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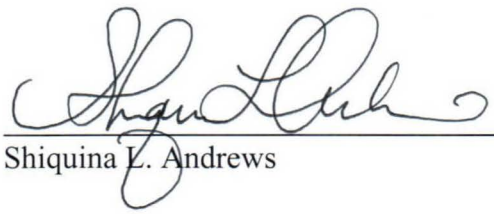

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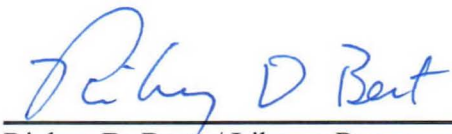

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THE ROLE OF LOCUS OF CONTROL AND RELIGIOUS PROBLEM-SOLVING STYLE IN PSYCHOLOGICAL HELP-SEEKING

Shiquina L. Andrews

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THE ROLE OF LOCUS OF CONTROL AND RELIGIOUS PROBLEM-SOLVING STYLE IN PSYCHOLOGICAL HELP-SEEKING

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THESIS ABSTRACT

THE ROLE OF LOCUS OF CONTROL & RELIGIOUS PROBLEM-SOLVING STYLE IN PSYCHOLOGICAL HELP-SEEKING

Shiquina L. Andrews

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Drawing on a college and community sample, this study utilized hierarchical multiple regression to examine the relative contributions of demographic variables, experiences with psychological services, frequency of religious service attendance, locus of control dimensions, and religious problem-solving style in predicting scores on the Attitudes Towards Seeking Professional Psychological Help instrument. Women, those holding a graduate degree, and those with current/past experience with psychological services held more positive attitudes toward psychological help-seeking. While neither the locus of control scales nor the religious problem-solving scales added significant explained variance upon entry, several significant interaction effects were observed. God-centered locus of control was a positive predictor, but only for older participants. Chance locus of control was a negative predictor, but only for those holding a graduate degree. Lastly, self-directing religious problem solving style was a negative predictor, but only for individuals also endorsing a deferring religious problem solving style.

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THE ROLE OF LOCUS OF CONTROL AND RELIGIOUS PROBLEM-SOLVING STYLE IN PSYCHOLOGICAL HELP-SEEKING

Since the dawn of civilization, humans have tried to apply logic to a world of chaos and to explain how their actions affect the world. Over time, psychologists have formulated several theories to explain this phenomenon, but none as appealing as *locus of control*. Simply put, locus of control is the degree to which one believes in his or her ability to influence life outcomes (Berrenberg, 1987; Chipperfield & Greenslade, 1999; Duttweiler, 1984; Levenson, 1974; Welton, Adkins, Ingle, & Dixon, 1996). Though considered a relatively new concept in comparison to other psychological constructs, locus of control quickly gained the interest of researchers and has grown to be one of the most widely investigated and recognized topics in psychology. Forty years after Julian Rotter (1966) introduced this revolutionary concept, locus of control has had many worthwhile applications and continues to remain relevant and worthy of further investigation.

Religion, like locus of control, has also been used as a way to make sense of one's life path (Spilka, Hood, Hunsberger, & Gorsuch, 2003). In discussions of important life factors, one would be remiss if one neglected to consider the role that one's religion plays in defining who a person is and how that individual looks at life. In fact, when people are asked to describe themselves, a religious preference or orientation is among the first things they identify after sex, race, and age. William James, a pioneer in the field of psychology, even called religion "mankind's most important function" (as cited in Forsyth, 2003, p. 110). He also noted that a person's religious beliefs often serve as effective means of reframing life's difficulties and are at times reflective of their

highest personal aspirations (Forsyth, 2003). More recently, a poll conducted by Gallup and Lindsay (1999) showed that the overwhelming majority of Americans, approximately 97%, believe in God. These results were obtained by using a random-digit phone sampling method in order to obtain a representative sample of the population of the United States according to the 1990 census. Indeed, religion acts as a unifying, defining force among many people, especially in the United States.

J. Milton Yinger once said, "Any definition of religion is likely to be satisfactory only to its author" (as cited in Spilka et al., 2003, p. 7). Indeed, religion is a psychological construct that encompasses a wide range of concepts and is, therefore, hard to define. Psychological researchers have struggled with the task of operationalizing religion, or defining the construct of religion by its observable behaviors. Mainly, this has been an arduous undertaking because some beliefs defy scientific, objective description. Aside from the behavioral and cognitive aspects of religion, researchers have had to account for the emotional aspects of the religious experience. Additionally, a person's level of *spirituality*, or personal adherence to a set of beliefs, may differ from his or her level of *religiosity*, which examines more of a person's involvement with established religious institutions and traditions (Miller & Thorensen, 1999; Worthington, Kurusu, McCullough, & Sandage, 1996). Since psychologists prefer the tangible over the intangible, researchers in the area of religion have traditionally preferred to examine religiosity over spirituality because the former lends itself to more specificity in terms of observable behaviors (Spilka et al., 2003).

Though not easily defined, *religion* may be generally characterized as a person's belief in the existence and nature of a deity, including his or her beliefs about the divine

being's role in the universe and in the person's life (Holt & McClure, 2006; Jackson & Coursey, 1988; McAuley, Pecchioni, & Grant, 2000; Spilka et al., 2003). No matter the creed, most religions have underlying themes of social support through caring connections with others, treating others with respect, and submitting to a higher power beyond one's own realm of understanding (Olsen, 2002; Pollner, 1989; Steere, 1997). Most religions expect its followers to express their acceptance of the faith through the expression of established rituals, including such behaviors as church attendance, prayer, fasting, and giving tithes to the church or donations to the poor. Such outward behaviors are not necessarily regarded as an absolute measure of a person's commitment to the religion, but they are encouraged to strengthen and maintain one's faith.

Aside from the typical outward shows of piety, some parishioners may consider divine submission as an obligation to present all problems to God with the expectation that he will solve them in some way; this is seen as the absolute measure of faithful commitment. However, it is unclear at which point the person's effort or responsibility in problem-solving ends and God's role begins. It is also unclear whether the type of problem dictates the type of response. While help-seeking for physical illnesses is seen as acceptable, help-seeking for psychological matters may be equated with a lack of faith (Neighbors, Musick, & Williams, 1998). Likewise, psychological problems may be seen as a consequence of a lack of faith or piety (Spilka et al., 2003). The stigma associated with seeking "worldly" help in matters that should be reserved for one's faith may prevent genuinely distressed people from getting the professional help they need. This places believers in a difficult position; in addition to their suffering, they carry not only the shame associated with the distress but also the guilt of considering secular resources.

An in-depth understanding of help-seeking may be essential to the proliferation of the fields of clinical and counseling psychology. Once psychologists understand the barriers that hinder those who are in serious need of psychological help from seeking that help, they may be able to effectively circumvent or remove those barriers. Researchers have long realized the connection between attitudes toward seeking help and service utilization and have sought to study which human characteristics are more related to a propensity to refrain from seeking help (Alvidrez, 1999; Blazina & Marks, 2001; Blazina & Watkins, 1996; Kearney, Draper, & Baron, 2005). Yet few studies have considered the motivations, or lack thereof, of the religious population. Could it be that the spiritual are less likely to rely on themselves to solve problems? If they do not rely on themselves, what portion of the responsibility do they place on God, if any? Or could it be that, even though they believe in God, they also believe other forces are at play, such as fate or powerful others? The purpose of the present study is to investigate how those who identify themselves as religious or spiritual view the causes of their psychological problems and how they attempt to solve those problems. To gain a clearer perspective of this issue, one must better understand the underlying concepts of locus of control, religious problem-solving and psychological help seeking.

Locus of Control

Julian Rotter's research on the connection between expectancies and reinforcement can be seen as the genesis of the locus of control construct, originally known as "locus of control of reinforcement." Rotter (1966) synthesized the elements of cognitive and behavioral theory to pose an interesting question: At which point is reinforcement seen as a reflection of one's own abilities or as a mere twist of fate? He

hypothesized that an individual's perception of personal control varied between an internal and an external locus. Those with an internal locus viewed themselves as the source of the reinforcement or outcome; those with an external locus attributed outcomes to some force outside of themselves.

The distinction between locus of control and simple reinforcement is in the potential weight the reinforcement may have for a person's future actions. For example, if a student studies for an exam and passes it, the extent to which he will study in the future rests in his perception of control. If he believes that the positive outcome (the passing grade) was a direct result of his efforts (studying), he is highly likely to continue his efforts. On the other hand, if he believes the positive outcome to be the result of luck, the fact that the teacher may like him, or any other factor beyond his control, he may not engage in the same efforts. Though the reinforcement was the same, the student's interpretation of the reinforcement, or locus of control, may differ, causing a change in potential responses. To detect an individual's locus, Rotter developed the Internal-External Scale, also known as the I-E Scale. It became the first widely used assessment of locus of control.

Rotter's I-E Scale, once the hallmark measure of personal control, has since been reevaluated. Many scholars challenged Rotter's notion of locus of control in an attempt to illuminate the subtle differences in thinking between internality and externality. These scholars preferred to regard locus of control as more of a multidimensional concept, especially with regard to the external locus (Berrenberg, 1987; Duttweiler, 1984). Hannah Levenson (1974) was among the first researchers who saw the need for a new

measure that distinguished different aspects of externality, thus changing the way the field looked at locus of control.

Rather than conceptualize locus of control as lying on a spectrum between internal and external as Rotter did, Levenson noted that some people attributed the source of outcomes to one of three independent dimensions: internal, chance, or powerful others, the latter two being distinct dimensions of externality (Levenson, 1974). She noted that individuals who believe that they are powerless and their world is chaotic would think and behave differently than those who believe in an orderly world yet still feel ineffectual within it. Levenson also postulated that these three dimensions of control may be endorsed simultaneously (Levenson, 1981). For example, some people may believe that they are mostly responsible for their life outcomes (internal), but that there are some things, such as death, that are influenced by chance and totally beyond their control. Levenson subsequently developed the Multidimensional Locus of Control Scale to detect the presence of one of three locus of control orientations: Internality, Powerful Others, and Chance.

Though Levenson's revision of the I-E Scale elaborated upon sources of external control more than Rotter's original did, it still left room for ambiguity within the powerful others realm, specifically in reference to the religious population. Two noteworthy studies have considered the role of God or a supreme being in the attribution of personal control – Berrenburg's 1987 study of God-mediated control and Welton, Adkins, Ingle, and Dixon's 1996 revision of the Levenson Multidimensional Locus of Control (MLC) Scale.

Berrenburg (1987) introduced the concept of God-mediated control, juxtaposed against direct internal and direct external control. Those with direct internal control believe that outcomes are the direct result of their own actions. Those with direct external control believe that outcomes are the direct result of some other source, such as chance or powerful others. However, mediated control is the belief in outcomes that are indirectly produced by one's efforts with an external agent mediating between the efforts and the outcomes, such as a supernatural or social force. Simply put, the external force aids the person in the achievement of outcomes.

Though Berrenburg's work with mediated control is thought provoking, the work of Welton and colleagues represents the marriage between religion and locus of control research. Welton, Adkins, Ingle, and Dixon (1996) introduced a revision of the Levenson MLC scale based on the idea of God as a source of control distinct from the chance and powerful others of the external dimension. These researchers noted that those with a religious orientation may have been forced to endorse internal items on the previous scale that were unrepresentative of their views because there were no questions that referenced God directly, or that these people may have been erroneously inferring items in the powerful other dimension as a reference to God. Their revision of the MLC scale solved these problems. Their study also found that those who scored high in the God-control dimension also scored highly on many of the same positive outcomes as internals, suggesting an active rather than passive approach to life.

According to Lefcourt (1992), locus of control was originally conceptualized as a means to explain and to correct maladaptive behaviors. When modern day practitioners speak of locus of control, they are speaking in terms of lowering unemployment rates,

lowering delinquency rates, increasing health service utilization, and remedying other social ills; they are speaking in terms of practical application. Unlike other characteristics, locus of control lends itself to application because it is seen as an adaptable, malleable construct, capable of therapeutic intervention (Lefcourt, 1992). For example, in a study that analyzed locus of control and coping in relation to age, Blanchard-Fields and Irlon (1988) found that younger people scored higher on measures of external locus of control than older individuals, with younger adults exhibiting a more generalized locus of control than older adults do. This suggests that, though external locus of control is seen as maladaptive, it is not static and can change over time.

While Rotter (1966) himself mentioned the malady of being at either extreme, those with internal locus of control tendencies are generally viewed more positively than those with a more external viewpoint did. A belief in internal locus of control has been linked to a host of positive outcomes, such as high self-esteem, achievement, and psychological adjustment and lower levels of depression and anxiety (Berrenberg, 1987; Judge, Erez, Bono, & Thoresen, 2002; Ormel & Schaufeli, 1991). However, making overarching generalizations with regard to the benefits of an internal locus is careless and dubious. An investigation of the relationship between locus of control and health care utilization yielded very counterintuitive results as to the possible causes of low health care utilization among internals (Chipperfield & Greenslade, 1999). Investigators found that a sense of control alleviates some of the symptoms of stress, causing those high in internal locus of control to ignore problems, resulting in low health service use. Internals may also view the act of seeking care as a relinquishing of control, which is viewed more negatively by internals than externals. However, Chipperfield and Greenslade (1999)

also noted that internals may engage in more proactive health behaviors than externals, in effect preventing any future serious health problems.

Making any generalizations regarding locus of control is still careless because, though more conceptually sensitive measures have been introduced and validated, some researchers still rely solely on the Rotter I-E Scale or the Levenson MLC Scale as a means of comparing groups, which virtually ignores perceptions of God as a source of personal control. This practice disregards the prominence of such a sociologically important construct as religion in the life of the individual. Therefore, more investigations of the relationship between locus of control and religiosity are needed to detect the differences in personal control between and within religious populations.

Psychology and Religion: An Overview

Though both fields share common goals, psychology has had a long history of being rejected in certain faiths, just as religion was once discredited and vilified in psychology. Yet both religion and psychology can involve healing of the mind or soul through self-actualization and maintaining healthy relationships. In the case of religion, the most important of these relationships is the one with God. The pioneering work of Gordon Allport began to bridge the gap of understanding between the two disciplines.

In his earlier writings, Allport (1950) recognized the importance that religion holds in people's lives and questioned the motivation of holding religious values. In his landmark study of religious motivation and prejudice, Allport (1966) identified two differing types of religious orientations, intrinsic and extrinsic. The extrinsically motivated person used religion, while the intrinsically motivated person lived it. Extrinsics use religion for security, stability, and status. They value the positive benefits

associated with their religion. Intrinsics, on the other hand, have truly adopted the values of their religion and try to live them daily. Allport developed a scale to measure religious motivation and found that those who were extrinsically religiously motivated were also more racially prejudiced.

In a later study, Allport and his colleague J. Michael Ross (1967) further improved upon the Religious Orientation Scale (ROS) and clarified earlier findings regarding prejudice. They noted that some respondents endorsed all the items on the scale. They called those people "indiscriminately pro-religious." Those respondents saw all religious items as good and therefore endorsed both intrinsic and extrinsic items. When prejudicial attitudes were reevaluated in light of the indiscriminately proreligious, those respondents were found to be even more prejudiced than extrinsically motivated people.

While the ROS was a groundbreaking measure of religious motivation, some scholars disagreed with the way that intrinsic commitment was operationalized. Hoge (1972) thought that research in the area of religious motivation was plagued by vague definitions and weak scale construction. He especially stressed the importance of discovering the motivations for religious behaviors such as attendance and prayer, rather than simply accepting the religious behaviors themselves as evidence of an intrinsic motivation. Others have also suggested revising the ROS by removing frequency of attendance as a measure of intrinsic commitment (Genia, 1993) or making it a three-scale measure to explain the subtle differences in extrinsic motivation better (Leong & Zachar, 1990).

Furthermore, scholars maintained that there were more complex dimensions to both the intrinsic and extrinsic constructs and that the ROS could be improved in light of this. Batson (1976) expounded on Allport's theory of the role of religious motivation in prejudice by taking a closer look at the intrinsically motivated religious person. He agreed that extrinsics use their religion to accomplish other goals; for them, religion is a "means" to gaining something else. Moreover, while he agreed that some followers are motivated by religion for unselfish motives, he also differentiated between people of "blind faith," those who just accept their religion with no questions asked, from another type of believer. For the unquestioning believer, their religion is the "be all, end all," their supreme motivation in life; these people see religion as an "end." On the other hand, there are some believers who view religion as a "quest," a never-ending process of questioning and challenging one's own religious viewpoints when faced with difficult periods in life. In his novel research, Batson went on to develop a scale to measure these three types of religious orientations: religion as means, religion as end, and religion as quest.

Because religious individuals tend to show an inclination toward social desirability, Batson, Naifeh, and Pate (1978) revisited the Allport and Ross study of religious motivation and prejudice with interesting results. They incorporated the three new types of orientation into their study – religion as means, end, and quest – as well as accounted for the presence of the "indiscriminately proreligious" by adding a social desirability measure. When controlled for social desirability, they found results contrary to that of Allport and Ross. Intrinsic religion ("religion as end") corresponded positively with both prejudice and social desirability. However, the "religion as quest" orientation

had a negative relationship with prejudice. This somewhat controversial connection between bigotry and "true faith" led the way for other researchers to investigate the effects of religion on a host of other variables.

Though early research on religion may have cast a somewhat doubtful eye on the beneficial role that religion may play in people's lives, it has been linked to a host of positive outcomes. In the realm of physical health, the presence of individual religiosity or spirituality has been associated with better quality of life, reduced substance abuse, lower blood pressure, and positive health behaviors (Weaver & Koenig, 2006). In a study of African-American college students, those who were "proreligious" were more likely to engage in "health-promoting behaviors," such as eating a balanced diet, exercising, and seeking a health professional when needed (Turner-Musa & Wilson, 2006). Benjamins and Brown (2004) also observed a relationship between religious salience (the importance of religion in one's life) and another heath factor, health care utilization. Among the elderly, those who scored high on religious salience were more likely to use preventative health care services. Strawbridge and colleagues (2001) discovered the impact of religious attendance on improving and maintaining health behaviors such as smoking, exercise, and alcohol. They even identified improved mental health, as measured by lower levels of depression, as being associated with church attendance. Although HIV prevention and support may be a taboo topic in some churches because of its methods of transmission, studies have also shown a positive relationship between church attendance and HIV testing and receiving medical care for the disease (Latkin, Tobin, & Gilbert, 2002).

Despite these findings, some in the medical field remain skeptical about religion's positive effects on health. Sloan, Bagiella, and Powell (1999) argued that the research on health and religion has been highly inconsistent. This inconsistency may be due to the different operational definitions for religion and spirituality. Because of these inconsistencies, they warned health practitioners to be wary of promoting faith as helpful in treatment. Yet, because of the changing dynamics of health care, medical professionals should consider adopting a more holistic approach to patient care (Parmer & Rogers, 1997).

The positive effects of religion on mental health have also been evidenced. Schnittker (2001) recounted the well-documented evidence of the positive association between religious involvement and psychological well-being. Yet, he questioned the nature of this association, postulating that it might be the stress-buffering role of religion that accounts for religion's positive effects. He investigated the effect of three measures of religious involvement – attendance, salience, and help-seeking – on depression. He found that attendance may increase perceptions of acceptance and support. He also noted that the relationship may be curvilinear, meaning that too much religious involvement may be as detrimental as too little. Specifically those very high and very low on religious salience were more depressed than those in the moderate range were. Lower levels of psychological distress were also found in a variety of religious populations, such as the Catholic, Protestant, Buddhist, and Jewish faiths (Jarvis, Kirmayer, Weinfield, & Lasry, 2005).

Religious Problem-Solving

While the work of Allport and Ross (1967) and others investigated the general role of religion in an individual's life, Kenneth Pargament and colleagues (1988) wanted to ascertain how people use their religious beliefs in coping with and confronting life's problems. They noted that problem-solving in general involved several steps: definition of the problem, generation of alternate solutions, selection of a solution, implementation of the solution, and redefinition of the problem and its solution once the problem has been solved. For some, religion permeates each of these stages. Based on interviews and the available data at the time, three styles of problem solving emerged – self-directing, deferring, and collaborative. One who utilizes a self-directing problem solving style takes active responsibility for problem solving and relies more on personal resources than God. Self-directors believe that God gives people the freedom and resources to manage their own lives. Conversely, the deferring problem-solving style involves placing responsibility solely on God. Deferrers look to God as their source and passively wait for solutions to arise. Pargament and colleagues (1988) noted that this style may be tied to those who subscribe more closely to religious dogma and tradition. Finally, there are those who employ a more collaborative style of problem solving, in which they see themselves in partnership with God in problem solving. In other words, both parties are actively responsible for solving problems.

Research has shown that the deferring and collaborative scales correlate significantly with each other, as well as with a sense of control by God. Though the collaborative and deferring styles appear more similar to one another than to the self-directing style, there are important subtle distinctions to be made between the

collaborative and deferring styles. For example, in the case of collaborative problem solving, the control may be referring to more of an active exchange between the individual and God than to a manipulation of the individual by God (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988). The researchers also pointed out that different problem solving strategies may be used in different situations. Whereas a self-directing style may be used for events that a person sees as controllable, a more deferring or collaborative style may be used for seemingly uncontrollable situations.

Researchers in the medical field are appropriately becoming increasingly aware of the impact of religion on the lives of patients and have made efforts to understand exactly how certain populations solve physical health problems in light of their faith. In a study of African American women with breast cancer, spirituality played a significant role in health locus of control factors, with many participants reporting that God determined their health (Holt, Clark, Kreuter, & Rubio, 2003). McAuley and collegues (2000) also investigated the role of religious beliefs in influencing direct or indirect health behaviors by looking at differences in qualitative interview data in rural, elderly White and African American populations. They found that the elderly African Americans saw religion as more of a component of daily life, and reported a more personal relationship with God. Because of this perceived intimate relationship, they were also more likely to see God as instrumental in determining health and more likely to ascribe a healing role to God than the elderly White population. From a religious problem-solving standpoint, it may also be possible that the participants in both studies perceived their health situation as beyond their control, and therefore were more likely to adopt more deferring or collaborative styles.

Though advances in research with regard to religion and physical health are not to be undervalued, few studies have attempted to discover how the underserved religious population views solving mental health problems. To motivate religious populations to utilize professional therapy, one must first understand the reasons that they are hesitant to do so. People that identify religion as an important part of their lives may be hesitant to seek psychological help because they may feel their faith and values would be undermined or misunderstood in therapy (Worthington et al., 1996). They may also feel that seeking help for emotional issues outside of the church would be in direct violation of their faith and beliefs. Because of this, some parishioners may prefer to present mental health problems solely to their minister, despite the fact that church leaders may be less equipped to handle the nature of their problems (Neighbors, Musick, & Williams, 1998). In addition to the "normal" stigma associated with having psychological problems, religious populations may believe that their mental troubles are the result of personal sin or other transgressions, or that an evil force is at work, attempting to test their level of faith (Holt & McClure, 2006). This places two burdens on the believer: the shame of guilt associated with sin and being unable to cope with its supposed mental effects, yet also being unable to ask for professional (secular) help for fear of being seen as faithless.

Aside from discovering and possibly removing that stigma, the goal of the present study is to determine how the religious population analyzes and attempts to solve specific challenges related to mental health. While there once existed a long-standing belief that religion promoted a passive, submissive approach to solving the problems of life, research has repeatedly shown that not all religious people employ that style. Taking a closer look at how the religious population analyzes and attempts to solve emotional and

psychological problems may finally promote understanding and remove the barrier of cooperation between the two fields.

Psychological Help-Seeking

Edward Fischer and John Turner initially undertook the task of measuring an openness or propensity toward seeking professional help. They developed the most noted measure of psychological help seeking, the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) Scale (Fischer & Turner, 1970). The ATSPPH was developed by gathering written statements from a group of professionals that were representative of an orientation toward help seeking. These statements were ranked in order of relevance and labeled as positive or negative items. The items were also subjected to factor analysis. Four factors emerged that resulted in moderate consistency: (a) recognition of need for help, (b) stigma tolerance, (c) interpersonal openness, and (d) confidence in mental health professionals. The resulting measure, consisting of 29 questions, proved to be internally consistent and reliable, and was subsequently used in a host of studies. Later, Fischer and Farina (1995) introduced a shortened form of the ATSPPH that was as psychometrically sound as the original. The shortened form consisted of only ten questions, with no subscales. Fisher realized that the factorial dimensions of the subscales were not as stable as they should be; therefore, he claimed that the total scale score should be used as a measure of orientation toward help-seeking rather than making interpretations based on the subscales.

Yet, even after a revision of the original measure, there has been some disagreement about whether attitudes accurately predict actual help-seeking behavior. Some researchers believe that intentions are more indicative of behavior than mere

attitudes (Wilson, Deane, Ciarrochi, & Rickwood, 2005). With this in mind, Wilson and colleagues (2005) developed the General Help-Seeking Questionnaire (GHSQ) as a more direct measure of actual intentions to seek help for a variety of problems from a variety of sources. However, the GHSQ may also be criticized for focusing on intentions to seek help in general rather than intentions to seek professional psychological help. Likewise, Mansfield, Addis, and Courtenay (2005) developed a measure that targeted barriers to help-seeking rather than attitudes towards help seeking, citing that the ATSPPH treated help-seeking as stable rather than contextually based.

Despite recent deviation, the ATSPPH has been used in many studies to understand differences in help seeking. Perhaps the most natural query concerning differences in help-seeking would be the differences in the attitudes toward help-seeking between the sexes. Generally speaking, women are more likely to report physical illness and psychological distress than men are (Verbrugge, 1989), as well as seek help for those problems. In American culture, males are socialized to be more autonomous and self-reliant, whereas females are allowed to be more dependent. Moreover, males are also taught to be emotionally reserved, especially with negative emotions such as sadness and vulnerability, while females are allowed more of a free range of emotions. Stereotypically, those who use the mental health services of psychologists are seen as weak or vulnerable, and the act of therapy itself is typified as a time of delving into your deepest and most private emotions. Therefore, one could logically infer that men, who are socialized to be stoic and imperturbable, are generally going to be less inclined to seek professional help for a problem than women would be (Mansfield et al., 2005). Perhaps for men, the mere act of seeking help may be seen as a relinquishing of power or

control, and, therefore, threatening to the masculine ego (Blazina & Marks, 2001; Blazina & Watkins, 1996).

Culture can have a profound influence on a person's life and may also play a role in help-seeking. According to Bronfenbrenner, everyone exists within environmental systems or "spheres of influence" that effect how they perceive the world around them (as cited in Cause, Paradise, Domenech-Rodriguez, Cochran, Shea, Srebnik, & Baydar, 2002). Culture can be seen as a set of norms, beliefs, and values that are shared among a certain people that can be conceptualized on a host of levels (i.e., racial, national, political, etc.). Since culture is so salient, it is no wonder that attitudes about the nature and causes of mental health issues are often tied to culture, and that culture may inhibit or facilitate help-seeking (Alvidrez, 1999; Cauce, et al., 2002; Sheikh & Furnham, 2000).

In keeping with a discussion of the effects of culture, several studies have investigated correlations between certain racial and ethnic groups and help seeking. It was once assumed that minorities underutilize health services because of a lack of access to services, but several studies have shown that that conclusion may be an overgeneralization (Ashton, Collins, Peterson, & Wray, 2003; El-Khoury, Dutton, Goodman, Engel, Belamaric, & Murphy, 2004). Alvidrez (1999) observed that African American and Latina woman were still less likely than European women to seek help were, despite equity of resources. Cauce and colleagues (2002) noted that Asian Americans believe it is best to ignore problems and ensure hardships. Service utilization may also be low among minorities because they do not see professional services as relevant to their needs, or they may be discouraged from seeking help outside of certain

culturally sanctioned places, such as family and community (Kearney, Draper, & Baron, 2005; Zhang, Snowden, & Sue, 1998).

Because of its profound influence, religion, like race or ethnicity, may also be considered a culture that affects the way people make important decisions. The religious population may not be encouraged to place great faith or trust in secular sources of help, much like certain ethnic groups distrust formal health services (Kearney et al., 2005). For example, African Americans are traditionally more inclined to use church as a health resource (El-Khoury et al., 2004). To deviate from the norm by seeking "outside" help may bring unwanted reprimand or disdain from the members of the culture.

It is important to realize the difference in perception between help-seeking for psychological problems as opposed to help-seeking in general. While the majority of the physically sick are not seen as threatening, a lack of understanding of mental illness has led to a fear of the mentally ill in the past. Mental illness was once attributed to a personal cause, while physical illness may have been seen as more natural and unrelated to the sufferer. Now that societal views of mental illness and the mentally ill have changed, attitudes about psychological help-seeking range greatly. While some see help-seeking as a brave step, others still see it as the final blow. It is no wonder that, in the face of those obstacles, there remains somewhat of a stigma attached to seeking psychological services. Negative perceptions of the mentally ill and the therapeutic experience and fears of stigmatization are strongly related to negative attitudes toward psychological help-seeking and low mental health service utilization (Gonzalez, Tinsley, & Kreuder, 2002; Komiya, Good, & Sherrod, 2000; Leong & Zachar, 1999; Lopez, Melendez, Sauer, Berger, & Wyssmann, 1998; Wrigley, Jackson, Judd, & Komiti, 2005).

Psychological help-seeking may further be analyzed as a matter of locus of control, or owning personal responsibility for solving one's own emotional problems. Fischer and Turner (1970) initially established the connection between locus of control and professional help seeking. They found that those with a more internal locus were more likely to seek psychological help than externals, a correlation that has been subsequently supported in the literature (Simoni, Adelman, & Nelson, 1991). In other words, internals were more motivated to action than externals.

The act of seeking help may be seen as involving three steps: recognizing that a problem exists, making a decision to seek help, and selecting a person to provide that help (Cause et al., 2002). Moreover, help-seeking is more likely to occur when a problem is seen as undesirable and unlikely to resolve itself. Given this information and research that indicates that religious populations are less likely to seek professional psychological help, it is currently unknown at which point religion intercepts the help-seeking process. Is it the case that the religious population fails to recognize symptoms of mental illness or psychological distress as problematic? Or is it that they do recognize that a problem exists, but prefer not to utilize the services of mental health professionals because of unfamiliarity? If they prefer not to use professional services, do they rely solely on God in their hour of need? These and other questions have largely been ignored in the religious population with regard to psychological help seeking. The purpose of this study is to investigate how religious populations ascribe causation to and solve life problems in general and how these control perceptions and coping styles may relate to their propensity to seek psychological services.

Hypotheses

In keeping with previous research linking internal locus of control to positive help-seeking behavior (Fischer & Turner, 1970; Simoni et al., 1991), the present study assumes that individuals holding a predominantly internal locus of control will report more positive attitudes toward seeking professional psychological help. This assumption is based on similar findings in prior research, mostly in regards to help-seeking in general or in regards to help-seeking for physical problems (Welton et al., 1996). In addition to having a basis in prior research evidence, this assumption can be argued logically. Theoretically, people who have an internal locus believe that they are ultimately in control of their lives. Because they are in control, they are also ultimately responsible for the outcomes of their actions (or failures to act). Since internals believe that the burden of responsibility to solve problems lies with them, they may be more inclined to take action by actively seeking psychological help from a mental health professional than an individual who perceives a predominantly external locus of control.

As previously mentioned, though, the role of cultural values and teachings, including religiosity, cannot be ignored in this relationship. Embedded in the above assumption is a more fundamental assumption that individuals perceive professional psychological services as an acceptable and reasonable option in the face of subjective distress. Individuals with an internal locus of control may see themselves as responsible for taking actions to remedy their psychological problems, but may not see mental health professionals as a culturally sanctioned or acceptable source of help. Finally, individuals perceiving an internal locus of control may also be inclined to avoid seeking any external aid, believing that only their own behavior and efforts can alleviate psychological

problems and that nothing and no one outside the person can serve as an aid (Chipperfield & Greenslade, 1999). These concerns not withstanding, internal locus of control is predicted to be significantly and positively associated with more positive attitudes towards psychological help seeking.

While internals view themselves as capable, those who ascribe to the chance and powerful others loci feel ineffectual and perceive that their own choices and behavior will have little impact on life outcomes. Whereas the internal is assumed to take it upon himself or herself to seek psychological help, the external may wait on fate or some influential other to provide a solution. Therefore, those perceiving a chance or powerful other external loci of control are predicted to express more negative attitudes toward psychological help seeking. However, in regards to at least the powerful others perspective, a logical alternative prediction does exist in which such individuals might be more receptive to seeking help from a professional who is perceived as an expert with the necessary tools and power to solve psychological problems. While this trend is plausible, those with the powerful others view are assumed to hold a generally passive view of coping and help-seeking and are predicted to generally report negative attitudes towards psychological help-seeking. As with internal locus of control, cultural factors could play a strong role here as well. Individuals holding the powerful others view may actually be more inclined to seek psychological help, if they perceived mental health professionals as a culturally-sanctioned or legitimate source of authority or wielders of expert social power.

General religious involvement has been associated with positive mental health outcomes and health service utilization (Benjamins & Brown, 2004; Strawbridge, et al.,

2001; Turner-Musa & Wilson, 2006; Weaver & Koenig, 2006). However, much of the research in this area has not examined specifically the issue of psychological services and help-seeking for psychological problems. As mentioned, the historical overlap and conflict between religious institutions and the mental health field creates a need to examine more closely the religiosity-help-seeking connection. Assuming religiosity promotes positive general health outcomes or higher rates of healthcare utilization, this may be because religious involvement provides the individual with additional coping skills and/or social support (Schnittker, 2001; Strawbridge et al., 2001). Alternatively, this trend could be true because religious teachings may argue that help-seeking and self-care is a duty (Holt & McClure, 2006). Perhaps members of the religious community believe that self-care is as important as having faith that God will provide for you (Latkin et al., 2002). On the other hand, some religious believers may view seeking help as a sign that their faith is lacking, as sufficient religious faith should preclude the need for help. Additionally, religious believers may receive direct messages from religious leaders that seeking professional psychological help is particularly antithetical to living a pious and faithful lifestyle. In such a scenario, the individual may be actively encouraged to seek help within the faith and from clergy, as opposed to seeking help from a professional, secular source (Neighbors et al., 1998).

The present study seeks to determine whether the deciding factor in psychological help-seeking among religious populations is the type of locus of control the individual harbors or the style of religious problem solving endorsed. In theory, those with a God-centered locus of control perceive an intangible divine power as the primary source of life outcomes and events. Yet the type of control ascribed to a God-figure among those

individuals can take on many subtle differences. Pargament's religious problem solving constructs may provide a means to better specify the distinct way in which an individual perceives God to be involved in mediating control over life outcomes. Past research has suggested that those with a God-centered locus of control who also tend to utilize a more self-directing problem solving style may tend to take it upon themselves to actively seek help (Pargament et al., 1988). Conversely, those who perceive a God-centered locus of control and use a more deferring style will tend to rely solely on God for solutions, since in this case a deity is viewed as mainly responsible for outcomes anyway. From this, one could infer that both God-centered self-directors and God-centered deferrers would both have more negative views of psychological help seeking, since they may rely on the self or God more so than people to resolve mental or emotional troubles. However, those who are God-centered with a collaborative problem solving style may rely on themselves to find psychological help, while also relying on God to help guide them towards the most appropriate course of action – an intermediate position. The larger point here is that embedded in the God-mediated locus of control construct may be these three different religious problem-solving styles.

The present study will examine the relationships between locus of control, religious problem solving, and attitudes towards psychological help-seeking through a hierarchical multiple regression analysis. The analysis will control for demographic variables and other variables of interest in the first step, and enter the locus of control and religious problem solving scales in the subsequent steps two and three. The analysis will also check for moderation effects by education level, age, race and sex as well as any other moderation effects that appear to be present based on observations of the beta

weights in the initial model. In terms of a priori hypotheses, the following are offered based on the literature review and preceding theoretical view of the relationships among the variables:

Hypothesis 1a: Upon entry of the locus of control variables in step 2, internal and God-centered loci of control scales will be positively correlated with psychological help seeking.

Hypothesis 1b: Upon entry of the locus of control variables in step 2, both the chance and powerful others loci of control scales will be negatively correlated with psychological help seeking.

Hypothesis 2a: Upon entry of the religious problem-solving variables in step 3, the self-directing and collaborative problem-solving styles will be positively correlated with psychological help seeking.

Hypothesis 2b: Upon entry of the religious problem-solving variables in step 3, the deferring problem-solving style will be negatively correlated with psychological help seeking.

Hypothesis 2c: The God locus of control's contribution to the regression model will be rendered non-significant upon entry of the religious problem solving scales. If true, this would suggest that the potential ability of the God-mediated locus of control scale to predict help-seeking is better accounted for by the religious problem solving measures.

Method

Design and Analysis

This study utilized a within-subjects design, as all participants completed each measure. Hypotheses were assessed by using hierarchical multiple regression analysis, with the four locus of control scales and the three religious problem solving scales serving as predictor variables, and the psychological help-seeking scale as the dependent variable. Several control variables were entered at the initial step of the hierarchical regression analysis. These variables were chosen based on prior research indicating their correlative relationship with help-seeking and included age, sex, level of education, frequency of attendance at religious services, and a single-item measure of prior experience with psychological services.

Age and sex have been shown in prior research to have a bearing upon help-seeking attitudes, and strong arguments exist that education and prior experience with psychological services should theoretically have a bearing on psychological help-seeking in particular. Logically speaking, one could infer that those with higher levels of education are more likely to have been exposed to psychological concepts and may have an increased likelihood of viewing professional psychological help as a scientifically based, culturally sanctioned and valid source of health care. Additionally, those with exposure to the university environment may be less likely hold stigmatizing views of mental illness or psychological problems due to exposure to different opinions of mental health services and the mentally ill or to the courses that argued for a medical view of such conditions. The same argument holds for people who are currently or in the past have received professional psychological services.

The degree to which participants had prior experience with professional psychological services was assessed through a single item, worded, "Have you ever received or are you currently receiving professional psychological services?" The respondent was asked to answer "yes" or "no" to this item. Religious service attendance was also assessed by a single item, which asked, "How often do you go to religious services?" Respondents chose from the following choices: more than once a week, every week or more often, once or twice a month, every month or so, once or twice a year, or never. Lastly, respondents were asked to indicate their highest degree obtained: no high school diploma, a high school diploma, some college, Bachelor's degree, or an earned graduate degree. See Appendix E to view each of these items as they appeared in the protocol.

These control variables were entered at step 1 followed by the locus of control scales entered as a group at step 2. The religious problem solving scales were entered as a group at step 3. The results were then examined for significant increases in explained variance, based on changes in the R^2 statistics at each step, in the measure of attitudes towards psychological help seeking. Individual beta weights for each predictor variable were also examined to assess the magnitude of their relationship with help-seeking and corresponding statistical significance levels.

Participants

Participants were recruited from various undergraduate and graduate courses at Auburn University Montgomery and from church congregations in the Montgomery and Mobile metropolitan areas. The undergraduate participants were recruited across a wide range of courses, not only from psychology courses because restricting the student

sample to psychology students could have strongly biased the results. It could be argued that psychology students innately have more positive views of psychological help-seeking than other student populations; therefore, a more diverse sample of college majors was preferred. As a result, only 33 participants were recruited from psychology courses; the other undergraduate participants were recruited from classes in sociology, biology, literature, education, nursing, and political science. Of the older adult participants, most of the churches that agreed to participate were predominately African-American.

When recruited, all participants were told that the survey involved questions about personal religious views and opinions about mental health. All participants were also ensured that their responses would remain anonymous and confidential. Student participants from Auburn University Montgomery were also offered course credit as allowed by their class instructor.

Of the 234 respondents, 190 produced completed protocols. One participant's protocol was discarded because of an extremely low score on the ATSPPH that resulted in a significant studentized residual during preliminary regression analyses, e.g. this participant's studentized residual in the regression model was -3.4. By convention, residuals reflecting more than 2.5 standard deviations reflect outliers relative to the overall regression model. A cumulative distribution function was calculated for the studentized residuals, which yields a probability statistic for each residual reflecting the chance of the residual occurring. Six participants had studentized residuals above 2.5. To control for the act of evaluating multiple probability values each residual's probability statistic was then multiplied by six. After doing so, only the participant with a studentized

residual of -3.3 exhibited a probability statistic below 0.05. Following the guidelines for evaluating regression residuals recommended by Norusis (1997), this participant was removed from the final regression analysis.

Therefore, the final analysis sample consisted of 189 participants. The sample was mainly composed of well-educated adults (approximately 58% of the participants had earned a Bachelor's or graduate degree). The mean age for the entire sample was 35.60 (*SD*=13.78), with ages ranging from 16 to 81. The majority of respondents were also African-American women (see Table 1). Most respondents also identified with a specific religious group (*n*=135) and denied prior experience with mental health services (*n*=147). The overwhelming majority of respondents affiliated with a specific religion identified themselves as members of denominations within the Christian religion. Of the Christian denominations, Baptist was endorsed the most frequently (*n*=74), followed by non-denominational Christian (*n*=29), Catholics (*n*=12) and Methodists (*n*=7). Outside of the Christian religion, one participant was Hindu, one was Muslim, and one was a member of the Church of Religious Science. On average, the respondents in this sample reported occasional monthly religious service attendance on the single-item assessment of religious attendance (*M*=3.89, *SD*=1.61).

Table 1

Demographic Characteristics of Respondents

Characteristic	Frequency	Percent
Sex		
Male	38	20
Female	152	80
Age		
Under 20	9	4.7
20 – 29	80	42.1
30 – 39	39	20.5
40 – 49	23	12.1
50 – 59	28	14.7
60 and above	11	5.8
Race/Ethnicity		
African American/Black	134	70.5
Asian American/Pacific Islander	2	1.1
Hispanic/Latin American	6	3.2
Native American	2	1.1
White/European American	45	23.7
Other/Of Mixed Heritage	1	.5
Educational Level		
Non-high school graduate	3	1.6
High School Diploma/GED	23	12.1
Some College/Associate's Degree	54	28.4
Bachelor's Degree	59	31.1
Master's Degree, J.D., Ph.D., M.D., etc	51	26.8
Religious Affiliation		
Agnostic	6	3.2
Atheist	8	4.2
Spiritual, not affiliated with a religion	41	21.6
Affiliated with a specific religious group	135	71.1
Religious Service Attendance		
More than once a week	28	14.7
Every week or more often	62	32.6
Once or twice a month	30	15.8
Every month or so	23	12.1
Once or twice a year	27	14.2
Never	19	10.0

Measures

Multidimensional Locus of Control Scale – God Control Revision (MLCS-GCR; Welton et. al, 1996): The MLCS-GCR (Appendix A) is a revision of the Multidimensional Locus of Control Scale as developed by Levenson (1981). This instrument was designed to identify how individuals view the relationship between their efforts and their outcomes. This measure of locus of control orientation is based on four dimensions of control: internal, chance, powerful others, and God. Respondents with an internal locus believe themselves to be solely responsible for life outcomes. Those with a chance locus believe fate to be solely responsible for life outcomes. Those with a powerful others locus believe that others in positions of power are solely responsible for life outcomes. Those who most identify with a God locus believe God to be solely responsible for life outcomes.

The MLCS-GCR is a thirty-two item questionnaire with eight items in each subscale. The Internal subscale includes such items as "Whether or not I get to be a leader depends mostly on my ability" and "My life is determined by my own actions." The Chance subscale includes such items as "It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune" and "I have often found that what is going to happen will happen." The Powerful Others subscale includes such items as "Getting what I want requires pleasing those people above me" and "If important people were to decide they didn't like me, I probably wouldn't make many friends." The God subscale includes such items as "In order to have my plans work, I make sure that they fit in with the commands of God" and "When good things happen to me it is because of God's blessing." Responses range from (-3) strongly

disagree to (3) strongly agree. Possible subscale totals range from 0 to 48; higher scores indicate a stronger belief in the particular locus.

Welton and colleagues (1996) found that their God control scale demonstrated high internal consistency, as alpha coefficients ranged from .85 to .89. Because the God control scale should be conceptually related to higher religiosity, concurrent criterion-related validity was also investigated by examining correlations between other measures of religiosity such as Hoge's Internal Religiosity Scale (1972). They found that the God scale correlated highly with these measures. Additionally, the internal locus and the God centered locus showed a small negative zero-order correlation, indicating that they are measuring two conceptually different entities. Moreover, they submitted the Carver COPE scale to factor analysis and noticed that a trend emerged in which several of the subscales loaded into three factors, which they called "personal control" (active coping and planning solutions), "environmental coping" (seeking support from others), and "passive coping" (using restraint and acceptance). They found that personal coping on the COPE scale showed a statistically significant positive relationship with the internal and God loci and a significant negative relationship with the chance locus. This finding argues for the validity of the MLCS-GCR in predicting more active problem-solving styles among internals and those who ascribe control to God.

In the present study, the God scale of the MLCS-GCR exhibited strong internal consistency (α = .92). The internal consistency of the Internal, Chance, and Powerful Others scales were acceptable but lower than desired, with Cronbach's alphas of .60, .69, and .72, respectively.

Religious Problem-Solving Scale (RPSS; Pargament et al., 1988): The RPSS (Appendix B) measures problem-solving styles in light of the presence of God. Its 36 items divide into three subscales with twelve items each. The Self-Directing subscale measures a tendency to view one's self as the active agent in problem solving; God's role is to give the individual the resources to solve problems themselves. "When I have difficulty, I decide what it means by myself without help from God" is an example of a Self-Directing item. Conversely, the Deferring subscale measures a tendency to view God as the absolute active agent, and the person's role is to wait patiently. "When faced with a decision, I wait for God to make the best choice for me" is an example of a Deferring item. The Collaborative subscale measures the tendency to believe that responsibility for problem-solving is held jointly by God and the individual. "When a hard time has passed, God works with me to help me learn from it" is an example of a collaborative item.

Responses range from (0) never to (4) always, and scale totals range from 0 to 48. Higher scores indicate a stronger tendency to use the particular problem-solving style. Mean scores for the original sample were 36.02 (SD = 10.67) for the Collaborative scale, 29.70 (SD = 10.71) for Self-Directing, and 25.81 (SD = 9.19) for Deferring. Pargament and colleagues (1988) found that the scales demonstrated high internal consistency, with alpha coefficients ranging from .91 (Deferring) to .94 (Self-Directing and Collaborative). It also demonstrated high test-retest reliability, with one-week reliability estimates of r = .87 for Deferring, r = .93 for Collaborative, and r = .94 for Self-Directing.

To understand the relationship between the three coping styles and other theoretically similar religiosity constructs better, Pargament and colleagues (1988)

evaluated the RPSS against the Kopplin God Control scale (designed to measure control by God), the Hoge Intrinsic Religious Motivation scale (designed to measure level of religious commitment), and a revised version of the Batson Orthodoxy scale (designed to measure level of adherence to religious dogma). The self-directing scale showed negative relationships with each of the religiosity measures, while the deferring and collaborative scales showed positive relationships with those scales. More specifically, the deferring scale was more related to measures of God control and orthodoxy than the collaborative scale, which showed more of a relationship to the Hoge Intrinsic Religious Motivation scale. In other words, it seemed that the self-directing scale was wholly unrelated to religiosity and the deferring scale reflected more of a traditional (and, perhaps, superficial) view of God's role in problem solving.

The researchers also wanted to assess the RPSS for relationships with measures of personal control by using Levenson's Personal Control and Chance Control scales and with measures of ability to actively solve problems by using Tyler's Behavioral Attributes of Psychosocial Competence (BAPC) scale. They found that the deferring scale was negatively related to personal control and BAPC but positively related to the chance locus. The self-directing and collaborative scales showed positive relationships with personal control, yet only the collaborative style showed a negative relationship with the chance locus. Interestingly, neither the self-directing nor the collaborative scale showed a significant relationship with BAPC. They theorized that the self-directing style involved more of a reliance on one's own abilities with less religious involvement. The deferring style, they said, reflected more of a belief in the randomness of life and a stronger sense of insecurity about one's abilities, resulting in a reduced likelihood to

engage in active planful problem solving. The collaborative style was reflexive of an adoption of religious values with a belief in one's ability to problem-solve. So, the collaborative style should be related to more proactive help seeking.

In the present study, all three scales of the RPSS demonstrated strong internal consistency (Self-directing, α = .95; Deferring, α = .95; Collaborative, α = .96).

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fisher & Turner, 1970): The ATSPPH (Appendix C) is a measure of an individual's attitude toward seeking professional help for personal and emotional problems. The measure consists of 29 items, with answer choices ranging from (0) disagree to (3) agree. An example of an item is: "If a good friend asked my advice about a mental problem, I might recommend that he see a psychologist." The measure also includes reverse-scored items, such as "There are certain problems that should not be discussed outside of one's immediate family." Scores can range from 0 to 87, and higher scores indicate more of a help-seeking inclination. At its inception, the ATSPPH demonstrated good internal consistency, with alpha coefficients ranging from .83 (n = 406) to .86 (n = 212). It also appeared to have high test-retest reliability, with reliability coefficients ranging from .86 at five days to .84 at two months. This oft-used measure has also demonstrated strong internal consistency in subsequent validity studies, even given changes in the racial, cultural, and socioeconomic characteristics of the sample (Fischer & Farina, 1995; Lopez et al., 1998; Sheikh & Furnham, 2000). For this study, the word *psychologist* was substituted for *psychiatrist*. The researcher wanted to prevent respondents from inferring the use of medications in treatment (typically, only psychiatrists are allowed prescription privileges), emphasize the "talk-therapy" aspect of treatment, and negate the notion that

the measure was asking about very serious emotional disturbances, rather than any level emotional difficulty. Other studies used the same substitution (Blazina & Marks, 2001; Blazina & Watkins, 1996). Moreover, the ATSPPH demonstrated acceptable internal consistency (α = .87) in the present study.

Social Desirability Scale-17 (SDS-17; Stöber, 2001): The SDS-17 (Appendix D) is a basic measure of social desirability. It is important to control for socially desirable responding in religious populations, as they have a tendency to report aspirations, or what they "should do," instead of actual behaviors or attitudes. The measure consists of sixteen items, with true-false answer choices. Examples of items include: "I always eat a healthy diet" and "Sometimes I only help because I expect something in return." This measure also includes reverse-scored items. Each true answer choice is worth one (1) point and each false is worth zero (0) points. Possible totals range from 0 to 16, with higher scores indicating a tendency to present an unrealistically positive self-image.

The SDS-17 was used in lieu of the more traditionally used Marlowe-Crowne (1960) measure of social desirability because of its more modern content. It demonstrated reliability and internal consistency comparable to the Marlowe-Crowne, with an alpha coefficient of .72 and a test-retest reliability coefficient of .82 over a four-week period (Stöber, 2001). It also demonstrated strong convergent validity with the Marlowe-Crown scale and the Lie Scale of the revised Eysenck Personality Questionnaire, with correlations of .74 and .60, respectively. Though the SDS-17 was developed and validated on a European sample, it has also been evaluated for use in US populations. Blake and colleagues (2006) administered the survey to both university and community samples in a three-part study. Upon analysis, the researchers discovered that

the SDS-17 demonstrated strong convergent validity with the Marlowe-Crown scale, with Pearson correlations ranging from .70 ($p < .001$) and .91 ($p < .001$). In their study, the SDS-17 also showed internal consistency, with alpha coefficients ranging from .64 to .92. The results of the Blake study present a strong argument for the suitability of use of the SDS-17 on US populations. In the present study, the SDS-17 demonstrated acceptable internal consistency ($\alpha = .74$).

Demographic Questionnaire: General demographic information was obtained through the completion of a demographics questionnaire (Appendix E). This survey asked participants their age, sex, race or ethnicity, relationship status, level of education, approximate yearly income, religious affiliation, frequency of religious service attendance, and experience with psychological services.

Procedure

After being informed about the nature of the study, participants with internet access were directed to the researcher's website. They were then instructed to follow a link that led them to the web survey, which was administered over a secure-encrypted web site (www.surveymonkey.com). The participants initially read the informed consent statement (Appendix F), then clicked to signify their electronic consent before completing each of the research instruments. On the last page of the survey, participants were prompted to provide the last four digits of their student identification number and instructor's name if they wished to receive academic extra credit.

Some participants recruited through churches chose to complete a paper-and-pencil version of the online survey after they were given a separate informed consent statement to review (Appendix G). Paper and pencil surveys were completed in a single

administration, and most respondents completed the survey within the projected twenty-minute period.

One-Way ANOVAs were conducted with the method of administration, paper-and-pencil vs. web-based, as the independent variable and the scores on Attitudes Towards Professional Psychological Help-seeking instrument. No significant difference emerged between these two different method of administration groups ($F = .10, p = .75$). Additionally, the two administration groups did not significantly differ in the distributions of racial groups ($\chi^2 = 2.18, p = .14$), though significant differences were present in terms of education levels ($\chi^2 = 15.57, p = .004$). In terms of education levels, the paper-and-pencil group consisted of less individuals holding a Bachelor's degree or higher than did the individuals completing the instrument via internet. Based on the lack of any significant differences between the groups in terms of the Attitudes Towards Professional Psychological Help-seeking scale, the groups were merged and entered as a group into the hierarchical regression analysis.

Results

Preliminary Analyses

Analysis of Race. Initially, racial differences were to be included among the predictor variables. However, the obtained sample was less racially diverse than anticipated, resulting in much smaller cell sizes for different racial groups (there were 134 African Americans and only 45 Whites). Therefore, a preliminary exploratory analysis was conducted to assess the potential role of race in regards to the research questions and to determine the utility of including race in the regression model. A One-Way Analysis of Variance was conducted with race as the independent variable and psychological help-seeking as the dependent variable; no significant differences emerged between Whites, African Americans, and an "Other" race category ($F_{2,186} = 1.25, p = .25$). Additional One-Way ANOVAs were conducted with race as the independent variable and the other continuous predictor variables as the dependent variable. Several racial differences emerged here, though no differences were observed between Whites and the "Other" racial group. Based on this, a final analysis was conducted with a binary racial independent variable of African Americans and a combined group of White and "Other" participants. In this simplified comparison, African Americans generally appeared more religious than Whites, as evidenced by their scoring significantly higher on the God-Centered Locus of Control Scale ($F_{1,187} = 63.6, p < .001$) and the Collaborative ($F_{1,187} = 43.7, p < .001$) and Deferring ($F_{1,187} = 51.4, p < .001$) Religious Problem Solving Scales than the combined White and "Other" racial group. African Americans also scored significantly lower on the Self-Directing Religious Problem Solving Scale ($F_{1,187} = 36.7, p < .001$). They also reported attending religious services to

a greater degree and reported higher education levels compared to the combined White and "Other" racial groups. Lastly, there were again no differences observed on the ATSPPH scale when using the binary race variable ($F_{1,187} = 1.6, p = 2.00$).

Interaction cross products were then calculated using this binary racial variable and multiplying it by a centered version of each of the other continuous predictor variables. After the entire regression model was constructed with locus of control and religious problem solving scales entered, the race interaction variables were entered and no significant beta weights were observed for any of the race interaction effects. This indicates that race, while relating to differences in religiosity measures and education levels, did not directly predict scores on the dependent variable, nor was any significant moderation/interaction effect present for the final regression model in terms of racial group membership. Consequently, race was not included in the final regression model.

Descriptive Statistics of Research Variables. In this sample, there were higher mean scores for the God-centered and internal loci than the chance or powerful others loci (see Table 2). The sample also scored higher on deferring and collaborative problem solving styles than the self-directing one. Mean scores for this sample were lower than the original study sample on the Self-directing and Collaborative scales. Skewness and Kurtosis statistics were calculated for each continuous variable and all results were within acceptable ranges, i.e. between -2 and 2.

Table 2

Descriptive Statistics for Research Variables

Variables	Mean	SD
Locus of Control		
Internal	33.74	6.04
Chance	19.67	6.59
Powerful Others	18.66	6.82
God	36.64	10.87
Religious Problem Solving Style		
Self-directing	15.37	12.43
Deferring	29.73	12.87
Collaborative	22.37	12.06
Attitudes Toward Seeking Professional Psychological Help	59.40	12.54

Note. Possible scores on the locus of control scales range from 0 to 48, with higher scores indicating a stronger belief in that particular locus. Possible scores on the religious problem-solving scales also range from 0 to 48, with higher scores indicating a stronger tendency to use that particular style. Possible scores on the ATSPPH range from 0 to 87, with higher scores indicating more favorable views of seeking professional psychological help.

Correlations between Research Variables. Only a few variables demonstrated moderate to strong correlations in general. Of note is that the religious attendance variable entered into the correlational analysis was dichotomized into a low attending group (participants who endorsed "never", "once or twice per year", and "every month or so") and a high attending group (those who endorsed "once or twice per month", "every week", or "more than once per week"). Likewise, the education item was similarly dichotomized into a low education group ("no high school diploma", "high school diploma", and "some college") and a high education group ("Bachelor's Degree" and "Graduate Degree").

In relation to help seeking, it appears that women, the better educated, and those with previous experience with psychological services were more receptive to seeking

psychological help (see Table 3). Note that the relationship between prior experience and attitudes towards help-seeking seems negative because of the way the responses were coded ("yes" was coded as "1" and "no was coded as "2"); therefore, as inexperience with psychological service decreased, favorable attitudes toward psychological help-seeking increased. It also appeared that women were more likely to attend church services, which is consistent with volumes of prior research on the gender-religion relationship. As the literature suggested, religious service attendance was moderately correlated with a God-centered locus of control. Service attendance was also negatively correlated with a self-directing religious problem solving style, but was positively correlated with the collaborative and deferring religious problem solving styles.

In regards to the locus of control variables, the Powerful Others and Chance scales were modestly positively correlated. This finding supports the literature in that both seem to involve an external locus, yet they are unique expressions of externality. Interestingly, the God centered locus and the internal locus showed no relationships with other subscales. This discovery suggests that those two scales are distinct measures of locus of control. However, the God-centered locus was moderately correlated with the three religious problem-solving scales, which may indicate that they are expressing similar constructs, perhaps a general religiosity factor. As expected, there was a negative relationship between the God centered locus and the self-directing problem solving style. Logically, those who do not assign control to God would be less likely to perceive a deity as integral in solving life problems.

Within the RPSS, all three scales showed statistically significant correlations with each other. Though this sample saw the self-directing style as distinct from the

collaborative and deferring styles, they did not seem to distinguish between the latter two, as those styles were strongly correlated with each other in this study. This result may reflect a tendency among the participants to respond in the affirmative to any items that invoke religious associations, or have an "indiscriminately pro-religious" response set. The moderate to high correlations between the religious problem solving scales limits the ability of the present analysis to detect distinct relationships between these scales and the outcome variables. Also, this finding calls into some question the distinct construct validity of the three religious problem solving styles.

Table 3

Intercorrelations between Research Variables

		1	2	3	4	5	6	7	8	9	10
1	*ATSPPH*										
2	AGE	0.184 *									
3	SEX	0.249 **	-0.077								
4	BACH	0.079	0.168*	-0.043							
5	GRAD	0.232 **	0.197**	0.127	-0.259**						
6	REL	-0.009	0.041	0.229 **	0.044	0.158 *					
7	EPS	-0.328 **	-0.083	-0.173 *	-0.055	-0.162 *	0.024				
8	ILC	0.099	0.088	-0.097	0.086	-0.091	-0.210**	0.014	(0.600)		
9	CLC	-0.179 *	-0.144*	-0.102	-0.086	-0.077	-0.200**	-0.008	-0.108	(0.690)	
10	POLC	-0.033	-0.087	-0.055	0.028	-0.046	-0.163*	-0.070	0.129	0.411 **	(.717)
11	GCLC	0.024	-0.101	0.168 *	-0.024	0.096	0.455**	0.065	-0.070	0.110	0.126
12	SDRPS	-0.130	-0.033	-0.151 *	-0.006	-0.093	-0.413**	-0.116	0.133	-0.006	0.100
13	CRPS	0.069	0.066	0.075	0.027	0.051	0.359**	-0.001	0.037	0.069	0.005
14	DRPS	-0.029	0.081	0.055	-0.044	0.002	0.353**	0.181*	-0.087	0.174 *	0.059

Table 3 Continued

		11	12	13	14
11	GCLC	(.917)			
12	SDRPS	-0.674 **	(.947)		
13	CRPS	0.702 **	-0.607 **	(.960)	
14	DRPS	0.661 **	-0.467 **	0.729 **	(.945)

Note. BACH = dummy code for Bachelor's degree, GRAD = dummy code for graduate degree, REL = frequency of religious service attendance, EPS = experience with psychological services, ILC = internal locus of control, CLC = chance locus of control, POLC = powerful others locus of control, GCLC = god-centered locus of control. SDRPS = self-directing problem solving style. CRPS = collaborative problem solving style, DRPS = deferring problem solving style. ATSPPH = attitudes toward seeking professional psychological help
Note. BACH and GRAD are dummy-coded with participants with less than a Bachelor's degree as the omitted reference group
Note. The numbers in parentheses are Cronbach Alphas for the selected scales
*$p < .05$ **$p < .01$

Hierarchical Regression Analysis

As previously mentioned, an initial version of the hierarchical regression analysis was conducted (in the same format as will be described below); however, the standardized residual of one participant was below -3.3 due this participant's very low score on the ATSPPH. This participant was excluded from the analysis, and the hierarchical regression was conducted again, the results of which are described below. What follows is a narrative summary of the results of the hierarchical regression analysis.

At step 1, sex, age, level of education (dummy coded as BACH and GRAD with those with less than a Bachelor's degree serving as the omitted reference group), past experience with religious service, and frequency of religious service attendance (dichotomized) were entered into the regression model (see Table 4). The overall regression model was statistically significant ($F_{6,182} = 8.02, p < .001$), and approximately 21% of the variance in scores on the ATSPPH was explained ($R^2 = .21$). In step 1, significant beta weights were observed for sex ($\beta = .22, p < .01$), indicating that women scored significantly higher on the help-seeking measure than male respondents (see Table 4). Also, those with higher levels of education reported more positive attitudes towards psychological help-seeking as evidenced by the significant beta weight for GRAD ($\beta = .18, p < .05$), though the beta weight for BACH was not significant ($\beta = .10, p > .05$). This indicates that participants holding a graduate degree scored significantly higher than those holding less than a Bachelor's degree, though those holding a Bachelor's degree did not score significantly higher than those holding less than a Bachelor's degree. Finally, a significant beta weight was observed for the EPS (prior experiences with psychological services) variable ($\beta = -.24, p < .001$). Again, it is important to note that, "yes" was

coded as "1" and no was coded as "2", therefore the negative beta weight indicates that those with prior experience reported more positive attitudes towards psychological help seeking. Finally, the beta weight for frequency of religious services was not statistically significant at this step.

Table 4

Summary of Hierarchical Regression Analysis Predicting the ATSPPH (Step 1)

Predictors	B	Std. Error	Beta	R^2	$R^2\Delta$
AGE	0.117	0.062	0.131	0.209	0.209 **
SEX	6.770	2.139	0.220 **		
BACH	3.570	2.421	0.104		
GRAD	5.024	2.026	0.181 *		
REL	-2.379	1.771	-0.093		
EPS	-7.155	2.028	-0.241 **		

Note. BACH = dummy code for Bachelor's degree, GRAD = dummy code for graduate degree, REL = frequency of religious service attendance, EPS = experience with psychological services, ATSPPH = attitudes toward seeking professional psychological help.
Note. BACH and GRAD are dummy coded with participants with less than a Bachelor's degree as the omitted reference group.
Note. Numbers in parenthesis reflect specific increases in R^2 attributable to each of the interaction terms
*$p < .05$ **$p < .01$

At step 2, the four locus of control scales were entered (see Table 5). The overall regression model remained statistically significant ($F_{10,178} = 5.68, p < .001$), though the change in R^2 from .21 to .24 was not statistically significant ($R^2\ \Delta = .03,\ F_{4,178} = 1.78, p > .05$), indicating that the inclusion of the locus of control variables did not contribute any additional explanation of variance in psychological help-seeking attitudes. Also at step 2, with the locus of control scale accounted for, the beta weights observed for the variables entered in step 1 exhibited the same direction, magnitude and significance levels. Though

the locus of control scales as a group did not contribute significantly to explained variance, there was a trend in the beta weight observed for the chance locus of control scale ($\beta = -.15, p = .052$).

Table 5

Summary of Hierarchical Regression Analysis Predicting the ATSPPH (Step 2)

Predictors	B	Std. Error	Beta	R^2	$R^2\Delta$
AGE	0.102	0.063	0.114	0.242	0.033
SEX	6.306	2.135	0.205 **		
BACH	3.040	2.412	0.089		
GRAD	4.849	2.016	0.175 *		
REL	-3.637	2.070	-0.142		
EPS	-7.557	2.023	-0.255 **		
ILC	0.169	0.142	0.083		
CLC	-0.278	0.142	-0.149		
POLC	-0.016	0.134	-0.009		
GCLC	0.103	0.088	0.091		

Note. The same abbreviations apply from Table 4, with the addition of the following: ILC = internal locus of control, CLC = chance locus of control, POLC = powerful others locus of control, GCLC = God-centered locus of control.
Note. BACH and GRAD are dummy coded with participants with less than a Bachelor's degree as the omitted reference group
Note. Numbers in parenthesis reflect specific increases in R^2 attributable to each of the interaction terms
*$p < .05$ **$p < .01$

At step 3, the three religious problem solving scales were entered (see Table 6) and again the overall regression model was significant ($F_{13,175} = 5.01, p < .001$). Yet, the observed increase in R^2 from .21 to .24 was not significant ($R^2\ \Delta = .03, F = 2.35, p > .05$), indicating that the religious problem solving scales failed to explain a statistically significant amount of unique variance in psychological help-seeking from what was already accounted for by the variables entered in step 1 and 2. Only the self-directing

religious problem solving scale exhibited a significant beta weight (β = -.247, $p < .05$), with those scoring higher on the self-directing scale tending to score lower on the help-seeking measure. Also at step 3, the chance locus of control scale emerged a significant predictor (β = -.16, $p < .05$), indicating that participants endorsing a view of chance or fate as determining life outcomes were likely to report more negative attitudes towards psychological help-seeking. Lastly, the dichotomous religious attendance variable, REL, emerged as a significant predictor (β = -.16, $p < .05$) indicating that those attending religious services less (the group coded as "0") reported more positive attitudes towards psychological help-seeking when the effect of the other variables in the regression modeled are controlled. All other beta weights exhibited similar magnitudes and significance levels to those observed in step 1 and 2.

The Tolerance statistic was calculated for each predictor at each stage of the hierarchical multiple regression. By convention, when Tolerance drops below 0.2, extreme multicollinearity is present, and the validity of the regression model is threatened. None of the predictors exhibited Tolerance statistics below 0.2 at any step of the analysis, indicating acceptable levels of multicollinearity.

Table 6

Summary of Hierarchical Regression Analysis Predicting the ATSPPH (Step 3)

Predictors	B	Std. Error	Beta	R^2	$R^2\Delta$
AGE	0.072	0.065	0.080	0.271	0.029
SEX	6.021	2.120	0.196 **		
BACH	3.037	2.399	0.089		
GRAD	4.978	2.011	0.179 *		
REL	-4.181	2.067	-0.163 *		
EPS	-8.477	2.106	-0.286 **		
ILC	0.209	0.144	0.103		
CLC	-0.307	0.143	-0.164 *		
POLC	0.054	0.136	0.030		
GCLC	-0.104	0.134	-0.091		
SDRPS	-0.246	0.096	-0.247 *		
CRPS	-0.035	0.110	-0.036		
DRPS	0.075	0.112	0.073		

Note. The same abbreviations apply from Tables 4 and 5, with the addition of the following: SDRPS = self-directing problem solving style. CRPS = collaborative problem solving style, DRPS = deferring problem solving style.
Note. BACH and GRAD are dummy coded with participants with less than a Bachelor's degree as the omitted reference group
Note. Numbers in parenthesis reflect specific increases in R^2 attributable to each of the interaction terms
$*p < .05$ $**p < .01$

Interaction Effects. As a *post hoc* analysis moderation effects for race and sex were undertaken through entry of interaction cross products between each demographic variable and each of the other predictors in the model. As mentioned previously, this analysis for race yielded no significant interaction effects, suggesting that none of the findings were moderated by racial group membership. Sex interaction effects were also entered. Likewise, no significant beta weights for the sex interaction cross products were observed, suggesting that sex group membership did not moderate any of the relationship observed in the overall regression model.

Interaction cross products between a centered version of the age variable and each of the other predictor variables were entered into a fourth step of the analysis (see Table 7). Here only one age interaction emerged as significant – Age * God-centered Locus of Control (GCLC).

Table 7

Summary of Hierarchical Regression Analysis Predicting the ATSPPH (Step 4)

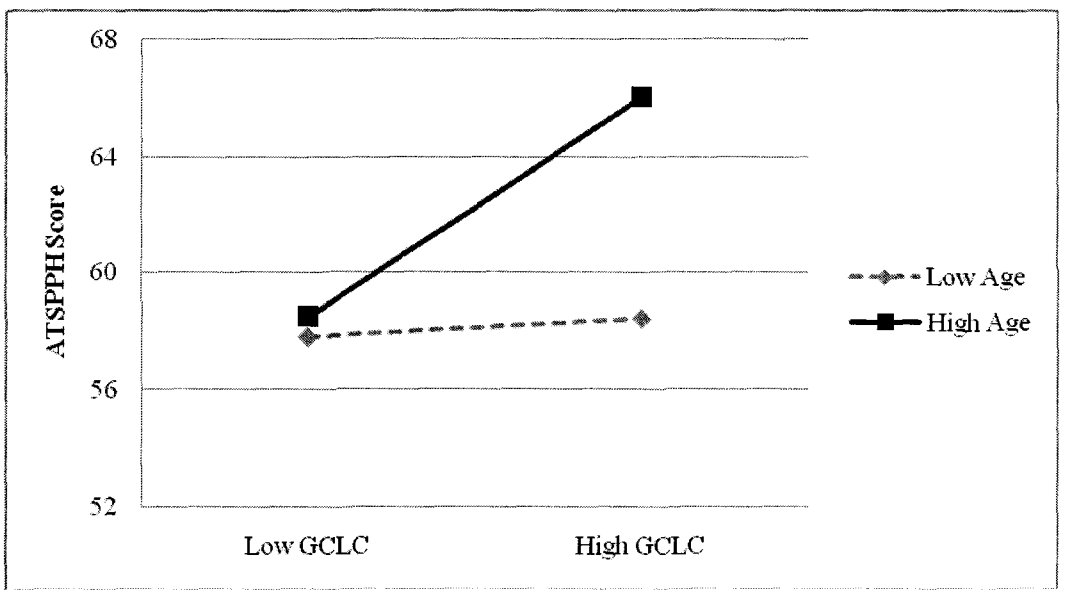
Predictors	B	Std. Error	Beta	R^2	$R^2\Delta$
AGE	0.130	0.064	0.145 *	0.344	0.073 **
SEX	4.881	2.056	0.159 *		
BACH	2.382	2.322	0.070		
GRAD	4.060	1.956	0.146 *		
REL	-3.581	2.000	-0.139		
EPS	-8.590	2.047	-0.290 **		
ILC	0.134	0.143	0.066		
CLC	-0.126	0.155	-0.067		
POLC	0.043	0.132	0.024		
GCLC	0.065	0.138	0.057		
SDRPS	-0.279	0.099	-0.281 **		
CRPS	-0.026	0.108	-0.027		
DRPS	0.017	0.110	0.016		
$SDRPS^2$ * $DRPS^2$	0.000	0.000	0.053		(0.018) *
SDRPS * DRPS	-0.012	0.006	-0.196 *		(0.023) *
CLC * GRAD	-0.597	0.276	-0.166 *		(0.018) *
AGE * GCLC	0.012	0.005	0.138 *		(0.015) *

Note. The same abbreviations apply from Tables 4, 5, and 6 with the addition of the following: $SDRPS^2$ * $DRPS^2$= quadratic term of self-directing problem solving style by deferring problem solving style interaction, SDRPS * DRPS= self-directing problem solving style by deferring problem solving style interaction, CLC * GRAD = chance locus of control by graduate education interaction, AGE * GCLC = age by God centered locus of control interaction.
Note. BACH and GRAD are dummy coded with participants with less than a Bachelor's degree as the omitted reference group
Note. Numbers in parenthesis reflect specific increases in R^2 attributable to each of the interaction terms
*$p < .05$ **$p < .01$

Figure 1 illustrates the AGE*GCLC interaction effect graphically. GCLC exhibited no main effect; in the main analysis, its beta weight was not significant in predicting ATSPPH. Yet, the interaction effect demonstrates that GCLC is a significant positive predictor of ATSPPH, but only for older participants. In other words, it appears that older participants who had a more God-centered locus of control expressed a greater willingness to seek professional psychological help than older participants with less of a God-centered view of personal control. For younger participants, GCLC and ATSPPH appear unrelated to one another.

Figure 1

*Interaction Effect for GCLC * Age*



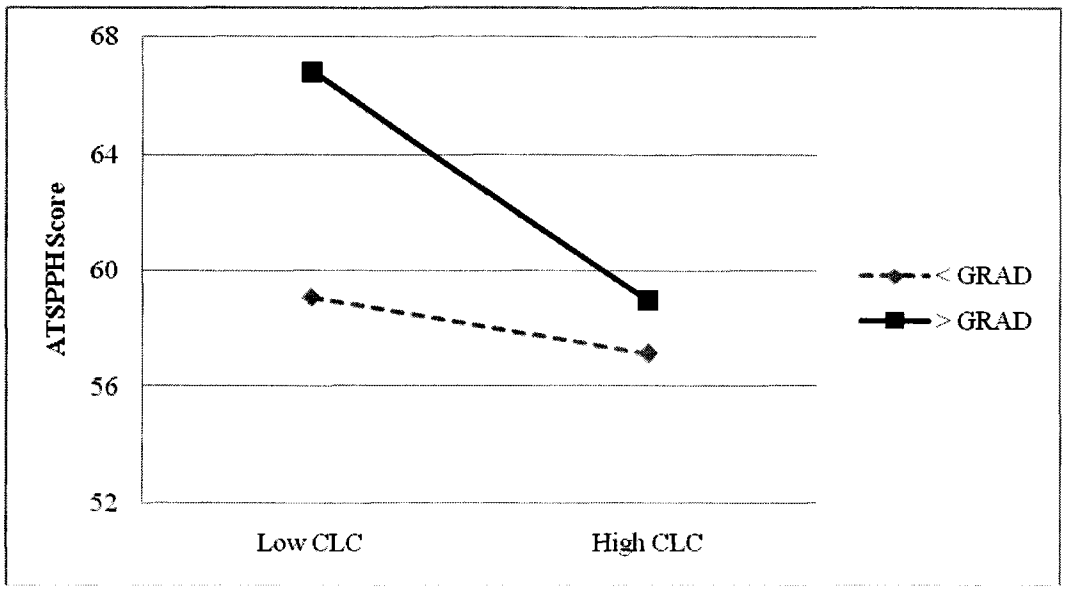
Note. Means shown in the line graph reflect the adjusted means (least square regression means) from the total regression model

Interaction effects by level of education were also checked by calculating cross products for both the BACH and GRAD dummy-coded variables with each of the other

predictors. These were also added to the original regression model in the fourth step (refer to Table 7). Here only the interaction between GRAD (indicating participants with a graduate degree) and Chance Locus of Control (CLC) was significant. Figure 2 illustrates this interaction effect graphically. This significant interaction suggests that CLC is a significant negative predictor, only for participants that have earned a graduate degree, essentially highly educated individuals. For participants having earned less than a graduate degree, GCLC is not a significant predictor. This effect was not true when comparing participants with a Bachelor's degree to those with less than a Bachelor's degree, as the GCLC * BACH interaction term was not significant. In order to fully delineate this finding, a *post hoc* one-way ANOVA was conducted with four levels of education: (a) having earned a high school diploma or less, (b) some college or currently enrolled in college, (c) having earned Bachelor's degree, and (d) having earned a graduate degree. Level of education was then entered as an independent variable with ATSPPH as the dependent variable. The F-test was significant ($F_{3,185} = 4.33$, $p < .01$). Tukey *post hoc* tests were conducted to assess significant differences between the four levels. Those with a graduate degree scored significantly higher than those with a high school diploma or less. However, there were no differences between those with a graduate degree, a bachelor's degree, or some college.

Figure 2

*Interaction Effect for GCLC * GRAD*



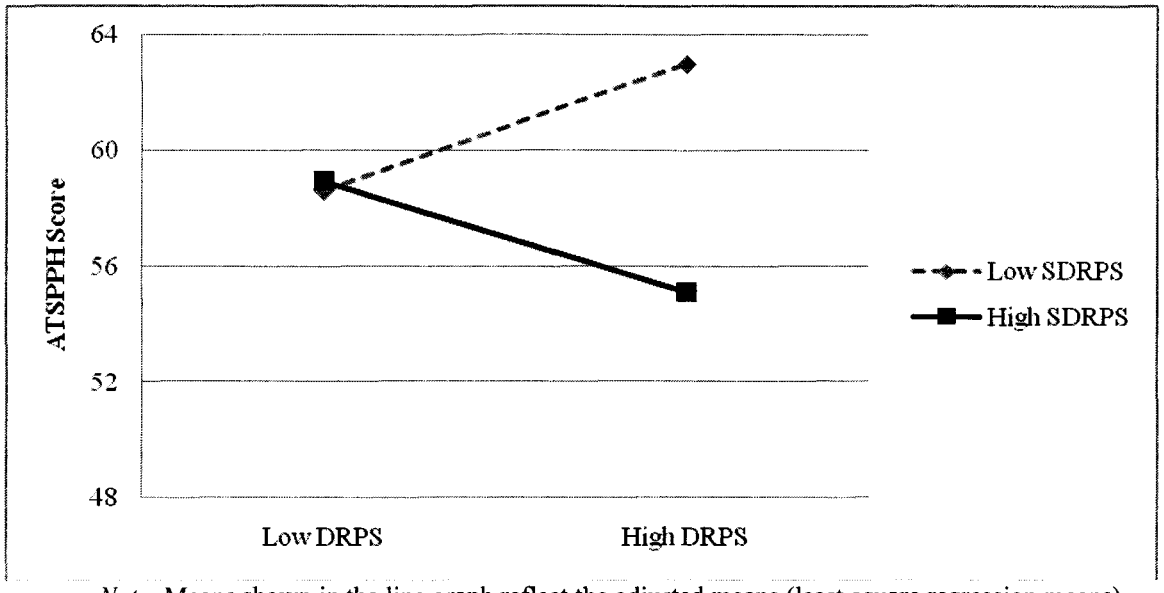
Note. Means shown in the line graph reflect the adjusted means (least square regression means) from the total regression model

Self-Directing Religious Problem Solving (SDRPS) exhibited no zero-order correlation with the ATSPPH, yet was a significant predictor at step 3, though the religious problem solving scales as a group did not contribute a significant addition to explained variance. Therefore, SDRPS was only a significant predictor when the contributions of the other predictors were held constant. To determine whether this reflected an interaction between SDRPS and one of the other predictors, interaction cross products between SDRPS and the other predictors preceding it were also added to the regression model in the fourth step (refer back to Table 7). Here, a significant interaction effect was observed only for the SDRPS * Deferring Religious Problem Solving (DRPS) interaction term.

Complicating the interpretation of this significant interaction effect is that SDRPS and DRPS exhibit a moderately strong zero-order negative correlation. Though not yielding a Tolerance statistic below .2, such multicollinearity between the constituent variables of an interaction term poses a statistical problem. As outlined by Cortina (1993), when the constituent variables of an interaction cross product are highly correlated, a significant interaction term can occur simply due to the presence of non-linear effects (curvilinear) that are not accounted for in the regression model. If non-linear effects are included in the model, the contributions of the simple interaction terms are sometimes nullified. To check for such spurious findings, Cortina recommended entering a quadratic term into the analysis representing the potential non-linear effects between the two constituent variables. Therefore, instead of x * y, a non-linear term of x^2 * y^2 is calculated. In light of this recommendation, the interaction stage of the analysis was run again, except this time a quadratic term was entered ($SDRPS^2$ * $DRPS^2$) along with SDRPS * DRPS. The results showed that the non-linear term was not significant and SDRPS * DRPS remained significant. Figure 3 presents this interaction effect graphically. It appears that SDRPS shows up as a significant predictor in step 3, despite no zero-order correlation with the dependent variable, due to its interaction with DRPS. A check of partial correlations confirms this finding, as SDRPS exhibits a mild and non-significant zero-order correlation with ATSPPH ($r = .130, p > .05$). Yet when DRPS is controlled for, the partial correlation between SDRPS and ATSPPH is mild but significant ($r = -.162, p < .05$).

Figure 3

*Interaction Effect for SDRPS * DRPS*



Note. Means shown in the line graph reflect the adjusted means (least square regression means) from the total regression model

Discussion

Upon evaluation of the results of the regression analyses, it seems that the relationship between help-seeking and perceptions of personal control is more complex than previously assumed. Before investigation, the researcher proposed that those with internal loci and God centered loci would view psychological help-seeking more favorably than those who endorsed more chance and powerful others loci. This prediction was based on the findings of prior research as well as theoretical-logical speculation. However, only the chance dimension of locus of control in step 3 was a significant predictor of negative attitudes toward help seeking. Ultimately, the main effect for CLC was better interpreted as an interaction effect between CLC and level of education, with CLC being a negative predictor only for respondents with graduate degrees. The researcher also proposed that people who employ the more active self-directed and collaborative problem solving styles would be more likely to seek help than those who were passive deferrers. Yet, a self-directing style showed a negative relationship with help seeking, at least for individuals who also endorsed a deferring religious problem solving style. Overall, the obtained model yielded findings worthy of further discussion, but often contradictory to the researcher's predictions.

Sex, Education, Psychological Experience, and Help Seeking

Though few solid assumptions could be made about the effects that religiosity played on help seeking, it is interesting to note that sex, level of education, and experience with psychological services continued to play a substantial role in attitudes toward help-seeking while controlling for other variables of interest. This finding supports previous research indicating women are more likely than men to seek

psychological services (Blazina & Marks, 2001; Blazina & Watkins, 1996; Leong & Zachar, 1999; Mansfield et al., 2005; Russo & Sobel, 1981; Verbrugge, 1989). Perhaps, as other researchers have suggested, there are strong gender roles tied to the act of help-seeking that transcend other psychsocial factors, such as religiosity and perceived control.

The results of this study also support the general notion that those who are more educated would view psychological services more favorably than others would (Fischer & Cohen, 1972; Hines-Martin, Usui, Kim, & Furr, 2004; So, Gilbert, & Romero, 2005; Surgenor, 1985). As suggested earlier, higher education may translate into experiences that are more diverse. The university environment not only provides the opportunity for students to gain knowledge about an array of subjects; it also exposes students to cultures, values, and axioms that may be divergent from what they were familiar with in the home or neighborhood environments, which may open their minds to reconsider certain viewpoints that remained unchallenged before. While the author is not suggesting that less educated persons are stubbornly closed-minded due solely to their lack of education, she is suggesting that the collegiate environment exposes people to professionals and resources that might have been unavailable or lacking in other environments.

Exposure to mental health services is key in changing negative attitudes toward mental health and negative perceptions of those who receive those services (Alvidrez, 1999; Gonzalez et al., 2002). In this study, those who have received psychological services viewed help-seeking more positively than those who had not. Perhaps positive encounters with mental health treatment left those individuals with more positive views of psychological services. Alternatively, perhaps those respondents who already had

more "open" help-seeking inclinations were the ones who had experience with mental health services.

Locus of Control Findings

Internal locus of control and God centered locus of control were predicted to be positively correlated with attitudes toward help seeking. This was not found at step two of the analysis; ILC and GCLC exhibited non-significant beta weights. However, GCLC did exhibit a positive relationship with the ATSPPH, but only for the older members of the sample. This suggests that locus of control is not a good general predictor of attitudes towards psychological help seeking. Furthermore, chance locus of control and powerful others locus of control were predicted to be negative predictors of help-seeking at step two. However, CLC was a significant negative predictor but only for participants who held a graduate degree. In contrast, POLC appeared to have no relationship with the dependent variable either as a main effect or as an interaction effect with a third variable. Perhaps the powerful others dimension has various relationships with help-seeking depending upon the individual, therefore no general relationship emerged. As previously mentioned, people endorsing this view may actually be more likely to seek help given their view that "experts" possess control of life's outcomes, to the extent that they view mental health professionals as culturally-sanctioned experts. Perhaps the study could have outlined a relationship between POLC and help-seeking if some operational measure of the degree to which mental health professionals were seen as experts was included in the model. The interaction effect for CLC will be discussed in more detail later.

Overall, the locus of control variables did not contribute significantly to explained variance to the model at step 2. However, the interaction effects for GCLC*AGE and CLC *GRAD did contribute approximately 3.3% of explained unique variance in ATSPPH. The locus of control variables had significant relationships with the dependent variables, but only when the moderating effects of a third variable were accounted for. First, this finding suggests that the robust relationship between locus of control and psychological help-seeking that was predicted does not appear at present. Perhaps the lack of a significant relationship can be explained by the fact that locus of control is often measured psychometrically as a broad index of beliefs about control over life outcomes. Theoretically, such a broad construct as locus of control is impacted by a host of other variables including self-efficacy in a specific context, cultural factors, and, in the present study's case, developmental effects related to aging and education. Simply put, locus of control may be too broad a variable to be characterized as "generally" related to help-seeking, though previous research findings would often contradict this assertion.

How are the specific locus of control interaction effects obtained in the present study best explained? First, there is the peculiar issue of the observed relationship between a belief in randomness as the root of outcomes and educational attainment in this study. The highly educated respondents who also endorsed beliefs in chance reported less favorable attitudes towards seeking professional psychological help. In other words, those holding a graduate degree were generally predisposed to positive attitudes towards psychological help seeking, that is, unless they harbored a belief in chance. Another way to view this interaction effect is that the negative relationship of chance with help-seeking was most pronounced for highly educated individuals, or, alternatively, highly educated

individuals' tendency to view psychological help-seeking favorably was tempered by the presence of chance locus of control beliefs.

Of note is that CLC's individual beta weight was rendered non-significant upon entry of the interaction term, though GRAD's was not, suggesting that interpreting CLC as having a general relationship with ATSPPH is inappropriate and that CLC's only relationship with the dependent variables occurs through interaction with education. In contrast, GRAD's beta weight remained significant even after the interaction term was included, suggesting that a general trend for those with graduate degrees to hold more favorable attitudes towards psychological help-seeking can be said to exist, though this trend is strongly tempered among those individuals believing that chance factors were involved in life outcomes. Also of note is that educational attainment was unrelated to CLC in the present sample; examination of mean scores on CLC across educational levels showed no statistically significant difference. Therefore, educational attainment did not appear to predispose someone to chance views; rather, chance views were only related to attitudes about psychological help-seeking among the highly educated participants. Also of note is that holding a graduate degree was, for most of the participants, a strong predictor of holding positive attitudes towards psychological help seeking.

Though the researcher expected a negative relationship between chance and help-seeking in general, this observation of connections between education, chance, and help-seeking may be explained in one of two ways. The first explanation hinges on an assumption that post-secondary education may foster, for some people, increases in a belief in chance or random factors in the world. Education in general, and post-secondary

education in particular, may introduce increased ambiguity and complexity into an individual's views of his or her world. For these individuals, an increased sense of the world's complexity and the role of random factors may eventually be applied to personal contexts as well as intellectual ones. Perhaps such individuals are likely to view efforts to impose control and certainty on outcomes, personal or global, as inherently caught up in the complexity and randomness present in life and in the world in general. At the same time, however, graduate education often equips individuals with advanced methods of making sense of disparate data and findings. Perhaps some people leave a graduate program with only an increased sense of complexity and the possibility that the world is truly governed by chaotic and random forces, while others leave with more of a trust in the methods of investigation and decision-making taught in post-secondary education. That difference in thinking about the world may be the dividing line between the respondents holding a graduate degree who endorsed chance beliefs, people who leave graduate school with a increased tolerance for complexity, as opposed to those who did not, who have an increased sense of trust in methods of inquiry.

The second explanation hinges on the assumption that a chance belief is more of a manifestation of a pessimistic personality rather than an appreciation for or respect of the randomness and unpredictability of life. One could assume that individuals who feel helpless (i.e., they think that they nor anyone else has any measure of "real" control over their lives) and/or hopeless (i.e., they think that even if they did attempt to effect any changes, their attempts would be unsubstantiated) would be likely to view help-seeking in general, and psychological help-seeking in particular, as an act unlikely to yield positive results. Interestingly, the other group of graduate degree holders who did not

believe in chance had a tendency to view psychological help-seeking as a relatively good practice. Again, the dividing line between these two groups of educated individuals may be more of a personality or disposition.

In addition to the interaction findings related to CLC, the God-centered locus of control variable similarly exhibited no main effect relationship with psychological help seeking, contrary to this study's hypothesis. However, an interaction effect between GCLC and age emerged that suggests that this dimension of locus of control is related to help-seeking but only for older respondents. Specifically, older respondents who also endorsed a God-centered locus of control reported more favorable attitudes towards help seeking. As in the case of chance locus of control, this finding highlights the broad nature of locus of control dimensions and generates skepticism as to the prospect of locus of control having a general relationship with help seeking.

Prior research has demonstrated that generally religiosity increases with age; yet, in the present study age and GCLC were uncorrelated. Therefore, there were similar proportions of GCLC individuals across different age groups in this sample, but GCLC only had an impact on help-seeking attitudes among the older participants. Perhaps a belief in GCLC among younger respondents is more of a mimicking of familial and culturally sanctioned religiosity than a more serious, truly adopted belief. If this were the case, then GCLC would not be expected to have much of an impact on attitudes towards how to cope with and solve psychological problems.

Interaction of Self-Directed and Deferring Religious Problem Solving

Self-directing religious problem solving exhibited a main effect relationship with help seeking, even when the interaction between self-directing religious problem solving

and deferring religious problem solving was included in the model. This finding suggests that, while the negative relationship between SDRPS and help-seeking is generally robust, it is amplified by the presence of the deferring problem solving style. In other words, people who harbored both a self-directing and deferring religious problem solving style had the least favorable attitudes towards seeking help from a psychological professional.

The results of this study in regards to psychological help-seeking and employing self-directing problem solving styles most paralleled those of Chipperfield and Greenslade's (1999) study of the effects of perceived control on health care service utilization in senior citizens. Just as those seniors who were high in perceived control were less likely to use health care services, members of this sample with more proactive problem-solving styles generally held more negative attitudes toward help seeking. It is important, though, not to confuse internal locus of control with self-directing religious problem solving. In the present sample, ILC and SDRPS were not significantly correlated, indicating that these two constructs must be viewed independently. Moreover, ILC was not related to help-seeking in the present study. Theoretically, these two constructs seem similar, and similar relationships between each of these variables and a target variable would be expected. So why did a correlation not occur? These two constructs differ in that ILC does not involve any assessment of the respondent's attitudes about the role of a deity in coping and problem solving, whereas SDRPS explicitly assesses the degree to which a respondent views a deity's role as minimal in such situations. The SDRPS is measuring one's attitudes about the degree of validity with which an individual views involving another entity, in this case a perceived God, in

solving life problems. In contrast to ILC, which simply asseses whether people believe they have the power to mitigate circumstances, SDRPS assesses how the person views invoking external aid, at least in terms of a deity. Perhaps those people who reject seeking aid from God to solve or cope with problems also generalize the same attitudes about seeking aid to other "real people," i.e., mental health professionals. One question the current study cannot answer is whether the negative relationship between SDRPS and help-seeking relationship is limited only to psychological help-seeking attitudes.

In the present study, the self-directing religious problem solving style had both a generally negative relationship with psychological help-seeking as well as a moderated relationship. The beta weight for SDRPS remained significant even after the inclusion of the SDRPS*DRPS interaction term, which was itself significant. The interaction effect suggests that SDRPS's negative relationship with help-seeking was most pronounced for individuals who also scored highly on the deferring scale. This finding is curious and difficult to explain logically. No prior research has found similar findings. What makes interpreting this effect so difficult is that SDRPS and DRPS exhibit a significantly moderate and negative zero-order correlation with one another. In other words, those high in self-directing problem solving were likely to score low on deferring problem solving.

An alternative way to conceptualize this interaction effect is to state that DRPS's relationship with psychological help-seeking is positive for low SDRPS individuals and negative for high SDRPS individuals, yielding no general relationship between DRPS and help seeking. If viewed in this manner, the interaction effect seems easier to interpret. A deferring style, or "leaving it to God," predicts poor psychological help-seeking attitudes when individuals also harbor the seemingly paradoxically belief that "God

expects me to solve things on my own." Those individuals may have an ambivalent view of God's role in coping and problem solving. They simultaneously view problems as something to be "left in God's hands," but also endorse beliefs that they are on their own in problem solving. Perhaps such an attitude reflects a conflicted set of attitudes about the perceived role of a deity in one's coping and problem solving. This interaction effect also suggests that deferring individuals who are not also high on the self-directing dimension are likely to hold favorable views of seeking psychological help. That possible conclusion is intriguing because it shows that an essentially passive and externalized style of coping is associated with positive views of mental health services under certain conditions. Perhaps high DRPS/low SDRPS people would be receptive to mental health services if they perceived them to have a divine origin, or as a "gift from God" that should be utilized to the fullest. Overall, though this finding seems counter-intuitive, because an individual with a deferring religious problem solving style should supposedly be more likely to reject external, particularly secular, sources of help. However, in the present study, this tendency was moderated by the individual's level of self-directing religious problem solving beliefs.

African American Women and Psychological Help Seeking

Readers should note that the racial and gender composition of this sample is atypical, in that the majority of participants were relatively highly educated women of color; 44% of the sample were African American women with a Bachelor's or graduate degree. The unique demographic composition of this sample may account for differences between previous research and the results of this study in regards to psychological help seeking. In general, race did not directly predict help-seeking in this study, as several

previous studies have insinuated. As is the case with many psychological research studies in general, most help-seeking studies have been conducted with university samples, composed mainly of middle-class, young White adults. Even research on minorities in general is typically performed with so-called "underprivileged populations," consisting of participants from poor or working class backgrounds with low levels of educational attainment. While it was not the intention of the researcher to gain such a large sample of middle class, African-American women, interpreting these results while ignoring the make-up of the sample would be a grievous error. The following discussion considers the nuances in help-seeking attitudes among African-American women.

In comparison to Pargament's (1988) original study, which employed a mostly White sample, the mean scores of this sample as a whole were lower on the self-directing and collaborative dimensions of religious problem solving. Within this sample, African Americans were higher on collaborative and deferring styles and lower on the self-directing style than the combined White/Others racial category. In a similar study of religious problem solving among a community sample of African American adults, African American women reported higher deferring scores and collaborative scores than African American men (Lewis-Coles & Constantine, 2006).

Furthermore, African-American respondents in this sample were also higher on church attendance than the White/Other group. Perhaps the reason why Black women score higher on the coping styles that evoke more reliance on God is that they are more reinforced to do so through their contacts with religion. In a qualitative study of Black women's meaning-making and coping with adverse experiences, Mattis (2002) found that what would be conventionally thought of as a deferring or passive coping style in regards

to spirituality (called "spiritual surrender" in her study) was often employed, yet seen as a last resort, when all the women's inner resources were exhausted. In this study, church attendance was a negative predictor of help seeking, but in traditional research, it was a positive predictor of health-promoting behaviors. Perhaps religion plays different roles in different situations.

Viewed from this angle, the curious SDRPS*DRPS interaction finding makes more sense. Given that this interaction was found in a sample of educated African American women, who generally tend to hold more deferring or passive views of God's role in their lives, the finding may reflect the unique socio-cultural position of the African-American female parishioner. Specifically, African American women may be socialized within African American churches to take the "spiritual surrender" position described in Mattis's work. And perhaps "spiritual surrender" is conceptually similar to the deferring problem solving style. However, these women were also, for the most part, highly educated. The educational experience is likely to promote a sense of trust in one's own intellectual and personal resources, which might be the antithesis of what is taught in their religious lives. Perhaps the interaction effect reflects the conflicting values of the women in this sample, who are both deferring in keeping with their cultural traditions and self-directing in keeping with their educational experiences. Maybe this conflict serves as a barrier to seeking help for psychological problems. In other words, these women may believe they should externalize problems to a deity while taking independent action, resulting in the rejection of external human aid and the resolution of dilemmas through both personal faith and personal effort. This interpretation must be viewed with caution, however, because the study's sample sizes by race are not large enough to directly test

whether a significant three or four way interaction is present for the SDRPS*DRPS effect by race and/or sex.

Limitations

Readers are warned not to generalize these results to general samples of religious populations or African Americans. This sample, composed of mainly Christian denominations, may utilize different coping methods other than religious sects. Furthermore, one should not generalize these results to all African Americans or even African American women because there were not enough African American men for comparison purposes and because the African American women were more educated than the typical community sample. This sample as a whole was more educated than the typical community sample, which may have been a function of the mode of administration of the survey protocol. Web-based surveys demand at least a minimal amount of computer savvy.

Additionally, the measure of previous psychological experiences item may have been too simple. Maybe some respondents who did not have direct experience with psychological services had favorable attitudes toward psychological help-seeking because of indirect experiences with the mental health field. Maybe they have noticed the positive effects of therapy on a close friend or relative. Because psychotherapy and medication use for emotional problems is advertised more on television and discussed more in the media and popular culture than in earlier years, seeing a psychologist or being medicated for certain mental illnesses may not hold the stigma that it once held, making it socially acceptable for more members of society to use those type of services. In sum, it would be beneficial to know the type of exposure (personal or vicarious) to

mental health services. Likewise, the response options for the measure of religious service attendance somewhat overlapped, serving only as a gross approximation of a person's religious service attendance.

Furthermore, the alpha coefficients of the Internal, Chance, and Powerful Others dimensions of the MLCS-GCR scale were weaker than expected. Likewise, respondents did not seem to differentiate between the collaborative and deferring scales of the RPSS. Just as Allport and Ross (1967) discovered, some members of this sample may have been "indiscriminately pro-religious." In other words, they may have endorsed all items that mentioned God positively without realizing the difference between the two. Perhaps further research should be done to formulate and validate personal control and religious coping measures that are sensitive to this type of responding.

While the ATSPPH is a reliable, valid measure of views of professional help seeking, it ignores the fact that some people may view help-seeking as context-specific. The public may view professional help-seeking as an extreme solution to be utilized only for very serious problems. Therefore, views of the necessity of help-seeking may really depend on the nature of the problem. Perceptions of control may also be context-specific, depending on the problem at hand. For example, people may see getting a terminal illness, such as cancer, as something beyond their personal control, and be likely to assign control of that situation to God or chance. There are always individual differences to consider in the interpretations of and response to stressors (Pyant & Yanico, 1991; Cutrona, Russell, Hessling, Brown, & Murry, 2000).

Implications for Practice

All in all, people high in both self-directing problem solving and deferring problem solving may feel inhibited from actively seeking secular help due to both personal and religious reasons. If that is indeed the case, community mental health professionals should start working more closely with church leaders and others in the community to recognize the need for services in a population that is not going to ask for help explicitly. For example, certain churches keep records of parishioners who are ill, grieving, or otherwise in need of support. If an important figure in the church could refer those people to the appropriate "outside" services, maybe it would increase the likelihood of them using the service because the service would be approved by the church.

Moreover, it is heartening to discover that the older God-centered respondents were more receptive to psychological help seeking, because they may be more likely to be facing unique problems that can be effectively managed by a mental health professional such as depression, signs of dementia, and bereavement issues. Yet this positive attitude may or may not translate into actual service utilization. There may be other barriers, such as transportation or financial issues. Just as this researcher earlier suggested working through churches to reach those unlikely to seek help, maybe church referrals are a good idea in order to lead this particular population to the appropriate resources. In short, a more practical, "meet-the-people-where-they-are" approach to providing services might prove more effective than expecting them to come out of their comfort zone.

Alternatively, seminary schools can start to train their students more rigorously in recognizing and treating certain emotional problems. Since some parishioners may feel

more comfortable with seeking advice or console from their pastor, why not properly train the minister? Of course, there are professionals who specialize in religious counseling. There are also ministers who have received a certain level of counseling training at a theological seminary. Since the pastor may be the first "line of defense" so to speak, he or she should be properly trained to recognize and adequately treat symptoms of distress, or refer the individual to the proper mental health professional if more extensive treatment is warranted. An even more basic concept would be to validate the benefits of psychological help-seeking by speaking about it openly in the church.

Finally, reframing the concept of psychological help-seeking at the cultural community level may prove helpful in addressing inability to cope with stress, depression, and anxiety. Instead of it being a formal affair, in which the person must make an appointment with a doctor, maybe community mental health workers and mental health specialists that work in state or government funded agencies could host support groups and seminars about self-care, or distribute information about effective stress management in community centers and other easily accessible areas in the neighborhood. Similar "grassroots" efforts in relation to physical health care seem to be successful in reaching underserved populations and encouraging them to maintain regular physical healthcare. As this study suggested, past exposure to mental help services are related to positive attitudes about psychological help seeking. Once psychological services are seen repeatedly and psychological help-seeking is increasingly seen as something that is accessible and beneficial for a wide variety of challenges, perhaps attitudes and behavior (i.e., mental health service utilization) will also change.

Implications for Future Research

Since we cannot assume homogeneity of groups, especially religious groups, it would behoove future researchers in the area of religion to compare help-seeking views among denominations within the Christian faith. It would also be interesting to garner greater participation from members of religions outside of the Christian faith, to see if attitudes on help-seeking vary by religion. It would also be interesting to gain equal racial groups in order to make meaningful comparisons between those groups. If those groups were equal in number, yet education and experience still better explained differences in help seeking, it would provide a stronger argument for the necessity to evaluate the idiosyncratic differences of individuals within certain groups.

Because the ATSPPH asked about help-seeking for general emotional problems, it may be more helpful to provide future participants of such studies with vignettes so that they can evaluate the need for help depending on the presenting problem, as well as assign what they feel would be appropriate help. For example, Schnittker, Freese, and Powell (2000) used the 1996 General Social Survey (GSS) to explore racial differences in perceptions of the cause and treatment of mental illness. The GSS employed a vignette design so that participants could choose the appropriate treatment (i.e, go to a general practitioner, go to a psychiatrist, go to a therapist/counselor, talk to a minister) based on their perceived causes (i.e., biological, chemical, familial upbringing, life stressors, bad personal character, or God). Perhaps the present study should have asked participants who did not feel comfortable with seeking professional help about other types of help-seeking would they employ, if any.

Finally, the ultimate goal of psychological research in the realm of religion should be to help foster more understanding and collaboration between ministerial leaders and psychologists. Before researchers engage in a plethora of quantitative research regarding religion and psychological help seeking, perhaps psychologists should perform more qualitative studies to understand the constructs and people involved more intimately. This study is an argument for qualitative research in this area because of the results, which were contrary to previous research in locus of control and problem solving in the religious population. This study also contributes to the growing knowledge-base seeking to understand religion and the religious population on its terms, without the judgments that have plagued the religion-psychology relationship for far too long.

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Appendix A

Multidimensional Locus of Control Scale – God Control Revision

The following is a series of attitude statements. Each represents a commonly held opinion. There are no right or wrong answers. You will probably agree with some items and disagree with others. We are interested in the extent to which you agree or disagree with such matters of opinion. Read each statement carefully. Then indicate the extent to which you agree or disagree using the following responses:

If you agree strongly, respond +3
If you agree somewhat, respond +2
If you agree slightly, respond +1
If you disagree slightly, respond -1
If you disagree somewhat, respond -2
If you disagree strongly, respond -3

First impressions are usually best. Read each statement, decide if you agree or disagree and the strength of your opinion, and then respond accordingly. GIVE YOUR OPINION ON EVERY STATEMENT. If you find that the answer choices don't adequately reflect your own opinion, use the one that is closest to the way you feel. Thank you.

1. Whether or not I get to be a leader depends mostly on my ability.	-3	-2	-1	+1	+2	+3
2. To a great extent my life is controlled by accidental happenings.	-3	-2	-1	+1	+2	+3
3. What happens in my life is determined by God's purpose.	-3	-2	-1	+1	+2	+3
4. I feel like what happens in my life is mostly determined by powerful people.	-3	-2	-1	+1	+2	+3
5. Whether or not I get into a car accident depends mostly on how good a driver I am.	-3	-2	-1	+1	+2	+3
6. When I make plans, I am almost certain to make them work.	-3	-2	-1	+1	+2	+3
7. My life is primarily controlled by God.	-3	-2	-1	+1	+2	+3
8. Often there is no chance of protecting my personal interests from bad luck happenings.	-3	-2	-1	+1	+2	+3
9. When I get what I want, it is usually because I'm lucky.	-3	-2	-1	+1	+2	+3
10. Although I might have good ability, I will not be given leadership responsibility without appealing to people in positions of power.	-3	-2	-1	+1	+2	+3
11. When I am anxious, I rely on God for inner peace.	-3	-2	-1	+1	+2	+3
12. How many friends I have depends on how nice a person I am.	-3	-2	-1	+1	+2	+3

13. I have often found that what is going to happen will happen.	-3	-2	-1	+1	+2	+3
14. Whether or not I get into a car accident depends on God's plans.	-3	-2	-1	+1	+2	+3
15. My life is chiefly controlled by people who are more powerful than me.	-3	-2	-1	+1	+2	+3
16. Whether or not I get into a car accident is mostly a matter of luck.	-3	-2	-1	+1	+2	+3
17. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.	-3	-2	-1	+1	+2	+3
18. In order to have my plans work, I make sure that they fit in with the commands of God.	-3	-2	-1	+1	+2	+3
19. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.	-3	-2	-1	+1	+2	+3
20. Getting what I want requires pleasing those people above me.	-3	-2	-1	+1	+2	+3
21. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.	-3	-2	-1	+1	+2	+3
22. If important people were to decide they didn't like me, I probably wouldn't make many friends.	-3	-2	-1	+1	+2	+3
23. I can pretty much determine what will happen in my life.	-3	-2	-1	+1	+2	+3
24. When things don't go my way, I ought to pray.	-3	-2	-1	+1	+2	+3
25. I am usually able to protect my personal interests.	-3	-2	-1	+1	+2	+3
26. When faced with a difficult decision, I depend on God to guide my feelings and actions.	-3	-2	-1	+1	+2	+3
27. Whether or not I get into a car accident depends mostly on the other driver.	-3	-2	-1	+1	+2	+3
28. When I get what I want, it's usually because I worked hard for it.	-3	-2	-1	+1	+2	+3
29. When good things happen to me it is because of God's blessing.	-3	-2	-1	+1	+2	+3
30. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.	-3	-2	-1	+1	+2	+3
31. My life is determined by my own actions.	-3	-2	-1	+1	+2	+3
32. It's chiefly a matter of fate whether or not I have a few friends or many friends.	-3	-2	-1	+1	+2	+3

Appendix B

Religious Problem-Solving Scale

We are interested in how people analyze and respond to life's problems. There are lots of ways to deal with problems. This questionnaire asks you to indicate what you generally do and feel when you are confronted with a problem. Obviously, different problems evoke different responses, but think about what you usually do when faced with a problem.

Please respond to each item by circling one number on your answer sheet for each item, using the response choices listed below. Please try to respond to each item separately in your mind from each other item. Choose your answers thoughtfully, and make your answers as true FOR YOU as you can. Please answer every item. Once again, there are no right or wrong answers, so choose the most accurate answer for YOU – not would you think "most people" would do or say or how you feel you "should" respond to problems. Indicate what you usually do when you are faced with a problem.

Please indicate how often each of the following statements applies to you:
If never, respond 0.
If seldom, respond 1.
If sometimes, respond 2.
If most of the time, respond 3.
If always, respond 4.

1. I don't worry too much about making the right decisions, since God will make me go in the right direction.	0	1	2	3	4
2. When I have difficulty, I decide what it means by myself without help from God.	0	1	2	3	4
3. I do not become upset or nervous because God solves my problems for me.	0	1	2	3	4
4. When a hard time has passed, God works with me to help me learn from it.	0	1	2	3	4
5. Rather than trying to come up with the right solution to a problem myself, I let God decide how to deal with it.	0	1	2	3	4
6. When I run into trouble, I simply trust in God knowing that He will show me the possible solutions.	0	1	2	3	4
7. When deciding on a solution, I make a choice independent of God's input.	0	1	2	3	4
8. I act to solve my problems without God's help.	0	1	2	3	4
9. When I'm upset, I try to soothe myself, but I also share my unpleasantness with God so He can comfort me.	0	1	2	3	4
10. When faced with a decision, I wait for God to make the best choice for me.	0	1	2	3	4

11. God doesn't put solutions to my problems into action, I carry them out myself.	0	1	2	3	4
12. In carrying out my solutions, I work hard at them knowing God is working right along with me.	0	1	2	3	4
13. When faced with a decision, I make the best choice I can without God's involvement.	0	1	2	3	4
14. God solves problems for me without my doing anything.	0	1	2	3	4
15. When I feel nervous or anxious, I calm myself without relying on God.	0	1	2	3	4
16. In carrying out solutions to my problems, I wait for God to take control and know somehow He'll work it out.	0	1	2	3	4
17. I do not think about different solutions to my problems because God provides them for me.	0	1	2	3	4
18. After solving a problem, I work with God to make sense of it.	0	1	2	3	4
19. When a troublesome issue arises, I leave it up to God to decide what it means for me.	0	1	2	3	4
20. When faced with trouble, I deal with my feelings without God's help.	0	1	2	3	4
21. When a situation makes me anxious, I wait for God to take those feelings away.	0	1	2	3	4
22. When I feel nervous or anxious about a problem, I work together with God to find a way to relieve my worries.	0	1	2	3	4
23. When I run into a difficult situation, I make sense out of it on my own without divine assistance.	0	1	2	3	4
24. God and I talk together and decide upon the best answer to my questions.	0	1	2	3	4
25. When I have a problem I try not to think about it and wait for God to tell me what it means.	0	1	2	3	4
26. When I am trying to come up with different solutions to troubles I am facing, I do not get them from God but think of them myself.	0	1	2	3	4
27. When thinking about a difficulty, I try to come up with possible solutions without God's help.	0	1	2	3	4
28. When I have a problem, I talk to God about it and together we decide what it means.	0	1	2	3	4
29. After I've gone through a rough time, I try to make sense of it without relying on God.	0	1	2	3	4
30. The Lord works with me to help me see a number of different ways that a problem can be solved.	0	1	2	3	4
31. Together, God and I put plans into action.	0	1	2	3	4
32. When a difficult period is over, I make sense of what happened on my own without involvement from God.	0	1	2	3	4
33. When faced with a question, I work together with God to figure it out.	0	1	2	3	4

34. When it comes to deciding how to solve a problem, God and I work together as partners.	0	1	2	3	4
35. When considering a difficult situation, God and I work together to think of possible solutions.	0	1	2	3	4
36. I don't spend much time thinking about troubles I've had; God makes sense of them for me.	0	1	2	3	4

Appendix C

Attitudes Toward Seeking Professional Psychological Help

This questionnaire asks you to indicate your views and opinions about seeking psychological services. Please respond to each item by indicating how much you agree or disagree with each statement. Remember, there are no right or wrong answers. Simply choose the answer that best describes your own personal outlook. Indicate the extent to which you agree or disagree using the following responses:

If you disagree, respond 0.
If you partially disagree, respond 1.
If you partially agree, respond 2.
If you agree, respond 3.

PLEASE REMEMBER TO ANSWER EVERY STATEMENT.

1. Although there are clinics for people with mental troubles, I would not have much faith in them.	0	1	2	3
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychologist.	0	1	2	3
3. I would feel uneasy going to a psychologist because of what some people would think.	0	1	2	3
4. A person with strong character can get over mental conflicts by himself, and would have little need of a psychologist.	0	1	2	3
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.	0	1	2	3
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	0	1	2	3
7. I would willingly confide matters to an appropriate person if I thought it might help me or members of my family.	0	1	2	3
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychological treatment.	0	1	2	3
9. Personal and emotional troubles, like many things, tend to work out by themselves.	0	1	2	3
10. There are certain problems that should not be discussed outside of one's immediate family.	0	1	2	3
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.	0	1	2	3
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3
14. Having been a psychological patient is a blot on a person's life.	0	1	2	3

15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	0	1	2	3
16. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.	0	1	2	3
17. I resent a person – professionally trained or not – who wants to know about my personal difficulties.	0	1	2	3
18. I would want to get psychological help if I were worried or upset for a long period of time.	0	1	2	3
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	0	1	2	3
20. Having been mentally ill carries with it a burden of shame.	0	1	2	3
21. There are experiences in my life I would not discuss with anyone.	0	1	2	3
22. It is probably best not to know *everything* about one's self.	0	1	2	3
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3
24. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.	0	1	2	3
25. I might want to have psychological counseling in the future.	0	1	2	3
26. A person should work out his or her own problems; getting psychological counseling would be a last resort.	0	1	2	3
27. If I had received treatment in a mental hospital, I would not feel that it ought to be "covered up."	0	1	2	3
28. If I thought I needed psychological help, I would get it no matter who knew about it.	0	1	2	3
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	0	1	2	3
30. If people could be more emotionally stable with medication, they should take it.	0	1	2	3
31. If a doctor told me that I would feel better mentally or emotionally if I took a pill, I would take it.	0	1	2	3

Appendix D

Social Desirability Scale-17

Below you will find a list of statements. Please read each statement carefully and decide if that statement describes you or not. If it describes you, circle the word "true"; if not, circle the word "false." Please remember to answer every statement.

1. I sometimes litter.	True	False
2. I always admit my mistakes openly and face the potential negative consequences.	True	False
3. In traffic, I am always polite and considerate of others.	True	False
4. I always accept others' opinions, even when they don't agree with my own.	True	False
5. I take out my bad moods on others now and then.	True	False
6. There has been an occasion when I took advantage of someone else.	True	False
7. In conversations, I always listen attentively and let others finish their sentences.	True	False
8. I never hesitate to help someone in case of emergency.	True	False
9. When I have made a promise, I keep it – no ifs, ands or buts.	True	False
10. I occasionally speak badly of others behind their back.	True	False
11. I would never live off other people.	True	False
12. I always stay friendly and courteous with other people, even when I am stressed out.	True	False
13. During arguments, I always stay objective and matter-of-fact.	True	False
14. There has been at least one occasion when I failed to return an item that I borrowed.	True	False
15. I always eat a healthy diet.	True	False
16. Sometimes I only help because I expect something in return.	True	False

Appendix E

General Demographics Questions

Please complete the following by filling in the blank or placing a mark next to your answer where appropriate.

Age: _____ **Sex:** _____

Race/Ethnicity:

_____ African American/Black
_____ Asian American/Pacific Islander
_____ Hispanic/Latin American
_____ Native American
_____ White/European American
_____ Other: _____

Relationship Status:

_____ Single, never married
_____ Married/engaged to be married
_____ Separated, divorced, or widowed

Approximate yearly income:

_____ $0 - $20,000
_____ $20,001 - $40,000
_____ $40,001 - $60,000
_____ $60,001 - $80,000
_____ $80,001 and above

Level of Education:

_____ Non-high school graduate
_____ High School Diploma/GED
_____ Some College/Associate's Degree
_____ Bachelor's Degree
_____ Master's Degree, J.D., Ph.D., M.D., etc.

Questions about your religious beliefs and practices:

_____ Agnostic
_____ Atheist
_____ Spiritual, but not affiliated with a religion
_____ Affiliated with a specific religious group, please specify: _____

How often do you go to religious services?

1 - More than once a week
2 - Every week or more often
3 - Once or twice a month
4 - Every month or so
5 - Once or twice a year
6 - Never

Besides religious services, how often do you take part in other activities at a place of worship?

1 - More than once a week
2 - Every week or more often
3 - Once or twice a month
4 - Every month or so
5 - Once or twice a year
6 - Never

Have you ever received or are you currently receiving psychological services?

_____ Yes
_____ No

Appendix F

Web-based Informed Consent

Informed Consent

For: The Role of Locus of Control and Religious Problem-Solving Style in Psychological Help-Seeking
Auburn University Montgomery Psychology Department

You are invited to participate in a study of opinions about seeking professional mental health services. We hope to learn what factors are associated with a reluctance to seek these services. You were selected as a possible participant because you are either a college student or a member of a local church. However, if you fall outside of the aforementioned descriptors, you may still participate.

If you decide to participate, I, Shiquina Andrews, a graduate student at Auburn University Montgomery, will be asking you to complete the questionnaires over a secure-encrypted web page. Your participation will require between 20 – 30 minutes of your time. You will be asked to answer questions regarding your personality, your personal religious/spiritual views, and your views about seeking professional mental health services. Upon completing the questionnaire, please return it to the investigator or research assistant. There are no foreseeable risks to your participating in this research. No information regarding your personal identity will be gathered as part of this research, though you will be asked to provide data regarding your personal demographics. You may be offered academic extra credit by your college instructor for participating in this research study. If so, please enter the last four digits of your student identification number and your instructor's last name when prompted on the last page of the survey. As part of your participation in this study you may also benefit by gaining an increased awareness of mental health services and your likelihood to seek these services may also increase. However, I cannot promise you that you will receive this benefit.

Any information obtained from you as a part of your participation in this study will be kept confidential. You will not be asked for your name during the survey, and please do not type your name in any section of the survey. If you provide an identification number in order to receive extra credit, these numbers will be deleted once the academic extra credit has been administered. I plan to use the data you and others provide as a part of my thesis requirements in the completion of my Master's degree, and to use your responses and the responses of others in preparing scientific manuscripts for publication in a psychology journal.

Your decision whether to participate will not prejudice your future relations with Auburn University Montgomery. Once you have responded to the research questions over the internet, you will not be able to withdraw your consent and to discontinue participation.

This is because any identifying information, e.g. identification number will not be linked to your responses and therefore there will be no means of identifying which answers to the research questions are yours.

If you have any questions, I will be happy to answer them. I can be reached by phone at (251)716-8106 or by email at sandrew4@student.aum.edu. Additionally, feel free to contact my faculty advisor, Dr. James Stefurak, at (334) 244-3589 or jstefura@mail.aum.edu. Please print a copy of this informed consent statement for your records.

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* Electronic Consent

○ You are making a decision whether to participate in the research described above. Checking the circle to the left of this text will serve as your electronic signature, and indicates you have decided to participate in the research having read the informed consent.

Appendix G

Paper-and-Pencil Informed Consent

Informed Consent

For: The Role of Locus of Control and Religious Problem-Solving Style
in Psychological Help-Seeking
Auburn University Montgomery Psychology Department

You are invited to participate in a study of opinions about seeking professional mental health services. We hope to learn what factors are associated with a reluctance to seek these services. You were selected as a possible participant because you are either a college student or a member of a local church. However, if you fall outside of the aforementioned descriptors, you are invited to participate as well.

If you decide to participate, I, Shiquina Andrews, a graduate student at Auburn University Montgomery, will be asking you to complete the questionnaires either in person or over a secure-encrypted web page. For either method, your participation will require between 20 – 30 minutes of your time. You will be asked to answer questions regarding yourself and your personality, your personal religious/spiritual views, and your views about seeking professional mental health services. There are no foreseeable risks to your participating in this research. Your name will not be gathered as part of this research, though you will be asked to provide information regarding your background and demographic status. If you are a student at AUM, you may benefit from your participation in this research in that you may receive course credit. In terms of other benefits, you may also gain an increase in your awareness of mental health services and your likelihood to seek these services may increase. However, I cannot promise you that you will receive this benefit.

If you agree to participate in this research by clicking your electronic consent (see below) or signing and returning the affidavit below, any information obtained from you as a part of your participation in this study will be confidential. Please *do not* type or write your name in any blank provided on the research questionnaires. I plan to use the data you and others provide as a part of my thesis requirements in the completion of my degree.

Your decision about participation will not prejudice your future relations with Auburn University Montgomery. Once you have responded to the research questions and submitted them via the website or in person, you will not be able to withdraw your consent and to discontinue participation because there will be no means of identifying which answers to the research questions are yours.

If you have any questions, I expect you to ask me. If you have additional questions later, I will be happy to answer them. I can be reached by phone at **(251)716-8106** or by email

at **sandrew4@student.aum.edu**. Additionally, feel free to contact my faculty advisor, Dr. James Stefurak, at **(334) 244-3589** or **jstefura@mail.aum.edu**. Please keep a copy of this informed consent statement for your records.

YOU ARE MAKING A DECISION WHETHER TO PARTICIPATE IN THE RESEARCH DESCRIBED ABOVE. BY SIGNING BELOW OR CHECKING THE CIRCLE TO THE LEFT OF THIS TEXT (FOR WEB PARTICIPANTS), YOU ARE INDICATING THAT YOU HAVE DECIDED TO PARTICIPATE, HAVING READ THE INFORMATION PROVIDED ABOVE.

Respondent Signature	Date Time
Respondent's Printed Name	Witness