PsycHology, PsychiatrY & Brain NeuroscIence Section

Brief Research Report

God Image and Happiness in Chronic Pain Patients: The Mediating Role of Disease Interpretation

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Abstract

Objective. The present study explored the role of the emotional experience of God (i.e., positive and negative God images) in the happiness of chronic pain (CP) patients. Framed in the transactional model of stress, we tested a model in which God images would influence happiness partially through its influence on disease interpretation as a mediating mechanism. We expected God images to have both a direct and an indirect (through the interpretation of disease) effect on happiness.

Design. A cross-sectional questionnaire design was adopted in order to measure demographics, pain condition, God images, disease interpretation, and happiness. One hundred thirty-six CP patients, all members of a national patients’ association, completed the questionnaires.

Results. Correlational analyses showed meaningful associations among God images, disease interpretation, and happiness. Path analyses from a structural equation modeling approach indicated that positive God images seemed to influence happiness, both directly and indirectly through the pathway of positive interpretation of the disease. Ancillary analyses showed that the negative influence of angry God images on happiness disappeared after controlling for pain severity.

Conclusion. The results indicated that one’s emotional experience of God has an influence on happiness in CP patients, both directly and indirectly through the pathway of positive disease interpretation. These findings can be framed within the transactional theory of stress and can stimulate further pain research investigating the possible effects of religion in the adaptation to CP.

Key Words. Quality of Life; Psychosocial Factors; Psychology; Chronic Pain

Introduction

A recent study revealed that nearly one in five Europeans suffer from chronic pain (CP) [1]. This pain condition has a devastating impact on both the individual and the society, leaving individuals depressed, unable to function properly in daily life, and frequently held back in their work [1]. Despite this detrimental influence of CP on the quality of life, very few studies exist on the role of psychosocial factors, and especially religion, on individuals’ adjustment to CP. However, the few existing studies indicate that religion might indeed influence the well-being of CP patients by, for example, mitigating stress or offering tools for coping [2–5]. Because CP impacts heavily on the lives of individuals, and because religion seems to play an important role for these patients, further research in this field is warranted. Consequently, we investigated how the experience of God (i.e., God images) influenced the
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well-being of CP patients. Further, we explored one possible underlying mechanism explaining this relationship, that is, positive disease interpretation.

Religion: A Mitigating Role in the Confrontation with CP?

Some researchers suggested that aspects of religion may mitigate or buffer the negative consequences of stressors on well-being [6,7]. This idea is inspired by the transactional model of stress in which adjustment is viewed as a dynamic and active process [8]. During this process, individuals try to cope with various life demands by using cognitive appraisals and by relying on certain coping strategies. Within this view, the function of religion in the appraisal of events can be twofold. On the one hand, it can influence the primary appraisals of stressful events (i.e., evaluating the situation as harmful, threatening, or challenging, such as evaluating the illness as part of a broader divine plan). On the other hand, religion can influence the secondary appraisals of stressful events (i.e., evaluating one’s abilities to handle the situation, such as feeling supported by God to cope with pain). In addition, religion can also provide specific tools of coping behavior such as prayer. Park and Folkman [9] elaborated further on the stress and coping framework by emphasizing the process of meaning making when confronted with a stressful life demand. They stated that religion can be seen as a global meaning system which can provide meaning to a stressor at several levels (i.e., personal significance, causal explanation, coping). Gall and colleagues [10] used the basic tenets and the structural components of the transactional model as a framework for the integration of the research on spirituality and health.

Although the role of religion in appraisal and coping with CP is a valuable and interesting approach, studies implementing this perspective in pain research remain scarce (see [11], for a theoretical argumentation). Despite this paucity in research, we hypothesize that enduring pain may evoke existential reflections concerning the meaning and purpose of life, and could trigger the religious meaning system of CP patients. However, the small amount of studies investigating the relation between religiosity and well-being in CP populations mainly focuses on religious/spiritual coping with pain [12,13]. These studies seem to indicate that religious coping is indeed important for CP patients. For example, Keefe and colleagues [14] found that in a sample of rheumatoid arthritis patients, the use of religious coping methods was associated with positive mood. Abraido-Lanza, Vasquez, and Echeverria [15] revealed a direct effect of religious coping on the psychological well-being of patients with arthritis. Framing these studies in the transactional model of stress, religion is operationalized in terms of religious coping and, hence, as a possible type of coping behavior. However, no attention is paid to aspects of religion that can play a role in the appraisal of a chronic stressor such as long lasting pain.

Affective Aspect of Religion: God Image

Religion is a multidimensional concept and encompasses cognitive, emotional, behavioral, and motivational aspects, with each of these aspects relating differently to well-being [16]. The main focus in research studying the association between religion and well-being is on religious behavior and religious attitudes [17]. However, the aspect of God representation is an underinvestigated but valuable aspect of religion and focuses on how the individual experiences God. In line with Rizotto’s earlier work [18] on God representations, recent research [19,20] pointed out that, besides a cognitive and intellectual understanding of God (labeled God concept), people also have an emotional and personal experience of God (labeled God images).

The spiritual framework of coping [10] pays attention to the spiritual connection with a transcendent other (God) and its role in the coping process. Indeed, recent studies already pointed out that these God representations play a role in coping with stress. For instance, Gall [21] revealed that in a sample of breast cancer patients, a benevolent God concept was associated with less psychological distress, whereas a negative God concept was related to more emotional distress [22]. Further, Pargament and colleagues [23] found that individuals’ attributions of negative life events to a punishing or angry God resulted in poorer psychological outcomes. Some recent studies [24; Schaap-Jonker H, Eurelings-Bontekoe E, Zock H, Jonker E, Corveleyn J, unpublished data] stated that negative God images were associated with high levels of psychological distress and negative affect, whereas positive God images (POS GI) were associated with positive affect in community samples.

Based on these research results, we hypothesize that God images, being an essential aspect of the religious meaning system, will influence the lives of individuals, by providing possible anchors for appraisal and coping behavior. In line with Gall and colleagues [10], we assume that the relationship with God can fulfill several functions such as provision of comfort, a sense of belonging, empowerment, and control. Furthermore, framed in the transactional theory of stress, we assumed that the positive interpretation of a disease might be a valuable mediator in the relationship between God images and well-being. The presence of POS GI may offer a deepened sense of coherence and comprehensibility of reality and enhance the creation of meaning [10,25]. Indeed, the experience of enduring pain can have significance before an omniscient divinity and therefore gain significance for the patient as well. Thus, the God images can contribute to a sense of meaningfulness, which can be expected to have a significant effect on well-being [26]. For CP patients, this might be concretized in the reframing or reinterpretation of their pain and disease experience. Relatedly, Park and Cohen [27] found that individuals who attributed negative life events (i.e., the death of a close friend) to a loving God, were more likely to report higher positive reinterpretation coping and, subsequently, higher personal growth. In line with this, Maton [28] suggested that the use of spiritual support (for example,
offered by the presence of a benevolent God image) can influence well-being through enhancing positive, adaptive appraisals of a traumatic event.

The Purpose of This Study

The present study explored the role of God images for the happiness of CP patients. Happiness can be defined as the positive affective aspect of subjective well-being [29]. Studies showed that positive affects are important for CP patients because they seem to foster resilience when pain is high [30]. Therefore, we tested a model in which God images would influence happiness partially through its influence on disease interpretation as a mediating mechanism. We expected the God images to have both a direct and an indirect (through the interpretation of disease) effect on happiness. The direct relations between God images and happiness for CP patients were predicted as follows: we expected 1) positive associations between POS GI and happiness; and 2) negative associations between negative God images and happiness. In terms of the indirect effect of God images on happiness, we predicted that 3) POS GI would be related to higher levels of positive interpretation of disease and, subsequently, to higher levels of happiness; whereas 4) negative God images would be related to lower levels of positive interpretation of disease and, subsequently, to lower levels of happiness.

Method

Participants

The sample consisted of CP patients who are members of a national patients’ association. The study was part of an ongoing collaboration between the Center for the Psychology of Religion and two patient associations (i.e., the Flemish Pain League and the Ray of Hope association). The board of the patient associations distributed 250 questionnaires by mail to their members. One hundred thirty-six patients filled out the entire questionnaire. Selection criterion of at least 6 months pain duration was reached by all participants. Anonymity was guaranteed and participants were informed that the return of the completed questionnaire indicated informed consent. The majority of the sample was female (72%) and age ranged from 22 years to 83 years (M = 51.34, standard deviation [SD] = 10.96). The marital status was single for 21% of the participants, married for 63%, cohabiting for 9%, widowed for 3%, and divorced for 4%. The highest educational level was primary school for 8.1%, secondary school for 50.7%, and higher education for 41.1% of the sample. Mean pain duration was 16 years (SD = 11.03, range 2–60). Level of church attendance was weekly for 11% of the participants, monthly for 11%, on special occasions for 41%, and never for 36%. The majority of the participants were Catholics (31%), 24% were Christians without affiliation with the Catholic church, 22% were believers without any church affiliation, 14% were unbelievers, 4% were agnostics, and 5% were others (e.g., Protestant Christians, spiritual seekers). The religious profile of the sample was representative for the Belgian population.¹

Instruments

Religiosity

Church attendance (“how often do you go to church”; 1 = never, 5 = several times a week) and Denomination (“what kind of denomination do you have?”) were measured with a single item. Church attendance and Denomination were only assessed for the purpose of sample description. In addition, participants filled out the Dutch Questionnaire of God Images (QGI; [31]). The scale covers both an affective component and a more cognitive component. The affective component is used in this study and consists of three scales namely a positive emotional experience of God (e.g., closeness, security), a subscale focusing on anxiety in the experience of God (e.g., uncertainty), and a subscale focusing on angry feelings when interacting with God (e.g., anger, dissatisfaction). Participants rated the 17 descriptors of the QGI on a 5-point Likert scale ranging from 1 (totally not descriptive) to 5 (totally descriptive). Estimates of internal consistency (Cronbach’s alpha) were 0.98 for the positive subscale, 0.89 for the anxiety subscale, and 0.86 for the anger subscale.²

Happiness

The 8-item Oxford Happiness Questionnaire [32] was administered. Items were rated on a 6-point scale (1 = strongly disagree, 6 = strongly agree). The scale measures the affective aspect of subjective well-being (e.g., “I feel that life is very rewarding”). Cronbach’s alpha of the scale was 0.71.

Pain

Besides pain duration (“since how long do you suffer from pain”), pain intensity was measured with three questions (“what is the level of pain at this moment,” “what was the highest pain level last week,” and “what was the lowest pain level last week;” [12]). A composite pain index was obtained through calculating the mean of these items. Cronbach’s alpha of the three items was 0.83.

¹ Data from the European Value Study [52] showed that in a Flemish sample of believers (N = 1,049), 91.1% were Christians, 0.2% Jewish, 4.8% Muslim, 0% Hindu, 0% Buddhist, 0.6% Orthodox, and 3.4% other. Belgium is a secularized country with a strong Catholic history. Most Belgians denote themselves as Catholic or as Christian, although active participation and involvement is low.

² Although some participants denoted themselves as unbelievers or agnostics, almost all participants (except five) filled out the Questionnaire God Image. Due to the small size of this group, these participants are kept out of the analyses. Analyses are thus performed on the group of participants who filled out the entire questionnaire (N = 136). We assume that the remaining part of unbelievers/agnostics who filled out the questionnaire based themselves on culturally constructed God images formed by socialization processes.
Positive Interpretation of Disease

To measure the way their illness is perceived, a subscale of the Spiritual and Religious Attitudes in Dealing with Illness scale [33] was administered. The subscale “Positive Interpretation of Disease” consists of five items rated on a 5-point scale (1 = never, 5 = very often). The scale measures an appraisal coping in which illness is seen as an opportunity to change life or to reflect upon what is essential in life (e.g., “illness encourages me to get to know myself better”). Cronbach’s alpha was 0.76.

Results

Preliminary Analyses

First, we investigated the relations among all study variables and the socio-demographic variables (age, gender, and education). No significant mean-level differences were found between men and women concerning levels of positive interpretation of disease, happiness, POS GI, anxious God images (ANX GI), and angry God images (ANGER GI) (Hotellings’s trace = 0.05, F(7/128) = 0.84, P = 0.55). All correlations among the variables are shown in Table 1. We used Cohen’s d [34] to describe the effect sizes. POS GI was small but significantly related with age (r = 0.29, P < 0.01), and ANX GI was small but significantly related with the duration of pain showed a medium significant positive correlation with age (r = 0.41, P < 0.01), and a small positive correlation with POS GI (r = 0.18, P < 0.05). Pain severity showed a small negative correlation with positive interpretation of disease (r = -0.25, P < 0.01), a medium negative correlation with happiness (r = -0.32, P < 0.001), and a small positive correlation with ANGER GI (r = 0.20, P < 0.05).

As hypothesized, the experienced God image was significantly related with happiness in CP patients. POS GI showed a medium positive correlation with happiness (r = 0.37, P < 0.001) and ANGER GI showed a small negative correlation with happiness (r = -0.20, P < 0.05). Finally, positive interpretation of disease showed a medium significant positive correlation with POS GI (r = 0.18, P < 0.05), and a small negative correlation with ANGER GI (r = -0.19, P < 0.05).

Primary Analyses

Measurement Model

The intervening role of positive interpretation of disease in the relationship between God images and happiness was examined by means of structural equation modeling using LISREL 8.54 [35] on latent variables. These latent constructs were modeled based on the items from the respective scales. Because gender, age, and educational level were not systematically related with happiness or disease interpretation, they were not included in the model. To evaluate model fit, we used Goodness of Fit Index (GFI), Comparative Fit Index (CFI), and Root Mean Square Error of Approximation (RMSEA).

Table 1 Correlations between the socio-demographic variables and the study variables

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Education</th>
<th>Pain Duration</th>
<th>Pain Severity</th>
<th>POS GI</th>
<th>ANGER GI</th>
<th>ANX GI</th>
<th>Positive Disease Interpretation</th>
<th>Happiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>—</td>
</tr>
<tr>
<td>Education</td>
<td>-0.13</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Pain duration</td>
<td>0.41***</td>
<td>0.08</td>
<td>—</td>
<td>—</td>
<td>0.28**</td>
<td>0.02</td>
<td>0.18*</td>
<td>0.00</td>
<td>—</td>
</tr>
<tr>
<td>Pain severity</td>
<td>0.01</td>
<td>-0.15</td>
<td>0.02</td>
<td>—</td>
<td>0.00</td>
<td>0.16</td>
<td>-0.05</td>
<td>0.20*</td>
<td>-0.06</td>
</tr>
<tr>
<td>POS GI</td>
<td>0.02</td>
<td>-0.16</td>
<td>-0.05</td>
<td>0.00</td>
<td>0.00</td>
<td>0.20</td>
<td>-0.06</td>
<td>-0.06</td>
<td>—</td>
</tr>
<tr>
<td>ANGER GI</td>
<td>0.08</td>
<td>-0.20*</td>
<td>0.03</td>
<td>0.11</td>
<td>0.29**</td>
<td>0.51***</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>ANX GI</td>
<td>0.00</td>
<td>0.07</td>
<td>0.00</td>
<td>-0.25**</td>
<td>0.27*</td>
<td>-0.19*</td>
<td>-0.01</td>
<td>-0.09</td>
<td>0.44***</td>
</tr>
<tr>
<td>Positive disease interpretation</td>
<td>0.13</td>
<td>0.04</td>
<td>0.11</td>
<td>-0.32***</td>
<td>0.37***</td>
<td>-0.20*</td>
<td>—</td>
<td>—</td>
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</tr>
</tbody>
</table>

* P < 0.05; ** P < 0.01; *** P < 0.001.
POS GI = positive God images; ANGER GI = angry God images; ANX GI = anxious God images.
inspected the Satorra-Bentler Scaled chi-squared (SBS-χ²) [36]. A SBS-χ² to degree of freedom ratio (SBS-χ²/d.f.) lower than 3.0 indicates good model fit [37]. Combined cut-off values close to 0.95 for comparative fit index (CFI) and close to 0.06 for root mean square error of approximation (RMSEA) indicate good model fit [38]. Estimation of the measurement model indicated good model fit (SBS-χ²/d.f. = 322.20/269 = 1.20, RMSEA = 0.04, CFI = 0.99).

Structural Models
In our study, the following three models were estimated and compared: 1) a direct effects model including the direct effects of God images on happiness; 2) a full mediation model in which God images are indirectly related to happiness through the hypothesized mediator (i.e., positive interpretation of disease); and 3) a partial mediation model including direct paths from God images to happiness and indirect paths through positive interpretation of disease. According to Cohen’s criteria [34], all significant paths were medium in effect size.

The direct effects model showed a good fit to the data (SBS-χ²/d.f. = 322.20/269 = 1.20, CFI = 0.99, RMSEA = 0.03). The path from POS GI to happiness (β = 0.42, P < 0.001) was significant, whereas the paths from ANX GI to happiness (β = -0.07, P > 0.05) and from ANGER GI to happiness (β = -0.22, P > 0.05) were not significant. Next, the full mediation model showed a good fit to the data (SBS-χ²/d.f. = 492.31/398 = 1.24, CFI = 0.99, RMSEA = 0.04). The independent paths from POS GI to disease interpretation (β = 0.32, P < 0.01) and from ANGER GI to disease interpretation (β = 0.26, P < 0.05) were both significant. The path from ANX GI to disease interpretation (β = 0.02, P > 0.05) was not significant. As expected, the path from disease interpretation to happiness was also significant (β = 0.62, P < 0.001). We compared these findings with the partial mediation model, in which the three direct relations from God images to happiness were added to the model. This partial mediation model showed an adequate fit (SBS-χ²/d.f. = 480.76/395 = 1.22, CFI = 0.99, RMSEA = 0.04), and adding the three direct paths from God images to happiness did significantly improve the model fit (χ²diff (3) = 15.20, P < 0.001) as compared with the full mediation model. This improvement was due to a positive path from POS GI to happiness (β = 0.56, P < 0.001) and ANGER GI (β = -0.25, P < 0.05) to positive interpretation of disease remained significant. In a final model, we trimmed the paths which did not reach significance (i.e., paths from ANX GI to disease interpretation and to happiness). This final model (Figure 1) showed a good fit to the data (SBS-χ²/d.f. = 484.64/398 = 1.22, CFI = 0.99, RMSEA = 0.04).

Ancillary Analyses
Because of the significant associations between pain severity and both disease interpretation and happiness, we performed an additional set of analyses in order to control for the influence of pain severity by allowing paths from this variable to all other variables in the model [39]. The direct effects model showed a good fit to the data (SBS-χ²/d.f. = 389.86/340 = 1.15, CFI = 0.99, RMSEA = 0.03) with a positive path from POS GI to happiness (β = 0.43, P < 0.001). Pain severity had a significant effect on happiness (β = -0.32, P < 0.001) and ANGER GI (β = 0.23, P < 0.05) but not on the other God images. The full mediation model showed a good fit to the data (SBS-χ²/d.f. = 77.91/483 = 0.20, CFI = 0.99, RMSEA = 0.04) with a significant path from POS GI to positive interpretation of disease (β = 0.32, P < 0.001), and a significant path from disease interpretation to happiness (β = 0.56, P < 0.001). However, in contrast with the previous model, without pain severity, the path from ANGER GI to disease interpretation did not reach significance. The partial mediation model (SBS-χ²/d.f. = 565.51/480 = 1.18, CFI = 0.99, RMSEA = 0.04), which significantly improved the model fit (χ²diff (3) = 17.51, P < 0.001), showed an additional direct significant path from POS GI to happiness (β = 0.32, P < 0.01), whereas the paths from the other God images to happiness were not significant. In the final model (Figure 2), we trimmed the nonsignificant paths.

Figure 1 Truncated partial model representing positive interpretation of disease as mediator of the relation between God image and happiness. Coefficients are standardized path coefficients. *P < 0.05; **P < 0.01; ***P < 0.001. POS GI = positive God images; ANGER GI = angry God images; ANX GI = anxious God images.
resulting in a more parsimonious model with a good fit (SBS-χ²/d.f. = 572.66/484 = 1.18, CFI = 0.99, RMSEA = 0.04).

Discussion

In the present study, we explored the relationship between God images and happiness when one is confronted with a severe stressor such as enduring pain. Results showed indeed that happiness was positively related with POS GI and negatively related with ANGER GI. These findings are in line with the findings of others [16] indicating that distinct aspects of religion (i.e., aspects of the God image) relate differently to well-being. In order to obtain a more fine-grained view on these associations, we framed this study in the transactional model of stress and focused on the possible mediating role of disease interpretation in the relationship between God images and happiness. Correlational analyses indeed confirmed that disease interpretation was related with both God images and happiness. Path analyses further showed that, in the context of enduring pain, disease interpretation had a mediating function between God images and happiness. However, because pain severity had a significant influence on both the interpretation of disease and on happiness, we controlled for pain severity in an ancillary set of analyses. The resulting model showed that especially POS GI were important in the prediction of happiness. POS GI had both a direct effect as well as an indirect effect (through the path of interpretation of disease) on happiness, irrespective of the level of pain severity.

Our findings indicated that, when taking into account pain severity, patients with POS GI (consisting of feelings of kindness, love, and warmth) are more able to reappraise their pain and illness experience in positive terms. They probably focus more on the growth and learning possibilities in this situation and less on the threatening or harmful character of it. This finding might point in the direction of a mitigating role of affective aspects of religion when confronted with CP. The direct positive path from POS GI to happiness can be framed in the coping literature as well. There is a consensus in the field that perceived social support enhances psychological well-being and buffers the impact of life stress in particular [40]. Moreover, Feldman, Downey, and Schaffer-Neitz [41] showed that there is evidence of a buffering effect of support on distress in CP patients. Furthermore, Pollner [26] already stated that individuals may also perceive social support from persons who may or may not actually exist such as a deity. We can thus assume that the presence of POS GI relate to the well-being of CP patients, more precisely by the support of a divine attachment figure with whom the individual is in relationship.

Additional analyses revealed that the path from ANGER GI to disease interpretation was not supported across all conducted analyses. This path, which was found in the initial path models, was probably due to the detrimental impact of pain severity on both ANGER GI and disease interpretation. As such, when controlling for pain severity in the subsequent path models, this indirect pathway became nonsignificant. Moreover, the impact of pain severity on ANGER GI is in line with earlier research showing that CP patients in greater pain report feeling angrier [42] than patients experiencing less pain. Moreover, some researchers state that these patients have greater difficulty expressing these angry feelings [43]. It might be possible that some patients take the anger they experience in reaction to the painful experience and project that anger onto an unseen figure such as God. For these patients, it might be safer to blame God for their

Figure 2 Trimming partial model representing positive interpretation of disease as mediator of the relation between God image and happiness, controlled for pain severity. Coefficients are standardized path coefficients. *P < 0.05; **P < 0.01; ***P < 0.001. POS GI = positive God images; ANGER GI = angry God images; ANX GI = anxious God images.
pain condition and express their anger toward God instead of toward others because they fear compromising their relationships with people on whom they depend. An alternative explanation might be that individuals feel disappointed in and develop angry feelings toward God. The idea of God as the all-good, benevolent, and omnipotent protector might turn out to be disappointing to some patients if the pain is not relieved or if the patient’s prayers are not answered. Exline and colleagues [44,45], for example, stated that suffering persons may find it difficult to resolve anger toward God because God will not apologize to them. This negative view of God can color one’s perceptions of the world, leading to greater distress [46].

An important avenue for further research is whether attachment to God is involved in the relationship between God image and happiness as well. A line of studies, based on the attachment theory of Bowlby [47] focuses on the role of attachment to God and the possible correlates of a secure or insecure attachment. Some studies have shown that individual differences in attachment to God are related with loneliness, depression, and general adjustment [48,49]. We hypothesize that God image and attachment to God are interrelated constructs. Therefore, it is important to determine whether the belief of how the individual experiences God is important, or rather the security of the perceived relationship with God [49]. In line with this, Belavich and Pargament [50] stated that attachment to God may clarify why individuals choose particular coping strategies when responding to stressful events. Therefore, it is plausible that a warm and secure relationship with God can help individuals with reframing a negative stressor such as enduring pain in a way that it has some meaning. However, in line with Granqvist and Kirkpatrick [51], we can assume that our model may only apply to patients who experience God as an attachment figure.

Limitations and Conclusions

Even though this study offers a significant contribution to the underinvestigated areas of God images and CP, it has several limitations. First, the domain of God representations still is a very complex field. Although some researchers [19,20] have recently advocated to differentiate the emotional experiences of God and the intellectual understanding of God, it remains difficult to make a sharp distinction between the affect-laden God image and relatively affect-neutral God concepts [31]. A further theoretical as well as empirical study of these aspects of God representation is warranted. Second, longitudinal work is required to investigate more thoroughly the direction of the associations. For example, it could be possible that being happy might lead to a more positive experienced God image and to framing pain in more positive ways. Next, it is possible that the participants in this study, members of a patients association, are a more active group of patients than are patients in the general CP population. This active attitude might be related with a more frequent use of positive appraisal, which might subsequently influence the results of the study. A replication study with a broader group of CP patients, including patients in pain treatment or in a pain hospital, might nuance our results. Finally, although the fairly large sample size is a strength in this field of research, replication with larger samples is necessary in order to confirm the stability of the model.

Further, these findings, when replicated, can have some clinical implications. Framed within a multidisciplinary approach toward the treatment of pain, a religious history as part of an anamnesis or intake might be worth considering [16]. The clinician can obtain information about the patient’s religious background and whether the patient uses religion to help cope with his or her pain. This can offer the clinician a broader view on the coping resources of a patient. However, because of the paucity of research on this topic, more empirical evidence is necessary before clear guidelines can be offered.

In sum, this study offers a new perspective on the relationship between religion and well-being when one is confronted with a severe stressor such as enduring pain. The results indicate that a positive God image has an influence on the happiness of CP patients, both directly and indirectly through the pathway of positive disease interpretation. These findings can be framed within the transactional theory of stress and can stimulate further pain research investigating the possible mitigating or stress-buffering effects of religion.

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References


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