THE EFFECTS OF PSYCHOEDUCATION AT A RELIGIOUS INSTITUTION ON
MENTAL HEALTH HELP SEEKING ATTITUDES AMONG CHINESE
AMERICANS

By

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A Dissertation submitted to the
Graduate School-New Brunswick
Rutgers, The State University of New Jersey
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
Graduate Program in Psychology
written under the direction of
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New Brunswick, New Jersey

[October, 2011]
ABSTRACT OF THE DISSERTATION

The effects of psychoeducation at a religious institution on mental health help seeking attitudes among Chinese Americans

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This study looked at the effects of a 12-week psychoeducation ‘Sunday School’ course on general mental health issues on help seeking attitudes among Chinese American members of a large, dominantly Chinese American church. When compared to other Sunday School classes, and controlling for pre-course attitudes, the psychoeducation course was associated with more favorable attitudes toward mental health help seeking at the completion of the course. No difference was found between Sunday School courses in their impact on reported likelihood to seek pastoral or professional mental health help for oneself or to recommend it to others. At baseline, this study found that age, spirituality, and Asian values related to recommending that others seek help. Older participants were more likely to recommend that others seek pastoral and professional help. Spirituality was positively correlated with pastoral help seeking for self and others, and higher adherence to Asian values was positively correlated with recommendation for others to seek pastoral help. There were, however, limitations to the measures and design that reduced the chances of obtaining further findings. Future directions for Asian American help seeking research are discussed.
ACKNOWLEDGEMENTS AND DEDICATION

I am grateful to so many people for their guidance and support. I would like to express my gratitude to my advisor, Dr. Brenna Bry, for her invaluable mentorship during years of graduate school. I would also like to thank Dr. Maurice Elias, Dr. Sandra Harris, Dr. Cary Cherniss, and Dr. Yee C. Chiew for being on my dissertation committee, for providing positive and constructive feedback, and last but not least, for making my dissertation proposal and defense enjoyable and intellectually stimulating.

I would like to specifically thank my family for their support throughout the years. They have always encouraged me in whatever endeavors I undertook during six years of graduate school. In particular, I feel incredibly blessed to have parents who allowed me to triumph and make mistakes on my own and hence encouraged my personal growth. And so, my gratitude goes out to them.

This dissertation would not have been possible if it were not for Pastor Wilson Chang, who championed my cause for mental health awareness and provided invaluable help when I experienced stressors in my life. I am touched by his expressions of care and generosity that is so valued and professed in the Christian faith.

I am dedicating this dissertation to Rutgers Community Christian Church and to the youth group, especially the senior high students who I worked with over the years. They were the inspiration for this dissertation. *Soli Deo gloria.*
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INTRODUCTION

Asian Americans are one of the fastest growing ethnic minority groups in the United States. Nearly all generations (from first-generation to fifth-generation Asian Americans) are represented in the country, although a majority appears to be immigrants (Kung, 2004; Miville & Constantine, 2007). There is also considerable heterogeneity within the Asian American ethnic minority group, with more than 25 distinct sub-groups identified within the United States. This variety in generational status and national heritage leads to the rich cultural and linguistic diversity within the Asian American population (Kim, 2007).

Despite the diversity that exists among Asian Americans, researchers have found similar cultural values that pervade across a majority of the Asian American sub-groups. Asian Americans generally conform to a collectivistic mindset, which emphasizes the needs of the family over individual wishes and desires. There is also an emphasis on interdependence within the family – Asian Americans prefer to rely on their own family members for assistance and support. Familial loyalty and pride are also important to Asian Americans; many strive to bring much honor and praise to their family, while minimizing any activity that may bring shame or dishonor to the family name by displaying a lack of self-control or restraint (Kim, 2007).

It may not be a surprise then that Asian Americans have one of the lowest help-seeking rates in the United States as compared to both European American and other ethnic minority sub-groups (Office Of The Surgeon General, 2001; Akutsu, Snowden, & Organista, 1996). Statistics from national epidemiological studies have found that most Asian Americans with a clinical disorder will not seek a mental health professional for
help during times of distress. Among those who do initiate contact with a mental health service provider, about one-third do not show up for the first intake appointment (Akutsu & Chu, 2006). Although researchers have debated the prevalence rates for various disorders for Asian Americans, most are in agreement that as a whole, this ethnic group consistently underutilizes mental health services (Barry & Grilo, 2002).

Asian Americans also have less positive attitudes toward psychological services and are less likely to endorse emotional and personal problems compared to European Americans (Chang & Chang, 2004). In the past, the low rates of mental health utilization have been used to support the ‘model minority’ myth (Yi & Tidwell, 2005), which states that Asian Americans are the ‘model minority’ because of their low rates of deviant behavior, alcohol and illicit drug abuse, and a supposedly ‘low’ need for mental health services. Researchers and current events (such as the Virginia Tech shooting in 2007) have debunked this myth, stating that low mental health utilization may not necessarily be indicative of low need, but rather of the existence of cultural and logistic barriers that may make it more difficult for Asian Americans to seek psychological therapy or counseling. Depression, for one, has recently been found as one of the most common problems for Asian Americans, sometimes at rates which exceed rates found for White Americans (Akutsu & Chu, 2006). Despite this, Asian Americans seem reluctant to seek services in response to such emotional distress. Abe-Kim and colleagues (2007) reported that 8.6% of Asian Americans sought help from any service, with 4.3% seeking help through medical professionals and 3.1% from mental health professionals – rates that are lower than many other ethnic minority groups. Help-seeking rates remained low among those who have a probable diagnosis for a mental disorder. Asian Americans who
successfully initiate treatment also terminate treatment earlier than non-minority consumer groups (Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005). This reluctance to initiate and commit to treatment also decreases the likelihood of successful treatment. By the time Asian Americans seek help, they also report higher levels of psychological distress compared to individuals from other groups initiating help seeking for the first time (Akutsu & Chu, 2006). Thus, a vicious cycle may be established in which Asian Americans (already reluctant to use mental health services) engage in therapy or counseling at a point where successful treatment is less likely; and subsequently, this ‘futile’ experience with therapy may lead such Asian Americans to confirm the negative perceptions they may have had about mental health professionals in the first place. Therefore, it is important for researchers to gain a comprehensive understanding of factors that make it more difficult for Asian Americans to seek out therapy so that the discrepancies eventually can be addressed.

Although researchers have focused on cultural attitudes that may impact help seeking among Asian Americans, there has been a growing interest in other types of barriers to mental health treatment. Limited access to care and lack of awareness may be some of the reasons why immigrant populations have low help seeking rates (Kwok & Sullivan, 2007). Cultural beliefs, stigma, and religiosity/spirituality may also play a role. As such, a full understanding of why Asian Americans are not likely to engage in help seeking must include a discussion of logistical barriers to treatment as well as cultural obstacles. These factors must be considered when attempting to implement a community intervention that aims to make it acceptable for Asian Americans to engage in public help seeking. An overview of some of the most established factors affecting help seeking is
presented below as background for a psycho-social-educational intervention to increase help seeking in Asian Americans, which will be tested in this study.

Adherence to Cultural Values

Although Asian Americans are less likely to utilize mental health services than other ethnic groups, the rates of help seeking within the Asian American population tend to vary depending on generational status and acculturation. Asian Americans who are born in the United States are more likely to use mental health services than their immigrant counterparts and also display significantly higher rates of service usage than immigrants, although age may be a confounding factor (Abe-Kim et al., 2007). In general, however, it appears that those who are considered “3rd generation” or later display higher use of any type of mental health services than their predecessors. It is very possible that perhaps more time spent in the United States provides more time for Asian Americans to become aware of the mental health services available to them. Moreover, time spent in the United States may be correlated with increased language fluency, making it much easier for Asian Americans to feel comfortable in communicating their needs to a mental health professional.

This process of becoming acclimated to the dominant culture is called acculturation, traditionally described as “adaptation to the norms of a new culture” and progressively less maintenance of the norms of the indigenous culture (Kim, 2007). It is hypothesized that the more acculturated an individual becomes to the norms of the dominant culture (in this case the European American culture), the easier it will be for said individual to engage in help seeking behaviors. Higher acculturated Asian Americans report correspondingly higher rates of psychotic disorders than less
acculturated Asian American individuals (Akutsu & Chu, 2006), leading researchers to believe that it may be more acceptable for more acculturated individuals to admit they are in need of help to someone else than it is for those who are not as acculturated to mainstream society.

Acculturation displays the strongest positive correlation with help seeking when it is defined as a multi-dimensional construct. Kim (2007) suggested that it may be important to parse the concept of acculturation into smaller concepts, specifically acculturation as adaptation of new norms and enculturation as the retention of the norms of the indigenous culture. Within the Asian American literature, the word *acculturation* emphasizes the assimilation of new norms, while ignoring the impact of enculturation. It is believed that studying enculturation and one’s ability to successfully maintain ‘old’ cultural values, while incorporating new ones – may be crucial in understanding Asian American help seeking. It has been found that after controlling for enculturation, acculturation was not found to be a significant predictor of help seeking for Asian American college students, and enculturation was inversely associated with general willingness in help seeking (Kim, 2007). Kim (2007) hypothesized that it may be that the ‘loss’ of traditional Asian values is a stronger predictor of help seeking than the ‘gain’ of European values. Also, the lack of a significant correlation between enculturation and acculturation in study participants may suggest that the process of adhering to Asian cultural values is unrelated to the process of adhering to the European American cultural values, and an orthogonal model of acculturation may be necessary for researchers to fully understanding the impact of acculturation on Asian Americans. Regarding the determinants of help seeking, it appears that high adherence to Asian cultural values
decreases help seeking for mental health concerns. As such, it is important to assess how the level of adherence to Asian cultural values may affect the effectiveness of an intervention designed to encourage help seeking among Asian Americans.

Cultural Beliefs and Stigma

Cultural values that individuals hold may either encourage or discourage positive outcomes in counseling (Miville & Constantine, 2007). For Asian Americans, it appears that Asian cultural values make successful help seeking attempts and positive experiences in therapy less likely.

It has been hypothesized that the high value Asian cultures place on self-control and restraint may lead Asian Americans to be less attracted to the Western style of therapy, in which clients are often encouraged to play the “sick role”, to admit helplessness or lack of control over certain problems, and to disclose personal thoughts and weaknesses to a relative stranger (Miville & Constantine, 2007). The extent to which this may have an impact on help seeking depends on therapeutic orientation. It has been found, for instance, that Cognitive-Behavioral Therapy (CBT) may be a particularly efficient therapeutic approach in working with Asian Americans because of its emphasis on self-efficacy, skills training, and collaborative relationship between therapist and client (Shen, Alden, Sochting, & Tsang, 2006). Other therapeutic orientations may prove to be less consistent with Asian traditional values, but more research is needed in this area.

Asian cultures also do not traditionally believe in the dichotomy of body and mind (Barry & Grilo, 2002). While some European cultures under the influence of Judeo-Christian values view the body as an entity separate and distinct from the ‘soul’ or
mind, Asian philosophies tend to meld body, mind, and spirit as one. One of the ways this belief in a completely integrated self is manifested is in Asian Americans’ tendency to present psychological problems in somatic terms (Akutsu & Chu, 2006). Asian Americans who suffer from depression may endorse symptoms of insomnia, various aches and pain, fatigue and subsequently seek the help of a medical professional rather than a mental health provider. Indeed, Asian Americans have been found to complain of symptoms that are of a physical nature (e.g., hypersomnia, chest pain, inability to breathe, loss of weight) and are less likely to endorse feelings of hopelessness, having a depressed mood, experiencing anhedonia, and other ‘emotional’ or cognitive symptoms of depression (Parker, Cheah, & Roy, 2001).

In addition to the emphasis Asian Americans place on self-control and their conceptualization of the body-mind integration, culturally bounded beliefs on self-construal and self-identity also affect help seeking among Asian Americans. Asian Americans are more likely to identify with an interdependent than independent outlook, in which the self is defined in terms of its relationship with others rather than individual beliefs, desires and hopes (Barry & Grilo, 2002). For example, Asian Americans may place emphasis on their abilities to function as a mother, father, friend, or sibling rather than the extent to which they are fulfilling personal goals in life that others may not share. Because Asian Americans are more focused on the ‘greater good’ than some other ethnic groups, psychological factors such as self-control and conformity to norms are important in producing a sense of belonging within the Asian American community (Kim, 2007). Hierarchical relationships (e.g., patriarchal family system), collectivistic orientation, and filial piety are valuable concepts among Asian Americans. These
cherished values, all meant to bring recognition and honor to the family, can run contrary to values that are more salient to European Americans, such as individualism, mastery of the environment, and autonomy (Sue & Sue, 2003). This difference in worldview, moreover, is also implicated in unjustified negative perceptions of Asian Americans by therapists from other ethnic backgrounds. It has been found that Asian Americans demonstrate complacent, avoidant, and hypervigilant coping styles, which therapists tend to interpret as dysfunctional coping styles (Yeh, Inman, Kim, & Okubo, 2006). From a collectivistic viewpoint, however, these coping styles may actually be culturally congruent and healthy as they limit escalation of serious interpersonal conflicts within the family. The cultural values and beliefs discussed here all have tremendous impact on Asian American help seeking, although there probably exist many more relevant factors that have yet to be successfully defined in the scientific literature.

Although Asian Americans have a high sense of responsibility toward their family, ironically a huge concern among Asian Americans seeking mental health treatment – fear of stigma – is centered on family. This fear of stigma can be described as a fear of being judged by others as being morally weak or lacking basic coping skills that a productive individual in the community ‘should’ have, and thus receiving perceived negative attention and treatment from others. Seventy-eight percent of Asian drug users in San Francisco said they had good relationships with their family, but about half hid their drug use from them (Lee, Law, & Eo, 2003). Consistent with this finding, other studies have found that Asian Americans tend to hide their problems instead of seeking help from family members out of fear of shaming the family or experiencing cultural stigma (Ja & Aoki, 1993). Japanese participants who experienced higher levels
of stigma from their family for their depression were less likely to continue treatment than those with friends and family more supportive of therapy, and perceived stigma about counseling partially mediated the relationship between Asian cultural values and intentions to seek counseling among Asian American college women (Miville & Constantine, 2007). This fear of being criticized, labeled, or gossiped about by family and Asian American community members makes initiating contact with mental health providers very discomforting for Asian Americans. It is believed that fear of stigma is associated with Asian Americans’ attempt to quit drug use on their own before seeking treatment (Lee, Law, & Eo, 2003). Higher adherence to Asian values has also been found to inversely predict willingness to see a counselor, even after controlling for related demographic variables (Kim & Omizo, 2003). As such, Asian Americans may not seek therapy until the problem has become so severe that they can no longer normally function or is significantly impairing their ability to uphold other cultural values (e.g., academic success).

Stigma tends to be reflected in not explicitly stated values but rather in behavioral preferences among Asian Americans. In other words, even though when queried Asian Americans may endorse help seeking for other people, they are not likely to engage in help seeking themselves. Kwok and Sullivan (2007) reported that while Asian Americans consistently rate preventative healthcare as useful, their own rates of preventative care utilization is low. The fear of stigma may induce Asian Americans to take a reactive versus a preventative outlook on help seeking. It is possible that Asian Americans, in order to minimize possibility of stigma, will not help seek until it is absolutely necessary. At the same time, research has shown that Asian Americans often
hold contradictory values. Among a convenience sample of 425 Asian American
respondents, it was found that most respondents surveyed have positive attitudes about
helpfulness of treatment programs for individuals with substance use problems. At the
same time, however, they also expressed the opinion that people with problems should be
able to abstain and quit on their own if they really wanted to (Lee, Law, & Eo, 2003).
Nguyen and Anderson (2005) reported similarly that Asian Americans may express a
positive view toward mental health services, but the same individuals stated that they
would not seek treatment (for themselves or a family member) unless the problem is
‘very serious.’ It has been hypothesized that perhaps the seemingly incongruous attitudes
may be indicative of Asian Americans’ emerging understanding on the utility of various
health services, but that such understanding has not yet led to a change in actual behavior
(Lee, Law, & Eo, 2003). It is clear that an individual’s internal attitude toward help
seeking may be very different from their verbally stated acceptance of such behaviors.
Therefore, interventions targeted to enhance help seeking should address such
discrepancies and be sensitive to them during assessment of a person’s help seeking
attitudes and behaviors.

Gender

Many studies on Asian Americans’ help seeking behavior have been conducted
on women (Miville & Constantine, 2007; Parker, Chan, & Tully., 2006). Despite the
general findings in these studies that Asian American women tend to not engage in help
seeking as much as do women from other ethnic groups, Asian American females tend to
hold more positive attitudes about therapy and counseling than do Asian American males
(Miville & Constantine, 2007). Asian American women are more likely to report
problems with depression than men (Akutsu & Chu, 2006), and more readily accept self-labeling and others’ labeling due to a mental disorder (Chiu, 2004). This points to a serious disconnect between self-report and behavior as Asian American females do not show high rates of mental help seeking. For males, it is possible that factors such as a patriarchal family system, the role of the Asian male as the provider, and other previously discussed cultural beliefs and values (e.g., self-constraint) create the ‘perfect storm’ in producing very low help seeking rates among males. Asian American males’ reticence in admitting they need emotional or mental help from a therapist may be better understood after considering the well-known Confucian maxim: “Real men shed blood, not tears.” The pride Asian American males take in self-restraint and maintaining control over (especially emotional) aspects of any situation may drastically lower help seeking rates among that population, although more empirical research is needed in this area. Help seeking interventions should assess carefully the possible differential impact of the intervention on Asian American males and females.

Perception of Mental Health and Services Available

In addition to these factors impacting help seeking rates, one that clearly affects the likelihood of Asian Americans seeking treatment is the image of mental health services within the Asian American community. Various studies designed to assess Asian Americans’ perceptions of mental healthcare have produced results that are of concern to the mental health community. A study conducted specifically on crisis hotlines found that Asian Americans who try crisis hotlines report the set-up to be unfriendly and not at all conducive to problem solving (Chiu, 2004). They state that the unreliability (not knowing the person answering the call) and inconsistency (not knowing
if the same counselor can be reached on follow-up calls) of the service is unattractive and make them question the effectiveness of the entire system. Asian Americans have also reported concerns over lack of cultural relevancy, sensitivity, and competency among therapists (Kim, 2007). The authenticity and effectiveness of mental health services appear to be especially important for Asian Americans, despite age and generational status.

As stated before, Asian Americans are also less likely to engage in services that employ a public, self-disclosing, and helpless approach to therapy. Lee, Law and Eo (2003) found that out of all forms of active therapy options available, only 5.9% of Asian Americans would consider support groups such as Alcoholics Anonymous as a viable option for people with substance use disorders. Only doing nothing (5%) and inpatient detox treatment programs (0.6%) ranked lower in the list of treatment options that respondents could choose from. All other options, including “attempt to quit on my own” and “talking to counselor/therapist,” were rated as significantly more viable sources of help.

Asian Americans’ willingness to help seek may also be impacted by the understanding they have of mental disorders. Asian Americans are more likely than other populations to perceive emotional distress as a lack of will power and personality weakness (Kung, 2004), and as such are more likely to endorse attempts to solve emotional problems on one’s own. Furthermore, for those who hold very traditional religious and cultural values, mental illness can be seen as a punishment for bad conduct (either in the present or a past life), an indication of bad parenting or ‘bad blood’ that runs in family (Wynaden et al., 2005). It is easy to see how these beliefs can interact with
family loyalty and fear of stigma to significantly lower help seeking tendencies in Asian American individuals. It is important then that any intervention for help seeking among Asian Americans be conducted in a place that is non-threatening, alleviates the fear of being labeled as ‘weak’ or ‘bad,’ and allows participants to feel that they are still a functioning member of their ethnic community.

Awareness

For some Asian Americans, however, the use of therapy may simply be an issue of awareness and access. Because Asian Americans are more likely to present problems in somatic terms (Akutsu & Chu, 2006), they are also more likely to present with problems to general practitioners than mental health professionals. They themselves may not be aware that mental help may be a valid venue by which their problems can be addressed. By the time such individuals access mental health care (or when the physician realizes that such care is necessary), the problem has progressed to an extent where successful professional intervention is less likely (Chiu, 2004). If they do not present mental disorders as somatic complaints, Asian Americans are also more likely to interpret mental disorders as spiritual issues and are more likely to utilize community resources such as priests, Buddhist monks, or traditional healers than therapists and counselors (Nguyen & Anderson, 2005). Korean Americans, an Asian sub-group that has adopted Christianity as one of its dominant religions, were found to seek help from family and church rather than mental health professionals following the September 11, 2001 attacks on the World Trade Center (Wynaden et al., 2005). Therefore, mental health programs for Asian Americans may best by conducted through partnership with community resources, such as traditional healers and religious institutions.
Religion and Spirituality

One important factor that may impact help seeking attitudes among all ethnic groups is the individual’s religiosity and spirituality. In the United States, Gallup polls report that 96% of Americans believe in a higher power, 90% pray, and 85% report that religion is very or fairly important to them (Gallup Organization, 2006). Religious and spiritual beliefs offer individuals a worldview by which they can understand experiences and cope with various difficulties (Ardelt, 2003; Tomer & Eliason, 2000). Studies have generally shown that religious affiliation and an individual’s sense of spirituality have an impact on mental well-being. Higher levels of religiosity, for instance, have been associated with increased life satisfaction, psychological functioning, physical health, and happiness, and fewer suicidal attempts for adolescents and decreased self-perceived stigmatization for some ethnic minority groups (Frank & Kendall, 2001). Religious involvement at intake for a drug abuse program predicted lower problem behavior during program, even after controlling for peer use and family support (Barret, Simpson, & Lehman, 1988). Spiritual resources are often seen as a viable alternative to individual therapy, especially for those who are struggling with addictive behaviors (Gonzalez et al., 2007), and higher self-report ratings on “spirituality or religious support” are a positive predictor of abstinence from heroin and cocaine (Galanter et al., 2007). In general, it has been reported that faith-based rehabilitation programs are more effective than secular programs, and that there is an inverse relationship between personal religiosity and self-reported delinquency (Chu, 2007). Some researchers, however, have found that these general findings may vary across drug types, and that distinct dimensions of religious
involvement yield differentially protective effects against drug use (Bartkowski & Xu, 2007).

To further complicate the issue, there is some disagreement among researchers as how to best measure religiosity and spirituality, and whether these two constructs are related or categorically different from each other. Religiosity and spirituality have been hard to define because religious experience is “inward, subjective, and highly individualized” (Chu, 2007). Older studies often treated religiosity as a one-dimensional construct, but questions have been raised regarding the distinction between individual psychological characteristics versus the social characteristics of religion (Bartkowski & Xu, 2007), and which one accounts for behavior change in individuals. Despite this awareness of religiosity and spirituality as multi-dimensional constructs, many scales do not capture the whole range of religious experience or more in depth religious experience, such as study of religious texts, time of praying, or faith and belief in a deity (Chu, 2007). In addition, many studies merge spirituality and religiosity in one measure (Carrico, Gifford, & Moos, 2007), while others use severely limited measures to define “religiosity,” such as frequency of church attendance and talking to clergy members. There exist some multidimensional religiosity and spirituality scales (De Jong, Faulkner, & Warland, 1976; Murray, Ciarrocchi, & Murray-Swank, 2007), although there is no one definitive measure that is widely used. Researchers have also raised concern over assessing religiosity and spirituality as separate ‘public and private’ constructs, proposing that they are interrelated rather than distinct from each other (Hill et al., 2000).

It has been hypothesized that religiosity and spirituality work through different mechanisms of action to evoke behavior or attitude change in individuals. Generally
speaking, religiosity can be thought as beliefs, practices and rituals related to a particular religion that an individual observes. This may also include affiliation to a community of people who share the same set of values and beliefs regarding the supernatural and faith-based beliefs. Barret, Simpson and Lehman (1988) proposed a social bonding theory of religiosity, in which commitment to conventional values of one’s family, religion and school act to prevent deviant responses (Barret, Simpson, & Lehman, 1988). Conformity-commitment and religiousness have been found to relate to decreased drug use and decreased chances of initiating smoking (Barret et al., 1988; Gonzalez et al., 2007). Along the lines of social learning theory, people who claim religious affiliation to an institution are less likely to associate with deviant peers (Barret, Simpson & Lehman, 1988). In one study, frequent attendance at religious services provided the most consistent and robust protection against all forms of drug use, compared to trust in a deity and civic engagement (Bartkowski & Xu, 2007). It is believed that claiming affiliation with a religious institution – or defining oneself in terms of a religious community – prevents people from engaging in behaviors that are deemed taboo by other members of the community.

While distinct theories focused on social learning and social capital have been cited to explain the impact of religiosity on attitudes and behaviors, the mechanism of action for spirituality on behavior is not as clear. Some propose that spirituality is the broader construct which includes religiosity, while others argue that spirituality is a separate construct, more related to an individual’s experience with a “higher power” (Cotton, Grossoehme, & Tsevat, 2007). For instance, a person’s spirituality may or may not incorporate the rules, rituals and behaviors of a religious group (LaPierre, 1994).
Others hypothesize that spirituality could be a personality trait, much like the Big Five (Murray, Ciarrocchi, & Murray-Swank, 2007). Literature that focuses on the inner, more experiential dimensions of religion and spirituality have found some positive results. For one, personal prayer is associated with lower levels of drug use (Chu, 2007). Religious faith also has a protective effect on depression and other stressful life events (Chu, 2007). Frank and Kendall (2001) posit that personal acts like prayer may be used as a coping mechanism (Frank & Kendall, 2001) for individuals to increase their tolerance for stressful and negative life events. Spirituality beliefs and values may also add meaning and purpose to specific recovery goals (Carrico, Gifford, & Moos, 2007). Compared to “public religiosity,” however, personal spirituality seems to have less impact on experimental use of cigarettes and alcohol, effective birth control, and no link with emotional distress in one study (Nonnemaker et al., 2003). Furthermore, spirituality generally relates positively with cognitive-based life satisfaction and positive affect, but shows no relationship with negative affect (Walsh, Ciarrocchi, Piedmont, & Haskins, 2007). It may be that spirituality provides a framework in which to view one’s current life events, but does not provide the social support that is necessary to facilitate some behavioral and attitudinal changes.

Despite the generally positive findings associated with religiosity/spirituality and mental health, some researchers have pointed to the potential negative impact of these factors on a person’s well-being. Negative experiences with religion may lead to negative outcomes in behavior as people feel blamed or judged by members in a religious community for their perceived shortcomings (Cotton, Grossoehme, & Tsevat, 2007). Furthermore, engagement in religious belief and practice does not protect against
substance use for homosexual youths, and it is proposed that religion may become a source of conflict rather than comfort for these youths in terms of developing their self-identity (Rostosky, Danner, & Riggle, 2007). The impact of religiosity and spirituality on various dimensions of an individual’s well-being is complex and merits further research.

Religion, Spirituality, and Help Seeking

Among specific ethnic groups, religion has been proposed to affect the likelihood of individuals seeking help from mental health professionals. Although leaders of religious organizations, such as ministers, report that issues such as depression are highly relevant to their congregations, they may not necessarily feel competent in treating such issues (Kramer, Blevins, Miller, et al., 2007). Furthermore, they report difficulty in navigating the mental health system and discovering resources available to them. There may also be a lack of trust among consumers, clergy, and mental health professionals. For example, perhaps individuals with a religious background feel that their spiritual views, which are important to them, may be disparaged or ignored by secular mental health professionals. A survey of adherents of mainstream religion, alternative religion, and no religion found that 70% of all participants believed that belief systems should be taken in account by health professionals (Smith & Simmonds, 2006). At the same time, however, individuals may view health professionals as people who work only within their specialty, and may not use the holistic approach that many prefer (Smith & Simmonds, 2006).

Some ethnic minority groups have been found to endorse help seeking within a religious context more than do Caucasian Americans. It has been found, for example,
that African Americans are more likely to endorse prayer and other spiritual rites as coping strategies than Caucasians (Bourjolly, 1998). It has been proposed that for individuals for whom religiosity and spirituality are integral parts of their identity, seeking traditional psychotherapy may not be as helpful as seeking help from a religious source who would be equipped to understand their problems holistically (Bell & Mattis, 2000). It is also important to note the distinction between help seeking attitudes versus actual behavior in individuals. For instance, although African American women were more likely to endorse using prayer as a way to cope with physical abuse than Caucasian women, actual rates of use of clergy or medical professionals did not vary between the two ethnic groups (El-Khoury et al., 2004). Therefore, help seeking attitudes and help seeking behavior may be two different constructs that need to be examined individually.

While having access to a religiously affiliated counselor may make it seem easier for individuals to find help, religious and spiritual beliefs may also hinder help seeking as well. For example, clergy who endorse, either explicitly or implicitly, views that depression is a result of sin or that battered women should maintain her wedding vows, may discourage people from seeking help (El-Khoury et al., 2004). Also, individuals with strong religious or spiritual convictions may be more likely to engage in ‘private’ help seeking behaviors, such as meditation and prayer. On the other hand, prior private help seeking behaviors that did not lead to a solution of their problems (e.g., unanswered prayer) can also make individuals more doubtful that any person or being would be able to help them (Levkoff, Levy, & Weitzman, 1999). Indeed, it has been found that among Filipino Americans, high religiosity was associated with comparable rates of help seeking from religious clergy or mental health professionals, but that high spirituality was
associated with lower rates of help seeking in general (Abe-Kim, Gong, & Takeuchi, 2004).

For Chinese Americans, spiritual beliefs often interact with cultural beliefs. Traditional beliefs on the importance of *chi* (or universal life energy) and how various foods can affect a person’s temperament, physical and emotional well being are prevalent among Chinese populations. The use of herbs, specific diets, and what Western medicine considers complementary treatments (e.g., acupuncture) are considered first-line treatments for various physical and emotional ailments for Chinese individuals, and Western medicine is often seen as a last resort or for ailments that are considered extremely serious or causing significant pain (Holroyd, 2002). Prayer (either to a deity or to an ancestor) is seen as a viable way to seek help for a specific problem. Moreover, given the emphasis on harmony and interdependence, an individual’s problem is considered a problem for the immediate family as well. This interplay between cultural beliefs and dependence on spiritual and ‘non-Western’ rites can affect Chinese Americans’ likelihood to seek professional help from outside sources.

Although it is clear that religiosity and spirituality can have an impact on mental health and help seeking attitudes and behaviors, it is not thoroughly clear how these two factors affect help seeking among Chinese Americans or other Asian American subgroups. Religiosity and spirituality remain important variables to consider when considering ways to encourage help seeking in Asian minority populations. By studying these two variables, clinicians can be better informed as they partner with community and religious leaders in creating mental health interventions for Asian Americans.

*Implications*
While a discussion on the potential negative impact of these numerous factors on help seeking may seem discouraging, these variables may also provide the key to making mental healthcare more accepted and available within the Asian American population. One suggestion is to structure interventions in an educational support group format, versus individual therapy (Miville & Constantine, 2007). It is believed that reframing therapy as an educational experience shared with other Asian Americans may decrease the likelihood of stigma. Along these lines, some have proposed that online help may be more readily received by Asian Americans, since it ensures a higher level of anonymity. Preliminary studies have produced mixed results; for instance, Chang and Chang (2004) found that international college students and Asian Americans did not prefer seeking help online more than traditional mental help. It is hypothesized that this unexpected finding may be due to the fact that online help successfully reduces stigma threat but also makes treatment seem less credible. Perhaps online help as complementary mental health resources may be more acceptable, but current data suggest that such a format is not credible as a source of professional help for Asian Americans (Chang & Chang, 2004). Psychoeducation or workshops, on the other hand, may be a good middle ground between online consultation and standard therapy.

Given the dramatic impact the family can have on Asian American individuals, therapy may need to focus more on interpersonal issues than on individually-oriented topics. Effective psychoeducation for Asian Americans should include considerable time investigating the role of the client’s family on his/her functioning and how to navigate between addressing the individual’s own need and the needs of others within the community. Furthermore, with Asian Americans in particular, it may be helpful to work
from a collaborative approach, where feelings of helplessness are minimized. Perhaps an intervention to increase help seeking for Asian Americans should then discuss mental health issues using interpersonal examples rather than focus on individual factors, in order to make the material more relevant to the population. Moreover, the intervention might also allow time for Asian American individuals to discuss topics with others in the community, creating a collaborative atmosphere in which people can provide mutual support.

Finally, it is worth noting that despite similarities, Asian Americans remain extraordinarily diverse in terms of specific worldviews within each sub-group. Perceptions of substance use problems, for example, vary within Chinese, Indian, Korean, and Vietnamese populations (Lee, Law, & Eo, 2003). The above-mentioned shared factors merely provide some general guiding principles for clinicians to consider when tailoring outreach programs or therapy to specific Asian American populations.

With all these considerations in mind, an effective program to increase help seeking in specific Asian American sub-groups probably should possess the following qualities: using an educational approach; focusing on collaboration; normalizing topics discussed, and minimizing stigma; providing opportunities for participants to see mental health issues as topics that can safely be discussed in their community; integrating the learning experience within a cultural and religious framework; and conducting it at a location that is considered safe and non-threatening. A study focused on testing the effectiveness of a psychoeducational outreach program for Asian Americans, while keeping the aforementioned factors in mind, could shed detailed information on variables that affect Asian American's help seeking tendencies as well as investigate the potential
of one specific approach in which clinicians in the community can effectively outreach to this minority group.

Current Study

In short, researchers have found that Asian Americans display relatively low rates of help seeking compared to White Americans. Furthermore, although they may explicitly endorse help seeking for others, they are less likely to consider seeking psychological help a viable option for themselves. Some studies have proposed that psychoeducational workshops within the community may enhance help seeking among Asian Americans. Indeed, psychoeducation has been found to decrease perceived stigma and family burden of various mental disorders, such as PTSD and schizophrenia (Chan, Yip, Tso, Cheng, & Tam, 2009; Gould, Greenberg, & Hetherington, 2007). Furthermore, providing these workshops in a setting that is comfortable and safe for Asian Americans (such as religious institutions) may enhance the participants’ experience by promoting free discussion of psychological issues and support from other members of the group. The knowledge of whether a psychoeducational workshop on mental health issues would be effective in increasing help seeking in an Asian American population (much less any Asian American sub-group) is scant.

This study seeks to investigate the impact on help seeking of a 12-week psychoeducational course among Chinese American attendees of a nondenominational Christian church in New Jersey. The course offers an overview of general topics within the realm of mental health (e.g., depression, anxiety, couples distress), discusses common interventions for such issues, and incorporates small group time in which members of the course answer questions posed by the course instructor in small group format.
Secondarily, the study also examines which factors correlate with help seeking at baseline. It is predicted that:

- Chinese Americans who participate in the course will demonstrate more favorable attitudes toward mental health help seeking by the end of the course, compared to the attitudes of other Chinese Americans not attending the course.

- Possible differential effects of the course on Chinese Americans based on their gender or baseline assessments of Asian values and religiosity and spirituality will be examined, but no predictions can be made at this point.

- Female Chinese Americans will have more favorable attitudes toward mental health help seeking than male Chinese Americans at baseline assessment.

- Adherence to Asian values will affect mental health help seeking as well. Individuals who adhere more strongly to Asian values are expected to be less likely to endorse help seeking at baseline assessment.

- Those who are higher on religiosity and spirituality will be less likely to endorse professional mental health help seeking but more likely to endorse pastoral mental health help seeking at baseline assessment.
METHOD

Participants

The data of 45 participants who took part in both the baseline and post-class assessments were used in this study. Seventeen of the 45 students attended the 12-week psychoeducational “Sunday School” course, while 28 participants attended other courses being taught during the same times as the psychoeducational course. The first survey was administered to the participants in the first week of March during the first meeting of all of the courses; the last survey was administered during the last week of classes in May. All participants identified themselves as Chinese American. All participants chose to attend English language “Sunday School” courses, instead of Chinese language courses, which were available at the same church. Twenty-four participants (53.3%) were male; 21 (46.7%) were female. The mean age range of the participants was 20.73, the youngest participant at 14 and the oldest at 43. Thirty-six participants (80%) reported they were born in the United States and had spent a majority of their life here. Around ninety-one percent of participants prefer speaking in English over Chinese.

Procedure

The psychoeducational course was titled “Christians, Counseling, and Emotions” and offered as a ‘Sunday School’ course in a large Chinese American church in Central New Jersey to members of its English-speaking congregation. The titles of the other courses were: “Prodigal God”, “The Book of Hebrews”, “God Is…”, “Old and New Testament Survey”, “Senior High Baptismal Class”, “Advanced Discipleship”, and “Children Ministry Serving And Training”. The courses began in March 2009 and continued until the end of May 2009 for a total of 12 weekly sessions, each running for
one hour. Data were collected during the first class and last class. Because the last classes occurred on Memorial Day weekend, fewer post-data could be collected than pre-data. The survey is a comprehensive questionnaire containing questions on help seeking patterns, attitudes toward help seeking, spirituality/religiosity, acculturation, and demographic variables such as age, gender, and generational status (see Appendix).

Participants were recruited through a church bulletin that circulated for one month prior to the start of the courses, which provides a description of all Sunday School classes being offered in the coming three months. Other participants were also recruited through word-of-mouth from members of the congregation who had taken the course when it was offered in the previous year in its pilot format. Prior to the advertisement of the psychoeducational course, the instructor had developed a long-term (3 years span) relationship with the church by volunteering in the church as a youth group leader and counseling intern, which included responsibilities in working with the youth, coordinating events for high school students, and presenting workshops and talks on mental health-related issues. Brief talks were also offered by the researcher to various small group/cell groups of the congregation in which the instructor informed the small group attendees about the course. The courses were offered during two different sessions each week, on Saturday evenings (6:30 pm – 7:30 pm) and Sunday late mornings (11:00 pm – 12:00 pm) to accommodate the needs of participants who attend different church services. The same material and activities were provided during each of the sessions.

Participants in the classes were administered the survey by trained university research assistants. In all cases, the survey was explained and participants had an opportunity to review the attached information form on the survey, which listed the study
procedure, potential risks and benefits, freedom to withdraw from participation, and anonymity of participants’ responses in the survey. Before the surveys were distributed, participants were given another opportunity to ask questions and voluntary participation was again emphasized. All students chose to participate in the surveys. As the surveys were distributed, students were informed that they were free to skip any questions they did not feel comfortable answering, free to terminate the survey at any time with no penalty, and to choose to not have their responses used. In order to preserve anonymity, participants were asked to put the last four digits of their telephone number on the survey instead of their names in order to link their pre- and post-surveys. Participants were thanked for their participation at the end of the survey. Furthermore, they were also given the opportunity to sign up for a lottery to win one of three $20 Barnes and Noble gift cards. The contact sheets for the lotteries were collected and stored separately from the surveys to preserve response anonymity, and participants were informed of this procedure as a way of ensuring their survey responses remain anonymous. Lottery winners were contacted via email.

Data Collection for Minors

Because Sunday School classes were open to high school students as well as adults, there was a possibility that data would be collected from minors. To address the issue of consent properly, letters to parents of teenagers who attend Sunday service at the church were distributed two weeks prior to the first data collection. Passive consent was acquired, in that parents who did not want their children to participate were instructed to return the letter indicating their choice and what course their child was taking to the
Sunday School administrator’s mailbox at the church. No parent withheld consent. The Rutgers University IRB approved of the procedures.

Psychoeducational Course

The psychoeducational course was a 12-week curriculum meeting once weekly for an hour each. The course was designed to offer a general overview of various psychological issues/disorders and current conceptualizations and popular treatments for the disorder. The second part of the didactic portion included a theological component in which Biblical verses relating to the current topic were offered and their relevance and applicability discussed in understanding these psychological issues. The last 15 minutes of the class consisted of a small group discussion period in which the class was divided into groups of 4-5. These small groups then discussed questions the researcher prepared beforehand. These questions were general questions, aimed to help the group discuss ways to reach out to family members or individuals who may be experiencing the psychological issues discussed during the didactic portion. Examples are: “If someone close to you started showing symptoms of depression we talked about in today’s class, what would you do?” and “How might we encourage our friends to look for professional help for anxiety when they need it?” Other questions were chosen so that the group members would reflect on their own opinions of the topic and were designed to provide opportunities for group members to support each other and provide feedback. Examples are: “What do you think is the best way to encourage positive body image in yourself and others?” and “What are some instances in your own life where you had a hard time communicating with someone?”
The instructor taught from a structured lesson plan and used written notes each week to teach the course. The weekly topics for the course were:

1. General overview of mental health
2. Depression
3. Anxiety
4. Body image and eating disorders
5. Suicide
6. Substance use
7. Couple distress
8. Adolescent and child-related issues
9. Secondary trauma
10. Trauma, grief and loss
11. Common counseling issues
12. Wrap-up and Q&A session

The course concluded with a wrap-up and Q&A session in which participants asked the teacher any remaining questions they had on the topics discussed during the course. The instructor also provided a general summary of all the topics discussed during the course.

A co-teacher was also present each week to help monitor the students’ progress and to facilitate discussion during small group time, if necessary. A fidelity measure was created in which the instructor and co-teacher rated the instructor’s fidelity to the written course material. Both the instructor and co-teacher provided individual ratings on the percentage of written class notes covered by the instructor for each class session by
answering the question, “What percentage of the curriculum was covered in this session?” Their ratings were positively correlated \((r = .59)\). The average adherence to the lesson plans was 98.02, ranging from 90 to 100.

The goals of the course were to provide participants with a safe space where they could discuss mental health issues (reduce stigma and normalize problems); to provide information in an educational format, which Asian Americans find to be appealing; to engage participants in discussion and encourage social support within a community that holds similar cultural values; and to provide an opportunity for participants to integrate newfound knowledge with their own ideas through discussion and the Q&A session.

Measures

**Sex.** Sex was assessed by a single item asking for participants’ birth sex \((0 = \text{male}, 1 = \text{female})\).

**Age.** Age was assessed by a single item asking for participants’ age in years.

**Immigration status.** Immigration status was assessed by a single item asking for participants’ immigration status \((0 = \text{Born and lived a majority of his/her life in the US}, 1 = \text{Born in a foreign country, and lived a majority of his/her life in the US}, 2 = \text{Born and lived majority of his/her life in a foreign country})\).

**Language.** Preferred language was assessed by a single item asking for the language participants feel most comfortable speaking \((0 = \text{Chinese}; 1 = \text{English})\). Although immigration and language may not be the most robust instruments for acculturation, it is expected that acculturation will not play a robust role in this study, since the participants are a self-selected group of individuals who choose to attend English-speaking church services and Sunday School courses instead of Chinese-
speaking alternatives the church provides. Because of low variability in this factor and in immigration status, they were dropped from the regression analyses and were used only descriptively.

_Spirituality (Private)._ Private spirituality and religiosity were assessed using an abbreviated, 12-item version of Paloutzian and Ellison’s (1982) Spiritual Well-Being Scale (SWBS). For the purposes of this study, items belonging to the “Existential Well-Being” subscale of the SWBS were omitted (e.g., “I feel that life is a positive experience.”), as our study focuses on spirituality and not overall well-being or happiness, specifically. The SWBS is a 20-item questionnaire asking how much participants agree with each statement (1 = strongly agree, 2 = moderately agree, 3 = agree, 4 = disagree, 5 = moderately disagree, 6 = strongly disagree). Items include “I believe that God loves me and cares about me” and “My relation with God contributes to my sense of well-being.” This scale has shown good internal consistency (α = .89). Items were reverse-scored where appropriate, and a mean score was calculated for each participant. This scale has good internal consistency in this study’s sample, with a Cronbach’s alpha of .90.

_Religiosity (Public)._ Public religiosity was measured using an abbreviated version of De Jong, Faulkner, and Warland’s (1976) Religiosity Scale. The original scale is comprised of items of various types, such as fill-in-the-blank items, matching questions, Likert-type statements, and forced choice factual questions. Items were designed to measure six dimensions of religiosity and spirituality: belief, experience, religious practice, individual moral consequences, religious knowledge, and social consequences. For the purposes of this study, five items from the religious practice sub-
scale were used to assess the more ‘public’ aspects of religiosity and spirituality, such as affiliation to a church or religious institution, contribution of funds to religious institutions, reading of the Bible, and affiliation with various religious organizations, groups, or activities. Each item was assigned Likert-scale values to answer choices, ranging from 0 to 6. Due to the high collinearity between the religiosity and spirituality scale \((r = .41, p < .01)\), low internal consistency \((\alpha = .20)\), and zero variance in two items (frequency of service attendance and church membership), however, religiosity was dropped from regression analyses.

**Adherence to Asian American values.** Adherence to Asian American values was measured by the Asian American Values Scale - Multidimensional (AAVS-M; Kim, Li, & Ng, 2005). This is a 42-item questionnaire divided into five factors: collectivism, conformity to norms, emotional self-control, family recognition through achievement, and humility. Items are scored on a 1-7 Likert scale (1 = strongly disagree, 2 = moderately disagree, 3 = mildly disagree, 4 = neither agree nor disagree, 5 = mildly agree, 6 = moderately agree, 7 = strongly agree). Examples of items are, “The welfare of the group should be put before that of the individual”, and “One’s emotional needs are less important than fulfilling one’s responsibilities.” Items were reverse-scored where appropriate, and an overall mean score for each participant was used for this study. The AAVS-M has demonstrated reliable consistency (.89) and had good internal consistency for our sample \((\alpha = .83)\).

**Help seeking attitudes.** Help seeking attitudes were assessed by the Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (ATSPPH-S; Fischer & Farina, 1995). The ATSPPH-S is a shortened 10-item version of Fischer and
Turner’s (1970) 29-item scale, which measures attitudes toward seeking psychological help. The ATSPPH-S includes items such as “I might want to have psychological counseling in the future.” Participants are prompted to indicate whether they agree, partly agree, partly disagree, or disagree with each item (3 = agree, 2 = partly agree, 1 = partly disagree, 0 = disagree). Items were reverse-scored where appropriate. A mean score was computed for each participant. The ATSPPH-S demonstrated sufficient internal consistency in this study (baseline $\alpha = .75$; post $\alpha = .77$).

*Likelihood to seek help for self.* Participants’ likelihood to seek help for themselves from others (e.g., pastor, professional clinician) was assessed by two items, embedded among 6 others, each prefaced with the following: “If you were extremely distressed and talking to friends and family has not helped, is it likely that…” For example, one item states, “you will talk to a counselor/psychologist/social worker?” These items were developed for this study. Participants were asked to rank their responses on a 1-4 Likert scale (3 = likely, 2 = somewhat likely, 1 = somewhat unlikely, 0 = unlikely).

*Recommendation of help seeking for others.* Participants’ likelihood to recommend help seeking to others in distress, either from a pastor or a professional mental health professional, was assessed by two items, embedded among 6 others, each prefaced with the following: “If a friend was extremely distressed and you feel as if his/her problems are beyond your and others friends/family members’ ability to solve, how comfortable would you feel…” followed by various scenarios, such as “...recommending him/her to talk to your local pastor?” These items were developed for this study. Participants were asked to rank their responses on a 1-4 Likert scale (3 =
comfortable, 2 = somewhat comfortable, 1 = somewhat uncomfortable, 0 = uncomfortable).

Class satisfaction. To provide more insight as to the students’ receptiveness to the Sunday School classes, three questions were asked in the post-test survey for all participants. Students were asked “How much did you like this Sunday School class?”, “How likely are you to recommend this class to a friend?”, and “How applicable is this class to your life?” Items were scored on a 1-5 Likert scale (1 = strongly unfavorable response to the course, 2 = unfavorable response, 3 = neutral response, 4 = favorable response, 5 = strongly favorable response). The course satisfaction scores for the psychoeducational course were not significantly different than the mean scores of other Sunday School courses (overall mean = 3.12). This scale had a Cronbach’s alpha of .84.
RESULTS

Participant Flow

A total of 95 participants completed the baseline survey. Of these participants, the data of 45 participants who completed the post-class survey, attended three Sunday School sessions or more, and indicated they were of Chinese American descent were used in statistical analyses (26 participants completed only one survey, 11 did not indicate they were Chinese American, and 13 participants attended two or fewer sessions). Among those who indicated they attended the psychoeducational class, the data of participants who reported attending 3 classes or more were included in the statistical analyses, resulting in a conservative intent-to-treat analysis. Seventeen participants were enrolled in the psychoeducational course, and 28 were enrolled in other Sunday School classes (see Figure 1). Attrition analyses were conducted on all variables using baseline data. There was no significant difference between those whose data were included in the regression analyses and those whose data were not. T-test and chi-square analyses found no significant difference between those who were enrolled in the psychoeducational class and those who were not in their baseline data across any descriptive or study variables.

Baseline Descriptive Statistics

Descriptive analyses were conducted on all measures (see Table 1). Twenty-two (52.3%) participants report attending 11 to 12 of their Sunday School classes, followed by 12 (27.3%) participants attending 9 to 10, 6 (13.6%) participants attending 7 to 8, 2 (4.5%) participants attending 5 to 6, and none (0%) attending 3 to 4 classes. All participants indicated they attend church services weekly and consider themselves members of a religious institution. The means and standard deviations for other variables
can be found in Table 2. Correlational analyses were conducted to measure the relationships between all variables and test for collinearity (Table 3). A significant correlation was found between our scales for spirituality and religiosity, \( r(44) = .41, p < .01 \), and for age and immigration status, \( r(44) = .62, p < .001 \). Religiosity and immigration status variables were subsequently dropped from regression analyses. Skewness of the remaining variables was acceptable.

**Sex and Help Seeking**

Independent samples t-tests were conducted on whether or not sex affects help seeking. Sex was not found to be significantly related to any of the six measures of help seeking at baseline: help seeking attitudes, \( t(43) = .37 \), likelihood to seek pastoral help for self, \( t(43) = .362 \), likelihood to seek professional help for self, \( t(41) = -.42 \), recommendation for others to seek pastoral help, \( t(43) = -.08 \), nor recommendation for others to seek professional help \( t(43) = 1.11 \).

**Age and Help Seeking**

Correlation analyses found a significant positive correlation between age and recommendation of professional help for others at baseline, \( r(44) = .40, p < .01 \), and recommendation of pastoral help for others at baseline, \( r(44) = .35, p < .05 \).

**Adherence to Asian Values and Help Seeking**

Correlation analyses found a significant positive correlation between adherence to Asian values and recommendation for others to seek pastoral help at baseline, \( r(44) = .42, p < .01 \).

**Spirituality and Help Seeking**
Correlation analyses found significant positive associations between spirituality and likelihood to seek pastoral help for self at baseline, $r(45) = .46, p < .01$, and recommendation for others to see pastoral help at baseline, $r(45) = .54, p < .001$.

**Regression Analyses**

A multiple regression analysis was conducted on each of the dependent help seeking variables (see Table 2 for means and standard deviations). To analyze the post-class data, all independent variables were entered in regressions simultaneously along with the respective baseline score of each dependent variable (help seeking attitudes, likelihood to seek professional or pastoral help for self, and recommendation of professional and pastoral help for others), for a total of five regression analyses. The independent variables entered in the regression analyses were age, sex, spirituality, adherence to Asian values, and psychoeducational course enrollment. To check for moderating variables, step 2 regression analyses were conducted on all regression analyses with a statistically significant $R^2$ in step 1. The step 2 regression analyses examined possible interactions as dictated by step 1 findings. Independent variables were mean-centered to avoid nonessential collinearity among the independent variables (Cohen, Cohen, West, & Aiken, 2003). Tolerance statistics did not indicate multicollinearity concerns. No influential outlier was identified.

A multiple regression analysis on attitudes toward help seeking was conducted, with the data of one individual who did not complete the AAVS excluded from the analysis. The regression analysis indicates that when all independent variables are considered together, they significantly predict attitude towards help seeking at the end of course, $R^2 = .43, F(6, 43) = 6.48, p = .000$, C.I. [1.37, 1.72] (see Table 3). The results
indicate that whether or not students took the psychoeducational course was a significant predictor of attitudes toward help seeking for the post-class survey, $\beta = .32$, $t = 2.61$, $p = .01$, C.I. [0.07, 0.54], with students in the psychoeducational course indicating significantly more favorable help seeking attitudes ($M = 1.91$) than those in other classes ($M = 1.59$), after controlling for other IVs. Baseline attitudes toward help seeking also significantly contributed to the prediction of post-class attitudes, $\beta = .52$, $t = 4.15$, $p = .000$, C.I. [0.28, 0.80],

Likelihood to seek pastoral help for self at post-class also was significant, $R^2 = .53$, $F(6, 43) = 8.91$, $p = .000$, C.I. [1.72, 2.40] (see Table 4). The data of the individual who did not complete the AAVS were also excluded from this analysis. The results indicate that age was a significant predictor of likelihood to seek pastoral help for self, $\beta = .27$, $t = 2.38$, $p = .02$, C.I. [0.01, 0.06], with older age significantly predicting increased likelihood to seek pastoral help for self ($R = .41$) in the context of all of the other independent variables. Baseline likelihood also significantly contributed to the prediction, $\beta = .50$, $t = 3.98$, $p = .000$, C.I. [0.26, 0.81]. Whether or not students took the psychoeducational course did not significantly contribute to this variable.

Likelihood to seek professional help for self at post-class also was significant, $R^2 = .42$, $F(6, 41) = 5.86$, $p = .000$, C.I. [1.14, 1.68] (see Table 5). The data of the participant who did not complete the AAVS scale and two participants who did not complete the baseline measure of the DV were not included in this analysis. The results indicate that in the context of all of the other independent variables, spirituality and gender were significant predictors of likelihood to seek professional help for self, $\beta = .37$, $t = 2.92$, $p = .006$, C.I. [0.11, 0.63], and $\beta = .32$, $t = 2.59$, $p = .014$, C.I. [0.09, 0.78],
respectively. Males were less likely to seek professional help for themselves (M = 1.38) than females (M = 1.95), and higher levels of spirituality predicted with increased likelihood to seek professional help for oneself (R = .43). Baseline likelihood also significantly contributed to the prediction, $\beta = .39$, $t = 3.14$, $p = .003$, C.I. [0.12, 0.57].

Post survey measures of recommendation of pastoral or professional help for others were not significantly predicted.

Interaction terms were created for whether or not students took psychoeducational course x baseline scores of each significant DV. In addition, because there were significant predictors in step 1 for likelihood to seek pastoral help for self, age x class enrollment was created; for likelihood to seek professional help for self, spirituality x class enrollment, and gender x class enrollment were used to test for potential moderators. These terms were incorporated into a second step of the respective regression analyses. Independent variables were mean-centered to avoid nonessential collinearity in the interaction terms (Cohen, Cohen, West, & Aiken, 2003). The $R^2$ change for Step 2 analysis with attitudes toward help seeking was not significant, $R^2$ change = .005, $F(1, 36) = .40$, $p = .53$. It was also not significant for likelihood to seek pastoral help for self, $R^2$ change = .018, $F(1, 35) = .82$, $p = .45$, nor likelihood to seek professional help for self, $R^2$ change = .022, $F(1, 32) = .50$, $p = .69$. In summary, no interaction was found for any of the dependent variables.

**Course Satisfaction**

The course satisfaction scores for the psychoeducational course were not significantly different than the mean scores of other Sunday School courses (M = 3.12). In qualitative survey feedback, participants of the psychoeducational course remarked
that they appreciated having a class where they could discuss mental health issues without fear of stigma, receive support from both instructors and peers, and learn how to respond to erroneous assumptions people often make about psychotherapy and counseling (i.e., “psychotherapy is only for crazy people”). Despite the novelty and uniqueness of the course, participants also remarked that they found the topics discussed to be relevant to their spirituality and enjoyed the discussions on faith and psychology.
DISCUSSION

In the post-class data, a treatment effect was found for attitudes towards help seeking. Enrollment in the psychoeducational course was a predictor of higher help seeking scores on the ATSPPH on the post-class survey after pre-class attitudes were controlled. To date, this is one of the first studies investigating the potential effects of a community-based psychoeducational course on help seeking for Chinese Americans. Researchers have speculated on the potential strengths of providing psychological interventions to Asian American populations in a community setting and within an educational framework, mainly to minimize fear of stigma (Miville & Constantine, 2007; Shen et al., 2006). This finding that a psychoeducational course can improve attitudes towards professional psychological help seeking is very promising.

The participants in the psychoeducation course provided a great deal of qualitative feedback to the instructor following the end of the course through a separate feedback form provided by the church. In it, many expressed that they felt the course was sorely needed to address an area often ignored or ‘hidden’ in the community, and some explicitly mentioned that they found having a non-stigmatizing setting in which they can ask questions and discuss issues with peers to be a source of immense help and relief for their personal struggles. In the class satisfaction variable, this psychoeducational course was equally rated and accepted as the comparison courses, which were routinely offered at the church. This highlights that such community-based outreach, even among groups with relatively low help seeking attitudes and behavior, can be effective and accepted within the community. Perhaps, as was true in this study, it is important that the coordinator of such outreach efforts establishes his/her presence in the
community and earns the trust of its members. The face-to-face contact the instructor had and the availability of the instructor to answer questions during class may have lent this course a sense of legitimacy and personal connection that may not have been present in other previous interventions that sought to enhance help seeking (e.g., internet-based resources) (Chang & Chang, 2004).

Although research has suggested that a structured, CBT-like, and psychoeducational approach may be best with some Asian American populations to decrease stigma (Miville & Constantine, 2007), it is possible that the addition of process-based, supportive groups could increase intervention effects as well in the Chinese American community. For example, after enrollment in the psychoeducational course, some students may be open to continuing in a supportive group therapy format with the instructor, since they may feel more comfortable about sharing their challenges with a smaller group of peers. Perhaps increasing the length and content of the psychoeducational course could also affect rates of actual help seeking.

A secondary goal of the study was further to understand Chinese American help seeking in general at baseline. We also learned what variables affected the Chinese American participants’ help seeking variables before the intervention began. We found spirituality was positively correlated with participants’ likelihood to seek pastoral, but not professional, help at baseline. Age significantly predicted a participant’s reported likelihood to recommend professional and pastoral help for others. This may not be surprising as youths may see their pastors and mental health professionals as authority figures rather than close confidants. In addition, youths may be more inclined to seek
help from more accessible sources (e.g., internet, Facebook, friends). Further research may help to clarify patterns of help seeking for teenagers.

Spirituality, meanwhile, was significantly related to a participant’s likelihood to seek pastoral help, and to recommend help from a pastor to others. There was no significant relationship found, however, for pre-class inclination to seek professional help for oneself.

Research among religious African American populations has found that religiosity is negatively correlated with help seeking, and that those who are more religious are less likely to help seek. This may be due to fear of stigma, in that religious African American individuals are afraid to disclose their problems out of fear that others will look negatively upon them and their ‘lack of faith’ and their racial group (El-Khoury et al., 2004). It is possible that our different finding may be a result of a variety of reasons. For one, in this study, we distinguished very specifically between pastoral and professional help seeking, and endorsement of help seeking in terms of self versus others. It may be that those who are spiritual in this Chinese American population prefer to disclose problems to pastors who they know, trust, and who respect confidentiality. It may also be that very spiritual Chinese Americans feel that “secular” mental health professionals may not understand the context of their issues or approach their problems in a holistic manner, and may even fear being labeled or judged negatively for their spirituality. Our finding that spirituality is significantly associated with pastoral help seeking is somewhat similar to Abe-Kim et al. (2004)’s finding for Filipino Americans, in which high religiosity was associated with comparable rates of help seeking from religious clergy, although there were some specific inconsistencies. This highlights the
importance of treating Asian populations as discrete groups instead of a corporate minority population in help seeking research. Differences in familial structures, perceptions toward Western medicine, and other cultural variables can result in significant differences in help seeking among specific Asian American sub-groups. Moreover, the present study also focused on a more internal, experiential measure of spirituality versus other measures of spirituality and religiosity, which may use external measures of behavior, or a combination of both in the development of a ‘spirituality/religiosity’ measure. Further research is needed to tease out how belonging to a religious group is correlated with specific help seeking variables, and whether there are ways in which mental health professionals can work collaboratively with community leaders so that centers of worship can become a place where individuals can confidently and without fear access resources to psychological help.

We found that higher adherence to Asian values is correlated with increased recommendation for others to seek pastoral help, but not with any of the other help seeking measures. Like our findings on spirituality, perhaps those who adhere strongly to Asian values believe that it is better to seek help from someone with a similar background. It is also possible that adherence to Asian values is related fear of stigma and more specifically, a desire to keep mental disorders “within group.” Knowledge on Asian Americans’ views and conceptualizations of mental illnesses may be helpful in clarifying the relationship between adherence of Asian values and help seeking.

Our different findings on likelihood to seek help for self versus recommending help seeking for others underline the importance of defining specific help seeking measures in research, as it is possible that individuals’ perception of what is acceptable
help seeking for themselves is not the same as what they perceive for others. This also suggests that there may be different mechanisms for perceptions of acceptability of help seeking behaviors and perceived stigma in regard to self versus others.

Contrary to other studies on Asian Americans, we did not find significant correlations between sex and help seeking. Because of the low variance in this study in immigration and language status, we could not meaningfully incorporate them into the regression analyses. It would be interesting to see whether or not differences in immigration and language status mediate the effect of sex on help seeking. As this study was conducted with Chinese American church-goers who chose to attend English-speaking services when Chinese-speaking ones were available, the effects of a similar psychoeducational course may be quite different if implemented with a population that is less acculturated and may provide more knowledge on potential moderators for the relationship between sex and help seeking.

The construction and use of a reliable and validated measure of perceived stigma for Chinese American populations, when used in conjunction with a measure such as AAVS, may help to discover whether psychoeducational classes of this nature can significantly lower the fear of stigma that can prevent many individuals from seeking treatment. Research of this type may also provide more knowledge on the different mechanisms that affect help seeking attitudes and behavior. Kim and Omizo’s (2003) findings that help seeking attitudes can be a mediator between Asian values and willingness to see a counselor, for instance, suggest that different measures of help seeking can interact in complex ways. Clearly, more research needs to be done on how to change behavior following attitude change. Furthermore, future research conducted on
believers of other faiths (e.g., Buddhism) may qualify the current findings on the impact of psychoeducation on attitudes about help seeking. Collaboration between the different forms of psychological interventions and studying additional factors and their potential effects merit additional research.

Limitations

There are some limitations to this study worth noting. First, four of dependent variables (endorsement of pastoral and professional help seeking for self or others) are based on original items created by the author. Without rigorous testing of their psychometric properties, we do not know if the items used in the scales are completely appropriate for what we are trying to measure. Although the items have face validity, it would be extremely useful to focus on the development of sophisticated and validated scales to measure people’s acceptance of help seeking for themselves, versus the acceptability of encouraging other people to seek help for their own problems. The wording of the self vs. other scales used in this assessment was also not completely parallel. Secondly, we were unable to randomly assign participants to Sunday School courses because of the community-based nature of the study. Random assignment would have been ideal in ensuring that any observed differences between students in the intervention course and students in other courses in this study are truly a result of the psychosocial intervention. We also experienced significant attrition, mostly from students who completed the baseline survey but were not present for the post-class survey. A more structured method for follow-up with students and adding incentives for students to be present to complete the post-class survey may decrease attrition rates, as well as conducting the survey during a different semester. The post-class survey was
conducted the last week of May, which coincided with a holiday weekend and thus caused many students to be absent from their courses because of vacations. Also, tailoring separate psychoeducation courses depending on age groups or level of adherence to Asian values may affect the impact of psychoeducation on help seeking in this population.

Lastly, the effects of the psychoeducational course on help seeking may have been affected by previous psychoeducational workshops and seminars conducted in the past in the church. Although this was the first psychoeducational course offered in this institution over an extended period of time, it is possible that participants who attended mental health seminars in the past may have affected this study’s ability to discover significant findings or may have impacted the degree of significant difference we found in the attitude measure. Future research in how this course may be received by a community group that has never been exposed to any form of mental health outreach may help address this issue. Alternatively, all participants could have been asked how much previous exposure they have had to the psychoeducational course content so that this exposure could have been controlled for statistically.

Conclusions

This is one of the first studies examining the potential effects of a community-based psychoeducation course, sex, age, spirituality, and adherence to Asian values on help seeking as defined by attitudes, likelihood of engaging in help seeking, and recommendation of help seeking for others among Chinese Americans in a local church community. The psychoeducation course significantly affected positively help seeking attitudes. It was also found that age related to recommending professional and pastoral
help for others, with those who were older more likely to recommend that others seek help. Meanwhile, spirituality was associated with pastoral help seeking for self and others. Those who were more spiritual were more likely to seek pastoral help and recommend that others do the same. Asian values also correlated positively with the tendency to recommend pastoral help for others.

With a larger sample of Chinese Americans, the psychoeducational intervention in this study can be reinvestigated to determine more specifically its impact on help seeking. Overall, this exploratory study suggests that community-based psychoeducational courses in mental health can have a positive impact on some measures of help seeking. Tailoring the course to suit specific populations and to target specific measures of help seeking may lead to more effective interventions to increase help seeking.
REFERENCES


Appendix: Baseline Survey

Sunday School Survey

#___________________

Please put a check next to the appropriate response.

I am:

Male  Female

How old are you? ____________ years old

Please circle the answer that best describes you.

How often do you attend Sabbath/Sunday worship services?
1. Every week
2. About twice a month
3. About once a month
4. A few times a year
5. Never

Do you presently belong to a church or religious institution?
1. Yes
2. No

Do you contribute funds to the church?
1. Never
2. Sometimes
3. Regularly

How would you describe your use of the Bible?
1. I read the Bible regularly for devotional purposes.
2. I read the Bible, somewhat irregularly, primarily for devotional purposes.
3. I read the Bible occasionally for its ethical and moral teachings.
4. I read the Bible occasionally for literary or historical purposes.
5. I read the Bible for diverse purposes.
6. I seldom, if ever, read the Bible.
7. I never read the Bible.
In how many religious affiliated organizations, groups, or activities EXCLUDING Sunday School (such as choir, youth groups, committees, and boards, etc.) do you participate?

- None
- One
- Two
- Three
- Four
- Five or more
For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree  D = Disagree
MA = Moderately Agree  MD = Moderately Disagree
A = Agree  SD = Strongly Disagree

<table>
<thead>
<tr>
<th>Statement</th>
<th>SA</th>
<th>MA</th>
<th>A</th>
<th>D</th>
<th>MD</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I don’t find much satisfaction in private prayer with God.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>2. I don’t know who I am, where I came from, or where I’m going.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>3. I believe that God loves me and cares about me.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>4. I believe that God is impersonal and not interested in my daily situations.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>5. I have a personally meaningful relationship with God.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>6. I don’t get much personal strength and support from my God.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>7. I believe that God is concerned about my problems.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>8. I don’t have a personally satisfying relationship with God.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>9. My relationship with God helps me not to feel lonely.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>10. I feel most fulfilled when I’m in close communion with God.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>11. My relation with God contributes to my sense of well-being.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
<tr>
<td>12. I believe there is some real purpose for my life.</td>
<td>SA</td>
<td>MA</td>
<td>A</td>
<td>D</td>
<td>MD</td>
<td>SD</td>
</tr>
</tbody>
</table>
Below are some questions. Please indicate if you agree, partly agree, partly disagree, or disagree with each statement by putting a checkmark in the appropriate box.

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Partly agree</th>
<th>Partly disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td></td>
<td></td>
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<tr>
<td>2. The idea of talking about problems with a psychologist or counselor strikes me as a poor way to get rid of emotional conflicts.</td>
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<td></td>
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<tr>
<td>3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in counseling or psychotherapy.</td>
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<td></td>
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</tr>
<tr>
<td>4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.</td>
<td></td>
<td></td>
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<tr>
<td>5. I would want to get psychological help or counseling if I were worried or upset for a long period of time.</td>
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<td></td>
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<tr>
<td>6. I might want to have counseling in the future.</td>
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<td></td>
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<tr>
<td>7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.</td>
<td></td>
<td></td>
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<tr>
<td>8. Considering the time and expense involved in counseling or psychotherapy, it would have doubtful value for a person like me.</td>
<td></td>
<td></td>
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<tr>
<td>9. A person should work out his or her own problems; getting psychological counseling would be a last resort.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>10. Personal and emotional troubles, like many things, tend to work out by themselves.</td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If you were extremely distressed and talking to friends and family has not helped, is it likely that...

<table>
<thead>
<tr>
<th></th>
<th>Likely</th>
<th>Somewhat likely</th>
<th>Somewhat unlikely</th>
<th>Very unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will talk to a pastor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>You will talk to a counselor/psychologist/social worker?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will talk to a close friend?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will talk to a family member?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will try to wait for the problem to resolve itself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will try to spend more time solving the problem through prayer and devotions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will try to work it out on your own?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will try to find advice anonymously (calling a helpline, sending a question to a website, etc.)?</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
If a friend was extremely distressed and you feel as if his/her problems are beyond your and others friends'/family members’ ability to solve, how comfortable would you feel…

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Comfortable</th>
<th>Somewhat comfortable</th>
<th>Somewhat uncomfortable</th>
<th>Uncomfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommending him/her to talk to your local pastor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommending him/her to consider psychotherapy or professional counseling?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommending him/her to talk to other close friends?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommending him/her to talk to a family member?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommending him/her to wait for the problem to resolve itself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggesting that he/she spend more time in prayer and devotions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggesting that he/she can try to resolve the problem with his/her own ability?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggesting for him/her to get advice anonymously (calling a helpline, asking a question to a website, etc.)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INSTRUCTIONS: Use the scale below to indicate the extent to which you agree with the value expressed in each statement.

1 = Strongly Disagree  
2 = Moderately Disagree  
3 = Mildly Disagree  
4 = Neither Agree or Disagree  
5 = Mildly Agree  
6 = Moderately Agree  
7 = Strongly Agree

_____1. One should recognize and adhere to the social expectations, norms and practices.
_____2. The welfare of the group should be put before that of the individual.
_____3. It is better to show emotions than to suffer quietly.
_____4. One should go as far as one can academically and professionally on behalf of one’s family.
_____5. One should be able to boast about one's achievement.
_____6. One’s personal needs should be second to the needs of the group.
_____7. One should not express strong emotions.
_____8. One’s academic and occupational reputation reflects the family’s reputation.
_____9. One should be able to draw attention to one's accomplishments.
_____10. The needs of the community should supercede those of the individual.
_____11. One should adhere to the values, beliefs and behaviors that one’s society considers normal and acceptable.
_____12. Succeeding occupationally is an important way of making one’s family proud.
_____13. Academic achievement should be highly valued among family members.
_____14. The group should be less important than the individual.
_____15. One’s emotional needs are less important than fulfilling one’s responsibilities.
_____16. Receiving awards for excellence need not reflect well on one's family.
_____17. One should achieve academically since it reflects on one’s family.
_____18. One’s educational success is a sign of personal and familial character.
_____19. One should not sing one's own praises.
_____20. One should not act based on emotions.
21. One should work hard so that one won’t be a disappointment to one’s family.

22. Making achievements is an important way to show one’s appreciation for one’s family.

23. One’s efforts should be directed toward maintaining the well-being of the group first and the individual second.

24. It is better to hold one’s emotions inside than to burden others by expressing them.

25. One need not blend in with society.

26. Being boastful should not be a sign of one's weakness and insecurity.

27. Conforming to norms provides order in the community.

28. Conforming to norms provides one with identity.

29. It is more important to behave appropriately than to act on what one is feeling.

30. One should not openly talk about one’s accomplishments.

31. Failing academically brings shame to one’s family.

32. One should be expressive with one's feelings.

33. Children's achievements need not bring honor to their parents.

34. One need not sacrifice oneself for the benefit of the group.

35. Openly expressing one's emotions is a sign of strength.

36. One’s achievement and status reflect on the whole family.

37. One need not always consider the needs of the group first.

38. It is one’s duty to bring praise through achievement to one’s family.

39. One should not do something that is outside of the norm.

40. Getting into a good school reflects well on one’s family.

41. One should be able to brag about one’s achievements.

42. Conforming to norms is the safest path to travel.
Please circle one answer for each item.

I identify myself as:  
- Chinese American  
- Asian American but not Chinese  
- Other (please indicate, optional): ___________________

I was:  
- Born and lived a majority of my life in the US.  
- Born in a foreign country, but lived a majority of my life in the US.  
- Born and lived majority of my life in a foreign country.

The language I feel most comfortable speaking is:

- Chinese  
- English
For the questions below, please circle the number that applies.

How much did you like this Sunday School class?
1 I hated it 2 3 It’s ok 4 5 I loved it

How likely are you to recommend this class to a friend?
1 Not at all likely 2 Neutral 3 4 5 Very likely

How applicable is this class to your life?
1 Not applicable 2 3 Somewhat applicable 4 5 Very applicable

About how times did you come to class this quarter?
0 None 1 2 3 4 5 6 7 8 9 10 11 to 12

At any point during this Sunday School quarter, did you ever attend the course Christians, Counseling & Emotions? (circle one)
Yes  No

Do you have any comments or feedback about your Sunday School class? Let us know your thoughts in the space below (optional):

THANK YOU FOR YOUR PARTICIPATION!
### Table 1

**Sample Characteristics (N=45)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class enrollment</td>
<td></td>
</tr>
<tr>
<td>Psychoeducational course</td>
<td>37.8</td>
</tr>
<tr>
<td>Other</td>
<td>62.2</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>53.3</td>
</tr>
<tr>
<td>Female</td>
<td>46.7</td>
</tr>
<tr>
<td>Immigration</td>
<td></td>
</tr>
<tr>
<td>Born/spent majority of life in the US</td>
<td>80.0</td>
</tr>
<tr>
<td>Born in foreign country but spent majority of life in US</td>
<td>15.9</td>
</tr>
<tr>
<td>Born/spent majority of life in foreign country</td>
<td>2.3</td>
</tr>
<tr>
<td>Preferred language</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>9.1</td>
</tr>
<tr>
<td>English</td>
<td>90.9</td>
</tr>
<tr>
<td>Class attendance</td>
<td></td>
</tr>
<tr>
<td>3 to 4 classes</td>
<td>0.0</td>
</tr>
<tr>
<td>5 to 6 classes</td>
<td>4.6</td>
</tr>
<tr>
<td>7 to 8 classes</td>
<td>14.0</td>
</tr>
<tr>
<td>9 to 10 classes</td>
<td>27.9</td>
</tr>
<tr>
<td>11 to 12 classes</td>
<td>53.5</td>
</tr>
<tr>
<td>Church Attendance</td>
<td></td>
</tr>
<tr>
<td>Every week</td>
<td>100.0</td>
</tr>
<tr>
<td>Church membership</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>100.0</td>
</tr>
<tr>
<td>No</td>
<td>0.0</td>
</tr>
<tr>
<td>Tithing</td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>15.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>84.4</td>
</tr>
<tr>
<td>Regularly</td>
<td>0.0</td>
</tr>
<tr>
<td>Use of Bible</td>
<td></td>
</tr>
<tr>
<td>Regularly for devotional purposes</td>
<td>46.7</td>
</tr>
<tr>
<td>Purpose</td>
<td>Percentage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Irregularly for devotional purposes</td>
<td>28.9</td>
</tr>
<tr>
<td>Occasionally for moral teachings</td>
<td>4.4</td>
</tr>
<tr>
<td>Occasionally for literary/historical uses</td>
<td>0.0</td>
</tr>
<tr>
<td>Read for diverse purposes</td>
<td>17.8</td>
</tr>
<tr>
<td>Seldom read</td>
<td>2.2</td>
</tr>
<tr>
<td>Never read</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Table 2

*Means (M) and Standard Deviations (SD) for Independent and Dependent Variables (N = 45)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Overall M</th>
<th>Overall SD</th>
<th>Psychoed M</th>
<th>Psychoed SD</th>
<th>Other courses M</th>
<th>Other courses SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>20.51</td>
<td>8.01</td>
<td>23.00</td>
<td>10.30</td>
<td>19.00</td>
<td>5.96</td>
</tr>
<tr>
<td>Spirituality</td>
<td>4.41</td>
<td>0.68</td>
<td>4.27</td>
<td>0.81</td>
<td>4.49</td>
<td>0.58</td>
</tr>
<tr>
<td>AAVS</td>
<td>2.84</td>
<td>0.64</td>
<td>2.72</td>
<td>0.58</td>
<td>2.97</td>
<td>0.57</td>
</tr>
<tr>
<td>ATSPPH baseline</td>
<td>1.44</td>
<td>0.45</td>
<td>1.50</td>
<td>0.36</td>
<td>1.41</td>
<td>0.49</td>
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<tr>
<td>Professional help for self baseline</td>
<td>1.42</td>
<td>0.76</td>
<td>1.50</td>
<td>0.73</td>
<td>1.37</td>
<td>0.79</td>
</tr>
<tr>
<td>Pastoral help for self baseline</td>
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<td>0.93</td>
<td>2.00</td>
<td>1.06</td>
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<td>Professional help for others baseline</td>
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<td>0.64</td>
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<td>0.74</td>
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<tr>
<td>Pastoral help for others baseline</td>
<td>2.18</td>
<td>0.94</td>
<td>2.29</td>
<td>1.05</td>
<td>2.11</td>
<td>0.88</td>
</tr>
<tr>
<td>ATSPPH post</td>
<td>1.71</td>
<td>0.46</td>
<td>1.91</td>
<td>0.34</td>
<td>1.59</td>
<td>0.49</td>
</tr>
<tr>
<td>Professional help for self post</td>
<td>1.64</td>
<td>0.68</td>
<td>1.76</td>
<td>0.66</td>
<td>1.57</td>
<td>0.69</td>
</tr>
<tr>
<td>Pastoral help for self post</td>
<td>2.04</td>
<td>0.98</td>
<td>1.94</td>
<td>1.09</td>
<td>2.11</td>
<td>0.92</td>
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<tr>
<td>Professional help for others post</td>
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<td>0.90</td>
<td>2.12</td>
<td>0.99</td>
<td>1.57</td>
<td>0.79</td>
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<tr>
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<td>2.18</td>
<td>0.94</td>
<td>2.29</td>
<td>1.05</td>
<td>2.11</td>
<td>0.88</td>
</tr>
<tr>
<td>Class satisfaction</td>
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<td>3.12</td>
<td>0.66</td>
<td>3.12</td>
<td>0.79</td>
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</table>
Table 3

*Intercorrelations for the Independent and Dependent Variables (N = 45)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Sex</td>
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</tr>
<tr>
<td>B. Age</td>
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<td></td>
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<tr>
<td>C. Spirituality</td>
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<td></td>
<td>.11</td>
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<td>D. AAVS</td>
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<td>.21</td>
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<td>.49**</td>
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<td>-.11</td>
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<tr>
<td>G. Class attendance</td>
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<td>.10</td>
<td>-.02</td>
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<td>H. ATSPPH baseline</td>
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<td>.22</td>
<td>.24</td>
<td>-.17</td>
<td>-.00</td>
<td>-.13</td>
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<tr>
<td>I. Professional help for self</td>
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<td>.09</td>
<td>.07</td>
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<td>for self baseline</td>
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<tr>
<td>J. Pastoral help for self</td>
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<td>.46</td>
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<td>-.20</td>
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</tbody>
</table>

* p < .05.  ** p < .01  *** p < .001.
Table 3

*Intercorrelations for the Independent and Dependent Variables Continued (N = 45)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>O</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>K. Professional help for others baseline</td>
<td>-.17</td>
<td>.40**</td>
<td>.24</td>
<td>-.06</td>
<td>.01</td>
<td>.12</td>
<td>.43**</td>
<td>.29</td>
<td>.20</td>
<td></td>
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<tr>
<td>L. Pastoral help for others baseline</td>
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<td>.35*</td>
<td>.54***</td>
<td>.42**</td>
<td>.12</td>
<td>.01</td>
<td>.28</td>
<td>.27</td>
<td>.52***</td>
<td>.54***</td>
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<td>M. ATSPPH post-test</td>
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<td>.30*</td>
<td>.27</td>
<td>.01</td>
<td>.06</td>
<td>.02</td>
<td>.60***</td>
<td>.32*</td>
<td>.33*</td>
<td>.44**</td>
<td>.33*</td>
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<tr>
<td>N. Professional help for self post</td>
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<td>.19</td>
<td>.40**</td>
<td>-.04</td>
<td>.05</td>
<td>.26</td>
<td>.36*</td>
<td>.44**</td>
<td>.35*</td>
<td>.26</td>
<td>.44**</td>
<td>.57***</td>
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<td>O. Pastoral help for self post</td>
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<td>.40**</td>
<td>.51***</td>
<td>.32*</td>
<td>.07</td>
<td>.05</td>
<td>.31*</td>
<td>.35*</td>
<td>.69***</td>
<td>.20</td>
<td>.38**</td>
<td>.18</td>
<td>.40**</td>
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<td></td>
</tr>
<tr>
<td>P. Professional help for others post</td>
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<td>.40**</td>
<td>.27</td>
<td>.15</td>
<td>.17</td>
<td>.14</td>
<td>.15</td>
<td>.19</td>
<td>.50***</td>
<td>.59***</td>
<td>.52***</td>
<td>.50***</td>
<td>.30*</td>
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</tr>
<tr>
<td>Q. Pastoral help for others post</td>
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<td>.40**</td>
<td>.48**</td>
<td>.42**</td>
<td>.20</td>
<td>.16</td>
<td>.16</td>
<td>.20</td>
<td>.55***</td>
<td>.40**</td>
<td>.56***</td>
<td>.15</td>
<td>.21</td>
<td>.69***</td>
<td>.48**</td>
<td></td>
</tr>
</tbody>
</table>

* p < .05.  ** p < .01  *** p < .001.
### Results of Regression Analysis on Attitudes Toward Seeking Professional Help (N = 44)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class enrollment</td>
<td>0.30</td>
<td>0.12</td>
<td>0.32</td>
<td>2.61</td>
<td>0.01</td>
<td>.07 , .54</td>
</tr>
<tr>
<td>Sex</td>
<td>0.13</td>
<td>0.11</td>
<td>0.14</td>
<td>1.14</td>
<td>0.26</td>
<td>-0.10 , .35</td>
</tr>
<tr>
<td>Age</td>
<td>0.01</td>
<td>0.01</td>
<td>0.08</td>
<td>0.63</td>
<td>0.53</td>
<td>-0.01 , .02</td>
</tr>
<tr>
<td>Spirituality</td>
<td>0.10</td>
<td>0.09</td>
<td>0.14</td>
<td>1.14</td>
<td>0.26</td>
<td>-0.08 , .27</td>
</tr>
<tr>
<td>Adherence to Asian values</td>
<td>0.11</td>
<td>0.10</td>
<td>0.14</td>
<td>1.12</td>
<td>0.27</td>
<td>-0.09 , .32</td>
</tr>
<tr>
<td>Attitude toward help seeking baseline</td>
<td>0.54</td>
<td>0.13</td>
<td>0.52</td>
<td>4.15</td>
<td>0.00</td>
<td>.28 , .80</td>
</tr>
</tbody>
</table>

R² = .43, F(6, 43) = 6.48, p = .000, 95% C.I. [1.37, 1.72]
Table 5

Results of Regression Analysis on Likelihood To Seek Pastoral Help For Self (N = 44)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class enrollment</td>
<td>-0.28</td>
<td>0.23</td>
<td>-0.14</td>
<td>-1.21</td>
<td>0.24</td>
<td>-.74 , .19</td>
</tr>
<tr>
<td>Sex</td>
<td>0.18</td>
<td>0.21</td>
<td>0.09</td>
<td>0.85</td>
<td>0.40</td>
<td>-.25 , .61</td>
</tr>
<tr>
<td>Age</td>
<td>0.03</td>
<td>0.01</td>
<td>0.27</td>
<td>2.38</td>
<td>0.02</td>
<td>.01 , .06</td>
</tr>
<tr>
<td>Spirituality</td>
<td>0.28</td>
<td>0.18</td>
<td>0.20</td>
<td>1.61</td>
<td>0.12</td>
<td>-.08 , .64</td>
</tr>
<tr>
<td>Adherence to Asian values</td>
<td>0.13</td>
<td>0.19</td>
<td>0.08</td>
<td>0.68</td>
<td>0.50</td>
<td>-.26 , .53</td>
</tr>
<tr>
<td>Pastoral help for self baseline</td>
<td>0.54</td>
<td>0.13</td>
<td>0.50</td>
<td>3.98</td>
<td>0.00</td>
<td>.26 , .81</td>
</tr>
</tbody>
</table>

$R^2 = .53$, $F(6, 43) = 8.91$, $p = .000$, 95% C.I. [1.72 , 2.40]
Table 6

Results of Regression Analysis on Likelihood To Seek Professional Help For Self

\((N = 42)\)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>(\beta)</th>
<th>t</th>
<th>p</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class enrollment</td>
<td>0.13</td>
<td>0.18</td>
<td>0.09</td>
<td>0.72</td>
<td>0.48</td>
<td>-0.24 , .50</td>
</tr>
<tr>
<td>Sex</td>
<td>0.44</td>
<td>0.17</td>
<td>0.32</td>
<td>2.58</td>
<td>0.01</td>
<td>0.09 , .78</td>
</tr>
<tr>
<td>Age</td>
<td>0.01</td>
<td>0.01</td>
<td>0.11</td>
<td>0.85</td>
<td>0.40</td>
<td>0.01 , .03</td>
</tr>
<tr>
<td>Spirituality</td>
<td>0.37</td>
<td>0.13</td>
<td>0.37</td>
<td>2.92</td>
<td>0.01</td>
<td>0.11 , .63</td>
</tr>
<tr>
<td>Adherence to Asian values</td>
<td>-0.12</td>
<td>0.15</td>
<td>-0.10</td>
<td>-0.80</td>
<td>0.43</td>
<td>-0.43 , .19</td>
</tr>
<tr>
<td>Professional help for self</td>
<td>0.35</td>
<td>0.11</td>
<td>0.39</td>
<td>3.14</td>
<td>0.00</td>
<td>.12 , .57</td>
</tr>
</tbody>
</table>

\(R^2 = .42, F(6, 41) = 5.86, p = .000, 95\% \text{ C.I.} [1.14 , 1.68]\)
Figure 1. Study Flow Chart

- Participants completing baseline surveys: \( N = 95 \)

- Total number excluded: 50
  - Did not complete both surveys: \( n = 26 \)
  - Not Chinese American: \( n = 11 \)
  - Attended two Sunday School sessions or less: \( n = 13 \)

- Participants included in analyses: \( N = 45 \)

  - Psychoeducational class: \( n = 17 \)
  - Other Sunday School classes: \( n = 28 \)
Curriculum Vitae

Wei Yin Yan

9/00 – 2/04  Barnard College, Psychology, B.A.
9/05 – 10/07  Rutgers, The State University of New Jersey, Psychology, M.S.
10/07 – 10/11  Rutgers, The State University of New Jersey, Psychology, Ph.D.

2/04 – 9/10  Research Assistant: Columbia University Medical Center, New York State Psychiatric Institute, Princeton Center for Leadership Training
9/05 – 5/06  Graduate Assistant: Rutgers, The State University of New Jersey
9/06 – 5/10  Teaching Assistant: Rutgers, The State University of New Jersey
9/06 – 5/10  Graduate Clinician/Graduate Extern: The Psychological Clinic at Rutgers University, Children’s Specialized Hospital, Rutgers Counseling and Psychological Services, University of Medicine and Dentistry of New Jersey
8/10 – 8/11  Predoctoral Intern, U.S. Department of Veterans Affairs, VA Connecticut Healthcare System