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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.

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

received from the spiritual advisor in the past 12 months – very satisfied, satisfied, neither satisfied or dissatisfied, dissatisfied, or very dissatisfied?"

Quality of care (excellent, very good/good/fair/poor) – Assessed from "How would you rate the overall quality of services you received from the spiritual advisor?"

Completion of care (completed/continuing care, quit care, refused/missing) – Derived from two questions: "Have you stopped seeing the spiritual advisor or are you still in treatment?" and "Did you complete the full recommended course of treatment? Or did you quit before the spiritual advisor wanted you to stop?"

Lifetime and past-year referral for mental health treatment (yes, no) – Assessed from "Did a spiritual advisor ever recommend that you go to a mental health specialist, clinic or program?" and "Did a spiritual advisor recommend that you go to a mental health specialist, clinic, or program in the past 12 months?"

3.2.2. Independent variables

The main independent variables were ethnicity, nativity and 12-month mental disorder. To account for nativity-related heterogeneity among ethnicity groups, *ethnicity-nativity* was characterized as: Vietnamese–USB, Vietnamese–foreign-born (FB), Filipino–USB, Filipino–FB, Chinese–USB, Chinese–FB, Other Asian–USB, Other Asian–FB. A range of psychiatric disorders were assessed using a modified version of the World Mental Health Survey Initiative's World Health Organization Composite International Diagnostic Interview (WMH-CIDI), a fully structured diagnostic instrument based on the criteria of the Diagnostic and Statistics Manual of Mental Disorders, Version 4 (DSM-IV) (Kessler and Ustun, 2004). *Any 12-month mental disorder* was defined based on a DSM-IV diagnosis during the past 12 months of at least one disorder in these four categories: anxiety disorders (agoraphobia without panic, generalized anxiety disorder, panic disorder, social phobia, or posttraumatic stress disorder), depressive disorders (major depressive disorder or dysthymia), substance use disorders (alcohol abuse, alcohol dependence, drug abuse, drug dependence) and any other DSM-IV disorder.

3.2.3. Analysis

First, we estimated lifetime and 12-month prevalence of mental health service use from a religious/spiritual advisor, overall, by ethnicity-nativity and among those with a mental disorder. Bivariate associations were examined using design-based Pearson's chi-squared tests. Analyses were conducted in Stata/MP 12.1 (StataCorp, College Station, TX), weighted to accommodate NLAAS's complex sample survey design (Heeringa et al., 2004; Heeringa and Liu, 1998) and provide results representative of the Asian American population.

Table 1
Weighted sample characteristics of Asian Americans: 2002–2003 National Latino and Asian American Study.

Weighted sample size = 7.8 million	Unweighted sample size, $n = 2095$	%
Age		
18–34 years	799	40
35–49 years	716	32
50–64 years	416	18
65 years or more	164	10
Women	1097	53
Ethnicity–nativity		
Vietnamese, USB	18	<1
Vietnamese, FB	502	12
Filipino, USB	159	7
Filipino, FB	349	15
Chinese, USB	125	5
Chinese, FB	473	23
Other Asian, USB[a]	152	11
Other Asian, FB[a]	315	26
English proficiency – speaks fair/poor English	797	33
Education		
<12 years	316	14
12 years	371	18
13–16 years	1018	48
17 years or more	389	20
Annual household income		
Poor, <100% FPL	357	17
Near poor, 100–199% FPL	207	9
≥200% FPL	2342	73
Lacks any public/private health insurance	290	13
Marital status		
Married	1376	65
Never married	512	26
Widowed, separated, divorced	205	9
Religious affiliation		
Atheist, agnostic, no religious affiliation	417	21
Protestant	370	21
Catholic or Orthodox	622	25
Buddhist, Hindu or Muslim	551	25
Other or missing	135	7
Attendance at religious services		
Never or less than once a month	1179	57
1–3 times per month	224	12
Once a week or more	682	32
Religious coping – often relies on religious means for support	611	28
Any lifetime DSM-IV mental disorder	382	18
Any 12-month DSM-IV mental disorder	201	10

Notes: FPL = U.S. Federal Poverty Level, USB = US born, FB = foreign-born.
DSM-IV = Diagnostic and Statistics Manual of Mental Disorders, Version 4.
[a] The "other Asian" category included those identifying as Japanese, Korean, Asian Indian and other Asian ethnicity.
Percentages shown are weighted. Analyses account for the National Latino and Asian American Study's complex sample survey design.

4. Results

4.1. Sample characteristics

Table 1 shows great heterogeneity in sociodemographic characteristics. Approximately three-quarters were immigrants, 53% were women, 40% were under 35 years of age, 65% were married, 32% had twelve years or less of education, 27% were poor or near poor and 13% were uninsured. In terms of religiosity, 44% attended service at least once a month and 28% reported relying often on religious means for support. Eighteen percent had a lifetime mental disorder while 10% had a 12-month mental disorder.

4.2. Lifetime mental health service use

Overall, the lifetime prevalence of mental health service use from a religious/spiritual advisor (Table 2) was 5.5%. Significant differences existed by ethnicity-nativity (ranged from 1.5% for Chinese-FB to 15.4% for Chinese-USB) and USB generally showed higher prevalence of use than immigrants. These differences were mainly driven by nativity; ethnicity-related differences were smaller and nonsignificant (results not shown). The lifetime prevalence of use was greater among those with a mental disorder than those without a disorder (21% vs. 2% for a lifetime disorder, 23.6% vs. 3.5% for a 12-month disorder). Religious/spiritual advisors were seen as commonly as psychiatrists (6.5%) and other mental health professionals (7.2%) but less commonly than MHS (10.3%) and GMP (10.4%). This pattern was generally observed within each ethnicity-nativity group among all individuals with a lifetime mental disorder and those who sought treatment.

Notably, Table 3 shows that the majority (70.0%) of individuals with lifetime use from a religious/spiritual advisor had a lifetime mental disorder, 40.3% of whom did not see any mental health professional (54.8% did not see a psychiatrist) and 27.1% sought

Table 2
Lifetime and 12-Month prevalence of mental health service use from a religious/spiritual advisor among Asian Americans: 2002–2003 National Latino and Asian American Study.

		Religious/spiritual advisor			Mental health specialist[a]									General medical[c]			Any service use[d]		
					Any			Psychiatrist			Other mental health[b]								
	Unweighted sample size	%	SE	*p*-Value	%	SE	*p*-Value	%	SE	*p*-Value	%	SE	*p*-Value	%	SE	*p*-Value	%	SE	*p*-Value
Lifetime prevalence of use																			
Total	2095	5.5	(0.9)		10.3	(1.0)		6.5	(0.8)		7.2	(0.9)		10.4	(0.9)		20.9	(1.3)	
Ethnicity-Nativity																			
Vietnamese, USB	18	9.2	(6.1)	0.002	6.5	(6.2)	<.001	0.0	0.0	0.010	6.5	(6.2)	0.001	4.3	(4.6)	0.008	23.6	(9.9)	0.002
Vietnamese, FB	502	2.2	(0.8)		6.1	(1.2)		5.5	(1.2)		2.1	(0.8)		8.3	(1.9)		13.6	(3.3)	
Filipino, USB	159	6.8	(2.4)		15.6	(4.1)		9.6	(3.2)		9.9	(2.6)		14.1	(3.4)		31.2	(6.0)	
Filipino, FB	349	4.7	(1.2)		7.0	(1.8)		5.2	(1.4)		5.1	(1.4)		13.3	(2.4)		21.2	(2.5)	
Chinese, USB	125	15.4	(3.6)		26.4	(5.4)		16.0	(4.1)		22.7	(5.0)		21.4	(3.9)		40.9	(5.3)	
Chinese, FB	473	1.5	(0.5)		6.6	(1.0)		1.8	(0.7)		5.4	(1.1)		4.8	(1.3)		15.1	(1.7)	
Other Asian, USB	152	8.4	(2.4)		15.1	(2.2)		7.7	(1.9)		9.8	(2.2)		14.8	(2.9)		29.6	(2.7)	
Other Asian, FB	315	7.4	(3.0)		10.6	(3.0)		8.7	(3.0)		7.4	(2.6)		9.6	(2.6)		19.1	(4.2)	
Any lifetime mental disorder																			
No[e]	1713	2.0	(0.5)	<.001	4.9	(0.6)	<.001	2.9	(0.6)	<.001	3.3	(0.4)	<.001	5.6	(0.6)	<.001	12.2	(0.9)	<.001
Yes	382	21.0	(2.6)		34.0	(2.9)		22.3	(2.4)		24.5	(2.8)		32.0	(2.5)		60.0	(2.8)	
– Yes and with any lifetime use	221	35.1	(4.4)		56.6	(3.9)		37.2	(4.0)		40.8	(4.3)		53.3	(4.5)				
Any 12-month mental disorder																			
No	1894	3.5	(0.6)	<.001	6.8	(0.7)	<.001	4.1	(0.5)	<.001	4.5	(0.6)	<.001	7.3	(0.8)	<.001	16.2	(1.0)	<.001
Yes	201	23.6	(4.2)		41.7	(4.6)		27.7	(3.9)		31.7	(5.0)		38.8	(4.1)		64.1	(3.6)	
12-Month prevalence of use																			
Total	2095	1.0	(0.3)		3.3	(0.5)		1.9	(0.3)		2.3	(0.5)		4.2	(0.5)		8.6	(0.7)	
Ethnicity-Nativity																			
Vietnamese, USB	18	0.0	0.0	0.033	0.0	0.0	0.001	0.0	0.0	0.001	0.0	0.0	0.006	0.0	0.0	0.137	0.0	0.0	0.183
Vietnamese, FB	502	0.6	(0.3)		4.0	(0.9)		3.5	(1.0)		1.4	(0.6)		5.7	(1.8)		9.8	(2.7)	
Filipino, USB	159	1.2	(0.8)		4.4	(1.5)		1.5	(0.9)		2.9	(1.5)		5.7	(2.2)		11.0	(2.8)	
Filipino, FB	349	1.5	(0.7)		2.0	(0.9)		1.0	(0.6)		1.6	(0.8)		4.8	(1.6)		7.1	(1.8)	
Chinese, USB	125	4.6	(2.8)		11.7	(4.2)		8.8	(4.0)		8.7	(3.8)		8.4	(3.3)		17.6	(4.4)	
Chinese, FB	473	0.6	(0.3)		2.5	(0.8)		0.8	(0.4)		2.0	(0.8)		1.8	(0.8)		5.5	(1.5)	
Other Asian, USB	152	1.3	(1.0)		5.3	(2.4)		2.7	(1.9)		4.8	(2.2)		7.0	(2.7)		11.6	(3.0)	
Other Asian, FB	315	0.5	(0.4)		1.5	(0.4)		1.0	(0.3)		1.0	(0.5)		2.9	(1.2)		8.0	(2.7)	
Any 12-month mental disorder																			
No[e]	1894	0.3	(0.1)	<.001	1.9	(0.4)	<.001	1.2	(0.3)	<.001	1.3	(0.4)	<.001	3.1	(0.4)	<.001	5.6	(0.6)	<.001
Yes	201	7.5	(2.2)		16.2	(2.6)		8.4	(1.6)		11.5	(2.9)		13.8	(3.3)		35.9	(2.8)	
– Yes and with any 12-month use	72	21.6	(5.8)		44.9	(5.5)		23.9	(5.2)		32.0	(6.8)		38.1	(7.4)				

Notes: USB = U.S.-born, FB = foreign-born, SE = standard error. Percentages shown are weighted. Analyses account for the National Latino and Asian American Study's complex sample survey design.
p-Value shown for design-based Pearson's χ^2 tests of difference in proportions across categories.
[a] Includes psychiatrist or other mental health professional (e.g., psychologists, psychotherapist, mental health nurse) seen in any setting, or use of a mental health hotline.
[b] Includes psychologists, psychotherapist, mental health nurse or other mental health professionals seen in any setting, or use of a mental health hotline. 12-Month use of other mental health specialist additionally included use from social worker and counselor seen in a mental health setting.
[c] Includes general practitioner, other medical doctor, nurse, occupational therapist, other health professional.
[d] Includes specialist, generalist, human service (social worker/counselor seen in any setting, religious/spiritual advisor), complimentary/alternative medicine service (e.g., chiropractor, self-help group). For 12-month use, human service included social worker or counselor seen in non-mental health setting and religious/spiritual advisor.
[e] *p*-Value shown for design-based Pearson's χ^2 tests of difference comparing those with and without a mental disorder.

treatment in the absence of any healthcare provider. Among the 16.8% who saw a religious/spiritual advisor exclusively and the 15.1% who saw a religious/spiritual advisor and a non-healthcare provider, 42% and 79% had a mental disorder, respectively (results not shown).

4.3. Twelve-month mental health service use

The 12-month prevalence of mental health service use from a religious/spiritual advisor (Table 2) was 1%. There were significant differences by ethnicity-nativity with Chinese-USB Americans having the highest prevalence of use (4.6%). These differences were driven by nativity; ethnicity-related differences were smaller and marginally significant (results not shown). The 12-month prevalence of use from a religious/spiritual advisor was greater among those with a 12-month mental disorder (7.5% vs. .3% with no mental disorder). Among treatment-seeking Asian Americans with a 12-month mental disorder, religious/spiritual advisors were seen (21.6%) as commonly as psychiatrists (23.9%) but less commonly than MHS (44.9%) and GMP (38.1%).

Similar to results for lifetime use, most (70.9%) of the individuals with 12-month use from a religious/spiritual advisor had a 12-month mental disorder, of whom 37.8% did not see any mental health professional (71.4% did not see a psychiatrist) and 26% sought treatment in the absence of any healthcare provider and exclusively from the religious/spiritual advisor. The three most common reasons cited for help-seeking by those with a mental disorder were – to deal with general body complaints (e.g., tiredness, headaches) (42%), help with emotions (e.g., sadness, anger) (41%), and to control problem behaviors (e.g., drinking problems, gambling) (37%). In comparison, help with emotions (41%), coping with ongoing stress (41%) and coping with recent

Table 3
Other types of providers seen by Asian Americans using mental health services from a religious/spiritual advisor: 2002–2003 National Latino and Asian American Study.

	Total[a]		Other type of provider seen									
			Religious/spiritual advisor only		Psychiatrist		Any mental health specialist[b]		General medical provider[c]		Any healthcare provider[d]		Any non-healthcare provider[e] only	
	%	(SE)	%	(SE)	%	(SE)	%	(SE)	%	(SE)	%	(SE)	%	(SE)
With lifetime use, $n=101$			16.8	(4.7)	41.5	(7.1)	55.5	(8.1)	12.6	(4.8)	68.1	(6.4)	15.1	(5.0)
Without lifetime mental disorder	30.0	(4.5)	32.4	(12.7)	32.9	(14.0)	45.8	(13.6)	11.0	(9.3)	56.8	(14.1)	10.8	(7.5)
With lifetime mental disorder	70.0	(4.5)	10.0	(3.5)	45.2	(6.1)	59.7	(7.6)	10.0	(7.5)	72.9	(5.6)	17.0	(5.4)
With 12-month use, $n=25$			35.5	(10.2)	24.5	(12.3)	53.3	(12.3)	9.2	(6.6)	62.6	(10.5)	2.0	(2.0)
Without 12-month mental disorder	29.1	(9.6)	58.6	(16.7)	14.9	(13.4)	31.6	(17.0)	3.0	(3.1)	34.6	(16.9)	6.8	(6.7)
With 12-month mental disorder	70.9	(9.6)	26.0	(11.1)	28.6	(16.9)	62.2	(15.4)	11.8	(8.4)	74.0	(11.1)	0.0	0.0

Notes: SE = standard error. Percentages shown are weighted row percentages for use from each type of provider unless indicated otherwise. Analyses account for the National Latino and Asian American Study's complex sample survey design.

[a] Percentages shown are weighted column percentages of respondents with any lifetime use and any 12-month use of a religious/spiritual advisor.

[b] Includes psychiatrist or other mental health professional.

[c] Includes any general medical provider (e.g., general practitioner, other medical doctor, nurse, occupational therapist, other health professional) *and* no use from any mental health specialist.

[d] Includes psychiatrist or other mental health professional or any general medical provider.

[e] Includes social worker or counselor (seen in any setting for lifetime use, seen in a non-mental health setting for 12-month use) or complimentary and alternative care provider, and no use from a healthcare provider.

stressful events (31%) were cited by those without a 12-month mental disorder.

4.4. Perceived outcomes of mental health service use and referral for mental health treatment

Assessments of 12-month use from a religious/spiritual advisor were mixed (Table 4). A significant majority found the care a lot helpful (71%), felt accepted or understood (71%), and felt satisfied (86%). However, only 31% rated the quality of the care as excellent and 27% reported quitting before completing their recommended full course of treatment. Intensity of use from a religious/spiritual advisor and the subset of those with a 12-month mental disorder was less compared to MHS (mean: 6.5 and 7.0 vs. 12.6 and 15.8 visits/year, respectively, results for MHS not shown). Among those with lifetime and 12-month mental health service use, referral for professional mental health treatment by a religious/spiritual advisor (Table 5) was low (13.5% and 11.7%, respectively), even among those with a lifetime and 12-month mental disorder (17.2% and 9.6% respectively).

5. Discussion

In a nationally representative sample of Asian Americans, five key findings emerge about their mental health service use from religious/spiritual advisors. First, while overall lifetime and 12-month prevalence of use from a religious/spiritual advisor is low, religious/spiritual advisors are a key source of mental health treatment, sought out by 35% of treatment-seeking Asian Americans with a lifetime mental disorder. These findings are consistent with prior research on the U.S. population showing low 12-month prevalence of mental health service use overall (2.7%) and among White (2.3%), Black (2.5%) and Latino/a (2.2%) Americans (Mills, 2012; Substance Abuse and Mental Health Services Administration, 2012) but higher prevalence of use (25%) among treatment-seeking individuals with a mental disorder (Wang et al., 2003).

Second, for lifetime and 12-month use of mental health services, religious/spiritual advisors were seen as commonly as psychiatrists but less commonly than MHS and GMP, even among those with a 12-month mental disorder. Comparing service use from a religious/spiritual advisor of Asian Americans and the U.S. population with a mental disorder, the 12-month prevalence of use was similar (7.5% vs. 6.3%) and similarly less common than use from GMP (13.8% vs. 22.1%). In contrast, they were seen as commonly as psychiatrists (7.5% vs. 8.4%) rather than less commonly as found in the U.S. population (6.3% vs. 11.7% for psychiatrists) (Substance Abuse and Mental Health Services Administration, 2012). The surprisingly similar prevalence of use from psychiatrists and more common use from GMP may reflect recent trends of increasing rates of treatment obtained from GMP, psychiatrists and MHS in the U.S. (Kessler et al., 2005; Wang et al., 2006). Future studies should further investigate these patterns of use in larger samples to clarify whether the less common use of a religious/spiritual advisor compared to other providers reflect less religiosity and religious support, perceptions of them as barriers to receiving mental health services and/or greater preference for and access to MHS.

Third, approximately 70% of those with lifetime and 12-month mental health service use from a religious/spiritual advisor had a mental disorder, significant proportions of whom did not see a MHS or even a healthcare provider. Our results suggest that greater proportions of Asian Americans seen by religious/spiritual advisors have mental disorders (70%) than found in the U.S. population (51.8%) which may also explain the greater 12-month prevalence

Table 4
Perceived outcomes of 12-Month mental health service use from a religious/spiritual advisor among Asian Americans: 2002–2003 National Latino and Asian American Study.

	Among those with 12-month use of a religious/spiritual advisor		Among those with 12-Month use of a religious/spiritual advisor and a 12-Month mental disorder	
	% or mean	(SE)	% or mean	(SE)
Completion of recommended full course of care				
Completed/continuing	59.7	(11.3)	64.9	(12.6)
Quit	27.5	(11.0)	23.8	(10.8)
Refused/missing	12.8	(7.5)	11.4	(8.5)
Quality of care				
Excellent	31.3	(11.4)	31.1	(14.7)
Poor, fair, neutral, very good	58.3	(13.5)	57.5	(16.2)
Missing	10.5	(7.0)	11.4	(8.5)
Feeling accepted/understood				
Felt accepted/understood – a lot	71.0	(10.4)	76.8	(11.0)
Felt accepted/understood – some	18.6	(8.0)	11.9	(7.3)
Missing	10.5	(7.0)	11.4	(8.5)
Helpfulness of care				
A lot helpful	71.0	(10.4)	76.8	(11.0)
Some, very little, not at all helpful	18.6	(8.0)	11.9	(7.3)
Missing	10.5	(7.0)	11.4	(8.5)
Satisfaction with care				
Very satisfied or satisfied	85.9	(7.8)	83.5	(9.8)
Neither satisfied nor dissatisfied, dissatisfied, very dissatisfied	3.7	(3.5)	5.2	(5.2)
Missing	10.5	(7.0)	11.4	(8.5)
Average number of visits in the past year	6.5	(1.9)	7.0	(2.6)

Notes: SE = standard error.
Percentages shown are weighted. Analyses account for the complex sample survey design of the National Latino and Asian American Study.

Table 5
Referral for specialty mental health treatment among Asian Americans with mental health service use from a religious/spiritual advisor: 2002–2003 National Latino and Asian American Study.

	Did a spiritual advisor ever recommend that you go to a mental health specialist, clinic or program?				Did a spiritual advisor recommend that you go to a mental health specialist, clinic, or program in the past 12 months?			
	Lifetime users of a religious/spiritual advisor, %	(SE)	Lifetime users of a religious/spiritual advisor with a lifetime mental disorder, %	(SE)	Past-year users of a religious/spiritual advisor, %	(SE)	Past-year users of a religious/spiritual advisor with a past-year mental disorder, %	(SE)
Yes	13.5	(4.2)	17.2	(5.5)	11.7	(7.9)	9.6	(9.2)
No	68.5	(4.1)	68.6	(7.7)	88.4	(7.9)	90.4	(9.2)
Missing	18.0	(4.4)	14.2	(5.0)	0.0	0.0	0.0	0.0

Notes: SE = standard error.
Percentages shown are weighted column percentages. Analyses account for the complex sample survey design of the National Latino and Asian American Study.

of use from healthcare providers (63%) than found in the U.S. population (39%) (Wang et al., 2003).

Fourth, consistent with other studies documenting nativity as a determinant of mental health service use, we find that USB Asians were generally more likely to have lifetime mental health service use from a religious/spiritual advisor than immigrants, most strikingly observed among Chinese Americans (Abe-Kim et al., 2007; Le Meyer et al., 2009). Contrary to our hypothesis, Chinese-USB were more likely to use a religious/spiritual advisor than Filipino Americans which may reflect their more established histories in the U.S. and/or differences in socioeconomic and religious characteristics. Small sample sizes of some sub-groups studied (e.g., Vietnamese-USB) and low 12-month prevalence of service use from a religious/spiritual advisor prevented in-depth examinations of ethnicity and may have resulted in less precise estimates which should be interpreted cautiously. While nativity appears to be a stronger determinant of use from religious/spiritual advisors than ethnicity, future studies need to more systematically explore both in larger, more ethnically diverse samples to account for differences in religious characteristics and mental health which may influence treatment-seeking.

Fifth, while some perceived outcomes of 12-month use from a religious/spiritual advisor were positive (helpfulness, satisfaction with care), quality and completion of care and extremely low referral rates for specialist mental health treatment among those with a lifetime mental disorder and 12-month mental disorder warrant further attention for research and mental health service delivery. Without evidence of the efficacy of non-speciality mental health service use, longitudinal studies are needed to better establish the benefits and limitations of such use.

Our findings suggest a need for religious/spiritual advisors to better serve as bridges to MHS and services. Greater collaboration between the religious community and the mental health system can help to identify and connect the significant proportions of treatment-seeking Asian Americans with a mental disorder, many of whom are neither seen by nor referred to MHS, with appropriate mental health care. More than 40% of Asian Americans with a mental disorder cited seeking treatment for somatic issues, which may reflect a common, cultural tendency to somatize psychological symptoms. In a study of Asian American Christian clergy in California, prior mental health education, knowledge of mental illness, education level, time spent providing individual counseling and referral to general practitioners were positively associated with making mental health referrals (Yamada et al., 2012). Increasing referral to specialist mental health treatment could also help improve retention for

mental health treatment (Fortuna et al., 2010). Efforts are needed to foster better linkages between religious/spiritual advisors and the mental health system and help increase timely use of effective mental health services, particularly among the significant proportion of Asian Americans with potentially debilitating mental disorders seeking help.

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Contributors

D. John led the conception and design of the study, conducted the statistical analyses and drafted the manuscript. D. Williams contributed to the conception and design of the study, interpretation of the results and the critical review and revision of the manuscript. All authors contributed to and approved the final version.

Conflict of interest

We declare no conflict of interest.

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References

Abe-Kim, J., Gong, F., Takeuchi, D., 2004. Religiosity, spirituality, and help-seeking among Filipino Americans: religious clergy or mental health professionals? Journal of Community Psychology 32 (6) 675–689.

Abe-Kim, J., Takeuchi, D.T., Hong, S., Zane, N., Sue, S., Spencer, M.S., Appel, H., Nicdao, E., Alegria, M., 2007. Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. American Journal of Public Health 97 (1) 91–98.

Alegria, M., Takeuchi, D., Canino, G., Duan, N., Shrout, P., Meng, X.L., Vega, W., Zane, N., Vila, D., Woo, M., Vera, M., Guarnaccia, P., Aguilar-Gaxiola, S., Sue, S., Escobar, J., Lin, K.M., Gong, F., 2004. Considering context, place and culture: The National Latino and Asian American Study. International Journal of Methods in Psychiatric Research 13 (4) 208–220.

Bohnert, A.S., Perron, B.E., Jarman, C.N., Vaughn, M.G., Chatters, L.M., Taylor, R.J., 2010. Use of clergy services among individuals seeking treatment for alcohol use problems. The American Journal on Addictions/American Academy of Psychiatrists in Alcoholism and Addictions 19 (4) 345–351.

David, E.J.R., 2010. Cultural mistrust and mental health help-seeking attitudes among Filipino Americans. Asian American Journal of Psychology 1 (1) 57–66.

Ellison, C.G., Vaaler, M.L., Flannelly, K.J., Weaver, A.J., 2006. The clergy as a source of mental health assistance: what Americans believe. Review of Religious Research 48 (2) 190–211.

Farrell, J.L., Goebert, D.A., 2008. Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness. Psychiatric Services (Washington, DC) 59 (4) 437–440.

Fortuna, L.R., Alegria, M., Gao, S., 2010. Retention in depression treatment among ethnic and racial minority groups in the United States. Depression and Anxiety 27 (5) 485–494.

Gong, F., Gage, S.L., Tacata, L.A., 2003. Helpseeking behavior among Filipino Americans: a cultural analysis of face and language. Journal of Community Psychology 31 (5) 469–488.

Heeringa, S.G., Wagner, J., Torres, M., Duan, N., Adams, T., Berglund, P., 2004. Sample designs and sampling methods for the Collaborative Psychiatric Epidemiology Studies (CPES). International Journal of Methods in Psychiatric Research 13 (4) 221–240.

Heeringa, S.G., Liu, J., 1998. Complex sample design effects and inference for mental health survey data. International Journal of Methods in Psychiatric Research 7 (1) 56–65.

Islam, N.S., Khan, S., Kwon, S., Jang, D., Ro, M., Trinh-Shevrin, C., 2010. Methodological issues in the collection, analysis, and reporting of granular data in Asian American populations: historical challenges and potential solutions. Journal of Health Care for the Poor and Underserved 21 (4) 1354–1381.

Kessler, R.C., Ustun, T.B., 2004. The World Mental Health (WMH) Survey Initiative version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI). International Journal of Methods in Psychiatric Research 13 (2) 93–121.

Kessler, R.C., Demler, O., Frank, R.G., Olfson, M., Pincus, H.A., Walters, E.E., Wang, P., Wells, K.B., Zaslavsky, A.M., 2005. Prevalence and treatment of mental disorders, 1990 to 2003. The New England Journal of Medicine 352 (24) 2515–2523.

Koenig, H.G., King, D.E., Carson, V.B., 2012. Handbook of Religion and Health, 2nd ed. Oxford University Press, New York.

Le Meyer, O., Zane, N., Cho, Y.I., Takeuchi, D.T., 2009. Use of specialty mental health services by Asian Americans with psychiatric disorders. Journal of Consulting and Clinical Psychology 77 (5) 1000–1005.

Leavey, G., King, M., 2007. The devil is in the detail: partnerships between psychiatry and faith-based organisations. The British Journal of Psychiatry: The Journal of Mental Science 191, 97–98.

Leavey, G., Loewenthal, K., King, M., 2007. Challenges to sanctuary: the clergy as a resource for mental health care in the community. Social Science & Medicine (1982) 65 (3) 548–559.

Lee, S.Y., Martins, S.S., Keyes, K.M., Lee, H.B., 2011. Mental health service use by persons of Asian ancestry with DSM-IV mental disorders in the United States. Psychiatric Services (Washington, DC) 62 (10) 1180–1186.

Leong, F.T., Lau, A.S., 2001. Barriers to providing effective mental health services to Asian Americans. Mental Health Services Research 3 (4) 201–214.

Mills, M.L., 2012. Unconventional mental health treatment: reexamining the racial-ethnic disparity in treatment-seeking behavior. Psychiatric Services (Washington, DC) 63 (2) 142–146.

Matsuoka, J.K., Breaux, C., Ryujin, D.H., 1997. National utilization of mental health services by Asian Americans/Pacific Islanders. Journal of Community Psychology 25 (2) 141–145.

Moran, M., Flannelly, K., Weaver, A., Overvold, J., Hess, W., Wilson, J., 2005. A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area. Pastoral Psychology 53 (3) 255–266.

Neighbors, H.W., Musick, M.A., Williams, D.R., 1998. The African American minister as a source of help for serious personal crises: bridge or barrier to mental health care? Health Education & Behavior: The Official Publication of the Society for Public Health Education 25 (6) 759–777.

Payne, J.S., 2009. Variations in pastors' perceptions of the etiology of depression by race and religious affiliation. Community Mental Health Journal 45 (5) 355–365.

Pennell, B.E., Bowers, A., Carr, D., Chardoul, S., Cheung, G.Q., Dinkelmann, K., Gebler, N., Hansen, S.E., Pennell, S., Torres, M., 2004. The development and implementation of the National Comorbidity Survey Replication, the National Survey of American Life, and the National Latino and Asian American Survey. International Journal of Methods in Psychiatric Research 13 (4) 241–269.

Pew Research Center, 2012. Asian Americans: A Mosaic of Faiths. Washington, DC.

Spencer, M.S., Chen, J., Gee, G.C., Fabian, C.G., Takeuchi, D.T., 2010. Discrimination and mental health-related service use in a national study of Asian Americans. American Journal of Public Health 100, 2410–2417.

Substance Abuse and Mental Health Services Administration, 2012. Mental Health, United States, 2010. HHS publication no. (SMA) 12-4681. Substance Abuse and Mental Health Services Administration, Rockville, MD.

Takeuchi, D.T., Zane, N., Hong, S., Chae, D.H., Gong, F., Gee, G.C., Walton, E., Sue, S., Alegria, M., 2007. Immigration-related factors and mental disorders among Asian Americans. American Journal of Public Health 97 (1) 84–90.

Uehara, E.S., Takeuchi, D.T., Smukler, M., 1994. Effects of combining disparate groups in the analysis of ethnic differences: variations among Asian American mental health service consumers in level of community functioning. American Journal of Community Psychology 22 (1) 83–99.

Wang, P.S., Berglund, P.A., Kessler, R.C., 2003. Patterns and correlates of contacting clergy for mental disorders in the United States. Health Services Research 38 (2) 647–673.

Wang, P.S., Demler, O., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C., 2006. Changing profiles of service sectors used for mental health care in the United States. The American Journal of Psychiatry 163 (7) 1187–1198.

Weaver, A.J., Flannelly, K.J., Flannelly, L.T., Oppenheimer, J.E., 2003. Collaboration between clergy and mental health professionals: a review of professional health care journals from 1980 through 1999. Counseling & Values 47 (3) 162.

Xu, Y., Okuda, M., Hser, Y., Hasin, D., Liu, S., Grant, B.F., Blanco, C., 2011. Twelve-month prevalence of psychiatric disorders and treatment-seeking among Asian Americans/Pacific Islanders in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions. Journal of Psychiatric Research 45 (7) 910–918.

Yamada, A., Lee, K., Kim, M., 2012. Community mental health allies: referral behavior among Asian American immigrant Christian clergy. Community Mental Health Journal 48 (1) 107–113.