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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; Bergin, 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

psychologists about healthy religiosity as opposed to unhealthy or neurotic religiosity. The idea therefore arose of clarifying the concept of healthy religiosity in order to assist mental health care workers in their daily work.

Since the appearance of the 4th edition of the Diagnostic and Statistic Manual of Mental Disorders (DSM-IV) in 1994, a new category has been added: V62.89 'religious or spiritual problem' (Hall, Tisdale & Brokaw, 1994). This has been done because religious and spiritual themes represent important dimensions of people's social and personal lives and therefore deserve attention in mental health care (Kroll, 1995). The commentary in DSM-IV indicates that the additional category is designed to draw the attention of mental health care workers to the importance of religious and other existential experiences in the healing process, since these experiences bring people face to face with their innermost core and their problem-solving abilities. The new DSM category can be used if the focus of treatment or diagnosis is a psycho-religious or psycho-spiritual problem that cannot be ascribed to a mental disorder. In diagnostic nomenclature this category is non-pathological (Lukoff, Lu & Turner, 1992). A complementary view nowadays is that clinicians should consider the potential impairment of religious and spiritual functioning that arises from mental disorders. Clinically significant religious impairment is thus defined as a reduced ability to perform religious activities, achieve religious goals or experience desired religious states because of a psychological disorder (Hathaway, 2003; Hill & Kilian, 2003; Scott et al., 2003).

Since Christian pastors work in an institutional church context, it might seem self-evident that the issue of religious faith should arise in their pastoral conversations. The object in this respect is not so much to talk about matters concerning faith as to talk about all matters in a faith-oriented way (Heitink, 1996). Still, it may embarrass pastors to talk about faith. It was noted that pastors working in (for instance) a prison setting were inclined to rely on psychologists in the matter of healthy or unhealthy religious faith in their pastoral clients. This is quite amazing. It hardly seems necessary for theologians to consult psychologists about such matters, since they have at their disposal the theological literature of many centuries which — implicitly, at any rate — deals with this subject. Well-known examples from different centuries are the *Confessions* by Augustine (around the year 400) and the *Imitation of Christ* by Thomas a Kempis (1420). The central theme in both manuscripts is the development of personal faith. Nowadays, however, since religion often occupies a more marginal place in society as a whole, pastors are more hesitant about bringing up the subject of faith in a pastoral conversation.

In Western society, people's lives are more fragmented and compartmentalised and their faith is often seen as only a segment of the whole. It might be

characterised as 'religion à la carte', which means that everyone chooses those personal beliefs that suit him best (Dekker, 1995).

A pastor who is willing to guide pastoral clients in their personal faith usually concentrates on whether an individual's faith is salutary, while at the same time trying to understand that individual in his or her life situation and in relation to God (Ganzevoort, 1998). The question of whether or not faith is salutary, or healthy, is typically a question for our time, since great value is attached nowadays to personal benefit. Often it is not clear to a pastor which criteria can be used in evaluating someone's faith, and so the pastor tends to use psychological terms, 'baptised' for the occasion (Stollberg, 1969). To assist Christian pastors in their daily work, it therefore seemed important to establish criteria for the evaluation of a pastoral client's faith. Thus the idea arose of clarifying the concept 'salutary faith' from a (pastoral) theological perspective.

In general, theologians use the word 'faith' for the whole of a person's religious experience and specifically the experience of God in their lives. Usually the concept 'religion' refers to a particular set of beliefs and practices which identifies a faith or denomination. The term 'religiosity' refers to the degree in which religious beliefs, attitudes and behaviours permeate the life of an individual. Because it is essential for psychology/psychiatry to know how these factors influence people and their lives — as is also implied in concepts like 'religious sentiment' or 'religious orientation' (Allport, 1950, 1960), 'religious functioning' (Atkinson & Malony, 1994) and 'mature religious life' (Paloutzian, 1983) — the term 'religiosity' seems the most apt for this perspective. Religiosity implies 'religiousness', but the latter is a bit awkward and seldom appears in the literature (Kauffman, 1979).

The objectives of this study are

- 1) to assist the development and theoretical grounding of criteria for assessing the quality of a person's religiosity/faith, from a psychological/psychiatric and a theological point of view respectively;
- 2) to assist in clarifying the ideas of pastors and psychiatrists/psychologists on how to evaluate a person's faith/religiosity in practice.

Question Addressed in the Study

The question addressed in this study is:

- A. How is the quality of a person's religiosity/faith evaluated, both in psychology/psychiatry and in theology?

- A1. What is understood by healthy religiosity in psychological/psychiatric literature?
- A2. What is understood by salutary faith in theological literature?
- B. What, in practice, are the evaluative standards used by psychologists/psychiatrists and pastors to assess a person's faith/religiosity?

Preliminary Definitions

It is clear that, while science cannot be used to prove God's existence, it can illuminate the embodied and embedded character of religion — how it is expressed within and through people, over history and within communities (Looy et al., 2005). Religiosity/faith from both a psychological/psychiatric and a theological point of view may be defined as follows: 'Faith/religiosity is a personal relationship with a transcendent reality, named God, that takes shape and is lived through or experienced in practice.' In this definition — which is based on a more general definition by R. H. Touless (cited by Vergote, 1971) — two components are combined, namely the relationship with God and the influence this has on human beings and their lives.

The definition of health that is used here derives from the definition by the World Health Organisation in 1976: 'Health is a state of physical, mental and social well-being, and not merely the absence of disease or infirmity.' Here, health is equated with integral 'well-being'. The concept is broader than the biopsychosocial model presented by Engel (1977, 1980), which is generally used in health care. The three distinct dimensions — the biological, the psychological and the social — are not sufficient to define the whole of 'well-being'. For high-quality health it is essential to add a fourth dimension (Leetun, 1996), namely an orientation regarding adherence to consistent self-transcendent values which give meaning to life; in other words, a philosophy of life or, more specifically, a religion (Allport, 1964; Rümke, 1947). In the literature such an additional dimension is characterised by such terms as Theos (Ingram, 1995), theological-existential (Bouwer, 1998), transcendental (Boulding, 1956, cited in Hutschemaekers & Neijmeijer, 1998) and spiritual (Meadow, 1986; Coan, 1977; Ellison, 1983). We shall return to the question of which is the most appropriate term.

The concepts 'salutary' and 'salvation' refer to being saved from fundamentally negative conditions such as evil, pain, sickness and death. Salvation also implies the elevation of the whole world to a higher level by restoring its pristine state as recorded in the history of creation: a life in harmony with God, without suffering and death (Van der Lans, 1991). Above all it means the intervention of God in human life to achieve the transition to completeness. People have to cooperate in some way, if only by calling on the divine name

for help (Eliade, 1987). Salvation characteristically pervades the whole person, as an individual and in all of his relationships. This divine influence is the Holy Spirit (Heitink, 1996; Cobb, 1978). Thus the concepts 'salvation' and 'salutary' comprise two meanings: first, redemption and liberation itself (which in the New Testament is focused on divine help and redemption by Jesus the Messiah) and second, the renewed life that flows from this redemption. This implies that a person follows Jesus Christ, from whom he derives assignment, foundation and destination (Barth, 1949; Miskotte, 1966). It is mainly the second meaning that is evoked by the composite term 'salutary faith'.

Method

Processing the Literature

Our starting point is that psychology/psychiatry and (pastoral) theology are seen as converging options (Mette & Steinkamp, 1983). This means that the two types of sciences have different perspectives from which they view and clarify a theme — in this case, the evaluation of a person's religiosity/faith.

Psychological/psychiatric scientific literature is studied which, either implicitly or explicitly, addresses the issue of 'healthy religiosity'. While arranging the literature three main streams emerged.

In the first place there is psychoanalysis with its various schools of thought. From the start, philosophy of life has been a theme in the formulation of psychoanalytical theories, with the result that several authors have expressed ideas about healthy religion/religiosity. The most influential of these authors are Sigmund Freud, Carl Gustav Jung, Erich Fromm and Erik Erikson. There are also the object-relation theory and the self psychology.

In the second place there are those authors who concerned themselves with healthy religion/religiosity in the framework of the psychology of religion. Some important representatives of this category are included, because they tried to distinguish between different kinds of religiosity: William James, Gordon Allport and Kenneth Pargament.

Finally, there are the schools of humanistic and existential psychology, both of which emphasise meaning and existential themes. From these, other aspects can be derived that are important for the conceptualisation of healthy religiosity. The selected authors here are Abraham Maslow, Irvin Yalom and Viktor Frankl.

For purposes of empirical research, the most characteristic aspects of healthy religion/religiosity are selected from every school of thought. Diversity of terminology and content are borne in mind, also the accuracy with which the authors' thinking is reflected. The object-relation theory appears to include most of the elements found in this range of work. The literature is also

characterised in terms of three core concepts — ‘comprehensiveness’, ‘sincerity’ and ‘openness’, which are seen as possible core elements of a definition.

Also (pastoral) theological scientific literature is studied which, either implicitly or explicitly, addresses the issue of ‘salutary faith’. Our aim has been to find a true focus on the theological literature, in order to emphasize the different perspective. Consequently we did not confine ourselves to pastoral theological literature, because contemporary pastoral theological concepts often include psychological presumptions. When reflecting upon ‘salutary faith’, concepts were also drawn from systematic theology. A thematic approach seemed the most suitable one for arranging the literature of many centuries.

Our starting point was an experience-oriented anthropology. It was Heidegger who placed the phenomenon of time at the centre of human existence, with the dimensions of past, future and present. These could be connected with the Christian core concepts of faith, hope and love, because the apostle Paul’s triad of faith, hope and love is an early Christian summary of the faith that encompasses also the whole of human existence. This alignment follows the contemporary insights of pastoral theology, which relate people’s daily experiences to biblical words and stories. It is called hermeneutical pastoral care, which tries to take a middle position between pastoral care as proclamation (postulated by Thurneysen among others) and pastoral care as therapy of, for example, Hiltner (Heitink, 1994; Henning Luther, 1992). In practice this means that pastoral care often makes daily life its starting-point, with its experiences and life stories, which are then related to the biblical narratives (Van Knippenberg, 1998; Dingemans, 2000; Van der Meulen, 2004; Berkhof, 1985).

The literature is subdivided into several focal themes, namely ‘anthropological point of departure’, ‘the experience of faith’, ‘the experience of hope’, ‘the experience of love’ and, finally, the connection of the three time dimensions (past, future and present) with faith, hope and love respectively, resulting in ‘the unlimitation of the time dimensions by faith, hope and love’. Elements are derived from these that are vital to the conceptualisation of salutary faith.

For empirical research, the most characteristic aspects of salutary faith are selected. Diversity of terminology and content are borne in mind as well as the accuracy with which the themes are represented. The literature is further characterised in terms of three core concepts: ‘amazement’, ‘perseverance’, and ‘fulfillment’, which are regarded as possible core elements for a definition.

The Delphi Method

The Delphi method is particularly suitable for the clarification of a complex subject like this one (Scheffer & Rubinfeld, 2002). Its advantage is that the

study proceeds in several stages or rounds, so that ideas can be processed and arranged among the respondents (Crisp, Pelletier et al., 1997; Jones & Hunter, 1995). Experts are consulted, anonymously and repeatedly, which makes it possible for the respondents to adjust their opinions. The main goal is to achieve consensus. The most frequently cited and most apt definition is that of Linstone and Turoff (1975): 'Delphi may be characterized as a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem.'

The Delphi Panel

In the examples of studies described in the literature, the number of panel members varies, as does the number of items employed, from a few to a few hundred (Polit & Hungler, 1991).

Because our study in fact comprises two panels (consisting of psychologists/psychiatrists and theologians respectively), we decided on the basis of a matrix to have 24 respondents in each panel — hence 48 in all.

For inclusion in the panel, psychologists/psychiatrists had to show affinity with the subject of 'religiosity', and (pastoral) theologians with the subject of '(mental) health care'. A proportional division between the two religious mainstreams in the Netherlands (Roman Catholic and Protestant) was maintained. Moreover, the diverse participants were selected from four different kinds of work settings (congregation or parish for pastors and private practice for psychologists and psychiatrists or mental health care or a somatic setting or university for both psychologists/psychiatrists and pastors). We strove for a composition that would be one-quarter female and diverse in terms of age.

The Questionnaire

A questionnaire was sent to those panel members who had agreed to participate. The questionnaire was sent by e-mail if the participant agreed to it, otherwise by post.

On the analogy of a study by Van Leeuwen (Van Leeuwen, 1998; Van Leeuwen & Hunink, 2000), an encompassing term in English was used, so that we could ask the panel members what, in their opinion, would be the best translation into Dutch. We thought the general term that would best cover both 'healthy religiosity' ('gezonde godsdienstigheid' in Dutch) and 'salutary faith' ('heilzaam geloof' in Dutch) would be 'mature religion' — because the term 'mature' is used both in the psychological/psychiatric literature (Allport, 1950, 1961; Strunk, 1965) and in the theological literature (Louw, 1999), while the concept 'religion' is a fairly neutral term for both perspectives. By using this

term, we postulate a process of religious development that is directed toward a desirable target state of mature religiousness (Fowler, 1989; Oser & Gmünder, 1984) and determined by theological-philosophical reflection (Kläden & Feeser-Lichterfeld, 2006). It has been stated recently that in empirical theology and the psychology of religion the notion of 'religious maturity' (meaning much the same as 'mature religion') remains an important yet elusive construct. It is a construct that needs to be developed and tested against theological as well as psychological criteria (Francis & Pocock, 2007), and that is exactly what we did.

The questionnaire consisted of various sections: 'translation of the label mature religion', 'qualifying characteristics for the evaluation of a person's faith/religiosity as mature religion' and 'core concepts for a definition of mature religion'. The central question was: what does the respondent consider important in evaluating a person's faith, from the point of view of his or her professional practice? So the main part of the questionnaire was concerned with the qualifying characteristics. In the hope of gaining additional insights into the evaluation of 'mature religion', however, we also asked for the favourite translation of 'mature religion' and an overall definition of 'mature religion', using the core concepts found in processing the literature.

The alternative translations presented were 'intrinsic faith/religiosity', 'salutary faith/religiosity', a literal translation of 'mature faith/religiosity' in the Dutch language, 'adult faith/religiosity' and 'healthy faith/religiosity'. The qualifying characteristics were derived from the propositions at the end of each paragraph of both the psychological/psychiatric and the (pastoral) theological literature.

The 25 qualifying characteristics from the psychological/psychiatric perspective, and the 25 from the (pastoral) theological perspective, were presented at random. Respondents were asked to rate each item on a 5-point Likert scale to indicate the usefulness, in their opinion, of the item as a criterion for evaluating someone's faith/religiosity (1 = totally agree, 2 = agree, 3 = neither agree or disagree, 4 = disagree, 5 = totally disagree).

To arrive at a definition, the triads emerging from the summaries of the psychological/psychiatric and (pastoral) theological literature were presented.

In addition, panel members were explicitly asked to provide commentary on their scores and to make suggestions with regard to reformulation. Space was also provided at the end of each section to make additions if aspects were missing.

Analysis

On receipt of the questionnaire, the data were processed and analysed both quantitatively and qualitatively. Consensus was determined by several criteria.

In the literature we found no standard set of criteria. We followed Van Leeuwen and Hunink (2000): percentage agreement of at least 66,66%; standard deviation of 1,2 at most (which means that the deviation is small, so there is considerable consensus); median no higher than 2 (so at least half the answers are in the range of agree/ totally agree); mean no higher than 2,5 (which also guarantees considerable consensus). If an item met the criteria, it was included in the new inventory.

The outcomes of the two main groups (psychiatrists/psychologists and theologians) were analysed statistically for significant differences in their answers. Based on the scores for 'the translation' and 'the qualifying characteristics', the degree of consensus was determined for the whole panel and for the two main groups separately. In the first round, panel members were asked to place the proposed 'core elements for a definition' in a ranking order. To obtain more uniform information, however, panel members were asked in the second round to rate this section on a 5-point Likert scale.

The comments and suggestions advanced by panel members were processed and used to modify and expand the criteria. In the inventory for the second round, formulations were presented that had already been presented in the first round, as well as altered or totally new ones.

Results

Participation

Of the invited respondents, 90% was willing to participate, which can be considered a high percentage. For the other 10%, replacements were sought.

Because one respondent turned out to be Roman Catholic instead of Protestant as expected, he was regarded as 'additional' and the number of participants in the end was 49.

After the first round, using SPSS, we looked among other things for significant differences in responses between psychiatrists/psychologists on the one hand and theologians on the other. We concluded that there were hardly any differences between the two groups. This we consider an interesting finding. It was decided in consequence that the panel would continue as a single group, of which the main characteristic was that the respondents were experts in the field of 'mature religion'.

The whole panel, 100%, also participated in the second round. This is a particularly high score, because the literature indicates — as a disadvantage of the Delphi method — that the risk of drop-out increases with the number of rounds.

Preliminary Outcomes of the Delphi Research

Based on the panel's answers, a questionnaire for the second round was composed. In the section 'translation' some suggestions from respondents were included, as well as two translations that had attained a high score in the first round, namely 'adult faith' and 'healthy faith'. The alternatives for the second round were presented without the additional term 'religiosity', because most suggestions from panel members mentioned only the term 'faith' and their commentaries, too, largely favoured the term 'faith'. With regard to the section 'qualifying characteristics', 39 characteristics went through to the second round, some of them partially rephrased. In the section 'core elements for a definition', the term 'amazement' scored the highest, followed by 'openness' and 'sincerity'. Neither the group of psychiatrists/psychologists nor the group of theologians seemed to show a clear preference for core elements derived from their own literature. In the following round, core elements were added that came from a synthesis of conceptualisations derived from theology and the psychology of religion (Malony, 1985). This was done in order to see whether the panel found these core elements ('identity', 'integrity' and 'inspiration') appealing.

Apart from items that reached consensus, there were items in the second round that had already attained consensus in the first round but were nonetheless rephrased because of comments from panel members. This was done when it seemed that a higher percentage of consensus could be attained by doing so. In some cases, however, the alteration resulted in no consensus being attained in the second round. Such items were included in the list of final consensus criteria in the (apparently) better formulation of the first round.

Final Outcomes of the Delphi Research

An outcome of the Delphi research on 'mature religion' is, first of all, that the panel of experts had a preferred translation: 'integrated faith'. This translation originated in the suggestions of respondents in the first round. What it means is that one's faith is integrated in one's daily life and one's daily life, in turn, is integrated in the perspective of one's faith. Another translation, namely 'adult faith', also attained consensus.

Altogether 23 qualifying characteristics reached consensus. By means of a factor analysis (principal component analysis: KMO= 0,61; factors= 3; factor loading < 0,40; varimax rotation; missing listwise), 21 of these 23 items could be classified into three distinct factors which explain 25,3%, 12,9% and 8,6% respectively, altogether 46,8% of the variance. The items constituting the factors are presented in a sequence of highest to lowest factor loading. The com-

mon theme of the items was established and, based on this, an encompassing label for each factor.

Table 1: Criteria of ‘mature faith’ expressed in terms of three factors

Factor I: Orientation to higher values out of a sense of inner freedom

Willingness to look for answers to existential questions about death, freedom, isolation, meaninglessness

Deciding on one’s own attitude both freely and responsibly

An orientation to ‘being’ rather than ‘having’

Striving for the highest values of love, truth and justice out of a sense of inner freedom

Developed along with the personality

Supportive of one’s sense of self-esteem and identity

Sincere rather than out of obligation or fear

An open and at the same time serious quest for God

Being guided by values that transcend mere biological and social adaptation

Factor II: Trust in God pervades the entire life

Finding meaning and significance in one’s life in relation to God

The sense of integration in a relationship with God

Trust in God, also in times of trial and tribulation

A move toward entrusting oneself more and more to God

The experience of God in one’s life motivates one to take difficult decisions for the sake of the good

Knowing God’s love as fundamental for one’s entire life

Factor III: Responsibility for fellow humans and creation

Praying for and doing justice to as being inextricably linked

Willingness to account to God and one’s fellow humans for one’s own faith and actions in the world

Applicable to all areas of life

Striving to love one’s fellow human beings as they are, out of the knowledge of God’s love for human beings

Table 1: (cont.)

Accepting that one's personal freedom is limited by responsibility for God's creation

Realizing that all aspects of the personality are comprehensively involved

The remaining two qualifying characteristics

Integrated with other aspects of human nature such as basic instincts and social aspects

Experiencing amazement through the sense of the entirely other

The applicability of the three factors does not differ much. Factor I consists of items derived entirely from the psychological/psychiatric literature. Factor II consists of two items derived from the psychological/psychiatric literature and four from the (pastoral) theological literature. Factor III consists of three items from the psychological/psychiatric literature and three from the (pastoral) theological literature.

Of the presented core elements for a definition, six attained consensus:

Table 2: The core elements

Sincerity	Inspiration	Integrity
Amazement	Identity	Openness

Of the six core elements, five could be correlated with Factor I but not with the other factors. This outcome raises the question of whether it is valid to use these core elements to formulate a definition. There was no correlation between the core element 'amazement' and any of the factors. For a definition that needs to be concise, the labels of the three factors are probably the most apt. In terms of catchwords, these are: orientation to higher values, trust in God, responsibility for creation.

Conclusions and Discussion

Reflection on the Outcomes

The empirical research shows that the panel of experts found 'integrated faith' and 'adult faith' to be good translations of the encompassing term 'mature faith'. Altogether 23 qualifying characteristics attained consensus. They could

be clustered into three factors with the labels 'Orientation to higher values out of a sense of inner freedom', 'Trust in God pervades the entire life', 'Responsibility for fellow humans and creation'. Six core elements attained consensus: sincerity, amazement, inspiration, identity, integrity and openness.

We related these results to the scientific literature, from which most of them had originated. Our purpose in doing so was to discover whether the outcomes cover the whole of the literature or part of it and, in that case, which part. Considering the 23 evaluative criteria, it is striking that all three described mainstreams of the psychological/psychiatric literature are represented in the consensus items, as are four out of the five described main themes of the (pastoral) theological literature. Not represented as a main theme of the (pastoral) theological literature is 'the experience of hope'. A possible explanation is that nowadays people live mainly in the here and now and take less thought for the middle and long term, which might have affected the opinions of panel members.

An important finding with regard to the six core elements is that the three catchwords which scored the highest — namely 'sincerity', 'amazement' and 'inspiration' — derived equally from the psychological/psychiatric literature, the (pastoral) theological literature and a language field that is considered to be a synthesis of the two language fields concerned in the study. In doing so, the respondents indicate in their underlying vision regarding 'mature religion' that they have a common language field, which indicates a common vision and conceptual framework with regard to 'mature religion'.

This underlying common vision with regard to 'mature religion' is further explored by relating to the studied literature the two translations that reached consensus, the qualifying characteristics that did not reach consensus and also the results as a whole. The underlying common vision can therefore be characterised by such expressions as 'integrated', 'growth/development orientated', 'down to earth' and 'fundamentally relational'.

Attitudes toward oneself, toward God and toward one's fellow man and creation are well expressed in the three factors and their labels. They are also recognizable in the biblical golden rule. Jesus's command contains all other commands and, in the way it is put, amounts to a promise as well (Luke 10:27): 'You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbour as yourself.' This rule concerns the most integrated and complete attitude to life (Heitink, 1996; Fortmann, 1968; Allport, 1964). Living by this rule, a human being can find shalom or well-being, which may be described as the integral experience of a person who is functioning as God intended — in harmony with God, with others, and within oneself (Ellison & Smith, 1991;

Lang, 1994). This well-being and happiness is not so much a human striving as a gift of God (Dingemans, 2000).

The loving relationship with God lies at the core. This love permeates all human functions, including the attitude toward fellow humans. The relationship with Christ illuminates and clarifies the relationship with God, and relationships with fellow humans are a manifestation of it (Fuchs, 2001). Practical theology is materially concerned with the interaction between God and humanity on the one hand and the interaction between people on the other, the latter being qualified by the former (Schmälzle, 2003). The three relationships could be characterised as intrapersonal, transpersonal and interpersonal (VanderPloeg, 1981; also Benner, 1989). They are reminiscent of Cloninger's three dimensions or traits in character development (Cloninger, Svrakic & Przybeck, 1993; Cloninger, 1999) — self-directedness, self-transcendence and cooperativeness.

Scientific Relevance, Research Limitations and Suggestions for Further Research

Characteristics of the concepts 'healthy religiosity' and 'salutary faith' were derived from the literature. A panel of experts then assessed the extent to which the resulting criteria apply to professional practice, thus developing criteria for the evaluation of an individual's faith. This resulted in a new kind of inventory which we did not find in the existing literature. This list can be used to evaluate a person's religious faith, both in psychology/psychiatry and in theology.

In relating the findings to the literature that had been studied — both the psychiatric/psychological and the theological literature — it turned out that these criteria reflect almost the whole spectrum of the literature in a way that is compact, contemporary in its formulation and suited to professional practice.

Psychologists/psychiatrists and theologians have contributed to these research results. It is useful, moreover, that both disciplines participated. This seems to be unique, which makes the inventory one of a kind. It can be assumed that someone who scores well on all the factors will have a comprehensively mature religion. This outcome demonstrates the value of a study that exceeds the limits of a single discipline if the subject should seem to warrant it, as in this case.

It turned out to be effective and efficient to send the questionnaires by e-mail. The majority of participants (<90%) agreed to this procedure.

The limitations of the research are as follows. The ratio of the number of respondents (49) to the number of criteria (23) is not optimal for factor analysis. This implies that the outcomes are tentative and further research is needed

for consolidation. The criteria might be formulated even more unambiguously. For inclusion in the panel, psychologists/psychiatrists had to show affinity with the subject of 'religiosity' and (pastoral) theologians had to show affinity with the subject of '(mental) health care'. While this increases the level of expertise in respect of the subject, the disadvantage is that the results cannot readily be accepted as representative of both disciplines.

Suggestions for further research are that the 23 consensus items can be used as criteria guiding the assessment of a person's faith; the three factors can be developed into a diagnostic instrument for use by (mental) health care professionals and pastors; the six catchwords can be used in dialogue both in (mental) health care and in pastoral care — for instance, in a variation of the self-confrontation method (Hermans, 1993).

Vision of Interpersonal Care

Reflection on the outcomes of this study has yielded a vision of interpersonal care and its practical and social relevance.

It is proposed that justice should be done to all relevant dimensions of human existence. The three factors that emerge from this study fill in the new and complementary dimension of human life that should be added to the well-known biopsychosocial model, as stated under the heading 'Preliminary definitions'. All dimensions of this model influence each other, and that is also the case when the new dimension is added. For instance, the first factor (concerning the relationship to oneself) most affects the bio-psychological dimension. The third factor (concerning the relationship to others) has the greatest consequences for the social dimension. The second factor (concerning the relationship to God) influences the other dimensions also, since this relationship pervades the entire life.

The aptest term for the new dimension appears to be 'spiritual'. It seems clear that spirituality must be seen as a wider concept than religion; but the two terms also overlap, since the search for meaning goes to the heart of both phenomena (Tirri, Nokelainen & Ubani, 2006). The spirit, or the spiritual core of a person, may be considered the inner centre of that person. It is here, at the core, that the person is open to the transcendent dimension and experiences ultimate reality (Hense, 2006).

According to the theologian Tillich (1967, 1963/1978, III/ IV, I, XXII) the spiritual dimension transcends and pervades the other dimensions. He discerns two meanings in the concept 'spiritual':

- the human search for unambiguous or eternal life and thus for the meaning of existence;

- the experience of the Spirit of God who realises what the human spirit is incapable of, namely the creation of unambiguous life.

The advantage of the Latin word *spiritus* (from which the words ‘spirituality’ and ‘inspiration’ are derived) is that it can also be used in a more general sense and is applicable to the Christian faith. Christian spirituality may be seen as a deep relationship with God made possible by faith in Jesus Christ and the life of the indwelling Holy Spirit (Benner, 1989).

Thus the suggestion is to speak of a biopsychosocialspiritual model (see also Coan, 1977; Sulmasy, 2002; Corr, 1992), conveniently abbreviated to BPSS.

A consequence of this proposal is that (mental) health care and pastoral care are seen as distinct but not separate. It is suggested that, in terms of the four dimensions, the appropriate professional disciplines should be involved in care. For the biological dimension this means the family doctor or another medical professional; for the psychological dimension, the psychiatrist or psychologist; for the social dimension, the social worker or systems therapist; and for the spiritual dimension, the pastor. For all these professionals it is important to use a dialogue to discern the core of the problems and the dimension to which this belongs — consulting one another if necessary or making an appeal. In complex situations the various professionals could cooperate more closely, organising meetings to discuss and decide the contribution of each.

The addition of the spiritual dimension can certainly make a difference. For instance, it can prevent existential needs from being swept under the carpet by translation into psychological/psychiatric terms of depression; or confusions about the relationship with God from being explained in terms of social relationships.

Finally, the same line of thought is followed tentatively with regard to society as a whole. We are caught up nowadays in the complexity of transition — a time that is still influenced by the remnants of Enlightenment rationalism as well as by the often confusing apparent irrationalities of postmodernism (Hurding, 1995). In this situation, integrated faith is seen as the answer to a disintegrating society. Empirical research shows that the most consistent values are provided by religion (Brown, 1986), which is also the greatest source of inspiration for values and of fulfillment (Cloninger, 1999). This merits attention if we are trying to find ways in which people can get more involved in the community and more caring about one another. Christianity in particular is convinced that its inherent values are salutary for all people, as the Bible means them to be. Because witnessing is considered to be the essence of humanity (Marcel, 1935), churches today may be expected to proclaim an appealing spiritual message which also adds to the other dimen-

sions (Sanders, 2004). So, by promoting the spiritual dimension, we ensure that the other three dimensions too are borne in mind in a more balanced way.

Note: Dr Margreet de Vries-Schot, the first author of this article, is both a psychiatrist and a theologian. The article is a short version of her dissertation 'Healthy religiosity and salutary faith. Clarification of concepts from the perspectives of psychology, psychiatry and of theology'. This dissertation is written in Dutch except for the summary. There is a commercial edition which can be ordered from the publisher, Eburon, in Delft, the Netherlands: www.eburon.nl.

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