Healthy Religiosity and Salutary Faith: Clarification of Concepts from the Perspectives of Psychology, Psychiatry and of Theology

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Abstract
The object of this research is to clarify the concepts ‘healthy religiosity’ and ‘salutary faith’ in order to provide criteria for the assessment of a person’s faith both in (mental) health care and in pastoral care. Based on the scientific literature, a questionnaire composed according to the Delphi method was presented in several rounds to a panel of psychologists/psychiatrists and theologians. The preferred ‘translation’ of the English term ‘mature religion’, chosen as an encompassing term, into Dutch was ‘integrated faith’; another favoured term was ‘adult faith’. Six core elements achieved consensus: sincerity, amazement, inspiration, identity, integrity, openness. Twenty-one (21) criteria could be clustered into three factors: ‘Orientation to higher values out of a sense of inner freedom’, ‘Trust in God pervades the entire life’, ‘Responsibility for fellow humans and creation’. After due reflection on the outcomes, it is proposed that justice should be done to all relevant dimensions of human existence by extending the biopsychosocial model to a biopsychosocial-spiritual model, abbreviated to BPSS.

Keywords
religiosity, faith, health care, pastoral care, delphi method

‘The main purpose of religion is not to make people healthy, but to help them fit themselves into the Creator’s context for them’
(Allport, 1964)
Introduction

This study was motivated by the experience that even now, in the present-day praxis of mental health care, the subject of religion is receiving hardly any attention. This is remarkable, since a growing volume of literature attests the relationship between religiosity and mental health measures. The studies indicate that religiosity makes a difference to mental health, mostly in a positive way (Hackney & Sanders, 2003). Religious affiliation and church attendance are usually correlated with better mental health (Moreira-Almeida, 2006; Koenig et al., 2001). This is also the case with intrinsic religiosity, by which is meant that people integrate religion into their lives and live by it. Extrinsic religiosity, on the other hand, means that people are more inclined to use their faith for the achievement of other goals — such as social relationships or comfort. This is associated with poorer mental health (Allport & Ross, 1967; Ber- gin, 1983; Masters & Bergin, 1992; Watson et al., 1994; Dezutter et al., 2006). Although the concepts of intrinsic and extrinsic religiosity are still very appealing, their operationalisation turned out to be something of a hybrid and did not make the specific difference that was intended. That is why the idea arose of starting anew and studying a range of literature in order to find a new operationalisation that would effectively evaluate a person’s faith.

Another observation was that mental health care workers’ attitude to religion seemed to have changed. A decade ago they seemed somewhat opposed to it. In recent years, younger colleagues seem more open to the subject on the one hand, but at the same time more hesitant about what kind of questions to ask and how to handle the subject in practice. While educating assistant physicians in the Northern Netherlands in psychiatry during the final phase of their training, it appeared that they were certainly interested in religion. Without exception, however, their studies failed to teach them anything about it or about the place or power of faith in healing the mind and body. Very occasionally the subject would be brought to their attention by a supervisor who was interested in it. Although this is not a new phenomenon (Paloutzian & Kirkpatrick, 1995; Larson, Pattison et al., 1986; Pieper & Van Uden, 2005), it remains a conspicuous one. It is, after all, one of the basic assumptions of mental health care that the therapist should respond with empathy to everything that is important to the client. It is also essential, while treating clients, to search for powers and resources that contribute to their health, and to enhance these. Since religion is a central theme in the lives of many people, it seems no more than logical that mental health care workers should pay attention to it. The fact that in practice they ignore it is not an indication of unwillingness but rather of ignorance and embarrassment (Bergin, 1989, 1991). That is why it seemed necessary to study the opinions of psychiatrists and