Construction and validation of the apperception test God representations : An implicit measure to assess God representations

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Chapter 8.

Summary and Discussion

Introduction

Research has shown that religiosity/spirituality is predominantly positively related to well-being and mental health (Koenig, King, & Benner Carson, 2012; Koenig, McCullough, & Larson, 2001), and the way religious people perceive and experience their personal relationship with God might be a key factor in this association (Davis, Granqvist, & Sharp, 2018). However, studies on the association between mental health and religiosity suffer from the fact that there are no well-validated implicit measures of God representations (Sharp et al., 2019). Such measures are urgently needed, because —in line with object-relations and attachment theory— God representations are for an important part thought to be determined by implicit processes, governed by schemas that are developed in early childhood, under the influence of experiences with important caregivers (Hall, Fujikawa, Halcrow, Hill, & Delaney, 2009; Hall & Fujikawa, 2013). Besides, existing assessment measures have not been validated in patient groups. This is important because many forms of psychopathology, especially personality disorders, are characterized by disturbed views of self and others (Livesley, 1998). Because God representations can be considered as a special type of self-object representations (Brokaw & Edwards, 1994; Jones, 2008; Rizzuto, 1979), a high level of psychopathology may also influence inner representations of the self in relation with God.

Most studies in this domain have used self-reported representations of God. These self-reports are in fact explicit measures of God representations. However, there is less knowledge about implicit God representations, and about the way they relate to explicit God representations.

This thesis reports on a series of studies on the validity and reliability of a newly constructed instrument to assess implicit representations of God: the Apperception Test God Representations (ATGR). This test is comparable to the Thematic Apperception Test (Murray, 1943), where participants are requested to tell stories about various pictures. The scoring of the ATGR narratives is based on the TAT scoring system originally developed by Westen (1985): the Social Cognition and Object Relations Scale (SCORS) The SCORS scale *Complexity of Representations of People* was adapted to the ATGR scale *Complexity of Representations of God*; the SCORS scale *Affect Tone of Relationships Paradigma's* was adapted to the ATGR scales *Affect Tone of the relationship with God,* scored for *character* of the narrative and for respondent; *person*), the SCORS scale *Capacity for Emotion Investment in Relationships and Moral Standards* was adapted to the ATGR scale *Emotional Investment in the relationship with God,* and the SCORS scale *Understanding of Social Causality*

was adapted to the ATGR scale *Agency of God*. Beside these scales, we also developed some experimental scales to assess implicit attachment to God: God as a safe haven, God as a secure base, and the composite Attachment to God (overall) scale.

The main aims of the present studies were 1) to examine the associations between God representations in general and psychological functioning, in order to get more insight into the relevance of God representations within mental health, and 2) to describe the construction, reliability and validity of this newly developed measure of implicit God representations.

Aims of the several studies and research questions

Aim 1: Examining the associations between God representations and psychological functioning:

1. Do measures of God representations in general have stronger associations with well-being and distress than more general or behavioral measures of religiosity/spirituality?
2. Are God representations in general associated with indicators of interpersonal functioning as conceptualized by object-relations and attachment theory?

Aim 2: Describing the construction, reliability and validity of the ATGR:

3. What is the reliability of the ATGR?
4. What is the validity of the ATGR?
5. Is the ATGR sensitive to changes in God representations after treatment and are these changes associated with changes in distress and relational functioning?

Main Findings of the Thesis Study

The first aim of the thesis — examining the associations between God representations in general and psychological functioning— with the corresponding research questions (1 and 2), is addressed in the first article. This article contains results of a meta –analysis demonstrating that God representations are associated with well-being and distress. Positive God representations were more strongly associated with well-being than with distress, and negative God representations were more strongly associated with distress than with well-being. God representations were also moderately associated with view of self, view of others, and neuroticism as an indicator of affect-regulation. Moreover, the results corroborated the idea that God representations are a special form of object-relational functioning and of attachment relations.

The second aim of the thesis — describing the construction, reliability and validity of the ATGR— is addressed in the remaining five articles. Research questions 3 and

4 (reliability and validity of the ATGR) are addressed in article 2-5, and research question 5 (sensitivity to change) is addressed in article 6.

In the second article we demonstrated that the interrater reliability for scoring the SCORS based ATGR scales was sufficient for all but two scales. As expected, patients scored less favorable than nonpatients on most of the implicit God representation scales. In the nonpatient group, the implicitly measured God representation scales were hardly associated with explicitly measured distress, whereas in the patient group these associations were much stronger, and even stronger than the associations between the explicit God representation (as assessed with the Questionnaire God Representations, (GQR, Jonker, 2008) and explicitly measured distress. Our most important expectation, tested in the patient group only —that the implicit God representation scales were associated more strongly than the explicit God representation scales with implicit measures of distress— was only confirmed with respect to the clinician rated DSM-IV Global Assessment Scale, but not for the clinician rated Outcome Questionnaire (OQ45-II)

In the third article we examined the reliability and validity of the experimental attachment-theory based scales of the ATGR. Besides a composite overall Attachment to God scale, we examined two specific subscales, i.e. the (God as) Safe Haven subscale, and the (God as) Secure Base subscale. The interrater reliability per couple of scorers of the composite Attachment to God scale ranged from good to excellent (0.83-0.90). The patient group scored —as expected— significantly lower (less favorable) on the Safe Haven subscale than the nonpatient group. Results did not confirm our most important expectation: in the clinical group overall the implicit attachment to God measures were not (as expected) more strongly than the two explicit attachment to God measures associated with implicit measures of distress. In the nonpatient group only, the implicit attachment to God measures were, as expected, to a lesser extent associated with explicit distress than the explicit attachment to God measures. In the patient group, the implicit distress measures that specifically focus on interpersonal functioning were more strongly associated with implicit than with explicit attachment to God measures. Results suggest that the attachment-theory based ATGR scales validly measure the Safe Haven function of attachment to God, especially with regard to Avoidant attachment to God. The evidence for the validity of the used operationalization of Anxious attachment to God and of the Secure Base function was much weaker.

In the fourth article we examined the validity of the ATGR scales by comparing associations of implicit God representations with well-validated implicit and explicit measures of object-relational functioning (OR) with the associations between explicit God representations and implicit and explicit OR measures. In the nonpatient group, as expected, all same method associations were stronger than all mixed method

associations. In the patient group, however, the implicit God representations showed stronger associations with both implicit as well as explicit OR-measures than the explicit God representation scales. In both groups, implicit measures of complexity of representations of people were related to various aspects of God representations. Finally, in the patient group the implicit God representations were in particular associated with enduring frustrations in interpersonal relationships and to a lesser extent with understanding of social causality, whereas in the nonpatient group the reverse was true.

In the fifth article we further examined the validity of the ATGR scales by comparing the associations with an explicit measure of personality functioning, the Severity Index of Personality Pathology (SIPP) with associations found between explicit God representation scales and scales of the SIPP. Results confirmed our expectations: in the nonpatient group the explicit God representation scales were associated much more strongly with explicitly measured personality functioning than the implicit God representation scales. Although in the patient group the size of the correlations between the implicit God representations and the SIPP scales was comparable to the size of the correlations between the explicitly assessed God representations and the SIPP scales, the number of SIPP scales that showed significant correlations with the ATGR scales was larger than the number of SIPP scales that correlated significantly with the explicit Questionnaire God Representations.

The significant correlations of aspects of implicit God representations with specific personality scales corroborated the construct validity of the ATGR scales: the complexity of God representations was associated with purposefulness, the affect tone of relationship with God was associated with personality scales that focus on the self: identity integration and self-control; emotional investment in the relationship with God was associated with personality scales that focus on the relationship with others: relational capacities and responsibility; and the attribution of agency to God was associated with the personality scale that assesses self-control.

In article 6 we report results of a study pertaining to the sensitivity to change of the ATGR scales in the patient group, by comparing its scores before and after a 9 to 12 month psychotherapy program and by examining associations with changes in implicitly and explicitly measured distress and explicitly measured object-relational functioning. A change in mean group scores on the aggregated explicit distress scale indicated significantly improved functioning, with medium to (nearly) large effect sizes. No significant changes were found in mean group scores on the aggregated implicit God representations and object-relational functioning scales. On single ATGR scale level, there was a significant increase over time in positive feelings towards God, with large effect sizes. Changes in God representations were, against expectations, not associated with changes in explicitly or implicitly measured distress, but —as expected— they were significantly associated with changes in explicit object-relational functio-

ning. The results of cross-lagged analyses suggested that interpersonal representations affected God representations more than vice versa.

Discussion

The present study aimed at validating a performance based measure for assessing implicit God representations. We found that a first requisite for validity, the interrater reliability, was sufficient. For validation we examined associations between God representations and distress, object-relational functioning and personality functioning in a nonpatient and in a patient group. God representations and object-relational functioning were in both groups assessed both implicitly as well as explicitly. In the nonclinical group, distress was assessed with self-report only. In both groups, personality functioning was assessed with self-report only.

It was hypothesized 1) that in both groups same-method correlations would be stronger than mixed-method correlations, 2) that patients would score significantly lower than non-patients on the implicit God representations scales 3) that the correlations between implicit and explicit measures would be stronger in the nonpatient than in the patient group, 4) that implicit God representations would have meaningful associations with implicitly and explicitly measured object-relational functioning and distress, and with explicitly measured personality functioning, and 5) that changes in implicit God representations would be associated with changes in implicit and explicit distress and with explicitly measured object-relational functioning.

Hypothesis 1.

In the nonpatient group same-method correlations between God representations and object-relational functioning were stronger than mixed-method correlations, and the explicit God representations were more strongly than the implicit God representations associated with explicitly measured distress. Likewise, among patients, the implicit God representations were more strongly than the explicit God representation associated with implicit object-relational functioning and with one of the implicit distress measures. Contrary to expectations, among patients, but not among nonpatients, implicitly assessed God representations showed stronger associations with explicit measures of distress, object-relational and personality functioning than the explicit God representations.

Hypothesis 2.

As expected, the mean scores of the patient group on most ATGR scales were significantly lower than those of the nonpatient group.

Table 1. *Summary of Significant Differences and Associations of the Study's Main Variables*

		Implicit God representations: ATGR scales					
		Complexity	Affect Tone character	Affect Tone person	Investment	Agency	Attachment to God
t test difference NP-P		*** NP > P		*** NP > P	*** NP > P	*** NP > P	* NP > P
t test difference patients t1-t2				* t1 < t2			
Explicit God Representations							
QGR	NP	Positive feelings*	Ruling/Punishing*	Positive feelings* Anxiety* Supportive actions** Ruling/punishing*			Ruling/Punishing*
	P	Supportive actions*	Positive feelings* Anger** Supportive actions*	Positive feelings* Anger** Supportive actions**	Anxiety* Supportive actions**		Positive feelings* Anxiety* Anger** Supportive actions*** Passivity**
Explicit Attachment to God							
AGI	NP						
	P		Anxiety*				
Explicit distress							
OQ	NP						
	P	Symptom distress** Anxiety/Somatic distress* Total scale**	Interpersonal relations* Social role* Symptom distress* Total scale**	Social role**	Symptom distress* Total scale*	Total scale*	Interpersonal relations** Social role** Symptom distress* Total scale**
Implicit distress							
OQcl/ GAF	P	Global assessment of functioning*				Global assessment of functioning*	Interpersonal relations*

Table 1 (Continued).

		Implicit God representations: ATGR scales					
		Complexity	Affect Tone character	Affect Tone person	Investment	Agency	Attachment to God
Explicit object-relation functioning BORI	NP	Insecure attachment* Social inadequacy*					
	P		Insecure attachment*$^{\Delta}$ Egocentricity$^{\Delta}$ Social inadequacy$^{\Delta}$ Total scale*	Social inadequacy$^{\Delta}$	Alienation**$^{\Delta}$ Egocentricity**$^{\Delta}$ Total scale**	Egocentricity$^{\Delta}$ Total scale*	Social inadequacy$^{\Delta}$
Implicit object-relation functioning SCORS	NP		Complexity of representations* Social causality*		Complexity of representations* Social causality**	Complexity of representations* Social causality** Emotional investment*	Complexity of representations*** Social causality***
	P	Complexity of representations** Emotional investment**	Emotional investment*		Complexity of representations**	Complexity of representations** Emotional investment**	Complexity of representations** Social causality* Emotional investment**
Explicit Personality Functioning SIPP-Domain	NP						
	P		Self-control* Identity*** Responsibility*	Social Concordance*	Relation* Responsibility*	Self-control*	Self-control* Identity*

Note. *= $p \leq .05$; **= $p \leq .01$; *** = $p \leq .001$; $^{\Delta}$= significant association ($p \leq .05$) between changes in both scales; NP = nonpatient group; P = patient group

Hypothesis 3.

Contrary to what was expected, correlations between implicit and explicit God representations were stronger in de patient group than in the nonpatient group.

Hypothesis 4.

In the patient group, the Attachment to God measures were, as to be expected, more strongly associated with distress related to interpersonal and social role functioning than with symptomatic distress, anxiety or psychosomatic distress. Meaningful patterns of correlations between SCORS-based God representation scales and aspects of explicitly measured personality functioning in the patient group corroborated the validity of the ATGR scales. See also Table 1 for an overview of significant differences and associations.

Hypothesis 5.

Contrary to expectations, changes in implicit God representations were not associated with changes in implicitly and explicitly measured distress. In line with expectations, changes in implicit God representations were significantly associated with changes in explicitly measured object-relational functioning

Because of differences between the patient and the nonpatient group in patterns of correlations, results will be discussed for both groups separately.

Validity of the ATGR in the nonpatient group

The preliminary evidence of this study indicates that the ATGR reliably and validly assesses implicit aspects of God representations in the nonpatient group. The significant associations of the ATGR with implicit, but not with explicit object-relational functioning are an indication for convergent and divergent validity as aspects of its construct validity in this group. Scores of non-patients on most scales (except the Affect Tone character scale) differed significantly from scores of patients, which contributes to the concurrent validity as an aspect of the criterion validity of the ATGR

Although correspondence between implicit and explicit God representations was viewed as a characteristic of nonpatients, in the nonpatient group the implicit God representations were hardly associated with explicit God representation measures. They were, as predicted, also hardly associated with explicitly measured personality functioning and distress. We had no measure for implicit distress in this group. Results indicate that in the nonpatient group implicit God representations remain relatively detached from self-reported daily functioning and from the person's mood or conscious view of him or herself.

The findings in the nonpatient group may partly be explained by the phenomenon of same-method variance, implying that associations between explicit God

representations and explicit psychological functioning may have been inflated by factors such as social desirability and doctrine effects (Tehseen, Ramayah, & Sajilan, 2017), to which especially self-reports are very susceptible. Results among nonpatients are in line with the general notion that implicit and explicit measures of comparable constructs (as e.g. attachment style) are hardly associated (Roisman et al., 2007).

On the other hand, the relatively strong associations between explicit God representations and explicit measures of psychological functioning in the nonpatient group do reflect that religious people derive confidence in self and others from a perceived positive relationship with God, and vice versa, as results of our meta-analysis also demonstrate. Therefore, for nonpatients the assessment of God representations with explicit measures is certainly useful and seems to tap aspects of perceived psychological functioning, related to experienced wellbeing and personality functioning.

In this group implicitly measured complexity of representations of others and understanding of social causality were significantly associated with most aspects of implicit God representations, but not with any of the explicit God representation measures. We assume that these significant correlations reflect real associations that cannot be explained away by same-method effects. Therefore explicit measures of representations of self, others and God may not adequately reflect underlying less conscious vulnerabilities in this group. They might fail to predict how a person would function under pressure and whether he or she could still derive strength from the relationship with God. This implies that measurement of implicit God representations besides explicit God representations could be a valuable addition for non-patients.

Validity of the ATGR in the patient group

There are various indications for the convergent/divergent and longitudinal validity as aspects of the construct validity of the ATGR scales. However, there were also results that contradicted our expectations. In our discussion of the results we look for reasonable explanations of the contradictory findings. This especially regards the stronger associations between implicit and explicit measures in the patient group.

We hypothesized that the correlations between implicit and explicit measures would be stronger in the nonpatient than in the patient group, based on the notion that especially persons with personality pathology are known for a general lack of self-insight (Eurelings-Bontekoe, Luyten, Remijsen, & Koelen, 2010; Shedler, Mayman, & Manis, 1993) and that correspondence between implicit and explicit God representations as an indication of integration, is considered to be healthier. However, the reverse was true: in the patient group, the implicit God representations measures were as strong as or stronger than the explicit God representation measures associated with explicitly measured object-relational and personality functioning, and the implicit

God representations were more strongly than in the nonpatient group associated with explicit God representations.

One potential explanation for the stronger associations between implicit and explicit measures in the patient group might be that among patients implicit representations might invade explicit awareness more, and might be less suppressed than in the nonpatient group. Hall and Fujikawa (2013) stress the importance of (differences in) correspondence, or, as they name it, *integration*, between implicit and explicit God representations, but they do not assume a general relation between integration and healthiness. They suggest that a person's attachment style may predict the extent and type of discrepancy/integration between explicit and implicit God representations. They expect (the greatest) discrepancies for people with a dismissing (avoidant) attachment style, because these persons use overregulation of negative affect, and therefore have less access to their implicit, internal world. Interestingly, Dozier and Kobak (1992) found that subjects that used deactivating strategies in the Adult Attachment Interview showed increases in physiological distress (skin conductance) when they had to answer questions regarding separation from caregivers. These results imply that the conscious expression of attachment related distress and the implicit experience thereof are decoupled among persons with deactivating strategies. More correspondence is expected for anxious attached persons, who would have both negative implicit and explicit God representations because they are easily flooded by negative emotions about others and themselves. This implies that Hall and Fujikawa simply define 'integration' as 'correspondence between implicit and explicit levels, despite their content. We would prefer not to use the term 'integration' for situations when negative implicit representations invade or overwhelm also existing more positive explicit representations. To us this seems to be more a 'lack of healthy differentiation' between the two levels. Based on the results of our study, we are now more prone to say that the extent of healthy integration cannot be derived from the extent of correspondence between implicit and explicit God representations at all, because weaker correspondence may mean that implicit negative aspects of God representations are suppressed (as could have been the case in the nonpatient group), and stronger correspondence may imply that explicit positive God representations are overwhelmed by implicit negative God representations, as in the patient group. Perhaps it is better to reserve the term integration for the integration of positive and negative aspects of God representations, as emphasized by object-relations theory. During child development, representations of self and others become increasingly complex and integrated, implying that positive and negative aspects of self or others can be experienced simultaneously, without the need to split representations. This type of integration is assessed by the ATGR scale Complexity of God representations and our results demonstrated that the patients had significantly more difficulties with integration and differentiation than the nonpatients, and that these difficulties were also associated with

(implicitly measured) complexity of interpersonal representations as assessed with the SCORS.

In line with the explanation of implicit representations overwhelming the explicit representations, the generally stronger association between implicit and explicit measures in the patient group may also suggest a diminished influence of potential social desirability and doctrine effects on the explicit measures.

Other research on the associations between God images, personality and distress also found different patterns among patients and nonpatients. Schaap-Jonker, Eurelings-Bontekoe, Verhagen, and Zock (2002) found that in a group of 46 patients, the associations between explicitly measured God representations and distress could be fully explained by personality pathology, whereas Eurelings-Bontekoe, Hekman-Van Steeg, and Verschuur (2005) found that among nonpatients personality was a less important moderator of the association between (explicitly measured) God representations and psychological distress than religious culture. Stable persons could keep their God representations free from the potentially negative influence of psychological distress. Another interesting finding in this respect is that for nonpatient orthodox Christians, their belief in a judgmental/punishing God was unrelated to anxiety and even related to positive feelings about God, whereas orthodox psychiatric patients that believed in a punishing God were more anxious (Jonker, 2007). In the same line, Schaap-Jonker, van der Velde, Eurelings-Bontekoe, and Corveleyn (2017) found a combination of scores on God representation scales that was present in the patient group only, a profile they named "the 'Negative-Authoritarian' type of God image, characterized by anxious and/or angry feelings towards God and viewing God as ruling and punishing. All these findings corroborate the findings of this thesis that psychopathology is associated with more negative God representations and modifies the associations between on the one hand implicit God representations and on the other hand explicit God representations, implicit and explicit distress and object-relational functioning, and explicitly measured personality functioning.

The finding that associations between various psychological and religious variables are much stronger in the patient group than in the nonpatient group, parallels one aspect of the network perspective on psychopathology of Borsboom and Cramer (2013), when they assume that in the development of psychopathology various clusters of symptoms that initially function relatively independently, start to affect each other in such a way that the system of the person cannot adapt anymore and collapses. This phenomenon is called hysteresis: some trigger events cross a certain threshold and bring the system so strongly out of its equilibrium that it does not quickly and automatically return to its former state, thereby losing its resilience. In the absence of psychopathology, they call the principles that cause these interactions between symptoms dormant or dispositional. However, Borsboom and Cramer try to explain associations between overt psychopathology symptoms, emphatically excluding latent

variables, which seems contradictory to our assumption that implicit representations play an important role in the manifestation of psychopathology.

Changes in God representations. The results of our study suggest that implicit God representations changed over time and that this change co-occurred with changes in object-relational functioning that have been an important focus of the therapeutic program. There was a significant increase over time in positive feelings towards God. Patients who reported a more positive implicit God representation after treatment, felt less insecure and anxious for rejection, and were less egocentric and less shy and hesitating in interpersonal relationships. Because the study design does not permit causal inferences, it remains to be clarified whether the changes in implicit God representations and object-relational functioning after treatment were caused by the therapeutic program.

Changes in implicit God representations were not significantly associated with changes in perceived distress. It is possible that changes in implicit God representations and changes in perceived distress do not occur simultaneously: changes in implicit God representations might be lagging behind changes in perceived distress. Moreover, the severe personality problems of the patient group might have influenced the level of distress to a greater extent than the God representations. This explanation is in line with the (already mentioned) results of Schaap-Jonker et al. (2002) who found that in a group of 46 patients, the associations between explicitly measured God representations and distress were fully mediated by personality pathology.

Taken together, the findings of the present study suggest that studies on the association between God representations and mental health should take patient status into account. Patients and nonpatients seem to show different patterns of correlations between implicit and explicit measures of God representations and implicit and explicit aspects of psychological functioning. This implies that results found in nonpatient groups cannot be generalized to patients and vice versa. We elaborate in more detail about the (clinical) implications of the results of this thesis after a discussion of its limitations.

Limitations

The results of this study should be interpreted in the context of various limitations.

First, although we assume that the psychological processes related to God representations are working for all adherents of theistic religions worldwide, the results of the Dutch protestant samples of this study may not be generalized to patients with other religions.

Second, although for a study that assessed and coded narratives (15 ATGR cards were assessed 182 times) the samples were relatively large, their size restricted the

statistical power of various statistical analyses to significantly detect small effect sizes or to compare scores of subgroups, especially the small group that was tested also after treatment.

Third, the observational design of the studies does not allow for conclusions about causal effects.

Fourth, the mixed-method design of the empirical study was not as neat and complete as we had wished and as would be preferable. In the nonpatient group no implicit distress measure was assessed and using clinicians' ratings of their patients functioning as an indication for implicit distress has not yet been studied on its validity. There was no measure available for the implicit assessment of personality functioning.

Fifth, although the implicit measure for object-relational functioning we used (SCORS, Westen, 1985) is well-validated, we derived the implicit God representation measure from this measure, which may have led to same-method variance that caused part of the associations between implicit God representations and implicit object-relational functioning. The fact that the explicit God representation measure was not an operationalization of exactly the same theoretical constructs as both the implicit God representation and the implicit object-relational functioning measures, may have influenced the results concerning the validity of the implicit God representation measure.

Sixth. Low internal consistencies of some scales of the study (one BORI scale in the nonpatient group and three BORI scales in the patient group) could have weakened the associations with implicit and explicit God representations, which in turn may have affected the comparison of the associations of both God representation measures with implicit and explicit measures of object-relational functioning.

Seventh. In some of our articles we used Multi-Dimensional Scaling, based on estimated distances between the variables in a two-dimensional space. In articles 2 and 4, we based these distances on the absolute value of the correlations. However, this approach does not yield the accuracy that can be obtained by recoding scale scores so that all scores have the same interpretation of low (negative, unhealthy) and high (positive, healthy). We used the appropriate approach in art. 3, and we also checked whether the results described in the other articles with this approach would hold. They did.

Eighth. Due to delays in this thesis project, results of the implicit measures of object-relational functioning that we also assessed after treatment in the patient group, could not be coded and analyzed in time. It would be insightful to know whether the implicit interpersonal representations also changed and whether and to which extent these changes were associated with changes in personality functioning, God representations, and distress.

Nineth. The study misses a follow-up assessment after, for example, three or six months, to examine whether changes in God representation and their associations

with distress are indeed lagging behind changes in interpersonal representations and their associations with distress, and to examine whether changes in implicit God representation are stable over a longer period of time.

A final limitation is that the distress measures in this study have a somewhat limited focus on symptoms and functioning, whereas it is plausible that changes in God representations are more strongly associated with changes on a deeper level that is not assessed with these measures.

Clinical implications

Assessment

Results show that in the clinical group the association between implicit and explicit measures of God representations is stronger than in the nonclinical group, suggesting that the use of self-report in the assessment of the God image also taps into the more implicit aspects thereof. However, among nonpatients, results of self-reports might be biased more by social desirability and doctrine, although they do reflect perceived wellbeing and personality functioning. In the clinical group we found various indications for the convergent/divergent and longitudinal aspects of the construct validity of the implicit God representation measure. Therefore, for religious patients we recommend the use of (this) implicit God representation measure(s) to enhance insight in the implicit processes that affect their personal relationship with God.

Treatment

In working with religious patients we strongly recommend to address as a standard practice God representations in assessment and treatment goals, because research, as summarized in our meta-analysis, strongly suggests that the experienced relationship with a personal god may act as an important potential source of strength and support. This is also in line with the recovery movement in psychiatry (Huguelet et al., 2016; Jong & Schaap-Jonker, 2016; Mohr et al., 2012; Roberts & Wolfson, 2004), that emphasizes that recovery from a mental illness should not only focus on the cure of symptoms, because absence of illness is not what defines health. Health is complex and has also to do with learning how to live with psychiatric problems, self-management, participating in the community despite and with psychiatric problems, focusing on personal goals and learning to develop a sense of identity and self-worth that is not totally defined by what happiness looks like in Western society, with its associations with being able to realize dreams and potential, and with being successful. In this respect, purpose and meaning in the latest decennium suddenly have become very important psychological concepts. Resilience is also an important concept, emphasizing the importance to be able to cope with illness and life circumstances. For many religious

patients, the relationship with God may therefore be a potential source for finding personal meaning and self-worth, for coping with illness and difficulties; a source for resilience.

Deteriorated God representations as part of the illness. However, the results of this study also demonstrated that the implicit God representations of the patients were significantly more negative than the implicit God representations of the nonpatients. So this potential source to strengthen the personal/existential identity was, in case of personality pathology, often less available. Clinicians should be aware of this entanglement of psychological and religious aspects on a deep, implicit, and probably difficult accessible level. In applying a recovery approach, the pitfall of only focusing on positive aspects of God (as may wrongly be inferred from a positive psychology approach) may not be very helpful, in line with Leffel's (2007a, 2007b) remarks about too simple spirituality. As our meta-analysis demonstrated, positive and negative God representations are not extremes on one and the same dimension. Explicit God representations may be susceptible to the influence of current mood. Temporarily relief, brought by for example a good conversation or sermon, may involve changes on an explicit level while leaving the implicit God representations unchanged. Change should focus on the slow process of integration of positive and negative aspects of someone's God representations, of which awareness and acceptance will be an important first step. Religious clinicians therefore should also know and accept their own (implicit) negative feelings toward God; anxiety, anger or doubt. Perhaps assessment with the ATGR could be helpful here too.

Helping patients to find purpose and meaning. Recent developments in the field of positive psychology address earlier criticism of being too individualistic and hedonistic, by emphasizing the process of finding meaning and purpose in a cultural-historical context, by giving a voice to counter stories that are not characterized by redemption after problems, and by emphasizing that personal well-being or growth may not be the ultimate goal for human beings (Westerhof, 2019). It seems that the patients in this study, due to their personality pathology, also have difficulties to invest in longer term goals that transcend the focus on symptoms, on relational frustration and (not) feeling good. Learning to base/develop a sense of personal worth on values and beliefs might be very therapeutic. More insight into negative God representations, such as achieved by this study, can contribute to increased insight in entries for psychologically based therapeutic interventions on religious content. The associations between changes in God representations and changes in perceived object-relational functioning emphasize that they entail an important factor that is also stressed by the recovery approach and that seems an important ingredient of resilience.

Therapeutic approaches. Because of the entanglement of interpersonal and God representations, for religious patients suffering from personality pathology we advocate an integrated therapeutic approach that focuses on change in both

interpersonal and God representations. A first step should be to achieve more awareness of implicit negative representations. Probably not all approaches will be equally suitable for elaborating on God representations. Mentalization based treatment, for example, relies heavily on awareness of emotional reactions to the here-and -now experiences in the patient-clinician interaction. However, various non-religious approaches have also been tailored for working with God representations, for example schema therapy (Cecero, Marmon, Beitel, Hutz, & Jones, 2004); mindfulness, (Trammel, 2018); and narrative therapy (Olson et al., 2016). Recently, art therapy as a promising additional approach for working with cluster B patients has gained some attention (Haeyen, van Hooren, van Der Veld, & Hutschemaekers, 2018). This approach integrates interventions from mentioned therapeutic schools, and we assume that its focus on imagination can be applied well to working with God representations.

Future Research

Results of this study demonstrated that in the nonpatient group the implicit God representations were significantly associated with implicit object-relational functioning, but hardly or not with explicit measures of distress, object-relational or personality functioning. It would be valuable to study whether explicit or implicit God representations best predict the support derived from religion/the relationship with God under serious life circumstances.

In this study we did not use implicit or indirect measures of personality pathology. In future research with the ATGR, it would be advisable to include such a measure, for example the STIP-5, a semi-structured interview for personality functioning (Berghuis, Hutsebaut, Kaasenbrood, De Saeger, & Ingenhoven, 2013); or the Structured Interview of Personality Organization (STIPO, Clarkin, Caligor, Stern, & Kernberg, 2004; Stern et al., 2010).

Because of the differences between nonpatient and patient group in this study, the influence of biographical factors, especially religious culture (denomination and upbringing) on the ATGR scale scores remained unclear. More research into this is needed.

It would be very insightful to conduct a randomized clinical trial, using a manualized protocol for religious interventions focusing on God representations. As outcome measures it would be preferable to assess implicit God representations with the ATGR, to include a symptoms-focused distress measure as the OQ, and —besides that—also measures of, for example, meaning and purpose, hope, optimism, religious or existential well-being or worldview.

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