

Systematic Review

Spirituality and Mental Health Among Vulnerable Women: A Systematic Review

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Abstract

Spirituality and religiosity are increasingly recognized as important factors influencing mental health, particularly among women exposed to diverse vulnerabilities such as interpersonal violence, trauma, HIV infection, homelessness, and socioeconomic disadvantage. This systematic review aimed to synthesize evidence on the associations between spiritual or religious resources and mental health outcomes in these populations. A systematic search was conducted in Scopus, PubMed, and Web of Science to identify studies examining the association between spirituality, religiosity, and mental health outcomes in vulnerable women. A total of 28 studies were identified, including cross-sectional, longitudinal, and mixed-methods designs, which measured spirituality and religiosity using validated instruments such as SWBS, DUREL, FACIT-Sp-12, and Brief RCOPE, alongside standardized mental health measures. Narrative synthesis revealed that the majority of studies ($n = 15$) reported that higher spiritual well-being, intrinsic religiosity, and adaptive religious coping were associated with lower depression, anxiety, and post-traumatic stress, and with higher resilience, quality of life, and post-traumatic growth. These associations appeared to be shaped by contextual factors, including the type and severity of trauma, cultural and religious frameworks, and the lived experiences of the populations studied. Negative associations were primarily linked to negative religious coping ($n = 5$ studies), rather than religiosity per se. Additional factors that attenuated or reversed the expected positive effects included higher trauma severity or ongoing adversity ($n = 4$), reactive patterns in which greater psychological distress was associated with increased use of religious coping ($n = 3$), maladaptive religious beliefs such as interpretations of trauma as divine punishment ($n = 2$), and cultural or contextual influences ($n = 3$). Overall, the evidence suggests that spirituality and specific dimensions of religiosity (e.g., intrinsic religiosity, religious coping) can support mental health among vulnerable women, though personal, cultural, and situational factors shape their impact. These findings suggest the potential value of integrating spiritual resources into interventions and the need for further longitudinal and culturally sensitive research.



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Keywords: spirituality; religiosity; mental health; vulnerable women; intimate partner violence; trauma; coping; post-traumatic stress; depression; anxiety

1. Introduction

The relationship between spirituality and mental health has emerged as a critical frontier in healthcare, particularly for vulnerable populations. Spirituality and religiosity are related but conceptually distinct constructs that are often used interchangeably in the literature. Spirituality is generally understood as a broad, multidimensional construct involving a sense of meaning, purpose, and connection to something transcendent or sacred, which may or may not be expressed within formal religious frameworks [1,2]. In contrast, religiosity typically refers to engagement with organized systems of beliefs, practices, and rituals associated with institutional or community-based religion, including attendance at services, doctrinal adherence, and participation in religious activities [3,4].

Among vulnerable female populations, including those affected by socioeconomic deprivation and domestic instability, psychological distress is often compounded by the structural realities of social marginalization [5]. Consequently, elucidating how spiritual beliefs and practices influence mental health outcomes in this demographic is imperative for the design of culturally congruent and efficacious clinical interventions [6]. In this review, “vulnerable women” refers to populations exposed to substantial and well-established risk factors for adverse mental health outcomes, including interpersonal violence, trauma, chronic illness, forced displacement, homelessness, and severe socioeconomic disadvantage. This definition is grounded in the presence of structural, social, or health-related adversity that significantly increases the risk of psychological distress, rather than in more general or situational challenges.

Current research indicates a robust, generally positive correlation between spiritual involvement and psychological resilience. Extensive studies suggest that high levels of spiritual well-being are associated with reduced symptoms of depression and anxiety [7,8]. However, the field is characterized by divergent theoretical perspectives concerning the nature of this relationship. One prominent school of thought, the ‘Spirituality as Resilience’ hypothesis, contends that spiritual frameworks facilitate cognitive reframing, thereby serving as a protective buffer against the deleterious effects of trauma [9]. Alternatively, the ‘Spiritual Bypass’ hypothesis suggests that certain metaphysical frameworks can function maladaptively. By framing psychological distress through a lens of moral failing or divine punishment, individuals may experience intensified internal conflict and a prolonged latency in seeking professional clinical intervention [10,11].

Despite the proliferation of primary studies, there remains a lack of synthesized evidence specifically focusing on the “vulnerability” intersection of gender and socioeconomic instability. Much of the existing literature is fragmented across different cultural contexts, making it difficult for practitioners to implement unified evidence-based strategies [12].

This systematic review seeks to consolidate contemporary literature regarding the spiritual-mental health nexus among women facing systemic adversity. The analysis reveals that spirituality serves as a robust protective factor; however, its therapeutic value is mediated by the ‘quality’ of spiritual engagement. The findings underscore that integrating spiritual metrics into routine mental health evaluations remains a pivotal, though neglected, strategy for pursuing health equity [13,14].

2. Results

A total of 1378 records were identified through the database and other searches. After removing duplicates, 1035 records were screened based on title and abstract, of which 244 full-text articles were assessed for eligibility. Following this assessment, 28 studies met the inclusion criteria and were included in the review. Several full-text articles initially appeared eligible but were excluded for specific reasons, including not meeting the inclusion criteria. In the study “Post-Traumatic Stress Disorder and Coping Strategies Among

People with HIV in Lira District, Uganda: A Cross-Sectional Study”, results were reported for the overall sample, and although gender was included as a covariate in the analysis, the outcomes were not disaggregated by gender. Specifically, the study reported that being male was associated with lower odds of PTSD compared to females (AOR = 0.49, 95% CI 0.30–0.81, $p = 0.005$), but separate effect estimates or subgroup analyses exclusively for women were not provided. Consequently, the study does not allow for gender-specific interpretation of PTSD prevalence or coping strategies among women living with HIV in this setting [15].

A flow diagram illustrates the complete search and selection process, showing the number of records at each stage from identification to final inclusion (Figure 1).

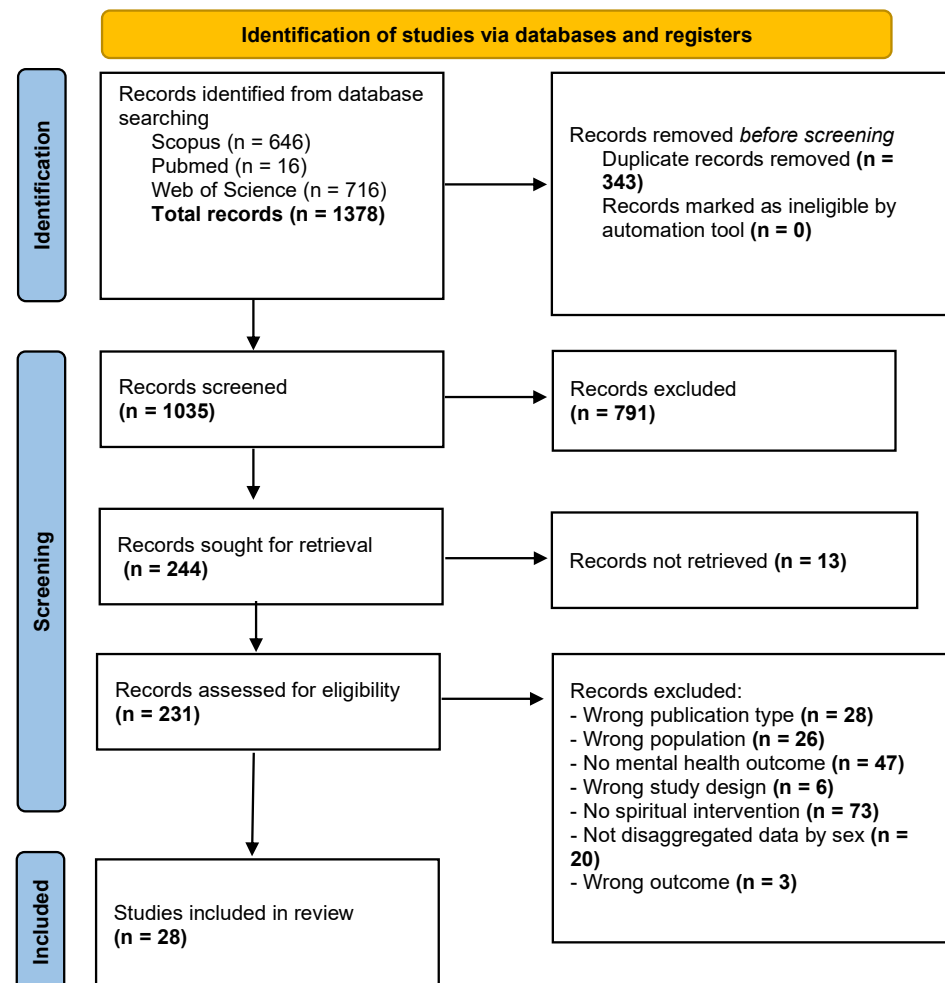


Figure 1. PRISMA flow diagram illustrating the identification, screening, and inclusion process for studies examining the relationship between spirituality/religion and trauma-related outcomes among women. Studies were excluded under “wrong publication type/study design” if they were non-original articles (e.g., reviews, editorials, commentaries), not peer-reviewed, conducted without human participants, or did not include empirical data relevant to spirituality/religion and trauma-related outcomes. Additional exclusions were applied when studies did not report results specific to women (e.g., results not disaggregated by gender), included adolescent-only samples, or did not assess spirituality or religion as a study variable.

2.1. Study Characteristics

Table 1 presents the review, which included 28 studies published between 2000 and 2025, primarily conducted in the USA ($n = 19$), with additional studies from Türkiye, Sweden, Israel, Norway, Rwanda, South Africa, Tunisia, and the UK. Study designs were mostly

cross-sectional ($n = 21$), with several longitudinal cohort studies ($n = 4$), secondary data analyses ($n = 2$), and mixed-methods or survey-based observational studies ($n = 1$). Sample sizes varied widely, ranging from 41 [16] to 3543 [17] participants, totaling 9506 women across all studies. Participants were primarily adult women aged 18–95 years, with mean ages ranging from 29.5 [16] to 52.7 [18] years, depending on the population and context.

Most studies focused on women exposed to interpersonal violence, including intimate partner violence and sexual assault, as well as other forms of vulnerability such as homelessness, HIV infection, trauma exposure, and adverse social circumstances. Additional vulnerabilities included low socioeconomic status, minority ethnic background, and refugee or migrant status. The different vulnerability profiles represented across the included studies are summarized in Table 2. In this review, spirituality and related constructs were primarily interpreted as mediating factors, as several studies examined their role in explaining the pathways linking adversity (e.g., trauma exposure) to mental health outcomes, rather than testing whether they altered the strength or direction of these relationships.

It is important to note that some dimensions captured under spirituality—particularly meaning, purpose, and inner peace—may overlap conceptually with aspects of psychological well-being. Although most studies employed validated instruments intended to distinguish these constructs from mental health outcomes, this overlap may reduce the specificity of spirituality as an independent explanatory variable in some cases.

Although grouped under the umbrella term of vulnerability, these populations represent heterogeneous contexts of adversity and the nature and severity of vulnerability vary across studies.

Spiritual well-being was assessed across the included studies using a variety of validated psychometric instruments designed to capture different dimensions of spiritual and religious experience. In this review, constructs were operationalized according to how they were measured in the primary studies. Instruments assessing meaning, peace, transcendence, or existential well-being (e.g., FACIT-Sp-12, DSES, SWBS existential subscale) were categorized as measures of spirituality, whereas instruments assessing religious practices, beliefs, or institutional involvement (e.g., DUREL, CRS-15, religious coping scales) were categorized as measures of religiosity.

Commonly used measures included the Spiritual Well-Being Scale (SWBS), the Daily Spiritual Experience Scale (DSES), the Brief Religious Coping Scale (Brief RCOPE), the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale (FACIT-Sp-12), the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS), the COPE inventory, the Centrality of Religiosity Scale (CRS-15), the Duke University Religion Index (DUREL), and the WHOQOL Spirituality, Religiousness and Personal Beliefs module (WHOQOL-SRPB). Some studies also employed study-specific instruments, such as the Jewish Supportive Domestic Violence Religious Norms Scale, to capture culturally specific aspects of religious beliefs and practices. These instruments assessed domains including religious coping strategies, intrinsic and extrinsic religiosity, organizational and non-organizational religious activity, existential and spiritual well-being, forgiveness, meaning-making, faith-based support, and moral injury. A detailed overview of the spirituality and/or religiosity measures used across the included studies is presented in Table 3.

Table 1. Included studies ($n = 28$).

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
1 2025 USA Cross-sectional quantitative study [19]	• N = 210 women survivors of IPSV • Mean age: 42.60 years (SD = 14.30) • Age range: 18–80 years • Religion: Christian (Protestant 67.6%, Catholic 26.2%, LDS 6.2%) • Sexual orientation: 90% heterosexual • Race: 67.1% White • Income: 31% $\geq$ \$100,000 • Prevalence of IPSV: 79% reported ≥ 1 IPSV experience	• R/SS • 26 items • 6 subscales: Divine, Demonic, Interpersonal, Moral, Ultimate Meaning, Doubt • $\alpha = 0.95$ • PCBS • 14 items • Subscales: • Gender Roles ($\alpha = 0.76$) • Shame and Guilt ($\alpha = 0.75$)	• DASS-21 • 21 items • $\alpha = 0.94$ • EMIS-C • 17 items • Subscales: • Self-directed MI ($\alpha = 0.92$) • Other-directed MI ($\alpha = 0.92$) • Full scale $\alpha = 0.94$ • IPSV • SCI-R • $\alpha = 0.87$	• Correlations • IPSV $\leftrightarrow$ Psychological distress: $r = 0.39$ ($p < 0.001$) • IPSV $\leftrightarrow$ R/SS: $r = 0.29$ ($p < 0.001$) • IPSV $\leftrightarrow$ Self-directed MI: $r = 0.39$ ($p < 0.001$) • IPSV $\leftrightarrow$ Other-directed MI: $r = 0.43$ ($p < 0.001$) • MI $\leftrightarrow$ Psychological distress: $r = 0.62$ (self); $r = 0.54$ (other), $p < 0.001$ • Moderations • PCB–Gender Roles moderated IPSV $\rightarrow$ R/SS • $\beta = 0.05$, SE = 0.02, $p = 0.03$ • $r^2 = 0.18$ • PCB–Shame and Guilt: Not significant • Mediation • R/SS mediated IPSV $\rightarrow$ Self-directed MI • Indirect effect: 95% CI [0.12, 0.35] • Model $r^2 = 0.48$ • R/SS mediated IPSV $\rightarrow$ Other-directed MI • Indirect effect: 95% CI [0.11, 0.30] • Model $r^2 = 0.38$ • Moral Injury mediated IPSV $\rightarrow$ Psychological Distress • Self-directed MI indirect effect: CI [0.11, 0.32] • Other-directed MI indirect effect: CI [0.02, 0.19] • Model $r^2 = 0.50$
2 2025 Türkiye Cross-sectional descriptive quantitative study [20]	• N = 92 women victims of violence staying in shelters (≥ 15 days) represent a highly vulnerable group due to exposure to interpersonal violence • Age groups: ≤ 20: 5.4%; 21–30: 42.4%; 31–40: 39.1%; ≥ 41: 13.0% • Education and socioeconomic: Majority primary school graduates; most are not employed; economic situation varied—many reported “very bad” or “bad” • Psychiatric diagnosis: 64.1% had at least one mental health diagnosis; depression was most common (32.2%)	• SWBS • 29 items • $\alpha = 0.88$	• BSI • 53 items • Other tools • CTS • CAES-SF	• Mental health burden: • 64.1% had at least one psychiatric diagnosis; depression was the most frequent • Association between Spiritual Well-Being and Psychological Symptoms: • Inverse correlations were found between SWBS scores and all BSI symptom subscales (except somatization). That is, higher spiritual well-being was associated with lower psychological symptoms (e.g., depression, anxiety, hostility) among women victims of violence, $p < 0.05$ • Spiritual Well-Being and Conflict Tactics: • Higher spiritual well-being scores were inversely associated with measures of conflict tactics, indicating women with greater spiritual well-being reported lower psychological/physical conflict scores

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
3 2024 Sweden Cross-sectional study with quantitative associations [21]	• N = 46 Women experiencing homelessness (socially excluded population) • Mean age: 47.6 years (SD = 10.4)	• FACIT-Sp-12	• GHQ-12	• Higher spiritual well-being was significantly associated with: • Lower psychological distress (lower GHQ-12 scores) • The Meaning and Peace dimensions showed the strongest associations. • Correlational analyses indicated moderate negative associations between spirituality and distress. • Spiritual well-being emerged as a protective factor for mental health in homeless women.
4 2024 Israel Cross-sectional quantitative study Machine learning (Random Forest, regression tree) + linear regression predictive modeling [22]	• N = 261 Israeli JUO women, survivors of IPV: 52% regularly abused; 36% abused daily; • Mean age: 39.15 years (SD = 10.51) • 57% experienced multiple types of violence • 34% currently exposed to violence • 76% divorced/separated/widowed	• Brief RCOPE • 10 items • $\alpha = 0.93$ • Jewish Supportive Domestic Violence Religious Norms Scale (developed for study) • $\alpha = 0.84$	• PCL-5 • $\alpha = 0.94$ • Continuous severity score • Clinical cutoff ≥ 31–33 • BIT • $\alpha = 0.91$	• Predicting PTSD • Strongest predictors: • Self-stigma • Perceived unsafe world • Disengagement coping • Help-seeking • Religious variables: • Positive religious coping was not a primary predictor of PTSD severity. • Religious norms supporting violence did not significantly predict PTSD. • Model performance: • Random Forest test RMSE = 12.38 (vs. NULL 16.86) • Correlation predicted vs. observed = 0.70 • Predicting Well-being • Higher well-being predicted by: • Lower self-stigma • Higher religious faith (positive religious coping) • Engagement in recovery actions • Regression tree finding: • High faith (>3) + low self-stigma $\rightarrow$ higher well-being • Model performance: • Random Forest RMSE = 0.69 (vs NULL 0.86) • Correlation predicted vs. observed = 0.60

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Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
5 2022 USA Cross-sectional baseline analysis Latent Profile Analysis Secondary analysis of a behavioral intervention study [23]	• N = 116 Black/African American women living with HIV • Mean age: 49.16 years (SD = 10.88) • Trauma history required • Low-income sample • 52.6% Baptist • Type of vulnerability: HIV-positive; Trauma-exposed; High discrimination exposure; Low socioeconomic status	• Brief RCOPE	• CES-D (20 items) • $\alpha = 0.88$ • Mean = 22.07 (above clinical cutoff) • DTS • $\alpha = 0.84$ • Mean = 44.49 (above cutoff 40) • PTCI (36 items) • $\alpha = 0.96$	• 4 latent profiles identified: • Low resilience/low adversity (19.8%) • Low resilience/high adversity (13.8%) • High resilience/low adversity (59.5%) • High resilience/high adversity (6.9%) • Significant profile differences: • Depression: • $\chi^2(3) = 14.88, p = 0.002$ • Low resilience groups had significantly higher depression • PTSD: • $\chi^2(3) = 21.54, p < 0.001$ • Highest PTSD in HR/HA and LR groups • Religious coping was: • Highest in HR/HA group • Contributed to resilience profiles • Higher resilience (including religious coping) + lower adversity → better mental health outcomes.
6 2021 Norway Cross-sectional quantitative study (part of a larger mixed-methods project) [24]	• 63 female Eritrean refugees • Mean age: 29.5 years (SD = 9.0) • Living in 8 asylum reception centres • Education $\geq$ 8th grade • Religion: 49% Orthodox; 22% Catholic; 16% Muslim	• WHOQOL-SRPB	• WHOQOL-100 • QoL	• Religiosity/spirituality was positively and independently associated with: psychological QoL (B = 0.367, $p < 0.001$), level of independence (B = 0.184, $p = 0.028$), social QoL (B = 0.500, $p = 0.003$), environmental QoL (B = 0.323, $p < 0.001$), and overall QoL (B = 0.213, $p < 0.001$) • No association with physical QoL • No differences between religious affiliations
7 2021 Rwanda Cross-sectional epidemiological analysis [25]	• N = 371 women exposed to genocide and trauma. • Mean age: 42.6 years (SD = 16.2) • Religious context: Predominantly Christian population • Adherence to childhood religion: 62.8% (233/371) reported continued adherence to their childhood religious affiliation	• Self-reported adherence to childhood religious affiliation • Religious affiliation included various Christian denominations common in Rwanda (though a specific denomination was also considered in adjusted models).	• MINI • PCL-C	• Adherence to childhood religious affiliation was statistically significantly associated with lower odds of serious suicide intentions compared with women who had not adhered to their childhood religion. • Odds Ratio (OR): 0.321 • 95% Confidence Interval (CI): 0.13–0.78 • $p < 0.01$ • This association remained significant after adjusting for: • Socioeconomic background • Court-designated genocide victim status • Trauma exposure level • Major depressive episode • PTSD diagnosis • The protective association persisted even after controlling for specific religious denomination

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
8 2021 South Africa Longitudinal cohort study (followed from pregnancy to postpartum) [26]	• N = 1480 Pregnant women attending antenatal care in KwaZulu-Natal, South Africa; assessed at pregnancy (baseline), 14 weeks, and 9 months postpartum • Mean age: 25.5 years (interquartile range [IQR] = 21.3–28.6) • Average gestational age of pregnancy: 25 weeks (IQR = 20.7–29.5) • Average relationship length: 4.5 years (IQR = 1.5–6.2). • IPV exposure • Many of low socioeconomic status with some HIV co-morbidity	• Religiosity: Composite of two items: frequency of church/faith activity attendance • Self-rated strength of religious beliefs (standardized and averaged).	• HSCL-25 • 25 items • Assessed at baseline and both postpartum follow-ups.	• Physical/sexual IPV during pregnancy predicted increased postpartum emotional distress. • Religiosity did not significantly moderate the IPV–distress association at either 14 weeks or 9 months postpartum. • Other moderators, such as baseline distress and socioeconomic status, were significant buffers/exacerbators
9 2021 USA Cross-sectional Military-based recruitment [27]	• N = 76 active-duty women • Age range: 18–45 years • Mean age: 30.25 years (SD = 6.62) • Service branch: Air Force 44 (57.9%), Army 17 (22.5%), Marine Corps 6 (7.9%), Navy 5 (6.6%), Activated Navy Reserves 1 (1.3%) • Rank: Enlisted 40 (52.6%), Officer 33 (44.3%) • Deployment experience: Combat 24 (33.3%); Non-combat 23 (30.3%); Never deployed 36 (47.4%) • Relationship status: Married/civil union 47 (61.8%), Single 9 (12.8%), Divorced 12 (15.8%), Cohabiting 4 (5.3%) • Religious affiliation: Protestant 25 (33.3%), Catholic 15 (20.0%), Agnostic 9 (11.8%), Atheist 8 (10.5%), Other 13 (17.3%)	• DUREL • Organizational religious activities (attendance at religious institutions) • Non-organizational activities (prayer, scripture reading, meditation) • Intrinsic/subjective religiousness • $\alpha = 0.91$	• PHQ-9 • GAD-7 • PC-PTSD • AUDIT • TEQ • MSPSS • SEQ-DoD	• PTSD symptoms were strongly associated with sexual hostility ($r = 0.65, p < 0.01$) and sexist hostility ($r = 0.55, p < 0.01$). • Depression symptoms were positively associated with physical pain ($r = 0.40, p < 0.01$). • Intrinsic religiosity moderated the relationship between deployments and waist circumference: – Interaction effect: $b = -0.12, p = 0.020$ – Low intrinsic religiosity: deployments predicted higher waist circumference ($b = 0.78, p = 0.002$). – Higher intrinsic religiosity buffered this relationship. • Spiritual variables were not significantly associated with depression, anxiety, or PTSD symptoms in correlation analyses. • Social support from a significant other also buffered the relationship between deployments and waist circumference (interaction $b = -0.24, p = 0.004$).
10 2023 UK Cross-sectional community-based recruitment [16]	• N = 41 migrant Muslim women • Age range: 18–57 years • Mean age: 30.44 years (SD = 8.99) • Ethnicity: 22 South Asian, 6 Middle Eastern, 6 West African, 6 East African, 1 North African • Marital status: 28 married, 11 single, 1 divorced, 1 widowed • Education: 30 had secondary school or higher • Migration: >5 years in UK = 23; <5 years = 18	• COPE • CRS-15 • 15 items • $\alpha = 0.95$	• PSS-10	• Mediation analysis showed religiosity fully mediated the relationship between religious coping and perceived stress • Religious coping → higher religiosity ($b = 1.33, p < 0.001$) • Religiosity → lower perceived stress ($b = -0.55, p < 0.001$) • Total effect of religious coping on stress: $b = -1.11, p < 0.001$ • Indirect effect via religiosity: $b = -0.74$, bootstrapped 95% CI [−1.19, −0.29] • Model explained 55% of the variance in perceived stress

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
11 2020 USA Secondary data analysis of a parent study on psychosocial and spiritual health [28]	• N = 43 active-duty women • Mean age: 31.7 years (SD = 7.2) • Ethnicity: 74.4 White non-Hispanic; 7% Black; 7% Asian; 2.3% Hispanic/Latina; 9.3% Other • Religious affiliation: Protestant 37.2%; Catholic 14%; Agnostic 16.3%; Atheist 7%; Other 18.6% • Military branches: Air Force 67.4%; Army 16.3%; Marine Corps 7%; Navy 7%; Activated Navy Reserves 2.3%; • 46.5% officer status	• DUREL	• TEQ • 13 items • PC-PTSD • 4 items, yes/no • cutoff ≥ 3 for positive screen) • $\alpha = 0.83$	• Moderation by spirituality: • Trauma $\times$ organized religion: $b = -0.49, p = 0.030$ • Trauma $\times$ non-organized religion: $b = -0.47, p = 0.023$ • Trauma $\times$ intrinsic religiousness: $b = -0.64, p = 0.003$ • High levels of spirituality buffered the effect of traumatic stress on post-traumatic stress symptoms; low spirituality was associated with higher PTSD symptoms with increased trauma • Severity of trauma (impact at the time/now) positively correlated with PTSD symptoms ($r = 0.44, p = 0.009$; $r = 0.46, p = 0.006$) • No direct association between total trauma exposure and PTSD symptoms
12 2020 USA Longitudinal cohort study (prospective) [29]	• N = 108 postpartum women oversampled for childhood abuse histories • Age: >22 years old: 90.7%; <22 years old: 9.3 • Predominantly Christian (74%), but includes non-religious and non-Christian groups • Assessed at 6, 12, and 15 months postpartum.	• BMMRS subscales at 6 months postpartum: • DSES ($\alpha = 0.92$) • Meaning ($\alpha = 0.71$) • Forgiveness ($\alpha = 0.78$) • Private Religious Practices ($\alpha = 0.79$) • Religious and Spiritual Coping ($\alpha = 0.77$) • Organizational Religiousness ($\alpha = 0.79$)	• PDSS at 12 and 15 months ($\alpha \geq 0.95$) • QOL: Modified Quality of Life Index ($\alpha \geq 0.80$) at 12 and 15 months.	• Forgiveness subscale (self- and others-forgiveness) predicted lower postpartum depression symptoms and higher quality of life at both 12 and 15 months. • Other R/S domains generally were not associated with mental health outcomes, except organizational religiousness, which showed a negative association with quality of life at 12 months.
13 2019 Tunisia Cross-sectional survey over 6 months [18]	• N = 79 women with breast cancer who had undergone surgical treatment • Age: 29–65 years • Mean age: 52.7 years (SD = 9.8) • Marital status: Married 73.8%, Single 15.0%, Divorced 5.0%, Widow 5.0% • Occupation: Unemployed 71.3%, Employee 11.3%, Worker 8.8%, Retired 7.5% • Breast cancer stage: 0–III; majority Stage II (56.3%) • Surgery type: Conservative 22.5%, Radical mastectomy 76.3% • Cancer recurrence: 3.8%	• SWBS	• PTGI • 21 items • DASS-21 • MSPSS	• Highest reported PTG changes: discovering personal strength (70.0%), stronger religious faith (65.0%), better acceptance of life events (63.8%) • PTG positively correlated with anxiety ($r = 0.301, p = 0.007$) and social support ($r = 0.321, p = 0.004$) • PTG negatively correlated with age ($r = -0.264, p = 0.019$) • Multiple regression: anxiety ($\beta = 0.298, p = 0.043$) and social support ($\beta = 0.296, p = 0.007$) were significant predictors of PTG
14 2018 USA Cross-sectional study [30]	• N = 116 women exposed to IPV (past 6 months) • Age range: 22–59 years • Mean age: 32.33 years (SD = 6.53) • Majority non-Hispanic Black (68%) • 75% below the federal poverty line • Recruited from IPV community agencies	• DSES • 15 items • $\alpha = 0.94$	• GAD-7 • $\alpha = 0.91$	• Spirituality negatively correlated with GAD symptoms ($r = -0.26, p < 0.01$). • In hierarchical regression, spirituality remained a significant predictor of lower anxiety ($\beta = -0.20, p = 0.02$), controlling for IPV severity, income, stressful life events, and other social supports. • Higher spirituality is associated with fewer anxiety symptoms.

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
15 2017 USA Cross-sectional survey with semi-structured interviews [31]	• N = 112 women who experienced IPV in the past 6 months • Age: 22–49 years • Mean age: 32.12 years (SD = 5.78) • Race/ethnicity: Black 67.8%, Multi-ethnic 14.9%, White 11.6%, Other 5.7% • Socioeconomic status: 71.9% annual income < \$20,000; 50.4% unemployed • IPV exposure: avg. 176.94 events in past 6 months (~7/week) • IPV type: Psychological aggression 98.3%, Physical assault 91.5%, Sexual coercion 64.1%, Injury 79.5% • Lifetime violent partners: 57% in multiple violent relationships	• DSES • LSNS-R • 12 items • $\alpha = 0.89$ • CCS • 6 items • $\alpha = 0.89$	• LEC • 17 items • CTS-2 • 78 items • $\alpha = 0.95$ • Number of Violent Partners • CD-RISC • 25 items • $\alpha = 0.91$	• Higher education → higher resilience ($\beta = 0.30, p = 0.002$) • More lifetime violent partners → lower resilience ($\beta = -0.33, p < 0.001$; $\beta = -0.25, p = 0.003$ in final model) • Protective factors associated with higher resilience: Spirituality ($\beta = 0.28, p = 0.002$), Social Support ($\beta = 0.24, p = 0.009$) • Community cohesion and ethnic identity are not significant • Variance explained: Model 1 = 9.0%, Model 2 = 18.9%, Model 3 = 36.5%
16 2017 USA Longitudinal design with a 10-week time interval [32]	• N = 325 African American women recruited from an urban level-1 trauma public hospital • Mean age: 35.96 years (SD = 9.87) • Marital status: 32% single/never married, 30% partnered, 27.4% divorced/separated, 6% married, 7.2% widowed • Socioeconomic vulnerability: 43.4% homeless; 85% unemployed • Clinical vulnerability: All participants had attempted suicide in the previous year with serious intent and/or need for medical intervention • Trauma exposure: ~50% reported physical, emotional, or sexual abuse (partner or stranger); 23% serious accident; ~25% exposure to life-threatening situations or witnessing harm to loved ones • Additional vulnerability: Many participants reported cumulative and complex trauma histories, including childhood maltreatment	• SWBS	• DTS • BSS • PDS • 17 items • $\alpha = 0.83$ • BHS • 20 items • $\alpha = 0.94$	• PTSD → Existential well-being: • Higher PTSD linked to lower existential well-being at baseline. • $r = -0.26, p < 0.01$; $R^2 = 0.07$ • PTSD → Religious well-being: • No significant association. • $R^2 \approx 0$ • Existential well-being → Hopelessness (T2): • Mediated PTSD → hopelessness. • Indirect effect $b = 0.50$, 95% CI [0.14–1.13]; $R^2 = 0.10$ • Religious well-being → Hopelessness: • No mediation. • $b = -0.03$, 95% CI [−0.33–0.06] • Existential well-being → Suicidal ideation (T2): • Mediated PTSD → suicidal ideation. • Indirect effect $b = 0.60$, 95% CI [0.19–1.25]; $R^2 = 0.27$ • Direct effect PTSD → suicidality: $b = 1.44$, 95% CI [0.23–2.65] • Religious well-being → Suicidal ideation: • No mediation. • $b = -0.20$, 95% CI [−0.91–0.43] • Correlations: • PTSD → suicidal ideation: $r = 0.25, p < 0.01$ • Existential well-being → lower hopelessness: $r = -0.31, p < 0.01$ • Existential well-being → lower suicidal ideation: $r = -0.21, p < 0.05$ • Religious well-being → higher suicidal ideation: $r = 0.33, p < 0.01$

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
17 2016 USA Cross-sectional observational study [33]	• N = 111 African American women exposed to IPV • Low socioeconomic status • Age range: 18–56 years • Mean age: 37.05 years (SD = 10.31)	• SWBS	• BSS • CTS-2	• Higher existential and religious well-being were independently associated with lower depression and suicidal ideation among women exposed to IPV, suggesting spiritual well-being buffers the impact of IPV on mental health (effects reported via regression coefficients controlling for covariates).
18 2015 USA Cross-sectional quantitative study [34]	• N = 752 Latino women who experienced IPV; • Mean age: 44.52 years (SD = 14.44)	• BMMRS	• PCL-C • LTVH • BSRI-Short Form	• Certain religious/cultural beliefs were associated with greater PTSD symptoms. In particular, beliefs that trauma represented divine punishment increased PTSD severity, likely via increased guilt and self-blame.
19 2015 USA Longitudinal survey study (2-wave design examining predictors of PTSD symptoms over 1 year) [35]	• N = 252 African American female sexual assault survivors (subset from larger study) • Mean age: 36.66 years (SD = 10.94) • Recruited from a community sample • Education: 56% some college; 23.6% high school graduate; ~20% less than high school • Employment: 44% employed • Marital status: 62% single; 20% married/cohabiting; 16% divorced/separated; 1% widowed • 67% had children • Household income: 49% ≤ \$10,000; 49% \$10,001–\$50,000; 2% > \$50,000	• Brief COPE	• PDS	• Cross-sectional associations: • Religious coping positively correlated with PTSD symptoms • Time 1: $r = 0.24, p < 0.001$ • Time 2: $r = 0.14, p = 0.020$ • Longitudinal regression results: • Religious coping at Time 1 did not significantly predict PTSD symptoms at Time 2 • $\beta = -0.02, p = 0.723$ • Social support associated with fewer PTSD symptoms at Time 2 • $\beta = -0.24, p < 0.001$ • Survivors with higher PTSD symptoms reported greater use of religious coping, possibly reflecting attempts to manage distress rather than a protective effect.
20 2015 USA Observational quantitative study (mediational analysis) [36]	• N = 192 African American women • Mean age: 34.9 years (SD = 9.29) • 58.2% in a relationship, 41.8% not • 81.9% had children • 54% homeless, 86.7% unemployed • Monthly income: 56.1% \$0–\$249; 15.3% \$250–\$499; 21.7% \$500–\$999; 6.9% > \$999	• SWBS	• CTQ • ISA • DTS • 17 items, summed frequency + severity • $\alpha = 0.95$	• Negative religious coping is associated with greater PTSD symptoms • $\beta \approx 0.23, p < 0.01$ • Positive religious coping is not significantly associated with PTSD symptoms • Greater lifetime trauma exposure significantly predicted higher PTSD severity • Findings suggest spiritual struggle (negative religious coping) may exacerbate PTSD symptoms among African American women living with HIV.

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
21 2014 USA Cross-sectional [37]	• N = 91 women, IPV survivors from shelters and the community • Mean age: 33.3 years (SD = 9.15) • 45 European American, 46 African American	• MMRI • 12 items • $\alpha = 0.83$	• PTSD • WAS • 32 items • $\alpha = 0.85$ • CTS-R • 78 items	• IPV exposure $\rightarrow$ PTSD symptoms • Higher IPV exposure was significantly associated with higher PTSD symptoms. • Effect measure: Correlation $r = 0.35$, $p = 0.001$; Regression $\beta = 0.02$–0.03, $p = 0.007$–0.01 • World assumptions as mediator (IPV $\rightarrow$ PTSD) • More negative world assumptions were significantly related to higher PTSD symptoms and mediated the relationship between IPV exposure and PTSD. • Effect measure: Regression path a (IPV $\rightarrow$ World Assumptions): $\beta = -0.04$, $p = 0.003$ • Regression path b (World Assumptions $\rightarrow$ PTSD): $\beta = -0.15$, $p = 0.016$ • Sobel test for mediation: $z = 2.12$, $p = 0.034$ • Religiosity $\rightarrow$ PTSD symptoms • Greater religiosity was positively associated with higher PTSD symptoms. • Effect measure: Regression $\beta = 0.39$ (European American), $\beta = 0.36$ (African American); $p = 0.012$ and 0.026, respectively • Ethnic differences • African American women reported higher IPV exposure and religiosity than European American women. • Effect measure: • IPV: $M = 346.41$ vs. 254.45, $d = 0.58$, $p < 0.01$ • Religiosity: $M = 23.71$ vs. 17.13, $d = 0.78$, $p < 0.001$ • No significant difference in world assumptions or PTSD symptoms between ethnic groups. • World assumptions and PTSD by ethnicity • Negative world assumptions are significantly related to PTSD for African American women only. • Effect measure: Regression $\beta = -0.17$, $p = 0.029$ (African American); $\beta = -0.13$, $p = 0.145$ (European American, not significant)

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
22 2013 USA Correlational descriptive study using structured interviews [38]	• N = 206 African American urban women • Mean age: 36.6 years • Marital status: Unmarried 91% • Children: 78% had children • Education: M = 12.8 years; 62% high school/GED • Employment: 40% employed (full or part-time) • Income: 90% earned < \$20,000/year • Criminal justice involvement: community sample vs. probation	• SWBS	• TLEQ • $\alpha = 0.81$ • ASI	• Existential well-being is negatively associated with traumatic life events, depression ($r \approx -0.32$), anxiety ($r \approx -0.31$), alcohol ($r \approx -0.24$), tobacco ($r \approx -0.14$), and cocaine use ($r \approx -0.22$) • Religious well-being is negatively associated with alcohol, tobacco, and marijuana use • Trauma exposure is positively associated with depression, anxiety, and cocaine use • Moderation: existential well-being reduced the impact of trauma on cocaine use • Regression: existential well-being protective for depression (-46%) and anxiety (-47%); reduced days of alcohol (-42%) and cocaine use (-74%)
23 2008 USA Cross-sectional quantitative study [39]	• N = 178 African American women, who experienced IPV within the past year • Age range: 18–55 years • Mean age: 34.57 years (SD = 9.22) • Low-income, recruited from an urban public hospital • 92.1% indicated faith or religious affiliation	• SWBS	• BSI • DTS • Brief MAST • Alcohol, $\alpha = 0.84$ • Brief DAST • Drugs, $\alpha = 0.91$ • TSEI • 16 items • $\alpha = 0.62$ • MSPSS • 12 items • $\alpha = 0.89$	• Stages of change: most women in Contemplation (M = 35.18, SD = 4.06), fewer in Precontemplation (M = 17.97, SD = 5.71) • Readiness to change positively correlated with perceiving the relationship as abusive, anxiety, PTSD symptoms, substance use, and spiritual well-being • Readiness negatively correlated with the number of children and self-esteem • Hierarchical regression: factors explained 17% of the variance in readiness to change • Only PTSD symptoms ($\beta = 0.22, p < 0.05$) and spiritual well-being ($\beta = 0.28, p < 0.01$) uniquely predicted readiness to change • High spiritual well-being is associated with greater readiness to change abusive situations
24 2007 USA Baseline data from a larger HIV education and prevention study [40]	• N = 393 women • Mean age: 33.7 years (SD = 7.4) • Ethnicity: 42% Hispanic, 38% Black non-Hispanic, 14% White non-Hispanic, 6% Other • Education: 74% less than high school • 85% had lifetime criminal justice involvement; 49% drug-related arrests; 79% incarceration • 83% had minor children; 15% had legal custody	• Brief COPE • SIBS • 26 items • $\alpha = 0.83$	• PSS • PDS • SOC • 13 items • $\alpha = 0.70$ • ASI-Alcohol • $\alpha = 0.78$ • ASI-Drugs • $\alpha = 0.70$	• Perceived stress positively related to drug addiction severity ($\beta = 0.21, p < 0.0001$) • PTSD symptoms positively related to alcohol addiction severity ($\beta = 0.19, p < 0.01$) • Coping responses negatively related to drug addiction severity ($\beta = -0.15, p < 0.05$) • Spirituality and SOC were negatively associated with perceived stress ($\beta = -0.37, -0.32$ respectively, $p < 0.0001$) • PTSD negatively associated with SOC ($\beta = -0.22, p < 0.0001$) • Spirituality and SOC did not mediate the relationship between stress/PTSD and substance use outcomes • Model explained significant direct and indirect paths between stress, PTSD, coping, and addiction severity

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
25 2006 USA Cross-sectional observational study [41]	• N = 65 women • Mean age: 32.2 years (SD = 7.45) • Age range: 18–52 years • Ethnicity: 73.8% African American, 15.4% African, 6.2% Caribbean, 4.6% Other African • Recruitment: 75.4% shelters, 15.4% outpatient group therapy, 9.2% victim outreach • Education: 26.2% did not finish high school, 16.9% GED, 13.8% high school diploma, 27.7% some college, 12.3% bachelor's, 3.1% graduate • Employment: 32.3% full-time, 6.2% part-time, 35.4% unemployed worked past year, 26.2% unemployed • Personal income: 54.7% < \$10,000; 12.3% \$10–20 k; 12.3% \$20–30 k; 9.2% \$30–40 k; 10.7% > \$40 k • Marital status: 38.5% never married, 35.4% married but not living together, 7.7% married and living together • Religious affiliation: 46.2% Baptist; others varied	• COPE • DSES • 16 items • $\alpha = 0.89$ • ISEL • 40 items • $\alpha = 0.93$ • RBB • $\alpha = 0.73$	• PCL • BDI • CTS-2	• Higher exposure to physical assault ($r = 0.38, p < 0.01$) and psychological abuse ($r = 0.25, p < 0.05$) → higher PTSD symptoms • Higher spirituality ($r = -0.28, p < 0.05$) and religious involvement ($r = -0.29, p < 0.05$) → lower depression • Religious involvement negatively associated with PTSD symptoms ($r = -0.25, p < 0.05$) • Spirituality positively associated with religious coping ($r = 0.41, p < 0.01$) and social support ($r = 0.32, p < 0.01$) • Social support positively associated with religious involvement ($r = 0.28, p < 0.05$) • Mediation analyses: • Religious coping did not mediate the spirituality–depression link • Religious coping did not mediate spirituality–PTSD • Social support did not mediate religious involvement–depression or PTSD
26 2005 USA Baseline data from a larger study on IPV and suicidal behavior [42]	• N = 134 women • Mean age: 34.6 years (SD = 9.37) • Ethnicity: 92% African American • Education: 32% completed high school, 27% some education beyond high school • Marital/relationship status: 28% married/cohabitating • Employment: 20% employed • Income: 48% < \$500/month, 21% \$500–1000/month • Other: 52% reported being homeless; 64% received food stamps; 31% received welfare support	• Brief RCOPE	• CTQ • ISA • DTS • TSEI • MSPSS	• High levels of PTSD symptoms (DTS M = 81.71, SD = 32.46) • Significant correlations: • Childhood abuse → adult abuse: sexual $r = 0.21$, physical $r = 0.21$ • Total abuse (child + adult) positively correlated with PTSD symptoms ($\beta = 0.38, p < 0.001$) • Self-esteem negatively related to PTSD ($\beta = -0.34, p < 0.001$) • Social support negatively related to PTSD ($\beta = -0.18, p < 0.05$) • Negative religious coping positively related to PTSD ($\beta = 0.20, p < 0.05$) • Mediation: • Self-esteem and negative religious coping mediated the relationship between abuse and PTSD • PTSD also mediated the relationship between abuse and both self-esteem and negative religious coping

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
27 2001 USA Cross-sectional, survey-based study [17]	• N = 3543 women veterans who experienced sexual assault • Women who experienced sexual assault • Age range: 19–89 years • Mean age: 42.7 years (SD = 11.5) • Women who reported no sexual assault: • Age range: 21–95 years • Mean age: 48.8 years (SD = 17.0)	• Organizational religiosity: frequency of religious service attendance (5-point scale) • Subjective religiosity: strength/comfort of religious beliefs (5-point scale)	• SF-36 • 36 items • CES-D	• Women with MSA had poorer mental health (MCS 42.7 vs. 49.5; CES-D 10.7 vs. 7.2) • Organizational religiosity (service attendance) buffered mental health outcomes for women with MSA: higher attendance → higher MCS, lower CES-D • Subjective religiosity (religious strength/comfort) is also associated with better mental health; the buffering effect is more pronounced among women with MSA, but the interaction is mostly non-significant, except for extreme category comparison (CES-D reduction −2.04 vs. −0.75)

Table 1. Cont.

Study No. Year Country Design Reference	Population Characteristics	Measures of Spirituality/Religiosity	Mental Health Outcomes and Instruments	Key Findings and Effect Measures
28 2000 USA Cross-sectional, survey-based study [43]	• N = 50 women residing ≥ 21 days in four battered women's shelters • Age range: 19–60 years • Mean age: 33.9 years (SD = 8.9) • Ethnicity: 20 African American, 11 European American, 11 Hispanic, 5 Asian American, 1 Native American, 2 other • Children: 41 (82%) had children; 28 (66%) had children with them in the shelter • Employment: 8 employed • Annual household income: mean \$3676; access to income: mean \$2525 • All participants had experienced abuse from a partner; physical and sexual assaults were recorded	• SPS • 10 items • $\alpha = 0.87$;	• SCL-90 • Nine primary dimensions: somatization, obsessive-compulsiveness, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism • $\alpha = 0.76$–0.98	• Battering experience: • Minor assaults mean 31.2 ± 25.6 (range 0–75) • Severe assaults mean 33.5 ± 34.9 (range 0–125) • Severe assaults, including sexual assault, mean 39.9 ± 39.3 (range 0–150) • Psychological distress (SCL-90) vs. normative sample: • Significantly higher distress across all nine dimensions and three global indices • PTSD prevalence: 28/50 (56%) • Spirituality correlations: • Higher SPS scores associated with lower distress in: • Obsessive-compulsive: $r = -0.34, p < 0.05$ • Interpersonal sensitivity: $r = -0.31, p < 0.05$ • Hostility: $r = -0.37, p < 0.01$ • Spiritual practices (prayer, meditation, reading, service attendance) positively correlated with SPS scores ($p < 0.01$ to 0.0005) • Other observations: • Spiritual beliefs rated as helpful by 94% • Mean importance of spiritual beliefs: before shelter 7.76 ± 2.80; after shelter 9.16 ± 1.49

ASI: Addiction Severity Index; AUDIT: Alcohol Use Disorders Identification Test; BDI-II: Beck Depression Scale; BIT: Brief Inventory of Thriving; BHS: Beck Hopelessness Scale; BMMRS: Brief Multidimensional Measure of Religiousness/Spirituality; BSI: Brief Symptom Inventory; BSRI: Bem Sex Role Inventory; BSS: Beck Scale for Suicide Ideation; CAES-SF: Childhood Abuse Experiences Scale Short Form; CCS: Community Cohesion Scale; CD-RISC: Connor–Davidson Resilience Scale; CES-D: Center for Epidemiologic Studies Depression Scale; COPE: Coping Orientation to Problems Experienced Inventory; CRS: Centrality of Religiosity Scale; CTQ: Childhood Trauma Questionnaire—Short Form; CTS: Conflict Tactic Scale; CTS-R: Conflict Tactic Scale Revised; CTS-2: Conflict Tactics Scales-2; DASS-21: Depression Anxiety Stress Scales-21; DAST: Drug Abuse Screening Test; DSES: Daily spiritual experiences; DTS: Davidson Trauma Scale; DUREL: Duke University Religion Index; EMIS-C: Expressions of Moral Injury–Civilian; FACIT-Sp-12: Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being; GHQ-12: General Health Questionnaire-12; HSCL-25: Hopkins Symptoms Checklist; IPSV: Intimate Partner Sexual Violence; ISA: Index of Spouse Abuse; ISEL: Interpersonal Support Evaluation List; JUO: Jewish Ultra-Orthodox; LEC: Life Events Checklist; LDS: Latter Day Saint; LSNS-R: Lubben Social Network Scale Revised; LTVH: Lifetime Trauma and Victimization History; MAST: Michigan Alcoholism Screening Test; MCS: mental component summary; MEIM-R: Multigroup Ethnic Identity Measure-Revised; MINI: Mini International Neuropsychiatric Interview; MMRI: Multidimensional Measure of Religious Involvement; MSA: Military sexual assault; MSPSS: Multidimensional Scale of Perceived Social Support; P-IPV: Psychological Intimate Partner Violence; PCBS: Purity Culture Beliefs Scale; PDS: Post-traumatic Diagnostic Scale; PCL-C: PTSD Checklist—Civilian version; PCL-5: Post-traumatic Stress Disorder Checklist for DSM-5; PC-PTSD: Primary Care PTSD Screen; PDS: Post-traumatic Stress Diagnostic Scale; PDSS: Postpartum Depression; PSS: Perceived Stress Scale; PTCL: Post-Traumatic Cognitions Inventory; PTGI: Post-traumatic Growth Inventory; PTSD: Post-Traumatic Stress Disorder; RBB: Religious Background and Behavior Scale; RCOPE: Positive Religious Coping subscale; R/SS: Religious and Spiritual Struggles Scale; SCI-R: Adapted Sexual Coercion Inventory-Revised; SCL: Symptom Checklist-90-Revised; SD: standard deviation; SEQ-DoD: Sexual Experiences Questionnaire—Department of Defense; SF: Short Form Health Survey; SIBS: Spiritual Involvement and Beliefs Scale; SOC: Sense of Coherence; SRLW: Survey of Recent Life Experiences; SPS: Spiritual Perspectives Scale; SWBS: Spiritual Well-Being Scale; TEQ: Traumatic Events Questionnaire; TLEQ: Traumatic Life Events Questionnaire; TSEI: Taylor Self-Esteem Inventory; UK: United Kingdom; USA: United States of America; WHOQOL: World Health Organization Quality of Life; WHOQOL–SRPB: World Health Organization Quality of Life—Spirituality, Religiosity and Personal Beliefs.

Table 2. Types of Vulnerability Represented in the Included Studies.

Type of Vulnerability	Studies (Study No.)	Description
Intimate Partner Violence (IPV)/Domestic violence survivors	1, 4, 8, 14, 15, 17, 18, 21, 23, 25, 26, 28	Women exposed to physical, sexual, or psychological violence by a partner, including those residing in shelters or recruited from IPV services.
Sexual violence/sexual assault survivors	1, 19, 27	Women exposed to sexual assault or interpersonal sexual violence.
Women living with HIV	5	HIV-positive women experiencing trauma, discrimination, and socioeconomic disadvantage.
Homeless women/housing instability	3, 20	Women experiencing homelessness or unstable housing conditions.
Refugee or migrant women	6, 10	Women exposed to forced migration, displacement, or asylum processes.
Women exposed to war/genocide trauma	7	Women exposed to genocide-related trauma and conflict-related violence.
Pregnant or postpartum women exposed to psychosocial risk	8, 12	Women assessed during pregnancy or postpartum, often with IPV exposure or abuse history.
Women with chronic illness (e.g., cancer)	13	Women living with breast cancer after surgical treatment.
Active-duty military women/veterans	9, 11, 27	Women serving in the military or veterans, exposed to deployment stressors or military sexual trauma
Women with severe trauma histories or suicide attempts	16	Women with prior suicide attempts and complex trauma histories.
Women involved in criminal justice or substance use contexts	22, 24	Women experiencing trauma exposure, substance use, and criminal justice involvement.

Mental health outcomes were evaluated using validated clinical and psychological instruments, including the Depression Anxiety Stress Scales (DASS-21), the Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder Scale (GAD-7), the PTSD Checklist (PCL-5 and PCL-C), the Hopkins Symptom Checklist (HSCL-25), the Center for Epidemiologic Studies Depression Scale (CES-D), the Davidson Trauma Scale (DTS), the Beck Scale for Suicide Ideation (BSS), the Postpartum Depression Screening Scale (PDSS), the Mini International Neuropsychiatric Interview (MINI), the General Health Questionnaire (GHQ-12), and the Post-traumatic Growth Inventory (PTGI). These measures evaluated a broad range of psychological outcomes, including stress, depression, anxiety, post-traumatic stress symptoms, suicidal ideation, hopelessness, quality of life, and post-traumatic growth. A detailed overview of the instruments used to measure mental health outcomes is presented in Table 4.

Although spirituality and religiosity were conceptually distinguished in this review based on measurement, there was notable heterogeneity across studies in their operationalization. Several studies employed validated multidimensional instruments that clearly differentiate between spiritual well-being and religious practices or beliefs. However, other studies used broader or less clearly defined measures that encompassed a wide range of experiences, including meaning, purpose, emotional well-being, and connection, sometimes overlapping with psychological constructs. This variability may limit comparability across studies and complicate the interpretation of findings.

Table 3. Instruments Used to Measure Spirituality and/or Religiosity.

Instrument	Construct Measured	Studies Using the Instrument (Study No.)
SWBS—Spiritual Well-Being Scale	Religious and existential well-being	2, 13, 16, 17, 20, 22, 23
DSES—Daily Spiritual Experience Scale	Daily spiritual experiences	12, 14, 15, 25.
Brief RCOPE	Religious coping (positive/negative)	4, 5, 26
COPE/Brief COPE	Religious coping strategies	10, 19, 24, 25
FACIT-Sp-12—Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being	Spiritual well-being (meaning, peace, faith)	3
WHOQOL-SRPB—World Health Organization Quality of Life—Spirituality, Religiosity and Personal Beliefs	Spirituality, religiosity and personal beliefs	6
CRS-15—Centrality of Religiosity Scale	Centrality of religious belief	10
DUREL—Duke University Religion Index	Organizational and intrinsic religiosity	9, 11
BMMRS—Brief Multidimensional Measure of Religiousness/Spirituality	Multiple religious/spiritual domains	12, 18
MMRI—Multidimensional Measure of Religious Involvement	Religious involvement	21
SIBS—Spiritual Involvement and Beliefs Scale	Spiritual beliefs and practices	24
SPS—Spiritual Perspective Scale	Religious affiliation or faith engagement	7, 8, 27
R/SS—Religious and Spiritual Struggles Scale	Spiritual struggle	1

Table 4. Instruments Used to Measure Mental Health Outcomes.

Instrument	Outcome Measures	Studies Using the Instrument (Study No.)
DASS-21	Depression, anxiety, stress	1, 13
BSI	Psychological symptoms	2, 23
GHQ-12	Psychological distress	3
PCL-5/PCL-C	PTSD symptoms	4, 18
DTS	PTSD severity	5, 20, 23, 26
PHQ-9	Depression	9
GAD-7	Anxiety	9, 14
PC-PTSD	PTSD screening	9, 11
HSCL-25	Anxiety and depression	8
CES-D	Depression	5, 27
PSS-10/PSS	Perceived stress	10, 24
PTGI	Post-traumatic growth	13
PDSS	Postpartum depression	12
PTDS	Post-traumatic stress disorder	16, 19, 24
BHS	Hopelessness	16
BSS	Suicidal ideation	16, 17
SCL-90	Psychological distress symptoms	28
SF-36	Mental health functioning	27

Across the included studies, higher levels of spirituality, intrinsic religiosity, and spiritual well-being were generally associated with lower levels of depression, anxiety, PTSD symptoms, and psychological distress, as well as higher resilience, quality of life, and post-traumatic growth.

Several studies reported statistically significant associations between spirituality-related variables and mental health outcomes. For example, higher spiritual well-being was associated with lower suicidal ideation and hopelessness in women with PTSD symptoms. In contrast, greater religiosity and positive religious coping were associated with lower depressive symptoms and improved psychological well-being in populations exposed to interpersonal violence or other traumatic experiences. Several studies suggested that the effects of spirituality and religious coping do not occur in isolation but are closely intertwined with other coping resources, particularly social support. For example, higher levels of spirituality were positively associated with perceived social support in some studies, and both factors independently or jointly contributed to improved mental health outcomes. These findings indicate that religious coping may function as part of a broader coping system rather than as a standalone mechanism.

Across the 28 included studies, the majority reported predominantly positive associations between spirituality and/or religiosity and mental health outcomes ($n = 15$). These studies found that higher levels of spiritual well-being, intrinsic religiosity, or adaptive religious coping were associated with lower psychological distress and improved well-being (Table 5).

Table 5. Direction of Associations Between Spirituality/Religiosity and Mental Health Outcomes.

Category of Findings	Number of Studies (n)	Description
Positive	15	Higher spirituality/religiosity associated with better mental health outcomes (e.g., lower depression, anxiety, PTSD; higher resilience and well-being)
Mixed	7	Both positive and negative or context-dependent findings, depending on the dimension (e.g., positive spirituality but negative religious coping)
No association	2	No statistically significant relationship between spirituality/religiosity and mental health outcomes
Negative	4	Worse mental health outcomes associated with certain forms of religiosity (e.g., negative religious coping, beliefs of punishment)

A total of 7 studies reported mixed or context-dependent findings, in which the direction of the association varied depending on the dimension of spirituality/religiosity assessed or the specific mental health outcome. Two studies found no significant association between religiosity/spirituality and mental health outcomes.

Finally, 4 studies reported negative associations, primarily in relation to negative religious coping or maladaptive religious beliefs, which were linked to worse mental health outcomes such as increased PTSD symptoms or psychological distress.

However, findings were not entirely consistent. In some studies, particularly those involving survivors of sexual assault or individuals experiencing ongoing adversity, religious coping was positively associated with PTSD symptoms, suggesting that individuals experiencing greater distress may engage more frequently in religious coping strategies. Additionally, several studies reported non-significant associations between religiosity and certain mental health outcomes.

Several factors were identified as contributing to reduced or inconsistent positive effects of spirituality and religiosity on mental health outcomes. The most frequently reported factor was the use of negative religious coping strategies ($n = 5$ studies), which were associated with higher levels of psychological distress and PTSD symptoms. Additionally, 4 studies reported that greater trauma severity or ongoing adversity attenuated or altered the protective effects of spirituality/religiosity (Table 6).

Table 6. Factors Associated with Reduced or Mixed Effects of Religiosity/Spirituality.

Factor	Number of Studies (n)	Description
Negative religious coping	5	Associated with higher PTSD, distress
Trauma severity/ongoing adversity	4	Reduced or altered protective effects
Cultural/contextual factors	3	Influenced the direction/strength of associations
Reactive coping (distress $\rightarrow$ coping)	3	Coping reflects distress rather than protection
Maladaptive religious beliefs	2	e.g., divine punishment, guilt

Cultural and contextual factors were identified in 3 studies as influencing the direction and strength of associations, highlighting the role of sociocultural norms and religious frameworks. Furthermore, 3 studies suggested that higher levels of distress were associated with increased use of religious coping, indicating a possible reverse or reactive relationship rather than a protective effect. Finally, 2 studies reported that certain religious beliefs, such as interpretations of trauma as divine punishment, were associated with worse mental health outcomes.

A temporal analysis of the included studies (2000–2025) suggests an evolution in how spirituality and religiosity are conceptualized and investigated. Earlier studies (approximately 2000–2010) were predominantly cross-sectional and tended to assess general religiosity or spiritual involvement using relatively unidimensional measures, often without distinguishing between different types of religious coping. Studies published in the subsequent period (2011–2018) increasingly employed validated multidimensional instruments and began to differentiate between spirituality and religiosity as related but distinct constructs. More recent studies (2019–2025) demonstrate greater conceptual and methodological refinement, including the routine distinction between positive and negative religious coping, the use of more complex analytical approaches (e.g., mediation, moderation, and machine learning models), and increased attention to contextual, cultural, and trauma-related factors influencing mental health outcomes. This progression reflects a shift toward a more nuanced understanding of the conditions under which spirituality and religiosity may be beneficial or detrimental.

2.2. Risk of Bias

Risk of bias for the four cohort studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Cohort Studies [44]. All studies were rated as having low risk of bias, demonstrating clearly defined cohorts, valid and reliable measurement of exposures and outcomes, and appropriate statistical analyses. Overall, the methodological quality of the longitudinal studies was considered satisfactory (Table 7). Risk of bias for the cross-sectional studies was assessed using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Analytical Cross-Sectional Studies, and the results are presented in Table 8. Overall, most studies met most quality criteria, including clearly defined inclusion criteria, detailed descriptions of participants and study settings, and the use of validated instruments to measure spirituality/religiosity and mental health outcomes. Appropriate statistical analyses were generally applied. However, some studies did not clearly report

strategies to address potential confounding factors. Overall, the methodological quality of the cross-sectional studies was considered moderate to high.

Table 7. JBI checklist for cohort studies.

Question	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Quality
Reyes et al. [26]	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Low
Handelzalts et al. [29]	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Low
Florez et al. [32]	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Low
Cadigan et al. [35]	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Low

The synthesis included 28 cross-sectional studies and four cohort studies examining the relationship between spirituality, religiosity, and mental health outcomes among women exposed to various forms of vulnerability, including intimate partner violence, sexual assault, trauma exposure, homelessness, HIV infection, and refugee status.

Most studies used validated instruments to measure spirituality or religiosity, such as the Spiritual Well-Being Scale, religious coping measures, or related constructs, alongside standardized mental health instruments assessing depression, anxiety, PTSD, or psychological distress.

Risk-of-bias assessment using the JBI Critical Appraisal tools indicated that the overall methodological quality of the included studies was moderate to high, with most studies clearly defining inclusion criteria, describing participants and settings in detail, and using reliable and valid outcome measures.

A quantitative meta-analysis was not conducted due to substantial heterogeneity across studies in terms of study design, populations, exposure measures (spirituality and religiosity constructs), and mental health outcomes assessed. Therefore, results were synthesized narratively.

Overall, the direction of the association across studies suggested a predominantly protective role of spirituality and specific dimensions of religiosity (e.g., intrinsic religiosity, religious coping) for mental health outcomes. Higher spiritual well-being and intrinsic religiosity were generally associated with lower psychological distress and better mental health indicators. However, the relationship between religious coping and mental health outcomes was more variable, with some studies reporting positive associations between religious coping and PTSD symptoms, particularly in populations experiencing severe or ongoing trauma.

Variability in study findings appeared to be influenced by several factors, including differences in the type of trauma or vulnerability experienced, cultural and religious contexts, and the specific dimensions of spirituality or religiosity assessed. For example, studies examining intrinsic religiosity or spiritual well-being more frequently reported protective associations with mental health outcomes, whereas studies focusing on religious coping sometimes observed mixed or context-dependent relationships.

Population characteristics also contributed to heterogeneity. Studies involving survivors of intimate partner violence or sexual assault often reported stronger associations between spirituality-related variables and mental health outcomes compared with studies involving other vulnerable populations, such as women experiencing homelessness or chronic illness.

No formal sensitivity analyses were conducted because a meta-analytic synthesis was not performed. However, the consistency of findings across multiple populations and study designs suggests a broadly similar pattern of associations between spirituality-related constructs and mental health outcomes.

Table 8. JBI checklist for analytical cross-sectional studies.

JBI Critical Appraisal Checklist	Were the Inclusion Criteria for the Sample Clearly Defined?	Were the Study Participants and the Study Location Described in Detail?	Was the Exposure Measured Reliably and Validly?	Were Objective and Standardized Criteria Used to Assess Health Status?	Were Confounding Factors Identified and Addressed?	Have Strategies Been Established to Manage Confounding Factors?	Were the Outcomes Measured Reliably and Validly?	Was the Appropriate Statistical Analysis Applied?
Kanter et al. [19]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emirza et al. [20]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rosenblad et al. [21]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Szyfer et al. [22]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Boga et al. [23]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Abraham et al. [24]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kasen et al. [25]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lacks et al. [27]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ozeto et al. [16]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Richardson et al. [28]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Fekih-Romdhane et al. [18]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Schaefer et al. [30]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Howell et al. [31]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Fischer et al. [33]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cuevas et al. [34]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Zhang et al. [36]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lilly et al. [37]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Staton-Tindall et al. [38]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bliss et al. [39]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Arévalo et al. [40]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Watlington et al. [41]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bradley et al. [42]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chang et al. [17]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Humphreys et al. [43]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Due to the absence of a quantitative meta-analysis and the heterogeneity of study designs and outcomes, formal statistical assessment of reporting bias (e.g., funnel plots or publication bias tests) was not conducted. Nevertheless, efforts were made to minimize reporting bias by conducting a comprehensive literature search and applying predefined inclusion criteria.

The overall certainty of evidence was considered moderate. While many studies used validated measurement instruments and appropriate statistical analyses, the predominance of cross-sectional designs limits the ability to establish causal relationships. Additionally, variability in exposure definitions and outcome measures across studies contributes to uncertainty in the strength of the observed associations.

3. Discussion

The 28 included studies collectively highlight a complex but generally protective role of spirituality and/or religiosity in the mental health of women facing diverse vulnerabilities, such as intimate partner violence, sexual assault, trauma, homelessness, HIV infection, and socioeconomic disadvantage. Across cross-sectional and longitudinal studies, higher levels of spiritual well-being, intrinsic religiosity, and adaptive religious coping were frequently associated with lower symptoms of depression, anxiety, post-traumatic stress, and psychological distress. Conversely, these spiritual resources were positively associated with resilience, quality of life, and post-traumatic growth, suggesting that spirituality may function as both a buffer against psychological harm and a facilitator of recovery and personal growth. A key methodological consideration across the included studies is the conceptual and measurement overlap between spirituality and religiosity. Although related, these constructs capture distinct dimensions of human experience, and variability in how they were defined and operationalized likely contributed to heterogeneity in findings.

A central finding of this review is that the relationship between spirituality, religiosity, and mental health is highly context-dependent. Cultural frameworks, the nature and severity of trauma, and the lived experiences of the populations studied play a decisive role in shaping both the expression of spiritual or religious beliefs and their psychological impact [45]. Rather than reflecting universal effects, the findings suggest that spirituality and religiosity operate within specific social and cultural contexts, shaping whether they serve as protective, neutral, or even detrimental factors.

The distinction between spirituality and religiosity remains a debated issue in the literature. As noted by Koenig and others, overly broad definitions of spirituality may reduce its conceptual clarity and limit its usefulness as an analytical construct [1]. The findings of this review support this concern to some extent, as variability in how spirituality was defined and measured across studies introduced challenges in comparing results and interpreting associations with mental health outcomes. While many recent studies demonstrate improved conceptual differentiation using validated instruments, inconsistencies remain. This highlights the need for greater standardization and conceptual precision in future research to enhance the interpretability and cumulative value of findings in this field.

Several studies identified specific mechanisms underlying these associations. Spirituality appeared to promote coping through meaning-making, fostering a sense of coherence and purpose in the face of trauma [46,47]. Social support linked to religious communities or spiritual networks was also commonly cited as a mediating factor, enhancing emotional regulation and reducing the impact of stressors [48,49]. This aligns with the notion that spirituality may facilitate access to supportive networks or enhance interpersonal connectedness, thereby indirectly contributing to psychological well-being. Future research should more explicitly examine interactions between religious coping and other coping mechanisms to better understand their combined influences. Some studies highlighted

moral injury and forgiveness as key pathways through which spiritual beliefs may mitigate psychological harm, particularly among women exposed to interpersonal violence or chronic adversity [19,50].

However, the relationship between spirituality and mental health was not uniform. A subset of studies reported non-significant or context-dependent effects, especially regarding positive religious coping and post-traumatic stress outcomes. In some cases, higher use of religious coping was observed among women with more severe symptoms, suggesting that spiritual practices may reflect attempts to manage existing distress rather than preventing it. Importantly, negative associations were primarily linked to negative religious coping, rather than religiosity per se. The heterogeneity of findings was influenced by factors such as type and severity of trauma, cultural or religious background, age, and socioeconomic status [51]. Additionally, measurement variability—ranging from standardized instruments like SWBS, FACIT-Sp-12, and DUREL to study-specific scales—further contributed to differences in observed effects.

Overall, these results indicate that while spirituality and/or religiosity often support mental health among vulnerable women, their protective effects are influenced by contextual factors, personal beliefs, and coping strategies. This underscores the importance of considering the multidimensional, culturally embedded nature of spirituality when designing interventions or interpreting research outcomes [52]. The evidence aligns with broader literature suggesting that spirituality can serve as both a resource and a coping mechanism, particularly in contexts of trauma, adversity, and social marginalization.

The findings also reflect an important evolution in the field over time. Earlier research largely emphasized the protective role of religiosity, often treating it as a uniform construct [53]. In contrast, more recent studies adopt a more differentiated perspective, highlighting that the impact of spirituality and religiosity on mental health depends on the nature of religious coping, individual beliefs, and contextual factors such as trauma severity and cultural background [54]. This shift toward greater conceptual clarity and methodological sophistication may help explain inconsistencies in the literature and underscores the importance of assessing not only the presence of religiosity but also its quality and function in individuals' lives.

It is also important to distinguish between mediating and moderating roles of spirituality and religiosity. In the included studies, these constructs were more frequently conceptualized as mediators, helping to explain how or why adverse experiences influence mental health outcomes (e.g., through meaning-making or social support). Fewer studies examined moderation effects, in which spirituality would buffer or exacerbate the strength of these associations. Future research should more systematically explore both pathways to better understand the complex role of spirituality in mental health.

A critical issue in this field concerns the conceptual overlap between spirituality and general psychological well-being. Many instruments used to assess spirituality include dimensions such as meaning, peace, and purpose, which are closely related to constructs commonly measured within mental health research. As a result, part of the observed association between spirituality and improved mental health outcomes may reflect conceptual or measurement overlap rather than distinct effects. This raises questions about the incremental value of spirituality as a separate construct in some contexts.

In contrast, religiosity is typically defined in terms of observable practices, beliefs, and institutional affiliations, which may yield more clearly delineated and measurable variables, though potentially less universal across cultural contexts [55]. While spirituality is often presented as a broader and more inclusive construct, this breadth may come at the cost of reduced conceptual precision.

Importantly, the findings of this review do not support the notion that spirituality or religion is uniformly beneficial. Negative religious coping, spiritual struggle, and maladaptive beliefs (e.g., interpretations of trauma as divine punishment) were consistently associated with poorer mental health outcomes. These findings highlight that both spirituality and religiosity can have complex and context-dependent effects, underscoring the need for careful conceptualization and measurement in future research.

The use of “vulnerability” as an umbrella term should be interpreted with caution. While all included populations share exposure to significant risk factors for poor mental health, the type, severity, and context of these adversities differ substantially. Grouping these populations may obscure important differences and limit the specificity of conclusions. Future research would benefit from more precise categorization of vulnerability to enhance the comparability and applicability of findings.

Based on the findings of this review, a conceptual framework is proposed to integrate the mechanisms through which spirituality and religiosity influence mental health outcomes among vulnerable women (Figure 2). In this model, spirituality and religiosity function as upstream resources that shape psychological well-being through several mediating pathways, including meaning-making, social support, adaptive coping strategies, and processes such as forgiveness and moral integration. These mechanisms contribute to reduced symptoms of depression, anxiety, and post-traumatic stress, while promoting resilience, quality of life, and post-traumatic growth. However, the strength and direction of these relationships are influenced by contextual factors, such as the type and severity of trauma, cultural and religious background, and socioeconomic conditions, which may either enhance or attenuate the protective effects of spirituality.

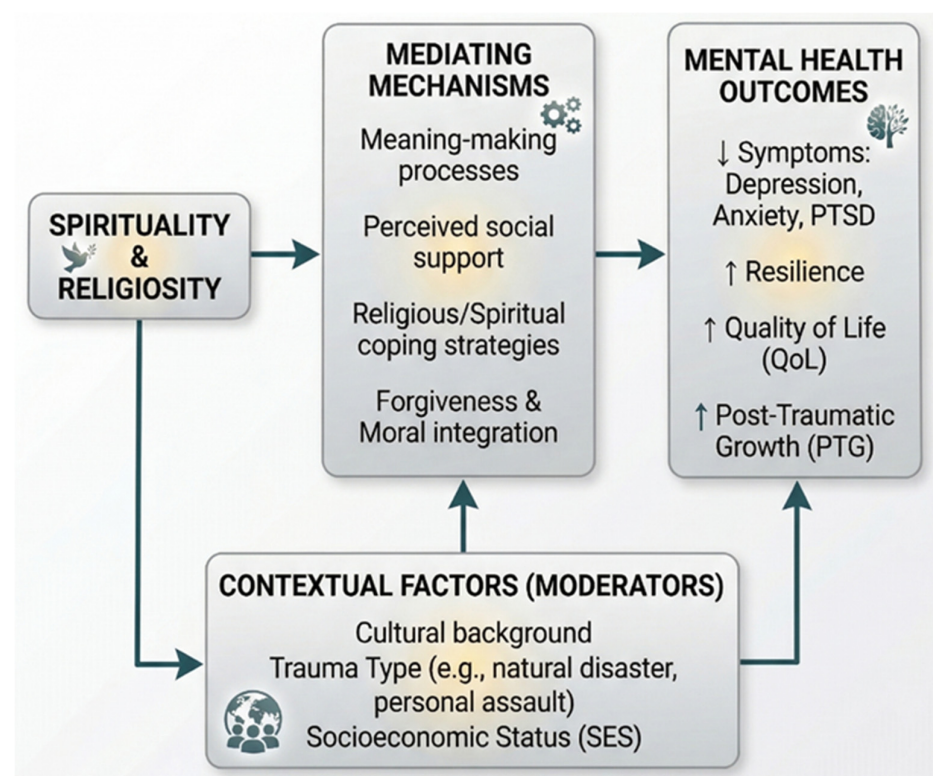


Figure 2. Conceptual model of spirituality-mediated mental health pathways in vulnerable women.

These findings caution against overly universal interpretations and underscore the importance of context-sensitive approaches in both research and clinical applications.

3.1. Strengths

This review represents the first synthesis of evidence specifically focused on vulnerable women. By integrating multiple dimensions of vulnerability and encompassing a wide array of contexts through the rigorous use of validated instruments, this study provides a robust and reliable evidence base. This multidimensional approach not only addresses a persistent gap in the literature but also ensures that the findings possess high external validity and significant clinical or social applicability.

3.2. Limitations

Several limitations within the included studies should be acknowledged. First, most studies were cross-sectional, limiting causal inferences regarding the impact of spirituality on mental health outcomes. Only four longitudinal cohort studies provided temporal data, and even among these, effect sizes for longitudinal associations were often small or non-significant. Second, variability in the measurement of spirituality and mental health outcomes—ranging from validated scales to study-specific instruments—complicates comparisons across studies. Third, many studies relied on self-reported measures, introducing potential biases such as social desirability and recall bias. Finally, study populations were heterogeneous in terms of culture, vulnerability type, and exposure severity, which may limit the generalizability of the findings to other groups of women or settings.

The review process itself also has limitations. Due to the heterogeneity of study designs, populations, and measurement instruments, a quantitative synthesis (meta-analysis) was not feasible, and results were synthesized narratively. Consequently, formal assessment of statistical heterogeneity and publication bias (e.g., funnel plots, Egger's test) could not be conducted. Additionally, the lack of consistent differentiation between spirituality and religiosity across primary studies limits the precision with which their independent effects on mental health outcomes can be interpreted.

3.3. Implications for Practice, Policy, and Future Research

The findings have several implications. Clinically, recognizing the potential protective role of spirituality can inform holistic interventions for women exposed to trauma or adversity, integrating spiritual resources, faith-based support, or meaning-centered approaches into mental healthcare. For policy, programs addressing women's mental health could consider culturally sensitive approaches that respect and incorporate spiritual beliefs and practices.

For future research, longitudinal and intervention studies are needed to clarify causal relationships and identify mechanisms through which spirituality influences mental health. Standardized, multidimensional measures of spirituality should be used to enhance comparability across studies. Furthermore, studies should explore potential adverse effects of spirituality, including spiritual struggles or maladaptive religious coping, particularly in populations with ongoing adversity. Finally, research in underrepresented cultural contexts and diverse vulnerability types is warranted to ensure findings are generalizable and applicable in global settings.

4. Materials and Methods

4.1. Research Question

This systematic review addresses the following research question:

RQ1: What is the relationship between spirituality and mental health outcomes among vulnerable women, and how do social, economic, and health-related vulnerabilities influence this relationship?

The review follows the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) 2020 guidelines and was prospectively registered on PROSPERO (2026, CRD420261301478), a publicly available database [56].

4.2. Eligibility Criteria

4.2.1. Inclusion Criteria

Studies will be included if they meet all of the following criteria:

- Population: Adult women (≥ 18 years) classified as vulnerable, defined as experiencing one or more conditions of social, economic, health-related, or life-course vulnerability (e.g., low socioeconomic status, chronic illness, caregiving responsibilities, migrant or refugee status, exposure to violence, older age, or limited access to healthcare services).
- Exposure/Intervention: Spirituality or religiosity, including spiritual practices, spiritual coping, meaning-making, or engagement with religious communities.
- Outcome: Mental health outcomes, including depression, anxiety, stress, psychological distress, or general well-being, measured with validated tools or self-reports.
- Study design: Observational studies (cross-sectional, cohort, case-control), interventional studies, and qualitative studies providing relevant quantitative outcomes.
- Language: Publications in any language.
- Publication type: Peer-reviewed articles, including full-text publications.

4.2.2. Exclusion Criteria

Studies will be excluded if they:

- Include men only or do not disaggregate data by sex.
- Focus solely on non-spiritual coping strategies without measuring spirituality.
- Were editorials, letters, commentaries, conference abstracts without full data, or grey literature.
- Lack sufficient detail to extract relevant outcomes.

Grouping for synthesis: Studies will be grouped by vulnerability type, spirituality/religiosity measure type, and mental health outcome domain.

4.3. Information Sources

The following databases will be systematically searched:

- PubMed
- Scopus
- Web of Science

Additionally, reference lists of included studies and relevant reviews will be screened manually. The last search will be conducted on February 2nd, 2026.

4.4. Search Strategy

A comprehensive search strategy was developed with consultation from a health sciences librarian. Keywords and MeSH terms included combinations of:

- “spirituality” OR “religiosity” OR “religious coping” OR “meaning-making”
- “mental health” OR “depression” OR “anxiety” OR “stress” OR “well-being”
- “women” OR “female”
- “vulnerable populations” OR “low socioeconomic” OR “caregiver” OR “chronic illness” OR “migrant” OR “refugee”

Boolean operators (AND, OR) were applied. The full query is listed below:

(spiritual* OR religio* OR “religious coping” OR “spiritual coping”) AND (depression OR anxiety OR stress OR “psychological distress” OR wellbeing) AND (“intimate partner

violence" OR abuse OR trauma OR poverty OR refugee* OR homeless*) AND (women OR woman).

4.5. Study Selection Process

All identified records were exported to Rayyan [57], and duplicates were removed. Two independent reviewers (FC and SDG) will perform:

- Title and abstract screening to exclude irrelevant studies.
- Full-text screening to assess eligibility based on inclusion/exclusion criteria.

Disagreements were resolved by discussion or by consulting a third reviewer (AC). A PRISMA flow diagram documents the study selection process (Figure 1).

4.6. Data Collection Process

Data was extracted independently by two reviewers (FC and SDG) using a standardized extraction form piloted on a subset of studies. Extracted data will include:

- Study characteristics (author, year, country, design).
- Population characteristics (age, type of vulnerability, sample size).
- Measures of spirituality/religiosity.
- Mental health outcomes and instruments used.
- Key findings and effect measures.

Any missing or unclear information will be requested from the study authors.

4.7. Data Items

4.7.1. Outcomes

The primary outcomes include mental health measures: depression, anxiety, stress, psychological distress, and general well-being. All reported measures compatible with these domains will be collected, including validated scales (e.g., PHQ-9, HADS, DASS) or validated survey instruments.

4.7.2. Other Variables

Other variables extracted: age, type and level of vulnerability, country/setting, study design, sample size, spiritual/religious measure, and funding source. Any assumptions regarding missing or unclear data will be documented.

4.8. Risk of Bias

Risk of bias was assessed independently by two reviewers (FC and SDG). The appraisal tools were selected according to the study design. The Joanna Briggs Institute (JBI) Critical Appraisal Checklists were used to assess the methodological quality of the included observational studies [44]. Discrepancies will be resolved by discussion or consultation with a third reviewer (AC).

4.9. Effect Measures

For quantitative studies, effect measures such as correlations, regression coefficients, odds ratios, or mean differences were extracted when reported. Due to the heterogeneity in study designs, populations, and measures of spirituality/religiosity and mental health outcomes, a meta-analysis was not considered appropriate. Therefore, the findings were synthesized using a narrative approach, summarizing the direction and strength of associations across studies.

4.10. Synthesis Methods

4.10.1. Criteria for Study Grouping

Studies will be grouped by:

- Type of vulnerability (e.g., health-related, socioeconomic, social/structural);
- Type of spirituality/religiosity measure;
- Mental health outcome domain.

4.10.2. Data Preparation

Where necessary, data were converted to comparable formats (e.g., mean $\pm$ SD). Missing summary statistics were handled by contacting the authors or by estimating from available data, following Cochrane recommendations.

4.10.3. Presentation of Results

Results were presented in structured tables summarizing study characteristics, outcomes, effect measures, and risk of bias. To enhance the interpretability of the findings, study outcomes were categorized by the direction of the association between spirituality/religiosity and mental health outcomes. Studies were classified as showing: (i) predominantly positive associations (i.e., higher spirituality/religiosity associated with better mental health outcomes), (ii) negative associations (i.e., associated with worse outcomes), (iii) no significant association, or (iv) mixed or context-dependent findings (i.e., both beneficial and adverse or non-significant results depending on the dimension or outcome assessed).

4.10.4. Synthesis Approach

A narrative synthesis was conducted to identify and summarize patterns across different types of vulnerability, spirituality and religiosity constructs, and mental health outcomes. Due to the heterogeneity in study designs, populations, and measurement instruments, a quantitative meta-analysis was not performed.

4.10.5. Exploration of Heterogeneity

Potential sources of heterogeneity, including differences in population characteristics, study design, type of vulnerability, and measurement instruments, were explored through narrative comparison of study findings.

4.10.6. Sensitivity Analysis

Formal sensitivity analyses were not conducted because no quantitative meta-analysis was available. However, the methodological quality of the included studies was taken into account when interpreting the findings.

4.11. Reporting Bias Assessment

Because a quantitative synthesis was not performed, formal statistical assessment of reporting bias (e.g., funnel plots or Egger's test) was not conducted. Instead, potential reporting bias was considered qualitatively by examining study characteristics, publication sources, and the completeness of reported results.

4.12. Certainty of Evidence

The certainty (confidence) in the body of evidence will be assessed using the GRADE framework, considering risk of bias, consistency, directness, precision, and publication bias. Certainty ratings (high, moderate, low, very low) will be reported for each outcome.

The systematic review process used Rayyan, an AI-assisted tool for organizing and screening references. Rayyan was used solely to support study selection, and all decisions regarding inclusion, exclusion, and data extraction were made independently by the authors. No generative AI was used to write, analyze, or interpret the manuscript content.

The complete PRISMA checklist can be found in the Supplementary Materials Table S1.

5. Conclusions

This systematic review synthesized evidence from 28 studies involving 9506 women to elucidate the relationship between spirituality, religiosity, and mental health outcomes among those facing systemic and interpersonal vulnerabilities. The findings consistently indicate that spirituality and religiosity serve as a robust protective factor against the deleterious psychological effects of trauma, including depression, anxiety, and PTSD. Specifically, higher levels of spiritual well-being, intrinsic religiosity, and adaptive religious coping were positively associated with greater resilience, improved quality of life, and enhanced post-traumatic growth.

The narrative synthesis identified several critical mechanisms, such as meaning-making, social support, and the mitigation of moral injury, through which spiritual resources buffer the impact of adversity. However, the efficacy of these resources is not monolithic; it is deeply mediated by the ‘quality’ of spiritual engagement. While positive spiritual coping fosters recovery, maladaptive frameworks such as viewing suffering as divine punishment can exacerbate internal conflict and delay professional help-seeking.

From a clinical and policy perspective, these results underscore the imperative of integrating spiritual and religious dimensions into routine mental health evaluations and trauma-informed care. Such integration is a pivotal strategy for advancing health equity, as it enables the development of culturally congruent interventions that resonate with the lived experiences of marginalized women.

Despite the strengths of the reviewed literature, the predominance of cross-sectional designs limits causal inferences. Future research should prioritize longitudinal methodologies and culturally sensitive assessments across diverse global contexts to better understand the temporal dynamics of spiritual resilience. Ultimately, acknowledging spirituality as a legitimate component of the biopsychosocial-spiritual model is essential for a comprehensive and equitable approach to women’s mental health in the face of systemic adversity.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/women6030045/s1>, Table S1: PRISMA 2020 checklist.

Author Contributions: Conceptualization, methodology, software, visualization, and data curation, S.D.G.; writing—original draft preparation, validation, formal analysis, investigation, and resources, F.C. and S.D.G.; writing—review and editing, F.C., A.C., P.M. and S.D.G.; supervision, project administration, S.D.G., A.C. and P.M. All authors have read and agreed to the published version of the manuscript.

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Data Availability Statement: Data supporting the findings and conclusions are available upon request from the corresponding author.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

ASI	Addiction Severity Index
AUDIT	Alcohol Use Disorders Identification Test
BDI-II	Beck Depression Scale
BIT	Brief Inventory of Thriving
BHS	Beck Hopelessness Scale
BMMRS	Brief Multidimensional Measure of Religiousness/Spirituality
BSI	Brief Symptom Inventory
BSRI	Bem Sex Role Inventory
BSS	Beck Scale for Suicide Ideation
CAES-SF	Childhood Abuse Experiences Scale Short Form
CCS	Community Cohesion Scale
CD-RISC	Connor–Davidson Resilience Scale
CES-D	Center for Epidemiologic Studies Depression Scale
COPE	Coping Orientation to Problems Experienced Inventory
CRS	Centrality of Religiosity Scale
CTQ	Childhood Trauma Questionnaire—Short Form
CTS	Conflict Tactic Scale
CTS-R	Conflict Tactic Scale Revised
CTS-2	Conflict Tactics Scales-2
DASS-21	Depression Anxiety Stress Scales-21
DAST	Drug Abuse Screening Test
DSES	Daily spiritual experiences
DTS	Davidson Trauma Scale
DUREL	Duke University Religion Index
EMIS-C	Expressions of Moral Injury-Civilian
FACIT-Sp-12	Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being
GHQ-12	General Health Questionnaire-12
HSCL-25	Hopkins Symptoms Checklist
IPSV	Intimate Partner Sexual Violence
ISA	Index of Spouse Abuse
ISEL	Interpersonal Support Evaluation List
JUO	Jewish Ultra-Orthodox
LEC	Life Events Checklist
LDS	Latter Day Saint
LSNS-R	Lubben Social Network Scale Revised
LTVH	Lifetime Trauma and Victimization History
MAST	Michigan Alcoholism Screening Test
MCS	Mental component summary
MEIM-R	Multigroup Ethnic Identity Measure-Revised
MINI	Mini International Neuropsychiatric Interview
MMRI	Multidimensional Measure of Religious Involvement
MSA	Military sexual assault
MSPSS	Multidimensional Scale of Perceived Social Support
PCBS	Purity Culture Beliefs Scale
PCL-C: PTSD	PTSD Checklist—Civilian version
PDS	Post-traumatic Stress Diagnostic Scale
PCL-5	Post-traumatic Stress Disorder Checklist for DSM-5
PC-PTSD	Primary Care PTSD Screen
PDSS	Postpartum Depression
P-IPV	Psychological Intimate Partner Violence
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses

PSS	Perceived Stress Scale
PTCI	Post-Traumatic Cognitions Inventory
PTGI	Post-traumatic Growth Inventory
PTSD	Post-Traumatic Stress Disorder
RBB	Religious Background and Behavior Scale
RCOPE	Positive Religious Coping subscale
R/SS	Religious and Spiritual Struggles Scale
SCI-R	Adapted Sexual Coercion Inventory-Revised
SCL	Symptom Checklist-90-Revised
SD	Standard Deviation
SEQ-DoD	Sexual Experiences Questionnaire–Department of Defense
SF	Short Form Health Survey
SIBS	Spiritual Involvement and Beliefs Scale
SOC	Sense of Coherence
SRLW	Survey of Recent Life Experiences
SPS	Spiritual Perspectives Scale
SWBS	Spiritual Well-Being Scale
TEQ	Traumatic Events Questionnaire
TLEQ	Traumatic Life Events Questionnaire
TSEI	Taylor Self-Esteem Inventory
UK	United Kingdom
USA	United States of America
WHOQOL	World Health Organization Quality of Life
WHOQOL–SRPB	World Health Organization Quality of Life—Spirituality, Religiosity and Personal Beliefs

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