

Review

The Multidimensional Measurement of Religious/Spiritual Well-Being: Recent Developments in Scale Validation and Clinical Applications

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Abstract: Religiosity and spirituality (R/S) have been described extensively as being an integral part of subjective well-being and mental health, especially in Anglo-American regions. Accordingly, the Multidimensional Inventory for Religious/Spiritual Well-Being (MI-RSWB) was developed in the European context to be able to contribute to the further development of this research field by means of a validated measure. In this paper, after an introduction to basic considerations about the scale, more recent developments (from 2012 to 2022) regarding the use of the MI-RSWB are presented. Thus, it is intended to focus here on (1) the presentation of standard values for the MI-RSWB for the Austrian general population, (2) several scale translations into different languages, (3) more recent data on the relationship between RSWB, personality, and mental health, and (4) the potential clinical applications of the RSWB dimensions. As a conclusion, further potential applications of the RSWB concept are discussed.

Keywords: mental health; psychological well-being; religiosity; scale development; spirituality



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1. Introduction

1.1. The Concept of Spiritual Well-Being

Religion and spirituality as a subject of research in psychology and medicine have received increasing interest in recent decades (Cook 2020; Marks 2005; Rosmarin et al. 2020). Thereby, the religious–spiritual dimension is described as part of subjective well-being and as an important resource in coping with illness (McClain et al. 2003). The conceptual separation of religiosity and spirituality still appears difficult, although there is at least agreement that both areas should be measured multidimensionally in their own right (Pargament 1999; Zinnbauer et al. 1997). The concept of Spiritual Well-Being (SWB) and the associated scale were originally developed by C. W. Ellison and colleagues (Bufford et al. 1991; C. W. Ellison 1983). The basic idea was to measure the amount of a person’s spiritual health or quality of life. In this context, SWB was conceptualized as a two-dimensional construct, which is also reflected in two independent subscales: On a vertical axis, the degree of Religious Well-Being (RWB) is placed, which indicates the extent of well-being in the relationship with God or a higher power (transcendent area of perception). On the horizontal axis is the amount of Existential Well-Being (EWB), which describes the extent to which sense of life or even life satisfaction is experienced. Here, only the amount of well-being regarding an immanent space of perception is addressed. Subsequently, by adding up the two subscales EWB and RWB a total score of SWB can be formed, which considers both existential and religious aspects of well-being. There was always some criticism of the scale, especially in the Anglo-American regions, since ceiling effects repeatedly appeared, particularly in studies where samples of the normal

population were investigated (Ledbetter et al. 1991). However, these problems did not arise for the German version of the scale (Unterrainer et al. 2014a). As there are currently numerous applications, especially for the Anglo-American area, the SWB scale can be seen as a highly established instrument within the empirical field of psychology of religion (L. L. Ellison 2006).

1.2. The Multidimensional Assessment of Religious/Spiritual Well-Being

The Multidimensional Inventory of Religious/Spiritual Well-Being (MI-RSWB; Unterrainer et al. 2014a) can be regarded as a multidimensional alternative to the original SWB scale. The content of the six dimensions was developed on the basis of an interdisciplinary discussion group as well as extensive literature research (Unterrainer et al. 2014a). The originally theoretically assumed five dimensions were replaced by a final six-factor solution during the course of the test development, based on empirical data (a more detailed description of the phases of the test's construction can be found in Unterrainer et al. 2014a).

The original differentiation of the SWB scale into two sub-dimensions, an immanent and transcendent perception space, is maintained in the MI-RSWB. However, these two areas are now addressed in a more differentiated way. Thereby, Religious/Spiritual Well-Being (RSWB) has been defined as “the ability to experience and integrate meaning and purpose in existence through a connectedness with self, others or a power greater than oneself” (Unterrainer et al. 2011, p. 116). The MI-RSWB comprises six subscales: General Religiosity (GR), Connectedness (CO), Hope Transcendent (HT) or Hope Immanent (HI), Forgiveness (FO), and Experiences of Sense and Meaning (SM). The first three subscales (GR, CO, and HT) can be summarized into a sub-score for Transcendent Well-Being (equivalent to the SWB subscales: Religious Well-Being) and the latter (HI, FO, and SM) to a sub-score for Immanent Well-Being (equivalent to the SWB subscale: Existential Well-Being). Furthermore, it is possible to calculate a total score of Religious/Spiritual Well-being (RSWB) by summarizing all six subscales. Each of the 48 items have to be answered by means of a 6-point Likert scale ranging from 1—totally disagree to 6—totally agree. Unterrainer et al. (2012) reported a substantial high correlation between the English version of the MI-RSWB scale and the original SWB scale ($p < 0.001$). A short description of the content of each MI-RSWB subscale together with an item example can be retrieved from Table 1. A more detailed analysis of the content of each of the subscales can be found in Unterrainer et al. (2014a).

Subsequently, the instrument was successfully validated in studies involving different patient groups and various samples from the normal population. Thereby, a significantly lower level of RSWB was observed in different psychiatric patient groups such as individuals who were diagnosed for depressive disorders or substance use disorders (Unterrainer et al. 2014a). Furthermore, the RSWB dimensions (in particular, HI and FO) showed a positive relationship with various mental health parameters (e.g., Sense of Coherence or more adequate stress coping) as well as negative associations with symptoms of mental illness (e.g., depression or anxiety) The results of the first phase of the instrument's development (2002–2012) were summarized by Unterrainer et al. (2014a).

Table 1. Schematic presentation of the six RSWB dimensions.

Dimension	Area of Perception	Content	Marker Item	Number of Items
General Religiosity (GR)	T	Religious belief in the traditional sense, which is institutionalized. Affiliation to a religious community.	<i>"My faith gives me a feeling of security."</i>	8
Connectedness (CO)	T	The feeling of being integrated into a larger whole, regardless of a religious community. A spiritual attitude to life.	<i>"I have experienced the feeling of being absorbed into something greater."</i>	8
Hope Transcendent (HT)	T	The hope for a better life after death or that life after death continues (as opposed to fear of death and dying).	<i>"I often think about the fact that I will have to leave behind my loved ones."</i> (coded reversely)	8
Hope Immanent (HI)	I	The hope for a more fulfilling life in the future or that things will change for the better.	<i>"I view the future with optimism."</i>	8
Forgiveness (FO)	I	The ability to forgive yourself or other people or to resign yourself to things that have gone wrong.	<i>"There are things which I cannot forgive."</i> (coded reversely)	8
Experiences of Sense and Meaning (SM)	I	Significant life experiences, for example of honesty and openness, true friendship, loyalty, or gratitude.	<i>"I have experienced true (authentic) feelings."</i>	8
Immanent Well-Being (IWB)	I	Subjective amount of well-being regarding the immanent area of perception.	-	24
Transcendent Well-Being (TWB)	T	Subjective amount of well-being regarding the transcendent area of perception.	-	24
Religious/Spiritual Well-Being (RSWB)	I/T	Total score of all six subscales (see also global definition)	-	48

Note. I = Immanent area of perception; T = Transcendent area of perception.

2. Norm Values for the Austrian General Population

The MI-RSWB has been used in various studies with both clinical and non-clinical groups (Unterrainer and Fink 2013). Based on the resulting datasets from the non-clinical area, a dataset could be built up that corresponds to the overall Austrian condition in terms of distribution by age and gender. With the help of the aggregated dataset ($N = 1500$), the norm values for the MI-RSWB for the Austrian normal population could be presented. As displayed in Table 2, the psychometric properties regarding Cronbach α for the subscales and the total scale proved to be very satisfactory (Unterrainer and Fink 2013). In line with general assumptions, women exhibited a higher amount of RSWB than men, as they also scored higher in all the subscales ($p < 0.001$ for all), with the exception of HT, where Austrian men exhibited a substantially higher amount than women ($p < 0.01$). We also observed a minor but statistically relevant increase in RSWB with increasing age ($p < 0.01$). This relationship was especially reflected in the GR subscale ($p < 0.001$). With regard to the other variables examined (e.g., partnership, employment, or school education), there were no significant associations with RSWB. Regarding the affiliation to a religious community, a predominant part of the respondents (70%) stated that they belong to the Catholic faith. A more detailed description of the distribution of religious affiliation can be found in Unterrainer and Fink (2013).

Table 2. Internal consistencies, Means and Standard Deviations, and Inter-correlations for the MI-RSWB (total score and sub scales).

	GR	CO	HT	HI	FO	SM	RSWB
α	0.94	0.77	0.72	0.84	0.84	0.76	0.89
M (SD)							
Total	28.73 (12.26)	27.15 (8.95)	30.39 (8.15)	35.76 (7.56)	34.66 (9.27)	37.75 (6.78)	194.44 (31.70)
Females	31.17 (11.63)	28.51 (8.67)	29.98 (8.27)	36.43 (7.20)	35.91 (9.08)	39.04 (6.34)	201.03 (30.23)
Males	26.29 (12.40)	25.78 (9.03)	30.80 (8.01)	35.10 (7.80)	33.42 (9.31)	36.42 (6.97)	187.85 (31.78)
Dimension							
GR	-	0.49 ***	0.01	0.23 ***	0.34 ***	0.33 ***	0.75 ***
CO		-	0.04 *	0.33 ***	0.10 ***	0.43 ***	0.65 ***
HT			-	0.07 **	0.35 ***	-0.08 **	0.35 ***
HI				-	0.17 ***	0.17 ***	0.57 ***
FO					-	0.10 ***	0.62 ***
SM						-	0.60 ***
RSWB							-

Note. $N = 1500$ (Austrian general population); adapted from (Unterrainer and Fink 2013); α = Cronbach α ; M = Mean; SD = Standard Deviation; GR = General Religiosity; CO = Connectedness; HT = Hope Transcendent; HI = Hope Immanent; FO = Forgiveness; SM = Experiences of Sense and Meaning; RSWB = Religious/Spiritual Well-Being. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

The inter-correlations of the MI-RSWB subscales and the correlations with the MI-RSWB total score are displayed in Table 2. In general, the basic assumptions regarding the scale can be considered as confirmed, as (with a few exceptions) all the sub-dimensions show low to medium positive correlations with each other and there are significantly higher positive correlations with the RSWB total score ($p < 0.001$ for all). It can therefore be assumed that each subscale independently addresses a specific content and at the same time contributes to a larger whole (RSWB total score). Not surprisingly, we observed a substantially high correlation between the two transcendent dimensions GR and CO ($p < 0.001$); however, both of them showed almost no connection with the HT dimension. This result mirrors the findings from previous work, where HT was consistently observed to be linked the weakest with the whole RSWB concept. Accordingly, HT also showed the weakest connection with the RSWB total score. However, due to considerations regarding the RSWB content, it was decided to continue to include the HT dimension for the RSWB assessment.

More recently, a short version of the scale was presented specifically for use in clinical surroundings (Fuchshuber and Unterrainer 2021). This short version of the scale consists of 12 items whereby the scale has been shortened to four sub-dimensions (GR, CO, HI, and FO; every dimension is assessed by means of three items each). The short scale shows convincing psychometric parameters both in terms of the total score as well as the subscales.

3. MI-RSWB Scale Translations into Different Languages

At the present stage of development, the scale has been translated into the following languages: Bosnian (Malinovic et al. 2016), English (Unterrainer et al. 2012), Italian (Stefa-Missagli et al. 2014), Mexican-Spanish (Berger et al. 2016), Persian (Farsi) (Dadfar et al. 2019), Russian (Agarkov et al. 2018), and Swedish (Wenzl et al. 2021). All translations into the respective languages were carried out by native speakers and reverse translations were made to ensure optimal matching with the original version. Overall, the MI-RSWB proved to be a highly reliable and valid measuring instrument across all language versions. An overview of the mean values and standard deviations and the internal consistencies with regard to the different language versions can be found in Table 3.

Table 3. Internal consistencies of the MI-RSWB in different language versions (total score and sub scales).

Short Name	Language	N	Sample	α_{GR}	α_{CO}	α_{HT}	α_{HI}	α_{FO}	α_{SM}	α_{RSWB}
MI-RSWB-B	Bosnian ⁽¹⁾	290	Students	0.94	0.69	0.66	0.76	0.78	0.72	0.83
MI-RSWB-E	English ⁽²⁾	400	Students	0.96	0.82	0.75	0.82	0.84	0.77	0.91
MI-RSWB-I	Italian ⁽³⁾	421	Students	0.95	0.72	0.72	0.79	0.83	0.68	0.85
MI-RSWB-MS	Mexican-Spanish ⁽⁴⁾	190	Students	0.94	0.75	0.77	0.81	0.86	0.86	0.91
MI-RSWB-P	Persian (Farsi) ⁽⁵⁾	442	Convenience	0.89	0.66	0.19	0.77	0.72	0.58	0.82
MI-RSWB-R	Russian ⁽⁶⁾	192	Students	0.94	0.81	0.62	0.86	0.86	0.68	0.90
MI-RSWB-S	Swedish ⁽⁷⁾	1011	Students	0.97	0.81	0.77	0.81	0.85	0.67	0.90

Note. GR = General Religiosity; CO = Connectedness; HT = Hope Transcendent; HI = Hope Immanent; FO = Forgiveness; SM = Experiences of Sense and Meaning; RSWB = Religious/Spiritual Well-Being; α = Cronbach α ; ⁽¹⁾ Malinovic et al. (2016); ⁽²⁾ Unterrainer et al. (2012); ⁽³⁾ Stefa-Missagli et al. (2014); ⁽⁴⁾ Berger et al. (2016); ⁽⁵⁾ Dadfar et al. (2019); ⁽⁶⁾ Agarkov et al. (2018); ⁽⁷⁾ Wenzl et al. (2021).

As displayed in Table 3, the MI-RSWB mostly showed satisfactory to very satisfactory internal consistencies in all language versions ($\alpha > 0.6$ for all subscales or $\alpha > 0.8$ for the RSWB overall scale). The only exception is the HT subscale for the Persian (Farsi) version of the scale (Dadfar et al. 2019), a fact that possibly points to intercultural differences, which could be further investigated. It is noteworthy that the Persian sample was the only community sample.

4. The Relationship between RSWB Dimensions, Personality, and Mental Health

4.1. The Relationship between Religious/Spiritual Well-Being and Personality Structure

4.1.1. Correlations with the Big Five Personality Factors

The concept of the Big Five of personality or Five Factor Model (FFM) is one of the most established concepts in order to describe human personality characteristics based on a lexical approach (McCrae and Costa 1997). Accordingly, human personality can be measured by means of five factors: Extraversion (E) means the extent of communicativeness and conviviality or how safe someone appears at social events; Neuroticism (N) summarizes the (non-pathological) degree of anxiety, depression, and compulsiveness or how much one tends to feel guilty; Agreeableness (A) indicates how sensitive or how sympathetic someone is; Conscientiousness (C) may be understood as the extent to which someone behaves ethically correct, reliably, and productively; Openness to experiences (O) means the extent of non-conformist and unusual thinking processes but also non-conformist behavior. R/S dimensions were extensively researched in the context of the FFM (MacDonald 2000; Piedmont 1999; Saroglou 2002). Thereby, some effort was made to characterize a sixth factor, "Spirituality", by expanding the Big Five to a Big Six of personality.

As shown in Table 4, Hiebler-Ragger et al. (2018) observed some substantial correlations between the RSWB dimensions and the Big Five of personality factors as assessed with the Big Five Inventory (BFI; Lang et al. 2001). The E factor was found to be especially highly correlated with the RSWB dimensions representing the immanent area of well-being, such as HI, FO, or SM ($p < 0.001$ for all). In correspondence to this, there was also a high association between E and the RSWB total score ($p < 0.001$). These findings were mirrored by the connections between the N factor and the RSWB dimensions. Here, we found substantial negative correlations between N and HI and FO, respectively, but also for HT ($p < 0.001$ for all), which points to the anxiety-buffering effect of hope and forgiveness. In line with the literature, we observed the A factor as especially highly linked to nearly all RSWB dimensions ($p < 0.001$ for all dimensions with the exception of HT), which can best be seen as being represented in the high correlation with the RSWB total score ($p < 0.001$). Somewhat in contrast to the existing literature, there was hardly any significant correlation between the C factor and the RSWB dimensions. A highly relevant relationship was only found for FO ($p < 0.001$). However, there was a strikingly high connection with IWB. Unsur-

prisingly, the O factor was linked to the CO dimension as highly significant. Furthermore, there was a strong connection between O and SM ($p < 0.001$ for both; see Table 4).

Table 4. Correlations between the RSWB dimensions and the Big Five of personality.

Dim.	GR	CO	HT	HI	FO	SM	TWB	IWB	RSWB
E	0.24 **	0.31 ***	0.19 *	0.56 ***	0.30 ***	0.48 ***	0.35 ***	0.60 ***	0.52 ***
N	−0.14	−0.03	−0.34 ***	−0.43 ***	−0.28 ***	−0.12	−0.20 **	−0.38 ***	−0.32 ***
A	0.35 ***	0.37 ***	0.10	0.29 ***	0.53 ***	0.36 **	0.42 **	0.54 ***	0.53 ***
C	0.11	0.11	0.13	0.17 *	0.27 ***	0.24 **	0.17 *	0.41 ***	0.32 ***
O	0.08	0.34 ***	0.08	0.15	0.13	0.35 ***	0.24 **	0.27 ***	0.28 ***

Note. $N = 171$; adapted from Hiebler-Ragger et al. 2018; Dim.= Big Five dimensions; E = Extraversion; N = Neuroticism; A = Agreeableness; C = Conscientiousness; O = Openness to Experience. GR = General Religiosity; CO = Connectedness; HT = Hope Transcendent; HI = Hope Immanent; FO = Forgiveness; SM = Experiences of Sense and Meaning; TWB = Transcendent Well-Being; IWB = Immanent Well-Being; RSWB = Religious/Spiritual Well-Being. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

4.1.2. Correlations with Different Parameters of Personality Pathology

Furthermore, the generally confirmed positive relationship between the RSWB dimensions and more favorable personality traits (see also Section 4.1.1) can be critically questioned by relating the RSWB dimensions to further parameters of personality pathology. This approach should enable an in-depth analysis of the RSWB subscales (see Bennett et al. 2013; Lynam and Widiger 2001 for an enhanced discussion). Accordingly, both potentially underlying positive and negative aspects of superficially high RSWB levels were studied in relation to schizotypy, as a potential precursor of a schizophrenic disorder (Unterrainer et al. 2014b), to the Dark Triad of Personality: narcissism (Narcissistic Personality Inventory (NPI); Schütz et al. 2004), Machiavellianism (Machiavellianism Scale—German adaptation; Christie and Geis 1970), psychopathy (Levenson’s Psychopathy Self Report Scale—German adaptation; Levenson et al. 1995), as well as deficits in personality structure (as assessed with the Inventory for Personality Organisation (IPO)—short version (Zimmermann et al. 2013; Kämmerle et al. 2014). Lastly, the RSWB dimensions were related to the amount of Religious Fundamentalism (Innsbrucker Religious Fundamentalism Scale; Schnell 2010; Unterrainer et al. 2016a). Table 5 gives an overview of the observed relationships between the RSWB dimensions and various parameters of personality pathology.

Table 5. Correlations between the RSWB dimensions and parameters of personality pathology.

	GR	CO	HT	HI	FO	SM	RSWB
Schizotypy ⁽¹⁾	−0.08	0.09	−0.27 ***	−0.41 ***	−0.28 ***	−0.16 ***	−0.23 ***
Cognitive-perceptual Abnormalities	0.13 ***	0.37 ***	−0.08	−0.11 ***	−0.12 ***	0.04	0.07
Interpersonal Deficits	−0.14 ***	−0.10	−0.28 ***	−0.45 ***	−0.28 ***	−0.25 ***	−0.33 ***
Disorganized Thinking	−0.20 ***	−0.01	−0.28 ***	−0.42 ***	−0.28 ***	−0.18 ***	−0.29 ***
Dark Triad of Personality ⁽²⁾							
Narcissism	−0.05	0.20 ***	−0.08	0.43 ***	−0.11	0.27 ***	0.17
Machiavellianism	−0.19	−0.15	−0.24 ***	−0.11	−0.38 ***	−0.26 ***	−0.34 ***
Psychopathy	−0.26 ***	−0.21 ***	−0.25 ***	−0.23 ***	−0.38 ***	−0.34 ***	−0.44 ***
Structural Personality Deficits ⁽²⁾	−0.03	0.10	−0.37 ***	−0.30 ***	−0.19	−0.19	−0.21 ***
Religious Fundamentalism ⁽³⁾	0.55 ***	0.32 ***	0.05	0.05	0.16	−0.06	0.33 ***

Note. GR = General Religiosity; CO = Connectedness; HT = Hope Transcendent; HI = Hope Immanent; FO = Forgiveness; SM = Experiences of Sense and Meaning; RSWB = Religious/Spiritual Well-Being; ⁽¹⁾ adapted from Unterrainer et al. (2014b); $N = 400$; ⁽²⁾ adapted from Kämmerle et al. (2014); $N = 312$; ⁽³⁾ adapted from Unterrainer et al. (2016a); $N = 327$. *** $p < 0.001$.

As depicted in Table 5, we observed a generally negative correlation pattern between the RSWB dimensions and several facets of schizotypy ($p < 0.001$; assessed with the short Schizotypy Personality Questionnaire (SPQ)—German Adaptation; Raine and Benishay

1995), with the exception of cognitive-perceptual abnormalities. Here, we found a relevant positive correlation with the CO dimension ($p < 0.001$). Since productive/positive symptoms (such as creative ideas) can be assumed in the case of cognitive-perceptual abnormalities, this facet of schizotypy seems to be reflected above all in the CO dimension (Unterrainer and Lewis 2014). In general, however, the postulated positive connection between the RSWB dimensions and psychological well-being is obtaining further confirmation, as we observed consistently negative correlations between the RSWB dimensions and the negative symptoms of schizotypy (interpersonal deficits, disorganized thinking; $p < 0.001$). Accordingly, Unterrainer et al. (2014b) then applied canonical correlation analysis to describe two different states of mind (by explicitly including the immanent as well as transcendent area of perception) as being linked to schizotypy: On the one hand, a positive association between the cognitive/perceptual features of schizotypy and “spiritual connectedness” emerged. On the other hand, a more global negative relationship between feelings of spiritual isolation and despair was observed for all aspects of schizotypy. These findings critically challenge previous results, where a one-dimensional negative relationship between schizotypy and various measures of subjective well-being was reported (Abbott and Byrne 2012).

Furthermore, the RSWB dimensions were related to the Dark Triad of Personality (narcissism, Machiavellianism, and psychopathy) (Kämmerle et al. 2014), as displayed in Table 5. Within the Dark Triad concept, narcissism is used here to further describe the (not pathological) tendency to self-exaltation or self-enhancement; Machiavellianism means the tendency to manipulate other people for exploitative reasons; psychopathy can be understood as an increased potential for aggression or the tendency to violate (legal) norms (Christie and Geis 1970). As expected, psychopathy showed an increased negative correlation with all RSWB dimensions ($p < 0.001$ for all) as did Machiavellianism for most of the scales ($p < 0.001$ for all except GR, CO, and SM). We further observed some positive correlations between several RSWB dimensions (CO, HI, and SM; $p < 0.001$ for all) and narcissism, which might represent a certain kind of exalted optimism or opportunism (Kämmerle et al. 2014).

In the same study, we also examined deficits in personality structure by applying the Inventory of Personality Organization (IPO), which is a short screening instrument to measure structural deficits in the domains: Primary defenses (devaluation of the other), identity diffusion, and reality testing (depersonalization, derealization). Notably, we observed here some substantial negative correlations with the HT and HI dimensions as well as with the RSWB total score ($p < 0.001$ for all). In an additional study (Unterrainer et al. 2016a), we found some substantial correlations between CO and Impaired Reality Testing as well as Identity Diffusion ($p < 0.001$ for both). Lastly, as displayed in Table 5, we observed some relevant correlations between Religious Fundamentalism (orthodox belief systems; eventually devaluations of other belief systems) with the GR and the CO dimensions in addition to the RSWB total score ($p < 0.001$ for all). This is not surprising, since an orthodox belief system should be co-determined by a high degree of R/S belief (Altemeyer and Hunsberger 1992). Correspondingly, we did not observe any other relevant connections with the RSWB sub-dimensions.

4.2. The Role of Religious/Spiritual Well-Being in Different Clinical Patient Groups

In recent years, the MI-RSWB has also been used to investigate various clinical samples such as dermatological and different psychiatric patient groups, mostly in comparison to various non-clinical groups. Overall, we observed a general lower extent of RSWB in all clinical patient groups; however, psychiatric patient groups exhibited a significantly decreased amount of RSWB (see Unterrainer et al. 2014a for an extensive overview). For the group of persons with dermatological diseases, the RSWB dimensions were related to various parameters of mental health and illness (Pilch et al. 2016; Unterrainer et al. 2016b; also for a detailed description of the different kinds of skin disease). Thereby, as displayed in Table 6, we observed some substantial negative correlations with psychiatric symptoms

such as somatization, anxiety and depressiveness as well as with the total score, the Global Severity Index of psychiatric symptoms (GSI; assessed with the Brief Symptom Inventory; Franke et al. 2017). The dimensions HI and HT, as well as the RSWB total score and partly the FO dimension, were shown to be especially negatively connected with the psychiatric symptom burden ($p < 0.01$ for all). In line with these findings, we observed a positive connection between HT, HI, and the total RSWB score with the Global Index of Mental Health (a sub-dimension of the SF-36 Quality of Life questionnaire; Bullinger et al. 1995). Furthermore, in individuals receiving psychiatric inpatient treatment, between the HI, FO, and the RSWB total score, we observed a relevant negative connection with the amount of clinical depression (Unterrainer et al. 2014a). Here, the amount of depression was assessed with the Beck Depression Inventory (BDI; Beck et al. 1961).

Table 6. Correlations of dimensions of Religious/Spiritual Well-Being with different groups (dermatological and various psychiatric patient groups).

	GR	CO	HT	HI	FO	SM	RSWB
Global Severity Index ⁽¹⁾	−0.07	0.18 *	−0.34 **	−0.37 **	−0.22 **	0.1	−0.21 **
Somatization	−0.04	0.14	−0.23 **	−0.24 **	−0.15	0.16	−0.10
Anxiety	−0.11	0.12	−0.31 **	−0.33 **	−0.21 *	0.03	−0.23 **
Depressiveness	−0.04	0.20 *	−0.36 **	−0.40 **	−0.20 *	0.02	−0.22 **
Mental Health ⁽²⁾	0.12	0.01	0.27 ***	0.49 ***	0.25 **	0.01	0.37 ***
Psychoticism ⁽³⁾	−0.13	−0.01	−0.01	−0.30	−0.09	−0.17	−0.25
Depression ⁽⁴⁾	−0.11	−0.12	−0.16 *	−0.47 ***	−0.32 ***	−0.17 *	−0.36 ***

Note. GR = General Religiosity; CO = Connectedness; HT = Hope Transcendent; HI = Hope Immanent; FO = Forgiveness; SM = Experiences of Sense and Meaning; RSWB = Religious/Spiritual Well-Being; ⁽¹⁾ adapted from Pilch et al. (2016); $N = 149$; ⁽²⁾ adapted from Unterrainer et al. (2016a); $N = 149$; ⁽³⁾ adapted from Unterrainer et al. (2015); $N = 39$; ⁽⁴⁾ adapted from Unterrainer et al. (2014a, 2014b); $N = 220$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Somewhat in contrast to our assumptions, we did not observe any relevant connection between the RSWB dimensions and psychoticism (as a sub-dimension of the Brief Symptom Inventory), as we had expected at least one positive connection between the CO dimension and psychotic experiences (Unterrainer et al. 2015). Corresponding to these results, Mohr et al. (2006) described positive coping strategies in schizophrenia patients (apart from the psychotic experience). However, it should be noted that the sample of $n = 39$ in our study was very small for the group of schizophrenia patients. It can therefore be assumed that employing a larger sample might lead to some different findings.

By means of a multicenter study (the participating centers were in Bolzano, Graz, and Rome), we were also able to demonstrate a negative relationship between the RSWB dimensions and suicidality in general psychiatric groups as well as samples from the normal population, partly from Southern Styria (Austria) as well as from several parts of northern Italy. Additionally, suicidality was also investigated to determine its relation to other personality traits (Stefa-Missagli et al. 2019). In general, it can be summarized from these works that the extent of RSWB in the various psychiatric patient groups can be regarded as reduced. Here, the depressive symptoms seem to manifest for the immanent space of perception, especially in a reduced level of HI and FO. However, there are also exceptions to this general trend, as a particularly high level of CO was found in the group of people with substance use disorders (Unterrainer et al. 2013).

5. Clinical Applications and Future Perspectives

5.1. Towards a Spiritually Integrated Psychotherapy

After a prolific debate in the past two decades, the important role of religion and spirituality in therapeutic use can be seen as well-documented in the meantime (Garssen et al. 2021; Koenig 2009; Lucchetti et al. 2021; Kao et al. 2020; Rosmarin et al. 2020). Furthermore, spirituality was considered as a potential resource for addressing the threats posed by the COVID-19 pandemic (Arslan and Yildirim 2021; Coppola et al. 2021). In addition to spiritually oriented or integrated therapeutic approaches, such as Mindfulness-

Based Stress Reduction (MBSR) training (Goldin and Gross 2010) or Yoga (Ramakrishna Rao 2011), there are primarily “secular” concepts such as Mentalization-Based Therapy (MBT; Bateman and Fonagy 2004), in which spirituality is not explicitly mentioned. However, these secular methods also put the focus on cognitions and emotions that take place on a higher (neocortical) level of processing in the brain (see Choi-Kain and Gunderson 2008 for an in-depth discussion).

Furthermore, many spiritually integrated (psycho)therapeutic interventions nowadays are (at least partly) related to the original concepts of Analytical Psychology (Jung 1934): Apart from an explicit consideration of Jungian archetypes, all of these approaches assume a transcendent area of perception, which should be related significantly to one’s experience of health and illness (Miller 1999; Sperry and Shafranske 2005). However, the nature of this transcendent area may vary individually. According to Shafranske (2009), a spiritually oriented kind of (psychodynamic) psychotherapy “pays in particular attention to the roles that religious and spiritual beliefs, practices, and experiences play in the psychological life of the client” (p. 14). Accordingly, a psychology or psychopathology of religion and spirituality cannot make any statements as to whether the content believed in is true or false. This may be a more appropriate question for theology or maybe pastoral psychology (Capps 1999).

A good example of the explicit consideration of a spiritual dimension in the treatment process is the community of Alcoholics Anonymous (AA; or in a broader context: the 12-step programs; Forcehimes 2004). Therein, an addictive disease might be overcome by getting in contact with a higher power (whatever this may be). Due to its (existentially threatening) severity, addictive diseases can no longer be cured in the immanent space of perception. Therefore, the person suffering from an addictive disease has to experience a higher power in the transcendent space to make a spiritual transformation happen. Accordingly, Bill Wilson (a co-founder of the AA group and himself an ex-alcoholic) and Carl Gustav Jung found a common formula to fight the “booze devil”: “Spiritus contra Spiritum!” (because one drives out the other) became the battle cry of the anonymous groups (Jung [1961] 1975). Literally, a holy spirit is assumed here, competing against the spirit of wine—in the end, only one can dwell in man. From the perspective of attachment theory, the relationship to this higher power, as well as the group community, may be helpful here. This assumption also gets some additional support from an evolutionary point of view: spirituality as well as the membership in a group can be seen as an evolutionary advantage (Pargament 2013).

After confirmation of the positive correlation between the RSWB dimensions and the different parameters of mental health in different clinical and non-clinical groups, as a next step it was intended to develop an own clinical intervention program, based on the RSWB concept. In that sense, some pioneering work has been conducted by Aberer et al. (2018), who developed a clinical intervention program for dermatological patient groups based on Ignatian spirituality concepts (see especially Aberer et al. 2018 for a detailed description of the contents of the program), which was subsequently applied to a group of dermatological patients in a pilot study. In the intervention group, we observed a significant increase of the HT dimension; in line with previous research, the HT dimension especially showed an association with an increased amount of mental health in a larger sample of dermatological patients. Furthermore, Sollgruber et al. (2018) observed in a group of patients with chronic pain that the amount of RSWB can be substantially increased by a single session of meditative intervention. These findings mirror further results of our own studies, where we found a substantial connection between RSWB dimensions and the degree of personal involvement in Yoga, as well as in Mindfulness-Based Stress Reduction (MBSR) training (Gaiswinkler and Unterrainer 2016). Lastly, there is a single case study where a 19-year-old adolescent male, who described himself as anxiously depressed after a phase of severe drug abuse, was treated by a combined approach of Neurofeedback (a variant of biofeedback, where brain waves are stimulated by means of a feedback routine) and psychodynamic therapy over a span of 10 weeks (Unterrainer et al. 2014b). Here,

we observed a substantial decrease of anxious/depressive symptoms from the first point of measurement (beginning of treatment) to the second point of measurement (end of treatment after 10 weeks), which was sustained until a two-month follow-up assessment. These findings were inversely mirrored by a minor increase in RSWB dimensions, especially in HI, FO, and CO as well as in the RSWB total score. Notably, although the young man exhibited a high number of anxious/depressive symptoms at the beginning of treatment, he still exhibited a high amount of RSWB (percent rank > 90, which became nearly 100 in the course of treatment). This was somewhat in contrast to our expectations, as we normally would await a low amount of RSWB in anxious/depressive individuals. From a clinical perspective, there are several explanations possible (which of course are highly speculative, based on the data of a single case study): Therefore, it might be possible that the anxious/depressive symptom burden and the extent of the RSWB dimensions were not related to one another or maybe at a certain point of disease exacerbation decoupled from one another. Furthermore, one could think that despite the increase of anxious/depressive symptoms, the young man could still have access to a transcendent (spiritual) area of perception, which after becoming abstinent could then have favored the recovery process. The latter assumptions receive some additional support from a study of larger samples of SUD patients, as, for example, [Piedmont \(1999\)](#) was able to show that SUD patients with a higher degree of “Spiritual Transcendence” exhibited better results in the context of a drug withdrawal program. With regard to our single case study, it should be added that the results regarding the efficiency of neurofeedback, in combination with conventional psychotherapy, could subsequently be confirmed by employing larger samples of SUD patients here in Austria ([Lackner et al. 2016](#)).

5.2. Concluding Remarks—Where Do We Go from Here?

In the current literature, there is convincing evidence that topics such as religion and spirituality are still relevant in our societies, which probably can be studied most adequately by means of an interdisciplinary approach ([Pargament 1999](#); [Plante 2007](#); [Thoresen 1999](#)). In correspondence to this, R/S experiences such as those associated with meditation, prayer, and rituals have been described in the biomedical, psychological, anthropological, and religious literature ([Newberg and d’Aquili 2000](#)). In correspondence to this, our findings underline the importance and usefulness of the RSWB dimensions and the application of the MI-RSWB in research and interventions focused on improving mental health ([Unterrainer et al. 2017](#)). While research to date included mostly general psychiatric or SUD patients, who traditionally exhibit a low level of RSWB ([Lackner et al. 2016](#)), research exploring the relevance of RSWB in other specific psychiatric diagnoses is still very much needed.

Overall, the MI-RSWB can be considered a reliable and widely used questionnaire for the assessment of R/S dimensions ([Hodapp and Zwingmann 2019](#)). Regarding the future development of the MI-RSWB, versions in additional languages (Turkish, Portuguese) are currently being prepared for publication. Here, it would also be interesting to further investigate different R/S backgrounds worldwide, in all possible religions (see e.g., [Hiebler-Ragger et al. 2020](#) for further discussion). Lastly, the conceptualization of a treatment manual integrating the RSWB dimensions for the clinical–therapeutic context is currently underway. An initial version of this RSWB treatment program will focus on increasing self-regulation in different groups of psychiatric in- and outpatients.

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