Knockin' on Heaven's Door

Religious and Receptive Coping in Mental Health

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Introduction

When I find myself in times of trouble
Mother Mary comes to me
Speaking words of wisdom
Let it be

And in my hour of darkness
She is standing right in front of me
Speaking words of wisdom
Let it be

Let it be, let it be
Let it be, let it be
Whisper words of wisdom
Let it be

And when the broken hearted people
Living in the world agree
There will be an answer
Let it be

For though they may be parted, there is
Still a chance that they will see
There will be an answer, let it be.

Let it be, let it be
Let it be, let it be
There will be an answer
Let it be

Let it be, let it be
Let it be, let it be
Whisper words of wisdom
Let it be

And when the night is cloudy
There is still a light that shines on me
Shine until tomorrow
Let it be

I wake up to the sound of music
Mother Mary comes to me
Speaking words of wisdom
Let it be

The Beatles: *Let it be*

The above Beatles lyric perfectly illustrates how religious ('Mother Mary') and receptive ('let it be') coping styles can be salutary in times of trouble.

1. Religious and receptive coping

The present volume is to be regarded as a successor to our book *Religion and Coping in Mental Health Care* (Pieper & Van Uden 2005). In the present one, we report on the results of subsequent research regarding religious and receptive coping in mental health, which was carried out in line with the earlier volume. Further topics that we will deal with in this book are: well-being, narcissism, prayer, mature religiosity and ritual counseling. In particular, we report on our attempts to use Pargament's three religious problem-solving styles in the Netherlands, on the problems we have faced and on the additional scale we have tried to develop: the Receptivity Scale.

In the years since the publication of our 2005 book, further developments have occurred in the area of religious coping, and this book should be read against the background of these developments. Pargament's (1997) understanding of religious coping is situated within the Judaeo-Christian tradition, in which a personal relationship with God has a central position. Recent research has shown that the measuring instruments used appear to be compatible also with the beliefs of the third great monotheist religion: Islam (Ai et al. 2003; Khan & Watson 2006; Aflakseir & Coleman 2009; Braam et al. 2010). In Dutch society, however, there is, alongside secularization, also an upsurge of unattached (Kronjee & Lampert 2006) or new spirituality (Meester 2008; De

Hart 2011). This implies that religious coping has to be understood in a broader sense and has to include spiritual coping. The following examples show how this could happen. Ahmadi (2006) interviewed 51 Swedish cancer patients. Pargament's coping scales were a good instrument for analyzing part of the subjects' narratives. However, several subjects did not turn towards a personal God, but towards a 'sacred spring'. And there were still other coping styles that could only be understood in the context of Swedish culture. Ahmadi mentions being connected with one's spiritual self, sanctification of nature, meaningmaking, meditation, listening to spiritual music, positive evaluation of solitude, healing, etc. Baldacchino & Draper (2001) conducted a literature review regarding nursing research into patients' spiritual coping strategies. Apart from religious coping strategies they also found more spiritual ones, like being connected with one's self, being connected with others, experiencing nature, experiencing art, hope, helping others, etc. Alma, Pieper & Van Uden (2003) and Van Uden Pieper & Alma (2004) too have signposted the limited applicability of Pargament's measuring instruments in the secularized Netherlands (see Chapter 1 in the present book). In order to complement this, they have developed the Receptive Coping Scale, in which Pargament's active, personal God image is abandoned. This scale measures an attitude of trust, in which people are open to answers falling to them in times of crisis. No explicit references are made to something or someone, e.g. God, providing these answers. The scale contains 8 coping process descriptions, e.g. 'When I have problems, I trust that a solution will be presented to me'. The scale does not only measure an immanent attitude of basic trust. Correlations with a scale measuring orientation towards the transcendent are, after all, high (Van Uden et al., 2004). Furthermore, theology students scored higher on this scale than psychology students. The idea behind this scale is derived from Fortmann (1974), who defines mental health as the ability to develop oneself as well as to lose oneself.

A different kind of complement to Pargament is provided by the anthropologist Kwilecki (2004). She argues that present-day coping research has neglected two forms of religious coping: magical rituals and particular religious experiences. For Kwilecki, magic is not an inferior form of religiosity. Magic ritualizes human's optimism, puts trust above doubt. Magic is timeless. Present-day manifestations are: short prayers, amulets, sacred stones, wicca, satanism, etc. In this context, we can also mention the appeal of so-called 'paramarkets' (Jespers 2007). Two par-

ticular forms of religious experiences are described by Kwilecki as coping strategies. Near-death experiences are reported by 5% of Americans. They have a positive effect on the lives of those who go through them: less anxiety, more love, and more zest for life. Van Lommel (2007) too, in his bestseller *Eindeloos bewustzijn* (Consciousness without End), reports similar effects. Making contact with the deceased and with spirits ('after death communication') is another way of coping, orientated towards processing experiences of loss. TV programs on this subject are proof of its popularity. In addition to this, Ahmadi appeals for more attention for the unconscious course of religious coping. This in contrast with the idea of religious coping as a process of making rational choices. William James (1902) has already highlighted the unconscious roots of the conversion process. In a recently completed doctoral dissertation research regarding religious coping in lung cancer patients, Körver (2013) has developed a new measuring instrument, going from the above line of reasoning: the Spiritual-Magical Coping List. Items from this list are e.g., 'I experience contact with the departed' and 'I'm wearing bracelets or medals having special powers'.

Finally, complements are also pursued going from a narrative approach (Folkman & Moskowitz 2004). Coping, and hence also religious coping, is interwoven with telling the story of one's life. Analyzing these stories can retrieve ways of coping not occurring in standard questionnaires. In the Netherlands, Ganzevoort (1998) has already drawn attention to this.

2. Conclusion

Religious coping is one of the research areas within psychology of religion that is also reflected in general psychology. For instance, in the recently published handbook on 'stress, health and coping' (edited by Folkman, 2011), room has been made for religious coping. This is the result of Pargament's efforts in particular. For this recognition of religious coping to take place in other than Anglo-Saxon countries also, religious coping research will have to accustom to other cultural conditions. In the Netherlands, secularization, the 'new spirituality', and the multicultural society will have to be taken into account. The latter aspect implies, on the one hand, that new measuring instruments have to be developed, but, on the other hand, that Pargament's measuring instru-

ments continue to be valid for certain groups within Dutch society (e.g. for traditionally committed Christians).

Furthermore, religious coping research would gain in relevance if the effects of positive and negative coping could be made more transparent from a theoretical point of view. In our view, attribution theory and attachment theory (see also Granquist 2005) appear to be fruitful theories for this. Attribution theory might even be able to build a bridge towards theology, via the notion of 'theodicy'. The soothing effects of ritual behavior could be explained through current insights from the neurosciences.

Finally, there are also implications for spiritual care. We start by again emphasizing our basic assumption: the necessity of attention to religious coping in mental healthcare. People *keep on knockin' on heaven's door*. Although the role of institutionalized religion is declining in Western society, religion remains a substantive factor in human life, especially in times of trouble. For healthcare insurers, contributing to the improvement of clients' (religious) coping is an important legitimation for funding hospital and community spiritual care (Hopman 2006). Furthermore, insights gained from religious coping research will have to be embedded in healthcare chaplains' training. It is, for instance, important to know that 'spiritual distress' can have a considerably negative impact on clients' well-being. It is also useful to know that not only the affective bond with God, but also more popular ritual devotions, are an important component of clients' coping repertoires. In this respect, establishing an 'expertise center for religious coping' might be beneficial. There could be a surplus value in combining the research efforts that are now undertaken separately in several universities in the Netherlands.

3. Preview

The first chapter, *Bridges over troubled water. Coping, religious coping and the Receptive Coping Scale*, presents the definitive version of our so-called Receptivity Scale. The Receptivity Scale does justice to a more impersonal view of God. Furthermore, the scale takes into account that people are not always directly focusing 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 situa-

tion, people can be open to what might be in store for them. This scale 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 it still differs from basic trust in its positive relationship with some concept 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 second chapter, *Unchain my heart. Religious coping and well-being in a forensic psychiatric institution*, we present some results of a study among patients in a forensic psychiatric hospital in the Netherlands. We focused on the following issues: the patients' general religious beliefs and activities; the patients' religious coping activities; the patients' well-being; the relationships between general religious beliefs and activities, religious coping activities, receptive coping and well-being. We compared the results among this population with some results of our earlier research in various other psychiatric settings. In this research we also used the Receptivity Scale. The receptive coping style is, as stated earlier, divided into two separate factors: 'receptive-agent' and 'receptive-no agent'. The items of the first factor ('receptive-agent')

refer to an active agent who is present and who reveals, presents and shows something. The formulations make it possible to imagine this agent as a more or less personal God. The items of the second factor ('receptive-no agent') seem to refer to opening oneself to fate or cosmic laws. The agent is absent and something reveals itself. Our respondents have more faith in an undefined cosmic power than in a more or less personal god figure. Finally, it becomes clear that the influence of all modes of religious coping on well-being (existential and psychological) work through the route of negative religious coping. Hence, the negative aspects of religion have a stronger impact than the positive ones.

In the third chapter, *Whenever God shines his light on me. Religious coping in healthcare institutions*, we present an overview of data collected in institutional settings in the Netherlands in order to make visible the significance of religious coping in these settings. These settings, i.e. general psychiatry (two institutions), forensic psychiatry (from Chapter 2) and nursing homes, are institutions in which patients with different religious backgrounds and different problems are hospitalized. The research questions are: a) to what extent do patients use religious coping activities in dealing with their problems? b) what are the effects of religious coping activities on well-being in these groups of patients? For the populations of inpatients in these institutions, religion was found to be an important resource for coping with their problems. Seventy-four per cent of respondents in the nursing homes reported a positive influence. The studies in the two general psychiatric settings also showed that there was a positive influence, be it somewhat less pronounced (54%). Even in the forensic hospital, the score for positive influence was 50%. The scores for negative influence were low: 16% in the general psychiatric settings, 8% in the forensic hospital and only 4% in the nursing homes. The positive influence often seemed to be translated into an increased well-being: anxiety decreased and existential well-being increased. However, when the negative influence of religion was included in the analyses, it became clear that this negative influence determined well-being to a far greater extent.

Chapter four, *Religious and receptive coping. Importance for the well-being of Christian outpatients and parishioners*, presents the results of a study among two groups of religious people in the Netherlands, one consisting of Christian outpatients and one consisting of parishioners. 165 outpatients and 171 parishioners responded. In this chapter we focus on the following main questions: 1. To what degree did these two

groups of Christians (with and without psychological treatment) practice positive and negative religious coping and to what degree receptive coping? 2. What were the relationships between these three ways of coping? 3. To what degree were positive religious, negative religious and receptive coping activities related to the respondents' (with and without psychological treatment) well-being? 4. What were the best predictors of well-being: positive religious, negative religious or receptive coping? The results showed that positive, negative and receptive coping were independent predictors of well-being. Negative religious coping was the best predictor of well-being.

In chapter five, *Religious and non-religious coping among cancer patients*, we present the results from a pilot study that was conducted at the outpatient clinic of the Department of Medical Oncology of Radboud University Nijmegen Medical Centre. The goal was to draw up an inventory of religious and non-religious coping strategies of patients with a life threatening disease such as cancer. Current research focuses on various forms of coping. An often neglected coping strategy is religious coping. Research in this field so far was conducted mostly in the USA. When it comes to religion and worldview, the Netherlands differ from the USA in important respects. In this chapter, we explore religious coping in the context of Dutch society.

Chapter six *Ritual counseling and religious coping processes in cancer patients*, gives more details on the project presented in Chapter five. Here we deal with the religious and ritual counseling options for cancer patients. In this pilot study, we have chosen to offer patients a new format of brief pastoral care. This brief pastoral care has a directive character and takes the patient's worldview as its starting point. It is brief: it takes up only two sessions. And it focuses on ritual, creative and/or imaginative dimensions. We have called this Ritual Counseling. Two research questions were formulated. The first one was: Which religious and non-religious coping strategies can be differentiated in people with a life-threatening illness like cancer?' (see Chapter 5 in this book). The second question was: What is the effect of brief pastoral care on the coping processes of people with a life-threatening illness like cancer? The present chapter deals with this second question. The purpose of the intervention was to activate and encourage the religious coping process. The intervention could take several forms: for example, reading a religious text, discussing a piece of literature or art, listening to a piece of music, implementing a goodbye ritual, etc. The intervention had to acti-

vate the patient's world of religious imagination and representation. We found that a positive effect could be noted in half of the cases that we assessed. In one case, a negative effect could be noted. In the remaining cases, there was no measurable effect in this first pilot study. It appears to be a promising method for offering realistic support within a limited timeframe.

Chapter seven, *Praying and coping. The relation between varieties of praying and religious coping styles*, reports on a study focusing on different varieties of prayer in relation to different coping styles. A total of 337 Dutch and Flemish respondents answered a questionnaire containing Pargament's Religious Coping Scale, the Receptivity Coping Scale of Alma, Pieper and Van Uden (2003), and a Dutch prayer inventory. Three types of prayer were distinguished: religious, petitionary and meditative prayer. The first two are typically traditional, involving a classical image of a personal God, while the third one is modern, focusing on the self rather than on God. This is a distinction that applies more or less to Pargament's three coping styles as well as to the Receptivity Scale. Pargament's religious coping styles, i.e. the collaborative and the deferring coping styles, assume the presence of an active and personal God, a view lacking in the receptive coping styles. Based on this resemblance, an analysis was made of the relationships between coping styles and the varieties of prayer, which showed the following: (1) a relationship was found between religious prayer and the collaborative and deferring coping styles, (2) a relationship was also found between meditative prayer and the receptive coping styles, and (3) no relationship was found between petitionary prayer and the deferring style.

Chapter eight, *I just believe in me. Narcissism and religious coping*, reports on a study of the relationship between narcissism, as an important personality trait in individualistic societies, and religious styles of coping. We distinguished between two dimensions of narcissism: overt and covert narcissism, and four different styles of religious coping: self-directing, collaborative, deferring and receptive. The study was carried out by inviting 116 students to complete questionnaires about narcissism and religious coping. It revealed a positive correlation between covert narcissism and the collaborative, deferring and receptive styles of religious coping, and a negative correlation between covert narcissism and the self-directing style. Overt narcissism had a positive correlation only with the receptive style. The significance of the relationships between narcissism and styles of religious coping is discussed in detail.

Chapter nine *Still knockin' on heaven's door. Narcissism and prayer*, reports on a study of the relationship between narcissism and different varieties of prayer. We distinguished between two kinds of narcissism (overt and covert), and four types of prayer (petitionary, religious, meditative and psychological). The study was carried out by inviting 99 students to complete questionnaires about narcissism and prayer. It revealed a positive correlation between covert narcissism and petitionary and religious prayer. Overt narcissism correlated positively with meditative and psychological prayer. The study discusses in detail the significance of the relationships between narcissism and varieties of prayer.

Chapter ten, *Mature Religiosity Scale. Validity of a new questionnaire*, reports on a validation study of a new questionnaire, the Mature Religiosity Scale (MRS). The questionnaire was presented to a sample of 336 subjects, 171 of which were parishioners and 165 outpatients of Christian mental health clinics. A first version of this questionnaire was designed by studying both psychiatric/psychological and theological literature. Validity and reliability were explored by including other questionnaires, among them the Spiritual Well-Being Scale (SWBS), the Duke Religion Index, the Religious Coping List (RCOPE), the Receptive Coping Scale and the State-trait Anxiety Inventory (STAI). The results indicate that 16 items of the 19-item questionnaire make up one factor with good internal consistency, which is measured by Cronbach's alpha. This factor was used as the Mature Religiosity Scale in this study. Correlations with other validated scales and with characteristics of known groups showed evidence that this scale has good validity. The Mature Religiosity Scale is suitable for use in both mental healthcare and pastoral care. It is designed and validated for these two groups, giving direction to professional communication about faith and the meaning of life.

Finally, we want to emphasize that the present book is the result of contributions that have already been published in various scientific journals. We have maintained as much as possible the existing structures of these original contributions. Because of this, a certain amount of repetition has been unavoidable in some chapters; however, this enables the reader to read the various chapters on their own.

We hope that our book will make the reader enthusiastic about research into religious and receptive coping. The references to various pop songs in the chapter titles might also encourage other ways of being receptive: 'Listen to the Music…'.