INTRODUCTION

We will start this introduction by substantiating this volume’s basic assumption: the necessity of attention to faith and worldview in mental health care. We will do this by making connections with the results of research in the area of ‘religious coping’, carried out in the United States. After this, we will briefly indicate the findings of our own research in this area in the Netherlands. Our research was focused, on the one hand, on the position that, according to clients, faith and worldview have in their coping with their mental health problems; on the other hand, on the position that therapists assign to this dimension in the treatment process. In the subsequent chapters of this volume, these data will be further elaborated. We will continue this introduction with some conclusions about the research results’ significance for mental health care, and we will finish with a preview of the chapters of this volume.

1. Religious coping

In the psychology of religion, the study of the relationship between religion and mental health has always been a main theme. Already at the discipline’s inception at the end of the nineteenth century, James (1994/1902) explored the boundaries between, on the one hand, profound religious and mystical experiences and, on the other hand, psychopathology, whilst Leuba (1896) and Starbuck (1899) were concerned with the significance of conversion experiences for the converts’ mental health. In Chapter 1 of this volume we will consider at length the complex relationship that exists between the phenomena of religion and mental health. In the last few decades, this relationship has been studied in particular within the ‘religious coping’ paradigm, that has been formulated most comprehensively by the American psychologist of religion Kenneth Pargament (1997; see also Harrison 2001). In this line of research, a bridge is being built from theory to
the practice of physical and mental health care. Many studies are concerned with the significance of religion for coping with physical and mental health problems in people admitted to a general or psychiatric hospital. Within this approach, religion is portrayed as a positive force in conquering physical and mental adversities.

Let us first consider the ‘coping’ aspect of ‘religious coping’. Research on coping has flourished in particular with the rise of cognitive psychology, within which coping processes are seen as a form of information processing, in which the individual is not being directed by structural personality characteristics, but engages in a dynamic interaction with the environment. Lazarus & Folkman (1984) have developed the most elaborate theory. They define ‘stress’ as follows, “Psychological stress is a particular relationship between person and environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her well-being”. Hence, stress is not an automatic response of the individual to a stimulus, but is the consequence of a process in which the cognitive appraisal and assessment of the stressor play an important role. It will be obvious that people differ in the extent to which they experience stress with the same stressor. This ‘cognitive appraisal’ is a mental process in which a differentiation can be made between ‘primary appraisal’ and ‘secondary appraisal’. ‘Primary appraisal’ refers to the question whether a situation or event counts as a threat to the individual’s well-being. ‘Secondary appraisal’, on the other hand, relates to the assessment of the resources that a person has for meeting the requirements of the situation or event. These resources are diverse: material (money, shelter, food, transport), physical (health, vitality), psychological (insight, motivation, knowledge, emotional skills), social (the extent of social support, social networks) and religious (e.g. closeness to God, embeddedness in a religious community).

After these cognitive appraisals, the individual makes efforts to manage the situation, i.e. the actual coping. Coping is “a cognitive and behavioral effort to master, tolerate, or reduce external and internal demands and conflicts among them” (Folkman & Lazarus 1980). According to Folkman & Lazarus (1980), a differentiation has to be made between two forms of coping, viz. ‘emotion-focused’ coping (refers to control of the emotional response to the stressor) and ‘problem-focused’ coping (aiming at solving the problem by modifying the situation or by changing one’s own behaviour). Some also use here the terms ‘palliative and instrumental coping’. Although problem-focused
coping (e.g. gathering information or seeking help) used to be seen as the more effective form of coping, the assumption nowadays is that the effectiveness of coping behaviour largely depends on the possibility of taking action in a certain situation. As such, effective coping in an unchangeable situation means that no problem-solving behaviour will take place, but that emotion regulating work will be done. In this context, Pargament (1997) referred to the following prayer, “God, grant me serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference”. The elderly in particular use emotion regulating strategies, because they have fewer of the physical, social and economic resources that are necessary for action-oriented coping, because they more often consider situations to be unchangeable, and because they are more often confronted with experiences of loss (loss of work, health, friends and loved ones). An important question regarding these coping activities is: why do they arise, what are their fundamental motivations? This concerns the functions of coping behaviour. A very important motive is, of course, the need to solve the problem, but in emotion-focused coping the point is also the maintenance of our psychological equilibrium. In this context, we want to mention three motives: the need for control regarding the arrangement of one’s own life; the need for meaningmaking; and the need for maintaining or enhancing one’s sense of self-respect. Finally, much attention is paid in the coping literature to the effects of the coping process, at the physical, the psychosocial and the existential levels.

Let us now turn to the religious aspect of religious coping. Here, we rely in particular on Pargament’s (1997) book *The Psychology of Religion and Coping*. According to this investigator, religious coping focuses on ‘the search for significance’. In coping too the intentionality of human action finds expression. This relates to maximising central values, and not to a rapid reduction of the tensions connected with stress. Coping not only results in the removal of the stressor, but also in the coper’s growth (accumulation of significance). In the coping process, this ‘search for significance’ can be filled in in two ways: either old values will be retained and emphasised (‘conservation of significance’), or new values will emerge (‘transformation of significance’). Often, religious coping will only occur where non-religious coping fails. In particular in situations of loss of life, health or relational embeddedness, religious coping often will be one of the last remaining emotion-focused coping strategies. Are there situations that
are pre-eminently managed in a religious way? This usually refers to profoundly influential life events, to boundary situations for which there are no satisfactory inner-worldly explanations. Also situations that injure the sense of justice often lead to religious emotion management. Within religious coping, a differentiation can be made between individual and social/institutional religious coping, i.e. on the one hand, private religious acts or, on the other hand, church attendance or asking a pastor for help (institutional). In the latter case, the religious dimension is closely linked with obtaining social support. Social support is a very important variable in religious coping research. To illustrate the extent of the occurrence of religious coping, we refer to an investigation by Tepper et al. (2001) about the degree to which people with long-standing psychological complaints used religious coping behaviour. 80% of their Los Angeles respondents indicated that their faith or their devotional activities contributed to their coping with their symptoms, difficulties and frustrations.

Research on religious coping has also been considering the effects of religious coping on the respondents’ physical, psychological, social and spiritual well-being. In this way, it connects with a research line that exists already since a long time in the psychology of religion, regarding the link between religion and mental health. Research has been carried out into the effects of religious coping upon origin and course of depression in the elderly; psychiatric patients’ managing of psychosocial problems; dealing with being a victim of the Oklahoma bombing; caring for a chronically ill child; dealing with losing a relative through suicide; dealing with a renal transplant; students’ dealing with relational problems; dealing with cancer; managing the loss of a child through cot death; dealing with parents’ divorce; loss of employment; coming to terms with the Gulf War; etc. In general, the effects are positive. Recent reviews (Harrison 2001; Matthews et al. 1998) conclude that the greater part of published empirical data shows that religious coping has a favourable influence on dealing with mental and physical illness. Daaleman has summarised the possibilities of religion as follows: “through social integration and support; through the establishment of personal relationships with a divine order; through the provision of systems of meaning and existential coherence, and through the promotion of more specific patterns of religious organization and personal lifestyle” (Daaleman 1999, 220). In keeping with this, this predominantly American research argues that neglecting faith and religion in physical and mental health care, leaves
an important source of health promotion unused.

Finally, we have to note that the coping paradigm emphasises that religion’s positive effects on well-being usually only occur when the individual’s general religiosity can be transformed into concrete religious coping activities with respect to the stressor. Religious coping mediates between general religiosity and well-being. This is the so-called ‘stress-buffering model’, which contrasts with the ‘main-effect model’ in which religion, broadly speaking, results in an existence with more well-being, also when separate from its influence on the coping process.

2. Religious coping in Dutch mental health care

The above mentioned positive findings originate mainly from research in the United States. It is a well-known fact that the American population is more religious than the population in the more secularised Netherlands. Moreover, much research is carried out by researchers with a manifestly positive regard for, in particular, the Jewish-Christian tradition. This implies that their findings cannot be automatically transposed to the Netherlands (see chapters 6 and 7 in this volume). We will now briefly describe some important results from our own research in the past ten years, which we carried out among clients and therapists in community and residential mental health care in the Netherlands (this research is reported comprehensively in chapters 2, 3 and 5 in this volume). When we survey the client data, it is clear that for 39% (community) to 54% (residential) of people with mental health problems faith and worldview contribute positively to their coping with their problems. In particular for hospitalised elderly patients, faith and worldview are an important source of coping with regard to their psychosocial problems. We have drawn here the following conclusion: “Patients who are hospitalised in institutions experience their life situation as relatively unchangeable. They lack coping resources focused at problem-solving. For that reason, they revert to coping resources focused at emotionally managing their problems. One of the most important emotion-focused coping resources is religion” (Pieper & Van Uden 2001, 39). However, faith and worldview can also have a negative influence. This was mentioned by 36% of community and 16% of residential patients.

The above data show that also in the Dutch situation, attention to
faith and worldview for many patients can contribute to an improvement of their life situation. Positive influences can be supported and negative influences can be tempered. In order for faith and worldview to attain a place in the treatment process, psychotherapists will have to have knowledge of and concern for faith and worldview. Our 1996 research among therapists (see chapter 3 in this volume) can provide some insight regarding this issue. On the subject of their faith/worldview background, we can infer the following. Compared to the average Dutch citizen, therapists believe less in God, attend church less often, believe less in the existence of a transcendent reality, and less often have religious experiences. With respect to the relationship between faith/worldview and psychosocial problems, therapists think that such a relationship exists in only about 18% of clients. They see equally often positive and negative influences of faith/worldview on the problems. Negative influence is, according to the therapists, particularly connected with guilt problems, sexual problems and depression. Positive influence is, according to them, in particular connected with the healthy effects of religious rituals upon the processing of experiences of loss. When faith and worldview aspects are playing a role, most therapists state that they will address them. At the same time, a majority (two thirds) of them thinks that they do not have sufficient skills to treat these aspects adequately; connected with this, 46% indicate a need for further training. They hardly use specific religious therapeutic techniques. Contacts with clergy/chaplains are sparse; through-referrals to them occur in only 1% of cases. There is ambivalence regarding enhancement of these contacts.

Clients provided us with additional data. How satisfied are they with the degree to which and the way in which therapists treated the faith and worldview aspects of their problems? Two-thirds of former clients show satisfaction in their response to the question, “Did the Riagg [community mental health agency] offer sufficient opportunity to address the faith/worldview aspects of your problems?” One client states, “My therapist was open to my worldview and respected me regarding this issue. She herself didn’t have the same belief as I did, and she frankly admitted that she didn’t know whether my thinking in this respect was right or wrong. But she did use my worldview in her therapy with me!” About 60% of respondents is satisfied in response to the question, “Does the therapist usually understand what you mean when talking about faith/worldview questions?” Yet, at the same time, only one third is satisfied with the way in which their treatment con-
nected with the faith/worldview aspects of their problems. In one cli-
ent’s words, “I could tell how I dealt with my faith problems. But I
didn’t get an answer. She herself didn’t know faith, much to my re-
gret.” It appears that therapists are able and willing to listen with re-
gard to faith and worldview, but that in their treatments they find it
harder to take adequate initiatives in this area.

3. Conclusions

To start with, based on the above we can draw a number of conclu-
sions about the significance of faith and worldview for coping with
psychosocial problems. Coping research in the United States indicates
primarily a positive effect of faith and worldview, and hence recom-
mends that structurally space is secured to faith and worldview in
treatment. Our own research among community and residential pa-
tients in the Netherlands also showed that faith and worldview support
between 39% (community) and 54% (residential) of them in emotion-
ally coping with their problems. However, we also found faith to have
a negative influence, in particular in community patients. This means
that therapists should have sufficient knowledge of and concern with
faith and worldview. However, many therapists feel that they lack
skills in this area, and almost half of them indicate a need for addi-
tional training. The clients’ opinions point in the same direction: ther-
apists are able and willing to listen to their faith/worldview narra-
tives, but lack the skills for making adequate treatment interventions
in this area. Clients often also indicate the therapists’ inadequate
knowledge regarding religious beliefs and practices (the case study in
chapter 4 will show the very complexity of treatment in this area).

All these conclusions taken together justify the recommendation
that the faith/worldview dimension should get a more prominent place
in treatment than is presently the case, in order to guarantee quality
treatment for clients having faith/worldview aspects in their problems.
To this end, additional training for professionals in mental health care
is a necessary interim step. In our research among therapists, it be-
came manifest that about half of them indicated a wish for more train-
ing in the area of faith and worldview. As a start, we have begun to
develop, and to pilot in several places, a so called problem-oriented
training module in “Clinical Psychology of Religion”. We will present
this training model in the final chapter (chapter 8) of this volume.
4. Preview

Finally, we will present a synopsis of the following chapters in this volume.

In the first chapter we give an overview of the complex relationship between mental health and religion. We start with a discussion of the concept of mental health. Next we present five ways in which mental health and religion are connected: religion as therapy, suppression of deviant behaviour by religious socialization, religion as a haven, religion as an expression of mental disorder and religion as a hazard to mental health. These different connections will be illustrated by several cases from the literature and clinical work. Briefly formulated, religion can hinder as well as promote mental health. The chapter ends with a critical methodological discussion on how to explain some of these contradictory connections.

Because of the lack of empirical evidence, in 1992 we started a research project among community mental health care patients in the Netherlands, the results of which are presented in chapter 2. How do patients evaluate their treatment? In order to get an answer, we questioned about 425 former clients of the Heerlen Riagg (a community mental health agency situated in a mainly Roman Catholic region in the Netherlands) and about 330 former clients of the Zwolle Riagg (situated in a highly Protestant region in the Netherlands). The questions addressed three main areas. Firstly, we asked about the ways in which religion and worldview are related to mental health problems: is there any relation, and if so, is this a positive or a negative one? Secondly, we asked about the ways in which therapists had reacted to these religious and worldview dimensions: had they been dealt with as relevant to therapy or had they been avoided? Thirdly, we asked some questions about the former clients’ wishes and needs regarding the roles religious and worldview dimensions should play in therapy.

In the third chapter we concentrate on the results from an investigation among Riagg therapists, but we also refer to some results obtained from Gliagg therapists (therapists working in a community mental health agency with a more explicit religious signature). This is done in order to clarify in which ways Riagg therapists differ from Gliagg therapists in managing religious aspects of their clients’ problems. The investigation started with an overview of the religious backgrounds and religious practices of the therapists. Some equations with average Dutch citizens are made. The next part of the study deals
with psychotherapists’ perceptions of religious issues connected with psychosocial problems. How often in their opinion is there a relationship, and what kind of relationship is at issue? The third part of the study considers the way in which psychotherapists treat these religious issues. Do they attend to them and what kinds of religious interventions are used? Special attention is given to the amount of contacts with clergy/chaplaincy. We conclude that religion should be given a more pronounced place in general mental health care and that Riaag psychotherapists in particular should become better equipped to deal with religious issues.

In the next chapter (chapter 4) the case history of a patient with an obsessive-compulsive disorder is presented. We show how important it is to look at the religious frame of reference of a patient and how this can be managed in psychotherapeutic treatment. The case is positioned within the theoretical perspective of symbolic interactionism. Through this case we want to show how complex the role of religion is in the individual’s psyche. Even in an a-religious (often even anti-religious) psychotherapeutic approach like cognitive behaviour therapy, attention paid to religion and meaning can be of great importance. Challenging negative religious cognitions and offering more positive ones leads to psychotherapeutic progress. In general, the training of counsellors and psychotherapists leaves hardly any room for paying attention to this dimension of existence.

Some results of a study among two samples of psychiatric patients in mental hospitals in the Netherlands are presented in chapter 5. We focus on the following issues:

- the religious and spiritual beliefs and activities of the inpatients;
- their religious coping activities, measured using Pargament’s three coping styles and a positive religious coping scale;
- the influence of religious coping on psychological and existential well-being;
- the predictive value of general religiousness, as compared with religious coping activities, regarding psychological and existential well-being.

For these populations of inpatients, religion had a positive influence on their ways of dealing with problems; religious coping was positively correlated with existential and psychological well-being. General religiousness as well as religious coping were positively correlated with existential well-being, whereas psychological well-being primarily was predicted by positive religious coping. We discuss the
results in the context of theoretical notions of religious coping, addressing in particular the positive influence of religious beliefs, relying on God, religious activities and religious social support in times of psychological and existential crisis.

The chapter “When I find myself in times of trouble…” (chapter 6) reports on our attempts to use Pargament’s three religious problem-solving styles in the Netherlands, on the problems we have met and on the alternative scale we have tried to develop: the Receptivity Scale. The main problem with Pargament’s threefold conceptualisation of religious coping (self-directing, deferring and collaborative) is the underlying view of an active, personal God. This ignores the idea of a more impersonal God, which is probably more common in the secularised Netherlands. The Receptivity Scale does justice to this more impersonal view of God. Furthermore, the scale takes into account that people are not always directly focused on the solution of problems, either with or without God. A receptive attitude might allow them to be open to what they cannot control. Confronted with a problematic situation, people can be open to what might be in store for them. The scale we present consists of three items in which no reference is made to a specific interpretation of a transcendent reality. The items are about trust, finding deeper meaning, about receptivity, and enlightenment. The scale yielded some interesting results, but we came to the conclusion that it was too brief and that more items should be added.

The chapter “Bridge over troubled water” (chapter 7) presents a more definitive version of our so-called Receptivity Scale. This version was administered to two populations in Belgium and two in the Netherlands. We examine the precise meaning of this scale by comparing the respondents’ scores on the scale with their scores on other measures of religiosity and other psychological measures. We also compare the scores of theology students with the scores of psychology students on the scale. In this way, we obtain more insight in the validity of the scale. In our investigation among 77 psychology students and 36 theology students, we relate the results of our Receptivity Scale to the results of Pargament’s coping scales, to a Basic Trust Scale and to an Anxiety Scale. Our research showed that the Receptivity Scale consisted of two subscales: one referring indirectly to an agent who helps coping with problems, and another one referring to an attitude of trust without feeling helped by an agent. ‘Receptive-agent’ relates positively to religiosity and to the deferring and collaborative
coping styles in which the person feels helped by God. It is negatively related to the self-directing scale. ‘Receptive-no agent’, however, is not significantly related to any of the scales mentioned. It is positively related to basic trust and to commitment to the transcendent. We conclude that this coping style is less clearly religious in the traditional sense of a belief in God than ‘receptive-agent’, but still it differs from basic trust in its positive relationship with a conception of transcendence. We come to the conclusion that between the basic attitudes of trust on the one hand and trust in a personal God on the other hand, there are different degrees of relating to the transcendent in times of trouble. ‘Receptive-agent’ comes closer to belief in God; ‘receptive-no agent’ comes closer to, but is not the same as, basic trust in general.

In the final chapter (chapter 8) we present part of a course in “Clinical Psychology of Religion” that has been developed in the Netherlands with the aim of introducing mental health professionals into the field of the clinical psychology of religion. Clinical psychology of religion aims at applying insights from the general psychology of religion to the field of clinical psychology. Clinical psychology of religion can be defined as that part of the psychology of religion that deals with the relationship between religion, worldview and mental health. Like the clinical psychologist, the clinical psychologist of religion deals with psychological assessment and psychotherapy, but concentrates on the role religion or worldview play in mental health problems. This course uses a special teaching method: Problem Oriented Education. In our research we have found that there is substantial need among psychotherapists to become better equipped in this area. Hence, this course could fill a gap.

In summary

This volume consists of eight previously published papers on the topics of religion, coping, and mental health care. The papers cover a broad territory: the complex relationships between religion and mental health, surveys that present the views of therapists and patients about the interface between religion and mental health, a case study of a religious patient struggling with psychological problems, empirical studies of religious coping among various groups, and a method for teaching the clinical psychology of religion. Although the papers are di-
verse, they are unified by several themes. First, the papers convey a balanced approach to religion and psychology. They address the potentially positive and negative contributions religion can make to health and well-being. Second, several of the papers focus on the role of religious coping among patients in the Netherlands. This focus is noteworthy, since the large majority of this kind of theory and research has been limited to the United States. Third, they underscore the value of a cross-cultural approach to the field. The surveys point to the importance of religious/worldview perspectives to many patients (and therapists) in the Netherlands, even though Dutch culture is more secularised than the United States. However, the papers also suggest that the manifestation of these religious/worldview perspectives may take different shape in the Netherlands. For example, we identify another form of religious coping based on the notion of “receptiveness” that does not rest on beliefs in a personally active God. Fourth, the papers have clinical relevance. The case history of the obsessive-compulsive patient contains an example of the way in which religious resources can be accessed to counteract dysfunctional behaviours.

References


