INTRINSIC CHRISTIANITY, PSYCHOLOGICAL DISTRESS AND HELP-SEEKING

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ABSTRACT

Research consistently reveals an association between 'intrinsic' religion (a 'lived', committed religion) and indices of psychological well-being. Whilst many reasons for the association have been proposed and tested, research mainly shows correlations between isolated researcher-chosen variables. Most studies to date have been conducted with non-clinical, non-UK samples, which are often of mixed religion; hence the generalisability of findings is limited. Research also suggests that Christians prefer to seek help that adheres to Christian values, addresses spiritual as well as psychological issues and is from a religious source. However, only one study on Christians' help-seeking has been conducted in Britain. I theorised that construing problems in Christian terms might affect both coping and help-seeking behaviours. This study had three research questions: whether intrinsic, Protestant Christians construe psychological difficulties in Christian terms; how intrinsic Christians see their faith as helping or hindering them in coping with psychological distress; and the grounds upon which intrinsic Christians choose where to seek help. I conducted interviews with a clinical sample of 12 British, intrinsic, Protestant Christians and analysed these using a grounded theory approach. From my analysis I developed a tentative model of the psychological resources provided by intrinsic Christianity. I also developed a questionnaire, based on helper characteristics that participants identified as influencing their help-seeking. This assessed the relative importance of these characteristics and was completed by participants at follow-up interviews. Findings indicated that psychological difficulties were predominantly construed in lay-psychological terms, but aspects were regarded as spiritual; that attachment to God and belief in his benevolent control were central to a range of aspects of faith that were perceived to facilitate coping; and that helpers' approach to Christianity could be a primary concern to Christian help-seekers. Finally, I related my findings to psychological theories and previous research findings and considered their implications for future research, clinical practice and Christian communities.

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CHAPTER 1: INTRODUCTION AND SUMMARY OF BACKGROUND LITERATURE

Overview of Introduction and Summary of Background Literature

Christianity in Britain

> "Religion is the most important social force in the history of man"
> Hogan, 1979, p.4

Christianity was once the prevailing worldview in Britain: education, law and politics were based on the authority of the Bible and the centrality of God (Schaeffer, 1987). However, over the twentieth century there has been a fundamental shift away from a worldview that "was at least vaguely Christian" Schaeffer (1987, p.17). Surveys support this appraisal: commitment to Christianity in Britain has fallen over this century and indifference towards Christianity has increased (Brierley & Wraight, 1998). This trend is often attributed to the rise of faith in modern science, which purported to explain humanity, the universe and their origins within a materialist, evolutionary framework, without reference to God. Richards and Bergin (1997, p.24) suggest that "The prestige and technical successes of science, combined with the lack of persuasive response from religious institutions, contributed to the decline in status and influence of [religion]" .

However, despite the lowered profile of Christianity in British culture, it is still a significant force in society. In 1995, an estimated 38.1 million people in the UK (65% of the population) described themselves as trinitarian[1] Christians and 6.36 million were members of UK Christian churches (Brierly & Wraight, 1998). In a British survey 23% said that they 'know God really exists and ... have no doubt about it' (British Social Attitudes Survey, 1991). This is

[1] 'Trinitarian' refers to belief that God is three persons – Father, Son and Holy Spirit – in one.

a sizeable minority which compares to the British ethnic minority population of 3 million (5.5%; Census of Population Base Statistics, 1991). Despite the recent overall decline in church membership, considerable growth (68% in England between 1989 and 1998) is evident in mainstream Evangelical[2] churches; Evangelical Christians comprised 37% of the church-going population in England in 1998 (Brierley, 2000).

What is Christianity?

Whilst Christianity down the ages and across cultures and denominations has been expressed in diverse forms and with different emphases and theologies, some tenets of the faith are shared by most, if not all, Christian groups. These are summarised below (from Stevenson, 1987; and Schaeffer 1968).

Christians believe in one God, who encompasses the three persons of the Trinity: Father, Son and Holy Spirit. He is omnipotent, just, without fault and unconditionally loving. He[3] created the world and its contents; men and women were uniquely made in a form that reflects God in order to relate to him. Christians thus regard loving and obeying God as their primary purpose.

Christians acknowledge that they are morally guilty before God and that this guilt disrupts their relationship with him. God demands justice through punishment for wrongdoing. The tension between his mercy and love for people, and his requirement of justice, is resolved in Jesus Christ's[4] substitutionary death for all people, which demonstrates the ultimate victory of good over evil. Those who admit their wrongdoing, reject sinful[5] ways of living, and accept Jesus' death as 'buying back' their fellowship with God and freeing them from the consequences of their sin, are thus exonerated, their relationship with God restored and they receive eternal life.

The Holy Spirit (the "Spirit of Christ"; the 'life-force' of God[6]) is given to all who believe in Jesus in this way. The Holy Spirit is the presence of God, active in the lives of individuals and the Christian community. Through him, Christians are 'cleansed' from moral guilt, enabled to live according to God's preferences rather than according to their inherent sinfulness, may receive spiritual insights and experience a personal, intimate relationship with God.

Christians believe that the Bible is inspired by the Holy Spirit (a "divine message in human speech" (Walls, 1998, p.114)), and is the ultimate source of Christian belief, providing

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[2] See Appendix D for the tenets of Evangelical Christianity. These concur with my description of Christianity below.
[3] The Bible describes God in both masculine and feminine terms in the Bible. However, in line with Christian convention, pronouns I use will refer to God in the masculine.
[4] A historical person who the Bible describes as the 'Son of God', God in a human form.
[5] 'Sin' refers to both 'acts of transgression, a nature or disposition and a force in opposition to God. … It is both a violation of law and a violation of relationship.' (Jones & Butman, 1991, pp. 50-52)
[6] From the Hebrew term for spirit used in the Old Testament, 'ruah', meaning 'breath' or 'life force'.

their benchmark of truth. Private reading of the Bible is encouraged, particularly in Western, Protestant denominations.

Christians regard themselves as part of "a universal, time-transcending, corporate body" (Walls, 1998, p.113) of people, i.e. the church. This is identified and may be expressed quite differently across cultures and generations.

Psychology and Religion

> "… in psychology, anyone who gets involved in or tries to talk in an analytic, careful way about religion is immediately branded a meathead; a mystic; an intuitive, touchy-feely sort of moron."
>
> Hogan, 1979, p.4

The discipline of psychology in Britain tends to reflect and is implicated in the prevalent culture of religious indifference: "… it is possible to study psychology in a British University now where the whole issue of personal spirituality and faith is simply not referred to" (Hall, 2000). Religious belief has been neglected in psychology research and practice, whilst "naturalism, agnosticism, and humanism … have dominated the field", (Bergin, 1980, p.95)[7]. The important role that religious faith has played in the lives of many, if not neglected, has been interpreted naturalistically (i.e. reduced to explanations that discount the spiritual) in psychology texts, (e.g. Hilgard, Atkinson & Atkinson, 1979). In the clinical application of psychology (for instance in psychoanalytic and cognitive therapies), "theoretical opposition to metaphysical beliefs has been both influential and orthodox" (Crossley, 1995, p.284). For example, diagnostic instruments like the Minnesota Multiphasic Personality Inventory (MMPI), ask about religious belief, practice and experience, and treat affirmative answers as evidence of psychopathology (Batson, Schoenrade & Ventis, 1993). Current psychological theory and practice does not tend to accommodate the possibility of the existence of God or spiritual forces, or the influence of these, or beliefs in these, in peoples lives; and where it does it may be viewed as pathological.

Despite indifference towards issues of faith[8] and spirituality in psychology, the zeitgeist has been changing. "Science has lost its authority as the dominating source of truth it once was" and shown to be "an intuitive and value-laden cultural form" (Bergin, 1980, p.95). Epistemological similarities between science and religion have also been recognised (Watts, 1996), for example, "the interaction of data and theory (or experience and interpretation)" (Barbour, 1990, p.65); and the absence of proof, its place taken by "judgements rendered by the paradigm community" (p.65). Disenchantment with positivism in the human sciences has

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[7] Bergin (1980) contrasts a theistic value system with the predominant atheistic systems of belief in clinical psychology, (which he terms 'clinical pragmatism' and humanistic idealism'). Their implications for clinical practice are self-evident (See Appendix A).

[8] The term 'faith' will be used from here on to refer to religious faith.

occurred alongside disillusionment with mechanistic behaviourism and the growth of social constructionist approaches. This, along with growing interest in spirituality in the population in general (Richards & Bergin, 1997) has set the stage for "a new examination of the possibility that presently unobservable realities – namely, spiritual forces – are at work in human behaviour" (Bergin, 1980, p.96).

Reflecting these changing attitudes, the number of articles in the psychological and psychiatric literature relating to religion and mental health has risen from an average of 4 per year from 1981-1990, to an average of 48 from 1991-95 and 58 in 1996 (as recorded in Bath Information Data Services Social Sciences Database). The vast majority of research relates to Christianity and has been undertaken in the USA. However, the publication of a new British Journal, 'Mental Health, Religion and Culture' and The Mental Health Foundation's recent survey of mental health service users ('Knowing Our Own Minds') indicates a growing awareness in Britain that spirituality / religion can play a significant part in mental health. The latter reports that, "… this survey suggests that religious or spiritual beliefs can be profoundly important for many people with mental health problems … [these] beliefs played a part in the lives of … just over half of the people in the survey", (Mental Health Foundation, 1997, p.73). It would seem that psychology, especially in the psychotherapeutic / mental health arena, should not ignore religious or spiritual issues.

The potential mismatch between theistic values of religious clients and the atheistic perspectives predominant in psychology (Bergin, 1980) clearly has implications for clinical practice. Whilst there is often concord between secular psychological therapies and theistic values there may be a radical difference between their prioritisation of ultimate goals. The former may aim solely for improvement at a symptomatic level, whereas the pursuit of religious goals might involve emotional distress. Thus, "What may appear as a restriction [or an affliction] to the outside observer may in fact be freely chosen as a road to spiritual blessing" (Batson et al. 1993, p.197). As psychotherapeutic approaches, "vary widely in terms of how explicitly the influence of philosophical assumptions are acknowledged" (Jones & Butman, 1991, p. 30), clinicians may not be aware of the philosophical underpinnings of their practice and thus how these may be discordant with a religious worldview. They may therefore be ill-equipped to adhere to professional guidelines that recommend adherence to client values.[9] Research suggests that clients take on some of their therapist's values (Kelly & Strupp, 1992; Worthington, 1991), and so religious clients may be vulnerable to taking on secular clinician values in secular therapy.

[9] The BPS Professional Practice Guidelines (BPS, 1995, Section 3.1.2) state that "psychologists must ensure that they do not unreasonably impose their own values nor those of the institution in which care is being provided to clients or their carers. They are not, however, obliged to accept the client's values. They must not condone those that are illegal, immoral or harmful to the client or others. Where there is a

Psychological Implications of Christian Commitment

> "The operative contents of our faiths – whether explicitly religious or not – shape our perceptions, interpretations, priorities and passions."
>
> James Fowler, 1981, p.31

Christian faith can "touch… all of thought and all of life" (Schaeffer, 1987, p.54). It may provide a solution to guilt, a relationship with an unconditionally loving and accepting, divine father, a church 'family' availing a rich social network, a framework for finding meaning in suffering, access to divine resources, knowledge of God's support, reason for one's own value, guidance, purpose and a basis for identity. Presented in this way, it would be reasonable to expect Christianity to be psychologically beneficial.

However, alternative perspectives on faith have been expressed. (For a comprehensive critique of religion from a range of perspectives, see Wulff, 1997). Freud considered religion to be a "kind of universal neurosis that civilisation substitutes for a more authentic personal reality based on scientific knowledge" (Jones & Butman, p.77). He viewed religion as an 'illusion' (Freud, 1921, p.123), regarding it as an unhealthy defence against anxiety (for example, by creating a divine father figure, anxiety can be avoided) that inhibits exploration and resolution of the conflicts at the source of anxiety. In another vein, Ellis (1980, p.637) suggests that, "[devoutly religious] People largely disturb themselves by believing strongly in absolutistic shoulds, oughts, and musts … Religiosity, therefore, is in many respects equivalent to irrational thinking …" Ellis & Bernard (1985) propose that devout belief increases emotional disturbance, and Gestalt therapists can perceive willingness to adhere to God's guidance and morality as a form of unhealthy, "dependent, ingenuine "other-regulation"" (Jones & Butman, 1991, p.315).

Christianity and Psychological Health: Research Findings

The research on the relationship between religion and mental health has produced mixed and sometimes contradictory results. Some reviewers conclude that no consistent relationship exists between mental health and religion, (e.g. Levin & Vanderpool, 1987). However, it is possible that contradictory and often weak associations reflect a lack of sensitivity to the multidimensionality and diversity of religious belief and practice, inconsistencies in how religious faith and mental health are measured and defined, and which other variables are controlled for. Evidence for this is found in Batson et al.'s (1993) and Gartner's (1997) reviews of the literature (the vast majority of which was conducted in the US with non-clinical samples), which distinguish between indicators of psychological well-being and find clearer associations with religious involvement.

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conflict of values, the psychologist must weigh up the need for the client to receive the help they are seeking against the risks, and may need to assist the client to find alternative sources of support and care."

In these reviews, religious involvement was found to be positively associated with some indicators of psychological well-being, including marital satisfaction, freedom from worry, guilt and mental illness and reduced suicide and depression; and negatively associated with indicators including personal competence and control, self-acceptance or self-actualisation, open-mindedness, and tolerance of ambiguity. More complex or ambiguous relationships were found between religion and measures of anxiety, self-esteem and sexual disorders.

The main body of research in Britain in this field has explored the relationship between religion (mostly Christianity) and the personality variables of neuroticism and psychoticism. No evidence of a relationship between neuroticism and religious faith has been found, but a significant negative relationship has been shown between psychoticism and religiousness (Francis, 1992).

Whilst some clarification of the research has occurred by discriminating between different conceptions or aspects of mental health, it is a distinction between *religious types* that has proved most illuminating. In particular, striking differences have been found between those with an '*intrinsic'* faith and those with an '*extrinsic'* faith.

Intrinsic Christianity

Allport originally made a distinction between mature (later to be termed 'intrinsic') and immature ('extrinsic') religion. Those whose faith is 'intrinsic' regard it as a "meaning-endowing framework in terms of which all of life is understood" (Donahue, 1985, p. 400) and regard it as an end in itself. For those whose religion is 'extrinsic', their religion is one "of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself" (p. 400). The intrinsic - extrinsic distinction between religious types is one of the most popular used in empirical research.

Batson, Schoenrade and Ventis (1993) undertook a review of the empirical research that distinguished between intrinsic and extrinsic religion. The vast majority of studies were undertaken in the US and mainly related to a Christian faith. The review revealed negative relationships, which tended to be weak, between extrinsic religion and indicators of mental health in 48 of 80 findings. The clearest negative relationships were for appropriate social behaviour, freedom from worry and anxiety, personal competence and control, and open-mindedness and flexibility. 31 findings indicated no clear relationship with aspects of psychological health including self-acceptance, self-actualisation and unification and organisation of the self. Only one positive relationship with an aspect of mental health (absence of depression) was found.

Contrasting with findings relating to an extrinsic faith, 49 of the 93 relevant findings showed positive associations between intrinsic faith and psychological health. Some of the clearest associations were with freedom from worry and anxiety, personal competence and control, life-satisfaction, well-being and unification and organisation of the self. 30 findings

showed unclear relationships, relating to perceived locus of control, ego-strength, guilt, open-mindedness, flexibility, self-acceptance and self-actualisation. Further research in these areas goes some way towards exploring these unclear relationships. It often reveals that the outcome measures used are inadequate for a religious population (e.g. Welton, Adkins, Ingle & Dixon, 1996). Negative correlations were evident in 14 findings, and included weak associations with measures of depression and exploitative narcissism. Koenig, George and Peterson (1998) conducted a later study (one of few longitudinal studies) with a clinical population. 97% of their sample were Christian; all were medically ill and diagnosed with a depressive disorder. They found that for every additional 10-points in 'intrinsicness' score (i.e. 10 point difference between patients; score range: 10-50), there was a 70% increase in speed of remission of depression.

Clearly, there is little evidence that an extrinsic orientation is associated with psychological health and considerable evidence that intrinsic religious faith is associated with psychological health. In fact, of the dimensions of religious faith developed so far, intrinsic religion is the most consistently associated with indices of mental health. However, research samples tend to be drawn from non-clinical, North American populations and these can represent a range of religions within a study. The generalisability of findings, therefore, is questionable.

As most relevant studies are correlational and cross-sectional, associations between mental health and religion or religious type are open to a number of possible interpretations. Associations between mental health and religion may indicate an effect of one on the other – in either direction. The literature most frequently assumes that associations suggest an effect of religion upon psychological well-being; many ideas as to why and how this might occur have been offered, and some supported empirically (see 'Psychological Implications of Christian Commitment', p. 11 and 'How Intrinsic Christianity Might Enhance Psychological Health', below). However, it is also possible that psychological health may predispose religiousness, e.g. higher self-esteem may give rise to confidence in being accepted by God or religious communities, whereas lower self-esteem might lead to the belief that one is not 'good enough' to be religious. Similarly, psychological well-being may predispose intrinsic faith, and poor psychological health, extrinsic faith; e.g., higher levels of trust and openness towards others (one index of psychological health, e.g. Bartholomew & Horowitz, 1981) may facilitate unreserved commitment to God, whereas fearfulness may lead to a more regulated, or extrinsic, religiousness. Another explanation for the correlations between mental health and religiousness is that religiousness and mental health are both independently associated with a third variable, and therefore associated with each other by default, rather than due to any direct effect of one upon the other. For example, socio-economic status is a predictor of religion, with members of the middle class being more likely to be church members (Batson et al., 1993) and also a correlate of mental health (e.g. Kessler, McGoriagle, Zhao, Nelson, Hughes, Eshleman,

Wittchen & Kendler, 1994). Of course, all three possible explanations outlined above may contribute to the association between psychological wellbeing and religion.

How Intrinsic Christianity Might Enhance Psychological Health

Various reasons for associations between Christianity and psychological adjustment have been proposed; some of the main ideas are outlined briefly below. They tend assume an intrinsic type of faith and consider how this might influence psychological health rather than vice versa. This study will focus on intrinsic Christianity and therefore possible reasons for associations between extrinsic faith and mental health outcomes will not be explored here.

Meaning in life

> "Man positively needs general ideas and convictions that will … enable him to find a place for himself in the universe. He can stand the most incredible hardships when he is convinced that they make sense; … It is the role of religion to give a meaning to the life of man."
>
> Jung, 1964, p.89

Many (e.g. Pollner, 1989) have suggested that religion helps people to make sense of problematic situations and provides meaning and direction in life. Supporting this notion, intrinsic religion has been found to correlate with existential meaning and purpose (Batson et al. 1993). Intrinsic Christians may make sense of inexplicable events by attributing them to 'God's will' (e.g. Gorsuch & Smith, 1983) and using their faith's meaning framework to make sense of uncontrollable life stresses; this appears to buffer against the potential for depression (Park, Cohen & Herb, 1990). Making sense of stressful life events and a general perception of life as meaningful have been linked with positive mental health outcomes in a number of studies, (e.g. Coleman, Kaplan & Downing, 1986; Zika & Chamberlain, 1992). Thus religion's hypothesised influence on well-being may be mediated by enhancing meaning-making.

Social support derived from the church community and support from God

Social support is well established as a correlate of mental health. It has been defined variously, but Maton (1989) reports that the stress-buffering components often emphasised are the perception that one is cared for, loved, esteemed and valued. Bergin (1980) suggests that "religious communities [may] provide … a network of loving, emotional support network" (p. 102). This network of people with shared beliefs and experiences holds the potential for particularly meaningful relationships.

Maton's (1989) prospective study suggests that perceived support from God ("perceptions and experiences of God's personal love, presence, constancy, guidance, and availability for the self", p.319) relate to higher levels of well-being. His study is limited because it assesses support from God using researcher-generated items, which may not express

aspects of most meaning to religious people. It also fails to distinguish between different faiths or religious types. Nonetheless, on the basis of his work, Maton (1989) suggests two possible hypotheses that require further testing: that support from God may enhance self-esteem and reduce negative affect or enhance positive appraisals of negative events.

Identity and self-esteem

It has been suggested that religion can enhance a sense of personal identity and self-esteem and that self-concept can mediate the relationship between religious belief and psychological adjustment (e.g. Blaine, Trivedi & Eshleman 1998; Pollner, 1989). Jones and Butman (1991, p.42) express some of the Christian beliefs that may account for these findings:

> "Far from being the chance products of blind causal forces, with lives that are thereby unintelligible and meaningless, we were created intentionally. … We accrue *value* in at least three ways. … we are the work of the Lord, and all of God's works have value. (…"God doesn't make junk"). Second, … we are the only aspect of creation specifically said to be created in God's "image." Finally, … we have value because God chose to make his Son a human … and to die for us. Surely, God would not waste [his] life … on beings that are without value."

Attachment to God

Religion has been interpreted as attachment behaviour, in which God functions as an attachment figure (e.g. Kirkpatrick, 1992). He takes on the parental roles of providing a 'safe haven' to which a child may retreat for comfort in the face of threat, and a 'secure base', from which a child is empowered to explore the world. Attachment styles have been distinguished and may broadly be categorised as secure or insecure (e.g. Ainsworth & Wittig, 1969). Bartholomew and Horowitz (1991) propose a four category model, based on two dimensions of attachment style that relate to individuals' internal working models of themselves and of others; either may be positive or negative. A positive working model of oneself and of others maps onto a secure attachment style; the various combinations that include at least one negative working model relate to different insecure attachment styles. Numerous researchers (e.g. Hazan & Shaver, 1987) demonstrate that individual differences in childhood attachment style parallel adult attachment styles (i.e. in relationships between adults), and correlate with indices of psychological well-being.

Research indicates that attachment to God is a more powerful indicator of psychological health than other religious measures: Clarke and Noller's (unpublished) research shows associations of psychological health with the former but not with measures of church attendance, religiousness or religious commitment. In this study, secure and insecure attachments to God related to measures of good and poor mental health respectively. They proposed two hypotheses with respect to the development of an attachment style to God: that either a) this would correspond to general adult attachment style; or b) it would compensate for

an insecure general attachment style, and thus show features of a secure attachment in otherwise insecurely attached individuals. However, their results supported neither hypothesis. Whilst a full understanding of the relationship between style of attachment to God and general adult attachment style has yet to be developed, this research suggests that the quality of a relationship with God is an important factor relating to psychological well-being, irrespective of general attachment style.

Coping

Park et al. (1990) suggest that 'an intrinsic religious belief system' provides additional coping resources, including "a sense of mastery … through one's relationship with a benevolent and omnipotent God" (p. 563). It "might reduce the perceived threat or loss associated with experienced negative events, might enhance an individual's evaluation of coping resources, and might result in a reliance on effective coping strategies" (p.563). Pargament's series of studies (e.g. Pargament, Ensing, Falgout, Olsen, Reilly, Van Haitsma & Warren, 1990) reveal numerous ways in which Christian faith can influence coping, both in terms of appraising events (e.g., 'Found the lesson from God in the event') and providing an array of religious coping activities (e.g. 'used Christ as an example of how I should live'). Intrinsicness was not found to be negatively related to appraisals of stressful events as threatening but was associated with 'opportunity to grow' appraisals (Pargament, Olsen, Reilly, Falgout, Ensing & Van Haitsma, 1992).

From interviews with church members, Pargament et al. (1990) identified religious coping activities. Some types of coping were positively associated and some were negatively associated with psychological outcomes of stressful events. Religious coping variables predicted outcomes *beyond* the effects of non-religious coping variables; the most potent predictor of positive outcomes was 'spiritually based' coping (which emphasises the individual's relationship with God). Intrinsic Christianity was found to be associated with 'spiritually based' coping and with 'religious avoidance' (which relates to religious activities that divert attention from a negative event). However, it was also negatively associated with 'non-religious avoidance' and positively associated with 'problem solving' (Pargament, et al., 1992). Whilst these studies provide a rich source of information, their validity may be limited by their reliance on retrospective self-report of the life events and coping concerned. Also, they are cross-sectional and thus do not address the issue of direction of association. Their generalisability is limited as they use non-clinical samples and focus on stressful *events* rather than ongoing stresses or psychological difficulties. Pargament (1997) acknowledges that the catalogue of religious coping activities his studies identified, is "not the last word in the conceptualisation … of religious coping" (p. 186) that it does not include all important coping approaches.

Problem-solving style

Pargament (1997) suggests an alternative to an enhanced self-efficacy view of coping suggested by Park et al. (1990): "the religious world helps people *face* their personal limitations and *go beyond* themselves for solutions" (p. 8, my italics). Pargament, Kennell, Hathaway, Grevengoed, Newman and Jones (1988) formulated three religious problem-solving styles based on variations of two dimensions in the individuals' relationship with God: "the locus of responsibility for the problem-solving process, and the level of activity in the problem-solving process" (p.91). These are deferring, collaborative and self-directing. A deferring style involves passively deferring responsibility for coping to God and waiting for solutions to emerge through his efforts; in a collaborative style responsibility is viewed as being held jointly by oneself and God, and both are active; and a self-directing style involves an internal locus of responsibility and active problem-solving by the individual. They found that a deferring style was negatively associated with measures of competence, a collaborative style was positively associated with personal control and self-esteem, and a self-directing style was associated with some, but not all, measures of competence. However, in some circumstances a deferring style was positively associated with better outcomes and a self-directing style negatively associated with these. Pargament (1997) suggests that this may occur when individuals face situations in which they have very little control. He also reports that "a consistent pattern of findings emerges only for collaborative coping. The shared sense of power and control embodied in this approach seems to bode well for both general mental health and the outcomes of specific negative situations" (p. 294).

Forgiveness

Forgiveness is central to Christian belief and is highly valued by Christians (Rokeach, 1973); others have raised objections to it on various grounds (Enright, 1991). Claims for the physical and psychological benefits of forgiveness have been made, but McCullough and Worthington (1994) conclude from a review of the literature that "Only a smattering of evidence, mostly drawn from studies with weak methodology, supports these claims" (p.5). Subsequent to this review, studies have shown forgiving others to be positively associated with measures of psychological wellbeing (e.g. Rye, unpublished dissertation; Freedman & Enright, 1996).

How Intrinsic Christianity Might Inhibit Psychological Health

> "History demonstrates that religions and religious values can be destructive, just as psychotherapy can be if not properly practised."
>
> Bergin, 1980, p.100

Despite the broad association between intrinsic religiousness and psychological health, very little research investigates the exceptions to this 'rule'. Associations with intrinsic faith are not entirely unambiguous. This could be due to the poor psychometric properties of the original measure of intrinsicness (Trimble, 1997) which has been used in many studies; it is also possible that some aspects of intrinsic faith may *contribute* to psychological difficulties. A number of people have speculated about this; few speculations are substantiated empirically. Those that may relate to an intrinsic orientation are briefly described below.

Christians' pursuit of high moral standards may enhance awareness of shortcomings, increase guilt and undermine self-esteem (e.g. Meek, Albright & McMinn, 1995)[10]. Watson, Morris and Hood (1988) suggest that if people are unable to see beyond their own sinfulness and guilt and have failed to locate the solution in God, then anxiety and depression are likely to follow. Lovinger's (1997, p.347) "10 markers of probable religious pathology" (derived from clinical experience), include 'scrupulosity' ('an intense focus on the avoidance of sin or error'); 'relinquishing responsibility' (e.g. "the devil made me do it"); and 'hurtful love in religious practice' ('unnecessarily hurtful, damaging, or very painful experiences with others [that] may generate confusion … as to what love is'). Pargament (1997) also suggests that the religious community might create difficulties. For example, in Christian communities which "run counter to where the individual wants to go", "friction and strain" may result (p.335). Other findings (Pargament et al., 1990) suggest that some religious coping responses (e.g. 'feeling angry with or distant from God') are related to poor psychological outcomes.

Clearly, more research is needed to explore the differential relationship between intrinsic religion and mental health and the processes by which an intrinsic faith can help people cope and change.

Implications of Intrinsic Christianity for Help-seeking

The literature on psychological help-seeking tends to centre on factors associated with seeking or not seeking professional help. There is much to learn about how people come to receive one type of help rather than another: there is "little information about either patterns or pathways to care" (Pescosolido & Boyer, 1999, p.408). Even less attention has been given to how religious commitment influences the processes of help-seeking. However, Barker, Pistrang, Shapiro and Shaw, (1990) recognise the cultural and contextual influences that lead psychological help-seekers in multiple directions, and not just to mental health services. They suggest that cultural contexts affect not only the perception of potential problems but also condition ways of dealing with problems. Conceptualised as a cultural force, religion clearly has the potential to influence pathways to help.

[10] Meek, Albright and McMinn (1995) found that intrinsic religiousness was associated with greater guilt-proneness but also greater likelihood of self-forgiveness and feelings of forgiveness from God compared to extrinsic religiousness.

Sorgaard, Sorensen, Sandanger, Ingebrigtsen and Dalgard (1996), in a study of Norwegians showed that religious commitment influenced whether people sought help from a priest or from a psychologist, psychiatrist or GP for emotional problems. Those with religious beliefs were not less likely to seek help from a GP, though they were significantly more likely to seek help from a priest. They also found that average ratings of symptomology were similar amongst those contacting priests and those contacting GPs. Of a of over 1000 UK adults, Barker et al., (1990) found that 17% stated that they would tend to go to a 'priest' for help with emotional problems, compared to 16% who said they would go to a mental health professional. The use of the term 'priest' may be problematic for Protestant Christians, as many belong to denominations that do not have priests. Thus, this study may under-represent the extent to which religious leaders (or other religious help-sources, e.g. Christian counsellors) are approached for help.

It has been suggested that an individual's construal of their problem may affect choice of help-source.

> "… If individuals see mental health problems as crises of faith, … they may consult faith healers, spiritualists, the clergy, or other people … If they conceptualise their problem as physical illness … then they may visit physicians …"
>
> Pescosolido and Boyer 1999, p.408

However, to my knowledge, no-one has investigated whether Christians perceive psychological problems as spiritual, and if they do, whether they would *solely* seek religious counsel. However, Mitchell and Baker's (in press) study of British Evangelical Christians' construal of help-sources revealed the belief "that [the] spiritual and emotional parts of me are linked – to treat one without the other is not a full solution". Some participants were concerned that secular helping professionals would "neglect the important spiritual aspect", demonstrating a perceived link between religious faith, problem-construal and choice of help-source. Others studies have shown that Christians prefer counselling or treatment plans that are congruent with their religious beliefs (e.g. Dougherty & Worthington; 1982; Rokeach, 1967). However, these studies are based on self-reported attitudes, and their findings cannot be assumed to equate with behaviour. Also, they provide no indication of the interaction or relative importance to Christians of the issues they consider when seeking help.

Whilst intrinsic faith has been shown to correlate with positive attitudes towards counselling per se (Miller & Eells, 1998) the basis upon which particularly intrinsic Christians decide to seek help from a secular rather than Christian source, or vice versa, has not been examined. Perceptions of whether psychological services accommodate their particular needs may have important implications regarding equality of access. Alternatively, other issues of relevance that have not been considered in the literature may be implicated in Christians' help-seeking, for example, waiting time (Baker, personal communication).

This Study

This study will focus on Protestant, intrinsic Christianity. Protestant Christianity is the predominant religion in Britain (Brierley, 2000, p.52) and intrinsic faith appears to provide resources that may prevent and help people to cope with psychological distress. I chose to draw on a clinical population as little research has been conducted with 'actual clients' (Worthington et al. 1996) and because the relationship between faith and psychological distress more likely to be salient for these than for people with fewer difficulties. Also, intrinsic Christians who have psychological difficulties run counter to the trend of intrinsic faith being associated with psychological well-being they may provide more insights into the limitations of intrinsic Christianity or the ways in which it may contribute to psychological distress.

Longitudinal research suggests that intrinsic faith predisposes psychological health, rather than vice versa (e.g. Koenig et al., 1998), and many explanations for this have been proposed (see above). Nonetheless, Worthington, Kurusu, McCullough and Sanders (1996), following a review of the relevant empirical research, propose that "more research needs to be done to determine why religion sometimes has positive and sometimes negative effects and "*how* does religion help people cope, change and heal?" (p. 480, my italics). Research has also not adequately addressed what aspects of faith might be important to the individuals concerned and how *they* understand its psychological effect. This study aims to address these issues.

A range of Christian sources of help for emotional difficulties are available, including Christian counselling services[11] and 'inner healing' courses. Understanding why some people choose these sources of help in preference to secular services and vice versa, may highlight some of the issues of importance to Christian help-seekers and may indicate how psychological services might become more accessible to them and more appropriately address their needs. Thus, I include in this study people who have sought help from a range of sources, both secular and Christian.

A qualitative methodology seemed most suited to addressing the above issues, as they have not been the subject of much research. I chose a grounded theory approach (Glaser & Strauss, 1967) because it "seeks … to take account of how reality is viewed by participants themselves" (p.253). It focuses on whole, complete events (as opposed to isolated variables) in their natural settings, taking social context into account. Given the exploratory nature and the complexity of the subject matter, this method seemed the most appropriate for my purposes.

I gathered data using a semi-structured interview, choosing this format so that I could obtain data that was pertinent to my research questions, construed in participants' terms and from their perspectives, and because it is "highly flexible … and … capable of producing data

[11] The British Association of Christian Counsellors (ACC) currently has 1,665 UK members (ACC, personal communication). This compares with the British Psychological Society's (BPS) Division of Clinical Psychologists' 1999 membership of 3938 (BPS Annual Report, 1999, p.42).

of great depth … [and] a method with which most research participants feel comfortable …" (King, 1994, p.14). As I wanted participants to be able to introduce ideas and topics that I had not anticipated and I wanted the opportunity to explore relevant themes with participants, this seemed the most appropriate method of data collection. As I also wanted my *analysis* of the data to be grounded in participants' perspectives, or if inconsistent in any way with these, to understand any such discrepancies, I conducted follow-up consultations. In these I described my analyses to them, obtained their feedback and made amendments where these added to understandings relating to my research questions. These consultations also gave me the opportunity to clarify my understandings of participants' accounts, and to obtain further data using a questionnaire developed from my grounded theory analysis.

From this point forward I use the term 'Christian' or 'Christianity' to refer to Protestant, intrinsic Christianity.

Aims and Research Questions

This study aims to develop understanding of how Christians understand their faith to affect psychological distress and help-seeking. It is structured around the following questions:

1. Do intrinsic Christians construe their psychological distress in Christian terms?

2. How is an intrinsic Christian's faith perceived to help or hinder coping with psychological distress? Which aspects of their faith are important to them in this and why?

3. On what grounds do intrinsic Christians decide where to seek help for psychological distress?

CHAPTER 2: MY EPISTEMOLOGICAL AND PERSONAL POSITION IN RELATION TO THIS STUDY

Overview of 'My Epistemological and Personal Position in Relation to This Study'

Epistemological Stance

My Position in Relation to this Study

Epistemological Stance

> "… it is no longer assumed that there is one reality that can be revealed through the utilisation of correct methodology. … the researcher and subject of research are both conscious beings interpreting and acting on the world around them within networks of cultural meaning"
>
> Madill, Jordan and Shirley, 2000, p.7

This research attempts to understand experiences of intrinsic Christians in psychological distress, assuming a 'contextualist constructionist' epistemology (Madill et al., 2000). It does not claim to identify or discover universal or immutable empirical facts. Rather, it is interpretative both from the participants' and the researcher's positions and is intended to generate new understandings and theory, which will be contextually bound.

In reporting my analysis I use a language style that deliberately remains close to participants' perspective. This differs from the stance taken by other researchers in this area. For example, in her grounded theory analysis of Christians' experiences, Dunn (1999) gives functional explanations for their attributions of events to God. She suggests that "attributions to the divine" for positive events serve to "maintain … the content of participants' assumptive worlds" (p. 98). However, this covertly implies rational calculation, falling into the trap of the humunculus problem, and assumes an 'extrinsic' (see 'Intrinsic Christianity', page 12) motivation in Christian interpretations. The alternative view that I take is that situations are interpreted to be consistent with religious schemas. For example, if an individual believes that 'all good things come from God' (the Bible[12], James 1:17), then this alone may explain attributions to God for positive events; recourse to functional explanations is unnecessary.

I chose to use language that assumes that God exists rather than that which implies that belief in God is a subjective phenomenon. For example, I will report that, "Participants felt God's love" rather than "Participants felt a sense of love which they perceived was from God". As universally accepted proof does not exist for the existence or non-existence of the objective Christian God, I would argue that either position rests on a degree of faith. I invite the reader to interpret my account from their chosen perspective. Whilst I take a theistic stance in my

[12] All Bible texts are taken from the New International Version (1973), London: Hodder & Stoughton.

writing, I also believe that psychological processes influence people's experiences and their interpretations of these and thus self-report does not equate to 'objective truth' (or consistency with orthodox Christian expression), but represents (albeit incomplete) constructed reality.

My Position in Relation to this Study

Following Charmaz's (1990) recommendation, and consistent with a contextualist epistemology, I declare my 'researcher perspective' below. Whilst my aim is to conduct and present this study without bias, I may be unconscious of some of my biases, and therefore unable to put them aside. My 'declaration' is therefore intended to help readers to evaluate the extent to which my particular perspectives and interests might influence what I highlight, promote, sideline or cloud in my analysis and presentation.

I am a white, female psychologist in my final year of clinical training. I do not subscribe to any particular theoretical orientation but am familiar with a range. I have been an Evangelical Christian for over 20 years and score the maximum 40/40 on the Intrinsic Christianity scale (Gorsuch & McPherson, 1989). I view the spiritual and psychological as inter-connected such that psychological processes may have a spiritual dimension and vice versa.

My common perspective with my participants may allow me "to be sufficiently in tune with the culture under study to understand the nuances of psychological transactions"; however I also strive towards "impartiality and commitment to scientific validity" (Good & Watts, 1989 p.256). I did this by constantly reflecting on my understandings of the data, memoing my personal reactions and considering alternative views, especially when I found my experience resonating with my interviewees' accounts.

My motivation for this study comes primarily from experiencing and seeing in others beneficial psychological changes, which seem to me (as a lay person) to have occurred through a relationship with God and commitment to Christian beliefs. These observations make me curious to explore systematically and in depth, the interaction between Christianity and psychological distress and change. The personal agendas I bring to this research are described as follows.

As discussed above, the psychological world lacks awareness of the spiritual resources Christians may bring to psychological difficulties and of the difference in Christian values and those prevalent in mainstream psychology. These are issues of particular pertinence in the practice of clinical psychology with Christian clients and, if substantiated in this study, I hope to bring these to the attention of psychologists through this research.

I have experienced 'Christian' cultures and activities that have been psychologically unhelpful for some and would like to further my knowledge of how Christianity and its expression can contribute to psychological distress. I would hope that this understanding could

help inform Christian church practices so as to promote those that are not psychologically harmful *and* are true to a Christian perspective.

If religious processes are integral to psychological change in Christians, then it is likely that this will influence whether they seek help that is specifically Christian or not. My experience that Christians frequently, but not always, seek Christian help makes me curious to find out the basis for their decision making. I hope to find out whether mainstream clinical psychology services are accessible and adequately tailored to the particular needs of Christians, and if not, how they might be adapted to be so.

CHAPTER 3: METHOD

Overview of Method

Participants

Recruitment

I recruited 12 participants by 'snowballing' (word of mouth), through both Christian and psychology / counselling contacts and local churches. My contacts approached possible participants (people whom they knew to be Christians and to have received help for psychological difficulties) and gave them either a brief or a full information pack, as appropriate. I offered a £10 store voucher for those who were interviewed, as an incentive to respond. Brief packs (which included a brief information sheet (see Appendix B) and a stamped reply postcard to request further information) were intended for those with whom the study had not been discussed. If I received a completed reply postcard, I sent the respondent a full information pack. Full information packs (which included a full information sheet (see Appendix C), screening questionnaire (see Appendix D) and stamped reply envelope for the return of the completed questionnaire) were intended for those who knew something of my study and were considering participating. Through these means, I remained unaware of the identities of possible participants unless they initiated contact with me.