Mental Health and the Korean American Church: Understanding the Needs of Korean American Church Leaders

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Introduction

Studies have shown that Korean Americans (KAs) have greater depressive symptoms compared to other East Asian groups and experience depression twice that of the general US population (Bernstein et al., 2011). Despite the prevalence of mental health issues, KA immigrants are a strikingly underserved group with health services and research (Jo et al., 2010). In addition to KA immigrants ranking the lowest in having medical insurance among other ethnic minority groups and having limited English speaking skills (Lee et al., 2008), there are other barriers: stigma around mental health, lacking culturally competent mental health providers, and lacking resources (Park et al., 2013). These barriers are why it is crucial to take an approach that is effective for KAs.

One of the unique aspects of KA immigrants is that 61-71% self-identify as Christians or regularly attend church services (Pew Research, 2012). Churches clearly play a pivotal role in providing community support as a social, political, and educational center (Lee et al., 2008).

By leveraging the pre-existing community structure within the KA community, Mustard Seed Generation created the Mental Health Training Program for Korean American Church Leaders (MHT Program). The goal of the MHT Program is to educate church leaders with mental health and self-care tools, and support church leaders to connect with local mental health professionals. The 7-week program was designed based on the insights gathered from a needs assessment, the details of which can be found at [https://www.mustardseedgeneration.org/reports]. In 2022, MSG oversaw four MHT cohorts in April (1st cohort), June (2nd cohort), September (3rd cohort), and October (4th cohort). This paper will analyze the data collected from the first and second cohorts.

Methodology

The board of Mustard Seed Generation (MSG) created a programming committee composed of mental health professionals and church leaders and charged them with developing a program to address the urgent need to equip Korean American church leaders with practical mental health resources. Under the programming committee's leadership, the MHT Program developed and launched a 7-week-long curriculum (via an online learning platform) that is specifically tailored to Korean American (KA) church leaders. The structure of this curriculum was based on the results of a needs assessment survey from late 2021 (Kang et al., 2022) to better address the needs of KA church leaders serving in the field.

Cultural Consideration. The MHT Program incorporated Korean American culture and Christian beliefs. More specifically, the program is designed to educate and empower KA church leaders across several domains such as KA Christian mental health, KA youth, depression, anger management, suicidal ideation, and self-care in a manner that is culturally specific to Korean Americans. First, we provided the materials (e.g., slide decks) and programs in both Korean and English throughout the implementation: 1) needs assessment and program evaluation survey in both Korean and English, 2) videos with English speakers and Korean subtitles, 3) slide decks and graphics in both Korean and English, and 4) small group discussions held both in Korean and English. Further, cultural specificity was achieved by having 1) Korean American presenters, and 2) content developed with Korean Americans in mind (e.g., information on KAs, and examples of other KAs), and 3) collaboration and iterative feedback process with community stakeholders (e.g., clergies, Korean American mental health professionals).

In addition to the didactic presentations, this 7-week program also incorporated synchronous discussion groups. These discussion groups were facilitated by KA mental health professionals who are fluent in English as well as those fluent in Korean. The mental health professionals received two sessions of one-hour training before they started facilitation. Participants were able to choose their discussion group based on their preferred language and preferred times. During the weekly discussion groups, the church leaders participated in a range of activities such as role plays, case studies, and discussions. In the spirit of the training program, facilitators modeled some of the principles from the curriculum, such as creating a safe space to encourage vulnerability, focusing on practical steps and resources, and fostering a sense of community among participants.

Participants

MSG distributed flyers through email and social media channels to Korean American churches (both domestic and abroad) and by word-of-mouth. KA church leaders interested in the program were directed to an online platform where they were able to register for the program.

Across the first two cohorts (May 2022 for first cohort & July 2022 for second cohort), there were 84 KA church leaders who signed up and 83 KA church leaders who participated in the pre-survey (See Table 1). In order to participate, the participants had to be (a) 18 years old or older; (b) serving in a leadership role in a church; (c) regularly interacting with Korean American individuals. The participants were between 25 and 62 years old (M=42.26, SD=10.81), with more females (n=54; 65.07%) than males (n=29; 34.93%). The majority of church leaders identified themselves as 1.5 generation (39.2%) or 2nd generation (37.7%) immigrants. The largest proportion of participants (36.8%) served in leadership positions for 1-5 years, followed by 23.5% who served for 5-15 years and less than a year respectively. The smallest proportion of participants (16.2%) served for more than 16 years. The participants' leadership positions include pastor (n=13; 16.1%), assistant pastor (n=13; 16.1%) youth pastor (n=11; 13.58%), small group leader (n=9; 11.1%), deacon (n=12; 14.85%), elder (n=2; 2.47%), and other.

Those who registered for the program were asked to view the pre-recorded lectures online (asynchronously) each week (approximately 1 hour) prior to participating in the weekly discussion groups (1 hour). After small group sessions, participants submitted their weekly survey to share their experiences and provide feedback. They also received a survey prior to their first session and after graduating from the program. The last meeting was a virtual graduation celebration where all participants, MSG board and staff, MSG donors, and the program facilitators and contributors were invited.

Measures

MSG distributed pre- and post-program surveys and weekly feedback surveys to participants in order to examine the changes in their knowledge, attitudes, and confidence related to mental health issues before and after completing the program. All participants were asked to complete questionnaires in their preferred language (English or Korean). We examined the difference between the pre-test and post-test using independent sample t-tests and Cohen's d effect size. The results are summarized in Table 2 and Figure 1.

Characteristics	Total	Pre-course survey	Post-Course Survey	p-value
	N=130	N=81	N=49	
Cohort				0.82
Cohort 1	70 (53.85%)	43 (53.09%)	27 (55.10%)	
Cohort 2	60 (46.15%)	38 (46.91%)	22 (44.90%)	
Age	42.13 (11.07)	42.26 (10.81)	41.92 (11.59)	0.87
Gender				0.47
Male	48 (36.92%)	28 (34.57%)	20 (40.82%)	
Female	82 (63.08%)	53 (65.43%)	29 (59.18%)	
Immigrant Generation				0.99
1st gen immigrant	22 (16.92%)	13 (16.05%)	9 (18.37%)	
1.5 gen immigrant	51 (39.23%)	32 (39.51%)	19 (38.78%)	
2nd gen immigrant	49 (37.69%)	31 (38.27%)	18 (36.73%)	
3rd gen immigrant	2 (1.54%)	1 (1.23%)	1 (2.04%)	
Other	6 (4.62%)	4 (4.94%)	2 (4.08%)	
Language Preference (cohort 2)				0.96
Both	12 (9.23%)	7 (8.64%)	5 (10.20%)	
English	24 (18.46%)	16 (19.75%)	8 (16.33%)	
Korean	24 (18.46%)	15 (18.52%)	9 (18.37%)	
Church Denomination				0.95
Assemblies of God	11 (8.46%)	8 (9.88%)	3 (6.12%)	
Baptist	3 (2.31%)	2 (2.47%)	1 (2.04%)	
Evangelical Covenant Church	4 (3.08%)	2 (2.47%)	2 (4.08%)	
Full Gospel	8 (6.15%)	4 (4.94%)	4 (8.16%)	
Methodist	15 (11.54%)	10 (12.35%)	5 (10.20%)	
Non-denominational	17 (13.08%)	9 (11.11%)	8 (16.33%)	
Other	1 (0.77%)	1 (1.23%)	0 (0.00%)	
Presbyterian	47 (36.15%)	30 (37.04%)	17 (34.69%)	
United Methodist Church	24 (18.46%)	15 (18.52%)	9 (18.37%)	
Size of congregation				1.00
1 Less than 50	12 (9.23%)	7 (8.64%)	5 (10.20%)	
2 50-100 members	19 (14.62%)	12 (14.81%)	7 (14.29%)	
3 100-200 members	24 (18.46%)	15 (18.52%)	9 (18.37%)	
4 200-500 members	25 (19.23%)	15 (18.52%)	10 (20.41%)	
5 500-999 members	35 (26.92%)	22 (27.16%)	13 (26.53%)	
6 Larger than 1000	12 (9.23%)	8 (9.88%)	4 (8.16%)	
Missing	3 (2.31%)	2 (2.47%)	1 (2.04%)	
Type of serving ministry				
Missions Ministry	11 (8.46%)	8 (9.88%)	3 (6.12%)	0.46
Children's Ministry	32 (24.62%)	20 (24.69%)	12 (24.49%)	0.98
Youth Ministry	47 (36.15%)	29 (35.80%)	18 (36.73%)	0.91

Table 1. Demographics

Characteristics	Total	Pre-course survey	Post-Course Survey	p-value
Korean Ministry	31 (23.85%)	20 (24.69%)	11 (22.45%)	0.77
English Ministry	56 (43.08%)	35 (43.21%)	21 (42.86%)	0.97
Other	24 (18.46%)	16 (19.75%)	8 (16.33%)	0.63
Type of Leadership Role				
Pastor	18 (13.85%)	13 (16.05%)	5 (10.20%)	0.35
Assistant Pastor	26 (20.00%)	13 (16.05%)	13 (26.53%)	0.15
Youth Pastor	19 (14.62%)	11 (13.58%)	8 (16.33%)	0.67
Deacon	18 (13.85%)	12 (14.81%)	6 (12.24%)	0.68
Elder	4 (3.08%)	2 (2.47%)	2 (4.08%)	0.61
Teacher	27 (20.77%)	17 (20.99%)	10 (20.41%)	0.94
Small Group Leader	16 (12.31%)	9 (11.11%)	7 (14.29%)	0.59
Other	30 (23.08%)	21 (25.93%)	9 (18.37%)	0.32
Length of serving position				0.83
1 Less than a year	24 (18.46%)	16 (19.75%)	8 (16.33%)	
2 1-5 years	44 (33.85%)	25 (30.86%)	19 (38.78%)	
3 5-15 years	45 (34.62%)	29 (35.80%)	16 (32.65%)	
4 More than 16 years	17 (13.08%)	11 (13.58%)	6 (12.24%)	

Table 1. Demographics

Results and Interpretation

The research committee reviewed the responses of the pre- and post-evaluation surveys from the first and second cohorts, with the objective of identifying 1) a change in the participants' knowledge in mental health and 2) a change in the participants' level of action to address mental health issues. The surveys included both 5-point Likert scale (i.e., 1 - Strongly disagree, 5 - Strongly agree) and short answer questions. A total of 81 participants completed the pre-evaluation survey and 49 participants completed the post-evaluation survey. In order to identify the pattern, the questions were grouped into three categories that indicate the participants' mental health awareness (knowledge, 4 questions), level of taking action to address mental health issues (action, 5 questions), and level of confidence about addressing mental health related issues (confidence, 8 questions). All three domains show the high level of reliability evidenced by Cronbach's alpha, with knowledge at 0.74, action at 0.79, and confidence at 0.92.

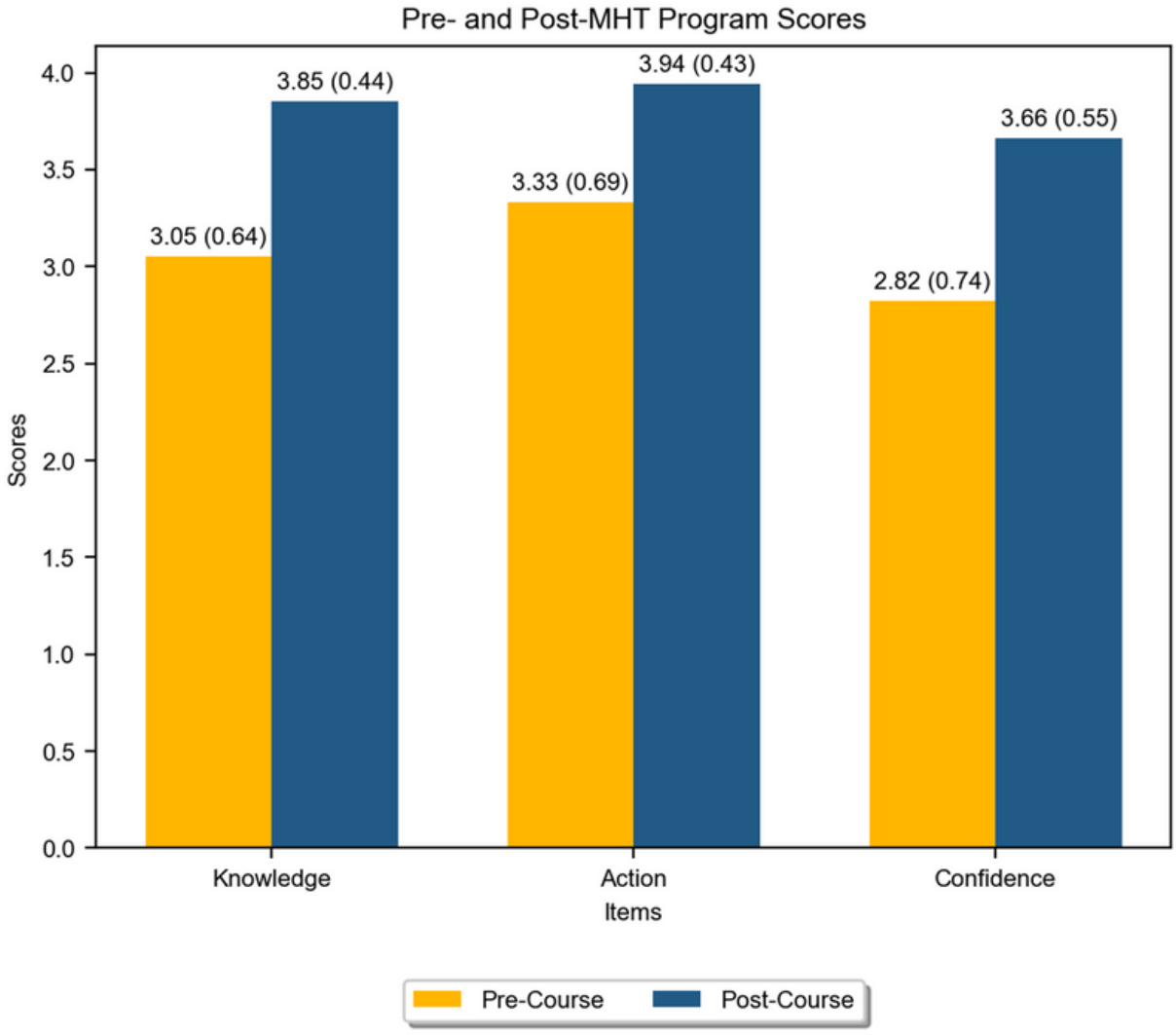

Figure 1. Comparison of Means between Pre- and Post-MHT Program

Knowledge

The knowledge category consists of 5-point Likert scale questions on participants' mental health literacy status. These questions ask participants to indicate their level of agreement with statements that relate to their knowledge of mental health, such as "I understand what a mentally healthy church looks like" or "I know whom to refer youth and families to when they are struggling with mental health issues." Responses ranged from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). The survey results indicated that there was a general increase in the participants' knowledge of mental health within the Korean American community, after participating in the MHT Program. The mean for knowledge increased from 3.05 to 3.85 ($t=-7.68$, $p<.0001$). Prior to the MHT Program, around 50.6% of the

participants (*n*=41) agreed or strongly agreed with the statement, "*I have knowledge about mental health issues.*" Strikingly, after completing the program, about 85.7% of participants (*n*=42) who also completed the post-survey agreed or strongly agreed with the statement. This suggests that not only do participants have greater knowledge about mental health issues, but a large majority of participants endorsed that they have greater knowledge.

Action

Besides the participants' overall mental health knowledge, we also observed a rise in their willingness to take action when addressing mental health issues. The action category includes 5-point Likert scale questions on participants' level of taking action to tackle mental health issues and prioritize their own mental health. Example statements include "*I can effectively communicate the significance of mental health within the church*" or "*I regularly take care of my own mental health.*" The average score for action rose from 3.33 to 3.94, indicating the participants' increased level of action (t=-5.51, p<0.0001). For example, prior to the program, around 39.5% of the participants (*n*=32) agreed or strongly agreed with the statement "*I am adequately equipped to address mental health issues in my church.*" After completing the MHT Program, 69.4% of participants (*n*=34) responded that they agreed or strongly agreed. These results indicate that church leaders have acquired skills to implement change within their communities, rather than just obtaining information.

Confidence

The confidence category includes 5-point Likert scale questions on participants' level of confidence in addressing specific mental health related issues. The statements include "*I feel confident about addressing the following issues*" on 8 topics: Marital Conflict, Family Conflict, Mental Health of Korean American Youth, Anger Management, Depression, Suicide/Self-Harm, Stigma, and Confidentiality. Overall, the results suggest that there are statistically significant differences between pre-test and post-test for all categories of confidence. Specifically, the mean scores for the pre-test were lower than the mean scores for the post-tests, with t-values ranging from -3.14 to -6.87 and p-values less than 0.001. Among statements, we found the most sharp increase in depression (pre-test m=2.69, post-test m=3.73) and confidentiality (pre-test m=2.84, post-test m=3.86). Thus, in addition to obtaining knowledge and acquiring skills to take action, the participants are feeling

more confident to make change in their communities. Though confidence is a subjective and personal experience, it is a good predictor of actual steps that will be taken.

Effectiveness of Training

We assessed the effectiveness of the training program by analyzing responses from participants who completed a post-training survey (n=41). This analysis aimed to identify changes at the individual level that occurred as a result of the training. The findings indicate that the training had a notably positive influence on participants' knowledge (β=0.732, p<0.0001), their actions (β=0.610, p<0.0001), and their confidence (β=0.886, p<0.0001). Importantly, these effects remained significant even when accounting for factors such as age, gender, and immigrant generation. Additionally, we observed that older participants experienced a greater increase in their actions (β=0.015, p<0.05) following the training. On the other hand, female participants showed a decrease in the magnitude of the effect on both their actions (β=-0.271, p<0.05) and their confidence (β=-0.313, p<0.05) compared to male participants.

Satisfaction

According to the post-training survey, the finding suggests a high-level of satisfaction. all participants agreed that they learned useful tools from the training that will help their ministry. Furthermore, 48 participants (96.96%) would recommend this training to other church leaders.

Conclusion

Korean American church leaders experience culturally unique mental health challenges that require tailored attention. While church leaders are often sought out as first responders to mental health challenges in the Korean American community, they often struggle to provide support due to limited resources and knowledge. To address those challenges, Mustard Seed Generation (MSG) developed a 7-week mental health training program customized to the specific mental health needs of Korean American church leaders. We collected survey responses from the program participants before and after the program to gain insight into their overall experience with the training and to test the MHT Program's effectiveness.

Our results demonstrated substantial growth among church leaders in terms of mental health awareness, level of taking action to address mental health issues, and confidence in handling mental health-related matters within the church context after participating in MSG's Mental Health Training Program. Additionally, program participants reported high satisfaction with the training. The learning outcomes indicate that the culturally tailored MHT Program may effectively contribute to transforming the discourse of mental health within the Korean American community.

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