Factors influencing the relationship between the level of religiousness and religious care needs: The role of religious comfort, religious strain and the belief that religion plays a role in psychological problems

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Abstract

Religion is important to religious individuals and previous research shows beneficial effects of integrating religion in treatment. However, not all religious individuals experience a need to address religious aspects in their treatment. This study was conducted to investigate which variables predict the needs to address religious issues in care. It was hypothesized that the level of religiousness predicts the religious care needs. Furthermore, it was hypothesized that religious comfort, religious strain and the belief that religion plays a role in psychological problems do predict religious care needs. Moreover, it was hypothesized that those three predictors would moderate the relationship between level of religiousness and religious care needs. Participants (N = 117) were recruited in two mental health clinics, i.e., a Christian mental health clinic (N = 77) and a regular mental health care hospital (N = 40). The hypotheses were tested using correlation analysis and three moderation analyses. The results showed that the level of religiousness, religious strain, and the belief that religion plays a role in psychological problems all predict the religious care needs directly. In contrast with the predictions, religious comfort did not predict the religious care needs. Moreover, religious comfort, religious strain and the belief that religion plays a role in psychological problems did not affect the relationship between level of religiousness and religious care needs. For future research, it is recommended to investigate more possible variables that might predict the religious care needs.

Keywords: religiousness, comfort, strain, religious care needs, mental health care

Introduction

Approximately 50 percent of the Dutch population is part of a religious denomination (Centraal Bureau voor de Statistiek, 2016). Besides religious people who are institutionalized, 17 percent of the Dutch population describes themselves as believing without belonging, referring to religious people who do not belong to a religious denomination (Bernts & Berghuijs, 2016). When talking about these different forms of religion, it becomes clear that religion can be defined in several ways. The definitions about religion in the literature are diverse and inconsistent, which makes religion hard to define (Baumsteiger & Chenneville, 2015). Nowadays, it corresponds a lot with the definition of spirituality. However, religiousness is seen as institutional, while spirituality is characterized as personal and subjective (Zinnbauer et al., 1997). In the context of this study, religion is defined as the self-reported belief of an individual in a God, without the necessity to adhere to a church or other religious institution.

Since religion plays an import role in people's lives (Park, 2005), about 30 percent of religious individuals tries to find religious help first (Chadda, Agarwal, Singh, & Raheja, 2001). In a religious sample, approximately 55 percent preferred to discuss religious issues in therapy (Rose, Westefeld, & Ansley, 2001). In a study among older adults, 82 percent believed that discussing religious issues in treatment was important (Stanley et al., 2011). Several studies examined the effects of adding religious aspects into treatment. Some studies, like Paukert et al. (2009) showed that integrating religion into treatment could have beneficial effects for religious individuals in terms of decreased rates in anxiety and depression. Similar results were found in a recent meta-analysis of Goncalves, Lucchetti, Menezes, and Vallada (2015), which manifested the beneficial effects of religious interventions in the reduction of clinical symptoms, in particular anxiety. An older study of Propst, Ostrom, Watkins, Dean, and Mashburn (1992) reported a stronger reduction in depression, improvement in social adjustment, and general symptomatology when religious individuals received Religious Cognitive Therapy (RCT), compared to individuals who received standard Cognitive Behavioral Therapy (CBT). However, there are some studies which show comparable effects for both treatments. Koenig, Pearce, Nelson, and Daher (2015) compared Religious Cognitive Behavioral Therapy (RCBT) versus Standard Cognitive Behavioral Therapy (SCBT) and found that both treatments were equally effective for Major Depression Disorder (MDD) and chronic medical illness. However, when religious care needs are not met in treatment, there is an increased risk for depressive symptoms (Pearce, Coan, Herndon, Koenig, and Abernethy, 2012).

Given the importance of providing care consistent with religious needs, it is important to identify individuals that would benefit by including religion in their therapy (Fitchett et al., 2004). First of all, religiosity is positively associated with the need for addressing religious issues in therapy (Exline, Yali, & Sanderson, 2000; Propst et al., 1992; Stanley et al., 2011). Especially, when religious people see their problems as religiously involved, they tend to use their religion to understand the suffering (Pargament, 2001). This is confirmed by a qualitative study, in which is found that the stronger religious people think that their religion is related to their disorder, the more they want their religion to be integrated in therapy (van Nieuw Amerongen-Meeuse, in press). However, approximately 18 percent, did not want religion involved in therapy (Rose et al., 2001). The main reason for this was that religious issues were not related to current problems.

Another factor that might influence the needs for religion in care is the way in which God is perceived. Since religion would usually include a relationship with God, religious people have several beliefs about the nature and attributes of God (Berkhof, 2007; Kirkpatrick, 1998). There are two main representations of God mentioned in the literature (Johnson, Cohen, & Okun, 2016; Pargament, 2011). The first representation is that God is a kind, loving, merciful, and benevolent God, the second is that God is a moralizing, punishing, and authoritarian figure. Those different representations can be a source of religious comfort or strain. The image of an authoritarian God can create a lot of stress for religious people. Conversely, the image of a loving God can create feelings of comfort. However, not only the different views of God can create comfort and strain, but religious life itself as well. Individuals can, for example, have disagreements about dogma, feel fear for the devil or have doubts about the existence of God. In most cases both comfort and strain play a role and some aspects of religion can create feelings of comfort, while others can create feelings of strain (Exline et al., 2000). However, not all forms of strain are destructive and a certain amount of strain is part of religious life (Exline et al., 2000). Still, especially individuals who experience religious strain, wanted to address those issues in their treatment. This might be understandable, while those issues can threaten an individual's deepest values, like thoughts and feelings (Pargament, 2011). Addressing those issues in therapy can lead to comprehension of the suffering. On the other hand, religious individuals who experience religious comfort might use their religion as a coping mechanism for psychological problems in treatment (Koenig, 2009; Park, 2005; Pieper, van Uden, van Uden, 2005).

Summarizing, there are several studies indicating that religious individuals could benefit from adding religious components to their treatment or from discussing religious issues (Propst

et al., 1992). Braam, Beekman, and van Tilburg (2003) suggested that therapists should address religious issues more often during treatment. However, some patients might not want to have religious aspects in treatment. Therefore, it is important to identify the individuals with needs for religious care, to match the needs with the provided care (Stein, Kolidas, & Moadel, 2015). Most studies about this topic have been done in America among Christian samples, and it is not clear what characterizes patients who would like to address their religion in treatment. Furthermore, some studies stress the importance to match client characteristics with the involvement of religion in treatment. So, it might be important to examine what kind of religious people in the Netherlands would prefer aspects of religion to be involved in their therapy. This study tries to give more insight in possible variables that predict the religious care needs in religious individuals. In addition, these variables might be taken into account when treating religious people in the future.

The present study

This study aims to examine the role of several variables in predicting the patients' needs of integrating religion in treatment, namely the level of religiousness, the level of religious comfort, religious strain, the belief that religion plays a role in psychological problems, and their interaction. First, it is hypothesized that a higher level of religiousness in individuals predicts a higher amount of religious care needs in mental health care (Exline et al., 2000; Propst et al., 1992; van Nieuw Amerongen-Meeuse, in press). Second, it is expected that the belief that religion plays a role in psychological problems predict a higher level of religious care needs. Third, it is hypothesized that the link between level of religiousness and religious care needs is stronger when individuals assume that their religion plays a role in their problems. On the other hand, it is hypothesized that there will be no effect when individuals do not perceive their problems related to their religion (Rose et al., 2001). Fourth, it is expected that the level of religious comfort has a positive influence on religious care needs. Individuals who find comfort in their religion might want to involve it in their treatment (Exline et al., 2000; van Nieuw Amerongen-Meeuse, in press), since their religion might be a way to cope with their problems (Koenig, 2009; Park, 2005; Pieper et al., 2005). Fifth, it is hypothesized that religious comfort will moderate the relationship between level of religiousness and religious care needs. When individuals experience more religious comfort, it is expected that this strengthens the relationship between the level of religiousness and religious care needs, as individuals who experience comfort from their religion use it to understand their problems. In addition, it is expected that there will be no moderating effect, when there is little religious comfort, because

those individuals might not use their religion as a way of coping. Sixth, it is hypothesized that religious strain has a positive influence on religious care needs, since strain can induce mental distress that individuals want to address in treatment. In line with the article of Exline et al. (2000) the effect is expected to be higher for religious strain compared to comfort. Seventh, the studies of Exline et al. (2000) and van Nieuw Amerongen-Meeuse (in press) found that especially individuals who experience religious strain would address their issues in therapy. Therefore, it is hypothesized that the relationship between the level of religiousness and religious care needs is stronger when individuals experience high levels of religious strain than for individuals who experience low levels of religious strain (see Figure 1).

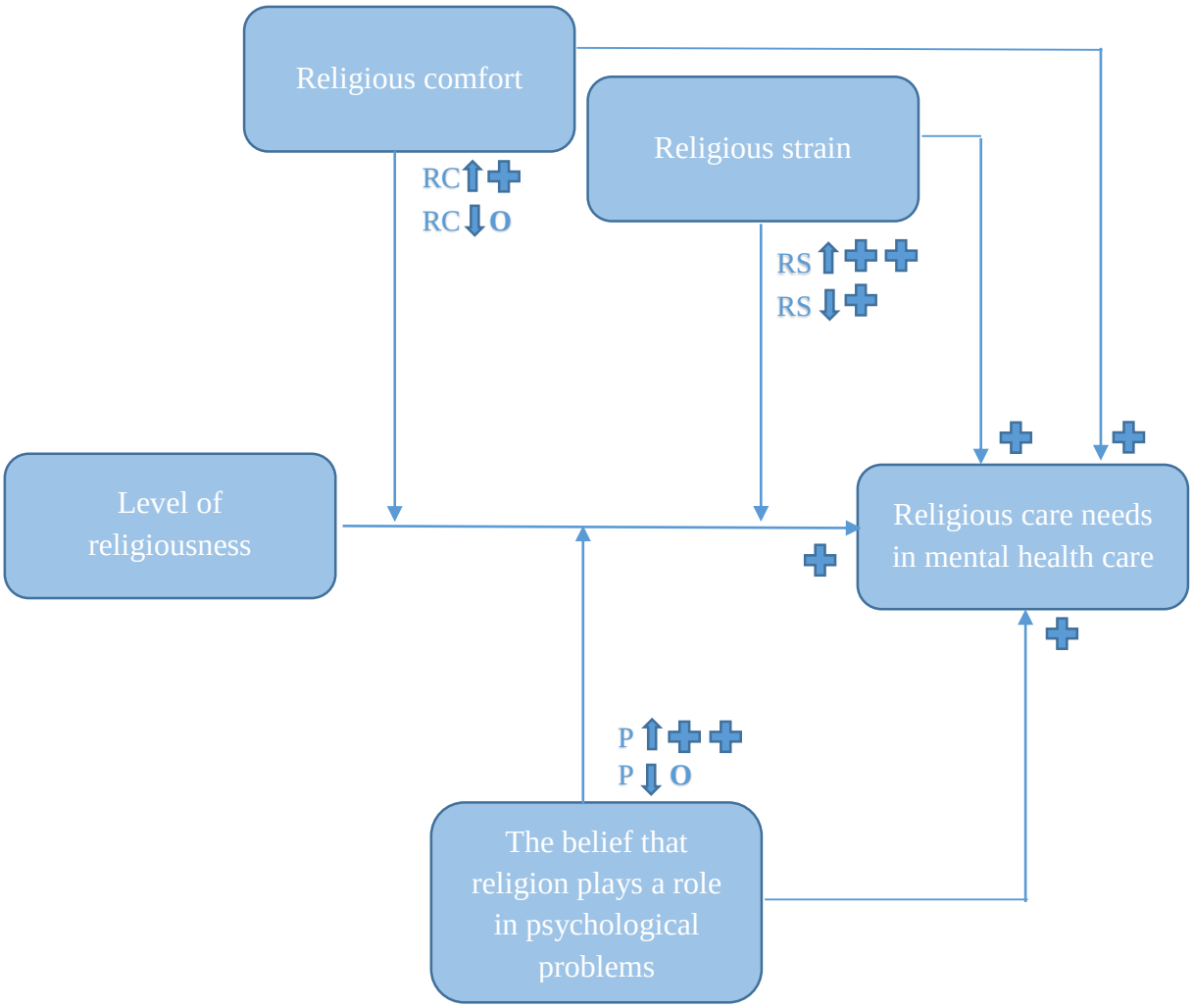

Figure 1. The hypothesized relationship between level of religiousness, religious comfort, religious strain, the belief that religion plays a role in psychological problems, and religious care needs.

Methods

Procedure and participants

Participants were recruited in two mental health clinics, where they received day treatment or clinical treatment, i.e., a Christian mental health clinic and a regular mental health care hospital. Mental health patients, who labeled themselves as religious, aged between 18 – 65, with all types of diagnoses, were included in the study. Patients with severe problems, such as mania or psychosis, and cognitive and intellectual impairments were excluded from this study. Requests for participation including information about the research were posted on message boards in all departments. Additionally, the researchers recruited patients by giving brief explanations about the study at the departments. In that way, people could directly sign up for the research. To enhance participation a patient incentive was provided.

Potential participants received an extra information letter containing information about the purpose of the study, the anonymity of the personal data, and the duration of the questionnaire. If they wanted to continue, they needed to sign an informed consent. By signing an informed consent, the participants declared that they understood the voluntary basis of the study, that they received enough information to participate, understood that the data would be confidential and the participation could be stopped any time. After signing, the participants got the paper-pencil questionnaire or a link via their e-mail, to fill in the questionnaire online. To maintain the anonymity of the participants, the participants received unique codes, which they had to fill in on the questionnaire. The questionnaire existed in total of 106 questions, as this study is part of a larger investigation concerning a religiosity gap and its relation to treatment alliance and compliance in mental health centers. However, for the current study not all measured variables were used.

The sample consisted of 117 patients (26 males, 91 females), 77 from the Christian mental health clinic and 40 from the regular mental health care hospital. Participants' age ranged from 19 to 68 years with a mean age of 41.55 years ($SD = 12.37$). Of these participants, 2.6% finished elementary school, 24.8% high school, 37.6% secondary vocational education, 26.5% higher professional education and 8.5% university. Regarding ethnicity, 99.1% of the participants were Dutch and 0.9% did not report their ethnicity. Most participants were raised with Christian faith (87.2%) and the majority still was member of a religious denomination (81.2%). From the ones who belong to a religious denomination, most participants were part of a certain form of Christian community (98.9%) and only one person was part of an Islam grouping (1.1%). The self-reported mental health problems were very diverse and most patients reported comorbid disorders. Depression (29.9%), bipolar mood disorder (12.0%), a personality

disorder (15.4%) and several kinds of anxiety disorders (6.8%) were mostly reported. Furthermore, 6.8% did not report their diagnosis. Around 70-80 percent of the participants agreed to participate. The non-response was due to a language-barrier or no interest in the study. Moreover, it was noticeable that mostly Muslims did not want to participate.

Measures

Level of religiousness. The level of religiosity was measured by two questions of the questionnaire 'God in Nederland' (Bernts & Berghuijs, 2016). This questionnaire was developed to get an impression of the alterations in religiousness through the years. The questions used from this questionnaire were: 'Are you religious?', with answer categories: 'yes', 'no' and 'I don't know'. Only the people who answered 'yes' were included in the study. The second question was: 'Does the belief have a meaning in your life, and if so, how important is that meaning?'. The answers were rated on a four-point scale ranging from 0=no, no meaning to 3=yes, considerable meaning. Higher scores indicated a higher level of religiousness.

Disorder related to religion. The belief that religion plays a role in psychological problems was based on a single item, namely 'Religion and/or spirituality plays a role in my mental health problems'. The participants could answer with 0=no or 1=yes.

Religious comfort and strain. The religious comfort and strain were assessed by the Religious Comfort and Strain Scale (RCSS; Exline et al., 2000). This twenty-item measurement consisted of seven items which measured religious comfort (e.g., 'The feeling that God is near') and thirteen items that measured the religious strain. The questions about religious strain can be divided into three subscales: Alienation from God (e.g., 'The feeling that God has left you'), Fear and Guilt (e.g., 'Fear of evil or the devil') and Religious Rifts (e.g., 'Disagreement with a family member or friend about religious matters'). The items were rated on a four-point scale ranging from 0=not at all, to 3=extremely. The first seven items were scored by using the average with higher scores indicating more religious comfort. The last thirteen items were scored by using the average with higher scores indicating more religious strain. The RCSS in the present sample had a Cronbach's alpha of .88 for religious comfort and .83 for religious strain.

Religious care needs. The religious care needs in mental health care was measured by the questionnaire that was based on a qualitative study (van Nieuw Amerongen-Meeuse, in press). The questionnaire consisted of thirteen questions. For the current study, seven questions that focused on the treatment by a mental health practitioner were used. Patients filled in to what extent they preferred e.g. 'Explanation about religion and/or spirituality and illness by the

therapist' and 'Therapist with a similar life vision'. The items were rated on a four-point scale ranging from 0=not at all to 3=very strong. Higher scores indicated more needs for religious care. The Cronbach's alpha of this questions in the present sample was .78.

Data analyses

Data analyses were performed with the 24th version of IBM SPSS Statistics. Firstly, descriptive statistics were computed and bivariate correlations between the variables were analyzed by Pearson correlations. Secondly, to test whether correlation coefficients between religious comfort and religious strain on religious care needs differed significantly, Meng, Rosenthal, and Rubin's (1992) method of comparing two dependent correlations was used. Thirdly, the hypotheses were tested by three single moderation analyses using the PROCESS tool of Andrew F. Hayes (Hayes, 2013). The level of religiousness was used as independent variable and religious care needs as dependent variable, whereas religious comfort, religious strain and the belief that religion plays a role in psychological problems were used as moderators. The coefficients were reported in the unstandardized form (b). Simple slopes were tested on the levels low (M – SD), moderate (M), and high (M + SD), when the interactions were significant.

Results

The correlation matrix and descriptive statistics of the study variables are presented in Table 1. Correlation analyses revealed that the level of religiousness, religious strain and the belief that religion plays a role in psychological problems, were positively related to religious care needs. Furthermore, the level of religiousness was positively and religious strain was negatively related to religious comfort. The level of religiousness and religious strain were both positively related to the belief that religion plays a role in psychological problems.

Table 1

Bivariate correlation coefficients between the level of religiousness, religious comfort, religious strain, belief that religion plays role, and religious care needs, Means, Standard Deviations, Minimum and Maximum (N = 117)

Variable	1	2	3	4	*M*	*SD*	Minimum	Maximum
1.Religiousness	-				2.26	0.79	1.00	3.00
2.Religious comfort	.49**	-			1.96	0.74	0.00	3.00
3.Religious strain	-.11	-.47**	-		1.24	0.60	0.00	2.77
4.Belief that religion plays role	.29**	.03	.20*	-	0.76	0.43	0.00	1.00
5. Religious care needs	.27**	.09	.40**	.31**	1.62	0.64	0.00	3.00

Note. *p < .05, **p < .01

Using Meng, Rosenthal, and Rubin's z, the correlation between the religious strain and religious care needs (.40) was significantly higher than the correlation between religious comfort and religious care needs (.09), $Z = 2.06$, $p = .04$.

Table 2 contains the unstandardized regression coefficients (b's) of the moderation analyses. The first moderation analysis, with the belief that religion plays a role in psychological problems as moderator, was significant, $R^2 = .15$, $F(3, 113) = 7.560$, $p < .001$. There was a significant, positive, direct effect of the belief that religion plays a role in psychological problems on religious care needs. The second moderation analysis, with religious comfort as moderator, was significant, $R^2 = .10$, $F(3, 113) = 3.566$, $p = .02$, however, there was only a significant, positive, direct effect of level of religiousness on religious care needs. The third moderation analysis, with religious strain as moderator, was significant, $R^2 = .26$, $F(3, 113) = 13.773$, $p < .001$. There was a significant, positive, direct effect of level of religiousness and religious strain on religious care needs. However, all three interactions between the level of religiousness and the moderators were not significant. Thus, the level of religiousness, religious strain and the belief that religion plays a role in psychological problems, predicted the religious care needs.

Table 2

Summary of the unstandardized regression coefficients (b's) from the moderation analyses for variables predicting religious care needs (N = 117)

	Moderators	Belief that religion plays role	Religious comfort	Religious strain
		b	b	b
Religiousness		.15[#]	.22*	.26***
Moderator		.30*	-.07	.47***
Religiousness*moderator		-.29	-.17	-.08

Note. [#]p < .1, *p < .05, **p < .01, ***p < .001

Discussion

The present study examined the relationship between religiousness and the needs to involve religion in treatment, and the role of religious comfort, religious strain, and the belief that religion plays a role in psychological problems on this relationship. The study was carried out among patients in two mental health clinics.

In general, the present findings confirm previous research partly. Firstly, the level of religiousness predicts the religious care needs. This is in line with previous research (Exline et al., 2000; Propst et al., 1992; van Nieuw Amerongen-Meeuse, in press). The more religious people are, the more they want their religion to be involved in therapy. Secondly, the belief that religion plays a role in psychological problems predicts the religious care needs directly. Thus, when religious individuals believe that their religion plays a role in their psychological problems, they have more needs for religious care. This is in line with previous research (Rose et al., 2001; van Nieuw Amerongen-Meeuse, in press). Thirdly, the results further showed, as expected and in line with previous research, religious strain appears to have a direct effect on religious care needs (Exline et al., 2000; van Nieuw Amerongen-Meeuse, in press). Therefore, individuals who experience more religious strain, are more willing to discuss religion in their treatment.

In contrast with previous research, religious comfort does not predict the religious care needs (Koenig, 2009; Park, 2005; Pieper et al., 2005). This indicates that religious individuals who experience more religious comfort do not have more religious care needs. This result may however be due to the high correlation with the level of religiousness. The high correlations cause an overlap in the variance, so they do not show a unique variance. On the other hand, the

results are in line with Exline et al. (2000) who stated that especially individuals who experience religious strain want to address this in treatment. Furthermore, same sorts of results are found in the article of Sherman, Simonton, Latif, Spohn, and Tricot (2005), who found stronger effects for negative religious coping than for positive religious coping in response to illness. The way in which they measured the constructs of coping does overlap with the current constructs of religious comfort and strain. This might indicate that religious strain has more impact than religious comfort when dealing with a psychological problem, and that therefore people who experience religious strain have more religious care needs than people who experience more religious comfort. Moreover, this study did not explicitly measure whether the individuals who experience comfort from their religion also use their religion as a coping mechanism. It might be possible that religious individuals experience religious comfort, but do not use it to cope with their psychological problems. This might explain why they do not have religious care needs. However, the current study does not confirm a relation between religious comfort and religious care needs.

Moreover, according to this study, religious comfort, religious strain, and the belief that religion plays a role in psychological problems do not affect the relationship between the level of religiousness and religious care needs. These findings can also be contributed to the high correlations between the level of religiousness and religious comfort and the belief that religion plays a role in psychological problems. However, this is not the case for religious strain. Therefore, there is insufficient proof to confirm these hypotheses by the current study.

Limitations and future research

Several limitations of this study need to be acknowledged. First of all, there is a measurement limitation. The question that measured the belief that religion plays a role in psychological problems, consisted of only two answer categories. This question made it impossible to distinguish between people who saw their problems highly related to their religion and patients who only saw a small relation. It might be possible that people do believe that their problems were related to religion, but only to a certain extent. Future research should use a questionnaire with a wider range of answers for the belief that religion plays a role in psychological problems.

Furthermore, during recruiting, it appeared that most Muslims did not want to participate to the current study. This could be due to a language barrier. However, questions can be raised whether those religious individuals have different religious care needs. This study consisted of mostly Christians, which is due to the Christian mental health clinic, as well as the

Christian background of the Dutch population (Knippenberg, 1992). However, it might still be possible that religious care needs differ between religions, which might make it difficult to generalize to other religions. Future research should try to get a more diverse population in terms of religion.

Another limitation is the high correlations between the independent variables. As mentioned above, those high correlations could be the cause of the non-significance of the hypotheses. The high correlations are partly understandable, as some individuals stated in the study of van Nieuw Amerongen-Meeuse (in press) that their religion was their fundament, or most important in their life. Most of these individuals also reported a relation between religion and their disorder.

There are several recommendations for future research. Firstly, it is important to find more predictors that predict the religious care needs. This might increase understanding of which client characteristics predict the religious care needs. For example, there might be a deeper look into whether religious individuals use their religion in a way of coping and what sort of coping. Pargament, Smith, Koenig, and Perez (1998) identified multiple sorts of positive and negative religious coping. Those kinds of coping may influence the religious care needs. Secondly, there could be looked at more personal characteristics, like gender or age. Thirdly, it might be interesting to see whether several disorders might be related to more needs of religious care. The relationship between religion and mental problems is especially investigated among depression, anxiety, suicide, psychotic disorders, and substance abuse (Koenig, 2009; Stanley et al., 2011). Probably religious individuals with these problems have more religious care needs than other disorders.

Conclusions

The present study provides a contribution to the current knowledge about the needs to have religious care in treatment. Despite the limitations, this study suggests that there are religious care needs for individuals that are more religious, individuals who experience strain from their religion and those who belief that religion plays a role in their psychological problems. It might be important to identify those individuals, as not meeting the religious care needs can be harmful (Pearce et al., 2012). This indicates that it might be important for health professionals to be aware of these needs. However, the literature speaks of a ‘religiosity gap’, referring to the distance between religiosity of a health professional and a client (Cox, 1994). This distance often causes that health care professionals are not mentioning religious issues during treatment. However, this study underlines the importance of the reduction of the

religiosity gap. The gap can be reduced in several ways. First of all, more training for a mental health professional about the influence religion can have on the life of religious individuals and the connection with their disorder is from importance. As patients who experience religious strain have more religious care needs, a brief screening protocol, like one developed by Fitchett and Risk (2009) can be used to identify patients who may be experiencing religious struggle. Further, when health professionals do not have enough knowledge about religious struggles, referral to a pastoral counselor is recommended.

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