

The role of religiosity and spiritual care in health and well-being *O papel da religiosidade e do cuidado espiritual na saúde e no bem-estar*

[10.29073/jim.v6i1.970](https://doi.org/10.29073/jim.v6i1.970)

Recebido: 27 de dezembro de 2024.

Aprovado: 6 de outubro de 2026.

Publicado: XX de mês de 20XX.

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Abstract

Religion and other forms of spirituality are personal and social resources currently used by millions of people to deal with adversities and search for well-being and self-development. Despite the importance given to physical and mental health, research shows that spiritual care is a core component of human psyche, and social and spiritual well-being is a critical component of holistic care. If among people religion has been seen as an ally for those suffering from illness, several studies support a positive association between religious practices and health and well-being. This paper reviews a range of research into the influence of religiosity and spirituality on physical and mental health, well-being, primary prevention, risk behavior, and social support. Religiosity is discussed as coping strategy, an internal resource for individuals to understand and manage critical situations in their lives concerning health, safety, and well-being.

Keywords: Health; Religiosity; Social Support; Spirituality; Well-Being.

Resumo

A religião e outras formas de espiritualidade são recursos pessoais e sociais atualmente utilizados por milhões de pessoas para lidar com adversidades e procurar o bem-estar e o autodesenvolvimento. Apesar da importância atribuída à saúde física e mental, a pesquisa mostra que o cuidado espiritual é um componente central da psique humana, e o bem-estar social e espiritual é um componente crítico do cuidado holístico. Se, entre as pessoas, a religião tem sido vista como uma aliada para aqueles que sofrem de doenças, vários estudos sustentam uma associação positiva entre práticas religiosas e saúde e bem-estar. Este artigo revisa uma série de investigações sobre a influência da religiosidade e da espiritualidade na saúde física e mental, no bem-estar, na prevenção primária, nos comportamentos de risco e no apoio social. A religiosidade é discutida como uma estratégia de enfrentamento, um recurso interno para os indivíduos entenderem e gerirem situações críticas em suas vidas relacionadas à saúde, segurança e bem-estar.

Palavras-Chave: Apoio Social; Bem-Estar; Espiritualidade; Religiosidade; Saúde.

1. Introduction

The themes of religiosity and spirituality have always accompanied human beings, historically framed within the religious context. Religion is commonly described as a powerful social force, performing vital functions in such a way that, through its spiritual dimension, it becomes inseparable from human existence. Religiosity is “a measure that reflects how deeply and actively people engage with and express their religion” (Papaleontiou-Louca, 2024, p. 811). When dealing with life challenges, literature evidences that it has been attributed greater importance to the individuals’ spiritual and religious dimensions (Glock & Stark, 1965) — Ideological (belief), Intellectual (cognitive), Ritualistic (behavioral), Experiential (feelings and emotions), and Consequential (effects in individuals and groups’ life) — especially concerning resilient strategies in the face of adverse situations, in the way they interferes with cognitions, emotions, learning and behaviors (Mónico, 2011, 2021).

Throughout history, spirituality and religiosity have been seen as allies in the face of adverse situations and search for meaning in life and its vicissitudes, philanthropy, solidarity, cooperation, and active citizenship. The

collateral psychological, social and economic effects of the pandemic by Covid-19 and, more recently, the situations of war (Ukraine, Middle East...), caused an impact on mental health of individuals and on the ways of life in the community, placing, again, on the agendas the centrality of human and social frailty. During these unpredictable and suffering times, the religious and spiritual dimensions of the human being have been intensified. Issues such as contagion, disease, war, death, have occupied the first places in the media, and also in people's minds. The Pew Research study showed that, in 2020, a quarter of U.S. adults stated their faith had become stronger during the Pandemic. People have sought cognitive and emotional balance in connection with their perception of divine: Search for answers, understanding and meaning; Dealing with unpredictability, fear and anxiety; Recovering from suffering and disease; and/or Searching for peace and a more compassionate human being.

Religion consists of a shared system of beliefs, mythology and rituals associated with God or gods. Religiosity is seen as the individual's degree of adherence to the beliefs, doctrines and practices of a religion (Barker & Warburg, 1998). A similar expression to religious experience (Geerts, 1990), it refers to the extent to which an individual believes, follows and practises a given religious doctrine, seen between its two regulating poles - beliefs and rites (Mónico, 2021).

Both religion and religiosity have a manifestation in the form of spirituality, that is, the recognition of a non-material force that transcends all human and non-human endeavours, embodied in the search for meaning, unity, connection and human transcendence (Pargament, 1997). Although many authors refer to religious practice and religiosity using the term spirituality, the former differs from the latter by alluding to a specific doctrinal system of worship of a god and other deities, shared with a group (Koenig, 1999; Yuen, 2007).

Adopting Ellison's (1983) definition, we consider spirituality to be the set of all emotions and convictions of a non-material nature, with the assumption that there is more to life than can be perceived or fully understood, referring to questions such as the meaning and sense of life, not limited to any specific type of religious belief or practice (p. 331). Accordingly, Barros (2008) specifies that Spirituality comes from the Latin spiritus/spirare which means breath, breath, soul, life; spirituality is what gives life, animation, consciousness, what goes beyond the body, what relates us to the divine. Thus, spirituality can be seen as an attempt at self-transcendence and self-realisation and as an existential search for meaning (pp. 28-29). In these terms, and conceptualising the spirit as the immaterial, intellectual and moral component of the human being (World Health Organisation, 1998), spirituality translates into the search for meaning in and for life and the purposes of certain individual occurrences, and is not restricted to certain types of beliefs and/or religious practices (Barker & Warburg, 1998).

This paper aims to explore the relationship between religiosity, spirituality, and health, with a particular focus on their impact on physical and mental well-being. By synthesizing existing literature, the study seeks to: a) Examine how religiosity and spirituality contribute to the prevention, management, and recovery from illness, including chronic and severe mental health conditions; b) Investigate the role of spiritual well-being in enhancing life satisfaction, resilience, and overall quality of life; c) Analyze the protective factors associated with religious and spiritual practices, particularly in promoting healthier lifestyles, reducing risk behaviors, and fostering social support; d) Assess the effectiveness of religiosity and spirituality as coping mechanisms for stress, trauma, and existential crises; e) Highlight the gap in healthcare professionals' training regarding the integration of spiritual care into clinical practice, advocating for its inclusion in therapeutic approaches.

By addressing these objectives, this study contributes to the growing body of research advocating for a holistic approach to health that includes spiritual dimensions.

2. Literature review

2.1. Method

A narrative literature review was employed to explore the relationship between religiosity, spirituality, and health and well-being. A comprehensive search across multiple databases was conducted in WoS, Scopus, Proquest,

Pubmed and other scientific repositories to capture a wide range of studies and provide a holistic view of the topic (Heath et al., 2021; Rahim et al., 2024).

The empirical articles were selected from 1980 onwards. However, important classic works on the subject were also considered. As criteria for the inclusion of the studies, we focused on those that directly addressed the contributions to the relationship between religiosity, spirituality and health and well-being outcomes in the title and abstract. A total of 91 scientific publications was selected. The narrative literature review was conducted based on the information contained in these articles.

This review allows a flexible and comprehensive approach and synthesis of varied and complex literature, providing insights into how religiosity and spirituality impact physical and mental well-being (Ferrari, 2015; Sukhera, 2022). The findings synthesized aims to provide a coherent narrative that highlights the protective factors associated with religious and spiritual practices, identify gaps in the literature and discuss the implications for healthcare policy and practice (Sukhera, 2022).

2.2. Religiosity and Health

William James, the father of modern Psychology, claimed in 1902 that religion prevented certain forms of illness, along with science. Since then, several scientific studies have explored the relationship between religiosity/spirituality and health and well-being (e.g., Bozek et al., 2020). Although the ambiguity of the possible connections between the two interpretations of Man and the Cosmos — that of science and that of religion — has leaned towards the former over the last two centuries, we cannot understand science as an absolute matter, independent of historical, cultural and social ties (Mónico, 2011). Among the people, religion has been seen as a significant ally for those suffering from a particular illness: ‘religions have always been, in part, religions of healing’ (Paiva et al., 2001, p. 18). It is therefore pertinent to ask: to what extent do religiosity and spirituality help in the prevention, acceptance of a chronic illness, adherence to treatment, recovery from an illness, and promotion of well-being?

In 1998, the World Health Organisation (WHO) defined health as a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity. This definition inaugurated the WHO’s awakening to further research into the inclusion of the spiritual aspect in the multidimensional concept of health (WHO, 1998). Until the WHO’s involvement of the non-material dimension of health, Western medicine essentially had two attitudes towards the subject: neglect, as it considered the issue to be insignificant and outside the area of interest and intervention; and opposition, as it characterized the religious experience of patients as a symptom, often of psychopathology, opposing the perspective of Eastern medicinal practice, which has always aimed to interconnect the religious spheres with health promotion (Fabrega, 2000; Mónico, 2022).

Many studies have shown the influence of religiosity on people’s physical and mental health, as well as on primary prevention (Lutkajtis, 2022; Mónico, 2011, 2021, 2022). The pioneering research into the correlates of religiosity and health can be attributed to Osler (1910), an author who warned of the need for health professionals to be aware of patients’ faith. Since this author, a large number of investigations have been conducted in this area, with religion and spirituality being seen simultaneously as beneficial, irrelevant or even dangerous to health, a problem arising from the frequent gap between science and religion (Moreira-Almeida & Lucchetti, 2016; Noddings, 2008; Unger, 2007). In summary, among the various studies, 81 per cent point to the existence of benefits derived from religious practice, 15 per cent find neutral effects and only 4 per cent show negative effects (Skill et al., 1994).

In the Handbook of Religion and Health, Koenig et al. (2012) reviewed more than 3300 studies on the correlation between religiosity and health. Many authors have highlighted the association between religiosity and better perceptions of health, vitality, and quality of life (e.g. Mowat & Ryan, 2002; Mónico, 2022; Talley & Magie, 2014). Others report links between religious practices and a reduction in the onset of illness, as well as a better recovery (Curlin et al., 2007; Hill & Pargament, 2003). Schmidt and Leonardi (2020) highlight that individuals who engage

in spiritual practices often report better mental and physical health, suggesting that spirituality can serve as a protective factor against stress and illness.

A substantial number of studies have also been carried out in the field of mortality rates, with the majority showing a positive association between religiosity and longevity (Mónico, 2022). Some have found a probability of around 29% for highly religious individuals to be alive in any follow-up situation, compared to less religious individuals (McCullough et al., 2000), with regular attendance at religious services explaining a 25% reduction in mortality (Powell et al., 2003). It should be noted that such studies have been documented for all causes of mortality (Ferraro & Albrecht-Jensen, 1991; Idler & Kasl, 1992; Kark et al., 1996; Strawbridge et al., 1997) and, in particular, for deaths due to cardiovascular diseases and cancer (Dwyer et al., 1990; Fensler et al., 1999; Powell et al., 2003). For example, in the case of a heart transplant, there have been lower mortality rates and higher recovery rates after surgery (Harris et al., 1995), as well as a reduction in the risk of repeat myocardial infarctions (Thoresen, 1990). Among cancer diseases, a reduction in mortality was found in patients with breast carcinoma (Sherman et al., 2006).

In addition to being a health-promoting factor, religiosity influences the beginning, course and end of a disease. In individuals with a history of religious practices, there has been greater longevity, healthier lifestyles and a lower incidence of fatal diseases (Koenig et al., 2012; Salsman et al., 2005). Comparative studies show that, in contrast to religious practitioners, non-religious individuals have higher mortality rates for myocardial infarctions (Freedland, 2004), hypertension (Larson et al., 1989), emphysema, arteriosclerosis and other cardiovascular diseases (Zuckerman et al., 1984), as well as other pathologies such as multiple sclerosis, liver cirrhosis, arthritis, osteoporosis, colitis and different types of carcinoma (Fensler et al., 1999; Ferraro & Albrecht-Jensen, 1991; Gordon et al., 2002; McCauley et al., 2008). Religious practices have been associated with an increase in pain tolerance (Benyamini, 2005; Kaczorowski, 1989), a reduction in the more serious consequences of illness and failure to cope with it, as well as better recovery and longer survival (Ai et al., 2004; Ben-Arye et al., 2007; O'Connell & Skevington, 2005).

Although the literature on the correlations of religiosity and spirituality with health and well-being is abundant, there are few studies with samples of people with serious mental illnesses. Research conducted by Corrigan et al. (2003) looked at the comparative impact of religion and spirituality on a sample of institutionalized patients with mental problems who were integrated into a religious institution or merely belonged to the general population. Since religiosity was operationalized as participation in an institutionalized doctrine, while spirituality was defined as the individual search for meaning outside the immediate experience of the real world, the data showed that both were positively associated with psychological well-being and a reduction in psychiatric symptoms in people with serious mental illnesses. These indices were relevant to personal recovery, social inclusion, hope and empowerment, and were less enlightening in terms of the association between spirituality/religiosity and alcohol and drug problems. Nevertheless, participants who described themselves as religious were less prone to anxiety problems, depression or other psychiatric symptoms, and related more well-being in their day-to-day lives. Gonnerman et al. (2008) found also a decrease in loneliness, depressive problems and sleep difficulties in religious participants compared to those who reported not having any kind of religious practice.

In fact, there seems to be growing evidence in the literature that spirituality is a protective factor, both in medical issues and psychological problems, as well as in situations relating to the field of education and community intervention: those who engage in spiritual practices tend to exhibit healthier behaviors, which can lead to better overall health status (Ismail & Karimah, 2024). Levin and Chatters (1998) point to the potential importance of spirituality in terms of possible psychoneuroimmunological and psychophysiological mechanisms in promoting health and, specifically, mental health. These results were also supported by Ahan et al. (2023). The authors explored the interplay between spirituality and health, highlighting how spiritual practices can lead to measurable physiological outcomes. By linking ancient wisdom with contemporary health trends, the study advocates for a paradigm shift in healthcare that recognizes spirituality's importance. They suggest that

integrating spiritual care into health interventions can enhance holistic health and promote sustainable urban societies focused on intergenerational health.

Considering mental health, individuals with strong spiritual beliefs often report lower levels of depression, anxiety, and stress, suggesting that spirituality can serve as a protective factor for mental well-being (Ismail & Karimah, 2024). Religiosity is more strongly related to the end of mental illness than to mortality and the reduction of physical illness (Koenig, 1999, 2012). Many studies indicate a reduction in the onset and improvement of disorders related to anxiety and depression (Berg et al., 2013; Koenig, 1999, 2012; Talley & Magie, 2014; Parente & Ramos, 2018; Roger & Hatala, 2017). Compared to religious individuals, non-religious people are more often diagnosed with psychological problems (Salsman et al., 2005) and associated with suicide, low self-esteem, depression and other dysphoric illnesses (Koenig, 1999, 2012; Nad et al., 2008).

Martins et al. (2021) performed an integrative literature review examining the relationship between religiosity and mental health within the context of holistic care, focusing on 24 studies published from 2010 to 2018. Although the authors identified a beneficial influence of religiosity on individuals with mental disorders, healthcare teams often lack the confidence and training necessary to incorporate religiosity as a facet of spirituality in their practice (Mónico et al., 2022). This gap in understanding and training highlights the need for targeted educational programs that can equip healthcare professionals with the skills to integrate spiritual care into their therapeutic approaches, ultimately enhancing patient outcomes (Martins et al., 2021).

2.3. Protective Factors

Although in the majority of non-experimental studies the multiplicity of residual variability negatively affects the results, the most consistent results are related to the reflection of religion in terms of health benefits, via the promotion of healthy habits (Koenig et al., 2012). Individuals with strong spirituality and religiosity tend to engage in healthier lifestyle choices. For instance, they are more likely to exhibit lower alcohol consumption and other positive health behaviors, which can contribute to better health outcomes (Ismail & Karimah, 2024; Wallace & Forman, 1998). Martin and Carlson (1988) also argue that a spiritual lifestyle is positively associated with a reduction in the incidence of diseases and risk factors, as well as an increase in quality of life.

It has also been found that religious people wear their seatbelts more regularly, visit the dentist and take vitamins (Wallace & Forman, 1998). Subsequent studies have shown that religious children were rated by parents and teachers as having lower impulsivity than other children of the same age (McCullough & Boker, 2007). In adolescents, the majority of research is carried out in schools, where religious practices are protective factors against social problems (Regnerus & Elder, 2003). Religious practice is negatively associated with crime, delinquency, poverty, alcoholism and drug abuse among young people (Saunders et al., 2007). Religiosity is also negatively associated with suicide, deviant behavior, unwanted pregnancy, sexual permissiveness and risky sexual behavior (Barrett et al., 2007). Young religious practitioners also wait longer to begin sexual activity (Regnerus & Elder, 2003). With regard to the relationship between adolescents and their maternal parental figure, Brelsford and Mahoney (2008) found that a closer relationship with religion enables better levels of parent-child relationships and communication, more appropriate conflict resolution strategies, as well as greater relational closeness and less verbal aggression.

2.4. Spiritual Well-Being and Social Support

A recent literature review emphasizes that individuals who incorporate spirituality into their lives often experience greater life satisfaction and a more profound sense of purpose, which can lead to improved overall well-being (Fikri & Karimah, 2023; McCann, 2024). A significant body of researchers found that members of a population defined as believers had subjective well-being measured by increases in self-esteem, optimism, and life satisfaction (Mónico, 2011, 2021; Mónico et al., 2022), as well as happiness, family stability, marital satisfaction, and lower divorce rates (Fagan, 1996). McCann (2024) also highlights a significant link between spirituality and well-being, suggesting that spiritual practices can enhance health outcomes; this includes

addressing issues like addiction and trauma, where spiritual approaches may provide additional support for healing.

Spiritual well-being is also identified as one of the factors that helps to resist the negative effects of stress (Koenig et al, 2012). In addition, compared to non-religious individuals, religious practitioners find it easier to achieve their life goals in such important areas as work, home, and finances (Maton & Wells, 1995). Among university students, intrinsic religiosity was positively related to higher levels of authenticity, greater life satisfaction, and mitigation of mental health issues (Williams et al., 2024). However, Williams et al. (2024) found that the relationship between religiosity and mental health was not uniform across age groups: While intrinsic religiosity played a significant role for younger adults, quest religiosity was more relevant for older adults.

As an indicator of psychological health, the value of spiritual well-being is widely recognized by those who live under oppressive conditions (Hopps et al., 1995). It is already a reference in terms of culture among emigrant communities (Rodriguez, 1996). In addition, it is a coping strategy in stress-inducing situations (Mónico 2011, 2021, 2022). Parente and Ramos (2018) emphasize the loss of children and Ridnour and Hammermeister (2008) sports competition. Some studies also emphasize the effects of religiosity and spirituality on non-religious coping strategies, highlighting cognitive problem-solving and the improvement of distress symptoms (Koenig et al, 2012).

The literature on religion and social support was profoundly influenced by Durkheim's notion of religion. As an integrative and regulatory element, accessible individually to the believer, Durkheim (1897) explains that religion functions as a channel of collective energy, directed towards each individual in particular or towards society in general. In particular, Ellison and George (1994) identified a significantly wider social network among regular churchgoers compared to individuals who didn't participate in religious practices — Regular churchgoers had more frequent contacts with a greater number of people.

Many reasons are given in the literature as to why religious participation (especially if it takes place in a community) promotes social support, proving to be one of the best ways of developing social relationships and combating isolation (Gonnerman et al., 2008; Mónico, 2013). Looking at one of the types of social support provided in religious schools in the 1920s, pupils who spent more time in these schools performed better in tests assessing self-discipline (McCullough & Boker, 2007). Schmidt and Leonardi (2020) review and discuss how different forms of religious experience (community involvement, personal faith, religious practices) contribute to an individual's sense of well-being, and how these elements can enhance life satisfaction and emotional resilience. Several studies have also shown that religion and spirituality lead to better coping strategies (Ano & Vasconcelles, 2005; Mónico 2011, 2021; Pargament & Brant, 1998; Pargament, 1997; Pargament et al., 1988; Parente & Ramos, 2018). It should be noted, however, that a considerable number of studies on social and community support have emerged on the sidelines of analyzing the effects of religious participation, which are largely excluded from many researches.

2.5. Coping Strategies

The results presented have led some authors to view religion as a coping strategy (Mónico 2011, 2021, 2022), especially for chronic illness (Roger & Hatala, 2017) and terminal morbid states (Daaleman et al., 2008; Pargament et al., 2012). The strong relationship between the frequency of prayer and the various dimensions of health in adults was found in a study carried out in nine European countries (Hank & Schaan, 2008), which suggested that religion should be considered one of the relevant factors for future studies on the health of elderly Europeans. A positive relationship was also found between prayer and subjective well-being in the nine nations studied, with some authors recommending it as a form of occupational therapy (Farah & McColl, 2008; Maltby et al., 2008).

According to the World Health Organisation report (1998), the correlations found with subjective well-being and life satisfaction can possibly be explained by the fact that religiosity provides individuals with an internal resource for handling and understanding critical existential situations such as suffering, abandonment, loss, and death.

Religiosity is thus seen as an individual and community psychosocial resource (Fabrega, 2000). Mónico (2011, 2021) found that individuals whose optimism is based on external beliefs are more religious when compared to those who found their optimism on internal beliefs. The author discusses the individual's confrontation with his own frailty, powerlessness and fear, as predetermined factors to disembedding (as it is described by Giddens, 1991, 1997), while reembedding occurs with the individual regaining of self-control, based upon divine factors prone to optimism. In these circumstances, the perceived support is based upon external factors (supernatural help), establishing a self-regulating system which perpetuates religious beliefs and actions.

The integration of spirituality into healthcare practices is increasingly recognized as essential for holistic health (Hvidt & Hvidt, 2019). McCann (2024) emphasizes the necessity for healthcare professionals to understand the cultural and spiritual backgrounds of their clients. This understanding is crucial for providing effective care and fostering a healing environment that respects diverse traditions. Despite this, most clinicians do not receive any training in religiosity/spirituality (Mónico, 2022). In a survey about physicians' attitudes and beliefs about patients' spirituality/religiosity, around 90% of respondents said that physicians should be aware of their patients' spiritual/religious beliefs (Berg et al., 2013). However, in the context of clinical practice, there is a general lack of preparation on the part of health professionals to deal with the issues of patients' religiosity/spirituality, choosing to ignore them (Mónico et al., 2022). The lack of program contents in the curricula of the various health-related higher education courses has contributed to the perpetuation of this reality. Indeed, there is no one-size-fits-all approach to healing (McCann, 2024).

Mental health professionals are not in the habit of asking about their patients' religiosity (Hill & Pargament, 2003), which, according to Bartoli (2007), is a failure to apply a powerful resource for therapeutic purposes, but one that is totally underutilized. In fact, many authors have argued that future professionals should be taught in health schools how to identify and use the spiritual needs of patients in therapeutic counselling (e.g., D'Andrea & Sprenger, 2007; McCann, 2024), with a view to better recovery from illness and health promotion (Hill & Pargament, 2003; Koenig et al., 2012; Mónico, 2011, 2013, 2022); for example, in recovery from problems caused by alcoholism, drugs and separations, religious beliefs and practices prove to be sources of strength (Fagan, 1996). Thus, the term 'religious therapies' emerged to refer to the set of therapies linked to a particular religion or even religious institution. As Fagan (1996) points out, regular religious practices are an individual and social asset, as well as a powerful response to significant social problems. What's more, they are accessible to everyone and don't involve any costs.

Expanding on these insights could lead to innovative approaches in mental health care, integrating spiritual practices alongside traditional therapeutic methods to enhance patient outcomes. Such integrative strategies may empower individuals to cultivate resilience, foster a sense of purpose, and improve their coping mechanisms during challenging times. Research into these integrative strategies can also help identify specific spiritual practices that resonate with diverse populations, ensuring that mental health interventions are culturally sensitive and inclusive. By prioritizing a holistic approach to mental health, practitioners can better address the unique needs of individuals, ultimately leading to more effective and personalized care that acknowledges both psychological and spiritual dimensions. This comprehensive perspective not only enriches the therapeutic process, but also encourages collaboration among mental health professionals, spiritual leaders, and community organizations to create supportive environments that nurture overall well-being. Such collaborative efforts can pave the way for innovative programs that integrate mental health support with spiritual guidance, fostering a community-based approach to healing and resilience (Gross & Rutland, 2015).

Kamya (2000) warns of the importance of working in the field of social education for spiritual well-being. Just as students of social education need to learn new multicultural attitudes and be sensitised to gender issues, racial discrimination and other aspects of diversity, humanities professionals also have an obligation to develop multicultural attitudes that touch on the aspect of spiritual well-being.

In general terms, it is advisable to reframe the areas of health and wellbeing by embracing religion as a powerful ally. In conjunction with education and social work, some authors defend religiosity with a view to improving the human condition. However, we should heed Rémond's warning (2000): the historian believes that turning religion into a kind of therapy with the aim of seeking and achieving physical and psychological well-being is a way of instrumentalizing religion, of not understanding its essence. Religion, whatever it may be, does not consist of any technique that can be used to cure illnesses of the body and spirit, or solve specific problems in life. Even Buddhism, in which concentration techniques are widely used, cannot be considered a therapy. For believers, religion is a way of life, a totality, in which the relationship with God is 'unique and privileged (Rémond, 2000).

3. Discussion and conclusions

Religion has always been understood as a system of culturally shared representations and symbols, organized into beliefs about divine power, which transcends human experience and to which people pay devotion through religious practices (Mónico et al., 2018). In addition to giving meaning to existential vicissitudes, this system establishes a connection with the group, with the environmental ecology and, more generally, with humanity and the Universe (Mónico, 2011, 2015, 2021; Paiva et al., 2001). History and ethnography do not know of peoples without religion. In one way or another, all human societies have been shaped by religious thought. Science and religion have always shaped society and seem to present themselves as two distinct ways of understanding social man, albeit with different sources and verification criteria. People seek religiosity for a variety of reasons, summarised as a search for meaning, solutions and identities, resulting in comfort, ways of controlling and transforming their lives (Mónico, 2021, 2022). However, at no time in human history has there been a record of belonging to just one religion. The issue of religious freedom is emphasised when diversity arises: of ideologies, beliefs and practices, as opposed to the hegemony of a single way of believing and praising. Since religious identity is the part of the self-concept that comes from attachment to a religious doctrine or belief, in order to understand the influence of spirituality and religiosity on an individual's life it is essential to consider the cultural dimension and the role of religious groups in the most diverse cultures.

As a frame of reference for giving meaning to life and anticipating solutions to concrete problems and existential dilemmas, and as an anchor point for identity processes, religion fulfills such vital functions that make it inseparable from human existence itself. Consequently, the effects on those who practice it are manifold, including physical and mental health, subjective well-being, longevity, prevention of risk behaviors, and social and community interventions.

Spirituality and religiosity are also identified as effective coping mechanisms. Individuals who rely on their spiritual beliefs during challenging times are better equipped to handle stress and adversity, which can further enhance their mental and physical health. Focusing on this body of empirical evidence, in 2002 the American Psychological Association recognized the value of religiosity and spirituality in applied psychology and clinical interventions. Generally, studies show that people's religiosity is positively associated with better health and quality of life, supported by healthy lifestyles. However, many of these benefits have been attributed to the rules imposed on religious individuals, as well as the social support they receive from members of their group (McCullough & Boker, 2007).

Agenda 21 Global calls for 'social, economic and spiritual development', recognizing that 'individuals must be allowed to develop their full potential, including healthy physical, mental and spiritual development'. If we think of the 17 Sustainable Development Goals as a pyramid, we can rearrange it into 3 tiers: people, ecology, and spirituality. Sustainable Development Goals 1 to 10 are linked to people harmony, 11 to 15 to sustainability/ecological harmony, while 16 and 17 are related to spiritual harmony. Spiritual and religious practices can promote disease prevention, healthy lifestyle habits, and well-being for all, which corresponds to Sustainable Development Goal 3. Bearing in mind that faith communities are often the only support community, religious practices support diverse issues (e.g., active aging), broadening the interfaith capacity of communities for tolerance. These practices ingrain a sense of righteousness for the larger welfare of society, promoting inclusion (Sustainable Development Goal 16). For this reason, spiritual and religious practices can be recognized

and taken into consideration to promote sustainable peace and general sustainability. They also may allow a change in an exclusive perspective centered on profit, for a better vision of people and the planet (Sustainable Development Goal 17). In this sense, the role of spirituality can be relevant in guiding organizations and leaders in the pursuit of ethical excellence and sustainable development. Recognizing this interconnectedness allows for a richer dialogue about the role of spirituality in contemporary society, where religion can serve as a foundation for ethical behavior and social responsibility. This perspective encourages a reevaluation of how religious traditions can contribute to collective well-being, promoting empathy and cooperation in diverse communities. Such an approach not only deepens our appreciation for the role of faith in shaping moral frameworks but also invites us to consider how interfaith dialogue can bridge divides and foster mutual respect among differing belief systems.

Future research should explore the psychological and biological mechanisms through which spirituality and religiosity can influence health, and also how they influence health and well-being in different contexts (cultural, religious, socioeconomic, etc.). More research is also needed to understand how religiosity works in specific populations, such as patients with chronic diseases, the elderly, or palliative care patients. Cross-cultural and inter-religious comparative studies could clarify whether specific spiritual dimensions (e.g., transcendence, meaning-making, community participation) have universal effects or are culturally bound. As most studies are cross-sectional and adopt a non-experimental design, longitudinal and/or experimental studies are needed to establish causal relationships between religious/spiritual involvement and health and well-being outcomes (e.g., stress reduction, emotional regulation, disease progression/regression). Future research should also address how health systems can effectively integrate spiritual care into multidisciplinary settings, as well as how non-religious expressions such as mindfulness, meaning, or purpose contribute to health and well-being compared to traditional religious frameworks.

Concluding, this narrative literature review concludes that spirituality and religiosity play a crucial role in promoting mental and physical health, enhancing Quality of Life, and encouraging positive health behaviors. These findings suggest that integrating spiritual care into healthcare practices could be beneficial for patients' overall well-being. It also allowed to identify gaps in the literature regarding the integration of spiritual care into clinical practice and the training of healthcare professionals and discuss the implications of the findings for healthcare policy and practice, advocating for the inclusion of spiritual care in therapeutic approaches. Despite some empirical evidence, there are some methodological limitations of research on the consequences of religiosity, in particular the possibility of confounding between the 'religion' variable and the initial health conditions or other genetic, sociodemographic, and behavioural characteristics of the participants. Additional research into this field is necessary.

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Declaração Ética

Conflito de Interesse: Nada a declarar. **Financiamento:** Nada a declarar. **Revisão por Pares:** Simples-cega.



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