ANALYSIS OF THE ROLE OF RELIGION AND SPIRITUALITY DURING ADOLESCENCE IN THE CONTEXT OF HEALTH

Margita Kollárová

Ph.D. PhD., Assistant Professor, Institute of Social Medicine and Medical Ethics,
Faculty of Medicine, Comenius University in Bratislava, Slovak Republic
margita.kollarova@fmed.uniba.sk
https://orcid.org/0009-0000-9480-0436

https://doi.org/10.34017/1313-9703-2026-1(27)-2(28)-73-82

Анотация

Маргита Коларова. Анализът на ролята на религията и духовността в юношеската възраст в контекста на здравето. Изследването разглежда ролята на религията и духовността в юношеска възраст, със специален фокус върху религиозността като фактор за здравето сред младите католици в Словакия. Религиозността се разбира като многоизмерен феномен, анализират се нейните основни измерения, както и съществуващите типологии на вярващите. Обръща се внимание и на религиозността на подрастващите в по-широкия контекст на социалното развитие и прехода към зряла възраст. Освен това, изследването се фокусира върху структурата на свободното време на младите католици и връзката с религиозността и поведението, свързано със здравето. Свободното време се счита за важен компонент от начина на живот на подрастващите, отразяващ ценностните ориентации, социалната интеграция и поведенческите модели, които могат да повлияят както на физическото, така и на психическото благополучие. Емпиричният анализ се основава на представително количествено социологическо проучване, проведено сред ученици от 3-ти и 4-ти клас на средни училища в Словакия. Извадката се състои от 1968 респонденти и е представителна по отношение на пол, вид училище и регионално разпределение. В клъстерния анализ са включени 1208 респонденти, които се самоопределиха като римокатолици или гръкокатолици. Чрез клъстерния анализ изследването идентифицира емпирични типологии на младите католици в зависимост от структурата на техните дейности в свободното време. Тези типологии са интерпретирани във връзка с индивидуалните показатели на религиозността и поведението, свързани със здравето, което позволява по-задълбочено разбиране на взаимовръзката между религиозната активност, начина на живот и здравето на подрастващите. Резултатите допринасят за по-добро разбиране на религиозността като сложен социален фактор, който взаимодейства с поведението, свързано със здравето, и процесите на развитие в юношеска възраст. Изследването подчертава важността на отчитането както на институционалните, така и на субективно-емпиричните измерения на религиозността при анализа на нейното въздействие върху живота на младите хора.

Ключови думи: религиозност, измерения на религиозността, типове вярващи, преход към зряла възраст, юношеска религиозност, дейности в свободното време, емпирична типология на младите католици в Словакия според структурата на свободното време, здраве

Abstract

Margita Kollárová. Analysis of the role of religion and spirituality during adolescence in the context of health. The study examines the role of religion and spirituality during adolescence, with a particular focus on religiosity as a determinant of health among young Catholics in Slovakia. It conceptualizes religiosity as a multidimensional phenomenon and addresses its key dimensions

as well as established typologies of believers. Attention is also paid to adolescent religiosity in the broader context of social development and the transition to adulthood. In addition, the study focuses on the structure of leisure activities of young Catholics and their relationship to religiosity and health-related behavior. Leisure activities are understood as an important part of adolescents' lifestyle, reflecting value orientations, social integration, and behavioral patterns that can influence both physical and psychological well-being. The empirical analysis is based on a representative quantitative sociological survey conducted among 3rd and 4th year high school students in Slovakia. The sample consisted of 1,968 respondents and was representative in terms of gender, school type and regional distribution. A total of 1,208 respondents identifying as Roman Catholic or Greek Catholic were included in the cluster analysis. Using cluster analysis, the study identifies empirical typologies of young Catholics according to their leisure activity patterns. These typologies are further interpreted in relation to selected indicators of religiosity and health-related behaviors, allowing for a more detailed understanding of the relationship between religious engagement, lifestyle and adolescent health. The findings contribute to the understanding of religiosity as a complex social factor that interacts with health-related behaviors and developmental processes during adolescence. The study highlights the importance of considering both institutional and personal experiential dimensions of religiosity when analyzing its impact on young people's lives.

Keywords: religiosity, dimensions of religiosity, types of believers, transition to adulthood, adolescent religiosity, leisure activities, empirical typology of young Catholics in Slovakia according to the structure of their leisure activities, health

Анотація

Колларова, Маргіта. Аналіз ролі релігії та духовності в підлітковому віці в контексті здоров'я. У дослідженні розглядається роль релігії та духовності в підлітковому віці, з особливим акцентом на релігійність як фактор здоров'я серед молодих католиків у Словаччині. Релігійність розуміється як багатовимірне явище, і аналізуються її основні виміри, а також існуючі типології віруючих. Увага також приділяється релігійності підлітків у ширшому контексті соціального розвитку та переходу до дорослого віку. Крім того, дослідження зосереджується на структурі дозвілля молодих католиків та її зв'язку з релігійністю та поведінкою, пов'язаною зі здоров'ям. Вільний час вважається важливим компонентом способу життя підлітків, що відображає ціннісні орієнтації, соціальну інтеграцію та моделі поведінки, які можуть впливати як на фізичне, так і на психічне благополуччя. Емпіричний аналіз базується на репрезентативному кількісному соціологічному дослідженні, проведеному серед учнів 3-го та 4-го класів середніх шкіл Словаччини. Вибірка складалася з 1968 респондентів і була репрезентативною за статтю, типом школи та регіональним розподілом. У кластерний аналіз було включено 1208 респондентів, які ідентифікували себе як римо-католики або греко-католики. За допомогою кластерного аналізу дослідження визначає емпіричні типології молодих католиків відповідно до структури їхньої дозвіллєвої діяльності. Ці типології інтерпретуються стосовно індивідуальних показників релігійності та поведінки, пов'язаної зі здоров'ям, що дозволяє глибше зрозуміти взаємозв'язок між релігійною активністю, способом життя та здоров'ям підлітків. Результати сприяють кращому розумінню релігійності як складного соціального фактора, що взаємодіє з поведінкою, пов'язаною зі здоров'ям, та процесами розвитку в підлітковому віці. Дослідження підкреслює важливість врахування як інституційних, так і суб'єктивно-емпіричних вимірів релігійності під час аналізу її впливу на життя молодих людей.

Ключові слова: релігійність, виміри релігійності, типи віруючих, перехід до дорослого віку, релігійність підлітків, дозвіллєва діяльність, емпірична типологія молодих католиків Словаччини відповідно до структури дозвілля, здоров'я

Introduction. Religion and spirituality have long represented important dimensions of human life, influencing personal identity, value orientation, social relationships, and perceptions of health and well-being. Although contemporary societies are characterized by increasing secularization and religious pluralism, religion and spirituality continue to play a significant role in the lives of many individuals, including adolescents. The developmental period of adolescence is marked by profound biological, psychological, social, and moral changes, during which young people actively search for meaning, purpose, and identity. Consequently, religion and spirituality may become important resources that help adolescents interpret their experiences, cope with developmental challenges, and establish behavioral patterns that influence their present and future health outcomes.

"In the course of the history of faith and piety of ancient Israel, two religions were born: Christianity and Rabbinic Judaism. The greatest paradox is that they are completely autonomous and at the same time inseparably linked by several ties. Another paradox is that in the almost two thousand years that have passed since the birth of Christianity and Rabbinic Judaism, the followers of both religions have successfully tried to distance themselves from each other" (Kardis, 2020, p. 77). This is an important perspective of religious studies. However, from a sociological point of view, it is important to ask this question: how can Christian religiosity be measured?

Religiosity is a complex multidimensional phenomenon that takes many different forms. Individuals can be religious in different ways. And it is precisely the definition of the dimensions of religiosity that is very important when examining it, also considering the population within which it is examined. In connection with the research on religiosity, J. H. Fichter created (in the community-type survey of Southern Parish from 1948) a frame of reference for defining religiosity and identified these main dimensions:

1. Christian creed - certain truths of faith that all members of the church must believe.
2. Christian code of behavior - certain patterns of conduct, outlined basically in the Ten Commandments, the counsels of Christ, and the precepts of the Church.
3. Christian cult, or form of worship, comprises the sacramental, liturgical, and devotional system of the Church.
4. Finally, the Christian communion of all members with one another idealizes the essential social nature of the Church.

Subsequently, J. H. Fichter, for a deeper understanding of Roman Catholic parishioners, delineated and defined four types, namely nuclear, modal, marginal and dormant (Fichter, 1969, pp. 171-172).

The dimensions created by J. H. Fichter are analogous to those later developed by Charles Y. Glock (1962) and Yoshio Fukuyama (1961) or R. Stark and C. Y. Glock (1968) who in their famous work defined religiosity in a more abstract way using the following five dimensions of religiosity: belief, experience, practice, theology (knowledge) and consequences (ethics). The Polish sociologist of religion W. Piwowarski, in his concept of dimensions of religiosity, tried to consider the specific requirements placed on the research of Catholic religiosity. He also developed a system of suitable indicators for individual parameters/dimensions of religiosity: 1) overall relationship to faith, 2) knowledge, 3) ideology, 4) experience, 5) practice, 6) community, 7) consequences (ethics) (Piwowarski, 1996).

Lisa D. Pearce and Melinda Lundquist Denton, in turn, when examining adolescent religiosity, proceeded from the dimensions of religiosity that are often used in the Western context, considering the following three as the main ones: 1) Content of religious belief (belief in God and attitudes towards religious exclusivism - expressing the belief that only one religion is true and accepting the teachings of that religion in full, 2) Conduct of religious practices (frequency of individual prayer, participation in religious services and helping others outside of organized volunteer activities) and 3) Centrality of religion (importance of religion, closeness to God, frequency thinking about the

meaning of life), or what they developed as the three “Cs” (Pearce - Denton, 2011).

On this basis, they created five types (and profiles) of religiosity of adolescents, which they named as follows (calling them “five As”): 1) Abiders - according to all monitored indicators, they show a high level of religiosity. 2) Atheists – their religious identity is also characterized by relative agreement. They don't believe in God. 3) Assenters - they tend to believe in a personal God. Faith is not very important in their lives. Religious practice is occasional. 4) Adapters - belief in a personal God. Personal religious practice is at a high level. Public religious practice is variable. At a high level, the values are according to the indicator of help they need and according to the indicator of thinking about the meaning of life. 5) Avoiders - they show some faith in God, but it is faith in an impersonal (distant) God. Low level of religious behavior and religious centrality (Pearce - Denton, 2011, pp.38-55).

Researching and studying religion and spirituality during adolescence is important for two reasons. First, the confluence of dramatic biological, psychological, social, and economic changes in adolescence suggests that this is a prime time for religious or spiritual change and development. Youth in this age group are becoming more autonomous in many spheres of life, emerging and creating their own identity based on how they have been socialized. A second motivating factor for studying religious and spiritual trajectories in adolescence is that many studies have found that religiosity and spirituality is related to positive adolescent outcomes such as higher self-esteem, better physical health, and higher educational aspirations, as well as protection against early sexual activity, delinquency, and alcohol and drug use. (Pearce - Denton, 2011, pp.5-6).

The importance of religion and spirituality is particularly evident when considered within the broader framework of social determinants of health. Contemporary approaches to health emphasize that health outcomes are shaped not only by biological factors but also by social, cultural, economic, and environmental conditions. Family relationships, educational opportunities, peer networks, socioeconomic circumstances, and community resources contribute to adolescent health trajectories. Religion and spirituality intersect with many of these determinants and can function as either protective or risk factors, depending on the specific social and cultural context in which adolescents live and develop.

Within this framework, religion and spirituality can be viewed as psychosocial resources that influence adolescent health through multiple pathways, including social support, value formation, behavioral regulation, coping strategies, and community engagement (Koenig et al., 2012; Putnam - Campbell, 2010). Religion and spirituality can be understood as important psychosocial resources that contribute to adolescent health and well-being (Koenig et al., 2012; King - Boyatzis, 2015). During adolescence, young people face many developmental challenges related to identity formation, emotional regulation, social integration, educational attainment, and planning for the future (Arnett, 2000; Nelson, 2021). In this context, religious and spiritual beliefs can provide a framework of meaning and coherence through which adolescents interpret life experiences and navigate developmental transitions (Pearce - Denton, 2011).

Several mechanisms have been proposed to explain the relationship between religiosity, spirituality, and health. One of the most important is the provision of social support (Koenig et al., 2012). Religious communities often offer adolescents a sense of belonging, emotional security, social integration, and opportunities to form meaningful relationships with peers and adult role models (Putnam - Campbell, 2010). Such social resources can enhance resilience and protect against a variety of psychosocial risks (Smith - Denton, 2005).

Another mechanism is the promotion of health-related values and behaviors. Religious traditions often promote self-control, responsibility, compassion, and respect for self and others, while discouraging behaviors that may compromise health and well-being (Smith - Denton, 2005; Pearce - Denton, 2011). As a result, numerous studies report lower rates of substance use, delinquency,

risky sexual behavior, and other health-threatening activities among religious adolescents (Smith - Denton, 2005; Cotton et al., 2006).

Spirituality also appears to be associated with positive mental health outcomes. A sense of meaning, purpose, hope, and connection to a transcendent reality can help adolescents cope with stress, uncertainty, loss, and other challenging life events (Pargament, 1997; King & Boyatzis, 2015). Research has shown associations between spirituality and higher levels of life satisfaction, self-esteem, optimism, psychological well-being, and resilience, as well as lower levels of anxiety and depressive symptoms (Cotton et al., 2006; Koenig et al., 2012).

At the same time, the relationship between religion, spirituality, and health is not universally positive. Religious beliefs and practices can sometimes evoke feelings of guilt, fear, exclusion, or internal conflict, especially when adolescents experience tension between personal values and religious expectations (Pargament, 1997). Contemporary academic work therefore increasingly emphasizes the need to examine not only the presence of religiosity and spirituality, but also their specific forms, meanings, and social contexts (Pearce & Denton, 2011).

Today's transition to adulthood is a specific process, as well as a winding path, more complex, disjointed, and confusing than in previous decades (Smith, Longest, Hill, Christoffersen, 2014). The steps to and from school, long-term employment, marriage, and parenthood are simply less organized and coherent today than in previous generations (Arnett et al., 2014).

Perhaps the most characteristic feature of this transition to adulthood in contemporary Western societies is prolonged adulthood. Several important social changes have contributed to this phenomenon in recent decades. These include: (1) dramatic increases in educational participation; (2) delayed marriage and increased cohabitation; (3) the emergence of a global economy characterized by flexible and often unstable employment; (4) increasing financial and social support for children in later life by parents; (5) widespread availability of effective contraception; (6) the spread of postmodern values and media influence; and (7) economic prosperity and an expanding consumer culture (Smith, Longest, Hill, Christoffersen, 2014).

The result of these complex social transformations is the emergence of a distinct life stage referred to as emerging adulthood (Arnett, 2000). This period is associated with increasing independence, individuality, and the gradual transition from childhood to adulthood (Nelson, 2021; Arnett et al., 2014). Young people at this stage seek freedom, autonomy from parents, opportunities for self-development, and financial independence, while also facing uncertainty and concerns about their future.

These developmental and social changes are reflected in the daily experiences, lifestyles, and health-related behaviors of adolescents and emerging adults. Leisure activities, peer interactions, and participation in organized social settings are important contexts through which young people develop social competencies, behavioral patterns, and health-related habits.

For example, findings on students' leisure activities from the international HBSC (Health Behaviour in School-aged Children) study, which included online semi-structured interviews with 24 adolescents aged 14–17 in Slovakia, "showed that participation in OLTA (organized leisure activities) is associated with lower levels of school stress, better academic performance, better well-being and less problematic technology use because it helped adolescents build supportive social networks and develop goal-directed and self-regulatory skills. However, adolescents who engaged primarily in unstructured socializing activities, such as spending time with friends and extensive social networks, demonstrated poorer self-control skills, a greater likelihood of engaging in health-risk behaviors and lower academic performance" (Kosticova et al., 2024, p. 1981).

Methods and Results. In the next section, we analyze the results of a survey based on a representative random sample of 1,968 secondary school students (students of the 3rd and 4th grades of secondary schools in Slovakia), which concerns an empirical typology of young Catholics

(respondents belonging to the Roman Catholic and Greek Catholic Churches) according to the structure of their leisure activities (Field collection of primary empirical data was carried out using the technique of distributed and collected questionnaires, which was carried out by scientific and pedagogical workers of the Department of Sociology). 1,208 respondents were included in the typology. According to cluster analysis, we identified four empirical types. The first type consists of 230 respondents, the second type of 278 respondents, the third type of 389 respondents and finally the fourth type of 311 respondents.

The first type includes students for whom leisure time is primarily associated with sports: on the one hand, they often attend sports events and, on the other hand, they need to improve their conditions for active participation in (whether organized or unorganized) sports activities, as well as their participation in them. The second cluster consists of students who use their free time passively – they rarely attend sports and cultural events, only exceptionally go to discos and entertainment, as well as to cafes, pastry shops and restaurants, and do not consider it necessary to have more suitable conditions created for their free time activities. The third type consists of students who use their free time mainly to visit discos and entertainment, but also to visit cafes, pastry shops and restaurants. Finally, the fourth cluster consists of students who prefer to visit cultural events, concerts, exhibitions, theater performances and cinema in their free time and welcomed the improvement of conditions for carrying out their own artistic and other hobby activities.

The first cluster consists mainly of boys studying at 4-year-long study programs, for whom it is typical that, compared to other types of respondents, they hardly drink alcohol and do not smoke and it is also important for them to have good grades in school; however, in terms of various indicators of religiosity, there are no significant differences between them and other types of respondents. The second cluster consists mainly of girls studying at 8-year-long study programs, for whom it is typical that they practically do not drink alcoholic beverages, do not smoke and have no experience with using illegal drugs; at the same time, however, they are characterized by the fact that they rarely pray and rarely go to church.

The third type consists mainly of girls studying at secondary vocational schools, for whom it is typical that they often drink alcohol, regularly smoke at least one cigarette a day and, compared to other types, they also have the greatest experience with using illegal drugs. In terms of religiosity, this cluster of respondents is characterized by a low frequency of prayer, participation in church services, confession and communion. The fourth type is mainly made up of girls, who, among the other empirical types created, spend the most time preparing for teaching and their ambition is to study at a university abroad; however, in terms of individual indicators of religiosity, they do not differ fundamentally from the other clusters.

These patterns may also reflect the combined influence of peer group affiliation, school environment, and family background, which together shape adolescents' exposure to health-related norms. In this sense, behavioral differences between clusters may be interpreted as expressions of different social contexts rather than isolated individual choices.

The identified typology suggests that Catholic adolescents do not constitute a homogeneous social group in terms of their leisure activities, health-related behaviors, educational aspirations, or religious practices. On the contrary, the results indicate the existence of several distinct lifestyles, which are associated with different forms of participation in social life and varying degrees of engagement in behaviors that can either promote or threaten health and well-being. These differences also indicate that leisure-time structures may function as an important mechanism of social differentiation during adolescence, shaping not only current health-related behaviors but also longer-term developmental trajectories. From a life-course perspective, early patterns of leisure participation and peer interaction may contribute to the formation of stable behavioral dispositions that persist into emerging adulthood.

The contrast between the first and third clusters is particularly striking. The first cluster is characterized by active participation in sports activities, a relatively healthy lifestyle, low levels of alcohol and smoking consumption, and a strong orientation towards academic achievement. Although these respondents do not differ significantly from the other groups on most indicators of religiosity, their behavioral profile reflects several characteristics commonly associated with positive developmental outcomes and a healthy lifestyle. The findings suggest that participation in sports and physically active leisure activities may be an important protective factor contributing to adolescent well-being and the avoidance of health-risk behaviors.

In contrast, the third cluster shows a significantly different behavioral profile. Frequent participation in recreational activities combined with higher levels of alcohol consumption, smoking, and experience with illicit drugs may indicate a lifestyle associated with increased exposure to health risks. At the same time, this cluster records the lowest levels of religious practice and church attendance. Although causal relationships cannot be inferred from the data, the results are consistent with findings from previous studies that suggest that lower levels of religiosity are often associated with greater acceptance of behaviors that may negatively affect health and social functioning.

The second cluster presents an interesting profile. These respondents generally avoid health-risk behaviors and report very limited experience with alcohol, tobacco, or illicit substances. However, they also show relatively low levels of religious participation and prayer. This finding suggests that positive health-related behaviors in adolescents may be shaped by a broader set of socialization influences than religiosity alone, including family environment, school culture, peer relationships, or personality characteristics. Consequently, religiosity should not be understood as the sole determinant of adolescent behavior, but rather as one factor operating within a complex network of social and cultural influences.

The fourth cluster represents a group of adolescents characterized by cultural participation, educational ambitions, and a strong orientation toward self-development. Their interest in cultural activities and artistic hobbies, along with their ambitions to continue their studies at university abroad, can be interpreted as indicators of a future-oriented lifestyle that emphasizes personal growth and self-actualization. It is therefore noteworthy that this group also scored highest on the index of religious experience, suggesting that subjective dimensions of religiosity can coexist with intellectual curiosity, educational ambitions, and active involvement in cultural life.

Together, the identified empirical types illustrate the multidimensional nature of adolescent religiosity and its relationship to health-related behaviors. The findings suggest that religion and spirituality may be associated not only with explicitly religious practices but also with broader lifestyle patterns, value orientations, leisure activities, and educational ambitions. From a social determinants of health perspective, these factors interact and collectively contribute to shaping behavioral patterns that may influence adolescent health and well-being now and later in life.

Regarding the connections between the derived typology of Catholics with specific composite indices of religiosity, we identified a correlation with the index of religious experiences ($F(3.1146) = 3.008$; $p = 0.029$). The highest values of this index were recorded in the 4th type. The identification of religiosity profiles of adolescents is a very useful and valuable output of any research, which significantly contributes to a more detailed understanding of religiosity as a determinant level of health on both individual as well as public. Research conducted in Slovakia also confirms the positive impact of religiosity on the adult population, as well as on adolescents, for example in shaping and strengthening attitudes towards family life, marriage, active leisure activities, an active lifestyle, and also attitudes rejecting the use of alcohol and illegal drugs. Declared religiosity and religious practice are positively correlated with the attitude to study, with the level of education attained, as well as with the active use of free time (Kollár - Kollárová, 2014).

Discussion and Conclusions. Religion is present in most societies, either in the sense

that it plays a central role or remains rather marginal in the lives of individuals, social groups and populations. From a public health and sociology of health perspective, religion should therefore be understood as a potentially significant part of a broader system of social determinants of health. If we seek to develop a comprehensive explanatory framework of health and well-being, religion and spirituality must be considered alongside the social, cultural, political and economic factors that shape individual health trajectories (Idler et al., 2014).

Religious traditions across cultures provide structured systems of meaning and practices that become particularly visible during key life transitions such as birth, adolescence and death. These moments are often accompanied by ritualized practices that not only express collective beliefs but also function as mechanisms for social support, emotional regulation and identity formation. Especially in adolescence, such rituals and meanings can contribute to the stabilization of behavioral patterns, the formation of values, and the management of developmental uncertainty. In this sense, individual health and collective well-being are closely intertwined, as religious communities often respond to the needs of their members in times of vulnerability and change (Idler et al., 2014; Matulník et al., 2014).

The findings presented in this study, as well as the typology of adolescent Catholics based on leisure activities, highlight the heterogeneity of youth lifestyles and their relationship to religiosity. Rather than representing a single protective or risk factor, religiosity appears to be part of broader patterns of social behavior, leisure participation, and educational orientation. This supports the view that religious engagement should be analyzed as part of a complex network of influences, rather than as an isolated determinant of adolescent health.

In interpreting these relationships, it is important to consider that health-related behavior is not determined solely by access to information or objective knowledge of risks. Health-related decisions are therefore often the result of socially embedded interpretations rather than purely rational evaluations of available information. Within this framework, religiosity can function as a source of normative guidance, reinforcing shared standards of behavior and shaping attitudes toward risk, responsibility, and self-regulation.

These developments can also be interpreted within broader theories of health behavior, which emphasize the role of social norms, peer influence, and culturally shared expectations in shaping individual decision-making. In adolescence, behavioral choices are particularly sensitive to perceived social approval and group membership, meaning that health-related actions are often embedded in everyday social interactions rather than based solely on individual cognition. Within this context, both religiosity and digital communication environments may function as normative systems that provide guidance for acceptable and meaningful behavior.

As Capíková and Nováková (2020) emphasize, individual perception of health risks, emotional reactions, subjective experiences and normative social influences play a key role in shaping behavior:

"Factors such as subjective perception of health risks, personal experience with a health problem, risk-related beliefs in general and emotional reactions are also important for an individual's health behavior. Health information is important, but the individual filters and subjectively evaluates it, therefore individual perception of health risks, severity of consequences, etc. may be perceived differently by different people. And a given behavior is not always the result of a reasonable assessment of all available information and evaluation of advantages and disadvantages, sometimes it may rather be the result of compliance with shared public normative beliefs" (Capíková - Nováková, 2020, pp. 20–21).

Taken together, the findings discussed above suggest that adolescent health behavior is best conceptualized as socially embedded and interpretively constructed, rather than as a direct outcome of individual rational choice or informational awareness. In contemporary youth contexts,

religious and spiritual dimensions are increasingly shaped through interactions with digital media environments and peer-based communication networks, which contribute to the diversification and personalization of religious expression. Within this process, institutional religious affiliation may coexist with individualized, situational, and experience-based forms of spirituality, reflecting the fluidity of adolescent identity formation.

From a broader applied perspective, these patterns also indicate that religion and spirituality extend beyond behavioral and sociological interpretations and may be relevant for health care practice, particularly within holistic models of care that integrate physical, psychological, and spiritual dimensions of well-being.

A further implication emerging from these findings is the need for sustained empirical investigation of youth religiosity in the context of ongoing transformations in adolescent development. In contemporary societies characterized by prolonged educational trajectories, delayed transitions into full adulthood, and changing patterns of family formation and labor market entry, religiosity should be approached as a dynamic and context-sensitive phenomenon embedded in wider sociocultural structures. Rather than being conceptualized primarily through institutional participation or frequency of religious practice, religiosity should be understood as a multidimensional social phenomenon in which behavioral, experiential, and cognitive dimensions operate simultaneously and interactively. Adolescent research indicates that these dimensions play a significant role in meaning-making processes, psychological well-being, and coping strategies. Accordingly, religious practice may be understood as carrying multiple and overlapping meanings, including embodied, relational, and care-oriented dimensions that connect spirituality with health-related contexts and patient care, particularly in adolescence (Trizuljaková – Mego, 2024, pp. 31–55). Understanding these multidimensional relationships may contribute to a more comprehensive interpretation of adolescent health and provide valuable insights for both public health research and health care practice.

References

Arnett, J. J. (2000), “Emerging Adulthood. A Theory of development from the late teens through the twenties”, *American Psychologist*, Vol. 55, No. 5, pp. 469-480, viewed 5 May 2025, available at: https://doi.org/10.1037/0003-066X.55.5.469

Arnett, J. J. et al. (2014), *Emerging adulthood: The winding road from the late teens through the twenties*, Oxford University Press, New York, 2nd edn, 395p. ISBN 9780199983599.

Capíková, S. - Nováková, M. (2020), “Challenging COVID-19 times - possibilities and limitations of law in regulation of health behavior of individuals”, *Crisis as a challenge for human rights*. Edited by Florek, I., Koroncziová, A., Manzan J. L. Z. Comenius University in Bratislava, Bratislava, pp.13-35. ISBN 978-80-7160-551-5, viewed 5 May 2025, available at: https://www.flaw.uniba.sk/fileadmin/praf/Veda/Zborniky/Crisis_as_a_challenge_for_human_rights.pdf

Cotton, S. et al. (2006). “Religion/Spirituality and Adolescent Health Outcomes: A review", J*ournal of Adolescent Health*, Vol. 38, No. 4, pp. 472 – 480, viewed 16 April 2026, available, DOI: 10.1016/j.jadohealth.2005.10.005

Fichter, J. H., 1969, “Sociological Measurement of Religiosity“, *Review of Religious Research*, Vol. 10, No. 3 (Spring, 1969), pp. 169-177, viewed 5 May 2025, available at: http://www.jstor.org/stable/3510744

Fukuyama, Y, 1961, “The Major Dimensions of Church Membership", *Review of Religious Research,* Vol. 2, No. 4 [Effective City Church Study] (Spring, 1961), pp. 154-161, viewed 5 May 2025, available at: http://www.jstor.org/stable/3510955

Glock, C. Y. 1962, “On the study of religious commitment”, *Religious Education: The official journal of the Religious Education Association*, Vol. 57, No. S4, pp. 98 – 110, viewed 5 May 2025, available at: http://dx.doi.org/10.1080/0034408620575407

HBSC, https://www.hbsc.org/

Idler E. L. et al. (2014), *Religion as a social determinant of public health*, Oxford University Press, New York, 423 p. ISBN 9780199362202.

Kardis, M. 2020, “The Church and the Synagogue. Motives of Polemics between Judaism and Early Christianity”, *Theologos,* No. 2, pp. 77 – 89, viewed 5 May 2025, available at: https://www.unipo.sk/public/media/31348/Theologos2020_2.pdf

King, P. E., Boyatzis, C. J. (2015), "Religious and spiritual development", In Lamb, M. E., Coll, C. G. (Eds.), *Handbook of child psychology and developmental science* (7th ed., Vol. 3, pp. 975 – 1021). Hoboken, NJ: Wiley, ISBN 978-1-118-96341-8.

Koenig, H. G., King, D. E. & Carson, V. B. (2012), *Handbook of religion and health* (2nd ed.). Oxford University Press, 1169p. ISBN 9780195335958.

Kollár, R., Kollárová, M. (2014), “Voľnočasové aktivity.” [“Leisure activities"], *Analýza religiozity mladých katolíkov na Slovensku. Poznatky zo sociologického výskumu* [*Analysis of the Religiosity of Young Catholics in Slovakia. Findings from Sociological Research*], In Matulník, J. et al, Dobrá kniha, Trnava, pp. 185 – 218. ISBN 978-80-7141-884-9. [in Slovakia]

Kosticova, M., Dankulincova Veselska, Z., Sokolova, L., Dobiášová, E. (2024), "Late Bedtime from the Perspective of Adolescents: A Qualitative Study", *Nature and Science of Sleep*, No. 16, 1973 – 1985, viewed 5 May 2025, available at: https://doi.org/10.2147/NSS.S492595

Matulník, J. et al. (2014), *Analýza religiozity mladých katolíkov na Slovensku. Poznatky zo sociologického výskumu* [*Analysis of the Religiosity of Young Catholics in Slovakia. Findings from Sociological Research*] Dobrá kniha, Trnava, 347 p. ISBN 978-80-7141-884-9. [in Slovakia]

Nelson, H. (2021), “The theory of emerging adulthood 20 years later: a look at where it has taken us, what we know now, and where we need to go”, *Emerging Adulthood*, Vol. 9, No. 3, pp. 179 – 188, viewed 5 May 2025, available at: https://doi.org/10.1177/216769682095088

Pargament, K. I. (1997), *The psychology of religion and coping: Theory, research, practice*, Guilford Press: New York, 548p. ISBN 978-1-57230-214-3.

Pearce L. D., Denton, M. (2011), *A faith of their own: stability and change in the religiosity of America’s adolescents*, Oxford University Press, New York, 243 p. ISBN 978-0-19-975389-5.

Piwowarski, W. (1996), *Socjologia religii* [*Sociology of religion*], Red. Wydawnictw Katolickiego Uniwersytetu Lubelskiego, Lublin, 473p. ISBN 9788322804216 [in Polish]

Putnam, R. D., Campbell, D. E. (2010), *American grace: How religion divides and unites us,* Simon & Schuster, New York, 673 p. ISBN 978-1-4165-6671-7.

Smith, C., Denton, M. L. (2005), *Soul searching: The religious and spiritual lives of American teenagers*, Oxford University Press, Oxford, 346 p. ISBN 978-0-19-518095-4.

Smith, C., Longest, K., Hill, J., Christoffersen, K. (2014), *Young catholic America. Emerging adults in, out of and gone from the church*, Oxford University Press., New York, 336 p. ISBN 9780199341078.

Stark, R., Glock, C. Y. (1968), *American Piety: The Nature of Religious Commitment*, University of California Press, Berkeley and Los Angeles. 230 p. ISBN 978-0520017566.

Trizuljaková J., Mego, M. et al, (2024), *Duchovné aspekty starostlivosti o chorých* [*Spiritual aspects of patient care*], Univerzita Komenského v Bratislave, Bratislava, 92 p. ISBN: 978-80-223-5907-8. [in Slovakia]