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RELIGION AS AN EXISTENTIAL RESOURCE

On Meaning-Making, Religious Coping and Rituals

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In this paper, we make a contribution to the treatment of post-traumatic stress disorder. We show how religion can function as an existential resource. Religions enable people to perceive an underlying pattern of order and purpose below the surface of life's incomprehensible inevitabilities such as death and suffering. Religion then works as a meaning-making system that can positively influence the individual's mental health. Recently, the relations between religion and health have been studied particularly in the context of the 'religious coping paradigm'. Religious coping is aiming at a 'search for significance'. Religious coping will often occur where non-religious coping fails, especially in situations involving loss of life, health and relational embeddedness. Religious activities and acts can also enable religious coping. A crucial religious act is the ritual. What are the functions of ritual, and how can a ritual contribute to the mental health of an individual in crisis? What is, in this context, the role of myths and symbols? Several examples are given of how rituals can work as therapeutic tools in the treatment of traumatic disorders. We conclude by stating that religion, being a robust form of meaning-making, is not the sole system able to contribute to working through a trauma, and that its success is far from guaranteed.

Keywords: meaning-making, myth, post-traumatic stress, (religious) coping, ritual

Die Religion als Kraftquelle der Existenz: Über Sinngabe, religiöse Bewältigung und Rituale: Durch unseren Artikel möchten wir zur Behandlung der Folgen der posttraumatischen Belastungsstörung beitragen. Wir zeigen, wie die Religion als Kraftquelle der Existenz funktionieren kann. Die Religionen ermöglichen den Menschen, das Muster einer tieferen Ordnung und eines tieferen Sinnes in Bezug auf scheinbar unverständliche Beschaffenheiten des Lebens wie der Tod oder das Leiden, zu erblicken. Auf diese Weise funktioniert die Religion als ein Sinngebendes System, das die geistige Gesundheit positiv beeinflussen kann. Neulich wurden die Zusammenhänge zwischen Religion und Gesundheit im Rahmen des „religiösen Bewältigungsparadigmas“ geforscht. Das Ziel der religiösen Bewältigung ist die „Suche nach Bedeutung und Wichtigkeit“.

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Religiöse Bewältigung findet häufig dann statt, wenn die nicht-religiöse Bewältigung versagt, vor allem in Situationen, in denen Themen wie Verlust des Lebens, Gesundheit oder Beziehungen betroffen sind. Auch religiöse Taten und Handlungen können die religiöse Bewältigung ermöglichen. Eine der grundlegenden religiösen Handlungen ist das Ritual. Was sind die Funktionen des Rituals und wie kann das Ritual zur psychischen Gesundheit der in der Krise befindlichen Person beitragen? Welche Rolle spielen die Mythen und Symbole in diesem Zusammenhang? Wir zeigen zahlreiche Beispiele dafür, wie Rituale bei traumatischen Störungen zum therapeutischen Instrument werden können. Als Schlussfolgerung behaupten wir, dass die Religion – obwohl sie eine grundlegende Form der Sinngabe ist, aber doch nicht das einzige System, das zur Verarbeitung des Traumas beitragen kann und dessen Erfolg bei Weitem nicht sicher ist.

Schlüsselbegriffe: Sinngabe, (religiöse) Bewältigung, Rituale, posttraumatischer Stress, Mythos

1. Introduction

This paper will start from the perspective of the clinical psychology of religion. Clinical psychology of religion can be defined as the branch of psychology specifically studying the relations between religion and worldview on the one hand, and mental health on the other. Drawing on this perspective, we will try to make a meaningful contribution to the treatment of the consequences of post-traumatic stress disorder (PTSD) by discussing the relationship between religion and coping. We will consider three aspects, namely, religion and meaning-making, religious coping, and rituals.

The relationship between religion and mental health has been studied scientifically since the inception of the psychology of religion at the beginning of the previous century. Questions like these were asked: Can conversion be considered a pathological phenomenon, or does it, on the contrary, advance the psyche's integration? To what extent do profound religious and mystical experiences contribute to a mentally healthy existence? The antithesis between Freud and Jung is well known. Freud saw religion as an illusion that kept people immature and, hence, mentally unhealthy. According to Jung, however, religious rites, myths and symbols were indispensable for a healthy existence. Most present-day authors believe that religion can have positive as well as negative effects on mental health (UDEN 1996).

Religion can have therapeutic effects. Participating in rituals can add considerable value to recovery. Religion can also function as a refuge in which one can escape from the tensions of daily life. However, religion can also cause mental dysfunction or exacerbate existing mental problems. For instance, violating religious do's and don'ts can generate excessive guilt feelings and an inflated awareness of sin. A survey by PARGAMENT and BRANT (1998) shows that religion contributes to coping with problems in 32% of cases; in other cases it makes no difference (47%) or even makes problems worse (21%).

2. Religion and meaning-making

When we talk about the meaning of life, religion never is far away. PARGAMENT (1997, 32) defines religion as ‘a search for significance in ways related to the sacred’. Seen in this way, religion has a central importance in many people’s broad system of meaning-making, although its importance varies strongly among individuals. It is often said that religion originates from people’s need to understand the existential problems with which they are confronted. Religions enable people to perceive an underlying pattern of order and purpose below the surface of life’s incomprehensible inevitabilities, such as death and suffering. Compared with more secular non-religious systems (such as humanism), humans’ long-standing and almost universal dependence on religious systems of meaning has to do with the fact that religion is more comprehensive and can provide answers that are existentially more satisfactory. Moreover, religious systems of meaning are less susceptible to falsification; they have less difficulty in passing the test of criticism. As PARGAMENT and his colleagues stated:

The language of religion – faith, hope, transcendence, surrender, forbearance, meaning – speaks to the limits of human powers. When life appears out of control, and there seems to be no rational explanation for events – beliefs and practices oriented to the sacred seem to have a special ability to provide ultimate meaning, order, and safety in place of human questions, chaos and fear. (2005, 676)

Religious systems of meaning can enable the individual to explain events in the world in a satisfactory way. These systems of interpretation are very important when dealing with the most threatening aspects of human existence, such as suffering, death, disasters, traumatic experiences and injustice. Religion offers the possibility of explaining commonplace events as well as the more existential and extraordinary ones.

Apart from explicitly religious convictions, such as a belief in God’s existence and in the possibility of a life after death, religion often also has a crucial influence on general values and convictions like honesty, the fundamental goodness of humans and of the world, control and vulnerability. Thus, religion is important in a much broader context. The relations between religion and meaning-making are complicated. Just like other systems of meaning-making, religion influences the individual’s convictions, goals and emotions. Religion is unique in that it focuses on what people deem to be ‘sacred’ or of ultimate importance. In this way, religion transcends the commonplace level of meaning-making.

Defining what meaning or significance is, is troublesome. BAUMEISTER (1991, 15) suggested, ‘A rough definition would be that meaning is shared mental representations of possible relationships among things, events and relationships’, and he emphasised, ‘Thus meaning *connects* things’. Meaning-making is a means to adaptation, to controlling the world, to keeping oneself in hand and to belonging to something.

Earlier, FRANKL (1969) pointed to the ‘will to meaning’ as a crucial human motive. He pointed out that obtaining pleasure or power are not the most important goals in life. It is, rather, the discovery of significance and meaning in life. This meaning, however, is not inherent in life, but people have to search actively for the meaning of their existence. Hence, meaning is a central value in human existence.

People believe that they have control over their lives, that the world is reasonable and fair, that they are good people, that unpleasant things do not happen to themselves but to bad people, and that God is good and guards and protects them. In addition, people generally have the idea that they are on their way to realising their goals, and that they will acquire or retain things that they deem essential (BAUMEISTER 1991). If, however, something tragic happens to them, then these broad convictions as well as these broad goals are called into question, and people will experience feelings of meaninglessness and aimlessness. People will then also become more aware of their broad systems of meaning-making, and their everyday worries will disappear into the background.

Meaning-making refers to a process in which people attempt to restore their broad systems of meaning-making after they have been disrupted by a major life event. Traumatising events can also precipitate or even cause a crisis in meaning-making, because of questions arising about the meaning of life, about the meaning of suffering and about justice in the world (LAZARUS 1993).

3. Coping and religious coping

‘When I find myself in times of trouble’ – many readers will be able to complete the subsequent lines of the well-known Beatles song, ‘Mother Mary comes to me / Speaking words of wisdom: let it be.’ With this, we are talking about religious coping. In other words, about the ways in which the religious domain enables people to alleviate their problems in times of trouble (UDEN et al. 2014).

In a time of steadily increasing secularisation, the themes of religion and world-view have had to operate rather on the fringe of mental healthcare for years. However, it appears that recently these themes have become ‘trendy’ again. In social psychology and health psychology, attention to issues like spirituality or religion has long been unthinkable (UDEN & HECK 2005). However, within the psychology of religion, studying the relations between religion and mental health has always been a major theme. Already at the inception of this discipline at the end of the nineteenth century, LEUBA (1896) and STARBUCK (1897) investigated the implications of conversion experiences for the converts’ mental health, and more than a hundred years ago William JAMES (1982) explored the boundaries between profound religious and mystical experiences and psychopathology. In recent decades, these relations have been studied in particular in the context of the ‘religious coping paradigm’, articulated most extensively by the American clinical psychologist K.I. PARGAMENT (1997; 2007). Within this line of research, bridges are being built between the theory and

practice of physical and mental healthcare. Many studies focus on the significance of religion for the ways in which in-patients in general or mental hospitals in particular are coping with physical or mental problems. Within this paradigm, religion is depicted as a positive force in overcoming physical and mental adversities.

3.1. Coping

Coping research has flourished in particular through the advance of cognitive psychology, in which the process of coping is interpreted as a form of information processing. In this process, the individual is not directed by structural personality characteristics but enters into a dynamic interaction with the environment. LAZARUS and FOLKMAN have developed the most elaborate theory. They define psychological stress as 'a particular relationship between person and environment that is appraised by the person as taxing or exceeding his/her resources and endangering his/her wellbeing' (1984, 19). Hence, stress is not an individual's automatic response to a stimulus but is the result of a process in which the cognitive appraisal and assessment of the stressor play an important role. It should be clear that people differ in the extent to which they experience stress with respect to the same stressor. This cognitive 'appraisal' is a mental process in which a distinction can be made between 'primary appraisal' and 'secondary appraisal'. Primary appraisal relates to the question whether a situation or event constitutes a threat to the individual's well-being. By contrast, secondary appraisal relates to the assessment of the resources available to the individual for meeting the demands made by the situation or event. These resources are diverse in character: material (money, accommodation, food, transport), physical (health, vitality), mental (insight, motivation, knowledge, emotional skills), social (the extent of social support, social networks) and religious (closeness to God, being part of a faith community).

After these cognitive appraisals, the individual attempts to deal with the situation, which is their actual coping. FOLKMAN and LAZARUS (1980, 223) state that coping is 'a cognitive and behavioural effort to master, tolerate, or reduce external and internal demands and conflicts'. According to them, two forms of coping can be distinguished, 'emotion focused' coping, aiming at controlling the emotional response to the stressor, and 'problem focused' coping, aiming at solving the problem by changing the situation or by changing one's own behaviour. Although problem focused coping, for example gathering information or seeking help, usually was seen as the more effective way of coping, nowadays it is assumed that the effectiveness of coping behaviour depends largely on the (im)possibility of taking action in a specific situation. Seen in this way, effective coping in a situation deemed unchangeable means that no problem focused behaviour will take place but that emotion regulating work will be done. Elderly people in particular use emotion regulating strategies because they have fewer of the physical, social and economic resources at their disposal that are necessary for action focused coping, because they more often consider

situations to be unchangeable and because they are confronted with more experiences of loss (loss of work, health, friends and loved ones). An important question about these coping activities is this. Why do they arise; what are the underlying motivations? This is a question about the functions of coping behaviour. A very important motive is, of course, the need to solve the problem, but emotion focused coping is specifically also about maintaining a psychological equilibrium. In this context, three motives can be mentioned: (1) the need to control one's own life, (2) the need for meaning-making and (3) the need for maintaining or increasing one's sense of self-esteem. Finally, in the literature about coping, much attention is paid to the effects of the coping process at the physical, psychosocial and existential levels.

3.2. Religious coping

We will now turn to the religious aspect of coping. We refer here in particular to PARGAMENT'S book *The Psychology of Religion and Coping* (1997). According to this researcher, religious coping is aiming at 'the search for significance' (95). In coping, expression is also given to the intentionality of human behaviour. What matters here is the maximisation of the central values and central convictions in life rather than a quick reduction of the tensions connected with stress. Coping does not only result in the removal of the stressor, but it also produces growth and development in the individual who has to deal with it (accumulation of meaning). In the coping process, this 'search for significance' can be implemented in two ways: either the old values are maintained and will be emphasised (conservation of significance), or new values emerge (transformation of significance). Religious coping often will occur where non-religious coping fails.

Especially in situations involving loss of life, health and relational embeddedness, religious coping will often be one of the last remaining coping strategies for emotion regulation. One can ask whether there are situations that will be processed primarily in religious ways. The usual answer includes overpowering life events and boundary situations for which there are no adequate inner-worldly explanations. In addition, situations that injure the sense of justice often lead to religious emotion management. In religious coping, a distinction can be made between individual and social/institutional coping behaviour. The former refers to private religious acts, while the latter refers to church attendance or an appeal to a pastor (institutional). In the latter case, the religious dimension is closely connected to receiving social support. Social support is a very important variable in religious coping research because the religious domain's community function is very evident.

A study by TEPPER and her colleagues (2001) provides an illustration of the prevalence of religious coping. They investigated the extent to which people with long-term mental health complaints used religious coping behaviour. Eighty percent of respondents, all from Los Angeles, reported that their faith or their religious

activities contributed to their ability to cope with their symptoms, difficulties and frustrations.

A fifty-year-old woman, whose husband has disappeared without trace after a sailing trip on sea, explains: 'My sister lives in America. They pray there in church, and here too. So there's a lot of praying going on. And you notice that. That everywhere there are people thinking of you. That gives you strength. So I can just feel peaceful, without me having to do anything myself. That's indeed something that's free of charge.'

Religious coping research is also very interested in the effects of religious coping on people's physical, mental and spiritual well-being. In this way, it is linked to a long-standing research line on the connections between religion and mental health. For example, research has been carried out on the origin and development of depression in the elderly; coping with psychosocial problems in psychiatric patients; coping with being the victim of an assault; coping with the loss of a relative through suicide; coping with cancer; coping with losing a child through cot death; coping with parents' divorce; coping with loss of work; dealing with experiences from the Gulf War, and so on. In general, the effects are positive. In two review studies, HARRISON and his colleagues (2001) and MATTHEWS and his colleagues (1998) conclude that the majority of the published empirical data show that religious involvement has a beneficial influence on coping with mental and physical illness. The possibilities offered by religion can be summarised as follows: (1) religion provides social integration and support from the faith community; (2) religion offers a framework for meaning-making; (3) religion provides a personal bond with God or other divine beings; (4) religion offers the possibility of performing private and public religious activities, and (5) religion stimulates a healthy life style.

On the basis of such considerations, these mainly American investigations argue that neglecting faith and religion in physical and mental healthcare leaves an important resource for promoting health unutilised. Finally, it should be noted that the coping paradigm accentuates that religion's positive effects on well-being usually occur only if the individual's general religious experiences can be converted into concrete religious coping activities with respect to the stressor. Religious coping then will mediate between general religiosity and well-being.

4. Rituals

In the foregoing analysis, religious activities and actions have been highlighted as important elements of religious coping. In the present section, we will systematically discuss an important religious activity, namely ritual. We will consider both how rituals work and what functions they have. A concise definition of the concept understands ritual as 'the regulated and repeatable symbolic actions of individuals

and groups' (POST et al. 2002, 39, our trans.).¹ Examples include baptism, wedding, funeral, prayer, pilgrimage and Sunday church service.

Rituals can contribute significantly to coping with suffering (NORTON & GINO 2014) and people use rituals in a wide variety of problems, for example, in loss and mourning, sexual abuse, Parkinson's disease, pain, divorce, war trauma, psychosocial problems, important life transitions, disasters and AIDS. Rituals are effective not only for 'normal' adults: children, people with learning disabilities and psychiatric patients can benefit from them as well. Rituals are also beneficial for healthcare professionals who have to support people with serious problems. The efficacy of rituals is manifest in all cultures (PARGAMENT 1997) although it has to be noted that rituals also have a dark side. For instance, the use of rituals can be accompanied by the fear of not performing them in the right way, which can result in a preoccupation with sin and guilt. Ritual practices can also be an expression of an obsessive-compulsive disorder (SPILKA et al. 2003).

A large number of functions can be distinguished in the ways in which rituals work (LUKKEN 1999). There is the *channelling* function: rituals assist in providing a place and a shape for emotions. This function is linked with the *expressive* function of rituals: they offer an opportunity to express emotions as well as convictions. Furthermore, rituals have an *orienting* function. An example of this is the wedding ritual, which marks the position that we hold in life. Closely connected to the channelling function already mentioned is the *conjuring* function of rituals. They assist us in getting a grip on calamities that happen to us in life, such as a loved one's unexpected death, or a (traumatising) accident. Next, there is the *condensing* function. This means that complicated situations are compressed into one action. This enables us to distance ourselves from situations that were once overpowering. For rituals to be able to exercise their healing effects, distancing is one of the conditions. We will return to this later in this paper when we discuss SCHEFF's (1979) catharsis theory. Then, there is the *social* function of rituals. Participation in rituals creates connectedness with a community or group. For example, a funeral strengthens the mutual bonds between those who stay behind. Finally, there is the *transforming* function. Rituals mark the transition towards the next stage of life and assist in completing that transition. For example, a funeral service can help with the transition from the role of spouse to that of widower or widow. The *recuperative* qualities of rituals are evident from the positive connections between rituals and mental health. KOENIG (1988, 1995) compiled a number of bibliographies in which he reviewed hundreds of investigations regarding the relations between the use of rituals and mental health. Koenig's work showed that people for whom ritual practice is part of their lives suffer less from depression and anxieties. Additionally, this group shows a lower suicide frequency. Moreover, participation in rituals shows a positive connection with well-being and with problem-solving abilities.

¹ Original text: 'het geordende en herhaalbare symbolisch handelen van individuen of groepen'.

Many rituals take place within a group context. For that reason, it is difficult to differentiate between rituals and social activities. As a corollary, it is not easy to identify which element promotes well-being, the ritual or the social. Apart from this, the significance of rituals for mental health should not be overestimated. Many people experience a positive effect of rituals, but some experience no effect at all, and sometimes rituals have a contrary effect, as stated above.

Rituals, farewell rituals in particular, can be used in an instrumental way in psychotherapy, for example, with post-traumatic stress complaints (GERSONS 1988; GERSONS & OLFF 2005). In a farewell ritual, the traumatising event is experienced again with all the pain that characterised the original incident. But as it takes place within a ritual setting, it is experienced from a kind of distance. As a result, it is not as overpowering as it was in the original event while it is also more accessible.

HERMAN (1992) reports the example of a Jewish woman who had lost her first husband while being transported to a concentration camp. She had never been able to say goodbye to him or to mourn him. This loss returned with a vengeance after the death of her second husband, whom she had married shortly after the war. She grieved over two husbands, one of whom had died forty years earlier. Herman helped her to design farewell rituals that enabled her to mourn two husbands. This she did by selecting two different commemoration days from the Jewish calendar. In this way, she could commemorate both husbands separately yet with dignity, and grieving over the first husband did not interfere with grieving over the second one.

With this Jewish woman, the farewell ritual had a religious character as Jewish symbols were used. However, rituals used in the treatment of traumatic disorders need not have a religious character. An example is a woman who, after her daughter's sudden death, planted a tree and named it after her deceased daughter. In taking care of the tree, this woman took care, as it were, of her daughter. In this ritual, religion and religious language did not play any role.

Postulating a positive connection between ritual activities and coping with problems does not, in and of itself, provide insight into how rituals work. We will discuss this efficacy on the basis of the themes of myth and symbol. Additionally, we will discuss SCHEFF's (1979) catharsis theory.

4.1. Rituals, myths and symbols

After a shocking event, people can experience fear, uncertainty, chaos and meaninglessness. Drawing on myths can contribute to the processing of these problems. HART (1981, 95) defines myths as, 'stories that – in the community in which they are told – are deemed to be a truthful report of what has happened in the remote past (how one situation changed into another one)'. Myths are stories about the cause and the course of problems, and in addition they indicate what should happen in order to take life up again. In a therapeutic treatment that uses rituals and myths, the myth of the patient's life story often plays a significant role. In this myth, the patient's prob-

lems are described as a reaction to the stagnation of their life. Life is a succession of changes and transitions, and people usually endure and complete them without too many problems. However, sometimes transitions result in a crisis, for example, when one cannot cope with the death of a child. A therapeutic treatment using myths and rituals wants to try to complete precisely this transition.

In such cases, usually no use is made of existing myths. In the course of the therapy, ad hoc and in consultation with the therapist, a myth is constructed that applies to the patient's situation and in which the patient recognises themselves. HART (1981) calls this a 'therapeutic myth'. He reports the example of a woman who is afraid that she will kill her young son. In therapy, her fear is traced back to an unprocessed grief over a husband and child whom she had lost earlier in a traffic accident. The woman works this through by making paintings of both loved ones and subsequently burying them in a quiet spot. During the painting activity, many memories of her husband and child emerge, and this triggers strong emotions. The therapeutic myth (unprocessed grief) is incorporated in a farewell ritual. In this ritual (making paintings and burying them) the grief is 'worked through'.

In addition to myths, symbols and symbolic actions are important. Acting symbolically is 'acting as if'. By removing oneself from the symbol, one also distances oneself from what is symbolised, and this 'acting as if' is just as efficacious as when the action is carried out in reality. Dealing with the symbol is analogous to dealing with the person who is represented by the symbol. In terms of therapy, a symbolic action is therefore sometimes called an analogous action. An example is a woman who buries a photo of her husband, who had disappeared without a trace in a disaster. The woman who was left behind had never been able to 'really' bury her husband, and by burying the photo it is as if she were doing just that. In this way, she is able to say goodbye to her husband, and it becomes possible for her to go on living without him.

A symbol refers to something that is not the symbol itself, but at the same time it is part of that to which it refers. For that reason, symbols are often experienced in the same way and with the same intensity as what (or the one whom) they represent. In this context, the term 'symbolic identification' is sometimes used. In treatments that use rituals, the patient's affective reactions to a symbol are identified with the patient's feelings towards the person represented by the symbol. Symbolic actions run parallel with changes in the patient's life. Actions with a symbolic significance evoke new experiences and shape them. For example, throwing away a wedding ring does not only express the end of a marriage, it is the severance of the marital bond.

In acting symbolically, objects that represent people and situations from the patient's life can be connected to the patient in two ways: through similarity and through contiguity (HART 1981). A connection through similarity is based on a resemblance between the symbol and the person represented by it, for instance, a photo of someone who has died. Contiguity refers to the proximity between the symbol and the person concerned. Objects that used to be close to the person concerned – like clothes, jewellery or toys – symbolise that person.

The principles of similarity and contiguity are manifest in symbolic actions. The similarity principle dominates when a patient relinquishes a symbol and experiences this as saying goodbye to a person. This is the case when a patient experiences the burial of a photo as if a loved one had died and were buried again. The action with the photo contributes to the completion of the transition from having a relationship with a living person to having a relationship with someone who has died. The contiguity principle is manifest too, namely in the shape of *pars pro toto*. This means that a part represents a whole. What influences a part also influences the whole. In a ritual therapy, it is impossible for patients to involve everything that still connects them to a symbolised person. One or some salient objects are therefore usually chosen. By relinquishing these special objects, people simultaneously distance themselves from all other objects that connect them to a loved one. A widow still had so many of her husband's belongings that she took only a few of them to the farewell ritual. The rest she later put in the street in rubbish bags.

4.2. Rituals: closeness and distance

The American sociologist SCHEFF (1979) articulated a beautiful and compact theory regarding the efficacy of rituals. In order to clarify his theory, Scheff repeatedly used the example of the 'peekaboo' game: the mother hides her face behind her hands, keeps a watchful eye on the time and shows the child her smiling face while exclaiming 'peekaboo'. Children of a certain age cannot get enough of it. The mother's timing is important. If she shows her face too early, the game does not evoke tension and also no subsequent liberating laughter. If she hides her face for too long, the child will become frightened.

According to Scheff, 'peekaboo' contains all the elements of a liberating or cathartic ritual. The mother evokes tension by hiding her face, but the child knows that she has not really disappeared, and the tension is relieved in the laughter. In the game, there is an ideal combination of involvement and distance. Involvement because the mother appears to vanish, and distance because the child knows that mother has not really gone away. It is a game for the child, too. Scheff calls the balanced combination of involvement and distance 'aesthetic distance'. When aesthetic distance can be realised in rituals, their efficacy will be optimal. In that case, the tensions incurred in life can be relieved in the ritual and will have a therapeutic outcome.

However, one has to be a participant as well as an observer. One has to become engrossed in a ritual and at the same time to distance oneself from it. A liberating ritual demands belief as well as unbelief. An example is saying goodbye in ritual therapy. Patients say goodbye, but at the same time it is not a real goodbye. It has an 'as if' quality. By doing so, patients can be participants as well as observers of themselves. They suffer the pain of a goodbye because a loved one has departed from life, but this same pain does not overpower. It is an 'as if' goodbye. In this way, rituals

provide an opportunity of experiencing pain, but through their structuring power they prevent patients from disappearing in their pain.

Scheff postulates a contrast between aesthetic distance on the one hand and overdistance or underdistance (too long or too short a distance, respectively) on the other. When there is overdistance, observation is dominant and the patient is not a participant but an alien to themselves. There is no re-experiencing of emotionally charged events. The affective charge of what once happened does not penetrate. When there is underdistance, the past is overpowering. The patient is only a participant and not an observer of themselves. Flooded by memories, there is, as it were, a repetition of the event, without the possibility of distancing. Good rituals, according to Scheff, are rituals that are designed in such a way that an aesthetic distance becomes possible. They have to enable people to distance themselves as well as to be involved.

Other authors criticise Scheff in this respect and state that rituals work in a recuperative way via the connection with others, and not via an optimal balance between closeness and distance (JACOBS 1992). According to them, the crux of the matter is that, in rituals, other people will almost always be involved and that rituals strengthen the links with these others. They can be supernatural beings, spiritual leaders, communities, fellow-sufferers or whole societies. This connection with others creates an environment in which the person concerned can feel safe. This safe environment is a prerequisite for re-experiencing the past and for facing the confrontation with emotionally charged memories.

Still other authors linked Scheff's ideas about the efficacy of rituals to elements from the theory about the working-through of traumatising events. From Scheff's theory, JOHNSON and his colleagues (1995) borrowed the concepts of overdistance, underdistance and aesthetic distance. The theory about dealing with traumatising events drew their attention to the alternation between being overpowered by the past and avoiding it, which is so characteristic of trauma. According to Johnson and his colleagues, overdistance refers to avoiding the traumatic past. The past does not come to life. Underdistance refers to being overpowered, the past returning with great intensity. Good rituals offer a safe environment for re-experiencing the past, without it again being overpowering.

Based on these sources, the National Center for Posttraumatic Stress Disorder (a US government organisation for the aftercare of veterans) designed rituals that were utilised in reintegration programmes for Vietnam War veterans. An important part of such rituals is the 'Ceremony for the Dead'. Many veterans feel guilty because they survived the war, while their mates did not. They often carry the painful memories of their mates with them. The Ceremony for the Dead enables them to express their sadness and to give it a place. The veterans write the names of the dead whom they want to commemorate on a piece of paper. They can also add comments, poems, photos, mementos and so on. At a Vietnam War memorial, and in the presence of other veterans, every veteran calls out the names of the dead whom he wants to commemorate, after which the papers are burned. The veterans often react as if

their comrades had died again, the letters so to speak carrying their deaths. The ceremony brings their deaths close, while, at the same time, through the stylisation they are put at a distance. Evaluations of the re-integration programme show that veterans consider such ceremonies to be the most valuable parts of the programme. Similar rituals continue to be utilised with veterans with PTSD (TICK 2005).

Hence, rituals, whether religious in nature or not, can be applied meaningfully in the treatment of traumatic disorders. They are efficacious because they enable the re-experiencing of what was traumatising in such a way that the patient is not over-powered by it again, and supported by the connection with others.

5. Conclusion

In this paper, we have spoken in general terms about the functions of religion in the process of working mental problems through. In this context, religion can make significant contributions. However, it is necessary to have a realistic view of working-through. It does not mean that one ceases to suffer from a problem or a trauma. That would be too hedonistic a perspective on working-through because it suggests that it is possible to leave behind the negative consequences of a trauma once and for all. That is not true. Pain after a serious negative event will continue. A successful working-through means that one is able to live with this pain, and that suffering does not have the last word in one's life. There will always be sorrow, and it is an integral part of life. The crux is that people do not perish through it. In this context, religion can have an important function, in particular in events with a strong impact such as a trauma.

Of course, religion, being a robust form of meaning-making, is not the sole system that can contribute to the working-through of a problem, and its success is far from guaranteed. However, we hope to have made clear that it is a system having a large meaning-making capacity. Or, as BAUMEISTER (1991) states, religion is about the highest levels of meaning-making. Consequently, religion can provide meaning and significance to every life and every event, from a context that varies from the beginning of times to eternity. Hence, religion possesses a unique possibility of providing high-level meaning-making. Religion may not always be the best way of giving meaning to life, but in Baumeister's opinion it is the most comprehensive one. In this context, we should also highlight the fact that there are crucial differences between the various religious traditions in the ways in which they are able to deliver a system of meaning, depending on the individual in crisis and on the trauma with which they have been confronted (KÖRVER 2013).

Coping research in the United States predominantly indicates a positive efficacy of faith, worldviews and rituals, and proposes that a structural place be given to these themes in treatment. In the Netherlands research also shows that faith and worldviews are helpful in emotionally coping with problems in 39% of out-patients and 54% of in-patients in healthcare. However, as stated earlier, religion can also

have a contrary effect. In that case, religion has a negative influence on mental health. This applies to 36% of out-patients and 16% of in-patients (PIEPER & UDEN 2005). All this means that healthcare professionals in general should have sufficient knowledge of faith, worldviews and rituals. However, many therapists feel that they lack skills in this area, and almost half of them indicate a need for further training. Patients' judgements point in the same direction. They feel that therapists are able and willing to listen to their religious stories but that most of them do not have the skills for making appropriate interventions in this area in treatment. They often mention the therapists' poor knowledge of Christian and non-Christian religious beliefs, rituals and customs. It would be desirable for healthcare professionals, when treating religious patients, to have at their disposal the wealth of stories, rituals and symbols which is stored in the various traditions. This wealth could then be introduced in treatment in a more directive way as well. However, in order to prevent indoctrination, healthcare professionals should be able to adapt this tradition to the patient's personal standard. This can only be done adequately if they know and acknowledge their own religious biography. In technical terms: they should learn how to manage their countertransference reactions in the area of religion in a professional way (UDEN 1996). It is, however, a fallacy to assume that religious counsellors would be the better professionals in this respect. They in particular are running the risk of promoting the religious dimension too much. Professionals who are aware of both their own religious knowledge and ignorance are probably best equipped. They are teachable as well as able to learn.

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