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Beliefs About Etiology and Treatment of Mental Illness Among Korean Presbyterian Pastors

Ann-Marie Yamada[1] · Karen Kyeunghae Lee[2] · Min Ah Kim[3] · Megan Moine[1] · Hans Oh[1]

Abstract

This descriptive study explored pastors' beliefs about etiology and treatment of mental illness. Surveys were completed by mail by 202 Korean and Euro-American Presbyterian clergy. Nearly one-third of Korean pastors viewed bad parenting and demon possession as very important causes of mental illness, in contrast to the more than two-thirds of Euro-American pastors who viewed genetics and chemical imbalances as the most important causes. Compared with their Euro-American counterparts, Korean pastors soundly endorsed spiritual treatment of mental illness. The findings of this study suggest the value of understanding the views of pastors working with populations that underutilize formal mental health services.

Keywords Spiritual care · Survey methods · Christian clergy · Causal attributions · Psychiatry · Mental health service disparities

Introduction

Korean Americans with mental health problems underutilize formal psychiatric services (Abe-Kim et al. 2007; Lee et al. 2008) for numerous and complex reasons (Jang et al. 2009; Park et al. 2013; Shin 2002; Wang et al. 2003). Some of the reasons include misconceptions about mental illness (Jang et al. 2009; Wu et al. 2009), misgivings about mental health treatment (Yamada et al. 2012), and the absence of effective gatekeepers who can connect people in distress to available community services (Lee et al. 2008). Overcoming these obstacles requires culturally tailored outreach and engagement efforts that can flexibly accommodate the attitudes and views of the leaders, stakeholders, and

✉ Ann-Marie Yamada
amyamada@usc.edu

1 Department of Adult Mental Health and Wellness, USC Suzanne Dworak-Peck School of Social Work, University of Southern California, 669 West 34th Street, Room 102C, Los Angeles, CA 90089-0411, USA

2 Department of Social Work, California State University, Fullerton, USA

3 Department of Social Welfare, Myongji University, Seoul, Korea

general members of the Korean American community (Lee et al. 2015; Yamada et al. 2012).

Scholars have surmised that efforts to reach Korean Americans are more likely to be successful if implemented in partnership with community leaders such as in local churches (Choi 2003; Jo et al. 2010). According to the Pew Research Center (2013), approximately 71% of Korean Americans are Christians (the vast majority being Protestant). Churches have historically served as a space for Korean Americans to celebrate culture, build relationships, and engage in civic action (Chong 1998; Ecklund 2006; Hurh and Kim 1990; Min 1992). Thus, religious communities carry the potential to influence the pathways by which Korean Americans seek mental health services (Jo et al. 2010; Wu et al. 2009; Yamada et al. 2012).

Pastors in particular may play a key role in connecting people with mental health problems to appropriate services (Taylor et al. 2000). Pastors have a platform to disseminate information and dispel myths about mental illness and are often sought out for informal counseling. However, the extent to which pastors educate their congregations about mental illness or refer congregants to psychiatric services is not well understood and likely hinges on the beliefs and perceptions of the pastors. Few studies have examined pastors' perceptions of mental illness, primarily sampling pastors from African American and Euro-American churches (Anthony et al. 2015; Avent et al. 2015; Blank et al. 2002; Payne 2009; Stanford and Philpott 2011).

The views of Korean pastors toward mental illness have been linked to various factors. One study on this topic by Kim-Goh (1993) examined 50 Korean American pastors and found that those who held a psychological conceptualization of mental illness were significantly more willing to refer people to formal services than those who held a religious conceptualization. Korean pastors have also been shown to refer individuals to general practitioners rather than mental health specialists, implying some degree of belief in biological or somatic causes of mental illness (Yamada et al. 2012). In a recent study (Jang et al. 2017), Korean pastors tended to endorse spiritual beliefs underlying views that depression is absent from people who are deeply Christian. Some of the pastors also indicated some acceptance of biological causes of mental illness, accepting medication as an appropriate treatment (Jang et al. 2017). Currently, no study has used a comparative lens to explore whether Korean clergy have different views about mental illness and treatment than their Euro-American counterparts.

This descriptive study used survey-based data to compare the perceptions of Korean pastors with the perceptions of Euro-American pastors in the Protestant denomination to see whether the two groups differ in their beliefs about the etiology and treatment of mental illness. Understanding the extent to which Korean and Euro-American clergy beliefs converge or diverge is essential for involving pastors in efforts to reduce mental health service disparities.

Methods

Participants and Procedure

We mailed postal surveys between November 2010 and February 2011 to all Korean and Euro-American Presbyterian churches in California that were listed in publicly available directories. A total of 1066 surveys (503 Korean and 563 Euro-American) were mailed along with stamped return envelopes. One reminder postcard was also mailed to each

recipient. Postal surveys have proven to be a reliable and consistent method of data collection (de Leeuw et al. 2008).

The Presbyterian denomination was selected because it has a significant number of both Korean and Euro-American churches (Korean Christian Press 2010; Russell 2004). A total of 224 surveys were returned (85 from Korean clergy and 139 from Euro-American clergy), resulting in an overall response rate of 21% and a subgroup response rate of 17% and 25%, respectively. Twenty-two respondents did not meet the study inclusion criteria (e.g., not a pastor, not Euro-American), resulting in a final sample of 202 respondents. In lieu of individual incentives for the pastors' participation, a stakeholder consultant from each subgroup (Korean and Euro-American clergy) selected a Presbyterian organization to receive a $150 donation. This study was approved by the University of Southern California's institutional review board ethics committee affiliated with the researchers. Signed informed consent was waived for the mail surveys; an information sheet provided the same details without a signature requirement. The principles outlined in the Declaration of Helsinki were followed.

Measures

The surveys, administered in English or Korean (following guides for back-translation) (Brislin 1973), gathered data on clergy's attitudes toward mental illness and perceived behaviors of each clergy member's congregation. The survey content was largely drawn from the items included in the 2006 Presbyterian Panel Survey (Presbyterian Church Research Services 2006). For the purposes of this study, we analyzed questions specifically related to participants' etiology of mental illness and attitudes toward mental health treatment. The surveys collected sociodemographic characteristics (gender, education, place of the highest degree, marital status, US born, and mental health education) and church descriptors (i.e., years in ministry, years in current church, region and location of churches) without identifiable information.

Participants were asked about the degree of importance of nine possible causes of mental illness. Each response was scored independently using four categorical options ranging from "very important" to "not important." After initial data cleaning and review of the frequency of responses, we collapsed the four categories into three categories by combining "important or somewhat important" to provide indication of the general importance of multifactorial responses and retained "very important" to identify the most strongly endorsed beliefs. We also report select findings after dichotomizing the data into "important" and "not important" categories. Collapsing responses has been shown to minimize response ambiguity (Grimbeek et al. 2006).

Clergy's attitudes toward spiritual treatment of mental health were measured by seven items assessed on seven-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores reflect favorable attitudes toward spiritual treatment of mental illness. These items were drawn from a Korean measure developed to assess indigenous Korean values and beliefs related to mental illness (Park and Kim 1983).

Data Analysis

Descriptive statistics were used to highlight characteristics of each group of clergy. We also conducted *t* tests and Chi-square tests to check differences of characteristics between groups. We conducted Chi-square tests to examine subgroup differences between Euro-

American and Korean pastors with respect to each cause of mental illness. We conducted *t* tests to analyze the differences in means between the two groups regarding attitudes toward spiritual treatment. Results were based on two-tailed *p* values interpreted at the standard significance level of $p < .05$. All analyses were conducted using SPSS Statistics version 23.0 for Windows.

Results

The sample consisted of 202 Presbyterian clergy, specifically 123 Euro-American and 79 Korean pastors. As shown in Table 1, there was a significant difference between the two ethnic groups in terms of gender and marital status because very few Korean women serve as pastors and all the Korean respondents were married. The age of the pastors was comparable across ethnic groups, ranging from 30 to 79 years. As intended with our sampling strategy, the majority of Euro-Americans were born in the USA, whereas all Koreans were foreign born. Experience and stability of their ministry were similar across groups. The average number of years spent by pastors in ministry was 20.57 (SD = 10.36). Due to the large Korean population in Los Angeles, there were more surveys returned by Korean pastors in Southern California and in urban areas.

Differences in importance of each cause of mental illness were statistically significant across the two groups (see Table 2). A majority of Euro-American participants endorsed two causes as very important: genetic factors (75%) and chemical imbalance (78%). The majority of Koreans did not identify any particular category as very important. The greatest consensus among Koreans was that bad parenting (31%) and demon possession (32%) were very important in causing mental illness.

Considering importance versus non-importance (dichotomized), the majority of Euro-American respondents indicated that genetic factors (100%) and chemical imbalance (99%) were the most important factors in causing mental illness, whereas Koreans most often also identified genetic factors (99%) yet placed equal weight on bad parenting (99%) as causes of mental illness.

Across almost all items, Korean clergy had higher average scores, indicating more favorable attitudes toward spiritual treatment of mental health problems when compared to Euro-American clergy (see Table 3). However, both Korean and Euro-American pastors indicated that mental illness can be improved through healing prayers.

Discussion

We found that Korean Presbyterian clergy tended to both concur and differ in their views of the etiology of mental illness when compared to their Euro-American counterparts. Euro-American pastors demonstrated consensus in endorsing ascribed genetic or biological factors as important causes of mental illness; they also endorsed several psychological or social factors as strongly associated with psychopathology, as seen in previous studies (Farrell and Goebert 2008; Leavey et al. 2016).

Korean pastors also appeared to accept the basic premise of the currently favored psychiatric model of mental illness in which biological factors are given prominence over other etiological explanations. Unlike the Euro-American participants, however, Korean pastors did not view biological factors as the most dominant cause of mental illness. Instead, Korean pastors endorsed a multifactorial model of mental illness, rating many factors as important, and were more likely as a group to attribute mental illness to intra-

Table 1 Clergy and church characteristics by ethnicity (N = 202)

	Total N = 202[a]	Euro-American n = 123	Korean American n = 79	Test value
Age (M + SD)	54.6 + 8.8	54.5 + 9.2	54.72 + 8.2	t(197) = -.2
Gender, n (%)				$\chi 2 = 26.2^{**}$
Male	164 (81.2)	86 (69.9)	78 (98.7)	
Female	38 (18.8)	37 (30.1)	1 (1.3)	
Marital status, n (%)				$\chi 2 = 9.7^*$
Never married	9 (4.5)	9 (7.3)	0	
Married	188 (93.1)	109 (88.6)	79 (100)	
Previously married	5 (2.5)	5 (4.1)	0	
US born, n (%)				$\chi 2 = 185^{**}$
Yes	118 (58.7)	118 (96.7)	0 (0.0)	
No	83 (41.3)	4 (3.3)	79 (100)	
Education, n (%)				$\chi 2 = 0.9$
Master	125 (61.9)	73 (59.3)	52 (62)	
Ph.D.	77 (38.1)	50 (40.7)	27 (35.4)	
Place of highest degree, n (%)				$\chi 2 = 17.4^{**}$
USA	185 (92)	121 (98.4)	64 (82.1)	
Non-USA	16 (8)	2 (1.6)	14 (27.9)	
Mental health education, n (%)				$\chi 2 = 3.7$
Yes	92 (47.4)	62 (53)	30 (39)	
No	102 (52.6)	55 (47)	47 (61)	
Years in ministry (M + SD)	20.5 + 10.3 (1–46 years)	21.3 + 11.4	19.5 + 8.6	t(194) = 1.42
Years at current church (M + SD)	10.5 + 8.5 (.3–40 years)	9.7 + 8.3	11.6 + 8.6	t(197) = − 1.5
Church characteristics				
Region of churches, n (%)				$\chi 2 = 13.7^{**}$
Northern California	88 (44.2)	67 (54.5)	21 (27.6)	
Southern California	111 (55.8)	56 (45.5)	55 (72.4)	
Location, density, n (%)				$\chi 2 = 24.5^{**}$
Urban	81 (40.5)	33 (27)	48 (61.5)	
Suburban	90 (45)	65 (53.3)	25 (32.1)	
Rural	29 (14.5)	24 (19.7)	5 (6.4)	

*p < .05. **p < .001

[a]n sizes fluctuate slightly due to missing values. Total percentages may not equal 100% due to rounding error

and interpersonal factors that may contribute to greater stigmatization of persons and families affected by mental illness (Corrigan et al. 2001).

Consistent with Jang et al. (2017), Korean pastors tended to be in favor of spiritual treatment of mental illness. Although favoring spiritual treatment does not necessarily

Table 2 Etiology of mental illness among Euro-American and Korean Presbyterian pastors ($N = 202$)

Cause	n	Very important n (%)	Important or somewhat important n (%)	Not important n (%)	χ^2
Genetic factors					43.3*
Euro-American	116	87 (75)	29 (25)	0 (0)	
Korean	77	21 (27.3)	55 (71.4)	1 (1.3)	
Bad parenting					31.1*
Euro-American	112	11 (9.8)	70 (62.5)	31 (27.7)	
Korean	78	25 (32.1)	52 (66.7)	1 (1.3)	
Demon possession					50.5*
Euro-American	88	4 (4.5)	27 (30.7)	57 (64.8)	
Korean	76	25 (32.9)	41 (53.9)	10 (13.2)	
Socioeconomic problems					10.2*
Euro-American	113	8 (7.1)	72 (63.7)	33 (29.2)	
Korean	78	3 (3.8)	66 (84.6)	9 (11.5)	
Personal willpower					47.7*
Euro-American	112	3 (2.7)	39 (34.8)	70 (62.5)	
Korean	76	5 (6.6)	62 (81.6)	9 (11.8)	
Chemical imbalance					58.7*
Euro-American	119	93 (78.2)	25 (21)	1 (.8)	
Korean	77	18 (23.4)	51 (66.2)	8 (10.4)	
Spiritual weakness					54.6*
Euro-American	111	1 (.9)	34 (30.6)	76 (68.5)	
Korean	77	14 (18.2)	50 (64.9)	13 (16.9)	
Inconsistent parenting					19.5*
Euro-American	115	4 (3.5)	77 (67)	34 (29.6)	
Korean	78	8 (10.3)	66 (84.6)	4 (5.1)	
Relationship loss					27.8*
Euro-American	112	5 (4.5)	86 (76.8)	21 (18.8)	
Korean	78	18 (23.1)	60 (76.9)	0	

*$p < .001$

[a] n sizes varied slightly across items based on the number of missing responses

signify negative attitudes toward professional treatment, Korean pastors tended to endorse the belief that pastoral counseling is more effective than professional psychiatric treatment. Korean and Euro-American pastors concurred only regarding the healing power of prayer. Although further research is required, prayer may serve as a common element that could be included in intervention development efforts for both clergy subgroups.

These differences in beliefs may be traced to the cultural scripts endemic in each pastor's larger community and may capture attitudes that lead to service underutilization. Our findings also demonstrate that theology can give way to other cultural narratives or can interact syncretistically with these narratives to produce racial and ethnic variation in the

Table 3 Treatment beliefs of Euro-American and Korean Presbyterian pastors ($N = 202$)[a]

Topic and item	Pastors			
	Euro-American M (SD)	Korean M (SD)	t	p
Deepening faith Mental illness may be overcome through deepening one's religious beliefs	3.18 (1.75)	5.73 (1.33)	− 11.01	<.001
Pastoral counseling People with mental illness can get better when they feel understood, encouraged, or receive positive affirmation from a pastor or spiritual leader	4.20 (1.60)	5.72 (0.98)	− 7.51	<.001
Utilizing church resources A person can recover from mental illness by going to their place of worship	2.72 (1.45)	5.21 (1.28)	− 12.30	<.001
Preference for pastor to psychiatrist It is a much more effective treatment for people with a mental illness to be counseled by pastors than by psychiatrists	1.50 (0.85)	3.62 (1.55)	− 12.27	< .001
Spiritual retreat One useful treatment for people with mental illnesses is to go on a spiritual retreat, where they can experience peace	3.70 (1.65)	4.76 (1.34)	− 4.72	< .001
Healing prayers Mental illness can be improved through healing prayers	4.89 (1.38)	4.65 (1.59)	1.11	.27
Biblical treatment Reading the bible or religious texts may aid recovery from mental illness	4.48 (1.76)	5.23 (1.17)	− 3.34	.01

[a] n sizes varied slightly across items based on the number of missing responses

same denomination (Park 2013). Adjusting these narratives may be critical to increasing service referrals and use of mental health services among Koreans.

Pastors function as important gatekeepers and the beliefs that they hold about the etiology of mental illness can directly inform what they believe to be appropriate treatment and whether they refer individuals to professional treatment (see Hartog and Gow 2005). Indeed, the beliefs that clergy have about mental illness can span a wide spectrum (Payne and Hays 2016). In some instances, depending on their training, clergy may feel qualified to treat the individuals on their own (Payne 2014). Nearly a quarter of US congregations provide some sort of program to support people with mental illnesses, particularly at larger churches with more affluent congregants, where staff provide social and health services (Wong et al. 2018). Much of this informal care can be an important part of recovery for many individuals and should be recognized as a resource in the community. At the same time, these types of programs can and should work in conjunction with formal providers. More research on the impact of church-based services on Korean congregants is needed.

Our study has several potential limitations. The survey yielded a low response rate and may only reflect those clergy willing to take the time to discuss the subject of mental illness. Reminder cards were used to increase the response rate but had little impact. The low response rate limits the generalizability of the findings, yet is comparable to other studies of this nature (Yamada et al. 2012). Mail surveys with Asian populations often yield response rates of 5–10%, with response rates greater than 30% being rare (Royse 2008). The advantage of a mailed survey is that it is the recommended approach for collecting the most reliable data on topics likely to be biased by high levels of social desirability (de Leeuw et al. 2008). Similar to previous studies (Farrell and Goebert 2008), the survey was administered in a single state and may apply only to pastors in California. Although we sampled clergy from across the state and churches of various

sizes (small, medium, and large) to maximize representativeness, further comparative studies are needed, particularly across denominations (Trice and Bjorck 2006). Comparisons between the Korean and Euro-American pastors may be affected by sociodemographic differences within each subgroup. We were unable to control for the pastor characteristics that were statistically significant; there was greater homogeneity in the Korean sample that limited our ability to account for variables that could potentially affect their attitudes. A larger sample with greater variation among respondents and their congregations is necessary to examine the nuances affecting pastoral attitudes toward mental health problems.

Future studies should examine possible factors contributing to current conceptualizations among Korean pastors of the cause and preferable mode of treatment of mental illness. Church-based interventions (Rogers and Stanford 2015) and interventions targeting clergy (Wong et al. 2015) have been developed and implemented primarily based on research conducted with Euro-Americans and African Americans. Future studies should examine the effectiveness or cultural appropriateness of these interventions in Korean American churches.

Despite these limitations, our findings have practical implications. First, mental health providers can work with pastors to implement community-based educational programs with Korean congregations (Jang et al. 2014, 2017; Shin and Lukens 2002). Studies have shown that people with mental illnesses often seek counseling and support from the church, and while these interactions tend to be positive, there is still the possibility that the interactions can become negative when mental illness is attributed to demonic possession or personal sin (Stanford 2007). Mental health providers can inform pastors about the recovery process and promote positive narratives about mental illness within religious communities. Clergy have tremendous potential to dispel stigma and negative attitudes about mental illness. Second, Korean clergy can help promote greater cultural competence among mental health providers, who need to become familiar with religious concepts and cultural points of reference in order to conceptualize a culturally responsive treatment plan for Korean Americans (Benish et al. 2011; Kim 2003). Also, mental health providers may seek collateral information from pastors, who are familiar with the congregants/clients outside of the clinical context. Finally, mental health providers and pastors can develop partnerships to make bidirectional referrals (Kramer et al. 2007; Lee et al. 2008; Stanford and Philpott 2011). Clergy need to be trained to know how to conduct very basic assessments in order to determine when to refer congregants (Cheon et al. 2016), and at the same time, providers can refer religious clients to churches and religious groups, as social integration is an important component of recovery that clinicians have often struggled to provide. These recommendations require stronger partnerships between providers and clergy; however, such partnerships remain underdeveloped (Wu et al. 2009).

Conclusions

The Korean church has been aptly described as the "single most important organizing force for the immigrant community" (Lee et al. 2008, p 17). Pastors may serve as "boundary spanners" or individuals who can play bridge roles (Kim et al. 2006) in addressing discrepancies in mental health service use in the Korean community. Well-planned collaboration between mental health specialists and pastors may serve as a starting point to developing services for underserved Korean Americans.

Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

Human and Animal Rights All procedures performed involving human participants were in accordance with the ethical standards of the University of Southern California's institutional review board (IRB) and with the 1964 Helsinki Declaration and its later amendments. This article does not contain any studies with animals performed by any of the authors.

Informed Consent Signed informed consent was waived by the IRB for the mail surveys; an information sheet providing the same details as an informed consent (without a signature requirement) was sent to all individual participants included in the study.

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