

Spirituality, Religion, and Ayurveda in Relation to Sociology

A PRISMA-Informed Systematic Narrative Review

Ayusha Trivedi¹, Nivedita Suman^{1*}, Dr. Murlidhar Paliwal²

^{1,1*}Research Scholar, Department of Samhita and Sanskrit, Faculty of Ayurveda, Institute of Medical Sciences, Banaras Hindu University, Varanasi, India. Email: ayushatrivedi.samhita.2025@bhu.ac.in

²Professor, Department of Samhita and Sanskrit, Faculty of Ayurveda, IMS, BHU, Varanasi, Uttar Pradesh, India, 221005. Email: drmpaliwal@bhu.ac.in

*Corresponding Author: Nivedita Suman, Research Scholar, Department of Samhita and Sanskrit, Faculty of Ayurveda, Institute of Medical Sciences, Banaras Hindu University, Varanasi, India. Email: niveditasuman.samhita.2025@bhu.ac.in

Abstract

A person's concept of health is influenced not just by their physical body but also by relationships, culture, identity, meaning, and daily routines. Despite the fact that spirituality, religion, and Ayurveda interact with these dimensions in different but related ways, these linkages are often examined in different academic and professional domains. This review brings them together through a medical-sociological lens. A PRISMA-informed systematic narrative review was developed from English-language literature published primarily between January 2000 and June 2026, supplemented by seminal earlier works. Searches were framed around Scopus, Web of Science Core Collection, PubMed, JSTOR, ScienceDirect, and Google Scholar. The synthesis indicates that spirituality is particularly relevant to meaning-making, hope, emotional regulation, and coping; religion additionally operates through collective identity, norms, ritual, caregiving, and social networks; and Ayurveda links preventive health with diet, routine, behaviour, mind-body relationships, and culturally embedded understandings of balance. Medical sociology shows that these influences are shaped by family, class, gender, institutions, professional authority, and access to care. The evidence is stronger when it comes to health-related behavior and psychosocial well-being than when it comes to directly modifying the course of a disease. The review argues for an integrative but critical approach in which spiritual and traditional practices are respected, voluntarily incorporated, and evaluated alongside evidence-based healthcare.

Keywords: Spirituality; religion; Ayurveda; medical sociology; holistic health.

How to cite this article: Ayusha Trivedi, Nivedita Suman, Dr Murlidhar Paliwal. Spirituality, Religion, and Ayurveda in Relation to Sociology. *Int J Drug Deliv Technol.* 2026;16(84s):2218-2226. DOI: 10.25258/ijddt.16.84s.224.

1. Introduction

Health is more than the management of disease. It is experienced through the body, but it is also shaped by emotions, familial ties, social norms, cultural meanings, economic circumstances, and issues of identity and purpose. Despite the remarkable advancements in diagnosis and treatment made available by contemporary biomedicine, a disease-centered approach might not fully address some elements of illness. This is especially true in situations involving chronic illness, pain, aging, mental health, disability, grieving, and end-of-life care, where patients often have to cope with identity alterations and ambiguity even when receiving therapeutic therapy. Engel's (1977)¹ biopsychosocial model rejected a limited biological reductionism, while subsequent whole-person models argued that spiritual and existential aspects equally deserve legitimate attention in healthcare (Sulmasy, 2002)².

In this broader concept of health, religion and spirituality serve different but interconnected purposes. Spirituality can be manifested both inside and outside of organized religion and typically involves meaning, purpose, togetherness, inner

coherence, or transcendence (Hill et al., 2000; Puchalski et al., 2014)^{3,4}. Shared beliefs, rituals, moral codes, authority structures, collective identities, and structured communities are all possible components of religion, which is typically more institutionalized. From a sociological perspective, the difference is significant because spirituality may only operate through individual interpretation and meaning-making, while religion can also affect social norms, collective membership, caregiving relationships, and access to social assistance (Idler, 2014; Koenig, 2012)^{5,6}.

Another significant point of linkage is offered by Ayurveda. Ayurvedic philosophy describes health as a condition of balance involving physical functions, digestion and metabolism, tissues and waste elimination, and the contentment of the mind, senses, and self, rather than only as the absence of disease. Individualized diets, daily and seasonal routines, sleep, exercise, mental discipline, ethical conduct, yoga, meditation, and preventative care are all part of its practical interest. These practices make Ayurveda

relevant not only as a medical system but also as a deeply rooted way of organizing daily life.

Medical sociology offers a useful framework for discussing these subjects. Health practices are influenced by a number of factors that go beyond individual choices, including social class, education, gender, caste, family, religion, institutions, professional authority, and resource access (Cockerham, 2021; Link & Phelan, 1995)^{7,8}. In a similar vein, social narratives and interactions—rather than pathology alone—are used to interpret sickness (Conrad & Barker, 2010)⁹. Biomedical treatment may be combined with Ayurveda, yoga, meditation, prayer, ritual, or community assistance in medically plural settings. These combinations may be practical attempts to address different parts of illness: biomedical services may be sought for diagnosis and urgent therapy, while spiritual or traditional practices may offer meaning, continuity, identity, hope, or long-term self-management.

The sociological significance of these practices lies from their social embeddedness. Beliefs become health-relevant when they shape routines, food preferences, sleep patterns, physical activity, how symptoms are perceived, when and where to seek medical attention, treatment compliance, treatment adherence, and family decision-making. However, these practices are neither naturally beneficial nor harmful. Their results are influenced by a number of factors, including the social context in which they are carried out, the resources available to individuals, the authority held by practitioners or organizations, and the degree to which beliefs support or contradict effective treatment.

1.1 Aim of the Review

This review tries to summarize the sociological relationship between spirituality, religion, and Ayurveda in the context of health, illness, well-being, and healthcare. It focuses on the social mechanisms by which these areas affect medical pluralism, coping strategies, social support, health attitudes, and behaviors.

1.2 Objectives of the Review

- To clarify the conceptual distinctions and parallels between medical sociology, spirituality, religion, and Ayurveda.
- To examine into the psychological, behavioral, relational, and institutional ways that spirituality and religion may influence health and illness experiences.
- To interpret the fundamental principles of Ayurveda as daily health practices and culturally embedded health knowledge.
- To examine the ways in which medical sociology advances our knowledge of how social structure,

culture, institutions, inequality, and professional authority influence these practices.

- To discuss ideas about the implications for future interdisciplinary research, public health, integrative practice, and person-centered healthcare.

As a result, the review is guided by four main questions: What conceptual links exist between religion, spirituality, and Ayurveda? Through which social mechanisms might they influence health? What does the interdisciplinary literature support with reasonable confidence? And what methodological, ethical, and institutional issues should be considered when these domains enter healthcare?

2. Materials and Methods

A systematic narrative review design was adopted because the topic crosses several bodies of scholarship, including medical sociology, public health, psychology, religious studies, palliative care, traditional medicine, and integrative healthcare. A narrative synthesis was preferred to statistical meta-analysis because the included literature differs substantially in concepts, populations, interventions, outcome measures, and research designs. Reporting was informed by the PRISMA 2020 framework, particularly its emphasis on transparent search procedures, eligibility criteria, screening, and structured synthesis (Page et al., 2021)¹⁰.

The search strategy was framed around Scopus, Web of Science Core Collection, PubMed, JSTOR, ScienceDirect, and Google Scholar. Search concepts included spirituality, spiritual well-being, religion, religious coping, Ayurveda, traditional medicine, medical sociology, sociology of health, holistic health, integrative medicine, medical pluralism, health behaviour, healthcare utilization, coping, and well-being. The major publication window was January 2000 to June 2026; however seminal earlier works were retained when they were necessary for conceptual or theoretical basis.

Peer-reviewed empirical studies published in English, systematic reviews, theoretical contributions, and authoritative policy articles that addressed at least two of the study domains or directly influenced their sociological interpretation were all considered eligible sources. Publications that simply addressed the effectiveness of pharmacological efficacy and had no social, cultural, behavioral, or spiritual relevance were ignored. Additionally neglected were book reviews, editorials, conference papers, and research with inadequate methodological descriptions.

Study design, sampling, measurement validity, transparency, cultural appropriateness, consistency among findings, and the degree to which conclusions were supported by the evidence were all considered

when analyzing the literature. Conceptual distinctions, psychosocial and behavioral pathways, religion and social integration, Ayurveda and holistic health, and medical pluralism, inequalities, institutions, and policy were the five interrelated categories into which the findings were organized thematically.

The review does not provide numerical counts at identification, deduplication, screening, or final inclusion because the source manuscript did not keep an auditable record of these steps. Consequently, a numerical PRISMA flow diagram has not been fabricated. This is an important methodological safeguard: reporting invented screening numbers would create a misleading impression of reproducibility. The present article should therefore be understood as a PRISMA-informed systematic narrative synthesis rather than a quantitatively pooled systematic review.

3. Conceptual Foundations of Ayurveda, Spirituality, Religion, and Medical Sociology

Ayurveda, religion, and spirituality intersect on issues of balance, relationships, self-regulation, and meaning, but they should not be used interchangeably. The main components of spirituality are interpretative and experience. It might help people understand suffering, uncertainty, illness, death, and loss. Such issues can become crucial to a person's identity and future in cases of severe sickness, making spirituality relevant to both therapeutic interactions and everyday life (Balboni et al., 2022; Park, 2013)^{11,12}.

Religion provides a collective and institutional representation for many spiritual concepts. Beliefs are shared and maintained in social contexts developed through worship, festivals, fasting, pilgrimages, moral instruction, clergy, congregations, and religious organizations. Durkheim's traditional approach is nevertheless applicable in this situation since it highlights how collective religious activity can result in a sense of recognition, social integration, moral obligations, and belonging (Durkheim, 1995)¹³. Therefore, from a sociological perspective, religion may have an impact on health through both material channels, such as companionship, caregiving, information, food, transportation, and other types of practical aid, as well as symbolic pathways, such as meaning and identity.

Ayurveda is a formal medical knowledge system with its own diagnostic categories, preventive principles, techniques for therapy, professional institutions, educational frameworks, and regulatory systems, which sets it apart from both spirituality and religion. Nonetheless, Ayurvedic practice has historically developed within a larger cultural framework where ideas about consciousness,

discipline, food, ritual, ethical living, and spiritual growth may overlap. This historical proximity should not be used to support the notion that Ayurveda is a religion unto itself. Maintaining this distinction is essential for professional accountability and for evaluating clinical claims.

Medical sociology connects these domains by studying the production, interpretation, application, and distribution of health knowledge. Rather than focusing solely on the patient or individual believer, it highlights families, communities, institutions, markets, professional affiliations, societal inequities, and power systems. Therefore, depending on who engages in the practice, how it is carried out, what resources are available, and how it relates to a particular healthcare system, the same practice may have diverse meanings and outcomes.

Domain	Primary orientation	Potential health pathways	Sociologic al caution
Spirituality	Meaning, purpose, connectedness, transcendence	Coping, hope, emotional regulation, inner coherence	Spiritual struggle and distress may also occur.
Religion	Shared belief, ritual, morality, community	Social support, identity, norms, caregiving, collective action	May also produce stigma, coercion, or conflict with treatment.
Ayurveda	Medical system emphasizing balance, individualized prevention and care	Diet, routines, behaviour, mind-body practices, therapeutics	Should not be conflated with religion or exempted from safety evaluation.
Medical sociology	Social production and interpretation of health and illness	Culture, institutions, networks, inequality, professional authority	Prevents health outcomes from being reduced to individual belief alone.

4. Spirituality and Religion in Health and Illness

The study identifies a number of ways that religion and spirituality could be related to health. These routes frequently overlap, and rather than being distinct psychological systems, their effects are better viewed as socially mediated processes.

4.1 Meaning-Making and Biographical Continuity

One of the most frequently explored pathways in the literature is meaning-making. Employment, family responsibilities, bodily expectations, and future plans can all be disrupted by chronic disease. Bury (1982)¹⁴ called this sensation "biographical disruption." Spiritual stories may help people regain a sense of continuity by providing a lexicon for understanding suffering, uncertainty, and change. Reviews have associated higher spiritual well-being with lower distress, greater hope, and better perceived quality of life in serious illness (Balboni et al., 2022; Koenig, 2012)^{11,6}. These associations are important, but they should not be interpreted as evidence that spirituality directly changes disease pathology.

4.2 Religious and Spiritual Coping

Coping offers an additional route. Prayer, gratitude, forgiveness, trust, acceptance, collaborative problem-solving, and reaching out to a religious community for assistance are examples of positive religious or spiritual coping. These activities might offer emotional support during uncertain times. However, religious coping can sometimes become distressing. Suffering may be exacerbated by feelings of punishment, abandonment, spiritual guilt, conflict within a religious community, or the conviction that medical care should be refused. Pargament et al. (1998)¹⁵ therefore provide a useful distinction between positive and negative forms of religious coping. For healthcare professionals, the practical implication is that the content and function of a belief should be explored rather than assuming that religiosity is automatically protective.

4.3 Behavioural Regulation and Health Lifestyles

Religious and spiritual traditions can also influence everyday health behaviour. Dietary rules, fasting, moderation, bodily discipline, regular routines, avoidance of harmful substances, and responsibilities toward the body may shape lifestyle choices. Cockerham's (2021)⁷ health lifestyle perspective is particularly relevant because it recognizes the interaction between agency and social structure. A person may value a healthy routine, for example, but employment conditions, income, neighbourhood environments, family responsibilities, and education can affect whether that routine is realistically achievable. Religious norms may therefore support particular behaviours without being sufficient to determine them.

4.4 Mind-Body and Contemplative Practices

Another path is represented by contemplative prayer, yoga, meditation, mindfulness, and breathing techniques. Although effects vary across populations and intervention formats, evidence from structured interventions points to benefits for specific outcomes

like perceived stress, sleep, anxiety, recurrent depression, and pain-related distress (Black et al., 2015; Goldberg et al., 2018; Kuyken et al., 2016)^{16,17,18}. Additionally, yoga has been linked to improvements in stress-related outcomes and physical function (Ross & Thomas, 2010)¹⁹. However, these practices may become detached from their ethical, philosophical, and cultural contexts when they are introduced into clinical settings. Therefore, sociological analysis can be used to investigate how activities are reinterpreted in religious, traditional, commercial, and biomedical contexts.

4.5 Social Support and Collective Life

Through organized social support, religion may be particularly important. Companionship, caregiving, transportation, food, financial assistance, counseling, and health information are all services that faith communities can provide. Some studies have associated religious participation to better health outcomes and reduced loneliness, but it is challenging to interpret these associations as straightforward causal effects because socioeconomic circumstances, healthier behavior, social integration, and baseline health may also have an impact (Idler, 2014; VanderWeele, 2017)^{5,20}. Rather than seeing religious attendance as a medical treatment in and of itself, a sociologically careful interpretation is that communities might create social capital that promotes health.

4.6 Pain, Palliative Care, and the Experience of Suffering

Spirituality becomes crucial when an illness causes problems that cannot be resolved by medical therapies alone. Pain is more than just a sensory experience; its meaning is influenced by relationships, expectations, feelings, and social environment. Even when pain intensity persists, mindfulness and acceptance-based techniques may lessen suffering (Kabat-Zinn, 1982)²¹. Spiritual discomfort in palliative care can include guilt, unresolved relationships, loss of purpose, anxiety of dying, or issues with dignity. According to Puchalski et al. (2014)⁴ and Sulmasy (2002)², whole-person care entails compassionate communication, respectful attention to spiritual issues, and referral to qualified spiritual care providers upon the patient's request.

Pathway	Typical outcomes discussed	Interpretive position
Meaning and coping	Lower distress, hope, quality of life, adaptation	Moderate evidence, particularly observational and review-based; causality remains limited.

Social integration	Reduced loneliness; emotional and practical support	Moderate evidence; confounding and selection effects remain important.
Mind-body practices	Stress reduction, anxiety and sleep outcomes, pain-related distress	Moderate evidence for selected structured interventions.
Lifestyle regulation	Dietary discipline, routines, substance avoidance, adherence	Plausible and socially mediated; structural conditions matter.
Direct disease modification	Biomarkers, morbidity, mortality	Limited or condition-specific evidence; causal claims require caution.

5. Ayurveda and Medical Sociology

Ayurveda views health as a dynamic condition of equilibrium rather than merely the absence of disease. Concepts like prakriti, dosha, agni, ahara, vihara, dinacharya, ritucharya, and swasthavritta form a strategy for self-care and prevention. Sociologically, these concepts can be seen as elements of a health culture since they classify bodies, establish routines, shape conceptions of appropriate behavior, and influence interactions with food, the environment, family, professionals, and institutions.

When discussing everyday health and lifestyle, Ayurveda's emphasis on prevention is particularly relevant. Daily and seasonal routines, eating habits, sleep, physical activity, mental discipline, and ethical behavior give a structured vocabulary for thinking about prevention. It is important to distinguish between conceptual resemblance and actual equivalency, even though some of these issues are similar to contemporary health promotion aims. Classical Ayurvedic categories should not be presented as direct substitutes for modern biomarkers or clinical diagnoses without appropriate evidence. Their sociological importance also lies in the way they make health practices culturally meaningful and practically organized.

Ayurveda's attention to mind-body relationships further connects it with contemporary interest in psychosocial and contemplative practices. Mental states, sensory habits, social behaviour, and ethical conduct are treated as relevant to well-being. Yoga, meditation, pranayama, and sattvavajaya-oriented approaches may support self-awareness and

emotional regulation when appropriately practiced. Their incorporation into healthcare, however, should depend on practitioner competence, patient preference, safety, and evidence relevant to the particular condition.

Ayurveda can also be studied as a contemporary social institution. Its current form is influenced by professional education, state regulation, pharmaceutical markets, wellness industries, globalization, media, tourism, and debates about standardization and authenticity. These processes can increase visibility and access, but they can also commercialize tradition, simplify individualized knowledge, or create incentives for unsupported claims. Medical sociology therefore asks who has the authority to define 'authentic' Ayurveda, whose knowledge is institutionally recognized, how evidence is produced and legitimized, and how commercial interests influence therapeutic practice.

The relationship between Ayurveda and religion requires similar conceptual care. Patients may combine Ayurvedic care with prayer, ritual, meditation, pilgrimage, or other religious practices because these practices occupy a shared cultural environment. Nevertheless, clinical Ayurveda should remain distinguishable from faith healing. The distinction does not deny their historical or cultural intersections; rather, it makes room for respectful collaboration while retaining professional responsibility for evidence, safety, informed choice, and accountability.

Ayurvedic concept	Health-related orientation	Medical-sociological interpretation
Prakriti	Individualized constitution and susceptibility	A culturally meaningful framework for bodily identity and personalization.
Dinacharya and ritucharya	Daily and seasonal regulation	Institutionalized routines that organize everyday health behaviour.
Ahara and agni	Food and digestive/metabolic functioning	Food as simultaneously biological, familial, moral, cultural, and social practice.
Swasthavritta	Health preservation and prevention	A population-health orientation translated into everyday

		conduct.
Sadvritta and mental discipline	Ethics, relationships, emotional balance	Moral norms and social behaviour as components of well-being.

6. Discussion

The central insight emerging from the review is that spirituality, religion, and Ayurveda are most clearly connected to health through social processes rather than through a single, universal mechanism. They influence how people interpret bodily experiences, organize daily routines, mobilize support, decide when to seek care, and negotiate uncertainty. Medical sociology is particularly valuable because it prevents these processes from being reduced to private belief. A person's capacity to follow a spiritual or Ayurvedic routine, for instance, may depend on family expectations, employment, income, education, access to practitioners, and the legitimacy accorded to different forms of knowledge.

A second important point concerns the distinction between spirituality and religion. The two may overlap, but their social organization is different. Spirituality can be relatively individualized and may be expressed outside formal institutions. Religion generally embeds beliefs within communities, norms, rituals, authority structures, and collective identities. These differences matter for health because the potential resources and risks are also different. A personal spiritual practice may support meaning and emotional regulation, while an organized religious community may provide practical care and social connection. Conversely, institutional authority may introduce pressures, stigma, exclusion, or conflict with healthcare decisions. Treating 'religion and spirituality' as a single exposure can therefore obscure important variations.

A third theme concerns Ayurveda as both medical knowledge and social practice. Ayurveda's emphasis on routine, diet, prevention, and individualized care creates an important bridge between health knowledge and everyday life. Its sociological relevance is not limited to whether individual therapies demonstrate clinical efficacy. Ayurveda also shapes identities, professional relationships, consumption patterns, wellness practices, and ideas about what constitutes a healthy life. In contemporary India and in global wellness markets, Ayurvedic knowledge moves across households, clinics, educational institutions, commercial products, tourism spaces, and digital platforms. Each setting can alter how that knowledge is interpreted and practiced.

The review also suggests that an integrative approach should be neither dismissive nor romanticizing. Dismissing spiritual or traditional practices can overlook resources that patients genuinely value, particularly for coping, identity, social connection, and long-term self-management. Romanticizing them, however, can encourage unsupported therapeutic claims or obscure harms. A sociologically informed position recognizes both possibilities. The relevant question is not whether a practice is 'traditional' or 'spiritual', but how it works in a particular social context, what evidence supports it, who provides it, who benefits from it, and what risks may accompany its use.

This perspective also highlights the importance of inequality. Access to high-quality integrative care is uneven. Individuals with greater economic and educational resources may have more opportunities to choose among biomedical, Ayurvedic, psychological, and spiritual services. At the same time, marginalized groups may rely on traditional or community-based practices because formal healthcare is distant, unaffordable, culturally unfamiliar, or institutionally mistrusted. The same practice can therefore represent cultural continuity in one setting, a necessary alternative in another, and a commercial wellness commodity in a third. (Link and Phelan's 1995)⁸ account of social conditions as fundamental causes is useful for understanding why health choices cannot be separated from unequal access to resources.

There are also methodological implications. The literature uses spirituality, religiosity, meaning, spiritual well-being, mindfulness, religious attendance, and religious coping in different ways. These constructs should not be treated as interchangeable. Much of the available evidence is observational, making it difficult to determine the direction of causality. For example, better health may facilitate community participation, while serious illness may either increase or decrease spiritual engagement. Cross-cultural differences in the meaning of religious and spiritual practices also complicate comparisons. These limitations do not invalidate the literature; rather, they call for more precise concepts, culturally appropriate measurement, longitudinal designs, mixed-method approaches, and transparent reporting of adverse as well as beneficial outcomes.

A further issue concerns medicalization and commercialization. When spiritual practices enter clinical institutions, they can become standardized and measured in ways that may change their original meanings. Similarly, when Ayurveda enters wellness markets, complex individualized principles may be condensed into standardized products or lifestyle packages. (Conrad's, 2007)²² discussion of

medicalization and contemporary sociological work on institutions and professional authority encourage attention to who defines legitimate health problems and acceptable solutions. The movement of knowledge between religious, traditional, commercial, and biomedical settings should therefore be treated as a social process rather than a neutral transfer of techniques.

Taken together, the evidence supports a model of whole-person care that is pluralistic but critical. Such a model recognizes that patients may have bodily, psychological, social, cultural, and existential needs at the same time. It also recognizes that no single system of knowledge is sufficient for every clinical problem. The practical challenge is to create care environments in which patients can disclose beliefs without fear of dismissal, clinicians can discuss evidence and risk without disrespect, and traditional or spiritual practitioners can participate within clearly defined ethical and professional boundaries.

7. Implications for Clinical Practice and Public Policy

The review has several implications for healthcare practice. First, spiritual concerns can be explored through voluntary, brief, and clinically relevant conversations. Clinicians may ask whether a patient's beliefs or practices are important to coping, whether they influence treatment decisions, and whether the patient wants spiritual support. The purpose is not to promote religion but to understand resources, conflicts, and distress. Patients should be free to decline such discussion.

Second, cultural humility is more appropriate than assuming that a religious or cultural identity predicts a patient's preferences. Beliefs vary within every community, and patients may combine, reinterpret, or reject inherited traditions. Shared decision-making should therefore address the patient's goals, the available evidence, possible interactions, practitioner qualifications, costs, and the consequences of delaying effective treatment.

Third, integrative services require appropriate governance. Ayurvedic and mind-body interventions should be delivered by qualified practitioners within systems that support quality assurance, pharmacovigilance, referral mechanisms, documentation, and transparent communication about evidence. Respect for traditional knowledge should be compatible with critical evaluation of safety and effectiveness.

Fourth, faith-based organizations can contribute to public health through health education, vaccination outreach, caregiving, mental-health referral, community support, and disaster response. Such partnerships should maintain scientific and ethical

standards, avoid coercion, and protect minority and vulnerable populations.

Finally, policy and research should recognize spiritual well-being as a potentially meaningful patient-reported dimension without turning belief into a compulsory biomedical target. Whole-person care should respond to what matters to patients while avoiding the medicalization of every existential experience.

8. Conclusion

Spirituality, religion, and Ayurveda intersect around dimensions of health that extend beyond pathology, but they do so through different forms of knowledge and social organization. Spirituality can provide meaning, hope, self-awareness, and coping; religion adds collective narratives, rituals, norms, identity, and organized social support; and Ayurveda provides a medical and lifestyle framework that connects bodily processes with diet, routine, behaviour, mind, environment, and ethical conduct. Medical sociology helps explain how these influences are shaped by relationships, institutions, inequality, professional authority, markets, and culturally specific understandings of health and illness.

The evidence reviewed here is most persuasive for psychosocial well-being, coping, social support, selected health behaviours, and aspects of quality of life. Evidence for direct modification of disease outcomes is more limited and should be interpreted cautiously. The appropriate response is therefore neither wholesale rejection nor uncritical acceptance. An ethically grounded integrative model should prioritize patient autonomy, cultural humility, professional accountability, safety, transparent evidence, and timely access to effective healthcare. Such an approach can acknowledge the social and existential dimensions of health while maintaining the standards required for responsible clinical practice and scholarly inquiry.

References

1. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136. <https://doi.org/10.1126/science.847460>
2. Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, 42(Suppl. 3), 24–33. https://doi.org/10.1093/geront/42.suppl_3.24
3. Hill, P. C., Pargament, K. I., Hood, R. W., Jr., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour*,

- 30(1), 51–77. <https://doi.org/10.1111/1468-5914.00119>
4. Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine*, 17(6), 642–656. <https://doi.org/10.1089/jpm.2014.9427>
5. Idler, E. L. (2014). *Religion as a social determinant of public health*. Oxford University Press.
6. Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). Oxford University Press.
7. Cockerham, W. C. (2021). *Medical sociology* (15th ed.). Routledge.
8. Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 35(Extra Issue), 80–94. <https://doi.org/10.2307/2626958>
9. Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior*, 51(Suppl.), S67–S79. <https://doi.org/10.1177/0022146510383495>
10. Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., McGuinness, L. A., Stewart, L. A., Thomas, J., Tricco, A. C., Welch, V. A., Whiting, P., & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, 372, n71. <https://doi.org/10.1136/bmj.n71>
11. Balboni, T. A., VanderWeele, T. J., Doan-Soares, S. D., Long, K. N. G., Ferrell, B. R., Fitchett, G., Koenig, H. G., Bain, P. A., Puchalski, C. M., & Steinhauser, K. E. (2022). Spirituality in serious illness and health. *JAMA*, 328(2), 184–197. <https://doi.org/10.1001/jama.2022.11086>
12. Park, C. L. (2013). Religion and meaning. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (2nd ed., pp. 357–379). Guilford Press.
13. Durkheim, E. (1995). *The elementary forms of religious life* (K. E. Fields, Trans.). Free Press. (Original work published 1912)
14. Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness*, 4(2), 167–182. <https://doi.org/10.1111/1467-9566.ep11339939>
15. Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37(4), 710–724. <https://doi.org/10.2307/1388152>
16. Black, D. S., O'Reilly, G. A., Olmstead, R., Breen, E. C., & Irwin, M. R. (2015). Mindfulness meditation and improvement in sleep quality and daytime impairment among older adults with sleep disturbances: A randomized clinical trial. *JAMA Internal Medicine*, 175(4), 494–500. <https://doi.org/10.1001/jamainternmed.2014.8081>
17. Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Kearney, D. J., & Simpson, T. L. (2018). Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, 59, 52–60. <https://doi.org/10.1016/j.cpr.2017.10.011>
18. Kuyken, W., Warren, F. C., Taylor, R. S., Whalley, B., Crane, C., Bondolfi, G., Hayes, R., Huijbers, M., Ma, H., Schweizer, S., Segal, Z., Speckens, A., Teasdale, J. D., Van Heeringen, K., Williams, M., Byford, S., Byng, R., & Dalgleish, T. (2016). Efficacy of mindfulness-based cognitive therapy in prevention of depressive relapse: An individual patient data meta-analysis. *JAMA Psychiatry*, 73(6), 565–574. <https://doi.org/10.1001/jamapsychiatry.2016.0076>
19. Ross, A., & Thomas, S. (2010). The health benefits of yoga and exercise: A review of comparison studies. *The Journal of Alternative and Complementary Medicine*, 16(1), 3–12. <https://doi.org/10.1089/acm.2009.0044>
20. VanderWeele, T. J. (2017). Religion and health: A synthesis. In M. J. Balboni & J. R. Peteet (Eds.), *Spirituality and religion within the culture of medicine: From evidence to practice* (pp. 357–401). Oxford University Press.
21. Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation. *General Hospital Psychiatry*, 4(1), 33–47. [https://doi.org/10.1016/0163-8343\(82\)90026-3](https://doi.org/10.1016/0163-8343(82)90026-3)

22. Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*. Johns Hopkins University Press.