

Trends in Spirituality, Religiosity and Health in Adults of Colombia: A Descriptive Study

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ABSTRACT

Background:

Religiosity and spirituality have been associated with different health outcomes. Objectives: Determine the associations between spirituality, religiosity and health outcomes.

Methods:

Descriptive, population-based study, health history, lifestyles and spirituality/religiosity were evaluated. Results: 199 adults participated; The most common mental illnesses were anxiety and depression. 86.4% considered themselves spiritual and 76.4% religious. There were positive and significant associations between female sex and spirituality and between religiosity and self-perception of happiness. A lower frequency of depression was observed in those considered spiritual.

Conclusions:

An association was found between spirituality, religiosity and physical and mental well-being, especially in the perception of happiness and the lower frequency of mental disorders.

Keywords: Spirituality; Religion; Medicine; Mental, Health outcomes.

INTRODUCTION

Religion and spirituality have been part of the human experience since its origins, in ancient cultures, both terms were associated with the search for emotional balance and health. Multiple definitions have been described around the meaning of religiosity and spirituality (1).

The most contemporary concepts have established religiosity as a system of beliefs, spiritual practices or both, organized around the worship of an all-powerful deity or deities and which include behaviors such as prayers, meditations and participation in public rituals (2).

For its part, spirituality has been defined as a motivational construct, which reflects the efforts of an individual to create a broad sense of personal meaning for his or her life or, also as the search for an existential meaning or a transcendent dimension of human experience, which is discovered in the moments in which individual questions arise about the meaning of personal existence (placing the individual in a broader ontological context) (3).

For some authors, spirituality is considered one of the six factors of personality; and this factor is defined as an innate motivation that guides behavior in the effort to build a deeper meaning for life. The previous definitions implicitly carry the fact that religiosity is the way in which spirituality is molded, and that it is expressed through a community or social organization. Therefore, both concepts are different, although highly related and associated with transcendence.

It is established then that spirituality has a broader sense (which can include religiosity) and, therefore, in the same individual there can be, broadly speaking, four positions: a. Being spiritual and religious at the same time; b. Being only spiritual (without participating in any specific religion), c. Living religiosity without the spiritual sense (empty religiosity) and, d. Individuals who do not adhere to any type of belief about transcendence (4–7).

Different authors have been interested in the positive and/or negative effects of spirituality and religiosity on subjective and psychological well-being. Some studies have observed that those who consider themselves religious or spiritual beings tend to have lower subjective and psychological well-being, while others indicate that well-being may be greater.

Thus, it has been found that those individuals who “consider themselves” as religious and/or spiritual tend to have different results regarding subjective and psychological well-being, as well as in aspects such as openness, responsibility, extroversion, kindness, and neuroticism. Likewise, the clinical results of certain diseases may be influenced by religious and/or spiritual beliefs, both positively and negatively (8).

In this sense, most studies have focused on aspects such as psychological well-being, but very few have evaluated the effect it could have on other health conditions, this last aspect being very relevant, since people who suffer from chronic diseases tend to develop a certain emotional resistance, allowing them to generate and elaborate a different sense of life, which is why they elaborate said sense of life with a media effect, causing in many cases that they rethink their way of life, their aspirations, projects and dreams, allowing them to see life with a more holistic vision (integrating socially more easily, for example, with their friends, their partner, their family and their environment).

That is why, a significant number of diseases are related to the way or attitude in which individuals assume certain health conditions and, therefore, affective and cognitive states can influence the response to different treatments. Similarly, those people who discover their own meaning and/or purpose in life (and in whom the desire to continue living is present) tend to express greater emotional well-being, and may eventually respond better to treatments for such diseases (9,10).

Studies that have been designed to assess religiosity and spirituality in clinical contexts other than emotional well-being have focused on aspects such as: anxiety and cardiovascular risk, chronic pain, rehabilitation and adaptation to visual loss, survival in different types of cancer, physical well-being in cancer patients, rate of adverse events due to chemotherapy, treatment of alcoholism and substance abuse, smoking, withdrawal syndrome in individuals with drug abuse, eating habits and disorders, blood pressure levels, risk of HIV infection, levels of interleukins and cytokines, T-cell function, sleep quality and efficiency, suicide risk, cardiovascular mortality, progression of coronary artery disease, blood pressure levels, survival in people with chronic kidney disease, post-stroke rehabilitation, sexual abstinence, obesity, risk of arrhythmias, cardiac autonomy patterns, fertility rate, hospitalization time, among others (4–7,11,12).

Despite the published scientific literature, there are still many gaps in knowledge about how spirituality and religiosity can affect (positively or negatively) various health outcomes; hence the importance of investigating and conducting research on this subject that allows for hypotheses to be formulated and, eventually, determining whether spirituality and religiosity are capable of modifying these outcomes should be highlighted. Based on this theoretical framework, we set out to evaluate whether the spiritual and/or religious component had an association with certain outcomes of interest (insomnia, depression, anxiety, stroke, headache/migraine, among others).

Our research question was: *How can spirituality and religiosity possibly be involved in some common health outcomes in the adult population in Colombia?*

METHODS

A descriptive cross-sectional study was conducted, in which adults ≥ 18 years old participated, from the city of Popayán-Colombia. Non-probabilistic sampling (convenience) was applied through the concentration strategy. The inclusion criteria were: adults (≥ 18 years old) and who completed and signed the consent form.

The study was conducted between June 2023 and May 2024, the information collection technique was applied directly by the researchers, in order to maintain the confidentiality of the information, for this purpose and according to previous studies, an instrument was designed that contained questions about sociodemographic characteristics, family and personal history about their health situation, healthy lifestyles [measured according to the “Fantastico” test], the Personal Spirituality Scales (EEP) and the Personal Religiosity Scale (ERP) were used [13–15].

Fantastico test: This test is a generic instrument that allows to identify and measure the lifestyle of a particular population. It contains 25 closed items that explore nine categories or physical, psychological and social domains related to lifestyle. This questionnaire has a Cronbach’s Alpha coefficient of >0.67

EEP: This scale consists of 12 randomly distributed items; specifically, four items for each dimension (Intrapersonal Connection, Interpersonal Connection and Transpersonal Connection). The scale has a Cronbach’s Alpha coefficient of 0.84

ERP: This scale consists of 12 items organized into two main dimensions (Religious Beliefs/Attitudes, and Religious Practices). The scale has a Cronbach’s Alpha coefficient of 0.96.

The dependent variables were defined as considering oneself spiritual or religious; while the independent variables were the sociodemographic variables, the health status (such as weight, body mass index, comorbidities both physical and mental, variables related to healthy lifestyles such as physical activity, nutrition, consumption of alcohol, tobacco, psychoactive substances and variables regarding self-perception of spirituality/religiosity and state of happiness or sadness).

The information was analyzed in the statistical package SPSS version 25. Descriptive statistical variables were applied and to establish possible associations, the Chi square test and the Fisher test were applied, establishing a level of statistical significance with a p value <0.05 .

RESULTS

The study population consisted of 199 adults, of which 149 (74.9%) were women and 50 (25.1%) were men. The mean (and standard deviation –SD–) age was 27 years (SD: 13.9); 45.7% of the participants lived in a low socioeconomic stratum (1 and 2), 42.2% in a medium stratum and 10% in a high stratum; 75.9% reported having a higher educational level (technical/technological, pre or postgraduate university). Regarding health status, 110 of the participants (55.3%) were considered to have a normal weight, followed by overweight in 66 (33.2%), and 13 (6.5%) had some degree of obesity (body mass index ≥ 30 kg/m²) (Table 1).

Among the comorbidities evaluated, both mental and physical illnesses were found. Among the mental illnesses, anxiety disorders predominated, present in 45 people (22.6%), followed by depression in 33 of them (16.6%). The physical illnesses were broad, from metabolic and cardiovascular diseases to chronic pain syndromes such as migraine, lumbago or fibromyalgia; among them, the most frequent illnesses were migraine and thyroid disorders, representing 21.6% (n=43) and 11.1% (n=22), respectively.

Cardiovascular and metabolic diseases such as high blood pressure, stroke, diabetes and dyslipidemia were found in 18.5% (n=37); sleep disorders (insomnia) were found in 8.5% (n=17) of the participants (Table 2). The most relevant findings regarding lifestyle took into account some of the characteristics evaluated by the FANTÁSTICO Test, focusing in this case on sleep habits, alcohol consumption, tobacco, psychoactive substances, physical activity, use and enjoyment of free time and daily activities; in this sense, it was found that 161 people (80.9%) did not consume tobacco; while 56.3% (n=112) had occasional alcohol consumption;

likewise, 31.7% (n=63) described themselves as sedentary.

On the other hand, 66.4% (n=132) presented some alteration in the sleep pattern (they reported having a restful sleep “sometimes” or “almost never”). The consumption of psychoactive substances (PAS) was found in 9% (n=18) of the participants, with a frequency of consumption defined as “occasional” or “often”; the majority of the participants [93.5% (n=186)] considered that they enjoyed their free time (Table 3).

In relation to spirituality and religiosity, it was found that the majority of people considered themselves spiritual and/or religious (86.4% and 76.4%, respectively), 78.4% (n=156) considered themselves happy people; while 39.2% (n=78) reported feeling sad all the time or most of the time (Table 4).

Additionally, a Chi-square test and Fisher’s test were performed to evaluate the possible associations between the variables studied, finding that, in women, there was a significant association with greater spirituality –with respect to men– (P=0.012); a significant association was also found between spirituality and self-perception of happiness (P=0.002) and also between religiosity and feeling happy (P=0.032).

No significant differences were found between socioeconomic status and spirituality, as well as when evaluating the association between considering oneself spiritual and the consumption of psychoactive substances, although an association was found between this habit and religiosity (P=0.043).

No association was found between religiosity or spirituality and the presence of depression or anxiety. Regarding physical health, a lower frequency (significant) was found in diagnoses such as cerebrovascular disease in people considered spiritual (P=0.045), without documenting it between this aspect and the presence of fibromyalgia or headache (Table 5).

DISCUSSION

This study offers a more comprehensive view of the possible associations between spirituality, religiosity, and some health outcomes. These results may provide some information in the global context of patient care, as it addresses key aspects of mental and physical health in relation to spiritual and religious variables. The demographic composition of this study reflects a predominance of women and a diverse socioeconomic distribution.

This finding is consistent with previous studies suggesting gender differences in spirituality and health (16). In addition, the age of the participants (27 years) highlights the relevance of examining these aspects in young adults, a demographic group that may be particularly susceptible to mental and emotional health challenges.

In Colombia, the results on mental health are notably high for mental disorders such as anxiety and depression, with an approximate prevalence of 4802 cases and 3153 cases per 100,000 (respectively), evidencing the impact on health and disability-adjusted life years (DALYs).

Otherwise, a high frequency of depression was found, representing a third of it, and in them, an inverse relationship with spirituality was evidenced, finding that those considered as spiritual have a lower burden of depression with respect to those considered as non-spiritual (without finding differences with respect to religiosity).

The above contrasts with other studies, where a 22% decrease in the incidence of depression has been found in the religious population, with which we could assume that religion can have a negative or positive impact according to the cultural idiosyncrasy and the type of associated religious practice, for which additional studies should be carried out that measure the type of religious practice and its association with mental health (17,18). Likewise, a wide variety of associations between spirituality, religiosity and mental health has also been found, with less evidence with respect to physical health, this being a broad field to explore (17–19).

In our study, we found multiple somatic conditions, among which diseases such as migraine, thyroid disorders, fibromyalgia and cardiovascular diseases such as stroke stand out, without finding significant associations between spirituality, religiosity and the frequency of fibromyalgia or migraine, differing from other studies,

where it has been found that spiritual and integral intervention is associated with better control of symptoms associated with chronic pain syndrome (such as migraine), associated with a decrease in stress and a decrease in serum cortisol in relation to stress states.

On the other hand, it is highlighted that a relationship was found between spirituality and a lower presence of stroke in our population, however the sample of people with stroke in the study was very small ($n = 7$) which limits the interpretation of these results (19–22). In relation to lifestyle, the results regarding PAS consumption are highlighted, since we found an association between religiosity and a lower consumption of PAS, without obtaining a significant relationship between this variable and spirituality, which goes against previous studies, since the tendency in these studies is towards a significant association between PAS consumption and spirituality (17, 19–21); for example, a significant decrease has been found in relapses of heroin, cocaine/crack consumption in patients who undergo a spiritual intervention with respect to those considered religious, this being explained (probably) by the relationship between spirituality and a greater transcendence of personal values, therefore, this again suggests that religiosity can have a positive impact on health (20–24).

The spiritual and religious dimension also emerges as a significant aspect in this population and their self-perception of mental health status, taking into account that happiness, quality of life and self-perception of well-being go in the same direction (20, 22–25); in our study, a positive and significant association was found between religiosity and spirituality with the fact of feeling a happy person, which correlates with other studies and some systematic reviews, where similar results were evidenced, this tells us that both religiosity and spirituality are important tools in the comprehensive management of patients with mental and somatic diseases, since they positively influence healthy habits and the response to physical and emotional stress, which can impact on different health outcomes (25–27).

Several limitations can be identified in this study, for example, its descriptive nature does not allow for establishing “causal” associations; likewise, a phenomenon of residual confusion may arise, since the population studied was predominantly Catholic (and could “bias”, to a certain extent, the results obtained); it should also be considered that the sample size was relatively small, which may have influenced the power of the study.

Therefore, the studies carried out previously and, in accordance with those found in this research, provide some evidence about these links in different populations and cultural contexts, which reinforces the validity and relevance of the findings presented.

CONCLUSIONS

Spirituality is associated with positive mental health outcomes, and this finding is relevant in spiritual people, but not in religious people. Religiosity and spirituality are significantly related to self-perception of happiness and, therefore, to a better degree of physical and mental well-being. The population considered religious has a lower frequency of PAS consumption, without finding a protective relationship with respect to spirituality.

These results may have relevant implications for the development of interventions and health policies that promote the comprehensive well-being of people, taking into account both physical and emotional aspects, as well as their spiritual and religious dimensions. However, longitudinal studies and clinical trials are needed to validate and expand these findings, as well as to inform clinical practice and the formulation of health policies based on solid evidence in this regard.

Finally, we recommend conducting population-based studies that evaluate the dimensions of spirituality and religiosity in different clinical settings, with “control” groups and interventions based on strengthening both dimensions, evaluating the impact they may have on various health outcomes.

Author Contributions

H V–U, was the main coordinators of the project and were responsible for the conceptualization, writing the original draft, review and editing. All authors led the formal analysis and software and contributed to the review, writing and editing of the present article.

All authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement

The study was performed in line with the principles of the Declaration of Helsinki, and approved by the research ethics committee of the Universidad del Cauca–Colombia (June 2022).

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Data Availability Statement

The data presented in this study are available on request from the corresponding author.

Conflicts of Interest

The authors declare no conflicts of interest.

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Table 1. Sociodemographic characteristics.

Feature	Value	Percentage
Sex	Frequency	
Female	149	74.9
Male	50	25.14
Total	199	100
Age	Median	
Value	27 +/- 13.9	—
Employee	Frequency	
Yes	86	43.2
No	112	56.3
No response	1	0.5
Socioeconomic status	Frequency	
1	49	24.6
2	42	21.1
3	40	20.1
4	44	22.1
5	19	9.5
6	1	0.5
No response	4	2.0
Occupation	Frequency	
Employee	63	31.7
Unemployed	4	2.0
Independent	10	5.0
Student	107	53.8
Informal	10	5.0
No information	5	2.5
Educational level	Frequency	
None	2	1.0

High school	46	23.1
Technician/technologist	21	10.6
Student	81	40.7
Graduate	49	24.6
Ethnic group	Frequency	
Afro-descendant	2	1.0
Indigenous	10	5.0
Mixed	174	87.4
Other	13	6.5

Table 2. Health status.

Body mass index	Frequency	
Low weight	3	1.5
Normal	110	55.3
Overweight	66	33.2
Obesity grade 1	10	5.0
Obesity grade 2	2	1
Obesity grade 3	1	0.5
No response	7	3.5
Hypertension	11	5.5
Diabetes	6	3
Dyslipidemia	13	6.5
Thyroid diseases	22	11.1
Stroke	7	3.5
Anxiety	45	22.6
Insomnia	17	8.5
Depression	33	16.6
Arthrosis	7	3.5
Migraine/headache	43	21.6

Fibromyalgia	6	3
Allergies	35	17.6
Abortions	8	4

Table 3. Lifestyle of participants.

I exercise at least 20 minutes/day	Frequency	
Less than 1 time /week	63	31.7
1 to 3 times/week	64	32.2
4 or more times/week	71	35.7
No response	1	0.5
Daily cigarette consumption	Frequency	
None	161	80.9
1–10 per day	18	9.0
More than 10 per day	15	7.5
No response	5	2.5
I drink more than 4 drinks on one occasion	Frequency	
Often		
Occasionally	16	8.0
Never	112	56.3
No response	63	31.7
	8	4.0
I sleep well and feel rested	Frequency	
Almost always	64	32.2
Sometimes	105	52.8
Almost never	27	13.6
No response	3	1.5
I relax and enjoy my free time	Frequency	
Almost always	102	51.3
Sometimes	84	42.2

Almost never	12	6.0
No response	1.0	0.5
I feel satisfied with my activities	Frequency	
Almost always	110	55.3
Sometimes	76	38.2
Almost never	7	3.5
No response	6	3.0
Use of psychoactive substances	Frequency	
Often	2	1.0
Occasionally	16	8.0
Never	178	89.4
No response	3	1.5
Overuse of prescription and nonprescription medications	Frequency	
Often	11	5.5
Occasionally	42	21.1
Never	144	72.4
No response	2	1.0

Table 4. Assessment of spirituality and religiosity among study participants.

You consider yourself a spiritual person	Frequency	(%)
And	172	86.4
No	25	12.6
Unanswered	2	1.0
You consider yourself a religious person	Frequency	
And	152	76.4
No	47	23.6
Has had a close relative at risk of death	Frequency	
And	125	62.8

No	74	37.2
The diseases that affect him change his religious beliefs	Frequency	
And		
No	55	27.6
Unanswered	140	70.4
	4	2.0
You consider yourself a happy person	Frequency	
And		
No	156	78.4
Unanswered	41	20.6
	2	1.0
How often do you feel sad?	Frequency	
All the time	25	12.6
Most of the time	53	26.6
Sometimes	120	60.3
Unanswered	1	0.5

Table 5. Spirituality and religiosity and aspects of physical and mental health.

Sex						
Female	—	—	—	135	13	0.012
Male	—	—	—	37	12	
Socioeconomic stratum						
1	—	—	—	43	6	0.211
2	—	—	—	38	2	
3	—	—	—	31	9	
4	—	—	—	40	4	
5	—	—	—	15	4	
6	—	—	—	1	0	
No responde	—	—	—	4	0	
You consider yourself a happy person						
Yes	124	32	0.032	141	14	0.002

No	26	15		29	11	
PAS consumption						
Yes	10	8	0.043	14	4	0.25
No	139	39		155	21	
Do you feel depressed or sad						
Almost never	41	14		49	5	
Sometimes	88	22	—	101	9	0.04
Often	22	11		21	11	
No response	1	0		1	0	
Insomnia						
Yes	13	4	—	12	4	0.127
No	139	43		160	21	
Depression						
Yes	24	9	—	23	9	0.008
No	128	38		149	16	
Anxiety						
Yes	35	10	—	36	8	—
No	117	37		136	17	
Stroke						
Yes	—	—	—	4	3	0.045
No	—	—		168	22	
Migraine/headache						
Yes	—	—		38	5	
No	—	—	—	134	20	0.81
Fibromyalgia						
Yes	—	—	—	6	0	1.0
No	—	—		166	25	