An Examination of a Church-Based Recovery Program on the Quality of Physical and Spiritual Life of Mentally Ill Persons in Korea

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http://hdl.handle.net/2144/1347
Boston University
BOSTON UNIVERSITY

SCHOOL OF THEOLOGY

Dissertation

AN EXAMINATION OF A CHURCH-BASED RECOVERY PROGRAM ON
THE QUALITY OF PHYSICAL AND SPIRITUAL LIFE OF
MENTALLY ILL PERSONS IN KOREA

By

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Submitted in partial fulfillment of the
requirements for the degree of
Doctor of Ministry

2010
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AN EXAMINATION OF A CHURCH-BASED RECOVERY PROGRAM ON THE QUALITY OF PHYSICAL AND SPIRITUAL LIFE OF MENTALLY ILL PERSONS IN KOREA

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ABSTRACT

This study explores the effectiveness of a Church-based recovery program for the mentally ill in Korea where many Christian communities view mental illness as evidence of sin. Building on theological and psychological literature, an empirical study was conducted with participants in the alternative program of the Han-ma-um community. Data analysis revealed that this program, which views mental disorders as illness rather than sin, helps participants build self-respect and enables families to provide support as they move toward recovery. Based on this empirical examination, recommendations for refinement and expansion of the program and avenues for future research are proposed.
CHAPTER ONE

THE PROBLEM AND ITS SETTING

Statement of the Problem

The purpose of this project was to evaluate an alternative understanding and treatment response to the popular Christian views about mental illness in Korea. Many protestant denominations in the Korean Church view mental illness as the price of sin, and this has been the source of suffering and pain for many years.¹ This project explored a different view of mental illness and described an alternative response within the theological context of the majority of Korean protestant churches.

Background of the Problem

On October 2nd 2008, sensational news about a top Korean actress, Choi Jinsil, covered the front pages of every magazine; she had committed suicide in her own home. What surprised Korean society about the police report on her suicide was that she had been diagnosed with depression and had been suffering from insomnia for a long period of time. Also, she had been attending church every Sunday and had sought out counseling from the senior pastor of her church for her emotional issues. The senior pastor made an appearance on a TV interview in regards to this issue, which I found deeply painful to watch because of the way in which he responded to the reporters. He told them, “She was in pain; she suffered. But all I could do was to listen to her stories and pray for her. And for awhile she didn’t come to church, then she did such a thing.” Later it was found that she had not

¹ Yoon Tae Kim, “Relationship between the Psychiatric View and Christian View on Mental Illness” (master’s thesis, Goshin Graduate School of Theology, 1989), 51.
attended church for the six weeks leading up to her suicide. From my perspective, rather than appearing heartbroken or distressed, the tone of the pastor’s voice and his facial expression suggested that he felt he had done all that he was responsible for and was even relieved by the fact that she was not attending church at the time of her death. He seemed as though he was trying to let people know the limit of his moral responsibility.

Many other television programs also covered her suicide as a hot topic, including stories on why she was not able to get the right treatment for her depression. According to these reports, had the fact that she was being treated for her depression been made known to the public, it would have been unlikely for her to be cast in any dramas or movies. So, even if the symptoms worsened, it was better to keep it quiet than to have tabloids covering her regular visits to the hospital for mental issues.

In addition to the suicide of Choi Jinsil, there have been four other suicides of Korean celebrities due to depression over the past four years. Every time such news is covered, the sermons aired on Christian cable and preached on the following Sundays are almost identical in their content: “Suicide prevents one from being saved. Even if life is difficult, one should never give up one’s own life in order to be rewarded for it later in heaven.”

Many Korean pastors teach that medical treatments, in particular prescribed medications for depression, schizophrenia, personality disorders, or affective disorders, are for those who lack faith in God.\(^2\) Also, many churches in Korea criticize those who try to build recovery programs within the church counseling center for “liberalizing the church”

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\(^2\) Yong Gi Cho, *Sam-Bak-Ja Gu-Won* (Seoul: Young Shin Sa, 1979), 244.
and for “destroying the holiness of the church” with secular knowledge. They believe mental disorders are an area in which God must intervene to provide resolution. Because of these medically uninformed and distorted interpretations of mental disorders that are held by the Korean Church, today many mental patients in churches are being overlooked and avoided. In addition to their own illnesses, they also suffer because their family members are ashamed of their mental disorders. One must ask if such an attitude by the Korean Church indeed follows the intention of Jesus, who came to save the sinners and not the righteous. The following is the Korean Church’s view of mental patients:

First, Christian life needs only the Bible and prayer. Psychiatric therapy is not for born-again believers. If one becomes mentally ill and requires treatment, then one cannot be called a true believer.

Second, all mental disorders are due to demon possession, and therefore don’t require medication but rather prayer and the words of God. For this reason, the only person in church who can meet and teach is the senior pastor.

Third, mental disorders are a disease found among those who are cut off from God. Thus, they don’t have the spirituality to worship Him. God does not answer the prayers of mental patients, because they are not capable of praying wholeheartedly due to

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4 Kim, “Relationship between the Psychiatric View and Christian View on Mental Illness”, 53.


6 Kwang Il Kim, *A Research of Mental Disorders through Experienced Phenomena of Recovery in Christianity* (Seoul: Dae Hwa Publishers, 1982), 236.

their unstable state of mind.  

Fourth, if mental patients are present, the worship is not holy. Therefore, they must be restrained from attending church.  

Fifth, the family of a mental patient must look for the sins they have committed going back up to three generations, and pray with faith until they receive God’s forgiveness. For this reason, the recovery programs within the church are unnecessary because God is already punishing them for their sin.  

Lastly, if one counsels mental patients and has physical contact with them, that counselor could experience difficulties in personal and spiritual life because of the dark spirit of the mental patient’s influence.  

Due to these perceptions, many mental patients in the Korean Church avoid mentioning their illnesses in public. They refuse counseling, suffer from guilt over taking medication, and often stop taking medication, leading to even more suffering due to symptoms they now can’t treat. Therefore, many stay home and away from their family and society, except for the few (such as the ones with neurosis or personality disorders)

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8 Cho, Sam-Bak-Ja Gu-Won, 244-255.


10 Bong Tae Back, “Study for the Improved Perspective on Mental Illness in Pastoral Counseling” (master’s thesis, Graduate School of Theology Chong Shin University, 1986), 52.


12 Cho, Sam-Bak-Ja Gu-Won, 244-255.

13 Kun Min Kim, “Disease and Mental Health from a Christian Point of View” (PhD diss., California Central University, 2003), 10-15.
who keep their illnesses secret when they are with the public.  

However, there is a strong need for the Korean Church to gain a new perspective on mental illness. From the scientific perspective, the reason for mental illness is the same whether the patient is a believer or not. Common reasons may be genetic, vulnerability to illness, family and/or social environment, stress, biological factors, bacteria, physical and chemical factors, and viruses. The cause of mental illness is not simply demon possession, but rather a more complicated set of reasons. The church needs to acknowledge these scientific realities and admit the need for chemical, physical and psychological rehabilitation for mental patients. Their desperate situation brings them closer to God in their faith and provides an opportunity for them to mature as believers. If the church does not provide such an opportunity for growth in faith and experience of recovery when a member is ill—whether it’s physical or mental—the Korean Church needs to realize how big of a ministry opportunity it is losing. When the sick are welcomed and the church understands and sympathizes with them through prayer, patients in the Korean Church will experience faster recovery in the church koinonia.

**Significance of the Study**

The main purpose of this study was to provide an alternative understanding of mental illness to the Korean Church. For that reason, it was appropriate to first introduce

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14 Lee, “Reflection on the Korean Ministers’ Perception and Healing of Mental Illness: Special Study on Schizophrenia”, 3.

15 Kim, “Disease and Mental Health from a Christian Point of View”, 22.

16 Ibid.

the only church-based institution in Korea that provides recovery programs solely
dedicated to patients with mental illness, called the Han-ma-um Community. The ministry
of the Han-ma-um Community bases its work on an alternative biblical perspective. Since
the Han-ma-um Community is a real-life model for church ministry for the mentally ill that
is currently being operated, it is a tangible example of footsteps that other Korean churches
can follow in their ministry.

Second, the study also evaluated the effectiveness of the recovery programs
provided by the Han-ma-um Community in the quality of patients’ physical and spiritual
life. A thorough evaluation of the work of the Han-ma-um Community offers a different
perspective on the treatment of mental health within a theological context, which later can
help leaders in the Korean Church to correct misconceptions and prejudices against the
mentally ill. Furthermore, this study provides preliminary resources in order for churches
to plan a ministry that focuses on the recovery and spiritual growth of mental patients.

The following summarizes potential contributions of this study to the Korean
Church:

1) The effect of the Han-ma-um Community’s recovery programs on mental
patients’ physical, psychological, and spiritual aspect of life was analyzed.
2) The study is intended to help ministers in the Korean Church to realize how
they are misunderstanding and misinformed about mental patients in church.
3) The analysis of the Ha-ma-un Community offers a positive evaluation of an
alternative approach to mental illness.

Sources of the Study
The main sources of the study were psychological and scientific literature and the Han-ma-um Community. Literature was used to address how mental illness is viewed by pastors and pastoral counselors in the Korean Church. The Han-ma-um Community was the second main source of this study, which provided an alternative approach towards mental illness within the church through its system. The Han-ma-um Community also provided quantitative data from survey results obtained from its members, which helped in assessing the effectiveness of its program on the quality life of the mentally ill.

This thesis project has seven parts. The introduction provides the significance of the problem that motivated this project.

The Korean Church’s attitude toward Christian Counseling plays a crucial role in recovery of mental patients in church. For this reason, Chapter two was devoted to understanding the theological view that the majority of Korean churches hold toward Christian Counseling and issues raised from it, as well as recommendations that can be offered as a response. The current view that the Korean Church holds has created popularity for a specific school of psychology which was addressed in order to identify the source of the shortfall in understanding mental illness. This chapter closes by introducing the Han-ma-um Community with descriptions of the Han-ma-um Community’s recovery programs (art therapy, drama, table tennis, bible studies, prayer meetings, counseling, worship, and family therapy) in reference to the Han-ma-um Manual.18

Chapter three discusses the method of evaluation of the approach towards mental illness of the Han-ma-um Community as an alternative view of and response to mental illness, surveys among Community participants, and definitions of terms and limitations.

Chapter four reports the statistics from the survey and gives an overview of the survey results.

Chapter five is dedicated to analyzing data obtained by the survey, and to presenting the statistical findings. As for the comparative studies, the following literature was used: Hyun-Bong Ha, Chul-Soo Park, and Jin-Wook Sohn’s “Religious Beliefs, Practices, and Experiences of Psychiatric Patients,”¹⁹ Young Min Choi, Jung Ho Lee, and Gi Chul Lee’s “Influences of Christianity of Psychiatrists and Patients on Clinical Practice”²⁰ and Shin Duck Shin’s “Healing Experiences of Women with Mental Disorders”²¹.

Conclusions were drawn based on history and the survey in the final chapter.

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²¹ Duck Shin Shin, “Healing Experiences of Women with Mental Disorders” (PhD diss., Graduate School of Han yang University, 2004).
CHAPTER TWO
REVIEW OF RELATED LITERATURE

Overview of Mental Illness within the Korean Church

Korean pastors, although they are not trained clinical psychologists or psychiatrists, frequently encounter people with mental or psychological disabilities and even those who have mental illness. This is because many pastors are the first person that their parishioners consult when they have problems. Even those who do not consider themselves to be “spiritual caregivers” have an obligation to pay careful attention to people’s inner peace and eternal salvation. In general, believers are also very likely to follow the decisions of their pastor regarding their mental and psychological problems, no matter how little formal training and education their pastor has on such matters. Therefore, it is very important for pastors to possess general knowledge of mental health.¹

There are different approaches to this issue. Some pastors believe that pastors should not be involved in any treatment because treatment is the responsibility of professional doctors. There are also pastors who reject the Korean churches’ practice of exorcism because these methods are unscientific and unproved. The practice of exorcism involves a group of believers and pastors who combine different methods such as singing hymns, laying hands on a patient’s head while praying and slapping the patient’s body to cast out demons. However, the problem raised here is the wide-spread practice of exorcism and the denial of mental health care. Because this practice is so wide-spread, lay believers who suffer from mental illness and disabilities often turn to the practice of exorcism before

they look for professional help. In fact, it has been found that many patients in mental hospitals were previously treated with the practice of exorcism before they came to the hospital. It is widely known that there are many mentally ill patients in facilities that are based on religious treatment.²

As a result, there are many problems and criticism from psychiatrists on the practice of exorcism in Korean churches. Some pastors, although ignorant in physiological and mental causes of such illnesses, attribute the root of illness to demons and are devoted to practicing exorcism exclusively. However, no illness has the same root cause because the etiology of illness is interwoven with several factors. Especially when involving mental illness, exclusive practice of exorcism can worsen the problem. Knowledgeable and holistic understanding of mental illness plays a critically important role in providing proper treatments and prescriptions.³

In the Bible, demon-possessed people are cured several times by Jesus and his disciples. Based on these examples, when pastors encounter people with similar occurrences, they treat them as if all are demon-possessed and try to practice exorcism. Due to lack of general knowledge on mental illness, many Korean pastors limit the possibility of causation to demons even when the illness can be clearly identified as one of medical or mental conditions. This is problematic because it creates much confusion to the patients and family as well.⁴

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² Kwang Il Kim, *A Research of Mental Disorders through Experienced Phenomena of Recovery in Christianity* (Seoul: Dae Hwa Publishers, 1982), 236.


Hyung-gyoon Shin, Jin-ook Son, and Sung-il Woo said that the reasons for exclusive practice of exorcism are: lack of basic knowledge about mental health, inaccurate interpretation of the biblical accounts, conventional training from the older generations, effort to forcibly identify mysterious phenomena with demon possessions, using demons as a means to direct responsibility, and desire to prove spiritual authority as a pastor. Problems created as results of those reasons are: failure to solve mental and physiological illness, loss of opportunity to receive professional care, stigma following being labeled as a “demon-possessed person” and discrimination in the community. The pastor and the community together have the responsibility to take care of and love the mental patient and his or her family. In order to do this, pastors have to take more interest in mental health and widen the professional knowledge about the issue. At the same time, prevention of unscientific judgments and biased viewpoints on illness need to take place to stop patients from suffering physical and mental pain. Therefore, conditions of patients need to be thoroughly examined and cared for in an attentive and sensible environment. Provision of proper care can increase the chance of prognosis and decrease the likelihood of debility.

This chapter examines Korean pastors’ perceptions of mental illness and treatment as well as their theological and psychological understanding of mental illness and how Shamanism in Korea has influenced it. In addition, alternative theology, the present state of treatment within Korean churches, and an appropriate stance that a church may take for

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6 Lee, “Reflection on the Korean Ministers’ Perception and Healing of Mental Illness: Special Study on Schizophrenia”, 3-4.
patients are discussed in this chapter. Lastly, Han-ma-um Community, the study site, is introduced at the end.

**Shamanism vs. Religious Life in Korea**

Since 1885, the year that Christianity was first introduced in Korea, Korean churches have gone through several growth periods. Although there has been rapid growth of the church since the early 1970s, one of the problems caused by preexisting religions in Korea is syncretism. Among these religions, shamanism has been one of the most influential and widely practiced forms of religion for thousands of years; it has been a significant part of the culture.  

Shamanism in Korea has been a religion of the people since the period of Tangun, who is the founding father of the first Korean nation, and through the Period of Three States. In the subsequent nation, Koryo, whose state religion was Buddhism, Shamanism still prevailed and syncretized Buddhism. Even in the following nation, Chosun, whose state religion was Confucianism, Shamanism ended up being the folk religion for the people because it was rooted so deeply in the culture.

From a historical perspective, one can tell that the basic understanding of religion that is rooted in Korean people’s minds comes from the understanding of Shamanism. In 1973, there was a study reporting that many people, except highly educated groups, have

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7 Gi Gon Kim, *The Influence of Shamanism on Minds of Korean People: Book of dissertation of Samyook University* (Seoul: Samyook University, 1982), 125.

8 Dong Sik Yoo, *The History and Structure of Shamanism in Korea* (Seoul, Youn Sae University Publishers, 1975), 24-25.

9 Yoo, *History and Structure of Shamanism in Korea*, 82-87.

10 Yoo, *History and Structure of Shamanism in Korea*, 120.

lifestyles that are based on the beliefs of Shamanism\textsuperscript{12} and others showed that Shamanism has influenced even Christian philosophy in church.\textsuperscript{13} The following sections examine the effects of Shamanism on Korean Christians’ minds, lifestyles and church. This contributes to a deeper understanding of the attitudes that the Korean church displays towards people with mental illness in church.

Notion of God

In Shamanistic belief, among many idols, there is the highest being called Hanulnim. Hanulnim is a spiritual being that rules the world of heaven. This highest being is also called Chunjoo, which means the owner of everything, implying that Chunjoo is the highest, unique god. This notion of god actually allowed people to more easily accept the notion of one God in Christianity. A person with Shamanistic belief can easily accept the notion of God, but the concern comes when the person sees God in a different way than Christianity describes. The person can possibly see God as one of many other gods in Shamanism.

Regarding this issue, Dr. You Dong Sik points out that Koreans easily believe in the God of Christianity, but that their understanding of God is eventually limited to Shamanistic understandings of god.\textsuperscript{14} One of the reasons for the fast and wide spread of Christianity is the similarity that Christianity and Shamanism share. In Christianity, Jesus has the role of mediating between God and humans, a role similar to the idea of shamans

\textsuperscript{12} Tae Gon Kim, The Influence of Korean Shamanism on Life of Modern Korean People: Meaning of Shamanism in Modern Society. (Ilee: Institution of Folklore in Won Gang University, 1973), 73.

\textsuperscript{13} Kim, The Influence of Korean Shamanism on Life of Modern Korean People: Meaning of Shamanism in Modern Society, 15-16.

\textsuperscript{14} Dong Sik Yoo, Analysis of the Korean Culture (Seoul: Samsung Published, 1975), 37.
who communicate with god. The shaman has three roles that involve leading worship, healing the sick, and making predictions about the future.\textsuperscript{15}

Nonetheless, Jesus Christ, who appeared similar to shamans, was perceived with inaccurate understanding. A shaman can call on god in heaven and has the right to decide who would or would not receive fortune and blessing. Thus, people would pray to Jesus so that he would use the divine power of God to bless those who pray and stop any unfortunate disasters.\textsuperscript{16} This idea was extended to pastors in church as well. As if a pastor is able to do what shamans can do, people ask pastors to pray to God for them rather than praying for themselves. People sometimes ask them to visit in order to have a service in their houses.\textsuperscript{17}

This notion of god has had an impact on Korean’s prayer life. Before Christianity was introduced in Korea, many Korean women would wake up early in the morning to pray their hopes with purified water placed in front of them. They would sincerely repeat the words that request blessings because they believed that repetition would impress god and bring favor on them.\textsuperscript{18} They saw this ritual as a way to solve the problems in their lives and looked on it as an important part of their religious beliefs.

\textbf{Syncretism of Worship}

The symbolic ritual of Shamanism is Goot, and people believe that through Goot,

\textsuperscript{15} Bung Hoon Bae, “Christian Educational Alternatives to the Shamanistic Elements in the Korean Church’s Faith” (master’s thesis, Graduate School of Asia Unity Theology, 1999), 9.

\textsuperscript{16} Yoo, \textit{Analysis of the Korean Culture}, 430.

\textsuperscript{17} Bae, “Christian Educational Alternatives to the Shamanistic Elements in the Korean Church’s Faith”, 11.

\textsuperscript{18} Hoon Gu Lee. \textit{Traditional Religions in Korea and Korean Church} (Seoul: Gloria, 1991), 107.
a shaman can drive out evil spirits and bring fortunes, peace and health to people’s lives. The afterlife is not the focus of Goot and people are only interested in their life in this world. This sorcerous form of ritual is now so deeply rooted in some Christian minds that some Christians use similar types of rituals and believe that such form of worship will bring solutions to their problems. For instance, many Korean Christians pray out loud, which looks similar to how people participate in Goot. Goot involves loud noises of instruments and repetitive spells that are believed to cast out evil spirits and bring fortune. Similarly, some Korean Christians pray out loud, believing that God is more likely to listen to loud prayers. Also, some Christians invite pastors to their houses to pray or lead worship for their personal issues, which is similar to how people invite a shaman to perform Goot for their problems. There are other biases and beliefs that are influenced by Shamanism in Christianity as well. People make connections between sin and illness, and the connection makes them believe that illness is the result of their sin. Thus they make confessions to the pastor and ask the pastor to pray for them instead. Also, some believe that church services are a type of ritual which is led by a pastor’s divine power, so the presence of the Holy Spirit is dependent on the pastor’s power. This belief puts less emphasis on the hearts of worshipers because the pastor does everything for the rest. People can merely sit and watch the service without the attitude of active worship. One of the problems with this belief is that people avoid participating in services with mental patients because they believe their evil spirit disturbs the service, making their worship unholy.

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20 Bae, “Christian Educational Alternatives to the Shamanistic Elements in the Korean Church’s Faith”, 28.
Notion of Dependence

In Shamanism, people believe that every life is controlled by divine and godly power, so their lives and destiny depend on Chunjoo. This attitude is reflected in people’s dependence on a shaman, who is viewed as a mediator between people and spiritual beings. They pay a certain amount to a shaman to perform Goot and then passively wait on the fortune that it will bring to them.\(^{21}\) A similar attitude can be found in some Korean churches in which believers pay offerings and rely on the authority of pastors that can pray for them and bring answers to their problems. People believe that faith should be total obedience and dependence on pastors, who are seen as spiritually superior because they themselves are spiritually immature and weak.\(^{22}\) They are afraid of disobeying and criticizing pastors because pastors are spiritual mediators who can listen to the voice of God.

For example, treating mental patients with medication is often viewed as a faithless act within the church, so pastors sometimes forbid patients to be treated with medication. Not surprisingly, there are incidents where patients’ illnesses worsen because they followed the instructions of their pastor.\(^{23}\) Also, as an alternative to hospitalization, family members send patients to prayer centers where the patients participate in fasting and praying. When this does not help the patient, pastors put higher demands on the level of care for the patient. The family members and patient sacrifice their time and wealth and

\(^{21}\) Bae, “Christian Educational Alternatives to the Shamanistic Elements in the Korean Church’s Faith”, 109-110.

\(^{22}\) Boo Young Lee, Shamanism and Musok: Origin of idea in Korea (Seoul: Yang Young Gak, 1973), 92-93.

eventually blame themselves for the results because they believe they have not given enough care to the patient.\textsuperscript{24} This dependent attitude is a result of Shamanistic dependence on mediators and has very negative effects on patients.\textsuperscript{25} The truth is that the notion of dependence is not found in Christian faith and it can turn Christianity into a religion that creates anxiety and fear in its believers.

\textbf{Notion of Blessing}

Blessing in Shamanism is exclusively about earthly wealth in this world as opposed to the afterlife. They do not have any notion of blessing as related to the spirit or mind. This notion has permeated into Christian faith as well, resulting in people putting heavier emphasis on blessings of material, physical, and social wealth.\textsuperscript{26}

The notion of blessing has created two sides of family life with a mental patient. The struggles of mental patients are viewed as a means of punishment that God brings on believers. Mental patients are kept within the family and remain unknown to the public because of the stigma of their abandonment by God.\textsuperscript{27} Family members keep the presence of patients in the family as a secret so the patient is often locked in the house and fails to receive proper treatment. When the patient receives professional treatment, the record remains in the system and becomes an obstacle when other family members try to find jobs or get married. Therefore, too many lives of patients and their family members are double-sided within the church and society, because they have to try to hide and cover the fact that

\begin{itemize}
\item \textsuperscript{24} Ibid.
\item \textsuperscript{25} Hoon Gu Lee, \textit{Traditional Religions in Korea and Korean Church} (Seoul: Gloria, 1991), 111.
\item \textsuperscript{26} Seoung Jae Kang, \textit{Criticism of Good Fortune} (Seoul : Pulbit Mok Hae, 1990), 82.
\item \textsuperscript{27} Jang Sik Lee, \textit{Korean Churches’ Yesterday and Today} (Seoul: Dehan Gidokgooseohae, 1977), 109.
\end{itemize}
there is such an issue in their family. This often causes them to leave the church community and it is the main reason for under-utilized counseling and recovery programs in churches, although a great number of people need such care. This reveals that there is a close connection between the faith of Korean Christians and the Shamanistic notion of blessing.

Demon and the Practice of Exorcism

In the Protestant churches of some Korean denominations, there are people who exclusively practice exorcism, distorting the essence of the Gospel. Such pastors who support demonism argue that all types of suffering that people experience are the result of demons. They define demons as the afterlife existence of unbelievers. Such distorted beliefs influence the faith of many Christians. They claim that mental illness occurs when the demon, the spirit of dead ancestors, goes into someone’s body. Therefore, mental illness is equivalent to demon possession and in order to cast out the demon, the patient must be isolated from family members and the pastor must encounter the patient. Some pastors hit patients as one of the means of casting out the demon. This notion of demons likely comes from the traditional Shamanistic practice in which a ghost often appears with the identity and names of people’s dead ancestors.

This false belief might cause believers to see people with mental illness as a

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28 Bae, “Christian Educational Alternatives to the Shamanistic Elements in the Korean Church’s Faith”, 24-25.

29 Such as Sung-rak Baptist Church and Berea mission - There are typical Churches in Korea.

30 Gi Dong Kim, Discussion about Demon (Seoul: Be Rae A Publishing, 1984), 179.

phenomenon of demon passion within Korean churches. As a result, Christians turn immediately to pastors when they first encounter the symptoms of mental illness. If the pastor does not have accurate knowledge about mental illness, the pastor sees the illness as demon possession, which leads to delayed treatments and the worsening of conditions and prognosis of the patient.

Many cases have been examined where Christianity in Korea is influenced by Shamanistic beliefs. This shows how many Christians from different denominations (Presbyterian, Methodist, Baptist, Alliance, and non-denominational) with different theological backgrounds (Calvinism, Wesleyan, Pentecostal, and Baptism) display similar attitudes and mindsets about their faith. Hopefully this section has described how the attitudes towards mentally ill patients are illogical and irrational.

This section has described how shamanistic believes continue to influence the attitudes towards the mentally ill in Korea, and prevent them from receiving medical care for their illness. These attitudes account for the lack of church-based program to support the mentally ill and make an examination of the one existing such program even more crucial.

Korean Pastors’ Perceptions of Causes (Etiology) of Mental Illness

In order to treat and prevent mental illnesses, there should be general knowledge about mental illness with correct understanding of mental illness to begin with. Because correct understanding plays a critical role in treatment and prevention of mental illness in general, the community leaders’ attitudes towards mental illness have a great influence on providing necessary services for patients. Thirty thousand Christian leaders, among many
other leaders in different areas, interact frequently with believers because pastors are often scheduled to visit the members of the church and are available throughout the week. Therefore, they play an important role before metal patients are hospitalized and their opinions have such a great impact on the lay people in the church. This reason makes pastors’ understanding and attitudes towards mental illness very important and their attitudes require closer attention from psychiatrists and the department of mental health. Regarding this issue, in 1982, Jin-wook Son, and Boo-young Lee surveyed 500 Protestant pastors and 100 Catholic priests on their understanding of reasons for mental illness. Researchers found that 80.6% of the pastors thought an evil spirit was one of the major causes of mental illness, 11.7% believed in illness as God’s trial, another 11.7% saw illness as a result of sin and 3.9% as God’s curse. While 100% of priests chose inner conflict and psychological trauma as a cause, only 78.6% of pastors did. Genetic factors was one of the causes for 64.3% of the priests and 33% of the pastors. While 57.1% of the priests perceived brain abnormality as one of the main causes, only 21.4% of the pastors saw it as a cause.

In similar research conducted by Young-min Choi in 1992, the researcher surveyed pastors of five different denominations in Korea, which included Presbyterian, Methodist, and Full Gospel Churches. The study found that 71.2% of the respondents considered religious factors to be one aspect of cause, 63.3% as psychological factors, 48.2% as social factors, and 42.4% as biological factors. With religious factors, 90% of the pastors

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considered an evil spirit as a main cause, 39.9% as God’s trial, 20% as a result of sin, and 16.7% as God’s punishment. Based on the findings of the two surveys, it is clear that religious factors, especially evil spirits, are viewed as important causes of mental illness. Reverend Ki-Dong Kim, who is one of the well-known evangelical leaders in Korea, claimed that the root cause of all illness is the evil spirit, and that the patient can be cured through a process which includes steps such as encounter with the evil spirit, conversation between the person and the spirit, the spirit’s complaints, and the spirit’s fleeing.34 All disease cannot possibly have identical cause; thus demon possession cannot be the only cause of illness although demon possession is still a possibility because it is supported with biblical accounts.

Korean Pastors’ Means of Acquiring Knowledge on Mental Illness

According to the findings of a study done by Young-Min Choi, Korean pastors gain most of their knowledge about mental illness from the Bible and priests often learn from the media and lectures.35 Regarding the level of their knowledge, 55.3% answered that they somewhat know about mental illness, 26.0% said they do not know, and 16.2% said they know well enough. In addition, 72.6% of pastors said that they do not put any effort into learning about mental illness. These findings reflect that pastors heavily rely on the Bible as a means of gaining knowledge about mental illness and very little on lectures and texts. The reliance on the Bible means that mental illness is interpreted as demon possession and understood as supernatural phenomenon. The researcher pointed out that those respondents who answered “somewhat know” and “know well enough” meant that

they know mental illness in the spiritual realm and not in terms of psychology.

Attitudes Towards Treatment of Mental Illness

Korean pastors’ main part of ministry involves meeting and comforting people with physical or mental illness and guiding them to cure and recovery.\textsuperscript{36} In the ministry, pastors see practices of exorcism as important and effective as medical treatments; on the other hand, priests think that medical treatment is more important than the religious methods. Psychotherapies are supported by 33.0\% of the pastors and 67.9\% of the priests and taking medication is acceptable to 32.0\% of pastors and 60.7\% of priests. The reason for pastors’ preference for religious treatment is due to the belief that illness is most often originated by the evil spirits and their preference is followed by great expectations. The centralized authority structure of Catholicism allows priests to have a coherent view while the perspective of Protestant pastors is largely influenced by many various theological interpretations and by traditional outlook on mental illness.\textsuperscript{37}

There are several healing methods in ministry. Exodus 15:26 reads, “… I am the LORD, who heals you.” God uses many ways to bring healings. Since there are many methods, it is up to the minister which one suits him or her best.

Yong Kil Lee reports that there are ten ways to bring healing to people with mental illness or demon possessions that are currently used in the Korean church: healing by prayer, healing by faith, the laying on hands in prayer, confession, communion service, healing through great care, healing by gifts, healing through counseling, healing during

\textsuperscript{36} Jin Wook Sohn and Boo Young Lee, “The Concept of Psychosis and Therapy of Korean Pastors”, 57.

\textsuperscript{37} Ibid.
worship, and anointing with oil.\textsuperscript{38}

According to Jin Wook Son’s study,\textsuperscript{39} for people with mental illness, 60.0% of the pastors recommended inpatient-psychiatric treatment, 31.3% recommended religious methods, 6.7% recommended resting at home, and 2.0% recommended self-recovery.\textsuperscript{40} For the people with demon possessions, 33.3% of the pastors said that they use prayer and worship as a means of healing, and others use the laying on of hands (29.1%), counseling (8.5%), expelling prayer (6.0%), medical treatment (4.3%), fasting with prayer (2.6%), and others (12.0%).\textsuperscript{41} The interesting finding in this study is that although 60% of the pastors recommended inpatient-psychiatric treatment, only 4.3% make use of medical treatment. This finding is just a reflection of the mental hospital system in the early 80s that focused on isolation and detention of patients. Therefore, most pastors agreed on the idea of isolating patients. Medical treatments including medication and counseling are viewed as less helpful.

Young-Min Choi’s study in 1992 reports that pastors prefer psychiatric treatment (76.8%) over the religious methods (11.0%).\textsuperscript{42} The increase in preference suggests that the perception of psychiatric treatment is changing and medical and scientific treatments are gaining more acceptance than before. However, a large percentage of pastors (80.6%) still

\textsuperscript{38} Young Kil Lee.”Reflection on the Korean Ministers’ Perception and Healing of Mental Illness: Special Study on Schizophrenia” (master’s thesis, Korean Methodist Graduate School of Theology, 1995), 14.

\textsuperscript{39} Jin Wook Sohn, and Boo Young Lee, “The Concept of Psychosis and Therapy of Korean Pastors”, 56-57.

\textsuperscript{40} Choi, “The Attitude of Protestant Clergies on Mental Illness in Seoul Area”, 109.


believe in evil spirits as the ultimate root cause of mental illness. This overall consensus raises question of whether pastors are doing a good job in providing accurate advice and appropriate direction for those with mental illness.

Pastors’ Thoughts for Possible Distinction between Demon Possession and Mental Illness

The study by Jin-Wook Son and Boo-Young Lee shows that 72.8% of the pastors think that they are able to distinguish the differences between mental illness and demon possession, while 14.6% are unable to and 12.6% do not know.\textsuperscript{43}

In a study which examines Korean pastors’ assertion on demon possession, pastors claim that the big difference between mental illness and demon possession is found in the distinctive symptoms of the two different phenomena. A person with demon possession would be afraid of anything that has to do with the Bible, pastors, and Jesus, would dislike prayers, have spiritual vision, converse with spirits, act according to the will of the spirit, and often act violent and strange. On the other hand, mental patients would have reasonable, descriptive, and historical causes that can be explained (having nothing to do with religious cause), display no frantic behaviors, and medication and psychotherapies would be shown to be more effective in treating than using the religious methods.\textsuperscript{44} Yong-Kil Lee claims that although there are several different symptoms that help them differentiate, it is challenging to actually distinguish the two. Therefore, deeper knowledge and careful examination are necessary when diagnosing. The researchers also insist that the

\textsuperscript{43} Jin Wook Sohn, and Boo Young Lee, “The Concept of Psychosis and Therapy of Korean Pastors”, 60.

\textsuperscript{44} Hyeong Gyun Shin, Jin Wook Sohn, and Sung Il Woo, “Psychiatric Study on Demon Possession Alleged by Protestant Clergymen”, 1064.
symptoms of demon possession are often found in people with mental illness such as schizophrenia.45

Reasons for Pastors' Perception of Mental Illness as Demon Possession

Moo-Seok Lee points out that there are many problems that are created by the Korean pastors who blindly use religious methods without distinguishing schizophrenia from demon possession. One reason why pastors treat schizophrenia as demon possession is their lack of knowledge of psychopathology.46 As mentioned in Young-Min Choi’s study, 72.6% of the pastors who responded have not studied anything about mental illness, and they acquire most of their knowledge about mental illness from the Bible. Their understanding from the Bible leads to a belief that mental illness can be cured by fasting, prayers, and supernatural power, but the belief does not include any knowledge of the cause, symptoms and treatment of mental illness. Lee further adds that there are many occasions when the characteristics thought to be found in the demon-possessed are actually of schizophrenia and of other mental illness, and many cases which pastors consider to be demon possession are not different from those with schizophrenia.

The second reason is inaccurate knowledge and interpretation of the Bible. As Matthew 4:24 reads, “people brought to him all who were ill with various diseases, those suffering severe pain, the demon-possessed, those having seizures, and the paralyzed, and he healed them.” Pastors make the association between various diseases and demon possession, which leads them to put them all under the same category. Also, based on the

45 Lee, “Reflection on the Korean Ministers’ Perception and Healing of Mental Illness: Special Study on Schizophrenia”, 16.

man with evil spirit in Mark 5:1-20 and other different biblical accounts in Acts 16:16-18 and John 13:27, pastors believe that various diseases are the result of demon possession.

The third reason is that there are many pastors from older generations who performed the religious methods on those people with schizophrenia as if they were demon possessed. Pastors respect their senior pastors and believe that they are spiritually gifted.

The fourth reason is their mere desire to prove their spiritual authority as a leader of the church. Most of their attempts are to gain fame and reputation as a pastor and to remain influential in the community. The fifth reason comes from convenience. The origin of things that are unfamiliar and unknown to pastors can easily be pointed to as evil spirits. They do not necessarily want to touch on things they are not so sure about. Therefore, it is convenient to release the blame on evil spirits and avoid any problems that could arise in the process. However, these reasons cause huge problems to those with mental illness.\(^{47}\)

First of all, the patient would not get any opportunity to recognize and solve the problem because the pastor would be intervening as soon as it has been found. Some pastors do not allow the believers to seek professional help. This is critical in schizophrenia because the symptoms worsen and the chance of recovery decreases as time goes on. Those who receive proper treatment at the onset of the illness have a 30% chance of recovery. This chance decreases to 10% after five years.\(^{48}\) The second problem is stigma that the patient has to carry within the community. In Korean societies, which think highly of reputation, stigma hurts not only the patient but also the family of the patient. They have to live with the label which is a disgrace to the entire family. The third problem, according to

\(^{47}\) Ibid., 68.

Young-Kil Lee, is discrimination that comes after being labeled as demon-possessed or mentally ill.49

**Mental Illness from Korean Pastoral Counseling Point of View**

The majority of Korean churches that belong to certain denominations deny the notion of mental illness unless the illness has its natural causes. 50 J.E. Adams, who holds the same view, is the person that Korean churches support. He uses the word “sin” to explain mental illness and tries to find the causes from the Bible. Also, he tries to develop ways to treat people according to Scripture. Adams believes that people are simply hiding under this big umbrella called mental illness which was created by psychoanalysts who conceptualized the problems in secular/non-Christian ways.51 While it is not a disease, people with these problems are agreeing with the notion of mental illness in order to avoid moral responsibility. He further claims that psychiatry and psychology have stolen the professional responsibility that pastors need to take in the church.

Therefore, a psychiatrist who is a new kind of doctor that is developed according to the notion of mental illness does not have any traditional or functional ways to treat people. For him, mental illness means something that is caused by addiction, genetics, outer damages or brain abnormalities. Treating mental illness, thus, does not require any psychiatrist but can be done with cooperation between a medical doctor and a pastor.52

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49 Lee, “Reflection on the Korean Ministers’ Perception and Healing of Mental Illness: Special Study on Schizophrenia”, 55.

50 Ibid., xi-xvii.

51 Ibid., xxi.

According to Adams, the problems that mental patients have are problems of their own. They are not caused by any other but themselves. Humans were corrupted as soon as we departed from God. We are born as sinners who are led astray and speak lies from the womb (Psalms 58:3). Adams concludes that mental patients are those who have unsolvable problems that are naturally caused.  

He claims that the medical model which is the opposite of his understanding of illness attributes all problems to others and environments but not to the self. The model makes a set of assumptions that problems are other engendered but not self-engendered. This model does not bring any hope for recovery but rather causes a sense of helplessness and despair and raises ethical issues.

It is also important to note Adams’ understanding of abnormal behaviors of mental patients. The purpose of most abnormal behaviors is to attract attention and get care from others by going across the line of normality. When these behaviors are repeated, it is habituated and creates a pattern. The formed pattern of behaviors is not acceptable in the society which makes the individual alienated from the rest of society. The end is the isolation of the individual and the inner state of mind breaks down. He called this process the “downward spiral of sin.” This means that people respond to problems not in biblical ways but in sinful ways that repeat the cycle of the problems. As these sinful responses repeat, the problem itself is reflected in the abnormal behaviors and the pain is


54 Ibid., 5-7.

55 Ibid., 29-30.

56 Ibid., 146.
produced as experiences of abnormal emotions. In conclusion, mental illness should be redefined as our sinful responses to problems, sinful patterns of behaviors, and sinful emotions. Adams, whose idea is prominent in pastors who pursue biblical counseling, remains hugely influential in the majority of Korean churches.

Kyu-Myeong Hwang in his book, *The Principles and Methods of Bible Counseling*, writes that there are five causes of pain.57

(1) Personal Sin
This is pain not necessarily from the punishment for the sin, but from the troubles caused by the nature of sin. Roman 1:28 reads, “since they did not think it worthwhile to retain the knowledge of God, he gave them over to a depraved mind, to do what ought not to be done.” The punishment of being left out: sin brings pain to self and others and destroys.

(2) Sin of Others
We are born as sinners and the world is filled with sinners. We sin against each other and become victims of each other. This would be the most common cause of pain.

(3) Satan
He is the origin of evil and beginning of sin. Therefore, it is the cause of pain. Also, it intentionally gives pain to people, for instance, Job (Job2:3-7).

(4) Adam
His sin made all of us sinners, thus, caused us pain. The nature is destroyed and all creatures have to suffer. Romans 8:22 reads, “we know that the whole creation has been groaning as in the pains of childbirth right up to the present time.”

(5) God

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God does not delight when we suffer but sometimes He allows pain to touch our lives within His plans and providence. As God did to Job, he sometimes allows much suffering to us.

With this theological background, the belief that the ultimate cause of human suffering is sin is found in the biblical counseling of more than 15,000 churches in Korea. The J.E. Adams principles of biblical counseling began to be widely accepted when Professor Jung at Chong Shin University translated Competent to Counsel (1975) by J.E. Adams to Korean. They reject any other counseling methods because all other non-Christian counseling is based on Satan’s knowledge. Borrowing the words of J.E. Adams, “Throughout the human history, holy and unholy counsel co-existed demanding obedience from humans. History of individuals, family, and nations chose one of the two counsels. As Psalms tells us, there is no third counseling. There are only two ways: God’s way and Satan’s way.”

Also, other Christian counseling methods are not accepted by them because Adams

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58 She received a doctoral degree in pastoral counseling in 1980 from Westminster and continuing her teaching at Chong-Shin University and in Institute of Counseling Mission Research Center in Korea.

59 Since 1994, Professor David Powlison, Paul Tripp, Edward Welch, Kyu Myeong Whang from CCEF and Westminster opened the annual Biblical Counseling Seminary in Korea. In 1994, the seminar took place in Torch Center for pastors. It continued in 1995 at Soo Young Ro Church, in 1996 at Sarang Church, and in 1997 at Nam Seoul Church for laymen. In 1998, the biblical counseling education began with professor Joon Soo Kim who have founded counseling department in Asia United Theological Seminary and received a doctoral degree in Westminster. Also, professors from CCEF came to Korea annually to hold lectures and classes. After a while, the number of students who study counseling grew as more schools were built. In 2002, as graduate school of biblical counseling was established in Chong Shin University, professor Kyu Myeong Whang at Westminster joined as a faculty member. Until the year of 2008, there were seven graduating classes, and many graduated with concentration in biblical counseling. There are other institutions that have focus on biblical counseling such as Christian counseling training center, counseling school in Juan Presbyterian church and others. Kyu Myeong Whang. The principles and methods of bible counseling published by bible readers printed in Seoul Korea. 2008.pp. 44-45.

asserted that other Christian counseling methods make us turn away from God and put no faith in Him. “From counseling, people no longer depend on God and they believe that God is deceitful. These doubts, distortion, and denial are the results of counseling. Satan’s goal is to prevent us from trusting God.” 61

They strongly hold the position that counseling based only on the Bible is sufficient enough and thus reject all the other theories of psychology. In conclusion, all the diseases, mental illness and problems are caused by our sin. “There were many times when the sufficiency of the words of God was questioned and challenged. Many instigated distrust on God’s plan and holiness and turned people’s eyes away from God’s way to other alternative ways. They tried to build an unbiblical structure of counseling and it rapidly spread.” 62

Furthermore, they resist the entrance of Christian psychology and medical studies into the church, claiming that the resistance of exchange and communication of knowledge is keeping the holiness of the church.

there exists two grounds: compromise or resist. For a long period of time, Satan’s deceitful counseling has been used in the church. They cunningly fought against the brothers who hold truths. Often they had good motivation but headed to the wrong direction. They not only reject the useful counseling but confuses the ones in the middle ground. We need to challenge the individuals as well as their doctrines. When we challenge the churches that compromised with other principles of counseling, we can announce the revelation of Psalms 1. Psalms 1 demonstrates the clear differences between the holy and unholy one. 63

Adams argues that the Bible is the only text for counseling, and denies using medical terminology such as neurosis, personality disorders, and psychosis but rather

61 Ibid., 8.
62 Ibid., 9.
63 Ibid., 9.
replaces them with terminology that is more biblically grounded. For example, he would not use the term, “alcoholism” but replaces it with drunkenness. He further claims that there are three reasons to get diseases. The first reason is physiological such as illness, injuries, poisons, and genetic defect. The second reason is demon possession, and the third is direct or indirect punishment of our sin. Meanwhile, the notion of mental illness is not found in biblical accounts. He concludes that mental illness is illness of altered perception caused by the damage inflicted on the brain tissue.

Korean Christian counseling that accepts the claims of Adams puts emphasis on the authority of the Bible and the importance of the role that sin plays in mental illness. In addition, it includes forgiveness of the sin and hope for the healing. They insist that they have made great contributions to building J.E. Adams’ Christian counseling back on stronger biblical foundations. It is now no longer suppressed by worldly psychology and psychiatry.

However, Adams’ theory has several problems. It strictly rejects all the secular knowledge of psychology, especially all the empirical research and observations that are very strong evidence of the effectiveness of the other practices. It fails to integrate the person with the environment and points exclusively at the nature of sin. Individuals’ physical and social environments and developmental factors are completely ignored, which fails to look at the person as a whole. Thus, the method is too simple and fundamental to be applied. Also, Adams takes a different approach to the terminology than the approach to terminology that is used in psychiatry. Today, the categorization and standardization of

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mental illness in psychiatry are based on physiological causes and symptoms. It is people’s efforts to create useful but temporary common language that can objectively measure the abnormal behavioral responses. On the other hand, Adams’ perspective classifies illnesses from etiological bases. Since there are mental illnesses that have unknown causes until this day such as schizophrenia and bipolar, his perspective comes from incomplete background. There is a study done by Won-sung Sim in support of Adams’ theories.66 In his study of the bible as a resource for pastoral counseling, he says that pastoral counseling has to be done within the framework of God’s creation, the original sin and redemption through Christ.67 Thus, the most useful source in pastoral counseling is the bible. Only the scripture can bring transformation through honest self-realization (Matthew 7:3-5). Because the purpose of pastoral counseling is to bring transformation, the only tool that should be used in counseling must be the bible.68 The bible can be used as an absolute guideline to the highest ethics.69 On the other hand, other types of counseling that deny the relationship with God only justifies humans' wicked behaviors or accept it as they are something that cannot be avoided.70

Also, Sung-soo Kim goes along with him and says that the ultimate healing of distorted personality is done only through religious and spiritual healing in Christ. The healing of “human beings” within Christ is more procedural and goes through each stage of

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67  Ibid., 13-14.
68  Ibid., 18.
69  Ibid., 16-17.
70  Ibid., 14-15.
creation-fall-redemption-completion and eventually finishes the process of “being human”.  

In response to Kim, Woo-sung Oh claims in his book titled Communication Between the Bible and Psychology\textsuperscript{72} that it is necessary to develop “biblical psychology” in order to make theoretical and practical progress in biblical counseling in Korean churches. He shows how the mind itself is not a territory that exists by itself but that it co-exists with spirit and body in interactive relations. Biblical psychology demonstrates that the Holy Spirit plays an important role in the mind and may become the center of dynamic relationship. Biblical psychology emphasizes the wholeness of human beings which is largely missing in psychology. Therefore, the mind is in interactive relations with body and soul, the Holy Spirit has a huge influence on mechanisms of the mind. For the future direction, biblical psychology should be combined with studies done in church, then selectively accommodate the results from the field of psychology and progress with biblical interpretation. When biblical psychology is firmly established, Christian counseling and psychological scripture-interpretation will be able to secure their identities.\textsuperscript{73}

In response to this, Sung Ho Oak in his book Insufficient Christianity Contaminated by Psychology\textsuperscript{74} claims that Christians should never use any knowledge of


\textsuperscript{72} Woo Sung Oh, Communication on Between Bible and Psychology: Bible and Christian Psychology. (Seoul: The Christian Literature Society of Korea, 2007).

\textsuperscript{73} Oh, Communication on Between Bible and Psychology: Bible and Christian Psychology, 99-100.

\textsuperscript{74} Sung Ho Ok, Insufficientt Christianity Contaminated by Psychology. (Revolution and Reformation, 2007).
psychology. His reason is that the born again Christian's life is a "new creation" (Corinthian II 5:17) and a new creation by God is perfect; thus he/she does not need any mental cure or psychology to assist. Attempting to find solutions and cure in psychology is certainly not a behavior that Christians should have in the church because their desire of salvation and mental cure should be resolved in Christ, not in knowledge of psychology. Oak’s claim that psychology should not be needed in churches is like thorns to those who are struggling to get through mental disorders or other difficulties in the churches. His argument can further be interpreted as meaning that Christians with mental disorders, family issues, and addictive behaviors are not supposed to be in church, thus determining whether people are saved or not.

The claims of Sung-won Sim and Oak parallel the claims of Korean Christian counseling that sin is the cause of all diseases and that the bible itself is sufficient to cure mental illness. The trend of old and current pastoral counseling in Korea is well reflected in those claims.

**Alternative Psychological Point of View**

This section examines ways to connect and understand theology and psychology and explores how psychopathology should be understood and helped in church. The following are used to help us understand: Barths’ theology, object relation theory and self psychology.

The Trinity (Barths’) vs. Humanity (Object Relation Psychology and Self Psychology)

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75 Ibid., 317-327.
According to the claim of Donald K. Price, Karl Barths’ theology and object relation psychology share a common ground on understanding of humans: humans cannot be understood apart from the interactive net in which ones find each other. Price discusses the interactive relationship in which the two approaches ultimately arrive at the same place, although the two had different beginnings:

In Barths’ theology, the realm of relationship that regulates our natural character begins from the existence of the Holy Trinity. That is, God first makes relationship with father, son and holy spirit within himself. The group dynamic that exists in the initial relationship within Himself is also reflected in the relationship He makes with us. Similarly, the relationship between mom and baby in object relation psychology is also initiated by mom. In this two-way relationship between the mother and the baby, inner-psychological structure starts to develop. Therefore, the common ground of these two studies is that the initial relationship is the source of energy and the relationship plays an important role in developing human characters.

On the other hand, object relation theorists explain that human’s motive is rooted in searching relationships and humans pursue the fulfilling of the relationship.

D.W.Winnicott’s object relations theory would be the notion of good-enough mother. He believes that an infant’s initial mental activity begins with its perception of a mother’s nurturing and caring. He also believed that infants’ cognitive development begins as an infant tries to put together his experience. Therefore, this is why the good-enough mother is important, because the good-enough mother is a mother who in the beginning

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77 Ibid., in Price, 11, in Hunsinger, 89.

responds to and meets the infant’s needs in full, but gradually adjusts the degree of completeness in meeting the infant’s needs as the infant grows.79

Also, Heinz Kohut’s Self Psychology, in broad terms, is one model of Object Relation Theory, but also has a unique name, ‘Self Psychology.’ While Object relation psychologists generally focus on the object in the relationship, Kohut focuses on the self specifically. Kohut said that if self does not reach the healthy state, the true ideal relationship with the object cannot be established and unhealthy self can lead to problems such as narcissistic personality disorder.

Barth also sees our awareness in relation to an object. From his perspective, our awareness of objects in the world totally depends on our relationship with God. As the origin and ultimate objective of human awareness develops, God is known to us as a mediator of Godly knowledge and as a subject. Barth says the following:80 “Humans … perceive extraordinary things…however, the reasons why these things are to be important or essential to us are because God only meets directly with us through His works and holy rituals because the communication between God and humans happens only in the realm of creation and in the realm of object relation.”81

Therefore, two approaches both claim that the foundational character of human develop is an interactive relationship with an object.82 The primary purpose of Barth’s theology is to draw an interactive identity of the Holy Trinity and reveal that the identity is

79 Ibid., 14.
80 Hunsinger, “Theology and Pastoral Counseling-A New Interdisciplinary Approach”, 100.
81 Price, “Karl Barth’s Anthropology in Light of Modern Thought: The Dynamic Concept of the person in Trinitarian Theology and Object Relations Psychology”, 320.
82 Hunsinger, “Theology and Pastoral Counseling-A New Interdisciplinary Approach”, 100.
reflected in the interactive relationship of humans. The goal of theology is to investigate the relationship between God and human and between you and me. Deborah Deusen Hunsinger claims that the common interest of theology and object relation psychology is an individual’s relationship that is created between the one and other.83

Hunsinger explains how Price interpreted Barth’s theology that, “True human nature is Mitmenschlichkeit or being-in-encounter and the image of God is, in essence, relational” as following:84

It is the relationship with God and relationships with others that made us true human. Our relational existence is reflection of the relational existence of the Holy Trinity—the Father who loves son through the Holy Spirit. Through the words of God, we realize that we are destined to be united with God and to live in the essential relationship with God which is mediated by Jesus Christ.85

As God is in the relationship with the Holy Spirit and son, our human nature is presented in Jesus Christ who lived the life filled with the relationship with God and others. Then, our human nature is clearly relational. Humans are being-in-encounter. Therefore, none of humans can exist isolated, static or alone. Isolation from others and from God is sin and leads to destruction.86

From this perspective, Christianity is, in essence, a religion of relationship. In the Christian faith, the world is defined and understood in relation to the Creator and His creation, us humans and nature. While we live in the presence of God, He/She exists as a separate entity in our relationship with Him/Her as an interactive agent. This very notion in Christian faith allows Object Relation Psychology and Kohut’s theory to be an applicable counseling tool in church.

83 Ibid., 89-90.
84 Ibid., 92.
85 Ibid.
86 Price, “Karl Barth’s Anthropology in Light of Modern Thought: The Dynamic Concept of the person in Trinitarian Theology and Object Relations Psychology”, 233.
God as a Self Object

We, believers, read the book of Genesis which tells of the works of God that created all things through His almighty power. The story of Genesis is composed of humans created in the image of God, His values blown into us. Admiration and blessings can be read as the description about the process of developing self by Kohut. As the self of an infant began its life with the experience of warm admiration and compliment of parents, the first experience of humans also was filled with blessings and admiration by God. This also was displayed in the relationships between God and His creation, humans and His creation and man and woman. Here, God is self-object for humans.

Using the psychological concepts of self and self-object, we are able to come to understand features of our relationships with one another and with God in increasingly complex and dimensioned ways. To say it another way, these concepts enable us to discern and identify qualities of being and relating of which we would otherwise remain unaware.

The familiar stories in Genesis illustrating God’s creation of the world and Adam resemble much of what Kohut describes to be a birth of self. As an infant begins its formation of self through experiencing love and care of parents, humans’ first experiences

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87 Kohut also used various terms to describe “mirroring self object”: As a mother looks at her baby with a loving smile and gives caring attention, the baby builds positive perception of self and hope for self. In other words, the baby gains the desire to live in the world with energy. Such experience is called mirroring. This desire and vital power becomes the source of mental energy. Thus, the mental energy is not embedded within one’s instinct but comes from an external source, such as a positive mirroring experience. Heinz Kohut, The Self Psychology and the Humanities: Reflections on a New Psychoanalytic Approach. New York & London: W.W. Norton & Company, 1985. p.257.

88 Throughout Kohut’s study of self, it has been articulated that one’s development of self is not an independent process that one undertakes on one’s own; it is an off-spring of a relationship between the self and its outer environment (or the self object such as parents). A person with a rich experience of mirroring, idealization, and twainship will eventually develop a positive self. : Heinz Kohut, The Restoration of the Self (New York: International Universities Press, 1977), 12.
were also blessing and love of God. This positive first experience was not limited to only between God and humans, but it was also true for God and His creation, humans and nature, and males and females. In this sense, God is the Self Object for humans.

John Macmurray comments on human's interactive experience as following:
“Fundamentally, human’s experience is shared. Even in the most individualistic aspect of human life, it is communal to some degree. And human behavior is always followed by its individual “others” in fundamental structure… the unit of an individual is ‘you and me’ and ‘I’.”

Macmurray’s comment echoes the human as “being-in-encounter”, the “you and me” in interactive relationship that is introduced by Barth. For Barth, the origin is the interactive existence of the Holy Trinity. Humans can display the image of God only when dwelling in genuine encounter.

God functions as self object and shows His/Her great love in John 3:16, “For God so loved the world that he gave his one and only Son.” Believers should grow with the love of God, but it does not imply that one may reach a state in which there is no more need for

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89 Kohut also used various terms to describe “mirroring selfobject”: As a mother looks at her baby with a loving smile and gives caring attention, the baby builds positive perception of self and hope for self. In other words, the baby gains the desire to live in the world with energy. Such experience is called mirroring. This desire and vital power becomes the source of mental energy. Thus, the mental energy is not embedded within one’s instinct but comes from an external source, such as a positive mirroring experience. Heinz Kohut, The Self Psychology and the Humanities: Reflections on a New Psychoanalytic Approach (New York & London: W.W. Norton & Company, 1985), 257.

90 Throughout Kohut’s study of self, it has been articulated that one’s development of self is not an independent process that one undertakes on one’s own; it is an off-spring of a relationship between the self and its outer environment (or the self object such as parents). A person with a rich experience of mirroring, idealization, and twinnship will eventually develop a positive self. : Heinz Kohut, The Restoration of the Self (New York: International Universities Press, 1977), 12.


92 Ibid.
the love of God because the one is fully grown. Rather, growing spiritually means to get closer to God, and growing a child-like heart before God. This is done by our prayer and the way God listens and answers our prayer. We are developing relationship with God whether one notices it or not. This unconscious forming of relationship through prayer can be thought of as object relationship with God based on Kohut’s theories.

Christology vs. Transmuting Internalizing

Christology is at the center of the Christian doctrine of salvation. Christ functions as an intercessor who fills the gap and recovers the broken relationship. Barth’s primary interest is the real existence of God, the Holy Trinity, and human creatures that have relationship with God then, finally, the interactive relationship that reflects or fails to reflect the image of God. The way Barth refers to the interactive relationship of humans is derivative and secondary.93 In concepts of Self Psychology, Christ also does mirroring so that people can compare their present, sinful state of being and their original humanity created by God. When we look at Christ, we realize that we are sinners and at the same time, we can see how we should live our lives. He is our model that we need to idealize and thus identify ourselves with. This becoming like Christ is what Kohut would call “transmuting internalization.”94

What have been discussed so far above are not by any means equivalent in

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93 Hunsinger, “Theology and Pastoral Counseling-A New Interdisciplinary Approach”, 98.

94 According to Freud, a child internalizes parents’ values through a defense mechanism called identification. However, Kohut argues that not every child internalizes parents’ values, but only those who experience their parents as great enough to idealize with respect would internalize the values and ideals of their parents. The power and knowledge as well as the beautiful values a child witnesses by the father allows the child to experience the completeness of the self-object. (Kohut, The Analysis of the Self, 63-64) Also, Kohut said these idealizations are usually of a father. (Kohut, The Restoration of the Self, 185) The child learns to control the desire to expose his or her grandiose self. (Kohut, The Analysis of the Self, 45)
significance or in religious value. Kohut’s theory and the teaching of Christianity are not interchangeable ideas. The comparison between the two was simply to show how psychological interpretation of human nature can be applied in reading human nature within the biblical context, in hopes of introducing the possibility of creative reading of the two seemingly opposite perspectives at the same time. Indeed, psychology and theology in the above discussion were able to have two-directional communication as they discover they share common interest in learning about the wounded and ways to recovery—psychology focuses on self, while theology focuses on soul.

Kohut said that mental energy is generated from a person’s good experience in relationship. One’s mental energy is acquired through one’s positive emotional experiences. Kohut calls these experiences psychological oxygen.95 Kohut calls our attention to psychological oxygen, which is comprised of three experiences of mirroring, idealizing, and twinship. These experiences lead one to produce more and more powerful mental energy. Also, according to Kohut’s principle of affectivity, the degree of one’s psychological energy, vitality and/or propulsion is determined by the content and depth of one’s emotional experiences. In other words, the oxygen-like positive emotional experience makes one powerful and therefore psychological oxygen can be thought of as the key source of one’s passionate life.

Understanding human beings from different perspectives has an important role in understanding the meaning of one’s religious faith and spiritual experiences. This

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psychological understanding is important because Self Psychology and Object Relation theories can be harmonized with the Christian tradition of understanding humanity. Christians’ understanding of humans is that humans exist in the relationship between God and his creation, as well as the relationship between individuals. Fortunately, this idea lays a fundamental base in relation theory and the paradigm of relation theory that includes the similar idea of Christians’ understanding.\textsuperscript{96}

Sin vs. Psychopathology

The story of Genesis talks about original sin and the fall of humans. This is the human’s desire to become like God, which eventually destroyed the relationship of love with God. Hunsinger says that for Barth, mystery of sin is the mystery of broken relationship with God. Sin is a kind of fall towards non-existence. Humans can be restored to sound existence by restoring live relationship with God.\textsuperscript{97}

The human arrogance and pride which destroyed relationship between God and humans can also be interpreted as a narcissistic pathology of human nature.\textsuperscript{98} Still, there remains a difference in the perspective of looking at the problem. Genesis testimony of this broken relationship between God and human points to the human corruption as the cause of all, but Kohut describes that the cause of a broken relationship is failure in forming


\textsuperscript{97} Hunsinger, “Theology and Pastoral Counseling-A New Interdisciplinary Approach”, 104.

\textsuperscript{98} Kohut sees the destructive force as being a result of narcissistic injury and narcissistic blows. Here, narcissistic injury and blows can be thought of as a state in which one’s self-esteem is being hurt. This notion would imply that the destructive force may not have been repressed under one’s self, rather it has been developed through a series of situations that injures one’s self-esteem. While everyone has a different reason for narcissistic injury and the point at which narcissistic blows occur, it is developed through accumulation of negative experiences—instead of intrinsically embedded within one’s id from birth. : Heinz Kohut, \textit{How Does Analysis Cure?}, 77-78.
object relationship. Even though Kohut’s theory does not perfectly align with the Bible in identifying the cause of the broken relationship, it shares common description in explaining the post relationship and the process of recovering.

The doctrine of salvation in Christianity focuses heavily on the relational aspects of human lives. It is the recovery of relationship between God and humans, human and human, and nature and humans. Salvation requires one to make a decision called repentance. The process of repentance, from the Self Psychology perspective, functions as curing of oneself after recognizing the threat of disharmony and fragmentation in self. The self has to come to the realization that one cannot save oneself, and one is helpless when left alone by oneself. This also means to give up one’s defense mechanisms and start a new dependent relationship with a new self object, God.

In the beginning of his research, Kohut thought that his research was focusing only on narcissistic personality disorder, but he came to a conclusion that self is the main cause and obstacle in psychopathology. His implication was that shaping healthy self is the most important task in life. Kuhut calls this healthy self "cohesive self." Cohesive self is the state in which a person can keep the stable psychological condition and prevent the

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When the selfobject, such as the parents, responds to the baby in a supportive and accepting manner, the baby gains a positive sense of self-assertiveness and the empathic ability to react to other people; that is, the baby successfully develops a healthy cohesive self. One’s mental energy is derived from this subjective grandiosity. This subjective grandiosity, or the notion of grandiose self, is essential in one’s self development. However, it may take a form of destructive force when there is self fragmentation. According to Kohut, self fragmentation occurs when one fails to integrate self experiences. While self fragmentation may occur when any one of the three positive experiences is lacking, due to the grandiose self that emerges on the surface, one may show destructive tendencies. In other words, when self-cohesion fails as a result of an unsuccessful experience of mirroring, idealization or twinship, the grandiose self emerges as an attempt to escape from “empty self”—simply to show that one is still alive, although they have failed to develop a healthy cohesive self. Self fragmentation is a cause for the pathology and at the same time a direct motivation for destructive behavior. Heinz Kohut, *Self Psychology and the Humanities: Reflection on a New Psychoanalytic Approach*, 220.
fragmentation\textsuperscript{100} of \textit{self}. Kohut’s theories suggest new interpretation of psychopathology and explain the nature of sin and human’s weakness to temptation, which are mentioned in the Bible. Kohut’s theories provide a much different perspective on psychopathology than Freud’s understanding. If pastoral counselors and pastors have a thorough understanding of Kohut’s concept of psychopathology, it will help them understand the believers who have psychopathological behaviors in the church.

Kohut’s self psychology analyzes narcissistic pathology and introduces possible treatments that can be used in church for those believers who suffer from mental illness. Psychological contributions enable us to discern forms of suffering that would otherwise remain unnoticed and untreated. As such, these contributions contribute to the care of persons. Using only scriptural sources would be fatal—akin to trying to diagnose medical illnesses without the contributions of biology, chemistry, anatomy, etc.

Pastoral Counselors should remember to notice the linkage between physical health and one’s emotions through chemical reactions taking place in the brain. For instance, a high level of stress causes diabetes, and hypothyroidism results in depression or bipolar disorders. Some diseases are found with physical body and emotions closely affecting each other. So in these cases, mind and the body fall under the category of physical areas, according to Adams' argument, because the linkage is clearly “observable.” In addition, people who live their lives with unresolved grudges end up suffering from senile dementia, depression, cancer, diabetes, schizophrenia and many other illnesses which are not just regarded as a result of deficits in the brain and the body. Sometimes seniors in high school undergoing a lot of stress and pressure in the preparation for colleges

experience colitis and stomachaches. Doctors often suggest counseling therapy conducted by professional psychologists as well as physical treatment. Colitis and stomachaches in this situation may not have been caused by failure in body or brain function. Treating psychological problems must come before treating physical symptoms in this case. According to illnesses mentioned above that are caused by psychological reasons, medicine and psychology are too closely tied together to make a conclusion that psychology is separated from medical and natural science. Many psychologists who recognized such a close relationship between physical body and mentality have put a lot of effort into proving the “scientific” significance of psychology.

Psychological health and spiritual health are two quite different concepts and they cannot replace one another. However, it is also true that they are closely linked together. If a psychology that studies one’s mental health shares the same basic ideas of the world and humanity in general, then we should be open to the possibility of using psychology in church for times when spiritual issues are raised in relation to mental issues.

Practical Theology vs. Ministry in Church

The goal and the direction of pastoral counseling focus on the relationship of people as well as the relationship with God because the healing needs to take place not only in the inside but also in relationship with the subject. Pastoral counseling exists in the church to understand and share the pain of those whose souls are in sufferings and heal the hurt. It goes beyond diagnosing and analyzing the mind to know the reasons of the illness. One aspect of pastoral counseling, which is pastoral theology, involves application as one of the responsibilities under pastoral ministries and it is an essential ministry for the
community. Shirley C. Guthrie, Jr. emphasizes the importance of wide-spread pastoral counseling in everyday lives and church ministries. She says, “Those pastoral counselors who ignore the promise of God, preaching, the importance of ceremonies, fellowship and mission take away the purpose and source of healings from themselves and those who need healings.”¹⁰¹

Put simply, Korean churches need to take a new perspective on Christian psychology. As Oak warned, believers will eventually turn to secular psychology if they cannot find counseling within the church. It is the responsibility of today’s church to provide places for pastoral counseling to take care of their physical body, mind and spirit all together. In Foundations for a Practical Theology of Ministry, James N. Poling and Donald E. Miller comment on the changing ministries in today’s church, saying, “We believe that the current tendencies toward specialization and professionalization threaten the integrity of ministry.”¹⁰²

We need to reconsider why people are physically in the church but cannot live sufficient lives with the bible only. It is not people’s lack of faith but the churches that are creating environments that nurture problems without recognizing them. Poling and Miller comment on the importance of church ministry: “In fact, we suggest that when ministry begins to understand its center to be community formation rather than professional expertise or some other image, then ministry may become a model for secular professions


in our day.”

The goal of pastoral counseling is not only to find ways to heal including wounded inner self, but also to help one to recover the relationship with God and other individuals. Pastoral counseling fails to do its job unless counselors recognize the value of individual soul. Pastoral counseling is to understand and to share the emotional pain that believers might have in their lives, so that it can eventually help them overcome such obstacles. Simply giving out the diagnosis and analysis of the problem are not enough, for pastoral counseling is also ministry that can be characterized as an application of practical theology. It is not only useful in a church, but it is a necessary component of a church’s ministry work. Shirley C. Guthrie, Jr. explains how important pastoral counseling is in its role, and how it should be applied in church ministry as a whole and in the life of an individual. However, she also emphasizes the importance of incorporating the promise of God, preaching, Communion, and congregational gathering into pastoral counseling. Without doing so, the pastoral counselor fails to provide what the client needs in essence.”

I want the Korean Church to widen their perspective on Christian psychology. When believers in church are in need of counseling while the church ignores their needs, they will have to turn their attention to the “secular” psychology just as Adams feared. A church should be prepared for pastoral counseling that is open for all ranges of issues that are concerned with physical, mental, and/or spiritual problems. The reason why many believers in church do not find the Bible sufficient in carrying out their everyday may not

103 Ibid., 21.

be because their faith is not strong enough. Maybe it is the church environment that the
Korean Church has created. We can—by changing our perspective on secular knowledge—
transform the church to become a leading role model for the rest of the world.

I know that believers in the Korean Church live and enjoy their spiritual life that is
passionate in faith. With this confidence I now want to ask the readers of this paper
whether or not they want an environment in our church such that believers can grow and
practice their faith freely with the occasional help from a properly trained pastoral
counselor in the event of unexpected hardship in life, and to see how God brings peace in
times of suffering through their ministry work.

The Korean Church is ignoring the pain and suffering of believers simply because
it is being too cautious of the theoretical background work of psychology. Of course, there
are some ignorant psychologists whose minds are only occupied with wealth and
reputation, inside and outside of our church. But over-generalizing all and every pastoral
counselor as one of them is clearly flawed in its reasoning also.

In *Psychology through the Eyes of Faith*, David G. Myers says, “there is an
additional reason why the Bible does not give us a complete psychology and why we
therefore need science to understand psychology of humans. The Scripture must embrace
truth not just for us in the twenty-first century but for all people in the past, present, and
future.”¹⁰⁵ Elaborating on his point, Myers cites C.S Lewis:

Christianity has not, and does not profess to have a detailed political program for
applying “Do as you would be done by” to a particular society at any particular
moment. It could not have. It is meant for all men at all times and the particular
program which suited one place or time would not suit another. And, anyhow, that
is not how Christianity works…When it tells you to feed the hungry it does not…

…give you lessons in lessons in Hebrew and Greek, or even in English grammar. It was never intended to replace or suppressed the ordinary human arts and sciences: it is rather a director which will set them all to the right jobs, and a source of energy which will give them all new life, if only they will put themselves at its disposal. In summary, what Myers and Lewis are claiming is that as a Christian living in the present, one must be in balance with one’s faith and human arts and science—what people like Oak may call “worldly” knowledge—and be able to make use of it.

Scriptures do not enable us to discern and explain the wide diversity of human life, and of human suffering. We need a wide range of “secular” traditions (e.g., ethics, political theory, sociology, psychology, hermeneutics) to amplify our understanding of creation, and suffering, and care.

1. No theology is simply proclamation. All theology draws from sources beyond scripture.
2. There are various ways of constructing theology (see Frei, Poling and Miller).
3. Consider a point raised by Park, and in a different way by Watkins Ali: to care for the other, we must understand the other. To understand the other, we must do so from their point of view, within their world. If we use our theology across the board, we are arrogant, narcissistic, self-deceptive, and sinful—because we imply that our map is the territory, and that everyone is best understood in our terms alone.)

In a similar manner, I may further narrow this claim to validate the argument for the use of psychology in church appropriately and when necessary.

**Introduction of Study Site: The Han-ma-um Community**

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The Role of the Han-ma-um Community

The Han-ma-um community recovery program is unique within churches in Korea. Because of widely accepted misperceptions about mental illness, many denominations in Korean view mental illness as demon possession and a consequence of patients’ sin. For that reason, many churches in Korea do not provide chapel, counseling or recovery programs for the patients and their families.

The Han-ma-um community is the only church-based institution in Korea that provides recovery programs solely dedicated to patients with mental illness. The ministry of the Han-ma-um Community bases their work on a biblical perspective which differs from most Korean churches. As a currently operating, real-life model of church ministry for the mentally ill, the Han-ma-um Community is a tangible example of an alternative approach that other Korean churches could follow in their ministry. The Han-ma-um community focuses on patients’ growth in physical and mental areas that will eventually lead to spiritual growth as well. The community also helps patients make smoother transitions back into society.

Different Activities and Ministries

Within the community, there are many programs and ministries that help patients to recover from their mental illnesses, such as: chapel, prayer groups, bible study groups, counseling, art therapy, a drama team, a ping pong club, a hiking club, and family camping. Every program and activity in the community is entirely free and funded by individual donors.
Members of the Han-ma-um Community

Anyone can become a member of the Han-ma-um Community, but due to the nature of the work the Han-ma-um Community does, it is most likely to engage people with mental illness themselves or those who work closely with patients. Members who participate in the community can be categorized into four groups.

First, there is a group of staff members: one director, two psychiatrists, three ordained pastors, four nurses, five counselors, one art therapist, one coordinator, and seven leaders of programs within the community. Except for the coordinator, who receives minimal pay, other staff do not get paid. Also, the staff, except the coordinator, hold other jobs outside of the community during the week. Each staff member who has special events within their responsibility comes in twice a week to work with people in the community. On Sundays, the entire staff, which is equivalent to governing board, holds weekly meetings after the service to plan new events and review and evaluate previous events.

The second group consists of patients with diagnosable mental disorders: schizophrenia, MDI, depression, mania, personality disorder, addiction, behavioral disorder, anorexia, insomnia, etc… While the youngest among these patients is 15 years old, there is no set age limit and the community can take younger patients by making necessary adjustments and expanding the services that they provide. These patients are on prescribed medications from their doctors and they participate in the recovery program during the day time. None of these recovery programs cost the members anything, and anyone can join and participate in the programs as they wish. They all live with their families, who they are financially dependent on.

The third group consists of former patients—diagnosed mental patients with
improved states of physical, emotional, and spiritual well-being—who have returned to mainstream society and normal functionality in life activities. They work as volunteers in different programs within the community.

The fourth group consists of patients’ family members. The community runs programs that educate families about mental illness so that family members will know how to take care of the patient at home. Some family members serve some of the recovery programs as assistants.

Theological View of Han-ma-um Community\textsuperscript{107}

This section describes the theological view point of the Han-ma-um community. The Han-ma-um community provides an alternative theological view point to those containing misconceptions of mental illness and influenced by Shamanism.

The Han-ma-um Community holds the following suppositions:

First, mental illness is equivalent to disease. It is not the price of sin or God’s punishment. The price of our sin is paid by Jesus on the cross. There is no reason for God, who saved us through Jesus Christ, to punish us and ask us to pay the price of our sin. God is love. Therefore, all members of the Han-ma-um community are a part of the greater community of the body of Christ that is built upon God’s love.

Second, church is a community of people who share each other’s pain. Therefore, the purpose of the Han-ma-um community is to serve people with mental illness, to help them work their way through salvation, to find a cure and to share the pain of their diseases together.

Third, the Han-ma-um community recognizes everyone as the “royal priest” in 1 Peter 2:9. Anyone can participate in worshiping God and everyone is capable of building a personal relationship with God. The worship service in the community is no different than any other services commonly found in Protestant churches in Korea.

Fourth, any members of the Han-ma-um community can pray to God for their illness as well as for the brothers and sisters of the community.

Fifth, the community believes that God heals all kinds of illness and can also heal mental illnesses. Therefore, every program starts with a prayer that God will be present with his healing hands and ends with the same prayer.

Sixth, medical science is also a gift from God as a means of healing. Thus, everyone has the freedom to choose to receive any medical treatment that they wish to have.

Philosophy of the Han-ma-um Community

Mental illness is believed to have a low chance of recovery. Once a patient gets diagnosed, the ability to adapt to his or her new condition slowly deteriorates and it devastates the patient’s personality. Also, the patient’s symptoms, which are considered out of the ordinary by healthy people, become reasons for the healthy to avoid the mentally ill and motivation for patients’ families to hide their family member’s mental condition in public. In the past, the view of mental illness as an incurable disease prevented provision of support systems or patient-friendly environments for fast recovery from mental

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conditions. However, today even schizophrenia can be treated over a duration of 10 to 20 years. Also, knowing that a mental patient is still at the development stage encourages the use of developmental ability as a fuel to rehabilitation.\textsuperscript{110}

Once a sign of mental illness is observed, a patient receives an official diagnosis from a professional psychiatrist and begins treatment with prescribed medications. In hospitals, when a patient’s condition improves they discharge the patient with scheduled visits and prescriptions. The purpose of prescribing medication after discharge is to prevent recurrence of illness. Both counseling and medication, if given steadily, are crucial in treating mental conditions. When this rehabilitation is designed and practiced more professionally, especially with active participation of family members in helping the patient receiving the treatment, the patient’s vulnerability to stress can be reduced and the chance of recurrence of the illness can be decreased. Many of the rehabilitation programs in the Han-ma-um community were adopted from programs at the Yongin Mental Hospital in Korea.\textsuperscript{111} The philosophy of rehabilitation at the Yongin Mental Hospital is the basis and foundation of the philosophy of the Han-ma-um community. The main difference is that Han-ma-um emphasizes the spiritual aspect of recovery and the integration of Christian faith.

Recovery from Rehabilitation

The positive effects of rehabilitation should be well expressed so that rehabilitation

\textsuperscript{110} Lee, Mental Health of Modern Society and Community, 300-302.

\textsuperscript{111} Yongin Mental Hospital is funded by the state which provides financial support for those who needs treatment but cannot afford. There is no connection between the hospital and Han-ma-um but in-patients who are discharged after hospitalization are often told about the community by other means such as brochure, word of mouth, and Christian media.
becomes a part of treatment at an early stage. Practice is more important than theory with rehabilitation for mental illness. The following list is a summary of currently provided rehabilitation programs which began at the Yongin Mental Hospital in Korea but were later modified and applied for Han-ma-um.

1) Community Life

Designing a hospital environment that resembles real society is a key step towards rehabilitation. It is the goal of the community that before any medical treatment is given, patients will be able to carry out their daily tasks independently and cooperatively with other patients within the community. Different areas of community life are led by staff and often co-led with members of the community. There are different events that members can participate in everyday throughout the week. In addition, family members of patients are welcomed at all events.

2) Daytime Hospital

A daytime hospital is a form of psychiatric care that has the advantages of outpatient care. Since patients have difficulty adjusting to everyday life right after they have been discharged from the hospital, these patients can come to the hospital during the day and socialize with each other, continue with medical care, and return home for the night. This form of care advances their recovery by providing a smoother transition into a normal functioning life. This form of care is integrated into counseling and other therapies that are provided in the community.

3) Job Training

Job training is a part of psychiatric care which helps patients prepare for workplaces. As they learn to complete different tasks, they can work and take responsibility as a member
of society. Members of the community are encouraged to hold jobs and, in fact, many members have part-time jobs and full-time jobs. In the community, job training consists of learning social skills and practicing specialties through theater, dance, music and other church events where members can present their work. The training may take different forms depending on the patient. Staff sometimes lead a class with lessons to teach a group of members, and at times provide one-on-one training sessions that involve only one member at a time.

4) Acclimation to Local Community

This training is to recognize the patients’ conditions and deficiencies in their community then to help them reconcile any troubles due to the particular problems of the local area. The training mainly involves exposure to the environment outside of the Han-ma-um community. It consists of developing leadership skills in areas such as small groups and worship leading and volunteering in service learning projects in local communities. Additionally, members simply do exercises and spend time with people who do not have mental illness. These opportunities are found during the week, usually once a week. Members are usually by themselves in these settings, which helps them develop independent skills.

5) Weekly Rehabilitation Program

This program is a meeting among patients who support helping themselves. The focus of this meeting is to minimize people feeling like patients and help them begin to feel like ‘normal’ functioning members of society. As they help one another, they begin to experience themselves as useful members of the community. These meetings are held once a week with a staff member who does not get directly involved in leading the meeting.
Meetings are mainly run by the members.

6) Social Skills Training

Patients lack the ability to express themselves and to form relationships due to their mental conditions and other complications that come with them. Acquiring social skills is also crucial to getting a job. The social skills training program not only helps in preventing recurrence of patients’ conditions, but also proves to improve self-confidence, the ability to adapt to reality and quality of life in many ways. This weekly training session, for the most part, involves role-playing and discussions during which staff member takes minimal control.

7) Art Therapy

Art therapy provides a safe environment for patients to express themselves through various artistic activities. In particular, patients’ needs that cannot be verbalized are articulated during this therapy. Art therapy makes use of drawing, music, performance, and drama. Art therapy also has significance in the variety of its usefulness. It can be used as a tool of evaluation that can help identify the problem that the patient is currently struggling with. Then, the therapist can focus on the problem through counseling and other forms of therapy. In addition, art is a great way of communicating for those who are not able to freely express themselves through other means. The therapist and the patient can exchange their expressions through art and they can form mutual relationship through this communication.

Rehabilitation work helps mental patients coexist with non-patients in society.

When given constant care within a loving and accepting community that provides a context in which healing can take place, patients begin to recover. However, since the work of
taking care of the mentally ill requires much sacrifice from anyone who takes on this responsibility, the rehabilitation should take an organized and structured approach which involves many individuals rather than a single individual, so that patients can also acquire social skills and form relationships. If there is a church-based program of this kind, patients get more of a chance to learn how to interact with the congregation and make further use of their learning outside the church. A pastor is not a trained professional for rehabilitation of the mentally ill; therefore, he or she should advise patients and their families to recognize the need for psychiatric treatment. Also, it is important for the pastor to be well-informed about mental illness so that when needed, he or she can provide spiritual guidance throughout the recovery process and refer to congregants to professional facilities for psychiatric care.

Recovery through Family Support

*Educating Family*

An ideal notion of family is a community that builds upon love. 112 Each member of a family has responsibility for the family. While the roles of a spouse, parents, and children may appear to be different, they are not separated, but rather interconnected. Each person has his or her own relationship with God and with each other. If any relationship becomes dysfunctional, it affects the functionality of the entire family. 113

In particular, families with a patient suffering from schizophrenia go through relational issues within the family. In order to overcome this, the patient’s care within the

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family should be shared among the rest of the family members. When the family becomes one in helping and caring for the patient, the pace of recovery is much faster. In the Hanma-um community, there is the need for a commitment from the whole family for this program to work effectively.

_Necessity of Educating Family_

A major source of stress for the mentally ill is tension within the family. A patient experiences a higher level of stress in a social environment than non-patients. The following list names a few situations that enhance stress that a mental patient may experience.\(^ {114}\)

1. Family members are stressed out by the guilt and embarrassment of having a mental patient within their family.
2. Unclear chance of recovery.
3. Financial pressure when the cost of psychiatric care becomes a burden to everyone.
4. When family members are not well-informed about the symptoms a mental patient shows and the patient’s abnormal behaviors disorient them.
5. Abnormal behavior of the patient brings additional stress from nervousness and pressure to protect the patient.
6. As family members experience their incompetence in giving adequate care for the patient—due to lack of knowledge of the patient’s illness—they recommit the patient to the hospital.

These situations make not only the patient but also the family members stressed

out and create tension within the family. Family members experience a similar degree of stress as the patient. As the tension within the family accumulates, negative attitude towards the patient grows and this results in worsening the condition of the patient, who is much more vulnerable to stressful situations. Even when the patient’s conditions worsen and become increasingly difficult to bear, if the patient’s family members understand the symptoms and actively engage in positive communication with the patient, the patient may experience comfort and relax the conditions. Thus, the engagement of family is crucial in caring for the patient.

The caregiver should also take this into account and provide support for the family of the patient also. Through support of the family, a pessimistic view on the patient’s recovery, over-engagement in the patient’s emotional states, and/or explosive outlay of family’s stress before the patient, can be minimized. Also, helping the patient-family relationship take proper shape by caring for the patient through optimistic communication methods should be a part of the support for patient’s families. It is necessary to educate family members on conditions of the illness and possible complications as well as effective care-giving methods. This should be done over time, accompanied by counseling for the family members, so that more strategic measures can be taken towards the patient’s recovery.
CHAPTER THREE

METHODOLOGY

Method of Investigation

Subjects of Program Evaluation

From June 9th 2008 to December 31st 2008, I was able to gain experience at the Han-ma-um Community while completing the Supervised Ministry requirement at the proposal site. During that time I observed patients who recognized and accepted the reality of their illnesses and who were willing to receive treatment for them in order to return to their social lives. I also observed those who had already recovered and come back to the community as volunteers with their families. Given these observations, the current patients and recovered members of the Community were the subjects of this project. There are roughly 300 members in the Community, and 50% of them are active members who regularly come to meetings and different recovery programs. Among these people, participants of the study were selected if they fit the selection criteria that are discussed in the next section.

Evaluation Tool

The original version of this questionnaire, originally titled the McGill Quality of Life Questionnaire (MQOL), was first developed by S.R. Cohen1 and was used in the Oncology Day Center of the Royal Victoria Hospital. Cohen measured the life quality of

254 inpatients for 7.5 weeks using MQOL. In result, Cronbach’s overall alpha\(^2\) value was .89, the alpha value in the physical level was .85, the psychological level was .84, the existential level was .87, and the supportive level was .84. Subsequently, Kyungyi Yoon\(^3\) used a translated version of MQOL to measure the life quality of terminal cancer patients in Korea. Cronbach’s reliability test yielded .84 in the physical level, .79 in the psychological level, .76 on the existential level, .46 on the supportive level, and .86 as the general reliability. Because the supportive and existential levels did not provide adequate assessment of the spiritual level of patients, Seungyeon Yoo\(^4\) added questions on the spiritual level to Kyungyi Yoon’s version of MQOL in her study on effects of Hospice nurses in the life quality of terminal patients. Yoo’s questionnaire yielded Cronbach’s alpha value of .88, .73 on the physical level, .90 on the psychological level, .78 on the existential level, .86 on the supportive level, and .75 on the spiritual level.

In 2002, I modified Yoo’s questionnaire to measure the effect of pastoral care by adding more questions to the physical, psychological and spiritual levels. This questionnaire consisted of 14 questions for grasping general character and 26 questions for estimating quality of life. My instrument yielded Cronbach’s alpha value of .84, .90 on the physical level, .85 on the psychological level, .69 on the existential level, .73 on the supportive level and .91 on the spiritual level.

The questionnaire for this study was modified from the questionnaire used in my

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\(^2\) Cronbach’s alpha is a measure of reliability of a psychometric test score for a sample of examinees.

\(^3\) Kyung Yi Yoon, “Development of Instrumentation for Life Quality in Lives of Terminal Patients” (PhD diss., Yeon Saei University, 1997), 84-125.

thesis “Study of the Influence of Pastoral Care on the Terminal Patient’s Quality of Life”\(^5\) to examine the life quality of participants of the Han-ma-um program as their medical conditions differ from terminal patients.

The modification centered around the chief complaints in daily life during the period of treatment and the questionnaire was reviewed for its reliability by psychiatrists, theologians and psychologists who serve as staff in the Han-ma-um community.

As a result, six questions for grasping general character were removed and four questions for estimating life quality were added; the modified questionnaire consisted of eight questions for grasping general character and 30 questions for estimating life quality.

Three questions on the physical level, one question on the psychological level, seven questions on the supportive level, and eight questions on the spiritual level were changed based on patients’ chief complaints.

The questionnaire was structured as follows: General questions include gender, age, duration of treatment, religion, level of education, duration of Han-ma-um participation, stage of recovery and, where applicable, duration of Han-ma-um participation as guardian (there are guardians who were formerly patients). The remaining parts of the questionnaire had five sections: three questions on physical criteria (1-3), five on psychological criteria (4-8), six questions on existential criteria (9-14), eight questions on supportive criteria (15-22), and eight questions on spiritual criteria (23-30). Based on the responses to these five sections, the well-being of patients was measured through self-evaluation of their level of satisfaction; the higher their score, the better the life quality of the patient. The entire questionnaire is included in the appendix both in English and

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\(^{5}\) Mi Hyae Jung, “Study of the Influence of a Pastoral Care to the Terminal Patient’s Quality of Life” (master’s thesis, Graduate School of Christian Studies, Soong Sil University, 2002).
Korean as it was distributed.

Data Collection

To evaluate the effect of the Han-ma-um Community’s recovery programs on the quality of patients’ physical and spiritual life, the above described questionnaire were distributed among subjects.

Procedure

The questionnaire was sent by mail to every patient who fits the selection criteria (see below). It was then decided by an individual patient whether to complete the questionnaire or not. The responses of willing participants in this study was collected by the Community Coordinator via mail or in the collecting box placed in the Community office. Questionnaires were mailed out without being coded by numbers. The researcher did not have any way to know who the respondents were. Since the participants were not asked to sign their names, or provide any information that would directly identify them, their information was remained confidential throughout the study. All questionnaires were stored at a designated space with limited access only to the community coordinator who did not have any way to identify their questionnaire or access to the content of the questionnaire.

Criteria for selecting participants

There were two groups for the study. One group consisted of patients who had been a member of the Community for more than three months (even those who had subsequently left the Community) and the other group consisted of patients who had been a
member of the Community for less than three months. Individuals in both groups had received a minimum of middle school education received the questionnaire in the mail. Questionnaires were sent to 150 people and it was estimated that the return was roughly 75% which was greater than the initial expectation of 50%.

Analysis of Data

The data collected were quantitatively analyzed by using SAS, a statistical software. Conclusions were drawn based on the correlation between the Han-ma-um Community’s recovery programs and patients’ quality of life via t-test.

Definitions

1) Mental patient

In this project, a mental patient is defined as any person who is given a DSM IV diagnosis by mental health professionals at the Han-ma-um Community or other psychiatrist.

2) Recovery

The term recovery is used to denote the improved state of a diagnosed mental patient’s physical, emotional, and spiritual well-being, so that they can return to normal functioning in life activities.

3) Quality of Life

Regarding “Quality of Life”, Cohen⁶ said it is subjective well-being that the patient experiences and Cella & Cherin⁷ said that quality of life is self-evaluation and level of

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satisfaction on their functioning level at the present time compared to their ideal state that they can reach ultimately. For the purpose of this study, quality of life was understood as self-assessment of satisfaction with the current state of one’s well-being.

4) Patient Group 1

Patient group 1 refers to participants of the study who have been in the Han-ma-um Community’s recovery program for more than 3 months, and still suffer from their mental illness.

5) Ex-Patient Group

Ex-patient group refers to participants of the study who have been in the Han-ma-um Community’s recovery program for more than 3 months, but whose conditions now have improved enough to serve as volunteers at Han-ma-um Community.

This study used the questionnaire to examine the well-being of Han-ma-um participants in five criteria (physical, psychological, existential, supportive and spiritual) through self-evaluating the level of satisfaction; higher the score, better the life quality the patient has.

**Limitations**

1) Since the sampled patients were selected from the participants of the Han-ma-um Community who have been diagnosed and are continuing with treatments, the number of different mental illnesses was limited.

2) There had been only one other thesis project addressing the Han-ma-um Community, despite its ten year history. Also, there were no other comparable communities in Korea with whom Han-ma-um Community can compare. For this reason, it was difficult
to make reference to prior studies about the community.

3) In addition to the above limitations, the method which I employed relied heavily on the self report of individual questionnaires completed by willing patients. 4) Most of the materials used in research were Masters’ dissertations. This reflected the rarity of previous study on mental illness from the theological perspective or proposed work for altering the Korean Church’s current view on mental illness—at least from the academic field.
CHAPTER FOUR

ANALYSIS OF CASE STUDIES

This chapter is devoted to reporting the overall profile of the participants and statistical analysis of survey results. For the simplicity in language, among those who have been in the Han-ma-um Community’s recovery program for more than 3 months, ex-patient group refers to those who have those who have been patients before, but whose conditions now have improved enough to serve as volunteers at Han-ma-um Community, and the rest are refer to as patient group 1.

Profile of Participants from Patient Group 1 and Ex-Patient Group

To gain a general insight on the study participants, the first eight questions on the questionnaire focus on the participants’ age, gender, duration of treatment, religion, level of education, duration of Han-ma-um participation, and current status of treatment. There were 80 participants who had been in the recovery program for more than 3 months. The average age of the 80 participants was 44.18, with the youngest being 18 and the oldest being 68. On average, participants have been members of the Han-ma-um Community for 144.25 weeks (2.77 years), while their duration of treatment was 288.95 weeks (5.56 years) on average. There were twice the number of females than males (females being 71.3%). The majority (96.2%) were Christian (70 people being Presbyterian and 7 being Catholic), and no respondents identified Buddhism or Confucianism as their religion. For the highest level of education, the most frequent answer was college (42.5 %), followed by high school (33.8%). The current status of treatment had the lowest rate of response as there
were 13 people (16.3%) who did not provide any comments. However, the majority of those who respond were still in treatment (20 people without major difficulty in everyday life and 26 people with difficulty). Other responses included “currently receiving no treatment even with the presence of difficulty.” Among the respondents, 55 people (68.8%) were currently patients (thus in patient group 1) and the rest of 25 people were staff members who used to be patients themselves but came back to the Han-ma-um Community after their condition had improved (ex-patient group). The following table summarizes key statistics.

<table>
<thead>
<tr>
<th>1. Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>23</td>
<td>28.8 %</td>
</tr>
<tr>
<td>Female</td>
<td>57</td>
<td>71.3 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Religion</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presbyterian</td>
<td>70</td>
<td>87.5 %</td>
</tr>
<tr>
<td>Catholic</td>
<td>7</td>
<td>8.7 %</td>
</tr>
<tr>
<td>No Religion</td>
<td>1</td>
<td>1.3 %</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
<td>2.5 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Highest Level of Education</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middle School</td>
<td>7</td>
<td>8.7 %</td>
</tr>
<tr>
<td>High School</td>
<td>27</td>
<td>33.8 %</td>
</tr>
<tr>
<td>College</td>
<td>34</td>
<td>42.5 %</td>
</tr>
<tr>
<td>Graduate School</td>
<td>12</td>
<td>15.0 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Current Status of Treatment</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back to Daily Life</td>
<td>15</td>
<td>18.8 %</td>
</tr>
<tr>
<td>Finished with treatment and in the process of adjustment to the society</td>
<td>5</td>
<td>6.3 %</td>
</tr>
<tr>
<td>In treatment, but without major difficulty in everyday life</td>
<td>20</td>
<td>25.0 %</td>
</tr>
<tr>
<td>In treatment, but with difficulty in everyday life</td>
<td>26</td>
<td>32.5 %</td>
</tr>
<tr>
<td>Other Response</td>
<td>1</td>
<td>1.3 %</td>
</tr>
<tr>
<td>N/A</td>
<td>13</td>
<td>16.3 %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Relation to Han-ma-um</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>55</td>
<td>68.8 %</td>
</tr>
</tbody>
</table>
In addition to these figures, the next table summarizes the relationship between patients’ age and gender for the patient group 1 of 55 people. It also reports the t-statistic and p-value for difference in age, duration of treatment, and duration of participation in the Han-ma-um Community between male and female. The results show that there is no statistically significant difference between genders in these areas at 5% significance level.

<table>
<thead>
<tr>
<th>Difference in</th>
<th>Gender</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age between male and female</td>
<td>Male</td>
<td>17</td>
<td>36.88</td>
<td>13.119</td>
<td>-1.883</td>
<td>0.065</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>38</td>
<td>43.68</td>
<td>12.045</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of treatment between male and female</td>
<td>Male</td>
<td>17</td>
<td>9.06 yr</td>
<td>8.29 yr</td>
<td>0.841</td>
<td>0.404</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>38</td>
<td>7.27 yr</td>
<td>6.86 yr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Han-ma-um participation between male and female</td>
<td>Male</td>
<td>17</td>
<td>2.62 yr</td>
<td>2.39 yr</td>
<td>-0.732</td>
<td>0.467</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>38</td>
<td>3.12 yr</td>
<td>2.34 yr</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Categorical Analysis of Mean Scores from Patient Group 1 with Significance Level of 5% (α = 0.05)**

The questionnaire used in this study can be divided into five categories: physical, psychological, existential, supportive, and spiritual criteria. Each category has questions that address patients’ well-being from a different perspective through self-evaluation of their level of satisfaction on a 10-point scale. In particular, the physical criteria contain three major complaints often found among patients with mental illness.

In this section, key statistics for each question—only concerning the patient group of 55 people—are reported. From the survey results, one can see that question five from psychological criteria, which asks “Do you get angry often—about yourself, and/or your
surroundings?” has the lowest mean score of 5.85, indicating a moderate level of anger on average among patients. However, the highest score is 8.59 from question 29 of spiritual criteria that reads “Do you believe God loves you?” This result may be due to the large proportion of participants being Christian (96.3%). Interestingly, among the five categories, the lowest categorical mean was from psychological criteria, and the highest categorical mean was from spiritual criteria. The following five tables summarize the mean and standard deviation of each question and the categorical mean with its standard error.

1. Physical Criteria

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Categorical Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety</td>
<td>6.22</td>
<td>2.339</td>
<td></td>
</tr>
<tr>
<td>2. Insomnia</td>
<td>7.87</td>
<td>2.796</td>
<td></td>
</tr>
<tr>
<td>3. Side effects from long-term use of medication (for example, weight gain, loss of appetite, drowsiness, etc.)</td>
<td>7.00</td>
<td>2.867</td>
<td><strong>7.08 ± 2.66</strong></td>
</tr>
</tbody>
</table>

2. Psychological Criteria

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Categorical Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Do you experience loneliness?</td>
<td>5.67</td>
<td>2.373</td>
<td></td>
</tr>
<tr>
<td>5. Do you get angry often—about yourself, and/or your surroundings?</td>
<td>5.45</td>
<td>2.588</td>
<td></td>
</tr>
<tr>
<td>6. Do you believe you can control your current emotions by yourself?</td>
<td>6.24</td>
<td>2.285</td>
<td><strong>5.76 ± 2.50</strong></td>
</tr>
<tr>
<td>7. Do you feel sad?</td>
<td>5.58</td>
<td>2.347</td>
<td></td>
</tr>
<tr>
<td>8. How do you feel about your future?</td>
<td>5.89</td>
<td>2.954</td>
<td></td>
</tr>
</tbody>
</table>

3. Existential Criteria

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Categorical Mean</th>
</tr>
</thead>
</table>
10. In achieving the purpose of your life, if you have one, how do you evaluate your accomplishment?  

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. In achieving the purpose of your life, if you have one, how do you evaluate your accomplishment?</td>
<td>6.44</td>
<td>2.820</td>
</tr>
</tbody>
</table>

11. How do you value this moment in your life? 

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. How do you value this moment in your life?</td>
<td>7.60</td>
<td>2.557</td>
</tr>
</tbody>
</table>

12. How much control do you think you have over your life? 

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. How much control do you think you have over your life?</td>
<td>6.49</td>
<td>2.202</td>
</tr>
</tbody>
</table>

13. As a person, how much do you like yourself? 

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. As a person, how much do you like yourself?</td>
<td>6.55</td>
<td>2.616</td>
</tr>
</tbody>
</table>

14. How do you like your daily life? 

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. How do you like your daily life?</td>
<td>5.64</td>
<td>2.534</td>
</tr>
</tbody>
</table>

4. Supportive Criteria

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. How do you feel about the way your family treats you?</td>
<td>7.13</td>
<td>2.855</td>
</tr>
<tr>
<td>16. How do you feel about the way Han-ma-um staff, and/or other members of the Community treat you?</td>
<td>7.27</td>
<td>2.077</td>
</tr>
<tr>
<td>17. How much do you feel that you are being supported by your family?</td>
<td>7.40</td>
<td>2.521</td>
</tr>
<tr>
<td>18. How much do you feel that you are being supported by the Han-ma-um Community?</td>
<td>7.16</td>
<td>2.347</td>
</tr>
<tr>
<td>19. How satisfied are you by the help given to you from your family?</td>
<td>7.00</td>
<td>2.618</td>
</tr>
<tr>
<td>20. How satisfied are you by the help given to you from the Community staff?</td>
<td>7.07</td>
<td>2.581</td>
</tr>
<tr>
<td>21. Do you feel hurt or disappointed by your family?</td>
<td>6.69</td>
<td>2.538</td>
</tr>
<tr>
<td>22. Do you feel hurt or disappointed by Han-ma-um Community staff?</td>
<td>7.20</td>
<td>2.490</td>
</tr>
</tbody>
</table>

5. Spiritual Criteria

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Do you believe that God will help you recover from your illness?</td>
<td>7.49</td>
<td>2.707</td>
</tr>
<tr>
<td>24. Do you believe your life is worth living even during the time you are receiving treatment for your conditions?</td>
<td>7.71</td>
<td>2.242</td>
</tr>
<tr>
<td>25. Are you seeking forgiveness?</td>
<td>7.07</td>
<td>2.659</td>
</tr>
<tr>
<td>26. Do you think your sins have been forgiven?</td>
<td>8.27</td>
<td>2.313</td>
</tr>
</tbody>
</table>
27. How often do you think about the purpose of life and the meaning of your illness?  
28. Do you think your illness is a punishment from God for your sins?  
29. Do you believe God loves you?  
30. Do you feel hopeful about your future including your eternal life?  

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you think about the purpose of life and the meaning of your illness?</td>
<td>7.07</td>
<td>2.426</td>
</tr>
<tr>
<td>Do you think your illness is a punishment from God for your sins?</td>
<td>7.09</td>
<td>2.856</td>
</tr>
<tr>
<td>Do you believe God loves you?</td>
<td>8.31</td>
<td>2.418</td>
</tr>
<tr>
<td>Do you feel hopeful about your future including your eternal life?</td>
<td>8.15</td>
<td>2.155</td>
</tr>
</tbody>
</table>

**Mean Analysis of Mean Scores from Patient Group 1 with Significance Level of 5% (α = 0.05)**

In addition to the previous section on categorical result from 55 patients of patient group 1, this section makes comparison in mean score between patient group 1 and ex-patient group (of 25 people). Also, key statistics from comparing patient group 1 to patient group 2\(^1\) have also been reported within the table for each question. For all three questions in the physical criteria, there is statistically significant difference in the mean scores between patients and non-patients, where side effects from medication had the highest difference (t-statistic = -5.145) and insomnia had the lowest difference (t-statistic = -2.986).

In the psychological criteria, only question six concerning ability to control one’s current emotions was found to have no significant difference in mean scores (t-statistic = -1.699), while the highest difference was found in question four on loneliness (t-statistic = -2.434). Every question in the existential criteria was found to have difference in mean scores that were statistically significant. While question nine on how one feels about him/herself had the largest difference in mean score (t-statistic = -3.273), question 13 that asks how much one likes him/herself as a person had the lowest difference (t-statistic = -2.194). That is, patients find less meaning in their life compared to the staff, but they see themselves as

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\(^1\) Patient group 2 refers to those who have been in the Han-ma-um Community’s recovery program for less than 3 months.
likable people on a more relative scale. In the supportive criteria, the mean scores were close between patient and non-patient groups overall, except for question 20 which asks how satisfied one is by the help of Han-ma-um staff (t-statistic = -2.424). Lastly, the spiritual criteria questions 23, 24, 28, and 30 had different mean scores with statistical significance—the largest difference was found from question 24 that asks if one feels that life is worth living even while receiving treatment for the one’s illness (t-statistic = -3.111). The remaining questions that show no significant difference were mainly about one’s perception of forgiveness from God. Patients feel that their sin is forgiven and they are loved by God, while they still think their illness is punishment from God (question 28 addresses this issue, and the mean scores were different with t-statistic = -2.285).

For each question, the mean score and standard deviation from each group is summarized with the t-statistic and p-value for the difference in mean scores from patient group 1.

1. Anxiety

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.76</td>
<td>1.739</td>
<td>0.348</td>
<td>-3.284</td>
<td>0.002</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.22</td>
<td>2.339</td>
<td>0.315</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>3.56</td>
<td>1.501</td>
<td>0.265</td>
<td>6.443</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for anxiety level in everyday life between the patients and staff (p-value = 0.002). In other words, the patients who participated in the survey experience a higher level of anxiety in comparison to staff of the Han-ma-um Community.
2. Insomnia

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.24</td>
<td>1.300</td>
<td>0.260</td>
<td>-2.986</td>
<td>0.004</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.87</td>
<td>2.796</td>
<td>0.377</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>6.38</td>
<td>2.624</td>
<td>0.464</td>
<td>2.463</td>
<td>0.016</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for experience of insomnia in everyday life between the patients and staff (p-value = 0.004). In other words, the patients experience difficulty from insomnia more than the staff of the Han-ma-um Community.

3. Side effects from long-term use of medication (for example, weight gain, loss of appetite, drowsiness, etc.)

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.48</td>
<td>1.377</td>
<td>0.287</td>
<td>-5.145</td>
<td>0.000</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.00</td>
<td>2.867</td>
<td>0.387</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>6.03</td>
<td>2.571</td>
<td>0.455</td>
<td>1.577</td>
<td>0.119</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for side effects from long-term use of medication between the patients and staff (p-value = 0.000). In other words, the patients suffer more from the side effects from long-term use of medication in comparison to staff of the Han-ma-um Community.

4. Do you experience loneliness?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.04</td>
<td>2.226</td>
<td>0.445</td>
<td>-2.434</td>
<td>0.017</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>5.67</td>
<td>2.373</td>
<td>0.320</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.00</td>
<td>1.270</td>
<td>0.225</td>
<td>4.279</td>
<td>0.000</td>
</tr>
</tbody>
</table>
With the significance level of 5%, there is statistical evidence for difference in mean score for experience of loneliness between the patients and staff (p-value = 0.017). In other words, the patients suffer more from loneliness in comparison to staff of the Han-ma-um Community.

5. Do you get angry often—about yourself, and/or your surroundings?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>6.72</td>
<td>1.792</td>
<td>0.358</td>
<td>-2.212</td>
<td>0.030</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>5.45</td>
<td>2.588</td>
<td>0.349</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>3.84</td>
<td>1.483</td>
<td>0.262</td>
<td>3.690</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for frequent experience of anger between the patients and staff (p-value = 0.030). In other words, the patients feel angry more often in comparison to staff of the Han-ma-um Community.

6. Do you believe you can control your current emotions by yourself?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.12</td>
<td>1.833</td>
<td>0.367</td>
<td>-1.699</td>
<td>0.093</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.24</td>
<td>2.285</td>
<td>0.308</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.84</td>
<td>1.969</td>
<td>0.348</td>
<td>2.996</td>
<td>0.004</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for the ability to control one’s current emotions between the patients and staff (p-value = 0.093).

7. Do you feel sad?
<table>
<thead>
<tr>
<th></th>
<th>Deviation</th>
<th>Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>6.88</td>
<td>2.186</td>
<td>0.437</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>5.58</td>
<td>2.347</td>
<td>0.316</td>
</tr>
<tr>
<td>Group 2</td>
<td>31</td>
<td>4.13</td>
<td>1.522</td>
<td>0.273</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for feeling sad (p-value = 0.022). In other words, the patients feel sad more than staff of the Han-ma-um Community.

8. How do you feel about your future?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.44</td>
<td>2.123</td>
<td>0.425</td>
<td>-2.356</td>
<td>0.021</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>5.89</td>
<td>2.954</td>
<td>0.398</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>3.97</td>
<td>1.425</td>
<td>0.252</td>
<td>4.078</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for one’s feeling about the future between the patients and staff (p-value = 0.021). In other words, the patients feel less hopeful about their future in comparison to staff of the Han-ma-um Community.

9. How do you feel about yourself?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.48</td>
<td>1.661</td>
<td>0.332</td>
<td>-3.273</td>
<td>0.002</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.95</td>
<td>2.453</td>
<td>0.331</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.03</td>
<td>1.769</td>
<td>0.313</td>
<td>6.403</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for feelings about oneself between the patients and staff (p-value = 0.002). In other words, the patients feel their lives are meaningless and unimportant more than staff of the Han-
ma-um Community.

10. In achieving the purpose of your life, if you have one, how do you evaluate your accomplishment?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.96</td>
<td>1.744</td>
<td>0.349</td>
<td>-2.953</td>
<td>0.004</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.44</td>
<td>2.820</td>
<td>0.380</td>
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<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>3.88</td>
<td>1.755</td>
<td>0.310</td>
<td>5.219</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for frequent experience of anger between the patients and staff (p-value = 0.004). In other words, the patients feel that they are not making any progress more than staff of the Han-ma-um Community.

11. How do you value this moment in your life?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.60</td>
<td>1.414</td>
<td>0.283</td>
<td>-2.242</td>
<td>0.028</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.60</td>
<td>2.557</td>
<td>0.345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.59</td>
<td>1.829</td>
<td>0.323</td>
<td>6.359</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for self assessment of the current moment in one’s life between the patients and staff (p-value = 0.028). In other words, the patients feel the current moment is less valuable in comparison to staff of the Han-ma-um Community.

12. How much control do you think you have over your life?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.72</td>
<td>1.595</td>
<td>0.319</td>
<td>-2.821</td>
<td>0.006</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.49</td>
<td>2.202</td>
<td>0.297</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant</td>
<td>N</td>
<td>Mean</td>
<td>Standard Deviation</td>
<td>Mean Std. Error</td>
<td>t-Stat</td>
<td>p-value</td>
</tr>
<tr>
<td>-------------</td>
<td>----</td>
<td>------</td>
<td>--------------------</td>
<td>-----------------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.60</td>
<td>1.633</td>
<td>0.327</td>
<td>-2.194</td>
<td>0.032</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.55</td>
<td>2.616</td>
<td>0.353</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.28</td>
<td>2.129</td>
<td>0.376</td>
<td>4.157</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for how much one likes oneself between the patients and staff (p-value = 0.032). In other words, the patients find themselves more hateful than staff of the Han-ma-um Community.

14. How do you like your daily life?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.16</td>
<td>1.772</td>
<td>0.354</td>
<td>-3.095</td>
<td>0.003</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>5.64</td>
<td>2.534</td>
<td>0.342</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.25</td>
<td>1.646</td>
<td>0.291</td>
<td>3.089</td>
<td>0.003</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for how much one likes one’s daily life between the patients and staff (p-value = 0.003). In other words, the patients find their daily life more burdensome in comparison to staff of the Han-ma-um Community.

15. How do you feel about the way your family treats you?
<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.67</td>
<td>2.514</td>
<td>0.513</td>
<td>-0.800</td>
<td>0.436</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.13</td>
<td>2.855</td>
<td>0.385</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.03</td>
<td>2.102</td>
<td>.372</td>
<td>3.918</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for the treatment they receive from their family between the patients and staff (p-value = 0.436). In other words, there is no difference in the way one experiences their family’s treatment of him or her among patients and staff of the Han-ma-um Community.

16. How do you feel about the way Han-ma-um staff, and/or other members of the Community treat you?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.92</td>
<td>1.412</td>
<td>0.288</td>
<td>-1.383</td>
<td>0.171</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.27</td>
<td>2.077</td>
<td>0.280</td>
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<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.81</td>
<td>1.925</td>
<td>0.340</td>
<td>3.247</td>
<td>0.002</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for the treatment they receive from the members of Han-ma-um Community between the patients and staff (p-value = 0.171). In other words, there is no difference in the way one experiences the Han-ma-um Community member’s treatment of him or her among patients and staff of the Han-ma-um Community.

17. How much do you feel that you are being supported by your family?
With the significance level of 5%, there is no statistical evidence for difference in mean score for how much support one receives from family between the patients and staff (p-value = 0.553). In other words, there is no difference in how much support is given by his or her family among patients and staff of the Han-ma-um Community.

18. How much do you feel that you are being supported by the Han-ma-um Community?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.68</td>
<td>1.701</td>
<td>0.340</td>
<td>-0.987</td>
<td>0.327</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.16</td>
<td>2.347</td>
<td>0.317</td>
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<td></td>
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<tr>
<td>Group 2</td>
<td>31</td>
<td>5.87</td>
<td>2.078</td>
<td>0.373</td>
<td>2.553</td>
<td>0.012</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how much support one receives from the Han-ma-um Community between the patients and staff (p-value = 0.553). In other words, there is no difference in how much support is given by the Han-ma-um Community among patients and staff of the Han-ma-um Community.

19. How satisfied are you by the help given to you from your family?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.64</td>
<td>2.234</td>
<td>0.447</td>
<td>-1.059</td>
<td>0.293</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.00</td>
<td>2.618</td>
<td>0.353</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.38</td>
<td>1.930</td>
<td>0.341</td>
<td>3.310</td>
<td>0.001</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for satisfaction with the help one receives from family between the patients and staff.
(p-value = 0.293). In other words, there is no difference in how satisfied one is with the help from his or her family among patients and staff of the Han-ma-um Community.

20. How satisfied are you by the help given to you from the Community staff?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.20</td>
<td>1.528</td>
<td>0.306</td>
<td>-2.434</td>
<td>0.017</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.07</td>
<td>2.581</td>
<td>0.348</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>6.22</td>
<td>1.773</td>
<td>0.313</td>
<td>1.656</td>
<td>0.101</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is a statistical evidence for difference in mean score for the satisfaction with the help given by the Community staff between the patients and staff (p-value = 0.017). In other words, the patients are less satisfied with the help from the Community staff in comparison to staff of the Han-ma-um Community.

21. Do you feel hurt or disappointed by your family?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.60</td>
<td>1.633</td>
<td>0.327</td>
<td>-1.922</td>
<td>0.059</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>6.69</td>
<td>2.538</td>
<td>0.342</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.75</td>
<td>1.778</td>
<td>0.314</td>
<td>4.177</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how much one feels hurt or disappointed by family between the patients and staff (p-value = 0.059). In other words, there is no difference in disappointment from his or her family among patients and staff of the Han-ma-um Community.

22. Do you feel hurt or disappointed by Han-ma-um Community staff?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.24</td>
<td>2.107</td>
<td>0.421</td>
<td>-1.813</td>
<td>0.074</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.20</td>
<td>2.490</td>
<td>0.336</td>
<td>1.901</td>
<td>0.061</td>
</tr>
<tr>
<td>--------</td>
<td>----</td>
<td>------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>6.22</td>
<td>1.996</td>
<td>0.353</td>
<td>1.901</td>
<td>0.061</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how much one’s feels hurt or disappointed by Han-ma-um Community staff between the patients and staff (p-value = 0.074). In other words, there is no difference in disappointment from Han-ma-um Community staff among patients and staff of the Han-ma-um Community.

23. Do you believe that God will help you recover from your illness?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.84</td>
<td>1.748</td>
<td>0.350</td>
<td>-2.669</td>
<td>0.009</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.49</td>
<td>2.707</td>
<td>0.365</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.75</td>
<td>2.032</td>
<td>0.359</td>
<td>3.399</td>
<td>0.001</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for how likely one thinks that God will heal one’s illness between the patients and staff (p-value = 0.009). In other words, the patients find it less likely for God to help them recover from their illness than staff of the Han-ma-um Community.

24. Do you believe your life is worth living even during the time you are receiving treatment for your conditions?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.04</td>
<td>1.513</td>
<td>0.303</td>
<td>-3.111</td>
<td>0.003</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.71</td>
<td>2.242</td>
<td>0.302</td>
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<td></td>
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<tr>
<td>Group 2</td>
<td>32</td>
<td>5.59</td>
<td>2.198</td>
<td>0.388</td>
<td>4.275</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is a statistical evidence for difference in mean
score for how much one believes that life is worth living between the patients and staff (p-value = 0.003). In other words, the patients find their lives less worth living than staff of the Han-ma-um Community.

25. Are you seeking forgiveness?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.00</td>
<td>2.972</td>
<td>0.594</td>
<td>-0.109</td>
<td>0.913</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.07</td>
<td>2.659</td>
<td>0.358</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.28</td>
<td>2.399</td>
<td>0.424</td>
<td>-4.891</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how much one is seeking forgiveness between the patients and staff (p-value = 0.913). In other words, there is no difference in how much one is seeking forgiveness among patients and staff of the Han-ma-um Community.

26. Do you think your sins have been forgiven?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.08</td>
<td>1.381</td>
<td>0.282</td>
<td>-1.928</td>
<td>0.058</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>8.27</td>
<td>2.313</td>
<td>0.312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.50</td>
<td>2.328</td>
<td>0.412</td>
<td>5.379</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how much one believes his or her sins have been forgiven between the patients and staff (p-value = 0.058). In other words, there is no difference in how much one believes in forgiveness of his or her sins among patients and staff of the Han-ma-um Community.

27. How often do you think about the purpose of life and the meaning of your illness?
<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>7.48</td>
<td>3.164</td>
<td>0.623</td>
<td>-0.631</td>
<td>0.530</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.07</td>
<td>2.426</td>
<td>0.327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.88</td>
<td>2.075</td>
<td>0.367</td>
<td>4.290</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is no statistical evidence for difference in mean score for how often one thinks about the purpose of life and the meanings of one’s life between the patients and staff (p-value = 0.530). In other words, there is no difference in how often one thinks about the purpose and the meaning of life among patients and staff of the Han-ma-um Community.

28. Do you think your illness is a punishment from God for your sins?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>8.44</td>
<td>2.238</td>
<td>0.448</td>
<td>-2.285</td>
<td>0.026</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>7.09</td>
<td>2.856</td>
<td>0.385</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>4.81</td>
<td>2.039</td>
<td>0.360</td>
<td>4.319</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for how much one sees his or her illness as a punishment from God between the patients and staff (p-value = 0.026). In other words, the patients think more definitely about their illness as a punishment from God for their sins than staff of the Han-ma-um Community.

29. Do you believe God loves you?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.20</td>
<td>1.581</td>
<td>0.316</td>
<td>-1.961</td>
<td>0.054</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>8.31</td>
<td>2.418</td>
<td>0.326</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.88</td>
<td>1.827</td>
<td>0.323</td>
<td>4.930</td>
<td>0.000</td>
</tr>
</tbody>
</table>
With the significance level of 5%, there is no statistical evidence for difference in mean score for how much one believes God loves him or her between the patients and staff (p-value = 0.054). In other words, there is no difference in how much one thinks he or she is loved by God among patients and staff of the Han-ma-um Community.

30. Do you feel hopeful about your future including your eternal life?

<table>
<thead>
<tr>
<th>Participant</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean Std. Error</th>
<th>t-Stat</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex-Patient</td>
<td>25</td>
<td>9.28</td>
<td>1.242</td>
<td>0.248</td>
<td>-2.967</td>
<td>0.004</td>
</tr>
<tr>
<td>Group 1</td>
<td>55</td>
<td>8.15</td>
<td>2.155</td>
<td>0.291</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td>32</td>
<td>5.78</td>
<td>2.090</td>
<td>0.370</td>
<td>4.988</td>
<td>0.000</td>
</tr>
</tbody>
</table>

With the significance level of 5%, there is statistical evidence for difference in mean score for how often one feels hopeful about the future and eternal life between the patients and staff (p-value = 0.004). In other words, patients feel less hopeful about their future and eternal life than staff of the Han-ma-um Community.
CHAPTER FIVE

DATA ANALYSIS

This study examines a church-based recovery program of Han-ma-um Community in Korea that is dedicated to serving the mentally ill within the church with an alternative theology through various programs. One component of the examination is through the empirical data gathered from the patients in the recovery program. In the previous chapter, key statistics have been summarized with brief comments. This chapter offers a closer reading of statistical results presented in the previous chapter.

The empirical design of the study aims to discuss the quality of life of the mentally ill, taking into account physical, psychological, existential, supportive and spiritual criteria, and assuming that different criteria can be assessed separately. From the survey we have obtained statistical results showing the patients’ self report of their quality of life after they have attended the Han-ma-um Community’s recovery program for more than three months (this group of patients is the primary focus of this study and will be referred to as patient group 1 throughout this chapter). These results were also compared against the survey results from those who have been patients with mental illness, but later came back to the Han-ma-um Community after their condition had improved (which will be referred to as the ex-patient group) and those who have been in the Han-ma-um Community’s recovery program for less than 3 months (referred to as patient group 2). With the statistical results reported in the previous chapter, each of five categories will be discussed below in relation to the results of this study.

88
Quality of Life and Physical Criteria

Three questions are used for self-evaluation of quality of life using physical criteria. They address major complaints raised by patients with mental illness—anxiety, insomnia, and side effects from medication on daily life.

The data from this study show that the quality of life based on physical criteria is valued higher for patient group 1 than patient group 2 in all three segments. However, patient group 1 is still not as satisfied as the ex-patient group with the quality of life using physical criteria. The biggest difference between patient group 1 and the ex-patient group was observed from question three on side effects, while this was the only question that had no significant difference in mean score between patient group 1 and patient group 2. The mean analysis between these two groups reflects the fact that the Han-ma-um Community encourages patients’ use of prescribed medication and cares for any complications or side effects that may come from the prescription. The difficulty from side effects coming from prescriptions has the lowest score of 7.00 ± 2.867 on the 10-point scale, 0 being the worst. Side effects include weight gain, loss of appetite, drowsiness that affects the everyday life of a patient. At the same time, other common complaints such as anxiety and insomnia show a higher level of satisfaction for patient group 1 with statistical significance compared to the patient group 2. Such findings suggest that the patients in the recovery program willingly incorporate prescribed medicine in their treatment. Also, the longer the patients are in the program, the more informed and understanding they are about medication and its effects. This may be explained by the environment of Han-ma-um Community where side effects from the medication can be openly discussed and necessary help can be received.
Quality of Life and Psychological Criteria

In psychological criteria, there are five questions concerning patients’ psychological well-being. Questions address loneliness, anger, sadness, ability to control emotion, and how hopeful one feels about the future.

The data from this study confirms that the quality of life of a patient using psychological criteria is higher with statistical significance for patient group 1 than for patient group 2 in all five segments, while patient group 1’s mean scores were lower than the ex-patient group, except for question six. Question six asks about one’s ability to control current emotions. One contribution to this result is the Han-ma-um Community’s social environment that allows patients to build relationships and encourage each other. From constant and frequent exposure to this social setting, patients learn to work with their emotions more than those who have not been in the program for more than three months. In particular, the result for question four, “Do you experience loneliness?” turns out to have the biggest difference in mean scores both between group 1 and the ex-patient group (t-statistic = -2.434) and between patient group 1 and patient group 2 (t-statistic = 4.279). This indicates that special attention should be given to patients in this area. A more attentive manner in staff’s listening and counseling is necessary to increase satisfaction of patients in this regard.

Quality of Life and Existential Criteria

There are six questions that are used to assess the quality of life using existential criteria. Questions using existential criteria include the measure of self-importance, purpose of life and its progress, and subject valuation of the current moment, self and
everyday life.

The quality of life of a patient using existential criteria is found to be higher with statistical significance for patient group 1 than patient group 2 in all six questions. However, the results from patient group 1 show significantly lower mean scores in comparison to the ex-patient group in all six questions. In particular, for question nine, “How do you feel about yourself?” the mean score was the lowest (6.98 ± 2.453). This question was also where the biggest difference was found among different patient groups. This translates to the low level of dignity that is apparent for mental patients. But, with the help of staffs and family, patients can recognize their conditions as only an illness and further develop positive understanding of their self. From the results of comparing group 1 and 2, it can be suggested that Han-ma-um helps patients with restoration of one’s dignity, because the difference is even more apparent when compared to ex-patient group.

**Quality of Life and Supportive Criteria**

The quality of life using supportive criteria is measured by posing eight questions about how satisfied patients are with the support from their family and from Han-ma-um staff members.

In supportive criteria, the survey results suggest that the quality of life of a patient is higher for patient group 1 than patient group 2 in most areas, except for those questions concerning staff members. Question 22 that asks about one’s disappointment in Han-ma-um staff shows no significant difference in mean score between patient group 1 and patient group 2 or between patient group 1 and the ex-patient group. However, question 20 which asks about one’s satisfaction with the help from staff members shows significant difference
between patient group 1 and the ex-patient group, while the difference in mean score is not significant between patient group 1 and 2. This finding suggests that the level of disappointment in staff members is low for participants of the the Ham-ma-um’s recovery program—in fact, it is a similar level to that ex-patients have for staff members—while the level of satisfaction was also low. Patients are not hurt by the staff members, but patients (regardless of their duration of participation in the program) are not satisfied with the staff members either. Indeed, this was the only question that had significantly different mean scores between patient group 1 and the ex-patient group.

On the other hand, if mean scores were to be directly compared within the same group, the level of satisfaction was overall lower for support, help and treatment received from family members than from staff members. This finding is consistent for all three groups, with a growing gap for patient group 2. Patients indeed have more appreciation for the care from Han-ma-um staff members, and new comers to the program have not yet built the same level of appreciation in comparison to those who have been in the program for more than three months. Such a finding encourages educating patients’ family members on mental illness so that they can provide adequate care for patients. Understanding patients’ conditions and ability to sympathize with their difficulty become core elements in family support in patients’ recovery. The mean scores from questions that address satisfaction of patients with the support they receive and disappointment from their family and staff show a noticeable difference. Patients are more disappointed by their family than by the staff of the Han-ma-um Community. This may be caused by more frequent contact with and higher expectations for family than for staff. In the end, both family members and staff should pay more attention in their care-giving manner to patients, so that they do not
hurt them or disappoint them.

Quality of Life and Spiritual Criteria

The spiritual criteria consists of eight questions concerning how patients feel about themselves and their illness in relation to God, sin and its forgiveness, present and eternal life.

Before looking at the results, an important remark should be made about the participants of the study. 96.2% of the participants in patient group 1 and 90.9% in patient group 2 are Christians. Since the Han-ma-um Community is a church-based organization and given the profile of the participants, the Christian elements of the recovery program—bible study and prayer meetings—are believed to contribute a positive result in program review from the spiritual aspect.

The quality of life of a patient using spiritual criteria is reflected to be distinctively higher for patient group 1 than for patient group 2 from the difference in mean scores. In every question, patient group 1 had a greater mean score by 2 points or higher. In particular, between patient group 1 and the ex-patient group, the biggest score difference is from question 24 that asks if they believe their life is worth living while receiving treatment for their condition (t-statistic = -3.111). The biggest difference in scores between patient group 1 and 2 is from question 26 that concerns if they think their sin is forgiven (t-statistic = 5.379).

In addition to these finding, given the significant difference in mean scores among different groups of participants from question 28 which addresses if they believe that their illness is a punishment from God, the survey results show that many patients still have the
extra burden of believing their mental illness is a punishment for their sin. Constant care and education must be given to patients to help them realize their illness is not related to punishment. Also, for question 30 asking if patients feel hopeful about their future, including eternal life, the mean score did not indicate a strong hope for the future for patient group 1 in comparison to the ex-patient group (p-value = 0.000). Although their mean score in question 30 (8.15 ± 2.155) is much higher than that of patient group 2 (5.78 ± 2.090), it is lower than the mean score of the ex-patient group (9.28 ± 1.242) with statistical significance.

From the discussions above, one can see the overall quality of life in all five criteria is significantly higher on average for patient group 1 than patient group 2. In some segments, such as supportive criteria and some portions of spiritual criteria, patient group 1 shows no significant difference from the ex-patient group in self-assessment of their quality of life. This finding as a whole indicates that the Han-ma-um Community’s recovery program has positive effects on patients’ quality of life for those who attend for more than three months. Also, it supports the initial hypothesis of this study that the recovery process of mental patients can be positively enhanced with church-based recovery programs.

The survey results identified the areas in which the Han-ma-um Community should improve in its recovery program. In particular, the questions in psychological and existential criteria received mean scores that were significantly lower than that of the ex-patient group even for patient group 1 who have been long-time participants of the program. In the next chapter, how the Han-ma-um Community can begin to address this issue will be addressed with recommendations for future work and study.
CHAPTER SIX

CONCLUSIONS

Discussions

The goal of this study was to provide an alternative understanding of mental illness and treatment to the Korean Church. By evaluating the effectiveness of the Han-ma-um Community’s recovery program, it sought to present a real-life example of how such an alternative view on mental illness can be put to use in church programs. As a way to assess the effectiveness of this church-based recovery program, a questionnaire was designed for participants to self-evaluate the level of satisfaction in one’s quality of life after participation in the program. Five different criteria were used. The results from the survey support the hypothesis that when combined with psychiatric treatment for mental illness, the church-based recovery program was statistically effective for improving the quality of life of mental patients.

To explore this topic further, the researcher reviewed results from the five criteria (physical, psychological, existential, supportive, and spiritual) and compared these results with previous studies presented in the literature review.

In group 2 (members who participated in the group less than three months), members showed low satisfaction level on both positive effects and side effects of medication such as weight gain, loss of appetite, and drowsiness. The low satisfaction levels found in group 2 are because most of members in group 2 started taking medication after they began participating in the community; the individuals in group 2 yet did not have much time to express and experience the benefits of taking medication. In group 1
(members who participated in the group more than three months), members were satisfied with positive effects of medication although they showed relatively low satisfaction level regarding the side effects of medication. The difference found in two groups suggests that taking medication certainly reduces the symptoms of their disorder though they still struggle with side effects of medication.

As expected, ex-patient group showed very high satisfaction levels on both positive effects and side effects of medication because they are the ones that benefited from medication and are no longer need to take medication. Notably, there is a positive and progressive interpretation of the results that the satisfaction level with medication. The ex-patient group is accepting medication which is demonstrated by the positive results of their satisfaction.

This lays out the fact that the patients in the Han-ma-um Community are combining medication and the program together as their treatment. This approach to medication is contrary to the traditional belief\(^1\) in Korean Churches that mature Christians do not need medication to treat mental illness. Benefits shown in group 2 and ex-patient group suggest that medication is in fact an effective way to treat mental illness.

The individuals in the ex-patient group report functioning normally in their daily lives and able to help other members of the community as volunteers. Their recovery and functioning are consistent with the view of the Han-ma-um Community that God uses medication as a means of healing mental illnesses and that mental illness is a disease that needs treatment. This view provides an alternative to claims from Moo Seok Lee’s

research\textsuperscript{2} that identifies demon possession as the cause of mental illness and from Korean Christian Counseling\textsuperscript{3} that views mental illness as the result of sin. The results of the self-evaluation based on physical criterion provide a good opportunity to consider and accept positive use of medication in the church and to re-conceptualize the etiology of mental illness.

Based on the results of the psychological criterion questions, members’ quality of life correlates positively with length of involvement in the community. It was interesting to find that there was no significant difference found in question 6 “ability to control emotion” between the ex-patient group and group 1 (members who participated in the community more than three months). This finding implies that the members have set high standards in their own struggle with controlling emotion so that their ability to control and notice a change of emotion in others are in line with what is deemed appropriate in the main stream society. The high standard on their ability to control emotion is a good sign for people with mental illness because it can play an effective role in treating and modifying behaviors. The ability to control are learned skills that can be seen as a result of social and interpersonal training that are offered in the community. The Han-ma-um’s focus on the interpersonal relationships is consistent with Winnicott’s concept of \textit{good-enough mother}\textsuperscript{4}. The idea that individuals grow with formation of healthy relationships and fulfillment of internal needs is exemplified by participants’ growth in the community.


\textsuperscript{3} Kyu Myeong Whang, \textit{The Principles and Methods of Bible Counseling} (Seoul: Bible Readers, 2008), 108-109.

In the community, members who have mental illness are able to build relationships with non-patients and, through these relationships, patients can learn interpersonal skills and how to recognize and deal with their areas of weaknesses. Then, through staff care and healthy relationships, the internal needs of patients can be met. It is within the relationship that patients are able to recognize their psychological needs and are gradually trained to fulfill their needs by utilizing resources that are accessible to them. This approach differs from the teachings of Korean Christian counseling, which demands absolute obedience. Unlike this notion of total obedience, the Han-ma-um’ approach encourages patients to participate in their own healing process, and plants the idea of independence that can be reached through their efforts. Another benefit of this approach is that patients no longer need to be isolated within their family and hidden from public. It leads patients out into the community where family members and the church community can contribute to the healing process. The results of this study support this approach. The study found through self-evaluation on questions regarding loneliness, anger, sadness and how hopeful one feels about the future that participants benefit from participation in their healing. Group 1 (three months or more) was found to have a relatively higher satisfaction level than the group 2 (less than three months). In addition, the satisfaction level in the ex-patient group was found to be significantly high.

In other words, the Han-ma-um Community’s approach of relating all aspects of treatment—medication, social skills, relationships, and spirituality—facilitates increasing a patient’s quality of life.

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Using existential criterion, quality of life was positively correlated with the length of involvement in the community. In question nine, “how do you feel about yourself?”, there was an overall difference found between the ex-patient group and group 1. This result can be interpreted to mean that not same as feeling positive about quality of one’s life - awareness of reality improves as people are involved in the community longer. The difference found between the groups is reasonable because group 1 consists of people who are still receiving treatment for their diagnosis whereas the ex-patient group consists of individuals who are no longer diagnosable. However, the study showed that group 1 had high satisfaction levels in all the existential questions (questions 9 through 14) except the question 9, which suggests that the members are in fact restoring their self-esteem.

The result of this study parallels the findings of Shin Duck-Shin’s study that “the spirituality of a mental patient has a positive contribution on the patient’s recovery when the patient recognizes the purpose of life and tries to overcome his or her conditions through reforming the relationship with self, neighbors, and God.”\(^6\) The summary of the survey reveals that the patients in the community have a clear understanding of their own illnesses and the mismatch between reality and their view of self. The statistical data shows that they see themselves as having goals and direction in their lives although they carry mental illness. This also parallels Kohut’s, who says that “if self does not reach the healthy state, the true ideal relationship with the object cannot be established and unhealthy self can lead to problems such as narcissistic personality disorder.”\(^7\) This is a reflection of the

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\(^7\) Self, it is an off-spring of a relationship between the self and its outer environment (or the self object such as parents). A person with a rich experience of mirroring, idealization, and twinship will
community’s focus on strengthening and developing the “self.” Furthermore, the
volunteers from the ex-patient group give patients the hopeful and encouraging message
that they can be healed from mental illness as well.

The findings suggest disagreement on the traditional viewpoints put forward by
Kung Oh Lee and Yong Gi Cho that God does not answer the prayers of mental patients
due to their unstable state of mind. Rather it suggests that the environment within the
church plays an important role in healing and recovery from mental illness. In addition, the
results of this study are consistent with the findings of Choi, Young Min, Lee, Jung Ho,
Lee, and Gi Chul, who state that the Christian faith of a patient and/or a psychiatrist has
a positive contribution to the recovery of the patient’s mental condition.

Regarding supportive criterion, quality of life positively correlates with the length
of involvement in the community. The question 20, which asks about one’s satisfaction
with the help from staff members, showed that the ex-patient group had significantly
higher satisfaction level of the help from staff members than other two groups. It is
interesting to note that different groups had different satisfaction levels on the same staffs’
help that is offered to all the members of the community. Higher satisfaction level found in
the ex-patient group suggests that as patients learn to interact with staff members, they
come to value the importance of the relationship and value the help provided by the staff

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8 Lee, Kung Oh, “Christian Counseling for Mental Illness people :centering Alcholism” Master of

9 Yong Gi Cho, Sam-Bak-Ja Gu-Won (Seoul: Young Shin Sa, 1979), 244.

10 Choi, Young Min, Lee, Jung Ho, Lee, Gi Chul. “Influences of Christianity of Psychiatrists and
Patients on Clinical Practice” in Journal of the Korean Neuropsychiatric Association Vol. 33,
No.6,1994.1343.p. 1348
members. The finding also suggests that interpersonal support takes time to be effective in treatment process because they first learn how to build relationship with others and later benefit from valuing the importance of the relationships.

Also, the support from the staff was found to be more satisfying to patients than the support from patients’ family members. This result suggests that staffs have more skills that are helpful to patients and have experience that helps them relate to patients. Also, patients who are not involved in the community for a long period of time have family members who do not have enough skills to take care of the patient at home. This finding points to the staffs’ responsibility to teach family members the skills that they need in order to take care of the patient so when the environment at home and environment in the community become similar, the time required to treat individuals with mental illness can be shortened. This idea of integration disapproves the claim of many Korean churches and pastors\(^\text{11}\) that people with mental illness should be separated from their family members and be isolated for their treatment.

The statistical data shows that beneficial environments for mental patients are created by both the community of church and family members that can accept and accommodate the struggles of the patient.

Considering spiritual criterion, there was positive correlation between quality of life and length of involvement in the community. This has the implication that the programs offered by the community such as Sunday worship, bible study and prayer meetings are having a positive influence on the quality of their spiritual life. The statistical results show that there is a distinctively higher score for patient group 1 than for patient

group 2 from the difference in mean scores. In every question, patient group 1 had a greater mean score by 2 points or higher.

Question 24 which asks if they believe their life is worth living while receiving treatment for their condition (t-statistic = -3.111) showed a significant difference which means that patients who have participated in the community for a long period of time have applied new theological interpretation to their life with mental illness and have come to highly value their lives. On the other hand, low scores on question 26 which asks if they think their sin is forgiven (t-statistic = 5.379) and question 28 which addresses if they believe that their illness is a punishment from God are found among those who are involved in the community for a short period of time. The survey results show that many patients still have the extra burden of believing their mental illness is a punishment for their sin. This is consistent with the findings in the Ha, Hyun-Bong, Park, Chul-Soo, Sohn, Jin-Wook study that presents that psychiatric patients’ religious beliefs and practices are considerably different from that of healthy people and have negative effects on recurrence of mental illness, conditions and recovery.12

The low scores found in questions 26 and 28 can be viewed as an example of the negative influence of the Shamanistic teachings of churches that mental illness is a punishment from God. The findings in questions 26 and 28 have further implication that it is often difficult for new members to apply the theological view points of the Han-ma-um community to re-interpret the cause of mental illness, because of traditional Korean Church attitudes. Also, on question 30 asking if patients feel hopeful about their future,

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including eternal life, the mean score did not indicate a strong hope for the future for
patient group 1 in comparison to the ex-patient group (p-value = 0.000). Although their
mean score in question 30 (8.15 ± 2.155) is much higher than that of patient group 2 (5.78
± 2.090), it is lower than the mean score of the ex-patient group (9.28 ± 1.242) with
statistical significance. Simply, the statistical analysis suggests that longer participation in
the community has an impact on patients’ feelings of hopefulness.

Patients have difficulty creating positive world views unless they understand with
alternative theology that their sins are forgiven and they are thus set free from the sin. This
is another example of how Korean Christianity holds negative attitudes towards the
personality and spirituality of people with mental illness, because the ex-patient group that
accepted the theological view of the Han-ma-um community has shown high scores in all
aspects of spiritual criterion. The ex-patient group has acquired the right understanding of
mental illness and learned to build personal relationships with God through long
involvement in the community.

As mentioned above, Shamanistic understanding of mental illness (abandoned by
God, punishment for sin) and the means of treatment (the practice of exorcism) can prevent
people from participating in the more positive methods of a program like the Han-ma-um
community. By contrast, patients in the community model are showing improvement by
using combined methods of medication and other therapies.

The results of this study offer an alternative perspective and method of treatment
to the Korean Protestants’ perception of mental illness. Korean Protestant churches would
benefit from recognizing that their theological understanding is inappropriately applied to
people with mental illness and new perspectives need to be explored. The participants of
this study responded that the Han-ma-um recovery program has positively influenced the quality of their lives. This study evaluates and provides an example of the alternative recovery program that can effectively serve and help people with mental illness in their process of healing.

**Recommendations**

From the study of Han-ma-um Community, I recommend the following:

First, this study can be extended to compare evaluations from patients who have been in the recovery program for more than 3 months and those for less than 3 months in order to present the effectiveness of the program more clearly.

Two, in the future, the survey can be first given to the patients who are new to the Han-ma-um Community, then again after they have participated in the recovery program for some duration.

Three, a more in-depth analysis of the reliability of the survey results should be performed in order to refine the survey questions and their measurement.

Four, professional knowledge of mental illness and information about the Han-ma-um Community should be organized for educational purposes, so that the church leaders in Korea can learn from these resources.

Five, low scores found on the supportive criterion of staff suggest need for change in the areas of attitudes and training of staff. The staff of Han-ma-um should try to be more sensitive to the needs of patients. Also, staff need to put more effort into training and helping family members with their management skills at home. This can hopefully lead to creating similar environments in the community and at home.
Six, from the results of the spiritual criterion, there needs to be more focus on theological re-interpretation and education for the patients. The best way for the patients is to be able to indirectly see and experience how the lives of staff have changed since their involvement in the community. It requires a long period of time to apply and re-conceptualize illness, but in the process it is important for patients to be able to experience the love of God that is lived out by the other members of the community, especially the staff. In this sense, staff have more responsibility to be role models with greater commitment of love.

Seven, from the data that showed low scores on psychological and existential criteria from group 1 compared to the ex-patient group, there is more need for help from staff members. Staff can invest more interest in participating in sessions of individual counseling and other various therapies and interventions to fulfill the psychological and existential needs of the patients.

In conclusion, the results of this study showed that Han-ma-um community has positive influence on physical, psychological, existential, supportive, and spiritual aspects of the members’ lives. The alternative theology in Han-ma-um community provides different approach to understanding of mental illness and the community model presents effective treatment that integrates necessary aspects of healing. This study can speak to the pastors of Korean Churches that there are different ways to understand mental illness and ways of treatment that are proven effective and experienced by many in the community. Once pastors can recognize this different approach, planting equivalent and fully-functioning communities in other churches will be feasible and different communities can eventually work together to build broader social support network and share resources.
Loving and caring communities in which patients can experience healing is not only geared towards Christians but it can also be very effective tool to share the gospel with non-Christians whom we can share the grace that God shows in our lives.
APPENDIXES

Appendix A

Boston University
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Informed Consent Form

Title of Study: The Effect of Church-based Recovery Programs on the Quality of Physical and Spiritual Life of the Mentally Ill In Korea: Case Study of the Han-ma-um Community’s Recovery Program

Dear Community Member,

This research study is designed to evaluate the effectiveness of the programs at the Han-ma-um Community for a doctoral dissertation. The main purpose of my study is to provide an alternative understanding of mental illness to the Korean Church by investigating the effect of therapy programs offered by the Han-ma-um Community on mental patients’ recovery.

You are being invited to participate in this study because you either are currently, or have been in the recent past, a member of the community. You have been selected because you have participated in the program for at least three months. Also, you are considered to be academically and mentally capable of completing the questionnaire.

This questionnaire is mailed out to 150 members of Han-ma-um community and the expected number of participants in this study is about 70 to 100. If you agree to the terms and conditions of this study explained in this letter and decide to volunteer to participate in the study by completing the questionnaire, you may hold on to the questionnaire up to four weeks. Once you complete the questionnaire which will take you about 30 minutes, you may mail it back to the Han-ma-um Community office by using the self-addressed envelope which is included in this mail or drop it off in the box labeled “Jung Questionnaires” in the Community coordinator’s office. Then, your questionnaire will be used for the doctoral dissertation only. If you would like to change your decision on participating in the study or skip any question in the questionnaire, you may do so at any point. However, any incomplete questionnaire will still be helpful to us.

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There is no foreseeable lasting risk to participating. Since the questionnaire will be completed privately, there is no great risk expected by participating in the study. However, if you feel you have revealed too much of your thoughts, you may become more sensitive, and, if needed, can take your reactions to therapy at the community. Also, the researcher is going to be available by telephone or e-mail if you wish to share any of your concerns. If you want to talk to others about their reactions, the researcher will refer you to anyone whom you prefer. In case such situation takes place, you will not be held accountable or required to pay any penalty. Also, the situation will not negatively affect the relationships between you and the researcher or staffs.

Participants may benefit from having their opinions regarding their experience in the community heard and taken seriously. Your opinions, positive or negative, will be valued and will impact the future of the community. Once the feedback is provided, the community will have the opportunity to understand your needs and make appropriate improvements. Therefore, you will benefit from the changes that will take place in the community based on the feedbacks provided by you.

Taking part in this research study is voluntary. There will be no penalty or other consequences if you decide not to participate. You may choose not to take part at all. If you agree to participate in this study, you may stop participating at any time. You may also choose not to answer any of the questions in the questionnaire. If you decide not to take part, or if you stop participating at any time, your decision will not result in any penalty or loss of benefits to which you may otherwise be entitled.

This study will be entirely anonymous. Questionnaires will be mailed out without being coded by numbers. The researcher will not have any way to know who the respondents are. Since you will not be asked to sign your name, or provide any information that would directly identify you, your information will remain confidential throughout the study. All your questionnaires will be stored at a designated space with limited access only to the community coordinator who does not have any way to identify your questionnaire or access to the content of the questionnaire.

In the event of any report or publication from this study, your identity will not be disclosed. Results will be reported in a summarized manner in such a way that you cannot be identified.

If you have any questions, you can speak with the community coordinator, my advisor at Boston University (whose email is provided below) or directly with me at 010-9977-3139 or jmihyae@bu.edu. Also, if you have any questions regarding the rights of subjects participating in the study, please contact David Berndt at 617-353-4365 or dberndt@bu.edu.

Mi Hyae Jung
Doctor of Ministry Candidate
Boston University
Carole R. Bohn, Dissertation Advisor
Associate Professor of Counseling Psychology & Religion
Boston University
Email: cbohn@bu.edu
Phone: 617-353-3050

David Berndt
Charles River Campus
Institutional Review Board
Boston University
Phone: 617-353-6660
Appendix B

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www.bu.edu/sth

Please carefully read the questions and check the answer that applies to you.

1. Sex: Male (  ) Female (  )
2. Age: ___
3. How long have you been in treatment for your condition (either at Han-ma-um community or other psychiatric institution)? _______ months
4. What is your religion and how long have you been practicing that religion?
   ① Presbyterian ( ______ years)  ② Buddhism ( ______ years)
   ② Catholic ( ______ years)  ④ Confucianism ( ______ years)
   ⑤ Others ______________________ ( ______ years)
5. What is the highest level of education you have received?
   ① No Schooling ② Elementary School ③ Middle School ④ High School
   ⑤ College and/or Graduate School
6. How long have you been participating in the Han-ma-um Community’s recovery

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1 This questionnaire was translated to Korean before distribution. However, the format maintained as it has been displayed here.
program? ________ years ________ months

7. What is the current status of your treatment?

   Back to daily life (  )
   Improved (  )
   Finished with treatment and in the process of adjustment to the society (  )
   In treatment, but without major difficulty in everyday life (  )
   Still in treatment (  )
   Continuing problems (  )

8. If you are attending Han-ma-um Community’s recovery program as a guardian of a patient, how long have you been doing so? ________ years ________ months

Please circle the number on the following scales which most closely represent your response. For the physical condition(s) that you currently experience, please indicate the level of influence the condition(s) have on your daily life.

<table>
<thead>
<tr>
<th>Extremely Serious</th>
<th>Moderately Serious</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety: 0 1 2 3 4 5 6 7 8 9 10</td>
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<td></td>
</tr>
<tr>
<td>2. Insomnia: 0 1 2 3 4 5 6 7 8 9 10</td>
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<tr>
<td>3. Side effects from long-term use of medication (for example, weight gain, loss of appetite, drowsiness, etc.) 0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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<tr>
<td>4. Do you experience loneliness? Extremely Lonely Moderately Lonely None 0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
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<tr>
<td>5. Do you get angry often—about yourself, and/or your surroundings?</td>
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</table>
Extremely Angry    Moderately Angry    None
0    1    2    3    4    5    6    7    8    9    10

6. Do you believe you can control your current emotion by yourself?

Most Definitely    Definitely    None
0    1    2    3    4    5    6    7    8    9    10

7. Do you feel sad?

Extremely Sad    Somewhat Sad    Not at all
0    1    2    3    4    5    6    7    8    9    10

8. How do you feel about your future?

Not Hopeful    Okay    Very Hopeful
0    1    2    3    4    5    6    7    8    9    10

9. How do you feel about yourself?

Meaningless and Unimportant    Very Meaningful and Important
0    1    2    3    4    5    6    7    8    9    10

10. In achieving the purpose of your life, if you have one, how do you evaluate your accomplishment?

Not making any progress    Moving forward and progressing
0    1    2    3    4    5    6    7    8    9    10

11. How do you value this moment in your life?

Not Valuable at all    Very Valuable
0    1    2    3    4    5    6    7    8    9    10

12. How much control do you think you have over your life?

Not Control at all    Full Control
0    1    2    3    4    5    6    7    8    9    10

13. As a person, how much do you like yourself?

Very Hateful    Very Lovable
14. How do you like your daily life?

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<tbody>
<tr>
<td>Very Burdensome</td>
<td>Not Burdensome at all</td>
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15. How do you feel about the way your family treats you?

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<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Disrespectful and Cold</td>
<td>Responsive to my needs and Protective</td>
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16. How do you feel about the way Han-ma-um staff, and/or other members of the Community treat you?

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<tbody>
<tr>
<td>Disrespectful and Cold</td>
<td>Responsive to my needs and Protective</td>
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17. How much do you feel that you are being supported by your family?

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<tbody>
<tr>
<td>Very Much</td>
<td>Not at all</td>
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18. How much do you feel that you are being supported by the Han-ma-um Community?

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<th>10</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>Very Much</td>
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19. How satisfied are you by the help given to you from your family?

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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>Not Satisfied at all</td>
<td>Very Satisfied</td>
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20. How satisfied are you by the help given to you from the Community staff(s)?

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<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not satisfied at all</td>
<td>Very Satisfied</td>
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21. Is your feeling hurt or disappointed by your family?

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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very hurt and disappointed</td>
<td>Not hurt at all</td>
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</tbody>
</table>
22. Is your feeling hurt or disappointed by Han-ma-um Community staff(s)?

<table>
<thead>
<tr>
<th>Very hurt and disappointed</th>
<th>Not hurt at all</th>
</tr>
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<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
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</tr>
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</table>

23. Do you believe that God will help you recover from your illness?

<table>
<thead>
<tr>
<th>Very Unlikely</th>
<th>Absolutely Certain</th>
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</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
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</table>

24. Do you believe your life is worth living even during the time you are receiving treatment for your conditions?

<table>
<thead>
<tr>
<th>Worthless</th>
<th>Absolutely worth</th>
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</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
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</table>

25. Are you seeking forgiveness?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
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</table>

26. Do you think your sins have been forgiven?

<table>
<thead>
<tr>
<th>Nothing has been forgiven</th>
<th>All my sins have been forgiven</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
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</table>

27. How often do you think about the purpose of life and the meaning of your illness?

<table>
<thead>
<tr>
<th>Never</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
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</table>

28. Do you think your illness is a punishment from God for your sins?

<table>
<thead>
<tr>
<th>Most Definitely</th>
<th>Definitely Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>

29. Do you believe God loves you?

<table>
<thead>
<tr>
<th>Definitely Not</th>
<th>Most Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
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</tbody>
</table>
30. Do you feel hopeful about your future including your eternal life?

<table>
<thead>
<tr>
<th>No hope at all</th>
<th>Very Hopeful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0   1   2   3   4   5   6   7   8   9   10</td>
<td></td>
</tr>
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</table>
Appendix C

Boston University
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연구에 대한 부탁의 말씀

주제: 한국교회안의 치유 프로그램이 정신 질환환우들의 신체적 영적 삶의 질에 미치는 영향 (Case Study:한마음공동체의 치유프로그램에 참가하는 환우들 중심으로)

안녕하십니까?

저는 보스턴 대학교 신학대학원에서 목회학 박사과정을 이수하고 있는 정미혜목사입니다. 본인은 한국 교회 안에 있는 정신질환환우 여러분들의 삶의 질에 깊은 관심을 가지고 있으며 이와 관련하여 출업논문을 준비하고자 합니다.

본 설문지는 한마음 공동체 프로그램운영이 한마음에서 함께 활동하시는 선양생활을 하고 계시는 환우분들의 삶의 질에 얼마나 영향을(긍정적이고, 부정적이고) 미치고 있는지를 알아보기 위한 것으로 여러분의 솔직하고 성의 있는 응답내용은 여러분들을 보다 깊이 이해하며 더 나아가 삶의 질을 향상시킬 수 있는 한마음 프로그램 목회적 토론의 계획수립 시 기반이 될 것입니다.

현재 3개월 이상 한마음에 참석하고 계시거나 과거에는 참가였지만 지금은 치유되어 정상적인 삶을 사시는 분일지라도 한마음공동체에 3개월 이상 참석하셨던 분이라면 누구나 설문에 참여하실 수 있습니다.

이 연구는 자원해도 하실 분들만 응답하실 수 있으며 혹 설문지를 받으신 분 중 연구에 참여하고 싶지 않으신 분은 언제든지 거부하실 수 있으십니다.

혹시 설문지를 작성해 가시는 도중에 마음이 변하여 응답을 하고 싶지 않은 질문항목이나 문장가 일어나는 상황이 생기시면 언제나 그 질문 항목은 그냥 넘어가실 수가 있고 저에게 전화로 연락하실 수가 있습니다. 더 나아가 상담이나 대화를 원하시면 언제든지 저의 번호로 연락 주시고 또 제가 아닌 다른 분과의 연락을 원하시면 성심써 의결 제가 드겠습니다.

이 연구에 참여하시는 분들 개인에게는 어떠한 이익이나 불이익은 없습니다. 다만 논문이 다 작성된 후 연구결과를 한마음 스탭 분들께 보고 드려서 여러분들의 삶의 질을 향상시킬 수 있는 프로그램으로 발전 할 수 있도록 최대한 협조하겠습니다.
연구결과에 대하여는 다른 어떠한 목적으로도 사용되지 않을 것이며 응답 내용은 철저한 비밀이 보장될 것입니다. 한마음 간사님이 4주 동안 분리된 잠겨져 있는 사물함에 여러분들의 자료를 보관 할 것이며 열쇠는 간사님 혼자서 관리 하실 것이며 자료가 다른 곳으로 누출 되지 않도록 비밀은 철저히 보장 되도록 간사님이 약속을 지키실 것입니다.

저나 한마음 스탭 누구도 누가 응답을 하셨는지 아닌지에 대해서 전혀 알 수가 없도록 되어있습니다. 그러나 여러분들은 이름을 쓸필 필요가 없으시며 누구든지 무기명으로 이 질문지에 응답하실 수가 있으시므로 여러분들의 솔직한 의견을 해당번호에 표시 해주시면 되십니다.

신체적 심리적으로 많이 힘들신 상태임에도 불구하고 연구에 참여 하여 주셔서 진심으로 깊은 감사를 드립니다. 이 연구에 관련한 어떠한 질문이나 궁금하신 점이 있으시다면 한마음 간사님이나 저에게 연락 주실 수 있습니다. 그리고 혹시 보스턴 대학교에 게시는 저의 지도교수님이나 조사연구기관 책임자에게 질문이 있으시다면 아래의 연락처로 연락 주시면 감사하겠습니다.

2009년 8월
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Appendix D

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질문지

※ 다음 질문을 읽고 해당 라인에 √표를 해 주세요.

1. 성별: 남( ) 여( )
2. 연령: 만________________세
3. 증상에 대한 치료받은 기간은 얼마나 되십니까?________년________개월
4. 종교는 무엇이며 그 종교를 가진 기간은 얼마나 되십니까?
   ① 기독교____( 년 ) ②불교____( 년) ③카톨릭____( 년)
   ④ 유교____ ( 년) ⑤무교____( 년) ⑥ 기타______( 년)
5. 최종학력은 어떻게 되십니까?
   ① 무학______② 초등학교 졸______③ 중학교 졸______

   ④고등학교졸______⑤ 대학교 졸______⑥대학교졸업 이상______
6. 한마음 프로그램에 참석하신 기간은 얼마나 되십니까?
   ____________ 년 __________개월
7. 최근 치료상태는 어느 정도이십니까?
   ① 완전히 회복되었다____
   ② 약물치료는 끝났고 사회적응 훈련 중이다____
   ③약물 복용중이나 일상생활에 지장이 없다____
   ④약물치료 중이며 일상생활에 지장이 있다._______
   ⑤아직도 심한 증상들이 있다.____
8. 만약 환자가족으로 한마음에 참여하고 계시다면 한마음에 참여하신 기간은 얼마나 되신니까? _______년 _______개월

아래 중상 중 현재 일상생활에서 느끼는 당신의 느낄 정도를 해당항목에 √표를 해주세요.

<신체적 측면>

1. 일상생활에서 느끼는 당신의 불안감은 어느 정도이십니까?

<table>
<thead>
<tr>
<th>매우 심각하다</th>
<th>조금 심하다</th>
<th>전혀 없다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. 수면장애 중상 때문에 일상생활에 지장을 받고 계십니까?

<table>
<thead>
<tr>
<th>매우 심각하다</th>
<th>조금 심하다</th>
<th>전혀 없다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. 약물치료에 부작용으로 일상생활에 지장을 받고 계십니까? (예:제중 증가, 식욕부진, 몽상, 꿈에서 등 해당사항이 있어서 사회생활에 어려움이 있다면 그 정도를 숫자로 표시해 주세요.)

<table>
<thead>
<tr>
<th>매우 심각하다</th>
<th>조금 심하다</th>
<th>전혀 없다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<심리적 측면>

4. 현재 당신은 외로움을 느끼십니까?

<table>
<thead>
<tr>
<th>극도로 외롭다</th>
<th>보통이다</th>
<th>전혀 아니다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. 현재 자신이나 주변 사람들에 대한 분노가 있습니까?

<table>
<thead>
<tr>
<th>매우 화가남</th>
<th>보통이다</th>
<th>전혀 화가 나지 않음</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. 현재 감정을 스스로 조절할 수 있다고 생각하십니까?

<table>
<thead>
<tr>
<th>전혀 조절 할 수 없음</th>
<th>보통이다</th>
<th>전적으로 조절할 수 있다</th>
</tr>
</thead>
</table>
7. 현재 숨은 감정을 느끼십니까?

<table>
<thead>
<tr>
<th>항상 숨프다</th>
<th>보통이다</th>
<th>전혀 숨프지 않다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. 현재 당신의 미래에 대해 생각해 보신다면 어떤 느낌이 드십니까?

<table>
<thead>
<tr>
<th>희망적이지 않다</th>
<th>보통이다</th>
<th>매우 희망적이다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<실존적 측면>

9. 현재 귀하 스스로의 존재에 대해 어떻게 느끼십니까?

<table>
<thead>
<tr>
<th>무의미하고 중요 하지 않다</th>
<th>보통이다</th>
<th>매우 중요하고 의미 있는 존재다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. 만약 당신이 인생에 대한 목적이 있다면 현재 그 목적이 달성하는데 있어서 스스로가 어떻게 하고 있다고 생각하십니까?

<table>
<thead>
<tr>
<th>전혀 전진하지 못하고 있다</th>
<th>보통이다</th>
<th>목적달성을 위해 전진하고 있다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. 지금의 이사기가 당신에게 가치가 있다고 생각하십니까?

<table>
<thead>
<tr>
<th>전혀 가치가 없다</th>
<th>보통이다</th>
<th>매우 가치가 있다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. 일상적인 삶을 스스로 조절 할 수 있다고 생각하십니까?

<table>
<thead>
<tr>
<th>전혀 조절 할 수 없다</th>
<th>보통이다</th>
<th>완전히 조절 할 수 있다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. 한 인간으로서 자신에 대해서는 얼마나 좋게 느끼십니까?
14. 일상생활을 해 나가는 데 어느 정도 부담감을 느끼십니까?

<table>
<thead>
<tr>
<th>매우 심다</th>
<th>보통이다</th>
<th>아주 사양한다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1</td>
<td>2  3</td>
<td>4  5  6  7  8  9  10</td>
</tr>
</tbody>
</table>

15. 가족들이 당신의 치료를 위한 도움을 주기 위하여 얼마나 노력한다고 생각하십니까?

<table>
<thead>
<tr>
<th>매우 차갑고</th>
<th>나의 필요에 반응해주고</th>
</tr>
</thead>
<tbody>
<tr>
<td>강하지 않다</td>
<td>보통이다</td>
</tr>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>

16. 한마음 프로그램 스텝들이 당신의 치료를 위한 도움을 주기 위하여 얼마나 노력한다고 생각하십니까?

<table>
<thead>
<tr>
<th>매우 차갑고</th>
<th>나의 필요에 반응해주고</th>
</tr>
</thead>
<tbody>
<tr>
<td>강하지 않다</td>
<td>보통이다</td>
</tr>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
</tr>
</tbody>
</table>

17. 당신은 가족들로부터 얼마나 많은 이해와 협조를 받고 있다고 느끼십니까?

<table>
<thead>
<tr>
<th>전혀 그렇지 않다</th>
<th>보통이다</th>
<th>매우 많이 받고 있다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. 당신은 한마음 스텝들로부터 얼마나 많은 이해와 협조를 받고 있다고 느끼십니까?

<table>
<thead>
<tr>
<th>전혀 그렇지 않다</th>
<th>보통이다</th>
<th>매우 많이 받고 있다</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. 당신은 가족들의 도움에 얼마나 만족하십니까?

<table>
<thead>
<tr>
<th>전혀 만족 못함</th>
<th>보통이다</th>
<th>매우 만족</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. 당신을 위한 한마음 스텝들의 도움에 얼마나 만족하고 계십니까?

<table>
<thead>
<tr>
<th>전혀 만족 못함</th>
<th>보통이다</th>
<th>매우 만족</th>
</tr>
</thead>
<tbody>
<tr>
<td>0  1  2  3  4  5  6  7  8  9  10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
21. 당신은 현재 가족들로부터 상처를 받거나 실망감을 느끼십니까?

매우 심하게 느낀다  보통이다  전혀 느끼지 못한다
0 1 2 3 4 5 6 7 8 9 10

22. 당신은 현재 한마음 스팀들로부터 상처를 받거나 실망감을 느끼십니까?

매우 심하게 느낀다  보통이다  전혀 느끼지 못한다
0 1 2 3 4 5 6 7 8 9 10

<영적 측면>

23. 하나님이 당신의 병을 치료해 주실 거라 믿으십니까?

전혀 믿지 않음  가끔 흔들린다  매우 확신함
0 1 2 3 4 5 6 7 8 9 10

24. 치료를 받고 있는 기간에도 당신의 인생은 가치가 있다고 생각하십니까?

전혀 무의미함  보통이다  매우 가치 있음
0 1 2 3 4 5 6 7 8 9 10

25. 당신은 죄 용서를 확인 받기 위하여 얼마나 노력 하십니까?

전혀 관심 없음  보통이다  매우 많이 노력했다.
0 1 2 3 4 5 6 7 8 9 10

26. 당신의 죄는 용서 받았다고 생각하십니까?

아무 것도  모든 죄는
용서받지 못함  용서받았다
0 1 2 3 4 5 6 7 8 9 10

27. 당신은 얼마나 자주 인생의 목적과 병이 가지는 의미에 대하여 생각해 보십니까?

전혀 생각  가끔 생각한다  자주 생각한다
해 본적 없다

28. 당신의 병은 죄 때문에 하나님이 주시는 심판이라고 생각하십니까?

매우 그렇다고 생각한다 | 가끔 생각한다 | 절대 그렇지 않다고 생각한다
0 1 2 3 4 5 6 7 8 9 10

29. 하나님이 당신을 사랑하신다고 믿습니까?

절대 아니다 | 가끔 믿어진다 | 매우 확신한다
0 1 2 3 4 5 6 7 8 9 10

30. 당신은 미래(천국에 대한 소망 포함)를 생각하면 소망이 있으십니까?

전혀 아니다 | 보통이다 | 매우 희망적이다
0 1 2 3 4 5 6 7 8 9 10

하드심 가운데도 협조해 주셔서 감사합니다.
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