and talking behind his/her back. [John/Juan/Mary/Maria] was convinced that people were spying on him/her and that they could hear what he/she was thinking. [John/Juan/Mary/Maria] lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his/her room. [2006 ONWARDS: [John/Juan/Mary/Maria] became so preoccupied with what s/he was thinking that s/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, s/he was walking back and forth in [his/her] room.]*
>
> *[John/Juan/Mary/Maria] was hearing voices even though no one else was around. These voices told him/her what do and what to think. He/She has been living this way for six months.*

No problem:

> *[John/Juan/Mary/Maria] is a [white/African American/Hispanic] [man/woman] with an [eighth grade/high school/college education]. Up until a year ago, life was pretty okay for [John/Juan/Mary/Maria]. While nothing much was going wrong in [John's/Juan's/Mary's/Maria's] life he/she sometimes feels worried, a little sad, or has trouble sleeping at*

night. [John/Juan/Mary/Maria] feels that at times things bother him/her more than they bother other people and that when things go wrong, he/she sometimes gets nervous or annoyed. Otherwise [John/Juan/Mary/Maria] is getting along pretty well. He/She enjoys being with other people and although [John/Juan/Mary/Maria] sometimes argues with his/her family, [John/Juan/Mary/Maria] has been getting along pretty well with his/her family.

Notes

[1] Wamser et al. (2011) used the term "religious fundamentalists" in their work. For consistency, Conservative Protestant has been used here.

[2] The response category "go to a spiritual or a natural healer for help" was evaluated, but ultimately not included in this study. This decision was made because the use of faith healers is contested among religious conservatives (Bartkowski et al. 2011), there is vast interpretive ambiguity among religious people about what a spiritual healer actually is, and in preliminary analysis, this variable did not produce any meaningful results.

[3] One reviewer requested that we provide additional justification for the inclusion of some variables present in this study. We share the following observations in the interest of full disclosure and at that reviewer's request. First, it was suggested that we remove the SAVESOUL variable. We opted to retain this variable given that previous research on theological conservatism—both ethnographic and quantitative—has made a strong case for the inclusion of this or similar salvation belief measures (Hempel and Bartkowski 2008); while not necessarily the optimal measure of salvation beliefs, taking action to convince others to turn to Christ is evidence of the importance of this conviction within the believer's worldview. Second, it was suggested that we omit the adjustment for the series of measures on religiousness in Models 3 and 6. We again opted to retain these measures, as theological conservatism could vary across religious groups and practices, which can affect the preference types differently. Omission of these measures would open us to charges of spuriousness and would reflect deviation from prior publications. Finally, it was suggested that we omit the stigma control variables. We retained these variables to account for the influence of stigma associated with mental health. Furthermore, in additional analysis (not presented in this paper but available upon request) of the full models without the two stigma variables included, the results were nearly identical. These efforts reflect a commitment to analytical thoroughness on our part, and we are grateful for the reviewer's input.

[4] Initial assessment concluded that an index created with the four indicators of theological conservatism used here had good but not exceptional internal reliability (e.g., $\alpha = 0.69$; 2006 GSS data). Additional results are available by request.

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