

Religious Coping Styles and Recovery from Serious Mental Illnesses



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Recovery

- New concept in the mental health field
- Implies finding hope, satisfaction, and meaning in life despite the limitations imposed by mental illness
- Involves empowerment - taking responsibility and control over one's life, including mental health treatment
- Importance of non-professional support and involvement in non-traditional services to recovery



Religion and Mental Health

- Traditional attitudes towards religion by mental health professionals
 - Viewed as a symptom and contributor to psychopathology
 - Avoided at best, discouraged/pathologized at worst
- Current zeitgeist: growing attention to religious/spiritual issues in people's lives
 - Findings of positive associations between religion and physical and mental health outcomes



Role of Religion in Recovery

- Little empirical research on the subject
- Important ingredient of many consumers' recovery reported in qualitative studies and consumer narratives
- Commonly reported functions of religion:
 - Coping/problem-solving strategy
 - Social support
 - Meaning in the midst of tragedy and confusion



Religious Coping Styles

- Degree of responsibility and level of activity in problem-solving
- Collaborative, self-directing, deferring, and plead
 - “When it comes to deciding how to solve a problem, God and I work together as partners” (C).
 - “When faced with trouble, I deal with my feelings without God’s help” (S).
 - “When a troublesome issue arises, I leave it up to God to decide what it means for me” (D).
 - “When faced with difficulties, I plead with God to make things turn out okay” (P).



Religious Coping Styles

- Associations with psychosocial variables
 - Predictor of adjustment to negative events
- Consistently positive outcomes found only for collaborative style, others are mixed
- Controllability of situation is important in determining the effectiveness of a religious coping style.



Hypotheses

- 1. Higher religious salience and frequency of religious service attendance will relate to improved quality of life and fewer symptoms of distress.
- 2. Both religious salience and attendance will be negatively associated with amount of mental health service use.



Hypotheses

- 3. **Collaborative** and **Self-directing** religious coping styles will relate to a greater sense of empowerment and use of more active aspects of recovery.
- **Deferring** and **Plead** coping styles will predict a lower sense of empowerment and a more passive (traditional) approach to recovery.
- 4. **Collaborative** religious coping style will be associated with better quality of life and fewer symptoms of distress than the other styles.



Method: Participants

- 151 individuals with serious mental illnesses (508 certified)
- Mean age = 41.6, SD = 10.6
- 51% - female, 34% - minority
- Receiving services at a major case management agency in Hamilton County, OH



Method: Instruments

- Mini-Mental State Exam (MMSE)
- Probes for past/current religious delusions
- Demographic questionnaire
- Religious salience and attendance questions
- Short form of Religious Problem-Solving Scale (RPSS)



Method: Instruments

- Ohio Mental Health Outcomes Survey Adult Consumer Form
 - Symptom Distress
 - Quality of Life
 - Making Decisions Empowerment Scale
- Personal Vision of Recovery Questionnaire (PVRQ)
- Service utilization data from Hamilton County Community Mental Health Board



Method: Procedure

- PI and RA's approached consumers at the agencies and solicited their participation in the study.
- Consent and MMSE
 - If failed MMSE, were paid \$5
 - If completed the entire procedure, were paid \$20
- Permission to release diagnostic and service use information was obtained.



Results - general

- 95.4% reported belief in God/Higher Power
- High religious salience (mean=8.9 out of 12) and ~ bimonthly religious service attendance in the sample
- Positive correlations between religious salience & total PVRQ and Empowerment and between religious attendance and total PVRQ
- Low Cronbach alphas for subscales of Empowerment Scale & PVRQ
- Had to use total indices for Empowerment Scale & PVRQ
- Factor analysis of RPSS resulted in 3 correlated factors: Collaborative/Deferring, Self-directing, and Plead.



Results (cont.) - Hypotheses

- Hypothesis 1 was not supported
 - But positive association between religious salience & quality of life almost reached significance (Spearman $r=.15$, $p=.07$).
- Hypothesis 2 was not supported
 - No association between religious salience/attendance & service use
- Partial support for Hypothesis 3
 - **Collaborative/Deferring** style was related to higher PVRQ.
 - **Collaborative** religious coping style was significantly correlated with empowerment.
- Contrary to Hypothesis 3
 - **Plead** was related to higher involvement in recovery.
 - **Self-directing** style was associated with less involvement in recovery activities.



Results (cont.) - Hypotheses

- Support for Hypothesis 4
 - **Collaborative/Deferring** style was tied to better quality of life.
 - **Plead** was linked with higher symptom distress.
 - **Self-Directing** style was related to lower quality of life.
- Those who reported to be recovering had higher scores on religious service attendance, PVRQ, & Collaborative/Deferring factor.
- “Neither religious nor spiritual” participants had lower PVRQ scores than other groups.
- Catholic respondents were less collaborative/deferring than Protestants.



Results (cont.) - general

- Cluster analysis was performed to evaluate the religious coping profiles of respondents.
- 3 - cluster solution
 - Collaborative/Deferring/Plead (N=47);
 - Self-Directing (N=42);
 - Eclectic (N=58)
- Differed by race:
 - Minority Ss were more likely to be in the Collaborative/Deferring/Plead cluster than non-minority Ss.
 - Non-minority Ss over represented the Self-Directing cluster.



Discussion

- Quantitative support for the importance of religion/spirituality for seriously mentally ill
- Evidence of positive associations between a religious focus and recovery beliefs & activities
- Combination of collaboration & deferment in relationship with God is related to most positive psychosocial outcomes.
- Self-directing & Plead coping styles are associated with less positive psychological adjustment.



Discussion (cont.)

- Self-sufficiency does not promote well-being in this population, whereas religious faith does.
- Individuals who are more symptomatic may desperately call out to God for deliverance.
- Those who are less satisfied with their lives may have abandoned their spiritual/religious commitments altogether.
- Those with a better quality of life may be able to view religion more positively and relate to God in more secure ways.



Discussion (cont.)

- Self-directives' view of God as disinterested or less benign may also be reflected in a general pattern of social avoidance.
- Consistency of religious coping profiles in this sample with previous research reflects positively on the generalizability of current findings.



Discussion (cont.)

- Limitations & implications for future research:
 - Inadequate psychometric properties of PVRQ & Empowerment Scale in this sample
 - Limitations of service use data
 - Non-religious coping styles were not examined
 - Need to assess Ss' appraisal of controllability over specific situations relevant to recovery
 - Reliance on self-report
 - Cross-sectional nature of the study



Discussion (cont.)

■ Implications of the study:

- Reliance on religious faith by mental health service consumers needs to be taken seriously.
- Certain methods of religious coping can be empowering and consistent with recovery philosophy.
- Religious coping strategies can be encouraged and incorporated into treatment for those interested.
- Increased collaboration between mental health professionals and clergy working with this population is called for.



Contact information

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