

RELIGIOSITY, SPIRITUALITY, AND HELP-SEEKING AMONG FILIPINO AMERICANS: RELIGIOUS CLERGY OR MENTAL HEALTH PROFESSIONALS?

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Data from structured interviews with 2,285 respondents for the Filipino American Community Epidemiological Survey (FACES) were used to examine help-seeking for emotional distress among Filipino Americans. The influence of religious affiliation, religiosity, and spirituality upon help-seeking from religious clergy and mental health professionals was assessed after controlling for need (e.g., negative life events, SCL-90R scores, and somatic symptoms), demographic (e.g., age, gender, marital status, education, county of residence, generational status, and insurance coverage), and cultural variables (e.g., loss of face and language abilities). Rates of help-seeking from religious clergy versus mental health professionals were comparable (2.5% vs. 2.9%). High religiosity was associated with more help-seeking from religious clergy but not less help-seeking from mental health professionals, whereas high spirituality

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This study was based on data from the Filipino American Community Epidemiological Survey (FACES), funded by NIMH Grant AA09863, and supported by the National Research Center on Asian American Mental Health (NIMH Grant 44331). We would like to thank Chi-Ah Chun, Sharon Goto, and Wei Chin Hwang for providing feedback on earlier versions of the manuscript. We also extend our thanks to Loyola Marymount University for providing Rains funds to support our able research assistants, Marchella Shipp and Voranan (Luky) Pongquan.

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was associated with less mental health help-seeking. Implications for understanding how religious variables affect help-seeking were explored. © 2004 Wiley Periodicals, Inc.

Over the past few decades, help-seeking from religious clergy among distressed individuals in the United States has decreased, while help-seeking from mental health professionals has simultaneously increased (Gurin, Veroff, & Feld, 1960; Joint Commission on Mental Illness, 1961). Results of national epidemiological data indicate that Americans now seek help from mental health specialists at a higher rate (5.8% to 5.9%; Kessler, Frank, Edlund, Katz, Lin, & Leaf, 1997; Regier, Narrow, Rae, Mander-scheid, Locke, & Goodwin, 1993) than they seek help from religious clergy (2.8%; Larson, Hohmann, Kessler, Meador, Body, & McSherry, 1988). Nevertheless, religious clergy still play an important role in the provision of mental health care across a wide spectrum of U.S. populations (Voss, 1996; Eng, & Hatch, 1991; Larson et al., 1988; Neighbors, Jackson, Bowman, & Gurin, 1983). In a study based on data from the National Survey of Black Americans, for instance, Neighbors and his colleagues (1983) found that ministers were second only to private physicians in the rate at which they were sought for "serious personal problems" (18.9% vs. 22.3%). Yet, other than for African Americans, the role that clergy play in the help-seeking behaviors of ethnic minority populations has not been examined.

In the present study, we investigate the role of spirituality and religiosity in the help-seeking behaviors of Filipino Americans, an ethnic group characterized by low rates of mental health service utilization (Ying & Hu, 1994). According to the 2000 U.S. Census, Filipino Americans currently represent the second largest Asian American population in the United States, behind Chinese Americans (Barnes & Bennett, 2002). With a long history of Spanish domination and a period of U.S. colonization, Filipino immigrants are more likely than other Asian immigrants to speak English and to practice Catholicism (Sustento-Seneriches, 1997). About 83% of the Filipino population is Catholic (Sustento-Seneriches, 1997). Consequently, religion may be an important dimension of Filipino culture to assess in health-related issues, including patterns of help-seeking.

RELIGION AND HELP-SEEKING

Oman and Thoresen (2002) outline how religion may causally influence health through a variety of pathways, including the use of social support, positive health behaviors, and effective coping strategies (i.e., prayer, meditation, etc.). Religion, however, is a multidimensional construct, reflecting a variety of domains including a distinction between religiosity and spirituality. Religiosity tends to refer to more institutionalized and prescribed forms of religious practices and expression, while spirituality may include personal encounters with transcendence, search for ultimate truth, or search for an ultimate reality that is considered sacred to an individual (Seybold & Hill, 2001). Religiosity is typically measured in terms of such variables as frequency of religious service attendance, private devotional activity, or religious experience (Oman & Thoresen, 2002), whereas spirituality can be measured by such experiences as "I feel strength and comfort in my religion," and "I feel deep inner peace or harmony" (Fetzer Institute, 1999).

This distinction is important because the pervasive influence of Catholicism among Filipino Americans may be reflected in high levels of religiosity, but not necessarily high levels of reported spirituality. Miller and Thoresen (2003) note that the concept of religiosity is intrinsically rooted in religion, a social phenomenon. At the individual level, religiosity represents engaging in the beliefs and practices of a particular religion. In contrast, spirituality may or may not be rooted in any organized religion at all (Miller & Thoresen, 2003). Consequently, assessing religious affiliation (i.e., Catholic vs. non-Catholic), religiosity (i.e., engaging in institutionalized forms of religious beliefs and practices), and spirituality (i.e., beliefs and practices that transcend particular institutionalized forms of religion) independently of each other is needed to discern the specific nature of religious influences upon help-seeking patterns. At the same time, Hill and Pargament (2003) caution against an oversimplification of the polarization between these concepts since "all forms of spiritual expression unfold in a social context and . . . virtually all organized faith traditions are interested in the ordering of personal affairs" (p. 64).

We investigate three questions in the present study: (1) is there a relationship between religious variables (e.g., religious affiliation, religiosity, and spirituality) and levels of psychiatric distress in a Filipino American sample; (2) are Filipino Americans who seek help from religious clergy less emotionally distressed than those who seek help from mental health professionals; and (3) are religious clergy sought out more than mental health professionals among emotionally distressed Filipino Americans? Researchers in this area have increasingly noted that the examination of religion and spirituality variables with respect to health-related issues has been largely focused on Judeo-Christian, and, in particular, Protestant expressions of faith (Kier & Davenport, 2004; Hill & Pargament, 2003), and that there is a need for greater sensitivity for examining variations in these relationships by ethnicity (Seeman, Dubin & Seeman, 2003) and cultural characteristics (Hill & Pargament, 2003). In investigating these questions, this study explores how religious variables may affect Filipino American help-seeking patterns.

Greater religiosity and spirituality may be associated with lower levels of emotional distress reflecting research findings that there are multiple pathways between religion and health (Oman and Thoresen, 2002). For instance, the use of various forms of religious coping has been associated with better mental and physical health (Pargament, 1997). In an example of another pathway, individuals who report a higher number of "spiritual strivings" indicate greater purpose in life, better life satisfaction and greater well being (Emmons, Cheung, & Tehrani, 1998).

Research findings are mixed as to whether individuals who seek out religious clergy are, in fact, less distressed than those who seek out mental health professionals. Some psychiatric epidemiological data suggest that levels of distress and psychopathology among individuals who seek help from religious clergy versus mental health professionals are comparable (Larson et al., 1988), while other data suggest that help-seeking from mental health professionals is motivated by more serious or chronic problems than help-seeking from religious clergy (Sorgaard, Sorensen, Sandanger, Ingebrigtsen, & Dalgard, 1996). Regardless of their levels of distress, however, we hypothesize that Filipino Americans will seek out help from religious clergy at a rate greater than they seek help from mental health professionals due to low rates of mental health service utilization (Ying & Hu, 1994) and high rates of Catholicism in this population. This prediction contrasts with the current pattern observed for the general U.S. population.

To the extent that differences in religious worldviews create barriers to help-seeking, we would expect to find evidence of a “religiosity gap” for help-seeking from mental health services (Shafranske, 1996). That is, religious individuals may potentially seek out ministers and not mental health professionals because they construe the etiology of their problems as spiritual in nature, and not simply psychological in origin (Mitchell & Baker, 2000). Thus, a religious person may seek help from clergy precisely because her core beliefs and values are affirmed and reinforced by her minister/priest. In this case, we would expect high religiosity and/or spirituality to be simultaneously associated with increased help-seeking from religious clergy AND decreased help-seeking from mental health professionals because help-seeking from religious clergy would also imply a rejection of [secular] mental health professionals (i.e., a “divergent worldviews” approach).

Further, preexisting personal relationships with religious clergy may make them more accessible sources of care for highly religious individuals (Gottlieb & Olfson, 1987). In this instance, an individual who is high in religiosity may seek help from clergy primarily because his minister/priest is familiar to him, as a frequent attendee at church or temple. In this case, we would expect to find high religiosity to be associated with greater help-seeking from religious clergy but not necessarily lower levels of mental health help-seeking. That is, we would not expect highly religious individuals to avoid mental health professionals, but simply to avail themselves of the services of individuals most familiar to them (i.e., a “greater accessibility” approach). We will test whether patterns of Filipino American help-seeking from clergy versus mental health providers are more consistent with a “divergent worldviews” or a “greater accessibility” explanation.

FILIPINO AMERICANS AND HELP-SEEKING

Evidence suggests that Filipino Americans may be less comfortable seeking mental health services even compared with other Asian American populations (Tanaka-Koyanagi, 2001; Ying & Hu, 1994). In the most comprehensive study of help-seeking among Filipino Americans to date, Gong and Gage (in press) examined the influence of face concerns and language abilities upon help seeking across four sectors of care: general medical, mental health specialty, folk systems, and lay care (i.e., family and friends). Their results indicated 75% of their Filipino American respondents did not use any type of mental health care, but that among the four sectors of care, the lay system was the most frequently used (17%), followed by the general medical sector (7%), the folk system (4%), and finally the mental health specialty sector (3%). While Gong and Gage included clergy in their definition of the folk system of care, their definition of this sector also involved help-seeking from cultural resources, including spiritualists, herbalists, and fortune tellers, whereas the present study will focus solely on religious clergy as a source of help. Gong and Gage found the following relationships between face concerns, language abilities, and help-seeking across sectors: (1) high concern with loss of face issues was associated with reduced use of mental health services, but not reduced use of other forms of care (in fact, face concerns were positively associated with use of the lay system); (2) mono-English speakers and English-Filipino bilingual speakers were less likely to rely on the lay system, and more likely to use mental health services or general medical care compared with mono-Filipino speakers, and; (3) there were interaction effects between face concerns and language

ability such that face concerns were stronger for mono-Filipino speakers than for mono-English and bilingual speakers.

These findings provide important insights into the help-seeking patterns of Filipino Americans. Data for the present study are based on the Filipino American Epidemiological Survey (FACES), the same data set used by Gong and Gage. Whereas Gong and Gage provide a sweeping examination of help-seeking patterns across formal and informal sectors of care in general, however, we examine the specific role of religious variables (i.e., religious affiliation, religiosity, and spirituality) in particular, building upon their findings about the role of face concerns and language abilities to better understand Filipino American help-seeking behaviors. The current study examines help-seeking patterns from mental health professionals versus religious clergy, two different sectors of care that represent differing worldviews.

METHOD

Data Collection

Data are derived from FACES, a strata-cluster survey conducted in San Francisco and Honolulu, HI, in 1998–1999. A three-stage sampling procedure was designed to obtain a probability sample of Filipino American households that were representative of the Filipino American populations in each respective area: (1) selection of tracts from the available census tracts in each area cross-stratified by three factors, the percentage of Filipino American households in the census tracts, the median income for Asian Pacific households in the census tracts, and the racial/ethnic composition of the census tracts; (2) the random selection of 12 blocks within each of the tracts meeting the above criteria; and (3) the random selection of four households within each of these 12 blocks. Selection in the first two stages was designed with probabilities proportional to size, such that even though selection probabilities varied within each stage, final selection probabilities were the same for all Filipino American households. Weights were applied to the sample data to adjust for demographic variables and the differential probabilities of selection within the household. Weighted data were used for all analyses.

Bilingual interviewers, fluent in English and either Tagalog or Ilocano were recruited for the study and screened for interviewing skills, access to transportation, and presentation style. Interviews averaged approximately 90 minutes and were conducted in person in the respondent's language preference (i.e., English, Tagalog, or Ilocano). One eligible person within each of eligible households was randomly selected for the interview. Eligible persons included Filipino Americans between the ages of 18–65 years, residing in each respective area. Sample characteristics are presented in Table 1. Respondents from Honolulu made up 57.2% of the sample, while only 20.7% of respondents were U.S. born. The sample was 83.7% Catholic, and was split evenly between females (50.6%) and males (49.4%). A total of 2,285 interview were completed, representing a response rate of 78%.

Research Design and Analysis Plan

This study examines factors related to help-seeking for emotional distress among Filipino Americans, from religious clergy versus mental health professionals. These help-seeking sources comprised the two dependent variables. The independent variables

Table 1a. Unweighted Frequencies and Weighted Percentages for Categorical Variables Associated with Help-Seeking From Mental Health Providers and Religious Clergy

<i>Categorical Variables</i>	<i>Reference</i>	<i>Missing N</i>	<i>Unweighted N</i>	<i>Weighted %</i>
<i>Dependent variables</i>				
Mental health providers	—	13	64	2.9%
Religious clergy	—	13	59	2.5%
<i>Independent variables</i>				
<i>Need variables</i>				
Somatic symptoms (1+ symptoms)	none	0	1197	50.0%
<i>Demographic variables</i>				
Age: 18–29 years	50–65	0	502	23.3%
Age: 30–49 years	years	0	1048	45.8%
Sex (female)	Male	0	1395	50.6%
Marital status (unmarried)	Married	3	796	41.6%
Education: Not HS graduate	Some college	0	686	29.2%
Education: HS only		0	427	20.0%
County: San Francisco	Honolulu	0	979	42.8%
U.S. born	Immigrant	0	467	20.7%
Insurance (1 = Yes)	No	9	2049	89.8%
<i>Cultural variables</i>				
Speaking Filipino well	Not well	1	1877	81.3%
Speaking English well	Not well	1	1781	76.8%
<i>Religious affiliation</i>				
Catholic	Non-Catholic	11	1893	83.7%

were classified into four categories: three types of control variables (e.g., need, demographic, and cultural variables), and religious variables, which were the target of interest in this study. Hierarchical logistic regression analyses allow an examination of the contribution of religiosity and spirituality while controlling for the effects of the three control variable categories in a step-wise fashion. Analyses proceeded according to the following four steps: (1) *need for services* (i.e., negative life events, somatic symptoms, emotional distress); (2) *demographic variables* (i.e., age, sex, marital status, education, county of residence, generational status, and insurance coverage); (3) *cultural variables* (i.e., race and language), and (4) *religious variables* (i.e., religious affiliation, religiosity

Table 1b. Descriptive Statistics for Continuous Variables Associated with Help-Seeking From Mental Health Providers and Religious Clergy

<i>Continuous Variables</i>	<i>Missing N</i>	<i>Weighted M</i>	<i>Weighted SD</i>
<i>Need variables</i>			
Negative events (1–3+)	0	.537	.797
SCL-90R (1–5)	9	1.309	.460
<i>Cultural variables</i>			
Loss of Face Scale (1–7)	26	5.111	1.408
<i>Religious variables</i>			
Religiosity (1–5)	23	3.025	1.086
Spirituality (1–6)	36	5.507	.798

and spirituality). Only results from the last step are reported, since the focus of the paper is on examining the contribution of religiosity and spirituality to help-seeking from religious clergy versus mental health professionals, after controlling for the influences of the other variables.

Measures

Help-Seeking Sources. Respondents were asked about their help-seeking behaviors in the past year using the following stem question: "The following are different kinds of places and people where someone might get help for problems with emotions, nerves, drugs, alcohol, or their mental health. Have you been to any of these places in the past twelve months?" This method of assessing help-seeking has been widely used in psychiatric epidemiological studies, including studies of other Asian American populations (Kessler et al., 1997; Regier et al., 1993; Abe-Kim et al., 2002). Responses to these items were used to create dependent variables representing help-seeking sources in two categories: (1) mental health professionals (i.e., "... a psychiatrist or other mental health specialist at a health plan/family clinic . . ."; also, private practice; mental health center; outpatient, general hospital; outpatient, psychiatric hospital; outpatient, VA; social service agency), and (2) religious clergy (i.e., "... a minister or priest, including a priest in the Taoist or Buddhist temple"). The dependent variables represent the overall number of sources endorsed within each category. Note that responses to each of the dependent variables are not independent of each other in that respondents could endorse items across categories as well as multiple items within each category.

Need for Services. Level of need was broadly represented by variables for stress, health status, and psychological distress. For stress, respondents were queried regarding the occurrence of 10 negative events during the preceding 12-month period. These events included such experiences as being robbed, having a close relationship break up, an extended separation from a loved one, legal troubles, and so on (McGonagle & Kessler, 1990). The frequency of events ranged from 0, 1, 2, or 3+ events with "0 events" treated as the reference variable.

For somatic symptoms, respondents rated the extent to which they felt bothered by any of 17 somatic complaints (i.e., headaches, faintness/dizziness, pains in heart or chest, upset stomach, hot or cold spells, etc.) in the past 30 days. Ratings were provided on a five-point scale, ranging from 1 (extremely) to 5 (not at all). This variable was then dichotomized such that individuals who reported no somatic symptoms (1) were compared to those who reported one or more somatic symptoms (0).

The depression and other subscale items for the Symptom Checklist-90-Revised (SCLR-90-R) (Derogatis & Cleary, 1977) were used to assess psychological distress among respondents. Twenty items were chosen from the subscales to construct the distress index based on high reported factor loadings (Cronbach alpha = .92). Respondents were asked to assess the degree to which they had been "bothered" by these symptoms in the past 30 days. Items were rated on a five-point scale ranging from "not at all" to "extremely."

Demographic Variables. For demographic factors, we examined gender, age, marital status, level of education, county of residence, generational status, and insurance coverage. Age was divided into three categories, following other analyses of similar data sets

(Hwang, Chun, Kurasaki, Mak, & Takeuchi, 2000): (1) 18–29 years of age, (2) 30–49 years of age, and (3) 50–65 years of age. Marital status was dichotomized into (a) unmarried (including divorced and widowed) and (b) married. Education was split into three categories: (1) less than high school education, (2) high school graduate, and (3) some college or more. County of residence was either San Francisco or Honolulu. Generational status was divided into two categories, immigrant (0) or U.S. born (1). Respondents were asked whether they had insurance coverage, which was coded as “no” (0) or “yes” (1).

Cultural Variables. We wanted to control for language abilities and loss of face, given the importance of the latter two variables in help-seeking in Gong and Gage’s (2003) study. Two statements were used to assess Tagalog/Illocano and English language proficiency, namely “how well can you understand Filipino [English] when it is spoken?” which was coded on a 4-point scale ranging from (1) “very well” to (4) “not at all.” Responses to these two statements were used to create two dichotomous variables: (1) respondents who understood spoken Filipino languages “very well” (1) versus those who did not (i.e., those who responded with “some” “not much” or “not at all”); (0); and (2) respondents who understood spoken English “very well” (1) versus those who did not (0). Loss of face was measured using nine items from Zane’s scale (1993), which were rated on a 7-point Likert scale format ranging from “strongly agree” to “strongly disagree.” Respondents were asked to rate the extent to which they agree or disagree with statements such as “I try not to do things that will make people notice me,” “I do not criticize others because this may embarrass them,” and “I say I might be wrong before I comment on something.” Responses were coded so that higher scores would indicate greater concern for loss of face issues. Scale scores were computed by averaging item responses for each respondent. The alpha reliability was .85 in this sample.

Religious Variables. Religious affiliation refers to the identification with a formal religious preference and was coded as either Catholic (1) or non-Catholic (0). While the religiosity and spirituality items were not derived from a single scale, they were consistent with several domains (e.g., affiliation, organizational, private practices, coping, and spiritual experience) identified in the NIA/Fetzer Brief Measure of Religiousness and Spirituality (1999). All items were factor analyzed using the maximum likelihood method with a varimax rotation and found to fall into one of two factors, religiosity (accounting for 59% of the variance) or spirituality (accounting for 41% of the variance) factors, which accounted for 100% of the total variance. Religiosity includes activities associated with a formal system of worship and consisted of three commonly asked questions pertaining to the frequency of certain activities: (1) attendance at religious services, (2) participation in religious group activities, and (3) participation in other private religious activities. The first two religiosity items were assessed using a 5-point scale ranging from (1) “once a week or more” to (5) “never.” The last item (“How often do you participate in other private religious or spiritual activities?”) was assessed using a 7-point scale ranging from (1) “more than once a day” to (7) “never.” The alpha coefficient for the three religiosity items was 0.71.

There were five spirituality items which addressed the transcendent issues related to the meaning of life, including: (1) greater purpose in life, (2) sense of mission, (3) finding meaning even in incomprehensible situations, (4) life unfolding as part of a larger plan, and (4) suffering has meaning. These items were rated on a 6-point Likert

scale ranging from (1) strongly agree to (6) disagree strongly, with an alpha coefficient of 0.81. The correlation between religiosity and spirituality scales was modest ($r = .18$, $p < .001$).

RESULTS

Table 1 presents the weighted descriptive statistics for all dependent and independent variables. For all respondents, the weighted percentage for utilizing mental health care was 2.9% versus 2.5% for religious clergy. Findings from the fourth and final step of the hierarchical logistic regression analyses are presented for each of these two help-seeking sources. Odds ratios for these predictors of help-seeking are reported in Table 2. County of residence did not emerge as a significant predictor of help-seeking from any source; consequently, only overall sample results are reported.

Religion, Distress, and Help-Seeking

To examine whether religion was associated with lower distress, Pearson product-moment correlations were computed between (a) religiosity and SCL-90R scores and (b) spirituality and distress scores. There was no significant relationship between religiosity and distress, but there was a significant negative correlation between spirituality

Table 2. Hierarchical Logistic Regression Models (Odds Ratios and 95% Confidence Intervals) for Help-Seeking From Mental Health Providers and Religious Clergy

Variable	Reference	Mental Health Providers	95% Confidence Interval	Religious Clergy	95% Confidence Interval
Need variables					
Negative life events (1-3+)	—	1.26	(.92-1.73)	1.15	(.84-1.56)
Somatic symptoms (1+ symptoms)	None	2.15*	(1.05-4.38)	2.37*	(1.14-4.93)
SCL-90R (1-4.6)	—	3.91**	(2.67-6.18)	2.26**	(1.43-3.56)
Demographics					
Age: 18-29 years	50-65 years	1.69	(.67-4.26)	1.44	(.59-3.51)
Age: 30-49 years)		1.53	(.72-3.28)	1.09	(.53-2.24)
Sex (female)	Male	.67	(.35-1.26)	1.08	(.53-2.20)
Marital status (unmarried)	Married	1.63	(.81-3.29)	1.52	(.73-3.15)
Education: Not HS graduate	Some college	1.31	(.44-3.95)	1.06	(.37-3.04)
Education: HS only		.87	(.38-1.99)	.82	(.29-2.32)
County: San Francisco	Honolulu	1.12	(.46-2.70)	1.63	(.80-3.30)
U.S. born	Immigrant	.57	(.27-1.17)	.65	(.26-1.62)
Insurance (1 = Yes)	No	2.24	(.68-7.35)	.70	(.23-2.11)
Cultural variables					
Loss of face	—	.76*	(.60-.95)	.89	(.72-1.10)
Understand Filipino well	Not well	.42*	(.21-.85)	.40	(.16-1.01)
Understand English well	Note well	11.54**	(1.39-95.91)	.93	(.36-2.45)
Religious variables					
Catholic	Non-Catholic	1.12	(.51-2.45)	.70	(.37-1.33)
Religiosity	—	1.11	(.82-1.50)	2.67**	(1.88-3.79)
Spirituality	—	.65**	(.49-.85)	.83	(.54-1.28)

Note. N = 2212. * $p < .05$. ** $p < .01$.

and distress ($r = -.12, p < .001$). Thus, high levels of spirituality, but not religiosity, were associated with lower levels of emotional distress in our sample. Using weighted data, a t-test indicated that individuals who sought out mental health professionals ($n = 62, m = 1.93, SD = 0.82$) did not have significantly different mean SCL-90R scores compared to individuals who sought help from religious clergy ($n = 58, m = 1.73, SD = 0.56, t = 1.56, p = n.s.$

Help-Seeking From Religious Clergy Versus Mental Health Professionals

High levels of emotional distress (OR = 2.26) and a greater number of somatic symptoms (OR = 2.37) were associated with a higher probability of help-seeking from religious clergy compared with low levels of distress and fewer somatic symptoms. No demographic factors were significantly associated with help-seeking from this source. Consistent with our expectations, individuals with high levels of religiosity had a higher probability of seeking out religious clergy for their concerns (OR = 2.67). Catholic individuals, however, were no more likely to seek out clergy than non-Catholic individuals.

High levels of distress (OR = 3.91) and somatic symptoms (OR = 2.15) were also associated with a heightened probability of help-seeking from mental health providers. Individuals with greater sensitivity to face concerns had a lower probability of seeking out mental health providers (OR = .76). Individuals who understood spoken Filipino well had a lower probability of seeking mental health providers (OR = .42) than those who didn't understand a Filipino language as well, while individuals who understood spoken English well had a much higher probability (OR = 11.54) of seeking out mental health services compared with those who did not understand English well. Whereas religiosity was not related to mental health help-seeking at all, spirituality was inversely associated with help-seeking from mental health providers (OR = .66). Catholic individuals were not significantly different than non-Catholic individuals in the probability of seeking out mental health professionals.

DISCUSSION

We examined three major questions with respect to the role of religiosity and spirituality in help-seeking from clergy versus mental health professionals among Filipino Americans: (1) would religious variables be associated with levels of distress, (2) would levels of distress differ between individuals seeking help from mental health professionals versus those seeking help from religious clergy, and (3) would there be more help-seeking from religious clergy compared to mental health professionals. The overall goal of the study was to examine how religious variables were associated with help-seeking from mental health professionals in contrast to religious clergy, and the extent to which patterns of help-seeking were characterized by a "divergent world-views" and/or "greater accessibility" framework.

Religiosity, Spirituality, Distress, and Help-Seeking

Spirituality, but not religiosity, was significantly associated with lower levels of emotional distress in our sample. Nonetheless, Filipino Americans who sought help from religious clergy were just as emotionally distressed as those who sought help from

mental health professionals. Our results were consistent with the perspective that help-seeking from clergy versus mental health professionals is driven by similar levels of distress (Larson et al., 1988) rather than the view that help-seeking from these sources is motivated by qualitatively different types of need (Sorgaard et al., 1996).

Not surprisingly, highly religious individuals had an almost three-fold greater probability of seeking help from religious clergy compared with less religious individuals. Higher levels of religiosity, however, did *not* result in less help-seeking from mental health professionals. That is, religious individuals appeared to be more comfortable seeking help from clergy, although this did not appear to adversely affect their help-seeking behaviors towards mental health professionals. Our results were consistent with Sorgaard et al.'s (1996) finding that help-seeking from priests was not necessarily related to dissatisfaction with mental health professionals, and also support a "greater accessibility" explanation. That is, the familiarity and accessibility of priests and ministers arising from active involvement in a parish or congregation may have facilitated help-seeking from religious clergy among church-going members who become emotionally distressed. Findings that loss of face and language (specifically, not understanding spoken English) were barriers in seeking out mental health care, but did not discourage help-seeking from religious clergy are consistent with this explanation, as well.

Unexpectedly, spirituality, but not religiosity, was significantly associated with a reduced probability of seeking help from mental health professionals. Spirituality, however, was not associated with a greater probability of help-seeking from religious clergy. If there were a "religiosity gap" we would expect religiosity and spirituality variables to be associated with less help-seeking from mental health providers and more help-seeking from clergy because of the divergent worldviews represented in these two sectors of care. Instead, our findings may reflect a distinction between intrinsic and extrinsic religiosity (Donahue, 1985), in which case, the polarity between religiosity and spirituality would be highly accentuated. Extrinsically religious individuals are highly religious in their behaviors, but do not internalize their beliefs and may not be particularly spiritual. Individuals who are high in intrinsic religiosity would, by definition, be highly spiritual, but may not necessarily exhibit adherence to a particular religion and its precepts (e.g., high religiosity). If this is the case, then our findings indicate a more complex picture of help-seeking than that of a religiosity gap reflecting divergent worldviews between these two sectors of care. Instead, we find that individuals who are high in spirituality may indeed shy away from seeking out mental health professionals, but that their spirituality may not necessarily facilitate help-seeking from religious clergy either. Ironically, such individuals might conceivably experience "divergent worldviews" in both sectors of care.

Rates of Help-Seeking Among Filipino Americans

The rate of mental health help-seeking among Filipino Americans in this study (2.9%) was substantially lower than the 5.8% to 5.9% rates found in the general population (Kessler et al., 1997; Regier et al., 1993). Filipino Americans in our sample, however, sought help from clergy and mental health professionals at similar rates (2.5% vs. 2.9% respectively). On the one hand, these results suggest that Filipino Americans not only severely underutilize mental health services, but also don't seek much help from religious clergy either. These findings suggest that even while religious clergy may be

perceived as more accessible than mental health professionals, they are still not highly utilized as sources of help.

On the other hand, rates of help-seeking from religious clergy among our Filipino American sample were comparable to the five-site total rate (2.8%) found across five communities sampled for the ECA study (Larson et al., 1988). Thus, Filipino Americans seek out clergy similarly to the general population, in contrast to the gaping difference between these Filipino Americans and the general population in their utilization of mental health services.

CONCLUSION

Rarely, if ever, are religious variables examined in the context of cultural variables in understanding help-seeking pathways. Religiosity and spirituality appeared to exert different types of influences upon the help-seeking process, independent of individuals' religious affiliation (e.g., Catholic vs. non-Catholic). Spirituality was associated with lower distress and a lowered probability of seeking help from mental health professionals, while religiosity was associated with a preference for seeking help from religious clergy. Religious variables were thus related to help-seeking in multiple ways. Further, building on Gong and Gage's findings (2003), we found that religiosity and spirituality were associated with help-seeking, even after controlling for the influence of cultural variables, such as language abilities, and sensitivity to loss of face. Although cultural and linguistic barriers may represent powerful deterrents to help-seeking from mental health professionals, they did not appear to deter help-seeking from religious clergy indicating that barriers to help-seeking differ across sectors of care, as well. From a "glass half empty" perspective, overall rates of help-seeking from both sectors of care, mental health professionals as well as religious clergy, were low; from this perspective, we could say that the underutilization of services for emotional distress among Filipino Americans occurred across both sectors of care. From a "glass half full" perspective, Filipino Americans sought help from religious clergy at comparable rates to the general population; from this perspective, we could say that there are no group differences in rates of help-seeking from religious clergy, unlike the group differences in rates of help-seeking from mental health professionals.

A limitation of the study is that we operationally defined spirituality and religiosity as single linear dimensions. These constructs represent complex phenomena that get oversimplified when we characterize individuals as being either "high" or "low" in religiosity or spirituality (Miller & Thoresen, 2003). Examining different dimensions of religiosity and spirituality to better characterize these multidimensional constructs would be an important next step in conducting research in this area.

Further, due to the cross-sectional nature of the data and methodological constraints such as retrospective reporting, we could not: (1) longitudinally examine the relationship between religiosity, spirituality and emotional distress, or (2) ascertain *how* help-seeking from mental health professionals versus religious clergy fit into the overall pathway or the trajectory of an individual's help-seeking behaviors. Consequently, we could not address such questions as the sequence of help-seeking or the extent to which religious clergy may have played a gate-keeping role in their parishioners' help-seeking from mental health providers (Mollica et al., 1986; Coie, Constanzo, & Cox, 1975). Another limitation was that we did not assess other contextual variables, such as family dynamics, that may exert strong effects on help-seeking behavior (Abe-Kim et al., 2002; Lian-Ding, 1995).

Nonetheless, the present study represents a more nuanced approach to examining religious issues in help-seeking. A key strength of the study was the distinction made between religious affiliation, religiosity, and spirituality in examining help-seeking, an important health behavior, in a non-Protestant, non-White population. Further, most research conducted on the topic of help-seeking among Asian Americans is characterized by (a) the use of aggregated samples across multiple Asian American populations, and (b) a reliance upon acculturation as a non-specific indicator of cultural influences. While much research has been devoted to the role of acculturation on help-seeking behaviors (Tata & Leong, 1994; Ying & Miller, 1992; Atkinson & Gim, 1989; Burnam, Hough, Karno, Escobar, & Telles, 1987), the actual measurement of acculturation covers many domains that are quite distal to help-seeking processes (i.e., food or movie preferences). The present study, in contrast, examined the help-seeking patterns of Filipino Americans through (1) a focus on *specific constructs theoretically linked to help-seeking* (i.e., religiosity and spirituality), with (2) a consideration of *specific elements of culture* (i.e., controlling for loss of face and language) which (3) represented more proximal influences upon a *specific outcome of interest* (i.e., help-seeking) for (4) a *specific Asian American group*. Thus, this study enabled more complex insights into the nature of religious and cultural influences upon help-seeking within a specific ethnocultural population.

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