Scientific Research Publishing

Open Journal of Nursing, 2026, 16(4), 263-278
https://www.scirp.org/journal/ojn
ISSN Online: 2162-5344
ISSN Print: 2162-5336

The Role of Religious Affiliation in Seeking Mental-Health Help

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How to cite this paper: Yamawaki, N., Bley, S.U., Orton, A., Andal, S., Nowlon, E., Richeson, K. and Bautista, A. (2026) The Role of Religious Affiliation in Seeking Mental-Health Help. *Open Journal of Nursing*, **16**, 263-278.
https://doi.org/10.4236/ojn.2026.164018

Received: March 17, 2026
Accepted: April 17, 2026
Published: April 20, 2026

Abstract

This study examines how religious affiliation, atheism versus Christianity, impacted mental-health help-seeking intentions amid persistent service underutilization. A sample of 136 adults, self-identifying as atheist or Christian, completed an online survey assessing differing patterns of how attitudes, public, and self-stigma impact intention to seek help between Christians and atheists. Multivariate analysis of variance revealed that religious affiliation significantly influenced intentions to seek mental health services, with atheists reporting greater intention to seek help in comparison to Christians. Both attitude and self-stigma were significant predictors of intention to seek help. Interestingly, the relationship between self-stigma and intention to seek help was significantly negatively associated among atheists, and significantly positive among Christians. These findings highlight the role of religious affiliation in shaping help-seeking intention and underscore the importance of culturally sensitive approaches to intervention. The results contribute to the broader discourse on belief systems, stigma, and access to care in diverse populations.

Keywords

Mental Health, Intention to Seek Help, Atheist, Christian, Stigma

1. Introduction

In the United States, one in five adults is affected by some form of mental illness, yet only 43% of individuals who experience mental illness seek help [1]. Left untreated, mental health problems can lead to serious chronic physical conditions and impair social functioning, significantly worsening an individual's well-being [2] [3]. According to the World Health Organization (WHO), untreated mental health challenges can also progressively disrupt key areas of daily life such as em-

ployment, interpersonal relationships, and personal well-being, ultimately diminishing an individual's overall quality of life [3]. Delaying mental health care may contribute to lower self-esteem and heightened depressive symptoms, often creating a harmful cycle of self-blame, social withdrawal, and feelings of hopelessness [4]. This hesitancy or unwillingness to seek treatment is often shaped by deeply ingrained cultural norms and stigmas that discourage individuals from acknowledging or addressing their pressing mental health issues [5].

One such culture is religion. In the United States, around 65% of the population identifies as Christian [6]. Although the prevalence of mental illness is not affected by religious affiliation, current research suggests that atheists are twice as likely to seek counselling and professional mental health support compared to practicing Christians [7] [8]. However, individuals who integrate secular and spiritual approaches to treatment report their care as beneficial and, in many cases, profoundly rewarding [9] [10]. This disparity in help-seeking behaviors indicates that religious identity has a significant role in one's decision to seek mental health care.

1.1. Theoretical Background

While external factors such as religious background can help shape decisions about seeking mental health support, some internal variables, such as stigma, attitude toward seeking help, and the intention to seek help from mental health professionals, consistently predict rates of help-seeking behaviors [11] [12]. The Theory of Planned Behavior (TPB) guided this research to help understand how these attitudes, beliefs, and norms impact intention and lead to help-seeking behaviors. According to the TPB, the most reliable predictor of human behavior is a person's intention, which is shaped by attitude toward the behavior, subjective norms, and perceived behavioral control [13]. In this study, components of the TPB were operationalized such that public stigma represented subjective norms, reflecting perceived societal pressure regarding help-seeking behaviors. This conceptualization is appropriate because public stigma captures individuals' beliefs about how others view and evaluate seeking mental health support, which directly aligns with the TPB's emphasis on social expectations shaping intention. In contrast, self-stigma was conceptualized as perceived behavioral control, as it reflects the internalization of negative stereotypes that can diminish self-efficacy and one's perceived ability to seek help. By undermining confidence and fostering feelings of shame or inadequacy, self-stigma constrains an individual's sense of agency, thereby influencing their perceived control over engaging in help-seeking behavior.

1.1.1. Public Stigma

Subjective norms, an individual's perception of how people vital to them expect the individual to behave, can be used to describe our predictor of "public stigma" [13]. Public stigma is individuals' feelings or perceptions of social pressures to stigmatize people who seek help due to having mental or physical illnesses [5]. In the present study, the public stigma towards seeking help for mental illnesses can

negatively impact the intentions of an individual to seek professional help. Some examples of public stigma toward individuals with mental health disorders might entail consciously labelling individuals with anxiety symptoms as "dramatic," individuals with depressive symptoms as "weak," and individuals with schizophrenia as "dangerous" [14] [15]. While public stigma has decreased in recent years, it continues to foster negative actions toward individuals with mental health disorders [5].

Seeking help could inadvertently expose individuals with mental health problems to the public, leaving them susceptible to discrimination or social isolation. For example, individuals involved in religious communities who demonstrated high extrinsic religiosity, described as religious participation for external benefits rather than spiritual growth, were strongly associated with increased stigmatized attitudes toward individuals with mental illness [16]. Thus, it may result in an increased tendency for individuals diagnosed with mental health disorders to avoid seeking professional help [17]. This suggests that individuals with mental health issues may worry about how other individuals in their tight and cohesive religious community think of them.

1.1.2. Self-Stigma

In addition to social norms, the TPB also suggests that perceived behavioral control strongly influences an individual's intentions [13]. Perceived behavioral control refers to an individual's perception of their ability to perform a specific behavior and the extent of succeeding [13] [18]. Control and self-stigma are interconnected, affecting an individual's ability and willingness to seek help. Self-stigma can instill a sense of helplessness in an individual with mental illness due to the stereotypes they are exposed to. Notably, self-stigma is one of the most significant predictors of both self-esteem and self-efficacy of individuals with mental illness [19]. As individuals experience self-stigma due to internalizing societal stereotypes, they may feel less capable of overcoming challenges, in this case, seeking professional help by diminishing their own perceived behavioral control, making them believe they do not have the skills, resources, and confidence to carry out desired behaviors. Moreover, decreased perceived behavioral control can create a negative feedback loop, strengthening self-stigma and perpetuating a downward spiral [20]. More findings suggest that self-stigma acts as a mediating factor in the relationship between depressive symptomology and help-seeking intentions [4]. This supports the idea that self-stigma, which is interrelated with perceived behavioral control, plays a more active role in intervening in the help-seeking intentions of individuals struggling with mental illness.

In addition to the findings mentioned above, a recent study found that the adoption of societal stereotypes and the belief that an individual is viewed negatively due to their mental health problems has a more significant impact on the decision to seek help than the severity and presence of symptomology [17]. The fear of being exposed to stigma, whether public or self-stigma, has a greater impact on discouraging individuals from seeking help [17]. This reinforces the notion

that subjective norms and perceived behavioral control significantly influence the help-seeking intentions of individuals.

1.1.3. Attitude

Attitude is another component used to predict one's behavior in the TPB, referring to an individual's overall positive or negative evaluation of pursuing professional mental health services [21]. When attitudes toward mental health are shaped by misconceptions or a lack of knowledge, perceived stigma can often discourage individuals from considering professional treatment a viable option [11] [21]. A recent study found that emphasizing the knowledge of locating mental health information and the attitudes promoted help-seeking behavior [11]. Additional results showed that stigmatizing attitudes were linked to lower mental health knowledge, perpetuating negative views of help-seeking and increasing the likelihood of psychological distress [11]. This pattern suggests a cycle in which unfavorable attitudes toward mental health could drive individuals to avoid help-seeking or any related information, thereby intensifying distress. However, accurate beliefs about the prevalence of mental illness, coupled with basic mental health knowledge, can reduce stigmatizing views and foster more favorable attitudes, ultimately increasing a person's willingness to receive help.

Another factor contributing to poor help-seeking attitudes is distrust in mental health professions, a view particularly prevalent among ethnic and racial minorities [22] [23]. Although mistrust may not target specific providers, it can broadly extend to the healthcare system. Recent studies suggest that factors such as insufficient cultural competency and historical discrimination perpetuate a lack of trust, creating negative attitudes that lower rates of help-seeking [22]. Other research points to a variety of influences behind medical mistrust, including direct mistreatment, fear of exploitation, systemic complexity, and socioeconomic status [23]. Although attitude can improve or undermine professional help-seeking, it precedes intention, a deliberate cognitive commitment that shapes an individual's behavior. Overall, the link between one's attitudes influences their intention to seek help, ultimately impacting their help-seeking behavior.

1.1.4. Intention

Intention reflects a conscious and purposeful desire to engage in a behavior, encompassing one's readiness or plan to seek mental health services when necessary [13] [18]. It also marks the juncture between the three TPB components: public stigma, self-stigma, attitude, and actual behavior. However, it is essential to clarify that this study aimed to investigate one's intention rather than behavior due to previous studies demonstrating how intention predicted help-seeking behavior [24] [25].

Intention is widely recognized as an indispensable predictor of action, with various studies suggesting it explains around one third of the variance in health behavior [13] [18] [26]. Described as a proximal cognitive "end point," intention is the desired stage of cognition that serves as a catalyst for future behavior [18].

Through the deliberate isolation of intention, our goal was to observe how malleable cognitions such as self-stigma, public stigma, and attitudes combine within Christian and atheist communities to determine varying degrees of help-seeking intention. It also aimed to identify distinguishable intervention points for healthcare providers and mental health initiatives while avoiding the practical and ethical complications of monitoring private health decisions. Hence, this study was intended to focus on the readiness and intention of individuals within contrasting religious affiliations to engage in mental health help-seeking behavior, thereby aligning our design and methods.

1.2. Religious Affiliation and Help-Seeking Intention

The present study explored the roles of religious affiliation, mainly Christians and atheists, on their mental health help-seeking intentions. Here, Christians are defined broadly as people who believe in the life, ministry, and teachings of Jesus Christ. As previously mentioned, about 65% of Americans self-identify as Christian, creating a large population with varying levels of religiosity, or rather a group of people who may identify more closely with Christianity and heed its tenets more strictly than others [6]. However, recent trends of religious affiliation in the United States how that roughly 30% of Americans have moved away from Christianity and now identify as religious "nones," including atheists, agnostics, or those with no specific religious affiliation [27]. This growing shift is rapidly transforming the religious landscape in the United States and raises questions about the future of religion in America. Therefore, it is crucial to investigate the impact of religious affiliation on one's intention to seek help from mental health professionals.

Religiosity, or one's involvement and devotion to religion, can play an essential role in Christians' intentions to seek mental health help [10]. Research indicates that religiosity, particularly active participation in religious communities and positive religious experiences, often protects psychological and physical health [9]. For instance, aspects of religious life, such as structured rituals and supportive social networks, are linked to lower blood pressure, and reduced levels of depression [9].

However, these benefits can coincide with barriers to mental health care, especially in communities that emphasize alternative coping mechanisms such as prayer or counseling from religious leaders. A recent study suggested that Evangelicalism, one of the sects of Christianity, may endorse simplified theological beliefs that can contribute to negative attitudes towards psychotherapy [7]. By contrast, atheists reject the belief of any singular God or deity and deny them altogether, which may explain atheists' greater willingness to seek professional mental health care compared to Christians [28].

One such study found that clergy play a vital role in their congregant's help-seeking concerns. That is, their clergy's perceptions of help-seeking, how often they discuss it, and whether they refer their congregations to mental health ser-

vices significantly shape Christians' intention to seek care [29]. In communities that emphasize alternative coping mechanisms, such as prayer or counseling from religious leaders, the intention to seek professional help may not be encouraged. Therefore, by choosing not to believe in or seek help from a higher power while believing in the scientific modality of dealing with mental health problems, atheists may have greater intentions to seek professional help from licensed therapists, psychologists, and mental health services in comparison to Christians.

2. Purpose of Study

Despite increased awareness and efforts to destigmatize seeking help from mental health professionals, some factors, such as religious affiliation—especially atheism—have not been investigated in understanding individuals' likelihood to seek mental health services. This study examines the potential influence of religious affiliation, specifically comparing atheists and Christians, on their mental health help-seeking intentions using the TPB. Given that atheism is still an understudied topic in psychology [30], we believe this study is worthy of attention.

The purpose of this study was to compare help-seeking intention between Christians and atheists using the TPB. It was hypothesized that atheists would be more likely to seek professional help compared to Christians, as atheists are more likely to depend on scientific treatment modalities and less likely to encounter religious-based barriers to treatment. We also explored the predictive effects of self-and public stigma and attitudes toward seeking help on the intention to seek help between Christians and atheists.

3. Method

3.1. Participants

Participants were recruited from Prolific.co, an online survey platform. A total of 136 (87 Christian and 49 atheist) participated in this study. Participants were required to 1) be at least 18 years of age or older, 2) have a Prolific account, 3) have a United States nationality, 4) be located in the United States, 5) be fluent in English, and 6) be identified as Christian or atheist. Their ages ranged from 19 - 75 (M = 37.08, SD = 14.37), and participants identified their race as Asian (n = 6; 5%), Black or African American (n = 12; 9%), Native Hawaiian or Other Pacific Islander (n = 1; 1%), White (n = 105; 78%), and Other (place specify; n = 6; 4%). Six participants (4%) selected more than one race.

Participants were prescreened through Prolific to ensure they met eligibility criteria, including being at least 18 years old, residing in the United States, being fluent in English, and self-identifying as either Christian or atheist. Only individuals who met these criteria could access the survey. After data collection, responses were reviewed for completeness and quality. Participants who did not complete at least 80% of the survey or submitted incomplete responses were excluded from analyses and were not compensated. Missing data were handled using

listwise deletion, such that only participants with complete data on the variables of interest were included in each analysis. As a result, the final analytic sample size varied slightly across statistical models depending on data availability. Participants who met the completion requirement were compensated $4 in accordance with Prolific's guidelines.

This study was reviewed and approved by the Institutional Review Board (IRB) at Brigham Young University. All participants provided informed consent electronically prior to beginning the survey. Participation was voluntary, and respondents were informed of their right to withdraw at any time without penalty. All procedures were conducted in accordance with ethical guidelines for research involving human participants.

3.2. Dependent Measurement

Intention to Seek Counseling for Psychological and Interpersonal Concerns

The Intention to Seek Counseling for Psychological and Interpersonal Concerns (ISCPIC) is a widely used and validated 10-item subscale that is designed to assess the degree to which respondents are willing to seek help from mental health professionals for psychological or interpersonal problems (e.g., depression, anxiety, loneliness, feelings of inferiority, substance abuse) [31]. Respondents were asked to rate items on a 7-point Likert scale that ranged from 1 (not likely) to 7 (very likely). All 10 items were summed, and higher scores show a greater intention to seek help from mental health professionals. The Cronbach's alpha of this subscale was 0.93 for the present data.

3.3. Predictor Measurements

3.3.1. Self-Stigma of Seeking Help

This Self-Stigma of Seeking Help (SSOSH) scale consists of 10 items and is designed to measure self-stigma toward seeking help from mental health professionals (e.g., "I would feel worse about myself if I could not solve my own problems") [32]. Items were rated on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). A total score was calculated by reverse-coding five items and then summing the values across all 10 items. Higher scores indicate greater negative self-stigma. Internal consistency in this sample was 0.82 for the present sample.

3.3.2. Stigma of Seeking Professional Psychological Help

The Stigma of Seeking Professional Psychological Help (SSPPH) contains five items that evaluate respondents' perceptions of the societal stigma of seeking professional psychological help [33]. Respondents were asked to rate all five items on a 7-point Likert scale that ranged from 1 (strongly disagree) to 7 (strongly agree). Typical items of this scale are: "Seeing a psychologist for emotional or interpersonal problems carries social stigma," or "people tend to react negatively to those receiving professional psychological help." All five items were added, and higher scores reflect respondents' perception of greater societal stigma toward seeking

professional help. The internal consistency of this measure in the current study was 0.86.

3.3.3. Attitudes toward Seeking Professional Psychological Help-Short Form

The Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF) scale is a 10-item revised measure of help-seeking attitudes, and each item (e.g., "If I believed I was having a mental breakdown, my first inclination would be to get professional attention") was rated from 1 (strongly disagree) to 7 (strongly agree). Five items were reverse-scored, and all items were summed to create a total score. Higher scores represent greater positive attitudes toward seeking psychological services. Internal consistency in this sample was 0.90 [34].

4. Results

4.1. The Effects of Religion and Gender on the Measured Variables

A two-way MANOVA to examine the effect of the religion (Christian vs. atheist) and gender of participants (Male vs. Female) on intention to seek help, attitudes toward mental health professionals, public stigma, and self-stigma. There was a main effect for religion [F (4, 129) = 10.52, p < 0.001, η^2p = 0.25]. However, no main effect of gender or religion × gender interaction effect was found from this sample [F (4, 129) = 1.88, p = 0.117, η^2p = 0.55; F (4, 129) = 0.81, p = 0.522, η^2p = 0.02, respectively]. A Follow-up ANOVA revealed that atheist showed significantly greater intention to seek help [F (1, 136) = 10.55, p < 0.001; M Atheist = 49.25, s.d. = 11.87 vs. M Christian = 43.27, s.d. = 10.87], more positive attitudes toward seeking help from mental health professionals [F (1, 136) = 5.51, p = 0.02; M Atheist = 51.61, s.d. = 10.35 vs. M Christian = 47.41, s.d. = 11.99], and hold less public [F (1, 136) = 2.95, p = 0.044; M Atheist = 15.22, s.d. = 5.03 vs. M Christian = 16.94, s.d. = 6.64], and self-stigma [F (1, 136) = 3.46, p = 0.03; M Atheist = 47.49, s.d. = 6.05 vs. M Christian = 50.99, s.d. = 12.21] in comparison to Christians.

4.2. The Effects of Attitudes, Self-Stigma, and Public-Stigma on Intention to Seek Help

A multiple simultaneous regression analysis was conducted to examine the effects of the predictor variables (*i.e.*, attitudes toward mental health professionals, public -stigma, and self-stigma) on intention to seek help from mental health professionals. The results indicated that both attitude and self-stigma were significant predictors of the respondents' intention to seek help in case of various mental health concerns (β = 0.749, p < 0.001; β = 0.268, p = 0.007, respectively). That is, participants who hold a greater positive attitude and less negative self-stigma were inclined to show greater intention to seek help from mental health services. However, public stigma did not significantly predict their intention to seek help (β = −0.049).

4.3. The Moderating Effects of Attitudes, Self-Stigma, and Public-Stigma on Intention to Seek Help between Atheists and Christians

A hierarchical regression analysis was conducted to explore any differing patterns of the roles of self-stigma, public-stigma, and attitudes toward seeking help between atheists and Christians. All measured variables were centered prior to the analyses using the recommendation by Jaccard, Turrisi, and Wan [35]. In the first step, all possible moderators and religion were entered to evaluate the main effects for intention to seek help. Then, in the second step, two-way interaction terms were entered. The results of zero-order correlation analysis and means and standard deviations of all measured variables are presented in Table 1.

Table 1. Correlations among the dependent variable and the moderator variables and their means and standard deviations.

	1		2		3		4	
1) Self-Stigma	_							
2) Public-Stigma	0.507*		_					
3)Attitude	−0.678*		−0.443*		_			
4) Intention	−0.270*		−0.245*		0.589*		_	
	Christian	Atheist	Christian	Atheist	Christian	Atheist	Christian	Atheist
Mean	50.99	47.49	16.94	15.22	47.41	51.61	43.27	49.25
SD	12.21	6.05	6.64	5.03	12.00	10.35	10.87	11.87

Note. Self-Stigma = The Self-Stigma of Seeking Help scale; Public-Stigma = Stigma of Seeking Professional Psychological Help; Intention = Intention to seek counseling for psychological and interpersonal concern; Attitude = Attitudes toward seeking professional psychological help-short form. *$P < 0.01$.

The hierarchical regression analysis results showed a significant main effect of attitude on intention to seek help from mental health professionals. The result indicated that respondents who hold greater positive attitude were more likely to show their intention to seek help. The second step of the hierarchical regression analysis revealed that a significant interaction effect of religion and self-stigma on intention to seek help was significant. Simple effect analysis revealed that the relationship between self-stigma and intention to seek help was significantly negatively associated among atheists [$\beta = -0.393$, t (45) = −2.389, p = 0.021], while such a relationship was significantly positive among Christians [$\beta = 0.353$, t (45) = 2.390, p = 0.002]. The summary of the hierarchical regression analysis is presented in Table 2.

5. Discussion

The purpose of this study was to determine the relationships between self-stigma, public-stigma, and religion on an individual's propensity to seek mental health help. Utilizing the Theory of Planned Behavior, we examined how public-stigma, self-stigma, and attitude to seek help impact intention to seek help from mental

Table 2. Regression analyses of the effects of moderators on intention to seek counseling.

Régression model	β	t	df	ΔR^2
Step 1: Main effect				
Self-Stigma	0.201	1.856	128	
Public-Stigma	−0.026	−0.322	128	
Attitude	0.698	6.879**	128	
Religiosity	−0.091	−1.181	128	0.385**
Step 2: Interaction effect				
Self-stigma × Religiosity	−0.643	−3.119*	128	0.053*

Note. Self-Stigma = The Self-Stigma of Seeking Help scale; Public-Stigma = Stigma of Seeking Professional Psychological Help; Attitude = Attitudes toward seeking professional psychological help-short form; Religiosity = Christian or Atheist. *$P < 0.01$. **$P < 0.001$.

health professionals. We also investigated whether there were any differing patterns of intention between atheists and their Christian counterparts. This study is important given the growing shifts in religious identity in the United States and increases the need to understand religious identity's impact on mental health help-seeking intentions. There are a limited number of studies focused on investigating the effects of self-stigma, public-stigma, attitudes to seek help, and religion, especially comparing atheist and Christian, on intentions to seek mental health treatment. Further research on religious identity and its impact on the propensity to seek mental health treatment is vital to inform efforts addressing mental health disparities and barriers in seeking needed treatment.

5.1. The Effects of Religion, Self-Stigma, Public-Stigma, Attitudes toward Help-Seeking, on Intention to Seek Help

As expected, the results showed that atheists tended to hold greater positive attitudes, have higher intentions to seek help from mental health professionals, and hold less negative self-stigma in comparison to Christians. This reinforces the increasing emphasis in mental health counseling on inquiring about clients' religious status during intake. Exploring clients' religious beliefs not only constitutes a pertinent competent counseling ethics and culturally sensitive practice in therapy, but it additionally assists clinicians in better understanding the clients' strengths, vulnerabilities, and identities. Moreover, understanding the religious context that impacts one's ongoing propensity to seek help may aid clinicians' efforts to decrease possible ambivalence towards mental health services and increase intention to continue services. Motivational Interviewing is an evidence-based practice that assists individuals in changing their behavior [36]. Clinicians should consider utilizing techniques such as Motivational Interviewing with their Christian clients. This approach targets attitude changes and aims to increase the clients' desire and intention to change, aligning with the TPB.

This study highlights the need for mental health professionals and educators to

be proficient in assisting Christian clients in ameliorating attitudes toward seeking mental health services while practicing cultural humility. Clinicians should be aware that religious minorities, such as atheists, may resort to hiding their identity to shield themselves from discrimination, marginalization, and stigmatization. Moreover, clinicians should also be aware that seemingly minor expressions of bias toward religious minorities, which frequently are unintentional, can impact the therapeutic relationship, fostering feelings of misunderstanding and undermining the effectiveness of the treatment [37]. Indeed, Bishop [38] reported that such biases led atheist clients to disengage from therapy altogether. Thus, checking their biases towards atheists is recommended. Because Atheists are likely to seek help from mental health professionals, we recommend that as clinicians discuss the treatment plan, they inform atheist clients that science and evidence-based therapy will be used for their treatment. The rationale behind this treatment plan discussion is that atheists often want to deal with their mental health issues with science-based treatment rather than waiting for a supernatural being to "watch over them" [39].

5.2. Predicting Effects of Self, Public Stigma, and Attitudes on Intention to Seek Help

As expected, our analyses revealed that participants who hold a greater positive attitude and less negative self-stigma were inclined to show greater intention to seek help from mental health services. However, public stigma did not significantly predict their intention to seek help. In a recent study using meta-analysis, researchers concluded that both self and public stigma were significantly associated with each other, yet, after controlling for the effect of each other, self-stigma, but not public stigma, remained significantly associated with help-seeking attitude and help-seeking intention [40]. Results from this study indicated that ameliorating self-stigma may be more effective in increasing one's positive attitudes toward and intention to seek help from mental health professionals. However, since it is suggested that self-stigma may stem from the internalization of public stigma and a strong positive link between help-seeking public stigma and self-stigma, we cannot ignore the importance of reducing this association to promote help-seeking attitudes and intentions better [41].

Establishing effective stigma-reduction interventions and programs is crucial for improving mental health outcomes. Different approaches have been shown to combat stigma in distinctive ways. For instance, inter-group contact programs like SchoolSpace [42] were effective in reducing mental health stigma through facilitating personal contact with individuals experiencing mental illness. Similarly, psychoeducation interventions such as the Veterans Affairs Ending Self-Stigma Program seek to reduce stigma-related barriers to seeking help through mental health education [43]. Another promising approach is Group Compassion-Focused Therapy (CFT), which effectively reduces self-stigma by cultivating self-compassion and challenging self-critical thinking [44]. Each of these programs

highlights the importance of tailored interventions that address stigma from different angles.

5.3. Moderating Effects

The results from hierarchical regression analysis indicated that respondents who hold greater positive attitude were more likely to show their intention to seek help. However, the most interesting and confusing finding from this study was that the relationship between self-stigma and intention to seek help was significantly negatively associated among atheists. In contrast, such a relationship was significantly positive among Christians. Self-stigma impacted the intention to seek help for both Christians and atheists, but the impact between them was in the opposite direction. That is, Christians with more negative self-stigma were more likely to have a greater intention to seek help, while atheists with more negative self-stigma were less likely to have a greater intention to seek help. We urge researchers to replicate the result in future studies. Although this can be a mere speculation, differences between Christians and their relationships with faith, such as intrinsic or extrinsic relationships, can be used to explain these puzzling findings. One possible explanation for the observed differences between Christians and atheists may relate to variations in intrinsic and extrinsic religiosity. Intrinsic religiosity reflects a deeply internalized and personally meaningful commitment to religious beliefs, whereas extrinsic religiosity is characterized by engagement in religion for external or social benefits [45]. It is possible that individuals with higher intrinsic religiosity may be more motivated to overcome self-stigma through faith-based meaning-making, whereas those with more extrinsic orientations may be more influenced by social pressures and public stigma. However, because religiosity type (intrinsic vs. extrinsic) was not directly measured in the present study, this interpretation should be considered speculative. Future research should explicitly assess these dimensions to better understand their role in shaping help-seeking intentions.

Extrinsic religiosity refers to a relationship with a religion focused on external benefits rather than internal belief and commitment. Conversely, intrinsic religiosity is a relationship with a religion built on genuine belief, a deep commitment to religious values, and seeing one's religion as a central part of identity and purpose. Someone with intrinsic orientation tends to be motivated by spiritual goals [46] and to act as if they lived the religion [47]. On the contrary, someone who has an extrinsic orientation tends to be motivated by fulfilling some socialization or status needs [46] and uses religion as a way of obtaining approval and support, focusing only on the behavioral and social aspects of religion [48]. Understanding these characteristics, such as intrinsic religiosity, may significantly influence the relationship between self-stigma and intention to seek help. It is speculated that intrinsic religious individuals with negative self-stigma may try to overcome such negative stigma by motivating themselves through their faith in God to seek help for the sake of their psychological well-being and achieve spiritual purposes. As

people age, they experience significant life experiences, such as marriage, parenting, career changes, etc., and increase intrinsic religiosity. Moreover, the average age of our participants was 37 years, making it likely that they may have experienced significant milestones in their lives.

Again, this is our mere speculation since we did not measure their religiosity. However, we recommend that clinicians and educators assess whether Christians maintain an extrinsic or intrinsic relationship to their faith, as this difference may affect their vulnerability to the adverse effects of public stigma. Future research should seek to determine if Christians who report an intrinsic relationship with their faith are less likely to be deterred from seeking help despite self-stigma. Moreover, researchers should examine if atheists maintain greater self-stigma and lesser intention to seek help in regions of the world where atheism is more common than in the United States and establish the possibility of minority stress on help-seeking.

Several limitations should be acknowledged, including the reliance on self-report measures, the smaller sample size for atheist participants, and the study's non-generalizability to individuals outside the United States. Future research should include diverse religious and cultural groups, further differentiate different relationships with religion (*i.e.*, intrinsic or extrinsic relationship with faith), and investigate developmental and age-related implications. Additionally, denomination, frequency of religious practice, prior counseling use, and current mental-health status were collected; if not, add one sentence noting that these unmeasured factors could partly explain group differences. The current Christian-versus-atheist comparison may otherwise conflate affiliation with religiosity and treatment history.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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