Review Article

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# Spirituality and clinical outcomes in schizophrenia: an integrative review of the last decade

*Espiritualidade e desfechos clínicos na esquizofrenia: uma revisão integrativa da última década*

*Espiritualidad y resultados clínicos en la esquizofrenia: una revisión integrativa de la última década*

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**ABSTRACT:**
**Introduction**: Spirituality is an important factor in the treatment of any mental pathology, however, due to the presence of delirium and hallucinations with religious content, this pillar of treatment is often ignored in patients with Schizophrenia. **Objectives**: This study is an integrative literature review on the relationship between spirituality and patients with schizophrenia. **Methods**: Following PROSPERO registration, a search was conducted in PubMed, Cochrane, and SciELO using the terms "schizophrenia" and "spirituality," limited to English-language articles published in the last 10 years. Ten articles met inclusion criteria. Exclusions included articles not primarily addressing the topic, duplicates, unavailable full texts, or those linking spirituality to other disorders. **Results**: High spirituality was associated with greater remission rates (85.7% vs. 53.3%; $p < 0.001$) and fewer suicidal thoughts (16.3% vs. 33.3%; $p = 0.03$). There was no evidence that spiritual intensity caused psychotic exacerbations. On the contrary, spiritual and religious engagement correlated with reduced suicide mortality. **Discussion**: Findings regarding faith and adherence were mixed. Yet, positive spirituality was linked to improved functioning, reduced psychopathology, and enhanced coping. Beliefs contributed to social reintegration and lower mortality, especially when supported by resilience, meaning, and social networks. Methodological limitations, including small samples and heterogeneous measures, limit generalizability. **Conclusion**: High spirituality is associated with better clinical outcomes—higher remission and fewer suicidal ideations. Nonetheless, it appears to affect emotional and psychological domains rather than treatment adherence directly.

**Keywords:** spirituality, schizophrenia, treatment adherence and compliance, patient compliance, therapeutics, treatment outcome, suicide

**RESUMO:**
**Introdução**: A espiritualidade é um fator importante no tratamento de qualquer patologia mental. No entanto, devido à presença de delírios e alucinações com conteúdo religioso, esse pilar do tratamento é frequentemente negligenciado em pacientes com esquizofrenia. **Objetivos**: Este estudo é uma revisão integrativa da literatura sobre a relação entre espiritualidade e pacientes com esquizofrenia. **Métodos**: Após registro no PROSPERO, foi realizada uma busca nas bases PubMed, Cochrane e SciELO utilizando os termos "schizophrenia" e "spirituality", limitada a artigos em inglês publicados nos últimos 10 anos. Dez artigos atenderam aos critérios de inclusão. Foram excluídos artigos que não abordavam diretamente o tema, duplicados, textos completos indisponíveis ou que relacionavam espiritualidade a outros transtornos. **Resultados**: Alta espiritualidade foi associada a maiores taxas de remissão (85,7% vs. 53,3%; $p < 0,001$) e a menos pensamentos suicidas (16,3% vs. 33,3%; $p = 0,03$). Não houve evidências de que a intensidade espiritual causasse exacerbações psicóticas. Pelo contrário, o envolvimento espiritual e religioso correlacionou-se com menor mortalidade por suicídio. **Discussão**: Os achados sobre fé e adesão ao tratamento foram variados. Ainda assim, a espiritualidade positiva foi associada a melhor funcionamento, redução da psicopatologia e maior capacidade de enfrentamento. As crenças contribuíram para a reintegração social e menor mortalidade, especialmente quando apoiadas por resiliência, sentido de vida e redes sociais. Limitações metodológicas, incluindo amostras pequenas e medidas heterogêneas, limitam a generalização dos resultados. **Conclusão**: Alta espiritualidade está associada a melhores desfechos clínicos — maior remissão e menos ideação suicida. No entanto, parece afetar mais os domínios emocionais e psicológicos do que a adesão direta ao tratamento.

**Palavras-chave:** espiritualidade, esquizofrenia, adesão e conformidade ao tratamento, adesão do paciente, terapêutica, desfecho do tratamento.

**RESUMEN:**
**Introducción**: La espiritualidad es un factor importante en el tratamiento de cualquier patología mental. Sin embargo, debido a la presencia de

delirios y alucinaciones con contenido religioso, este pilar del tratamiento a menudo es ignorado en pacientes con esquizofrenia. **Objetivos**: Este estudio es una revisión integradora de la literatura sobre la relación entre la espiritualidad y los pacientes con esquizofrenia. **Métodos**: Tras el registro en PROSPERO, se realizó una búsqueda en las bases de datos PubMed, Cochrane y SciELO utilizando los términos "schizophrenia" y "spirituality", limitada a artículos en inglés publicados en los últimos 10 años. Diez artículos cumplieron con los criterios de inclusión. Se excluyeron los artículos que no abordaban principalmente el tema, los duplicados, los textos completos no disponibles o aquellos que relacionaban la espiritualidad con otros trastornos. **Resultados**: Una alta espiritualidad se asoció con mayores tasas de remisión (85.7% vs. 53.3%; $p < 0.001$) y con menos pensamientos suicidas (16.3% vs. 33.3%; $p = 0.03$). No hubo evidencia de que la intensidad espiritual causara exacerbaciones psicóticas. Por el contrario, la participación espiritual y religiosa se correlacionó con una menor mortalidad por suicidio. **Discusión**: Los hallazgos sobre la fe y la adherencia al tratamiento fueron mixtos. Sin embargo, la espiritualidad positiva se relacionó con un mejor funcionamiento, una reducción de la psicopatología y una mayor capacidad de afrontamiento. Las creencias contribuyeron a la reintegración social y a una menor mortalidad, especialmente cuando estaban respaldadas por la resiliencia, el sentido de la vida y las redes sociales. Las limitaciones metodológicas, incluyendo muestras pequeñas y medidas heterogéneas, limitan la generalización de los resultados. **Conclusión**: Una alta espiritualidad se asocia con mejores resultados clínicos: mayor remisión y menos ideación suicida. No obstante, parece afectar más los ámbitos emocionales y psicológicos que la adherencia directa al tratamiento.

**Palabras clave:** espiritualidad, esquizofrenia, adherencia y cumplimiento del tratamiento, cumplimiento del paciente, terapéutica, resultado del tratamiento, suicidio.

## Introduction

Schizophrenia is a complex and severe psychiatric disorder, with a lifetime prevalence of approximately 1% [1]. It is characterized by symptoms that may present both persistently and episodically [2].

Rather than a single pathognomonic symptom, schizophrenia encompasses a cluster of behavioral, cognitive, and emotional impairments. Diagnosis is

based on the presence of these symptoms in conjunction with a decline in occupational or social functioning [3].

The disorder is strongly associated with suicide risk [4]. Approximately 5%–6% of individuals with schizophrenia die by suicide, and around 20% attempt it at least once. Many more experience significant suicidal ideation. This risk remains elevated throughout the lifespan, particularly among younger males with comorbid substance use. Additional risk factors include depressive symptoms, hopelessness, unemployment, recent hospital discharge, agitation, prior suicide attempts, substance misuse, fear of mental disintegration, poor treatment adherence, and recent loss [3 - 4].

Delusions and hallucinations, especially those with religious content, are hallmark positive symptoms of schizophrenia. These manifestations complicate the understanding of religion's role in the disorder: whether it serves as a protective or risk factor remains debated, and the clinical implications of spirituality and religiosity (R/S) have been underexplored in this population [5].

Religious practice and spiritual engagement are known to impact various psychiatric conditions [6]. They have been linked to improvements in well-being, a sense of purpose, and social belonging [6 - 7], while also being associated with reduced self-esteem, perfectionism, depression, and self-rejection in some contexts [7]. In schizophrenia, however, R/S is often viewed with caution due to the potential for religious content to appear within delusions or hallucinations, leading to skepticism regarding its therapeutic inclusion [7].

Nonetheless, emerging evidence highlights the clinical relevance of religion in psychotic disorders, including schizophrenia [5]. Religious involvement is frequently associated with improved well-being, reduced symptoms of depression and anxiety, enhanced social support, and lower rates of substance use [7]. A recent meta-analysis confirmed a significant correlation between R/S and mental health outcomes [6].

Importantly, spiritual and religious experiences in schizophrenia may be influenced—or confounded—by the nature of psychotic symptoms themselves. Religious content appears in approximately 26% of hallucinations and delusions [8], and a sense of divine presence has been associated with improved social, though not necessarily occupational, functioning [5].

Given the complexity of these interactions, this review aims to synthesize the current literature and clarify the relationship between schizophrenia and religious or spiritual manifestations.

## Methods

This study is an integrative literature review aimed at synthesizing recent evidence regarding the relationship between spirituality and clinical outcomes in patients with schizophrenia.

The review was registered on the PROSPERO platform (ID CRD42023444506) and conducted according to the following steps: formulation of the research question, definition of inclusion and exclusion criteria, literature search, data selection, analysis, and synthesis.

A systematic search was conducted in April 2024 in the PubMed, Cochrane Library, and SciELO databases using the keywords "schizophrenia" and "spirituality," combined with Boolean operators. Filters were applied to select articles published in the last 10 years, in English, involving human participants. The reference lists of included articles were also screened for additional studies.

Inclusion criteria comprised empirical studies published between 2014 and 2024 that investigated the relationship between spirituality and patients diagnosed with schizophrenia, including clinical outcomes such as treatment adherence, symptom remission, functioning, quality of life, and suicidality.

Exclusion criteria included: (1) studies not exclusively focused on schizophrenia or without stratified analysis; (2) lack of full-text availability; (3) duplicate entries; (4) non-English publications; (5) non-empirical works (e.g., editorials, opinion articles); (6) purely theoretical or theological discussions with no clinical application; (7) studies that addressed spirituality as a peripheral concept without clear correlation to clinical outcomes; and (8) studies involving only caregivers or healthcare professionals, without patient data.

Two independent reviewers screened titles and abstracts, followed by full-text analysis. Discrepancies were resolved by consensus. The selection process is illustrated using a PRISMA flow diagram (Figure 1). Data extraction was performed using a standardized form including study design, population, instruments, outcomes, and findings.

## Results

*Search results and study characteristics*

A total of 55 articles were initially identified. Of these, 9 met the inclusion criteria and were selected for full-text analysis. During the evaluation process, one additional article was included, as it fulfilled the eligibility criteria, resulting in a final sample of 10 studies. The study selection process is illustrated in the PRISMA flowchart (Figure 1).

Among the selected studies, one employed a longitudinal design [9], eight were cross-sectional [10, 11, 12, 13, 14, 15, 16, 17], and one was a systematic literature review [18]. Table 1 presents the key data extracted from the ten studies included in this review.

*Spirituality and treatment adherence*

Only one study specifically investigated the association between spirituality and treatment adherence [12]. The sample included 109 patients diagnosed with schizophrenia (93 men and 16 women). Inclusion criteria required participants to be in remission (i.e., treatment completed, signs of symptom stabilization, and developed insight), aged 18 or older, with no comorbid psychiatric, physical, or neurological conditions that could impair their ability to complete the study instruments.

Spirituality and religiousness were assessed using the Santa Clara Strength of Religious Faith Questionnaire, while adherence to treatment was measured using the Morisky Adherence Scale. Additionally, participants responded to a 10-item questionnaire assessing their demographic and socioeconomic characteristics.

The mean religious faith score was 31.36 ± 7.22, indicating a high level of religious commitment among participants. However, treatment adherence was suboptimal: 29.3% of participants were classified as adherent, 35.8% as moderately adherent, and 34.9% as non-adherent.

No statistically significant correlation was found between the Santa Clara religious faith scores and adherence levels measured by the Morisky scale ($p > 0.05$), suggesting that the intensity of religious faith did not influence treatment adherence in this sample.


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The study's limitations include its small sample size, significant gender imbalance, and single-site design, which constrain the generalizability of its findings.

*Spirituality and its influence on relapses*

Although none of the included studies evaluated spirituality and treatment adherence as a primary outcome, two studies [11,15] provided relevant secondary findings on this topic.

Esan et al. [11] evaluated 215 participants from two psychiatric hospitals in Nigeria, aged 20 to 60 years, with an approximately equal gender distribution (50.7% male). The instruments used included a Sociodemographic Questionnaire, the Daily Spiritual Experiences Scale (DSES), the WHO Composite International Diagnostic Interview (CIDI) Version 3.0, the 17-item Hamilton Depression Rating Scale (HDRS), the Positive and Negative Syndrome Scale (PANSS), and the Social and Occupational Functioning Assessment Scale (SOFAS-DSM-IV). While the primary focus was the relationship between spirituality and suicidality in stable patients with schizophrenia, secondary analyses revealed a significant association between spirituality and symptom remission: 85.7% of participants with high spirituality were in remission, compared to 53.3% of those with low spirituality ($p < 0.001$).

The authors noted that all participants were clinically stable, which may limit the generalizability of findings. Furthermore, the study did not specify the treatments (pharmacological or otherwise) patients were receiving at the time of data collection.

Kéri et al. [15] assessed 120 patients with schizophrenia and 120 healthy controls across three psychiatric institutions in Hungary. The aim was to explore associations among schizophrenia, spirituality, and Christian religiosity. Inclusion criteria required clinical stability, capacity to consent, and no medication adjustments for at least four weeks (mean chlorpromazine-equivalent dose: 445 mg/day, SD = 275.3). Participants completed the Mini-International Neuropsychiatric Interview and underwent a comprehensive neurological examination. Individuals with substance use disorders were excluded. Symptomatology was assessed using the PANSS, and subjective psychotic experiences were evaluated with the Bonn Scale for the Assessment of Basic Symptoms (BSABS).

Higher levels of both positive and negative spirituality were associated with increased severity of self-disorders, perceptual disturbances, and positive

symptoms ($p < 0.05$). Notably, patients with schizophrenia exhibited significantly higher positive spirituality scores than controls, with no significant difference in negative spirituality—suggesting that increased spiritual engagement did not contribute to fear, paranoia, or distress. Furthermore, patients experiencing religious delusions exhibited greater self-disorder severity than those without such delusions (mean BSABS score: 2.6 [1.3] vs. 1.5 [1.2]).

Key limitations included the cross-sectional, correlational design, which precluded causal inference, the lack of data on fluctuations in spirituality over time, the small number of participants with religious delusions, and the absence of broader clinical outcome measures such as quality of life or general health.

*Spirituality and suicide*

A cross-sectional study by Esan et al. [11] reported a significant association between spirituality and lifetime suicidal ideation ($p = 0.03$). Individuals with low spirituality were more likely to have experienced suicidal thoughts (33.3%) compared to those with high spirituality (16.3%). The study also confirmed a significant relationship between spirituality and remission status: 85.7% of participants with high spirituality were in remission, compared to 53.3% of those with low spirituality ($p < 0.001$).

Pearson correlation analyses revealed that higher levels of spirituality were negatively associated with the severity of negative symptoms, general psychopathology (PANSS general subscale), total PANSS scores, and depression severity (HDRS total score) (all $p < 0.001$). Conversely, spirituality was positively correlated with higher levels of functioning, as measured by the SOFAS ($p < 0.001$).

A systematic review by Harris et al. [18], conducted according to PRISMA guidelines, analyzed 27 studies to identify psychological constructs associated with resilience to suicidal thoughts and behaviors. Four primary domains were identified: (1) perceived social support; (2) religious and spiritual beliefs; (3) reasons for living; and (4) perceived personal strengths and coping skills.

Findings showed that support from significant others reduced both suicidal ideation and attempts. Religious and spiritual beliefs—especially satisfaction with those beliefs, spiritual engagement, and religious coping—


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were also associated with lower suicide rates. Factors such as survival and coping beliefs, family responsibility, and moral objections to suicide (as measured by the Reasons for Living Inventory) were linked to reduced suicidal behavior. Additional protective factors included quality of life, self-acceptance, emotional regulation, recovery experiences, internal locus of control, and active problem-solving skills. Emotional clarity was particularly protective, with greater ability to process emotions associated with lower suicidality.

A key limitation of the review was the exclusion of gray literature, which may have narrowed the scope, though the authors note that such literature often lacks methodological rigor.

Das et al. [17] conducted a cross-sectional observational study with 48 individuals diagnosed with schizophrenia in remission. The study examined associations between spirituality, religiousness, and coping strategies. Psychopathology was assessed using the PANSS, and functioning was measured with the Personal and Social Performance Scale (PSP). Spirituality and religiousness were evaluated through the WHOQOL-SRPB, and coping mechanisms were assessed using the Ways of Coping Checklist.

Significant positive correlations ($p < 0.05$) were found between multiple dimensions of spirituality—including connection with a higher power, meaning and purpose, awe and wonder, wholeness and integration, inner peace, faith, hope, and spiritual strength—and adaptive coping strategies such as distancing, self-control, acceptance of responsibility, planful problem solving, and positive reappraisal.

However, the generalizability of these findings is limited, as the study was conducted in a hospital-based sample. Moreover, potentially influential variables such as family support, emotional expressiveness, and understanding of the illness by both patients and family members were not assessed.

*Spirituality and other associated effects*

Irawati et al. [10] conducted a descriptive qualitative study at the Yogyakarta Mental Health Hospital in Indonesia, focusing on Muslim patients aged 40–60 years with a diagnosis of schizophrenia. Using purposive sampling, six participants were selected based on the following criteria: not being in an acute phase, absence of religious delusions, and willingness to participate in interviews. Data were collected through semi-structured interviews and analysis of hospital spiritual care procedures and

medical records. The study adhered to the COREQ guidelines for qualitative research reporting.

The interview guide addressed religious practices within the hospital context, including the types of religious activities performed, their perceived impact, institutional support, and challenges encountered. Thematic analysis revealed five major themes: (1) frequency of Salat and Dhikr during hospitalization, (2) timing of these practices, (3) barriers to performing them, (4) perceived health benefits, and (5) negative effects of discontinuation. Participants noted that performing Salat (prayer) and Dhikr (remembrance of God) helped promote relaxation and reduce anxiety, enhancing emotional regulation and self-discipline during hospitalization.

Although the study illuminated the spiritual needs of Muslim patients with schizophrenia, its generalizability is limited due to its single-site design and exclusive focus on Islamic practices. Barriers experienced by individuals from other faith traditions were not explored.

Two studies [13,16] examined the relationship between spirituality and resilience, reporting divergent findings.

Gooding et al. [16] investigated resilience from the perspective of individuals diagnosed with schizophrenia. Twenty-three participants (14 men, 9 women) were recruited from outpatient mental health services in North West England. Eligibility criteria included a clinical diagnosis, age over 18, capacity to consent, and English fluency. Data were collected using the Resilience Appraisal Scale and the Suicidal Behaviors Questionnaire-Revised. Semi-structured interviews explored definitions of resilience and contributing factors. Thematic analysis revealed internal (e.g., emotional regulation, coping strategies) and external factors (e.g., social support, reciprocal relationships, religious beliefs) as key to resilience. Several participants identified their religious faith as a source of strength in managing adversity.

Limitations included recall bias due to retrospective reporting of stressful events, a lack of cultural diversity (predominantly White British), and omission of explicit evaluation of coping strategy effectiveness.

Mizuno et al. [13] conducted a cross-cultural study involving 369 participants: 189 from Austria and 180 from Japan. The sample included

112 patients with paranoid schizophrenia, 120 with bipolar I disorder, and 137 healthy controls. Participants met DSM-IV criteria and were clinically stable, with no medication changes for six months. Assessments included the Mini-International Neuropsychiatric Interview, the Resilience Scale (RS), the FACIT-Sp (Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale), the Personal and Social Performance Scale (PSP), and disorder-specific psychopathology scales.

Healthy controls exhibited significantly higher resilience scores than patients with either bipolar disorder or schizophrenia ($p < 0.01$). No significant difference was found between the two clinical groups. A strong positive correlation was observed between spiritual well-being (FACIT-Sp total scores) and resilience (RS scores) ($r = 0.584$, $p < 0.001$), and spiritual well-being emerged as the strongest predictor of resilience ($\beta = 0.590$, $p < 0.001$). In subgroup analyses, religious service attendance predicted resilience in the Austrian cohort, but not in the Japanese group.

Limitations included the chronic stage of illness in participants, sample heterogeneity, unbalanced denominational representation, and unmatched recruitment settings between countries, which may restrict cross-cultural comparability.

Ho et al. [14] employed a grounded theory approach to explore the meanings of spirituality among individuals with schizophrenia and mental health professionals in Hong Kong. Eighteen service users (10 men, 8 women) and a range of mental health professionals (e.g., psychiatrists, nurses, occupational therapists) were interviewed. Clients viewed spirituality in practical and experiential terms—such as achieving inner peace, emotional stability, and personal growth—whereas professionals adopted broader conceptual frameworks. Both groups acknowledged spirituality as a key factor in recovery.

Limitations included the culturally homogeneous sample and reliance on verbal interviews, which may have constrained expression in participants with limited verbal fluency.

Lanfredi et al. [9], as part of the PERDOVE project in Italy, analyzed data from 403 individuals with schizophrenia spectrum disorders living in medium- to long-term residential facilities. Spirituality and religiousness were assessed using the Spiritual Well-Being Scale (SWBS), and quality of life (QoL) was measured with the WHOQoL-BREF. Greater satisfaction with


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spiritual well-being was positively correlated with psychological and environmental QoL domains (p = 0.002 and p = 0.001, respectively).

Study limitations included the limited analytical power due to small subsample sizes for structural equation modeling, and the use of a single-item measure for social support, which may have oversimplified a multidimensional construct.

**Discussion**

As reported by Altun et al. [12], spirituality was not a significant factor in treatment adherence among individuals with schizophrenia, as no correlation was found between the strength of religious faith and adherence levels. However, the study had important limitations, including a small sample size, gender imbalance, and a single-center design, which limit the generalizability of its findings.

In contrast, Esan et al. [11] found that participants with high levels of spirituality were more likely to be in remission than those with low levels. This was supported by Kéri et al. [15], who noted that individuals with schizophrenia exhibited elevated levels of positive spirituality, which did not appear to contribute to paranoia or fear. However, they also observed that patients with religious delusions showed greater severity in self-disorder than those without such symptoms.

Esan and colleagues further demonstrated that individuals with low spirituality were more likely to report lifetime suicidal ideation than those with high spirituality. In addition, spirituality was negatively correlated with negative symptom severity (PANSS total score), depression severity (HDRS score), and positively correlated with overall functioning (SOFAS score) [11].

Harris et al. [18] identified several protective factors associated with reduced suicide risk, including strong social support, satisfaction with religious beliefs, spiritual coping, a sense of purpose, emotional regulation, internal locus of control, personal recovery, and high quality of life. Their findings highlight the importance of integrating these elements into mental health interventions.

These results align with previous literature. Grover et al. [19] noted that religion and religiosity in patients with schizophrenia were associated with greater social integration, lower risk of suicide attempts, decreased


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substance use, reduced smoking rates, improved quality of life, and better prognosis. Religion may also influence decisions related to suicide, functioning as a protective factor in both psychotic and non-psychotic populations. As Huguelet et al. [20] emphasized, suicide prevention strategies for individuals with schizophrenia should incorporate these findings.

Das et al. [17] reinforced the protective role of spirituality in managing suicidality, particularly through mechanisms such as self-distancing, emotional regulation, acceptance of responsibility, planned problem solving, and positive cognitive reappraisal. Key spiritual constructs associated with these outcomes included connection with a higher power, meaning and purpose, awe and wonder, inner peace, hope, and faith.

Regarding anxiety, Irawati et al. [10] demonstrated that religious practices such as Salat (prayer) promoted relaxation, reduced anxiety, and helped patients cope with daily stress and hopelessness by reinforcing their trust in God.

Resilience also emerged as a key outcome. Internal coping strategies (e.g., emotional regulation) and external factors such as social support and religious beliefs contributed significantly to psychological resilience [16]. Mizuno et al. [13] found that spiritual well-being was the strongest predictor of resilience among all factors evaluated. However, healthy controls scored significantly higher in resilience than clinical groups, and no significant difference in resilience was observed between patients with bipolar disorder and those with schizophrenia.

In terms of clinical stability and recovery, Ho et al. [14] found that individuals with schizophrenia often conceptualized spirituality in concrete terms, such as self-awareness, emotional calmness, and transformation following illness, highlighting its practical importance in their recovery processes. Similarly, Lanfredi et al. [9] reported that higher satisfaction with spiritual well-being was positively associated with psychological and environmental quality of life.

Nevertheless, several methodological limitations across studies must be acknowledged. Small sample sizes, gender imbalance, and single-site recruitment limited generalizability. The cross-sectional and correlational designs prevented examination of the dynamic interaction between spirituality and symptom progression. Other constraints included recall bias, ethnic homogeneity, exclusion of acute-stage patients, and lack of

comprehensive assessments of clinical outcomes. These factors must be considered when interpreting the findings.

**Conclusions**

Higher levels of spirituality appear to be associated with better clinical outcomes in individuals with schizophrenia, including higher remission rates and reduced suicidal ideation. However, religious faith did not show a direct impact on treatment adherence. These findings suggest that spirituality plays a greater role in emotional and psychological recovery than in behavioral compliance. Future research should investigate the mechanisms involved and how spiritual aspects can be thoughtfully integrated into treatment strategies for schizophrenia.

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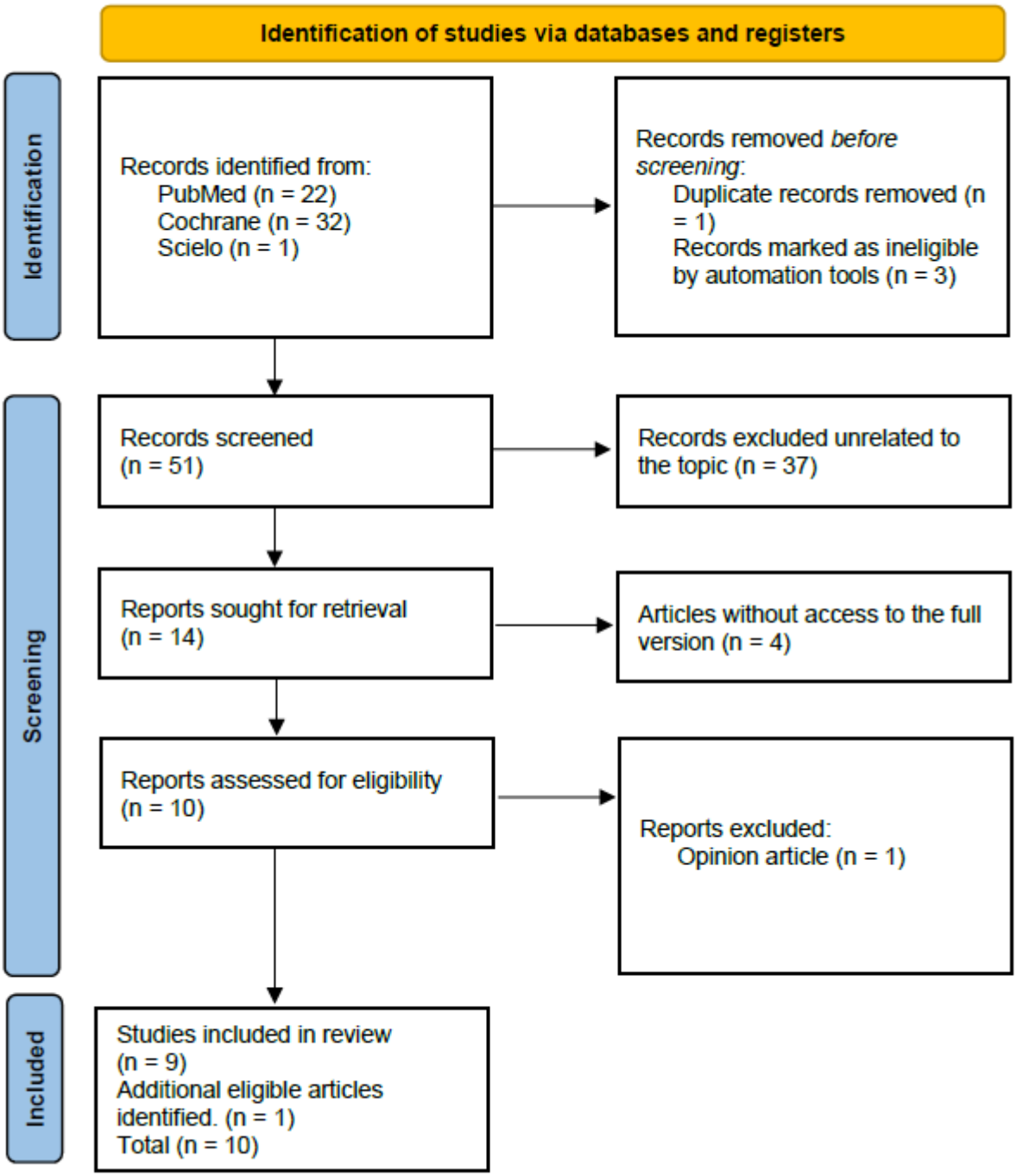


**Figure 1.** Identification of studies via databases and registers
**Fonte**: Os autores


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**Table 1**. Summary of the studies

| Authors | Study design | Study population | Objective | Evaluated spiritual practice | Results |
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| Lanfredi et al., 2014 | Longitudinal | Patients with a diagnosis of schizophrenia spectrum disorders (N=139); age between 18 and 64 years; | Detecting predictors of QOL by assessing service satisfaction and spiritual and religious well-being in patients with schizophrenia living in RFs | SWBS | Moderate-high satisfaction with spiritual and religious well-being was positively associated with three different domains of QOL; Whereas spiritual and religious higher scores were positively associated with psychological and environment domain scores in VSSS. |
| Kéri et al., 2016 | Cross-sectional | Patients with schizophrenia (N = 120) and 120 non-clinical individuals. Average age: 39,6 +-13 x 39,1 +-12,9. | Explores the relationship among schizophrenia, spirituality, and Christian religiosity. | BMMRS, PANSS, BSABS | Enhanced positive spirituality and decreased positive congregational support in patients with schizophrenia relative to non-clinical individuals. The schizophrenia patients with religious delusions exhibited higher positive spirituality than the patients without religious delusions. There were no |

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| | | | | | significant between-groups differences in Christian religiousness, BMMRS negative spirituality, forgiveness, religious–cultural practices, and negative congregational support. There were several significant correlations that survived corrections for multiple comparisons: Higher positive spirituality was associated with more severe self-disorder, perplexity, perceptual disorder, and positive symptoms. Higher negative spirituality was associated with more severe self-disorder, perceptual disorder, and positive symptoms. The schizophrenia patients with religious delusions displayed more severe self-disorder than the patients without religious delusions |
| Ho et al., 2016 | Cross-sectional | 18 patients diagnosed with schizophrenia | This study investigated the meaning and roles | Semi-structured interview, | Patients tend to seek for stability, peace, and growth rather than an existential |


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| | | (ages of 18 and 65 years) and 19 mental-health professionals (psychiatrists, psychiatric nurses, occupational therapists/physiotherapists, social workers) from public hospitals and mental-health community rehabilitation centers in Hong Kong. | of spirituality from the perspectives of persons with schizophrenia and mental-health professionals. | all of the interview questions were open-ended. | quest; while professionals hold a more pathological perspective, viewing spirituality as a means to relieve symptoms, increase social acceptance, and cope with illness experiences. |

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| Gooding et al., 2017 | Cross-sectional | Patients who had schizophrenia and suicidal thoughts and behaviours. (N = 21, 14 male and 7 female). | The goal of this study was to investigate resilience to negative stressors in people with disorders on the schizophrenia spectrum using a qualitative methodology. | RAS, SBQ-R | Psychological mechanisms described participants' views about the meaning of resilience which ranged from passive acceptance to resistance, and then to active strategies to counter stressors. These themes were also evident in narratives expressing personal resilience strategies but, additionally, included emotional coping techniques. External factors were highlighted that supported resilience, including, social support, reciprocity, and religious coping. |
| Mizuno et al., 2017 | Cross-sectional | Three-hundred sixty-nine subjects were recruited from Austria (n = 189) and Japan (n = 180), consisting of 112 outpatients with paranoid schizophrenia, 120 with bipolar I disorder (DSM-IV), | The impact of religious/spiritual activities on clinical outcomes in patients with serious mental illnesses (paranoid schizophrenia, bipolar I disorder) | FACIT-Sp, Resilience Scale (RS), Personal and Social, PSP, PANSS, MADRS, YMRS | Attendance of religious services and importance of religion/spirituality do not show significant associations with resilience. In contrast to the findings regarding religiosity, spiritual well-being showed a strong positive correlation with resilience. |

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| | | and 137 healthy controls. | | | |
| Das et al., 2017 | Cross sectional study | 48 patients (age 18-65 years, diagnosis of schizophrenia as per DCR-10, in remission - PANSS Score <60. | To evaluate the association between spirituality, religiousness and coping skills in patients with schizophrenia in remission. | PANSS, PSP, WHO Quality of Life-Spirituality, Religiousness and Personal Belief scale (WHOQOL-SRPB) and Ways of Coping Checklist - Revised (WCC). | Significant correlation between religiousness/spirituality and coping skills (managing their stress as they used all the adaptive strategies like planful problem solving, positive reappraisal, distancing, self-controlling, seeking social support rather than maladaptive skills like confrontive coping and escape avoidance). |
| Altun et al., 2017 | Cross-sectional | 109 patients, diagnosed with schizophrenia according to the DSM-V | To determine schizophrenic patients' strength of religious faith and its relationship with adherence to treatment. | A personal information form, the Santa Clara Strength of Religious Faith Questionnaire and the | The schizophrenic patients showed a high level of religious faith; however, a majority of them were insufficiently adherent to their treatment. Their religious faith level was found not to be one of the |

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| | | | | Morisky Adherence Scale. | factors that affect their adherence to treatment. |
| Harris et al., 2019 | Systematic literature review | 27 relevant studies. Sample sizes across studies varied between 30 and 257,372 participants in the quantitative studies, between 19 and 115 in the qualitative studies, and between 36 and 145 in the mixed-methods studies.Participants aged 16 years or older or described as adults; At least 50% of the participants had schizophrenia diagnoses or non-affective psychosis determined by clinical diagnostic criteria | To appraise the evidence for psychological factors which confer resilience to suicidal thoughts and behaviours, and categorize these psychological factors into broader psychological constructs which characterize resilience. | x | Four factors which characterize resilience to suicidal thoughts and behaviors in people with schizophrenia were identified. The first category was perceived social support, the second category was holding religious and spiritual beliefs,the third category was having reasons. |


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| Esan et al., 2021 | Cross-sectional | Stable patients with schizophrenia attending the follow-up outpatient clinic who met the DSM-IV. There were 215 participants in this study. The ages ranged from 20 to 60 years. A total of 109 (50.7%) were males. | The aim of this study was to investigate the relationship between spirituality and suicidality among stable patients with schizophrenia in Nigeria. | Sociodemographic questionnaire; DSES; WHO; CIDI Version 3.0; HDRS; PANSS; SOFAS-DSM-IV | Participants who had low spirituality (33.3%) were more likely to have had suicidal thoughts in their lifetime than those with high spirituality (16.3%). The relationship between spirituality and remission was significant.<br><br>Participants with high spirituality (85.7%) were more likely to be in remission than those with low spirituality (53.3%) Cr |
| Irawati et al., 2022 | Cross-sectional | The study interviewed 6 schizophrenic inpatients from 40-60 years old, not delusion or in an acute phase. (Plus, additional 2 nurses who took the interview) (N=6) | Explore data about spiritual needs and collect themes related with religiousness in muslim schizophrenic patients | Semi-structured interview method. | Muslim schizophrenic patients need and enjoy performing the salat (daily prayers) and dhikr (remembrance of Allah). The positive effects on their mind and body can decrease anxiety, restlessness symptoms. |

**Fonte**: Os autores
**Notas**: **QQL**=Quality of life; **RF**=Residential Facilities; **SWBS**=Spiritual Well-being scale; **VSSS**=Verona Service Satisfaction Scale; **BMMRS**=Brief Multidimensional Measure of Religiousness/Spirituality; **RAS**=Resilience Appraisal Scale; **SBQ-R**=Suicidal Behaviours

Questionnaire-Revised; **DSES**=The Daily Spiritual Experiences Scale; **WHO**=The World Health Organization; **CIDI**=Composite International Diagnostic Interview; **HDRS**=The 17-item Hamilton Depression Rating Scale; **PANSS**=The Positive and Negative Syndrome Scale; **SOFAS**=Social and Occupational Functioning Assessment Scale; **BSABS**=Bonn Scale for the Assessment of Basic Symptoms; **DACIT-Sp**=Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being Scale; **PSP**=Personal and Social Performance Scale; **MADRS**=Montgomery– Asberg Depression Rating Scale; **YMRS**=Young Mania Rating Scale;