God imagery and affective outcomes in a spiritually integrative inpatient program

Joseph M. Currier\textsuperscript{a,⁎}, Joshua D. Foster\textsuperscript{a}, Alexis D. Abernethy\textsuperscript{b}, Charlotte V.O. Witvliet\textsuperscript{c}, Lindsey M. Root Luna\textsuperscript{c}, Katharine M. Putman\textsuperscript{d}, Sarah A. Schnitker\textsuperscript{c}, Karl VanHarr\textsuperscript{e}, Janet Carter\textsuperscript{e}

\textsuperscript{a} University of South Alabama, Psychology Department, Mobile, AL 36688, USA
\textsuperscript{b} Fuller Theological Seminary, Graduate School of Psychology, Pasadena, CA, USA
\textsuperscript{c} Hope College, Psychology Department, Holland, MI, USA
\textsuperscript{d} Department of Graduate Psychology, Azusa Pacific University, Azusa, CA, USA
\textsuperscript{e} Pine Rest Christian Mental Health Services, Grand Rapids, MI, USA

\textbf{A B S T R A C T}

Religion and/or spirituality (R/S) can play a vital, multifaceted role in mental health. While beliefs about God represent the core of many psychiatric patients’ meaning systems, research has not examined how internalized images of the divine might contribute to outcomes in treatment programs/settings that emphasize multicultural sensitivity with R/S. Drawing on a combination of qualitative and quantitative information with a religiously heterogeneous sample of 241 adults who completed a spiritually integrative inpatient program over a two-year period, this study tested direct/indirect associations between imagery of how God views oneself, religious comforts and strains, and affective outcomes (positive and negative). When accounting for patients’ demographic and religious backgrounds, structural equation modeling results revealed: (1) overall effects for God imagery at pre-treatment on post-treatment levels of both positive and negative affect; and (2) religious comforts and strains fully mediated these links. Secondary analyses also revealed that patients’ generally experienced reductions in negative emotion in God imagery over the course of their admission. These findings support attachment models of the R/S-mental health link and suggest that religious comforts and strains represent distinct pathways to positive and negative domains of affect for psychiatric patients with varying experiences of God.

1. Introduction

An extensive body of research has illuminated the complex interplay between mental health and religion and/or spirituality (R/S; e.g., Koenig et al., 2012). Despite a tenuous history in the behavioral sciences, there is consensus that mental health professionals need to develop competence in addressing R/S in their work (Saunders et al., 2010; Vieten et al., 2013). From a multicultural standpoint, R/S is a meaningful component of human diversity that shapes relationships and emotions, along with the most sacred beliefs of many persons (for review, see Park (2014), Whitley (2012)). Findings from the Gallop Poll (2014) and Pew Research Center (2014) indicated that one half of persons in the US endorse religion as being very important and/or attend a religious service at least monthly. While the proportion of people who endorse ties to traditional religious groups has been steadily decreasing, nearly 90% of the US general population nonetheless report a belief in God (Gallop Poll, 2014; Pew Research Center, 2014). Patients seeking psychiatric care can espouse a range of views regarding the divine, including benevolent and loving, punitive and cruel, or disinterested and distant from human affairs (Exline et al., 2015; Johnson et al., 2015; Silton et al., 2014). Understanding the affective consequences of such God images may clarify intervention targets of spiritually integrative approaches with patients who are drawing on their faith systems in adaptive and maladaptive ways.

Consistent with a generally positive relationship between adaptive aspects of R/S and mental and physical health (Koenig et al., 2012),
research has demonstrated associations between beliefs about God and mental health. For example, studies with college students in the US found that construing God in loving terms (e.g., supportive, nurturing, and protective) was linked with more positive mood (Wiegand and Weiss, 2006) and less depressive symptomatology (Wood et al., 2010). Similarly, people who view God as being benevolent and engaged in human affairs have reported greater happiness, less anxiety and less depressive symptomatology (Silton et al., 2014; Rosmarin et al., 2009a, 2009b). In contrast, researchers have found a direct relationship between belief in a cruel deity and forms of psychopathology (Burker et al., 2005; Exline et al., 2011; Silton et al., 2014). This study addresses several possible limitations in this emerging body of work. First, researchers have primarily utilized cross-sectional designs. Second, God imagery has not been thoroughly studied in psychiatric settings. Third, researchers have relied on adjective checklists and other brief quantitative assessments that potentially restrict the richness of participants’ beliefs about God. Finally, consistent with a crucial distinction between concepts vs. images of God (Davis et al., 2013), research has focused on “head knowledge” (i.e., God concepts), which is largely propositional in nature (e.g., theological beliefs about God’s traits). By contrast, the more affect-laden “heart knowledge” (i.e., God images), relevant to how patients may experience God in times of acute distress, has been largely absent from empirical research.

Drawing on attachment-based models of the R/S-mental health link (for review, see Granqvist and Kirkpatrick (2013)), God images broadly refer to internalized working models of a divine attachment figure (e.g., Allah, Buddha, Jesus Christ) and experience of self in the context of relationship with this deity (Davis et al., 2013). In contrast to relationships that develop via repeated physical interaction with perceptible individuals via input from sensory systems (e.g., touch, vision), Davis et al. (2013) suggest that God images are best viewed as representations of symbolic attachment figures that are internalized via implicit, emotional, and incidental learning. Moreover, like other types of internalized representations (Baldwin, 1992), Davis et al. (2013) argue that God images might be activated in the presence of intrapersonal triggers (e.g., mood, cognition) as well as situational factors (e.g., environmental features, presence of certain people). Given the variety of attachment figures—both positive and negative—the resulting God images may also cover a broad range of affective states. In fact, research suggests that these relational and emotional schemas of God function similarly to other attachment relationships in times of acute distress (Granqvist and Kirkpatrick, 2013; Johnson et al., 2015). From a clinical standpoint, these notions might explain why certain people derive comfort from their faith systems when seeking psychiatric care whereas others experience their relationship with a divine attachment figure as an additional source of emotional strain.

Inter-related lines of inquiry have underscored a variety of pathways by which R/S can provide resources for mental health as well as hinder recovery in the context of psychiatric care (for reviews, see Ano and Vasconcelles (2005), Park and Slattery (2014)). Adaptive dimensions of R/S may inform beliefs/behaviors that provide a sense of grace and peace in times of distress (e.g., forgiveness, belonging with others, feeling protected from harm). However, struggles with R/S (e.g., feeling abandoned by God, questioning God’s love, or feeling punished by God) have been linked with greater risk for a variety of psychiatric disorders (for review, see Exline (2013)). Findings from an initial study from this dataset aligned with these opposing patterns (Abernethy et al., 2016). Namely, drawing on Exline et al.’s (2000) measurement approach, R/S comforts and strains were each concurrently linked with severity of patients’ depressive symptomatology in these anticipated directions. In addition, patients’ ability to derive comfort from R/S at pre-treatment uniquely predicted less depression at the discharge assessment. These results indicated that patients who derived comfort from their faith systems at the time of their admissions fared better in this spiritually integrative treatment program. In contrast, whether focusing on adaptive or maladaptive aspects of R/S, baseline depression was not predictive of R/S comforts or strains at discharge in the same manner.

The primary goal of this mixed method study was to expand upon these findings by examining a model whereby R/S comforts and strains serve as intervening pathways between patients’ God images and affective outcomes. Contemporary models suggest that positive and negative affect are not opposite ends of a single continuum but represent distinct domains with varying predictors and health-related correlates (e.g., Fredrickson, 2001; Salovey et al., 2000); therefore, they could each be similarly linked with different dimensions of R/S in the context of psychiatric care. However, these distinctions have not been thoroughly examined with respect to R/S and emotional functioning in treatment-seeking samples. Drawing on qualitative responses to an open-ended item regarding how patients experience themselves in relationship with a divine attachment figure, these two hypotheses were tested:

1) Patients with higher levels of adaptive God imagery at baseline would endorse greater positive affect at discharge; R/S comforts would partly account for this positive association.
2) Patients with lower levels of adaptive God imagery at the start of treatment would report more negative affect at discharge; R/S strains would partially explain this inverse relationship.

Secondary aims of this paper were to explore changes in patients’ God imagery related to oneself over the course of this spiritually integrative program. Addressing these aims will inform future research and offer support to clinicians in addressing adaptive and maladaptive forms of God imagery that might affect responses to mental health treatment.

2. Method

2.1. Sample description

This study focused on 241 patients who completed an acute psychiatric hospitalization with Pine Rest Christian Mental Health Services, a non-profit behavioral health center that is centralized in Grand Rapids, Michigan. Ranging from outpatient treatment options to partial and acute hospitalization programs, this large center provides therapeutic services in behavioral health to persons of varying ages across a continuum of care. This sample was recruited from six inpatient units at the Grand Rapids location between 2013 and 2015. Designed for adults with acute psychiatric problems or severe mental illness who require safety monitoring and crisis stabilization, these units provide short-term psychotherapeutic and medical care via a multi-disciplinary team of professionals. The average length of stay in the sample was 7.19 days (SD = 3.89). Besides medication management, participants resided in a therapeutic setting, participated in individual and group-based interventions (e.g., supportive psychotherapy), and received an individualized plan for transition to a less intensive level of care at discharge. While the center specializes in spiritually integrative mental health care from within a Christian framework and also offers a non-religious spiritually-focused group, these units provide services to persons of all spiritual backgrounds and are accredited by the Joint Commission on Accreditation of Healthcare Organizations and Commission on Accreditation of Rehabilitation Facilities. Table 1 outlines demographic and diagnostic characteristics of the present sample.

2.2. Procedures

Inclusion was restricted to patients who were at least 18 years of age and not presenting active psychotic symptoms, cognitive impairments, or other concerns that might interfere with the ability to provide valid data on measures that provide the basis for this study. All participants completed assessments within 48 h of admission and again at discharge. Specifically, after a patient was identified as a potential participant, a
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