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Effect of Religious Support and Perception of Available Social Support on Seeking Formal Psychotherapy

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Abstract

This study sought to investigate the relationship between perceived availability of social support and religious support on willingness to seek professional mental health counseling. Sixty-five (41 females and 18 males, 6 gender unspecified) students at Eastern Illinois University completed measures of religiosity (the Duke University Religion Index; DUREL), perceived availability of social support (the Late Adolescent Social Support Inventory; LASSI), religious support (from God, from religious leaders, from fellow religious participants; the Multi-Faith Religious Support Scale; MFRSS) and willingness to seek counseling (Willingness to See a Counselor scale; WSC). Religiosity did not play a significant role in influencing the willingness of participants to seek counseling. Religious support from God had a significant negative relationship with WSC; perceived availability of support had a marginally significant positive relationship to willingness to seek counseling, contrary to our prediction of a negative effect. In a further deviation from predictions, support from religious leaders and support from religious co-participants did not significantly predict WSC. Furthermore, there was no evidence that the interactions between the LASSI and religious support variables added to our ability to predict WSC. These findings suggest that there is a need for much more work on the relationships among willingness to seek counseling, religious support, and more general social support.

Keywords: formal psychotherapy, willingness to seek counseling, perceived availability of social support, religious support.

Dedication

The journey to completing this thesis was filled with a lot of emotions. I am so glad about its successful completion. I would like to dedicate this thesis to my lovely parents, Mr. Basil and Mrs. Rita, Akubueze for being the best parents.

Also, to my boyfriend, Chike Oputa for always encouraging and supporting me to be the best version of myself.

I would also like to dedicate this thesis to my sisters, brothers, and friends, whose love and support kept me motivated.

I would also like to dedicate this thesis to my thesis supervisor, Dr Scher, the absolute best. He made the journey bearable for me.

Finally, I would to dedicate this thesis to Almighty God for giving me the strength I needed for this beautiful journey.

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The Effect of Religious Support and Perception of Available Social Support on Seeking Formal Psychotherapy

Mental health disorders are common in the United States; approximately 44 million adults and 13.7 million children are affected each year. Eighty to ninety percent of suicide victims are suffering from a mental illness (Russell, 2010). Yet there is an enormous gap between the need for treatment of mental disorders and people's decision to seek formal psychotherapy. In developed countries with well-organized health care systems, between 44% and 70% of patients with psychiatric disorders do not receive treatment. In developing countries, the figures are even more startling, with the treatment gap being close to 90% (WHO, 2003).

Many factors seem to relate to one's decision to seek formal mental health services. These include the level of distress, duration and nature of the mental disorder, demographic factors, and the stigma associated with mental health (Pescosolido & Boyer, 1999; Kagan, Itack &Tal-Katz, 2017; Shaw, Lombardero, Babins- Wagner & Sommers- Flangans, 2019). The current study explores the relationships among the use of religious support, the perception of available non-religious social support, and individuals' decisions about seeking formal psychotherapy.

Social support can come from many sources. In the current study, we distinguish between religious support and non-religious social support. For the sake of simplicity, we will generally use the term *social support* to refer to any non-religious support and specify *religious support* when that is what we are referring to.

Religious Support and Religiosity

Pargament (1997) defined religion as a pursuit of meaning as it concerns the sacred. Pargament et al. (2000), further, refer to religion as that which makes an individual feel in

control in the face of hard events; they also posited that religion provides social identity, intimacy, and support to various individuals (Pargament et al., 2000).

Religious support for the purpose of this study refers to the help/assistance or support received from one's church or religious institution. Religious support includes factors such as counselling from pastors, praying and fasting with pastors or church leaders, feelings of being appreciation by God, and/or religious leaders, feelings of being cared for by other participants in ones' religious group, feelings of being confident that their religious leaders would help if something went wrong in their lives.

The research literature on religiosity, religious support, and its effect on seeking formal psychotherapy is not consistent. Religious individuals may prefer to seek help in religious contexts (McGowan & Midlaskry, 2012), and Koenig (2012) suggests that religious patients may feel like seeking formal therapy means they are doing wrong by abandoning their faith in search of secular treatments. Kovess-Mastefy et al. (2010) suggested that for some people, religious advisors could be viewed as informal members of the mental health care system, as these religious leaders often provide advice and support for mental health problems to those in their congregation. Bossley and Crosby (2012) found a negative correlation between preferences for seeking psychological help from a religious advisor and attitudes toward seeking professional psychological help.

Quackenbos et al. (1985) surveyed laypeople on their attitudes and opinions regarding the relationship between religion and psychotherapy. Results indicate that 35% of the respondents preferred some form of religious counseling. For 79% of the participants, it was important for religious values to be discussed in therapy, and 53% shared that they would seek counseling at a pastoral center if it were available. However, Quackenbos et al. (1985) found that secular therapy

was preferred for severe mental problems irrespective of the religious practices or church attendance levels of the respondents.

Privette et al. (1994) examined religious values in counseling and preferences for religious or secular advice. Participants differentiated religious from secular counseling and shared the benefit of religious counseling which addressed religious concerns. Slightly less than one-third of these participants preferred religious counseling. Small minorities reported biases against religious or nonreligious counseling. Counseling options desired were dependent on the type of problem: religious counseling was preferred for marriage and family problems, and secular counseling was preferred for mental illness and addiction, but religious and non-religious counseling were equally chosen for depression.

Greenawalt et al. (2011) studied Operation Enduring/Iraqi freedom veterans with a high level of depression and post-traumatic stress disorder (PTSD) symptoms. As they hypothesized, the use of religious coping was positively associated with seeking spiritual counseling, but contrary to expectation, it was unrelated to seeking specialty mental health services (i.e., treatment with medication or individual/group therapy).

Religiosity refers to the degree of adherence to the practices and beliefs of an organized church or religious institution (Shafranske & Maloney, 1990). It seems reasonable to assume that the greater a person's degree of religiosity the more likely they will be to seek religious support for their problems. Therefore, correlations between religiosity and attitudes towards or actual seeking of professional help can inform us about the likely relationship of these variables with religious support.

Moreno et al. (2017) found that levels of religiosity were negatively related to attitudes towards professional mental health services. The study also investigated whether internal or

external religious coping mediated the relationship and it was found that external religious coping – defined as activities such as seeking advice from a religious counselor or connecting with religious support groups -- mediated the relationship between religiosity and negative attitudes towards mental health services for men (but not for women).

McGowan and Midlarsky (2012) found that intrinsic religiosity was negatively related to attitudes toward psychotherapy among a sample of older adults. On the other hand, Pickard (2006) found that both intrinsic religiosity and the frequency of private religious activities had positive associations with the actual use of formal mental health services. A study on attitudes towards help-seeking by Eells and Miller (1998) revealed that participants who reported higher degrees of religiosity were neither more nor less likely to recognize the personal need for help or to have assurance in the effectiveness of therapy.

In a qualitative study that examined religiosity, coping with adversity, and facilitators of seeking different types of mental health services in a sample of 17 religious Latino men and women, Moreno and Cardemil (2013) found that religiosity is related to coping and attitudes toward formal mental health services among religious Latinos, as well as the importance of context in understanding these processes. Results from this study show that depending on the nature of the concern, participants might seek formal psychotherapy. For instance, some participants indicated a willingness to seek formal mental health services if they were struggling with challenging situations, which primarily consisted of chronic and severe mental health problems, such as major depressive disorder, consistent with the findings of Quackenbos et al. (1994), discussed above.

Chen et al. (2007) conducted a study investigating religious participation as a predictor of mental health status and treatment outcomes among older persons with depression and/or anxiety

disorders. There were no significant disparities in the use of mental health services between those who identified as religious and those who did not. There was no association between the use of mental health services and frequency of involvement in religious activities.

Pickard (2006) found that private religious activities and intrinsic religiosity were positively related to help seeking among a sample of participants who were 65 or older. That is, the more time a person spent in private religious activities, the more likely they were to use mental health services.

Results from these studies imply that more research is needed to examine whether religious affiliation/support affects one's decision to seek formal psychotherapy and the role of other factors in this regard.

Perception of Available Social Support

Social support refers to both material and psychological assistance provided by significant people in a person's life, especially during times of need. Social support can come from family, friends, teachers, mentors, and more. This thesis focuses on the perception of the availability of social support as a factor that affects one's willingness to seek formal therapy. (Cohen, 2004; Thoits, 2011a) posited that social support promotes the use of successful coping strategies, thereby directly and indirectly decreasing the risk for psychopathology. Given the fact that a goal of counseling is also to promote the use of successful coping strategies (American Psychological Association, 2020), we assume that the belief of a person concerning the amount of social support available to them creates an assurance that one is not alone, leading to the likelihood that one could seek for help from social sources rather than formal sources when needed.

Cardella (2010) found that among high school students, the willingness/likelihood of formal/professional help-seeking was negatively correlated with perceived social support: the higher the level of social support, the less the adolescents sought help from formal sources. Goodman, Sewell, and Jampol (1984) report a similar finding among college students: given an equal number of stressful events, students who had more social support decreased in their actual behavior of seeking therapy. Pickard (2006) also found that availability of social support is negatively associated with the actual use of mental health services.

Pillay and Rao (2002) similarly found that those in their sample who sought formal psychological treatment had smaller social networks, and perceived support as less available than did non help-seekers. More of the non-help seekers sought help from family members while more help-seekers preferred to seek help from outside the informal network.

Thoits's (2011b) findings add nuance to these previous findings. She found that while availability of social support largely reduces the actual use of treatment entry, when individuals' mental conditions are more serious, caring relationships increase the chances of mental health utilization; for people with higher social support, the more severe their mental disorders, the more likely they will seek formal treatment under pressure or with mixed desire.

Current Study

To extend the body of literature on college students' decision to seek professional psychotherapy, the current study will investigate the relationship of social support and religious support with willingness to seek professional mental health counseling. Although previous research has investigated each of these variables' relationship to seeking counseling, only Pickard's (2006) study seems to have examined the effect of both of these variables

simultaneously. However, this study did not examine the interaction between religious variables and social support. Investigating these constructs in one study can illuminate how they combine.

Hypotheses

Religious and social support may combine in either an additive or a multiplicative fashion.

The Additive Model. Religious support and social support may each have a main effect on willingness to seek formal counseling. In other words, the additive model suggests that increasing levels of either type of support will correspond to a lesser willingness to seek formal counseling. Hypothesis 1 therefore proposes that an increase in levels of either religious or social support will correspond to a lesser willingness to seek formal counseling. Both variables will be significant predictors of willingness to seek professional counseling.

The Multiplicative Model. On the other hand, an individual with either religious support or social support may be less likely to seek formal counseling, but the combination/availability of the two support types might not decrease the willingness to seek formal counseling any further. Therefore, only those with both low levels of religious support and low levels of social support would have an increased willingness to seek formal mental health services. However, people who have high levels of either or both forms of support will have an equal willingness to seek professional help. Hypothesis 2, therefore, suggests an interaction between religious and social support in the prediction of willingness to seek formal counseling. This model predicts a positive regression coefficient for the interaction, because there would be a negative relationship between social support and seeking counseling for those with low religious support; however, as religious support increases, that slope would become less negative (i.e., more positive).

Methods

Participants

This study recruited 65 (69% females and 27% males, 9% gender unspecified) students at Eastern Illinois University to complete the study as part of a research requirement in their Introductory Psychology class. Of the participants, 37.3% identified as other Christians 20.3% were Catholics, 13.6% were Atheist or Agnostic, 3.4% indicated that they were Protestants, , 1.7% were Muslims, 1.7% were Buddhists, 1.7% were Pagans or Wiccans, and 20.3% identified their religion as "Other". Equal numbers of participants (45.8%) were White and Black/African American, 3.4 % were Asians and 5.1% identified as mixed race. Mean age was 18.90 (*SD* = 0.96, range: 18 to 22).

Measures

Willingness to See a Counselor

The Willingness to See a Counselor scale (WSC; Gim, Atkinson, & Whiteley, 1990) presents 24 problems frequently experienced by college students. Respondents were advised to assume that they have these issues and indicate their willingness to seek counseling for each of the problems listed on a 4-point Likert scale ranging from "Not Willing to See a Counselor" to "Willing to See a Counselor". The scale has three subscales representing willingness to see a counselor for Personal Problems, Academic/Career Problems, and Health Problems; for the current study, however, only the total score was used. In a previous study that used the WSC, Chronbach's alpha was .94 (Choi & Miller, 2014). The alpha for the current study was also .94.

Multi-Faith Religious Support Scale

The Multi-Faith Religious Support Scale (MFRSS; Bjork & Maslim, 2011) is a 21-item scale that was developed based on Fiala et al.'s (2002) 21-item Religious Support Scale (RSS).

Christian language (e.g., “church,” “congregation”, “clergy”) in the RSS limits its use with other religious populations. However, the MFRSS avoids these limitations, employing faith-generic terms to assess persons’ perceived support respectively from: (a) fellow adherents to their faith, (b) their religious leaders, and (c) their God concept if they believe in one. Bjork and Maslim (2011) reported good factorial validity for the three-factor structure of their measure (support from God, from one’s religious congregation, and from one’s religious leaders).

The MFRSS begins with five introductory items, enquiring whether participants believe in God, more than one God, are part of a religious group, have religious leaders, and/or have relationships with their religious group members. These items were not included when scoring the MFRSS but were used as manipulation checks and/or covariates. Thus, for instance, if a person does not believe in God, a rating of “1” on items related to God may mean *not applicable* instead of a s*trongly disagree* regarding support. Alternatively, if a person does believe in God, ratings of “1” on items relating to God seemingly means *strongly disagree*.

In the current study, Cronbach’s alpha was .96 for the Support from God subscale and .91 for both the Support from Religious Leaders and Support from Religious Participants subscales.

The Late Adolescent Social Support Inventory

The Late Adolescent Social Support Inventory (LASSI; Scher, Yeakel, & Hebert, 2020) asks participants to indicate their beliefs about how frequently they have someone to help them in each of 36 ways that are commonly needed by students in high school or college. Ratings are made on a 6-point Likert scale ranging from Never to Very Often. Items in the LASSI were selected by factor analysis from a larger pool of items that represented four dimensions of social support suggested by House (1981): Instrumental Support, Appraisal Support, Emotional Support, and Informational Support. Cronbach’s alpha for the current study was .97.

The Duke University Religion Index

The Duke University Religion Index (DUREL; Koenig & Büssing, 2010; Koenig, Meador, & Parkerson, 1997) is a five-item scale that measures three dimensions of religious involvement. Organizational religious activity (ORA) refers to public religious activities such as attending religious services or engaging in some other group-related religious activity such as prayer groups or Scripture study groups. Non-organizational religious activity (NORA) consists of religious activities done in private, such as prayer, Scripture study, watching religious TV or listening to religious radio. ORA and NORA are measured with single items. Intrinsic religiosity (IR) is measured with three items assessing degree of personal religious commitment, drive, and motivation. Cronabach's alpha for the IR scale in the current study was .92.

Procedure

All participants completed the materials required for this survey online. Participants completed a brief demographic questionnaire asking for gender, age, race, and religious affiliation. This was followed by the completion of the WSC, the MFRSS, the LASSI and the DUREL.

Results

Table 1 presents means and standard deviations for all the variables in this study, along with correlations among the variables. Neither the LASSI nor the MFRSS subscales were significantly correlated with WSC scores. However, a linear regression analysis was used to further examine the extent to which these independent variables affect the willingness of people to seek therapy.

Table 1.

Descriptive Statistics and Correlations

	Mean	SD	WSC	RSS_P	RSS_RL	RSS_G	LASSI	ORA	NORA	IR
WSC	2.426	.747	1	.						
RSS_P	3.414	.983	.096	1						
RSS_RL	3.325	.968	.059	.913***	1	.				
RSS_G	3.752	1.240	-.099	.703***	.648***	1				
LASSI	3.853	.677	.198	.468***	.435***	.400***	1			
ORA	3.36	1.573	.173	.632***	.618***	.663***	.318**	1		
NORA	2.47	1.726	.106	.561***	.508***	.550***	.312**	.648***	1	
IR	3.351	1.268	.134	.635***	.546***	.716***	.242	.631***	.620***	1

*p<.10, **p<.05, ***p <.01

Note: ***WSC= willingness to seek counseling, RSS_P= Religious support seeking from participants, RSS_RL= Religious support seeking from religious leaders, RSS_G= Religious support seeking from God, DUREL_ORA =Religiosity for organized religious activity, DUREL_NORA=Religiosity for non- organized religious activity, IR= DUREL INSTRINSIC, LASSI= Late Adolescent Social Support Inventory,***

A stepwise regression analysis was used for this study. The outcome variable was willingness to seek counseling (WSC) and the predictors were religious social support (MFRSS subscales) and perceived availability of social support (LASSI). Religiosity (DUREL variables) was entered as a control variable in all models.

Religiosity factors (ORA, NORA, IR) were entered in the first step. In the second step, the additive model was tested by adding perceived availability of social support (LASSI) and religious support (MFRSS subscales). The social support and religious support variables were centered. In the third step, the multiplicative model was tested by adding the interactions of each MFRSS subscale with the LASSI (all centered) to the model.

Results of this analysis are reported in Table 2. The religiosity variables did not significantly predict Willingness to Seek Counseling. However, the addition of support variables did significantly increase the prediction of WSC. In particular, support from God (MFRSS_God Subscale) significantly predicted WSC and the perceived availability of social support (LASSI) was a marginally significant predictor ($p = .10$).

The addition of the interactions did not significantly increase predictability. In Model 3, MFRSS_God was still a significant predictor; LASSI scores were not.

Discussion

The purpose of this study was to examine the effect of religious support and the perceived availability of social support on willingness to seek formal psychotherapy. We were surprised to find that religiosity did not play a significant role in influencing the willingness of participants to seek counseling. However, the addition of religious support and social support variables did increase prediction of people's willingness to seek formal psychotherapy. The coefficients for religious support from God indicated that this variable was a significant predictor

Table 2

Summary of Multiple Regression Analysis for the prediction of seeking formal psychotherapy:

	Model 1	Model 2	Model 3
ORA	1.98	.363	.331
NORA	-.015	-.142	-.009
IR	.111	.324	.464
RSS_ P	--	.431	.239
RSS_RL	--	-.280	-.120
RSS_G	--	-.636**	-.722**
LASSI	--	.288*	.265
L ASSI X RSS_P	--	--	-.197
LASSI X RSS_RL	--	--	-.085
LASSI X RSS_G	--	--	.081
F	1.012	1.899*	1.433
R_2	.076	.287	.323
ΔR_2	.076	.211	.036
F-Change	1.012	2.445*	.534

*p<.10, **p<.05, ***p <.01

Note: ***WSC= willingness to seek counseling, RSS_P= Religious support seeking from participants, RSS_RL= Religious support seeking from religious leaders, RSS_G= Religious support seeking from God, DUREL_ORA =Religiosity for organized religious activity, DUREL_NORA=Religiosity for non- organized religious activity, IR= DUREL INSTRISIC, LASSI= Late Adolescent Social Support Inventory,***

of WSC; the coefficient for the LASSI indicated that the perceived availability of social support was a marginally significant predictor. However, support from religious leaders and support from religious co-participants did not significantly predict WSC. Furthermore, there was no evidence

that the interactions between the LASSI and religious support variables added to our ability to predict WSC.

The findings of this study thus support an additive model for the prediction of willingness to seek counseling: perceived support from God and perceived availability of support from others each independently contributed to prediction. However, these findings did not entirely support our version of the additive model. Support from God and not the other sources of religious support (support from religious leaders and from other religious participants) significantly predicted willingness to seek counseling. Furthermore, perceived availability of social support was positively related to willingness to seek counseling, as opposed to the prediction of our study that a negative relationship would be found.

Our predictions were based on the assumption that religious and non-religious support could substitute for each other, such that individuals who are not religious but have other sources of social support would still feel they had sufficient available resources and psychological assistance, and this would therefore reduce their willingness to seek formal counseling. Likewise, individuals who had religious support and no other social support, we predicted, would feel sufficiently supported and would also have a lesser willingness to seek counseling.

The findings on social support being positively related to willingness to seek counseling is similar to the findings of Nagai (2015), who found that help seeking intentions among a sample of Japanese university students was positively related to social support. However, one should be hesitant to relate these findings too closely to the present study. The many cultural differences between Japan and the U.S. raise questions regarding the comparability of Nagai's (2015) study. In any event, future studies need to consider the severity of the participant's mental health challenges. Future research should also focus on cultural differences in these relationships.

The positive relationship between perceived availability of social support and willingness to seek counseling could be because people are becoming more aware of the detriment of not seeking mental health care early. Thus, rather than waiting for the situation to get worse, people's social support system could encourage the use of formal psychotherapy.

Also, the population of this study are students and as such, might have most of their social system being physically far away from them, which could serve as a reason for their likely preference for formal psychotherapy. In a similar vein, family members and friends, might be more likely to encourage their loved ones to seek formal psychotherapy because they know that they are physically far away from them. This does not disregard the fact that some student have friends and classmates as social support systems and proximity might not be an issue. However, in those cases, it is likely that systems have become more aware of the need to seek formal help in order to avoid deterioration of the situation. In addition, Eastern Illinois University has a counseling clinic that offers free counseling for students, which might reduce barriers for seeking formal therapy.

The fact that the availability of support from religious leaders and fellow religious participants did not significantly affect people's willingness to seek formal psychotherapy was also inconsistent with our hypothesis. One explanation for religious support from God being the only significant predictor among the other sources of religious support for WSC could be because people perceive their God to be all-powerful and all-knowing, so they may feel that support from humans (religious leaders and religious participants) was superfluous.

Another reason for the result found in this study could be because with religious support from God, people could assume that their God's solution is absolute, and their God will do it for them. On the other hand, when people seek support from their counselors, religious leaders and

religious participants, they may feel like they will have to do more of the work. When the client compares the different sources of help, help from God seems like the easiest and surest option: "God will do it for me and I might not have to do anything."

Support from religious leaders and fellow religious participants may not affect WSC because seeking help from these sources requires revealing ones' problems to humans who are not supernatural. Hence, the factor of shame, confidentiality/lack of trust, and lack of professionalism, might have played a role in its lack of effect on WSC. Moreover, religious places may feel like sacred and safe places for people; revealing their secrets and struggles to other religious members or their religious leaders might make them feel unsafe or uncomfortable in that space.

Limitations

One limitation of this study is that it did not use random sampling and as a result, the findings cannot be generalized to a larger population of students and all the participants of the study were from the Psychology Department at Eastern Illinois University. Also, only college students were used as participants in this study. Thus, generalizability of findings is limited. Future studies will benefit from the use of random sampling and inclusion of participants who are not students as well.

A further limitation of this study is the limited number of participants. This study intended to use approximately 75 participants. However, as a result of the disruptions prompted by the Coronavirus pandemic, the available sample size was restricted. The reduced power increases the likelihood of committing a Type II error. Some of the null findings (no significant relationship between religious support from religious leaders and participants, no interaction effect between religious support and perception of available social support on WSC), therefore,

may in fact be erroneous. Of course, there is no way to know if this is true and, if so, which effects might actually exist in the population. Only further research can answer those questions.

It is also important to note that perceived support measures may be influenced by individual variation in perception, judgment, and memory that may result in an altered or unreal perception of supportive networks or events (Lakey et al. 1996).

Further studies will benefit from including variables measuring received social support and perceived social support in the same study, in order to investigate any differences in results. This might have produced a different result in this study because people might have a perception that their social network wants the best for them and will encourage them to go for therapy. However, there is a chance that if people really received social support, they might feel better, no matter how short-lived the positive feeling is, and therefore be unwilling to seek formal psychotherapy.

Also, the current study investigated people's thoughts about going to therapy (willingness), asking them to assume that they had the problems listed in the questionnaire. However, some of the participants might have never gone for therapy or had the said problems. Thus, a lot of the responses were based on assumptions which might not really be a true reflection of what they would do if they really had those problems and had to decide to go for therapy. Again, some of the literature that were reviewed in this study measured actual use of psychotherapy as opposed to willingness to seek therapy which is more hypothetical. Future studies will benefit from comparing actual seeking of psychotherapy and willingness to seek psychotherapy in the same study.

Future research should investigate the effect that other variables such as age, race, gender and more on WSC. Nadler (1997) found that in a lot of countries, women have been reported to

seek more help than men. It will be interesting to see whether gender might moderate the relationships examined in the current study. (Unfortunately, the size of subsamples of different genders and races were too small to permit the examination of these questions with the current data).

Conclusions

This study helped to clarify the relationship of religious support and perceived availability of social support with willingness to seek formal psychotherapy within a college student population. Increased perception of support from God was found to be associated with lesser willingness to seek formal mental health services. Perceived availability of social support was a marginally significant predictor of willingness to seek counseling, but in the opposite direction of our prediction, in that it was found that increased perception of social support led to increased WSC as opposed to our prediction of a negative relationship. Future research is needed to find out why the difference in prediction was found.

Our findings add to existing literature and imply a need for further studies on perceived availability of social support and religious support on WSC. Very few studies have investigated the effect of these two variables on WSC simultaneously. Investigating these constructs in one study illuminated how they combine. Therefore, there is a need to further test the additive and multiplicative models as they relate to this research topic.

Implications

Despite the limitations of this study, the finding tells us a lot about willingness to seek formal psychotherapy. First, people's perception of having support from God leading to less willingness to seek counseling shows that as professionals in the field of mental health, there is a need to be cognizant of this happening. Spirituality might be a beneficial aspect of therapy that

needs to be discussed more often. It might also be beneficial to understand how individuals perceive their God and why support from God was a significant predictor of WSC and not support from religious leaders and religious participants.

Again, this study showed that increased perception of available social support leads to a greater willingness to seek counseling. Although this was not the prediction of this study, it is important to see when this occurs and if other factors would affect the findings. The participants in this study were all students, and the distance from their loved ones, and the fact that they were in school could have affected these results. Also, as far as social support is concerned, support from family members could have been regarded differently from support from friends, colleagues and more. If these supports were considered different, would they yield different results or remain the same? Exploring these possibilities in future studies will be beneficial in understanding how the context of the lives of an individual can influence the effect of their different sources of social support on WSC.

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Appendix

The Multi-Faith Religious Support Scale

1. My religious leaders give me the sense that I belong.

2. My religious leaders care about my life and situation

3. I can turn to my religious leaders for advice when I have problems.

4. I feel appreciated by my religious leaders.

5. I am valued by my religious leaders.

6. If something went wrong, my religious leaders would give me help.

7. I do not feel close to my religious leaders.

8. God cares about my life and situation.

9. I can turn to God for advice when I have problems.

10. I am valued by God.

11. If something went wrong, God would give me help.

12. I feel appreciated by God.

13. God gives me the sense that I belong.

14. I do not feel close to God.

15. I am valued by other participants in my religious group.

16. I feel appreciated by other participants in my religious group.

17. Other participants in my religious group give me the sense that I belong.

18. If something went wrong, other participants in my religious group would give me help.

19. Other participants in my religious group care about my life

and situation.

20. I can turn to other participants in my religious group for advice when I have problems.

21. I do not feel close to other participants in my religious group.

Willingness to See a Counselor. Gim, Atkinson, and Whiteley's,1990

INSTRUCTIONS: The following items present problems that some college students may have. Please assume that you have these issues and rate your willingness to seek counseling for each of the problems listed below. We are not asking whether you have these issues; rather, we are interested in your willingness to see a counselor IF YOU HAD these issues. Please use the rating scale given below to indicate your willingness for each item.

Rating Scale 1 = Not Willing to See a Counselor; 3 = Probably Willing to See a Counselor 2 = Probably Not Willing to See a Counselor; 4 = Willing to see a Counselor

_____ 1. General Anxiety

_____ 2. Alcohol Problems

_____ 3. Shyness

_____ 4. College Adjustment Problems

_____ 5. Sexual Functioning Problems

_____ 6. Depression

_____ 7. Conflicts with Parents

_____ 8. Academic Performance Problems

_____ 9. Speech Anxiety

_____10. Dating or Relationship Problems

_____11. Financial Concerns

_____12. Career Choice Problems

_____13. Insomnia

_____14. Drug Addiction

_____15. Loneliness or Isolation

_____16. Inferiority Feelings

____ 17. Test Anxiety

____ 18. Alienation

____ 19. Problems Making Friends

_____20. Trouble Studying

_____21. Ethnic or Racial Discrimination

_____22. Roommate Problems

_____23. Ethnic Identify Confusion

_____24. General Health Problems

The Duke University Religion Index (DUREL).

(1) How often do you attend church or other religious meetings? (ORA)

1 - Never; 2 - Once a year or less; 3 - A few times a year; 4 - A few times a month; 5 - Once a week; 6 - More than once/week

(2) How often do you spend time in private religious activities, such as prayer, meditation or Bible study? (NORA)

1 - Rarely or never; 2 - A few times a month; 3 - Once a week; 4 - Two or more times/week; 5 - Daily; 6 - More than once a day

(3) In my life, I experience the presence of the Divine (i.e., God) - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

(4) My religious beliefs are what really lie behind my whole approach to life - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

(5) I try hard to carry my religion over into all other dealings in life - (IR)

1 - Definitely not true; 2 - Tends not to be true; 3 - Unsure; 4 - Tends to be true; 5 - Definitely true of me

Late Adolescent Social Support Inventory (LASSI):

Options for each item on the LASSI is the same with Never (1), Rarely (2), Sometimes (3), Often (4), and Very Often (5).

Item Number	Category	Item
1	App22	Do people listen to you when you discuss problems you're having at home or school?
2	Emo21	Are there people who are attentive to your needs?
3	Ins3	Do people close to you help you work out an issue you've had at school or at home?

4	Emo25	Are there people who will listen to your innermost feelings without criticizing them?
5	Info3	Can you count on people close to you to give you good advice?
6	Emo13	Are there people you can count on to be there for you when you need them?
7	App6	Are you normally offered support by people close to you during a difficult time?
8	App21	Are there people who check in with you to see how you are doing?
9	Emo16	Are there people who will comfort you?
10	App9	Do you feel there are people close to you who support your interests?
11	App17	Do you feel there are people who care about you?
12	App18	Are there people who are genuinely interested in how your day was?
13	Ins19	Do people spend time with you when you need help?
14	App8	Do you have people who will reassure you after you've had a bad day?
15	Emo27	Do people close to you make you feel welcome and good about yourself?
16	Info8	Do you feel that you have guidance when you're struggling with personal problems?
17	Info9	Are there people close to you who you talk over important decisions with?
18	Emo30	Do people show you they are proud of you?
19	App13	Do you feel valued by people close to you?
20	App30	Do people close to you push you to do your best?
21	Emo1	Are there people who enjoy hearing about what you think?
22	Info19	Are there people who help point you in the right direction when you're unsure of what to do?
23	Ins11	Do people show you support when you've gone through a difficult time in your life?
24	Emo18	Do you feel there are people who will listen to you when you need to talk?
25	Emo26	When you feel tense or under pressure, are there people who help you feel more relaxed?
26	Info5	Are there people who have helped you to think of ways to de-stress when you're overwhelmed?
27	Info7	Are there people you turn to for advice with your personal problems?
28	Info11	Are there people who help guide you in thinking about your future?
29	Ins22	Are there people you can count on for help over an extended period of time?
30	Info10	Do people offer you advice to help you avoid making mistakes?
31	Info2	Are there people in your life who you can trust to tell you when there is something you can improve on?
32	Ins26	Are there people who help you develop your academic and/or career goals?
33	Ins16	Do people help you if you're struggling with a concept in class, or a technique for sports/band/other activities?
34	Ins23	Do people spend extra time with you to help you work out a problem?
35	Ins4	Are there people who help you practice, rehearse, or do school work?
36	Ins18.	Are there people you can count on in an emergency?