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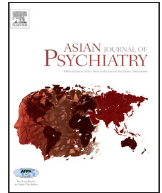

Mental health service use from a religious or spiritual advisor among Asian Americans

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ABSTRACT

Background: Asian Americans experience significant underuse of mental health treatment. Religious clergy and spiritual advisors play a critical role in delivering mental health care in the United States. Limited knowledge exists about their use among Asian Americans.
Objective: We describe mental health service use from a religious/spiritual advisor among Asian Americans.
Methods: We analyzed data from 2095 respondents in the 2002–2003 National Latino and Asian American Study.
Results: Lifetime and 12-month prevalence of mental health service use from a religious/spiritual advisor (5.5% and 1% overall, respectively) was generally higher among U.S.-born Asians and those with a 12-month mental disorder (23.6% and 7.5%, respectively). Religious/spiritual advisors were seen by 35% of treatment-seeking Asian Americans with a lifetime mental disorder. They were seen as commonly as psychiatrists but less commonly than a mental health specialist or general medical provider. Approximately 70% of those seeking treatment had a mental disorder, significant proportions of whom sought treatment in the absence of a psychiatrist, a mental health specialist or even a healthcare provider. A significant majority with 12-month use perceived the care as helpful, felt accepted/understood and satisfied (71–86%). However, only 31% rated the care as excellent, 28% quit completing care, and referral rates for specialty mental health treatment were low, even among those with a mental disorder (9.5%).
Conclusions: Religious/spiritual advisors are a key source of treatment-seeking for Asian Americans with a mental disorder. Quality of care and low referral rates for specialty mental health treatment warrant further attention and need for increased collaboration with the mental health system.
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1. Introduction

Asian Americans are an extremely heterogeneous, fast-growing yet understudied racial/ethnic group in the U.S. that experiences significant underuse of mental health treatment and help-seeking (Abe-Kim et al., 2007; Takeuchi et al., 2007; Xu et al., 2011; Le Meyer et al., 2009; Lee et al., 2011; Matsuoka et al., 1997). Data from the National Latino and Asian American Study (NLAAS) indicate that 17% of Asian Americans had any lifetime mental disorder and 9% had a past-year mental disorder (Takeuchi et al., 2007) with substantial underuse of mental health treatment. Approximately 9% had some past-year mental health service use and only 34% of those with a probable 12-month mental disorder reported any past-year use (Abe-Kim et al., 2007). Multiple barriers ranging from limited access to affordable, linguistically and culturally responsive services, cultural factors including loss of face, social stigma and culturally informed notions of mental well-being, and perceived discrimination are associated with underuse of formal mental health services and/or help-seeking from informal lay and community support sources (Abe-Kim et al., 2004; David, 2010; Leong and Lau, 2001; Spencer et al., 2010).

Religious institutions and communities have a long history of caring for and serving those with mental health needs (Koenig et al., 2012). Religious and spiritual advisors often serve as primary sources of treatment-seeking and frontline mental health workers and even a secondary role as gatekeepers for access to treatment and bridges to specialty mental health care through referrals, particularly in some racial/ethnic minority groups; they are sought out first and sometimes at greater rates than mental health specialists (Bohnert et al., 2010; Ellison et al., 2006; Neighbors et al., 1998; Wang et al., 2003; Weaver et al., 2003). Among treatment-seeking individuals with a mental disorder in the

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National Comorbidity Study, 25% contacted clergy, more commonly than psychiatrists (16%) and general practitioners (17%). Black and Latino/a Americans are less likely to seek outpatient or inpatient mental health treatment than their White counterparts but more likely to seek treatment from a religious or spiritual advisor (Mills, 2012). The latter may be perceived as more caring, credible and accessible than mental health specialists, a valued coping resource and link to needed services, offering care more closely aligned with their religious and cultural values.

However, some studies indicate that individuals seeking help from clergy initially are less likely to seek professional mental health services, few or non-existent linkages between clergy and mental health specialists and need for greater collaboration to identify and meet mental health needs (Farrell and Goebert, 2008; Leavey and King, 2007; Leavey et al., 2007; Neighbors et al., 1998; Weaver et al., 2003). Studies of clergy suggest that they may have limited knowledge of mental health, lack adequate training, time and resources to counsel and provide effective mental health care, and hesitate to refer for formal mental health services (Leavey et al., 2007; Moran et al., 2005; Payne, 2009).

The extent to which Asian Americans seek mental healthcare from religious and spiritual advisors is unclear from key national studies of mental health service use (Abe-Kim et al., 2007; Xu et al., 2011; Lee et al., 2011; Spencer et al., 2010). Few studies that examined mental health service use from clergy and spiritual advisors focused on specific Asian American ethnic groups. In the 1993–1994 Chinese American Epidemiology Study (CAPES), 8% of Chinese Americans experiencing mental health problems in the past six months sought help from a priest or minister, more than mental health professionals (6%) and medical doctors (4%). In the 1998–1999 Filipino American Epidemiological Study (FACES), 25% of Filipinos reported any past-year mental health service use with the mental health specialty sector being least used (3%) and the lay system (friend or relative) being most commonly used (17%), followed by the general medical sector (7%), and folk system including clergy or folk/indigenous healers (4%) (Gong et al., 2003). Understanding the extent and outcomes of treatment-seeking from religious/spiritual advisors and whether they serve as barriers or bridges to specialty mental healthcare can inform potential reasons for underuse.

Furthermore, understanding how help-seeking varies by ethnicity and nativity is important. Considerable diversity exists in the religious, linguistic, cultural and socioeconomic backgrounds and immigration contexts characterizing different Asian ethnic subgroups, factors which are also associated with differences in help-seeking, access to, use and outcomes of mental health services (Islam et al., 2010; Leong and Lau, 2001; Pew Research Center, 2012; Uehara et al., 1994). A greater proportion of Asian Americans are religiously unaffiliated than the U.S. population (26% vs. 19%), with U.S.-born (USB) Asians more likely to be religiously unaffiliated than immigrants (31% vs. 24%) (Pew Research Center, 2012). However, important differences exist by ethnicity. For example, half of Chinese Americans (both USB and immigrants) are religiously unaffiliated compared to Vietnamese (20%) and Filipino Americans (8%) (Pew Research Center, 2012). Immigrants are also less likely to use any service and specialty mental health service than USB Asians (Abe-Kim et al., 2007) and, among treatment-seekers, less likely to perceive the treatment as helpful. Therefore, studying the prevalence, patterns and outcomes of mental health service use from a religious/spiritual advisor is essential for understanding their role in mental health service delivery among Asian Americans.

2. Objective

In this descriptive study, using data from a nationally representative sample of Asian Americans, we aim to:

(1) Examine lifetime and 12-month prevalence of mental health service use from a religious/spiritual advisor among Asian Americans (overall, by ethnicity and nativity) and among those with a mental disorder;
(2) Compare mental health service use from a religious/spiritual advisor to use from other healthcare sectors (general medical providers, psychiatrists and mental health specialists);
(3) Examine the perceived outcomes of 12-month mental health service use from a religious/spiritual advisor.

Given the heterogeneity in religiosity among Asian Americans described above, we hypothesized that help-seeking from a religious/spiritual advisor may be more prevalent among USB than immigrants and among Filipino Americans than Chinese Americans. Given documented underuse and barriers in using formal mental health services among Asian Americans, we also hypothesized that use from a religious/spiritual advisor may be more common than use from mental health specialists.

3. Methods

3.1. Data source and study population

We analyzed data from Asian respondents ($n = 2095$) in the NLAAS, the first nationally representative epidemiological survey of Asian Americans to primarily assess mental illness and mental health services use. The design and sampling procedures are described in detail elsewhere (Alegria et al., 2004; Heeringa et al., 2004; Pennell et al., 2004). Eligible Asian respondents were 18 years of age or older, living in the non-institutionalized population of the coterminous U.S. or Hawaii, and of Asian descent. The instrument was administered by trained, bilingual, lay interviewers in the respondent's choice of the following languages: English, Chinese, Vietnamese, Tagalog (overall response rate: 66%).

3.2. Measures

3.2.1. Outcomes

Outcomes of interest were lifetime and 12-month use from a religious/spiritual advisor and assessments of 12-month use. *Lifetime use* was assessed by asking "Which of the following types of professionals did you ever see about problems with your emotions or nerves or your use of alcohol or drugs?" from a comprehensive list of help-seeking sources. Follow-up questions assessed 12-month use and quality and outcomes of use. Lifetime and 12-month use were classified as such: *religious/spiritual advisor* like a minister, priest, pastor, rabbi; *mental health specialists* (MHS) including *psychiatrists* and *other mental health* professionals such as psychologists; *general medical providers* (GMP) including general practitioner or family doctor, other medical doctor, nurse, occupational therapist; and *any service use* (MHS, GMP, human service provider such as social worker or counselor, complementary and alternative providers such as herbalist or chiropractor).

Follow-up questions assessed the intensity (number of visits in the past year), quality and outcomes of 12-month mental health service use from a religious/spiritual advisor:

Feeling accepted/understood (a lot, some, little or not at all) – Assessed from "Did the spiritual advisor accept you and make you feel understood?"

Helpfulness of care (a lot, some, very little or not at all helpful) – Assessed from "Did the spiritual advisor help you a lot, some, a little, or not at all?"

Satisfaction with care (very satisfied/satisfied, neither satisfied or dissatisfied/dissatisfied/very dissatisfied) – Assessed from "In general, how satisfied are you with the treatments and services you

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