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Dimensions of Spirituality and Social Health among Women Pilgrims of the Shahcheragh Shrine: A Survey Analysis of Self-Awareness, Spiritual Needs, and Spiritual Activities

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Original Article

Abstract

Background and aim: Iranian studies have mostly measured religiosity or spirituality with a single composite score, leaving the distinct contributions of its components to social health unclear. This study examined the relationship between four dimensions of spirituality and the social health of women pilgrims at the Shahcheragh Shrine in Shiraz and compared the independent contribution of each dimension.

Data and method: A cross-sectional survey was conducted in 2023–2024. Of 400 questionnaires completed face-to-face by women aged 18 and over, 399 valid cases were analyzed. Respondents were selected through convenience sampling. Data were collected using Parsian and Dunning's Spirituality Questionnaire and Saffarinia's 28-item Social Health Questionnaire and analyzed using descriptive statistics, separate linear regressions, backward multiple regression, and a simultaneous model with background variables.

Findings: The mean age of the respondents was 36.4 years (range: 18–67). In the separate regressions, all four dimensions of spirituality were positively associated with social health ($p < .001$). In the final model, self-awareness ($\beta = .305$), spiritual needs ($\beta = .230$), and spiritual activities ($\beta = .129$; $p = .006$) were retained and jointly explained 36% of the variance in social health ($R^2 = .360$). In the controlled model, place of residence was the only significant background variable, whereas age was not significant ($p = .684$).

Conclusion: In the studied sample, self-awareness, spiritual needs, and spiritual activities account for differences in social health better than the declared importance of spiritual beliefs. These results reflect associations within this sample and do not permit causal inferences.

Keywords: Women Pilgrims, Social Health, Spirituality, Shahcheragh, Cross-sectional Survey.

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Introduction

Social health refers to individuals' appraisal of the quality of their relationship with society and of their functioning within the social environment. Keyes conceptualizes this construct in terms of five dimensions: social integration, social acceptance, social contribution, social actualization, and social coherence. A person with higher social health regards herself or himself as part of society, values her or his own contribution, accepts others, perceives society as capable of growth, and evaluates social events as orderly and comprehensible (Keyes, 1998). Social health, therefore, cannot be reduced to mental health, personal satisfaction, or the number of social ties. Religion and spirituality are among the resources that the sociology and psychology of religion have linked to such appraisals, since they lend meaning to individual life and connect the individual to the collective.

Analyzing the relationship between spirituality and social health requires distinguishing concepts that are sometimes used interchangeably in the literature. Religiosity refers to beliefs and practices organized within a religious tradition; spirituality encompasses a range of experiences of meaning, connection with the transcendent, self-understanding, and spiritual practice; spiritual health concerns the individual's condition in this domain; and social health reflects the quality of the individual's relationship with society. Conflating these concepts may result in overlapping measures and an inflated association (Hill & Pargament, 2003; Koenig & Carey, 2025). Accordingly, the present study treats spirituality as a multidimensional construct and measures social health with a separate instrument.

A review of previous research indicates that an association between religion, spirituality, and dimensions of social well-being is broadly accepted, whereas the internal structure of this association has received less attention. First, many Iranian studies have relied on an overall score of religiosity or spirituality, so it remains unclear which component makes an independent contribution to explaining social health once the overlap among dimensions is controlled (Tajbakhsh et al., 2022; Atefi Hanzani et al., 2023; Mahdavi et al., 2024). Second, these studies have mostly been conducted among university students, female heads of household, or clinical groups, while pilgrims have received little attention. Third, pilgrimage studies have mainly described personal experience, meaning, or the general outcomes of pilgrimage and have not measured social health multidimensionally. For instance, Jørgensen et al. (2020) and Tykarski and Mróz (2024) demonstrated links between pilgrimage, self-reflection, and social relationships; however, the cultural context and organization of pilgrimage in these studies differ from those of urban Shiʿi pilgrimage.

Accordingly, the central problem of the present study is to determine which dimension of spirituality contributes most to explaining social health. Distinguishing among the importance of beliefs, spiritual activity, spiritual need, and self-awareness makes it possible to clarify which form of spirituality primarily underlies the association between spirituality and social health. Multivariate analysis is well suited to this question, because it separates the bivariate association of each dimension from the contribution that the same dimension makes to explaining the dependent variable once the other components are controlled.

To address this problem, the present study focuses on women pilgrims at the Shrine of Ahmad ibn Musa (Shahcheragh) in Shiraz. The choice of this population rests on two considerations. First, women's social experience is shaped to a considerable extent within family, kinship, care, and

religious networks, and the quality of these networks may be related to both variables of the study; Farahmand et al. (2023) likewise reported an association between spiritual health and the quality of life of Iranian women. Second, as the most important shrine in Shiraz, Shahcheragh is not only a religious site but also a social space in which individual prayer, collective rituals, family visits, and interaction among pilgrims take place side by side. In Durkheim's account, ritual assembly and the use of shared symbols can strengthen the sense of membership and moral obligation (Durkheim, 1912/1995, pp. 217–218, 231–232). Women pilgrims of this shrine therefore constitute an appropriate population for studying the various dimensions of spirituality and their relationship with social health.

The aim of this study is to determine the relationship between the dimensions of spirituality and the social health of women pilgrims at the Shahcheragh Shrine and to compare the independent contributions of these dimensions. Three questions are addressed: How are the demographic characteristics and the levels of the two main variables distributed in the sample? How is each of the four dimensions of spirituality related to social health in separate analyses? And which components retain a significant contribution to explaining social health once the dimensions of spirituality and the background variables are entered simultaneously?

Literature Review and Theoretical Considerations

Relevant Iranian studies can be grouped according to their research questions and designs. The first group comprises surveys that have examined the relationship between religiosity and social health in different populations. Tajbakhsh et al. (2022), among women in the city of Shush, and Marzban (2022), among students in Chabahar, reported positive associations of religious attitude or religiosity with social health. Atefi Hanzani et al. (2023) incorporated family social support into a structural model of the relationship between religiosity and social health among female heads of household. These studies suggest that the association between religion and social health may depend on support networks; however, differences in the definition of religiosity, measurement instruments, and sample characteristics limit the generalizability of their coefficients to women pilgrims.

The second group consists of intervention studies and research conducted in specific populations. Niabati Charandabi et al. (2022) examined changes in social health following group spirituality therapy in a clinical sample. Heidari Kebriti et al. (2023) also employed an intervention design among university students, and Pourtaleb et al. (2024) assessed the spiritual, social, and mental health of mothers within an educational program. These findings are useful for examining the malleability of the variables; nevertheless, the content of a structured intervention is not equivalent to the everyday experience of spirituality or pilgrimage. Moreover, the sample sizes and the conditions for entering these interventions differ from those of the present survey.

The third group focuses on mechanisms of meaning and on the validity of instruments. Mahdavi et al. (2024) examined the role of religious beliefs and meaning in life in a model related to women's social health. Ahmadi Bighash (2025) reported associations of spiritual health with social health and with its dimensions of integration and contribution among Arbaeen walking pilgrims. Alipoor et al. (2024) developed and validated a short form of the social health questionnaire, and Khaleghi (2023) argued for the cultural reinterpretation of instruments measuring religious, spiritual, and social health. Taken together, this body of work shows that research findings depend not only on the study population but also on how constructs are delimited and on the degree of item overlap, both of which affect the magnitude of the observed association.

In international research, too, the relationship between religion or spirituality and well-being has depended on the type of measure and the research design. Yuniartika et al. (2023) examined changes in quality of life following an intervention based on social interaction and spirituality for older adults. Farahmand et al. (2023) found that levels of spiritual health were associated with quality of life in a sample of Iranian women. By contrast, Gomez and Watson (2023), re-evaluating the factor structure of a spiritual well-being questionnaire, showed that the way dimensions are combined can alter the validity of the results. These differences caution against treating spirituality as a unitary construct with a fixed relationship to all health outcomes.

Research on pilgrimage has largely focused on relational and meaning-making processes. In a study of pilgrims walking the St. Olav Way, Jørgensen et al. (2020) reported personal reflection, connection with others, and perceived social outcomes. Tykarski and Mróz (2024) likewise linked the experience of the Camino de Santiago to changes in dialogue, trust, and family relationships. These studies illuminate possible mechanisms linking spiritual experience and social relationships; however, because of pilgrims' self-selection and the reliance on experiential reports, it is difficult to separate the outcomes of pilgrimage from participants' prior motivations and characteristics. The same consideration applies to the interpretation of the cross-sectional data of the present study.

Review and methodological studies likewise do not support a homogeneous relationship. Long et al. (2024) argue that integrating spirituality into health policy should be contingent on cultural sensitivity, freedom of choice, and the avoidance of coercion. Al-Thani (2025) showed that the relationship between religion and well-being does not carry the same meaning across different cultural contexts. In reviewing the domains of spiritual well-being, Gomez (2025) reported more stable associations for some personal domains and weaker associations for certain communal or transcendental domains. Furthermore, the longitudinal meta-analysis by Garssen et al. (2021) estimated the overall effect of religion and spirituality on mental health to be small. Comparing dimensions and restricting inference to the observed associations are therefore essential for the present analysis.

In sum, the literature suggests that three elements should be brought together within a single model: the differentiation of the four dimensions of spirituality, a five-dimensional measurement of social health, and attention to the pilgrimage context. The present study examines these three elements among women at an urban shrine. Its contribution lies in comparing relationships within the construct of spirituality rather than in demonstrating an effect of pilgrimage.

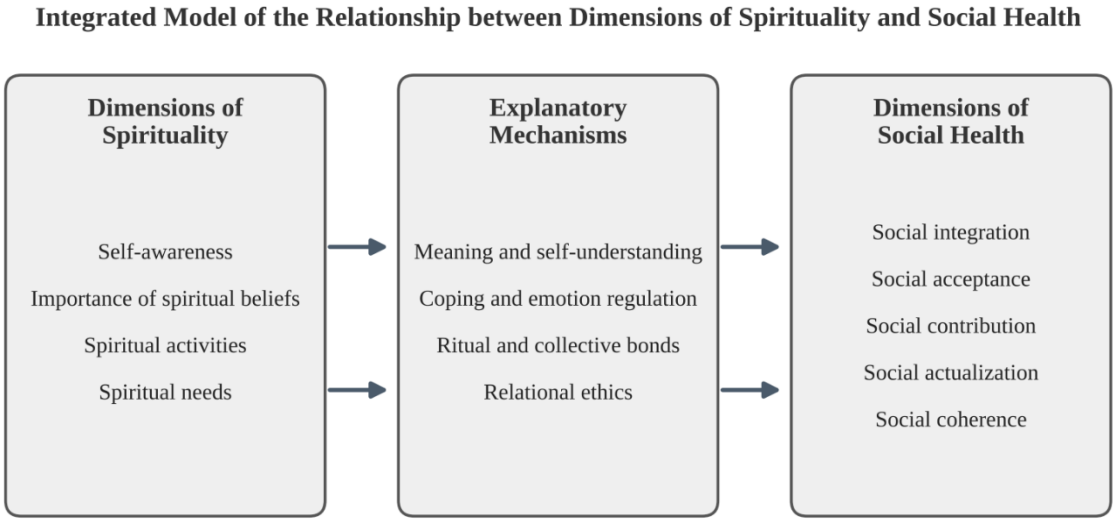
Theoretical Framework and Explanatory Model

In Keyes's model, social health consists of five related but distinct appraisals. Social integration captures the sense of belonging to and sharing with society; social acceptance refers to a relatively positive and realistic evaluation of others; social contribution expresses the feeling that one's contribution to the collective is valuable; social actualization reflects the belief in society's potential for growth; and social coherence concerns perceiving social life as orderly and comprehensible (Keyes, 1998). Social health thus represents not merely the extent of contact or the support received, but the individual's judgment of her or his relationship with society.

Spirituality refers to the search for meaning and purpose in life, to connection with oneself, others, and the transcendent, and to the effort to organize one's life on the basis of this connection. Unlike religiosity, which emphasizes the beliefs and practices of a specific religious tradition, spirituality centers on inner experience, meaning-making, and the individual's personal orientation toward the sacred (Hill & Pargament, 2003). Parsian and Dunning (2009) conceptualized this construct in four dimensions. Self-awareness concerns the individual's understanding of her or his values, life direction, and inner experience. The importance of spiritual beliefs captures the place of beliefs in life and decision-making. Spiritual activities encompass the practical forms of spirituality, such as prayer, meditation, and ritual action. Spiritual needs refer to the need for meaning, hope, peace, and connection with the transcendent. This differentiation enables a comparison of belief, practice, need, and self-understanding and prevents spirituality from being treated as a single composite score.

To explain the relationship between the two constructs, theories with limited and specific functions are drawn upon. Durkheim accounts for the ritual and collective mechanism: repeated action, co-presence, and shared symbols can strengthen the sense of membership and moral obligation (Durkheim, 1912/1995, pp. 217–218, 231–232). Pargament views spirituality as a resource for interpreting and coping with stress; individuals may organize their experience by reappraising the situation, seeking spiritual support, or attributing meaning (Pargament, 1997, pp. 90–95, 144). Allport and Ross's (1967) distinction between intrinsic and extrinsic religious orientation further suggests that the declared importance of belief is not necessarily equivalent to its internalization. In this article, these theories serve an explanatory role and are used to interpret the observed relationships between the dimensions of spirituality and social health.

In the explanatory model, self-awareness and spiritual needs are expected to be associated with social coherence and social actualization by organizing the individual's meaning and experience. Spiritual activities may be related to social integration and social contribution through ritual participation and collective experience. The importance of beliefs, insofar as it is linked to values and relational ethics, may accompany social acceptance. These pathways guide the formulation of the hypotheses, although the present statistical analysis tests only the direct relationships between the dimensions of spirituality and the overall social health score (Figure 1).



Note. Arrows indicate theoretical relationships; the cross-sectional design does not permit causal inference.

Figure 1- *Integrated Conceptual Model of the Study*

Research Hypotheses

Hypothesis 1: Each of the dimensions of self-awareness, importance of spiritual beliefs, spiritual activities, and spiritual needs is positively associated with social health.

Hypothesis 2: When the dimensions of spirituality are entered simultaneously, self-awareness, spiritual needs, and spiritual activities make significant independent contributions.

Hypothesis 3: The relationship between the main dimensions of spirituality and social health persists after controlling for background variables, including age.

Methods and Data

The study employed a cross-sectional survey design, with the individual female respondent as the unit of analysis. The accessible population comprised women aged 18 and over who were present at the Shrine of Ahmad ibn Musa in Shiraz during 1402 SH (2023–2024). According to an estimate by the shrine's research unit, the annual number of visitors was 1,544,000. Using Cochran's formula with a 95% confidence level and a 5% margin of error, the minimum sample size was calculated as 384. To compensate for incomplete questionnaires, 400 questionnaires were collected; after one invalid questionnaire was excluded, data from 399 respondents were included in the analysis.

The questionnaires were completed face-to-face by approaching women present at the shrine. As no list of all women pilgrims was available, respondents were selected through convenience sampling. The inclusion criteria were being female, being aged 18 or older, attending as a pilgrim or visitor, being able to complete a Persian-language questionnaire, and consenting to participate. Incomplete or inconsistent questionnaires were excluded from the analysis. Given the cross-sectional design and

the sampling method, the results pertain to associations among variables in the studied sample, and differences in social health scores cannot be attributed to presence at the shrine.

The demographic section of the questionnaire included items on age (in years), educational attainment, ethnicity, place of residence, and income. Age was recorded as an open-ended item and was entered into the regression analyses as a continuous variable; the age categories presented in Table 1 serve only to describe the sample. The mean age of the respondents was 36.4 years, with a range of 18 to 67 years.

Spirituality was measured using the 29-item questionnaire developed by Parsian and Dunning (2009), rated on a four-point Likert scale. The instrument comprises four subscales: self-awareness, importance of spiritual beliefs, spiritual activities, and spiritual needs. In the original study, Cronbach's alpha was reported as .94 for the total scale and between .80 and .91 for the subscales. A study of the Persian version also confirmed the four-factor structure and reported an alpha of .90 for the total instrument (Aminayi et al., 2015). In the present study, the total alpha was .93, and the coefficients for self-awareness, importance of spiritual beliefs, spiritual activities, and spiritual needs were .91, .92, .78, and .85, respectively.

Social health was measured using Saffarinia's 28-item questionnaire. Based on Keyes's model, this instrument assesses five dimensions—social integration, social acceptance, social contribution, social actualization, and social coherence—on a five-point scale. In a normative study of 554 residents of Tehran, Saffarinia (2014) confirmed the five-factor structure of the instrument and reported a test–retest coefficient of .85 and a Cronbach's alpha of .77. Higher scores indicate a more positive appraisal of one's relationship with society. In the present data, the alpha for the total social health questionnaire was .85.

Data analysis was conducted in three stages. First, the characteristics of the respondents and the distribution of the main variables were examined using descriptive statistics. Second, to determine the bivariate association of each dimension of spirituality with social health, four separate linear regressions were performed. Third, a backward multiple regression was used to estimate the independent contributions of the dimensions, and a simultaneous model including age and other background variables was reported. The significance level was set at .05, and p values displayed as .000 in the software output are reported as $p < .001$.

Findings

1) Sample Characteristics

Table 1 presents the demographic characteristics of the 399 respondents. The most frequent age group was 35–43 years (38.3%), followed by 26–34 years (32.6%). In terms of ethnicity, most respondents were Persian (77.2%), followed by Lur (10.3%), Turk (7.8%), and Arab (3.3%). Overall, 85.7% of the respondents lived in the provincial capital (Shiraz), 10.8% in other towns of the province, and 3.5% in rural areas. Regarding education, holders of a bachelor's degree formed the largest group (38.8%). The monthly income of about two-thirds of the respondents (68%) was below three million tomans.

Table 1- *Demographic Characteristics of the Sample (N = 399)*

Variable	Category	Frequency	Percent
Age	18–25 years	43	10.8
	26–34 years	130	32.6
	35–43 years	153	38.3
	44–52 years	50	12.5
	53–67 years	23	5.8
Ethnicity	Persian	308	77.2
	Lur	41	10.3
	Turk	31	7.8
	Arab	13	3.3
	No response	6	1.5
Place of residence	Provincial capital (Shiraz)	342	85.7
	Other towns	43	10.8
	Rural areas	14	3.5
Education	Lower secondary	110	27.6
	High school diploma	37	9.3
	Bachelor's degree	155	38.8
	Master's degree	81	20.3
	Doctorate	16	4.0

Note. Age was recorded as a continuous variable (in years) and is presented here in five categories for descriptive purposes; $M = 36.4$; range = 18–67.

2) Distribution of Social Health and Spirituality

As shown in Table 2, most respondents fell into the medium category for both social health and spirituality. For social health, 67.92% of the respondents were at the medium level, 17.79% at the low level, and 14.29% at the high level. For spirituality, the medium category accounted for 66.67%, and the low and high categories comprised 20.05% and 13.28%, respectively. These categories were formed on the basis of the scoring procedures of the instruments and are appropriate for within-sample comparison; in the absence of population norms, they cannot be used to judge whether the situation of all women pilgrims is favorable or unfavorable.

Table 2- *Distribution of Social Health and Spirituality Levels (N = 399)*

Variable	Level	Frequency	Percent
Social health	Low	71	17.79
	Medium	271	67.92
	High	57	14.29
Spirituality	Low	80	20.05
	Medium	266	66.67
	High	53	13.28

Note. Percentages are based on $N = 399$; because of rounding, totals may not equal exactly 100.

3) Separate Regressions of the Dimensions of Spirituality

To compare the bivariate associations of the dimensions of spirituality with social health, each dimension was entered into a separate model. As shown in Table 3, all coefficients were positive and significant ($p < .001$), but the explanatory power of the models differed. Self-awareness explained the largest share of the variance in social health ($R^2 = .241$), followed by spiritual needs ($R^2 = .194$), spiritual activities ($R^2 = .120$), and the importance of spiritual beliefs ($R^2 = .079$). These values cannot be summed, because the four components overlap conceptually and statistically.

Table 3 provides several complementary indices for each model. R indicates the strength of the linear relationship, and R^2 represents the proportion of the variance in social health explained by the model. The small difference between R^2 and adjusted R^2 reflects the small number of predictors relative to the sample size. B indicates the expected change in the raw social health score per one-unit change in the predictor, whereas β is more appropriate for comparing relationships on a standardized scale. In single-predictor regression, β equals the correlation coefficient. The F and t statistics report the significance of the same slope in two computational forms and should not be regarded as two independent tests of one relationship.

In the self-awareness model, $R = .491$ and $\beta = .491$, and this variable explains 24.1% of the variance in social health. Spiritual needs ranks second ($R = .440$; $\beta = .440$), explaining 19.4% of the variance. For spiritual activities, $\beta = .346$ and $R^2 = .120$. The importance of spiritual beliefs yields the weakest separate model ($\beta = .281$; $R^2 = .079$). Comparing the B coefficients is not appropriate for ranking these dimensions, because the score ranges of the subscales differ; the ranking is therefore based on β and R^2 rather than on the magnitude of the unstandardized coefficients.

A value of $p < .001$ in all four models indicates that the coefficients are statistically significant; it provides no information about the magnitude or theoretical importance of the relationships. With a sample of 399 respondents, even moderate or smaller associations can reach statistical significance. Moreover, the models in Table 3 were derived from a single sample, and their predictors are not independent of one another. The results of this stage are therefore limited to comparing bivariate associations. To determine how much information each dimension adds once shared variance is controlled, the results of the backward model must be examined.

Table 3- *Separate Regressions of Social Health on the Dimensions of Spirituality*

Predictor	R	R^2	Adj. R^2	B	β	F	t	p
Self-awareness	.491	.241	.239	0.728	.491	124.480	11.157	< .001
Importance of spiritual beliefs	.281	.079	.077	0.839	.281	33.651	5.801	< .001
Spiritual activities	.346	.120	.117	0.998	.346	52.942	7.276	< .001
Spiritual needs	.440	.194	.192	0.782	.440	93.778	9.684	< .001

4) Multivariate and Controlled Models

The results of the backward regression showed that, once the dimensions were entered simultaneously, the importance of spiritual beliefs made no significant independent contribution and was removed from the final model. In the first model, self-awareness alone yielded $R^2 = .246$. Adding spiritual needs in the second model increased R^2 to .312, an increase of 6.6 percentage points in

explained variance. Adding spiritual activities in the third model raised R^2 to .360, a further increase of 4.8 percentage points. The final model thus contains three predictors, with self-awareness retaining the largest standardized contribution.

The indices in Table 4 show a gradual improvement in model fit. R increased from .496 in the first model to .559 in the second and .600 in the third. Adjusted R^2 was .244, .308, and .354, respectively. The increase in this index after each variable was added indicates that the rise in R^2 is not merely a consequence of including more predictors. Nevertheless, variable selection in the backward procedure relies on the data of this sample, and a different sample might produce a different order. Accordingly, the steps of the model should not be interpreted as a temporal sequence or a causal hierarchy among the dimensions of spirituality.

The standard error of the estimate decreased from 7.154 in the first model to 6.845 and then to 6.616. This change indicates that the gap between observed and predicted social health scores narrowed, although the reduction is modest and 64% of the variance in social health remains unexplained by the final model. The analytical value of Table 4 lies in assessing the incremental information contributed by each predictor. The retention of a variable in the model does not imply its causal necessity, and the removal of the importance of beliefs does not demonstrate the absence of a theoretical role for belief.

Table 4- *Summary of the Backward Multiple Regression Models*

Model	Retained variables	*R*	R^2	Adj. R^2	SE of estimate
1	Self-awareness	.496	.246	.244	7.154
2	Self-awareness + Spiritual needs	.559	.312	.308	6.845
3	Self-awareness + Spiritual needs + Spiritual activities	.600	.360	.354	6.616

Table 5 reports the coefficients of the final backward model. Holding the other two predictors constant, the unstandardized coefficients were 0.452 for self-awareness, 0.410 for spiritual needs, and 0.371 for spiritual activities. In terms of relative strength, the standardized coefficients show that self-awareness ranks first (β = .305), followed by spiritual needs (β = .230) and spiritual activities (β = .129). The coefficients for self-awareness and spiritual needs were significant at $p < .001$, and the coefficient for spiritual activities at $p = .006$.

Table 5- *Coefficients of the Final Backward Regression Model*

Variable	*B*	*SE*	β	*t*	*p*
Self-awareness	0.452	0.074	.305	6.097	< .001
Spiritual needs	0.410	0.081	.230	5.080	< .001
Spiritual activities	0.371	0.134	.129	2.761	.006

To assess the stability of the coefficients, a simultaneous model including age, ethnicity, place of residence, education, income, and the four dimensions of spirituality was estimated. The overall model was significant (R = .629; R^2 = .396; adjusted R^2 = .375; F = 18.830; p < .001). As shown in Table 6, self-awareness, spiritual activities, and spiritual needs retained significant coefficients in this model, and among the background variables only place of residence was significantly associated with social health (β = .119; p = .005). Age, ethnicity, education, income, and the importance of spiritual beliefs were not significant. This result indicates that the overall order of the three main dimensions was preserved after the background variables were entered.

Adding the background variables increased R^2 from .360 in the three-dimension model to .396. This increase of 3.6 percentage points relates to the set of added variables and to differences in model specification and does not represent the contribution of any single variable. In the controlled model, the standardized coefficients were .309 for self-awareness, .232 for spiritual needs, and .156 for spiritual activities. The proximity of these coefficients to those of the backward model indicates the relative stability of the direction and order of the relationships within the sample. The coefficient for the importance of spiritual beliefs was negative and non-significant (β = −.059; p = .316). This change of sign cannot be interpreted as a genuine negative relationship; overlap among predictors or range restriction can produce such a pattern.

Age, which was entered into the model as a continuous variable (in years), did not have a significant coefficient (β = .018; p = .684). Thus, after controlling for the other variables, no independent linear relationship between age and social health was observed among the women in the sample, and the coefficients of the dimensions of spirituality did not change substantially after age was entered into the model.

Table 6- *Coefficients of the Simultaneous Model Controlling for Background Variables*

Variable	*B*	*SE*	β	*t*	*p*
Age	0.016	0.040	.018	0.407	.684
Ethnicity	0.380	0.371	.042	1.025	.306
Place of residence	2.104	0.742	.119	2.834	.005
Education	0.013	0.133	.004	0.095	.924
Income	< 0.001	< 0.001	−.049	−1.110	.268
Self-awareness	0.458	0.076	.309	6.044	< .001
Importance of spiritual beliefs	−0.176	0.175	−.059	−1.004	.316
Spiritual activities	0.449	0.179	.156	2.507	.013
Spiritual needs	0.413	0.084	.232	4.909	< .001

Note. Dependent variable: social health. Model fit: R^2 = .396; adjusted R^2 = .375; F = 18.830; p < .001.

Taken together, the results of Tables 3 to 6 support three propositions. First, all four dimensions are positively and significantly associated with social health in the separate models. Second, in the multivariate model, only self-awareness, spiritual needs, and spiritual activities retain an independent contribution. Third, the direction and order of these three coefficients do not change substantially after the background variables are entered. This relative stability pertains to the data of the present sample, and its generalization as a causal or universal pattern requires further research.

Conclusion and Discussion

The main question of this study was whether the dimensions of spirituality contribute equally to explaining the social health of women at the Shahcheragh Shrine. The findings showed that all four dimensions are positively associated with social health in separate analyses, but once shared variance is controlled, only self-awareness, spiritual needs, and spiritual activities remain in the model. Self-awareness has the largest β, whereas the importance of spiritual beliefs, despite its initial association, shows no independent contribution. The data therefore do not support a uniform, equal-sized relationship between all forms of spirituality and social health.

The difference between the results of the separate and multivariate models stems from the correlated structure of the dimensions. The coefficient of each separate model contains both the specific contribution of that dimension and part of the shared experience of spirituality. In the multivariate model, the coefficient of each predictor reflects only its unique portion. The decline in the contribution of the importance of beliefs after the other three components were entered suggests that its bivariate association is likely shared with self-understanding, spiritual need, or spiritual activity.

Self-awareness was the strongest predictor in the final model. Within Keyes's framework, clarity of values and life direction can render an individual's appraisal of her or his social position more coherent and enhance the comprehensibility of the social environment. This finding is comparable to the role of meaning in life in the study by Mahdavi et al. (2024) and to Gomez's (2025) report of more stable associations between the personal domains of spiritual well-being and other forms of well-being. In other words, women who have a clearer understanding of their values and life direction appraise their position in society as more meaningful and comprehensible.

The interpretation of self-awareness should be bounded by the content of the subscale. This dimension measures self-understanding, value orientation, and attention to inner experience and is not equivalent to clinical self-awareness, mindfulness, or Allport's intrinsic religiosity. Its association with social health may arise through several pathways: clearer values can make one's appraisal of one's social contribution more coherent; the ability to articulate one's needs may facilitate help-seeking; and a sense of direction in life can organize one's judgment of the comprehensibility of the social world. At the same time, some self-understanding items may be close in content to a positive evaluation of life. The critique by Koenig and Carey (2025) and the reanalysis by Gomez and Watson (2023) remind us that part of the association may stem from overlap between measures.

Spiritual needs had the second-largest standardized coefficient. Pargament explains the need for meaning, hope, and connection with the sacred in terms of the individual's effort to interpret and cope with stressful situations (Pargament, 1997). On this basis, spiritual resources can organize individuals' experience and orient their relationships with others. The observed relationship is comparable to the findings of Farahmand et al. (2023) on the spiritual health of women and to the model of Atefi Hanzani et al. (2023) regarding the role of social support.

In Pargament's theory, coping is not merely a set of soothing behaviors but a search for significance in stressful circumstances, which takes a religious form when the sacred is present in the individual's orienting system (Pargament, 1997). This framework also emphasizes the multiplicity of outcomes

of religious coping: a spiritual strategy can serve as a source of support or be accompanied by conflict, feelings of abandonment, and greater distress (Pargament, 1997). Accordingly, the positive coefficient of spiritual needs in this study should be interpreted in light of this multiplicity; the need for meaning and hope, when accompanied by supportive resources, can improve an individual's appraisal of her or his position in society.

Spiritual activities remained significant after controlling for self-awareness and spiritual needs, although their β was smaller than those of the other two dimensions. This result is comparable to the role of the ritual dimension in the study by Tajbakhsh et al. (2022), to the association of spiritual health with integration and contribution in the study by Ahmadi Bighash (2025), and to the findings of pilgrimage studies on dialogue and social bonds (Jørgensen et al., 2020; Tykarski & Mróz, 2024). From Durkheim's perspective, ritual action performed under conditions of co-presence and shared symbols can strengthen the sense of membership (Durkheim, 1912/1995).

A Durkheimian reading of spiritual activities depends on the collective quality of their performance. Durkheim refers to situations in which assembly, repeated action, and the coordinated expression of emotion strengthen the sense of membership (Durkheim, 1912/1995). Not every spiritual activity has this characteristic; prayer or meditation may be performed individually, and even collective activity may have different outcomes depending on the sense of acceptance, the individual's position in the group, and opportunities for participation. Jørgensen et al. (2020) and Tykarski and Mróz (2024) also examined pilgrimage as a process comprising movement, dialogue, and reflection rather than mere physical presence at a site. Hence, the coefficient of spiritual activities may be related to personal discipline, communication networks, ritual habits, or collective experience.

The importance of spiritual beliefs was significant in the separate model but was not retained in the final model. This result is comparable to Gomez's (2025) report on differences between the relationships of personal and transcendental domains, and it is methodologically related to the critique by Koenig and Carey (2025) concerning overlap between measures of spirituality and health. The removal of a variable from a backward model does not imply that belief is unimportant. In a population selected while present at a shrine, variation in the importance of beliefs may be limited. Furthermore, part of the role of belief may be reflected in need, activity, or self-awareness and may appear as shared variance in the multivariate model.

Two further statistical explanations should also be considered. The first is range restriction: in a sample in which all respondents were selected while present at a shrine, the importance of belief may be concentrated at relatively high levels and may not vary sufficiently to allow independent prediction. The second is conceptual collinearity: the importance of beliefs may be correlated with self-awareness, spiritual need, and spiritual activities, in which case the multivariate model evaluates only its residual, non-shared portion. If this portion is small or less reliable, the removal of the variable does not necessarily indicate the absence of an overall relationship. A mediating explanation is also possible: belief may be related to social health by shaping need, self-understanding, or practice.

The finding that more than two-thirds of the respondents were at the medium level of social health and spirituality is comparable to some Iranian studies, although differences in instruments and cut-off points preclude direct comparison of samples (Marzban, 2022; Atefi Hanzani et al., 2023). Regarding age, which was entered into the simultaneous model as a continuous variable, no significant coefficient was observed (p = .684), and the direction and order of the coefficients of the

dimensions of spirituality remained stable after controlling for age; hence, the observed association between the dimensions of spirituality and social health cannot be attributed to age differences among the respondents. Among the background variables, only place of residence was significantly associated with social health; this finding may reflect differences in access to social networks and opportunities for participation among residents of the provincial capital, other towns, and rural areas, and it points to the importance of the residential context alongside the dimensions of spirituality.

The three-dimension model explains 36% and the controlled model 39.6% of the variance in social health. These values are useful for comparing models within the present data but should not be interpreted as the general share of spirituality in women's social health. More than 60% of the variance relates to other variables, measurement error, and individual differences. The longitudinal meta-analysis by Garssen et al. (2021) likewise reported a small effect size for religion and spirituality in relation to mental health.

The unexplained portion of social health indicates that spirituality is only one of the factors associated with this variable. Social health is a multifaceted construct, and other structural, familial, and individual factors also play a role in women's appraisals of their position in society; the present findings should therefore be regarded as an account of the contribution of the dimensions of spirituality alongside these factors.

The theoretical framework accounts for the findings at several levels. Keyes's model specifies the components of the outcome. Durkheim's theory raises the possibility of a link between ritual action and social integration and contribution (Durkheim, 1912/1995). Pargament's theory explains the role of meaning and spiritual coping (Pargament, 1997). Allport's distinction formulates the possibility of a difference between internalized belief and a general declaration of belief. The data of this study show that the results are consistent with these pathways.

The theoretical contribution of the study lies at the level of comparing dimensions. Using a single score for spirituality could have concealed the differences among self-understanding, need, practice, and the importance of belief. This finding underscores the necessity of measuring spirituality multidimensionally in studies of social health.

Conclusion

The results showed that the dimensions of spirituality do not contribute equally to the social health of the women in the sample. Self-awareness, spiritual needs, and spiritual activities retained their independent associations after the overlap among dimensions was controlled, whereas the importance of spiritual beliefs was excluded from the final model. The order of the standardized coefficients did not change substantially in the model that included background variables. The direct answer to the research question is that self-awareness has the largest standardized contribution, followed by spiritual needs and spiritual activities. This result pertains to the women pilgrims of the Shahcheragh Shrine in the studied sample.

The first hypothesis, concerning the positive association of all four dimensions with social health in the separate models, was supported by the data. The second hypothesis was supported for self-awareness, spiritual needs, and spiritual activities but not for the importance of spiritual beliefs. The

third hypothesis was consistent with the data to the extent that the coefficients of the three main dimensions remained relatively stable after the background variables were entered. These three results should be distinguished from one another: significance in a simple model, retention of a unique contribution in a multivariate model, and stability of a coefficient after control are different propositions, and none of them alone determines the causal direction of the relationship.

The findings are consistent with the interpretation that experienced forms of spirituality—namely, self-understanding, the need for meaning, and spiritual practice—provide more information about differences in social health in this sample than the declared importance of belief. This result does not negate the role of belief; belief may underlie the formation of need, practice, or self-awareness, and its contribution may be absorbed into the shared variance of the dimensions. The principal contribution of the study, therefore, is the differentiation it introduces within the construct of spirituality.

Practical Implications

From a practical standpoint, the results can inform the design and evaluation of voluntary programs in pilgrimage spaces. Activities such as guided dialogue about meaning and social roles, respectful access to guidance and counseling, peer support, and opportunities for women's social participation should first be implemented and evaluated on a small scale. The criterion for evaluating such programs is not an increase in declared belief but specific outcomes such as a sense of belonging, participation, social acceptance, and access to support.

The regression coefficients indicate priorities for research rather than direct prescriptions for intervention. The higher β of self-awareness may justify attention to programs that address self-understanding and the articulation of social roles. The association of spiritual needs underscores the importance of examining access to resources of meaning and support. The retention of spiritual activities justifies examining the role of collective participation and voluntary networks. Any intervention should be evaluated using a comparative design, pre- and post-tests, and independent outcome indicators, and non-participation should not be regarded as a spiritual deficiency.

Suggestions for Future Research

The findings of this study pave the way for complementary studies using different methods. First, qualitative research adopting phenomenological or grounded theory approaches and in-depth interviews with women pilgrims could reveal the lived meaning of self-awareness, spiritual needs, and spiritual activities from the pilgrims' own perspective and show how these experiences are linked to a sense of belonging and social participation.

Second, ethnographic studies based on participant observation at the Shahcheragh Shrine, particularly during collective ceremonies and religious occasions, could clarify the differing functions of individual and collective spiritual activities in shaping pilgrims' social bonds and extend the Durkheimian reading of ritual to the context of urban Shiʿi pilgrimage.

Third, mixed-methods (quantitative–qualitative) designs and structural equation modeling could examine mediating pathways—such as meaning in life, social support, and a sense of belonging—in the relationship between the dimensions of spirituality and each of the five dimensions of social health (integration, acceptance, contribution, actualization, and coherence).

Fourth, longitudinal and panel designs that follow pilgrims over several time points would make it possible to study the dynamics of the relationship between spirituality and social health over time and in connection with repeated pilgrimage experiences.

Fifth, comparative research at other shrines in Iran, such as those of Imam Reza in Mashhad and Hazrat Masoumeh in Qom, as well as among male pilgrims and non-pilgrim groups, could show the extent to which the pattern identified in this study is replicated in other cultural and demographic contexts. In addition, given the significance of place of residence in the present study, a comparison of urban and rural pilgrims merits independent investigation.

Ethical Considerations

All ethical considerations, including confidentiality, informed consent, citation accuracy, respect for contributors, adherence to ethical data collection standards, and participant privacy, have been taken into account by the researchers. Participation in the study was entirely voluntary; respondents were informed of the aims of the research before completing the questionnaire and were assured of the anonymity and confidentiality of their responses.

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Authors' Contributions

Ehsan Hamidizadeh supervised the research and contributed to the conceptualization, study design, data analysis, and writing and revision of the manuscript. Zahra Zarei Doodeji contributed to the literature review, data collection, data analysis, and preparation of the initial draft. Both authors read and approved the final version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

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References

Ahmadi Bighash, F. (2025). The relationship between spiritual health and social health among Arbaeen walking pilgrims. *Pajouheshnameh-ye Maʿaref-e Hosseini*, *10*(37), 47–64. [In Persian]

Alipoor, F., Rafiee, H., Baloochi, M., Eslami, F., & Afsharpooya, H. (2024). Construction and validation of the short form of social health questionnaire in Iran (SHQ16). *Social Welfare Quarterly*, *24*(94), 257–278. [In Persian] https://doi.org/10.32598/refahj.24.94.4475.1

Allport, G.W., & Ross, J.M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*(4), 432–443. https://doi.org/10.1037/h0021212

Al-Thani, H. (2025). Religion and spiritual well-being: A qualitative exploration of perspectives of higher education faculty in Qatar and its challenge to western well-being paradigms. *Frontiers in Psychology*, *16*, 1549863. https://doi.org/10.3389/fpsyg.2025.1549863

Aminayi, M., Asghari Ebrahimabad, M.J., Azadi, M., & Soltani Shal, R. (2015). Reliability and validity of Farsi version of Parsian and Dunning spirituality questionnaire. *Fundamentals of Mental Health*, *17*(3), 129–134. [In Persian] https://doi.org/10.22038/jfmh.2015.4319

Atefi Hanzani, Gh., Shekarbeigi, A., & Ahmadi, A. (2023). Structural relationships between religiosity and social health in female heads of household: The mediating role of family social support. *Journal of Health Promotion Management*, *12*(1), 43–55. [In Persian] https://doi.org/10.22034/JHPM.12.1.43

Durkheim, E. (1995). *The elementary forms of religious life* (K.E. Fields, Trans.). New York: Free Press. (Original work published 1912)

Farahmand, M., Amiri, P., Ramezani Tehrani, F., Cheraghi, L., & Azizi, F. (2023). Health-related quality of life in women with various levels of spiritual health. *Women & Health*, *63*(5), 392–401. https://doi.org/10.1080/03630242.2023.2223674

Garssen, B., Visser, A., & Pool, G. (2021). Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. *The International Journal for the Psychology of Religion*, *31*(1), 4–20. https://doi.org/10.1080/10508619.2020.1729570

Gomez, R. (2025). Relations of the Spiritual Well-Being Questionnaire domains with other areas of well-being: A commentary based on existing published studies. *Journal of Religion and Health*, *64*, 3406–3418. https://doi.org/10.1007/s10943-025-02410-7

Gomez, R., & Watson, S. (2023). A reevaluation of the factor structure, reliability, and validity of the Spiritual Well-Being Questionnaire (SWBQ). *Journal of Religion and Health*, *62*, 2112–2130. https://doi.org/10.1007/s10943-022-01619-0

Heidari Kebriti, M., Hajibagheri, A., Nemati, L., Jalalvand, A., & Karimi, A. (2023). The effectiveness of spirituality therapy on psychological security and social health of students. *Islamic Life Style Centered on Health*, *7*(2), 352–358. [In Persian]

Hill, P.C., & Pargament, K.I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*(1), 64–74. https://doi.org/10.1037/0003-066X.58.1.64

Jørgensen, N.N., Eade, J., Ekeland, T.-J., & Lorentzen, C.A.N. (2020). The processes, effects and therapeutics of pilgrimage walking the St. Olav Way. *International Journal of Religious Tourism and Pilgrimage*, *8*(1), Article 6. https://doi.org/10.21427/v0cc-7135

Keyes, C.L.M. (1998). Social well-being. *Social Psychology Quarterly*, *61*(2), 121–140. https://doi.org/10.2307/2787065

Khaleghi, A. (2023). The need to reinterpret the global tools for evaluating social, religious, and spiritual health indicators. *Journal of Research on Religion & Health*, *9*(4), 1–6. [In Persian] https://doi.org/10.22037/jrrh.v9i4.43087

Koenig, H.G., & Carey, L.B. (2025). Approaches for analyzing the relationship between spirituality and health using measures contaminated with indicators of mental and social health. *Journal of Religion and Health*, *64*, 1276–1286. https://doi.org/10.1007/s10943-025-02249-y

Long, K.N.G., Symons, X., VanderWeele, T.J., Balboni, T.A., Rosmarin, D.H., Puchalski, C., Cutts, T., Gunderson, G.R., Idler, E., Oman, D., Balboni, M.J., Tuach, L.S., & Koh, H.K. (2024). Spirituality as a determinant of health: Emerging policies, practices, and systems. *Health Affairs*, *43*(6), 783–790. https://doi.org/10.1377/hlthaff.2023.01643

Mahdavi, M., Bahreinian, A., Shahabizadeh, F., & Jarrahi Feriz, J. (2024). Explaining the model of social health based on the intensity of stressful events mediated by religious beliefs and meaning of life in women victims of infidelity with regard to attachment style. *Pars Journal of Medical Sciences*, *22*(1), 39–49. [In Persian]

Marzban, A. (2022). The relationship between religious attitude and social health among students of Chabahar Maritime University. *Journal of Marine Medicine*, *4*(2), 101–107. [In Persian] https://doi.org/10.30491/4.2.101

Niabati Charandabi, H., Mohammadkhani, Gh., & Isazadeh, F. (2022). The effectiveness of group spirituality therapy on social health and depression in people with gender identity disorder. *Islamic Life Style Centered on Health*, *6*(2), 51–59. [In Persian]

Pargament, K.I. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford Press.

Parsian, N., & Dunning, T. (2009). Developing and validating a questionnaire to measure spirituality: A psychometric process. *Global Journal of Health Science*, *1*(1), 2–11. https://doi.org/10.5539/gjhs.v1n1p2

Pourtaleb, N., Shaker Dioulagh, A., Janmardi, F., & Safaee, A. (2024). The effectiveness of parenting training based on acceptance and commitment on the spiritual health, social health and mental health of mothers with teenage children. *Spirituality Research in Health Sciences*, *2*(2), 173–182. https://doi.org/10.34172/srhs.2024.015

Saffarinia, M. (2014). Validity, reliability and standardization of the social health questionnaire among residents of Tehran. *Social Psychology Research*, *4*(15), 45–56. [In Persian] https://dor.isc.ac/dor/20.1001.1.23221283.1393.3.11.6.7

Tajbakhsh, G., Sharifi, E., & Al-Kasir, S. (2022). Investigating the relationship between religiosity and social health in Shoush. *Islamic Studies of Women and Family*, *9*(16), 75–98. [In Persian]

Tykarski, S., & Mróz, F. (2024). The pilgrimage on the Camino de Santiago and its impacts on marital and familial relationships: An exploratory study. *Journal of Religion and Health*, *63*, 109–132. https://doi.org/10.1007/s10943-023-01825-4

Yuniartika, W., Kartinah, K., & Sudaryanto, A. (2023). Social interaction using spirituality therapy to improve the quality of life of the elderly in the community. *Evidence Based Care*, *13*(2), 65–74. https://doi.org/10.22038/EBCJ.2023.67206.2757