Look Beyond and Rejoice: A Spiritual Intervention for Patients with Life-Threatening Illness or Chronic Pain

Jung H. Park

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LOOK BEYOND AND REJOICE:
A SPIRITUAL INTERVENTION FOR PATIENTS WITH
LIFE-THREATENING ILLNESS OR CHRONIC PAIN

By
Jung H. Park

A Dissertation in Partial Fulfillment of the Requirements for the
Degree of Doctor of Public Health in Health Education

October, 2008
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Each person whose signature appears below certifies that this dissertation, in his/her opinion, is adequate in the scope and quality as a dissertation for the degree of Doctor of Public Health.

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ABSTRACT OF THE DISSERTATION

Look Beyond and rejoice: A Spiritual Interevention for Patients with Life-Threatening Illness or Chronic Pain

by

Jung H. Park

Doctor of Public Health Candidate in Health Promotion and Education

Loma Linda University, Loma Linda, California, 2008

Jerry W. Lee, Chair

Recently, the study of religious coping has increased dramatically. Researchers have recognized that cognitive-behavioral interventions imbued with spiritual dimensions may have greater impact when they incorporate a persons’ belief system. Based on scientific literature and Christian coping methods in the Bible, the Look Beyond & Rejoice [LB&R] Healing Model was developed to provide a theoretical framework for an intervention aimed at improving spiritual, mental, and physical health. The model includes: (a) positive reframing of illness that may change a patient’s perception from a threat to challenge and hope, and (b) daily transcendent visualization and verbalization, through looking beyond adversity and looking to God and God’s promises.

This study investigated the impact of an LB&R intervention in 40 Korean-Americans with life-threatening illness or chronic pain. Participants were randomly assigned to an immediate or delayed intervention group. The program consisted of nine
sessions—three times a week, for three weeks. Participants were assessed—at baseline, 3 weeks from baseline, and 6 weeks from baseline. Measurements included daily spiritual experiences, meaning of illness, positive affect, negative affect, pain, use of medications, mental and physical health. Eleven of the immediate group and six of the delayed group completed all three questionnaires. Six individuals in a pretest had gone through the identical program and were added to the immediate group for analysis.

Levels of love, physical health, and mental health improved during the program but not before or after. Both groups showed improvements across the three measurement points in meaning of illness and joy, as well as, decreases in negative affect and both types of pain. Positive change in daily spiritual experience is significantly correlated with a reduction in negative affect from pretest to posttest. An increase in negative affect from pretest to posttest is significantly correlated with an increase in bodily pain, unpleasant pain, and a decrease in mental health across those two time points.

The results of the current study suggest that the LB&R intervention, can increase positive mind-body outcomes. It is hoped that the present study will stimulate researchers and practitioners to further investigate the practice of Biblical coping methods.
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DEDICATION

This dissertation is dedicated to

the memory of my parents,
Chang-Dong and Ang-Ja Park
for their love and endless support for me

my wife, Jungla Park,
who devoted herself to my recovery
from an incurable illness
and has been my lifetime companion and supporter.

and to
my God
who made all of this possible
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A. Statement of the Problem

Evidence that psychosocial and spiritual factors impact physiologic health has increased steadily during the past few decades (Engel, 1977; Schwartz, 1982; Herbert & Cohen, 1993; Linden, Stossel, & Maurice, 1996; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). Studies of religious coping, which are directly related to mind-body interaction, have increased dramatically recently (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Researchers have found that, in coping, people call more upon religion as situations become increasingly threatening and harmful (Koenig, Larson and Larson, 2001; Lindenthal et al., 1970). Johnson (1959) stated that “When the values of life are at stake, there is reason to be earnest. In times of crisis, religion usually comes to the foreground. The more urgent, the need the more men seek for a response” (p. 82).

In a study of psychological adjustment among individuals facing the stresses of transplant surgery, Tix and Frazier (1998) concluded:

Religious coping is associated with adjustment to stress over and above the effects of nonreligious coping and social support...

Religious coping adds a unique component to the predication of adjustment to stressful life events that cannot be accounted for by other established predictors (p. 420).

Several other studies have found that religious coping predicts the positive outcomes of negative life events beyond the effects of nonreligious coping (Pargament,
Ensing, Falgout, Olsen, Reilly, Van Haitsma, & Warren, 1990; Maton, 1989). In a literature review of the spiritual factors related to cancer, Creagan (1997) concluded that “among the coping methods of long-term cancer survivors, the predominant strategy is spiritual” (p. 163).

As early as 1978, Marks anticipated the possibility of implementing spiritual intervention after he reviewed instances of dramatic behavior change following religious experiences: “When it works, faith healing has a power far surpassing existing psychotherapy technology. The order of magnitude of this difference is like that between nuclear and more conventional explosives (p. 530).”

Religion offers the transcendent dimension, a unique solution and response to the problem of human insufficiency. People often look beyond themselves to religion for coping when they experience loss of control. There has been a recent surge in incorporating religion and spiritual support in patient care (Kearns, 2002; Cunningham, 2005; Bretbart, 2002). Researchers in the larger psychological community have recognized that cognitive-behavioral interventions imbued with spiritual dimensions may have greater impact when they incorporate the patients’ belief systems (Pargament, 1999; Propst, 1980; Miller, 1999; Propst, 1996).

Particularly relevant to our study is this: in their research of 298 random samples of breast cancer survivors, Ferrell, Grant, Funk, Otis-Green, and Garcia (1998) found that spiritual support was more helpful to patients with cancer than counseling, support groups, peer support, or even spousal support. Spiritual health represents meaning and purpose in life that may positively impact mental health and physical outcomes, as well
as motivation for practicing positive health behaviors (Hawks, 2004; Hammermeister & Peterson, 2001).

There has been a growing use of ritual, forgiveness, and meditation in 12-step programs and practitioners of psychotherapy that draw from religious methods of coping (Harris et al., 1999). The types of spiritual intervention that have been studied are meditation (e.g., Tacon, 2003), Buddhist philosophy (e.g., Avants & Margolin, 2004), prayer (e.g., Palmer, R. F., Katerndahl, D., & Morgan-Kidd), hypnosis (e.g., Montgomery, G. H., David, D., Winkel, G., Silverstein, J. H., & Bovbjerg), those based on theories of self-transcendence (Coward, 1998), and Victor Frankl's logotherapy (e.g., Southwick, Gilmartin, McDonough, & Morrissey, 2006). Most of these strategies are based on the secular theory or Eastern philosophy/practice.

According to the recent review of religious coping conducted by Harrison, Koenig, Hays, Eme-Akwari, and Pargament (2001), studies are moving from globally defined religion to more fine-grained analyses of particular populations grappling with particular illnesses and challenges through the use of particular methods of religious coping. They anticipate that this kind of research is likely to yield a clearer picture of the roles religion plays in health and illness.

Even though religious and spiritual coping have significant beneficial effects on patients—effects now widely acknowledged—and even though the need to include religion and spirituality in clinical practice has emerged (Miller, 1999; Propst, 1996), very little systematic study has so far been done on the therapeutic use of this dimension (Cunningham, 2005).
According to a recent Gallup Poll report (Newport, 2007, p. 1), in United States, approximately 82% of Americans identified with a Christian religion, and 56% of Americans have said religion is very important. As the influence of spirituality and religion on health is recognized, health care professionals are increasingly called to treat patients of different religions and value systems. Since the mid-1980s, many researchers have studied spirituality and its effects on health. The vast majority of more than 1,200 studies conducted in the last two decades were observational, not interventional: researchers investigated how the participants (most of whom were Christians) utilize spirituality and religion to have a positive impact on their health (Koenig, 2004, p. 9). Gallup data reported by Bart (1998) show that 81 percent of respondents desire to integrate their spiritual belief systems into the therapeutic process. Given this desire and given that researchers generally found the association of religion or spirituality with health to be positive—it seems strange that researchers seldom develop an intervention based on their observations. There are a few such interventional studies (e.g., Hawkins, Tan, & Turk, 1999; Garzon, 2005) but these target mental rather than whole-person health. Thus, given the paucity of this type of research and its potential to improve health outcomes of patients—I view developing and testing a Christian intervention not only as a logical extension of past research but an essential task.

B. Purpose of the Study

The purpose of this study is to examine the impact of a spiritual intervention, based on Christian coping methods in the Old Testament and New Testament Bible and on scientific literature, in a cohort of people experiencing life-threatening or chronic pain.
Each religious tradition offers a unique worldview and coping method on traumatic events. This study measured effects of an intervention conveying the religious coping methods of a specific religious tradition, Christianity. As Tan (1999) noted, there is a need to develop Christian healing models that have Christian elements as the main focus. Such a focus allows incorporation of intervention concepts into Christian patients’ belief systems.

The term *religion* and *spirituality* are often used interchangeably (Zinnbauer, Pargament, Cole, Rye, Butter, Belavich, Hipp, Scott, and Kadar, 1997). *Religion* relates to a person’s adherence to the beliefs, values, and practices proposed by an organized institution which is devoted to the search for the divine (Thoresen, 1998). *Spirituality* has been defined as a search for the sacred or divine through any life experience or route (NIHR, 1997). A broader definition of spirituality includes connectedness with the self, a community, nature; and a search for the meaning or purpose of life (Bellingham et al., 1989).

In our study we selected patients with life-threatening illness or chronic pain as participants to examine the impact of a spiritual intervention for their whole-person health. Those patients may suffer a wide variety of difficulties and sources of stress, including feelings of uncertainty and loss of control that may lead them to feel human insufficiency and seek a means beyond themselves for coping. Patients with life-threatening illness or chronic pain often suffer from negative thoughts and feelings that lead to a negative prognosis in their health (see Figure 1.1). The LB&R healing model is
designed to redirect this negative process into a positive process that leads to positive health prognosis.

Regarding the relationship between spirituality and health, most research has focused on medical populations with life-threatening illnesses, such as cancer, cardiovascular disease, coronary disease, and AIDS. However, an important group, patients with chronic pain, has been overlooked and deserves greater attention (Rippentrop, 2005). The number of people with chronic illness is rapidly increasing as the size of the aging population increases. Chronic illness has become a major public health problem, both in terms of suffering and the economic burden to society (Arnoff, 1998; Turk, 1996). In recent years, the Medicare and Medicaid programs have spent $84 billion annually on five major chronic conditions, specifically diabetes, heart disease, depression, cancer, and arthritis (U.S. Department of Health and Human Services, 2002). One of the most challenging situations individuals face is living with a chronic illness. They often face various difficulties and stressors, such as pain, feelings of uncertainty, and changes in body image. Such problems may lead them to greater psychological distress, such as anxiety and depression. In patients with chronic illness, religion or spiritual beliefs have been found to be one way to cope with suffering (Koenig, 2004; Cronan, Kaplan, Posner, Blumberg, & Kozin, 1989; Bill-Harvey, Rippey, Abeles, Donald, Downing, Ingenito, & Pfeiffer, 1989). Patients with chronic illnesses often face an array of difficulties and stressors, such as alteration in self-perception and self-control, the need to grieve over a long period of time, the need to readapt to the limitations imposed by the illness, the need to deal with the uneasy responses of others, and the need to come to
terms with significant spiritual issues (Stoll, 1989). Stoll identified three spiritual beliefs that are significant resources in adapting to live with chronic illness and pain: trust, hope, and courage (Stoll, 1989, p. 194).

The present study investigated the impact of a spiritual intervention based on a Christian Scripture approach to spiritual, psychological, and physical health in patients with life-threatening or chronic pain. For this purpose we developed the Look Beyond & Rejoice [LB&R] healing model to provide theoretical, as well as, an applicable framework for the LB&R intervention.

C. The Look Beyond and Rejoice Healing Model

The fundamental principle of the LB&R healing model is based on looking up to the Healer. In the Old Testament, it is manifested as the Israelites, dying of venomous snakebites, looked up at the brass serpent on the pole (believed, by Christians, to symbolize Jesus), and were healed (Numbers 21:4-8). The New Testament emphasizes healing by looking up to Jesus on the Cross “Let us fix our eyes on Jesus, the author and perfecter of our faith” (Hebrews 12:2), “By His wounds we are healed” (1 Peter 2:24; cf. Isaiah 53:5).

Maton (1989) suggested two major pathways of positive influence for spiritual supports: (a) a “cognitive mediation pathway” that contributes to the adoption of a positive cognitive appraisal of the meaning and implications of negative life events, and (b) an “emotional support pathway” (the perceptions of being valued, loved, and cared for by God) that leads to enhanced self-esteem and reduced negative affect (p. 311).
Likewise, the LB&R program is designed to help participants using these two pathways. The spiritual lessons would lead them to engage in reappraisals and reframing that focus on the potential benefits, so that in their illness they may gain a new perspective on life and explore new opportunities for meaningful living. An enhanced spiritual perspective may change a person’s experience of a stressful event from a sense of threat to a sense of challenge and hope that leads to positive emotional health. Concurrently, the participants would be guided to practice transcendent visualization and verbalization in their daily practice through looking to Jesus. Their transformed view of adversity, from loss to gain, and their involvement in transcendent practice may positively influence their whole being.

O’Leary and Ickovics (1995) described three possible outcomes from transformational change following challenge: survival, recovery, and thriving. Those who merely survive cannot recover their previous level of functioning and those who do recover return to their previous level of functioning. However, those who thrive go beyond their previous level of functioning. The LB&R program is designed to help participants target and experience thriving through spiritual-transcendent coping in their adversity. Participants may experience thriving in the sense of whole-person healing even if they are not being cured physically.

Figure 1.2 shows the major processes and components of the LB&R healing model. The whole process of the LB&R healing model may be subdivided into the five steps listed below. The first three steps are the Action stage and the last two steps the Outcome stage.
1. Selective Attention – choosing to look up to God and the invisible realm, and giving attention to the spiritual, instead of looking up to the negative processes and components of illness.

2. Reappraisal and Reframing – not focusing on the “cons” of the illness; instead, perceiving the “pros” by meaning making and benefits finding in the light of Biblical teachings.

3. Visualization and Verbalization – projecting a positive future image by transcendent visualizing and creative verbalizing based on the promise of God.

4. Emotional Response – experiencing positive emotional change as a result of selective attention, reframing, visualization and verbalization described above.

5. Mind-Body Well-being – experiencing a positive health outcome (spiritual, psychological, and physical) and improved quality of life as a result of the positive emotional change.

The key Bible texts in developing the model are these: “Test everything. Hold on to the good” (1 Thessalonians 5:21); “Fixing our eyes on Jesus” (Hebrews 12:2); “Faith is being sure of what we hope for and certain of what we do not see” (Hebrews 11:1); “Rejoice always, Pray continually, and give thanks in all circumstances, for this is God’s will for you in Christ Jesus” (1 Thessalonians 5:21). Figure 1 shows the major processes and components before (figure 1.1) and after (figure 1.2) LB&R intervention.
Figure 1.1. The Detrimental Processes and Components of Negative Cognitive Appraisal and the Consequent Emotional Response and Prognosis of Patients with Life-Threatening Illness or Chronic Pain

Figure 1.2. The LB&R Healing Model Showing the Processes and Components of Each of the Five Steps.

“Test everything. Hold on to the good.” “Fix our eyes on Jesus.”
“Faith is being sure of what we hope for and certain of what we do not see.”
“Rejoice always.” “Pray continually.” “Give thanks in all circumstances.”
(1 Thessalonians 5:21; Hebrews 12:2; Hebrews 11:1; 1 Thessalonians 5:16-18).
The intervention model implies that if patients control their input channel (eye and ear) by selective attention, and control output channel (mouth) and inner dialogue positively, then they may control the emotions that exert a positive influence on health. We propose that this spiritual intervention would enhance the participants' ability to control stress and depression, alleviate pain, support positive emotions generated by their new coping practices, and improve mind-body well-being. The LB&R healing model is an innovative coping method, although it may be a coping method that Christians have been encouraged to practice since the days of the early church. However, as far as we can ascertain, the LB&R intervention is the first systematic approach to investigate the impact of this ancient, "paradoxical" Christian coping method on whole-person health. Literature supporting each of the areas of the model may be found in chapter 2, and more details of the methods to be applied are in chapter 3. The reason the term paradoxical is used will be explained in chapter 3 in section H 2.

D. Research Questions

The goal of the present study is to investigate the impact on spiritual, psychological, and physical health of a spiritual intervention based on Christian coping methods found in the Old and New Testament Bible. Research hypotheses include: (a) the LB&R intervention will help patients to find the meaning of their illness and to have a positive reappraisal of their adversity, (b) the LB&R intervention will enhance positive and reduce negative emotion and that will result in an improvement of spiritual, psychological, physical health, and quality of life.
The research questions:

1. What is the impact of the LB&R spiritual intervention on finding meaning for patients with life-threatening illnesses or chronic pain?

2. What is the impact of the LB&R spiritual intervention on positive and negative emotional responses in patients with life-threatening illnesses or chronic pain?

3. What is the impact of the LB&R spiritual intervention on perceived pain in patients with life-threatening illnesses or chronic pain?

4. What is the impact of the LB&R spiritual intervention on mind-body well-being (spiritual, mental, and physical health) in patients with life-threatening illnesses or chronic pain?

E. Theoretical Justification

Contemporary theories consider coping as a transactional process that involves personal, situational, and social variables (Aldwin, 1994; Lazarus, & Folkman, 1984). Lazarus and Folkman’s transactional model of stress and coping defines coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). When faced with a stressful event, a person evaluates the potential threat (primary appraisal) and his or her ability to handle the situation and manage negative emotional reactions (secondary appraisal). The transactional model distinguishes between emotion focused coping, which regulates the emotional response to the risk, and problem focused coping, which manages the risk.
itself. In Lazarus and Folkman's transactional model, individual’s appraisal or interpretation of a situation defines threat and determines the level of stress in the situation. Reappraisals can decrease the harmful impacts of the stressful event and can sometimes even produce positive outcomes (Park & Folkman, 1997). Positive reappraisal is often taught and utilized in cognitive behavioral therapy (e.g., Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998).

Recent extensions of the transactional model modified it to take into account positive psychological states. Folkman proposed that a theory of stress and coping needs to accommodate positive psychological states (Folkman, 1997). Figure 2 shows how a spiritual intervention might be fitted into the transactional model. The diagram of the transactional model is from Wenzel, Glanz, and Lerman (2002). The spiritual intervention box and dashed line have been added to show the proposed impact of the LB&R program.
Figure 1.3 How the Spiritual Intervention Fits into The Transactional Model of Stress and Coping. Adapted from Wenzel, Glanz, & Lerman (2002).

The primary strategy of the proposed spiritual intervention is to assist participants to experience positive, meaning based, Christian coping responses. Meaning-based coping processes may then lead to positive psychological states that lead to reappraisal and increasingly effective coping. These states include positive reinterpreting, transforming perspective, reframing suffering, and enhancing awareness of the presence and love of God. Positive reinterpretation of an illness leads the patient to look beyond the objective situation for new meaning and purpose in the stressful event. We added the dotted lines in Figure 2, to show the impact paths of LB&R intervention, since we believe the primary impact of the meaning-based coping is changing the primary appraisal and secondary appraisal. It is because, with the increased belief and awareness of God’s
promises and help, within the process of primary appraisal, patients’ perceptions about the threat may be changed to challenge (primary appraisal) and within the process of secondary appraisal, the perceived resources available to deal with stressful events may be increased. This process of spiritual intervention for healing involves self-transcendence.

Frankl (1963) describes self-transcendence as an inherent capacity of humans to reach out beyond themselves and, through this reaching out, find meaning and renewed purpose. He suggests that people find meaning and transcend themselves in three ways: by creating a work or doing a deed, by experiencing something or encountering someone, and by the attitude they take toward unavoidable suffering. Frankl’s existential theory (1963) suggests the search for meaning is a significant and primary motivating force in people. The diagnosis of life-threatening or chronic illness may be seen as a crisis and the experience of despair and hopeless may offer an opportunity for meaning and growth.

Reed (1991a, 1991b) proposed self-transcendence as expansion of self-boundaries within the framework of lifespan developmental theory. Reed suggests self-transcendence as a characteristic of developmental maturity, which involves expanding personal boundaries beyond an immediate or constricted view of self and the world, toward broader life perspectives and purpose. Self-transcendence is defined as “the expansion of one’s conceptual boundaries inwardly through concerns about others’ welfare, and temporally by integrating perceptions of one’s past and future to enhance the present” (Reed, 1991a, 5p). Life events that confront a person with end-of-life issues, such as cancer, provide opportunities for personal development and healing.
Niebuhr (1955) contends that self-transcendence occur for the individual when he knows himself confronted by God. It is only in confrontation with a greater transcendent being, that our own feelings of self-transcendence and freedom are verified. It means we have to stand outside of ourselves and to see ourselves as God sees us because we never have a broad enough perspective with which to stand back and get a clear picture of ourselves.

The LB&R program was developed that uses a mixture of spiritual lectures to enhance participants' awareness of the existence and love of God that may help them to reframe their adversity from threat to challenge and to a blessing of God. In LB&R, the new enlightened insight may induce the emotion of gratitude that possesses happiness-producing properties (Emmons & McCullough, 2003).

F. Significance to Health Education

Cancer patients describe their religious and spiritual beliefs as providing a profound method of coping with the disease and improving their quality of life (Mytko & Knight, 1999). However, there has been almost no research verifying the health benefits (value) of these beliefs and very little intervention study has so far been done specifically designed to enhance the spiritual experience of these patients (Cunningham, 2005).

If the hypothesis of this study is validated—that an intervention to teach distinctively Christian responses to stressors such as cancer significantly improves the patient’s emotional health, psycho-spiritual health, physical health, and quality of life—then a positive effect of the LB&R program may be an increase in similar spiritual interventions for many patients with life-threatening and chronic illness. Such spiritual
enlightenment may help patients to reframe their sickness into a blessing. Such Christian-spiritual group interventions then can be expanded to other groups of people who experience traumatic life events. Health education also embodies the spiritual aspect of a person’s life and the results of this study may assist health educators in planning more appropriate programs for various patients who encounter life-threatening diseases. Various health professionals, include clergy, may utilize the program for their patients, too. The LB&R intervention model also can be utilized to help prevent future loss and to lessen the impact of wounds from traumatic events—by educating people as to how to strengthen the inner self beforehand.
CHAPTER 2
REVIEW OF THE LITERATURE

Over the past 20 years, mind-body interactions have become an extensively researched field and mind-body medicine has provided considerable evidence that psychological factors can play a pivotal role in the development and progression of various types of illnesses. Researchers have also found that mind-body interventions can be effective in the treatment of illnesses, enhancing the quality of life. This literature review covers a wide range of topics ranging from post-traumatic growth and religious coping, to emotion and positive expression, as well as to spiritual interventions that may have a great potential for the curing and healing of various illnesses. This chapter provides an overview of topics related to our study—topics such as meaning-making, benefit-finding, finding goals, imagery, visualization, hope, and joy. This chapter concludes with a summary of the literature review and its relevance to current study.

A. Posttraumatic Growth and Religious Coping

1. Posttraumatic Growth

Comments of cancer patients or accident victims describing their adversity as “the best thing that ever happened” are not uncommon (Dossey, 1995; Aldwin, 1994). Even though it seems paradoxical, some cancer patients express that being diagnosed with cancer has been a positive experience and their lives have been enriched and changed for the better by their disease (Taylor, 1983). A growing body of evidence
reveals that stressful and traumatic life events such as cancer can have positive, in addition to negative, consequences.

Reports of perceived benefits have been found in people who have experienced bereavement (Lehman, Davis, DeLongis, Wortman, Bluck, Mandel, & Ellard, 1993), HIV infection (Schwartzberg, 1993), natural disasters (Joseph, Williams, & Yule, 1993), serious illness (Thompson, 1991), accidents (Bulman & Wortman, 1977), rape and sexual abuse (Burt & Katz, 1987). These positive changes in the aftermath of stressful experiences have been referred to as posttraumatic growth (Tedeschi & Calhoun, 1995) or stress-related growth (Park, 2004).

In the discussion of suffering and well-being, Emmons (1999) described, “Paradoxically, it may be that enjoyment of life is not only possible in the face of suffering, but that suffering may be one road to deep and lasting happiness” (p. 156). Writing in a humanistic context, King and Pennebaker (1998) stated that “it is in the context of negative life events that the human capacity for positive functioning, for experiencing realistic joy, and for development are most dramatically manifested” (p. 54). Maslow (1955) noted that “the most important learning experiences... were tragedies, deaths, and trauma... which forced change in the life-outlook of the person and consequently in everything that he did” (p. 23).

A traumatic event challenges one’s cognitive schema (a fundamental set of beliefs and perspectives that incorporate identity, worldview, and spirituality); creates uncertainty; and raises questions about meaning and purpose in life (Janoff-Bulman & Frantz, 1997). Trauma disrupts and often reshapes the schema, and healing involves
struggling with beliefs about self, world, and spirituality (Saakvitne, Tennen, & Affleck, 1998).

2. Religious Coping

In the process of rebuilding shattered assumptions (Janoff-Bulman, 1992), religion and spirituality provide for many an enhanced sense of meaning in life and a greater existential awareness (Yalom, & Lieberman, 1991), and traumatic events can lead to an enhanced religious or spiritual life. A number of researchers have found that spirituality is the most common and prime resource of meaning making when people are faced with traumas (Kotarba, 1983; Gilbert, 1989; Pargament et al., 1990). Jenkins and Pargament (1995) found cancer patients, in general, tend to find comfort and support through their religion that provides meaning for their experience.

Religious beliefs have been found helpful to people who have cancer or who are experiencing stressful events, such as major disasters (Jenkins and Pargament, 1995; Seybold & Hill, 2001; Taylor, 2001). In confronting death, cancer patients often recount a significant spiritual event (related to their existential issues) as having helped them find meaning and purpose in life (Kinney, 1996).

Religious beliefs have been found to provide existential meaning and a purpose in life. Lewis (1989) examined 57 patients with advanced cancer and found that finding meaning and purpose in life was the best predictor of psychosocial adjustment. In the research on breast cancer patients, religious faith has been found to be an important source of support in their illness (Heim, Augustiny, Shaffner, & Valach, 1993). In cancer patients, the presence of religious beliefs has been associated with decreased levels of
pain, anxiety, hostility, and depression; as well as with enhanced immune functioning, and life satisfaction (Acklin et al., 1983; Kaczorowsk, 1989; Jenkins and Pargament, 1995; Schaal, et al., 1998; Yates et al., 1981).

For many people, religion is an important philosophical orientation that affects their understanding of the world, and that makes reality and suffering understandable and bearable (Pargament, 1997). In reconstructing meaning following a stressful or traumatic event, religious reframing can be a powerful strategy. Reframing illness as God’s will has been found to be more common than other appraisals among people with serious medical problems (Pargament & Sullivan, 1981; Emery, 2000). Pargament (1997) described the transformational coping power of religion:

When the sacred is seen working its will in life’s events, what first seems random, nonsensical and tragic is changed into something else—an opportunity to appreciate life more fully, a chance to be with God, a challenge to help others grow, or a loving act meant to prevent something worse from taking place (p. 223).

In this light, methods of religious coping seem to contribute something special to adjustment to critical life events. Pargament, Olsen et al. (1992) indicated that religion may operate as a general orienting system that affects how to view and understand one’s world. Rabbi Kushner (1989) describes, “Religion is not primarily a set of beliefs, a collection of prayers, or a series of rituals. Religion is first and foremost a way of seeing. It can’t change the facts about the world we live in, but it can change the way we see those facts, and that in itself can often make a real difference” (p. 27).
A change in peoples’ perspective on life has been commonly found in the literature on posttraumatic growth, either in their perceptions of events or their values of life (Daaleman, Kuckeman, and Frey, 2001; Aldwin, 1994). In many instances, such as life-threatening illness or traumatic accident, people gain wisdom and grow through the process of getting through stressful life events. Nozick (1989) defined wisdom as “being able to see and appreciate the deepest significance of whatever occurs... knowing and understanding not merely the proximate goods but the ultimate ones, and seeing the world in this light” (p.276). Thompson and Janigian (1988) defined the search for meaning as “a search for meaningfulness, for understanding how the event fits into a larger context” (p 263), and religion functions to show that larger context.

B. Meaning-making, Benefit-finding, and Finding goals

1. Meaning-Making

The accumulating literature on stress-related growth demonstrates the concept of “meaning” as a key construct mediating between stress and positive change (Gilbert, 1989; Greil, Porter, Leitko, & Riscilli, 1989; Pargament, Ensing, Falgout, Olsen, Reilly, Haitsma, & Warren, 1990): “meaning making” is a very powerful coping process after victimization, and persons who are able to find positive meaning in traumatic events cope better. According to Taylor (1995), meaning making or finding meaning is the process of integrating the previous experience of order and the present sense of disorder into a new, more mature model of reality. Leslie (2003) writes on the coping strategies of rape survivors based on the extensive interviews, “We live in trauma until we can reorganize, classify, and make sense of it.”
Reframing is, as Capps defines it (1990), the process of changing the frame in which a person perceives events in order to change their meaning. When the frame is changed, the meaning is changed, which, in turn, induces an altered response, and changes behavior.

Research has shown that individuals who are able to find and focus on positive meaning in traumatic events cope better (Thompson & Collins, 1995). Thompson (1985) surveyed people whose homes were damaged or destroyed by a fire to identify the relation between focusing on the positive and coping. Five ways of focusing on the positive were measured in this study: finding side benefits, making social comparisons, imagining worse situations, forgetting the negative, and redefining. The results of the thirty-two respondents’ reports showed that positive reevaluators coped better, and had more positive emotions, and fewer symptoms, both immediately after the fire and 1 year later.

Janoff-Bulman and Frantz (1997) proposed that successful adjustment to the traumatic event involves two elements: trying to make sense of the event and finding benefit in the experience. Likewise, Davis, Nolen, and Larson (1998) argued that the construct of “finding meaning” in a traumatic event should be differentiated into two processes: making sense of the loss (e.g., why did it happen?) and finding something positive in the experience (e.g., growth in character). In this context, in the stress and coping literature, meaning-making and benefit-finding are often used synonymously to describe how survivors find something positive in their struggle with traumatic events.
2. Finding Benefits

Finding benefits in traumatic events is one way that individuals seem to find meaning in their experience (Davis, Nolen-Hoeksema, & Larson, 1998; Park & Folkman, 1997). Tennen and Affleck (2005) reported, “benefit-finding appears to be common among individuals facing a myriad of threatening events, and it predicts emotional and physical adaptation months and even years later” (p. 589). Taylor, Wood, and Lichtman found that sixty percent of their cancer patients reported beneficial changes in their lives as a consequence of their cancer (1983) and stated, “Construing benefit from a victimizing event, then, goes much farther than simply finding something positive about it. Victims often learn from their experiences, and the meaning gained can greatly enrich their lives” (p. 33). In the school of trauma, survivors are “educated by dread” (Kierkegaard, 1944); and often victims become victors as they gain wisdom, positive personality changes, more meaningful relations with others, and more productive lives in the aftermath of threatening encounters (Collins, Taylor, & Skokan, 1990).

Benefit finding is a form of cognitive adaptation effort in which individuals evaluate their traumatic events positively to minimize its negative impacts (Taylor, 1983). According to Taylor, Wood, & Lichtman (1983), benefit-finding is typically viewed as a “selective evaluation”; and “selective evaluation processes minimize victimization by focusing on these beneficial qualities of the situation” (p. 26).

Research has shown remarkable consistency in identifying three types of benefits from trauma discovered by people in the aftermath of their stressful experiences: growing in character, gaining a new perspective, and strengthening of relationships (Tedeschi and
Calhoun, 1995; Tennen & Affect, 1999; Tedeschi, Park, & Calhoun, 1998). Tedeschi and Calhoun identified a significant element in the positive change that individuals experience in the traumatic events is a transformation of their understanding of themselves, of their understanding of the priorities of life, and of their place in the universe.

3. Finding Goals

Research reveals perceived meaning and purpose to be the best predictor of psychosocial adjustment (Lewis, 1989). Researchers have found personal goals appear to be prime components of the meaning-making process in the face of adversity (Folkman & Stein, 1997; Emmons, Colby, & Kaiser, 1998).

Individuals who were preoccupied with self-focused goals coped more poorly with the loss, but individuals who had the self-transcendent goals—goals that promote the connection horizontally with others and vertically to a higher power—appear to facilitate the recovery process (Emmons, Colby, & Kaiser, 1998, p. 151). Trauma survivors often transform the trauma into altruistic acts that provide some meaning and value in their lives. Acting with benevolence and passing along to others what one has gained and learned is an important part of the process of healing and growing (Debats, 1999).

In traumatic events individuals are searching for ways to regain or enhance what they hold as important in their lives. Pargament calls it “a search for significance in times of stress” (Pargament, 1997, p. 90). This concept is directly relevant to the current study because patients in the LB&R program were led to search for elements they have gained
in their experience of cancer rather than focusing on their loss and pain. Such an active, goal oriented, value driven striving contains a search for the sacred. Theologian Packer (1993) states that the ultimate purpose in life is to know God: “What makes life worthwhile is having a big enough objective, something which catches the imagination and lays hold of our allegiance... what higher, more exalted, and more compelling goal can there be than to know God?” Given the crucial role that spiritual goals and commitments appears to play in the restoration of meaning, researchers have expressed that therapists and other professionals need to be both keenly aware and appreciative of their clients’ spiritual and religious orientations (Kelly, 1995; Shafranske, 1996).

C. Imagery and Visualization

The modern research in psychoneuroimmunology (PNI) has shown the mind and body are linked intimately as one. The mind and body communicate through interactions among the nervous system, the endocrine system, and the immune system. The mind and body communicate messages to each other, and these messages affect the biochemical and physiological changes that drive health and disease. Imagery affects a person very powerfully, emotionally and physically (Freeman, 2004, p. 277). Imagery is the very foundation of mind-body interactions and effects; it is the essential and activating element in the clinical use of relaxation therapy, meditation, biofeedback, and hypnosis (Freeman, 2004, p. 278). Imagery is defined by Murphy (1994) as a process by which sensory experiences are stored in memory and internally recalled and performed in the absence of external stimuli.
Imagery has been used increasingly by healthcare professionals with impressive results. Imagery has been found beneficial in treating eczema, acne, birth pain, diabetes, breast cancer, arthritis, migraine and tension headaches, and severe burns (Freeman, 2004, p. 279). Guided imagery is a therapeutic technique in which patients use their imagination to visualize improved health, or to “attack” a disease, such as a tumor. Through guided imagery is currently understood to be mainly an “alternative” or “complementary” therapeutic technique, it has been used in many religious and healing traditions. Samuels observes, “Philosophers and priests in every ancient culture used visualization as a tool for growth and rebirth....Most religions have used visualization as one of their basic techniques in helping people to realize their spiritual goals. Visualization intensifies any experience” (p. 21). The term ‘visualization’ is often used interchangeably with imagery. Mike and Nancy Samuels (1975) wrote in their book, Seeing with the Mind’s Eye: The History, Techniques and Uses of Visualization, “If there are two important ‘new’ concepts in 20th century American life, they are meditation and visualization” (p. 34).

Positive expectation embedded with positive imagery, often in the form of the placebo effect, can also heal. The placebo effect has been reported to account for healing in 30% to 70% of all drug and surgical interventions (Freedom, 2004, p. 279). The field of sports psychology has been built on the premise that the body-mind does not know the difference between actual events and imaged ones (Brigham, 1994). They are a communication mechanism among perception, emotion, and bodily change and act as a
bridge between body and mind. Rossman (2003), one of pioneers of mind and body imagery, stated the role of the emotions as they relate to imagery in the healing processes:

Imagery is closely tied to our emotions, and emotions can directly and indirectly help or hinder us in our efforts to heal. Emotions are important in mind-body healing, not only because they motivate us to action, but because they also produce physiologic changes in the body by varying patterns of muscle tension, blood flow, respiration, metabolism, and biochemistry. Emotion is the key modulator of chemicals secreted by the brain, gut, and immune systems. In addition to being a rapid route to insight, understand, and motivation, imagery can have direct physiologic consequences and effects (p. 86).

Related to the influences of visualization and verbalization, researchers have shown the pivotal role of images and self-verbalizations on rational-emotional-behavior changes (Bergman & Craske, 2000; Ellis, 2003; Singer, 2006, p. 109). These studies contain a significant concept involved in the current study because the major intervention strategies of our study are visualization and verbalization (includes self-talk).

Oncologist O. Carl Simonton and psychologist Stephanie Simonton first used imagery as a psychological intervention in treating clients with advanced cancer and reported startling results of unexpected longevity in cancer patients who had used imagery combined with traditional medical treatment. The study followed up 159 clients diagnosed with incurable cancer and a 1-year life expectancy and 63 patients remained alive after 2 years. In addition, 22.2 percent showed no evidence of cancer and 19.1
percent showed tumor regression. The median survival for these clients was 8 to 19 months longer than the national average (Simonton, Simonton, & Creighton, 1980).

Walker, Walker, Ogston, Heys, Ah-See, Miller, Hutcheon, Sarkar, and Eremin (1999) compared two groups of cancer patients. One group received relaxation therapy with peaceful imagery and the other received relaxation therapy only. Women in the peaceful imagery group were, “more relaxed and easy going, had fewer psychological symptoms and had a higher self-rated quality of life during chemotherapy” (p. 267). Also these women showed, “enhanced lymphokineactivated killer cytotoxicity, higher numbers of activated T-cells and reduced blood levels of tumor necrosis factor” (p. 267).

Bridge, Benson, Pietroni, and Priest (1988) designed a randomized study to see whether stress could be lessened in 155 early breast cancer patients. Patients were divided into three groups: control group members were encouraged to talk about themselves; relaxation group participants were taught concentration on individual muscle groups; a relaxation plus imagery group was taught to imagine a peaceful scene. Patients saw one of the two researchers once a week for six weeks. The results showed that at six weeks the total mood disturbance score was significantly less in the intervention groups, patients in the combined intervention group were more relaxed than those receiving relaxation training only, and mood in the control group was worse compare to its initial score.

Roffe, Schmidt, and Ernst (2005) evaluated the controlled clinical trials on the use of guided imagery as a sole adjuvant therapy for cancer patients. They examined six randomized trials. Researchers in three studies reported significant improvements in anxiety, comfort or emotional response to chemotherapy for patients who received guided
imagery relative to the control groups. However, two studies showed no difference between guided imagery and other interventions in any of the outcome measures. In one study, the results could not be evaluated since no statistical analysis was reported. Roffe et al. concluded that guided imagery, as a sole adjuvant cancer therapy may be psychologically supportive and increase comfort and that the data were sufficiently encouraging for the use of guided imagery as an adjuvant cancer therapy. In fact, as Rossman (2003, p. 100) describes, our body is a complex organization that healing imagery impacts to whole being—body, mind, and spirit—a vision to follow.

D. Emotion and Positive Expression

1. Emotion

Aldwin illustrates the pivotal role of emotion: neuroendocrine and immune systems suggest that thoughts and emotions can alter biology and emotions are the “glue” that mediates and ties the whole system together (1994, p. 19). Research outcomes have clearly suggested that negative emotions play a critical role in developing various kinds of diseases (Pennebaker, 1985; Jonas, Franks, & Ingram, 1997; Scheier and Bridges, 1995). On the other hand, increasing evidence shows that positive emotions may promote and protect health. Researchers have found a relationship between positive emotion and better immune functioning (Futterman, Kemeny, Shapiro, & Fahey, 1994; Dillon, Minchoff, & Baker, 1985; Davidson et al., 2003).

Mounting evidence shows that if stressful emotion is not expressed overtime, it may lead to disease processes and an increased susceptibility to illness (Pennebaker, 1985; Scheier and Bridges, 1995; Pennebaker and Hoover, 1986). In contrast, studies
suggest that expression of feelings about a traumatic event in written form or verbally to others is potentially beneficial. Over a decade of research suggests the efficacy of emotional expression interventions in improving physical health and psychosocial adjustment (Pennebaker and Beall, 1986; Stanton, Danoff-Burg, et al, 2002; Stanton, Danoff-burg, Cameron, et al, 2000; Esterling, Antoni, Kumar, Schneiderman, 1990).

2. Positive Expression

Pennebaker and Beall (1986) designed a randomized controlled study: forty-six participants were divided into four groups and asked to write an essay on four nights. The four groups were as follows: (a) trauma-fact group – wrote a traumatic event without referring to their feelings about it, (b) trauma-emotion group – wrote their feelings about the event without writing about the event itself, (c) trauma-combination group – wrote about the traumatic event and their feelings about it, and (d) control group – wrote about a trivial event. Participants in groups a, b, and c had short-term significant increases in physiologic stress responses and group d had the least response of the four groups. Additionally, there was a long-term (6 months) reduction in health center visits for illness in groups b and c, but groups a and d showed insignificant changes in health status. Ventilation of feelings or catharsis only has been found to be effective if it is accompanied by cognitive processing (Lewis and Bucher, 1992).

Emotional suppression seems to be associated with poorer adjustment to cancer. Stanton, Danoff-Burg, et al (2002) found that breast cancer patients who wrote their thoughts and feelings about their cancer experienced showed improvements in physical and psychological well-being compared with women who wrote only about the facts of
the experience. In another study, Stanton, Danoff-Burg, Cameron, et al (2000) found in their 92 women with breast cancer patients that those who coped through expressing emotions had less distress and better physical health and vigor over the next 3 months than those who did not.

Other researchers have found speaking about traumatic events promotes healing and suggested that verbal expression is more effective than writing for enhancing immunity and improving health outcomes. For example, Esterling, Antoni, Fletcher, Margulies, and Schneiderman (1994) designed a study in which undergraduates (N=57) who were healthy but seropositive for the Epstein-Barr virus were randomly assigned to write or talk about stressful events, or to write about trivial events, during three weekly 20-minutes sessions, after they provided a blood sample. The results showed that individuals assigned to the verbal/stressful condition had significantly lower EBV antibody titers (suggesting better cellular immune control over the latent virus) after the intervention than those in the written/stressful group and the written/trivial control group.

Pennebaker, Barger, and Tiebout (1989) found that, among Holocaust survivors, those who expressed the most emotional words when they disclosed particularly traumatic war-related experiences, demonstrated the greatest health improvements in the year after an interview. This suggested that orally disclosing an extremely traumatic event, even 40 years after its occurrence—can have positive health benefits.

3. **Music Therapy**

Over the past 25 years, music therapy also has emerged as an important method to deal with emotions such as fear, anger, guilt, and anxiety. Music therapy can
be defined as the controlled use of music and its influence on the human being to aid in physiologic, psychologic, and emotional integration of the individual during the treatment of an illness or disease (Freeman, 2004, p. 21). Several studies (Cunningham, Monson, & Bookbinder, 1997; White, 1992; Winter, Paskin, & Baker, 1994) reported a decrease in patients’ anxiety from pre- to post-treatment. For example, White examined the effects of classical music on increased state anxiety among 40 patients who had experienced an acute myocardial infarction. The experimental group that listened to music experienced a decrease in state anxiety levels compared to the control group, which had a rest period with no music. Even though some studies (Barnason, Ximmerman, & Nieveen, 1995; Elliott, 1994) found no significant reductions in anxiety between the experimental and control groups, music generally appears to be most beneficial during the pre- and perioperative, critical, and normal care periods for hospitalized patients (White, 2000).

4. Supportive-Expressive Group Therapy

Researchers have found a positive association between social support and physical health and social support showed powerful implications for morbidity and mortality. (Berkman & Syme, 1979; Davis & Swan, 1999; Cohen & Syme, 1985). Social support has been identified as an influential component in preventing and alleviating depression and anxiety in cancer patients (Bloom and Spiegel, 1984; Ord-Lawson and Fitch, 1997). Also, social support has been suggested as a potential source of survival benefit (Spiegel and Bloom, 1983; Spiegel, Bloom, Kraemer, & Gottheil, 1989; Maunsell, Brisson, & Deschenes, 1995). Spiegel et al. (1989) provided what he now calls “supportive-expressive group therapy” to 50 women with metastatic breast cancer, while
36 control patients were randomly assigned to receive only the conventional therapy that all participants received. The results showed that patients in a support group program offered in conjunction with their conventional cancer treatments lived twice as long as those who did not participate. At 10 year follow-up after 1 year weekly group sessions, only 3 of the patients were alive, and death records were obtained for the other 83. There was a significant difference of survival from time of onset of intervention: 37 months in the intervention group compared with 19 months in the control group.

Recently, researchers have found that positive emotions are more than simply the absence of the negative emotions and are associated with health outcomes beyond the effects of negative emotions (Richman, Kubzansky, Maselko, Kawachi, Choo, & Bauer, 2005; Penninx, Guralnik, Bandeen-Roche, Kasper, Simonsick, Ferrucci, & Fried, 2000). Penninx et al. examined the relationship between two positive emotions, hope and curiosity, and health among 1,041 patients with hypertension, diabetes mellitus, and respiratory tract infections by a questionnaire. They found that higher levels of hope were associated with a decreased likelihood of having or developing a disease across of all three diseases. Fredrickson (1998) identifies four positive emotions—joy, interest, contentment, and love—in her broaden-and-build model of emotion. The model shows that positive emotions have such a powerful impact because they broaden the scope of attention, cognition, and action in new and better direction and because they build physical, intellectual, and social resources to optimize our coping capacities. As Fredrickson (2001) indicates, positive meaning and positive emotions have a reciprocal relation—one stimulates the increase of the other. We now review two positive
emotions—hope and joy—because among positive emotions they are the most relevant to the current study.

E. Hope and Joy

1. Hope

One of a person’s most powerful resources in healing is hope. Hope has emerged as one of the most essential elements that fortify both psychological and physiologic defenses in the lives of cancer patients. Qualitative studies have identified hope as a resource which contributes to the well-being, cure and survival of cancer patients (Miller, 1989; Herth, 1989; Nowotny, 1991). Conversely, loss of hope reduces quality of life and may induce catastrophic consequences such as hastening death (Breitbart, W., Rosenfeld, Bl, Pessin, H., et al., 2000; Seligman, 1975). Frankl (1963) underscored that hope is so vital to life that its loss is equated with the loss of life itself.

Studies of patients with recurrent cancer show that hope is an orientation toward the future that needs to be maintained regardless of the future’s uncertainty (Mahon, Cella, & Donovan, 1990; Paul, 1994; Yates, 1993; Ballard, Green, McCaa, & Logsdon, 1997). Cutliffe (1995) and Urquhart (1999) described hope as an inner strength that can enable individuals to look beyond their current pain, suffering, and turmoil and enrich their lives. Dufault and Martocchio (1985) defined hope as, “a multidimensional dynamic life force characterized by a confident, yet uncertain, expectation of achieving good, which to the hoping person, is realistically possible and personally significant” (Dufault and Martocchio, p. 380). They identified various characteristics and dimensions of hope, including affective (sensations and emotions), cognitive (thoughts, insights, and
imagination), affiliative (connectedness with others), temporal (time sense), and contextual (life circumstance). According to Forbes (1994), based on the literature, hope involves feelings, thoughts, actions, and relationships.

Hope is an intrinsic component of life that is composed of religious faith as well as secular optimism. Secular optimism perceives life as good and leads to having a positive attitude in spite of challenges. Religious faith offers hope by giving a sense of security even when all in life looks dark; a benevolent higher power has a purposeful grand plan in mind. On this notion, Myer (2000, pp. 64–65) cited Julian of Norwich (1373/1901):

Aware as we are of . . . the great enemies, suffering and death, religion offers a hope that in the end, the very end, ‘all shall be well, and all shall be well, and all matter of things shall be well’.

Qualitative studies of hope have identified potential hope fostering strategies across age and illnesses. These research findings have provided potential hope-fostering strategies and have laid the groundwork for the future intervention studies. Herth (1990) interviewed 30 terminally ill patients and found seven hope-fostering strategies: interpersonal relationships, light-heartedness, personal attributes (determination, courage, and serenity), attainable aims, a spiritual base, uplifting memories and affirmation of worth.

Farran, Herth, and Popovich (1995) have investigated hope and health over twenty seven years as nurses and they conceptualized hope as consisting of experiential, spiritual/transcendental, relational, and rational thought processes. The experiential process refers to acknowledging the pain of loss and suffering. Dynamic hope seems to
arise in the concept of suffering, illness, and death. The *relational process* refers to open, caring relationships needed to mobilize and support hope. The *spiritual/transcendent process* refers to transcending the finite and finding purpose and meaning in life in the connection with something greater than self, as God. The *rational thought process* refers to cognitive processes such as cognitive reframing strategies, refining goals, and reinforcing their accomplishment. Herth (2001) implemented a Hope Intervention Program to 38 patients with first recurrence of cancer. The program consists eight weeks of group meetings (two hours a week). The descriptive questionnaire data showed participants used intervention strategies that represented all these four attributes of hope and the intervention affected the participants’ rebuilding and maintenance of hope. Participants’ overall evaluation of the program was positive, with 98% rating the program as extremely helpful and the remaining 2% as helpful.

Rustoen and Hanestad (1998) evaluated the impact of an intervention based on two hope attributes (experiential process and rational thought process) on hope and quality of life using a quasi-experimental design with 96 newly diagnosed cancer patients, primarily women with breast cancer. The results showed hope levels increased significantly for members of the hope group after intervention but not after 6 months.

A pioneering study of Greer, Morris, Pettingale, and Haybittle (1990) showed that breast cancer patients who sustained a positive, optimistic attitude were more likely to be free of any recurrence five, ten, and even fifteen years later; whereas, patients who responded with fighting spirit or with denial (positive avoidance) were significantly more likely to be alive and free of recurrence than were patients with fatalistic or
hopeless/helpless response. Since then, there has been a mix of studies reporting positive associations (Derogatis, Abeloff, & Melisaratos, 1979; Jensen, 1987) and negative ones (Cassileth, Walsh, & Lusk, 1988; Dean, Surtees, 1989; Buddeberg, Sieber, Wolf, et al., 1996).

2. Joy

Joy is defined as (a) intense and especially ecstatic or exultant happiness, and (b) the expression or manifestation of such feeling (Pickett, 2000).” Joy is not just a smile or a laugh but something that is deep within and doesn't leave quickly. However, we review literature on both laughter and joy as there is some relatedness as we see. Relatively less research has examined the impact of positive emotions in promoting health compared to stress and negative emotions. Humor and laughter enable us to experience joy even when faced with adversity. The idea that humor and laughter benefit health is not new. In the 14th century Henri de Mondeville, a French professor of surgery wrote, “Let the surgeon take care to regulate the whole regimen of the patient's life for joy and happiness, allowing his relatives and special friends to cheer him, and by having someone tell him jokes (Walsh, 1928).” Cousins (1979), a pioneer of mind-body medicine, describes how laughter helped him recover from a devastating disease. He wrote, “The joyous discovery that ten minutes of genuine belly laughter had an anesthetic effect” that allowed him hours of relief from chronic pain (p. 39). He believed experiencing laughter could open him to feelings of joy, hope, confidence and love that induce healing. Since then, a modest number of empirical reports have followed to affirm that humor and laughter may ameliorate pain, reduce stress, and promote functioning of
the immune system (Cogan, 1987; Berk, Tan, Fry, Napier, Lee, Hubbard, Lewis, & Eby, 1989; Berk, Tan, Napier, & Eby, 1989). Studies have shown that humor and laughter reduce anxiety (Cann, Holt, & Calhoun, 1999), reduce tension (Seltzer, 1986), reduce stress (Bizi, Keinan, & Beit-Hallahmi, 1988), reduce depression (Danzer, Dale, & Klions, 1990), enhance hope and energy (Bellert, 1989), and provide a sense of empowerment and control (Wooten, 1996). More specifically, Cousins (1989) found cancer patients got health-enhancing benefits from joining in a humor support group. Recently, Christie and Moore (2005) found, in their in-depth literature reviews on 20 studies, that humor is an effective intervention with a potentially enormous impact on the health and well-being of patients in numerous settings. The decreased capacity of feeling pleasure is one of the most frequent psychological symptoms occurring in cancer patients (Rubinow, 1990; Messina, Lissoni, Bartolacelli, Tancini, Villa, Gardani, & Brivio, 2003).

There are an increasing number of researchers and clinical practitioners utilizing laughter and joy for health benefits. For example, Humphrey (2003), a clinical psychologist, developed The Joy Formula for health and beauty which is based on her experiences of research, teaching, and psychotherapy with patients. It specifies the key psychological ingredients of a joyful life as: (a) positive emotions, (b) coping with stress, (c) self-expression, and (d) good relationships.

Mahoney, Burroughs, and Hieatt (2001) write that “the use of laughter as an antidote to pain has long been recommended by folk wisdom. According to a Jewish proverb, ‘When you’re hungry, sing; when you’re hurt, laugh.’ Empirical research has provided some support for popular beliefs” (p. 217).
The current study is based on these concepts and related scientific findings. It sounds paradoxical to "rejoice always" as the Bible (1 Thessalonians 5:16) says, even when in the predicament, but, if rejoicing is possible, it looks as if it may be the best way to cope. It would be an ecstasy experience as Nouwen says:

It is a joy that does not separate happy days from sad days, successful moments from moments of failure, experiences of honor from experiences of dishonor, passion from resurrection. This joy is a divine gift that does not leave us during times of illness, poverty, oppression, or persecution. It is present even when the world laughs or tortures, robs or maims, fights or kills. It is truly ecstatic, always moving us away from the house of fear into the house of love, and always proclaiming that death no longer has the final say. (p. 99).

The word "happy" was derived from the same old English root, \textit{hap}, as the word "happening" \textit{(Webster's New Twentieth Century Dictionary, 1980, p. 824-825)}. It suggests earthly happiness is based on something happening to us. Happiness is circumstantial and conditional. It is based on fleeting and temporal things that, sooner or later, can easily shift and vanish. The joy in the Bible is based on something deeper than the fleeting and conditional joys or happiness of the world. As Hansel (1985) states, "it is not a feeling; it is a choice. It is not based upon circumstances; it is based upon attitude. It is free, but it is not cheap. It is the by product of a growing relationship with Jesus Christ" (p. 54-55).
We discuss the topic joy as related to the present study further in the section in chapter 3 describing the Rejoice Pathway.

F. Spiritual Interventions

Many studies have shown benefits of psychosocial interventions in reduction of psychological stresses for cancer patients (Meyer and Mark, 1995). A meta-analysis confirmed that psychosocial interventions positively affect emotional and functional adjustment, and treatment of disease-related symptoms (Meyer and Mark, 1995). The role of cancer group interventions has traditionally been to provide information, group support, facilitate emotional expression, and coping methods. Only a limited number of intervention trials have specifically addressed existential or spiritual themes or outcomes as their main focus. However, a relatively small but growing number of studies are exploring the impact of group trials for cancer patients based on spiritually based interventions.

As early as 1980, Propst (1980) examined the different efficacy of religious imagery treatment to nonreligious imagery treatment. In a sample of mildly depressed college students, with eight 1-hour sessions over 4 weeks, he found that a cognitive religious imagery treatment reduced mild depression symptoms significantly more than non-religious cognitive imagery on both behavioral and self-report measures.

Pecheur and Edwards (1984) compared the effectiveness of secular cognitive behavior modification with a similar modality modified to incorporate Christian beliefs and practices. Twenty one depressed Christian college students were randomly assigned to secular therapy, Christian therapy, and a wait-list control group. They participated in
programs twice a week for four weeks. Both the secular and the religious cognitive behavior modification groups experienced significantly more depression reduction than the wait-list control group. However, no significant differences were found between the two therapeutic groups at one-month follow up, although the authors noted that the Christian therapy group showed a consistent trend of more positive changes across the dependent outcomes.

Breitbart (2001) found, in his review of spirituality-centered and meaning-centered group interventions for cancer patients, that the majority of psychotherapy intervention work has utilized the related concepts of “meaning-making” and “self-transcendence.”

Coward (1998) examined the effectiveness of a support group intervention for women with breast cancer that utilized self-transcendence theory and was designed to facilitate self-transcendent views and perspectives to enhance emotional and physical well-being. Sixteen women who had recently been diagnosed with breast cancer participated in a 90-min support session that met weekly for 8 weeks. Specific strategies to be used with the pilot groups were based on those used in previous cancer support group intervention studies. They were: values clarification, problem solving, assertive communication skill training, feelings management, pleasant activity planning, constructive thinking, and relaxation training. Coward found self-transcendence and emotional well-being were increased from baseline, but only the increases in functional performance state, mood state, and satisfaction with life reached statistical significance.
Propst, Ostrom, Watkins, Dean, & Mashburn (1992) randomly assigned 59 depressed clients to either a cognitive behavioral treatment or similar condition that integrated a spiritual framework or waiting list group. The spiritually framed intervention provided eighteen 50-minute sessions for three months which gave Christian religious rationales for the procedures, used religious arguments to counter irrational thoughts, and used religious imagery procedures. The results indicated patients in a group receiving integrated therapy with a spiritual framework reported significantly lower depression than standard protocol or waiting list group patients.

Moritz et al. (2006) examined the impact of a spirituality program on mood disturbance in emotionally distressed patients. One hundred sixty-five participants were randomized into a spirituality group (an 8-week audiotaped spirituality home-study program), a meditation group (attendance at facilitated classes for 8 weeks), or a wait-list control group. Results showed that the spirituality program group decreased total mood disturbance, in the short term. No significant differences were found for either the control group or the meditation group.

Kinney, Rodgers, Nash, & Bray (2003) reported the results of an integrated mind-body-spirit self-empowerment program for breast cancer patients. Fifty-one women at various stages of breast cancer participated in a 12-week program, using a support group format with weekly 3-hour sessions on mind, body, and spirit education; focusing and relaxation techniques; stress reduction and coping skills; guided imagery and meditation practices; and dream interpretation. The program’s goals were to enable participants to experience a reduction in distress, improve perceived quality of life, reach a deeper sense
of meaning and purpose in life, and experience a greater sense of perceived wellness. The results showed statistically significant improvement in all variables and large estimated effect sizes on all four measures.

McCullough (1999) concluded, in his meta-analysis of five studies on the effectiveness on spiritually modified cognitive behavior therapy, that religious approaches can be as effective as standard approaches to depressed persons. As McCullough describes it, mounting evidence suggests that religion- or spirituality-centered cognitive therapy could be considered a well-established intervention for treating Christian patients.

G. Conclusions

There is now convincing evidence that a positive psychological outlook and the ability to imbue negative events with positive meaning have positive effects on psychological-spiritual functioning and quality of life, and can be helpful for patients with life-threatening or chronic illness. Researchers have shown that the mind-body approach has potential benefits and advantages and those mind-body interventions can be effectively used in the treatment of illnesses. Studies related to post-traumatic growth and religious coping have shown that negative life events can not only be turned to personal growth but also to a path to deep and lasting happiness as an individual’s perceptions change. Studies of imagery and visualization, hope and positive emotion have shown the potential for the positive impact of psychological-spiritual interventions on life-threatening and chronic illnesses.
H. Relevance of These Findings to the Present Study

This literature review supports a spiritual intervention that focuses on positive perspective change and positive expression through the Biblical methodology of transcendent coping. With the Biblical methodology and a scientific background, a spiritual intervention—*Look Beyond and Rejoice*—was developed and implemented. The intervention supported participants as they transform their view of adversity from loss to gain and involve positive practices—transcendent visualization and verbalization—that may positively influence their whole being. Since many patients with life-threatening illness or chronic pain suffer from a negative impact of their psychological-spiritual state, this paradoxical, spiritual intervention might prove beneficial.
CHAPTER THREE
METHODOLOGY

A. Design

To evaluate the effectiveness of the Look Beyond and Rejoice [LB&R] intervention, a true-experimental study was conducted using randomized experimental groups with immediate and delayed treatment. Patients were randomly assigned to the immediate or delayed program groups. The LB&R program consists of nine sessions, three times a week, for three weeks. In the immediate program group, patients were surveyed three times: at the beginning of the first session, at the end of the last session, and three weeks after the last session. In the delayed program group patients were also tested three times: three weeks before the first session, at the beginning of the first session, and at the end of the last session. Structurally, the design can be represented as follows:

\[
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R & O & O & X & O \\
& & & 3 \text{ weeks} & 3 \text{ weeks} \\
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Differences were assessed with measures of meaning-making, positive and negative affect, spiritual health, and physical-psychological-social health. This study received institutional review board approval from Loma Linda University.
B. Sample and Recruitment

Patients with life-threatening illness or chronic pain were recruited from the Southern California area. Patients were eligible if they are: Korean-American fluent in written and spoken Korean; between 18 and 70 years of age; willing to consent to take part in an overtly Christian intervention; currently receiving either curative or palliative treatment from a health professional; alert, oriented, and capable of giving informed consent; capable of attending a 9 session, 3 times a week training program. Twenty three patients (seventeen in immediate group and six in delayed group) attended program and completed the all three questionnaires.

Two recruitment strategies were used. The first strategy was advertising in two Korean-American newspapers and a magazine. Another strategy was contacting Korean-American pastors through phone and letter in the areas and requesting them to recruit patients in their churches or communities. The investigator sent them letters describing the study and poster of the program so that they could distribute. Additionally, the principle investigator visited churches and presented the LB&R program to promote the recruitment of patients. Patients who are interested in participating in the program were invited to telephone the investigator. Patients with a suspected or confirmed diagnosis of brain metastases, psychiatric history, reported alcohol or drug problems were excluded through advertisement and a brief telephone interview that was developed for the study.

C. Procedures

Eligible participants were matched on age, gender, general well-being and then randomly assigned to the immediate group or to a delayed group. A flipping coin method
was used to randomize the patients into an immediate group and delayed group. Randomized patients were called to be informed that which program group they are belonged to and they were guided on the procedure of documentation. The immediate group filled out and signed the consent form and filled out the self-report questionnaires at the beginning of the first session. The delayed group received consent form, procedure chart, time-line, self-report questionnaires, and self-addressed pre-stamped envelopes through the mail. Delayed group participants filled out and signed the consent form, filled out the questionnaire and sent both back to the investigator. In the consent form, participants were told that participants who miss more than two sessions would be excluded from the program.

1. Intervention

The program consisted of nine, 2-hour structured group sessions, three times a week, for three weeks. Each led by a certified health education specialist (the principle investigator and the developer of the LB&R program) and an assistant who facilitated the process and led in singing hymns. The program was conducted in Adams College class room in Los Angeles. Participants met in groups of 6 to 12 patients.

The LB&R program included both problem-focused (e.g., reframing and restructuring) and emotion-focused (e.g., positive verbalizing, praising) coping strategies. The intervention focused on transforming people’s perspective on their illnesses from negative to positive through their relationship with God. The participants learned how to visualize and verbalize positively in their daily living through looking beyond their adversity and looking to Jesus.
The first session was an introductory session where the program was introduced, the group members introduced to each other, the first topic ("Transformation of Tragedy") presented, and discussion of the topic facilitated. Each of the following eight sessions focused on a specific component of the LB&R framework. Table 1 provides details of the specific topic, goals, and content that were included in each of the sessions. The last session was a summing-up session which provided a time for participants to reflect on their experience in the program, evaluated the program as a whole and reflected on where to go from that point.

Each session included didactics, in-session exercise, discussion, and singing of classic and gospel styles of Christian hymns. To enhance the impact of the program interaction was facilitated through in-session activities and out-of-session homework assignments. In-session activities were a form of writing a personal reflection and strategy or practice related to the lessons of the session. Table 2 shows in-session exercises and out-of-session homework. Homework was a form of spending time practicing techniques introduced in class. In each session, didactic, in-session activity, and homework assignment materials were handed out to participants so that in their daily life participants may reflect on and practice the lessons. Patients were asked to record their daily practices on a provided log and turn in the log once a week.
<table>
<thead>
<tr>
<th>Session</th>
<th>Topic</th>
<th>Goals</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction Transformation of Tragedy</td>
<td>To familiarize participants with the program as a whole and to become acquainted with the others in the group; To be aware of the opportunity to transform adversity to gain; To consider the value of being active and hold fast to what is good</td>
<td>Overview of the sessions; Trauma and traumatic growth; Examples and characteristics of posttraumatic growth</td>
</tr>
<tr>
<td>2</td>
<td>Meaning-making Benefit-Finding Resilience</td>
<td>To be aware of the meaning of life and illness; To become aware of the value of loss to gain and grow; To learn the way of gaining from loss; To learn and adopt the attitude of resilience in God’s power</td>
<td>Presenting various meanings of illness and life; Examples of failure and success; The principles of resilience</td>
</tr>
<tr>
<td>3</td>
<td>Imagery and Visualization</td>
<td>To learn about mind-body medicine; To be aware of the influence of imagery; To learn the principle of visualization; To practice and adopt the visualization principle in daily life</td>
<td>Presenting the history and impact of mind-body medicine; Examples of visualization &amp; guided imagery; The power and principles of visualization</td>
</tr>
<tr>
<td>4</td>
<td>Look Beyond The Spiritual Coping Method</td>
<td>To be aware of the influence of beholding in the transformation; To learn how to look beyond the problem and look up to God and imagine a positive future outcome; To practice and adopt the look beyond visualization</td>
<td>Examples of visualization in the Bible and in actual life; The principles of transcendent visualization; Visualizing healthy-happier outcome</td>
</tr>
<tr>
<td>5</td>
<td>Creative Verbalization Positive Expression</td>
<td>To learn the creative and healing power of God’s word; to account God in God’s word; To learn the healing or destructive power of human words; To select and practice the healing, self-strengthening word</td>
<td>Presentation of the power of the word; Pray on the promise of God; Positive self-talk; Expressing emotion by journaling</td>
</tr>
<tr>
<td>6</td>
<td>Rejoice The Paradoxical Coping</td>
<td>To be aware of paradoxical truth in the Bible and in real life; To be aware of the power of gratitude, joy, and hope; To practice and adopt Rejoice coping by looking beyond pain and looking up to God and His promise</td>
<td>Presenting examples of paradox in the Bible and in actual life; Seeking positive things in illness; Delighting in adversity</td>
</tr>
<tr>
<td>7</td>
<td>Humans’ Suffering, God, &amp; Healing</td>
<td>To view the big picture of universal controversy and learn the problem of oneness and separation; To learn God’s answer to human’s suffering; God’s health plan</td>
<td>Presentation of the great controversy; Job in the great controversy; Healthy lifestyle and healing in the Bible</td>
</tr>
<tr>
<td>8</td>
<td>The Core of Life and Thriving</td>
<td>To be aware of the importance of one’s relationship—the core of life—with God and with others; To learn the value of forgiveness and choose to forgive; To love self, others, and God—the way of thriving</td>
<td>Practicing forgiving self, others, and God; Praying and helping others; Identifying and accepting goals and mission of life</td>
</tr>
<tr>
<td>9</td>
<td>Conclusion Hold Fast to What is Good</td>
<td>To review all LB&amp;R sessions; To keep practicing the LB&amp;R healing method in life; To share the impressions of the program; To summarize and evaluate LB&amp;R</td>
<td>Outlining of the all lessons of LB&amp;R; Sharing the experience of LB&amp;R; The follow-up strategies; Evaluation</td>
</tr>
<tr>
<td>Sessions</td>
<td>Topic</td>
<td>In-Session Exercises</td>
<td>Out-of-Session Exercises</td>
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</tr>
<tr>
<td>1</td>
<td>Introduction Transformation of Tragedy</td>
<td>• Writing a reflection on the subject and personal goals for the transformation of tragedy</td>
<td>• Having time to read and meditate Bible and/or other spiritual writings at least 20 minutes a day</td>
</tr>
<tr>
<td>2</td>
<td>Meaning-making Benefit-Finding Resilience</td>
<td>• Writing a reflection on the subject. Finding meaning and benefits of personal suffering and writing about them</td>
<td>• Having time to read and meditate Bible and/or other spiritual writings at least 20 minutes a day</td>
</tr>
<tr>
<td>3</td>
<td>Imagery and Visualization</td>
<td>• Writing a reflection on the subject and strategies and how to practice transcendent visualization</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization at least 5 minutes a day</td>
</tr>
<tr>
<td>4</td>
<td>Look Beyond The Spiritual Coping Method</td>
<td>• Practicing transcendent visualization</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization at least 5 minutes a day</td>
</tr>
<tr>
<td>5</td>
<td>Creative Word Power Positive Expression</td>
<td>• Writing a reflection on the subject and strategies of how to practice positive expression</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization &amp; verbalization, at least 5 minutes a day for each</td>
</tr>
<tr>
<td>6</td>
<td>Rejoice The Paradoxical Coping Method</td>
<td>• Practicing transcendent verbalization</td>
<td>• Keeping reading/meditating 20 minutes a day • Practicing transcendent visualization &amp; verbalization, at least 5 minutes a day for each • Rejoicing by singing hymns and praising God at least 10 minutes a day</td>
</tr>
<tr>
<td>7</td>
<td>Humans’ Suffering, God, &amp; Healing</td>
<td>• Writing a reflection on the subject and strategies how to implement the whole-person health plan</td>
<td>• Same as above</td>
</tr>
<tr>
<td>8</td>
<td>The Core of Life and Thriving</td>
<td>• Writing strategies of how to improve the relationships with self, others, and God</td>
<td>• Same as above</td>
</tr>
<tr>
<td>9</td>
<td>Conclusion Hold Fast to What is Good</td>
<td>• Writing a reflection on the whole program, how to maintain the strategies, and a resolution to keep them up</td>
<td>• Same as above</td>
</tr>
</tbody>
</table>
D. Measures

1. Demographics

Demographics relevant to the study and analysis were collected. These include gender, age, education, religious affiliation, frequency of attendance at religious meetings, illness and current treatments.

2. Meaning of Illness

The constructed Meaning Scale (CMS) was developed for the measurement of meanings associated with adaptation to life threatening illness by Fife (1995). Fife developed the scale on the basis of interviews with patients with cancer. The scale contains 8-items that measure 4-point Likert scale that varies from ‘strongly agree’ to ‘strongly disagree’. The total score can be obtained by summing the scores for the 8 items with reversing negative items. The highest possible score on the scale is 32 and it indicates the most positive meaning, whereas the lowest score of 8 indicates a negative sense of meaning. The statements of items include the effects of the illness on the individual's identity, interpersonal relationships, and the future. It has shown to have a good internal consistency of 0.81 (Fife, 1995). The items were modified to reflect a more general illness orientation as the original focused on cancer.

3. Positive and Negative Affect

The Positive and Negative Affect Schedule (PANAS) was developed by Watson, Clark, and Tellegen (1988) to measure the positive and negative affect. The PANAS consists of 10 positive affects (interested, excited, strong, enthusiastic, proud, alert, inspired, determined, attentive, and active) and 10 negative affects (distressed, upset,
guilty, scared, hostile, irritable, ashamed, nervous, jittery, and afraid). The scale contains items on a scale from 1 to 5, based on the strength of emotion from ‘very slightly or not at all’ to ‘extremely’. Positive and Negative scores were computed by summing scores to positive and negative items, respectively, and higher scores represented more positive affect and more negative affect. The Cronbach alpha coefficients ranged from 0.86 to 0.90 for positive affect and 0.84 to 0.87 for negative affect.

4. Joy and Love

Because the PANAS does not include Joy or Love as concepts in the positive emotions and because these are such central concepts in Christian Theology and in the intervention, we have chosen to add to the PANAS six affect items from Diener, Smith, and Fujita (1995) that measured these two concepts—joy, happiness, and contentment to assess Joy; and affection, love and caring, to assess Love.

5. Pain

The numerical rating scale (NRS) was developed by McCaffery and Beebe (1993) to measure the intensity of pain, 0 to 10, with 0 equivalent to no pain and 10 equivalent to severe pain experienced. NRS is easy to administer and score, and they can therefore be used in a greater variety of patients, and results can be easily scored to measure the changes of patient’s pain intensity. Whereas pain intensity reflects the overall magnitude of the pain, pain affect can be viewed as reflecting the unpleasantness or distress caused by the pain. As with pain intensity, pain affect can be assessed with NRS, and items having different anchors, for example, ‘not unpleasant’ and ‘most unpleasant feeling possible’. NRS’s validity and reliability have been well established.
through studies (Paice & Cohen, 1997; Ferraz, Quaresma, Aquino, Atra, Tugwell, & Goldsmith, 1990). Additionally, participants were asked about their use of pain medication.

6. Spiritual Experience

The Daily Spiritual Experience Scale (DSES) was developed by Underwood and Teresi (2002) to measure the level of religious coping/spirituality. It was developed to measure everyday spiritual experiences and the concepts of the scale are not limited to any particular religious tradition—though there does seem to be a monotheistic bias as all references to God are singular. The original scale contains 16-items and a shortened 6-item version scale was developed, too. The spirituality questions were self-report questions about how respondents live spiritually day-by-day. A 5-point Likert scale was used (1=Never, 2 = Rarely, 3 = Sometimes, 4 = Very often, 5 = Always). Internal consistency reliability estimates with Cronbach’s alpha were very high, 0.94 and 0.95 for the 16-item version of the scale. The scale has been shown to be culturally sensitive as it has been developed and tested with religiously diverse individuals.

7. Health Status

The SF-12 was developed by Ware, Kosinski, and Keller (1996) that is a multipurpose short-form (SF) generic measure of health stature. It is subset of the SF-36 Health Survey consisting of 12 items that cover the same eight dimensions as the SF-36. It measures an eight-scale profile of scores: physical functioning, role limitations due to physical health problems, bodily pain, general health, vitality (energy/fatigue), social functioning, role limitations due to emotional problems and mental health (psychological
distress and psychological well being). Physical and mental health composite scores are also available. Higher scores represent better health status. Acute 1-week recall version, instead of standard 4-week version, was used in current study. In a study of the SF-12, test-retest reliability was high (r = 0.89) and internal reliability was good, with Cronbach alphas ranging from 0.76 to 0.86.

8. Translation

We used Korean versions of the PANAS, and SF-12 as they were available. As Korean versions of DSES, CMS, and NRS were not available Korean versions of the measurements were developed with a back-translation procedure. Other portions of the questionnaire including the demographic section were also back-translated. In the process, one individual translated English to Korean and another individual back-translated Korean to English. The translator, back-translator, and one of investigators of present study discussed and resolved the differences in the back-translation. Then the original translator translated it again to Korean with those corrections and another person, not the original back-translator, produced a new back-translation which was then compared to the original. A pretest of the entire Korean questionnaire (PANAS, SF-12, DSES, CMS, demographics) was carried out on a small group of Korean speakers to check for problems. A few corrections were made as some individuals in the pretest raised questions regarding the meaning of questions. Dr. Underwood, developer of the DSES, was involved in the back-translation procedure of that scale twice, by reviewing the first back-translation and second back-translation. She also gave explanation and
suggestions to help with some of the subtle wording so that the original construct would be adhered to.

**E. Data Management**

All questionnaires were reviewed manually for missing data and, if possible, participants were contacted by phone to eliminate the missing data. During data entry, automated quality assurance reviews were conducted using SPSS Data Entry version 3 (SPSS Inc., 2001) to check for out-of-range entries and the discrepancies corrected. Data was also double entered and discrepancies between the entries corrected. SPSS version 15 was used for final data management (SPSS Inc., 2006).

1. **Data Cleaning**

Frequencies of all variables were examined for outliers and each outlier was rechecked against the original questionnaire. These were corrected if they were the result of data entry error. The expectation maximization (EM) procedure was used in SPSS to impute missing data for cases that have no more than 10% of items missing. Schafer and Graham’s (2002) recommendation to use all variables in the missing value imputation was followed.

**F. Analysis**

A 2 x 3 repeated measures analysis of variance was carried out with a six-week period between the pretest and the posttest for both immediate treatment group and delayed treatment group. The first factor was group (immediate or delayed treatment) and the second was time (pretest, 3-week and 6-week assessment). The magnitude of change between the pretest and double posttests of the immediate treatment group was
compared to the change of between the double pretests and posttest of delayed treatment group. Examination of the comparison allowed determination of the impact of LB&R program and possible delay or decay of impact.

Demographic variables found to be correlated with outcome variables were controlled in the analysis.

**G. Power**

The major problem with determining sample size is the size of the effect to be expected with the instrument. We were only able to find one study (Singh et al., 2006) that used the SF-12 to record change in a repeated measures experiment. Singh and her colleagues used the SF-12 to assess the effectiveness of acupuncture in the treatment of figromyalgia over a period of 2 months. They reported means and standard deviations on seven of the eight subscales of the SF-12. G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007, in press) allowed calculations of the effect size and sample size necessary to detect a change in each scale with 80% power at an alpha of .05. Since we were evaluating the power of a paired $t$-test for a pretest-posttest design we needed to estimate the test-retest correlation for the pretest-posttest. Hurst, Ruta and Kind (1998) compared test-retest reliability of the SF-12 and SF-36 in rheumatoid arthritis patients finding three-month test-retest correlations of .75 and .71 for the Physical and Mental Health Composite scores of the SF-12 respectively. However, these scores are derived by combining the individual subscales and, hence, are likely to be more reliable than the subscales assessed by Singh et al. Thus, we chose a more conservative test-retest estimate of .5. Using this
value the effect size estimates ranged from 1.08 to .16. The sample size estimates for the seven reported scales ranged from 9 to 308 with a median value of 60.

One major scale for this study is the Daily Spiritual Experience Scale (Underwood & Teresi, 2002). Elizabeth Johnston-Taylor has done work involving an intervention that changed the DSES. Based on means, standard deviations, and test-retest reliability derived from her study we found an effect size of .46 which would lead to a sample size estimate of 39.

Further power analysis involved comparing the posttest value of the immediate group with that of the delayed. Based on a simple independent samples $t$-test with power of 80%, $\alpha = .05$, and an effect size of $d = .5$ (what Cohen, 1992, calls a moderate effect size) a sample size of 51 per group was required. Keeping in mind that our power should be greater than .80 for the repeated measures ANOVA 55 participants per group should be adequate to allow for dropout. Based on all this we conclude that a sample size of at least 110 should give adequate power to detect changes in the DSES and most subscales of the SF-12. Power should be more than adequate for the composite physical and mental health scales.

**H. The Distinctive Characteristics of the Look Beyond and Rejoice Pathway**

As we mentioned earlier, the LB&R program is designed to help participants using two pathways: the Look Beyond pathway and the Rejoice pathway. The distinctive Characteristics of the Look Beyond pathway are transcendent coping, looking beyond, and focusing on the big picture. The Rejoice pathway is composed of paradoxical coping, creative word power, and positive medicine.
I. The Look Beyond Pathway

a. Transcendent Coping. Reed (1991) defined transcendence as expanding conceptual boundaries of the self beyond limits posed by the immediate situation, physical limitations, or otherwise constricted views of life and human potential. Tillich describes the self-transcendent experience as being “like the breathing-in of another air, an elevation above average existence” (1951, p. 236), and he perceives self-transcendence as being the “encounter with the holy” (1957, p. 8).

When patients’ resources have been exhausted and life appears out of control, they seek resources beyond themselves and may move toward the Divine. By taking into account the sacred and developing the Spirit—spirit relationship as described by Tillich (1951, p. 263), they may be lifted into the realm of the transcendent.

Wrestling with God—not with the problem nor people nor the devil—is the key to successful coping, as in the experience of Job, the archetypal sufferer in Bible. In all tragedies he kept his faith. In Job 1:21 he said, “The Lord gave, and the Lord has taken away; blessed be the name of the Lord.” In 2:10 he said, “Shall we receive good at the hand of the God and shall we not receive evil?” He affirmed the absoluteness of God's control over all things and clung to God in all his adversities—and in the end he was wonderfully blessed by God. The Bible makes it clear that keeping our eyes on God in difficult times is the way to not just survive trials but also to overcome them and receive great blessings. Encountering God is the greatest blessing of all—and this was Job’s experience: “I have heard of You by the hearing of the ear, but now my eye sees You” (Job 42:5).
An emerging theme from the literature is focusing on the relationships between self, others, and God (Conrad, 1985; Oldnall, 1996; Dyson, Cobb, & Forman, 1997). Hungelmann, Kennel-Rossi, Klassen, and Stollenwerk (1985) identified the interconnectedness of these three core elements as being at the heart of spirituality. Spirituality is commonly defined as the universal human desire for transcendence and connectedness (Carson, 1993; Reed, 1991b; Tanyi, 2002).

As patients awaken to God’s promise that they may be one in heart with Him, they may open their heart to be invested with extraordinary power beyond human’s finiteness and their self-identity becomes changed. The sense of God’s presence and personal care may transform life profoundly. Reaching inward to become acquainted with one’s past and present self, and reaching toward God for self-transcendence and toward others with renewed concern for their well-being—these are all manifestations of a new perspective that may promote healing.

If one confines oneself to the realm of human capacity and the visible world, then one neglects to ask for the spiritual power and love and good judgment that God promises (II Timothy 1:7). The current intervention was an attempt to help patients cope and transcend themselves beyond the realm of human capacity in the relationship with God.


A trauma is not what happened but the way we see what happened. A trauma is not a pathological event but a pathologized image, an image that has become intolerable... If we are ill because of these intolerable images, we get well because of imagination. (p. 47)
The Bible says, "Where there is no vision, the people perish (Proverbs 29:18)."

The LB&R intervention is, primarily, to help patients have a vision beyond themselves. They were led to look up to God, to consider His loving, just, omnipotent character, and to see their adversity as being in the hands of a God who is benevolent. Before a life can be transformed positively, there needs to be a shift in perspective. White says, "It is a law both of the intellectual and the spiritual nature that by beholding we become changed. The mind gradually adapts itself to the subjects upon which it is allowed to dwell. It becomes assimilated to that which it is accustomed to love and reverence" (1888, p. 555). Regarding the positive image in organizational development, Cooperrider (1990) states, "human systems are largely heliotropic in character, meaning that they exhibit an observable and largely automatic tendency to evolve in the direction of positive anticipatory images of the future. (p. 92)" In the use of the image for treatment, Jaffe and Bresler (1980) describe:

Imagining a positive future outcome is an important technique for countering initial negative images, beliefs, and expectations a patient may have. In essence it transforms a negative placebo effect into a positive one. . . . The power of positive suggestion plants a seed which redirects the mind—and through the mind, the body—toward a positive goal. (pp. 260-1)

The Bible says, "Faith is the substance of things hoped for, the evidence of things not seen (Hebrew, 11:1)," and it directs people in suffering to look up: "Let us fix our eyes on Jesus, the author and perfecter of our faith, who for the joy set before him
endured the cross, scorning its shame, and sat down at the right hand of the throne of God (Hebrews, 12:2).” In the same context, the Bible says that we are to fix the eyes of our hearts on the invisible; we are to reframe “adversity” so that we can overcome its negative effects on our courage: “Therefore we do not lose heart... So we fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal” (2 Corinthians, 4:18). Continuing this thought, White (1905) stated:

There are many who make life's burdens doubly heavy by continually anticipating trouble... Their happiness, both for this life and for the life to come, depends upon their fixing their minds upon cheerful things. Let them look away from the dark picture, which is [often] imaginary, to the benefits which God has strewn in their pathway, and beyond these to the unseen and eternal (pp. 247-8).

In the intervention, patients were guided to look up to their caring Creator, Jesus—the greatest healer—and “see” the Invisible, consciously and continuously, in their daily life. We believe the Biblical healing model on adversity is not removing it from the human’s experience but transforming it into perceived gains and blessings, received through the intervention of God and being with Him. In this context, Jesus, as His name “Immanuel” represents—“God with us”—is the ultimate answer to human suffering.

c. Big Picture. “Heal” and “healing” are derivatives of hal, in Anglo Saxon which meant “whole” (Webster's New Universal Unabridged Dictionary, 1972, p. 836). When the results of the LB&R healing model are assessed we distinguish between
curing and healing. Distinctions between curing (the actual eradication of a disease) and healing (the patient’s sense of wholeness and completeness) are important in caring for patients whose conditions may not be ‘cured’ in the usual sense of the word. Patients may have new and deep experiences of healing even if they are not “medically” cured. They may experience a profound sense of psychological or spiritual well-being and wholeness even when the actual disease remains.

Since the time of Newtonian mechanics and the Cartesian dualism between spirit and matter, as Bergesen (1995) suggests, people have been alienated from God, alienated from the human, and alienated from nature. With the emergence of scientific materialism, God was alienated from man by the focus shifting from God as the center of the cosmos to humankind.

As modern medicine began regarding the body as a machine and excluding the aspects of mental, emotional, and spiritual well-being, the health care problem has grown. We believe all forms of alienation have profoundly increased fear, disease, strife, war, ecological disaster, etc.

Recently, a new paradigm of perceiving our world has emerged as quantum physics has shown the conception of the material world as an interconnected web of relations (O'Murchu, 1998; Oppermann, 2003). As interpreted by Christian creationists (Schaeffer, 1979; Pearcey, 2005), this wholistic view of life is in accord with the Biblical view of life, that spirituality—a relationship with our Creator—is our destiny, if we so choose, and it is the choice we were created to make. The Bible says we live in a fallen, broken world and makes it clear that the purpose of God’s provision is to unite us with
God and with others in Jesus: “that in the dispensation of the fullness of the times He might gather together in one all things in Christ, both which are in heaven and which are on earth—in Him” Ephesians 1:10 NKJV).

We view, among Westerners, many longing souls have been tired and sick from the sense of alienation and deficiency of transcendent experience. Thus, many seek connectedness and transcendence in the New Age movement, Eastern religion and its practices, etc. However, the Bible suggests true healing comes in the connection with God as the center.

The LB&R intervention helped patients view the bigger picture beyond their adversity including spiritual and theodicy issues—as a cosmic conflict between God and Satan and freedom of choice between good and evil, and justice and grace. We hypothesize that if patients may find the meaning of their illness in the context of the big picture and feel a sense of oneness with God and others, their stress would be reduced and they would be given a peace of mind. The intervention also showed patients the whole-person health plan and principles of God for the human being from Eden to the Israelites and the Christian church so that they may grab and follow the health principles of God. And they may gain a new purpose in life; they may begin to pursue whole-person healing for themselves and seek to discover their personal role not only for their own healing but also for others and God in the larger setting. As Jesus became a linkage between God and human through His redemptive work and opened the way of healing people, the Bible invites Christians to join the mission of Jesus to unite all: “All this is
from God, who reconciled us to himself through Christ and gave us the ministry of reconciliation (2 Corinthians 5:18, NIV).”

2. Rejoice Pathway

   a. Paradoxical Coping. Webster’s dictionary (Nichols, 2001) identifies ‘paradox’ as ‘a seemingly contradictory or absurd statement that expresses a possible truth. The most striking of the strategies in the Bible is a paradoxical one. The message of the Bible is full of paradox because it is rooted in divine mystery—the “mystery of godliness” (I Timothy 3:16)—which goes beyond human comprehension. The Bible clearly calls believers to a paradoxical coping style—e.g., sing hymns in warfare (2 Chronicles 20: 21), love your enemy, bless those who curse you, turn the other cheek (Luke 6: 27-29), lose life to save it (Mark 8:35), be the last to be the first (Mark 10:44), be weak to be strong (2 Corintians 12:10), rejoice in suffering (1:2-4), etc.

   Sweet, a theologian, remarks in his book Jesus Drives Me Crazy! Lose Your Mind, Find Your Soul, “Once you become a disciple of Jesus, normal isn’t good enough anymore. Christians are part of the wisdom of the world that is to come… Christian spirituality is anything but sane if ‘sane’ means logical, predictable, serious, or safe” (2003, pp. 14, 19).

   How can it be possible? The Bible says that it is possible by looking up to Jesus. “The punishment that brought us peace was upon Him, and by His wounds we are healed” (Isaiah 53:5, NIV). In that relationship, we find new strength. Paradoxically, as we look up to Him on the Cross (John 3:4—as the Israelites, dying of venomous snakebites, looked up at the brass serpent on the pole, and were healed), He heals us, by
strengthening us to die; Jesus invites us to bear our cross—for us to experience transformation as He showed on His cross. By His death and resurrection He transformed His cross, paradoxically, into the perfect symbol of life, power, hope, victory.

When patients perceive the opportunity of gain in their loss, their experience may be transformed. As one imagines a bigger gain, one may be transformed even more. The illness may contribute to the attainment of a deeply felt life purpose and richly experienced relations with self, others, and God; this may have been implied by Jesus’ promise of an ‘abundant life’—here and now. The traumatic event may give the individual a unique opportunity to mature into an Enlarged-Self (three-dimensional self: deeper in more mature traits of character; broader in perspective and relationships with others; and higher in transcendence to the Devine) which, otherwise, might not have happened. From just such a transformed perspective the patient may experience positive feelings which may even reduce pain and promote healing. Even the sick whose physical condition is deteriorating may, with this perspective, experience healing of the spirit and heart.

Christianity, paradoxically, invites people to the way of suffering, especially with its emphasis on the transformational power of the cross. In the Beatitudes, Jesus said, “Blessed are those who mourn. They will be comforted” (Matthew 5:4). Jesus obeyed God’s will and went through suffering before the cross and on the cross. Because of this He was exalted to sit at the Fathers right hand and have the name above all names (Hebrews 12: 2; Philippians 2:9-11). And Jesus invites people to bear a cross, too.
“Whoever does not bear his cross and come after Me cannot be My disciple” (Luke 14:27). Peter also pointed out in 1 Peter 2:21: “To this you were called, because Christ suffered for you, leaving you an example, that you should follow in his steps.” Christians are obviously invited to the way of suffering to transform their adversity to the most valuable ones, such as, ceasing from sin (1 Peter 4:1), following God’s word (Psalms 119:67), salvation of soul (1 Peter 1:9), developing Christ-like character (James 1:3-4), sharing the sufferings of Christ (1 Peter 4:13), for comforting others in suffering (2 Corinthians 1:6-7), glorifying God (1 Peter 4:16). In these ways, through suffering, God’s purposes will be achieved and the sufferer will be matured into an Enlarged-Self (deeper, broader, and higher). The apostle Paul told the Corinthians, regarding the blessings which were prepared for the ones who follow Jesus with a cross: “No eye has seen, no ear has heard, no mind has conceived what God has prepared for those who love him. But God has revealed it to us by his Spirit. The Spirit searches all things, even the deep things of God” (1 Corinthians 2:9–10). C. S. Lewis recognized that we sometimes fail to appreciate the incredible being that God intends to give us. In his book, Mere Christianity, Lewis expresses apropos:

“Imagine yourself as a living house. God comes in to rebuild that house. At first, perhaps, you can understand what He is doing. He is getting the drains right and stopping the leaks in the roof and so on: you knew that those jobs needed doing and so you are not surprised. But presently He starts knocking the house about in a way that hurts abominably and does not seem to make sense. What on earth is He up to? The explanation is
that He is building quite a different house from the one you thought of — throwing out a new wing here, putting on an extra floor there, running up towers, making courtyards. You thought you were going to be made into a decent little cottage: but He is building a palace. He intends to come and live in it Himself” (1996, p. 176).

b. Creative Word Power. Human emotions are aroused externally by outside events and internally by the ongoing stream of inner dialogues as well as imaginings (J. L. Singer & Bonanno, 1990); and emotion can also be changed by cognitions and inner dialogues (Ellis, 1962, 2003; Hale & Strickland, 1976; Rosin, 1983; Lange, Richard, Gest, Vries, & Lodder, 1998). Harrell, Chambless, and Calhoun (1981) found that specific rational and emotional inner dialogues were found to be highly correlated with corresponding emotional states. The results of these studies are significant and closely related to the current study because changing imaginings and inner dialogues to the positive ones are the core strategies of transformation in this study.

It is a widely accepted fact by psychologists that thoughts shape the direction of our feelings and actions (Ellis, 1962, 2003; Graham, 1997; Kazak, Simms, Barakat, Hbbie, Foley, Golomb, Best, 1999). Words are a powerful component in our life because they are essential for our thoughts. It is possible to control our thoughts by choosing the words that we will allow to dominate our minds. Motivational speaker Robbins (1991) says, "Simply by changing your habitual vocabulary—the words you consistently use to describe the emotions of your life—you can instantaneously change how you think, how you feel, and how you live” (p. 202).
Negative inner dialogue and speech drain away energy and induce negative emotions that lead to disease and death and positive inner dialogue and speech bring energy and promote healing and health (Spegel, 1990; Diehm, 1988). Among the lessons in the Bible, the lesson about our “words” are vitally important because of their powerful influence on human life. This is shown vividly in the Divine warning, “The tongue has the power of life and death, and those who love it will eat its fruit (Proverbs 18:21).”

The Bible shows the world was created by the word of God, “By the word of the Lord the heavens were made... For He spoke, and it was done; He commanded, and it stood fast” (Ps. 33: 6, 9). Jesus, the Word of God became flesh, also used words to control weather, heal patients, and even raise the dead. The Bible says that we are created in the image of God (Gen. 1:26-27). This means the words that people use have a creative power that can change life and world.

As God used the power of words to create the world from chaos, patients may use their words to re-create health (whole-person) from the chaotic state of illness: “Reckless words pierce like a sword, but the tongue of the wise brings healing. (Proverbs 12:18 NIV).” Human’s words can add power when they are embedded with God’s omnipotent Word. One can be empowered by the saying of apostle Paul: “I can do all things through Him who strengthens me” (Phil. 4:13).

The force of words is magnified when they are spoken aloud (Diehm, 1988). Patients will be led to practice abstinence in negative expression and to promote positive expression in their inner dialogues, speeches. They will be guided to praise and thanksgiving through songs, too.
Figure 3.1 and 3.2 shows the resemblance of processes between the creation of God and the re-creation of health and new life from chaotic states. Patients will be guided to re-create health (whole person) from the state of chaos of illness through visualizing and verbalizing as God created the world through those processes. Also, as God affirmed His creation and celebrated by saying, “It is Good!” patients will affirm their re-creation of healing and celebrating by saying, “I will be healed and good! Praise God!,” and such an affirmation will induce further healing. As the arrow links directly from Visualizing & Verbalizing to Affirmation, based on the promises of God, patients may thank and praise God ahead of time by anticipating and visualizing the future state of Re-Creation of Health (whole-person). It will reinforce the process of Re-Creation of Health.
c. Positive Medicine. Voltaire (1694 - 1778), French author and philosopher, conjectured, “The art of medicine consists of amusing the patient while nature cures the disease.” Yet the western biomedical model has focused on “disease, illness, and negative concepts” (Bowling, 1991, p. 2) for three centuries and the physician’s role became “curer of disease” rather than “healer of the sick” (Cassell, 1976; Hauerwas, 1990). However, today’s chronic and degenerative illnesses, particularly stress related diseases, are directly linked to personal attitudes and lifestyle. The limitations of the biomedical model, as a natural result, lead to the emerging public interest in unconventional alternative medicine (Eisenberg et al., 1993).
Recently a growing body of research in the divergent fields as quantum physics, psychoneuroimmunology, biology, anthropology, and consciousness supports that unlike machines, humans have personalities, thoughts, feelings, and emotions all that can powerfully impact our immune system and resistance to illness and the healing process (Pert, 1997). Furthermore, recent findings demonstrate that the human mind is a powerful tool for self-healing (Dossey, 1999). According to Berk (2004), a psychoneuroimmunologist, “Positive emotions are a wonderful resource of self-generating pharmaceutical benefits within the body. Happiness breeds happiness. Positive emotions and behaviors regenerate our cells and invigorate our lives” (p. 46). In the book, Spontaneous Remission: An Annotated Bibliography (1993), neurochemists O'Regan and Hirshberg, who have collected a database of 3,500 medically documented cases of spontaneous remission of cancer, emphasized the importance of positive emotions: “It is increasing accepted today that the positive emotions (one of which is the belief that one can get well) stimulate the immune system and can be important factors in overcoming disease” (p. 46).

As the recent movement shows, medical circles are slowly but doubtlessly shifting to a new direction as O'Regan (1983), a neurochemist, predicted in his writing ‘Psychoneuroimmunology: The birth of a new field’ about two decades ago:

We will no longer be focused on only the reduction of symptoms or the removal of something negative, and instead begin to understand health and well-being as the presence of something positive. It may
well be the first step in the development of what might be called an affirmative science . . . a science for humankind (p. 3).

Biblical principles of healing suggest focusing on the positive, especially God, the ultimate positive one. The Bible suggests that healing and safety does not come from the absence of an ailment or danger, but rather from the presence of faith, courage, hope, love, gratitude, joy, and peace in God. In whole-person healing, eliminating bad things (e.g. an ailment) is not good enough; but what is needed is to add something good to replace what was eliminated, as in Jesus' parable: it was not enough for an evil spirit to be thrown out of the house; seven more came by, found the house clean and empty, and moved in (Matthew12, Luke11, Ephesians 6).

The Biblical prescription says, “A merry heart doeth good like a medicine: but a broken spirit drieth the bones” (Proverbs 17:22). “Rejoice in the Lord always. I will say it again: Rejoice! Let your gentleness be evident to all. The Lord is near. Do not be anxious about anything, but in everything, by prayer and petition, with thanksgiving, present your requests to God” (Philippians 4:4-6). Both the Bible and modern science now show that emotions are a bridge between mind and body, and root factors in health and healing. White wrote (1905) in her book Ministry of Healing:

Courage, hope, faith, sympathy, and love promote health and prolong life. A contented mind, a cheerful spirit, is health to the body and strength to the soul... Nothing tends more to promote health of body and of soul than does a spirit of gratitude and praise. It is a positive
duty to resist melancholy, discontented thoughts and feelings—as much a duty as it is to pray (pp. 241, 251).

"Rejoice always, pray continually, and give thanks in all circumstances" (1 Thessalonians 5:16-18) seems the core coping strategy the Bible gives for coping with stressful events even though we cannot easily understand how. The simple coping strategy seems to be, as Nehemiah says in the Bible, “Do not grieve, for the joy of the Lord is your strength” (8:10), a God’s prescription to human in adversity. We would like to call it “Positive Medicine” because it focuses and prescribes a positive attitude and action that directly impact people’s emotions which will boost their immune system as a good medicine.

I. Ethical Considerations

The basic principles of the Declaration of Helsinki (World Medical Association, 2004) guided this research. These principles include: Beneficence and Non-Malfeasance; Autonomy and Informed Consent; Confidentiality; and Justice.

1. Beneficence and Non-Malfeasance

The intervention is expected to help individuals cope with their illness but the health educator emphasized to the participants that they should continue with any medically approved treatment they are currently undergoing. Thus, only those patients currently under the care of a health professional were included in the study.

Development of problems beyond the scope of this intervention was referred to the health professional.
2. Autonomy and Informed Consent

Each research participant was informed of the aims and methods of the research. They were informed that they may withdraw from the study at any time. They were asked to sign a written informed consent. Participants were informed in the consent form that the intervention is overtly Christian.

3. Confidentiality

A list with a code number and the participant’s name, address and phone number were stored under lock and key separately from the data. All questionnaires were labeled only with the participants ID number.

4. Justice

The population targeted for this study is not based on any intent to exclude anyone but, nevertheless, included only Korean speaking Christians. Korean speaking individuals will be chosen because, the health educator delivering the intervention, Jung Park, is most fluent in Korean. This is no more exclusionary than limiting studies to individuals who only speak English a most common practice in U.S. research.

J. Study Limitations

The present study has some limitations that have to be addressed. First, the sample was taken from the Korean-American Christian population in Southern California area which limits the generalizability of the findings. While this research reveals important information on the impact of LB&R, if the intervention would be implemented to various ethnic groups, comparisons across different ethnicity would provide valuable information. Second, we focus on changes in a relatively short 6-week period, which
limits our ability to examine the long-term effects of the intervention. Future studies should collect data on multiple periods (e.g. at least 6 and 12 months later) to assess the long term effects of the LB&R. Third, the program was delivered by a single lecturer who has personally experienced posttraumatic growth and whole-person healing from chronic illness which may limit the generalizability. To promote the generalizability all the lectures were manualized so that it may be applied in variety of settings. Participants in the sample had various types of illnesses. It would be valuable to investigate the relationships between spirituality and individuals who have the same or similar illnesses in future studies.
CHAPTER 4

FIRST PUBLISHABLE PAPER

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LOOK BEYOND AND REJOICE:

A WHOLE-PERSON HEALING MODEL BASED ON THE BIBLE

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Abstract

Recently, studies of religious coping have increased dramatically. We propose the *Look Beyond and Rejoice* healing model to facilitate the understanding of Christian healing methods and its application for practice. The process of this model is subdivided into the five steps—selective attention, reappraisal and reframing, visualization and verbalization, emotional response, and mind-body well-being. In the model, patients are guided to look beyond their adversities and look up to God to transform their adversities into gains and blessings. An enhanced spiritual perspective may change a person’s experience of an illness from a sense of threat to a sense of challenge and hope. Concurrently, transcendent visualization, and creative verbalization methods may create healing power for the positive transformation that leads to improve mind-body well-being. The distinctive characteristics of the healing methods and implications for intervention are discussed.
Look Beyond and Rejoice:  
A Whole-Person Healing Model Based on the Bible

Studies of religious coping have increased dramatically recently (Harrison, Koenig, Hays, Eme-Akwari, & Pargament, 2001). Several studies have found that religious coping predicts the positive outcomes of negative life events beyond the effects of nonreligious coping (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Pargament, Eensing, Falgout, Olsen, Reilly, Van Haitsma, & Warren, 1990; Maton, 1989; Pargament, 1999). As early as 1978, Marks anticipated the power of spiritual intervention after he reviewed instances of dramatic behavior change following religious experiences: “When it works, faith healing has a power far surpassing existing psychotherapy technology. The order of magnitude of this difference is like that between nuclear and more conventional explosives” (p. 530). Researchers in the psychological community have recognized that cognitive-behavioral interventions imbued with spiritual dimensions may have greater impact when they incorporate the patients’ belief systems (Pargament, 1999; Miller, 1999; Propst, 1996).

Studies of religious and spiritual coping have shown significant beneficial effects for patients (most of whom were Christians)—effects now widely acknowledged—and have led some to posit the need to include religion and spirituality in clinical practice (Cunningham, 2005; Miller, 1999; Propst, 1996). Yet very little systematic study has been done on the *therapeutic use* of this dimension (Cunningham, 2005).

The purpose of this paper is to propose the Look Beyond and Rejoice [LB&R] healing model, based on Christian coping methods in the Old and New Testament. We
hope that the LB&R healing model will facilitate the understanding of distinctive characteristics of Christian coping methodology and will provide a theoretical framework, as well as, a framework for creating spiritual interventions for researchers and practitioners. This healing model has been developed from literature review, experience of cognitive-behavioral interventions, and by the personal experience of the first author of this paper.

The LB&R healing model is especially intended for those patients with life-threatening illness or chronic pain who may face the most challenging situations. Such patients suffer a wide variety of difficulties and sources of stress, including feelings of uncertainty and loss of control that may lead them to feel human insufficiency and seek a means beyond themselves for coping. Patients with life-threatening illness or chronic pain often suffer from negative thoughts and feelings that lead to a negative prognosis in their health (see Figure 1.1). The LB&R healing model is designed to redirect this negative process into a positive process that leads to positive health prognosis.

The fundamental principle of the LB&R healing model is based on looking up to the Healer. In the Old Testament, it is manifested as the Israelites, dying of venomous snakebites, looked up at the brass serpent on the pole, which in the New Testament symbolizes Jesus (John 3:14), and were healed (Numbers 21:4-8). The New Testament emphasizes healing by looking up to Jesus on the Cross “Let us fix our eyes on Jesus, the author and perfecter of our faith” (Hebrews 12:2), “By His wounds we are healed” (1 Peter 2:24; cf. Isaiah 53:5). Looking up to the Healer is, in reality, an action of belief.
Lazarus and Folkman’s transactional model of stress and coping defines coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). In Lazarus and Folkman’s transactional model, individual’s appraisal or interpretation of a situation defines threat and determines the level of stress in the situation. Reappraisals can decrease the harmful impacts of the stressful event and can sometimes even produce positive outcomes (Park & Folkman, 1997). Positive reappraisal is often taught and utilized in cognitive behavioral therapy (e.g., Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998).

Maton (1989) suggested two major pathways of positive influence for spiritual supports: (a) a “cognitive mediation pathway” that contributes to the adoption of a positive cognitive appraisal of the meaning and implications of negative life events, and (b) an “emotional support pathway” (the perceptions of being valued, loved, and cared for by God) that leads to enhanced self-esteem and reduced negative affect (p. 311).

Likewise, the LB&R healing model can be explained by using these two pathways—the Look Beyond pathway (a cognitive pathway) and the Rejoice pathway (an affective pathway). These spiritually enlightening directions will help patients to look up to the greatest Healer and the positive components that He promised rather than look down at the negative process and its components. The patients will be led to engage in reappraisals and reframing that focus on the potential benefits; and in their illness they may gain a new perspective on life and explore new opportunities for meaningful living. An enhanced spiritual perspective may change a person’s experience of a stressful event.
from a sense of threat to a sense of challenge and hope that leads to positive emotional health (Park & Folkman, 1997). Concurrently, the patients will be guided to practice—transcendent visualization and creative verbalization—the two vital methods taken from scripture in their daily practice to transform their experience of adversity. Related to the influences of visualization and verbalization, researchers have shown the pivotal role of images and self-verbalizations on the rational-emotional-behavior changes (Bergman & Craske, 2000; Ellis, 2003; Singer, 2006, p. 109).

A growing body of evidence reveals that stressful and traumatic life events such as cancer can have positive, in addition to negative, consequences (e.g., Thompson, 1991; Bulman & Wortman, 1977; Lehman, Davis, DeLongis, Wortman, Bluck, Mandel, & Ellard, 1993). These positive changes in the aftermath of stressful experiences have been referred to as posttraumatic growth (Tedeschi & Calhoun, 1995) or stress-related growth (Park, 2004). In the LB&R healing model, patients are guided to have this positive transformation in their tragedy: they are guided to look beyond their adversities and transform them into blessings; and to rejoice in God and His promises in order to potentially improve their spiritual outlook, psychological health, and immune function—which, in turn, can speed healing.

*The Processes and Components of Look Beyond and Rejoice Healing Model*

Figure 1.2 shows the major processes and components of the LB&R healing model. The whole process of the model may be subdivided into five steps, listed below. The first three steps are the *Action* stage and the last two steps are the *Outcome* stage.
1. Selective Attention – choosing to look up to God and the invisible realm, and giving attention to the spiritual, instead of looking up to the negative processes and components of illness.

2. Reappraisal and Reframing – not focusing on the “cons” of the illness; instead, perceiving the “pros” by meaning making (Park, 2005) and benefit finding (Helgeson, Reynolds, and Tomich, 2006) in the light of Biblical teachings.

3. Visualization and Verbalization – projecting a positive future image by transcendent visualizing and creative verbalizing based on the promise of God.

4. Emotional Response – experiencing positive emotional change as a result of selective attention, reframing, visualization and verbalization described above.

5. Mind-Body Well-being – experiencing a positive health outcome (spiritual, psychological, and physical) and improved quality of life as a result of the positive emotional change.

The key Bible texts in developing the model are these: “Test everything. Hold on to the good” (1 Thessalonians 5:21); “Fixing our eyes on Jesus” (Hebrews 12:2); “Faith is being sure of what we hope for and certain of what we do not see” (Hebrews 11:1); “Rejoice always, Pray continually, and give thanks in all circumstances, for this is God's will for you in Christ Jesus” (1 Thessalonians 5:21).
The LB&R healing model is an innovative coping method, although it may be a coping method that Christians have been encouraged to practice since the days of the early church. This model has received preliminary support from a feasibility study that was recently conducted for the patients with life-threatening illness or chronic pain (Park, 2008). Data analysis and patients’ verbal and written expressions show significant positive changes in variables such as physical health and mental health. The results suggest that LB&R model has potential for therapeutic effects at least in Christian patients. There are several distinctive characteristics that differentiate LB&R from other coping methods. Those elements are listed below.

**The Distinctive Characteristics of the Model and Methodological Implications**

As mentioned earlier, the Look Beyond and Rejoice healing model is designed to help patients using two pathways: a primarily cognitive pathway (Look Beyond) and a primarily affective pathway (Rejoice). The distinctive characteristics of the Look Beyond pathway are transcendent coping, looking beyond, and focusing on the big picture. The Rejoice pathway is composed of paradoxical coping, creative word power, and positive medicine.

1. **The Look Beyond Pathway**

   a. **Transcendent Coping.** O’Leary and Ickovics (1995) described three possible outcomes from transformational change following challenge: survival, recovery, and thriving. Those who merely survive cannot recover their previous level of functioning and those who do recover return to their previous level of functioning. However, those who thrive go *beyond* their previous level of functioning. The LB&R
Healing Model is designed to help participants target and experience thriving through spiritual-transcendent coping in their adversity. Patients may experience the transformation of adversity into gain and blessing as they practice Look Beyond and Rejoice. Participants may experience thriving in the sense of whole-person healing even if they are not being cured physically.

Spirituality is commonly defined as the universal human desire for transcendence and connectedness (Carson, 1993; Reed, 1991; Tanyi, 2002). Reed (1991) defined transcendence as expanding conceptual boundaries of the self beyond limits posed by the immediate situation, physical limitations, or otherwise constricted views of life and human potential. Tillich describes the self-transcendent experience as being “like the breathing-in of another air, an elevation above average existence” (1951, p. 236), and he perceives self-transcendence as being the “encounter with the holy” (1957, p. 8).

When patients’ resources have been exhausted and life appears out of control, they seek resources beyond themselves and may move toward the Divine. By taking into account the sacred and developing the Spirit—spirit relationship as described by Tillich (1951, p. 263), they may be lifted into the realm of the transcendent.

Wrestling with God—not with the problem nor people nor the devil—is the key to successful coping, as in the experience of Job, the archetypal sufferer in the Bible. In Job 1:21 he said, “The Lord gave, and the Lord has taken away; blessed be the name of the Lord.” In 2:10 Job said, “Shall we receive good at the hand of the God and shall we not receive evil?” He affirmed the absoluteness of God’s control over all things and clung to God in all his adversities—and in the end he was wonderfully blessed by God. The Bible
makes it clear that keeping our eyes on God in adversity is the way to not just survive trials but to overcome them and receive great blessings. Encountering God is the greatest blessing of all as Job experienced: “I have heard of You by the hearing of the ear, but now my eye sees You” (Job 42:5).

As patients awaken to God’s promise that they may be one in heart with Him, they may open their heart to be invested with extraordinary power beyond human’s finiteness and their self-identity becomes changed. The sense of God’s presence and personal care may transform life profoundly. Reaching inward to become acquainted with one’s past and present self, and reaching toward God for self-transcendence and toward others with renewed concern for their well-being—these are all manifestations of a new perspective that may promote healing.

b. Looking Beyond. The modern research in psychoneuroimmunology (PNI) has shown the mind and body are linked intimately and communicate messages to each other. Positive mental imagery affects a person very powerfully, emotionally and physically (Freeman, 2004, p. 277) and can promote relaxation and reduce stress, improve mood, control high blood pressure, alleviate pain, boost the immune system, and lower cholesterol and blood sugar levels (Longe, Blanchfield, Fundukian, & Watts, 2005, p. 880). It has been used increasingly by healthcare professionals with impressive results. Imagery has been found beneficial in treating eczema, acne, birth pain, diabetes, breast cancer, arthritis, migraine and tension headaches, and severe burns (Freeman, 2004, p. 278-79).
Positive expectation embedded with positive imagery, often in the form of the placebo effect, can also heal. The placebo effect has been reported to account for healing in 30% to 70% of all drug and surgical interventions (Freeman, 2004, p. 279).

Imagination is the ability to mentally visualize abstract ideas and concepts. It is a fundamental mental power through which people make sense of the world (Sutton-Smith, 1988, p. 22; Norman, 2000, pp. 1-2). A renowned theologian Niebuhr (1963) has stated:

We are far more image-making and image-using creatures than we usually think ourselves to be and... are guided and formed by images in our minds... Man... is a being who grasps and shapes reality... with the aid of great images, metaphors, and analogies.

Regarding the positive image in organizational development, Cooperrider (1990) states, “Human systems are largely heliotropic in character, meaning that they exhibit an observable and largely automatic tendency to evolve in the direction of positive anticipatory images of the future” (p. 92). White says, “It is a law both of the intellectual and the spiritual nature that by beholding we become changed. The mind gradually adapts itself to the subjects upon which it is allowed to dwell. It becomes assimilated to that which it is accustomed to love and reverence” (1888, p. 555). In the use of the image for treatment, Jaffe and Bresler (1980) describe:

Imagining a positive future outcome is an important technique for countering initial negative images, beliefs, and expectations a patient may have. In essence it transforms a negative placebo effect into a positive one. . . . The power of positive suggestion plants a seed which
redirects the mind—and through the mind, the body—toward a positive goal. (pp. 260-261)

Berk, Tan, & Berk (2008) found that looking forward to happy experiences may have health benefits. Sixteen participants were randomly assigned to either the experimental group (those anticipating a humorous event) or the control group. The results showed that the anticipation of a happy laughter experience lowered three stress hormones—cortisol by 39 percent, epinephrine by 70 percent, and dopac by 38 percent. In a previous study, Berk, Tan, and Westengard (2006) found that the anticipation of mirthful laughter had increased two beneficial hormones—beta-endorphins by 27 percent and human growth hormone by 87 percent.

In the Bible, vision for the future connotes vital importance: “Where there is no vision, the people perish (Proverbs 29:18).” A primary goal of the LB&R healing model is to help patients have a vision beyond themselves. There needs to be a shift in perspective before a life can be transformed positively. The Bible says, “Faith is the substance of things hoped for, the evidence of things not seen (Hebrew, 11:1),” and it directs people in suffering to look up: “Let us fix our eyes on Jesus, the author and perfecter of our faith, who for the joy set before him endured the cross, scorning its shame, and sat down at the right hand of the throne of God (Hebrews, 12:2).” Visualizing the positive reward was the coping method by which Jesus endured the cross for the joy set before him. It is the same coping method manifested in Moses: “By faith Moses… chose to be mistreated along with the people of God… because he was looking ahead to his reward” (Hebrews 11:24-26).
In the LB&R healing model, patients are guided to visualize future positive images—recovering from illness, a healthier and more mature self, or their caring Jesus—the greatest healer. Individuals may customize their visualization by choosing their favorite activities or therapies. For instance, at a pilot LB&R program, a cancer patient wrote his experience of visualization: “The LB&R program gave an unimaginable superpower to me who was depressed mentally and physically after cancer treatment. I always lived in dread of recurrence. However, it freed me from anxiety, and, as I imagined daily my healthy body in beautiful future, I felt comfortable, more joyful and vigorous.”

c. Big Picture. “Heal” and “healing” are derivatives of hal, in Anglo Saxon which meant “whole” (Webster's New Universal Unabridged Dictionary, 1972, p. 836). When the results of the LB&R healing model are assessed we distinguish between curing and healing. Distinctions between curing (the actual eradication of a disease) and healing (the patient’s sense of wholeness and completeness) are important in caring for patients whose conditions may not be ‘cured’ in the usual sense of the word. Patients may have new and deep experiences of healing even if they are not “medically” cured. They may experience a profound sense of psychological or spiritual well-being and wholeness even when the actual disease remains. They may say they are strong when they are weak, as did the Apostle Paul (2 Corinthians 12).

Since the time of Newtonian mechanics and the Cartesian dualism between spirit and matter, as Bergesen (1995) suggests, people have been alienated from God, others,
self, and nature. With the emergence of scientific materialism, God was estranged from man by the focus shifting from God as the center of the cosmos to humankind.

As modern medicine began regarding the body as a machine and excluding the aspects of mental, emotional, and spiritual well-being, the health care problem has grown. It seems to us that every form of humans' alienation from self, others, nature, and God has increased fear, disease, strife, war, ecological disaster, and similar negative outcomes.

Recently, a new paradigm of perceiving the world has emerged as quantum physics has shown the conception of the material world as an interconnected web of relations (O'Murchu, 1998; Oppermann, 2003). As interpreted by Christian creationists (Schaeffer, 1979; Pearcey, 2005), this wholistic view of life is in accord with the Biblical view of life, that spirituality—a relationship with the Creator—is human's destiny, it is the choice humans are created to make. The Bible says humans live in a fallen, broken world and makes it clear that the purpose of God’s provision is to unite individuals with God and with others in Jesus: “that in the dispensation of the fullness of the times He might gather together in one all things in Christ, both which are in heaven and which are on earth—in Him” (Ephesians 1:10 NKJV).

It seems, among Westerners, that many longing souls have become tired and sick from the sense of alienation and deficiency of transcendent experience. Thus, many seek connectedness and transcendence in the New Age movement, Eastern religion and its practices, etc. However, the Bible suggests true healing comes in the connection with God as the center (cf. Deuteronomy 32:39; Hosea 6:1).
The LB&R healing model will help patients view the bigger picture beyond their adversity including spiritual and theodicy issues—as a cosmic conflict between God and Satan and freedom of choice between good and evil, justice and grace. If patients find the meaning of their illness in the context of the big picture and feel a sense of oneness with God and others, their stress may be reduced and they will experience peace of mind. Additionally, they may gain a new purpose in life; they may begin to pursue whole-person healing for themselves and seek to discover their personal role, not only for their own healing, but also for others and God, in the larger setting.

2. The Rejoice Pathway

a. Paradoxical Coping. Webster’s dictionary (Nichols, 2001) identifies ‘paradox’ as “a seemingly contradictory or absurd statement that expresses a possible truth.” The most striking of the strategies in the Bible is a paradoxical one. The message of the Bible is full of paradox because it is rooted in divine mystery—the “mystery of godliness” (1 Timothy 3:16)—which goes beyond human comprehension.

The Bible clearly calls believers to a paradoxical coping style—e.g., sing hymns in warfare (2 Chronicles 20:21), love your enemy, bless those who curse you, turn the other cheek (Luke 6:27-29), lose life to save it (Mark 8:35), be the last to be the first (Mark 10:44), be weak to be strong (2 Corinthians 12:10), rejoice in suffering (Romans 5:3), etc. Sweet (2003), a theologian, remarks in his book Jesus Drives Me Crazy! Lose Your Mind, Find Your Soul, “Once you become a disciple of Jesus, normal isn’t good enough anymore. Christians are part of the wisdom of the world that is to come...
Christian spirituality is anything but sane if 'sane' means logical, predictable, serious, or safe” (pp. 14, 19).

Christianity, paradoxically, invites people to the way of suffering, especially with its emphasis on the transformational power of the cross. Jesus invites people to bear a cross (Luke 14:27), and Peter also pointed out “To this you were called, because Christ suffered for you, leaving you an example, that you should follow in his steps” (1 Peter 2:21). Christians are obviously invited to the way of suffering to transform their adversity to the most valuable outcomes, such as, ceasing from sin (1 Peter 4:1), following God’s word (Psalms 119:67), salvation of the soul (1 Peter 1:9), developing Christ-like character (James 1:3-4), sharing the sufferings of Christ (1 Peter 4:13), comforting others in suffering (2 Corinthians 1:6-7), and glorifying God (1 Peter 4:16). In these ways, through suffering, God’s purposes will be achieved and the sufferer will experience growth or thriving. C. S. Lewis (1996, p 176) recognized that individuals sometimes fail to appreciate the incredible being that God intends to give humans. In his allegory of a living house, Lewis expresses that God's work in our lives can be painful, but His ultimate goal is to transform individuals into something better—a house that God Himself will live in.

When patients perceive the opportunity of gain in their loss, their experience may start to be transformed. As one imagines a bigger gain, one may be transformed even more. The illness may contribute to the attainment of a deeply felt life purpose and richly experienced relations with self, others, and God; this may have been implied by Jesus’ promise of an ‘abundant life’—here and now. The traumatic event may give the
individual a unique opportunity to mature into an Enlarged-Self (three-dimensional self: 
*deeper* in more mature traits of character; *broader* in perspective and relationships with 
others; and *higher* in transcendence to the Divine) which, otherwise, might not have 
happened. It is why patients can praise and sing hymns in their adversity. As research on 
music therapy suggests (Cunningham, Monson, & Bookbinder, 1997; White, 2000; Blood 
and Zatorre, 2001), practicing praising God and singing hymns can be an important 
method to deal with negative emotions such as anxiety, fear, and anger and uplifting their 
positive emotions such as hope, joy, and contentment.

*b. Creative Word Power.* Human emotions are *aroused* externally by 
outside events and internally by the ongoing stream of inner dialogues as well as 
imaginings (Singer & Bonanno, 1990); and emotion can also be *changed* by cognitions 
and inner dialogues (Ellis, 1962; Rosin, 1983; Lange, Richard, Gest, Vries, & Lodder, 
1998). Harrell, Chambless, and Calhoun (1981) found that specific rational and 
emotional inner dialogues were highly correlated with corresponding emotional states. 
These studies imply that individuals can control thoughts and emotions by choosing the 
words that are allowed to dominate one's minds. Negative inner dialogue and speech 
drain away energy and induce negative emotions that lead to disease and death, while 
positive inner dialogue and speech bring energy and promote healing and health (Spigel, 
1990; Diehm, 1988). Inner dialogue has been increasingly noticed by researchers as an 
important strategy in self-awareness and self-regulation. The modification of inner 
dialogues has been emphasized as an important tool in cognitive behavioral therapy in the
process of learning to regulate feelings (e.g., Morin & Everett, 1990; Lange, Richard, Gest, Vries, & Lodder, 1998).

Among the lessons in the Bible, the lesson about "words" is vitally important because of their powerful influence on human life. This is shown vividly in the Biblical warning, "The tongue has the power of life and death, and those who love it will eat its fruit" (Proverbs 18:21). The Bible shows that the world was created by the word of God, "By the word of the Lord the heavens were made... For He spoke, and it was done; He commanded, and it stood fast" (Ps. 33: 6, 9). Jesus, the Word of God became flesh, also used words to control weather, heal patients, and even raise the dead. The Bible says that humans are created in the image of God (Gen. 1:26-27). This implies that the words that people use have a creative power that can change life and world. As God used the power of words to create the world from chaos, patients may use their words with care to re-create health (whole-person) from the chaotic state of illness: "Reckless words pierce like a sword, but the tongue of the wise brings healing (Proverbs 12:18)." The force of words is magnified when they are spoken aloud (Diehm, 1988). Conversation with God in prayer and praise and thanksgiving through songs are essential parts of positive, creative verbalization.

Figure 2.1 and 2.2 shows the resemblance of processes between the creation by God and the re-creation of health and new life from chaotic states. Patients will be guided to re-create health (whole person) from the state of chaos of illness through visualizing and verbalizing as God created the world through those processes. Also, as God affirmed His creation and celebrated by saying, "It is Good!" patients will affirm
their re-creation of healing and celebrating by saying, “I will be healed and good! Praise God!” and such an affirmation will induce further healing. As the arrow links directly from Visualizing & Verbalizing to Affirmation, based on the promises of God, patients may thank and praise God ahead of time by anticipating and visualizing the future state of Re-Creation of Health (whole-person). This will reinforce the process of Re-Creation of Health.

Patients need to be aware of the crucial role of their words in daily life and be led to train their inner dialogues and spoken words to become abstinent from negative expression and to promote positive expression in their inner dialogues and spoken words. The Bible invites individuals to attend to God’s words for their life and health: “Pay attention to what I say; listen closely to my words. Do not let them out of your sight, keep them within your heart; for they are life to those who find them and health to a man's whole body (Proverbs 4:20-22)”. Human’s words can add power when they are embedded with God’s omnipotent Word (e.g., one can be empowered by the saying of apostle Paul: “I can do all things through Him who strengthens me”, Philippians. 4:13).

c. Positive medicine. Voltaire (1694 - 1778), French author and philosopher, conjectured, “The art of medicine consists of amusing the patient while nature cures the disease.” Yet the western biomedical model has focused on “disease, illness, and negative concepts” (Bowling, 1991, p. 2) for three centuries, and the physician’s role has became “curer of disease” rather than “healer of the sick” (Cassell, 1976; Hauerwas, 1990). However, today’s chronic and degenerative illnesses, particularly stress related diseases, are directly linked to personal attitudes and lifestyle.
The limitation of the biomedical model, as a natural result, has lead to the emerging public interest in unconventional alternative medicine (Eisenberg et al., 1993).

Recently, a growing body of research in the divergent fields as quantum physics, psychoneuroimmunology, biology, anthropology, and consciousness supports that unlike machines, humans have personalities, thoughts, feelings, and emotions - all which can powerfully impact immune system and the healing process (Pert, 1997; Davidson et al., 2003). Furthermore, recent findings demonstrate that the human mind is a powerful tool for self-healing (Dossey, 1999; Berk, 2004). According to Berk (2004), a psychoneuroimmunologist, “Positive emotions are a wonderful resource of self-generating pharmaceutical benefits within the body. Happiness breeds happiness. Positive emotions and behaviors regenerate our cells and invigorate our lives” (p. 46). In the book, Spontaneous Remission: An Annotated Bibliography (1993), neurochemists O'Regan and Hirshberg, who collected a database of 3,500 medically documented cases of spontaneous remission of cancer, emphasized the importance of positive emotions: “It is increasingly accepted today that the positive emotions (one of which is the belief that one can get well) stimulate the immune system and can be important factors in overcoming disease” (p. 46).

As the recent movement shows, medical circles are slowly but doubtlessly shifting to a new direction as O'Regan (1983), a neurochemist, predicted in his writing ‘Psychoneuroimmunology: The birth of a new field’ more than two decades ago:

We will no longer be focused on only the reduction of symptoms or the removal of something negative, and instead begin to understand
health and well-being as the presence of something positive. It may well be the first step in the development of what might be called an affirmative science... a science for humankind (p. 3).

Biblical principles of healing suggest focusing on the positive, especially God, the ultimate positive one. The Bible suggests that healing and safety does not come from the absence of an ailment or danger, but rather from the presence of faith, courage, hope, love, gratitude, joy, and peace in God. In whole-person healing, eliminating bad things (e.g. an ailment) is not good enough; but what is needed is to add something good to replace what was eliminated, as in Jesus’ parable: it was not enough for an evil spirit to be thrown out of the house; seven more came by, found the house clean and empty, and moved in (Matthew 12).

The Biblical prescription says, “A merry heart doeth good like a medicine: but a broken spirit drieth the bones” (Proverbs 17:22). “Rejoice in the Lord always. I will say it again: Rejoice!” (Philippians 4:4). Both the Bible and modern science now show that emotions are a bridge between mind and body, and root factors in health and healing. “Rejoice always, pray continually, and give thanks in all circumstances” (1 Thessalonians 5:16-18) seems the core strategy the Bible gives for coping with stressful events even though we cannot easily understand how. The simple coping strategy seems to be, as Nehemiah says in the Bible, “Do not grieve, for the joy of the Lord is your strength” (8:10), a prescription from God to a human in adversity. We would like to call it “Positive Medicine” because it focuses and prescribes a positive attitude and action that
directly impact people’s emotions which will boost their immune system as a good medicine.

Conclusion

In many instances, such as life-threatening illness or traumatic accident, people gain new perspective and grow through the process of getting through stressful life events (Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1995). In this article, we proposed the LB&R healing model which is based on the Bible. We propose that in Biblical coping perspective change, meaning making, transcendent visualization, and creative verbalization are powerful methods for positive transformation. All of these methods are manifested when patients look beyond their adversities and look up to God and invisible things. Through those enhanced coping methods and spiritual perspective, patients’ experience of illness may be changed from a sense of threat to a sense of challenge and hope that leads to positive emotional health and physical health. It is consistent with rabbi Kushner (1989), “Religion is first and foremost a way of seeing. It can't change the facts about the world we live in, but it can change the way we see those facts, and that in itself can often make a real difference” (p. 27). As this implies, the essence of the LB&R coping is the transcendent experience, especially, in the relationship with God. It is hoped that this model will stimulate researchers and practitioners to further investigate and practice the Biblical coping methods for many Christian populations.
References


Figure 4.1 The Detrimental Processes and Components of Negative Cognitive Appraisal and the Consequent Emotional Response and Prognosis of Patients with Life-Threatening Illness or Chronic Pain (upper panel) Compared to the LB&R Healing Model Showing the Processes and Components of Each of the Five Steps (lower panel)

Life-threatening Illness or Chronic Pain
- Uncertainty
- Pain
- Death
- Disfigurement
- Disability

Cognitive Appraisal
- Meaninglessness
- Sense of loss
- Out of control
- Facing threats
- Helplessness
- Hopelessness

Emotional Response
- Fear
- Nervousness
- Distress
- Pain
- Joy
- Hope
- Gratitude

Mind-Body Well-being
- Physical
- Psychological
- Spiritual
- Social

Action

Step 3: Visualization & Verbalization

Visualizing
- Personal caring God
- Recovering/healed self
- Grown self
- Achieving purpose

Step 4: Emotional Response

- Joy
- Hope
- Gratitude
- Fear
- Nervousness
- Distress
- Grief

Step 5: Mind-Body Well-being

- Spiritual
- Psychological
- Physical
- Social

Outcome

Life-Threatening Illness or Chronic Pain
- Pain
- Death
- Uncertainty
- Disfigurement
- Disability

God & Promises of God
- Love/Grace
- Forgiveness
- Power
- Healing
- Growth
- Eternal Life

Step 1: Selective Attention

Step 2: Reappraisal & Reframing

- Meaning-making
- Benefits-finding & gaining
- Purpose of illness & life

Verbalizing
- Proclaim own healing to self/others
- Rejoice
- Pray
- Thanks in all circumstances
- Praise God

The key Bible texts of the model:
"Test everything. Hold on to the good." (1 Thessalonians 5:21) "Fix our eyes on Jesus." (Hebrews 12:2) "Faith is being sure of what we hope for and certain of what we do not see." (Hebrews 11:1) "Rejoice always." "Pray continually." "Give thanks in all circumstances." (1 Thessalonians 5: 16-18).
Figure 4.2 God and the Creation Process (upper panel) Compared to the Patient and the Re-Creation of Health Process (lower panel)

Chaos

Visualizing
&
Verbalizing

Creation
of
World

Affirmation
(every step)

"It is Good!"

Chaos
(of illness)

Visualizing
&
Verbalizing

Re-Creation
of
Health
(Whole-Person)

Affirmation
(every step)

"I will be Healed & Good!"

"Praise God!"
CHAPTER 5
SECOND PUBLISHABLE PAPER

For publication in the Journal of Religion and Health
LOOK BEYOND AND REJOICE:
A SPIRITUAL INTERVENTION FOR PATIENTS WITH
LIFE-THREATENING ILLNESS OR CHRONIC PAIN

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Abstract

We investigated the impact of Look Beyond & Rejoice, a spiritual intervention, on spiritual, psychological, and physical health in patients with life-threatening or chronic pain. Patients were randomly assigned to the immediate or delayed program groups and twenty-three patients completed all three questionnaires. There were statistically significant increases across the three measurement points in both groups in meaning in illness and joy, as well as, decreases in negative affect and both types of pain. Levels of love, physical health, and mental health improved during the program but not before or after. Spiritual intervention can lead to positive mind-body well-being outcomes.

Key words: spirituality; religion; intervention; coping; Christian
Look Beyond and Rejoice:
A Spiritual Intervention for Patients With Life-Threatening Illness or Chronic Pain

Evidence that psychosocial and spiritual factors impact physiologic health has increased steadily during the past few decades (Engel, 1977; Herbert & Cohen, 1993; Pargament, Koenig, Tarakeshwar, & Hahn, 2004). Several studies have found that religious coping predicts the positive outcomes of negative life events better than the outcomes of nonreligious coping (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Maton, 1989; Pargament, 1999).

As the influence of spirituality and religion on health is recognized, health care professionals are increasingly called to treat patients of different religions and value systems, and there has been a recent surge in incorporating religion and spiritual support in patient care (Kearns, 2002; Cunningham, 2005). Researchers in the larger psychological community have recognized that cognitive-behavioral interventions imbued with spiritual dimensions may have greater impact when they incorporate the patients’ belief systems (Pargament, 1999; Miller, 1999). Since the mid-1980s, many researchers have studied spirituality and its effects on health. The majority of more than 1,200 studies conducted in the last century were observational, not interventional: they investigated how the participants (most of whom were Christians) utilize spirituality and religion to have a positive impact on their health (Koenig, 2004a, p. 9).

Even though religious and spiritual coping have significant beneficial effects on patients and its effects are now widely acknowledged—and even though the need to
include religion and spirituality in clinical practice has emerged, very little systematic study has so far been done on the therapeutic use of this dimension (Cunningham, 2005). Given that the impact of religion was generally found to be positive, it seems strange that interventional studies have not followed observational studies to measure the health benefits of intervening with the positive coping methods that were identified as being used by many Christians. There are very few such interventional studies (e.g., Hawkins, Tan, & Turk, 1999; Garzon, 2005), but these target mental rather than whole-person health. Thus, given the paucity of this type of research and its potential to improve health outcomes of patients—we view developing and testing a Christian intervention not only as a logical extension of past research but an essential task.

The Look Beyond and Rejoice (LB&R) intervention proposed here involves religious-spiritual disciplines and practices designed to help participants. The spiritual lessons lead them to engage in reappraisals and reframing that focus on the potential benefits; and in their illness they may gain a new perspective on adversity and explore new opportunities for meaningful living. An enhanced spiritual perspective may change a person’s experience of a stressful event from a sense of threat to a sense of challenge and hope that may lead to positive emotional health. Concurrently, the participants are guided to practice transcendent visualization and verbalization in their daily practice by looking to Jesus. Their transformed view of adversity, from loss to gain, and their involvement in transcendent practices may positively influence their whole being. We propose that this spiritual intervention enhances the participants’ ability to control stress and depression, alleviate pain, support positive emotions generated by their new coping practices, and
improve mind-body well-being. In Lazarus and Folkman’s (1984) transactional model of stress and coping individual’s appraisal of a situation defines threat and determines the level of stress in the situation. Reappraisals can decrease the harmful impacts of the stressful event and can sometimes even produce positive outcomes (Park & Folkman, 1997). Related to the concept, a new healing model, the Look Beyond & Rejoice Healing Model was developed to provide a theoretical framework for an intervention. Aimed at individuals with life-threatening illness or chronic pain, LB&R is based on scientific literature and Christian coping methods in Old and New Testament Bible to improving spiritual, mental, and physical health.

The Look Beyond and Rejoice Healing Model

The whole process of the LB&R healing model may be subdivided into the five steps listed below. The first three steps are the Action stage and the last two steps are the Outcome stage.

1. Selective Attention – choosing to look up to God and the invisible realm and giving attention to the spiritual.

2. Positive Reframing – not focusing on the “cons” of the illness; instead, perceiving the “pros” by meaning making and benefit finding.

3. Transcendent Visualization and Verbalization – projecting a positive-transcendent future image by visualizing and verbalizing.

4. Positive Emotional Response – as a result of the reframing, visualization and verbalization just described, experiencing positive emotional change.
5. Mind-Body Well-being – experiencing a significant and discernibly positive health outcome (spiritual, psychological, and physical) and improved quality of life.

Figure 1 shows the major processes and components before (figure 1.1) and after (figure 1.2) the LB&R intervention, and key Bible texts related to the model. In this study, we examined the impact of LB&R intervention on the change of finding meaning of their illness, positive and negative emotion, perceived pain, and mind-body well-being in persons with life-threatening illnesses or chronic pain were investigated.

Methodology

Study Design

Participants were randomly assigned to an immediate or delayed intervention groups. In the immediate program group, patients were surveyed three times: at the beginning of the first session, at the end of the last session, and three weeks after the last session. In the delayed program group patients were also tested three times: three weeks before the first session, at the beginning of the first session, and at the end of the last session. The three survey occasions for the immediate group coincided in time with each of the three survey occasions for the delayed group.

Sample and Recruitment

Patients with life-threatening illness or chronic pain were recruited from the Southern California area. Patients were eligible if they were: Korean-American fluent in written and spoken Korean; between 18 and 70 years of age; willing to consent to take part in an overtly Christian intervention; currently receiving either curative or palliative
treatment from a health professional; alert and capable of giving informed consent; capable of attending all sessions. Twenty three patients (17 in the immediate group and 6 in the delayed group) attended the program and completed all three questionnaires.

Two recruitment strategies were used: (a) advertising in two Korean-American newspapers and a magazine and (b) contacting Korean-American pastors through phone and letter in the areas and requesting them to recruit patients in their churches or communities. Additionally, the first investigator visited churches and presented the LB&R program to promote the recruitment of patients. Patients who were interested in participating in the program were invited to telephone the investigator. Patients with a suspected or confirmed diagnosis of brain metastases, psychiatric history, reported alcohol or drug problems were excluded through advertisement and a brief telephone interview that was developed for the study.

Procedures

Eligible participants were matched on age, gender, general well-being and then randomly assigned to the immediate group or to a delayed group. Randomized patients were called to be informed that which program group they are belonged to and they were guided on the procedure of documentation. The immediate group filled out and signed the consent form and filled out the self-report questionnaires at the beginning of the first session. The delayed group received consent form, procedure chart, time-line, self-report questionnaires, and self-addressed pre-stamped envelopes through the mail. Delayed group participants filled out and signed the consent form, filled out the questionnaire and
sent both back to the investigator. In the consent form, participants were told that participants who miss more than two sessions would be excluded from the program.

Intervention

The LB&R program consisted of nine sessions—three times a week, for three weeks. Each was led by a certified health education specialist (the principle investigator and the developer of the program) and an assistant who facilitated the process and led in singing hymns. The program was conducted in Adams College chapel room in Los Angeles. Participants met in groups of 6 to 12 patients. Table 1 provides details of the specific topic, goals, and content that were included in each of the sessions. Each session included didactics, in-session exercise, discussion, and singing of Christian hymns. To enhance the impact of the program interaction was facilitated through in-session activities and out-of-session homework. In-session activities were a form of writing a personal reflection and strategy or plan related to the lessons of the session. Table 2 shows in-session exercises and out-of-session homework.

Measures

Demographics. Demographics relevant to the study and analysis were collected. These include gender, age, education, religious affiliation, frequency of attendance at religious meetings, illness and current treatments.

Meaning of Illness. The constructed Meaning Scale (CMS, Fife, 1995) was used for the measurement of meanings associated with adaptation to life threatening illness.

Positive and Negative Affect. The Positive and Negative Affect Schedule (PANAS, Watson, Clark, and Tellegen, 1988) was used to measure the positive and
negative affect.

*Joy and Love.* We chose to add six affect items from Diener, Smith, and Fujita (1995)—joy, happiness, and contentment to assess *Joy*; and affection, love and caring, to assess *Love*—to the PANAS.

*Pain.* The numerical rating scale (NRS, McCaffery, Beebe, 1993) was used to measure the pain intensity and pain affect.

*Spiritual Experience.* The Daily Spiritual Experience Scale (DSES, Underwood, Teresi, 2002) was used to measure the level of religious coping/spirituality.

*Health Status.* The SF-12 (Ware, Kosinski, Keller, 1996) was used to measure health status. Acute 1-week recall version was used.

*Translation.* We used Korean versions of the PANAS, and SF-12 as they were available. As Korean versions of DSES, CMS, and NRS were not available Korean versions of the measurements were developed with a back-translation procedure. Other portions of the questionnaire including the demographic section were also back-translated. A pretest of the entire Korean questionnaire (PANAS, SF-12, DSES, CMS, demographics, and any interstitial material) was carried out on a small group of Korean speakers to check for problems. Dr. Underwood, developer of the DSES, was involved in the back-translation procedure of that scale twice by helping with some of the subtle wording required to make this scale perform at its best.

*Analysis*

A 2 x 3 repeated measures analysis of variance was carried out. The first factor was group (immediate or delayed treatment) and the second was time (pretest, 3-week
and 6-week assessment). The magnitude of changes between the pretest, posttest, and 3-week posttest of the immediate treatment group were compared to the changes between the double pretests and the posttest of delayed treatment group. Examination of the comparison allowed determination of the impact of LB&R program and possible delay or decay of impact. Demographic variables found to be correlated with outcome variables were controlled in the analysis.
Results

Characteristics of Participants

Initially, forty registered patients were randomized into either the immediate group or the delayed group, but only 11 of the immediate group and 6 of the delayed group completed all three questionnaires. The number of patients who attended the program in the delayed group became much less than the number of patients in immediate group. Through phone contact, we learned the reasons: some patients had schedule changes due to traveling, etc.; some patients' condition became too severe to attend; some patients who wished to belong to the immediate group dropped out when they were assigned to the delayed group. We also found the reasons that some patients in the immediate group dropped: some patients’ condition became worsening; attended only the first session as spouse asserted to attend; considered the program was too difficult with the processing of consent and survey, etc. Six individuals in a pretest program had gone through the identical program so these were added to the immediate group for analysis purposes. Twenty-three participants then completed all questionnaires.

The mean age of the entire sample (N = 23) was 61.87 years, 63.94 years for the immediate group (N = 17), and 56 years for the delayed group sample (N = 6). There were 7 males and 10 females in the immediate group, and 3 males and 3 females in the delayed group. They tended to be well educated, 65% were college or graduate school graduates. However, delayed group participants were significantly more educated than the immediate group participants. The data shows 83.3% of the delayed group and 5.9% of the immediate group completed graduate school. There were no statistically significant
differences in age, gender, religion, or frequency of attendance of religious meetings between the immediate and delayed treatment groups. Among the 23 participants 18 were Protestants and 5 Catholics. Seven had the religion 1-10 years, 5 had 11-30 years, and 11 had over 30 years. Two attended no religious meetings in a month, 3 attended once or twice a month, and 14 attended one or more times a week. There was no statistically significant difference in the kinds of disease that participants had in the time of intervention between the immediate and delayed group, $\chi^2(7, N = 23) = 6.750, p = .455$. Cancer ($N = 5$) and cardiovascular disease ($N = 5$) were the most prevalent diseases and other diseases such as, arthritis, back pain, fibromyalgia, headache were followed.

**Outcome Variables**

Table 3 shows means and upper and lower 90% Confidence limits for the outcome variables. We used 90% confidence limits because this was a small, preliminary study of the LB&R methodology and we judged type II error to be a more serious threat than type 1 error. Table 4 shows the results of a repeated measures analysis of variance for the main study variables using the multivariate analysis of variance approach.

There were statistically significant increases across the three measurement points in both groups in meaning in illness and joy, as well as, decreases in negative affect and both types of pain. There were statistically significant interactions on love, physical health, and mental health. Love increased in the immediate treatment group during the period of treatment but then returned to baseline level. In the delayed group there was a drop in the love variable while awaiting treatment but a return to the original levels during treatment. It appears that both the immediate and delayed group individuals
improved physical health while they were in the program, but the physical health of the immediate group three weeks after intervention had returned to baseline level. Mental health improved in both immediate and delayed group individuals while they were in the program, but it slightly decreased in the immediate group three weeks after intervention.

The percentage of medication use at baseline, at 3 weeks, and 6 weeks, were 35.3%, 23.5%, and 23.5%, in the immediate group; 83.3%, 50.0%, and 33.3% in the delayed group; and 47.8%, 30.4%, and 26.1% in the total group. Medication use went down in both immediate and delayed groups. However, this drop was only significant when the two groups were combined—χ²(2, N=23) = 6.000, p = .0498, by Friedman’s test. When the groups were examined separately the drop was not significant for the immediate group and marginally significant for the delayed group—χ²(2, N=17) = 2.000, p = .368 and χ²(2, N=6) = 4.667, p = .097 respectively.

Correlations of changes in dependent variables from immediately before the intervention to immediately after the intervention in both treatment groups were investigated. For the immediate treatment group the baseline measures were subtracted from the third week measures; for the delayed treatment group the third week measures were subtracted from sixth week measures. This created a variable for both groups that represented change from immediately before to immediately after the intervention. The correlation results show a number of interesting associations. There were significant correlations between change in daily spiritual experience and change in negative affect (r = -.48, p = .02). For example, as daily spiritual experience went up negative affect went down. Also, there were significant correlations between negative affect change and
changes of bodily pain \( (r = .62, p = .00) \), unpleasant pain \( (r = .55, p = .01) \), and mental health \( (r = -.55, p = .01) \). For instance, as negative affect dropped, changes in bodily pain and unpleasant pain declined while mental health improved. Additionally, significant correlations were found between love change and changes of bodily pain \( (r = -.43, p = .04) \) and unpleasant pain \( (r = -.51, p = .01) \). For example, as love increased over time changes of bodily pain and unpleasant pain went down.

Association of Program Success with Demographics

One possibility could be that individuals with certain demographic characteristics might have greater program success. The association of gender, age, education, religious group (Protestant vs. Catholic), years a member of the religious group, and religious service attendance frequency with change in each of the 10 outcome variables was examined. For age, which was measured as a continuous variable, correlations of each demographic variable with each outcome variable were tested. For the other demographic variable, which were all measured as categorical variables, one-way ANOVAs or \( t \)-tests were used. Of the 60 associations tested only three were significant. The association of religious attendance with change in unpleasant pain, was statistically significant \( (p = .032) \) but oddly structured. Those who attended church once or twice a month \( (M = 2.3) \) and those who attended three or more times a week \( (M = 2.8) \) showed decreases in unpleasant pain compared to those who did not attend at all \( (M = -2.5) \). Significance levels by Dunnett’s test were .090 and .015 respectively for the two comparison. Those attending once \( (M = 0.7) \) or twice \( (M = 0.2) \) a week did not differ from the other groups. The association of religion (Protestants/Catholics) with change in
daily spiritual experience \((r = .68, p = 0.004)\) and change in meaning in illness were significant \((r = .56, p = 0.006)\). In both changes, Catholics showed bigger positive changes than Protestants. However, given the large number of significance tests performed on this data \((60)\) it is quite likely that at least some of these associations are spurious.

**Discussion**

In this study, we investigated the impact of a 3-week, LB&R group intervention for patients with a life-threatening illness or chronic pain. We observed the effect of the intervention on the patients’ spiritual, physical, and mental health. Our findings suggest that a spiritual intervention based on a Christian coping model can positively influence mind-body well-being outcomes. It is important to note that these results include the changes of pain and physical health in addition to the mental and spiritual health.

The first research question is about the impact of the LB&R spiritual intervention on finding meaning for patients with life-threatening illnesses or chronic pain. There were statistically significant increases across the three measurement points in both groups in meaning in illness. The present study suggests that the LB&R intervention helps patients to find meaning in life-threatening illnesses or chronic pain though the increase in meaning before the intervention in the delayed group would suggest that such an increase may also come from anticipation. Still, this finding is consistent with studies showing that religious faith is an important source of support for such patients in search of meaning \(\text{e.g.,} \) Jenkins & Pargament, 1995; Koenig, 2004b). Religious reframing may
facilitate the meaning-making process. The participants’ written and verbal responses showed their experience of reframing. For example, one patient wrote:

I shame myself that I blamed God with the reason that I had many hardships in life because I was born as an eldest daughter in a poor family, but I thank it strengthened me to overcome the troubled world and to live well. I wish the experience that I gained from suffering will be used as a tool to help others as I will be with them. I wish the bitter, painful, and disheartened past days will be polished and shined to reveal God’s glory.

Such a statement would also suggest a shift from what Pargament (2002) calls negative religious coping (which would include blaming God) to a more positive religious coping. Pargament, Koenig, Tarakeshwar, and Hahn (2004) have found positive religious coping to be associated with improvements in health while negative religious coping was associated with worsening health.

In addition to positive reframing, the patients were guided to practice transcendent visualization and verbalization—two vital methods taken from scripture—in their daily life. Related to the influences of visualization and verbalization, researchers have shown the pivotal role of images and self-verbalizations on the rational-emotional-behavior changes (Ellis, 2003; Singer, 2006, p. 109). Singer states, “Images and self-verbalizations of whether they expect to successfully produce certain outcomes are especially important in determining if they will initiate certain behaviors and how long they will persist in certain efforts” (p. 109).
The role of vision is significant in the Bible and people in suffering are directed to look up (cf., "Where there is no vision, the people perish" (Proverbs 29:18); "Let us fix our eyes on Jesus" (Hebrews, 12:2)). The significant role of "words" is also stressed in the Bible due to the powerful influence on human life (cf. "The tongue has the power of life," Proverbs 18:21; "Reckless words pierce like a sword, but the tongue of the wise brings healing," Proverbs 12:18). One patient’s writing shows how a positive-transcendent future image influenced him:

The LB&R program gave an unimaginable super power to me who was depressed mentally and physically after cancer treatment. I am recovering now, but I always lived in dread of recurrence. However, this program freed me from anxiety, and, as I imagined daily my healthy figure in beautiful future, I felt my mind comfortable and I found myself more joyful and vigorous.

The results are consistent with recent studies: Berk, Tan, & Berk (2008) found that looking forward to happy experiences may have health benefits. Sixteen participants were randomly assigned to either the experimental group (those anticipating a humorous event) or the control group and the results showed that the anticipation of a happy laughter experience lowers three stress hormones—cortisol by 39 percent, epinephrine by 70 percent, and dopac by 38 percent. In a previous study, Berk, Tan, and Westengard (2006) found that the anticipation of mirthful laughter had increased two beneficial hormones—beta-entorphins by 27 percent and human growth hormone by 87 percent.
The second research question is about the impact of the LB&R spiritual intervention on positive and negative emotions, and the third research question is on perceived pain. Our findings show the intimate associations between the positive and negative emotions and the perceived pain. Levels of self-reported love improved during the program, and both groups showed improvements in joy, and decreases in negative affect over the course of the study. There is evidence for the program having the hypothesized positive effects on the love. That is, individuals improved on love while they were in the program and showed a drop when they were not in the program.

The effects on joy, negative affect, pain intensity, and pain affect were less clear. While there was improvement on these variables while people were in the program, it was not clear that the improvement was greater when they were in the program than when they were not in the program. Even though in each case the change was larger during the period of the intervention in both groups, the implied interaction was not strong enough to be statistically significant, given the available sample size.

The correlation results show the change of spirituality is significantly correlated to the changes of negative affect \((r = -0.48, p = 0.02)\) and marginally significantly correlated to the change of mental health \((r = 0.38, p = 0.07)\). Therefore, it is possible that an increase in spirituality decreased the level of negative affect and that this in turn, decreased pain and increased mental health. It is also possible that increases in feelings of love also reduced pain. However, at this point, the causal direction is speculative. A study with enough participants to allow causal modeling to be done will be necessary to give a more definitive answer to the causality question. Another salient phenomenon in
the correlations between the changes of variables is the role of negative affect. Increase in negative affect from pre to post intervention is associated to a decrease in spirituality and mental health, and with an increase in both kinds of pain.

The final research question is about the impact of the LB&R spiritual intervention on mind-body well-being. The observed significant improvement in physical and mental health is consistent with studies which showed that positive emotions promote health (Salovey, Rothman, Detweiler, & Steward, 2000; Futterman, Kemeny, Shapiro, & Fahey, 1994). Several patients said or wrote that their pain (head, stomach, etc.) diminished or disappeared, and some patients reported that they could sleep well due to the peace of mind they experienced, even though they had been suffering from insomnia. Such qualitative information was consistent with our findings of a decrease in patients’ reported pain and medication use.

The patients’ positive changes in mind-body well-being, as deduced from the data and their verbal and written responses, likely came from a combination of two paths—(a) cognitive reframing, and (b) transcendent visualization and verbalization. The cognitive reframing path is consistent with Lazarus’s cognitive theory of emotion (Lazarus & Folkman, 1984) that suggests that cognition is a causal antecedent of emotion, and Fredrickson’s broaden-and-build theory (2001) that suggests that positive meaning and positive emotions have a reciprocal relation—one stimulates the increase of the other. In the visualization and verbalization path, the patients’ changes were consistent with the findings that human emotions are aroused externally by outside events and internally by the ongoing stream of inner dialogues and imaginings (Singer & Bonanno, 1990).
Although the results and qualitative data generally showed improvement, not all participants responded positively. A few patients showed almost no response. For instance, one patient, whose level on the spiritual scale was low, wrote that the spiritual lessons were difficult to understand; and two patients, who attended the program initially, as their spouses urged them to do, dropped out. Thus, it is possible that some of the apparent positive changes were due to the attrition problem: those who got better stayed in the program and those who did not drop out. However, this seems more likely to explain the general increase on some variables but less likely to explain the positive changes in physical health, mental health, and love that occurred only while an individual was in the program regardless of group they participated in.

Both physical health and mental health were improved during the program period in both groups, but the physical health and mental health of the immediate group returned to baseline levels or slightly decreased levels three weeks after the program ended. Two causes are hypothesized:

1. A three week program may not be long enough to make a persistent change in physical and mental health using a spiritual perspective change and the practice of transcendent coping. Patients wished, and suggested, that they be provided audio tapes of the lectures and hymns, so that they might remain aware of the lessons and practice them. The patients also wished to have monthly follow-up meetings to learn more on the subjects and to share their experiences practicing LB&R coping. As a result, several follow-up monthly meetings were held.
2. Three patients, at least in the immediate group, who expressed much improvement, couldn’t attend the follow-up meeting. We found through telephone contact that they had exerted too much in traveling or moving as their conditions improved, which resulted in deterioration in their condition. This could have negatively influenced the study results. The lesson learned was to caution the patients to be very careful not to exert themselves much even if they feel great.

Study Limitations

The present study has some limitations. First, the sample was taken from the Korean-American Christian population in the Southern California area which limits the generalizability of the findings. While this research reveals important information on the impact of the LB&R program, if the intervention would be implemented for various ethnic groups, comparisons across different ethnicity would provide valuable information. Second, we focused on changes in a relatively short 6-week period, which limits our ability to examine the long-term effects of the intervention. Future studies should collect data on multiple periods (e.g. at least 6 and 12 months later) to assess the long term effects of the intervention. Third, the program was delivered by a single lecturer who has personally experienced posttraumatic growth and whole-person healing from chronic illness which limits generalizability. To promote generalizability, manuals for all aspects of the program will be created so that the program may be applied in a variety of settings by a variety of facilitators. Forth, the high dropout rate may have affected our results. Future studies should use alternative strategies to reduce the dropout rate such as providing an incentive for participants, especially for the delayed group.
members, or having a wait-list control group rather than having immediate and delayed groups. Finally, the sample size adversely affects the power of the study. It potentially limits the generalizability of these findings. A future investigation with a larger sample size would be useful to corroborate the results obtained from this study.

Conclusions

Despite these limitations, the study provides significant implications for researchers and practitioners interested in integrating spirituality within their practice. The study results show the overall improvement in mind-body well-being. The LB&R approach combined methods of reframing, imagery, and positive expression, and imbued the intervention with spiritual dimensions in the patients’ belief system. The results of the current study suggest that a spiritual intervention, based on a Biblical framework, may have potential for therapeutic effects in mind-body well-being. If the pattern of results found in this study were repeated in subsequent, larger scale, multi-cultural studies which had fewer potential biases such interventions might have an impact in reducing the burden disease places on individuals, at least in Christian populations. Whether the LB&R methodology might also be used in the treatment of individuals with mental problems such as depression or individuals who have suffered traumatic events is something else that should be explored. It is hoped that the present study will stimulate researchers and practitioners to further investigate the practice of transcendent, Biblical coping methods.
References


Ellis, A. (2003). Early theories and practices of rational emotive behavior therapy and how they have been augmented and revised during the last three decades. Journal of Rational-Emotive & Cognitive-Behavior Therapy, 21, 219-243.


Table 5.1 *Main Topics, Goals, and Content of the Nine Sessions of Look Beyond & Rejoice Program*

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<th>Topic</th>
<th>Goals</th>
<th>Contents</th>
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<td>• Overview of the sessions</td>
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<td>Transformation of Tragedy</td>
<td>• To be aware of the opportunity to transform adversity to gain</td>
<td>• Trauma and traumatic growth</td>
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<td></td>
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<td>• To consider the value of being active and hold fast to what is good</td>
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<td>Meaning-making Benefit-Finding Resilience</td>
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<td>• To become aware of the value of loss to gain and grow</td>
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<td>• To learn the way of gaining from loss</td>
<td>• The principles of resilience</td>
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<td>• To learn and adopt the attitude of resilience in God’s power</td>
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<td>3</td>
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<td>• To be aware of the influence of imagery</td>
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<td>• To practice and adopt the visualization principle in daily life</td>
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<td>• To practice and adopt the <em>Look Beyond</em> visualization</td>
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<td>Creative Verbalization Positive Expression</td>
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<td>• Presentation of the power of the word</td>
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<td>• To learn the healing or destructive power of human words</td>
<td>• Pray on the promise of God</td>
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<td>• To select and practice the healing, self-strengthening word</td>
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<td>• To practice and adopt <em>Rejoice</em> coping by looking beyond pain and looking up to God and His promise</td>
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<td>7</td>
<td>Humans’ Suffering, God, &amp; Healing</td>
<td>• To view the big picture of universal controversy and learn the problem of oneness and separation</td>
<td>• Presentation of the great controversy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To learn God’s answer to human’s suffering</td>
<td>• <em>Job</em> in the great controversy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• God’s health plan</td>
<td>• Healthy lifestyle and healing in the Bible</td>
</tr>
<tr>
<td>8</td>
<td>The Core of Life and Thriving</td>
<td>• To be aware of the importance of one’s relationship—the core of life—with God and with others</td>
<td>• Practicing forgiving self, others, and God</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To learn the value of forgiveness and choose to forgive</td>
<td>• Praying and helping others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To love self, others, and God—the way of thriving</td>
<td>• Identifying and accepting goals and mission of life</td>
</tr>
<tr>
<td>9</td>
<td>Conclusion Hold Fast to What is Good</td>
<td>• To review all LB&amp;R sessions</td>
<td>• Outlining of the all lessons of LB&amp;R</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To keep practicing the LB&amp;R healing method in life</td>
<td>• Sharing the experience of LB&amp;R</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To share the impressions of the program</td>
<td>• The follow-up strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To summarize and evaluate LB&amp;R</td>
<td>• Evaluation</td>
</tr>
</tbody>
</table>
Table 5.2 In-Session and Out-of-Session Exercises of Look Beyond and Rejoice Program

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Topic</th>
<th>In-Session Exercises</th>
<th>Out-of-Session Exercises</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction Transformation of Tragedy</td>
<td>• Writing a reflection on the subject and personal goals for the transformation of tragedy</td>
<td>• Having time to read and meditate Bible and/or other spiritual writings at least 20 minutes a day</td>
</tr>
<tr>
<td>2</td>
<td>Meaning-making Benefit-Finding Resilience</td>
<td>• Writing a reflection on the subject. Finding meaning and benefits of personal suffering and writing about them</td>
<td>• Having time to read and meditate Bible and/or other spiritual writings at least 20 minutes a day</td>
</tr>
<tr>
<td>3</td>
<td>Imagery and Visualization</td>
<td>• Writing a reflection on the subject and strategies and how to practice transcendent visualization</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization at least 5 minutes a day</td>
</tr>
<tr>
<td>4</td>
<td>Look Beyond The Spiritual Coping Method</td>
<td>• Practicing transcendent visualization</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization at least 5 minutes a day</td>
</tr>
<tr>
<td>5</td>
<td>Creative Word Power Positive Expression</td>
<td>• Writing a reflection on the subject and strategies of how to practice positive expression</td>
<td>• Keeping reading &amp; meditating 20 minutes a day • Practicing transcendent visualization &amp; verbalization, at least 5 minutes a day for each</td>
</tr>
<tr>
<td>6</td>
<td>Rejoice The Paradoxical Coping Method</td>
<td>• Practicing transcendent verbalization</td>
<td>• Keeping reading/meditating 20 minutes a day • Practicing transcendent visualization &amp; verbalization, at least 5 minutes a day for each • Rejoicing by singing hymns and praising God at least 10 minutes a day</td>
</tr>
<tr>
<td>7</td>
<td>Humans' Suffering, God, &amp; Healing</td>
<td>• Writing a reflection on the subject and strategies how to implement the whole-person health plan</td>
<td>• Same as above</td>
</tr>
<tr>
<td>8</td>
<td>The Core of Life and Thriving</td>
<td>• Writing strategies of how to improve the relationships with self, others, and God</td>
<td>• Same as above</td>
</tr>
<tr>
<td>9</td>
<td>Conclusion Hold Fast to What is Good</td>
<td>• Writing a reflection on the whole program, how to maintain the strategies, and a resolution to keep them up</td>
<td>Same as above</td>
</tr>
</tbody>
</table>
Table 5.3 Means and Upper and Lower 90% Confidence Limits for the Outcome Variables.

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 week</th>
<th>6 week</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline 3 week 6</strong> week</td>
<td>3.05 (2.90, 3.20)</td>
<td>3.12 (2.93, 3.30)</td>
<td></td>
</tr>
<tr>
<td><strong>Immediate</strong></td>
<td>2.79 (2.56, 3.02)</td>
<td>3.02 (2.63, 3.41)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>3.13 (2.87, 3.38)</td>
<td>3.21 (2.90, 3.52)</td>
<td></td>
</tr>
<tr>
<td><strong>Positive Affect</strong></td>
<td>2.84 (2.52, 3.16)</td>
<td>3.23 (2.96, 3.49)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>3.15 (2.71, 3.59)</td>
<td>3.43 (2.96, 3.91)</td>
<td></td>
</tr>
<tr>
<td><strong>Negative Affect</strong></td>
<td>2.39 (2.02, 2.77)</td>
<td>1.92 (1.67, 2.18)</td>
<td></td>
</tr>
<tr>
<td><strong>Joy</strong></td>
<td>2.70 (1.84, 3.56)</td>
<td>2.07 (1.65, 2.49)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>3.28 (2.56, 3.99)</td>
<td>3.83 (3.26, 4.40)</td>
<td></td>
</tr>
<tr>
<td><strong>Love</strong></td>
<td>3.31 (2.95, 3.68)</td>
<td>3.53 (3.15, 3.92)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>3.83 (3.21, 4.45)</td>
<td>3.06 (2.41, 3.70)</td>
<td></td>
</tr>
<tr>
<td><strong>Bodily pain intensity</strong></td>
<td>4.06 (3.31, 4.80)</td>
<td>3.08 (2.18, 3.98)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>5.00 (3.75, 6.25)</td>
<td>4.00 (2.49, 5.51)</td>
<td></td>
</tr>
<tr>
<td><strong>Unpleasant pain affect</strong></td>
<td>2.76 (1.85, 3.67)</td>
<td>2.77 (2.11, 3.43)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>4.17 (2.66, 5.67)</td>
<td>3.67 (2.13, 5.20)</td>
<td></td>
</tr>
<tr>
<td><strong>Daily Spiritual Experience</strong></td>
<td>3.95 (3.44, 4.46)</td>
<td>4.27 (3.80, 4.73)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>4.11 (3.25, 4.97)</td>
<td>4.37 (3.59, 5.15)</td>
<td></td>
</tr>
<tr>
<td><strong>Physical Health</strong></td>
<td>37.19 (32.05, 42.33)</td>
<td>42.00 (37.62, 46.43)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>40.55 (31.89, 49.21)</td>
<td>39.70 (32.25, 47.07)</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>43.75 (38.77, 48.74)</td>
<td>50.50 (45.74, 55.16)</td>
<td></td>
</tr>
<tr>
<td><strong>Delayed</strong></td>
<td>45.54 (37.15, 53.94)</td>
<td>44.60 (36.69, 52.55)</td>
<td></td>
</tr>
</tbody>
</table>
Table 5.4

Group, Time, Group x Time Results from Repeated Measures from ANOVA

Multivariate Tests for Each Dependent Variable

<table>
<thead>
<tr>
<th>Measure and group</th>
<th>Group</th>
<th>Time</th>
<th>Group x Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(df)</td>
<td>p</td>
<td>F(df)</td>
</tr>
<tr>
<td>Meaning in illness</td>
<td>.47(1)</td>
<td>0.49</td>
<td>4.33(2)</td>
</tr>
<tr>
<td>Positive/Negative affect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>.52(1)</td>
<td>0.48</td>
<td>1.34(2)</td>
</tr>
<tr>
<td>Negative</td>
<td>.03(1)</td>
<td>0.87</td>
<td>4.16(2)</td>
</tr>
<tr>
<td>Joy and Love</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joy</td>
<td>.04(1)</td>
<td>0.85</td>
<td>7.77(2)</td>
</tr>
<tr>
<td>Love</td>
<td>.23(1)</td>
<td>0.64</td>
<td>2.54(2)</td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bodily pain intensity</td>
<td>.31(1)</td>
<td>0.58</td>
<td>11.70(2)</td>
</tr>
<tr>
<td>Unpleasant pain affect</td>
<td>.04(1)</td>
<td>0.85</td>
<td>7.23(2)</td>
</tr>
<tr>
<td>Daily Spiritual Experience</td>
<td>.14(1)</td>
<td>0.71</td>
<td>2.29(2)</td>
</tr>
<tr>
<td>Physical/Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>.43(1)</td>
<td>0.52</td>
<td>.74(2)</td>
</tr>
<tr>
<td>Mental</td>
<td>.01(1)</td>
<td>0.91</td>
<td>3.24(2)</td>
</tr>
</tbody>
</table>
Figure 5.1  The Detrimental Processes and Components of Negative Cognitive Appraisal and the Consequent Emotional Response and Prognosis of Patients with Life-Threatening Illness or Chronic Pain (upper panel) Compared to the LB&R Healing Model Showing the Processes and Components of Each of the Five Steps (lower panel)

**Life-threatening Illness or Chronic Pain**
- Uncertainty
- Pain
- Death
- Disfigurement
- Disability

**Cognitive Appraisal**
- Meaninglessness
- Sense of loss
- Out of control
- Facing threats
- Helplessness
- Hopelessness

**Emotional Response**
- ↑ Fear
- ↑ Nervousness
- ↑ Distress
- ↑ Pain
- ↑ Joy
- ↑ Hope
- ↑ Gratitude

**Mind-Body Well-being**
- Physical
- Psychological
- Spiritual
- Social

**Step 1: Selective Attention**
- God & Promises of God
  - Love/Grace
  - Forgiveness
  - Power
  - Healing
  - Growth
  - Eternal Life

**Step 2: Reappraisal & Reframing**
- Meaning-making
- Benefits-finding & gaining
- Purpose of illness & life

**Step 3: Visualization & Verbalization**
- Visualizing
  - Personal caring God
  - Recovering/healed self
  - Grown self
  - Achieving purpose

- Verbalizing
  - Proclaim own healing to self/others
  - Rejoice
  - Pray
  - Thanks in all circumstances
  - Praise God

**Step 4: Emotional Response**
- ↑ Joy
- ↑ Hope
- ↑ Gratitude
- ↓ Fear
- ↓ Nervousness
- ↓ Distress
- ↓ Grief

**Step 5: Mind-Body Well-being**
- Spiritual
- Psychological
- Physical
- Social

"Test everything. Hold on to the good." “Fix our eyes on Jesus.” “Faith is being sure of what we hope for and certain of what we do not see.” “Rejoice always.” “Pray continually.” “Give thanks in all circumstances.” (1 Thessalonians 5:21; Hebrews 12:2; Hebrews 11:1; 1 Thessalonians 5: 16-18).
CHAPTER 6
SUMMARY AND CONCLUSIONS

Over the past 20 years, mind-body interactions provided considerable evidence that psychological factors can play a substantive role in the development and progression of various types of illnesses. Researchers have also found sufficient evidence that mind-body interventions can be effective in the treatment of illnesses, enhancing the quality of life. In the same period, studies have been shown the positive influence of religion/spirituality on health and longevity and the relation between religion/spirituality and health has been increasingly demonstrated in numerous studies. Recently, studies of religious coping, which are directly related to mind-body interaction, have increased dramatically. Even though the need to include religion and spirituality in clinical practice has emerged very little systematic study has so far been done on the therapeutic use of this dimension. In the future, the most important step in the field of religious coping will be to move from research to practice. In this study, I developed and conducted the LB&R spiritual intervention to examine the therapeutic impact for the patients with life-threatening illness or chronic pain and we developed the LB&R Healing Model to support and guide the intervention. In this chapter I will answer the research questions that were raised in chapter one. Then, I will write the overall summary which includes study limitations, implications for future research, and implications for health education.
A. Answers to Research Questions

1. What is the impact of the LB&R spiritual intervention on finding meaning for patients with life-threatening illnesses or chronic pain?

There were statistically significant increases across the three measurement points in both groups in meaning in illness. The present study provides support for the hypothesis that the LB&R intervention helps patients to find meaning in life-threatening illnesses or chronic pain.

2. What is the impact of the LB&R spiritual intervention on positive and negative emotional responses in patients with life-threatening illnesses or chronic pain?

There was statistically significant improvement in love during the program. There is evidence for the program having the hypothesized positive effects on the love. That is, individuals improved on love while they were in the program and showed a drop when they were not in the program. The effects on joy and negative affect were less clear since both groups showed improvements in joy, and decreases in negative affect over the course of the study not just during participation. Although in both groups the change was larger during the period of the intervention, the implied interaction was not strong enough to be statistically significant, given the available sample size.

3. What is the impact of the LB&R spiritual intervention on perceived pain in patients with life-threatening illnesses or chronic pain?

There were significant decreases in pain intensity and pain affect in both groups over the course of the study. However, the effects were less clear. While there was
improvement on these variables while people were in the program, it was not clear that the improvement was greater when they were in the program than when they were not in the program. The implied interaction was not strong enough to be statistically significant, given the available sample size. Medication use went down in both immediate and delayed groups when the two groups were combined.

4. What is the impact of the LB&R spiritual intervention on mind-body well-being (spiritual, mental, and physical health) in patients with life-threatening illnesses or chronic pain?

There were statistically significant improvements regarding physical and mental health. It appears that both the immediate and delayed group individuals improved physical health while they were in the program, but the physical health of the immediate group three weeks after intervention had returned to baseline level. Mental health improved in both immediate and delayed group individuals while they were in the program, but it slightly decreased in the immediate group three weeks after intervention.

B. Overall Summary

The clearest results were for the physical health and mental health, and love variables where in each case there was improvement while a group was receiving the program. There was no significant association between demographic variables and the change of outcome variables.

Expectation effects may impact delayed group patients positively which resulted in improvement during the waiting period for the program. Both physical health and mental health were improved during the program period in both groups, but the physical
health and mental health of the immediate group returned to baseline levels or slightly decreased levels three weeks after the program ended. Two causes are hypothesized: (a) A three week program may not be long enough to make a persistent change in physical and mental health using a spiritual perspective change and the practice of transcendent coping. (b) Three patients in immediate group who expressed much improvement couldn’t attend the follow-up meeting. I found, through phone calls, they exerted themselves too much to travel or move house as their conditions were improved, but that these exertions caused them to deteriorate to terrible conditions. This, I assume, negatively impacted the study results. The lesson learned was to caution the patients to be very careful so that they may not exert themselves too much even in case they would feel great.

1. Study Limitations

The present study has some limitations that must be addressed. First, the sample was taken from the Korean-American Christian population in the Southern California area which limits the generalizability of the findings. While this research reveals important information on the impact of the LB&R program, if the intervention would be implemented to various ethnic groups, comparisons across different ethnicity would provide valuable information. Second, I focused on changes in a relatively short 6-week period, which limits our ability to examine the long-term effects of the intervention. Future studies should collect data on multiple periods (e.g. at least 6 and 12 months later) to assess the long term effects of the intervention. Third, the program was delivered by a single lecturer who has personally experienced posttraumatic growth and whole-person
healing from chronic illness which limits generalizability. To promote generalizability, all aspects of the program will be manualized so that the program may be applied in a variety of settings by a variety of facilitators. Forth, the high dropout rate may have affected our results. Future studies should use alternative strategies to reduce the dropout rate such as providing an incentive for participants, especially for the delayed group members, or having a wait-list control group rather than having immediate and delayed groups. Finally, the sample size adversely affects the power of the study. It potentially limits the generalizability of these findings. A future investigation with a larger sample size would be useful to corroborate the results obtained from this study.

2. Implications for Future Research

This study provides significant implications for researchers and practitioners interested in integrating spirituality within their professional practice. Studies related to post-traumatic growth and religious coping have shown that negative life events can not only be turned to personal growth but also to a path to deep and lasting happiness as an individual’s perceptions change. Studies of imagery and visualization (Walker et al., 1999; Roffe, Schmidt, & Ernst, 2005), hope (Herth, 2001; Rustoen & Hanestad, 1998) and positive emotion (Pert, 1997; Davidson et al., 2003) have shown the potential for the positive impact of psychological-spiritual interventions on life-threatening and chronic illnesses. The LB&R approach combined those methods and imbued the intervention with spiritual dimensions in the patients’ belief system.

The results of the current study suggest that a spiritual intervention, based on a Biblical framework, may have potential for therapeutic effects on Christian
populations. If the pattern of results found in this study were repeated in subsequent, larger scale, multi-cultural studies which had less potential biases (e.g., being delivered by individuals other than the developer of the program, avoiding the large amount of attrition in the control group, using more objective measures of mental and physical health), such interventions might have an impact in reducing the burden disease places on individuals, at least in Christian populations. To reduce the drop out rate, we suggest conducting the intervention in collaboration with local churches or hospitals as a joint project for their church members or patients. Providing an incentive to complete all measurements may be helpful, too. The spiritual experience was not significantly changed, although mental and physical health changed. We found some participants marked the highest level for all or most questions in the spirituality scale from the pretest that might influence the outcome. It would be helpful to ask participants to be very careful not to reflect their wished-for experience, but to reflect their actual experience. Based on the written and verbal expressions, and outward appearance of participants, many participants’ attitude seemed positively changed and the level of hope increased. Therefore, we suggest that future researchers include those variables in investigation of the impact of such an intervention. Even though the change of forgiveness was not measured in this short term intervention, it would be worthwhile including it in a long term intervention. It is hoped that the present study will stimulate researchers and practitioners to further investigate the practice of Biblical coping methods.
3. Implications for Health Education

In a recent literature review, Hawks, Smith, Thomas, Chrisley, Meinzer, and Pyne (2007) asserted that the current content focus of research in health education fails to harmonize with the multidimensional nature of health as generally defined. Hawks, Hull, Thalman, & Richins (1995) asserted the need of integration of the spiritual dimension of health in health education and promotion:

Health educators are in a position to develop, implement, and evaluate spiritual health interventions within the context of comprehensive programs. There is a need for training in the theoretical and methodologic foundations of interventions in areas such as meditation, imagery, and group support, and there is a need for more evaluation research regarding the impact of such interventions.

Health educators seldom measure or target spirituality in health education interventions. However, the present study steps into this uncharted territory of spiritual intervention in health education and promotion of Biblical healing strategies. I hope that this new health educational approach will stimulate efforts to integrate this important dimension into health education and promotion programs.

The current study results support the findings of previous research that a positive psychological outlook and the ability to imbue negative events with positive meaning have positive effects on psycho-spiritual functioning and quality of life, and can be helpful for patients with life-threatening or chronic illness. The results also support that the mind-body approach has potential benefits and advantages and those mind-body interventions can be effectively used in health education and promotion programs.
Such Christian-spiritual group interventions can be expanded for application to other groups of people who experience mental illness or traumatic life events. Empowerment, the process by which people gain more power in control over their health, has become the ‘new’ health promotion (Laverack, 2004). The LB&R intervention model may also be utilized to help prevent future loss, and to lessen the impact of wounds from traumatic events, by educating and empowering people as to how to strengthen the inner self preemptively.
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Appendix A: IRB Approval

INSTITUTIONAL REVIEW BOARD
Initial Approval Notice - Expedited Review
OFFICE OF SPONSORED RESEARCH • 11168 Anderson Street • Loma Linda, CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

To: Lee, Jerry W
Department: Health Promotion & Education
Protocol: A spiritually-based intervention for patients with life-threatening illness or chronic pain

This study was reviewed and approved administratively on behalf of the IRB. This decision includes the following determinations:

Risk to research subjects: Minimal
Approval period begins 21-Sep-2007 and ends 20-Sep-2008
Stipulations of approval:

Consent Form
Unless IRB has given a specific waiver of informed consent (as documented in the approval stipulations above) the IRB-approved and stamped consent form accompanies this letter. This now becomes the official master consent form for making copies to provide to study participants.

Adverse Events / Protocol Changes
The IRB should be notified in writing of any modifications to the approved research protocol. Adverse effects must be reported to the IRB in accordance with institutional policy. If sponsor or contractual adverse event reporting requirements differ from requirements for reporting to IRB, all reporting requirements must still be met.

Protocol Review
Your protocol is tentatively scheduled for review and renewal at least two weeks prior to the approval end-date indicated above. To assure uninterrupted approval of this project, you will be sent a report form to request renewal by completing and timely returning to Office of Sponsored Research. Anticipate the approval expiration so your study does not lapse; contact OSR for assistance if necessary. In addition to reporting the requested renewal status information, you may also use the form to close the study at that time, if applicable.

Records
All records relating to this project, including signed consent forms, must be kept on file for three years following completion of the study. Please note the PI's name and the OSR number assigned to this IRB protocol (as indicated above) on any future communications with the IRB. Direct all communications to the IRB c/o the Office of Sponsored Research. Thank you for your cooperation in LLU's shared responsibility for the ethical use of human subjects in research.

Signature of IRB Chair/Designee:

Loma Linda University Adventist Health Sciences Center holds Federally Assurance (FWA) No. 6447 with the U.S. Office for Human Research Protections, and the IRB registration no. is IORG026. This Assurance applies to the following institutions: Loma Linda University, Loma Linda University Medical Center (including Loma Linda University Children's Hospital, Loma Linda Community Medical Center), Loma Linda University Behavioral Medicine, and affiliated medical practices groups.

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Appendix B: Informed Consent in English

Loma Linda University
Informed Consent for
A Spiritual Intervention for Patients with Life-Threatening Illness or Chronic Pain

You are invited to participate in a study evaluating the spiritual intervention program entitled Look Beyond & Rejoice (LB&R) because you are a patient with life-threatening illness or chronic pain and currently under the care of a health professional. Studies show a connection of religion/spirituality with better positive mental health and wellbeing. The purpose of this study is to examine the impact of a spiritual intervention, based on Christian coping methods in the Bible, in a cohort of people experiencing life-threatening illness or chronic pain.

I am conducting this study as part of my doctoral research at Loma Linda University. I am a Certified Health Education Specialist (CHES). I have received awards from the Korean government (Minister's of Health & Welfare; President's) for health services in Korea.

You may participate if you are a Korean-American fluent in written and spoken Korean; age 18 year or older; willing to consent to take part in an overtly Christian intervention; currently receiving either curative or palliative treatment from a health professional; alert, oriented, and capable of giving informed consent; capable of attending 3 sessions, 9 times a week, for 2 hours each session, training program. Patients with a suspected or confirmed diagnosis of brain metastases, psychiatric history, reported alcohol or drug problems will be excluded. Screening for this was done on the telephone when I contacted you before sending you this consent form.

Procedures. You will be assigned by the flip of a coin to either receive the program as soon as possible (this is called the "immediate" group) or three weeks after the immediate group starts (the "delayed" group). The LB&R program will consist of a total of nine, two-hour sessions, meeting three times a week, for three weeks. If you are in the immediate group, you will be asked to fill out short questionnaires three times: at the beginning of the first session, at the end of the last session, and, by mail, three weeks after the last session. If you are in the delayed group, I ask that you to fill out the questionnaire that came with this consent form and return it by mail in the enclosed envelope. Then you will be asked to fill out the same questionnaire twice more: at the beginning of the first LB&R program session and at the end of the last session. Each time you will be asked about your positive and negative feelings, meanings, pain, spiritual health, and physical-psycho-social health. Also you will be asked to provide demographic information, including age, gender, education, religious background, illness and current...
Risks. While none of the exercises you will be asked to do are expected to make you uncomfortable, it is possible that you may become uncomfortable with the sessions or answering some of the questions. If so, you can stop your participation in the study at any time. The committee at Loma Linda University that reviews human studies (the Institutional Review Board) has determined that participating in this study exposes you to minimal risk.

Benefits. The results of this pilot study will help determine the effectiveness of the Look Beyond & Rejoice program. If the program works for you, it may improve your spiritual, psychological, physical, or social health, however, you may not experience any benefit. If the program is effective it will be used with other individuals like you to help them.

Participants Rights. You are free to choose to participate in the study. You may withdraw from the study at any time without any adverse effect on your relationship with anyone connected with the study or connected to the location where the study will take place, or any loss of benefit to which you are otherwise entitled. You may also refuse to answer some or all the questions if you don’t feel comfortable with those questions. To have reliable assessment of the effectiveness of the program, participants who miss more than two sessions among nine sessions will be excluded from the program.

Confidentiality
The information provided by you will remain confidential. Any published document resulting from this study will not disclose your identity without your permission.

Costs and Compensation
There is no cost to you for participating in this study, nor will you be paid.

Impartial Third Party Contact
If you wish to contact an impartial third party not associated with this study regarding any question or complaint you may have about the study, you may contact the Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647 for information and assistance.
A Spiritual Intervention for Patients with Life-Threatening Illness or Chronic Pain

Informed Consent Statement

a. I have read the contents of the consent form. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. Signing this consent document does not waive my rights nor does it release the investigators, institution or sponsors from their responsibilities. I may call Jung Park, MPH, MA, DrPHc, CHES during routine office hours at 909-229-2806 or contact him through email at sdapark@hanmail.net. If I wish to contact Jung Park’s research supervisor I may telephone Jerry W. Lee, PhD, at 909-558-4575 during routine office hours or email him at jlee@llu.edu.

b. I have been given a copy of this consent form.

c. I have received a copy of the California Experimental Subject’s Bill of Rights and have had these rights explained to me.

Signatures

Participant

Signature ____________________________ Typed/printed Name ____________________________ Date ____________

Investigator

I have reviewed the contents of the California Experimental Subject's Bill of Rights and this consent form with the person signing above. I have explained potential risks and benefits of the study.

Signature ____________________________ Phone number ____________________________ Date ____________

Page 3 of 3
Appendix C: Informed Consent in Korean

Loma Linda University
School of Public Health

서명을 위협하는 질환이나 만성질환을 가진 환자들을 위한 영적 치유 프로그램

당신은 생명을 위협하는 질환이나 만성중증을 가졌으며 Look Beyond & Rejoice (LB&R)라고 불리는 영적 치유 프로그램을 평가하는 연구 프로그램에 초대되었습니다. 연구들은 종교/영성과 같은 정신건강 및 행복의 연관성을 보여주고 있습니다. 이 연구의 목표는 성서적인 그리스도인 대처방법인 ‘Look Beyond & Rejoice’ 영적 프로그램의 효과를 검증하기 위한 것입니다.

저는 이 연구를 로마린다대학공 공중보건학 박사논문 프로젝트로 실행하며, 저는 공인 건강교육전문가입니다. 저는 건강교육으로 한국 정부 (보건복지부 장관 및 대표)로부터 표창과 감사장을 받았습니다.

참가가능하신 분들은 다음과 같습니다: 한인으로 한국어를 잘 읽고 쓰는 분, 나이는 18세 이상, 생명을 위협하는 질환이나 만성질환을 가진 환자로 현재 건강전문가로부터 치료를 받고 있는 분, 성직적 프로그램에 참여하기를 동의하는 분, 3주 동안 2시간씩 (오후 3시~5시), 9회 (1주 3회) 프로그램에 참여할 수 있는 분, 자녀들을 정신질환을 가지고 있어 암호나/또는 문제를 갖지 않은 분, 이에 대해서는 제가 참가동의서를 보내야 전 귀하와 전화를 할 때 하였습니다.

절차. 참가자들은 동참을 단정 가능한 뱀리 참가하게 되는데 (‘즉시 참가’ 그룹) 아니면 즉시 참가 그룹 프로그램이 시작한 후 3주 후에 시작하는 프로그램에 참가하게 (‘나중 참가’ 그룹) 됩니다. LB&R 프로그램은 전체적으로 9회, 2시간 1주 3회, 3주 프로그램으로 구성됩니다. 만일 당신이 즉시 참가 그룹에 속한다면, 당신은 흔한 설문지를 3회 작성하게 됩니다. 첫 회기 시작시, 마지막 회기 끝, 그리고 마지막 회기 3주 후에 서신으로, 만일, 당신이 나중 참가 그룹에 속한다면 저는 당신에게 이 동의서와 함께 동봉한 봉투에 넣어드려 보내 주시도록 요청합니다. 그 후에 당신은 같은 설문지를 두 번 더 작성하게 될 것입니다. LB&R 첫 회기 시작과 마지막 회기 끝에, 당신은 당신의 긍정적이고 부정적인 감정들, 의지, 정통, 영적 건강, 그리고 신체적, 정신적, 사회적 건강에 대해 답변하게 될 것입니다. 또한 당신은 나이, 성별, 교육정도, 신앙배경, 질병과

Participant Initials Date Page 1 of 3

A SEVENTH-DAY ADVENTIST HEALTH SCIENCES INSTITUTION

173
A Spiritual Intervention for Patients with Life-Threatening Illness or Chronic Pain

Current treatment is not providing relief. We are working with our patients to improve their quality of life. We find that many patients benefit from spiritual intervention. Our goal is to help our patients gain new perspectives and insights.

We meet weekly in a quiet, comfortable setting. Our meetings are led by our chaplain and a lay leader. Patients are encouraged to share their thoughts and feelings. Our meetings are confidential and are free of charge.

To participate in our spiritual intervention program, please contact your physician or our chaplain. We look forward to working with you.

Adams College chapel, Suite 200, 3550 W. 6th St., LA, CA 90020.

Contact Information:
Office of Patient Relations, Loma Linda University Medical Center, Loma Linda, CA 92354, phone (909) 558-4647.

Participant Initials: Date: Page 2 of 3
A Spiritual Intervention for Patients with Life-Threatening Illness or Chronic Pain

제공된 동의서

a. 나는 동의서의 내용을 읽었습니. 만약 내가 동의서의 내용에 대해 질문이 있다면, 나는 아래 번호로 연구자에게 연락하며 구두로 물을 것입니다. 이 연구와 관련된 나의 질문들은 만족스럽게 답변되었습니다. 그러므로, 나는 자원하여 이 연구에 참여하기로 동의합니다. 이 동의서에 사인함으로 나의 권리를 포기하거나 연구자나 기관 혹은 스폰서에게 권리를 양보하는 것이 아닙니다. 나는 연구자 박정환씨에게 전화를 할 수 있으며 (909-229-2806), 이메일을 할 수 있습니다 (sdapark@hanmail.net). 만약 내가 박정환씨 연구 감독교수와 접촉하고자 한다면 사무실 시간에 909-558-4575로 연락하거나 이메일 jlee@llu.edu로 연락할 수 있습니다.

b. 나는 이 동의서의 사본을 받습니다.

c. 나는 California Experimental Subject’s Bill of Rights 를 받고, 나에게 설명된 권리를 가집니다.

사인들

참가자

<table>
<thead>
<tr>
<th>사인</th>
<th>이름 정자 (한글/영어)</th>
<th>날자</th>
</tr>
</thead>
</table>

연구자

나는 California Experimental Subject's Bill of Rights 내용과 이 동의서를 상기 참가자와 살펴 보았습니다. 나는 연구의 잠재적인 위험요소와 유익점을 설명하였습니다.

[Signature]

사인

전화 번호 9-29-478-3997

날자 9-25-07
Appendix D: Recruitment Letter

“Look Beyond & Rejoice” A Spiritual Intervention Program for Individuals with Life-Threatening Illness or Chronic Pain

Three weeks, nine sessions two hours each in September and October at Loma Linda Korean Church, Grand Terrace, CA.

A certified health education specialist, Jung Park, will be conducting a spiritual intervention program for individuals with life-threatening illness or chronic pain. He developed ‘Look Beyond & rejoice (LB&R) program as a doctoral dissertation project. He himself has been suffered from Ankylosing Spondylitis, a painful, progressively crippling degeneration of the spine and joints, for over a decade. In the LB&R program, he has “formulized” the methodology using a Christian Biblical approach that he learned and practiced in his process of recovery and his studies of theology and public health education.

In recent decades, scholars have found that spiritually minded patients live longer and are mentally and physically healthier — more likely to suffer less pain and to recover and live longer than those who are not spiritually minded. LB&R program is designed to teach individuals how to look beyond their adversities and transform them into blessings, and how to rejoice in God and His promises so that individuals’ spiritual, psychological, and physical health may improve. LB&R is based on both previous scientific research and Christian theology. A study of its effectiveness is being funded by the School of Public Health at Loma Linda University.

Patients with life-threatening or chronic pain are being invited to participate in the study. Individuals will be eligible if they are:

- Korean-American, fluent in written and spoken Korean
- Age 18 years or older
- Willing to consent to take part in a Christian intervention
- Currently receiving either curative or palliative treatment from a health professional
- Capable of attending a 2 hour 9 session, 3 times a week training program
- No suspected or confirmed diagnosis of brain metastases, psychiatric history, or alcohol/drug problems

The program will be take place at Loma Linda Adventist Korean Church, 12408 Mount Vernon Ave, Grand Terrace. If you would like to participate the program or have any question, please call Jung Park, 909-478-3997 or 909-229-2806, or e-mail to the address: sdapark@hanmail.net

Thank you.

Jung Park, MPH, MA, DrPHc, CHES
생명을 위협하는 질환 혹은 만성통증을 가진 환자들을 위한
“Look Beyond & Rejoice (너머 보고 기뻐하라)”
영적 치유 전인건강 프로그램

2시간씩 9회, 3주 프로그램 10월~11월
로스앤젤레스 앨담스 대학 채플

생명을 위협하는 질환 혹은 만성통증을 가진 환자들을 위한 영적 치유 프로그램이 개발된 ‘Look Beyond & Rejoice’ 프로그램은 로마닌다대학교 공중보건학 박사수준 프로젝트입니다. 그는 심리건강 휴식화 만성질환인 긍정성정추임으로 고등을 겪었으며, 이 프로그램은 그가 투병과 회복 과정 중에 배우고 경험한 성서적 전인 치유방법을 신학적 보건교육학적으로 체계화하여 사용합니다.

직접 심리건강 학자들은 영적인 환자들은 그렇지 않은 환자들보다 고등을 적게 느끼고 회복이 잘 되고, 정신적-신체적으로 건강하고 오래 사는 것을 발전하였습니다. Look Beyond & Rejoice 프로그램은 환자들이 자신의 역경을 너머 하나님과 하나님의 약속을 바라보고 영적 원칙들을 실천함으로 전인적으로 건강해지고 삶의 질이 증진될 수 있도록 도와줍니다. 이 프로그램은 로마린다대학교 보건대학원에서 지원을 하며, 참가자들은 무료로 참가하고 교재를 제공받습니다.

참가자 90명을 선착순으로 모집하며 20-25명 소그룹으로 나누어집니다.
참가할 수 있는 분들은 다음과 같습니다.
• 한인으로 한국어를 잘 읽고 쓰는 분
• 나이는 18 세 이상 성인, 생명을 위협하는 질환이나 만성통증을 가진 환자로 현재 건강 전문가로부터 치료를 받고 있는 분
• 성서적 프로그램에 참여하기를 동의하는 분
• 3주 동안 2시간씩(오후 3시~5시)
• 9회 (1주 3회) 프로그램에 참여할 수 있는 분
• 병에 치료된 암이나 정신질환을 갖지 않고 약물/마약 문제를 갖지 않은 분.

참가자들은 무작위 선출에 의해 두 그룹 - 10월 넷째주에 프로그램을 시작하는 그룹과 3주 있다 시작하는 11월 셋째주에 시작하는 그룹 -으로 나누어집니다.

박정환 드림.
MPH, MA, DrPHc, CHES
Inviting Patients with Life-threatening Illness or Chronic Pain to a Mind-Body Well-Being Program

Look Beyond & Rejoice!

For What? Studies show a connection between religion/spirituality, better positive mental health and greater wellbeing. We are examining the impact of the ‘Look Beyond & Rejoice’ program, a spiritual-Biblical coping method for whole-person health. The program is designed to help patients to look beyond their adversities and transform them into blessings, and to rejoice in God and His promises so that patients’ spiritual, psychological, and physical health may be improved.

Who? - Korean-American, fluent in written and spoken Korean
- Age 18 years or older
- Willing to consent to take part in a Christian intervention
- Currently receiving either curative or palliative treatment from a health professional
- Capable of attending a 2 hour 9 session, 3 times a week training program
- No suspected or confirmed diagnosis of brain metastases, psychiatric history, or alcohol/drug problems

By Whom? A Health Education Specialist—doctoral candidate project of Loma Linda University, Dept. of Health Promotion & Education.

How? 8-15 participants will asked to participate in a three week program. Program sessions will be 2-hours, 3 times a week for the three weeks. They will participate in survey on their well-being, spirituality, and demographics three times.

When? September 24 – October 12, 2007
Where? Loma Linda Adventist Korean Church, 12408 Mount Vernon Ave, Grand Terrace.

If you would like to participate in the program or have question, please call Jung Park, 909-478-3997 or 909-229-2806
Appendix G: 참가자 모집 광고지
(Recruitment Flyer in Korean)
생명을 위협하는 질병 혹은 만성통증을 가진 분들을 전인건강 프로그램으로 초청합니다.

Look Beyond & Rejoice!

너무 보고 기뻐 하라

목적: 많은 연구들은 종교/영성과 좋은 정신건강 및 행복의 연관성을 보여주고 있습니다. 우리는 실사적인 ‘Look Beyond & Rejoice’ 프로그램을 개발하여 그 효과를 검증합니다. 이 프로그램은 환자들이 자신의 역경을 너머 하나님의 하나님의의 약속을 바라보고 영적 원칙들을 실천함으로 전인적으로 건강해지고 삶의 질이 증진될 수 있도록 돕고자 만들었습니다.

참석자: 선착순 90명 참가자를 모집합니다.
• 한인으로 한국어를 잘 읽고 쓰는 분
• 나이는 18세 이상 성인, 생명을 위협하는 질환이나 만성통증을 가진 환자로 현지 건강 문제가로부터 치료를 받고 있는 분
• 성서적 프로그램에 참여하기를 동의하는 분
• 3주 동안 2시간씩 (오후 3시-5시)
• 9회 (1주 3회) 프로그램에 참여할 수 있는 분
• 녀에 전이된 암이나 정신질환을 갖지 않고 알코올/마약 문제를 갖지 않은 분.

가상: 박정환 건강교육전문가 (미국 공인)이며, 로마도나대학 건강교육학 박사 후보. 심수년간 퇴행성 만성질환인 강직성척추염으로 투병하고 회복되는 과정에서 매우 광범위한 성서적 전인 치유방법을 신학적 보건교육적으로 제시하여 교육합니다.

일정: 90명 참가자들은 3주간 설출로 우선 참가 그룹 혹은 3주 후 참가 그룹으로 나뉘어 2시간씩 9회, 3주 동안 (1주 3회) 프로그램에 참가합니다. 참가자들은 영적필리, 의미, 감정, 전인건강 등에 대해 3회 설문조사에 참여합니다.


어디서? LA 아담스 대학 채플, Suite 200, 3550 W. 6th St., LA, CA 90020.
Appendix H: Telephone Screening Script

Thank you for calling to find out more about our research study. My name is Jung Park and I am a researcher at Loma Linda University. The purpose of this proposed study is to examine the impact of a spiritual intervention, based on Christian Biblical coping methods in the Old Testament and New Testament, in a group of people experiencing life-threatening illness or chronic pain. Specifically, we want to examine the impact of a spiritual intervention for whole-person health.

Do you think you might be interested in participating in that study? (Yes)

(If No) Thank you very much for calling.

I would like to ask you a few questions to get a preliminary idea of whether or not you might be eligible for the study. Is that all right? (Yes)

(If No) I am sorry for that. Thank you very much for calling.

It’s important that you give honest answers. All your answers will be kept confidential. Can I ask you questions? (Yes)

1. What is your name, in Korean and in English?
2. Your gender? _________
3. How old are you? _________ (18-70 years old)
4. Are you fluent in written and spoken Korean? (Yes)
5. Do you currently have any kind of life-threatening illness or chronic pain?
6. What kind of illness do you have?
7. Are you willing to consent to participate in a Christian intervention program? (Yes)
8. Are you currently receiving either curative or palliative treatment from a health professional? (Yes)
9. Are you capable of attending a 9 two-hour sessions, 3 times a week for a 3 week training program? (Yes)
10. Do you have any suspected or confirmed diagnosis of brain metastases, psychiatric history, reported alcohol or drug problems? (No)
If the person has any disqualifying answers they will be told, “I’m sorry, but you are not eligible to participate. This is a highly controlled and regulated scientific study. This means we are required to accept only subjects who fall within certain criteria. The fact that you are not eligible does not mean your problems are particularly bad or that you could not necessarily be treated successfully; it simply means you do not fall within the limits of this particular study group. Thank you for your interest and calling.”

If the person does not have any disqualifying answers they will be told,

**For immediate group:**
“We will send you consent forms, and self-addressed pre-stamped envelopes through the mail. You will be asked to sign an informed consent form and send it back to us. We will send you the detailed procedure so that you may follow it.

**For delayed group:**
“We will send you self-report questionnaires, consent forms, and self-addressed pre-stamped envelopes through the mailings. You will be asked to sign an informed consent form, complete the self-report pre-test questionnaires and send the informed consent and the questionnaire back to us. We will send you the detail procedure so that you may follow it.

Thank you very much for your interest and participate in our study.”
Appendix I: 전화를 통한 적격 참가자 심사 대본
(Telephone Screening Script in Korean)

안녕하세요. 이 연구 프로그램에 참석하기 위하여 전화를 주신 것에 감사드립니다. 제 이름은 박정환입니다. 이 연구의 목표는 성숙을 대처 방법을 사용할 때 환자들이 영적-정신적-신체적 건강이 어떻게 증진될 수 있는지 그 효과를 알아 보는 것입니다.

이 연구 프로그램에 참여하기를 바라십니까? (그렇습니다)

(만일 아니오) 그렇습니까. 어떻게 전화를 주서서 감사합니다.

그럼, 선생님이 이 연구 프로젝트에 참여하기에 적합하신지 않아 보기 위해 몇 가지 질문을 드리겠습니다. 좋습니까? (그렇습니다)

(만일 아니오) 그렇습니까. 어떻게 전화를 주서서 감사합니다.

솔직한 답을 주시는 것이 중요합니다. 주시는 모든 답변은 외부로 알려지지 않으니 안심하시기 바랍니다. 이제 질문을 시작할까요? (예)

1. 성함이 무엇이시지요? 한국말과 영어로요? ____________________

2. 성별은? ______

3. 몇 세이시지요? ______(18-70 세 이내)

4. 한국말을 읽고 쓰는데, 말하는데 능숙하신지요? (예)

5. 현재 생명을 위협하는 질환이나 만성 통증을 가지고 계신지요?

6. 어떤 종류의 질환을 가지고 있으신지요?

7. 기독교적 전인건강 프로그램에 참여하기를 동의하시는지요? (예)

8. 현재 건강전문가로부터 치료를 받고 있으신지요? (예)

9. 2 시간씩 9 회, 1 주 3 회 참석하는 3 주 프로그램에 참석할 수 있으신지요? (예)
10. 뇌에 이전된 암을 가졌습니까? 정신질환이 있습니까? 손이나 마약 중독 문제가 있습니다吗？(아니오)

만일 어떠한 자격이 없는 담을 한다면 다음과 같이 말한다.

“미안합니다만, 선생님은 참여하실 수가 없습니다. 이것은 아주 엄격하게 선정되고 통제된 과학적 연구기기 때문에 어떤 기준에 맞는 분들만 참여하실 수 있습니다. 선생님이 적합하지 않는다는 것이 선생님의 질병이 특별히 나쁘거나 치료를 성공적으로 할 수 없다는 것이 아닙니다. 다만 이 특별한 연구 그룹에 맞지 않는다는 것을 의미할 뿐입니다. 관심을 가지시고 전화를 주신데 대해 감사드립니다.”

만일 자격없는 담을 하지 않았다면 다음과 같이 말한다.

우선 참석 그룹에게:

“이제 제가 선생님께 참가 동의서와, 자세한 안내문과, 우표가 붙은 봉투를 보내드리겠습니다. 받으신 후에 읽으신 후 사인하시고 참가 동의서를 제게 돌려 보내주십시오.”

참주 후 참가 그룹에게:

“이제 제가 선생님께 참가 동의서와, 설문지들과, 우표가 붙은 봉투와, 자세한 안내문을 보내드리겠습니다. 참가 동의서에 사인하시고, 설문지들에 답을 하신 후에 참가 동의서와 설문지들을 돌려 보내주시기 바랍니다.”

“선생님의 관심과 이 연구 프로그램에 참여하신에 감사드립니다.”
Appendix J: The Procedure Chart to be Sent to Participants

This diagram will show you the process of the program and participants involvement.

Individuals will telephone the investigator and have a brief interview to determine eligibility for participation.

Individuals who are eligible will be assigned by the flip of a coin to either receive the program as soon as possible (this is called the immediate group) or three weeks after the immediate group starts (the delayed group).

**Immediate group**
Individuals will receive consent forms, procedure chart, time-line, and self-addressed pre-stamped envelopes through the mail.

Fill out and sign the consent form and return it to the investigator using the self-addressed pre-stamped envelope.

In the beginning of the first session, individuals will fill out the questionnaire (first time).

Attending the nine session program.

In the end of the last session, filling out the questionnaires (second time) and receiving the last questionnaire.

After three weeks from the end of program, individuals will fill out the questionnaire (third time) and returning it to the investigator.

**Delayed group**
Individuals will receive consent forms, procedure chart, time-line, self-report questionnaires, and self-addressed pre-stamped envelopes through the mail.

Fill out and sign the consent form, fill out the questionnaire (first time), and return both to the investigator using the self-addressed pre-stamped envelope.

After three weeks, individuals will fill out the questionnaire in the beginning of the first session (second time).

Attending the nine session program.

In the end of the last session, filling out the questionnaires (third time).
Appendix K: 참가자 용 순서 도표
(The Procedure Chart to be Sent to Participants in Korean)

이 도표는 프로그램의 절차와 참가자들의 참여 방식을 보여 줍니다.

참가하고자 하는 분들이 연구자에게 전화를 하고 간단한 전화 인터뷰를 하여 참가 적합

참가에 적합한 참가자들은 우선 프로그램 참가 그룹과 3주 후 프로그램 참가

우선 참가 그룹
참가자들은 참가 동의서, 점차 도표, 시간표, 우표가 붙여진 반송봉투를 우편으로 받는다.

참가 동의서를 작성하여 사인하고 우표가 붙여진 반송봉투를 사용하여 연구가에게

프로그램 첫회의 시작 전에 설문지를 작성.

전체 9회 프로그램에 참여한다.

마지막 프로그램 후에 설문지를 작성하고 (2회) 마지막 설문지(3회)와 우표가 붙은

3주 후, 프로그램 첫회의 시작 전에 설문지를 작성한다 (2회).

프로그램 마친 후 3주 후에, 설문지를 작성하여 (3회) 반송봉투에 넣어

마지막 프로그램 후에 설문지를 작성한다 (3회).
## Appendix L: Time Line to be Sent to Participants

### Immediate Group

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 days Before program</td>
<td>First day of program</td>
</tr>
<tr>
<td>Reminder Phone call</td>
<td></td>
</tr>
<tr>
<td>First survey</td>
<td></td>
</tr>
<tr>
<td>20 days after program</td>
<td>Last day of program</td>
</tr>
<tr>
<td>Reminder Phone call</td>
<td></td>
</tr>
<tr>
<td>Second survey</td>
<td></td>
</tr>
<tr>
<td>3 weeks after program</td>
<td></td>
</tr>
<tr>
<td>Third survey</td>
<td></td>
</tr>
</tbody>
</table>

### Delayed Group

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 days Before program</td>
<td>First day of program</td>
</tr>
<tr>
<td>23 days Before program</td>
<td></td>
</tr>
<tr>
<td>3 weeks before program</td>
<td></td>
</tr>
<tr>
<td>Receive first survey tool</td>
<td></td>
</tr>
<tr>
<td>Confirmation call</td>
<td></td>
</tr>
<tr>
<td>First survey</td>
<td></td>
</tr>
<tr>
<td>3 weeks after program</td>
<td></td>
</tr>
<tr>
<td>First survey</td>
<td></td>
</tr>
<tr>
<td>3 weeks after program</td>
<td></td>
</tr>
<tr>
<td>Third survey</td>
<td></td>
</tr>
</tbody>
</table>
Appendix M: 참가자용 시간표 (Time Line to be Sent to Participants in Korean)

우선 프로그램 참가 그룹

프로그램 2일전 첫날

프로그램 진행

프로그램 마지막 날

프로그램 20일 후 3주 후

Reminder 전화 첫 설문지

Reminder 전화 두번째 설문지

Reminder 전화 세번째 설문지

3주 후 프로그램 참가 그룹

프로그램 25일

프로그램 23일

프로그램 3주 전

프로그램 진행

프로그램 첫날

프로그램 3주 후

첫 설문지 확인 전화 첫

첫 설문지 둘째 설문지

둘째 설문지 세번째 설문지

받음 설문지
Appendix N: Questionnaire

Your Personal Information

We are very aware that you provide us information that is private. When you return your questionnaire, this page, which has your name and ID number on it, will be separated from the rest of the questionnaire, which only has your ID number on it. Then this page will be stored separately from the questionnaire in a locked cabinet and it will be accessible only to the study investigators.

ID number: ____________________________

Today’s Date _______ / ______/ ______
Month Day Year

Your full name, address and phone number.

____________________________________

Name (First, Middle, Last) Phone Number

____________________________________

Stress Address

____________________________________ State Zip
Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers. Thank you for completing this survey.

1. Gender  
   _____ Male  
   _____ Female

2. Age  
   _____ Years old

3. Education  
   _____ Less than High School Graduate  
   _____ High School Graduate  
   _____ Some Collage (two quarters or more)  
   _____ College Graduate (BA or BS Degree)  
   _____ Graduate School (Master/Doctoral Degree)

4. Religion  
   _____ Protestant  
   _____ Catholic  
   _____ Jewish  
   _____ Buddhist  
   _____ Other religion: Please write ____________________________  
   _____ No religion

5. How long have you had the view of religion you report in the last question?  
   _____ Less than 1 year  
   _____ 1-5 years  
   _____ 6-10 years  
   _____ 11-20 years  
   _____ 21-30 years  
   _____ Over 31 years
6. How often do you attend religious meetings in a typical month?

   _____ None
   _____ Once a month
   _____ Twice a month
   _____ Once a week
   _____ Twice a week
   _____ Three or more times a week

7. What kind of illness do you suffer from? ________________________________

8. What kind of treatment do you use now? ________________________________
A. Your Daily Spiritual Experience (Daily Spiritual Experiences Scale)

The list that follows includes items you may or may not experience. Please consider how often you directly have this experience, and try to disregard whether you feel you should or should not have these experiences. A number of items use the word ‘God.’ If this word is not a comfortable one for you, please substitute another word which calls to mind the divine or holy for you. Put a check mark (√) in the box that is most relevant to you.

<table>
<thead>
<tr>
<th></th>
<th>Many times a day</th>
<th>Every day</th>
<th>Most days</th>
<th>Some days</th>
<th>Once in a while</th>
<th>Never or almost never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel God's presence.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I experience a connection to all of life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>During worship, or at other times when connecting with God, I feel joy which lifts me out of my daily concerns.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I find strength in my religion or spirituality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I find comfort in my religion or spirituality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I feel deep inner peace or harmony.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I ask for God's help in the midst of daily activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I feel guided by God in the midst of daily activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I feel God's love for me, directly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I feel God's love for me, through others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I am spiritually touched by the beauty of creation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I feel thankful for my blessings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I feel a selfless caring for others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I accept others even when they do things I think are wrong.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I desire to be closer to God or in union with the divine.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat close</th>
<th>Very close</th>
<th>Very close as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, how close do you feel to God?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B. Meaning in your illness (Constructed Meaning Scale)

Please take a moment to think about the meaning of your illness. Put a check mark (✓) in the box that is most relevant to you.

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel my illness is something I will never recover from.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I feel my illness is serious, but I will be able to return to life as it was before my illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I feel illness has changed my life permanently so it will never be as good again.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I feel I have made a complete recovery from my illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I feel that I am the same person as I was before my illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I feel that my relationships with other people have not been negatively affected by my illness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I feel that my experience with illness has made me a better person.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I feel that having an illness has interfered with my achievement of the most important goals I have set for myself.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
C. Meaning in your life (Meaning in Life Questionnaire)

Please take a moment to think about what makes your life feel important to you. Put a check mark (✓) in the box that is most relevant to you.

<table>
<thead>
<tr>
<th></th>
<th>Absolutely Untrue</th>
<th>Mostly Untrue</th>
<th>Somewhat Untrue</th>
<th>Can't Say True or False</th>
<th>Somewhat True</th>
<th>Mostly True</th>
<th>Absolutely True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I understand my life's meaning.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I am always searching for something that makes my life feel meaningful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I am always looking to find my life's purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>My life has a clear sense of purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I have a good sense of what makes my life meaningful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I have discovered a satisfying life purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I am always searching for something that makes my life feel significant.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I am seeking a purpose or mission for my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>My life has no clear purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I am searching for meaning in my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
D. Your Positive and Negative Emotions (The Positive and Negative Affect Schedule)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then place a mark (✓) in the box which indicated to what extent you have felt this feeling or emotion during the past week.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Very slightly or not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Interested</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Distressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Excited</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Upset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Strong</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Guilty</td>
<td></td>
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<tr>
<td>7</td>
<td>Scared</td>
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<td>8</td>
<td>Hostile</td>
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<tr>
<td>9</td>
<td>Enthusiastic</td>
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<tr>
<td>10</td>
<td>Proud</td>
<td></td>
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<tr>
<td>11</td>
<td>Irritable</td>
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<tr>
<td>12</td>
<td>Alert</td>
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<tr>
<td>13</td>
<td>Ashamed</td>
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<tr>
<td>14</td>
<td>inspired</td>
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<td>15</td>
<td>Nervous</td>
<td></td>
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<tr>
<td>16</td>
<td>Determined</td>
<td></td>
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<tr>
<td>17</td>
<td>Attentive</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18</td>
<td>Jittery</td>
<td></td>
<td></td>
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<tr>
<td>19</td>
<td>Active</td>
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<td></td>
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</tr>
<tr>
<td>20</td>
<td>Afraid</td>
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<tr>
<td>21</td>
<td>Joy</td>
<td></td>
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<tr>
<td>22</td>
<td>Happiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Contentment</td>
<td></td>
<td></td>
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<tr>
<td>24</td>
<td>Affection</td>
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</tr>
<tr>
<td>25</td>
<td>Love</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Caring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
E. Your Pain

(NUMERICAL RATING PAIN SCALE)

Please circle the number to identify how much pain you had in the last week.

(Pain Intensity) In the last week, how much bodily pain have you had?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td>Moderate Pain</td>
<td>Worst Possible Pain imaginable</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Pain Affect) In the last week, how unpleasant has the pain been?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Bad at all</td>
<td>Most unpleasant feeling possible</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions on using medication:

1. Are you using any medication to relieve your pain? Yes No

2. If so, what pain medication(s) are you using? ____________________________

3. How often do you take your pain medications?
   1) Once a day
   2) Twice a day
   3) Three times a day
   4) Four times a day
   5) Five times a day
   6) Six or more times a day
F. Your Health and Well-Being (Acute SF-12 v2 Form)

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.
For each of the following questions, please place mark (√) in the box that is relevant to you.

1. In general, would you say your health is?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

<table>
<thead>
<tr>
<th></th>
<th>Yes, limited a lot</th>
<th>Yes, limited a little</th>
<th>No, not limited at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1 Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-2 Climbing several flights of stairs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-1 Accomplished less than you would like</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-2 Were limited in the kind of work or other activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

<table>
<thead>
<tr>
<th></th>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1 Accomplished less than you would like</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-2 Did work or other activities less carefully than usual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. During the past week, how much did pain interfere with your normal work (including both work outside the home and housework)?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
</table>

6. These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past week...

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-1 Have you felt calm and peaceful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-2 Did you have a lot of energy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-3 Have you felt downhearted and depressed?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

7. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (life visiting friends, relatives, etc.)?

<table>
<thead>
<tr>
<th>All of the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>None of the time</th>
</tr>
</thead>
</table>

Thank you for completing these questions!
Appendix O: 설문지
(Questionnaire in Korean)

A. 당신의 일상적인 영적 경험

다음에 나열된 목록은 당신이 경험하거나 하지 않은 경험을 포함합니다. 당신이 얼마나 자주 직접적으로 이 경험을 하는지 고려하여 보시고, 이 경험들은 반드시 해야 한다거나 하지 않아야 한다고 느끼는 바는 고려하지 않도록 하십시오. 몇 항목들은 '하나님'이라는 단어를 사용합니다. 만약 이 단어가 당신에게 편치 않은 것이라면, 당신에게 신성 혹은 거룩함을 생각나도록 부르는 다른 단어로 대체하도록 하십시오. 당신에게 가장 연관되는 빈칸에 (✔)을 체크하십시오.

<table>
<thead>
<tr>
<th></th>
<th>하루 중 여러번 (1)</th>
<th>매일 (2)</th>
<th>대부분 남들 (3)</th>
<th>어면 남들 (4)</th>
<th>간혹 한번씩 (5)</th>
<th>전혀 혹은 거의 아니 (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>나는 하나님의 임재하신은 느낀다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>나는 생명을 가진 모든 것에 연결됨을 느낀다.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>나는 예배 중, 혹은 하나님과 연결된 다른 시간에 나의 매일 업무들을 벗어나 나를 들어 올리주는 기쁨을 느낀다.</td>
<td></td>
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<tr>
<td>4</td>
<td>나는 나의 종교 혹은 영성에서 힘을 발견한다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>나는 나의 종교 혹은 영성에서 위로를 받는다.</td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>나는 긴장 내면의 평화 혹은 조화를 느낀다.</td>
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<td></td>
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<tr>
<td>7</td>
<td>나는 매일 활동을 가운데서 하나님의 도움을 구한다.</td>
<td></td>
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<tr>
<td>8</td>
<td>나는 매일의 활동을 가운데서 하나님에 의해 인도받음을 느낀다.</td>
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<tr>
<td>9</td>
<td>나는 나를 위한 하나님의 사랑을 직접 느낀다.</td>
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<tr>
<td>10</td>
<td>나는 나를 위한 하나님의 사랑을 다른 사람들 통해서 느낀다.</td>
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</tr>
<tr>
<td>11</td>
<td>나는 찬양의 아름다움에 의해 영적으로 감동을 받는다.</td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>나는 내의 욕망에 대하여 감사를 느낀다.</td>
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</tr>
<tr>
<td>13</td>
<td>나는 다른 사람들에게 위해 기꺼이 살아서 복음 설교를 느낀다.</td>
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<tr>
<td>14</td>
<td>나는 다른 사람들이 내가 생각하기에 잘못된 일을 할 때에도 그들을 받아들인다.</td>
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</tr>
<tr>
<td>15</td>
<td>나는 하나님의과 가까이 하기를 원하거나 신성과 연합됨을 갈망한다.</td>
<td></td>
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<tr>
<td></td>
<td>강하게 동의함</td>
<td>동의함</td>
<td>동의안함</td>
<td>강하게 동의안함</td>
<td></td>
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<td>---------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>나는 나의 질병이 걸리고 회복될 수 없는 것이라고 느낀다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2.</td>
<td>나는 나의 질병이 심각하다고 느낀다. 그러나 나는 나의 질병이 전에 있었던 것처럼 돌아갈 수 있을 것이다.</td>
<td></td>
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<tr>
<td>3.</td>
<td>나는 질병이 나의 삶을 영기롭게 변화시킨 것으로 느껴므로 이전 같이 좋아질 수 있을 것이다.</td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>나는 나의 질병으로부터 전환히 회복한 것으로 느낀다.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>나는 내가 나의 질병이 전에 나와 완전히 같은 사람으로 느낀다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>나는 다른 사람들과 나의 전제가 나의 질병에 의해 부정적으로 영향받지 않았다고 느낀다.</td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>나는 질병으로 인한 나의 경험이 나를 보다 나은 사람으로 만들었다고 느낀다.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>나는 질병을 가진 것이 내가 나 자신을 위해 세운 가장 중요한 목적이 되었다는에서 영광을 하였다고 느낀다.</td>
<td></td>
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</tbody>
</table>
C. 당신의 삶의 의미

무엇이 당신의 삶을 중요하게 느끼게 하는지 생각하는 시간을 잡아 가져 보십시오. 당신에게 가장 연관되는 빈칸에 (✓)을 체크하십시오.

<table>
<thead>
<tr>
<th></th>
<th>전적으로 다르다</th>
<th>거의 다르다</th>
<th>어느 정도 다르다</th>
<th>맞거나 다르다고 할 수 없다</th>
<th>어느 정도 맞다</th>
<th>거의 맞다</th>
<th>전적으로 맞다</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>나의 삶의 의미를 잊었다.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>나의 삶을 중요하게 느끼게 만드는 어떤 것을 찾고 있다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>나의 삶의 목적을 발견하려고 항상 찾고 있다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>나의 삶은 분명한 목적감을 가진다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>무의미한 삶을 중요하게 느끼는지에 대해 좋은 감각을 가지고 있다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>만족하게 만드는 삶의 목적을 발견하였다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>나의 삶을 중요하게 느끼도록 만드는 무의미한 삶을 항상 찾고 있다.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>나의 삶을 위한 목적 혹은 사명을 찾고 있다.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>나의 삶은 분명한 목적을 가지고 있지 않다.</td>
<td></td>
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<tr>
<td>10</td>
<td>나의 삶의 의미를 찾고 있다.</td>
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</tbody>
</table>
D. 당신의 중평적이며 부정적인 감정들

이 조사표는 다른 느낌들과 감정들을 묘사하는 말들로 구성되어 있습니다. 각 항목을 읽고
지난 한 주 동안 당신이 이러한 느낌이나 감정을 느낀 범위를 표시해주는 박스에 체크
☑해 주십시오.

<table>
<thead>
<tr>
<th></th>
<th>아주 조금 혹은 전혀 아님</th>
<th>조금</th>
<th>중간 정도</th>
<th>상당히</th>
<th>굉장히 많이</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>황미있는</td>
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<td>2</td>
<td>고민됨</td>
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<td>3</td>
<td>황분한</td>
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<td>4</td>
<td>속 뒤집힌</td>
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<td>5</td>
<td>강한</td>
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<td>6</td>
<td>가책을 느낀</td>
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<td>7</td>
<td>집나는</td>
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<td>8</td>
<td>화난</td>
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<td>9</td>
<td>열정적인</td>
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<td>10</td>
<td>자부심있는</td>
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<tr>
<td>11</td>
<td>화를 잘 내는</td>
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<tr>
<td>12</td>
<td>방심하지 않는</td>
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<tr>
<td>13</td>
<td>부끄러운</td>
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<tr>
<td>14</td>
<td>영감받은</td>
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<tr>
<td>15</td>
<td>신경성의</td>
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<tr>
<td>16</td>
<td>굳게 결심한</td>
<td></td>
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<tr>
<td>17</td>
<td>주의 깊은</td>
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<tr>
<td>18</td>
<td>신경파인의</td>
<td></td>
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<tr>
<td>19</td>
<td>활동적인</td>
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<tr>
<td>20</td>
<td>두려워하는</td>
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<tr>
<td>21</td>
<td>기뻐하는</td>
<td></td>
<td></td>
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<tr>
<td>22</td>
<td>행복한</td>
<td></td>
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</tr>
<tr>
<td>23</td>
<td>만족한</td>
<td></td>
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<tr>
<td>24</td>
<td>애정 어린</td>
<td></td>
<td></td>
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<tr>
<td>25</td>
<td>사랑하는</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>26</td>
<td>돌보아주는</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
E. 당신의 고통
당신이 지난 주에 얼마나 고통을 느꼈는지 번호에 동그라미를 그리시기 바랍니다.
1. 지난 한 주 동안, 당신은 얼마나 신체적 고통을 느꼈습니까?

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<thead>
<tr>
<th></th>
<th>1</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>고통</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>중간 정도의</td>
<td></td>
<td></td>
<td>상상 가능한</td>
</tr>
<tr>
<td>없음</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>고통</td>
<td></td>
<td></td>
<td>최악의 고통</td>
</tr>
</tbody>
</table>

2. 지난 한 주 동안, 고통이 얼마나 높았습니까?

<table>
<thead>
<tr>
<th></th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>전혀</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>가끔난</td>
<td></td>
<td></td>
<td>불쾌한 느낌</td>
</tr>
<tr>
<td>나쁘지</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>불쾌한 느낌</td>
</tr>
<tr>
<td>악음</td>
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</tr>
</tbody>
</table>

3. 당신은 통증을 감소시키기 위하여 어떤 약을 사용합니까? 그렇다 아니다

4. 만일 사용한다면, 무슨 통증 약(들)을 사용합니까? __________________________

5. 얼마나 자주 당신은 통증 약을 사용합니까?

1) 일주일에 몇회
   1) 하루에 1회
   2) 하루에 2회
   3) 하루에 3회
   4) 하루에 4회
   5) 하루에 5회 이상

6. 통증 약이 아닌 다른 약을 사용합니까? 그렇다 아니다

7. 만일 사용한다면, 무슨 약(들)을 사용합니까?

약 종류 | 사용 회수
---|---
1) | 일주일 몇회 하루 1회 2회 3회 4회 5회 이상
2) | 일주일 몇회 하루 1회 2회 3회 4회 5회 이상
3) | 일주일 몇회 하루 1회 2회 3회 4회 5회 이상

サテ4사\4나웃4\008

5장2008

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F. 당신의 건강과 삶의 질

본 설문지는 귀하의 건강 상태에 대한 귀하의 의견을 묻는 것입니다. 귀하의 대답은 귀하가 어떻게 느끼고 또한 일상 활동을 얼마나 잘 할 수 있는가를 계속적으로 관찰하는 데 도움이 됩니다. 가장 적합한 번호에 체크(✓)를 하여 주십시오.

1. 전반적으로 귀하의 건강 상태는 어떠함니까?

<table>
<thead>
<tr>
<th>채점</th>
<th>최고로 좋다</th>
<th>아주 좋다</th>
<th>좋다</th>
<th>조금 나쁘다</th>
<th>나쁘다</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

2. 다음 문항들은 귀하가 평상시 하는 활동에 관한 것입니다. 귀하의 건강 상태 때문에 이러한 일상적인 활동을 하는데 제한을 받습니까? 만약 그렇다면, 어느 정도 제한을 받습니까?

<table>
<thead>
<tr>
<th></th>
<th>예, 제한을 많이 받는다</th>
<th>예, 제한을 조금 받는다</th>
<th>아니오, 제한을 전혀 받지 않는다</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-1</td>
<td>다소 힘든 활동(예: 탐사 등기 기, 비로 방출기, 한두 시간 산보호기, 자전거 타기)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2-2</td>
<td>재단으로 여러 종 걸어 올라가는 것</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

3. 지난 한 주 동안에, 귀하의 신체적인 건강 때문에 귀하의 일이나 일상적인 활동을 하는데 다음과 같은 문제가 얼마나 자주 있었습니까?

<table>
<thead>
<tr>
<th></th>
<th>항상 그랬다</th>
<th>대부분 그랬다</th>
<th>때때로 그랬다</th>
<th>드물게 그랬다</th>
<th>전혀 그렇지 않았다</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-1</td>
<td>일하는 것보다 적은 양의 일을 했다</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3-2</td>
<td>일이나 다른 일상적인 활동 중에서 할 수 없는 것이 있었다</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Loma Linda University
Adventist Health Sciences Center
Institutional Review Board
Approved 9월 17일 2008
Void After 9월 26일 2008
# 57220 Chair R. W. Gesell, M.D.

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4. 지난 한 주 동안에, 정서적인 문제(예: 기분이 좋지 않거나 불안을 느끼는 것) 때문에 귀하의 일이나 일상적인 활동을 하는 데 다음과 같은 문제가 얼마나 자주 있었습니까?

<table>
<thead>
<tr>
<th></th>
<th>항상 그쳤다</th>
<th>대부분 그눴다</th>
<th>때때로 그랬다</th>
<th>드물게 그랬다</th>
<th>전혀 그렇지 않았다</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4-2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. 지난 한 주 동안에, 귀하는 몸의 풍종 때문에 정상적인 일 (집 밖의 일과 집안 일을 포함해서)을 하는 데 얼마나 지성이 있었습니까?

<table>
<thead>
<tr>
<th>전혀 없었다</th>
<th>약간 있었다</th>
<th>어느 정도 있었다</th>
<th>많이 있었다</th>
<th>대단히 극심했다</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

6. 아래의 질문들은 지난 한 주 동안 귀하가 어떻게 느꼈고, 또 어떻게 지냈는지에 대한 설문입니다. 아래의 각 항목에 대하여, 귀하가 느꼈던 것과 가장 가까운 번호에 답해 주십시오. 지난 한 주 동안에, 얼마나 자주 -

<table>
<thead>
<tr>
<th></th>
<th>항상 그쳤다</th>
<th>대부분 그뤘다</th>
<th>때때로 그랬다</th>
<th>드물게 그랬다</th>
<th>전혀 그렇지 않았다</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6-2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6-3</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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</tr>
</tbody>
</table>
7. 지난 한 주 동안에, 귀하의 신체적인 건강 문제 혹은 정서적인 문제로 인하여, 귀하의 사회 활동(예: 친구나 친지 방문하는 것)에 얼마나 자주 지장이 있었습니까?

<table>
<thead>
<tr>
<th>항상 그랬다</th>
<th>대 부분 그랬다</th>
<th>때때로 그랬다</th>
<th>드물게 그랬다</th>
<th>전혀 그렇지 않았다</th>
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</tbody>
</table>

설문조사를 완료해 주셔서 감사합니다!
Appendix P: Scripts of Reminder Phone Calls

When the consent documents have not been returned within 9 days of the date they were mailed:
Hello, my name is Jung Park, the investigator of the Look Beyond & Rejoice program. Are you ________? (Yes) Did you receive the package that I sent you? (If yes) Did you have any difficulty in filling out the materials? (If yes) Is there some way I can help you? [Explores the problem with the participant and tries to assist them in sending it back] (If, No) Then, I will send you the document again. When you receive it, please fill it out and send it back to me as soon as possible. Thank you. Bye.

Both groups, two days before the program starts for them:
Hello, my name is Jung Park, the investigator of the Look Beyond & Rejoice program. Are you ________? (Yes) How are you doing? (Fine) I am calling to remind you that the program starts just two days from now. Do you have any questions about that? [Answers any questions]

Will you be there? (If, No) Is there anything that I could do to help you be there? [Explores the problem with the participant and tries to assist them to find a way to come to the program.] (If, Yes) That’s good. I am expecting seeing you there. Thank you. Bye.

Immediate group, Third survey reminder call, 20 days after program finishes:
Hello, my name is Jung Park, the investigator of the Look Beyond & Rejoice program. Are you ________? (Yes) How are you doing? (Fine)
I am calling for reminding you so that you may fill out the last survey and send it to me.
Please don’t forget it.
Thanks for your cooperation. Bye.

Delayed Group, First survey reminder call, 23 days before their program:
Hello, my name is Jung Park, the investigator of the Look Beyond & Rejoice program.
Are you ________? (Yes)
How are you doing? (Fine)
I recently sent you some documents. Did you receive it?
(If no, I didn’t) Then, I will send you another packet.
(If yes) That’s good. Then please fill them out and sign and send them to me.
Thank you. I am expecting seeing you in the program.
Appendix Q: 기억을 돕는 전화 대본
(Scripts of Reminder Phone Calls in Korean)

참가 동의서류가 우송한 후 9일 이내 작성되어 돌아오지 않을 때:

안녕하세요. 저는 Look Beyond & Rejoice 프로그램 박정환입니다.
선생님이 _______님임이십니까? (예)
그간 어떻게 지내셨습니까? (잘 지냈습니다)
제가 보낸 메일을 받으셨는지요?
(‘예’라고 한다면) 아직 제가 답변을 받지 못하였는데 작성하는데 어떤 어려움이 있었습니다요?
(‘예’라고 한다면) 제가 어떻게 도와드릴 일이 있습니까?
[참가자와 함께 그 문제를 의논하고 그가 작성하여 반송하는 것을 돕는다]
(‘아니’라고 한다면) 그러면, 제가 다시 보내도록 하겠습니다. 그것을 받으신다면
최대한 빨리 작성해서 바로 보내주시기 바랍니다.
감사합니다. 안녕히 계세요.

두 그룹 모두에게, 프로그램이 시작하기 이틀 전:

안녕하세요. 저는 Look Beyond & Rejoice 프로그램 박정환입니다.
선생님이 _______님임이십니까? (예)
그간 어떻게 지내셨습니까? (잘 지냈습니다)
제가 전화를 건 것은 다르이 아니고 이제 프로그램이 이틀 남은 것을 알려드리고자
합니다. 그에 대해 혹 질문이 있습니까? [어떤 질문이든지 답한다]
이틀 후에 참석하시겠지요?
(만일, ‘아니’라고 한다면) 선생님이 참석하시도록 제가 도와드릴 수 있는 길이
있을까요? [참석자와 함께 참석자가 프로그램에 올 수 있는 방법을 찾기 위해
노력한다]
(‘예’라고 한다면) 예, 좋습니다. 그럼, 그 날 빨리 하겠습니다.
감사합니다. 안녕히 계세요.
우선 프로그램 그룹에게, 프로그램 마친 후 20 일 후:

안녕하세요. 저는 Look Beyond & Rejoice 프로그램 박정환입니다.
선생님이 __________ 님이실니까? (예)
그간 어떻게 지내셨습니까? (잘 지냈습니다)
 제가 전화를 건 것은 다름이 아니고 마지막 설문지를 작성해서 제게 보내주시는 것을 기억하시도록 하기 위함입니다. 잊지 마시고 그렇게 해주세요.
협조해 주셔서 감사합니다. 안녕히 계세요.

3 주 후 프로그램 그룹, 프로그램 23 일 전에 첫 설문 작성을 기억하도록 하는 전화:

안녕하세요. 저는 Look Beyond & Rejoice 프로그램 박정환입니다.
선생님이 __________ 님이실니까? (예)
그간 어떻게 지내셨습니까? (잘 지냈습니다)
 제가 얼마나 전에 메일을 보내였습니다. 받으셨는지요?
(반일, ‘아니’라고 하면) 그럼, 제가 다시 한번 메일을 보내드리겠습니다.
(‘예’라고 하면) 좋습니다. 그럼, 그것을 작성하시고 서인하셔서 제게 보내주시기 바랄니다.

감사합니다. 프로그램에서 빨기를 기대하겠습니다.
Appendix R: In-Session Worksheet

Session 1 - Transformation of Tragedy

Name: _______________________

1. Write your reflection and impression on the lesson today.

2. Write your personal goals for the transformation of the tragedy of your illness.
In-Session Worksheet
Session 2 - Meaning-making, Benefit-Finding, Resilience

Name: ________________________________

1. Write your reflection and impression on the lesson today.

2. Find meaning and benefits of your personal suffering and write about them.
In-Session Worksheet
Session 3 - Imagery and Visualization

Name: ________________________________

1. Write your reflection and impression on the lesson today.

2. Write your personal plan about how to practice transcendent visualization.
In-Session Worksheet
Session 4: Look Beyond - the Spiritual Coping Method

Name: __________________________

1. Write your reflection and impression on the lesson today.

2. Practice transcendent visualization and write your reflection (feelings & thoughts about it.)
In-Session Worksheet

Session 5 - Positive Expression & Word Power

Name: __________________________

1. Write your reflection and impression on the lesson today.

2. Write your personal plan about how you will practice positive expression to others and to yourself in your daily life.
In-Session Worksheet  
Session 6: Rejoice – the Paradoxical Coping Method

Name: ________________________________

1. Write your reflection and impression on the lesson today.

2. Write your personal plan for transcendent verbalization.
1. Write your reflection and impression on the lesson today.

2. Write your personal plan about how you will implement the whole-person health plan.
In-Session Worksheet

Session 8 - The Core of Life and Thriving

Name: ____________________________

1. Write your reflection and impression on the lesson today.

2. Write your personal plan about how you will improve the relationships with self, others, and God.
In-Session Worksheet
Session 9 - Hold Fast to What is Good

Name: ________________________________

1. Write your reflection and impression on the lesson today.

2. Write your personal plan about how to maintain the strategies taught in this program and write a resolution to keep using them.
Appendix S: 프로그램 실습
(In-Session Worksheet in Korean)

Look Beyond & Rejoice

1 회기– 좋은 것을 취하라

이름: ________________________________

1. 오늘 같은에 대한 이상과 생각을 써보시어요

2. 다시이고루를 경계로 자신에게 하고 있는 말/경향을 써보시어요

219
프로그램 실습
4회: Look Beyond – 영적 대처법

이름: ______________________

1. 오늘 갓의에 대해 이상과 산간을 써보십시오

2. 조원적 시각화를 연습하고 당시의 갓상(느낌과 색각)을 써 보십시오

NEUTECH
25% COTTON

222
프로그램 실습
5 회기- 창조적 말의 능력

이름: __________________________

1. 오늘 강의에 대해 이끌과 생각을 써보십시오.

2. 어떻게 긍정적/조강적 말을 당신의 일상에서 다른 사람들에게와 당신 스스로에게 실천할 것인지 개인적 계획을 써 보십시오.
1. 本产品适用于。

6 以下：不适用

看 您 个 价
프로그래임 실습
9 회기 - 충만한 삶

이름:

1. 오늘 강의에 대한 인상과 생각을 써보십시오.

2. 어떻게 당신이 태인, 자신, 그리고 하나님과의 관계를 증진시킬지 개인적 계획을 써 보십시오.
Appendix T: Monthly Spiritual Workout Sheet

Name: ______________________

* Please place a mark (✓) when you complete the workout for the day. (October – November)

<table>
<thead>
<tr>
<th>Date</th>
<th>Practice</th>
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<td>Having time to read and meditate Bible and/or other spiritual writings at least 20 minutes a day</td>
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<tr>
<td></td>
<td>Practicing transcendent visualization &amp; verbalization, at least 5 minutes a day for each</td>
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228
Monthly Spiritual Workout Sheet

* Please place a mark (✓) when you complete the workout for the day. (November – December)

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### Monthly Spiritual Workout Sheet

* Please place a mark (✓) when you complete the workout for the day. (December – January)

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### Appendix U: 월별 영적 심습
(Monthly Spiritual Workout Sheet in Korean)

이름: __________________

* 당신이 그 날 실행하였다면 체크 (✓)를 하십시오. (10월 - 11월)

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<td>성경이나 다른 영적인 글들을 적어도 하루 20분 이상 읽고 명상한다</td>
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# 월별 영적 실습

이름: 

* 당신이 그 날 실행하였다면 체크(✓)를 하십시오. (10월 - 11월)

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월별 영적 실습

이름: ______________________

* 당신이 그 날 실행하였다면 체크(✓)를 하십시오. (10월 - 11월)

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