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ARTÍCULOS DE REVISIÓN

Review of empirical studies on impact of religion, religiosity and spirituality as protective factors

Revisión de estudios empíricos sobre el impacto de la religión, religiosidad y espiritualidad como factores protectores

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Notas

This research is part of an extensive study performed as part o the author´s PhD thesis.

Summary

The purpose of this article is to review the empirical researches supporting the positive impact of religion, religiosity and spirituality as protective factors in various areas of human life. An analysis of each variable is performed individually and collectively. Among the conclusions of this work, researches show that they help people to have more self-esteem, are a source of strength and hope, are associated with greater satisfaction with life and spiritual well-being and increase the capacity for forgiveness. They provide emotional and social support, promote prosocial values, are associated with less use and abuse of drugs and less tendency to smoke. They help to have better physical and psychological health, contribute to prevention and help to speed recovery and promote tolerance to diseases. They help to decrease depression, anxiety, blood pressure and stress. They contribute to a better adaptation, help to cope with the disease and fear of death. Finally, they help to better deal with disability condition associated with chronic disease.

Key words: Spirituality, protective factor, religion, religiosity, health.

Resumen

El objetivo del presente artículo es revisar las investigaciones empíricas que sustentan el impacto favorable que tienen la religión, religiosidad y espiritualidad como factores protectores en las diversas áreas de la vida del ser humano. Se realiza un análisis de cada variable por separado y en conjunto. Entre las conclusiones se señala que las investigaciones evidencian que contribuyen a que las personas tengan mayor autoestima, son una fuente de fortaleza y esperanza, se asocian a una mayor satisfacción con la vida y bienestar espiritual e incrementan la capacidad de perdón. Sirve de apoyo emocional y social, promueven valores prosociales, se asocian a un menor uso y abuso de drogas y menor tendencia a fumar. Contribuye a una mejor salud física y psicológica, ayudan a la prevención, aceleran la recuperación y promueven la tolerancia frente al padecimiento de enfermedades. Disminuye la depresión, la ansiedad, la presión sanguínea y el estrés. Facilitan una mayor adaptación, contribuyen al enfrentamiento de la enfermedad y temor a la muerte, por último favorece a un mejor afrontamiento de la condición de discapacidad asociada a enfermedad crónica.

Palabras clave: Espiritualidad, factor protector, religión, religiosidad, salud

Introduction

At present, the society is characterized by a high technology development and huge advances in science but, in parallel, there is a great existential emptiness and affective deficiencies translated into a highest prevalence of some anxiety, depression and stress disorders at the global level, which are unfortunately part of life, from very early ages.

Strong emphasis on achievement, accumulation and independence resulted in a greater detachment, loneliness and unhappiness. Family ties, community belonging feeling and social bonds have been seriously affected (Abi-Hashem, 2001, as cited in Martínez, 2006).

It is evident that during the last decades there were significant discoveries and scientific advances, several countries emerged from their underdeveloped state and the level of life has continued to progress with very different rhythms according to each country. However, it seems that a feeling of disenchantment dominate (Delors, 1997). For example, suicide rates according to the World Health Organization (2012) reveal that every year almost one million people commit suicide, which supposes a global mortality rate of 16/100,000, or one death every 40 seconds. Everyday there is an average of almost 3,000 people who end their own life. Moreover, during the last 45 years, suicide rates have increased in 60% worldwide. Suicide is one of three first death causes between people aged from 15 to 44 in some countries, and which is really alarming, the second cause in a group aged from 10 to 24.

Purnell and Paulanka, in 2005 (as cited in Beltrán Guzmán, Torres, Martínez, Beltrán Guerra & Calderón, 2011) stated that the 21st century is consolidated as a diversity age, which is characterized by poverty, migration and political and religious conflicts forming a multicultural range at the global level. According to Jiménez (2005), we live in the context of a globalized economy and in a late modernity culture wherein existential doubts about the sense of life and own identity are an increasing discomfort and psychopathology source.

Of course, there is no doubt that even though progress was made in

science and technology, emotional and behavioral disorders increased in parallel, evidencing thus unimaginable social situations such as parricides, femicides, structural violence, abuses of personal dignity, evident increase in the number of divorces with subsequent family breakdown and an increasingly earlier sexual debut (e.g. in some country at age 10 and 11) with the corresponding consequences derived therefrom, among other problems experienced daily and, in many cases, due to everydayness insensitivity, apathy and dangerous social indifference were generated.

In view of the foregoing, there is a series of research works on the effects caused by religion, religiosity and spirituality in lives of human beings in the world of science, so that it is found that they are protective factors that allow to relieve and mitigate suffering, overcome adversity, reach a greater well-being, quality of life, more transcendence capacity and a sense of plenitude and self-actualization.

Those research works enabled to academically found Psicología de la Religión y la Espiritualidad (Religion and Spirituality Psychology), which refers to experiences and forms of religious participation, believes and spiritual-religious practices, religious coping, conversion and faith (Yoffe, 2007, as cited in Quiceno & Vinaccia, 2009) among other variables. This article is precisely inscribed in this line.

We should recall that, for decades, investigating variables linked to religion and spirituality was avoided for decades because they were not considered scientific. On this regard, Rivera (2007) states that the spiritual area of human life was largely segregated from the field of psychology, and it seems to be necessary at present that a place beyond faith passion and contemporaneous academicism skepticism should be assigned.

According to Miller and Thoresen, 2003 (as cited in Torres, 2003) there are two erroneous presumptions which influenced on underestimating the research: the assumption that spirituality cannot be subject matter of a scientific study and the assumption that spirituality should not be subject matter of a scientific study. According to Mitka, 1998 (as cited in Rivera, 2007) spirituality is a variable preferred not to talk about in the academic world.

In the 21st century, it is undeniable that we live in a scientific community between two contrary poles, one where the increasingly religious and spiritual dimension importance is recognized and another where an attitude of frank rejection and discrimination towards everything that represent them exists because of being incompatible with science or at best, unscientific.

Paradoxically, we can see that in the most developed countries where religious and spiritual dimension has been allegedly weakened inside people, there is a serious interest in scientific community to deal with variables related to faith, religious coping, spiritual conviction, and spiritual well-being, among others translated into significant research works. On the contrary, despite the historical and cultural significance of religion and spirituality in Spanish-speaking populations (Quiceno & Vinaccia, 2009) in the majority of Latin American countries, scientists have not made a research on these variables successfully (with few exceptions) by staying in several academic sectors, even a stereotyped and biased view which avoided to open doors to new knowledge.

Based on the foregoing, this work is purported to review empiric research works supporting the favorable impact of religion, religiosity and spirituality such as protective factors in several areas of human being life.

Studies on Religion Impact as a Protective Factor

Koenig, McCullough and Larson, 2001 (as cited in Quiceno & Vinaccia, 2009) propose that religion is an organized system of beliefs, practices, rituals and symbols designed to facilitate proximity to the sacred or the transcendent (God, a highest power, truth or ultimate reality). According to Vanistendael (2003), religion places spiritual life in a traditional community. This is based on faith in God, looks for community organization and expression, as well as support to spiritual life.

Religion refers to a series of practices and rules according to people's beliefs, but the substrate to them is spirituality, understanding it as that which precisely nurtures religion and gives it sense, that is, faith in God.

Levin, 1994 (as cited in Pérez, Sandino & Gómez, 2005) found out that

religion, particularly, church attendance, provides feelings of positive self-esteem and control as a result of public and private devotion activities, such as religious rites, prayer and meditation upon establishing and keeping a personal relationship with a divine being.

According to Pargament, 1997 (as cited in González, 2004) religion is an active coping strategy to overcome existence problems better, since the person is allowed:

- To look for an existential meaning for certain stressing situations of life.
- To construct or reconstruct life problems or events in terms of meaning.
- To provide coping processes with an existential orientation system.
- To translate the orientation system into specific coping methods.
- To look for meanings in the coping process through mechanisms for conservation and transformation of the meaning from vital events.
- To try to solve problems through several ways that are convincing to them.
- To solve problems through mechanisms inserted in their cultural system.

According to Ellison, Gay and Glass (1991), Ferraro and Koch (1994) Ellison et al., 1991 (as cited in Pérez et al., 2005), religion offers a sense of purpose that other types of social support cannot provide. It can be helpful for people to move forward after traumatic events, and to offer a source of hope to the ones who deal with their problems every day. Religious beliefs may even readjust the meaning of daily life problems for them to appear more manageable, increasing thus general levels of life satisfaction.

Pérez et al., (2005) found a significant negative correlation between the level of depression and the fact of actively belonging to a religious or spiritual group in adults both women and men.

A broad longitudinal analysis on Norwegian health called HUNT, conducted by scientists from the Norwegian University of Science and Technology, based on a sample of 120,000 people, allowed to integrate family and individual data as well as relate this information to the national sanitary records, establishing that church attendance is associated with a low blood pressure. Researchers found out there was, concretely, a positive relationship between time at church and a low blood pressure, both in men and women,

verifying that while more frequently participant people attended church, their blood pressure was lower. In other words, more actively religious people were healthier than non-actively religious ones (Lorenzo, 2012).

Other studies suggest that religion support effects are stronger for women. In 1994, Ellison et al., (as cited in Pérez et al., 2005) found out that religious women who regularly attended church reported to receive more benefits of social and expressive support than men and those women did not frequently attend church.

Religion plays an important role in coping with sickness and psychological stress (Handal, Black-López & Moergen, 1989; Williams, Larson, Buckler, Heckmann & Pyle, 1991; Pargament, 1997). It is associated with the capacity to forgive (Rye et al., 2000), kindness (Ellison, 1992), compassion (Wuthnow, 1991) and involvement in church according to Hodgkinson, Weitzman and Kirsch (1990), Schervish (1990), Regnerus, Smith and Sikkink (1998), Smith, Fabricatore and Peyrot (1999), Mattis et al., (2000). Besides, it is usually a predictor of altruism, volunteering and philanthropy (as cited in Martínez, 2006).

For other authors, religion is identified as a source of social support, help, strength, and hope in the middle of situations of sickness and disability. There is much documentation which indicates that believing in God and asking for his support helps a lot of people to cope with their limitations (Narayanasamy, 2002; Saudia & cols, 1991, as cited in Sánchez, 2009a). Likewise, prayer is related to feeling of control, and it is taken into account as a form of internal motivation. On this regard, many authors found that beliefs and religious practices tend to rationalize suffering, reduce stress, are a source of self-care and contribute to avoid depression (Sánchez, 2009a).

Research shows a relationship between religious beliefs and health maintenance and recovery, dealing with issues from the positive evolution of symptoms and behaviors to interventions. For example, the relevance of a religion for psychotherapy (Bergin, 1991), the promotion of a more positive state of mind (De Miguel, 1994), life satisfaction (De Miguel, 1996), lesser probability to be involved in smoking behavior (De Miguel, 1994/1996), recovery from alcoholism (Vaillant, 1995) and use of drugs in general (Avants,

Warburton & Margolin, 2001; Ahmed, Brown, Gary & Saadatmand, 1994), control of blood pressure (Steffen, Hinderliter, Blumenthal & Sherwood, 2001), cancer prognosis (Feher & Maly, 1996), anxiety reduction (Koenig et al., 1993), relief from depression (Commerford & Reznikoff, 1996) and stressing events (Shams & Jackson, 1993) in general (as cited in González, 2004).

Studies on the Impact of Religiosity as a Protective Factor

Religiosity is the behavioral expression of a system of organized beliefs, doctrine and ceremonies of religion. Religiosity is lived in the social sphere as a body of knowledge, behaviors, rites, rules and values governing or attempting to govern life of people interested in being associated with the divine. It is intended to be a commitment (not always achieved) to beliefs and practices which are a characteristic of a particular religious tradition (Peteet, 1994), expressed according to Walker and Pitts (1998) in creeds and rituals (as cited in Rivera, 2007).

Results from some research works seem to be clearly enough regarding relations between religiosity and subjective psychological well-being, vital satisfaction and achievement of the existential sense, some aspects that are closely related between each other. In 1978, Hadaway and Roof (as cited in Gallego-Pérez, García-Alandete & Pérez-Delgado, 2007) established that people considering religiosity as important expressed a bigger existential happiness and a highest hope to configure their own life, than the ones who did not appreciate it at all.

It was found that there is a negative association of intrinsic religiosity with anxiety and depression (Koenig, George & Siegler, 1988) and a negative association between religiosity related to religious organizations and depression (Strawbridge et al., 1998); as well as a relationship between the dimension of religiosity "personal devotion" and lower levels of depressive symptomatology (Kendler, Gardner & Prescott, 1997). Also, a greater religiosity was associated (Kendler, Gardner & Prescott, 1997; Kendler et al., 2003) with a lesser drug abuse (as cited in Rodriguez, 2006).

Other works follow the same direction, finding positive relations

between intrinsic religiosity and sense of life (Bolt, 1975; Crandall & Rasmussen, 1975) between vital satisfaction and attendance to religious worship (Hadaway & Roof, 1978; McClure & Loden, 1982); between self-esteem and achievement of sense of life in people experiencing feelings of belonging to "moral communities", particularly religious (Johnson & Mullins, 1990); between religiosity and the sense of life in elderly people (Gerwood, LeBlanc & Piazza, 1998); between religiosity, happiness, sense of life and self-actualization (French & Joseph, 1999); between mysticism, vital satisfaction and sense of life (Byrd, Lear & Schwenka, 2000); between subjective feeling of happiness and frequency of attendance to religious services, religious auto-definition, doctrinal orientation and belief in the fact that religion gives a perception of achievement of sense that would be a basis for personal well-being (Ferris, 2002); and according to Frederickson (2002) between religiosity and experience of positive fully-sensed emotions (as cited in Gallego-Pérez et al., 2007).

Moreover, positive effects of religiosity on mental health have been explained based on the following parameters: lesser use of drugs between religious people, bigger possibilities of social support, finding a sense in adverse situations based on a system of beliefs which given them sense and an additional resource to cope with stress (Smith, McCullough & Poll, 2003, as cited in 2006).

There are studies addressing favorable impacts of religiosity on health and in particular, on coping with cancer. For example, a research with hospitalized patients with cancer showed that religiosity has a positive correlation with satisfaction with life in general and a negative correlation with hopelessness (Ringdal et al., 1996). It was found that there is a relationship between intrinsic religiosity and spiritual well-being and hope in patients with cancer (Mickley & Soeken, 1993) and higher rates of depression reduction (Koenig, George & Peterson, 1998) in hospitalized elderly patients who have a greater intrinsic religiosity (as cited in Rodriguez, 2006).

Booth, Johnson, Branaman and Sica (1995) informed about high and direct correlations between religiosity and marital adaptation. In addition, doing rituals (for example, attend to the temple, participate in religious organizations, follow religious precepts) are facilitating agents of marital

adjustment (Wilkinson & Taner, 1980; Wilson & Flisinger, 1986). Bahr and Chadwick (1985) found that practicing a religion as well as attending to a religious service are associated with marital satisfaction. These authors found that more religious people tend to remain married for a longer period of time (as cited in Montero & Sierra, 1996).

Studies on Impact of the Spirituality as Protective Factor

Regarding spirituality, in 1991 Reed (as cited in Rodríguez, Fernández, Pérez & Noriega, 2011) proposed that the capacity for self-trascendency that allows people to wide personal borders and be oriented towards activities and objectives going beyond themselves, without rejecting the value of being in the present and favoring their maturing. In 1995 Ross (as cited in Rodríguez et al., 2011) stated that it is the understanding of the meaning and purpose, together with the willingness to live and faith in oneself, in others or in God.

For authors like Burkhart and Solari-Twadell (2001), Ferrer (2001), Monge and Benito (1996) and Gotterer, 2001(as cited in Martínez, Méndez & Ballesteros, 2004), the search for the meaning of life refers to the spiritual dimension of the person. According to Koenig, 2008 (as cited in Quiceno & Vinaccia, 2009), the concept of spirituality exceeds the limits of religion and of moral, especially in the Western world, until it becomes a construct widely studied by the health field.

Several studies suggest that the practice of spiritual activities can influence through positive emotions such as hope, forgiveness, self-steem and love, which can be important for mental health, through psychoneuroimmunology and psychophysiological action mechanisms (Gastaud et al., 2006).

Spirituality has been associated with lower mortality rates, less likely to develop depression, lower risk of cirrhosis, emphysema, suicide and death caused by cardiac ischemia, as well as less use of hospital services, and even less tendency to smoke. Moreover, the revision of more than 250 studies made by Levine in 1997 showed a reduction of cancer and other chronic illnesses, which was consistent with different religions and cultures (as cited in Pinto, 2007).

Several research works have shown an important implication of the spiritual dimension when facing disease and positive correlations between recovery and spirituality indexes (Mueller, Plevak & Rummans, 2001; Mytko & Knight, 1999), as well as between spiritual well-being and quality of life, and between spiritual well-being and adjustment to disease situations have been found (Cotton, Levine, Fitzpatrick, Dold & Targ, 1999; Brady, Peterman, Fitchett, Mo & Cella, 1999). Spirituality is a way of coping, more than a way of rejection or avoidance for patients, and some research works have shown that many patients would desire that their physicians talk about it (Mytko & Knight, 1999; Reiman, 1999) with them (as cited in Martínez et al., 2004).

Whetsell, Frederickson, Aguilera and Maya (2005) found a positive relationship between the levels of spiritual well-being and levels of strength related to health in a group of elderly people. Such authors state that high levels of spiritual well-being for the people studied mean that the nearness to God shows the way to achieve the adaptation in view of aging challenges (perception of environment as a source of opportunities and not of obstacles).

Other findings associated with the influence of spirituality on physical health, show that people who usually go to church, pray individually and read the Bible, have a much lower diastolic blood pressure than those who are less religious, they have fewer hospitalizations, tend to have healthier lifestyles, tend to avoid the abuse of alcohol and drugs and risky sexual behaviors. People who usually attend religious services have stronger immune systems than those who are less religious, and show significantly better results when suffering a disease than those who are less religious (Koenig, 2001 as cited in San Martin, 2007).

In patients with cancer, spirituality improves the immune function, increases survival, reduces the symptoms of the disease and adverse effects of treatment, favors lifestyles and healthier behaviors, and therefore, contributes to a lower risk of diseases, and in general, it improves quality of life (San Martin, 2007). Spirituality is associated with terminal disease in several aspects. The nearness to death appears to change it and some reports indicate a higher level of spiritual perspective in this situation (Coward & Kahn, 2005; Reed, 1991, cited in Sánchez, 2009b).

For example, in 1999, Feher and Maly (cited in Martínez et al., 2004) carried out a study with women with breast cancer, concluding that religious or spiritual beliefs were maintained or increased during the disease as an emotional support for 91% of women who participated in the study; patients found out the way to provide meaning to their life, specially during their experience with cancer.

Other researchers have documented the relationship between spirituality and health and between ritual development and religious practices and quality of life (Santos, 2000; Sprangers & Schwartz, 1999), how beliefs affect lifestyle (Avants, Warburton & Margolin, 2001), treatment (Matthees, Anantachoti, Kreitzer, Savik, Hertz & Gross, 2001), decisions on health care (Haddad, 1999; Gillman, 1999) and perception of the disease situation (Morrison & Thornton, 1999), as well as the association according to Haynes and Watt (2008) between spirituality and healthy behaviors (as cited in Sánchez, 2009a).

From the therapeutic perspective, the impact of spirituality on behavior when facing a disability condition was studied and documents showing how patients with disabling chronic illness could improve behaviors or results of some treatments, the way how spirituality had influence on their adaptation, association between beliefs and fears of hospitalized patients, strategies for positive coping, patterns of such coping and its relation to stress, association between values and coping, and support in positive coping day by day, were found. It seems to be a wide consensus between different authors when stating that spirituality can be useful for the care of those who have a disability condition associated with chronic illness, and that it provides tools allowing them to better face that situation and find meaning in experience to accept, grow and transcend (Sánchez, 2009a).

Studies collectively addressing the Impact of Religion, Religiosity or Spirituality

Since variables are closely related, there are studies where effects caused by each one are not differentiated, but their effects have been collectively investigated (since they address two or three of the studied factors) as follows.

Koenig, McCullogh and Larson en el 2001 (as cited in Jiménez, 2005) provided a critical, systematic and wide analysis of more than 1200 empirical studies and 400 revisions that analyzed relationships between spirituality and religion and several physical and psychic conditions. Correlational and longitudinal studies about heart diseases, hypertension, cerebrovascular disease, immunological dysfunction, cancer, mortality, pain and disability showed a 60% to 80% relationship between better health and religion or spirituality. Psychiatric conditions revised were psychosis, depression, anxiety, suicide and personality disorders. According to these authors, spirituality benefits are three: they contribute to prevention, speed recovery and promote tolerance to suffering.

Early religious and spiritual commitment plays an important role in the promotion of prosocial values (Mattis et al., 2000), and religiosity has been associated, in children and adolescents, with less antisocial activities (Johnson, Larson, Li & Jang, 2000) and a better academic performance (Donahue & Benson, 1995). Young people with more religious participation notice the world as a more consistent place (Bjarnason, 1998), and several studies offer positive correlations between several spirituality and religiosity measures and several adaptative personal and familiar aspects (as cited in Martínez, 2006).

Religiosity/spirituality and mental health appear to be positively related (Gastaud et al., 2006). In 2003, Hill and Pargament (cited in Rodriguez, 2006) stated that spiritual beliefs can provide support and stability in time of crisis, and they also can provide a feeling of ultimate meaning, even in very stressing vital situations; providing a unifying philosophy of life. These aspects are those that could be related to a better mental health in people with these characteristics. Variable that has been linked to a better health mental, such as the emphasis on having virtuous behaviors, social support, prayer, could be associated with such aspects.

Religion and spirituality play an important role in the life of several people, and patients frequently use spiritual and/or religious practices as a way to cope with stress caused by their condition (Ferrell, 2003; Flannelly, Weaver & Costa, 2004; Koenig, Pargament & Nielsen, 1998; Stefanek, McDonald & Hess, 2005; Taylor, 2001). Many patients say that they trust that

their religious and spiritual beliefs help them to successfully copy with stress provoked by such disease (Koenig, Pargament & Nielsen, 1998; Silberfarb et al., 1982 y 1991) or to adapt to that situation (Jenkins & Pargament, 1995). Koenig, George and Siegler (1998) found, in a study on attitudes and religious practices in hospitalized elderly patients, that around 40% of them said that their religious faith was the most important factor to face the situation (as cited in Rodriguez, 2006).

Regarding the adequate adaptation to disease, there was a relationship between spiritual believes and religious practice with the best adaptation to cancer situation (Jenkins & Pargament, 1995). The following specific aspects of such beliefs have been related to such positive adaptation: having an important sense of life and going to church (Acklin, Brown & Mauger, 1983), religious practice (Fenring et al., 1997), spiritual well-being (Kaczorowski, 1989), spiritual consciousness (Smith et al., 1993) and religious thoughts -Fehring, Miller and Shaw, 1997 (as cited in Rodriguez, 2006).

On the other hand, there was a positive relationship between intrinsic religiosity and hope, and between spiritual well-being and other positive moods in cancer patients (Fehring, Miller & Shaw, 1997). Those with better spiritual well-being showed less desire to die. (Breitbart, 2000). Several studies showed that strong religious beliefs in cancer patients were associated with low levels of pain, anxiety, hostility and social isolation and with higher levels of satisfaction with life (Acklin, Brown & Mauger, 1983; Holland et al., 1998; Kaczorowski, 1989; Koenig et al., 1992; Yates et al., 1981). Some patients have stated that such beliefs help them to have higher levels of well-being (Rowland, 1989b) and they are associated with lower levels of pain in patients with advance cancer (Yates et al., 1981). Such higher levels of well-being have been related to social support contributed by the fact of being part of a religious community (as cited in Rodriguez, 2006).

Spirituality also has an important influence on longevity, facing death and vital satisfaction. In 2011, Koenig (as cited in San Martin, 2007) found that elderly people who have a deep and personal religious faith has a greater sense of well-being and vital satisfaction compared to the less religious ones. Besides, he found that elderly people tend to rely more on their religious faith and prayer; when they are under stress, they tend to have far less or

no fear of death, when compared to their peers for whom faith and prayer are less important. Personal faith seems to help elderly people to cope with stress and fear of death rather than the religious activity itself. Religious faith seems to protect elderly people from the two most important afflictions of the end of life, cardiovascular disease and cancer, and it also seems to avoid for a longer time becoming disabled.

On the other hand, Canaval, González and Sánchez (2007) performed a study with abused women and they found that spirituality becomes an important resource for women who experience violence situations and it helps them to start and keep a change process that can lead to solve the conflict. The fact that more women make spiritual practices than men, mainly at religious level, could reflect an adaptative behavior; such behavior makes women find a resource of strength and effective adaptation (Rodríguez et al., 2011) specially when facing diseases, mistreatment, abuse or adversity in general.

Conclusions

1. The scientific research works show the important role of the religion, religiosity, spirituality as protecting factors in people´s life, which is evidenced not only in their health but also in the way how they interact with the environment, affecting their family, romantic, academic, work and social relations and impacting their visions about themselves and the world around them.

2. Based on the scientific research works, the following aspects can be stated:

a) Religion contributes to a greater sense of purpose and control feeling; it is associated with kindness and compassion. It is an altruism, volunteerism and philanthropy predictor. It serves as a strategy of active coping to overcome problems and help to rationalize suffering.

b) Religiosity provides a greater subjective psychological well-being, a better sense of meaning in life, happiness and self-actualization, and contributes to a better marital adaptation, satisfaction and adjustment.

c) Spirituality is associated with a better quality of life, healthier life styles, tendencies to avoid risky sexual behaviors, stronger immune systems, an increased life expectancy in cancer patients, lower mortality rates, less use of hospital services, as well as cancer reduction and chronic illnesses.

d) Research works together show that religion, religiosity and spirituality help people to have more self-steem, are strength and hope sources, are associated with a greater satisfaction with life and spiritual well-being and increase the capacity to forgive. They serve as emotional and social support, promote prosocial values, are associated with a less use and abuse of drugs and less tendency to smoke. They contribute to a better physical and psychological health, to prevention, speed recovery and promote tolerance to diseases. They reduce depression, anxiety, blood pressure and stress. They contribute to a better adaptation; help to cope with disease and fear to death, and to better cope with disabling conditions associated with chronic disease.

3. It must be emphasize that benefits of religion, religiosity and spirituality for human well-being are highly favorable, when they are experienced and lived through without fanaticism, dogmatism and any kind of impositions.

4. Although the increasing interest of science in the field of Religion and Spirituality Psychology, there is still a long way to go, since there are not rigorous theories and therefore, its epistemological status is still weak, thereby being one of the main challenges that must be faced in a near future. In this sense, it is essential to leave aside prejudices and stereotypes and on the contrary, sustained efforts must be put on performing research works with scientific precision to deal with challenges of wealth and complexity of the human being.

References

Beltrán Guzmán, F., Torres, I., Martínez, G., Beltrán Guerra, L. & Calderón, M. (2011). Valoración del sentido de vida y la autoestima en estudiantes

universitarios de Psicología. *Revista electrónica Medicina, Salud y Sociedad*, *1* (3), 1-23.

Canaval, G., González, M. & Sánchez, M. (2007). Espiritualidad y resiliencia en mujeres maltratadas que denuncian su situación de violencia de pareja. *Colombia Médica, 38* (2), 72-78.

Delors, J. (1997). *La educación o la utopía necesaria.* En J. Delors et al. *La educación encierra un tesoro. Informe a la UNESCO de la Comisión Internacional sobre la Educación para el siglo XXI.* (pp.7-30). Paris: Unesco. Recuperado de http://www.unesco.org/education/pdf/DELORS_S.PDF

Gallego-Pérez, J., García-Alandete, J. & Pérez-Delgado, E. (2007). Factores del Test purpose in life y religiosidad. *Univ. Psychol, 6* (2), 213-229.

Gastaud, M., Souza, L., Braga, L., Horta, C., De Oliveira, F., Sousa, P. & Da Silva, R. (2006). Bem-estar espiritual e transtornos psiquiátricos menores em estudantes de Psicologia: estudo transversal. *Rev. Psiquiatria, 28* (1), 12-8.

González, T. (2004). Las creencias religiosas y su relación con el proceso salud-enfermedad. *Revista Electrónica de Psicología Iztacala* Vol. 7 (2), 19-29. Recuperado de www.iztacala.unam.mx/carreras/psicologia/psiclin/.../vol7no2art2.pdf

Jiménez, J. (2005). La espiritualidad, dimensión olvidada de la Medicina. *Revista Gaceta Universitaria*, *1*, 92-101.

Lorenzo, M. (2012). *La religiosidad podría reducir la hipertensión, según un estudio.* ForumLibertas.com Diario digital 17/02/2012 – Sociedad. Recuperado de http://www.forumlibertas.com/frontend/forumlibertas/noticia.php?id_noticia=22168&id_seccion=8

Martínez, M., Méndez, C. & Ballesteros, B. (2004). Características espirituales y religiosas de pacientes con cáncer que asisten al centro javeriano de oncología. *Univ. Psychol. 3* (2), 231-246.

Martínez, Ma. (2006). El estudio científico de las fortalezas trascendentales desde la Psicología Positiva. *Clínica y Salud, 17* (3), 245-258.

Montero, M. & Sierra, L. (1996). Escala de Bienestar Espiritual: un estudio de validación. La Psicología Social en México, *AMEPSO, 6*, 28-33.

Organización Mundial de la Salud (2012). *Prevención del suicidio* (SUPRE). Recuperado de http://www.who.int/mental_health/prevention/suicide/suicideprevent/es/

Pérez, A., Sandino, C. & Gómez, V. (2005). Relación entre depresión y práctica religiosa: un estudio exploratorio. *Suma psicológica*, *12* (1), 77-86.

Pinto, N. (2007). Bienestar espiritual de los cuidadores familiares de niños que viven enfermedad crónica, *Investigación en Enfermería: Imagen y Desarrollo,* 9(1), 20-35.

Quiceno, J. & Vinaccia, S. (2009). La salud en el marco de la psicología de la religión y la espiritualidad *Diversitas Perspectivas en Psicología*, *5* (2), 321-336.

Rivera, A. (2007). *Modelo de intervención racional emotivo para la promoción del ajuste psicológico en el adulto mayor en un contexto religioso.* (Tesis doctoral). Universidad Nacional Autónoma de México. México.

Rodríguez, Ma. (2006). *Afrontamiento del cáncer y sentido de la vida: un estudio empírico y clínico.* (Tesis doctoral). Universidad Autónoma de Madrid. España.

Rodríguez, M., Fernández, M., Pérez, M. & Noriega, R. (2011). Espiritualidad variable asociada a la resiliencia. *Cuadernos Hispanoamericanos de Psicología, 11* (2), 24-49.

Sánchez, B. (2009a) Bienestar espiritual en personas con y sin discapacidad. *Aquichan, 9* (1), 8-22.

Sánchez, B. (2009b). Bienestar espiritual de enfermos terminales y de personas aparentemente sanas. *Investigación y Educación en Enfermería, 27* (1), 86-95.

San Martin, C. (2007). Espiritualidad en la tercera edad. Psicodebate 8. Psicología, Cultura y Sociedad. pp.111-128. Torres, W. (2003). *Utilización de internet y el bienestar psicológico en estudiantes universitarios de alto y bajo nivel de acceso a la tecnología de información por computadora.* (Tesis doctoral). Universidad Nacional Mayor de San Marcos. Lima, Perú.

Vanistendael, S. (2003). *Resiliencia y espiritualidad. El realismo de la fe.* Ginebra, Suiza: Oficina Internacional Católica de la Infancia.

Whetsell, M., Frederickson, K., Aguilera, P. & Maya, J. (2005). Niveles de bienestar espiritual y fortaleza relacionados con la salud en adultos mayores. *Aquichan, 5* (1), 72-85.