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# Types of God Representations and Mental Health: A Person-Oriented Approach

Hanneke Schaap-Jonker [a], Nathan van der Velde[a], Elisabeth H. M. Eurelings-Bontekoe[b], and Jozef M. T. Corveleyn[c]

[a]Centre for Research and Innovation in Christian Mental Health Care, Amersfoort, the Netherlands; [b]Department of Clinical Psychology, University of Leiden, Leiden, the Netherlands; [c]Department of Psychology, Catholic University of Leuven, Leuven, Belgium

**ABSTRACT**

As God representations are multi-facetted psychological processes regarding the personal meaning of God/the divine to the individual, this study examines how multiple aspects of God representations are configured within individuals belonging to a sample of psychiatric patients or a non-patient sample, and how these configurations are associated with mental health. By means of cluster analyses, three types of God representations were found: a Positive-Authoritative one, a Passive-Unemotional one, and, only among psychiatric patients, a Negative-Authoritarian one. Types of God representations were significantly related to affective state, as well as religious saliency and religious background. Patients with the negative type of God representation were more distressed and depressed, and Orthodox-Reformed patients reported significantly more negative types of God representations. This study demonstrates the value of a person-oriented approach, by showing that scale scores became especially meaningful in the context of the types, which enables more nuanced distinctions regarding subgroups.

## God representations as multidimensional processes

God representations are mental representations of the individuals' perceived relationship to God or the divine. They reflect both subjective experiences of God/the divine (e.g., experiences that are characterized by trust, thankfulness, fear or disappointment) and religious beliefs concerning God/the divine (e.g., God as the ground of being, a judge, a helping ultimate power) in a highly personal way. Psychological factors (such as attachment style and personality) and religio-cultural factors affect the content and structure of God representations. As core aspects of religiousness, God representations—both traditional, personal, and theistic ones, and impersonal, abstract ones—give a unique insight into the meaning of religious life and religious behavior (Davis, Moriarty, & Mauch, 2013; Hall & Fujikawa, 2013; Hoffman, 2005; Jones, 2007; Rizzuto, 1979; Schaap-Jonker, Eurelings-Bontekoe, Zock, & Jonker, 2008; Laarhoven, Schilderman, Vissers, & Verhagen, 2010).

From a relational theoretical perspective, which combines insights from object relations theory (ORT) and attachment theory (AT), God representations involve both relational and emotional understandings of God/the divine (God images), and conceptual and cognitive understandings of God/the divine (God concepts), which both may function on an explicit and implicit level of awareness (Davis et al., 2013; Hall, 2003; Hall & Fujikawa, 2013; cf. Rizzuto, 1979). Whereas God images refer to internal working models or object relations of God and the self in the perceived relationship to God, which are developed through a relational, and initially subconscious, process to

**CONTACT** Hanneke Schaap-Jonker h.schaap@kicg.nl Centre for Research and Innovation in Christian Mental Health Care, Eleos, P. O. Box 2778, 3800 GJ Amersfoort, The Netherlands.

which parents and significant others make important contributions, God concepts refer to sets of beliefs about this God, which are learned through a process of religious socialization (Davis et al., 2013; Hall & Fujikawa, 2013; cf. Rizzuto, 1979). In line with this, emotional understandings of God tend to be more affect laden and subcortically dominant and largely function at an implicit and largely nonverbal level, outside of conscious awareness. In contrast, the cognitive aspects of God representations are more belief laden and cortically dominant; they predominantly function at an explicit, verbal, and conscious level (Davis et al., 2013; Hall, 2003; cf. Zahl & Gibson, 2012, who referred to explicit cognitive understandings of God as "doctrinal" God representations, in contrast to experiential ones, which involve explicit emotional understandings of God). By implication, there is no such thing as a one-dimensional and consistent God representation; God representations are multidimensional and multifaceted processes in which cognitive and emotional aspects are dynamically interrelated, interacting on different levels and being activated in different constellations. In this way, God representations, like all representations, are dynamic, context-sensitive reconstructions in a connectionist memory system (Smith & Conrey, 2007). Thus, distinct aspects of God representations may be dominant or latent within psychic experience depending on psychological and contextual factors (Rizzuto, 1979; Rizzuto & Shafranske, 2013; Schaap-Jonker, Eurelings-Bontekoe, Zock, & Jonker, 2007; Zahl & Gibson, 2012; cf. Smith & Conrey, 2007). For instance, depressed individuals may experience God more as absent than as a helping and guiding power, or positive feelings may dominate negative feelings such as fear and anger among Evangelicals. God representations may also involve both aspects, representing an ambivalent or a rich and integrative perspective on God and a mature personality (cf. Kernberg, 2000).

## God representations and mental health

Both ORT and AT emphasize that interpersonal interactions in early infancy become internalized and form the psychic structure (ORT = configurations of object relations and accompanying defense mechanisms, AT = attachment styles and internal working models) that functions as a template (in which the polarity of interpersonal relatedness and self-definition plays a part) for future interactions and shapes these interactions (Blatt & Levy, 2003; Hall, 2003). In this way, the psychic structure also affects the representation of the relationship to God. Psychopathology is associated with disturbances in (interpersonal) relationships (regression or fixation to immature or disintegrated object relations and primitive defense mechanisms [ORT] or insecure attachment styles [AT], which are characterized by anxiety and/or avoidance). These disturbances are vulnerability factors for configurations of psychopathology in which either issues of interpersonal relatedness or issues of self-definition and self-worth are dominant (Blatt & Levy, 2003). In line with this, God representations in the context of struggling with relatedness or self-worth could also be one-sided, disintegrated, or laden with negative affect (such as anxiety or avoidance) and function in a manner that corresponds to representations of self and other. It is also possible that they fulfill a compensating function—or that they are compensating on an explicit level and corresponding on an implicit one (Granqvist & Kirkpatrick, 2016; cf. Hall & Fujikawa, 2013). In contrast, mental health could be conceptualized by a balance between interpersonal relatedness and self-definition, resulting in personal, interpersonal, and social adaptation, which is reflected in healthy personality traits, affective state, and well-being, among other things, as well as integrated, secure God representations in which ambivalence is tolerated (Blatt & Levy, 2003; Livesley, 2003).

God representations have been investigated in relationship to a wide range of personal and psychological variables, such as personality and personality pathology (e.g., Greenway, Milne, & Clarke, 2003; Schaap-Jonker, Eurelings-Bontekoe, Verhagen, & Zock, 2002), self-esteem (e.g., Francis, Gibson, & Robbins, 2001), depression (e.g., Braam et al., 2014), autism spectrum disorders (Schaap-Jonker, Sizoo, Schothorst-Van Roekel, & Corveleyn, 2013), sexual abuse (e.g., Kane, Cheston, & Greer, 1993), happiness and the experience of pain (Dezutter, Luyckx, Schaap-Jonker,

Büssing, & Hutsebaut, 2010), gender (e.g. Riegel & Kaupp, 2005), and treatment interventions (e.g. Cheston, Piedmont, Eanes, & Lavin, 2003; Thomas, Moriarty, & Anderson, 2011), as well as contextual variables such as religious denomination (e.g., Noffke & McFadden, 2001; Schaap-Jonker et al., 2008). Results of these studies are mainly in line with the theoretical view as just outlined, although the relationship between religion and mental health is complex. In general, psychopathology is related to more negatively valenced God representations, whereas mental health is related to more positively valenced God representations, which supports the correspondence hypothesis (e.g., Braam et al., 2014; Greenway et al., 2003; Schaap-Jonker et al., 2002; Schaap-Jonker et al., 2013). However, persons suffering from (severe) psychopathology or personality disorders may also report a positive spirituality and/or positively valenced experiences in relationship to God, which supports the compensation hypothesis (Bennett, Shepherd & Janca, 2013; Braam et al., 2014; Schaap-Jonker et al., 2013).

## A person-oriented approach to God representations

Nearly all studies that were just mentioned utilize a variable-oriented approach and examine different isolated aspects of God representations in association with other variables, approaching groups of individuals as uniform entities. How the multiple aspects of God representations are configured *within* individuals and how these different traits or facets of God representations function within (subgroups of) individuals has mainly remained outside the scope of researchers. However, this multidimensional perspective is highly relevant, given the multifaceted theoretical view on God representations that was just outlined.

In the present study, a quantitative person-oriented approach is adopted to investigate the organization and configuration of different aspects of God representations within individuals belonging to various samples, namely, a sample of psychiatric patients and a nonclinical sample. A person-oriented approach focuses on identifying several subgroups of individuals within a sample. Subjects with comparable scoring patterns on various scales that measure God representations are clustered, in such a way that within-group differences in scoring pattern are minimal and between-group differences in scoring pattern are maximal. This approach enables identification of rather homogeneous categories of individuals and making inferences about how these categories typically function. In contrast, within a variable-oriented approach, in which sample means of specific variables are typically compared, only statements about the direction and strength of associations between isolated variables are allowed. Interindividual differences are brushed aside because they are considered random, and thus negligible (Dezutter et al., 2014; Everitt, Landau, Leese, & Stahl, 2011; Von Eye, Bogat, & Rhodes, 2006). Over the past years, the person-oriented approach has gained popularity in areas such as developmental psychopathology research (e.g., Bergman, Magnusson, & El-Khouri, 2000; Von Eye, Bergman, & Hsieh, 2015), psychiatry (Ellis, Rudd, Rayab, & Wehrly, 1996), personality and identity research (e.g., Luyckx, Schwartz, Goossens, & Pollock, 2008; Schnabel, Asendorpf, & Ostendorf, 2002), research on meaning in life (Dezutter et al., 2014), and religious and spiritual well-being (Unterrainer, Ladenhauf, Wallner-Liebmann, & Fink, 2011). Within this approach, the individual is regarded as a living, active, and purposeful person who functions and develops as a total integrated being. Hence, different aspects or dimensions of human experience and human existence are not broken up in isolated pieces (variables) that are studied as separate entities but are investigated and understood as a whole, with explicitly taking into account interactions and bidirectional influences between different aspects (or components) of personhood, contextual factors, as well as conditional moderation and mediation effects (Bergman & Andersson, 2010; Bergman et al., 2000; Bergman & WåNgby, 2014; Magnusson & Törestad, 1993). In this way, the person-oriented approach bridges the gap between a nomothetic and ideographic point of view within psychology, as well as the gap between scientific research and clinical practice. It makes it easier to understand the clinical relevance of the results of psychological scientific research, as it focuses on the

individual instead of the group, the process instead of static entities (or linear models), and patterns of information in contrast to single variables (Bergman & Andersson, 2010; Corveleyn, Luyten, & Dezutter, 2013; cf. Molenaar, 2004).

## The present study

Focus of the present study is the relationship between types of God representations and mental health. We want to investigate how various aspects of God representations are interrelated and configured within individuals in clinical and nonclinical samples and how different types can be understood in terms of psychopathology (i.e., affective state).

On the basis of scientific literature, we expect that (a) a positively valenced type of God representation will be found, in particular in the nonclinical sample, in which supportive views of God will be strong and related to positive feelings toward God, and that (b) a negative configuration will be found, especially among psychiatric patients, in which ruling-punishing views of God will be related to anxiety and anger towards God.

Although the multidimensionality of God representations has been emphasized by various authors (Hall & Fujikawa, 2013; Sharp et al., 2013), types of God representations have yet not been examined in a person-oriented way, as far as we know. Hence, our study gives more insight into the functioning of different aspects of God representations within (subgroups of) individuals and, in line with this, into the supporting or hampering role of religion and spirituality in the context of mental health. By implication, professionals in mental health care, and spiritual or pastoral care, will be able to identify subgroups of patients that share similar ways of functioning on multiple dimensions of God representations, which may result into person-sensitive and specific interventions, which fits developments such as personalized psychiatry (Ozomaro, Wahlestedt, & Nemeroff, 2013) and values-based practice (Fulford, 2008).

## Method

### *Procedure*

Data were collected from 2010 to 2012. Therapists of two institutes for mental health care in the center and the north of the Netherlands distributed an inviting letter among patients who suffered from personality disorders, anxiety disorders, or mood disorders. The researchers distributed the same letter among individuals belonging to the general population who did not have any psychiatric diagnosis. This letter offered information about the aim of the study and ethical aspects such as anonymity and (for patients) the fact that the research was strictly separated from therapy. People were asked to complete a questionnaire on the web page of the Centre for Religion, Worldview and Mental Health (http://religieggz.dimence.nl) or to fill in paper questionnaires. Furthermore, people belonging to the general population were asked to send the information letter to others and to invite them for this study (snowball-sampling starting at a university and some churches). Because of this type of sampling, and because only those patients who wanted to participate returned an informed consent form, there is no information about the response rate.

All participants were asked whether they received psychological treatment, and if yes, which diagnosis was the reason for treatment. Diagnoses of the clinical sample were verified and therapists communicated *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) diagnoses of the psychiatric patients (because data were collected before the introduction of the *DSM–5*). These diagnoses were based on clinical assessments by experienced psychiatrists and psychologists (clinical interviews and diagnostic questionnaires). Patients signed an informed consent form, giving permission that their therapists informed the researchers about their (main) diagnosis. An approved Medical Ethical Committee determined that this study did not fall under the scope of the Dutch Medical Research Involving Human Subjects Act (WMO).

### Instruments

The Questionnaire of God Representations (QGR; Murken, Möschl., Müller, & Appel, 2011; Schaap-Jonker et al., 2008; 2016) is a 33-item questionnaire that is frequently used in God representation research (e.g., Braam et al., 2014; Dezutter et al., 2010; Schaap-Jonker, Sizoo, Schothorst-van Roekel, & Corveleyn, 2013). It has two dimensions. The first dimension concerns the feelings that are experienced in relationship to God/the divine (e.g., "When I think of God, I experience security") and includes three scales: Positive Feelings (nine items; $\alpha_{cl} = 0.95$, $\alpha_{n\text{-}cl} = 0.94$), Anger (three items; $\alpha_{cl} = 0.80$, $\alpha_{n\text{-}cl} = 0.61$), and Anxiety (five items; $\alpha_{cl} = 0.88$, $\alpha_{n\text{-}cl} = 0.80$). The second dimension taps perceptions of God's actions or divine power (e.g., "God rules") and consists of three scales: Supportive Actions (10 items; $\alpha_{cl} = 0.95$, $\alpha_{n\text{-}cl} = 0.97$), Ruling/Punishing behavior (RULP; four items; $\alpha_{cl} = 0.86$, $\alpha_{n\text{-}cl} = 0.90$), or Passivity (two items; $\alpha_{cl} = 0.72$, $\alpha_{n\text{-}cl} = 0.79$), which means that God does not act. Answers were scored on a 5-point Likert scale, ranging from 1 (*does not apply at all*) to 5 (*does completely apply*). Psychometric qualities of the questionnaire are adequate, and normative data are available for psychiatric patients and the general population and for persons who belong to different religious denominations (Schaap-Jonker & Eurelings-Bontekoe, 2009). A short version, which was constructed on the basis of Item Response Theory (IRT) analyses, is also available (Schaap-Jonker et al., 2016). In the current study, participants were instructed to indicate to which extent they experienced or recognized the feelings toward God and statements about God *personally*. In this way, their chronically accessible, experiential representations of God were captured (as shown by Zahl, Sharp, & Gibson, 2013) in a general and overarching way (in contrast to a situation-, context-, or time-specific way; cf. Fraley, Hudson, Heffernan, & Segal, 2015, who distinguish between general and relationship-specific attachment representations).

To gain more insight into the respondents' affective state during the past 2 weeks, the Dutch Positive and Negative Affect Schedule, a 20-item self-report instrument that was developed by Watson, Clark, and Tellegen (1988) was administered. Positive Affect (PA; 10 items, $\alpha = 0.86$) reflects the extent to which a person feels enthusiastic, active, energetic, and alert, being pleasurably engaged with the environment. Negative Affect (NA; 10 items, $\alpha = 0.90$) is a general factor of subjective distress, with high NA representing feelings of guilt, fear, hostility, and nervousness, as well as anger, contempt, and disgust. High scores on NA and low scores on PA characterize depressive patients, whereas anxiety is related to high NA but has an unclear association with PA (Clark & Watson, 1991). The Dutch version of the Positive and Negative Affect Schedule is a reliable and valid measure of the constructs of affective state. Normative data are available for nonclinical and clinical groups (Peeters et al., 1999).

To measure the extent to which religion is significant in the participants' daily lives, a five-item scale for religious saliency was used ($\alpha_{cl} = 0.93$, $\alpha_{n\text{-}cl} = 0.91$; Eisinga et al., 2002, p. 26; 'Eisinga et al., 2013). Items include "My faith is important to me" and "If I have to take important decisions my faith plays an important role." Answers were scored on a 5-point Likert scale, ranging from 1 (*does not apply at all*) to 5 (*does completely apply*). Although this scale is often used in the Netherlands, and in national surveys, it has not been validated, as far as we know.

In addition, respondents were asked about their age, gender, marital status, education, religious denomination, and frequency of church attendance, as well as main psychiatric diagnosis.

### Statistical analysis

To identify types of God representations, cluster analyses were done. With cluster analysis techniques, data are summarized meaningfully into a small number of groups (or clusters) of individuals with maximal in-group resemblance and maximal between-group difference in terms of scoring patterns (Everitt et al., 2011, p. 13). Thus, data are divided into clusters of individuals (in contrast to factor analysis, which aims to cluster groups of variables) whose means are most similar to those of one's own group and most distinct from those of other groups (Norušis, 2011). Cluster analyses were

conducted separately for the clinical and nonclinical groups, and separately standardized subscale scores were used because of differences in means on QGR subscales, which were related to mental health (cf. Schaap-Jonker et al., 2008). Using 150 (clinical groups) respectively 50 (nonclinical groups) random case orderings, the optimal start positions for the *k*-means algorithm were searched, that is, the smallest within-cluster sums of squares. These two optimal start positions were used to conduct the *k*-means SPSS procedure. This procedure was repeated for $k = 2$ to $k = 6$. Calinski-Harabasz index values were inspected to determine the most adequate number of clusters.

To test whether differences in clusters of God representations were related to religious background and to psychopathology as operationalized in affective state, multivariate analyses of variance (MANOVAs) were done. As most scales showed non-normal distributions and significant Box's tests revealed unequal variance–covariance matrices, indicating multivariate heterogeneity of variances, Roy's largest root was used, being a statistic robust to unequal sample sizes. Post hoc multiple comparisons were performed with the Games-Howell procedure (when comparing three groups or more), as this generally offers the best performance with unequal sample sizes, when there is doubt about equal group variances and in case one group is smaller than 50. (Field, 2013, p. 459). Effect sizes are expressed in partial eta-squared. Standards for interpreting effect sizes were as follows for partial $\eta^2$: 0.01 = small effect, 0.10 = medium effect, 0.25 = large effect (Vacha-Haase & Thompson, 2004).

To investigate internal consistency of the scales that were used, reliability analyses were done (Cronbach's alpha).

Respondents who did not report a specific God representation, scoring 1 (*not at all applicable*) on all items of the QGR, were excluded from the analyses because there was no variance. Often their response to an open question in the qualitative part of the study was that God does not exist at all.

### Participants

Two hundred ninety-seven people participated in this study. The nonclinical group consisted of 161 participants, who did not report any psychiatric diagnosis (54.2%). One hundred thirty-six people (45.8%) were psychiatric patients (clinical group; both inpatients and ambulatory patients). The following diagnoses were reported as main diagnoses: depressive disorder (16; 11.8%), anxiety disorder (10; 7.4%), obsessive-compulsive disorder (4; 3%), bipolar disorder (2; 1.5%), autism spectrum disorders (3; 2.2%), adjustment disorder (3; 2.2%), schizophrenia (1; 0.7%), identity or relational problem (4; 3%), personality disorder (PD) not otherwise specified (30; 22.1%), avoidant PD (20; 14.7%), dependent PD (6; 4.4%), borderline PD (4; 2.9%), and obsessive-compulsive PD (3; 2.2%). Thirty persons (22%) refused to communicate their diagnosis. Characteristics of the two separate samples are shown in Table 1. Most respondents were highly educated middle-age women and belonged to a Protestant denomination. On average, they were regular churchgoers to whom religion was very salient.

## Results

### Cluster analysis of QGR

The *k*-means cluster analyses yielded three clusters in the clinical group and two clusters in the nonclinical group. Subgroups of patients differed significantly on all QGR subscales. Clusters in the nonclinical group differed significantly on all QGR subscales, except for Anger towards God, $F(1, 159) = 0.08$, $p = .779$. To facilitate the interpretation and comparison of configurations within and across mental health subgroups, average subscale score profiles are represented in Figure 1.

The clinical and nonclinical group shared two configurations of God representations with a similar profile. In the first common type (represented in Figure 1 by the lines with black and white triangles), high levels of Positive Feelings and Supportive Actions were combined with low levels of

**Table 1.** Characteristics of nonclinical and clinical sample.

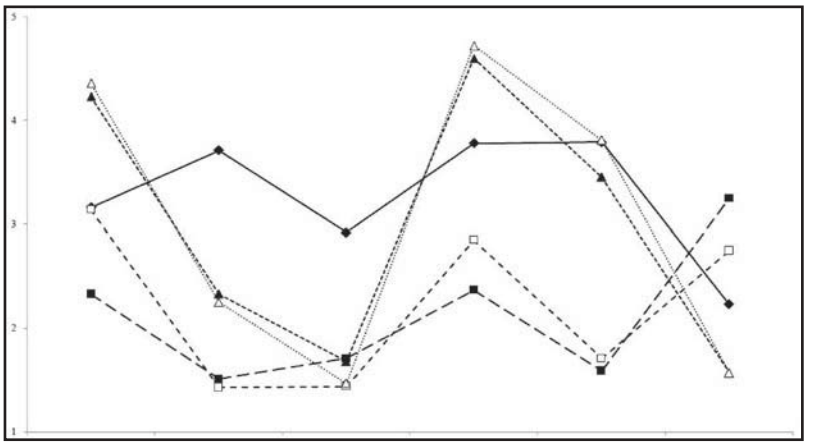
| | Clinical Sample[a] | | | | Nonclinical Sample[b] | | | |
|---|---|---|---|---|---|---|---|---|
| Variable | N | % | *M* | *SD* | N | % | *M* | *SD* |
| Female | 107 | 78.7 | | | 94 | 58.4 | | |
| Age | | | 33.10 [range = 18–67] | 11.8 | | | 38.81 [range = 18–83] | 15.6 |
| Marital status | | | | | | | | |
| No partner | 60 | 44.1 | | | 32 | 19.9 | | |
| With partner | 65 | 47.8 | | | 117 | 72.7 | | |
| No partner anymore | 10 | 7.4 | | | 11 | 6.8 | | |
| Education | | | | | | | | |
| Low (minimum of 8 years) | | | | | 1 | .6 | | |
| Average (minimun of 12 years) | 74 | 54.5 | | | 30 | 18.7 | | |
| High (minimum of 18 years) | 58 | 42.6 | | | 107 | 66.4 | | |
| Missing | 4 | 2.9 | | | 23 | 14.3 | | |
| Religious affiliation | | | | | | | | |
| Roman Catholic | 6 | 4.4 | | | 4 | 2.5 | | |
| Protestant – Ecumenical | 29 | 21.3 | | | 37 | 23.0 | | |
| Protestant – Reformed (Calvinistic) | 40 | 29.4 | | | 52 | 32.3 | | |
| Protestant – Orthodox-Reformed | 19 | 14.0 | | | 13 | 8.1 | | |
| Prostestant – Evangelical/Baptist | 29 | 21.3 | | | 19 | 11.8 | | |
| Islam | 2 | 1.5 | | | 5 | 3.1 | | |
| Buddhism/Other spirituality | 4 | 2.9 | | | 15 | 9.3 | | |
| No religion | 5 | 3.7 | | | 15 | 9.3 | | |
| Missing | 2 | 1.5 | | | 1 | 0.6 | | |
| Frequency of church attendance | | | | | | | | |
| Never | 8 | 5.9 | | | 9 | 5.6 | | |
| Less than once a month | 18 | 13.2 | | | 30 | 18.6 | | |
| Once a month | 10 | 7.4 | | | 11 | 6.8 | | |
| Every other week | 10 | 7.4 | | | 12 | 7.5 | | |
| Once on Sunday | 45 | 33.1 | | | 37 | 23.0 | | |
| Twice on Sunday | 45 | 33.1 | | | 62 | 38.5 | | |
| Religious saliency | | | 20.56 | 4.54 | | | 20.61 | 4.75 |

*Notes.* $N = 297$.
[a]$n = 136$.
[b]$n = 161$.

negative emotions (Anxiety and Anger towards God) and negative perceptions of God's actions or power (Passivity). Perceptions of God as Ruling/Punishing were also a common aspect for both patients and nonpatients with this God representation profile. Because of the relative importance of positive, supportive, and ruling/punishing aspects, this God representation profile was labeled as Positive-Authoritative God representation type; with this term, we parallel concepts of parental styles, authoritative parenting involving a combination of warm parental support with firm, demanding expectations, in contrast to authoritarian parenting, which combines high levels of demand with a cold, rigid emotional tone (Baumrind, 1991; Gunnoe, Hetherington, & Reiss, 1999; Nelson, 2009, p. 247). Overall, this Positive-Authoritative profile was found among 58.9% ($n = 175$) of participants: 49.3% ($n = 67$) of individuals in the clinical group and 67.1% ($n = 108$) in the nonclinical group, which suggests that this configuration of aspects of God representations was more prevalent among those without any psychiatric diagnosis than among the psychiatric patients.

The second type of common God representation profile was characterized by low scores on QGR scales, which measure feelings toward God (both positive and negative) and perceptions of Supportive Actions and Ruling/Punishing Actions, in combination with high scores on the Passivity scale; in Figure 1, these configurations are represented by the lines with black and white squares. This profile was labeled as the Passive-Unemotional God representation type (compare the uninvolved and permissive parenting style; Baumrind, 1991). Of the total group, 22.6% ($n = 67$) showed this profile—10.3% ($n = 14$) of the patients and 32.9% ($n = 53$) of the nonpatients.

Remarkably, both types of God representations share similar levels of Anxiety and Anger. However, these negative feelings toward God are combined with different levels of the other aspects




*Note.* POS = Positive Feelings; ANX = Anxiety; ANG = Anger;

SUP = Supportive Actions; RULP = Ruling/Punishing Actions; PAS = Passivity.

| | | |
|---|---|---|
| ▲ | Positive-Authoritative clinical God image type | (*n* = 67) |
| △ | Positive-Authoritative non-clinical God image type | (*n* = 108) |
| ■ | Passive-Unemotional clinical God image type | (*n* = 14) |
| □ | Passive-Unemotional non-clinical God image type | (*n* = 53) |
| ◆ | Negative-Authoritarian clinical God image type | (*n* = 55) |

**Figure 1.** Questionnaire of God Representations mean score profiles of clusters.

of God representations: The Positive-Authoritative configuration combines a high level of Anxiety and Anger with higher levels of Positive Feelings towards God, higher levels of Supportive and Ruling/Punishing Actions, and lower levels of Passivity, as compared to the Passive-Unemotional God image type.

Whereas these latter two God image profiles were found among both psychiatric patients and nonpatients, one configuration was found among psychiatric patients only, combining high levels of Anxiety and Anger towards God, high levels of Ruling/Punishing perceptions, and, in contrast to the Positive-Authoritative type, low levels of Positive Feelings and Supportive Actions. In Figure 1, the line with tilted black squares represents this configuration. Because of the combination of high levels of negative emotions and strong perceptions of Ruling/Punishing Actions this cluster was labeled as the Negative-Authoritarian God representation type ($n$ = 55; 40.4% of the patients, 0% of the nonpatients, and 18.5% of the total group). As just described, we parallel authoritarian parenting style with this term (Nelson, 2009; cf. Baumrind, 1991). Note that the levels of Ruling/Punishing perceptions are similar to those of the Positive-Authoritative type.

## *Secondary analyses*

To gain more insight into the psychological and religious background of the participants with different types of God representations and to relate the cluster solution to external criteria, various secondary

analyses were done. First, we wanted to know who the patients were who reported the Positive-Authoritative, Negative-Authoritarian, and Passive-Unemotional configurations in terms of affective state. Second, we analyzed the relationships between the religious background of all respondents, in particular religious saliency and religious denomination, and the God representation clusters.

A MANOVA with PA and NA as dependent variables and type of God representation as between-subject factors (fixed factors, $N = 3$) showed that patients with different types of God representations significantly differed in terms of affective state (Roy's Largest Root = .13), $F(2, 133) = 8.46$, $p < .001$, partial $\eta^2 = .11$. Patients with a Positive-Authoritative type of God representation reported more PA ($M = 31.79$, $SD = .78$), 95% confidence interval (CI) [30.25, 33.33], and less NA ($M = 26.90$, $SD = .93$), 95% CI [25.06, 28.73], than patients with a Negative-Authoritarian type ($M_{PA} = 27.76$, $SD = .86$), 95% CI [26.06, 29.47]; ($M_{NA} = 31.66$, $SD = .1.03$), 95% CI [29.63, 33.68], the latter being more distressed and depressed (cf. Clark & Watson, 1991). Norm tables suggest that psychopathology of patients with a Positive-Authoritative type of God representation is mostly characterized by anxiety (high NA, average PA), whereas patients with a Negative-Authoritarian type mainly suffer from depressive pathology (high/very high NA, low PA) (Clark & Watson, 1991; Peeters et al., 1999). Patients with the Passive-Unemotional profile did not differ from those with Positive-Authoritative and Negative-Authoritarian profiles regarding NA and PA.

Both religious saliency and religious denomination were examined in relation to the different clusters of God representations. An analysis of variance with religious saliency as dependent variable and five clusters of God representations (three clinical clusters and two nonclinical ones) as fixed factors was significant, $F(4, 289) = 89.96$, $p < .001$, partial $\eta^2 = .56$, and showed that there were significant differences between all types of God representations with large effect sizes, except between Passive-Unemotional types and between Positive-Authoritative types. In general, religion was far less important to respondents who reported a passive type of God representation than to respondents who reported a positive or negative type. Post hoc multiple comparisons revealed that participants belonging to the general population with a Positive-Authoritative type of God representation ($M = 23.22$, $SD = 2.34$, $p < .001$), 95% CI [22.77, 23.66], scored significantly higher on religious saliency than participants belonging to the general population with a Passive-Unemotional type of God representation ($M = 15.36$, $SD = 3.98$, $p < .001$), 95% CI [14.26, 16.46], or than patients with a Passive-Unemotional type of God representation ($M = 12.00$, $SD = 5.59$, $p < .001$), 95% CI [8.77, 15.23]. Psychiatric patients with a Positive-Authoritative type of God representation ($M = 22.66$, $SD = 2.35$, $p < .001$), 95% CI [22.08, 23.23], also scored significantly higher on religious saliency than patients with a Passive-Unemotional type ($M = 12.00$, $SD = 5.59$, $p < .001$), 95% CI [8.77, 15.23], and than patients with a Negative-Authoritarian type ($M = 20.19$, $SD = 3.54$, $p < .001$), 95% CI [19.21, 21.16]. Patients with a Negative-Authoritarian type ($M = 20.19$, $SD = 3.54$, $p < .001$), 95% CI [19.21, 21.16], reported a more significant role of religion in their lives than patients with a Passive-Unemotional type ($M = 12.00$, $SD = 5.59$, $p < .001$), 95% CI [8.77, 15.23]. These findings are confirmed by Table 2, which shows that respondents who do not belong to a monotheistic religion

**Table 2.** Types of God representation and religious denomination for the clinical and nonclinical sample.

| | Types of God Representation | | | | | |
|---|---|---|---|---|---|---|
| Religious Denomination | Passive (Clinical) | Positive (Clinical) | Negative (Clinical) | Positive (Nonclinical) | Passive (Nonclinical) | Total |
| Roman Catholic | 2 (33.3%) | 3 (50%) | 1 (16.7%) | 3 (75%) | 1 (25%) | 10 |
| Protestant/Ecumenical | 4 (13.8%) | 17 (58.6%) | 8 (27.6%) | 19 (51.4%) | 18 (48.6%) | 66 |
| Protestant/Reformed (Calvinistic) | 0 (0.0%) | 25 (62.5%) | 15 (37.5%) | 50 (96.2%) | 2 (3.8%) | 92 |
| Protestant/Orthodox-Reformed | 0 (0.0%) | 5 (26.3%) | 14 (73.7%) | 10 (76.9%) | 3 (23.1%) | 32 |
| Protestant/Evangelical-Baptist | 0 (0.0%) | 15 (51.7%) | 14 (48.3%) | 17 (89.5%) | 2 (10.5%) | 48 |
| Islam | 0 (0.0%) | 1 (50%) | 1 (50%) | 5 (100%) | 0 (0.0%) | 7 |
| Buddhism/Other spirituality/No religion | 8 (88.9%) | 0 (0.0%) | 1 (11.1%) | 3 (10%) | 27 (90%) | 39 |
| Total | 14 (10.4%) | 66 (49.3%) | 54 (40.3%) | 107 (66.9%) | 53 (33.1%) | 294 |

and/or indicate that they are not religious at all predominantly report a Passive-Unemotional type of God representation.

Furthermore, Table 2 points out that, although patients of all religious denominations report Positive-Authoritative and Negative-Authoritarian types of God representations, only Orthodox-Reformed patients report more Negative-Authoritarian than Positive-Authoritative types. Orthodox-Reformed patients do this significantly more than other protestant patients, with a medium effect, $\chi^2$ (3) = 9.05, $p < .05$, Cramer's V = .28.

Both the Positive-Authoritative and the Negative-Authoritarian type of God representations show high levels of Ruling/Punishing perceptions of God. To gain more insight into the nature of this image of God as a judge, the content of the RULP was explored in relation to type of God representation by means of a MANOVA, which included the 67 patients with the Positive-Authoritative type and the 55 patients with the Negative-Authoritarian type. Type of God representation was the between-subjects factor, with the four items of the RULP scale as the dependent variables. This MANOVA was significant (Roy's Largest Root = .12), $F(4, 117) = 3.49$, $p < .005$. Pairwise comparisons showed that patients significantly differed on only one item, namely, "God sends people to hell." Those with a Negative-Authoritarian type of God representation ($M = 3.38$, $SD = 1.33$), 95% CI [3.03, 3.74], scored significantly higher on this item than those with a Positive-Authoritarian type of God representation ($M = 2.63$, $SD = 1.43$), 95% CI [2.31, 2.95], $p < .01$.

## Discussion and Conclusions

*K* means cluster analyses revealed three types of God representations. Two of them were common to both patients and nonpatients: a Positive-Authoritative type (which comprised positively valenced feelings and cognitions in relationship to God) and a Passive-Unemotional type (in which perceptions of God's passivity dominate in combination with relatively low scores on the QGR scales which measure feelings toward God). A Negative-Authoritarian type (in which ruling/punishing perceptions of God are associated with strong anxious and angry feelings toward God) was observed among psychiatric patients only. More than half of all participants reported the positive configuration of aspects of their God representations, and this profile seems to be overrepresented in the nonclinical sample. The negative configuration was found among the psychiatric group only, although more patients reported a Positive-Authoritative configuration than a Negative-Authoritarian one. These findings support our hypotheses and suggest that mental health moderates the interactions between different aspects of God representations (cf. Granqvist, 2014). Probably those with mental health problems experience (or report) more religious struggles and negative feelings toward God. The Passive-Unemotional type of God representation, which we did not expect in terms of hypotheses, seems to be reported mainly by those who are not so highly involved in religion. Religion is less important to them than to respondents with Positive-Authoritative and Negative-Authoritarian types of God representations. However, only a small number of people reported this Passive-Unemotional type of God representation, as most participants were (female) regular churchgoers to whom religion was an essential element of their lives, and our clinical and nonclinical subsamples were rather homogeneous in this respect. Thus, the diversity of the Dutch religious culture, ranging from secularized and agnostic individuals to highly devoted orthodox-reformed Christians (Bernts & Berghuis, 2016), clearly affected our results, although our sample was not fully representative for this diversity and results could not be simply generalized to other samples; in fact, they could predominantly be generalized to samples of Protestants to whom religion is highly salient. Therefore, future studies should investigate types of God representations and mental health among more diverse subsamples, in terms of gender, age, educational level, religious denomination, and religious saliency.

### *God representations of psychiatric patients: Clinical implications and prospects for further study*

Psychiatric patients showed Positive, Negative, and Passive types of God representations. Psychiatric patients with the Positive-Authoritative and Negative-Authoritarian configurations reported comparable mean scores on the Ruling/Punishing subscale. However, when these scores are interpreted in the context of the configuration, the meaning of comparable high scores on Ruling/Punishing seems different. In a positive configuration, God's ruling/punishing actions have a supportive connotation. God could be described as the King who rules and guides, maybe even guaranteeing redemption of evil at the end of time and reward of the good, which is a comforting belief. This positive idea of God as a ruler was also found in earlier studies (Braam et al., 2008; Schaap-Jonker et al., 2008). However, in a negative configuration God's ruling/punishing actions are experienced as threatening and oppressing, God being experienced as a wrathful judge or a dictator who evokes fear of punishment, rejection, or condemnation because He may send you to hell. In this study, those who report this type of God representation also suffer from psychopathology—although the cross-sectional nature of the study prevents causal interpretations of this association. They also report more negative affects and less positive affects than patients who report a positive type of God representation, being more distressed and depressed (cf. Clark & Watson, 1991).

The associations mentioned suggest that the burden these patients have to cope with is relatively high. Therefore, clinicians should pay attention to the existential and/or religious aspects of their patients' pathology. Exploring patients' religiousness, they should focus on types or profiles of God representations, not on single aspects, and discuss them with the patient in relation to her or his specific context and psychic history, in particular to object relations and/or attachment style. In this way, the patient may gain insight into psychological processes (e.g., projection) and contextual factors that affect her or his dominant type of God representation, as well as her or his latent types of God representations. Insight may create a "potential space" for therapeutic growth and recovery. Change of God representations may be facilitated by implicit interventions, which indirectly change God representations through changing self-representations, and explicit interventions, which directly address God representations (Moriarty, 2007; Rizzuto & Shafranske, 2013).

The presence of both these positively and negatively valenced types of religious experience is in line with empirical literature about the relationship between religion and mental health. For example, although symptomatology and personality pathology are often associated with predominantly negatively valenced God representations (Braam et al., 2014; Schaap-Jonker et al., 2002), God representations may also remain positive, even in case of psychopathology (Bennett, Shepherd, & Janca, 2013). This observation raises the question of whether a positively valenced God representation among psychiatric patients is similar to that of nonclinical subjects, or is related to or a marker of a specific type of psychopathology, that is, schizotypal trait/psychotic vulnerability. In other words, do these positive experiences in relationship to God have a realistic or a magical nature? In line with results of Unterrainer and colleagues, who found religious and spiritual well-being to be significantly associated with magical thinking as an indicator of schizotypy, with religious and spiritual well-being reflecting both positively and negatively valenced aspects of a schizotypal personality (Unterrainer et al., 2011), it could be that positively valenced experiences in the perceived relationship to God might be a symptom of projection of magical wishes into the religious domain, and an expression of intolerance of frustration and aggression, maybe due to a psychotic personality organization (cf. Kernberg, 1975, 2000). More research is needed in this context to investigate whether positively valenced God representations of patients differ qualitatively from those of nonpatients.

Next, more research is needed on potential pathways through which negative types of God representations as aspects of religiousness/spirituality may facilitate or harm mental health. In this regard, Park and Slattery (2013, pp. 549–551) pointed to positive and negative affect as potential important pathways, among other things. They indicate that religions often promote spiritually

relevant positive emotions (such as love, thankfulness, comfort, and security), positive affect being related to higher levels of religions and spirituality and to mental health and emotional well-being. In contrast, specific types of religion may evoke negative affect, for example, because they stress the sinful nature of human beings, which may lead to feelings of guilt and fear and may increase the risk of depression and anxiety disorders. In the current study, causal mechanisms in the relationship between positive and negative affect, on one hand, and types of God representations, on the other, could not be detected. However, our results concerning religious background fit Park and Slattery's assumptions: Only the Orthodox-Reformed patients, who belong to churches in which man's sinfulness and unworthiness is stressed, in contrast to God's holiness and righteousness (cf. Eurelings-Bontekoe & Schaap-Jonker, 2010), report (far) more the negatively valenced God representation type than the positive type. However, the number of Orthodox-Reformed patients was rather small; hence, further studies should investigate the role of (a strict and orthodox) religious background among larger (sub)samples.

From an attachment perspective, the Positive-Authoritative, Negative-Authoritarian, and Passive-Unemotional types of God representations could be associated with a secure/autonomous attachment style with God, an anxious-ambivalent/preoccupied style, and an avoidant/dismissive attachment style with God, respectively (Granqvist & Kirkpatrick, 2016). Follow-up studies should examine relationships between attachment styles and types of God representations in the context of religious background.

### *Value of a person-oriented approach for the study of God representations*

In this study, the value of a person-oriented approach, operationalized by means of cluster analysis, was demonstrated. Because this approach is more nuanced, enabling refined distinctions concerning (smaller) subgroups, it is more informative and relevant, both in a scientific and a clinical context. The different meaning of the ruling/punishing aspect of God representations in different types that was found in the current study underlines the importance of this approach. By implication, as a scoring pattern is more informative than a single scale score, we highly recommend the use of scoring profiles rather than separate scales, both for scientific research and clinical diagnostics (cf. Eurelings-Bontekoe, Onnink, Williams, & Snellen, 2008). Furthermore, as the person-oriented approach provides a framework not only for theoretical conceptualizations but also for problem formulation, research strategy, research methodology, and for the interpretation of findings (Bergman & Andersson, 2010), we recommend the use of this approach for the study of God representations, God representations themselves being conceptualized as multifaceted and dynamic processes, comprising multiple aspects of psychic functioning, such as cognitive, affective, developmental, social, and cultural processes (see earlier; cf. Davis et al., 2013; Hall & Fujikawa, 2013; Rizzuto & Shafranske, 2013). In this regard, the person-oriented approach could not only enrich psychology (of religion) by bridging the gap between more cognitive-oriented explorations of God representations as cognitive constructs (e.g. Gibson, 2007; Lindeman, Pyysiäinen, & Saariluoma, 2002) and more affective, attachment-based approaches of God representation development and dynamics (e.g., Davis et al., 2013) but could also facilitate the articulation of associations between different psychological disciplines such as developmental, social, clinical and personality psychology, and psychology of religion.

### *Strengths and limitations of the current study*

Strength of the current study is that it combines data of both psychiatric patients and nonpatients. As such, it extends existent literature on religion and mental health, as many studies that addressed this relationship examined healthy populations rather than including samples of respondents who meet diagnostic criteria for mental disorders (Park & Slattery, 2013, p. 541). The results of the present study, showing that the Negative-Authoritarian configuration of God representations was

observed in the clinical sample only and that the Positive-Authoritative configuration of God representations occurs less frequent in patients than in nonpatients, emphasize the necessity of taking into account mental health status in the study of religion in general and God representations in particular (cf. Granqvist, 2014). However, the current study uses only self-report data (with no information about response rate or characteristics of non-responders) and has a cross-sectional design that yields descriptive, correlational results. The instructions regarding the QGR led to measuring the participants' chronically accessible experiential God representations on an explicit level. More situation- or context-specific types of God representations should be addressed in follow-up studies, which could also use other measures, including implicit and qualitative ones (Davis et al., 2016; cf. Smith & Conrey, 2007). Furthermore, the *why* of the current results could not be explained, as potential pathways or explanatory psychological processes are not included in the research design. Therefore, to gain more insight into the associations between religion (or God representations) and mental health (or symptomatology and personality pathology), follow-up studies should adopt a longitudinal design and should include more psychological variables that could explain the associations. For example, dimensional measures of symptomatology or personality could lead to a more adequate and refined understanding than only a general measure as affective state. A paper that addresses in more depth the questions about types of God representations, personality organization, and mental health is in preparation (Van der Velde, Schaap-Jonker, Eurelings-Bontekoe & Corveleyn, 2017).

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## ORCID

Hanneke Schaap-Jonker http://orcid.org/0000-0002-0825-6188

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