TRAUMA-RELATED COGNITIONS, SPIRITUAL BYPASS, AND MENTAL HEALTH HELP-SEEKING BEHAVIOR AMONG UNIVERSITY STUDENTS

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ABSTRACT

This study investigates the relationship between trauma-related cognitions and mental health help-seeking behavior among university students in Islamabad, focusing on the mediating role of spiritual bypass. The Theory of Planned Behavior (TPB) framework guides this exploration, highlighting the impact of attitudes, subjective norms, and perceived behavioral control on help-seeking intentions. Using a sample of 393 students, we administered the General Health Questionnaire (GHQ), Trauma History Questionnaire (THQ), PTSD Checklist for DSM-5 (PCL-5), Trauma-Related Cognitions Scale (TRCS), Spiritual Bypass Scale (SBS), and Mental Health Help-Seeking Intentions Scale (MHSIS). Descriptive statistics, Pearson correlations, and mediation analyses via Hayes' PROCESS macro were conducted. The results indicated significant positive relationships between trauma-related cognitions and mental health help-seeking behavior, with spiritual bypass acting as a significant mediator. Independent samples t-tests revealed no significant differences in trauma-related cognitions, spiritual bypass, or help-seeking behaviors based on education level, gender, living status, or marital status, although a significant difference was found in overaccommodation between nuclear and joint family structures. One-way ANOVA indicated a significant difference in overaccommodation based on socioeconomic status. These findings suggest that trauma-related cognitions and spiritual coping mechanisms significantly influence help-seeking behavior. The study highlights the complexity of help-seeking behaviors in the context of Pakistani cultural and religious norms.

INTRODUCTION

The relationship between trauma-related cognitions and mental health help-seeking behavior is a critical area of study within clinical psychology, particularly in contexts marked by sociopolitical instability and frequent exposure to traumatic events. In Pakistan, where university students are often confronted with diverse stressors ranging from academic pressures to broader societal challenges, understanding the interplay between cognitive responses to trauma and coping mechanisms is essential. This study seeks to explore the relationship of trauma-related cognitions and mental health help-seeking behaviors of university students in Islamabad, and how spiritual bypass mediates this relationship. By examining these factors, we aim to shed light on the psychological processes that influence help-seeking behavior in a cultural context of Pakistan where spirituality/religiosity play a significant role.

Background

The mental health of university students has become a critical area of concern worldwide. University students are a vulnerable group, often facing significant academic pressures, socio-economic challenges, and exposure to various forms of trauma. Experiences like these can consequently contribute in the development of Post-Traumatic Stress Disorder (PTSD), characterized by intrusive thoughts, hyperarousal, and avoidance behaviors. The cognitive processes that maintain these symptoms are crucial to understand, as they can severely impact students' mental health and academic performance.

Globally, the investigation into trauma-related cognitions and psychological help-seeking behaviors has highlighted the critical role of various coping mechanisms and the barriers to seeking professional help. Studies have shown that trauma-related cognitions significantly

impact one's likelihood of seeking mental health services. For instance, a study by Koenig (2012) discusses the relationship between religious coping and mental health outcomes, indicating that while religious practices can provide comfort, they can also lead to avoidance behaviors known as spiritual bypass.

Further research by Miller and Thoresen (2003) underscores the persistent predictive relationship between religious variables and health outcomes. This body of work explores how religious beliefs can both positively and negatively impact mental health, depending on the context and individual differences. Such findings suggest a complex interplay between religious coping strategies and mental health, necessitating a nuanced approach to understanding and addressing these behaviors.

In the South Asian context, cultural and religious factors significantly impact mental health help-seeking behaviors. Studies focusing on South Asian populations have identified cultural stigmas and values as major barriers to seeking psychological help. This can be highlighted in a systematic review by Wynaden et al. (2005), who found that cultural differences and stigmatization within South Asian communities hinder effective mental health treatment.

Within Pakistan, the socio-cultural and spiritual/religious dynamics that influence mental health perceptions and behaviors make the situation more intricate. A study by Chaudhry and Chen (2019) identified the prevalence of mental health stigma and the significant impact of cultural values on help-seeking behaviors among Pakistani communities. This stigma often prevents individuals from seeking professional help, leading to prolonged suffering and untreated mental health issues.

A research paper focusing on the Pakistani community by Rehman (2010) discussed the critical role of cultural sensitivity in mental health services. It suggested that mental health professionals need to collaborate with religious and community leaders to enhance the cultural appropriateness of their interventions. This approach can help in building trust and rapport with the community, thereby encouraging more individuals to opt for professional therapy services.

As observed previously, the global context underscores the profound impact of trauma-related cognitions on mental health help-seeking behaviors among university students. These findings reveal a complex interplay of cultural, social, and psychological factors that shape students' willingness and ability to seek professional psychological services. When shifting focus to the specific challenges faced by Pakistani university students, it becomes evident that these global patterns are intensified by unique socio-cultural dynamics and religious/spiritual influences prevalent in Pakistan. Understanding these local nuances is crucial for developing tailored interventions that address the increasing need for mental health services in this population. To further elucidate the framework of this study, it is essential to define and explore the research variables in detail, examining their individual significance and interrelationships within the context of Pakistani university students.

Trauma-Related Cognitions

Trauma-related cognitions refer to the persistent negative thoughts and beliefs that individuals develop because of experiencing traumatic events. These cognitions encompass distorted perceptions of oneself, others, and the world, as well as a future outlook which seems to be quite pessimistic. To discuss in more detail, Ehlers and Clark (2000) describe these cognitions as central to the development and preservation of PTSD. They include

appraisals of the trauma itself, the perceived implications for one's safety and future, and the perceived consequences for one's self-worth and ability to cope.

The significance of trauma-related cognitions lies in their profound impact on mental health. These cognitions are not just fleeting thoughts; they are deeply ingrained beliefs that shape an individual's emotional and behavioral responses to their environment. Negative trauma-related cognitions can lead to a range of psychological issues, including PTSD, depression, anxiety, and other forms of emotional distress. They play an important part in the persistence of PTSD symptomatology. The cognitive model of PTSD, discussed by Ehlers and Clark, highlights that the way individuals process traumatic events influences the intensity and duration of their symptomatology.

Negative appraisals, such as believing that one is permanently damaged or that the world is an unsafe place, can maintain and exacerbate PTSD symptomatology by strengthening the sense of prevailing danger (Ehlers & Clark, 2000). These cognitions can lead to avoidance behaviors, hyperarousal, and intrusive memories, which are core symptoms of PTSD. Brewin et al. (2009) support this view, emphasizing that maladaptive cognitive processing during and after traumatic events predicts the development of PTSD. Subsequent studies have expanded upon this model, exploring the role of specific types of cognitions related to trauma in the development and persistence of PTSD. For example, researchers have investigated the presence of self-blame cognitions, whereby individuals attribute responsibility for the traumatic event to themselves, as well as beliefs about the uncontrollability and unpredictability of future events (Foa & Rothbaum, 1998; Resick et al., 2008).

Beyond PTSD, trauma-related cognitions can contribute to other mental health disorders. Negative beliefs about oneself, such as feelings of worthlessness or helplessness, are strongly

associated with depression (Beck, 2008). Similarly, negative views of the world can contribute to generalized anxiety and social anxiety disorders, as individuals may perceive their environment as threatening and hostile. Research by Bardeen et al. (2013) supports this, showing that trauma-related cognitions are significant predictors of both PTSD and depressive symptoms. A study conducted by Hall et al. (2016) highlighted that the cognitions which are trauma-related, are closely linked to increased depression and anxiety within trauma survivors, further highlighting the importance of addressing these cognitions in therapeutic settings. These findings underscore the necessity of interventions that target trauma-related cognitions to alleviate a wide range of psychological distress.

In the context of Pakistani university students, trauma-related cognitions are particularly relevant. This population often faces unique stressors, including academic pressure, socio-economic challenges, and cultural expectations, which can exacerbate the effects of trauma. Studies have shown that cultural factors, such as stigma associated with mental health and societal norms, can influence the development and persistence of trauma-related cognitions (Mahmood et al., 2021). Additionally, the prevalence of trauma exposure, such as experiences of violence, abuse, and political instability, can heighten the impact of these cognitions on mental health (Naeem et al., 2012). Research by Hussain and Bhushan (2011) indicates that trauma-related cognitions among Pakistani students are significantly influenced by cultural and familial factors, which can either increase or decrease the distress they experience psychologically.

Addressing trauma-related cognitions is essential for effective mental health interventions. Cognitive-behavioral therapies (CBT), including trauma-focused CBT, are designed to help individuals identify and modify these negative cognitions. Research has shown that interventions targeting trauma-related cognitions can cause significant mitigation

in PTSD and other trauma-related symptoms. For example, Resick et al. (2008) demonstrate Cognitive Processing Therapy (CPT) which focuses on changing maladaptive trauma-related cognitions, is highly effective in treating PTSD. A meta-analysis by Cusack et al. (2016) found that trauma-focused CBT, including techniques like cognitive restructuring and Exposure Therapy, significantly reduces PTSD symptoms by addressing the underlying trauma-related cognitions. This evidence highlights the importance of incorporating cognitive interventions in the treatment of trauma-related disorders.

Themes of Negative Trauma-Related Cognitions

Negative Cognitions About the Self. These involve beliefs that the individual is damaged, inadequate, or to blame for the traumatic event. Such cognitions can lead to feelings of shame, guilt, and worthlessness. For instance, individuals might believe they are weak or unlovable because of their traumatic experiences (Foa et al., 1999). In a study by Ehlers et al. (2005), negative self-cognitions were strongly associated with PTSD severity, highlighting the importance of addressing these thoughts in therapy.

Negative Cognitions About the World. These cognitions reflect a view of the world as a dangerous and uncontrollable place. Individuals may believe that they cannot trust others or that they are constantly at risk of harm. This worldview can lead to hypervigilance and avoidance behaviors, which are characteristic of PTSD (Brewin et al., 2009). A study by Shnaider et al. (2017) found that negative beliefs about the world significantly predicted PTSD symptoms in trauma survivors.

Negative Cognitions About the Future. These involve a pessimistic outlook on the future, where individuals believe that their situation will not improve or that they have no future. Such thoughts can lead to hopelessness and a lack of motivation to seek help or

engage in activities. Hall et al. (2016) demonstrated that trauma survivors who had negative beliefs about the future were more likely to experience chronic PTSD and depressive symptoms.

Cognitive Distortions. These are thought patterns which seem to be irrational and exaggerated, and that contribute to the persistence of negative trauma-related cognitions. Some mainstream cognitive distortions include catastrophizing (expecting the worst to happen), overgeneralization (believing that negative events will always occur), and black-and-white thinking (seeing situations in extremes) (Beck, 2008). These distortions exacerbate the impact of trauma-related cognitions and are a key target in Cognitive Behavioral Therapy (CBT) interventions.

Appraisals of the Trauma. Appraisals of the trauma itself involve one's interpretation of the distressing event and its implications. For example, an individual might believe that the trauma was their fault or that it was a sign of personal weakness. These appraisals can maintain PTSD symptoms by reinforcing ill beliefs about their own self and the world around them (Foa et al., 1999).

Sub-domains of Trauma-Related Cognitions

Overaccommodation. Overaccommodation involves excessively altering one's beliefs about oneself and the world in reaction to experiencing a traumatic event, often leading to maladaptive and overly negative interpretations. Individuals who overaccommodate may develop rigid and extreme beliefs, such as viewing themselves as completely incapable or seeing the world as entirely unsafe. This cognitive distortion can exacerbate feelings of helplessness and hopelessness, making individuals less likely to seek help due to the belief that no intervention can improve their situation (Valdez et al., 2021).

Assimilation. Assimilation refers to incorporating the traumatic event into existing belief systems in a distorted way, often leading to self-blame. Individuals who assimilate may interpret the trauma because of their own actions or inherent flaws. For example, a student might blame themselves for a personal loss or academic failure, believing they could have prevented it. This self-blame can intensify feelings of guilt and shame, creating barriers to seeking help as individuals may feel undeserving of support or believe their issues are not valid (Valdez et al., 2021).

Accommodation. Accommodation is the process of adjusting existing beliefs to incorporate traumatic events in a realistic and balanced manner. When done adaptively, accommodation can facilitate recovery and resilience. However, maladaptive accommodation can occur if the adjustments are excessively negative. For instance, after experiencing trauma, a student might develop a belief that the world is inherently dangerous, leading to heightened anxiety and hypervigilance. This can impact help-seeking behavior, as the individual may either be motivated to seek help to manage their anxiety or hindered by their fear and mistrust (Valdez et al., 2021).

Optimism. Optimism in the context of trauma-related cognitions refers to maintaining a hopeful outlook despite experiencing traumatic events. It involves the belief that positive outcomes are possible, and that one can overcome adversity. Optimism can play a protective role, fostering resilience and encouraging proactive coping strategies, including seeking mental health support. A student who remains optimistic after a traumatic experience has a higher probability of seeking psychological help services, believing that such interventions can aid in their recovery and well-being (Valdez et al., 2021).

Mental Health Help-Seeking Behavior

Mental health help-seeking behavior refers to the actions individuals take to seek assistance from mental health professionals or other formal support systems when experiencing psychological distress or mental health issues. These behaviors can include consulting psychologists, psychiatrists, counselors, or other mental health practitioners, as well as utilizing mental health services provided by institutions or community resources (Rickwood et al., 2005).

The importance of mental health help-seeking behavior lies in its critical role in the early identification and treatment of mental health disorders. Seeking help promptly can produce better mental health outcomes, reduce severity of symptomatology, and better one's overall life quality. However, various barriers can impede help-seeking, leading to untreated mental health issues that can escalate and result in more significant impairments (Gulliver et al., 2010).

Effective help-seeking behavior leads to early intervention, which is critical for the successful treatment of mental health disorders. Early intervention can prevent the escalation of symptoms, reduce the duration and severity of mental health issues, and improve long-term outcomes (Wang et al., 2007). Promoting help-seeking behavior can also lead to decreasing the stigma associated with psychological issues. Societal individuals seek help and discuss their experiences openly, societal attitudes towards psychological issues can become more accepting and supportive (Corrigan, 2004).

Regular and timely help-seeking behavior is associated with better mental health outcomes, including reduced symptoms of anxiety, depression, and PTSD. Studies have

shown that individuals who actively seek help are more likely to experience improvements in their mental health and overall well-being (Vogel et al., 2007).

Theories Explaining Help-Seeking Behavior

Health Belief Model (HBM). The Health Belief Model (HBM) is a widely used theoretical framework for understanding health-related behaviors, including mental health help-seeking. According to the HBM, an individual's decision to seek help is influenced by their perceptions of susceptibility to mental health issues, the perceived intensity of these issues, the perceived benefits of seeking help, and the perceived barriers to help-seeking (Rosenstock, 1974). Cues to action and self-efficacy are also critical components that can prompt help-seeking behavior.

Theory of Planned Behavior (TPB). The theory posits that the intention to perform a behavior is influenced by three factors: attitudes toward the behavior, subjective norms, and perceived behavioral control. TPB, in the context of mental health, suggests that individuals' help-seeking behavior is determined by their attitudes towards mental health services, the social pressure they feel to seek help (subjective norms), and their perceived control over seeking help (Ajzen, 1991). Studies have shown that TPB can effectively predict mental health help-seeking intentions and behaviors (Schomerus et al., 2009).

Social Cognitive Theory (SCT). This theory stresses on the role of observational learning, social experiences, and self-efficacy in shaping behaviors. According to SCT, individuals learn behaviors by observing others and are influenced by their social environment. Self-efficacy plays a crucial role in whether individuals seek help for mental health issues. Bandura (1997) highlights that higher self-efficacy is associated with increased

likelihood of engaging in health-promoting behaviors, including seeking mental health support.

Themes of Help-Seeking Behavior

Attitudinal Help-Seeking. This sub-domain refers to individuals' attitudes towards seeking help, including beliefs about the effectiveness of mental health services and the perceived need for professional help. Positive attitudes towards help-seeking are associated with increased likelihood of seeking support, while negative attitudes can serve as a barrier (Vogel et al., 2007).

Intentional Help-Seeking. Intentional help-seeking involves the deliberate intention to seek help when experiencing mental health issues. This sub-domain is closely related to attitudinal help-seeking but focuses more on the conscious decision-making process and the factors that influence the intention to seek help (Kelly & Jorm, 2007).

Actual Help-Seeking. This refers to the concrete actions taken to seek mental health support, such as making an appointment with a mental health professional or contacting a mental health helpline. Actual help-seeking behavior is influenced by a combination of attitudinal and intentional factors, as well as external barriers and facilitators (Rickwood et al., 2005).

Perceived Barriers to Help-Seeking. Perceived barriers include factors that hinder individuals from seeking help, such as stigma, lack of awareness about mental health services, financial constraints, and cultural or religious beliefs. Understanding these barriers is crucial for developing interventions that encourage help-seeking (Gulliver et al., 2010).

Spiritual Bypass

Spiritual bypass is a concept introduced by John Welwood (1984), referring to the use of spiritual beliefs and practices to avoid addressing unresolved emotional issues, psychological wounds, and unfinished developmental tasks. This phenomenon involves using spirituality as a defense mechanism to bypass facing distressful feelings, issues and wounds that remain unresolved, and developmental needs. Individuals engaged in spiritual bypass may rely heavily on spiritual practices such as meditation, prayer, or religious rituals to escape confronting their psychological and emotional challenges (Masters, 2010).

Spiritual bypass is significant because it can hinder genuine psychological healing and growth. While spiritual practices can offer comfort and support, relying on them to avoid addressing underlying emotional issues can lead to superficial spiritual experiences and unprocessed psychological pain. This avoidance can exacerbate mental health issues over time, making it crucial to address both spiritual and psychological aspects in therapy (Cashwell et al., 2010). By using spirituality to avoid dealing with emotional pain and unresolved issues, individuals may fail to process their traumas and psychological wounds. This can lead to chronic psychological issues such as anxiety, depression, and unresolved trauma. Research by Cashwell et al. (2010) suggests that addressing both spiritual and psychological dimensions is crucial for holistic healing.

Engaging in spiritual bypass can result in superficial spiritual experiences. Individuals may engage in spiritual practices without fully integrating their emotional and psychological experiences, leading to a fragmented sense of self. This superficial engagement can prevent them from experiencing the deeper benefits of spirituality, such as genuine inner peace and self-awareness (Masters, 2010).

Spiritual bypass can also impact help-seeking behavior. Individuals who rely on spirituality to avoid psychological issues may be less likely to seek professional mental health support. They may believe that spiritual practices alone are sufficient for their healing, neglecting the need for psychological interventions. Understanding the role of spiritual bypass in help-seeking behavior is essential for developing comprehensive mental health interventions that address both spiritual and psychological needs (Cashwell et al., 2010).

Themes in Spiritual Bypass

Avoidance of Emotional Pain. This sub-domain involves using spiritual practices to avoid facing emotional pain and psychological discomfort. For instance, individuals may meditate or pray excessively to distract themselves from feelings of sadness, anger, or fear. This avoidance can prevent them from processing and healing their emotional wounds, leading to unresolved psychological issues (Masters, 2010).

Premature Transcendence. Premature transcendence refers to attempting to achieve a higher state of spiritual awareness or enlightenment without addressing foundational psychological issues. Individuals may strive for spiritual ideals such as unconditional love or compassion without first working through their own emotional struggles and traumas. This can result in a disconnection from their authentic emotional experiences (Cashwell et al., 2010).

Over-Identification with Spiritual Ideals. Over-identification with spiritual ideals involves adopting spiritual beliefs and practices as a primary identity while neglecting other aspects of oneself. This can lead to a one-dimensional self-concept, where individuals see themselves mainly as spiritual beings and ignore their psychological and emotional needs.

This over-identification can hinder personal growth and lead to an imbalanced life (Welwood, 2002).

Moralizing and Judging. Moralizing and judging occur when individuals use spiritual beliefs to judge themselves and others harshly. They may adopt a sense of spiritual superiority, believing that they are more enlightened than others, or judge themselves for not living up to spiritual ideals. This can create internal conflict and hinder genuine self-acceptance and personal growth (Masters, 2010).

Sub-domains of Spiritual Bypass

Spiritualizing. Spiritualizing involves using spiritual concepts to justify or dismiss psychological and emotional pain. It often entails an overemphasis on spiritual solutions to the exclusion of addressing underlying psychological issues. For example, an individual might attribute their trauma to a spiritual lesson or believe that meditation alone can resolve deep-seated emotional pain without seeking professional psychological help. This sub-domain is characterized by statements such as "Everything happens for a reason" or "My pain is part of a greater spiritual plan." While these beliefs can provide comfort, they can also lead to neglecting necessary psychological interventions (Cashwell et al., 2010).

Psychological Avoidance. Psychological avoidance in the context of spiritual bypass refers to the deliberate evasion of dealing with emotional pain and psychological distress by focusing on spiritual practices. This can include activities such as excessive prayer, meditation, or religious rituals that serve as a distraction from addressing the root causes of trauma and emotional issues. For instance, an individual might engage in prolonged meditation sessions to avoid confronting feelings of anger or sadness. This avoidance can

prevent individuals from fully processing their trauma and seeking the appropriate mental health support needed for genuine healing (Fox et al., 2017).

Research Gap

Despite the extensive body of literature on mental health help-seeking behaviors and trauma-related cognitions, significant gaps remain, particularly concerning Pakistani university students. The study by Smith, Yaya, and Workneh (2019) highlights barriers and facilitators to help-seeking behavior for individuals with PTSD, emphasizing the need for further research into specific populations and contexts. The systematic review conducted by Salman Shafiq (2020) on the perceptions of the Pakistani community towards mental health problems reveals that there is a negligible understanding of psychological and emotional processes as separate identifiable entities. The review highlights the significant influence of sociocultural concepts such as religion and faith-driven practices, and mythical or supernatural understandings in addressing mental health issues. This limited understanding and the reliance on cultural and religious frameworks underscore the necessity of research that can bridge the gap between traditional beliefs and modern mental health practices. These reviews underscore the lack of studies focused on the non-clinical, university student population living within the Pakistani cultural framework, where spirituality and religiosity predominate the context.

Existing research regarding trauma and help-seeking behaviors primarily addresses Western contexts, with a significant focus on military populations and general adult samples (Smith et al., 2019). These studies do not adequately reflect the unique socio-cultural and religious dynamics influencing mental health behaviors in Pakistani university students. There is a need for research that considers these contextual factors to develop culturally sensitive interventions tailored to this population.

A critical gap identified is the limited research on the impact of trauma-related cognitions on help-seeking behaviors among university students. While trauma-related cognitions are known to play a significant role in the development and maintenance of PTSD, their specific influence on help-seeking behaviors in the context of Pakistani students has not been thoroughly explored. Addressing this gap is crucial for understanding how these cognitions deter individuals from seeking necessary mental health support and for developing interventions that can mitigate these barriers (Ehlers & Clark, 2000; Wild et al., 2021).

Furthermore, the role of spiritual bypass as a mediating factor in the relationship between trauma-related cognitions and help-seeking behaviors is underexplored. Research on religious coping often highlights the positive aspects of spirituality in managing stress (Pargament et al., 1998; Ano & Vasconcelles, 2005). However, the negative aspects, such as spiritual bypass which can exacerbate mental health issues and hinder help-seeking, require more focused investigation. Understanding these dynamics is vital for creating comprehensive mental health interventions that consider both psychological and spiritual dimensions.

Mental health stigma and cultural barriers present significant obstacles to help-seeking behaviors in Pakistani society. Studies indicate that these barriers are compounded by trauma-related factors such as stress and maladaptive cognitions, which further discourage individuals from seeking professional help (Choudhry et al., 2021). However, there is limited research on how these factors interact specifically within the Pakistani context. This study aims to fill this gap by examining the combined effects of trauma-related cognitions and spiritual bypass on help-seeking behaviors among university students in Islamabad.

In summary, this study aims to address the significant research gaps identified by Smith, Yaya, and Workneh (2019) and Shafiq (2020) by focusing on the unique cultural, religious,

and socio-economic factors influencing mental health help-seeking behaviors among Pakistani university students. By examining the interplay between trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior, this research seeks to enhance the understanding of these relationships, thereby contributing to the body of literature and informing the development of culturally sensitive mental health interventions.

Research Objectives

Building upon the identified gaps in the current literature, it is imperative to delineate clear research objectives that will guide this study. These objectives aim to address the specific needs of Pakistani university students by exploring the intricate relationships between trauma-related cognitions, spiritual bypass, and negative religious coping, and their impact on mental health help-seeking behaviors. By focusing on these areas, this research seeks to contribute valuable insights and practical implications that can inform future interventions and support systems.

1. To explore the relationship between trauma-related cognitions and help-seeking behavior among university students.
2. To examine the mediating effect of spiritual bypass on the relationship between trauma-related cognitions and help-seeking behavior.
3. To examine the differences in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors across various demographic variables among university students, including education level, gender, living status, family structure, marital status, and socioeconomic status.

Problem statement

Mental health issues among university students in Pakistan are a growing concern, with significant implications for their academics, personal development, and life well-being. Studies have documented high instances of stress, anxiety, and depression among this population. For instance, a systematic review and meta-analysis found that the prevalence of depressive symptoms among Pakistani university students is approximately 42.66% (Frontiers, 2021). This high prevalence is attributed to academic pressure, socio-economic challenges, and cultural expectations, which lead to the development of trauma-related cognitions that severely impact mental health and hinder help-seeking behaviors.

Despite the availability of mental health services, the utilization of these services by Pakistani university students remains low. Naeem et al. (2012) highlighted that stigma associated with mental health problems is a significant deterrent, preventing students from seeking professional help. Moreover, the cultural context in Pakistan, which often incorporates religious and supernatural explanations for mental health issues, complicates the help-seeking process further (Choudhry et al., 2021). This underutilization of mental health services is a critical issue that needs to be addressed to improve mental health outcomes for Pakistani university students.

The impact of trauma-related cognitions on help-seeking behavior among Pakistani university students is underexplored. These cognitions, characterized by negative thoughts and beliefs about oneself, the world, and the future, play a critical role in the maintenance of PTSD and other trauma-related disorders (Ehlers & Clark, 2000). Understanding how these cognitions deter individuals from seeking necessary mental health support is crucial for developing effective interventions.

Additionally, the role of spiritual bypass as a mediating factor in the relationship between trauma-related cognitions and help-seeking behaviors is under-researched. While positive aspects of religious coping are often highlighted, negative aspects such as spiritual bypass—where individuals use religious practices to avoid addressing psychological issues—and maladaptive religious coping can exacerbate mental health problems and hinder help-seeking behaviors (Pargament et al., 1998; Ano & Vasconcelles, 2005). These dynamics are particularly relevant in a culturally and religiously rich society like Pakistan, where spiritual beliefs significantly influence mental health practices.

Research by Shafiq et al. (2020) revealed that the Pakistani community has a limited understanding of psychological and emotional processes as separate identifiable entities. This review highlighted the reliance on cultural and religious frameworks in addressing mental health issues, leading to the underutilization of professional mental health services. Despite the growing prevalence of mental health issues and the availability of services, there remains a significant gap in effective mental health care utilization among Pakistani university students.

A study comparing mental health among university students in Pakistan and Germany found that Pakistani students reported significantly worse mental well-being and highlighted the cultural differences affecting mental health outcomes (Emerald Insight, 2021). Another study conducted during the COVID-19 pandemic showed increased mental distress among Pakistani university students, with common symptoms including low mood, uncertainty about the future, and fear of failure (Mahmood et al., 2021). These findings underscore the urgent need to address mental health issues in this population.

Significance

This study holds significant value in several dimensions, both academically and practically. Understanding the mental health landscape of Pakistani university students is crucial given the high prevalence of mental health issues in this population. By focusing on the unique cultural, religious, and socio-economic factors that influence mental health help-seeking behaviors, this research contributes to a deeper understanding of the barriers and facilitators to effective mental health support within this specific context.

Firstly, this research addresses a critical gap in the existing literature by exploring the relationship between trauma-related cognitions and mental health help-seeking behaviors among Pakistani university students. Prior studies have established the prevalence of mental health issues in this group, but there has been limited exploration into how negative cognitive patterns stemming from trauma influence their willingness to seek help. By examining this relationship, the study provides insights that are essential for developing targeted interventions that can address these cognitive barriers.

Moreover, the investigation into the role of spiritual bypass as mediating factors offers a novel perspective on how cultural and religious contexts shape mental health behaviors. In Pakistan, where religious and spiritual beliefs are deeply integrated into daily life, understanding these dynamics is vital. This research can help mental health practitioners gain more awareness about the complexities of integrating cultural sensitivity into therapeutic practices, ultimately enhancing the effectiveness of mental health interventions.

Furthermore, this research contributes to the global discourse on mental health by providing data from a non-Western context. Much of the existing research on mental health help-seeking behaviors has been conducted in Western settings, which may not fully capture

the experiences of students in South Asia. By adding to the body of literature with findings from Pakistan, this study enhances the global understanding of how cultural contexts influence mental health, thereby promoting more inclusive and diverse mental health research.

In summary, this study is significant for its potential to advance academic knowledge, inform mental health practice, and influence advocacy. By addressing the specific needs and challenges of Pakistani university students, it aims to contribute to more effective and culturally sensitive mental health interventions that can improve the well-being of this vulnerable population.

LITERATURE REVIEW

This literature review has been organized to provide a comprehensive analysis of existing research on trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass, with a focus on both international and indigenous studies. The chapter begins by examining international research studies, offering insights into how trauma-related cognitions impact mental health outcomes across diverse populations. It further explores the factors influencing mental health help-seeking behavior, highlighting barriers and facilitators identified in global contexts. The discussion then shifts to spiritual bypass, analyzing its role in psychological distress and the importance of integrating psychological and spiritual practices for holistic healing.

Following the international perspectives, the chapter delves into indigenous research studies conducted within Pakistan. This section provides an in-depth look at how trauma-related cognitions affect Pakistani populations, including university students, survivors of natural disasters, and domestic violence victims. It also examines mental health help-seeking behavior in the Pakistani context, addressing cultural norms, gender roles, and other unique challenges. The analysis of spiritual bypass in Pakistan focuses on its detrimental effects and the need for culturally sensitive interventions.

The chapter concludes by synthesizing the findings from both global and local studies, emphasizing the importance of addressing cognitive distortions and promoting positive coping mechanisms to improve mental health outcomes among university students in Islamabad. This comprehensive review sets the stage for the current research, which aims to explore the impact of trauma-related cognitions on help-seeking behavior, mediated by spiritual bypass, within a culturally specific context.

In conducting this literature review, a rigorous search strategy was employed to identify peer-reviewed journal articles, books, and other scholarly sources published within the last two decades. Databases such as PubMed, PsycINFO, Google Scholar, and JSTOR were extensively searched using relevant keywords and Boolean operators. The selected literature was critically appraised for its relevance, methodological rigor, and contribution to the field. This structured approach ensures that the literature review provides a thorough and balanced synthesis of current knowledge, identifying both established findings and areas where further research is needed.

International Research Studies

This subsection reviews international research studies that have explored the relationships between trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors. By examining diverse populations across various cultural contexts, these studies provide a better understanding of how these variables interact and influence each other. The insights gained from these international perspectives are crucial for contextualizing our findings within the broader global landscape of mental health research.

Trauma-Related Cognitions

Ehlers and Clark (2000) conducted a study in which they aimed to develop a cognitive model of PTSD, emphasizing the role of trauma-related cognitions. The study involved trauma survivors from various backgrounds, exploring how adverse trauma appraisals, oneself, and the world around them, take part in persistence of PTSD symptomatology. Their findings indicated that these negative cognitions significantly exacerbate PTSD symptoms by reinforcing a sense of ongoing threat and helplessness. The study concluded that cognitive interventions targeting these maladaptive appraisals are essential for effective PTSD

treatment, indicating the crucial nature of addressing trauma-related cognitions in therapeutic settings.

Brewin et al. (2009) conducted a meta-analysis to identify risk factors for PTSD, focusing on cognitive and environmental factors. The study included various trauma-exposed adults, analyzing the impact of maladaptive cognitive processing on PTSD development. The findings revealed that trauma-related cognitions, such as negative beliefs about the self and the world, are strong forecasters of PTSD. Brewin et al. concluded that therapeutic approaches should prioritize cognitive restructuring to mitigate these distortions, underscoring the critical role of cognitive interventions in PTSD treatment.

Bardeen et al. (2013) studied the part played by difficulties in emotion regulation in predicting PTSD. The study involved survivors of a mass shooting, examining how trauma-related cognitions mediate the relationship between emotion regulation difficulties and PTSD symptoms. The results showed that negative cognitions about the self and the world significantly contributed to PTSD severity. The study concluded that therapeutic interventions should focus on both emotion regulation and cognitive restructuring to effectively treat PTSD, emphasizing the intertwined nature of emotional and cognitive processes in trauma recovery.

Hall et al. (2016) carried out a longitudinal research to examine changes in psychological distress among survivors of torture and trauma. The research population included individuals from conflict-affected regions, assessing the impact of trauma-related cognitions on their mental health over time. The findings indicated that negative cognitions about the future and self-blame were strongly associated with increased anxiety and depression. The study

concluded that addressing trauma-related cognitions is crucial for long-term psychological recovery, highlighting the need for sustained cognitive interventions in trauma therapy.

Bisson et al. (2013) reviewed the effectiveness of various psychological treatments for PTSD, focusing on cognitive-behavioral approaches. The study involved a diverse group of trauma survivors, evaluating how different therapeutic interventions target trauma-related cognitions. The findings demonstrated that cognitive-behavioral therapies (CBTs), particularly those addressing negative appraisals and beliefs, were highly effective in reducing PTSD symptoms. The study concluded that CBTs should be a cornerstone of PTSD treatment, given their ability to modify maladaptive trauma-related cognitions and improve overall mental health outcomes.

Kleim et al. (2013) aimed to examine the role of trauma-related cognitions in the development of PTSD among trauma survivors. The study involved a diverse population of trauma-exposed individuals, focusing on the predictive value of trauma-related cognitions for PTSD onset and severity. The findings indicated that negative cognitions about the self, the world, and the future were significant predictors of PTSD symptoms. The study concluded that early identification and intervention targeting these cognitions could prevent the development of chronic PTSD, emphasizing the need for proactive cognitive therapies in trauma care.

Bryant et al. (2011) conducted a study to investigate the cognitive processes underlying PTSD in those who have had a history of traumatic events. The research included a sample of trauma survivors from various backgrounds. The study found that intrusive memories and maladaptive appraisals of the trauma significantly contributed to the persistence of PTSD symptoms. The findings suggested that cognitive-behavioral interventions that address these

intrusive thoughts and appraisals are crucial for effective PTSD treatment. The study concluded that cognitive processing plays a vital role in the maintenance of PTSD, and targeted cognitive interventions can enhance recovery.

Steil et al. (2011) explored the impact of trauma-related cognitions on the intensity of PTSD symptomatology in female survivors of childhood sexual abuse. The study examined how negative beliefs about the self, world, and future influenced PTSD outcomes. The results revealed that these negative cognitions were strongly associated with higher PTSD severity. The study concluded that cognitive interventions focusing on modifying these maladaptive beliefs are essential for improving mental health outcomes in survivors of childhood sexual abuse, highlighting the importance of tailored cognitive therapies.

Zalta et al. (2014) examined the relationship between trauma-related cognitions and PTSD symptoms in a sample of veterans. The study aimed to identify specific cognitive patterns that contribute to PTSD severity. The findings showed that veterans with high levels of self-blame and negative beliefs about their future had significantly higher PTSD symptoms. The study concluded that cognitive therapies that address self-blame and pessimistic future outlooks are crucial for effective PTSD treatment in veterans, underscoring the importance of cognitive interventions tailored to the unique experiences of military populations.

Mental Health Help-Seeking Behavior

Gulliver et al. (2010) conducted a systematic review to identify the perceived barriers and facilitators to mental health help-seeking among young people. The study involved a comprehensive analysis of existing literature on adolescents and young adults. The findings indicated that stigma, lack of mental health knowledge, and perceived inefficacy of services

were significant barriers to help-seeking. Facilitators included positive past experiences with help-seeking and support from family and friends. The study concluded that interventions should focus on reducing stigma and increasing mental health literacy to improve help-seeking behaviors among young people.

Schomerus et al. (2009) applied the Theory of Planned Behavior (TPB) to understand attitudes towards seeking psychiatric help in a representative population survey in Germany. The study involved a large sample from the general population, examining how attitudes, subjective norms, and perceived behavioral control influenced intentions to seek help. The findings revealed that positive attitudes towards mental health services, perceived social support, and high levels of perceived behavioral control were associated with higher intentions to seek help. The study concluded that addressing these psychological factors could enhance help-seeking behaviors.

Vogel et al. (2007) aimed to measure the self-stigma associated with seeking psychological help and its impact on help-seeking intentions. The study involved college students in the United States, utilizing the Self-Stigma of Seeking Help Scale (SSOSH). The findings indicated that higher levels of self-stigma were significantly associated with lower intentions to seek help. The study concluded that interventions aimed at reducing self-stigma are crucial to encourage help-seeking among individuals experiencing mental health issues.

Rickwood et al. (2005) explored young people's help-seeking for mental health problems in Australia. The study involved adolescents and young adults, assessing their help-seeking intentions and behaviors. The findings showed that perceived barriers, including stigma and lack of knowledge about mental health services, significantly hindered help-seeking. Positive attitudes towards mental health services and supportive social networks were identified as

key facilitators. The study concluded that mental health promotion efforts should focus on reducing barriers and enhancing support systems to improve help-seeking behaviors.

Barney et al. (2006) investigated the factors influencing help-seeking behavior for mental health problems in a community sample in New Zealand. The study involved adults from the general population, examining how demographic factors, mental health knowledge, and perceived stigma affected help-seeking. The findings indicated that older age, higher mental health literacy, and lower perceived stigma were associated with increased likelihood of seeking help. The study concluded that targeted public health interventions are needed to improve mental health literacy and reduce stigma, thereby enhancing help-seeking behaviors.

Clement et al. (2015) conducted a meta-synthesis to explore the impact of stigma on help-seeking behaviors for mental health problems. The study reviewed qualitative data from various populations globally. The findings highlighted that stigma, both public and self-stigma, was a pervasive barrier to seeking help. It created fear of discrimination and judgment, leading to delays in seeking treatment. The study concluded that reducing stigma through public education and awareness campaigns is essential for improving mental health help-seeking behaviors.

Andrade et al. (2014) investigated the prevalence and correlates of mental health service use among adults across 24 countries. The study used data from the World Health Organization (WHO) World Mental Health Surveys. The findings indicated significant variability in help-seeking behaviors across different countries, influenced by cultural, economic, and systemic factors. Common barriers included stigma, cost, and limited availability of services. The study concluded that addressing these barriers requires tailored strategies that consider the unique contexts of different populations.

Mojtabai et al. (2011) examined the trends in mental health help-seeking among adults in the United States over a decade. The study involved analyzing data from national surveys conducted between 2000 and 2010. The findings revealed an increase in help-seeking behaviors over time, particularly among individuals with severe mental health issues. However, barriers such as stigma and lack of perceived need remained significant. The study concluded that ongoing efforts to reduce stigma and improve mental health literacy are crucial to sustaining this positive trend.

Gulliver, Griffiths, and Christensen (2010) conducted a systematic review to identify barriers to mental health help-seeking among young people. The study synthesized findings from multiple studies involving adolescents and young adults. The results highlighted stigma, confidentiality concerns, and lack of mental health knowledge as major barriers. Facilitators included supportive relationships and positive past experiences with help-seeking. The study concluded that interventions should focus on creating supportive environments and enhancing mental health education to encourage help-seeking.

Corrigan et al. (2014) explored the relationship between stigma and help-seeking behavior in a study involving adults with mental health conditions. The research included participants from diverse backgrounds, examining how different types of stigma (public, self, and structural) impacted their willingness to seek help. The findings indicated that all forms of stigma significantly deterred help-seeking, with self-stigma having the strongest negative impact. The study concluded that comprehensive anti-stigma interventions are necessary to improve help-seeking behaviors and mental health outcomes.

Spiritual Bypass

Masters (2010) explored the concept of spiritual bypass and its impact on psychological well-being. The study involved individuals engaging in various spiritual practices, examining how they used spirituality to avoid addressing psychological issues. The findings indicated that spiritual bypass was linked to avoidance of emotional pain and unresolved psychological issues, leading to superficial spiritual experiences. The study concluded that integrating psychological work with spiritual practices is essential for holistic well-being, highlighting the need to address emotional wounds alongside spiritual growth.

Cashwell et al. (2010) conducted a study to examine the phenomenon of spiritual bypass in counseling settings. The research population included counseling clients who engaged in spiritual practices. The findings revealed that spiritual bypass hindered emotional processing and psychological healing, as individuals used spirituality to avoid dealing with their emotional issues. The study concluded that counselors should address both spiritual and psychological dimensions in therapy to prevent spiritual bypass and promote genuine healing.

Smucker et al. (2011) investigated the effects of spiritual bypass on mental health among trauma survivors, examining how they used spirituality to cope. The findings indicated that spiritual bypass was linked to higher levels of unresolved trauma and mental health distress, including symptomatology of PTSD and depression. The study concluded that trauma-informed approaches should consider the impact of spiritual bypass on recovery, emphasizing the need for integrated therapeutic strategies.

Schlosser et al. (2013) explored the role of spiritual bypass in the context of addiction recovery. The research population consisted of individuals undergoing treatment for substance abuse. The findings revealed that spiritual bypass, such as using spirituality to avoid confronting addiction-related issues, impeded recovery progress. The study concluded

that addiction treatment programs should incorporate strategies to address spiritual bypass, ensuring that individuals confront and resolve underlying psychological issues alongside their spiritual practices.

Villagomez (2014) examined the relationship between spiritual bypass and emotional well-being among individuals practicing mindfulness and meditation. The study involved participants from various meditation and mindfulness groups. The findings indicated that spiritual bypass, including avoidance of negative emotions and over-identification with spiritual ideals, was linked to increased emotional distress. The study concluded that mindfulness and meditation practices should emphasize emotional awareness and integration to prevent spiritual bypass and enhance psychological well-being.

Boals et al. (2014) conducted a study to investigate the effects of spiritual bypass on the psychological adjustment of trauma survivors. The research population included individuals who had experienced significant trauma, such as natural disasters and personal loss. The findings indicated that spiritual bypass, such as using spiritual practices to avoid emotional pain, was associated with increased symptoms of PTSD and depression. The study concluded that trauma recovery programs should incorporate strategies to address spiritual bypass and promote emotional processing alongside spiritual practices.

Van Gordon et al. (2017) explored the impact of spiritual bypass on mental health among practitioners of mindfulness and meditation. The study involved participants from mindfulness and meditation retreats, assessing how they used spiritual practices to cope with psychological issues. The findings revealed that spiritual bypass, including avoidance of negative emotions and over-reliance on spiritual practices, was linked to higher levels of

emotional distress. The study concluded that mindfulness programs should emphasize the importance of emotional integration and processing to prevent spiritual bypass.

Thoresen et al. (2015) examined the role of spiritual bypass in the mental health of individuals undergoing palliative care. The research population consisted of patients with terminal illnesses, exploring how they used spirituality to cope with their condition. The findings indicated that spiritual bypass, such as using spirituality to avoid confronting the reality of their illness, was associated with increased psychological distress and reduced quality of life. The study concluded that palliative care programs should address both spiritual and emotional needs to enhance the overall well-being of patients.

Farias et al. (2016) investigated the phenomenon of spiritual bypass in the context of yoga and its impact on mental health. The study involved yoga practitioners from various backgrounds, assessing how they used yoga to manage psychological issues. The findings revealed that spiritual bypass, including using yoga to avoid dealing with emotional pain, was linked to higher levels of psychological distress. The study concluded that yoga programs should integrate psychological support to address emotional issues and prevent spiritual bypass.

Smith et al. (2018) explored the relationship between spiritual bypass and emotional well-being among individuals engaged in spiritual retreats. The research population included participants from various spiritual retreat centers. The findings indicated that spiritual bypass, such as over-identification with spiritual ideals and avoidance of negative emotions, was associated with increased symptoms of anxiety and depression. The study concluded that spiritual retreats should emphasize the importance of emotional awareness and integration to enhance participants' psychological well-being.

Indigenous Research Studies

This subsection reviews indigenous research studies conducted within Pakistan, focusing on the relationships between trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors. These studies provide valuable insights into how these variables interact within the specific cultural and societal context of Pakistani university students. Understanding these local perspectives is essential for tailoring mental health interventions that are culturally sensitive and relevant to the needs of the population.

Trauma-Related Cognitions

Mahmood et al. (2021) aimed to examine the psychological state of students during the COVID-19 outbreak in Pakistan. The study involved university students in Pakistan, investigating how trauma-related cognitions influenced their mental health. The findings revealed that high levels of trauma-related cognition were associated with increased anxiety and depression among students. Negative appraisals of the pandemic's impact on their future and personal safety significantly contributed to their psychological distress. The study concluded that mental health interventions for students should address trauma-related cognitions to reduce psychological distress, emphasizing the importance of cognitive restructuring in therapeutic settings.

Hussain and Bhushan (2011) explored cultural factors promoting coping among Tibetan refugees in India, with implications for similar populations in Pakistan. The research focused on how trauma-related cognitions influenced psychological distress among Tibetan refugees. The study found that these cognitions were significantly shaped by cultural and familial factors, affecting the refugees' psychological well-being. Negative self-appraisals and worldviews were key contributors to maintaining psychological symptoms. The study

concluded that culturally sensitive interventions are necessary to address trauma-related cognitions in refugee populations, suggesting that similar approaches could benefit Pakistani populations affected by trauma.

Naeem et al. (2012) investigated the stigma and mental health help-seeking behavior in Pakistan. The study involved Pakistani adults and examined how trauma-related cognitions, including self-stigma and negative beliefs about mental health services, impacted help-seeking behavior. The findings highlighted that these cognitions were prevalent and contributed to low rates of help-seeking, leading to a higher burden of untreated psychological distress. The study concluded that public health campaigns are needed to address trauma-related cognitions and reduce stigma, promoting mental health awareness and help-seeking behaviors in Pakistan.

Khan et al. (2019) assessed the impact of trauma-related cognitions on PTSD symptoms among survivors of terrorism in Pakistan. The study involved survivors of terrorist attacks, focusing on how negative cognitions influenced their PTSD severity. The findings indicated that negative cognitions about the self and the world, such as beliefs of helplessness and perceptions of the world as an unsafe place, were strongly associated with higher PTSD severity. The study concluded that cognitive-behavioral interventions targeting these negative cognitions are essential for effective PTSD treatment in terrorism survivors, emphasizing the need for tailored mental health services in conflict-affected regions.

Awan et al. (2019) explored trauma-related cognitions and their impact on mental health among internally displaced persons (IDPs) in Pakistan. The study examined how these cognitions affected the psychological well-being of IDPs. The findings revealed that IDPs exhibited high levels of negative trauma-related cognitions, including self-blame and

hopelessness, which were linked to increased symptoms of depression and anxiety. The study concluded that mental health interventions for IDPs should focus on addressing trauma-related cognitions to improve psychological outcomes, highlighting the importance of providing comprehensive cognitive-behavioral therapy in displacement settings.

Anwar et al. (2018) conducted a study to explore the relationship between trauma-related cognitions and mental health outcomes among survivors of natural disasters in Pakistan. The research involved individuals who had experienced significant natural disasters, such as earthquakes and floods. The findings indicated that negative trauma-related cognitions, including self-blame and mistrust in the stability of the environment, were strongly linked to higher levels of anxiety and depression. The study concluded that addressing these cognitions through cognitive-behavioral therapy (CBT) is crucial for improving mental health outcomes among disaster survivors.

Farooq et al. (2017) aimed to examine the impact of trauma-related cognitions on academic performance and mental health among university students in Pakistan. The study included students from multiple universities who had experienced various forms of trauma, such as personal loss or violence. The findings revealed that students with high levels of negative trauma-related cognitions exhibited poorer academic performance and higher levels of psychological distress. The study concluded that interventions addressing these cognitions are necessary to support both the academic and mental well-being of university students.

Javed et al. (2015) investigated the effects of trauma-related cognitions on PTSD and depression among survivors of domestic violence in Pakistan. The study focused on women who had experienced domestic abuse, examining how their cognitions influenced mental health outcomes. The findings showed that negative self-appraisals and beliefs about being

undeserving of support were significant predictors of PTSD and depression severity. The study concluded that therapeutic programs for domestic violence survivors should incorporate cognitive restructuring techniques to address these detrimental cognitions.

Ali et al. (2016) explored the relationship between trauma-related cognitions and help-seeking behavior among Pakistani adolescents exposed to community violence. The study involved adolescents from urban areas with high rates of violence, assessing how their cognitions impacted their willingness to seek help. The findings indicated that negative beliefs about the efficacy of help and mistrust in authorities were barriers to seeking support. The study concluded that interventions aimed at altering these cognitions could enhance help-seeking behaviors and improve mental health outcomes among affected adolescents.

Rehman et al. (2018) examined the role of trauma-related cognitions in the psychological adjustment of Pakistani refugees who had fled conflict zones. The study focused on refugees residing in temporary shelters, evaluating how their cognitions influenced their mental health. The findings revealed that negative cognitions about safety and trust significantly contributed to higher levels of anxiety and PTSD symptoms. The study concluded that providing cognitive-behavioral interventions in refugee camps is essential to help refugees adjust psychologically and improve their mental health.

Mental Health Help-Seeking Behavior

Naeem et al. (2012) investigated the stigma and mental health help-seeking behavior in Pakistan. The study involved Pakistani adults and explored how stigma affected their willingness to seek mental health services. The findings revealed that high levels of stigma, particularly self-stigma, significantly deterred help-seeking behavior. Participants reported fears of being judged or ostracized by their community. The study concluded that reducing

stigma through public health campaigns and increasing awareness about mental health services are crucial steps to improve help-seeking behaviors in Pakistan.

Siddiqui et al. (2014) assessed mental health problems and help-seeking behavior among Pakistani university students. The study included students from various universities in Pakistan, examining the factors influencing their help-seeking intentions. The findings indicated that students experienced high levels of psychological distress but had low rates of seeking professional help due to stigma and lack of awareness about mental health services. The study concluded that universities should implement mental health programs to increase awareness and reduce stigma, thereby promoting help-seeking among students.

Zafar et al. (2016) explored the help-seeking behavior for mental health issues among women in rural Pakistan. The study involved women from rural communities, focusing on the barriers they faced in accessing mental health services. The findings highlighted that cultural norms, gender roles, and limited availability of services were significant barriers to help-seeking. Additionally, stigma and lack of knowledge about mental health were prevalent. The study concluded that targeted interventions are needed to address these barriers and improve access to mental health services for rural women.

Javed et al. (2017) examined the attitudes and barriers to mental health help-seeking among Pakistani adolescents. The study included adolescents from urban and rural areas, investigating their perceptions of mental health services. The findings revealed that stigma, confidentiality concerns, and lack of mental health knowledge were major barriers to seeking help. Support from family and peers was identified as a facilitator. The study concluded that interventions should focus on educating adolescents about mental health and creating supportive environments to encourage help-seeking behaviors.

Khan et al. (2018) conducted a study to understand the help-seeking behavior for mental health issues among Pakistani healthcare professionals. The research involved doctors and nurses from various hospitals in Pakistan, exploring their attitudes towards seeking mental health support. The findings indicated that high levels of stigma and fear of professional repercussions were significant barriers to help-seeking. Many healthcare professionals preferred to manage their mental health issues privately rather than seeking formal support. The study concluded that institutional policies should be implemented to reduce stigma and support mental health help-seeking among healthcare professionals.

Farooq et al. (2018) conducted a study to examine mental health help-seeking behavior among Pakistani university students. The study involved students from several universities in Pakistan, focusing on the factors influencing their willingness to seek help. The findings revealed that stigma, lack of awareness, and cultural norms were significant barriers to help-seeking. Students also reported that support from friends and family facilitated their willingness to seek professional help. The study concluded that increasing mental health awareness and reducing stigma are essential for promoting help-seeking behaviors among university students in Pakistan.

Asad et al. (2015) explored the help-seeking behavior for mental health issues among Pakistani adolescents. The research involved adolescents from urban schools in Pakistan, investigating their attitudes towards mental health services. The findings indicated that adolescents experienced high levels of psychological distress but were reluctant to seek help due to stigma and confidentiality concerns. The study concluded that educational programs targeting adolescents should focus on mental health literacy and reducing stigma to encourage help-seeking.

Rizvi et al. (2017) examined the barriers to mental health help-seeking among Pakistani women with depression. The study included women from urban and rural areas, assessing how social, cultural, and economic factors influenced their help-seeking behaviors. The findings showed that stigma, financial constraints, and lack of accessible mental health services were major barriers. The study concluded that interventions should address these barriers by providing affordable and accessible mental health services and increasing awareness about mental health issues.

Ahmed et al. (2016) investigated the help-seeking behavior for mental health problems among Pakistani men. The study involved men from various socio-economic backgrounds, exploring their perceptions and attitudes towards mental health services. The findings revealed that cultural masculinity norms, stigma, and lack of mental health awareness were significant barriers to seeking help. The study concluded that public health campaigns should focus on changing cultural norms and increasing mental health awareness to promote help-seeking among men.

Iqbal et al. (2018) conducted a study to understand the mental health help-seeking behavior of Pakistani healthcare students. The research involved medical and nursing students from several institutions in Pakistan. The findings indicated that high levels of stigma and fear of academic repercussions were major barriers to seeking mental health support. Many students preferred to deal with their mental health issues privately rather than seeking professional help. The study concluded that universities should implement policies to reduce stigma and support mental health help-seeking among healthcare students.

Spiritual Bypass

Iqbal et al. (2017) explored the impact of spiritual bypass on mental health among Pakistani university students. The study involved students from various universities in Islamabad, examining how they used spiritual practices to avoid dealing with academic and personal stressors. The findings indicated that students engaging in spiritual bypass exhibited higher levels of anxiety and depression. The study concluded that university counseling services should address spiritual bypass by promoting emotional processing alongside spiritual growth to support students' mental health.

Ahmed et al. (2018) investigated the role of spiritual bypass in the psychological well-being of Pakistani women facing domestic violence. The study included women from both urban and rural areas who had experienced domestic abuse. The findings revealed that spiritual bypass, such as using religious practices to avoid confronting their trauma, was associated with increased psychological distress. The study concluded that mental health interventions for domestic violence survivors should incorporate strategies to address spiritual bypass to enhance their emotional healing and recovery.

Khan and Saeed (2019) examined the phenomenon of spiritual bypass in Pakistani healthcare professionals dealing with workplace stress. The research population consisted of doctors and nurses from several hospitals in Lahore. The findings indicated that healthcare professionals who engaged in spiritual bypass to cope with job-related stress experienced higher levels of burnout and psychological distress. The study concluded that healthcare institutions should provide support for addressing spiritual bypass and promote comprehensive stress management programs.

Sadaf and Ali (2020) conducted a study on the effects of spiritual bypass on mental health among Pakistani adolescents facing parental divorce. The research population included

adolescents from various schools who had experienced their parents' separation. The findings revealed that adolescents who used spiritual practices to avoid dealing with their emotional pain exhibited higher levels of depression and anxiety. The study concluded that school counseling programs should address spiritual bypass and provide emotional support to help adolescents process their feelings healthily.

Fatima et al. (2021) explored the impact of spiritual bypass on the mental health of Pakistani refugees who had fled conflict zones. The study involved refugees residing in temporary shelters, assessing how they used spirituality to cope with their traumatic experiences. The findings indicated that refugees engaging in spiritual bypass, such as using spirituality to avoid confronting their trauma, exhibited higher levels of PTSD and depression. The study concluded that mental health interventions for refugees should incorporate strategies to address spiritual bypass to promote emotional and psychological healing.

Javed and Khan (2018) investigated the phenomenon of spiritual bypass among Pakistani teachers dealing with occupational stress. The study involved teachers from various schools in Karachi. The findings revealed that teachers who engaged in spiritual bypass to cope with work-related stress exhibited higher levels of anxiety and depression. The study concluded that professional development programs for teachers should address spiritual bypass and promote healthy coping strategies to improve their mental health.

Shah et al. (2019) explored the impact of spiritual bypass on the mental health of Pakistani soldiers returning from conflict zones. The research population included military personnel who had experienced combat. The findings indicated that soldiers who used spiritual practices to avoid confronting their traumatic experiences exhibited higher levels of

PTSD and psychological distress. The study concluded that mental health support for returning soldiers should incorporate strategies to address spiritual bypass and promote emotional processing.

Anwar and Zafar (2020) examined the role of spiritual bypass in the mental health of Pakistani students facing academic pressure. The study involved students from several universities in Lahore. The findings showed that students who engaged in spiritual bypass to cope with academic stress exhibited higher levels of depression and anxiety. The study concluded that university counseling services should address spiritual bypass and provide support for emotional well-being alongside academic guidance.

Rafiq et al. (2021) conducted a study on the effects of spiritual bypass on the mental health of Pakistani women dealing with infertility. The research population included women from urban and rural areas struggling with infertility. The findings revealed that women who used spiritual practices to avoid dealing with their emotional pain exhibited higher levels of psychological distress. The study concluded that mental health interventions for women with infertility should incorporate strategies to address spiritual bypass to support their emotional and psychological health.

Saeed and Ali (2022) investigated the impact of spiritual bypass on the mental health of Pakistani adolescents experiencing bullying. The study involved adolescents from various schools who had been victims of bullying. The findings indicated that adolescents who engaged in spiritual bypass to cope with bullying exhibited higher levels of depression and anxiety. The study concluded that school counseling programs should address spiritual bypass and provide comprehensive support to help adolescents process their experiences and improve their mental health.

Conclusion

The comprehensive review of literature on trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass underscores the profound impact that these factors have on mental health outcomes across diverse populations, both globally and within Pakistan. International studies consistently highlight the role of trauma-related cognitions in the development and persistence of psychological distress, including PTSD, depression, and anxiety. These studies emphasize the effectiveness of cognitive-behavioral interventions in addressing maladaptive beliefs and promoting mental health (Ehlers & Clark, 2000; Brewin et al., 2009; Bardeen et al., 2013). Similarly, indigenous research provides robust evidence that negative trauma-related cognitions significantly affect Pakistani populations, including university students, survivors of natural disasters and terrorism, domestic violence victims, adolescents exposed to community violence, and refugees (Mahmood et al., 2021; Khan et al., 2019; Awan et al., 2019).

The literature on mental health help-seeking behavior highlights a complex interplay of factors that influence whether individuals seek professional support for psychological distress. International studies identify stigma, lack of mental health literacy, and perceived inefficacy of services as significant barriers to help-seeking, while facilitators include positive attitudes towards mental health services, support from social networks, and previous positive experiences with help-seeking (Gulliver et al., 2010; Schomerus et al., 2009; Vogel et al., 2007). Indigenous research further elaborates on these barriers and facilitators within the Pakistani context, revealing additional challenges such as cultural norms, gender roles, and limited availability of mental health services, particularly in rural areas (Naeem et al., 2012; Zafar et al., 2016; Ahmed et al., 2016). These findings emphasize the need for culturally sensitive public health campaigns and educational programs to improve mental

health literacy and reduce stigma, thereby encouraging help-seeking behaviors (Siddiqui et al., 2014; Javed et al., 2017).

The review of literature on spiritual bypass highlights its significant impact on mental health across various populations. International studies consistently reveal that spiritual bypass, which involves using spiritual practices to avoid addressing unresolved emotional and psychological issues, can lead to increased psychological distress, including symptoms of anxiety, depression, PTSD, and emotional dysregulation (Masters, 2010; Cashwell et al., 2010; Smucker et al., 2011). Indigenous research further elaborates on the detrimental effects of spiritual bypass within the Pakistani context, showing that spiritual bypass significantly exacerbates psychological distress among university students, domestic violence survivors, healthcare professionals, adolescents, refugees, teachers, soldiers, and individuals dealing with infertility and bullying (Iqbal et al., 2017; Ahmed et al., 2018; Khan and Saeed, 2019; Sadaf and Ali, 2020; Fatima et al., 2021). The pervasive influence of cultural and religious norms often amplifies these effects, highlighting the need for culturally sensitive interventions that address spiritual bypass and promote emotional processing and psychological resilience.

The findings from both global and local studies align with the objectives of the current research, which aims to determine the impact of trauma-related cognitions on help-seeking behavior among university students in Islamabad, while examining the mediating effects of spiritual bypass. By exploring how these factors influence mental health outcomes, this study seeks to fill a critical gap in the literature and provide evidence-based recommendations for improving mental health interventions in Pakistan. The synthesis of these studies highlights the urgent need for culturally sensitive interventions that address cognitive distortions and promote positive coping mechanisms, thereby setting the stage for the rationale of this study.

Overall, the literature on trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass provides valuable insights into the complex interplay between psychological, spiritual, and cultural factors in the context of trauma. By synthesizing and critically analyzing existing research findings, this literature review lays the groundwork for further exploration and understanding of these phenomena within the Pakistani context.

THEORETICAL FRAMEWORK

This chapter outlines the theoretical framework underpinning the current study, presenting the key theories and models that explain the relationships between the study variables. The theoretical framework integrates the Theory of Planned Behavior (TPB) to provide a comprehensive understanding of how trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors are interconnected. The conceptual model and study hypotheses are also delineated, establishing the foundation for the research design and analysis.

Theory of Planned Behavior

Ajzen (1991) developed the well-known psychological theory known as the Theory of Planned Behavior (TPB), which is depicted in figure 1 below and explains human behavior in terms of three main components: attitudes, subjective standards, and perceived behavioral control. These elements work together to influence a person's behavioral intentions and, in turn, their actual behaviors. The TPB is frequently used to analyze and forecast behaviors related to health in a variety of fields, including health psychology.

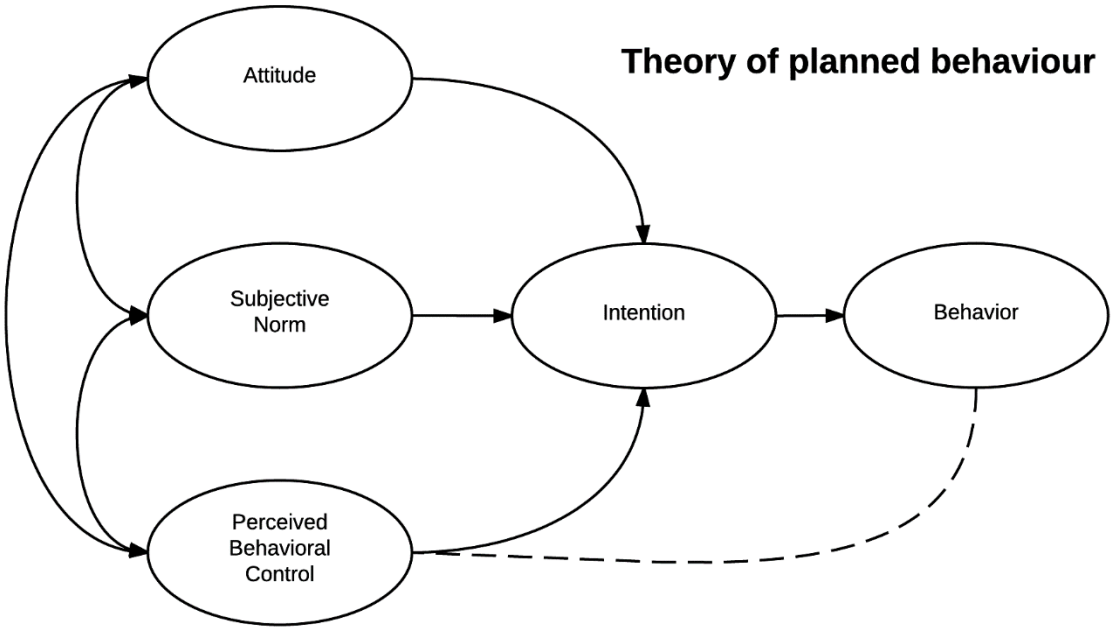


Figure 1: The Theory Model of Planned Behavior

Attitudes

Positive or negative assessments of engaging in an action are referred to as attitudes towards that behavior. These assessments are predicated on opinions regarding the behavior's effects and the advantages or disadvantages that are thought to come with it. In the context of this study, trauma-related cognitions influence attitudes toward behavior connected to obtaining mental health care. People who have a good attitude on asking for assistance are more likely to really seek assistance. For instance, students are more likely to see getting help positively if they think that getting care for trauma-related problems will improve their mental health.

Subjective Norms

Subjective norms refer to the perceived social pressure to perform or not perform a behavior. These norms are influenced by the individual's perception of whether important

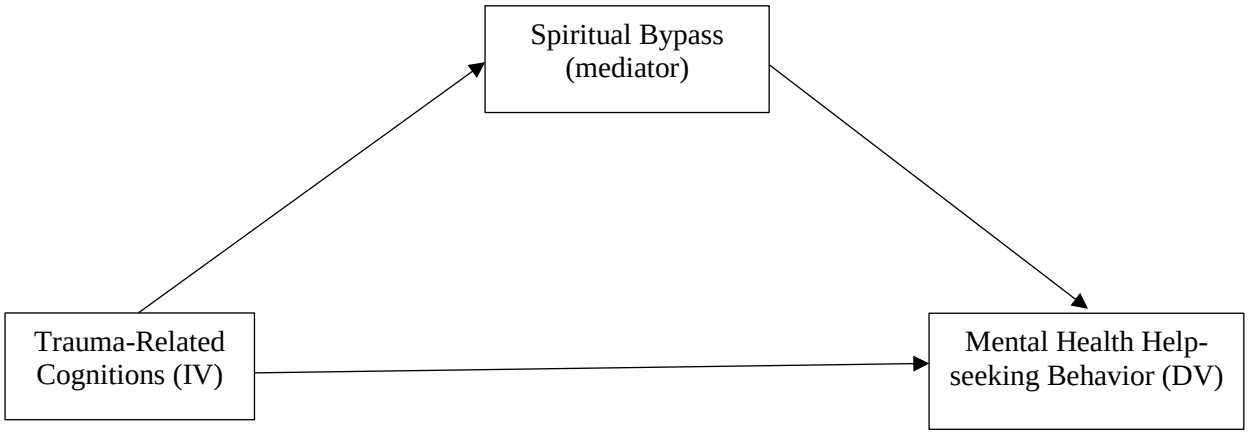
others (e.g., family, friends, religious leaders) think they should engage in the behavior. In this study, subjective norms are influenced by cultural and religious factors in the Pakistani context. The role of spiritual bypass can be understood as part of these subjective norms, where societal and religious expectations shape how individuals cope with trauma and their willingness to seek professional help. For instance, in a context where seeking mental health services is stigmatized, individuals may experience social pressure to use spiritual practices instead of professional help.

Perceived Behavioral Control

The term "perceived behavioral control" describes how someone feels about their capacity to carry out an action, considering any enabling or restricting circumstances. It relates to the person's belief in their ability to carry out the behavior and is similar to the idea of self-efficacy. Cultural norms, perceived stigma, the availability of mental health resources, and individual opinions regarding the effectiveness of these services can all have an impact on university students' perceived behavioral control over obtaining mental health treatment. For instance, a student is more likely to have high perceived behavioral control and, as a result, a stronger intention to seek help if they think that mental health treatments are easily available and effective.

The TPB posits that these three components—attitudes, subjective norms, and perceived behavioral control—jointly influence behavioral intentions, which in turn predict actual behavior. This theoretical framework is particularly relevant for understanding the complex interplay between cognitive and social factors that influence mental health help-seeking behavior among university students in Pakistan.

Conceptual Model



Trauma-Related Cognitions

Trauma-related cognitions are the negative beliefs and thoughts that individuals develop in response to traumatic experiences. These cognitions can profoundly impact an individual's mental health and their willingness to seek help. The study examines the four types of trauma-related cognitions: overaccommodation, assimilation, accommodation, and optimism.

Overaccommodation. This involves excessively altering one's beliefs to accommodate the traumatic event, often leading to maladaptive changes in worldview and self-perception.

Assimilation. This refers to the integration of the traumatic event into existing beliefs, often resulting in self-blame and guilt.

Accommodation. This involves adjusting one's beliefs to incorporate the traumatic event in a balanced manner, which can be either adaptive or maladaptive.

Optimism. This refers to maintaining a hopeful outlook and positive beliefs about the future despite the trauma.

Spiritual Bypass

Spiritual bypass is a coping mechanism where individuals use spiritual practices to avoid confronting psychological distress. While spirituality can provide comfort and resilience, spiritual bypass involves using spiritual beliefs to sidestep dealing with the emotional and cognitive aspects of trauma. In the Pakistani context, where religious and spiritual practices are deeply ingrained, spiritual bypass can significantly influence how individuals cope with trauma and seek help.

Psychological Avoidance. This sub-domain involves using spiritual practices to avoid dealing with emotional pain and psychological challenges.

Spiritualizing. This sub-domain involves attributing all aspects of the trauma and its aftermath to spiritual causes and solutions, often neglecting the psychological aspects that need addressing.

Mental Health Help-Seeking Behavior

Help-seeking behavior related to mental health concerns is the act of someone seeking professional assistance for psychological suffering. As shown by the TPB, attitudes, subjective norms, and perceived behavioral control interact to shape this behavior. Knowing how these elements work together might assist identify the obstacles to and enablers of aid-seeking behavior among college students.

Hypotheses

H1: Trauma-related cognitions will have a positive relationship with mental health help-seeking behavior among university students.

H2: Spiritual bypass will mediate the relationship between trauma-related cognitions and mental health help-seeking behavior among university students.

H3: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between undergraduate and postgraduate students.

H4: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between male and female students.

H5: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between day-scholars and hostelites.

H6: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between students from nuclear families and those from joint families.

H7: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between single and married students.

H8: There is a significant difference in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors across different levels of socioeconomic status (lower, middle, and upper).

METHOD

The present study investigated the relationship between trauma-related cognitions and mental health help-seeking behavior, with spiritual bypass as a mediating factor, among university students of Pakistan.

Research Design

A correlational (cross-sectional) study design was used.

Participants

The participants for this study were aged 18-30 and selected using non-probability convenience sampling method from universities in Islamabad, specifically Bahria, Air, NUST, FAST, and COMSATS. The target sample size for this study was 400 participants according to g-power analysis. The actual samples collected for the study were 415, however, after excluding the deviations from study parameters, the remaining sample was 393 participants.

Inclusion Criteria

- Participants having experienced at least one traumatic event in their lifetime, as assessed by the Trauma History Questionnaire (THQ).
- Participants aged from 18 to 29 years.
- Participants that can read and understand English language.
- Participants having experienced the traumatic event not more than once in their lifetime, as assessed by the Trauma History Questionnaire (THQ).

- Participants having experienced the traumatic event not earlier than at least one year prior to the research study, as assessed by the Trauma History Questionnaire (THQ).

Exclusion Criteria

- Participants scoring high (3-4 rating) for any mental health disorder on the General Health Questionnaire (GHQ-12) are excluded.
- Participants scoring above the cutoff score (33) for severe PTSD symptoms on the PTSD Checklist for DSM-5 (PCL-5) are excluded.
- Participants having gone or currently undergoing psychotherapy or counseling for mental health issues are excluded.
- Participants with a history of substance use disorder, as assessed by the demographic questionnaire item are excluded.

Measures

1. Informed Consent and Demographic Information Sheet
2. General Health Questionnaire
3. Trauma History Questionnaire
4. PTSD Checklist for DSM-5
5. Trauma-Related Cognitions Scale
6. Mental Health Help-Seeking Intentions Scale
7. Spiritual Bypass Scale

Informed Consent and Demographic Information Sheet

The informed consent form was used to provide participants with the information they need to decide to volunteer for this study. Demographic information sheet comprised of

statements estimating demographic characteristics with details about age, gender, birth order, education, family system and siblings, marital status, socio-economic status, past or ongoing mental health therapy experience, substance use history, etc.

General Health Questionnaire

Developed by Goldberg and Hillier (1979), the General Health Questionnaire (GHQ-28) is a screening instrument intended to detect brief changes in mental health in the general population. Four subscales comprise the 28-item GHQ: physical symptoms, anxiety and insomnia, social dysfunction, and severe depression. Examples of questions include "Have you recently lost much sleep over worry?" along with "Have you recently been able to enjoy your normal day-to-day activities?" Each question is rated by respondents on a four-point Likert scale, where higher scores correspond to more psychological suffering. According to Goldberg and Hillier (1979), the GHQ-28 has shown strong internal consistency, with alpha reliability coefficients usually surpassing 0.90. Because of its simplicity of use and dependability, the GHQ-28 is a useful tool for evaluating mental health in both clinical and research settings.

Trauma History Questionnaire

The Trauma History Questionnaire (THQ), developed by Green (1996), is a 24-item questionnaire designed to assess exposure to various types of traumatic events, their frequency, and the age at which it occurred. It does not have distinct sub-scales and uses a Yes/No response format. Sample items include "Serious accident, fire, or explosion?" and "Physical assault with a weapon?" The THQ does not have a specific cutoff score but is used to determine whether participants have experienced trauma in their lives.

PTSD Checklist for DSM-5

Weathers et al. (2013) created the PTSD Checklist for DSM-5 (PCL-5), a 20-item self-report tool that evaluates the existence and intensity of PTSD symptoms as specified by the DSM-5. Its four subscales—intrusion, avoidance, negative changes in mood and cognition, and arousal and reactivity—match the DSM-5 criteria for post-traumatic stress disorder. A few examples include "Repeated, disturbing, and unwanted memories of the stressful experience?" or "Feeling very upset when something reminded you of the stressful experience?" A 5-point Likert scale, with a cutoff score of 33, is used to collect participant responses. Higher scores indicate more severe PTSD symptoms, with 0 representing "Not at all" and 4 representing "extremely." The PCL-5 has shown to be incredibly reliable, with Cronbach's alpha coefficients typically above 0.90 for the total scale and around 0.80 to 0.90 for the sub-scales.

Trauma-Related Cognitions Scale

Participants' trauma-related cognitions are evaluated using the Trauma-Related Cognitions Scale (TRCS), which was created by Valdez et al. (2021). The 69-item multidimensional TRCS measure was created to identify trauma-related beliefs linked to cognitive functions like optimism, assimilation, overaccommodation, and accommodation. Statements about these cognitive processes are included in the sample items, and participants answer according to their trauma-related experiences and views. The responses on the scale are rated on a Likert scale. Both clinical and non-clinical samples show strong internal consistency with the TRCS, with Cronbach's alpha reliability values ranging from 0.62 to 0.97 across subscales. Each subscale's scale-score values are added together, and no severity or diagnostic cut-off scores are given. The TRCS has been validated across various populations and has strong psychometric properties, including reliability and validity (Valdez et al., 2021).

Mental Health Help-Seeking Intentions Scale

Fischer and Turner (1970) created the 3-item Mental Help Seeking Intention Scale (MHSIS) to gauge people's intentions to seek professional mental health assistance when they are experiencing mental health issues. Items in the MHSIS evaluate a person's propensity to ask for assistance in different situations. It uses a 5-point Likert scale, with 1 denoting "definitely not" and 5 denoting "definitely yes," and lacks distinguishing sub-scales. The three elements are scored by taking the mean of them; higher scores suggest a greater intention to seek assistance. Sample items include "If you were worried or upset and it was affecting your life in an important way, would you go for professional help?" and "If you were worried or upset and it was affecting your life in an important way, would you go to a mental health clinic for help?". The scale has demonstrated unidimensionality, good reliability, with Cronbach's alpha coefficients typically around 0.80 to 0.90.

Spiritual Bypass Scale

The Spiritual Bypass Scale-13 (SBS-13), developed by Fox, Cashwell, and Picciotto (2017), is used to assess spiritual bypass, a phenomenon where individuals use spiritual beliefs or practices to avoid confronting psychological challenges. Initially created with 25 items, the scale underwent factor analysis, resulting in 13 items across two facets: Psychological Avoidance and Spiritualizing, with a second-order facet of Spiritual Bypass. Sample items reflect behaviors of avoiding psychological issues through spiritual means. The scale uses a Likert rating scale for responses. Reliability testing across different samples yielded satisfactory results, and the scale demonstrated convergent, discriminant, predictive, and incremental validity when compared with measures of spirituality, religiosity, mindfulness, stress, anxiety, depression, and personality traits.

Procedure

Data was collected through printed copies of the survey questionnaires distributed around various universities in Islamabad. The printed surveys were handed out to students in common areas such as cafeterias, libraries, classes, and lecture halls. Participants were given sufficient time to complete the survey on-site or return it within a specified period.

Participants completed the survey anonymously to ensure confidentiality. They were informed that their participation is voluntary and that they can withdraw from the study at any time without any consequences. The estimated time to complete the survey was approximately 20-30 minutes.

Data is analyzed using SPSS (Statistical Package for the Social Sciences). Descriptive statistics are calculated to summarize the sample characteristics. Pearson correlation coefficients are used to examine the relationships between trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass. Independent two-sample t-tests are conducted to examine any significant differences in means between the demographic variables (Education, Gender, Living status, Family structure, Marital status), and a one-way ANOVA for Socioeconomic status. Mediation analyses are conducted using Hayes' PROCESS macro to test the mediating effect of spiritual bypass.

Ethical Considerations

The study was carried out following strict ethical guidelines:

- Informed consent was obtained from all participants prior to their participation in the study.

- Participants were reminded that they can withdraw from the study at any time and that their responses are kept confidential and are used solely for research purposes.
- Data has been stored securely on password-protected computers and is only accessible to the researcher. The data shall be kept only for one year (spanning the remaining duration of the degree).
- Anonymity is maintained by assigning unique identification codes to each participant's data.
- The study protocol was submitted for review and approval by the Institutional Review Board (IRB) of the respective university of the researcher prior to data collection.

RESULTS

The results chapter summarizes the conclusions drawn from the studies carried out to investigate the connection between trauma-related beliefs and university students' behavior when seeking mental health treatment, with an emphasis on the mediating function of spiritual bypass. This chapter starts with descriptive statistics that give an overview of the sample characteristics and the distributions of the important variables for all scales utilized in the study. In order to investigate the bivariate associations between trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass, Pearson r correlations are then given. Then, to look for any significant mean differences between the study variables and demographic factors, t-tests and one-way ANOVA were used. The final section includes comprehensive mediation studies utilizing Hayes' PROCESS macro to examine the mediating role of spiritual bypass on the link between trauma-related cognitions and help-seeking behavior.

Descriptive Statistics

This section begins by detailing the demographic information of the participants, including age, semester, department, university, type of university, education level, gender, number of siblings, birth order, living status, family structure, marital status, and socioeconomic status. Following this, descriptive statistics for the primary scales used in the study—including the General Health Questionnaire, and PTSD Checklist for DSM-5, and the specific scales related to trauma-related cognitions, mental health help-seeking behavior, and spiritual bypass—are presented.

Table 1

Descriptive statistics of the Demographic Characteristics of the Sample (N=393)

Variables	*f*	(%)	M	SD
Age (years)			21.64	2.77
Semester				
1	48	12.2		
2	55	14.0		
3	69	17.6		
4	66	16.8		
5	34	8.7		
6	38	9.7		
7	41	10.4		
8	42	10.7		
Department				
Psychology	82	20.9		
A&F	86	21.9		
CS	83	21.1		
IT	77	19.6		
Law	65	16.5		
University				
Bahria	77	19.6		
Air	69	17.6		
NUST	82	20.9		
FAST	85	21.6		
COMSATS	80	20.4		
Education				
Undergraduate	307	78.1		

Postgraduate	86	21.9
Gender		
Male	184	46.8
Female	209	53.2
Siblings		
1	119	30.3
2	137	34.9
3	108	27.5
4	12	3.1
5	13	3.3
6	4	1.0
Birth Order		
1st	130	33.1
2nd	121	30.8
3rd	87	22.1
4th	30	7.6
5th	25	6.4
Living Status		
Day-Scholar	304	77.4
Hostelite	89	22.6
Family		
Nuclear	283	72.0
Joint	110	28.0
Marital Status		
Single	352	89.6
Married	41	10.4

Socioeconomic Status		
Lower	54	13.7
Middle	232	59.0
Upper	107	27.2
Any Medical Issue		
Yes	9	2.3
No	384	97.7

Note: *f*= Frequencies of demographic variables, % = Percentage, M= Mean, and SD= Standard Deviation

Table 1 shows the demographic characteristics of the study sample. The mean age of the participants was 21 years. Participants were distributed across various semesters, with the highest representation in the third and fourth semesters. The sample included students from multiple departments and universities, with nearly equal representation. Most participants were undergraduate students, with the gender distribution slightly skewed towards females (53.2%). Mostly, participants were day-scholars, and a large portion came from nuclear families. Most participants were single, with only a small percentage being married. The socioeconomic status of the participants was predominantly middle class, followed by upper and lower socioeconomic statuses.

Table 2

Descriptive statistics and Reliability Analysis of Trauma-Related Cognitions (Overaccommodation, Assimilation, Accommodation, Optimism), Spiritual Bypass (Psychological Avoidance, Spiritualizing), Mental Health Help-Seeking Behavior, General Health Questionnaire, and PTSD Symptom Checklist (N=393)

Variables	*k*	*M*	*SD*	*Range*		*α*
				Actual	*Potential*	
Trauma-Related Cognitions	69	-	-	-	-	-
Overaccommodation	25	90.77	28.76	32-161	25-175	.96
Assimilation	13	53.53	13.86	19-84	13-91	.91
Accommodation	15	60.73	16.45	19-96	15-105	.93
Optimism	16	63.30	17.47	23-106	16-112	.93
Spiritual Bypass	13	29.39	07.98	15-47	13-52	.86
Psychological Avoidance	9	20.32	06.22	10-34	09-36	.87
Spiritualizing	4	09.06	03.11	04-16	04-16	.78
Mental Health Help-Seeking Behavior	3	12.58	04.63	03-21	03-21	.83
General Health	28	43.00	01.26	41-44	28-112	.70
PTSD Symptom Checklist	20	44.78	04.78	34-51	20-100	.72

Note: K= Number of items, M = Mean, SD = Standard Deviation, and α = Cronbach Alpha Reliability

Table 2 presents the descriptive statistics and reliability analysis for the study measures. The Overaccommodation, Assimilation, Accommodation, and Optimism subscales have Cronbach's alphas of 0.958, 0.909, 0.928, and 0.930, respectively, indicating high internal consistency. The Spiritual Bypass Scale has a Cronbach's alpha of 0.857, with its Psychological Avoidance and Spiritualizing subscales showing alphas of 0.865 and 0.776, respectively. The Mental Health Help-Seeking Behavior Scale, comprising 3 items, has a Cronbach's alpha of 0.832, reflecting good internal consistency.

Pearson Product Moment Correlation Analysis

It was hypothesized that trauma-related cognitions would have a positive relationship with mental health help-seeking behavior among university students and that spiritual bypass would mediate this relationship.

Table 3

Bivariate Correlation between Trauma-Related Cognition (Overaccommodation, Assimilation, Accommodation, Optimism), Spiritual Bypass (Psychological Avoidance, Spiritualizing), Negative Religious Coping, and Mental Health Help-Seeking Behavior (N=393)

Variables	2	3	4	5	6	7	8	9
1. Trauma-Related Cognitions	-	-	-	-	-	-	-	-
2. Overaccommodation	-	.47**	.28**	.24**	.48**	.48**	.27**	.45**
3. Assimilation		-	.28**	.39**	.48**	.45**	.32**	.52**
4. Accommodation			-	.25**	.29**	.31**	.14***	.31**
5. Optimism				-	.36**	.32**	.28**	.33**
6. Spiritual Bypass					-	.93**	.70**	.64**
7. Psychological Avoidance						-	.40**	.61**
8. Spiritualizing							-	.42**
9. Mental Health Help-Seeking Behavior								-

**p<.05, **p<.01, ***p<.001*

Table 3 shows the Pearson Product Moment Correlation Analysis that was conducted to examine the relationships between trauma-related cognitions (Overaccommodation, Assimiliation, Accommodation, Optimism), spiritual bypass (Spiritualizing, Psychological Avoidance), and mental health help-seeking behavior among university students. The results indicate significant correlations between these variables. The findings indicate that higher levels of trauma-related cognitions are associated with increased tendencies towards spiritual bypass and higher likelihoods of seeking mental health help. This supports the study's hypothesis and underscores the interconnectedness of cognitive processes, spiritual coping mechanisms, and help-seeking behaviors in the context of trauma.

Independent Samples t-test and One-way ANOVA

Independent samples t-tests and one-way ANOVA were conducted to explore differences in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors across various demographic variables. Independent samples t-tests were performed for the variables of education level, gender, living status, family structure, and marital status, while a one-way ANOVA was conducted to examine differences based on socioeconomic status.

Table 4

Results of t-test analysis for the demographic variable of Education level with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Undergraduate		Postgraduate		*t*	*p*	Cohens'*d*
	M	*SD*	*M*	*SD*			
Spiritual Bypass	29.15	08.02	30.21	07.81	-1.09	.277	0.133
Overaccommodation	89.93	28.40	93.72	29.99	-1.08	.281	0.129
Assimilation	53.25	13.93	54.53	13.63	-0.76	.448	0.092
Accommodation	60.95	16.20	59.97	17.41	0.49	.625	0.058
Optimism	63.44	17.39	62.80	17.83	0.30	.764	0.036
Mental Health Help-seeking	12.59	4.53	12.51	05.00	0.14	.886	0.016

Note: M=Mean, SD=Standard Deviation, *t*= t-test statistic

The independent samples t-test was conducted to compare trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between undergraduate and postgraduate students. The results indicated no significant differences between the two groups for spiritual bypass (t(393) = -1.089, p = .277), overaccommodation (t(393) = -1.080, p = .281), assimilation (t(393) = -.759, p = .448), accommodation (t(393) = .489, p = .625), optimism (t(393) = .300, p = .764), and mental health help-seeking behavior (t(393) = .144, p = .886). This suggests that the level of education does not significantly impact these variables among university students.

Table 5

Results of t-test analysis for the demographic variable of Gender with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Male		Female		*t*	*p*	Cohens'*d*
	M	*SD*	*M*	*SD*			
Spiritual Bypass	29.40	07.94	29.36	08.03	.048	.962	0.005
Overaccommodation	90.65	30.15	90.86	27.55	-.074	.941	0.007
Assimilation	53.17	14.12	53.85	13.65	-.480	.632	0.049
Accommodation	60.56	16.87	60.89	16.11	-.195	.845	0.020
Optimism	64.18	18.03	62.53	16.96	.939	.348	0.094
Mental Health Help-seeking	12.51	04.56	12.64	04.69	-.280	.780	0.028

Note: M=Mean, SD=Standard Deviation, *t*= t-test statistic

The independent samples t-test was conducted to compare trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between male and female students. The results showed no significant differences between the two groups for spiritual bypass ($t(393) = .048$, $p = .962$), overaccommodation ($t(393) = -.074$, $p = .941$), assimilation ($t(393) = -.480$, $p = .632$), accommodation ($t(393) = -.195$, $p = .845$), optimism ($t(393) = .939$, $p = .348$), and mental health help-seeking behavior ($t(393) = -.280$, $p = .780$). These findings indicate that gender does not significantly influence these variables among the students.

Table 6

Results of t-test analysis for the demographic variable of Living Status with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Day Scholar		Hostelite		*t*	*p*	Cohens'*d*
	M	*SD*	*M*	*SD*			
Spiritual Bypass	29.04	07.63	30.54	08.99	-1.56	.120	0.133
Overaccommodation	90.28	29.01	92.40	28.00	-.613	.541	0.129
Assimilation	53.19	13.78	54.69	14.13	-.893	.373	0.092
Accommodation	60.82	16.39	60.43	16.72	.199	.842	0.058
Optimism	63.45	17.16	62.81	18.56	.303	.762	0.036
Mental Health Help-seeking	12.53	04.57	12.73	04.84	-.359	.719	0.016

Note: M=Mean, SD=Standard Deviation, *t*= t-test statistic

The independent samples t-test was conducted to compare trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between day-scholars and hostelites. The results indicated no significant differences between the two groups for spiritual bypass (t(393) = -1.560, p = .120), overaccommodation (t(393) = -.613, p = .541), assimilation (t(393) = -.893, p = .373), accommodation (t(393) = .199, p = .842), optimism (t(393) = .303, p = .762), and mental health help-seeking behavior (t(393) = -.359, p = .719). This suggests that living status does not significantly impact these variables among university students.

Table 7

Results of t-test analysis for the demographic variable of Family Structure with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Nuclear		Joint		*t*	*p*	Cohens'*d*
	M	*SD*	*M*	*SD*			
Spiritual Bypass	29.38	08.06	29.38	07.78	0.00	1.00	0.005
Overaccommodation	88.80	29.14	95.81	27.24	-2.18	.030	0.007
Assimilation	53.20	13.64	54.39	14.43	-0.76	.444	0.049
Accommodation	59.74	16.15	63.29	17.01	-1.93	.055	0.020
Optimism	63.18	17.21	63.62	18.17	-0.22	.824	0.094
Mental Health Help-seeking	12.60	04.68	12.52	04.51	0.15	.879	0.028

Note: M=Mean, SD=Standard Deviation, *t*= t-test statistic

The independent samples t-test was conducted to compare trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between students from nuclear families and those from joint families. The results showed no significant differences between the two groups for spiritual bypass (t(393) = .000, p = 1.000), assimilation (t(393) = -.766, p = .444), accommodation (t(393) = -1.929, p = .055), optimism (t(393) = -.223, p = .824), and mental health help-seeking behavior (t(393) = .152, p = .879). However, a significant difference was found in overaccommodation (t(393) = -2.180, p = .030), suggesting that students from joint families experience higher overaccommodation compared to those from nuclear families.

Table 8

Results of t-test analysis for the demographic variable of Marital Status with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Single		Married		*t*	*p*	Cohens'*d*
	M	*SD*	*M*	*SD*			
Spiritual Bypass	29.43	07.94	28.98	08.36	0.34	.731	0.133
Overaccommodation	90.86	28.97	89.90	27.22	0.20	.840	0.129
Assimilation	53.78	13.77	51.37	14.57	1.05	.291	0.092
Accommodation	60.75	16.22	60.61	18.50	0.05	.960	0.058
Optimism	63.36	17.40	62.85	18.21	0.17	.862	0.036
Mental Health Help-seeking	12.68	4.57	11.68	05.04	1.30	.193	0.016

Note: M=Mean, SD=Standard Deviation, *t*= t-test statistic

The independent samples t-test was conducted to compare trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between single and married students. The results indicated no significant differences between the two groups for spiritual bypass (t(393) = .344, p = .731), overaccommodation (t(393) = .202, p = .840), assimilation (t(393) = 1.058, p = .291), accommodation (t(393) = .051, p = .960), optimism (t(393) = .174, p = .862), and mental health help-seeking behavior (t(393) = 1.305, p = .193). These findings suggest that marital status does not significantly influence these variables among university students.

Table 9

Means, Standard Deviations, and One-Way Analyses of Variance for the demographic variable of Socioeconomic status with Spiritual Bypass, Overaccommodation, Assimilation, Accommodation, Optimism, and Mental Health Help-seeking (n=393)

Logistic Parameter	Lower		Middle		Upper		*F*(2-390)	*p*
	M	*SD*	*M*	*SD*	*M*	*SD*		
Spiritual Bypass	30.24	07.98	28.78	07.82	30.25	8.25	1.61	.200
Overaccommodation	99.52	28.03	88.68	28.20	90.86	29.73	-1.08	.044
Assimilation	53.04	13.65	53.10	13.70	54.71	14.35	-0.76	.589
Accommodation	61.37	16.71	60.91	16.18	60.03	17.02	0.49	.859
Optimism	65.54	14.61	62.06	18.23	64.87	16.99	0.30	.233
Mental Health Help-seeking	12.65	04.38	12.48	04.63	12.75	04.77	0.14	.877

Note: M=Mean, SD=Standard Deviation

A one-way ANOVA was conducted to examine the differences in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors across different levels of socioeconomic status (lower, middle, and upper). The results indicated a significant difference in overaccommodation ($F(2, 390) = 3.148$, $p = .044$), suggesting that students from lower socioeconomic backgrounds experience higher overaccommodation compared to those from middle and upper socioeconomic statuses. No significant differences were found for assimilation ($F(2, 390) = .531$, $p = .589$), accommodation ($F(2, 390) = .151$, $p = .859$), optimism ($F(2, 390) = 1.462$, $p = .233$), spiritual bypass ($F(2, 390) = 1.616$, $p = .200$), and mental health help-seeking behavior ($F(2, 390) = .131$, $p = .877$). These findings suggest that socioeconomic status has a limited impact on these variables among university students, except for overaccommodation.

Mediation Analyses

It was hypothesized that Spiritual Bypass will act as a mediator between Trauma-related Cognitions and Mental Health Help-seeking Behavior. Mediation analysis was carried out between Trauma-related Cognitions (Overaccommodation, Assimilation, Accommodation, Optimism), Spiritual Bypass, and Mental Health Help-seeking Behavior, using *PROCESS macro* (Hayes, 2020).

Table 10

Mediation Analysis between Overaccommodation and Mental Health Help-seeking Behavior through Spiritual Bypass (N=393)

Antecedent	Consequent					
	Spiritual Bypass			Mental Health Help-Seeking Behavior		
	Coeff.	*SE*	*p<*	*Coeff.*	*SE*	*p<*
Constant	17.381	1.174	.001	.431	.726	.553
Overaccommodation	.477	.012	.001	.186	.007	.001
Spiritual Bypass	-	-	-	.553	.025	.001
	R^2 = .227			R^2 = .438		
	$F(1,391) = 115.022$, $p < .001$			$F(2,390) = 152.203$, $p < .001$		

Note: Coeff= standardized regression coefficient

Mediation results indicated that overaccommodation was found to be a positively significant predictor of spiritual bypass and mental health help-seeking behavior. Whereas Spiritual bypass was found to be a significant predictor of mental health help-seeking behavior. So, mediation was found to be significant as Indirect effect is (effect= .042, boot strap interval) which showed that an increase in overaccommodation tends to increase

spiritual bypass, whereas increase in spiritual bypass in turn increases mental health help-seeking behavior.

Table 11

Mediation Analysis between Assimilation and Mental Health Help-seeking Behavior through Spiritual Bypass (N=393)

Antecedent	Consequent					
	Spiritual Bypass			Mental Health Help-Seeking Behavior		
	Coeff.	*SE*	*p*<	*Coeff.*	*SE*	*p*<
Constant	14.732	1.416	.001	-1.042	.769	.177
Assimilation	.476	.026	.001	.274	.014	.001
Spiritual Bypass	-	-	-	.511	.024	.001
	R^2= .226			R^2= .470		
	$F(1,391) = 114.235$, $p < .001$			$F(2,390) = 172.767$, $p < .001$		

Note: Coeff= standardized regression coefficient

Mediation results indicated that assimilation was found to be a positively significant predictor of spiritual bypass and mental health help-seeking behavior. Whereas spiritual bypass was found to be a significant predictor of mental health help-seeking behavior. So, mediation was found to be significant as Indirect effect is (effect= .081, boot strap interval) which showed that an increase in assimilation tends to increase spiritual bypass, whereas increase in spiritual bypass in turn increases mental health help-seeking behavior.

Table 12

Mediation Analysis between Accommodation and Mental Health Help-seeking Behavior through Spiritual Bypass (N=393)

Antecedent	Consequent					
	Spiritual Bypass			Mental Health Help-Seeking Behavior		
	Coeff.	*SE*	*p<*	*Coeff.*	*SE*	*p<*
Constant	20.764	1.475	.001	-.033	.831	.969
Accommodation	.293	.023	.001	.138	.011	.001
Spiritual Bypass	-	-	-	.601	.023	.001
	R^2= .086			R^2= .429		
	$F(1,391) = 36.630$, $p< .001$			$F(2,390) = 146.505$, $p< .001$		

Note: Coeff= standardized regression coefficient

Mediation results indicated that accommodation was found to be a positively significant predictor of spiritual bypass and mental health help-seeking behavior. Whereas spiritual bypass was found to be a significant predictor of mental health help-seeking behavior. So, mediation was found to be a significant as Indirect effect is (effect= .049, boot strap interval) which showed that an increase in accommodation tends to increase spiritual bypass, whereas increase in spiritual bypass in turn increases mental health help-seeking behavior.

Table 13

Mediation Analysis between Optimism and Mental Health Help-seeking Behavior through Spiritual Bypass (N=393)

Antecedent	Consequent					
	Spiritual Bypass			Mental Health Help-Seeking Behavior		
	Coeff.	*SE*	*p<*	*Coeff.*	*SE*	*p<*
Constant	19.046	1.416	.001	.382	.809	.637
Optimism	.358	.022	.001	.118	.011	.005
Spiritual Bypass	-	-	-	.599	.024	.001
	R^2= .128			R^2= .424		
	$F(1,391) = 57.315$, $p< .001$			$F(2,390) = 143.321$, $p< .001$		

Note: Coeff= standardized regression coefficient

Mediation results indicated that optimism was found to be a positively significant predictor of spiritual bypass and mental health help-seeking behavior. Whereas spiritual bypass was found to be a significant predictor of mental health help-seeking behavior. So, mediation was found to be significant as Indirect effect is (effect= .057, boot strap interval) which showed that an increase in optimism tends to increase spiritual bypass, whereas increase in spiritual bypass in turn increases mental health help-seeking behavior.

DISCUSSION

This chapter provides a comprehensive analysis of the findings presented in the results chapter, contextualizing them within the existing body of literature. It aims to critically examine the relationships between trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior among university students in Islamabad. Each hypothesis of this study is discussed in detail, with results evaluated to determine whether they are supported or not. The chapter further explores the limitations of the study, offers recommendations for future research, discusses the implications of the findings, and concludes with a summary of key insights.

The study's results indicate a significant positive relationship between trauma-related cognitions and mental health help-seeking behavior, which supports the first hypothesis that these two behaviors will be positively correlated among university students. This result aligns with previous research that emphasizes the part trauma-related cognitions play in motivating people to seek treatment from professionals (Ehlers & Clark, 2000; Brewin et al., 2009). This association is especially important in the context of Pakistani university students because of the high rate of trauma and the stigma associated with mental health concerns in the culture (Mahmood et al., 2021). Pupils who encounter strong trauma-related thoughts may be more inclined to identify their discomfort and look for support to lessen their symptoms.

The significant positive relationship between overaccommodation and mental health help-seeking behavior suggests that students who excessively alter their beliefs to accommodate trauma are more likely to seek help. This finding aligns with studies showing that maladaptive cognitive processes, such as overaccommodation, often lead to heightened

psychological distress, prompting individuals to seek relief through professional support (Bardeen et al., 2013).

The positive correlation between assimilation and help-seeking behavior indicates that students who blame themselves for traumatic events are more inclined to seek mental health services. This aligns with literature emphasizing the role of self-blame in increasing psychological distress and the subsequent need for professional intervention (Foa & Kozak, 1986). The internalization of blame can exacerbate feelings of guilt and shame, motivating individuals to seek help to address these negative emotions.

Although accommodation did not significantly predict help-seeking behavior directly, its relationship through spiritual bypass highlights the complex interplay between cognitive adjustments and coping mechanisms. This finding underscores the need for a nuanced understanding of how cognitive processing of trauma influences behavior (Janoff-Bulman, 1992). Students who adaptively accommodate their beliefs to incorporate traumatic events might not directly seek help unless mediated by other factors such as spiritual bypass.

The positive relationship between optimism and help-seeking behavior suggests that maintaining a hopeful outlook can encourage students to seek help. This is consistent with research indicating that optimism fosters resilience and proactive coping strategies (Carver et al., 2010). Students with an optimistic outlook may believe in the efficacy of mental health services and seek them out to maintain their well-being.

The mediation analyses reveal that spiritual bypass significantly mediates the relationship between trauma-related cognitions and mental health help-seeking behavior, as hypothesized in the study. This finding aligns with existing literature that highlights how spiritual bypass can serve as a coping mechanism, either facilitating or hindering help-seeking behaviors

depending on its nature (Cashwell et al., 2010; Masters, 2010). In the Pakistani context, where religious and spiritual practices are deeply ingrained, the role of spiritual bypass has expressed itself to be a positive coping mechanism.

The mediation analysis indicated that overaccommodation was a significant predictor of spiritual bypass, which in turn predicted mental health help-seeking behavior. This suggests that students who excessively alter their beliefs to accommodate trauma may use spiritual practices to cope with their distress, which subsequently increases their likelihood of seeking professional help. This finding is consistent with the notion that spiritual bypass can provide a sense of control and comfort, facilitating help-seeking behaviors (Fox et al., 2017).

Assimilation was also found to be a significant predictor of spiritual bypass, which mediated its relationship with mental health help-seeking behavior. Students who internalize blame for traumatic events might turn to spiritual practices as a means of coping, which can either facilitate or hinder their help-seeking behavior depending on the nature of the spiritual bypass. This finding highlights the complex role of spirituality in coping with trauma and its impact on help-seeking behavior.

While accommodation did not directly predict help-seeking behavior, its relationship through spiritual bypass was significant. This suggests that the way students adjust their beliefs to incorporate trauma can influence their help-seeking behavior through spiritual coping mechanisms. This finding emphasizes the need for integrating spiritual and psychological interventions to support students in processing trauma effectively.

Optimism was also found to be a significant predictor of spiritual bypass, which mediated its relationship with mental health help-seeking behavior. Students with an optimistic outlook may use spiritual practices to maintain their positive outlook, which in turn facilitates their

help-seeking behavior. This finding underscores the importance of fostering optimism and spiritual well-being to encourage help-seeking behaviors among students.

The independent samples t-tests provided additional insights into how demographic variables influence the study's key constructs. The results indicated no significant differences in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors between undergraduate and postgraduate students. This suggests that education level does not significantly impact these variables among university students. However, it is important to consider that participants in this study might generally have more awareness about mental health issues, given their educational backgrounds, which could influence their intention to seek help.

Similarly, there were no significant differences between male and female students in trauma-related cognitions, spiritual bypass, and mental health help-seeking behaviors. This finding highlights that gender does not significantly influence these variables in the study sample. The lack of significant gender differences could be attributed to the sample's overall awareness and possibly social desirability bias, where participants report behaviors that are culturally expected or perceived as favorable.

The analysis showed no significant differences between day-scholars and hostelites. This finding suggests that living status does not significantly impact the key variables. However, the shared experiences of university life might level out differences that could be more pronounced in other contexts.

The results revealed a significant difference in overaccommodation between students from nuclear and joint families, with those from joint families experiencing higher levels. This finding suggests that family structure can influence specific trauma-related cognitions,

possibly due to the differing dynamics and support systems inherent in nuclear versus joint family settings.

No significant differences were found between single and married students in the study variables. This indicates that marital status does not significantly impact trauma-related cognitions, spiritual bypass, or mental health help-seeking behaviors among the participants.

The one-way ANOVA results showed a significant difference in overaccommodation based on socioeconomic status, with students from lower socioeconomic backgrounds experiencing higher levels. This finding is consistent with literature suggesting that lower socioeconomic status is associated with greater exposure to stress and trauma, leading to higher levels of negative cognitive appraisals (Evans & Kim, 2013).

Several points arise from these findings. The participants' relatively high levels of mental health awareness could explain their intention to seek help. University students, especially those from urban centers, might have better access to information about mental health, which can positively influence their help-seeking behaviors. Additionally, given the cultural context, students may report higher help-seeking behaviors to align with perceived societal norms or expectations. This social desirability bias could skew the results, suggesting a higher intention to seek help than what might be observed in practice.

In Pakistan, the distinction between spirituality and religiosity is often blurred, with both concepts being deeply integrated into the societal fabric. This overlap might affect how individuals engage with spiritual bypass and how it influences their mental health help-seeking behaviors. The positive impact of spiritual bypass on help-seeking behavior could be attributed to the strong religious beliefs prevalent in Pakistani society. These beliefs may provide a framework for understanding and managing psychological distress, encouraging

individuals to seek professional help for issues beyond their control. These findings underscore the complexity of factors influencing mental health help-seeking behaviors among university students in Pakistan, highlighting the need for culturally sensitive approaches in mental health interventions and support services.

Limitations

The study sample was limited to university students in Islamabad, which may not be representative of all Pakistani university students. The findings may not generalize to students from other regions or those with different socio-economic backgrounds. Future studies should consider including students from diverse geographical areas and varying socio-economic statuses to enhance the generalizability of the results.

The cross-sectional nature of the study limits the ability to infer causality. While significant relationships were identified between trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior, it is not possible to determine the directionality of these relationships or how they may change over time. Longitudinal studies are needed to explore the dynamics of these variables and establish causal pathways.

The use of self-report measures may introduce bias due to social desirability or inaccurate self-assessment. Participants might have over- or under-reported their trauma-related cognitions and help-seeking behaviors. Incorporating objective measures or multi-informant reports could enhance the validity of the findings. Future research should consider using a combination of self-report and objective assessments to obtain a more comprehensive understanding of the variables.

This study did not focus on the nature or type of trauma or the exact age/period of life when it occurred. Participants were only required to have experienced at least one traumatic

event at least six months prior to the study. This approach limits the ability to understand how different types of trauma or the timing of trauma exposure influence trauma-related cognitions and help-seeking behaviors. Future research should specify and categorize the types of trauma and consider the developmental timing of the traumatic events to provide a more detailed analysis.

While the study highlights the role of spiritual bypass in the Pakistani context, cultural nuances related to spirituality and mental health may have influenced the results. The cultural stigma surrounding mental health issues in Pakistan may have impacted participants' willingness to report their true thoughts and behaviors. Future research should incorporate qualitative methods to better understand cultural influences and the subjective experiences of individuals.

The study focused on specific variables—trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior—without examining other potential factors that could influence these relationships, such as social support, coping strategies, and personality traits. Future studies should include a broader range of variables to capture a more holistic view of the factors affecting mental health help-seeking behavior.

Future Recommendations

Future studies should aim to include a more diverse and representative sample of university students from different regions and socio-economic backgrounds across Pakistan. This would enhance the generalizability of the findings and provide a more comprehensive understanding of how trauma-related cognitions and help-seeking behaviors vary across different contexts. Including students from rural areas, smaller cities, and various educational institutions would offer valuable insights into the broader student population.

Conducting longitudinal research is essential to explore the dynamics of trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior over time. Longitudinal studies would allow researchers to examine how these relationships evolve and identify potential causal pathways. This approach would also help in understanding the long-term impact of trauma-related cognitions on mental health and the effectiveness of interventions aimed at promoting help-seeking behaviors.

Future research should specify the nature and type of trauma experienced by participants, as well as the timing of these traumatic events. Categorizing trauma types (e.g., interpersonal violence, natural disasters, accidents) and considering the developmental stage at which the trauma occurred would provide a more nuanced understanding of how different traumatic experiences influence cognitions and behaviors. This detailed analysis could help tailor interventions to address specific types of traumas and their unique effects.

To gain a deeper understanding of the variables under investigation, mixed methods approaches that integrate both quantitative and qualitative research should be incorporated. Qualitative techniques like focus groups and interviews may provide more in-depth understanding of the individualized experiences of trauma, spiritual bypass, and help-seeking behaviors. These qualitative data may provide further insights into the quantitative findings and shed light on the cultural subtleties that affect mental health in Pakistan.

Future studies should include a broader range of variables to capture a more holistic view of the factors affecting mental health help-seeking behavior. Variables such as social support, coping strategies, personality traits, and other psychological factors should be examined to understand their interplay with trauma-related cognitions and spiritual bypass. This

comprehensive approach would provide a more detailed understanding of the multifaceted nature of mental health help-seeking behavior.

Developing and testing interventions that integrate spiritual and psychological coping strategies is crucial. Intervention studies could explore the effectiveness of culturally sensitive mental health programs that address both cognitive distortions and spiritual bypass. These programs should be designed to promote resilience, positive coping mechanisms, and mental health literacy among university students. Evaluating the impact of such interventions would provide evidence-based recommendations for improving mental health services in educational institutions.

Future research should focus on translating findings into practical recommendations for policymakers, mental health practitioners, and educational institutions. Studies should explore how to effectively implement mental health initiatives within universities, including training for faculty and staff to support students in distress. Policy-oriented research could advocate for the integration of mental health services into the academic environment, ensuring that students have access to the necessary resources and support.

Given the cultural stigma surrounding mental health in Pakistan, future studies should investigate strategies to reduce stigma and promote mental health awareness. Research could explore the impact of public health campaigns, educational programs, and community-based interventions aimed at changing societal attitudes towards mental health. Understanding the cultural barriers to help-seeking behavior and developing targeted initiatives to address these barriers is essential for improving mental health outcomes.

Implications

Mental health practitioners should consider the role of spiritual bypass when designing interventions for trauma-related cognitions. Integrating spiritual and psychological coping strategies can provide a holistic approach to mental health care. For instance, combining cognitive-behavioral therapy (CBT) with spiritual counseling might be particularly effective in addressing the needs of students who rely on spiritual practices as a means of coping with trauma.

Given the deep-rooted cultural and religious influences in Pakistan, it is essential for therapists to adopt culturally sensitive approaches. Understanding the cultural context and incorporating culturally relevant practices can enhance the therapeutic alliance and increase the effectiveness of interventions. Therapists should be trained to recognize and address spiritual bypass while validating the cultural and spiritual beliefs of their clients.

The study highlights the importance of early identification of trauma-related cognitions and providing timely support to university students. Mental health professionals should work closely with educational institutions to develop screening programs that can identify students at risk of psychological distress. Early intervention can prevent the escalation of symptoms and promote positive mental health outcomes.

Policymakers should promote mental health literacy through public health campaigns. Increasing awareness about trauma-related cognitions, the benefits of seeking professional help, and reducing stigma associated with mental health issues are crucial. Such campaigns can encourage students to seek help without fear of judgment or discrimination.

Educational institutions should integrate mental health services within their campuses. Establishing counseling centers that offer both psychological and spiritual support can

provide students with accessible and comprehensive mental health care. Policymakers should allocate resources to ensure these services are adequately funded and staffed.

Faculty and staff at universities should be trained to recognize signs of psychological distress and provide appropriate referrals to mental health services. Training programs should include modules on trauma-related cognitions, spiritual bypass, and culturally sensitive approaches to mental health support.

Universities should implement educational programs that raise awareness about mental health issues and the importance of seeking help. Workshops, seminars, and courses that educate students about trauma, cognitive distortions, and effective coping mechanisms can empower them to take proactive steps towards their mental well-being. Establishing peer support networks can provide students with a platform to share their experiences and seek support from their peers. Peer counselors can be trained to offer initial support and refer students to professional services when needed. Such networks can create a supportive community that fosters help-seeking behaviors.

Incorporating mental health education into the university curriculum can normalize discussions about mental health and reduce stigma. Courses on psychology, counseling, and mental health can equip students with the knowledge and skills to understand and address their own mental health needs and those of their peers.

The findings suggest the need for developing and testing interventions that integrate spiritual and psychological coping strategies. Future research should focus on designing and evaluating programs that address cognitive distortions and promote resilience, positive coping mechanisms, and mental health literacy among university students.

Research should explore the impact of policy changes on mental health outcomes in educational institutions. Studies that assess the effectiveness of integrated mental health services, training programs, and awareness campaigns can provide evidence-based recommendations for policymakers.

Further research is needed to understand the cultural barriers to mental health help-seeking behavior in Pakistan. Investigating the influence of cultural norms, religious beliefs, and societal attitudes on mental health can inform the development of targeted initiatives to reduce stigma and promote help-seeking behaviors.

While this study is focused on Pakistani university students, the findings have broader implications for understanding the interplay between trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior in diverse cultural contexts. Future research can explore these relationships in other cultural settings to enhance the generalizability of the findings.

The study underscores the importance of adopting a holistic approach to mental health care that considers both psychological and spiritual dimensions. Mental health professionals worldwide can benefit from integrating these aspects into their practice to provide comprehensive support to individuals dealing with trauma.

Conclusion

This study highlights the significant relationships between trauma-related cognitions, spiritual bypass, and mental health help-seeking behavior among university students in Islamabad. The findings underscore the importance of addressing cognitive distortions and incorporating spiritual coping strategies to promote mental health help-seeking behaviors. By understanding these dynamics, mental health practitioners, policymakers, and educators can

develop more effective interventions and support systems tailored to the cultural context of Pakistani university students. Future research should continue to explore these relationships across diverse populations and settings to further enhance our understanding and improve mental health outcomes.

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Appendix

A - Detailed Information Sheet

I am **Aamir Mahmood,** a final year student of MS- Clinical Psychology from the Department of Professional Psychology, Bahria University, Islamabad. I am conducting research on **"Trauma-Related Cognition, Spiritual Bypass, Religious Coping and Mental Health Help-Seeking Behavior"** among university students of Islamabad, under the supervision of **Dr. Muhammad Faran.** You are invited to participate in this study, but first, it is important for you to understand why it is being conducted and what it shall involve. Please take time to read the following information carefully.

Purpose of the study

The purpose of the study is to explore the association between Trauma-Related Cognition, Spiritual Bypass, Religious Coping and Mental Health Help-Seeking Behavior among university students of Islamabad.

What you will be asked to do

This booklet contains a set of questionnaires that you are required to fill. The questionnaire includes questions about trauma-related cognition, spiritual bypass, religious coping, and mental health help-seeking behavior, and will approximately take 15 to 20 minutes of your time.

What will happen to your responses on the questionnaires?

A code number instead of your name will be assigned on your booklet and only this code number will be linked to your answers which will be stored in a computer file. Only researchers and my supervisor will have access to these computer files. In reporting the results of this study, answers from all participants will be combined and reported, hence it will not be possible to identify any particular individual's responses. Thus, the anonymity and confidentiality of data will be maintained.

Your Rights

Your participation is entirely voluntary, and you have right to withdraw from participation at any given moment without any consequences. Your withdrawal from the study will not be held against you in any way.

Your decision

It is solely your own decision to participate in the study. If you do so, you will be given this information sheet to keep and be asked to sign a consent form. If you have any query regarding this study or your participation, you may inquire and contact us through email.

Supervisor	**Student**
Dr. Muhammad Faran	Aamir Mahmood
Mfaran.buic@bahria.edu.pk	aamirmahmood566@gmail.com

Thank you for taking time to read the information sheet.

B – Informed Consent Form

I Mr/Ms _____**s**tate that I voluntarily agree to participate in the MS Psychology research titled as "**Trauma-Related Cognition, Spiritual Bypass, Religious Coping and Mental Health Help-Seeking Behavior"** under the supervision of **Dr. Muhammad Faran**, Department of Professional Psychology, Bahria University Islamabad Campus. The researcher has explained the purpose and procedure of the research to me. They have informed me that I may withdraw from participation at any time without prejudice and penalty. Furthermore, they have assured me that any information I give will be used for research purpose only and will be kept confidential and anonymous.

Signature of Researcher Signature of Participant

_____ _____

Date: _____ Date: _____

C – DEMOGRAPHIC INFORMATION

Age: _____

Semester: _____

Department: _____

University Name: _____

No. Of Siblings: _____

Birth Order: _____

Gender: □ Male □ Female

Religion: □ Muslim □ Non-muslim

Living Status: □ Day-scholar □ Hostelite

Family structure: □ Nuclear □ Joint

University Type: □ Public □ Private □ Semi

Marital status: □ Married □ Single □ Separated/Divorced

Socio-economic status: □ Lower □ Middle □ Upper

Level of education: □ Undergraduate □ Postgraduate

Any medical problem: □ Yes □ No

Any physical disability: □ Yes □ No

Any Psychiatric/Psychological diagnosis: □ Yes □ No

Any experience of getting professional mental health help: □ Yes □ No

Any history of substance use: □ Yes □ No

D - TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

	Crime-Related Events	**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		
	General Disaster and Trauma	**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**

5	Have you ever had a serious accident at work, in a car, or somewhere else? (**If yes**, please specify below) _____	No	Yes		
6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____	No	Yes		
7	Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? (**If yes**, please specify below) _____	No	Yes		
10	Have you ever been in any other situation in which you feared you might be killed or seriously injured? (**If yes**, please specify below) _____	No	Yes		

11	Have you ever seen someone seriously injured or killed? (**If yes**, please specify who below) _____	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**If yes**, please specify below) _____	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? (**If yes**, please specify relationship [e.g., mother, grandson, etc.] below) _____	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? (**If yes**, please specify relationship below) _____	No	Yes		
15	Have you ever had a serious or life-threatening illness? (**If yes**, please specify below) _____	No	Yes		
16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**If yes**, please indicate below) _____	No	Yes		
17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**If yes**, please indicate where below) _____	No	Yes		

Physical and Sexual Experiences		Circle one		*If you circled yes, please indicate*	
				Repeated?	**Approximate age(s) and frequency**
18	Has anyone ever made you have intercourse or oral or anal sex against your will? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		
24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**If yes**, please specify below) _____	No	Yes		

E – PTSD Symptom CheckList-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event:

_____

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4

10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “super alert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

F – Trauma-Related Cognitions Scale

We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking.

Instructions: Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement using the following rating scale. People react to traumatic events in many different ways. There are no right or wrong answers to these statements. (Tick Box)

	Strongly Disagree 1	**Disagree 2**	**Somewhat Disagree 3**	**Somewhat Agree 4**	**Agree 5**	**Strongly Agree 6**
1. I can trust my friends	**1**	**2**	**3**	**4**	**5**	**6**
2. I have no future	**1**	**2**	**3**	**4**	**5**	**6**
3. My life has been destroyed by the trauma	**1**	**2**	**3**	**4**	**5**	**6**
4. I knew better than to do what I did	**1**	**2**	**3**	**4**	**5**	**6**
5. The good things that happen in this world far outnumber the bad	**1**	**2**	**3**	**4**	**5**	**6**
6. I have made good and bad choices in life	**1**	**2**	**3**	**4**	**5**	**6**
7. Human nature is basically good	**1**	**2**	**3**	**4**	**5**	**6**
8. This event(s) could have been avoided	**1**	**2**	**3**	**4**	**5**	**6**
9. You never know when something terrible will happen	**1**	**2**	**3**	**4**	**5**	**6**
10. By and large, good people get what they deserve in this world	**1**	**2**	**3**	**4**	**5**	**6**
11. Some people can be trusted	**1**	**2**	**3**	**4**	**5**	**6**
12. I am a weak person	**1**	**2**	**3**	**4**	**5**	**6**
13. I am inadequate	**1**	**2**	**3**	**4**	**5**	**6**
14. I will get upset if someone pushes me too far	**1**	**2**	**3**	**4**	**5**	**6**
15. I am very satisfied with the kind of person I am	**1**	**2**	**3**	**4**	**5**	**6**
16. I blame myself for what happened	**1**	**2**	**3**	**4**	**5**	**6**
17. I did something that went against my values	**1**	**2**	**3**	**4**	**5**	**6**
18. Most people are basically caring	**1**	**2**	**3**	**4**	**5**	**6**
19. My reactions since the event mean that I am going crazy	**1**	**2**	**3**	**4**	**5**	**6**
20. It would not have happened if I would have been paying attention	**1**	**2**	**3**	**4**	**5**	**6**
21. I have lost my sense of freedom	**1**	**2**	**3**	**4**	**5**	**6**
22. I am a bad person	**1**	**2**	**3**	**4**	**5**	**6**
23. I should have known better	**1**	**2**	**3**	**4**	**5**	**6**
24. I will not be able to control my emotions, and something terrible will happen	**1**	**2**	**3**	**4**	**5**	**6**

25. Important people (such as parents, partner, friend) let this happen to me	**1**	**2**	**3**	**4**	**5**	**6**
26. It's as if my insides are dirty	**1**	**2**	**3**	**4**	**5**	**6**
	Strongly Disagree 1	**Disagree 2**	**Somewhat Disagree 3**	**Somewhat Agree 4**	**Agree 5**	**Strongly Agree 6**
27. I can't deal with even the slightest upset	**1**	**2**	**3**	**4**	**5**	**6**
28. People are basically kind and helpful	**1**	**2**	**3**	**4**	**5**	**6**
29. My emotions are typical of most people	**1**	**2**	**3**	**4**	**5**	**6**
30. Other people can be genuinely loving toward me	**1**	**2**	**3**	**4**	**5**	**6**
31. I hold myself responsible for what happened	**1**	**2**	**3**	**4**	**5**	**6**
32. Nothing good can happen to me anymore	**1**	**2**	**3**	**4**	**5**	**6**
33. Life is sometimes a gamble	**1**	**2**	**3**	**4**	**5**	**6**
34. If I think about the event, I will not be able to handle it	**1**	**2**	**3**	**4**	**5**	**6**
35. People will experience good fortune if they themselves are good	**1**	**2**	**3**	**4**	**5**	**6**
36. Sometimes bad things happen for no good reason	**1**	**2**	**3**	**4**	**5**	**6**
37. I can't trust that I will do the right thing	**1**	**2**	**3**	**4**	**5**	**6**
38. What I did was inconsistent with my beliefs	**1**	**2**	**3**	**4**	**5**	**6**
39. You can never know who will harm you	**1**	**2**	**3**	**4**	**5**	**6**
40. If you look closely enough, you will see that the world is full of goodness	**1**	**2**	**3**	**4**	**5**	**6**
41. I used to be a happy person but now I am always miserable	**1**	**2**	**3**	**4**	**5**	**6**
42. I did the best I could in an unpredictable situation	**1**	**2**	**3**	**4**	**5**	**6**
43. I have permanently changed for the worse	**1**	**2**	**3**	**4**	**5**	**6**
44. The event happened because I wasn't careful enough	**1**	**2**	**3**	**4**	**5**	**6**
45. Life is about surviving challenging events	**1**	**2**	**3**	**4**	**5**	**6**
46. Most people are capable of good things	**1**	**2**	**3**	**4**	**5**	**6**
47. There is something wrong with me as a person	**1**	**2**	**3**	**4**	**5**	**6**
48. I have made some mistakes, but that does not make me a bad person	**1**	**2**	**3**	**4**	**5**	**6**
49. I am not safe	**1**	**2**	**3**	**4**	**5**	**6**
50. The world has good and bad people in it	**1**	**2**	**3**	**4**	**5**	**6**
51. I will never be able to feel normal emotions again	**1**	**2**	**3**	**4**	**5**	**6**

52. The event happened because of the way I acted	**1**	**2**	**3**	**4**	**5**	**6**
53. There is more good than evil in this world	**1**	**2**	**3**	**4**	**5**	**6**
	Strongly Disagree 1	**Disagree 2**	**Somewhat Disagree 3**	**Somewhat Agree 4**	**Agree 5**	**Strongly Agree 6**
54. My reactions since the trauma show that I am a lousy coper	**1**	**2**	**3**	**4**	**5**	**6**
55. I could have prevented what happened to me	**1**	**2**	**3**	**4**	**5**	**6**
56. I lost my sense of manhood or womanhood	**1**	**2**	**3**	**4**	**5**	**6**
57. I blame myself for something I did, thought, or felt	**1**	**2**	**3**	**4**	**5**	**6**
58. Sometimes good people do bad things	**1**	**2**	**3**	**4**	**5**	**6**
59. I had some feelings that I should not have had	**1**	**2**	**3**	**4**	**5**	**6**
60. No shower can wash away how dirty I feel	**1**	**2**	**3**	**4**	**5**	**6**
61. I will not be able to control my anger and will do something terrible	**1**	**2**	**3**	**4**	**5**	**6**
62. Overall, I am a good person despite some of my faults	**1**	**2**	**3**	**4**	**5**	**6**
63. Danger is always present	**1**	**2**	**3**	**4**	**5**	**6**
64. I have lost respect for myself	**1**	**2**	**3**	**4**	**5**	**6**
65. I will not be able to tolerate my thoughts about the event, and I will fall apart	**1**	**2**	**3**	**4**	**5**	**6**
66. I comfort myself very well when I'm upset	**1**	**2**	**3**	**4**	**5**	**6**
67. One cannot always predict the outcome of a situation	**1**	**2**	**3**	**4**	**5**	**6**
68. The world is a good place	**1**	**2**	**3**	**4**	**5**	**6**
69. Sometimes bad things happen to good people	**1**	**2**	**3**	**4**	**5**	**6**

G – Mental Health Help-Seeking Intentions Scale

INSTRUCTIONS: For the purposes of this survey, "mental health professionals" include psychologists, psychiatrists, clinical social workers, and counselors. Likewise, "mental health concerns" include issues ranging from personal difficulties (e.g., loss of a loved one) to mental illness (e.g., anxiety, depression). Please mark the box that best represents your opinion.

If I had a mental health concern, I would intend to seek help from a mental health professional.

1 (Extremely unlikely)	2	3	4	5	6	7 (Extremely likely)

If I had a mental health concern, I would try to seek help from a mental health professional.

1 (Definitely false)	2	3	4	5	6	7 (Definitely true)

If I had a mental health concern, I would plan to seek help from a mental health professional.

1 (Strongly disagree)	2	3	4	5	6	7 (Strongly agree)

H – Spiritual Bypass Scale

Instructions: Please read each statement below and circle the degree to which you agree or disagree with the statement. Try to respond as honestly as you can without spending too much time on each question. There are no right or wrong answers. (tick box)

	Strongly Disagree 1	**Disagree 2**	**Agree 3**	**Strongly Agree 4**
1. My spiritual life helps me feel my emotions more fully.	1	2	3	4
2. When I feel emotional pain, the first thing I want to do is pray or meditate about it.	1	2	3	4
3. When I am in pain, I believe God will deliver me from it.	1	2	3	4
4. When something tragic happens (to me or to others) I say that God will intervene.	1	2	3	4
5. It is more important to me to seek spiritual guidance than to seek aid from a psychological helper.	1	2	3	4
6. When experiencing difficulties, I believe it is most important to deal with the spiritual source of my problems.	1	2	3	4
7. I believe it is preferable to cure emotional problems by being spiritually advanced.	1	2	3	4
8. It is more important for me to be spiritually awakened than to feel emotionally intact.	1	2	3	4
9. I believe that healing one's spirit takes precedence over healing their emotions.	1	2	3	4
10. When someone I know is in trouble, I believe it is because they have done something wrong spiritually.	1	2	3	4
11. When someone I know is experiencing hardship, I believe that it is due to spiritual attack/oppression.	1	2	3	4
12. When someone confronts me, I tend to overanalyze his or her spiritual motivations for confronting me.	1	2	3	4
13. When I face a life challenge, I always consult with a spiritual or religious teacher.	1	2	3	4

General Health Questionnaire (GHQ-28)

Full name of the patient:	Date accomplished:
Full name of the assessor:	

Please read this carefully. We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past. It is important that you try to answer ALL the questions. Thank you very much for your co-operation.

Have you recently...

	Questions	Choices			
A1	**been feeling perfectly well and in good health?**	◯ Better than usual	◯ Same as usual	◯ Worse than usual	◯ Much worse than usual
A2	**been feeling in need of a good tonic?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
A3	**been feeling run down and out of sorts?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
A4	**felt that you are ill?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
A5	**been getting any pains in your head?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
A6	**been getting a feeling of tightness or pressure in your head?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
A7	**been having hot or cold spells?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B1	**lost much sleep over worry?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B2	**had difficulty in staying asleep more once you are off?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B3	**felt constantly under strain?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B4	**been getting edgy and bad-tempered?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual

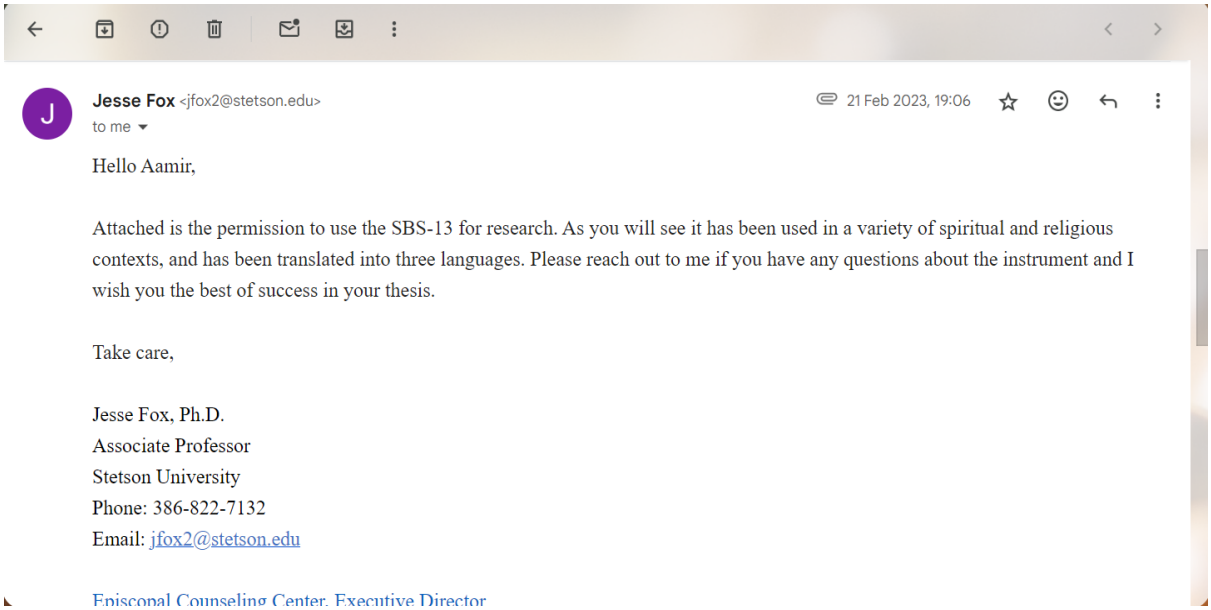
Questions		Choices			
B5	been getting scared or panicky for no good reason?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B6	found everything getting on top of you?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
B7	been feeling nervous and strung-up all the time?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
C1	been managing to keep yourself busy and occupied?	◯ More so than usual	◯ Same as usual	◯ Rather less than usual	◯ Much less than usual
C2	been taking longer over the things you do?	◯ Quicker than usual	◯ Same as usual	◯ Longer than usual	◯ Much longer than usual
C3	felt on the whole you were doing things well?	◯ Better than usual	◯ About the same	◯ Less well than usual	◯ Much less well
C4	been satisfied with the way you've carried out your task?	◯ More satisfied	◯ About same as usual	◯ Less satisfied than usual	◯ Much less satisfied
C5	felt that you are playing a useful part in things?	◯ More so than usual	◯ Same as usual	◯ Less useful than usual	◯ Much less useful
C6	felt capable of making decisions about things?	◯ More so than usual	◯ Same as usual	◯ Less so than usual	◯ Much less capable
C7	been able to enjoy your normal day-to-day activities?	◯ More so than usual	◯ Same as usual	◯ Less so than usual	◯ Much less than usual
D1	been thinking of yourself as a worthless person?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
D2	felt that life is entirely hopeless?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
D3	felt that life isn't worth living?	◯ Not at all	◯ No more than usual	◯ Less useful than usual	◯ Much more than usual
D4	thought of the possibility that you might make away with yourself?	◯ Definitely not	◯ I don't think so	◯ Has crossed my mind	◯ Definitely have
D5	found at times you couldn't do anything because your nerves were too bad?	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual

Questions		Choices			
D6	**found yourself wishing you were dead and away from it all?**	◯ Not at all	◯ No more than usual	◯ Rather more than usual	◯ Much more than usual
D7	**found that the idea of taking your own life kept coming into your mind?**	◯ Definitely not	◯ I don't think so	◯ Has crossed my mind	◯ Definitely has

A		B		C		D		Total:	

PERMISSIONS

Spiritual Bypass Scale (SBS-13)



Jesse Fox <jfox2@stetson.edu>
to me

21 Feb 2023, 19:06

Hello Aamir,

Attached is the permission to use the SBS-13 for research. As you will see it has been used in a variety of spiritual and religious contexts, and has been translated into three languages. Please reach out to me if you have any questions about the instrument and I wish you the best of success in your thesis.

Take care,

Jesse Fox, Ph.D.
Associate Professor
Stetson University
Phone: 386-822-7132
Email: jfox2@stetson.edu

Episcopal Counseling Center, Executive Director

PLAGIARISM REPORT

Thesis

ORIGINALITY REPORT

18%	10%	13%	3%
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PRIMARY SOURCES

1	Bond, Kiersten Lauren. "Factors Associated with Help-Seeking Intentions and Behaviors among College Students with Suicidal Thoughts and Behaviors", The University of Alabama, 2022 Publication	1%
2	Rudra, Praveen Kumar. "The Relationship Between Acculturation Levels, Help-Seeking Attitudes, and Self-Stigma of International Students", Capella University, 2024 Publication	1%
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5	Choy, Bayee Rebecca. "Improving Student Access and Utilization of Mental Health	1%