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Essay

How Clinical Psychology of Religion Can Support Mental Health: An Ecological–Existential View, Illustrated by the Case of Shame

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Abstract: This article argues how the clinical psychology of religion can support mental health and mental health care. The starting point is an ecological–existential approach to mental health, that stresses the interactions between person and environment, with an emphasis on the existential dimension of interactions. This approach will be related to religion and spirituality (R/S) and the study of R/S and mental health. To show the added value of an ecological–existential approach, the emotion of shame will be discussed as an illustrative case. Finally, implications for clinical psychology of religion and mental health care will be outlined and a clinical case report will be presented.

Keywords: clinical psychology of religion; mental health; mental well-being; ecological–existential view; shame

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1. Introduction

Mental health is not a private issue. Instead, it is determined by a complex interplay of individual, social and structural stresses and vulnerabilities, as a recent report of the World Health Organization (2022) states. Hence, it is often beyond the control of individuals. An illustration is the COVID-19 pandemic, which has had an impact on the mental well-being of many people, including young ones. Students reported more anxiety and depression, and the most symptoms of mental health problems were reported by schoolchildren and their parents during periods with high levels of restrictions and closed schools (Caring Universities 2022; Creswell et al. 2021; Fegert et al. 2020). The devastating effects of war, starvation, oppression and other crisis situations form another example, with people's stories speaking of loss, trauma, fear and grief. The damage is greater than the destruction of homes and building or damage to physical health. Feelings of safety and trust in life are destroyed too, as core beliefs about the world are violated, leading to a disruption of meaning making, which undermines mental well-being (Betancourt et al. 2013; Park 2016b, 2022; Park et al. 2016; Snyder et al. 2020). Experiences of damage and destruction, depression and disruption are also reported by psychiatric patients (e.g., Kauffman 2002). Hultberg (1988, p. 118) cited a traumatized woman who said: 'I feel so ashamed', which he interprets as: 'I feel so injured, I have been damaged in my innermost core, my soul has been violated, so that I can hardly live any longer'.

Shame is the illustrative case in the current article on the clinical psychology of religion and mental health. First, an ecological approach to mental health, which stresses the interactions between person and environment, will be described with an emphasis on its existential aspects. This ecological approach will be related to religion and spirituality (R/S) and the study of R/S and mental health. Subsequently, the emotion of shame will be discussed in relation to society and spirituality, in order to show the added value of an ecological–existential approach. Finally, the implications for clinical psychology of religion and mental health care will be outlined and a clinical case report will be presented.

2. An Ecological Approach to Mental Health: Mental Well-Being and Mental Health Problems Arise from Multiple Interactions

We live in a world of complex social, technological and economical networks, a world that is characterized by globalization and digitalization (e.g., Mayer and Vanderheiden 2021). Being part of this complex world requires that we are capable of engaging with and relating to our environment. This environment includes significant and less significant others, organizations, communities, institutions, society and societal developments, ecology and climate, and all the accompanying crises (Bronfenbrenner 1977, 1979; Page and Howard 2010). All these factors affect our mental health. Mental well-being and mental health problems arise from the different interactions we have (Van den Berg et al. 2018), ranging from intrapersonal interactions (bad sleep impacts on your mood, for instance) and interpersonal interactions (bullying may cause anxiety, depression or even suicidality; Swearer and Hymel 2015), to interactions with society, economic systems (Lund et al. 2010) and culture (Zhu et al. 2020). For instance, feelings of shame, guilt and powerlessness of victims of sexual assault increase when social systems do not provide the needed services (Campbell et al. 2009). Furthermore, a philosophy of life which characterizes the cultural climate has an impact on mental well-being. The ideology of neoliberalism, which is dominant in many parts of the Western world, was studied in relation to mental health. This ideology emphasizes that identity depends on successes and achievements, and that people are responsible for their own successes, focusing on 'winners' as opposed to 'losers' and leaving little room for failure (Adams et al. 2019). Empirical results show that neoliberalism reduces mental well-being and contributes to perfectionism, performance pressure, status anxiety, burn-out, loneliness, narcissistic personalities, and—not least of all—to feelings of shame (Becker et al. 2021; Kaufman 1996; Scharff 2016).

For a long time, mental health problems have been viewed through a medical lens: an individual with symptoms and complaints needs a diagnosis and a therapist—the approach parallels how physical diseases are treated (Clark et al. 2017). However, more pluralistic and person-centered movements have corrected this view, such as the recovery movement (e.g., Leamy et al. 2011). For example, in the Netherlands the redesigning psychiatry initiative, an innovative network for mental health care, opposes an individualistic approach, emphasizing that mental health problems are interactional problems (Van den Berg et al. 2018). Others also underline that recovery is relational in nature (Price-Robertson et al. 2017). Likewise, socio-ecological perspectives based on the work of Bronfenbrenner (1977, 1979) specify the influence of intrapersonal factors, interpersonal processes, institutional factors, community factors and public policy on health (Golden and Earp 2012; McLeroy et al. 1988). However, in scientific and clinical approaches to mental health, the multiple interactions and multidimensional networks in which people are involved are not always—or are often not—taken into account. For example, the hyperreactivity to sensory input of autistic people, or their struggles with flexible switching between scripts or actions are often considered to be their problem, resulting from their disorder, instead of an indicator that interactions between individuals and societal habits, values and expectations are disrupted (cf. Harper and Speed 2012).

For those reasons, an ecological view on mental health and mental well-being is needed, and deserves more attention from scientists, clinicians and policy makers. Reflecting on different levels of interactions and problem-maintaining interactional patterns will contribute to the resilience of individuals, groups and communities. In this context, recovery has to do with adaptation and finding a new equilibrium in changing circumstances, with restoring the balance, and with transformation within the interactional network (Bennett et al. 2018; Schultze-Lutter et al. 2016).

Well-being, recovery and resilience are associated with the capacity to lead a meaningful life, to tell one's own story and to define one's own narrative (Kerr et al. 2019; Roe and Davidson 2005; Waters and Fivush 2015). In short, they are associated with the ability to create and find meaning in one's life (Park 2022), which is linked to existential orientation and existential meaning-making domains (La Cour and Hvidt 2010). At these fundamental

domains of existence, we find the ground under our feet, a foundation on which to build our identities, sources of meaning and essential values, templates of narratives and myths, such as religious narratives (Foy et al. 2011; Pargament and Cummings 2010). Therefore, I argue for an ecological–existential view on mental health, which explicitly integrates interactions and interactional patterns with the multiple dimensions and forms of religion and spirituality. Without inclusion of the existential dimension, the socio-ecological view on mental health is not complete (De Haan 2017; Verhagen 2017). As human beings, we are capable of relating to our experiences, to take a reflexive and evaluative stance on these experiences, on ourselves and our situation, which opens up the existential dimension in our lives, with R/S being part of this dimension (De Haan 2017; La Cour and Hvidt 2010). Thus, when we are constantly interacting, we do not only relate to others and the surrounding world, but also to ourselves and to the existential or spiritual domain, or even to God (that is to say, to our representations of God or the divine) (La Cour and Hvidt 2010). These relationships could be represented as an existential quadrant, with our stance on ourselves, others, the world, or life in general (Janoff-Bulman and Frantz 1997), and God/the divine/the spiritual domain as four constantly interacting vertices (see Figure 1).

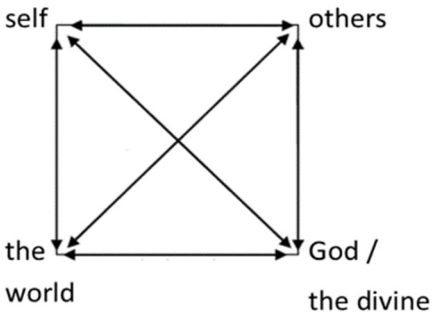

Figure 1. The existential quadrant: dynamic interactions between self, other, world and God/the divine.

As reflection on all four vertices implies issues of ultimate concern (e.g., 'Who am I? Is there a place for me in this world? What is the purpose of my life?'), all elements of the depicted quadrant are existential in nature. Within the proposed ecological–existential view on mental health, they are reciprocally related to all elements of the ecological model, and mutually interacting. Thus, in contrast to the biopsychosocial–spiritual model, which discerns various levels of functioning, the proposed ecological–existential view on mental health takes its starting point in one complex person–world network, with more emphasis on dynamic interactions (cf. (De Haan 2017)).

As the relationship to God/the divine or the spiritual domain is an element of the ecological–existential network (La Cour and Hvidt 2010), the clinical psychology of religion is a relevant field in the study of R/S and mental health (Van Uden and Pieper 2003). From an ecological–existential perspective, researchers who investigate R/S and mental health should not focus on diagnostic categories or on monolithic conceptualizations of religion or spirituality, as these are restricting in nature. Instead, dimensions of mental health should be examined in relation to dimensions of R/S. There are already interesting studies with a focus on dimensions (e.g., Jongkind et al. 2019; Lassiter et al. 2019). However, too often R/S is reduced to religious denomination or religious behavior such as religious attendance; thus, existential meaning-making is poorly included in this context (cf. Braam and Koenig 2019). Moreover, starting from a network theory of mental disorders (Kendler et al. 2011), dynamic patterns and interactions between these various dimensions are of primary interest. Methodologically speaking, this means the application of network models and of methods such as EMA (Ecological Momentary Assessment) or ESM (Experience Sampling Methods) (Verhagen et al. 2022). In this context there are some studies published in the field of the psychology of religion and related domains. For example, Wilt et al. (2021) used ESM to study interactions of religious/spiritual struggles and aspects of mental health, and Van Ments et al. (2022) developed an integrative adaptive network model for

formation and use of a mental God-model. However, *clinical* psychology of religion seems to be lagging in this area. We know that associations which are found among a general population need not to be the same among psychiatric samples (e.g., Braam and Koenig 2019). Therefore, studies are needed which map the interactional patterns mentioned in the context of psychopathology. To illustrate what this ecological–existential view on mental health and R/S yields and means in concrete terms, we will discuss the emotion of shame.

3. An Ecological–Existential View on Shame: Interactional Emotion and Existential Feeling

Shame is not only a painful emotion, but also a self-conscious, social and existential emotion, as it results from and functions within interactional and self-evaluative patterns (Ratcliffe 2009; Zhu et al. 2020). Involuntary physical reactions, such as blushing, show that shame is an embodied emotion. Mind and body make contact through continuously interacting subsystems, including the autonomic nervous system (Colombetti and Thompson 2008; Scherer 2000). Furthermore, there is the interaction between body and culture. On a cultural level, shame is related to sexuality and being naked (Groot 2014; Henriksen and Mesel 2021, p. 137ff); in the Judeo-Christian tradition, Adam and Eve feel ashamed when they discover that they are naked.

As an interpersonal or relational emotion, shame also results from interactions between individual and environment (De Young 2015). Shame is the way in which one relates to the other's gaze, the philosopher Jean Paul Sartre ([1943] 2021) states. This implies that shame is related to anxiety and the fear of being seen, judged and abandoned (De Young 2015; Gilligan 2003). Often this anxiety has its origins in (early) interpersonal interactions involving criticism, rejection, punishment or neglect (Claesson and Sohlberg 2002; Young et al. 2003). Consequently, the individual feels the urge to hide and to disappear.

The psychotherapist David Malan (1979) has emphasized the inner conflicts that are inherent in shame. Shame is related to hidden needs and desires or even forbidden impulses (interactions on a psychological level), and this results in defensive behavior, to protect the self from pain and anxiety. For example, Jill, the woman whose case report will be presented at the end of the current article, had parents who were neither sensitive nor attuned to her needs. She still longs to be loved and to be valued, but she is locked up in anxiety for rejection, anxiety for being not good enough to be loved. Therefore she rejects her needs and longings and judges them as infantile, which results in self-condemnation and shame and withdrawal in behavior. Thus, shame is not only related to fear of disconnection and abandonment, but also goes hand in hand with self-judgment, which implies that shame is related to aggression as well (Gilligan 2003; Knabb 2018).

Feelings of shame often have a persistent and accumulative nature (Zhu et al. 2020). For example, years after experiencing the original sexual trauma, survivors regularly report high levels of abuse-related shame (Feiring and Taska 2005).Moreover, interactions of the past may contribute to shame in the present in a more indirect way. Because interactional patterns during (early) development are internalized and represented in internal working models and schemas, they affect interactions in the here and now, both between and within persons, and between individual and society (Bretherton and Munholland 2008; Young et al. 2003). They are even repeated in current interactions, and also in the therapist's room (Malan 1979). Empirical research shows how childhood maltreatment in terms of neglect was associated with increased shame-withdraw via mental schemas characterized by incompetence (Mojallal et al. 2021). This explains why shame may become chronic and may take over one's whole identity, resulting in the belief 'that one's being is flawed, that one is defective as a human being' (Bradshaw 1988, p. vii). In this context, shame is a toxic emotion, felt in the core of one's being, and the painful inner conflicts concerning shame may take on all-consuming proportions, finding expression in feelings of helplessness and powerlessness, as the person feels unable to cope with what life is asking of her or him (Pattison 2000; Sanderson 2015). By implication, chronic shame in current interactions is

often a symptom of relational trauma rooted in insecure interactional patterns in childhood with disrupted attachment with primary caregivers (De Young 2015).

As a social and moral emotion, shame is related to societal norms, scripts and expectations, and to cultural values (Henriksen and Mesel 2021; Park 2016a). Cultural differences on the place of shame within social life can be observed (Zhu et al. 2020; cf. the (problematized but still used) distinction between shame cultures and guilt cultures; Benedict 1946). On a societal level, shame often fulfills a moral function. Think of expressions such as 'You ought to be ashamed of yourself', which contribute to processes of socialization. In this way, shame is instrumentally used for other purposes. Sometimes, this instrumental use has devastating effects, such as in cases of stigmatizing social discourses or public shaming, which is more present than ever due to social media (Leeming and Boyle 2004). Therefore, some authors speak of 'shame nations' in relation to a global epidemic of online hate (Scheff and Schorr 2017). They argue that we live in a culture of shame, with shame being taboo on the one hand (as everything is on display for the world to see), yet ubiquitous on the other (Scheff 2014). Society communicates specific expectations and promotes an ideal self, often with an economic interpretation in terms of achievements, level of wealth, job performance, success, et cetera. When these expectations are too high, when an individual perceives not only a distance to the ideal self that is promoted in society but also a closeness to an undesired self, then the result is shame, with all its consequences for mental health and social functioning (Henriksen and Mesel 2021; Zahavi 2014). As many studies cited above have demonstrated the impact of society on our well-being, including its existential aspects, we should take into account this impact more when we study existential issues such as identity and meaning-making capacities. When societal structures and networks impede the freedom that people have to tell their own story and undermine their identity, or when people are crushed by societal or political systems, they often experience not only financial losses and relational losses, but also losses in terms of human dignity, agency, autonomy and in terms of future possibilities. By implication, they feel helpless and powerless, but also ashamed (cf. World Health Organization and Calouste Gulbenkian Foundation 2014).

The multiple interactions that are involved in shame are not restricted to the elements that are mentioned above. Moreover, the interactive patterns on the physical, psychological, social and cultural level of shame are dynamically related. For instance, the interactions between shame and body are also influenced by societal images and expectations (Bessenoff and Snow 2006; Dolezal 2015). Within this dynamical interactive constellation, religion and spirituality (R/S), i.e., the existential domain, also plays a part (Park 2016a). R/S are not independent factors, but work on the psychological, social, political and cultural factors that are active in the network of interactions. In addition, R/S are multidimensional themselves, incorporating imagery, symbols, beliefs, practice, communities, et cetera. For instance, religious narratives and imagery about Adam and Eve may be interwoven with the interaction between body and culture, as mentioned above. Furthermore, the moral dimension of religion and of spiritual values affect the interactions between individual and society. Religious norms and spiritual values are associated with the ideal self, with whom someone wants to be and who s/he feels that s/he should be, which has a normative and a self-transcendent aspect as well as identity-formatting aspects (Henriksen and Mesel 2021). In this context, R/S can function in both a shame-eliciting or shame-enhancing as well as in a shame-reducing way. R/S may offer means to overcome shame by providing resources for self-experience and participation in a community that diminish feelings of shame. For example, when religions acknowledge the imperfect status of humans in relation to human dignity, and state that perfection is an implausible and inappropriate goal for a human being, they contribute to a realistic understanding of the ambiguities of the human condition that can hinder the development of shame (Nussbaum 2004; Ryan 2017).

In line with the notion that shame expresses the way in which one relates to the other's gaze and embodies the experience that one cannot hide oneself from the judgment of the other who sees right through you, spiritual values, providing normative 'standards of goodness' (Vu and Burton 2022) could function as a mirror and a specific form of 'the other's

gaze', eliciting or enhancing feelings of shame. The same applies to religion, as people's experience of the gaze of an omnipresent, all-knowing God who judges people in accordance with his standards of perfection may produce or enhance feelings of shame (Henriksen and Mesel 2021). A recent empirical study in the Netherlands provides a concrete illustration of this mechanism. Adolescents belonging to a strict Reformed denomination reported feelings of not being good enough; fears of failing because they could never meet God's high standards. These feelings not only resulted in chronic shame in relation to God, but also in relation to oneself and to others (De Bruin-Wassinkmaat et al. 2021), which shows that the four vertices of the existential quadrant should not and could not be seen apart, but as constantly interacting factors. In this context, Henriksen and Mesel (2021) emphasize that the connection with the R/S domain is often mediated by practices in which others are involved, pointing to the interactions between psychological, social, cultural and existential dimensions; how R/S works on shame in the context of personal identity and everyday life depends on psychological conditions, psycho-social development, social and cultural practices, and many other factors that are part of the ecological–existential network.

The chronic shame of the strict Reformed adolescents refers to the distinction between shame 'on the skin' and 'deep shame' (Hultberg 1988). The latter is experienced so intensely, that people just want the ground to swallow them. It refers to shame as an existential feeling or existential mode, which shapes how someone experiences and orients towards the world as a possibility space (Ratcliffe 2009). As such, it affects how one relates to oneself, reflects on interactions with others and society, and constructs the narrative of one's own identity in relation to others, the world and God/the divine. Shame as an existential feeling implies 'a lack of connectedness to the world, an absence of warming familiarity, of significance, of belonging' (Ratcliffe 2009, p. 180). As such, it involves anxiety of being excluded from one's own community and from human society, which (in the context of ecological networks with all the psychological, social and religious/spiritual dimensions) interacts with anxiety about mental disintegration, as the experience of being separated and disconnected may lead to the experience that one's very existence is at risk, as it is impossible to survive on one's own. Thus, fear of total abandonment, of not having a place in this world, may result in fear of psychic extinction and mental disintegration and vice versa (Hultberg 1988, p. 116; Morrison 1989).

From this existential perspective, it is hardly surprising that shame is related to multiple forms of psychopathology (Kaufman 1996). For instance, addiction could be viewed as a flight from shame (Cook 1991; Rahim and Patton 2015); the 'shame spiral of addiction' refers to a pattern of substance use to escape or avoid negative self-conscious emotions such as shame and that paradoxically leads to increased shame related to the stigma of being an addict (Batchelder et al. 2022). ADHD is also related to a shame spiral (or even shame epidemic), as symptoms of ADHD such as impulsivity give rise to shame and identity problems, with people feeling they are failing to meet up to the expectations of others and society (Schrevel et al. 2016). Trauma, especially sexual trauma, is often associated with chronic shame and the tendency to cover and to hide (Leskela et al. 2002; MacGinley et al. 2019; Plante et al. 2022). PTSD could be understood as a shame disorder (Herman 2011) and pervasive and hidden shame plays a central role in complex trauma (Zhu et al. 2020). Depression, which for a long time has often been considered to be related to feelings of guilt or emptiness, turns out to be significantly more strongly associated with shame than with guilt in the meta-review of Kim et al. (2011). The same is true for suicidality, as feelings of shame (although frequently ignored in this context) often elicit a desire to escape, to hide the self from further disgrace and condemnation; suicide may function as the ultimate escape (Hastings et al. 2000). Given the associations with a variety of mental health problems, shame as an existential feeling should neither be overlooked nor neglected, but taken seriously in relation to mental health, mental health care and also public health (cf. Zhu et al. 2020).

How can clinical psychology be a supportive factor in this context?

4. Clinical Psychology of Religion Supporting Mental Health

Clinical psychology of religion is a psychological discipline that works with psychological theories and research methods to explain and understand the interactions between religion, spirituality and mental health (Van Uden and Pieper 2003; cf. Aten et al. 2012). Clinical psychology of religion can support mental health through inclusion and prioritization of the existential dimension of mental health problems and through underlining an ecological–existential view on mental health (cf. De Marinis 2008). In this way, the discipline can make suffering patients and mental health practitioners sensitive to the existential dimension that often has an impact on the nature and severity of clinical symptoms, as well as their course and responsivity to treatment (Vieten et al. 2013). Clinical psychology of religion can describe how specific mental health problems, or symptoms, interact with aspects or dimensions of R/S (Rosmarin and Koenig 2020). Ignorance about these interactions may result in their neglect, which hinders recovery. When, for example, issues of identity, meaning and purpose are not part of the treatment of eating disorders, crucial aspects of pathology are missed, however necessary a focus on weight and food intake may be (Richards et al. 2020). Existential shame also deserves attention in this context, as people often feel totally bad and unworthy, with (self-)stigma about their eating behavior reinforcing these feelings (Brelet et al. 2021). Not paying attention to this existential mode can result in hiding and isolating oneself (Nathanson 1992). In contrast, recovery on this existential level may facilitate clinical, social and functional recovery (cf. Whitley and Drake 2010).

When existential recovery is one of the most crucial aspects of recovery, as psychiatric patients and other patients have emphasized more than once (Huber et al. 2016; Van de Loo et al. 2022), it makes sense to map existential themes in mental problems, preferably in a transdiagnostic way. How do existential themes, such as judgment and acceptance, freedom, hope, isolation and connectedness, relate to dimensions of psychopathology? Which existential feelings characterizes diverse mental health problems and how do they impact recovery? (Ratcliffe 2009, 2015; Søberg et al. 2018). Such an overview is helpful not only for psychiatrists and psychologists, but also for spiritual caregivers, pastoral counsellors and other professionals, as it gives directions to diagnostics, case conceptualizations, approach and interventions.

It is important to stress that patients have care needs in this context: Van Nieuw Amerongen-Meeuse et al. (2020) found several clusters of R/S care needs among clinical psychiatric patients. These R/S care needs included conversations about R/S and attention to existential issues in treatment, for example through psycho-education about the associations between their mental health problems and existential feelings or aspects of R/S. Unmet R/S needs turned out to have a negative impact on the working alliance between patient and therapist, which suggest that they are also a constraint for recovery (Van Nieuw Amerongen-Meeuse et al. 2021). Thus, paying attention to those care needs is no luxury. In fact, it can bring many benefits to the patient. Aspects of religion and spirituality may function as sources of meaning, values, support and hope. These aspects contribute to resilience and adaptation, to finding a new balance, to recovery as re-defining one's narrative and adopting a new perspective to live your life in a meaningful and self-confident way (Van den Berg et al. 2018; Boevink 2017; Pargament and Cummings 2010). Due to the attention to existential recovery, narrativity and life story, and the focus on R/S functions such as finding meaning, gaining control, comfort and closeness, and achieving intimacy with others and closeness to God (Pargament et al. 2013), the clinical psychology of religion has much to offer to psychiatry and mental health care. The ecological–existential view on mental health enables mental health care to take advantage of R/S contributions to perseverance, resilience and transformation. Empirical studies support the positive contribution of R/S, also in the context of public health. For example, Captari et al. (2022) found that doubts about divine presence and purpose amidst suffering, loss and uncertainty were related to feelings of depression among people in the global south during COVID-19 lock-

downs. However, this association was moderated by hope and the supportive functions of religion and spirituality (Captari et al. 2022).

The clinical psychology of religion can also support mental health and mental health care through its theories aimed at understanding people's experiences and behavior in relation to R/S. For mental health practitioners, it is helpful to use these theories as heuristic instruments within mental health care, which may inform diagnostic and therapeutic interventions. Pargament (1997) and Pargament et al. (2013) provide an influential theory on religious coping, for instance, which is not only helpful to understand the functions of R/S in crisis situations and the psychological mechanisms at stake, but also gives direction to counseling and treatment. In mental health care, different strategies of R/S coping could be applied (Koenig et al. 2020; Pargament and Exline 2022). By implication, various mental health practitioners should know the theories that constitute the field of the clinical psychology of religion.

Mental health problems result from disrupted relationships and problem-maintaining interactional patterns, as stated above (Van den Berg et al. 2018). This may also be the case in the religious and spiritual domain, as many people suffer from religious/spiritual struggles, experiencing disruptions in the relationship with God/the divine or with the religious community (Pargament and Exline 2021; Van Nieuw Amerongen-Meeuse et al. 2022). Sometimes, they even consider these struggles as the core of their problem (Pargament and Lomax 2013). In line with this, negatively valenced representations of God, reflecting feelings of anxiety, anger, guilt, shame and desolation, may color the interactions with God (Schaap-Jonker et al. 2017). These religious or spiritual struggles and negative feelings towards God/the divine do not automatically change during therapy, at least not always. Treatment regularly leads to an improvement in patients' psychological well-being and social functioning, but their relationship with God could still be problematic. Hence, specific interventions, which are aimed at the religious/spiritual domain, are needed, and the clinical psychology of religion can contribute to the development of these (R/S) interventions (e.g., Aten et al. 2012; Rosmarin 2018). In this way, the discipline might build a bridge between the disciplines of psychiatry and clinical psychology on the one hand, and spiritual care on the other. Of course, spiritual caregivers are specialists in the guidance of existential suffering, and they have a lot of expertise. However, other mental health practitioners also have a need to integrate meaning-making (and spirituality) in their treatments, but feel often incompetent to do so, as they recently indicated in a survey (Akwa 2021). They want interventions that fit their own professional guidelines and treatment methods. In this context, clinical psychology of religion cannot only contribute to the psychological interventions that could be used in the context of existential recovery for mental health problems. It can also stimulate and support the acquirement of skills that are needed to address existential themes, and the development of existential competencies (Vieten and Scammell 2015; cf. Wong and Hwang 2021). Wong and Hwang (2021) pointed to the importance of the development of the patient's existential competency in therapy in relation to shame. These authors list skills such as acknowledgment of one's failures and limitations, self-forgiveness and self-compassion, seeking a support group, seeking deeper meaning and self-transcendence. However, these skills are also useful for therapists as well, and sometimes even of vital importance (Newmeyer et al. 2016).

Applying interventions aimed at clinical and existential recovery does not only require professional knowledge and competencies of therapists, but also adequate diagnostics. From an ecological–existential perspective on mental health, network analyses are essential instruments in this regard, and R/S or existential factors are crucial elements of these network diagrams. Hodge (2000, 2013) even proposes spiritual and religious eco-maps. However, to take into account the multidimensional and dynamically interacting nature of all of the elements of the network, various R/S factors should be assessed in connection with multiple aspects of other network elements, such as psychological and social factors. Because of the foundational nature of the existential dimension, the dynamic interactions

of the existential factors with other elements of the network require explicit attention. To illustrate this, a clinical case report is presented:

> *Jill is a woman in her forties who seeks help for difficult interpersonal functioning and eating problems. Her life story is characterized by attachment trauma, emotional neglect and sexual abuse. Her parents 'were fighting with their own demons' of alcohol abuse and depression and neither paid attention to her emotional needs nor helped her to develop her own boundaries. As a teenager, she fell victim to sexually transgressive behavior of various friends and was raped several times. She felt ashamed and disgusted her body. 'The feeling of being totally naked was so overwhelming–I felt burning pain and I couldn't stop it.' Her parents labelled these sexual contacts as voluntary behavior and condemned them. They even condemned Jill as a person, scolding her and calling her a whore. She was told to leave home and to rent her own room. Furthermore, her father, whose religiousness was typified by fear of judgment and obeying the rules, asked the priest whether she could receive the holy communion any longer. Hence, Jill's conclusion is that she is a sinner who will never receive God's forgiveness and compassion. However, she does not share this existential core belief with the therapist during her anamnesis.*
>
> *The start of the therapy is hard. Jill's self-criticism hinders the therapeutic relationship. She regularly interprets her struggles as posturing, and considers herself to be a quitter who has to try harder. 'I am so stupid' she often says, being afraid of the therapist's judgments about her. At the same time, she feels worthless and empty, and her eating behavior is an attempt to deal with those feelings of emptiness. In addition, she feels uncomfortable to be seen and is delighted with online sessions during COVID-19 lock-downs, which enable her to hide her body as much as possible. Her therapist recognizes the central role of shame in Jill's pathology and identifies different coping strategies: avoidance, withdrawal, and, most of all, self-attack (Nathanson 1992). The therapist helps her to understand her self-judgment and assumptions about the therapist's evaluations as both an internalization of her parents' condemnation and neglect (implying that she is not good enough), and a defense mechanism to cope with shame, anxiety and fear of being abandoned (Arntz and Van Genderen 2020; Malan 1979). Her eating behavior has the same defensive function, leading to more shame and self-judgment. In this way, Jill discovers how traumatic interactional patterns of the past result in dysfunctional intrapersonal and interpersonal interactions in the present. She recognizes how shame dominates her psychic experience and daily behavior, making it impossible to connect to others and to receive their acceptance and compassion. 'I am unworthy', she repeatedly says, 'I am too bad.'*
>
> *During one of the sessions, Jill lets slip that God also does not want her any longer. Exploration of her feelings and thoughts about God reveals that Jill does not only associate God with her father's condemnation, but also with her body-related shame. She feels naked before God, 'he sees right through me', and she cannot hide herself for his gaze, as God is omnipresent, she believes. Sexuality plays a part in this context, which is negatively evaluated, as sexual sins are regarded as the most severe ones within religion and religious communities, according to Jill. From now on, the therapist does not limit himself to ecological analyses of Jill's shame from a psycho-social-cultural perspective (cf. Campbell et al. 2009; Zhu et al. 2020), but includes an existential and religious perspective. Her feelings of unworthiness and her urge to hide turn out to have ultimate proportions and hamper recovery: being convinced of God's absolute rejection and believing that he will never accept her lead to the experience that she has no ground under her feet, and will never find a foundation to build her life on. Hence, the therapist focuses on the interactions of Jill's existential assumptions and feelings with her present functioning. Her current feelings of shame and strategies to cope with them are understood within the network of interactions between existential core beliefs, experiences with her parents during her youth, current interactions with significant others, representations of God, ideas about and experiences with her past and present religious community, body-related views and*

> *feelings and the numerous emotions which characterize the different interrelated nodes of this network. For example, they explore how her shame towards God and her perceptions of God's penetrating gaze are dynamically related to violations of body integrity, her inability to set boundaries due to emotional neglect, her experiences with her parents, whose rejection and condemnation was associated with their punitive God representations and emphasis on authority, also within the religious community, their focus on purity with regard to religious practices and how these feelings and perceptions in relation to God affect other aspects of her experience and functioning, including the therapeutic relationship.*
>
> *With help of therapeutic interventions, such as schema therapeutic interventions and limiting reparenting, which provides new corrective emotional experiences of acceptance and safety (Arntz and Van Genderen 2020; Christian et al. 2012), Jill is invited to re-write her narrative, and to define her identity no longer in terms of a shameful sinner. Instead of attributing all guilt and shame to herself, she gradually learns to notice the guilt and negligence of others. As a result, there is more room for grief and pain due to victimhood, and self-condemning behavior decreases. Jill becomes more open to representations of God as accepting, loving and compassionate, which is mutually related to the development of self-compassion and the ability to receive the love, compassion and acceptance from others. (Knabb 2018)*

5. Conclusions

An ecological–existential view on mental health has the potential to function as an important basis for the support of clinical psychology of religion to mental health and mental health care, fitting new perspectives on recovery and mental health. The interactional discussion of the emotion of shame, which plays a part in many mental health problems, underlines the relevance of the ecological–existential view and the need for contributions of clinical psychology of religion to mental health and mental health care, involving theories about, diagnostics and treatment interventions regarding the interactions between R/S and mental health. Future empirical studies should focus on the impact of the existential dimension on recovery and resilience. Methods that are able to assess the dynamics and interactions of the various elements of the ecological–existential network are needed in this context.

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References

Adams, Glenn, Sara Estrada-Villalta, Daniel Sullivan, and Hazel Rose Markus. 2019. The psychology of neoliberalism and the neoliberalism of psychology. *Journal of Social Issues* 75: 189–216. [CrossRef]

Akwa GGZ. 2021. Alliantie kwalititeit in de geestelijke gezondheidszorg. In *Rapport Uitkomsten Online Panel Akwa GGZ Zingeving en Psychische Hulpverlening. Alliance Quality in Mental Health Care: Report Results Online Panel Akwa GGZ Meaning Making and Psychological Care*. Utrecht: Akwa GGZ.

Arntz, Arnoud, and Hannie Van Genderen. 2020. *Schema Therapy for Borderline Personality Disorder*, 2nd ed. Chichester: John Wiley & Sons.

Aten, Jamie, Kari O'Grady, and Everett Worthington Jr. 2012. *The Psychology of Religion and Spirituality for Clinicians: Using Research in Your Practice*. New York: Routledge.

Batchelder, Abigail W., Tiffany R. Glynn, Judith T. Moskowitz, Torsten B. Neilands, Samantha Dilworth, Sara L. Rodriguez, and Adam W. Carrico. 2022. The shame spiral of addiction: Negative self-conscious emotion and substance use. *PLoS ONE* 17: e0265480. [CrossRef] [PubMed]

Becker, Julia C., Lea Hartwich, and S. Alexander Haslam. 2021. Neoliberalism can reduce well-being by promoting a sense of social disconnection, competition, and loneliness. *The British Journal of Social Psychology* 60: 947–65. [CrossRef] [PubMed]

Benedict, Ruth. 1946. *The Chrysanthemum and the Sword; Patterns of Japanese Culture*. Boston: Houghton Mifflin.

Bennett, Jeanette M., Nicolas Rohleder, and Joachim P. Sturmberg. 2018. Biopsychosocial approach to understanding resilience: Stress habituation and where to intervene. *Journal of Evaluation in Clinical Practice* 24: 1339–46. [CrossRef] [PubMed]

Bessenoff, Gayle R., and Daniel Snow. 2006. Absorbing Society's Influence: Body Image Self-Discrepancy and Internalized Shame. *Sex Roles* 54: 727–31. [CrossRef]
Betancourt, Theresa S., Sarah E. Meyers-Ohki, Alexandra P. Charrow, and Wietse A. Tol. 2013. Interventions for children affected by war: An ecological perspective on psychosocial support and mental health care. *Harvard Review of Psychiatry* 21: 70–91. [CrossRef]
Boevink, Wilma. 2017. *Planting a Tree: On Recovery, Empowerment and Experiential Expertise*. Utrecht: Trimbos Instituut. Available online: https://www.trimbos.nl/wp-content/uploads/sites/31/2021/09/af1551-planting-a-tree.pdf (accessed on 27 September 2022).
Braam, Arjan W., and Harold G. Koenig. 2019. Religion, spirituality and depression in prospective studies: A systematic review. *Journal of Affective Disorders* 257: 428–38. [CrossRef]
Bradshaw, J. 1988. *Healing the Shame that Binds You*. Deerfield Beach: Health Communications.
Brelet, Lisa, Valentin Flaudias, Michel Désert, Sébastien Guillaume, Pierre-Michel Llorca, and Yves Boirie. 2021. Stigmatization toward People with Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder: A Scoping Review. *Nutrients* 13: 2834. [CrossRef]
Bretherton, Inge, and Kristine A. Munholland. 2008. Internal Working Models in Attachment Relationships: Elaborating a Central Construct in Attachment Theory. In *Handbook of Attachment, Second Edition: Theory, Research, and Clinical Applications*. Edited by J. Cassidy and P. R. Shaver. New York: Guilford Press, pp. 102–27.
Bronfenbrenner, U. 1977. Toward an experimental ecology of human development. *American Psychologist* 32: 513–31. [CrossRef]
Bronfenbrenner, U. 1979. *The ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.
Campbell, Rebecca, Emily Dworkin, and Giannina Cabral. 2009. An Ecological Model of the Impact of Sexual Assault On Women's Mental Health. *Trauma, Violence, & Abuse* 10: 225–46. [CrossRef]
Captari, Laura E., Richard G. Cowden, Steven J. Sandage, Edward B. Davis, Andrea Ortega Bechara, Shaun Joynt, and Victor Counted. 2022. Religious/spiritual struggles and depression during COVID-19 pandemic lockdowns in the global south: Evidence of moderation by positive religious coping and hope. *Psychology of Religion and Spirituality*. *Advance online publication*. [CrossRef]
Caring Universities. 2022. *The Mental Well-Being of Students during the COVID-19 Pandemic III: The Third Measurement by the Caring Universities Consortium*. Available online: https://caring-universities.com/wp-content/uploads/2022/03/The-mental-well-being-of-students-during-the-COVID-19-pandemic-III-report-by-Caring-Universities-31032022.pdf (accessed on 31 August 2022).
Christian, Christopher, Jeremy D. Safran, and J. Christopher Muran. 2012. The corrective emotional experience: A relational perspective and critique. In *Transformation in Psychotherapy: Corrective Experiences across Cognitive Behavioral, Humanistic, and Psychodynamic Approaches*. Edited by Louis G. Castonguay and Clara E. Hill. Washington, DC: American Psychological Association, pp. 51–67. [CrossRef]
Claesson, Katja, and Staffan Sohlberg. 2002. Internalized shame and early interactions characterized by indifference, abandonment and rejection: Replicated findings. *Clinical Psychology and Psychotherapy* 9: 277–84. [CrossRef]
Clark, Lee Anna, Bruce Cuthbert, Roberto Lewis-Fernández, William E. Narrow, and Geoffrey M. Reed. 2017. Three Approaches to Understanding and Classifying Mental Disorder: ICD-11, DSM-5, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest* 18: 72–145. [CrossRef] [PubMed]
Colombetti, Giovanna, and Evan Thompson. 2008. The feeling body: Towards an enactive approach to emotion. In *Developmental Perspectives on Embodiment and Consciousness*. Edited by Willis F. Overton, Ulrich Müller and Judith L. Newman. New York: Erlbaum, pp. 45–68.
Cook, David R. 1991. Shame, attachment, and addictions: Implications for family therapists. *Contemporary Family Therapy* 13: 405–19. [CrossRef]
Creswell, Cathy, Adrienne Shum, Samantha Pearcey, Simona Skripkauskaite, Praveetha Patalay, and Polly Waite. 2021. Young people's mental health during the COVID-19 pandemic. *The Lancet Child & Adolescent Health* 5: 535–37. [CrossRef]
De Bruin-Wassinkmaat, Anne-Marije, Jos de Kock, Elsbeth Visser-Vogel, Cok Bakker, and Marcel Barnard. 2021. 'It is never good. Really, it's just never good': A dominant theme in the life story accounts of strictly Reformed-raised emerging adults about their religious identity development. *Journal of Beliefs & Values* 43: 123–36. [CrossRef]
De Haan, Sanneke. 2017. The existential dimension in psychiatry: An enactive framework. *Mental Health, Religion & Culture* 20: 528–35. [CrossRef]
De Marinis, Valerie. 2008. The Impact of Postmodernization on Existential Health in Sweden: Psychology of Religion's Function in Existential Public Health Analysis. *Archive for the Psychology of Religion* 30: 57–74. [CrossRef]
De Young, Patricia A. 2015. *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach*. New York: Routledge.
Dolezal, Luna. 2015. *The Body and Shame: Phenomenology, Feminism, and the Socially Shaped Body*. London: Lexington.
Fegert, Jörg M., Benedetto Vitiello, Paul L. Plener, and Vera Clemens. 2020. Challenges and burden of the Coronavirus 2019 (COVID-19) pandemic for child and adolescent mental health: A narrative review to highlight clinical and research needs in the acute phase and the long return to normality. *Child and Adolescent Psychiatry and Mental Health* 14: 20. [CrossRef]
Feiring, Candice, and Lynn S. Taska. 2005. The persistence of shame following sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment* 10: 337–49. [CrossRef]
Foy, David W., Kent D. Drescher, and Patricia J. Watson. 2011. Religious and spiritual factors in resilience. In *Resilience and Mental Health: Challenges Across the Lifespan*. Edited by Steven M. Southwick, Brett T. Litz, Dennis Charney and Matthew J. Friedman. Cambridge: Cambridge University Press, pp. 90–102.

Gilligan, James. 2003. Shame, guilt, and violence. *Social Research: An International Quarterly* 70: 1149–80. [CrossRef]
Golden, Shelley D., and Jo Anne L. Earp. 2012. Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of Health Education and Behavior Health Promotion Interventions. *Health Education & Behavior* 39: 364–72. [CrossRef]
Groot, G. 2014. Schaamte zijn wij. [Shame we are]. *Psyche & Geloof* 25: 247–57.
Harper, David, and Ewen Speed. 2012. Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice* 6: 9–26. [CrossRef]
Hastings, Mark E., Lisa M. Northman, and June P. Tangney. 2000. Shame, guilt, and suicide. In *Suicide Science: Expanding the Boundaries*. Edited by Thomas Joiner and M. David Rudd. New York/Boston: Kluwer Academic/Plenum Publishers, pp. 67–79.
Henriksen, Jan-Olav, and Terje Mesel. 2021. *Shame's Unwelcome Interruption and Responsive Movements: Body, Religion, Morality—An Interdisciplinary Study*. Oslo: Cappelen Damm Akademisk.
Herman, Judith Lewis. 2011. Posttraumatic stress disorder as a shame disorder. In *Shame in the Therapy Hour*. Edited by Ronda L. Dearing and June Price Tangney. Washington, DC: American Psychological Association, pp. 261–75. [CrossRef]
Hodge, David R. 2000. Spiritual ecomaps: A new diagrammatic tool for assessing marital and family spirituality. *Journal of Marital and Family Therapy* 26: 217–28. [CrossRef] [PubMed]
Hodge, David R. 2013. Assessing spirituality and religion in the context of counseling and psychotherapy. In *APA Handbook of Psychology, Religion and Spirituality*. Edited by Kenneth I. Pargament, Julie J. Exline and James W. Jones. Washington, DC: APA, vol. 2, pp. 93–123.
Huber, Machteld, Marja van Vliet, M. Giezenberg, B. Winkens, Y. Heerkens, P. C. Dagnelie, and J. A. Knottnerus. 2016. Towards a 'patient-centred' operationalisation of the new dynamic concept of health: A mixed method study. *BMJ Open* 5: e010091. [CrossRef] [PubMed]
Hultberg, Peer. 1988. Shame: A hidden emotion. *The Journal of Analytical Psychology* 33: 109–26. [CrossRef] [PubMed]
Janoff-Bulman, Ronnie, and Cynthia McPherson Frantz. 1997. The impact of trauma on meaning: From meaningless world to meaningful life. In *The Transformation of Meaning in Psychological Therapies: Integrating Theory and Practice*. Edited by Mick Power and Chris R. Brewin. Hoboken: John Wiley & Sons Inc., pp. 91–106.
Jongkind, Matthias, Bart van den Brink, Hanneke Schaap-Jonker, Nathan van der Velde, and Arjan W. Braam. 2019. Dimensions of religion associated with suicide attempt and suicidal ideation in depressed, religiously affiliated patients. *Suicide and Life-Threatening Behavior* 49: 505–19. [CrossRef]
Kaufman, Gershen. 1996. *The Psychology of Shame: Theory and Treatment of Shame-Based Syndromes*. New York: Springer Publishing.
Kauffman, Jeffrey, ed. 2002. *Loss of the Assumptive World: A Theory of Traumatic Loss*. New York/London: Brunner Routledge.
Kendler, Kenneth S., Peter Zachar, and Carl Craver. 2011. What kinds of things are psychiatric disorders? *Psychological Medicine* 41: 1143–50. [CrossRef]
Kerr, Douglas J. R., Frank P. Deane, and Trevor P. Crowe. 2019. Narrative Identity Reconstruction as Adaptive Growth During Mental Health Recovery: A Narrative Coaching Boardgame Approach. *Frontiers in Psychology* 10: 994. [CrossRef]
Kim, Sangmoon, Ryan Thibodeau, and Randall S. Jorgensen. 2011. Shame, guilt, and depressive symptoms: A meta-analytic review. *Psychological Bulletin* 137: 68–96. [CrossRef]
Knabb, Joshua J. 2018. *The Compassion-Based Workbook for Christian Clients: Finding Freedom from Shame and Negative Self-Judgments*. London: Routledge. [CrossRef]
Koenig, Harold G., John R. Peteet, and Tyler J. VanderWeele. 2020. Religion and psychiatry: Clinical applications. *BJPsych Advances* 26: 273–81. [CrossRef]
La Cour, Peter, and Niels C. Hvidt. 2010. Research on meaning-making and health in secular society: Secular, spiritual and religious existential orientations. *Social Science & Medicine* 71: 1292–99. [CrossRef]
Lassiter, Jonathan M., Lena Saleh, Christian Grov, Tyrel Starks, Ana Ventuneac, and Jeffrey T. Parsons. 2019. Spirituality and Multiple Dimensions of Religion Are Associated with Mental Health in Gay and Bisexual Men: Results From the *One Thousand Strong* Cohort. *Psychology of Religion & Spirituality* 11: 408–16. [CrossRef]
Leamy, Mary, Victoria Bird, Clair Le Boutillier, Julie Williams, and Mike Slade. 2011. Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry* 199: 445–52. [CrossRef]
Leeming, Dawn, and Mary Boyle. 2004. Shame as a social phenomenon: A critical analysis of the concept of dispositional shame. *Psychology and Psychotherapy: Theory, Research and Practice* 77: 375–96. [CrossRef]
Leskela, Jennie, Michael Dieperink, and Paul Thuras. 2002. Shame and posttraumatic stress disorder. *Journal of Traumatic Stress* 15: 223–26. [CrossRef] [PubMed]
Lund, Crick, Alison Breen, Alan J. Flisher, Ritsuko Kakuma, Joanne Corrigall, John A. Joska, Leslie Swartz, and Vikram Patel. 2010. Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science & Medicine* 71: 517–28. [CrossRef]
MacGinley, Maureen, Jan Breckenridge, and Jane Mowll. 2019. A scoping review of adult survivors' experiences of shame following sexual abuse in childhood. *Health & Social Care in the Community* 27: 1135–46. [CrossRef]
Malan, D. H. 1979. *Individual Psychotherapy and the Science of Psychodynamics*. London: Butterworths.
Mayer, Claude-Hélène, and Elisabeth Vanderheiden. 2021. Shame in the Fourth Industrial Revolution, Industry 4.0, and the Age of Digitalisation. In *Shame 4.0: Investigating an Emotion in Digital Worlds and the Fourth Industrial Revolution*. Edited by Claude-Hélène Mayer, Elisabeth Vanderheiden and Paul T. P. Wong. Cham: Springer, pp. 1–25.

McLeroy, Kenneth R., Daniel Bibeau, Allan Steckler, and Karen Glanz. 1988. An ecological perspective on health promotion programs. *Health Education Quarterly* 15: 351–77. [CrossRef]
Mojallal, Mahsa, Raluca M. Simons, and Jeffrey S. Simons. 2021. Childhood maltreatment and adulthood proneness to shame and guilt: The mediating role of maladaptive schemas. *Motivation and Emotion* 45: 197–210. [CrossRef]
Morrison, Andrew P. 1989. *Shame: The Underside of Narcissism*. New York: Routledge.
Nathanson, Donald L. 1992. *Shame and Pride: Affect, Sex, and the Birth of the Self*. New York: WW Norton & Company.
Newmeyer, Mark, Benjamin Keyes, Kamala Palmer, Vanessa Kent, Sara Spong, Faith Stephen, and Mary Troy. 2016. Spirituality and Religion as Mitigating Factors in Compassion Fatigue among Trauma Therapists in Romania. *Journal of Psychology and Theology* 44: 142–51. [CrossRef]
Nussbaum, Martha C. 2004. *Hiding from Humanity: Disgust, Shame, and the Law*. Princeton: Princeton University Press.
Page, Lisa A., and L. M. Howard. 2010. The impact of climate change on mental health (but will mental health be discussed at Copenhagen?). *Psychological Medicine* 40: 177–80. [CrossRef]
Pargament, Kenneth I. 1997. *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford Press.
Pargament, K., and J. Cummings. 2010. Anchored by faith: Religion as a resilience factor. In *Handbook of Adult Resilience*. Edited by John W. Reich, Alex J. Zautra and John Stuart Hall. New York: The Guilford Press, pp. 193–210.
Pargament, Kenneth I., and Julie J. Exline. 2021. *The Psychology of Spiritual Struggle*. Full research review. Philadelphia: John Templeton Foundation. Available online: https://www.templeton.org/discoveries/the-psychology-of-spiritual-struggle (accessed on 21 July 2022).
Pargament, Kenneth I., and Julie J. Exline. 2022. *Working with Spiritual Struggles in Psychotherapy: From Research to Practice*. New York: The Guilford Press.
Pargament, Kenneth I., Melissa D. Falb, Gene G. Ano, and Amy B. Wachholtz. 2013. The religious dimension of coping: Advances in theory, research, and practice. In *Handbook of the Psychology of Religion and Spirituality*, 2nd ed. Edited by Raymond F. Paloutzian and Crystal L. Park. New York: Guilford Press, pp. 560–79.
Pargament, Kenneth I., and James W. Lomax. 2013. Understanding and addressing religion among people with mental illness. *World Psychiatry* 12: 26–32. [CrossRef] [PubMed]
Park, Christine J. 2016a. Chronic shame: A perspective integrating religion and spirituality. *Journal of Religion & Spirituality in Social Work: Social Thought* 35: 354–76. [CrossRef]
Park, Crystal L. 2016b. Meaning making in the context of disasters. *Journal of Clinical Psychology* 72: 1234–46. [CrossRef] [PubMed]
Park, C. 2022. Meaning Making Following Trauma. *Frontiers in Psychology* 13. [CrossRef] [PubMed]
Park, Crystal L., Kristen E. Riley, Login S. George, Ian A. Gutierrez, Amy E. Hale, Dalnim Cho, and Tosca D. Braun. 2016. Assessing disruptions in meaning: Development of the Global Meaning Violation Scale. *Cognitive Therapy and Research* 40: 831–46. [CrossRef]
Pattison, Stephen. 2000. *Shame: Theory, Therapy, Theology*. Cambridge: Cambridge University Press.
Plante, Wendy, Lea Tufford, and Tanya Shute. 2022. Interventions with survivors of interpersonal trauma: Addressing the role of shame. *Clinical Social Work Journal* 50: 183–93. [CrossRef]
Price-Robertson, Rhys, Angela Obradovic, and Brad Morgan. 2017. Relational recovery: Beyond individualism in the recovery approach. *Advances in Mental Health: Promotion, Prevention and Early Intervention* 15: 110–22. [CrossRef]
Rahim, Masuma, and Robert Patton. 2015. The association between shame and substance use in young people: A systematic review. *PeerJ* 3: e737. [CrossRef]
Ratcliffe, Matthew. 2009. Existential Feeling and Psychopathology. *Philosophy, Psychiatry, & Psychology* 16: 179–94.
Ratcliffe, Matthew. 2015. *Experiences of Depression: A Study in Phenomenology*. Oxford: Oxford University Press.
Richards, P. Scott, Sarah Weinberger-Litman, Michael E. Berrett, and Randy K. Hardman. 2020. Spirituality, religion, and eating disorders. In *Handbook of Spirituality, Religion, and Mental Health*. Edited by David H. Rosmarin and Harold G. Koenig. London: Academic Press, pp. 99–118.
Roe, David, and Larry Davidson. 2005. Self and narrative in schizophrenia: Time to author a new story. *Medical Humanities* 31: 89–94. [CrossRef]
Rosmarin, David H. 2018. *Spirituality, Religion, and Cognitive-Behavioral Therapy: A Guide for Clinicians*. New York: Guilford Press.
Rosmarin, David H., and Harold G. Koenig. 2020. *Handbook of Spirituality, Religion, and Mental Health*. London: Academic Press.
Ryan, Thomas. 2017. The Positive Function of Shame: Moral and Spiritual Perspectives. In *The Value of Shame: Exploring a Health Resource in Cultural Contexts*. Edited by Elisabeth Vanderheiden and Claude-Hélène Mayer. Cham: Springer, pp. 87–105. [CrossRef]
Sanderson, Christiane. 2015. *Counselling Skills for Working with Shame*. London: Jessica Kingsley Publishers.
Sartre, Jean-Paul. 2021. *Being and Nothingness: An Essay in Phenomenological Ontology*. Translated by Sarah Richmond. New York and Washington, DC: Square Press. First published 1943.
Schaap-Jonker, Hanneke, Nathan Van der Velde, Elisabeth H. M. Eurelings-Bontekoe, and Jozef M. T. Corveleyn. 2017. Types of God representations and mental health: A person-oriented approach. *International Journal for the Psychology of Religion* 27: 199–214. [CrossRef]
Scharff, Christina. 2016. The Psychic Life of Neoliberalism: Mapping the Contours of Entrepreneurial Subjectivity. *Theory, Culture & Society* 33: 107–22. [CrossRef]
Scheff, T. 2014. The Ubiquity of Hidden Shame in Modernity. *Cultural Sociology* 8: 129–41. [CrossRef]

Scheff, Sue, and Melissa Schorr. 2017. *Shame Nation: The Global Epidemic of Online Hate*. Chicago: Sourcebooks.
Scherer, Klaus R. 2000. Emotions as episodes of subsystem synchronization driven by nonlinear appraisal processes. In *Emotion, Development, and Self-Organization: Dynamic Systems Approaches to Emotional Development*. Edited by Marc D. Lewis and Isabella Granic. Cambridge: Cambridge University Press, pp. 70–99.
Schrevel, Samuel J. C., Christine Dedding, Jeroen A. van Aken, and Jacqueline E. W. Broerse. 2016. Do I need to become someone else? A qualitative exploratory study into the experiences and needs of adults with ADHD. *Health Expectations* 19: 39–48. [CrossRef] [PubMed]
Swearer, Susan M., and Shelley Hymel. 2015. Understanding the psychology of bullying: Moving toward a social-ecological diathesis–stress model. *American Psychologist* 70: 344–53. [CrossRef] [PubMed]
Schultze-Lutter, Frauke, Benno G. Schimmelmann, and Stefanie J. Schmidt. 2016. Resilience, risk, mental health and well-being: Associations and conceptual differences. *European Child & Adolescent Psychiatry* 25: 459–66. [CrossRef]
Snyder, Jordan D., David Boan, Jamie D. Aten, Edward B. Davis, Leif Van Grinsven, Tao Liu, and Everett L. Worthington. 2020. Resource Loss and Stress Outcomes in a Setting of Chronic Conflict: The Conservation of Resources Theory in the Eastern Congo. *Journal of Traumatic Stress* 33: 227–37. [CrossRef]
Søberg, Ane Inger Bondahl, Sigrid Helene Kjørven Haug, Lars Johan Danbolt, Lars Lien, and Torgeir Sørensen. 2018. Existential themes in the treatment of people at suicide risk. Understandings and practices of specialist healthcare professionals. *Mental Health, Religion and Culture* 21: 588–600. [CrossRef]
Van de Loo, D.T.M., N. Saämena, P. Janse, M. van Vliet, and A.W. Braam. 2022. De waardering van de zes dimensies van positieve gezondheid in de ggz The six dimensions of positive health valued by different stakeholders within mental health care. *Tijdschrift voor Psychiatrie* 64: 87–93.
Van den Berg, D., F. De Boer, M. Van Dijk, L. Jacobse, N. Tromp, S. Voerman, and B. Voorneman. 2018. Redesigning psychiatry: Samen innoveren voor het psychisch welzijn van toekomstige generaties #2. [Redesigning Psychiatry: Innovating Together for Mental Well-Being of Future Generatations]. Available online: www.redesigningpsychiatry.org (accessed on 31 August 2022).
Van Ments, Laila, Peter H. M. P. Roelofsma, and Jan Treur. 2022. How Empathic is Your God: An Adaptive Network Model for Formation and Use of a Mental God-Model and Its Effect on Human Empathy. In *Mental Models and Their Dynamics, Adaptation, and Control. Studies in Systems, Decision and Control*. Edited by Jan Treur and Laila Van Ments. Cham: Springer, vol. 394. [CrossRef]
Van Nieuw Amerongen-Meeuse, Joke C., Hanneke Schaap-Jonker, Gerlise Westerbroek, Christa Anbeek, and Arjan W. Braam. 2020. Conversations and Beyond, Religious/Spiritual Care Needs Among Clinical Mental Health Patients in the Netherlands. *Journal of Nervous and Mental Disease* 208: 524–32. [CrossRef]
Van Nieuw Amerongen-Meeuse, Joke C., Arjan W. Braam, Christa Anbeek, Jos W. R. Twisk, and Hanneke Schaap-Jonker. 2021. Treatment alliance and needs of care concerning religiousness and spirituality: A follow-up study among psychiatric inpatients. *International Journal of Social Psychiatry* 68: 1341–50. [CrossRef]
Van Nieuw Amerongen-Meeuse, Joke C., Hanneke Schaap-Jonker, Gerlise Westerbroek, and Arjan W. Braam. 2022. 'Why does this happen to me?' Religious and spiritual struggles among psychiatric inpatients in The Netherlands: A narrative analysis. *Religions* 13: 965. [CrossRef]
Van Uden, Marinus, and Jos Pieper. 2003. Clinical psychology of religion: A training model. *Archiv Für Religionspsychologie/Archive for the Psychology of Religion* 25: 155–64. [CrossRef]
Verhagen, Peter J. 2017. Psychiatry and religion: Consensus reached! *Mental Health, Religion & Culture* 20: 516–27. [CrossRef]
Verhagen, Simone, Jim van Os, and Philippe Delespaul. 2022. Ecological momentary assessment and other digital technologies for capturing daily life in mental health. In *Mental Health in a Digital World: Global Mental Health in Practice*. Edited by Dan J. Stein, Naomi A. Fineberg and Samuel R. Chamberlain. London: Academic Press, pp. 81–108. [CrossRef]
Vieten, Cassandra, Shelley Scammell, Ron Pilato, Ingrid Ammondson, Kenneth I. Pargament, and David Lukoff. 2013. Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality* 5: 129–44. [CrossRef]
Vieten, Cassandra, and Shelley Scammell. 2015. *Spiritual and Religious Competencies in Clinical Practice: Guidelines for Psychotherapists and Mental Health Professionals*. Oakland: New Harbinger Publications.
Vu, Mai Chi, and Nicholas Burton. 2022. The Influence of Spiritual Traditions on the Interplay of Subjective and Normative Interpretations of Meaningful Work. *Journal of Business Ethics* 180: 543–66. [CrossRef]
Waters, Theodore E. A., and Robyn Fivush. 2015. Relations Between Narrative Coherence, Identity, and Psychological Well-Being in Emerging Adulthood. *Journal of Personality* 83: 441–51. [CrossRef]
Whitley, Rob, and Robert E. Drake. 2010. Recovery: A dimensional approach. *Psychiatric Services* 61: 1248–50. [CrossRef]
Wilt, Joshua A., Julie J. Exline, and Kenneth I. Pargament. 2021. Daily measures of religious/spiritual struggles: Relations to depression, anxiety, satisfaction with life, and meaning. *Psychology of Religion and Spirituality*. [CrossRef]
Wong, Paul T. P., and Kwang-Kuo Hwang. 2021. The Second Wave Positive Psychology of Shame in East and West in the Age of the 4IR. In *Shame 4.0*. Edited by Claude-Hélène Mayer, Elisabeth Vanderheiden and Paul T. P. Wong. Cham: Springer. [CrossRef]
World Health Organization. 2022. *World Mental Health Report: Transforming Mental Health for All*. Geneva: World Health Organization.
World Health Organization, and Calouste Gulbenkian Foundation. 2014. *Social Determinants of Mental Health*. Geneva: World Health Organization.

Young, Jeffrey E., Janet S. Klosko, and Marjorie E. Weishaar. 2003. *Schema Therapy: A Practitioner's Guide*. New York/London: Guilford Press.

Zahavi, Dan. 2014. *Self and Other: Exploring Subjectivity, Empathy, and Shame*. Oxford: Oxford University Press.

Zhu, Peitao, Jared Lau, and Carryl P. Navalta. 2020. An Ecological Approach to Understanding Pervasive and Hidden Shame in Complex Trauma. *Journal of Mental Health Counseling* 42: 155–69. [CrossRef]