ABSTRACT

The Faithful and the Distressed: How Likely are Christians to Seek Psychotherapy Treatment for Psychological Distress?

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Differences in causation (biological, psychosocial, spiritual) of five psychological disorders (depression, bipolar disorder, schizophrenia, anxiety disorders, ADHD) and types of counseling/therapy (pastoral care, Christian therapy, secular therapy) were examined between four groups: 1) Hong Kong Chinese and Americans, 2) Christians and non-Christians, 3) Hong Kong Christians and Hong Kong non-Christians and 4) Hong Kong Christians and American Christians. A brief online survey was used to collect the data. Results were mixed as to how people of different groups attributed causes to psychological disorders. Generally, Christians more than non-Christians attributed spiritual causes to psychological disorders and they were also more likely to seek pastoral care or Christian therapy when in distress. Hong Kong Chinese reported being more willing to seek therapy (across types) than Americans. In terms of causation, Hong Kong Chinese generally rated psychosocial and spiritual causes higher, while Americans rated biological causes higher.

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THE FAITHFUL AND THE DISTRESSED: HOW LIKELY ARE CHRISTIANS TO SEEK PSYCHOTHERAPY TREATMENT FOR PSYCHOLOGICAL DISTRESS

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DEDICATION

The study is dedicated to my parents Shu Chun Choi and Pui Shan Kan, who have supported me in attending Baylor University and raised me up in love.

CHAPTER ONE

Introduction

> … in most case the sufferer consults the doctor in the first place, because he supposes himself to be physically ill, and because certain neurotic symptoms can be at least alleviated by drugs. (Jung, 1933, p. 227)
>
> For one thing, people prefer to look for physical causes of their difficulties, and the psychiatrist, being a medical man, may find such a cause… A cause in the body is less disturbing than a cause in one's character. (Allport, 1950, p. 78)
>
> Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus. (Philippians 3:14, New International Version)

Across time and culture, a majority of people have worshiped some form of a deity or deities. Religion has played a significant part in human history and human affairs. The belief in God is an integral part of many people's lives (Hood, Hill & Spilka, 2009). People draw from it their reason to live, turn to it for their reason to act and rely on it to deal with life's ups and downs. For many, religion gives them their worldview – a perception and explanation of the happenings in the world.

Nevertheless, the scientific study of religious beliefs did not really start until the past century and behavioral scientists are still trying to come up with theories to explain the belief, or lack thereof, in a God or gods, as well as the functions of it. Some researchers have suggested that religion serves as a meaning system for people to make sense out of this uncertain and dangerous world. Among all the uncertainties and misfortunes that the world offers are different psychological disorders. Throughout

history, however, there has always been a stigma against disorders that appear to be psychological in nature – although the line between biology and psychology is getting more and more blurry, in light of recent scientific evidence. Ironically, one of the major purveyors of stigma against individuals with psychological disorders has been religious institutions.

Many times persons who have psychological disorders are ostracized as demon-possessed, or looked down upon as faithless. Being one of the dominant religions of our world, Christianity has a lot of adherents and Christians are taught to "trust in God" and "lift up everything to God." The Bible is full of stories in which people are demon-possessed, which some psychologists or even lay people today would refer to as mentally ill. Depending on how a Christian stands theologically, he or she might attribute the causes of mental illness to a demon or other spiritual factors. Also, Christians are called to be "joyful always" (1 Thessalonians 5:16, New International Version) in the Bible; accordingly, some Christians may see "feeling blue" or "being depressed" as a sign of a weak faith. Unfortunately, Christians who maintain this view oftentimes hold that people who have mental illnesses or depressive disorders are not trusting God enough.

In light of this, there seems to be an inherent tension between religion (Christianity in specific) and psychology (Pargament, 2011). Although the scientific study of religion has not been revitalized until recent years, the implication of religion and its relationship with individuals' lives have been an interest to many psychologists. One question that psychologists have been asking is whether religion has a positive impact on people's mental health. William James classified religious individuals into two groups: the sick-souled and the healthy-minded. Religion, to him, was either where the

former group turned to find the "source of health" or what the latter group associated with the joy of life (Batson, Schoenrade & Ventis, 1993, p. 231-232). For Freud, however, religion was a mental illness itself and he called it a "universal obsessional neurosis" of humanity (Freud, 2012, p. 103). In a sense, Freud simply saw religious people as psychologically ill patients who needed therapy. Yet, one of his most prominent students seemed to have a completely different view. The psychologist Carl Jung saw religion as something that people turn to when they are distressed. He wrote, "there has not been one whose problem in the last resort was not that of finding a religious outlook on life" (Jung, 1933, p. 229). Individuals who are diagnosed with mental disorders may, in this sense, turn more to religion for answers and comfort. Gordon Allport even went one step further to argue that religion "is superior to psychotherapy in the allowance it makes for the affiliative need in human nature," although he also saw "the failure of religion to turn doctrine into practice" (1950, p. 82). To Allport, religion does not only provide comfort in and of itself but the community that it implies also brings therapeutic values.

Classical theorists disagree on whether religion is a blessing or a curse to an individual's life. Following this line of contention, much research has been done on whether religiosity or spirituality helps cope with stress and distress. However, little research has been conducted on whether religious individuals interpret the causes of psychological illness differently than non-religious people. In one of his renowned articles, Adam Cohen writes that, "religion is evident in interactions between individuals and their environments" (2009, p. 196). Coming from another direction, Freud thinks religion "contains a system of wish-illusions and a denial of reality" (2012, p. 104). If

Freud is right, would religious people respond to the reality of them having a psychological illness differently than non-religious people? Would they simply deny it or explain it in a different light? No matter if it is an illusion or not, following Freud's claim, it seems that religious individuals would explain and react to life events differently than non-religious individuals. It is true that religious and non-religious people experience the world very differently, but in terms of psychological disorder, do they also explain and react to them differently? This was the question that this study set out to answer. More particularly, this study was designed to understand whether Christians react to psychological disorders in terms of perceiving the causes and seeking treatment differently than non-Christians. Christianity was chosen because 1) it is one of the most prominent world religions, and 2) it is the majority religion in the United States (Farrell & Goebert, 2008).

However, the difference between Christians and non-Christians was not the only factor this study attempted to address. In his critique to the current research on culture, Adam Cohen mentions, "It is likely that psychological functioning at any given moment represents a pooling of influences of… many forms of cultural identity…" (2009, p. 200). In respect to religion, he discusses that religion should not be seen as a monolithic entity; rather, it is a part of culture that also interacts with other parts within and without (2009). Hence, when comparing between groups, it is often useful and needful to compare between different aspects of the groups. In this study, data from Christian and non-Christian populations in Hong Kong were also collected, so that more comparisons could be made and more light could be shed on the issue of cultural effects.

Research has shown that religious individuals perceive the causes of mental illness differently than non-religious individuals. More specifically, Wesselmann and Graziano (2010) proposed that some religious individuals might develop a stigma against mental illness because of their beliefs. White et al (2003) also found that religious patients in a clinical setting were more likely to explain mental illness in terms of demonic causes. In terms of how Christians view mental illness, which is one of the main foci of this study, researchers have proposed that Christians do perceive psychotherapy as well as mental health differently than non-Christians (For example, Gass, 1984).

Surveying evangelical Christian college students, Ritzema (1979) found that an attribution to supernatural causes was positively correlated with religious beliefs and practice. Hartog and Gow (2005) surveyed Australian Protestant Christians on their beliefs on different causal and treatment variables. In relation to major depression and schizophrenia they found that 38.2% of Australian Protestant Christians explained the former and 37.4% of participants explained the latter as demonic influences. They also found that religious beliefs or values are predicative of who would attribute religious causes to major depression and schizophrenia. Many studies have also shown that Christians explain mental illness, at least partly, in terms of demonic influences (Favazza, 1982; Ward & Beaubrun, 1981; McGuire, 1975). Other Christians see that mental illness resulting from a person's sin (Pargament, 1990; for a reference in the Bible, please see Daniel 5: 28-37). Similarly, studies have shown that some Christians perceive people who have mental illnesses as morally or spiritually weak (Armentrout, 2004; Rondeau, 2003; White et al., 2003). Christians also describe people who have mental illness as lacking faith (McGuire, 1975; White et al., 2003). Although there is sufficient evidence

to suggest that Christians explain mental illness differently than non-Christians, the perception of one factor being the cause to a specific mental illness does not however, preclude one's perception of other factors as also being causes (Hartog & Gow, 2005; Loewenthal & Cornwall, 1993).

Other than seeing mental illness differently, it has been suggested that religious individuals also perceive psychotherapy differently than non-religious individuals. Summarizing a few studies, Matthews suggested that religious individuals would rather not receive treatments from mental health professionals because they are afraid that their belief systems might be challenged (2007). Moreover, mental and emotional concerns are often times subsumed under the spiritual concern by religious adherents, thus, the clergy is seen as being able to deal with their mental health issues (Matthews, 2007). It has also been suggested that religious individuals are more likely to turn to spiritual counseling and less likely to non-religious interventions (Greenawalt et al., 2011). Bergin (1991) argued that personal values have an influence on psychotherapy and the belief that such influence does not exist was based on the dated assumptions of Freud. In fact, religious beliefs often times inform treatments and help-seeking behavior (Leavey, Loewenthal & King, 2007). In their 1999 study assessing different religious groups including Christians, Muslims, Hindus and Jewish, Cinnirella and Loewenthal found that as many as 92.31% of their participants thought that having a mental health professional who is of the same race or religion as themselves would be helpful. In a meta-analysis, Worthington, Kurusu, McCullough and Sandaage (1996) concluded that highly religious individuals including Protestant and Catholic Christians would rather seek help from counselors who were of the same religions as themselves. Stanford and Philpott concluded that Baptist pastors

prefer to refer their congregations to mental health professionals who are supportive of faith, though also seeing the significance of biological and psychosocial causes in mental disorders (2011). It can be assumed that this attitude of the Baptist pastors can in some degree reflects the general attitude of the Christian population towards psychotherapy.

In view of this, Christians may explain psychological disorders more in terms of spiritual causes than non-Christians. Also, if they are diagnosed with psychological illness, they may choose to seek help from their ministers or therapists who hold similar religious views as them rather than a secular mental health professional. In fact, people who have a strong tendency to explain mental illness in terms of spiritual causes may be wary of secular psychotherapy (Isser, 1991; Venter, 1998; White et al., 2003). On the other hand, the clergy does not always receive training in psychology or counseling, so for a non-religious person, they may be seen as lacking the credentials to pronounce a diagnosis or provide treatment to the illness (Jung, 1933).

In terms of the Chinese culture, people tend to be more reserved in talking about private and personal matters (Chen & Mak, 2008; Wong, 2011); people with mental disorders are normally looked down upon; and mental health patients do not receive proper treatment as a result (Kleinman & Cohen, 1997). In a study investigating the help-seeking behaviors between European Americans, Chinese Americans, Hong Kong Chinese and mainland Chinese, Chen and Mak (2008) found that the two former groups were more likely to seek help from a mental health professional than the latter two. Further, the field of psychology has not been developed in China/Hong Kong for as long as in Western society. As a matter of fact, Chinese are less familiar with different mental disorders and their closeness to “medical”/physiological disorders than their American

counterparts. Psychology appears to be something "foreign" to the Chinese culture (Hsu, Hall & Coe, 2007). Many Chinese are still unwilling to seek help from counseling or psychotherapy, and are afraid of receiving the labels "crazy" or "insane." (Chung & Chan, 2004; Lin, 1982). Although one could say that this stigma still exists in the United States and in the Western world in general but this stigma certainly exists in a higher degree in the Chinese society. Moreover, because of the nature of their culture, family and interpersonal relationships can potentially become sources of stress to the Chinese people (Tom & Wong, 2006; for a brief discussion of Chinese familial and social values, please refer to Chen & Davenport, 2005). As a matter of fact, in a recent study assessing Chinese immigrant relatives' causal beliefs of mental illness, Yang and Wonpat-Borja (2012) found that Chinese considered "general social causes" being the most important contribution to mental illness, "indigenous Chinese beliefs," which include spiritual influences (see Li & Phillips, 1990), being the second and "physical causes" being the least important. Previous studies have also shown that Chinese tend to regard social, rather than biological, factors as contributors to mental illness (Phillips, Li, Stroup & Xin, 2000; Yang et al., 2010). Furnham and Wong (2007) also found that Chinese (including people from both mainland China and Hong Kong) tended to perceive religious and superstitious factors as the causes of schizophrenia.

In light of the previous discussion, it is hypothesized that:

Christians verses Non-Christians

1) Christians would attribute psychological disorders to spiritual causes more so than non-Christians;

2) Christians would turn to pastoral care or Christian therapy in times of distress more so than non-Christians;
3) Non-Christians would turn to secular therapy in times of distress more so than Christians;

Hong Kong Chinese verses Americans

4) Hong Kong Chinese would attribute psychological disorders to psychosocial causes more so than Americans;
5) Americans would attribute psychological disorders to biological causes more so than Hong Kong Chinese;
6) Americans would be more likely to seek help (across treatment types) when they are in distress than Hong Kong Chinese.

Hong Kong Christians verses American Christians

7) Hong Kong Christians, because of their conservative nature of their culture, would attribute psychological disorders to spiritual causes more so than American Christians

To tests these hypotheses, the current study invited the participants to rate their explanation of and response to five different psychological disorders and in terms of psychotherapy, a loose definition was used. Following the claim that the *helping relationship* is at the center of all psychotherapy or counseling types and techniques (Gross & Capuzzi, 2007), in this study, psychotherapy and counseling were simply defined as where people turn to seek help.

CHAPTER TWO

Method

Participants

Two hundred and sixty-six participants took the online survey, of which 239 were included in the analysis (115 females, 124 males, $M = 31.87$ years, age range: 18-67 years).[1]

Participants of this study were recruited from two populations, 1) Hong Kong Chinese (68) and 2) citizens of the United States of America (157). Eight people reported taking the surveys elsewhere and 33 participants failed to report where they took the survey.

Of the participants included in the analysis, in terms of race, the sample consisted of: 94 Asians, 113 Caucasian Americans, 18 African-Americans, 2 Native Americans, 10 Hispanics and two participants indicated they are of "Another race/ethnicity." In addition, 143 participants reported being Christian while 96 were non-Christians.

The overall demographics and other characteristics of the participants are reported in table 1.

Recruitment

Participants in Hong Kong were recruited online, through Facebook, a social networking site, and through email. The link to the survey was posted on Facebook on the "walls" of different groups and an invitation to take the survey was also sent to individuals through Facebook. The link to the survey was also distributed through emails. It is impossible to trace the data of this study to the individual participants who completed the survey, except by a complicated way of mapping the IP addresses of specific cases in the data set with the actual participants, which few can do.

The American sample was largely recruited through MechanicalTurk, an online participants recruiting site operated by Amazon. The general population can sign up as "workers" on the site. Investigators would post their surveys on the site and workers can then take the survey and earn a small sum of money (normally below one dollar). In this study, one participant from the American sample was paid thirty cents for taking the survey and the rest of the participants (122) were paid fifty cents. Thirty-four American participants were recruited from Facebook, in the same manner that the Hong Kong participants were recruited (through posting on walls of groups).

All of the participants had the right to drop out of the study when they saw fit or if they decided they were no longer able to continue the survey, without losing any privilege or undergoing any punishment. A monetary reward (thirty or fifty cents) was given to participants recruited from MechanicalTurk. For participants recruited through Facebook, no reward was given, monetary or otherwise, except for the possible benefit of

gaining knowledge of oneself and the acknowledgement that one has contributed to a scientific investigation.

Materials

A 29-item survey was completed by all participants. The survey consisted of three parts.

Demographics

Seven questions on participants' demographics were asked. These items included the participants' race, gender, age, level of education and whether they were Christian.

Measures of attitudes on and exposure to religious experiences and mental illness

There were ten items in this part of the survey. Participants were asked to rate the importance of their religious faith (e.g., "On a 10-point scale, please rate the importance of religion to you", 1 = *not at all important*, 10 = v*ery important*) and their knowledge of mental illness (e.g., "On a 10-point scale, please rate your knowledge of mental illness", 1 = *completely ignorant*, 10 = *completely knowledgeable*). Participants were also asked their frequency of attending church service and whether they themselves or any relatives had been diagnosed with a mental disorder.

Measures on factors contributing to mental disorders and choice of professionals if counseling or psychotherapy was needed

There were ten questions in this part of the survey, five on participants' belief of contributions to different mental disorders and the other five on participants' choice of professionals if counseling or psychotherapy was needed. Five types of mental disorders were listed in this study and they were: depression, bipolar disorder, schizophrenia, anxiety disorders and attention deficit/hyperactivity disorder (ADHD). Participants were given nine possible causes of mental disorders and were asked to rate to what degree they thought a specific cause contributed to the development of a mental disorder (e.g., "Please rate the relative contributions of the following causes for Anxiety Disorders", 1 =

small contribution, 10 = *major contribution*). The causes that the participants needed to rate were: chemical imbalances in brain, excessive use of drugs and alcohol, inherited genes, inconsistent parenting, social pressure, spiritual poverty, demonic oppression, personal sin, and lack of faith. The causes were in turn grouped into three categories: biological (chemical imbalances in brain, excessive use of drugs and alcohol, inherited genes), psychosocial (inconsistent parenting, social pressure) and spiritual (spiritual poverty, demonic oppression, personal sin, lack of faith). This part of the survey was adapted from Lafuze, Perkins, and Avirappattu (2002).

Participants were also to rate, had they been diagnosed with a specific mental disorder, to what degree would they enlist help from a variety of professions (e.g., "For Anxiety Disorders, please rate on a 10-point scale your likelihood to go to a variety of professions for counseling or psychotherapy", 1 = *very not likely*, 10 = *very likely*). The professions that the participants had to rate were: pastor/spiritual leader, Christian licensed professional counselor (Christian LPC), licensed professional counselor (LPC), clinical psychologist (PhD/PsyD), and psychiatrist (MD).

To compare the differences of choices of professionals if counseling or psychotherapy was needed, the five different types of counseling/therapeutic professionals were likewise put into three groups: *Pastoral Care* (pastor/spiritual leader), *Christian Therapy* (Christian licensed professional counselor) and *Secular Therapy* (LPC, clinical psychologist, and psychiatrist). The scores that the participants assigned to each choice of professionals in the *Secular Therapy* group were added up as an aggregate score; this aggregate score and the scores of the other two treatment types of different groupings of participants were then compared.

Additional items

Participants were asked the location in which they filled out the survey i.e., Hong Kong or America.

The survey was first written in English and was translated into Chinese. American participants were given the English version of the survey and although there was a substantial bilingual population in Hong Kong, Hong Kong participants were advised to take the survey in Chinese.

CHAPTER THREE

Results

Four sets of independent-samples t-test were performed to compare the results of different groupings of participants. The differences between 1) Hong Kong Chinese and Americans, 2) Christians and non-Christians, 3) Hong Kong Christians and Hong Kong non-Christians and 4) Hong Kong Christians and American Christians were compared.

Hong Kong Chinese and Americans

For depression, the Hong Kong group rated psychosocial and spiritual causes higher than Americans. For bipolar disorder, the Hong Kong group attributed psychosocial and spiritual causes more than Americans as well. The Hong Kong group also attributed psychosocial and spiritual causes to Schizophrenia more than Americans. However, Americans seemed to attribute biological causes to this disorder more than the Hong Kong participants and the result trended towards significance ($p = .055$). For anxiety disorders, Americans tended to explain the illness in terms of biological causes while the Hong Kong group tended to explain it more in terms of psychosocial and spiritual causes. Finally, Hong Kong participants rated spiritual causes higher for ADHD than Americans.

Across all three types of choices of counseling professionals, Hong Kong participants reported being more willing to utilize these services than Americans.

No other significant results were found.

Detailed statistics of this set of comparison are reported in Table 2.

Christians and Non-Christians

Christians attributed spiritual causes to depression, bipolar disorder, schizophrenia, anxiety disorders and ADHD more than non-Christians.

Christians also reported being willing to seek pastoral care and seeking help from a licensed professional counselor who is also a Christian more than non-Christians.

No other significant results were found.

Detailed statistics of this set of comparison are reported in Table 3.

Hong Kong Christians and Hong Kong Non-Christians

The only significant results found in this set of comparison were the differences in the two groups' willingness to seek pastoral care and counseling from a Christian licensed professional counselor. Hong Kong Christians reported being willing to seek help from these two types of intervention more than Hong Kong non-Christians. However, there were trends in Hong Kong Christians being more likely to explain depression (p = .077) and anxiety disorders (p = .095) in terms of spiritual causes and Hong Kong non-Christians being more likely to seek secular psychotherapy and counseling than Hong Kong Christians (p = .051).

No other significant results were found.

Detailed statistics of this set of comparison are reported in Table 4.

Hong Kong Christians and American Christians

Across depression, bipolar disorder, schizophrenia and anxiety disorders, Hong Kong Christians rated psychosocial and spiritual causes higher than American Christians. Hong Kong Christians also rated spiritual causes higher for ADHD than American Christians.

In terms of choice of treatments, Hong Kong Christians rated pastoral care and therapy by a Christian licensed professional counselor higher than American Christians.

No other significant results were found.

Detailed statistics of this set of comparison are reported in Table 5.

CHAPTER FOUR

Discussion

Out of the seven hypotheses, five were supported (either completely or partially) and two were not supported. Hypothesis 1 was supported in that Christians attribute spiritual causes more to psychological disorders than non-Christians, the results were the same across all five types of disorder. In the same way hypothesis 2 was also supported in that Christians are more likely to turn to pastoral care and Christian therapy than non-Christians. Hypothesis 4 was mostly supported (except for the case of ADHD where no result was found) in that Hong Kong Chinese attribute psychosocial causes to psychological disorder more than Americans. Hypothesis 5 was only partially supported in that Americans attribute biological causes more than Hong Kong Chinese to anxiety disorder (although the result on schizophrenia was trending towards significance), no results were found in regard to other disorders. Hypothesis 7 was supported in that Hong Kong Christians attribute spiritual cause to psychological disorders more than American Christians, and the results were present across all five types of disorder. However, hypothesis 3 was not supported in that the data did not show that non-Christians would utilize secular therapy more than Christians. In fact, a difference in preference to or disfavor toward secular therapy does not seem to exist in this particular study. Hypothesis 6 was also not supported. The results showed that Hong Kong Chinese are more likely to seek help than Americans when in distress. This was consistent across all three treatment types.

In interpreting the results, caution has to be used for two reasons. First, in this study, the three different types of causes (*biological*, *psychosocial*, *spiritual*) were independent of each other. Participants could rate high on all three causes. In other words, there was no competition between the causes in this study. For example, the results showed that Christians rated spiritual causes higher than non-Christians, but the results did not show that Christians rated spiritual causes highest in comparison to the other two groups. All comparisons carried out in this study were between religious or national groups rather than within groups.

Second, although Christians rated spiritual causes higher than non-Christians, the differences might in fact be due to the national differences. Looking at the comparisons between Hong Kong Chinese and Americans, and Hong Kong Christians and Hong Kong non-Christians, the results of the former were almost exactly the same as the ones appearing in Christians versus non-Christians; however, almost no significant results were found in the comparisons between Hong Kong Christians and Hong Kong non-Christians. If the differences in attribution to spiritual causes truly lie in the difference between having and not having the Christian beliefs, than the same results should also be found in the comparisons between Hong Kong Christians and Hong Kong non-Christians, yet that was not the case. Nevertheless, the statistical analysis employed in this current study was not sufficient in addressing this question.

Despite the apparent difficulties in interpreting the results, differences in understanding of mental illness and one's reaction to such do seem to exist between Christians and non-Christians, and Hong Kong Chinese and Americans, although this study is insufficient in determining to what degree the differences exist. If this is indeed

the case, then it makes logical sense that in treating patients from different populations, the therapist would need to act differently, in order to better treat, or even, not further harm his/her patients. Researchers have called for mental health professionals' acknowledgement of spirituality and religiousness in their clients while interacting with them (Corrigan, McCorkle, Schell & Kidder, 2003). Some have also acknowledged that there are differences between religious clients and non-religious clients and sometimes a different approach for counselors is warranted (Bergin, 1980; Worthington, 1988). Bergin (1980) has argued that "until the theistic belief systems of a large percentage of the population are sincerely considered and conceptually integrated into our work, we are unlikely to be fully effective professionals" (p. 95).

At the same time, since studies have shown that at least in some capacities, religious individuals would prefer seeking counseling from their ministers or counselors of the same religious beliefs as themselves, there are also needs in training clergy to deal with the issues of mental health, as well as in facilitating a greater collaboration between the clergy and mental health practitioners. Gordon Allport (1950) wrote that, "[I]nsofar as the clergy is better able to deal with issues of basic belief, values, and orientation toward life, he has an inescapable role to play in the conversation and advancement of mental health" (p.85). He also wrote that "[p]astoral-psychiatric teamwork is a rapidly expanding conception…" although he acknowledged the need for psychiatrists to learn philosophy and theology, he "note[d] the vigorous disposition on the part of the clergy to include psychology in their program of training" (p. 85). Sixty years have already passed since these words were written, much still has to be done in this respect.

In his review on pastoral care, Yeo (2002) particularly called for a reconsideration in Asian pastoral training such that counseling skills may be taught in seminaries. Matthews (2007) also reported seeing a desire within the clergy to employ psychological treatment. In recent years, we have seen a greater yearning both within psychologists and the clergy to work with the other on the field of mental health. Models have already been proposed for the collaboration of mental health professionals and the clergy (e.g. Benes, Walsh, McMinn, Dominguez & Aikins 2000; McMinn, Aikins & Lish, 2003). This is why studies like this one are important. In order to better treat the mentally distressed, we have to understand more the delicate nuances within and between different individuals and groups. It is my hope that in conducting this study, I have not only contributed (though only mildly) to the science of psychology and the general understanding of human beings, but the results would help fine-tuning our approaches to mental health treatments of individuals of different cultural backgrounds.

Limitation

There were many limitations in this study, the greatest of which was obviously the sampling method. In terms of the Hong Kong participants, since they were recruited via Facebook and basically through word-of-mouth, it was a convenience sample. The problem of a convenience sample is that it might not reflect the characteristics of the overall population. Also, the samples of Hong Kong Chinese and Americans did not match on a number of variables. The Hong Kong participants were for the most part drawn from a more educated, urban and middle-class subset of the population, whereas the American participants constituted a more or less national sample.

As a matter fact, the differences between Hong Kong Chinese and Americans (and even between Christians and non-Christians, as discussed earlier) might actually be due to class differences and other cultural beliefs. As Cohen (2009) has pointed out, socioeconomic status, social class, and region of country can contribute to the differences in comparing different cultures. Moreover, whereas the American society has a more or less predominantly Christian expression, Christianity does not have a majority status in Hong Kong (Hsu, Hall & Coe, 2007) –although it is not the minority either. Again, the differences shown in the study may be due to the differences not accounted for in the groups being compared.

Further, the study only distinguished between Christians and non-Christians but not other religions. A non-Christian could well be a Muslim, Hindu, Buddhist or other religious beliefs, which might have a similar view toward mental illness and psychotherapy as a Christian. The study did not address this potential confound. Also, even among religious individuals, there are different coping methods (e.g. plead, self-directing, deferring, collaborative; Yangarber-Hicks, 2004). In this study, participants were "forced" to choose between different mental health professional to whom they might seek help; however, it should be acknowledged that seeking psychotherapy is not the only way one would react if diagnosed with a mental disorder. For example, one could pray. The study did not address this particular nuance of individual coping. Further, there are different denominations and theological orientations within Christianity, and the differences among the different Christian beliefs and practices may inform their adherents on mental illnesses and psychotherapy differently. Although one item in the

survey was added to address this problem but this particular item was not included in the analysis.

Among other limitations, this study was also susceptible to the problems that other self-report and online studies face, namely the social desirability issue and the attention and seriousness of the participants.

Future Research

In my own conceptualization, the current study is a pilot that will guide and inform future research. There are many directions that future research along this line of study can take. Gordon Allport (1950) thought that there are two different dimensions in which individuals treat religion: the extrinsic and the intrinsic. Batson, Schoenrade and Ventis (1993) added a third aspect and he called it the quest dimension. Future studies should be conducted to examine if there are any differences in their perceived causes and reactions to psychological illness between individuals with different religious orientations. Future research should also examine the different coping styles and methods of religious and non-religious individuals; the differences between people of different religious affiliations can in the same way be investigated.

In short, future studies should address the limitations of the study and improve upon them. Most importantly, a more rigorous sampling method should be employed and a wider variety of statistical tests should also be conducted in order to control for as many confounding variables as possible.

Finally, given that religion is an important part of many people's lives, I believe it is psychologists and therapists' obligations to study the effects of religion as well as to

address those effects in the therapeutic relationship. As such, I call for more research on religious faith in the field under the aspiration of gaining psychological knowledge and to better help those who are in need.

Endnotes

[1] Twenty-seven of the participants not included in the overall analysis had a significant portion of the survey unfinished and additionally, six of the remaining participants failed to report where they took the survey hence they were excluded from the analysis in which this piece of information was needed.

APPENDICES

APPENDIX A

Table 1

Demographics and other characteristics of participants

	Hong Kong Chinese			Americans		
	Overall (*n* = 68)	Christian (*n* = 45)	Non-Christian (*n* = 23)	Overall (*n* = 157)	Christian (*n* = 88)	Non-Christian (*n* = 69)
Gender						
Male	38	22	16	81	38	43
Feale	60	23	7	76	50	26
Age	*M* = 33.57 *SD* = 11.44	*M* = 30.33 *SD* = 9.35	*M* = 39.91 *SD* = 12.66	*M* = 31.66 *SD* = 2.65	*M* = 30.40 *SD* = 12.99	*M* = 33.28 *SD* = 12.12
Level of Education						
Below high school	0	0	0	0	0	0
High school	22	11	11	58	27	31
Undergraduate degree	39	29	10	83	50	33
Postgraduate degree	7	5	2	16	11	5
Years of being a Christian	-	*M* = 12.46 *SD* = 7.94	-	-	*M* = 26.00 *SD* = 14.76	-
Self-perceived importance of religion (1 = not at all important; 10 = very important	-	*M* = 8.33 *SD* = 2.07	-	-	*M* = 7.31 *SD* =2.66	-
Theological orientation (1 = conservative; 10 = liberal)	-	*M* = 6.70 *SD* = 1.81	-	-	*M* = 5.67 *SD* =2.61	-
Frequency of church attendance						
Never	-	1	-	-	11	-
Less than once a month	-	5	-	-	24	-
Once a month	-	0	-	-	10	-
Several times a month	-	6	-	-	10	-
Once a week	-	19	-	-	26	-
More than once a week	-	14	-	-	7	-

Satisfaction towards church/pastors/spiritual leader (1 = least satisfied; 10 = most satisfied)	-	*M* = 6.82 *SD* = 1.82	-	-	*M* = 6.69 *SD* =2.42	-
Self-reported knowledge of mental illness (1 = completely ignorant; 10 = completely knowledgeable)	*M* = 5.01 *SD* = 1.88	*M* = 5.16 *SD* = 1.73	*M* = 4.74 *SD* =2.16	*M* = 6.36 *SD* = 2.07	*M* = 6.53 *SD* =1.91	*M* = 6.14 *SD* = 2.26
Whether participant has been diagnosed with a mental disorder						
Yes	4	2	2	31	22	9
No	64	43	21	126	66	60
Whether participant's family members/friends have been diagnosed with a mental disorder						
Yes	22	19	3	68	42	26
No	46	26	20	89	46	43
Whether participant or family members/friends have received treatment from a mental health professional						
Yes	19	16	3	70	43	27
No	23	15	8	34	18	16

APPENDIX B

Table 2

Differences of attribution to psychological illness and choice of counseling professional between Hong Kong and American participants

Causes/Choice of Counseling	Hong Kong Chinese (*n* = 68) *M*	*SD*	Americans (*n* = 157) *M*	*SD*	*t*	df	*p*	Cohen's *d*
Depression – Biological	17.57	5.25	18.87	5.50	-1.64	223	.102	-
[a]Depression – Psychosocial	12.26	3.39	9.93	4.60	4.23	170.03	**<.001**	**.58**
Depression - Spiritual	17.94	8.34	12.46	9.16	4.23	223	**<.001**	**.63**
Bipolar Disorder - Biological	18.74	4.93	19.24	5.31	-.67	223	.503	-
[a]Bipolar Disorder – Psychosocial	12.50	3.74	7.18	4.45	9.24	150.22	**<.001**	**1.29**
Bipolar Disorder – Spiritual	16.28	8.30	9.94	8.66	5.11	223	**<.001**	**.74**
Schizophrenia – Biological	18.26	5.27	19.77	5.42	-1.93	223	.055	-
Schizophrenia –Psychosocial	11.65	4.27	6.13	4.47	8.62	223	**<.001**	**1.26**

Schizophrenia – Spiritual	15.31	8.67	9.10	8.27	5.10	223	**<.001**	**.73**
Anxiety Disorders – Biological	16.67	4.98	18.61	5.95	-2.36	223	**.019**	**.35**
[a]Anxiety Disorders – Psychosocial	12.40	3.55	10.52	4.89	3.23	172.13	**.002**	**.44**
Anxiety Disorders – Spiritual	18.28	8.34	11.22	8.96	5.54	223	**<.001**	**.82**
ADHD – Biological	17.34	4.44	16.73	5.72	.78	223	.438	-
ADHD – Psychosocial	7.69	4.68	7.40	5.21	.40	223	.693	-
[a]ADHD – Spiritual	11.18	7.95	7.60	6.79	3.23	111.18	**.002**	**.48**
[a]Pastoral Care	22.82	15.06	15.34	12.99	3.56	112.16	**.001**	**.53**
Christian Therapy	23.66	14.29	15.53	12.78	4.23	223	**<.001**	**.60**
[a]Secular Therapy	102.62	22.67	94.88	34.61	1.99	188.21	**.048**	**.26**

[a]Levene's Test was significant in this factor, hence equal variances of groups were not assumed.

APPENDIX C

Table 3

Differences of attribution to psychological illness and choice of counseling professional between Christians and Non-Christians

Causes/Choice of Counseling	Christians (*n* = 143) *M*	*SD*	Non-Christians (*n* = 96) *M*	*SD*	*t*	df	*P*	Cohen's *d*
Depression – Biological	18.42	5.14	18.32	5.75	.17	237	.869	-
Depression – Psychosocial	11.07	4.44	10.19	4.32	1.52	237	.129	-
[a]Depression - Spiritual	16.60	9.27	10.76	7.95	5.21	223.105	**<.001**	**.68**
Bipolar Disorder - Biological	18.93	5.19	19.18	5.25	-.36	237	.720	-
Bipolar Disorder – Psychosocial	9.26	4.76	8.23	5.09	1.59	237	.112	-
Bipolar Disorder – Spiritual	13.56	9.02	9.77	8.72	3.23	237	**.001**	**.43**
Schizophrenia – Biological	19.13	5.34	19.40	5.61	-.38	237	.708	-
Schizophrenia –Psychosocial	8.32	5.04	7.27	5.26	1.55	237	.122	-
Schizophrenia – Spiritual	12.44	8.92	9.39	8.71	2.62	237	**.009**	**.35**

Anxiety Disorders – Biological	17.94	5.37	17.99	6.25	-.06	234	.951	-
Anxiety Disorders – Psychosocial	11.26	4.51	11.02	4.76	.39	234	.699	-
Anxiety Disorders – Spiritual	15.79	9.34	10.04	8.28	4.86	234	**<.001**	**.65**
ADHD – Biological	16.67	5.56	17.28	5.22	-.84	234	.403	-
ADHD – Psychosocial	7.77	4.88	7.11	5.14	.99	234	.322	-
[a]ADHD – Spiritual	9.85	7.84	7.05	6.16	3.06	229.65	**.002**	**.40**
[a]Pastoral Care	22.30	13.78	10.86	11.05	7.03	224.740	**<.001**	**.92**
[a]Christian Therapy	23.57	13.25	10.22	9.90	8.81	229.29	**<.001**	**1.14**
Secular Therapy	97.88	29.32	96.73	34.02	.27	232	.784	-

[a]Levene's Test was significant in this factor, hence equal variances of groups were not assumed.

APPENDIX D

Table 4

Differences of attribution to psychological illness and choice of counseling professional between Hong Kong Christians and Hong Kong Non-Christians

Causes/Choice of Counseling	Hong Kong Christians (n = 45) *M*	*SD*	Hong Kong Non-Christians (n = 23) *M*	*SD*	*t*	df	*p*	Cohen's *d*
Depression – Biological	18.09	4.86	16.57	5.93	1.13	66	.261	-
Depression – Psychosocial	12.44	3.53	11.91	3.16	.61	66	.545	-
[a]Depression - Spiritual	19.07	9.19	15.74	5.96	1.80	62.11	.077	-
Bipolar Disorder - Biological	19.22	5.01	17.78	4.72	1.14	66	.257	-
Bipolar Disorder – Psychosocial	12.40	3.68	12.70	3.94	-.31	66	.760	-
Bipolar Disorder – Spiritual	16.87	8.81	15.13	7.24	.81	66	.418	-
Schizophrenia – Biological	18.62	5.27	17.57	5.31	.78	66	.438	-
Schizophrenia –Psychosocial	11.82	4.25	11.30	4.36	.47	66	.639	-
Schizophrenia – Spiritual	16.29	9.16	13.39	7.44	1.31	66	.194	-

Anxiety Disorders – Biological	17.09	4.57	15.53	5.19	.99	66	.326	-
Anxiety Disorders – Psychosocial	12.69	3.67	11.83	3.33	.95	66	.347	-
Anxiety Disorders – Spiritual	19.49	8.70	15.91	7.19	1.70	66	.095	-
ADHD – Biological	17.53	4.61	16.96	4.16	.50	66	.616	-
ADHD – Psychosocial	7.53	4.60	8.00	4.94	-.39	66	.700	-
ADHD – Spiritual	11.91	8.55	9.74	6.58	1.07	66	.290	-
[a]Pastoral Care	27.82	14.73	13.04	10.28	4.82	59.57	**<.001**	**1.16**
Christian Therapy	28.60	13.44	14.00	10.63	4.53	66	**<.001**	**1.20**
Secular Therapy	98.80	23.19	110.09	20.03	-1.99	66	.051	-

[a]Levene's Test was significant in this factor, hence equal variances of groups were not assumed.

APPENDIX E

Table 5

Differences of attribution to psychological illness and choice of counseling professional between Hong Kong Christians and American Christians

	Hong Kong Christians (n = 45)		American Christians (n = 88)					
Causes/Choice of Counseling	*M*	*SD*	*M*	*SD*	*t*	df	*p*	Cohen's *d*
Depression – Biological	18.09	4.86	18.73	5.41	-.67	131	.507	-
Depression – Psychosocial	12.44	3.53	10.34	4.70	2.64	131	**.009**	**.51**
Depression - Spiritual	19.07	9.19	15.36	9.26	2.19	131	**.030**	**.40**
Bipolar Disorder - Biological	19.22	5.01	18.89	5.32	.35	131	.726	-
[a]Bipolar Disorder – Psychosocial	12.40	3.68	7.70	4.48	6.46	105.39	**<.001**	**1.15**
Bipolar Disorder – Spiritual	16.87	8.81	11.83	8.69	3.15	131	**.002**	**.58**
Schizophrenia – Biological	18.62	5.27	19.52	5.26	-.93	131	.352	-
Schizophrenia –Psychosocial	11.82	4.25	6.53	4.38	6.66	131	**<.001**	**1.23**
Schizophrenia – Spiritual	16.29	9.16	10.36	8.19	3.80	131	**<.001**	**.68**

Anxiety Disorders – Biological	17.09	4.87	18.42	5.67	-1.34	131	.182	-
[a]Anxiety Disorders – Psychosocial	12.69	3.67	10.50	4.75	2.94	110.67	**.004**	**.52**
Anxiety Disorders – Spiritual	19.49	8.70	14.01	9.24	3.30	131	**.001**	**.61**
ADHD – Biological	17.53	4.61	16.35	5.86	1.18	131	.241	-
ADHD – Psychosocial	7.53	4.60	7.92	5.15	-.43	131	.672	-
ADHD – Spiritual	11.91	8.55	8.98	7.35	2.06	131	**.041**	**.37**
Pastoral Care	27.82	14.73	19.34	12.82	3.43	131	**.001**	**.61**
Christian Therapy	28.60	13.44	20.66	12.71	3.34	131	**.001**	**.61**
[a]Secular Therapy	98.80	23.19	97.56	33.05	.25	118.32	.802	-

[a]Levene's Test was significant in this factor, hence equal variances of groups were not assumed.

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