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The Santa Clara Strength of Religious Faith Questionnaire

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This article introduces the Santa Clara Strength of Religious Faith Questionnaire (SCSORF) and provides preliminary information on the instrument. The SCSORF is a quick, easy to administer and score, 10-item scale assessing strength of religious faith. The SCSORF and personality and mood measures (i.e., Symptom Check List-90-Revised, Weinberger Adjustment Inventory, Belief in Personal Control Scale, and several author-designed questions) were administered to 102 undergraduate students. Preliminary findings suggest that the SCSORF is both reliable and valid. Furthermore, significant correlations between strength of religious faith, self-esteem, interpersonal sensitivity, adaptive coping, and hope correspond with previous research, suggesting that mental health benefits are associated with strong religious faith. Implications for future research are also discussed.

Religious faith is important to many people, with approximately 95% of Americans reporting belief in God and about 50% being active in religious organizations (Gallup & Castelli, 1989). While some researchers have maintained that religion and religious beliefs are often neglected in psychological research (Jones, 1994; Kirkpatrick & Spilka, 1989; Plante, 1996), the continually growing body of research focusing on religious issues indicates that researchers are becoming increasingly aware of, and interested in examining, the influences of religion and religious faith on human behavior and psychological functioning (Jones, 1994). For instance, the inclusion of "Religious or Spiritual problem" as a diagnosis in the fourth

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edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), as well as the inclusion of religion as a human difference within the revised Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992), indicate that knowledge of religious issues is becoming increasingly relevant in psychological and psychiatric settings.

Although some researchers have noted an equivocal relationship between religion and mental well-being (Donahue & Benson, 1996; Pargament & Park, 1996), various positive contributions to overall mental health have been attributed to religious devotion. Larson, Sherill, Lyons, Craigie, Thielman, Greenwold, and Larson (1992) reviewed 139 studies utilizing measures designed to examine dimensions of religious commitment and found that a majority reported a positive relationship between extent of religious commitment and mental health. Ellison (1991) found that individuals with strong religious faith reported higher levels of life satisfaction, greater personal happiness, and fewer negative consequences of traumatic life events than did low faith individuals. Donahue and Benson (1995) noted that religiousness is positively associated with prosocial values and behavior, and negatively related to suicide ideation and attempts, substance abuse, premature sexual involvement, and delinquency in adolescents. Other research has suggested that religion can also substantially contribute to well-being among the elderly (McFadden, 1995).

Related research has suggested that positive correlations between mental health and religion are dependant upon type of religiosity. Utilizing the means, end, and quest measures of religion developed by Batson (1976), Ventis (1995) found that the end dimension, which measures characteristics associated with individuals who tend to maintain an open and internalized faith as opposed to those who tend to maintain a restrictive and detached faith (means dimension), showed predominantly positive relationships with mental health. In a review of research examining religion and mental health, Payne, Bergin, Bielema, and Jenkins (1991) noted positive influences of intrinsic religiosity on mental health in well-being, self-esteem, personal adjustment, social conduct, alcohol and drug abuse, sexual permissiveness, and suicide. Swensen, Fuller, and Clements (1993) found that terminally ill cancer patients at more mature stages of religious faith reported higher overall quality of life, higher quality of family life, and higher quality of psychological and spiritual life.

More specifically, religious faith has been positively associated with a number of factors contributing to beneficial mental health. The association between increased self-esteem and religion has been consistently reinforced by many recent research investigations (Forst & Healy, 1990; Jensen, Jensen, & Wiederhold, 1993; Johnson & Mullins, 1990; Nelson,

1990; Payne et al., 1991; Plante & Boccaccini, 1996; Sherkat & Reed, 1992; Slater, Groves, & Lengfelder, 1993). Specifically, increased self-esteem has been found to be associated with active participation in religious activities, including church attendance (Sherkat & Reed, 1992; Slater et al., 1993) and involvement in moral community groups (Johnson & Mullins, 1990), as well as with maintenance of religious faith (Plante & Boccaccini, 1996).

Religious faith has also been found to be a useful coping strategy for people experiencing severe stress. In an examination of adolescent cancer patients, Tebbi, Mallon, Richards, and Bigler (1987) noted that 17 of 28 subjects indicated that practicing their religion helped them cope by providing them with security in the face of death and better understanding and acceptance of their illness. In related research, Hughes, McCollum, Sheftel, and Sanchez (1994) examined coping strategies of parents of preterm infants in a neonatal intensive care unit and found that one-third of parents relied on religious faith as their primary coping strategy. Other findings have indicated that religious faith is beneficial in helping mothers cope with the loss of a child (Grahm-Pole, Wass, Eyeberg, & Chu, 1989) and in helping HIV patients cope with their illness (Hall, 1994; Jenkins, 1995).

Research has also indicated that religious beliefs are instrumental in providing many people with a source of hope during distressing experiences. Ross (1990) found lower levels of psychological distress among people maintaining religious beliefs, supporting her hypothesis that religion reduces demoralization and provides individuals with both hope and meaning. Similarly, religious beliefs have been found to be a source of hope for patients with life-threatening illnesses (Klenow, 1991), such as HIV patients (Hall, 1994).

A variety of religious orientations or ways of being religious have been formulated and assessed. Among these the most noteworthy are Allport's (1950, 1959, 1966; Allport & Ross, 1967) concepts of intrinsic and extrinsic religiousness, Allen and Spilka's (1967) committed and consensual religiosity, and Batson's (1976) quest which have attempted to operationalize mature religiosity. Allport's concept of religiosity is considered to be the most widely researched dimension of religiousness in the empirical study of religiosity (see Hall, Tisdale, & Brokaw, 1994 for a review). In the words of Allport and Ross (1967), "the extrinsically motivated person uses his religion, whereas the intrinsically motivated lives his religion" (p. 434). Allport and Ross (1967) developed the 20-item self-report Religious Orientation Survey (ROS) to measure intrinsic and extrinsic religiosity, while several authors have updated this instrument since 1967 (Gorsuch & Venable, 1983; Hoge, 1972).

Allen and Spilka (1967) developed the constructs of committed and consensual religiosity in order to clarify some of the cognitive differences associated with religious orientation. Committed religion is intended to define an authentic, internalized faith that is open, abstract, and discerning, whereas consensual religion is characterized by non-internalized faith with an accompanying cognitive style that is detached, restrictive, concrete, vague, and simplistic (Van Wicklin, 1990). Spilka, Stout, Minton, and Sizemore (1977) developed the Religious Viewpoints scale, a 40-item self-report measure, in order to empirically investigate committed and consensual religiosity. Batson (1976) followed Allen and Spilka's conceptual tuning of the intrinsic (committed) and extrinsic (consensual) dimensions operationalized by Allport and Ross with the 27-item self-report Religious Life Inventory (RLI). The RLI consists of three scales, means (extrinsic), end (intrinsic), and quest. The quest scale was designed to measure the extent to which an individual's religion involves an ongoing, existential dialogue with the practical realities of life (Van Wicklin, 1990).

Aside from the measures inspired by Allport's intrinsic and extrinsic constructs, a multitude of instruments have been developed to assess a wide variety of religious dimensions. These include the 20-item Spiritual Well-Being Scale (Ellison, 1983) developed to measure religious and existential well-being, the 36-item Religious Problem Solving Scales (Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988) which investigate the relationship between religion and problem solving, the 32-item Religious Status Interview (Malony, 1988) which measures eight theological categories in order to assess how Christian faith functions in people's lives, and the 160-item Religious Status Inventory (Hadlock, 1988; Massey, 1988) designed to examine what individuals believe, feel, and do in connection with their Christian faith.

Although these and a number of other instruments have been developed to measure various aspects of religiousness and religiosity, there does not currently exist an assessment tool that attempts to measure strength of religious faith. The aforementioned instruments measure dimensions of faith in persons who have already been categorized as being religiously faithful, and tend to be theoretically complex. Furthermore, the length and design of many of these measures renders them inappropriate for researchers or clinicians who require a brief and simple measure of strength of religious faith.

A concise assessment device that measures strength of religious faith could be useful to researchers who desire to utilize strength of religious faith as a variable in their research or to clinicians who desire to examine their client's strength of religious faith. Taking into account the beneficial role that religious faith has been found to play in the maintenance of men-

tal health, it is important that professionals have a useful and quick way to measure strength of religious faith for use in mental health research and practice. The Santa Clara Strength of Religious Faith Questionnaire (SCSORF) was designed with the aforementioned considerations in mind. The purpose of this investigation is to introduce a strength of religious faith questionnaire, to provide preliminary data on the instrument, and to examine it's correlation with mental health variables such as self-esteem, anxiety, and depression.

METHOD

Subjects

A sample of 102 undergraduate university students (78 females, 24 males) were utilized as research subjects(M = 19.25 years, SD = 2.24 years). All of the subjects were enrolled in a General Psychology course.

Measures

Santa Clara Strength of Religious Faith Questionnaire (SCSORF: see Appendix). The SCSORF questionnaire is a 10-item measure designed by the first author in order to measure strength of religious faith. Items on the SCSORF were generated from the first author's clinical contact with religious patients. Items are scored on a 4-point scale and were designed to measure strength of religious faith regardless of denomination. *Symptom Check List-90-Revised* (SCL-90-R; Derogatis, 1977). The SCL-90-R consists of 90 items scored on a 5-point scale that reflect nine validated symptom dimensions. The anxiety, depression, and interpersonal sensitivity scales were used in the current study. For anxiety, Derogatis (1977) reports a coefficient alpha of .85 and test-retest reliability as .80; concurrent validity is reported as .74. For depression, Derogatis (1977) reports a coefficient alpha of .90 and test-retest reliability as .82; concurrent validity is reported as .52. For interpersonal sensitivity, Derogatis (1977) reports a coefficient alpha of .86 and a test-retest reliability of .83; concurrent validity is reported as .48.

Hope Scale (HS; Snyder, 1995). The HS is a 12-item personality questionnaire that assesses the process of thinking about one's goals, and the motivation to move toward and the ways to achieve those goals. Snyder (1995) reports coefficient alphas from .74 to .84, and test-retest correlations from .73 to .82.

Weinberger Adjustment Inventory (WAI; Weinberger, 1991). The WAI is an 84-item personality questionnaire scored using a 5-point scale that assesses 11 personality traits. The repressive defensiveness (WAI-RD), denial of distress (WAI-DOD), and low self-esteem (WAI-LSE) subscales were utilized in this study. Weinberger (1991) reports coefficient alphas as .79 for repressive defensiveness and .75 for denial of distress.

Belief in Personal Control Scale (BPCS; Berrenberg, 1987). The BPCS is a 45-item personality questionnaire designed to measure three dimensions of personal control: general external control (F1), exaggerated control (F2), and God control (F3). Higher scores relate more internal control (F1), a more exaggerated belief in control (F2), and less belief in God as a mediator of control (F3). Berrenberg (1987) reports coefficient alphas of .85 for the external control factor (F1), .88 for the exaggerated control factor (F2), and .97 for the God control factor (F3), and four-week test-retest correlations of .81 (F1), .85 (F2), and .93 (F3).

Author-Designed Questions. Additional questions included a series of 10-point scale questions measuring strength of religious faith, perceived stress, and perceived coping. One multiple choice question was included to determine whether recent media accounts of priests sexually abusing children had diminished, increased, or had no impact on the subject's faith.

Procedure

The subjects were informed of the purpose of the study and were assured of confidentiality. After signing a consent form and agreeing to participate, subjects completed the series of questionnaires.

RESULTS

The mean strength of religious faith score assessed by the SCSORF was 26.39 (SD = 8.55, range = 33) and the median score was 26.00 (minimum = 7 and maximum = 40). The SCSORF was found to have high internal reliability (Chronbach Alpha = .95) and split-half reliability (r = .92).

A median-split procedure was used to divide the sample into high and low faith groups based on SCSORF scores. Subjects with a score of 26 or above were labeled as high faith whereas subjects who scored lower than 26 were labeled as low faith. One-way analyses of variance (ANOVA) were

Table 1. Means and Standard Devisyions for Personality and Mood Variables Among High Faith and Low Faith Subjects

	n = 52 High Faith		n = 50 Low Faith		
	M	*SD*	*M*	*SD*	
SCSORE					
Total	33.2	4.2	19.2	5.4	
Author-Designed Questions					
Strength of Faith	8.0	1.6	4.1	2.2	
Stress	6.2	2.1	6.0	2.1	
Coping	6.8	1.7	6.3	2.0	
SCL-90-R					
Anxiety	9.9	5.4	11.3	6.8	
Depression	15.2	8.4	17.3	8.7	
Interpersonal Sensitivity	9.3	5.5	13.0	7.0	**
Hope Scale					
Hope	36.0	3.8	34.8	4.5	
WAI					
Repressive Defensiveness	26.1	7.1	25.2	7.4	
Low Self-Esteem	12.6	5.7	14.9	5.8	*
Denial of Distress	22.1	5.9	21.2	5.3	
BPCS					
External Control	68.8	10.5	67.5	10.6	
Exaggerated Control	62.1	9.7	58.3	9.7	*
God Control	18.6	7.7	35.1	9.0	**

*$p < .05$; **$p < .01$.

computed on the personality and mood measures in order to examine differences associated with strength of religious faith.

Results from the SCL-90-R indicate that high faith subjects were less interpersonally sensitive than low faith subjects ($F(1,100) = 8.58, p < .01$), and WAI results suggest that high faith subjects had higher self-esteem than low faith subjects ($F(1,100) = 4.17, p < .05$). On the BPCS measure, high faith subjects scored higher on the exaggerated control dimension ($F(1,100) = 4.03, p < .05$) and lower on the God-mediated dimension ($F(1,100) = 99.08, p < .001$), with low scores on the God-mediated dimension indicating that the subject believes that God can be enlisted in the achievement of outcomes.

A multiple regression analysis was conducted using the total on the SCSORF measure as the dependent measure. The God control and interpersonal sensitivity scores were entered into the regression equation. A

multiple R of .84 surfaced accounting for 71% of the variance in SCSORF totals ($F(2,99) = 119.76, p < .01$).

Pearson correlation coefficients were calculated between the SCSORF score and personality measures (see Table 2). High scores on the SCSORF were positively correlated with perceived coping, hope, and belief in exaggerated control (r's = .20 to .27, p's < .05), and negatively correlated with low self-esteem, depression, God control, and interpersonal sensitivity (r's = .20 to .40, p's < .05).

The SCSORF has been utilized in two additional studies conducted by the first author, and similar results have been noted. In an examination of 48 collegiate baseball players Plante and Booth (1996) found significant correlations between the SCSORF (M = 23.21, SD = 8.47, range = 30, minimum = 10, maximum = 40) and denial of distress (r = –.25), external control (r = –.44), God control (r = –.51), and narcissism (r = .28). Thus subjects scoring high on religious faith were found to score low on denial of distress, external control, and God control, and high on narcissism. Plante, Lantis, and Checa (1996) found significant correlations between the SCSORF (n = 60, M = 26.65, SD = 8.04, range = 29, minimum = 10, maximum = 39) and both repression (r = .24) and anxiety (r = –.26) in their examination of aerobic fitness and stress responsivity in offspring of hypertensive parents. Thus subjects scoring high in strength of religious faith were found to score low in anxiety and high in repression.

DISCUSSION

This investigation introduces the SCSORF and provides preliminary information about the instrument. The SCSORF may be advantageous to many researchers and clinicians because of its brevity, compatibility with a diverse assortment of religious denominations, and simple system of administration and scoring. Preliminary findings suggest that the SCSORF is a reliable and valid measure of strength of religious faith. Initial internal reliability and split-half reliability results indicate the consistency with which responses were made on the SCSORF and imply that the measure is reliable. Significant correlations between scores on the SCSORF and the measure of God control from the BPCS support the instrument's validity.

Many of our findings between religious faith and mental health are consistent with previous research. High faith subjects had higher self-esteem, were less interpersonally sensitive, maintained a higher belief in extreme and unrealistic control, and were more likely to believe that God

Table 2. Pearson Correlations Among Study Variables

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13
SCSORF													
1. Total													
Author-Designed Questions													
2. Strength of Faith	.86**												
3. Stress	−.08	.01											
4. Coping	.23*	.20*	−.33**										
SCL-90-R													
5. Anxiety	−.12	−.13	.38**	−.22*									
6. Depression	−.20*	−.20*	.42**	−.45**	.66**								
7. Interpersonal Sensitivity	−.42**	−.42**	.26**	−.34**	.55**	.65**							
Hope Scale													
8. Hope	−.21*	.21*	−.36**	.35	.47**	−.59**	−.44**						
WAI													
9. Repressive Defensiveness	.18	.12	.02	.08	−.27**	−.27**	−.33**	.23*					
10. Low Self-Esteem	−.27**	−.16	.16	−.30**	.43**	.62**	.55**	−.58**	−.24*				
11. Denial of Distress	.13	.14	−.18	.31**	−.49**	−.44**	−.44**	.42**	.33**	−.36**			
BPCS													
12. External Control	.08	.03	−.12	.12	−.26**	−.20*	−.27**	.30**	.04	−.39**	.32**		
13. Exaggerated Control	.23*	.16	−.18	.28**	−.34**	−.34**	−.33**	.65**	.14	−.48**	.45**	.55**	
14. God Control	−.83**	−.76**	−.01	−.21*	.03	.09	.32**	−.09	−.11	.18	−.09	−.01	−.19

*$p < .05$; **$p < .01$.

can be enlisted in the achievement of outcomes than were low faith subjects. Numerous researchers have found the same positive relationship between religion and self-esteem (e.g., Forst & Healy, 1990; Jensen et al., 1993; Johnson & Mullins, 1990; Nelson, 1990; Payne et al., 1991; Plante & Boccaccini, 1996; Sherkat & Reed, 1992; Slater et al., 1993) indicating that high faith individuals consistently tend to maintain high levels of self-esteem. Similarly, other researchers have found similar positive correlations between religion and adaptive coping (Grahm-Pole et al., 1989; Hughes et al., 1994; Jenkins, 1995; Tebbi et al., 1987), and religion and hope (Hall, 1994; Klenow, 1991; Ross, 1990). Although the relationship between interpersonal sensitivity and religious faith has not been thoroughly investigated, some previous research has suggested that religious persons tend to be less interpersonally sensitive (Griffith, Mahy, & Young, 1988; Stones, 1982).

Overall, results tend to suggest that high faith individuals are generally better adjusted than low faith individuals. Donahue and Benson (1995), McFadden (1995), Larson et al. (1992), and Ellison (1991) have noted similar relationships between overall mental health and religious devotion. Perhaps one of the most significant contributing factors that may underlie the connection between positive mental health and religion is locus of control. In the current study high faith subjects were found to maintain beliefs in unrealistic and God control. It is likely that these individuals are able to maintain positive mental health characteristics because they believe that they have an unrealistic amount of control over their lives or that God does. This attenuated feeling of control, regardless of its genesis, may play a significant role in the religion/mental health equation. The relationship between locus of control and religion has been researched, and positive relationships between the two have emerged (Geist & Bangham, 1980; Rao & Murthy, 1984; Scheidt, 1973; Tebbi et al., 1987).

In summary, the SCSORF is a quick, reliable, 10-item scale which is easily administered and scored. Future research on the questionnaire is needed to further examine its reliability, validity, and to establish test norms. Results from the present study must be viewed cautiously due to the moderate number of subjects selected from one university. Consequently, future work should also include larger samples and a greater variety of subjects. Furthermore, results are based solely on self-report information and thus response set or bias may account for some of our results. For example, the positive association between strength of faith and mental health variables may be due to high faith subjects being more interested in presenting themselves in a favorable or socially acceptable light. Future research should take these issues into consideration and use non-self-report measures (e.g., direct observation or report by others).

APPENDIX

Santa Clara Strength of Religious Faith Questionnaire

Please answer the following questions about religious faith using the scale below. Indicate the level of agreement (or disagreement) for each statement.

1 = strongly disagreemms 2 = disagree 3 = agree 4 = strongly agree

_____1. My religious faith is extremely important to me.
____ 2. I pray daily.
____ 3. I look to my faith as a source of inspiration.
____ 4. I look to my faith as providing meaning and purpose in my life.
____ 5. I consider myself active in my faith or church.
____ 6. My faith is an important part of who I am as a person.
____ 7. My relationship with God is extremely important to me.
____ 8. I enjoy being around others who share my faith.
____ 9. I look to my faith as a source of comfort.
___ 10. My faith impacts many of my decisions.

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