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The Intersection of Religion and Mental Health Help-Seeking: Themes Within Youth Experiencing Early Psychosis

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Abstract

Little research has examined the intersection of religion and mental health among predominantly conservative communities – where religion tends to weigh heavily. It is known from the literature that religion and spirituality play a role in influencing treatment pathways and views towards mental health. The primary aim of the present study was to explore via secondary thematic analysis, the intersection of religion and mental health within a conservative Midwestern community of youth who are receiving treatment for early psychosis, with a secondary look at family dynamics. Seven participant transcripts were analyzed from the Narrative Enhancement and Cognitive Therapy-Young Adult (NECT-YA) adaptation study, where religious mentions emerged (N = 7). Three main themes were determined: religion as a support (n = 6), conflict between mental health and religion (n = 3), and unhealthy religion (n = 2). Findings from this research provide confirmation that religion indeed impacts mental health, treatment, and family dynamic among individuals with early psychosis, from a predominantly religious community; also, conclusions consistent with prior research – that religion be integrated with mental health, rather than divided.

Keywords: religion, spirituality, mental health, family, psychosis, religious community/individuals, youth/young adults

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It is generally agreed upon that psychosis is a part of severe mental illness (SMI) (National Institute of Mental Health, n.d.). It includes experiences such as disturbances of thoughts, perceptions, and understanding. Psychosis will be encountered by approximately three out of every 100 people at some point in their lifetime (National Alliance on Mental Illness, n.d.). More specifically, there are about 100,000 youth each year who have an experience with first-episode psychosis (FEP), which is the initial onset of a psychotic episode that may include symptoms of hallucinations, delusions, paranoia, anxiety, depression, incoherent speech, etc. (National Institute of Mental Health, n.d.; National Alliance on Mental Illness, n.d.). Coupled with that is the duration of untreated psychosis (DUP), which is relevant as it defines the time period between initial onset of FEP and first treatment (Smith, 2011).

For the purpose of ease and consistency, the terms “Black community/individuals” and “conservative or religious community” will be used to encompass all individuals of relevance to the study. Given the composition of the current sample and study aims, understanding the acceptance of religiosity among the Black community and within the Midwestern state where the study took place, is important. According to the *Religious Landscape Study* (Pew Research Center, n.d.), about 80% of the Black community considers themselves religious, with a large majority being Christian. Equally significant, 75% of the Black community reported religion as being “very important” in one’s life. When compared to other racial/ethnic compositions, the Black community reports some of the highest rates of religiosity. Similarly, 72% of adults in the Midwestern state where the study took place generally report identifying with Christianity, and 63% report being absolutely certain in their belief in God (Pew Research Center, n.d.).

Moreover, with that being said, other studies and reviews have demonstrated the intersection between psychosis and religion (Grover et al., 2014), which will be detailed later in the document.

The following literature review will provide a foundation for the present research study that will explore, through secondary analysis, themes related to factors of religion and family dynamics, as well as pathways to treatment, among youth receiving intervention for early psychosis. Goals of the current study are to explore religion, familial interaction/dynamics, and treatment impacts. This study contributes to the existing literature by examining these intersecting factors in a sample of youth that constitutes a predominantly religious and Black community, and who are/have experienced FEP. Additionally, the interviews were with the youth themselves; these aspects of the community, psychosis, and youth perspective, do not appear to be studied together or abundant in the literature. By exploring these unique aspects in singular study, the aim is to shed light on the roles these variables play, and how the impacts can be used to shape future considerations in the mental health field regarding family, religion, and intervention/treatment processes.

Religion and Mental Health

Given the prevalence of religiosity among the Black community and the Midwest (Pew Research Center, n.d.), it is necessary to consider the intersection of religion and mental health within specific populations – as it is important for mental health providers to reach their clients on a meaningful level. There are a few reviews and studies, which have noted both positive and negative effects from religious involvement in terms of mental illness (Breland-Noble et al., 2015; Koenig & Larson, 2001; Weber & Pargament, 2014). Over the years, there has been research and overviews that identify the changes in the relationship between mental health and

religion, its role in coping, and the potential integration of religion in assessment and intervention of SMI (Breland-Noble et al., 2015; Koenig & Larson, 2001; Mo'tamedi et al., 2014; Shadid et al., 2021; Weber & Pargament, 2014).

An earlier review by Koenig and Larson (2001) explored the association of mental health and religion by citing historical factors, the evolution of the role of religion, effects of religion, and field implications. There was once a larger interest in the connection between religion and mental health, albeit conflicting opinions over the relationship between the two, among early researchers and psychologists. Traditional figures in psychology, such as Sigmund Freud and Carl Jung, had differing opinions regarding the role of religion and spirituality, in that Freud largely denounced religion (Koenig & Larson, 2001; Weber & Pargament, 2014) citing what he believed were the neurotic underpinnings of religion; meanwhile, Jung referred to religion in a more positive light, referencing religious outlook and stability in life. The wedge between mental health and religion is at the fault of both religious communities who view therapy as secular and "antispiritual," as well as pathologizing of religion by some psychologists (Boyd-Franklin, 2006). Although clinicians tend to be less religious than their clients (Delaney et al., 2007), the majority of research studies fall in line with Jung's take on the religious dynamic in psychology (Koenig & Larson, 2001), and have found positive outcomes associated with religious beliefs, practices, and coping mechanisms, including greater life satisfaction (higher morale, purpose/meaning, optimism), less anxiety and depression, altruism, fewer symptoms, forgiveness and kindness, and an overall sense of well-being (Koenig & Larson, 2001; Weber & Pargament, 2014). On the contrary, a minority of findings reviewed by Koenig and Larson (2001) found negative effects on mental well-being in association with religion. Some of the conclusions made from the reviewed research are the fostering of guilt and shame, potentially related to religious

norms and non-conformity. Similarly, some fundamentalist communities believe that mental health conditions like psychosis are evil in nature and/or punishment from God (Compton et al., 2008), as will be discussed in more detail. Additionally, religion sometimes rationalizes the use of prejudice and judgment (Koenig & Larson, 2001). Despite these findings, 82% of psychologists still regard religion as potentially beneficial to mental health, as opposed to harmful (Delaney et al., 2007).

There is knowledge in the field of mental health and psychology, that social support is important for improving mental well-being, and this is supported in the systematic review (Koenig & Larson, 2001) – that religion can play an important role in the increase and presence of one's social support and network. Social support can have a positive impact on mental health. There is evidence supporting religious involvement and enhanced social support systems (Koenig & Larson, 2001; Mo'tamedi et al., 2014; Weber & Pargament, 2014). This is especially relevant among the Black community, where the church is often referred to as "family" and serves as a social function (Boyd-Franklin, 2006). A systematic review conducted by Koenig and Larson (2001) revealed a significant relationship between religious involvement and social support – 19 out of 20 studies reviewed produced this significant association. Additionally in their study, the majority of research reviewed found positive relationships among religion, marital stability, and satisfactions – which is a part of the social network for many individuals. In their literature review, Weber and Pargament (2014) also referenced religious community support and involvement, as a form of religious coping, and can result in greater social relations for the individual. Religion/religious community and social support appear to have an important relationship with mental health across the literature (Breland-Noble et al., 2015; Koenig & Larson, 2001; Mo'tamedi et al., 2014; Shadid et al., 2021; Weber & Pargament, 2014). Further,

it seems that the quality of these social networks is enhanced (Koenig & Larson, 2001; Weber & Pargament, 2014), and may act as a buffer and aid in the coping with distress, which by extension can certainly include FEP (Breland-Noble et al., 2015; Koenig & Larson, 2001; Mo'tamedi et al., 2014; Weber & Pargament, 2014). Mo'tamedi et al. (2014) suggested that future research look into religious support and family adaptability; their study on family resiliency and FEP re-affirmed the importance of the role of spiritual social support in terms of coping with a family member's FEP, however their finding did not produce statistically significant results. In contrast to the positive religious coping in terms of social support, Weber and Pargament (2014) reported that when religious delusions are associated with psychosis, there appears to be less religious communal support – which can be presumed to have adverse effects on mental health. This was also evidenced in another study, which found that in more than half of their sample of psychosis patients, they experienced negative religious coping, stigmatization, and less communal support when religious content was included in their delusions (Mohr et al., 2010).

As previously noted, there are negative aspects associated with religiosity and coping, especially when speaking about psychosis and related symptoms. Weber and Pargament (2014) reviewed multiple studies in which they found various spiritual struggles in relation to religious coping – anger with God, internal religious guilt and doubt, etc. – which were further associated with psychological distress, greater depression, suicidal ideation, anxiety, and alcohol use. Koenig and Larson (2001) also noted similar findings in their review of associations between religiosity and mental health: perfectionism, insecurity, depression, guilt/shame, etc.; although, the researchers recognized multiple methodological and sample limitations within the studies reviewed, and that only about 20% of the reviewed studies produced these associations.

Furthermore, another common aspect within this intersection includes psychiatric patients who experience delusions with religious content. Some delusional themes with religious content that are observed include: persecution, influence (control by spiritual entities), and self-significance (grandiosity and guilt) (Mohr et al., 2010). Research has found that when psychosis symptoms like delusions include religious content, individuals receive less support from religious communities (Mohr et al., 2010; Weber & Pargament, 2014). Some individuals also believe that schizophrenia or psychosis are caused by possession or punishment from God (Compton et al., 2008; Weber & Pargament, 2014). Additionally, reviewed studies provided some conclusions that suicidality is associated with religious delusions or hallucinations, and that individuals may experience an increase in severity of psychotic symptoms (Weber & Pargament, 2014). In contrast, Mohr et al. (2010) found that this did not result in more severe clinical status. Both studies, however, concluded that there is a reduced likelihood to adhere to psychiatric treatment (Mohr et al., 2010; Weber & Pargament, 2014). Sometimes, individuals may look to spirituality and religiosity as a form of coping, and it was hypothesized that this was to help give meaning and explanation to the psychosis symptoms experienced (Mohr et al., 2010). Mohr et al. (2010) concluded that healthy spiritual coping may indeed cohabitate with religious delusions.

Koenig and Larson (2001), in their review, found an inverse relationship between religious involvement and various psychiatric disorders. The majority of the research reviewed showed a decrease/lower rates, among the more religious, in the following areas – depression, suicide, anxiety, and substance abuse. A review of existing research in 2014 also noted these associations (Weber & Pargament, 2014). Further, a study by Shadid et al. (2021) found power in that of religious leaders, when it comes to mental health needs and treatment of individuals in their congregation. Importantly, their study also reported on collaborative religious coping,

which utilizes a sense of agency within the individual as well as a reliance on God too, for problem solving. As previously noted, there is a key role of spirituality in the Black community and culture (Breland-Noble et al., 2015; Pew Research Center, n.d.) which can influence youths' experiences of depression – and by extension, can likely assume it would in FEP as well. This is relevant for the current research due to its specific focus on Black and religious youth and the methodology used. Breland-Noble et al. (2015) studied religious coping in a sample of 28 African American and Black adolescents with depression and found themes of religion as treatment incentive; prayer and agency; mixed emotions; does not hurt, might help; finding support in the church; and prayer and church - barriers to treatment. Many youth reported on the importance of religion and prayer in addressing mental health, but also recognized their own role in self-care. In addition, many also felt encouraged by their religious community, some even engaging in self-disclosure of mental health concerns. On the other hand, some youth reported having mixed feelings about the support and judgment from those in their religious groups.

Taken together, the role of religion in the mental health field and psychosis presents both positive and negative aspects in terms of coping and support (Breland-Noble et al., 2015; Koenig & Larson, 2001; Mohr et al., 2010; Shadid et al., 2021; Weber & Pargament, 2014). Moreover, the directionality of the cross-sectional relationships between religion and mental health effects are difficult to definitively determine/conclude (Koenig & Larson, 2001). The intersection of religion and mental health appears to be a necessary construct of consideration with those who are religious and experiencing FEP. Moving forward, this research finds it beneficial to review the role of family dynamics in mental health and FEP.

Family Dynamics and Mental Health

Given the impact of family environment on youth, it is also important to consider the impact of family systems and dynamics on the mental health of youth experiencing FEP. With the literature available, it is reasonable to conclude the importance of families and their influence on treatment pathways. Furthermore, since youth typically inherit their religious views from family members, it is necessary to review literature on family dynamics, as religion is likely a confounding variable in the way families guide youth to treatment and react to psychosis diagnoses and mental health. Expressed emotion (EE) can be understood as the family environment of those with mental health issues and psychiatric disorders and includes the quality and patterns of the familial relationship (Amaresha & Venkatasubramanian, 2012). EE references the family member or caregiver's attitude toward the psychological disorder and includes factors like critical comments and hostility (Amaresha & Venkatasubramanian, 2012; Koutra et al., 2014). Koutra et al. (2014) reviewed studies that examined the link between family functioning and FEP; specifically, EE and family burden. Their research found that specifically among FEP patients' families, family burden was not a significant factor in the family dynamic, however this is likely because the symptoms of psychosis having not resulted in significant disruption that early on. Additionally, high EE was highly prevalent among families of FEP patients. Koutra et al. (2014) also noted the importance of a supportive and safe family dynamic and environment, contributing to recovery and well-being of FEP patients. Similarly, a systematic review evaluated the relationship between warmth and positive remarks in regard to psychosis outcomes such as relapse rates (Butler et al., 2018). Compared to the previous study (Koutra et al., 2014), this research set out to look at more positive aspects of the family dynamic and their impact (Butler et al., 2018). The results provided preliminary evidence of the protective

benefit of positive EE, and safe, warm family environments (Butler et al., 2018; Koutra et al., 2014); although, there are inconsistent findings among the research of the relationship between warmth/positivity and symptomatology, which require further studies and replicability.

Correspondingly, Mo'tamedi and colleagues (2014), evaluated familial strength and resiliency from the family member perspective of FEP patients. One hundred and seven family members with a child in FEP treatment were evaluated in terms of their stress management and coping, and unsurprisingly, results supported that greater strengths, resiliency, and coping strategies, likely lead to better outcomes for the FEP patients and treatment. In line with the research, social support and the resources to attain this network, were also a significant factor in facilitating family dynamics and adaptability to FEP (Mo'tamedi et al., 2014).

Furthermore, it is crucial to obtain the patient perspective in terms of familial dynamics and psychosis. It appears that the communicative and relational aspects of the family and support system dynamic play critical roles in how an FEP patient will experience their illness, as well as impact recovery and treatment (Boden-Stuart et al., 2021; Shadid et al., 2021). A unique approach taken by Boden-Stuart et al. (2021) explored the early psychosis experiences of 10 young adults currently in treatment. The participants in this study mapped out their familial contexts and researchers found that communication about their psychosis and relational reciprocity were confounding factors within the family dynamic. Likewise, Shadid et al. (2021) shed light on the significant effects of feedback, opinions, and advice given from family/friends and religious/spiritual leaders on mental health and treatment of those with psychiatric disorders; advice and opinions from the familial system ranged from positive/supportive to the complete opposite. Although this has some overlap with the other sections of the current literature review, it appeared essential to the discussion of the convergence of mental health and family dynamics.

Overall, it appears that family dynamics play a heavy role in the context of mental health. Research supports that familial attitudes, advice, support, and relationships have a significant impact on the experiences of mental health and FEP (Boden-Stuart et al., 2021; Butler et al., 2018; Koutra et al., 2014; Mo'tamedi et al., 2014; Shadid et al., 2021). To further the background, an evaluation of family dynamics and religion in terms of pathways to treatment, will be valuable to the present study.

Pathways and Barriers to Treatment

Altogether, the literature noted above cites important features in terms of the intersection between FEP, religion, and intrafamilial dynamics. An important consideration in early psychosis is accessing treatment early, so barriers to accessing is of concern. Notably, some of the most common barriers to treatment for FEP noted throughout the literature include a general lack of knowledge/recognition/awareness of the illness and symptoms (Chen et al., 2016; Dixon et al., 2017; dos Santos Martin et al., 2018; Hernandez et al., 2018), as well as concerns over stigma (Chen et al., 2016; Dixon et al., 2017; dos Santos Martin et al., 2018). As treatment for FEP and reducing DUP are essential elements in the field of mental health, this review evaluates literature primarily in terms of religious and family (mostly family-perspective) components in the pathways to treatment.

First, a unique study that regarded factors of both religion and family, in the realm of treatment-seeking impacts (Shadid et al., 2021) – the researchers wanted to determine the impact that both familial and religious support systems had on a religious individual suffering from a psychiatric illness. The study surveyed adult patients to gain a deeper understanding of advice given from both spiritual leaders and family/friends, about their mental health treatment. When the advice was compared to the treatment advice from a mental health provider, if it was

conflicting advice, results showed that this division had a significant correlation with a delay in treatment-seeking among psychiatric patients (Shadid et al., 2021). This research helps shed light on the significant and impactful effects that support systems like religion and family/friends can have on an individual's treatment seeking behaviors, especially when it conflicts with recommendations of mental health providers. Again, following the religious intersection of treatment-seeking, some treatment pathways are located in the work of Breland-Noble et al. (2015), who studied religious coping in African American and Black youth (ages 11 to 17) with depression; multiple themes emerged from this research. Some of the participants articulated religion as supportive of mental health treatment and decreased negative thought processes. Others from the study experienced ambivalence towards treatment due to mixed feelings of support vs. judgment from their religious communities. Notably, youth also reported that contradictory messages were sometimes given from the religious community, frowning on the use of professional mental health treatment (Breland-Noble et al., 2015); this is relatively consistent with the impact of conflicting advice as a barrier and delay in treatment (Shadid et al., 2021). Overall, this study is important in highlighting the importance of religion in the Black community, and differing pathways/barriers that may influence treatment-seeking (Breland-Noble et al., 2015).

Next, multiple studies examined pathways and barriers to treatment, while using the family or caretaker perspective of these elements. In general, family involvement helps shape pathways to care for individuals with early psychosis. In a sample of family members of clients receiving early intervention for FEP, delays and barriers to treatment were shaped by family ability to recognize and respond to symptoms (Dixon et al., 2017). In another study, researchers aimed to identify the barriers present when helping early psychosis youth seek out treatment (dos

Santos Martin et al., 2018). In a qualitative study of 12 relatives of young people with FEP, researchers found the following barriers to be most prevalent: recognizing mental illness, stigma, and where to seek treatment. It is important to note that in this study, and in line with existing research, family dynamics and bonds played an important role, and the relatives in this sample wanted to initiate and assist in the treatment-seeking process – which is not the case for every family. Results concluded the importance of family in the treatment-seeking pathway, and the barriers mentioned are of concern when expectation falls on the family member to help the youth obtain services for treatment. Moreover, a study focused on the minority population of Latinos, to give a cultural perspective in the area, aimed to investigate family processes and their role in treatment pathways for individuals with FEP, in relation to DUP (Hernandez et al., 2018). They grouped differences in family processes based on short and long DUP. In the qualitative analysis of both patients and caregivers, results uncovered the following themes: familial relationships – engagement and communication; awareness – symptoms, behavioral change threshold, treatment resistance, and accommodation; and treatment seeking – family or support network direct action (or lack thereof). These findings further underscore ways in which pathways to treatment may differ depending on context and barriers (Hernandez et al., 2018). Lastly, another goal present in the literature was to examine the pathway to treatment, in order to reduce DUP (Chen et al., 2016). The researchers wanted to identify critical periods in the treatment-seeking process for youth with FEP. Similar to dos Santos Martin et al. (2018), Chen et al. (2016) wanted to gain the parent-perspective and how they experienced their youth's FEP. Out of a sample of 16 parents, half of them reported that their adolescent had a childhood condition, and from those parents, most (87.5%) were unable to recognize the psychotic symptoms in their adolescent. Notably, the researchers of this study (Chen et al., 2016) were able to identify six critical points throughout

the treatment-seeking trajectory for FEP youth. With the identification of these critical periods in the process and findings from the study, it enabled Chen et al. (2016) to produce recommendations to reduce barriers and secure treatment for FEP youth: psychoeducation for parents, enhance community resources/facilitation, and family-focused interventions. These suggestions are in line with similarly noted propositions throughout the literature.

In conclusion, there are clear connections between pathways to care, family dynamics, and religion among youth. Although there has been some research around religion and mental health generally, it does not appear that the intersection has been looked at thoroughly, specifically among FEP youth within a predominantly religious community, where religious themes may occur spontaneously. Further, a secondary inclusion of family dynamics adds another layer that does not seem to be examined among this specific sample composition.

Present Study

The present study was a secondary analysis of data from a study administered among young adults receiving treatment for early psychosis. The purpose was to uncover themes related to religion, and impacts on treatment, among youth in a conservative religious community receiving intervention for early psychosis. The study utilized data collected from a study conducted to inform the adaptation of an intervention for self-stigma (Narrative Enhancement and Cognitive Therapy-Young Adult [NECT-YA]). The aim of the NECT-YA study was to adapt and tailor NECT so that it will be suitable and engaging for youth. The phase one qualitative interviews with early psychosis youth were examined for the goals of the present study. Ultimately, this exploratory research expected themes to emerge regarding familial and religious influences, and barriers or opportunities in treatment pathways, within narratives of the youth.

Methods

Participants

A sample of 14 youth, ages 15-24, who have experienced early psychosis/FEP were interviewed for the NECT-YA qualitative study. Participants were recruited from an FEP treatment program in a large Midwestern city. The participants have had an onset of psychotic symptoms within the last 5 years. Participants were compensated $35.00 for completing the interview, via cash or a secure online platform. The present study included a secondary analysis of only those whose qualitative interviews include any discussion of religion in relation to family relationship, help-seeking or stigma. Participants who did not meet this criterion were excluded from further analyses. Table 1 shows the characteristics of the overall sample and the participants who discussed religion in their interviews. As can be seen in Table 1, half of the overall sample (N = 7) mentioned religion, therefore seven youth were included in this study sample. The average age of the included sample was around 20 years (M = 20.71), with just under 2 years of treatment received for early psychosis (M = 23.86 months). Participants had typically completed high school. The majority of the current sample identified as male (n = 5), with only two female participants. Importantly, almost half of the current sample included Black participants (n = 3), followed by White, Latinx, and Asian-American participants (n = 2; n = 1; n = 1, respectively).

Table 1

Participant Demographics

	Youth (N = 14)	Youth Mentioning Religion (N = 7)
	Mean (SD) or n (%)	Mean (SD) or n (%)
Age	20.64 (1.95)	20.71 (1.7)
Years of Education	12.31 (.86)	12.57 (.79)
Months in Early Psychosis	23.23 (13.48)	23.86 (12.67)
Treatment		
Gender		
Cisgender Female	2 (14.3)	2 (28.6)
Cisgender Male	10 (71.4)	4 (57.1)
Transgender Female	0	0
Transgender Male	1 (7.1)	1 (14.3)
Non-Binary	1 (7.1)	0
Race/Ethnicity		
White	3 (21.4)	2 (28.6)
Black	7 (50)	3 (42.9)
Latino/a/x	2 (14.3)	1 (14.3)
Asian-American	2 (14.3)	1 (14.3)

Materials

As part of the Narrative Enhancement and Cognitive Therapy-Young Adult (NECT-YA) adaptation study, participants completed a baseline qualitative interview (Kranke et al., 2011) about their life experiences and mental health treatment.

NECT-YA Adaptation Study: Qualitative Interview Guide

Participants were interviewed with a qualitative interview adapted from Kranke et al. (2011). In addition to standard demographic questions (education, length of time in treatment, gender, and race/ethnicity) the interview was comprised of 47 open-ended questions that the interviewer probed the youth participants to answer. Participants responded to the questions under the following categories: “Mental Health Treatment Referral Experience”; “Treatment Experience”; “Help-Seeking Narrative/Pathway to Care”; “Parent/Guardian and Youth Interaction”; “Stigma”; and “Targeted Treatment”. The open-ended design of the qualitative interview allowed for participants to have more freedom in their responses and narratives. Specifically for the present study, the mention of religion by the participant had the potential to occur at any point throughout the interview, due to the nature of open-ended responding.

Mental Health Treatment Referral Experience. This section of the interview comprises five questions, aiming to address the reason the youth are receiving mental health services. It addresses concerns that the individual has about receiving treatment, as well as inquire about anyone else who may have been concerned about the youth. Lastly, this section asks about previous encounters with receiving mental health help.

Treatment Experience. This next section of the interview consists of five questions. These items inquire about first appointments and first treatments that the youth received. It also

seeks to find out how first treatment experiences were, what they were, and who made the suggestion for treatment in the youths' lives.

Help-Seeking Narrative/Pathway to Care. Containing 10 questions, this section seeks to ask about various pathways to care, such as who may have suggested mental health treatment, when treatment was first sought out, etc. Questions also address conversations with parents and family members about mental health treatment. This section lastly inquires about the terms used regarding their mental health treatment.

Parent/Guardian and Youth Interaction. There are nine questions residing in this section of the youth interview. It begins by asking about the relationship between the youth and their parents, throughout all stages of their mental health concerns and treatment (before, during, and after). Additionally, it asks about the youths' concerns and disagreements with their parents, and if their mental health treatment is one of those topics. The interview then asks about improving the relationship between the youth and their parents, and what that would look like to them.

Stigma. There are 12 questions in this section of the interview. It starts with asking about who the youth talk to about their mental health concerns, what they tell people about it, and how they feel when they share these various concerns. It then follows by asking about concerns of what others think, and how that impacts their own view of themselves and their help-seeking processes. The overall aim is to gather a sense of stigma that these youth may face when it comes to mental health and treatment-seeking.

Targeted Treatment. The last section of this interview is aimed at tailoring the intervention (NECT) toward the youth. This section is comprised of six questions, regarding the

youths' thoughts and opinions about the intervention. It addresses components, aspects, and features of the intervention – prompting the youths' input.

Interviews were conducted by trained research assistants and transcribed by a professional transcription service. All transcripts were deidentified prior to the present analyses.

Procedure

IRB approval was given for the Narrative Enhancement and Cognitive Therapy-Young Adult (NECT-YA) adaptation study. Participant recruitment for the NECT-YA study was COVID-19 dependent and included the following methods: waiting room announcements, community meetings, emails, and/or referrals from clinicians who distributed flyers to their clients. Participants were selected from a FEP treatment program in a large Midwestern city. Participants underwent initial screening for eligibility, and those willing to participate moved on to baseline assessment (and received appropriate compensation). Participants provided informed consent to participate in the NECT-YA research. A member of the research team conducted the baseline in-depth qualitative interview for the NECT-YA study. The qualitative interviews were approximately 1 hour long, conducted either in-person or via secure distance technology, dependent on participant preference and current COVID-19 restrictions. Information collected from the participants during the interview were then transcribed by a professional transcription service and deidentified before being made available for analysis.

Data Analysis Plan

The analysis of this study was conducted using a hierarchical open coding approach (Strauss & Corbin, 1990). The goal of this method is to organize the data and further identify meanings and patterns within the data (Braun & Clarke, 2012). The present study utilized inductive styles to thematic development. Since the purpose of this study was to uncover

common themes around religious and familial impacts, within the narratives of youths who are receiving treatment for early psychosis – themes were not created prior to analysis of the data.

Once the transcripts from participants were transcribed, this researcher explored each transcript in its entirety. First, this researcher organized and excluded participant transcripts that do not have mention of religion in the narratives. Once there was a refined set of transcripts, they were reviewed again, allowing for a hierarchical open coding strategy to be utilized (Kvale, 1996). The qualitative transcripts were coded and analyzed using the following core principles: contextualization and categorization. Transcript summaries were created that were used for contextualizing, while categorization of themes followed. Next, coding of the qualitative data occurred, followed by comparisons within and between categories. The strength of the categories and codes were evaluated, in which subcodes were needed and created to account for varying strengths in the narratives as well as for more discrete descriptive codes (Ryan & Bernard, 2003).

The multiple reviews of the transcripts allowed for a thorough analysis of the data. The codes derived were meant to represent the existing patterns and categories that were present within the data. For purposes of this research, codes were created around religious themes. The results of this data analysis were a comprehensive list of codes under major categories that represent themes related to religion and religious influence on mental health and treatment, that were present in the narratives.

Results

A total of seven participant transcripts, which included some mention of religion, were analyzed. Three major themes emerged from the data, and subthemes were created to fully encapsulate the religious aspects from the narratives (see Table 2). The following were the main

Table 2

Religious Themes

Major Theme	Subtheme	*N*
Religion as a support		6
	Prayer/scripture/faithfulness as a form of treatment/support	5
	Neutral or positive reaction from religious leader	4
Conflict between mental health and religion		3
	Expected/assumption of stigma	1
	Negative views on mental health treatment	3
Unhealthy religion		2
	Psychosis symptoms with religious ties	1
	Religion as a cause for psychosis	1

categories developed from this research: religion as a support, conflict between mental health and religion, and unhealthy religion. Participants were not mutually exclusive to the themes; some participants were included in multiple categories.

Religion as a Support

The majority of participants verbalized religion as being a support system – either for themselves, or from their family (*n* = 6). Some of the participants noted that prayer, scripture, and faithfulness were recommended by family members or religious members as a form of treatment and support, in response to the participants' mental health condition of early psychosis (*n* = 5). There were mixed responses regarding whether the participant felt that religion was helping them. Some indicated that religious treatment recommendations were suggested instead of mental health treatment with clinicians. Although these familial suggestions did not appear to directly influence treatment-seeking behaviors of the participants, it is vital to note, as it did emerge when asked about who they speak to about psychosis, reactions, and how families attempt to help with symptoms. One participant clearly stated that religion and God were helping them in terms of suicidality and mental health treatment. Many of the other participants spoke about how their religious family members were either recommending or attempting to utilize religion (praying, reading scripture, etc.) as a form of healing and support, even if it was not directly helping the participant. Many family reactions seemed to be guided by religious roots. For example, the following was reported by a Black female participant:

> So my mom, she's like a Christian. So she believed like we believe in God and what she did was you know, she believed in like anointing yourself with the holy oil. She believed in like – what she did was she typed, she went online and she put scriptures for healing because she believed that God was going to heal me and so she typed up scriptures for healing… Less helpful. I found that less helpful…

Another participant (a Latino male) specified that these types of responses from family members was interpreted as supportive, mainly because it was demonstrating a form of a support system

and family members caring – so even though it may not have been a source of treatment for this individual, the mere interpretation of familial support via religious responses were seen as helpful:

> … I'd be sitting in his room with him, kneeling with him against the bed and for about 30 minutes to an hour, just pray. So, I mean both the responses was amazing honestly, it helped a ton if everybody had a response, a system, support system…

Other participants in this category mentioned receiving or interpreting, neutral or positive reactions and responses from a religious leader about their mental health and psychosis (n = 4). A couple of the participants had family members who were simultaneously labeled as religious leaders. One participant, whose father pastors at a couple of churches, mentioned that they received supportive responses from their father, regarding their psychosis. Similarly, another participant's family member is a preacher and also viewed the responses as "hopeful." Two other participants mentioned that they talk about their diagnosis with their priest/pastor, and the responses appear more neutral toward the participant when speaking of psychosis and therapy (as opposed to negative), as the following participant mentioned (a Latino male):

> I talked about it with my sister, my priest… I will tell them about the illusions I had or the things I saw basically, which is the same thing… they were just like, unbelievable, like that's crazy.

Conflict Between Religion and Mental Health

Next, there appeared to be an overarching theme of conflict between mental health and religion (n = 3). This was apparent in how the participants discussed their religious family members' views and opinions regarding the psychosis and mental health treatment – this was evident from almost half of the participant transcripts analyzed, verifying the importance of

family dynamics in the participants' lives. One participant described a sense of stigma from religious communities and/or family (*n* = 1); although here, it is important to note that stigma may have not been experienced, only feared or assumed. For example, they explained that they did not want to tell their religious community/church about their diagnosis, fearing that the church community would not be supportive – the participant (a White female) anticipated judgment from their religious community about their mental health, specifically, early psychosis:

> … and the churches don't know. Because while they've always been really supportive of me, I'm very worried that they wouldn't be supportive of this aspect of me.

The same participant anticipated stigma, but did not experience it when they talked about their diagnosis and mental health treatment:

> I was expecting my dad to blow up on me. He's a really conservative pastor. I thought he was going to like, try and do like, the whole exorcism-like, thing. He didn't. He was actually like, "is there anything I can do to help you?" but that's what I was really expecting.

Additionally, some of the participants spoke about how those around them who are religious may have negative views toward mental health treatment, specifically medication and therapy (*n* = 3). For example, one of the participants talked about their father who is a pastor, as noted in the previous quote, and how his ideal world would not include the use of medication for treatment and healing. Another participant spoke about their "old school Catholic" upbringing, and that medication as a form of mental health treatment is controversial among religious communities. Even though these comments were significant enough for the participant to bring up within the interview, it did not appear to significantly influence treatment behaviors on behalf of the participant – since these participants are involved in formal psychosis treatment. The

following participant (a White transgender male) referenced their family members as being religious extremists, when discussing their views:

> And my dad believed that, you know, you don't need therapy. You just need to go to church. So he though that my mom putting me into therapy and getting me on antidepressants was my mom basically screwing over my soul.

Another example by a Latino male participant:

> So, the idea of getting medicine for help or the idea of mental disability aside from like autism and like all these other disorders was a very, what the real, like what's the word? It's a very confrontational idea, it's very old school catholic school, mind you, so like, when it came to the issues, they were like, oh, you can pray it away.

Although there are some similarities linking this major theme with the previous "religion as a support," it was important to include this in its own category, as to display the flip side of religious support, and what may be experienced by those diagnosed with early psychosis, within a predominantly religious community and family – the struggle that they may be experiencing with mental health treatment and the conflicting influence from their religious family members.

Unhealthy Religion

Finally, the last and least occupied major theme from this research, is unhealthy religion/unhealthy religious views, meant to capture a couple of the participants who connected their psychosis experiences with religion (n = 2). Specifically, one of the participants described church and spirituality as the cause of their psychosis; they felt they were "too into it" and that the roots of their psychosis were tied to the church (a Black male participant):

> Because I was really spiritual, I thought, I believed in a lot of spiritual stuff, so I just was too into it… When I was diagnosed with schizophrenia and that's when I got the real medication I needed and then that's when I got way better and I stopped going to church.

This participant also noted that their parents did not want them going back to church either, after experiencing early psychosis. This demonstrates an instance where "treatment" behaviors by the individual aligned with their family. Another participant, a Black male, seemingly from the transcript, linked their paranoia and psychosis to spirituality as well, in that they felt God was mad at them:

> God is mad at me. God doesn't love me… I didn't want God to be mad at me.

This particular participant also noted a connection to Christmas music, appearing to reference psychosis symptoms occurring when listening to this music. It is important to note however, that this participant also used their spirituality to cope, unlike the participant noted above.

Discussion

The current study examined transcripts of youth who had experienced early psychosis to explore the relevance of religion as it relates to mental health. The purpose was to uncover themes among young adults receiving treatment for early psychosis in a conservative religious community in the Midwest, with a sample constituting primarily Black individuals (recognizing that the sample did not consist of all Black individuals). Given the qualitative and exploratory nature of the study, themes were not created prior to analysis; however, the composition of the community and prior research in this area, allowed for this researcher to expect the emergence of themes around familial influences/input, and religiosity in terms of mental health views, coping, and treatment pathways.

The themes that were developed revealed a mix of positive, negative, and neutral religious impacts either from their families or religious/church communities – this was evident in much of the reviewed literature as well (Breland-Noble et al., 2015; Koenig & Larson, 2001; Weber & Pargament, 2014). The majority of the participants from the current study could be categorized under receiving religious suggestions/using religion as a support system or treatment for their mental health experiences, i.e., early psychosis. Unfortunately, the current results shed further light on the division that exists between mental health and religion (Shadid et al., 2021). Although families and religious communities attempted to utilize religion as a positive coping mechanism, and for some it was, but others appeared to experience a split between utilizing religion as a support *instead* of professional mental health treatment. Although there did appear to be a divide, some participants still considered the religious recommendations and support to be meaningful in their lives and their psychosis journey, which remains consistent with the importance of supportive contributions to FEP recovery (Koutra et al., 2014). In contrast to the literature that reported on the quality of social networks and social support in terms of religion (Koenig & Larson, 2001; Weber & Pargament, 2014), results from this study do not necessarily reveal an enhancement of the quality of these relationships, and do not conclude that they assisted in buffering and coping against distress and the participants' mental health struggles (Breland-Noble et al., 2015; Koenig & Larson, 2001; Mo'tamedi et al., 2014; Weber & Pargament, 2014) – most remained relatively neutral, with a lack of evidence supporting any significant shift in social support. Consistent with prior research on family dynamic (Koutra et al., 2014), family burden in relation to FEP patients (i.e., participants of this study) did not appear to be a significant factor within the transcripts of participants. When there was mention of family members, dynamic, etc., results did not reveal any trend or themes around familial

burden. Importantly, results from research conducted by Shadid et al. (2021) are crucial to keep in consideration when analyzing religion as a support – recommendations of treatment and reactions from religious leaders on mental health. Different from what they found, the current study did not present with any notable themes around delaying treatment or DUP when advice from family, friends, or spiritual leaders contrasted with that of a mental health professional. Similar to Shadid and colleagues (2021), the participants own beliefs and religious coping did not appear to play a role in treatment seeking either.

Next, approximately half of the sample collected reported statements that reflected a primary theme of a conflict between religion and mental health, citing religion as an inhibitor to receiving mental health treatment. As noted above, the mix of negative religious impacts are present in prior research as well as the present (Breland-Noble et al., 2015; Koenig & Larson, 2001; Weber & Pargament, 2014). Although religion can be of importance with one's support network (Koenig & Larson, 2001), and the church community may even be used as a source of support, it should be noted that this may not be the case with every community – as displayed from this study. Some individuals experience a sense of fear of not receiving support from their religious community and many choose to not disclose their psychosis or mental health experiences with that support system. This ambivalence experienced by participants in terms of disclosure and utilizing religious communities was also present in the research by Breland-Noble et al. (2015). In line with a previous study (Boden-Stuart et al., 2021), the present study located mentions of family dynamic difficulty, in that participants experienced a sense of fear or negative expectation in communicating their psychosis diagnosis to family members. This was especially true in the lens of religion in the current study. Apart from the religious aspect, the majority of the current sample appeared to experience assistance and initiative from relatives in

terms of seeking help for their mental health concerns. This role of the family as protagonists was also evidenced in a study by dos Santos Martin et al. (2018). This was not something that was directly analyzed from the data, but was a trend noticed by this researcher while analyzing the transcripts. Also, a general sense of anticipated, but not necessarily experienced, stigma was noted from a participant in this study. Concerns over stigma were present in prior research (Chen et al., 2016; Dixon et al., 2017; dos Santos Martin et al., 2018), however the current study analyzed the stigma component through a religious lens, rather than general stigma of psychosis. Further, falling under the categorization of negativity toward mental health, negative views towards medication and therapy were a predominant theme among participant transcripts. This was also evident in the literature reviewed, in terms of treatment seeking and pathways. It does not appear that this was a significant variable impacting treatment in the present study, but it was a notable factor. Similar to this study, Breland-Noble et al. (2015) studied religious coping among African American and Black individuals; they found that the religious community frowned upon professional mental health treatment, just as participants from the current study reported. About half of the participants from the current study verbalized that their religious family members did not prefer the method of professional treatment such as medication and therapy, as the ideal treatment pathway. There were reports of it being controversial, and that their religious methods, such as praying, reading scripture, and faith in God as being the ideal form of healing for the early psychosis patients.

Finally, with a slightly smaller portion of the sample, this research recognized a theme of what is categorized as unhealthy religion. This category was created to acknowledge those participants who connected their psychosis and symptoms to religion. One participant seemingly attributed their psychosis onset to excessive spirituality, and ultimately ceased attending church.

Another participant named religious undertones to spirituality and religion – it was unclear what exactly was meant by this participant's interview, however it is possible to hypothesize that the psychosis symptoms had a religious underpinning to them. Additionally, the participant felt as though there was anger from God in response to the early psychosis. Throughout the literature, these themes tend to be denoted as negative religious coping (Mohr et al., 2010; Weber & Pargament, 2014) or negative associations with mental health (Koenig & Larson, 2001). As this is a recognized pattern in previous literature on the association between religion and mental health, it was necessary to include as a couple of the participants in this study faced this negative or adverse type of experience, in connection to their religion and ongoing mental health concerns. Although this sample was too limited to recognize a larger pattern of unhealthy religion among this particular community and mental health experience, it was necessary to address that indeed it does exist, in line with prior research.

Lastly, additional clinical implications may include the integration of spirituality and religiosity into mental health treatments and intervention. There may be many missed treatment opportunities when keeping religion and mental health segregated, as evidenced in a chapter by Boyd-Franklin (2006) – especially among populations where spirituality may be a core aspect. Failure to recognize these considerations puts the mental health field at risk of not accounting for the "whole person" in treatment (Mezzich, 2007, as cited in Mohr et al., 2010). It may also be beneficial to include church members in therapy to help encourage treatment compliance or facilitate therapeutic conversations (Boyd-Franklin, 2006). It is difficult to conclude, based off of this study, if the participants would have mentioned anything more positive or different, but it is reasonable to conclude that many of the participants did not feel an overlap between their mental health treatment, family, and religiosity.

Limitations and Future Research

As with all research, limitations do exist within the present study. Foremost, the limited sample size prevents from definitive and generalizable conclusions to be drawn. The sample size itself allows for a basic understanding and surface-level view of young adults in a predominantly Black and religious community experiencing early psychosis; however, it does not allow for a deeper grasp on religious influence and roots and cannot be used to generalize across this particular population but can be used as a basis for future research that takes interest in this topic and population.

Although this is not a complete limitation to the current study, the methodology of secondary thematic analysis presents some constraints to the conclusions able to be drawn from the study. The secondary analysis allowed for a unique observations of patterns that emerged from interviews not originally intended to address these themes; but with that said, it also meant that this researcher could not probe for further information on the religious mentions that arose. This researcher was unable to uncover any deeper meaning or understanding of what was said by the participants in their interviews, which prevents from drawing any specific conclusions, but did allow for themes to be created to attempt to capture the primary concerns of participants in terms of religion and their psychosis experiences.

It should also be noted that there were no specific questions about the association between religion and mental health in the present study, so the information that was obtained was only from participants for whom the topic was important enough for it to be spontaneously raised in relation to the topics of family relationships, help-seeking and stigma. It is not possible to know how findings might have been different if all participants had been asked questions about the role of religion in relation to help-seeking and stigma.

Additionally, another limitation that exists within the methodology chosen for this study is the lack of any quantitative data to accompany the existing qualitative data. Although quantitative data is not necessary when a qualitative study is conducted, it may sometimes assist in drawing more definitive conclusions, as well as provide statistics to help solidify the research conducted. This goes along with the previous limitation, in that nothing was able to be added to this study – further questions, surveys, etc.

Given the limitations that are present within the current study, it provides a starting point for future, more rigorous research to be conducted. Further research may choose to study this population and community, but with a larger sample size, and with a mixed-methods study, to gain a deeper understanding of the impact of religion on mental health in a community that is largely religious. Utilizing a larger Black community may assist in better understanding the role and importance of religion among these individuals, and their views on mental health treatment and help-seeking. Also, future studies may choose to analyze more of the familial aspect in this realm, examining how religion plays a part in the intrafamilial dynamic and mental health or treatment-seeking pathways, which this study only minimally examined on a secondary level. Another study may choose to look at stigma that exists among religious communities towards mental health and why. Other possible studies may include utilizing an evaluative research method, after implementation of an integrative program, which includes the use of religious histories and spiritual components within mental health treatment, as previously suggested by much of the research (Breland-Noble et al., 2015; Koenig & Larson, 2001; Shadid et al., 2021; Weber & Pargament, 2014).

Conclusion

Overall, this research examined the intersection of religion and mental health among a predominantly Black and religious community – specifically, within young adults/youth receiving treatment for early psychosis. The study was a unique contribution in its analytic approach, as well as that it added another cultural perspective to the extant research, just as Hernandez et al. (2018) chose to do with a Latino population. The study allowed for discovery of themes and patterns that emerged spontaneously from participant interviews, who were not originally asked to reveal religious connections. This research located themes and subthemes around religious support and treatment, conflict between religion and mental health, and unhealthy religion among participants, their families, and religious community. This has permitted for the confirmation that religion impacts mental health, treatment, and family dynamic, and it is likely a larger contributing factor among this conservative population specifically. Additionally, this study concludes, along with prior research, that religion could be incorporated into the mental health realm, and this may strengthen the effectiveness of treatment, allow for positive religious coping, and even strengthen the family dynamic and support among a majority religious culture.

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