

## Article

# The Relationship of the Religious Faith and Practice of Student Youth and Adults in Southeastern Poland and Western Ukraine with Their Health Status and Attitudes toward Physical Culture

Wojciech J. Cynarski <sup>1</sup>, Stanisław Dyndał <sup>2</sup>, Jacek Wąsik <sup>3</sup>, Dariusz Mosler <sup>4</sup>, Iuliia Pavlova <sup>5</sup>,  
Jong-Hoon Yu <sup>6</sup>, Tadeusz Ambroży <sup>7</sup>, Krzysztof Kasicki <sup>8,\*</sup> and Łukasz Rydzik <sup>7</sup>

- <sup>1</sup> Institute of Physical Culture Studies, College of Medical Sciences, University of Rzeszow, 35-959 Rzeszów, Poland; wcnarski@ur.edu.pl
  - <sup>2</sup> 'Varsovia' University of Business and Applied Sciences, 00-389 Warsaw, Poland; stan.dynda@gmail.com
  - <sup>3</sup> Department of Kinesiology and Health Prevention, Jan Długosz University in Częstochowa, 42-200 Częstochowa, Poland; j.wasik@ujd.edu.pl
  - <sup>4</sup> Institute of Physical Culture Sciences, Jan Długosz University in Częstochowa, 42-200 Częstochowa, Poland; dariusz.mosler@gmail.com
  - <sup>5</sup> Department of Theory and Methods of Physical Culture, Lviv State University of Physical Culture, 79000 Lviv, Ukraine; pavlova.j.o@gmail.com
  - <sup>6</sup> Department of Exercise and Sport, North Park University, Chicago, IL 60625, USA; jyu@northpark.edu
  - <sup>7</sup> Institute of Sports Sciences, University of Physical Education, 31-571 Krakow, Poland; tadek@ambrozy.pl (T.A.); lukasz.rydzik@awf.krakow.pl (Ł.R.)
  - <sup>8</sup> Faculty of Medicine and Health Sciences, University Andrzej Frycz-Modrzejewski Krakow, 30-705 Krakow, Poland
- \* Correspondence: krzysztof.kasicki2@gmail.com



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**Abstract:** Background: Religious faith and practice are important aspects of human life and give meaning to human existence. The development of modernity and consumerism has significantly undermined the religious foundations of a present-day global society. The aim of this study is to determine the relationships of the religious faith and practice of student youth and adults in Poland (Podkarpacie and Lesser Poland regions) and in western Ukraine (Lviv region) with their self-rated health status and attitudes toward physical culture. Methods: The study was conducted online in Poland and Ukraine from January to April 2022. A convenience sample of 1458 people was recruited. The questionnaire included 16 questions about religiosity, attitudes towards physical culture, and self-rated health status. Questions regarding self-esteem and attitudes towards physical culture were assessed on a Likert scale of 1 to 5 points. Other questions contained single-choice answers. Data were analyzed using Statistica v. 13.3. Results: The component of health that was rated highest was physical health among believers and mental health among non-believers. The results of the analysis of variance showed significant differences between the individual variables depending on the declaration of faith in God. Conclusion: While the faith of the inhabitants of southeastern Poland and western Ukraine is largely related to their regular religious practice, irregularity dominates this practice. Respondents combined ratings of their faith and/or practice with self-rated health status; more religious people had statistically lower levels of self-rated health.

**Keywords:** relationship; health; faith; religiosity; physical culture; Western Ukraine

## 1. Introduction

In the current era of cultural globalization, extreme commercialization in many areas of human activity, and the popularization of consumerism in mass culture (e.g., materialism, hedonism), the question arises whether the post-industrial society has not lost sight of valuable contributors to human health. Is modern society aware of the connections of faith and religious practice with human health? Quality of life can be defined according to the

World Health Organization as “an individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHO 2020).

The theoretical perspective on the reflection and research undertaken in this study is, of necessity, multidisciplinary. According to the assumptions of this new paradigm of science (Cynarski 2014), contextual, temporal, and processual aspects should be taken into account, while the scientific theory itself should meet the requirements of a systemic, cultural, and humanistic (i.e., significantly anthropocentric) approach. In this context, the human being is to be treated as a whole: a personal and psycho-physical being. The reduction of humanity to its corporeal nature would lead to losing essential truth at the stage of asserting foundational assumptions. The Catechism of the Catholic Church teaches that “God created man in His image, in the image of God He created him” (Genesis 1:27). “Man occupies a unique place in creation: he was created, in the image of God” (I), by its very nature, humanity unites the spiritual and material world (II), humanity is created as man and woman (III), God gave them His friendship (IV) (Catechism of the Catholic Church) (*Katechizm Kościoła Katolickiego* 1994). Mankind was created in the image of God, man has an inherent dignity as a person: “He is not just something but somebody. He is able to know himself, to control himself, to give himself freely, and to form a fellowship with others; by grace, he is called into a covenant with his Creator, to give him an answer of faith and love that no one else can give” (Catechism of the Catholic Church) (*Katechizm Kościoła Katolickiego* 1994). “Man is a complex being”, composed of two elements: the body (i.e., matter) and the soul (i.e., spirit) (Bajor 2021; Krapiec 1992).

This new paradigm of scientific research implies the adoption of a concomitant pedagogy (Cynarski et al. 2016; Kobylecka 2017; Pawłucki 2003, 2017; Szyszko-Bohusz n.d.), a systemic theory of health (Capra 1987; Pietrzak and Cynarski 2000), the concept of holistic training (Ambroży 2005), along with holistically understood physical culture and health culture (Cynarski and Bajorek 2009), as co-creating a scientific framework for intellectual exploration. Holistic and personalistic pedagogy, with reference to Fromm’s radical humanism, places the human being (i.e., the participant of events) in the center of attention and the center of the axiosphere. This does not exclude the notion that the examined person often shows faith in God and aspirations resulting from it. In turn, the systemic theory of health requires taking into account all of its components: physical (biological), psychical (mental), moral, and spiritual health. According to the realistic concept of philosophy (Aristotelian-Thomistic philosophy is regarded as such), “man is a contingent being, that is, one which may exist, but does not have to. If he exists in the world, it is because God wants him to come into being and calls him into being through His creative act, destined for Himself, to live with Him in a happy eternity” (Wolicki 2008). This truth was expressed by St. Augustine in the declaration: “God created us for Himself, and the human heart is restless until it rests in Him” (Wolicki 2008).

In the present study, the investigations should be started with the definition of the term ‘religiosity’. According to Borowik, the term denotes “various contents and forms of manifestation of the basic subjective belief that the meaning of human life is not exhausted in its biological existence” (Borowik 2001). The forms and content of religiosity are acquired through cultural inheritance (i.e., appropriate cultural patterns in accordance with a given axionormative system) or individual pursuits. This content refers especially to beliefs about the nature of the world, mankind, moral norms, and the meaning of life. This study assumes that religiosity is manifested in the practice of a given religion.

From the standpoint of sociology, religious belief is considered an important factor integrating society and co-constituting its cultural/national identity, next to its language and the community of fate. It constitutes an axiom that everyone believes in something, but this ‘something’ is different. Mircea Eliade pointed to an inherent human need for the sacred. Erich Fromm (1995) stated that man needs orientation, honor, and transcendence. These statements raise the question of whether it is possible to be happy and spiritually healthy without religion or the pursuit of the sacred. Those who have rejected belief in

God usually look for substitutes in ideologies, magic, or spirituality, such as that of the vanishing New Age movement (Cynarski 2004). In some countries, where such beliefs have not been part of cultural identity, this spiritual void has been occupied by Islam or the cults of the Far East.

The research literature in this field reveals a relationship between physical exercise and mental health (Cai 2000). To date, research on religion has focused on its relationship with self-esteem and self-control skills (Abbott et al. 2016; Benson and Spilka 1973; Krause 1995). Scientists have also repeatedly looked for relationships between religion and sports (Abdulla 2018; Tejero-González 2020; Torevell et al. 2022). Links have also been documented between psychology and religion (Gorsuch 1988; Jung 2002), as well as their relationship with the dimensions of the contemporary pandemic (Wildman et al. 2020). It is difficult to draw a demarcation line between physical culture and health culture, as these are overlapping concepts. In turn, faith and religious practice ensure a sense of axiological security, moral order to function in society (as an axionormative system), and in the case of universalist religions, international solidarity (Kondrla and Pavlikova 2016). Faith ensures, in particular, moral, spiritual, and mental health, and shows the meaning of life (Levin 2001).

CBOS research on religiosity in Poland documents the religious status of Poles. In the present study, 92% of respondents described themselves as members of the 98 Roman Catholic Church. Among them, 8% said that they were “deeply religious”, while up to 7% claimed to be non-believers. About 50% of Poles reported engaging in religious practices regularly, i.e., at least once a week, whereas 38% did it irregularly. By contrast, 4% of respondents participated in the activities of religious communities, showing greater commitment and practicing religion more than once a week (as compared to mere participation in church services) (Boguszewski 2017).

The southeastern regions of Poland (Małopolska, Podkarpacie) and the nearby Lviv region of western Ukraine were the research area. These are geographically and culturally close areas. Until 1939, this region was composed of eastern Lesser Poland and the Lviv Province of the Second Polish Republic. Despite changing political boundaries, Ukrainians of Greek Catholic and Orthodox Christianity dominated the Lviv region.

There is a strong relationship between religion and national identity. In particular, the Uniate Greek Catholic church, which survived underground through the era of Soviet domination, was an expression of opposition to the atheization, sovietization, and subordination to the Moscow Orthodox Church. The Roman Catholic Church was particularly persecuted in Ukraine as part of the Soviet Union, especially during the Stalinist era (Kulczycki 2010).

Catholic religious practice translates into visiting the church to participate, for example, in the Sunday Mass. It involves traveling or walking to and from one’s destination, praying and singing, kneeling down, and standing up. In this respect, the practice requires regular motivation and thus can be considered a form of gymnastics. However, whether it contributes to physical fitness and health according to the self-assessment of the participants of this practice is an open question.

In the case of Orthodox Christians, there are similar requirements for participation in the Holy Mass every Sunday, as in the Roman Catholic Church and the Greek Catholic Church. The Orthodox Church is autocephalous. This means that the highest authority of the Church is the Holy Council of Bishops, which establishes the law for the individual Churches that make up the Autocephalous Church. Individual bishops’ ordinaries implement the law approved by the Holy Council in their dioceses and parishes, which is binding on the faithful living in parishes and Orthodox dioceses.

In contrast, Greek Catholics follow canons similar to those of the Roman Catholic Church. Theological and anthropological attitudes differ among various individual Christian denominations. Catholic personalism, from the standpoint of Karol Wojtyła (John Paul II), significantly appreciated human corporeality as a temple of the Holy Spirit and an instrument of action (Kosiewicz 1988; Wojtyła 1969; Weigel 2009). From this perspective, Andrzej Pawłucki also presents his reflections on the asceticism and ethos of sport, and the

pedagogy of sport and its relation to the human body (Pawłucki 2003, 2019). As a form of taking care of health, physical activity found recognition in the opinion of the greatest moral authority of our time, Pope John Paul II, who stressed its great importance, not only as a physiological phenomenon, but also in serving to spread such values as loyalty, perseverance, friendship, and community (Weigel 2009). It seems interesting to examine how the approach to health is understood by university students and people at a certain intellectual level in Poland and Ukraine, with the latter state characterized by religiously, culturally, and historically distinct approaches to the concept of health. A literature survey reveals a deficit in the search for a link between religious practice and physical activity and the concept of health, especially in the context of the territorial comparisons made in the present study.

The scientific problem discussed here is the relationship of the faith and religious practice of student youth and adults in Poland (Podkarpacie and Lesser Poland regions) and in western Ukraine (Lviv region) with the respondents' health status and attitudes toward physical culture. The scope of the research is specified with five research questions:

1. To what extent is the faith of the inhabitants of southeastern Poland and western Ukraine related to their regular religious practice?
2. Do the respondents relate their faith and/or practice to their self-rated health status, and if so, how do they relate the two?
3. How is health status self-rated (in terms of particular components) by the respondents?
4. How do the respondents assess their attitudes toward physical culture and their active participation in physical culture?
5. How do the individual answers correlate with the personal data of the respondents and their religious affiliation?

It is worth noting that the area of Podkarpacie (Podkarpackie Province, southeastern Poland) is an area where the Catholic faith and religious practice are still alive. The percentage of Catholics attending Sunday mass in the Przemyśl diocese in 2016 was 56.4%

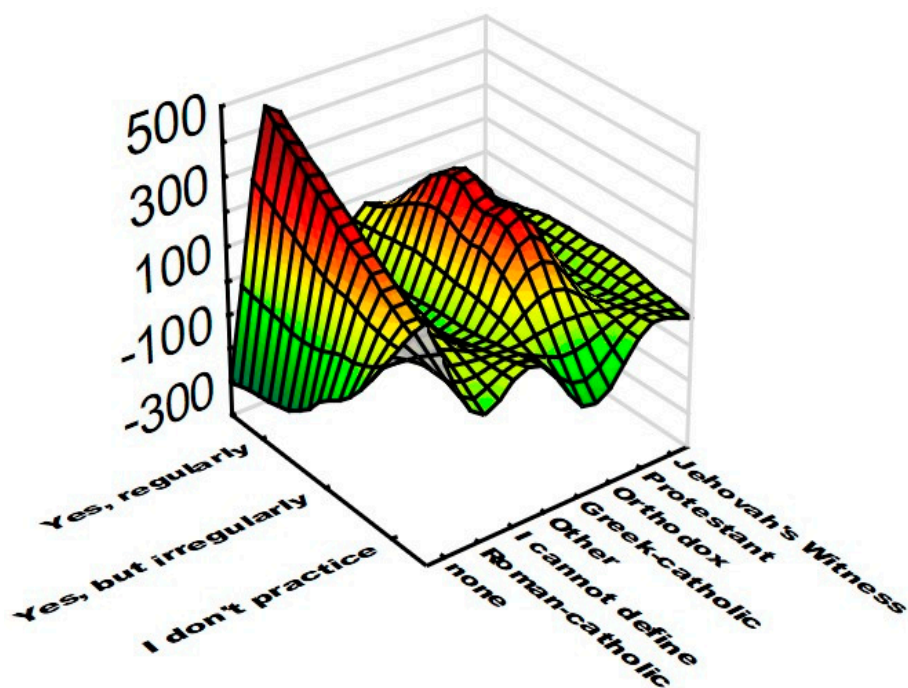
## 2. Results

Among people professing faith in God, the most numerous groups of people reporting a religious practice were Roman Catholics (39.9% of the respondents), followed by Greek Catholics (24.5%), and people professing the Orthodox faith (17.4%). Among people who could not define their religious affiliation, who did not practice religion at all, or who indicated a different belief tradition, only 22 people considered themselves to be practicing spirituality in any sense (Figure 1).

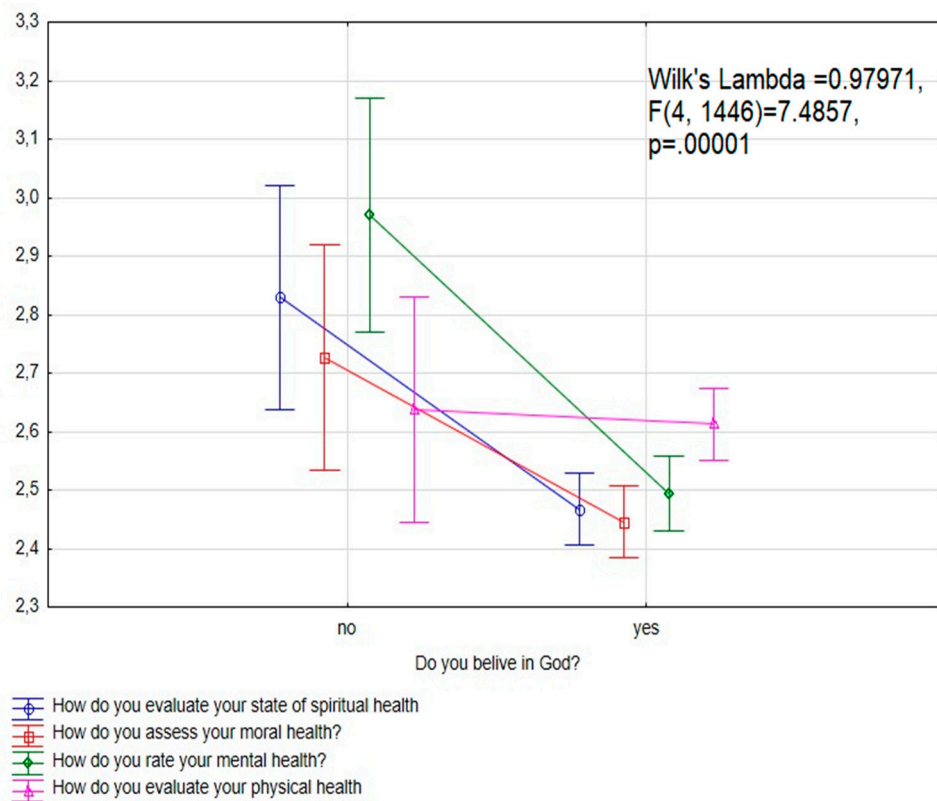
The average assessment of individual health components (i.e., spiritual, moral, mental, and physical) for believers ranged from 2.44 to 2.61 points, while for non-believers, it ranged from 2.64 to 2.97. The highest assessed component of health among believers was physical health (an average of  $2.61 \pm 1.14$ ), while among non-believers, this was mental health (an average of  $2.97 \pm 1.28$ ). Detailed results for each component are presented in Table 1. The results of the analysis of variance indicated a significant difference between the individual variables depending on professing faith in God (Figure 2). However, the t-test for each aspect showed no significant differences between believers and non-believers for moral, mental, and physical health aspects, with negligible effect size (Table 1).

On average, religious practitioners rated their spiritual health as the lowest, and their physical health as the highest (mean:  $2.18 \pm 1.14$  and  $2.53 \pm 1.13$ , respectively), while non-practitioners rated their moral health as the lowest, and their mental health as the highest (mean:  $2.56 \pm 1.19$  and  $2.84 \pm 1.25$ , respectively). The highest average ratings of health status were shown by respondents who practiced irregularly, with the lowest self-rated mental health and the highest self-rated spiritual health (mean:  $2.68 \pm 1.13$ , and  $2.77 \pm 1.02$ , respectively). Detailed results are presented in Table 2. The results of the analysis of variance indicated a significant difference between the individual variables depending on the frequency of religious practice for both joint effects (Figure 3) and a separate analysis of variance for each health aspect. Despite the statistical significance of

the results, the effect size was small but considerable only for spiritual and moral health, and negligible for mental and physical health (Table 2).



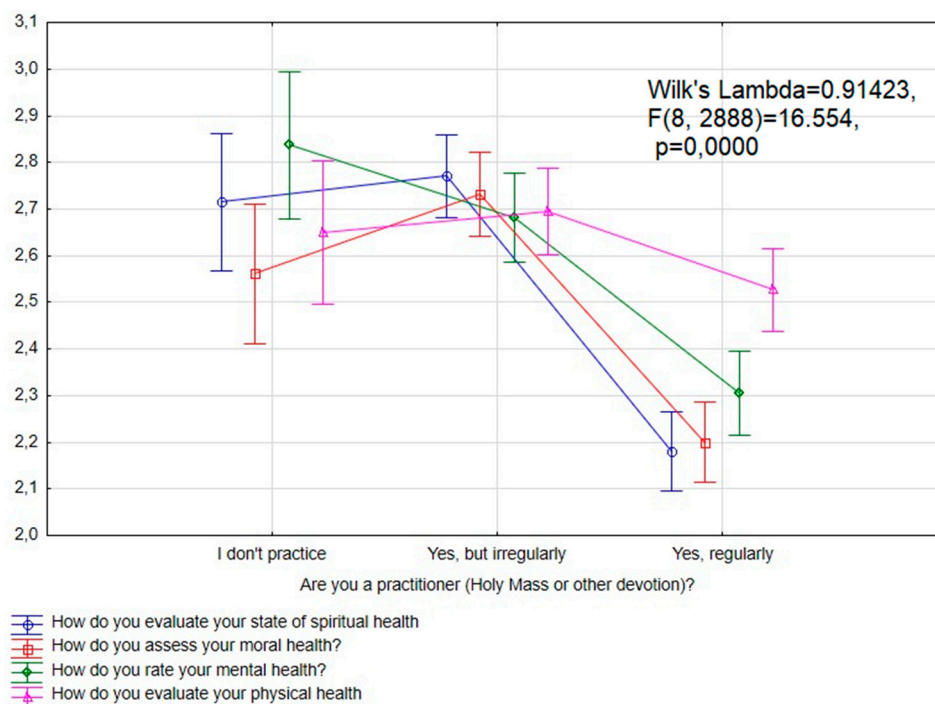
**Figure 1.** Graphical representation of the degree of faith of the respondents in the context of their regular religious practice (source: authors' research).



**Figure 2.** Graphical representation of the respondents' assessment of their faith in God and self-rated of health status (source: authors' research).

**Table 1.** Student’s t-test statistics for the relationships between individual health aspects and the respondent’s declaration of belief in God ( $p < 0.05$ ).

Health Aspect	Mean “No”	Mean “Yes”	t	SD “No”	SD “Yes”	F	p-Value	Effect Size
How do you rate your spiritual health?	2.83	2.47	3.54	1.29	1.12	1.32	0.021	0.0951
How do you rate your moral health?	2.73	2.44	2.74	1.27	1.13	1.27	0.054	0.0767
How do you rate your mental health?	2.97	2.49	4.49	1.28	1.17	1.18	0.175	0.1257
How do you rate your physical health?	2.64	2.61	0.25	1.20	1.14	1.11	0.398	0.0080



**Figure 3.** The frequency of religious practice (source: authors’ research).

**Table 2.** Descriptive statistics of health aspects by frequency of religious practice.

Health Aspect	Are You a Practitioner (Holy Mass or Other Church Services)?	Count	Mean	std	Min	25%	50%	75%	Max	F	p-Value	Effect Size
spiritual	I don't practice	214	2.71	1.19	1	2	3	3	5	49.539	0.00	0.2708
	Yes, but irregularly	590	2.77	1.02	1	2	3	3	5			
	Yes, regularly	652	2.18	1.14	1	1	2	3	5			
moral	I don't practice	214	2.56	1.19	1	2	2.5	3	5	36.419	0.00	0.2324
	Yes, but irregularly	590	2.73	1.10	1	2	3	4	5			
	Yes, regularly	649	2.20	1.11	1	1	2	3	5			
mental	I don't practice	214	2.84	1.25	1	2	3	4	5	24.898	0.00	0.1988
	Yes, but irregularly	590	2.68	1.13	1	2	3	3	5			
	Yes, regularly	649	2.30	1.18	1	1	2	3	5			
physical	I don't practice	214	2.65	1.20	1	2	3	3.75	5	3.540	0.029	0.0702
	Yes, but irregularly	590	2.69	1.13	1	2	3	3	5			
	Yes, regularly	651	2.53	1.13	1	2	2	3	5			

People who did not define their faith rated their spiritual health the best (mean:  $3.21 \pm 1.18$ ) while those of the Roman Catholic faith rated theirs the worst (mean:  $2.18 \pm 1.06$ ). Orthodox believers rated their moral health the best (mean:  $2.91 \pm 1.0$ ), while the Jehovah’s

Witnesses rated theirs the worst (mean: 2.0). A slightly higher result, indicated by a higher mean number, was reported by Catholics (mean:  $2.06 \pm 1.04$ ). Mental health was rated the highest by respondents indicating “other” as their religious affiliation (mean:  $2.91 \pm 1.23$ ) and by Jehovah’s Witnesses (mean: 3.0). Jehovah’s Witnesses rated their physical health the highest (mean: 3.25), followed by Protestants (mean:  $3.21 \pm 1.39$ ). The health status assessment results for this qualitative variable also revealed significant differences in the analysis of variance (Figure 4). Tables 3–7 present descriptive statistics as an auxiliary material to visualization in Figure 4.

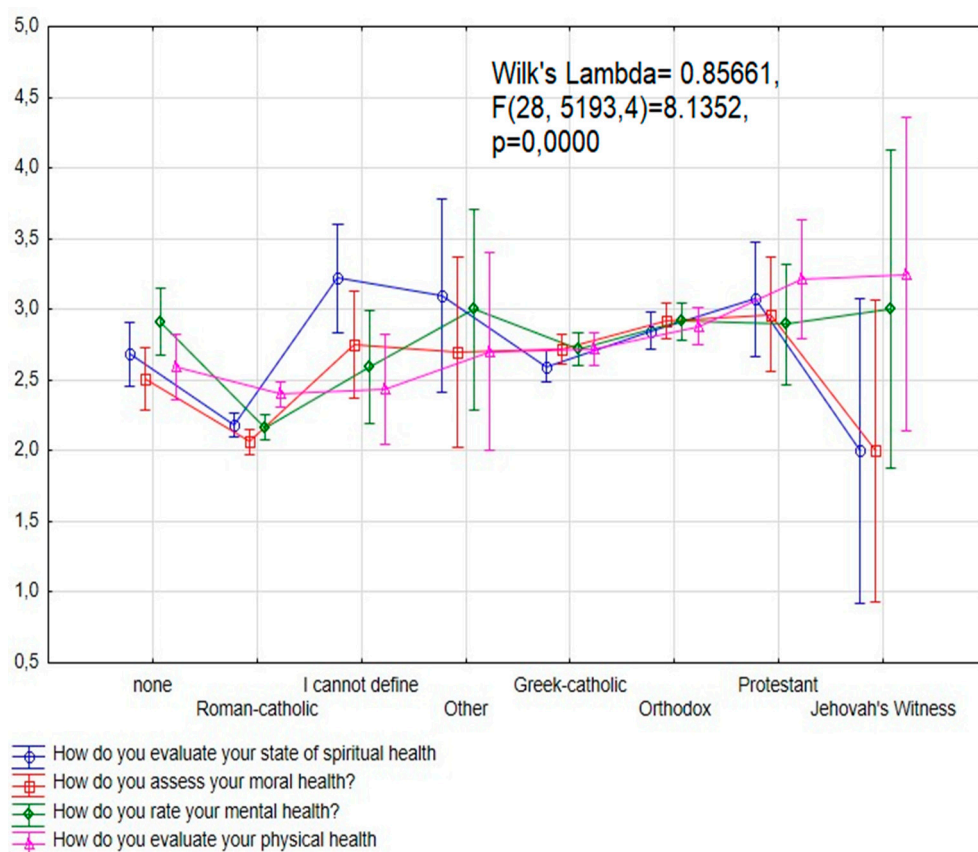


Figure 4. Self-rated health by professed religion (source: authors’ research).

Table 3. Descriptive statistics of spiritual health by religion.

Religion	Count	Mean	std	Min	25%	50%	75%	Max
Greek-catholic	386	2.59	1.07	1	2	3	3	5
I cannot define	32	3.22	1.18	1	2.75	3	4	5
Jehovah’s Witness	4	2.00	1.15	1	1	2	3	3
Orthodox	286	2.85	1.08	1	2	3	4	5
Other	10	3.10	1.60	1	2	3	4.75	5
Protestant	28	3.07	1.56	1	2	3	5	5
Roman-catholic	619	2.18	1.06	1	1	2	3	5
none	92	2.68	1.31	1	2	3	4	5

**Table 4.** Descriptive statistics of moral health by religion.

Religion	Count	Mean	std	Min	25%	50%	75%	Max
Greek-catholic	386	2.72	1.11	1	2	3	3	5
I cannot define	32	2.75	1.27	1	2	3	4	5
Jehovah's Witness	4	2.00	0.82	1	1.75	2	2.25	3
Orthodox	286	2.92	1.06	1	2	3	4	5
Other	10	2.70	1.49	1	2	2	3.75	5
Protestant	28	2.96	1.32	1	2	3	4	5
Roman-catholic	616	2.06	1.04	1	1	2	3	5
none	92	2.51	1.21	1	1.75	2	3	5

**Table 5.** Descriptive statistics of mental health by religion.

Religion	Count	Mean	std	Min	25%	50%	75%	Max
Greek-catholic	386	2.72	1.12	1	2	3	3	5
I cannot define	32	2.59	1.29	1	1.75	2.5	3.25	5
Jehovah's Witness	4	3.00	1.63	1	2.5	3	3.5	5
Orthodox	286	2.92	1.11	1	2	3	4	5
Other	10	3.00	1.56	1	1.5	3	4	5
Protestant	28	2.89	1.62	1	1.75	2	5	5
Roman-catholic	616	2.16	1.12	1	1	2	3	5
none	92	2.91	1.24	1	2	3	4	5

**Table 6.** Descriptive statistics of physical health by religion.

Religion	Count	Mean	std	Min	25%	50%	75%	Max
Greek-catholic	386	2.72	1.10	1	2	3	3	5
I cannot define	32	2.44	1.19	1	1.75	2	3	5
Jehovah's Witness	4	3.25	1.50	2	2	3	4.25	5
Orthodox	286	2.88	1.05	1	2	3	4	5
Other	10	2.70	1.34	1	2	2.5	3.75	5
Protestant	28	3.21	1.40	1	2	4	4	5
Roman-catholic	618	2.40	1.16	1	1	2	3	5
none	92	2.60	1.16	1	2	3	3	5

The analysis of the respondents' self-esteem revealed significant differences between the individual components of health depending on such variables as nationality, gender, age, and education. Analysis of the answers depending on nationality showed that Poles reported lower mean values for health components compared to Ukrainians. Poles assessed their moral health as the lowest (mean:  $2.07 \pm 1.07$ ), and their physical health as the highest (mean:  $2.39 \pm 1.17$ ). In contrast, the average scores among Ukrainians ranged from 2.72 to 2.82 points. The division of respondents by sex also revealed significant differences, while the nominal mean values were similar, with 2.52 for women and 2.45 for men. The distribution of self-rated values depending on age showed a tendency for a lower perception of spiritual, moral, and mental health with the increasing age of the respondents, while the self-rated physical health did not reveal such correlations. In this case, the oldest respondents rated their physical health as the highest (mean: 2.82 points), while the lowest ratings for physical health were found in those between the ages of 27 and 40 years (mean: 2.42 points). The general health status depending on the level of education did not reveal any clear tendency, although respondents with a bachelor's degree reported the highest ratings of individual components, in contrast to physical health, with individuals with vocational education rating their health higher. A detailed breakdown is presented in Table 7.



**Table 7.** Self-rated health status by recorded data.

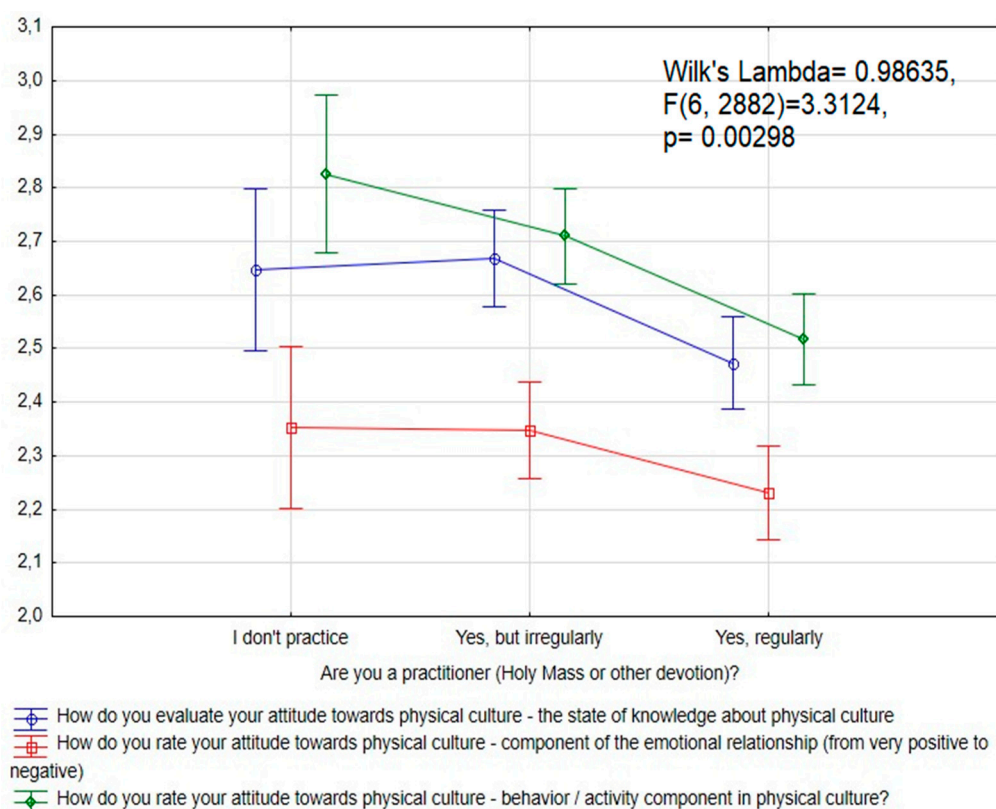
Categorial Variable		Spiritual Health		Moral Health		Mental Health		Physical Health		ANOVA	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD	F	p-Value
Nationality	Polish	2.25	1.13	2.07	1.07	2.21	1.17	2.39	1.17	43.345	0.000
	Ukrainian	2.72	1.11	2.82	1.10	2.82	1.13	2.81	1.08		
Gender	Female	2.52	1.12	2.54	1.14	2.59	1.17	2.68	1.10	6.581	0.000
	Male	2.45	1.20	2.29	1.15	2.38	1.24	2.43	1.23		
Age	18–26	2.68	1.10	2.67	1.14	2.73	1.19	2.64	1.16	12.431	0.000
	27–40	2.35	1.19	2.28	1.12	2.34	1.18	2.48	1.13		
	41–65	2.24	1.12	2.14	1.06	2.20	1.09	2.61	1.10		
	65+	1.65	0.97	1.79	0.96	2.12	1.07	2.88	1.24		
Education	Elementary	1.98	1.03	1.86	0.86	1.86	0.90	2.74	1.17	4.792	0.000
	Secondary	2.46	1.14	2.39	1.12	2.52	1.17	2.61	1.16		
	Vocational	2.32	1.15	2.42	1.11	2.42	1.12	2.69	1.00		
	Bachelor’s	2.68	1.13	2.68	1.15	2.71	1.20	2.66	1.18		
	Master’s	2.36	1.14	2.26	1.16	2.33	1.21	2.44	1.12		

As in the case of self-rated health, attitudes toward physical culture and its individual components were significantly different for the previously presented divisions. In general, Ukrainians reported attitudes higher than those of Poles (differences in the spread ranged from 2.38 to 2.86 points to 2.21 to 2.39 points). In the case of attitudes toward physical culture, women reported better attitudes in all components, with the highest difference for the state of knowledge about physical culture, and the smallest difference related to the emotional attitude toward physical culture. Respondents up to the age of 65 answered similarly in terms of their self-rated state of knowledge (2.52 to 2.63 on average), while the group of respondents aged 66 years and above rated this noticeably lower, at a mean of  $2.23 \pm 1.08$  points. On the other hand, the other components of physical culture were best rated by respondents over 65. Among all components of physical culture, the best mean of attitudes was reported by respondents with vocational education, while the lowest average results were reported by those with primary and secondary education. Details of these ratings are presented in Table 8.

**Table 8.** Attitudes towards individual components of physical culture by recorded data.

Categorial Variable		The State of Knowledge about Physical Culture		Component of the Emotional Relationship toward Physical Culture		Behavior/Activity Component in Physical Culture		ANOVA	
		Mean	SD	Mean	SD	Mean	SD	F	p-Value
Nationality	Polish	2.31	1.16	2.21	1.04	2.39	1.12	38.543	0.000
	Ukrainian	2.81	1.04	2.38	1.19	2.86	1.03		
Gender	Female	2.66	1.08	2.32	1.11	2.74	1.06	14.052	0.000
	Male	2.36	1.21	2.24	1.16	2.39	1.16		
Age	18–26	2.60	1.11	2.30	1.16	2.69	1.10	2.754	0.003
	27–40	2.52	1.18	2.25	1.04	2.50	1.12		
	41–65	2.63	1.13	2.32	1.11	2.60	1.03		
	65+	2.23	1.08	2.40	0.98	2.79	1.24		
Education	Elementary	2.42	1.07	2.33	0.97	2.63	1.11	2.318	0.006
	Secondary	2.49	1.12	2.23	1.13	2.55	1.08		
	Vocational	2.81	1.05	2.49	1.04	2.80	1.07		
	Bachelor’s	2.62	1.11	2.28	1.16	2.73	1.09		
	Master’s	2.51	1.22	2.33	1.11	2.49	1.15		

The respondents rated their attitudes towards individual components of physical culture significantly differently depending on the frequency of their religious practice. Regardless of the intensity of religious practice, respondents rated the component of active participation in physical culture as the highest, while the mean responses were significantly different. With an increase in the intensity of religious practice, the rating of attitudes toward physical culture decreased (from a mean of 2.82 to 2.51 points). A similar tendency was observed in the other components, except for the highest rating for the state of knowledge about physical culture, reported by people practicing religion irregularly (mean of  $2.67 \pm 1.12$  points). Details are presented in Figure 5, with joint effects of analysis of variance showing significant differences between analyzed variables. However, an additional one-way analysis of variance showed no significant differences in the attitudes toward physical culture (Table 9).

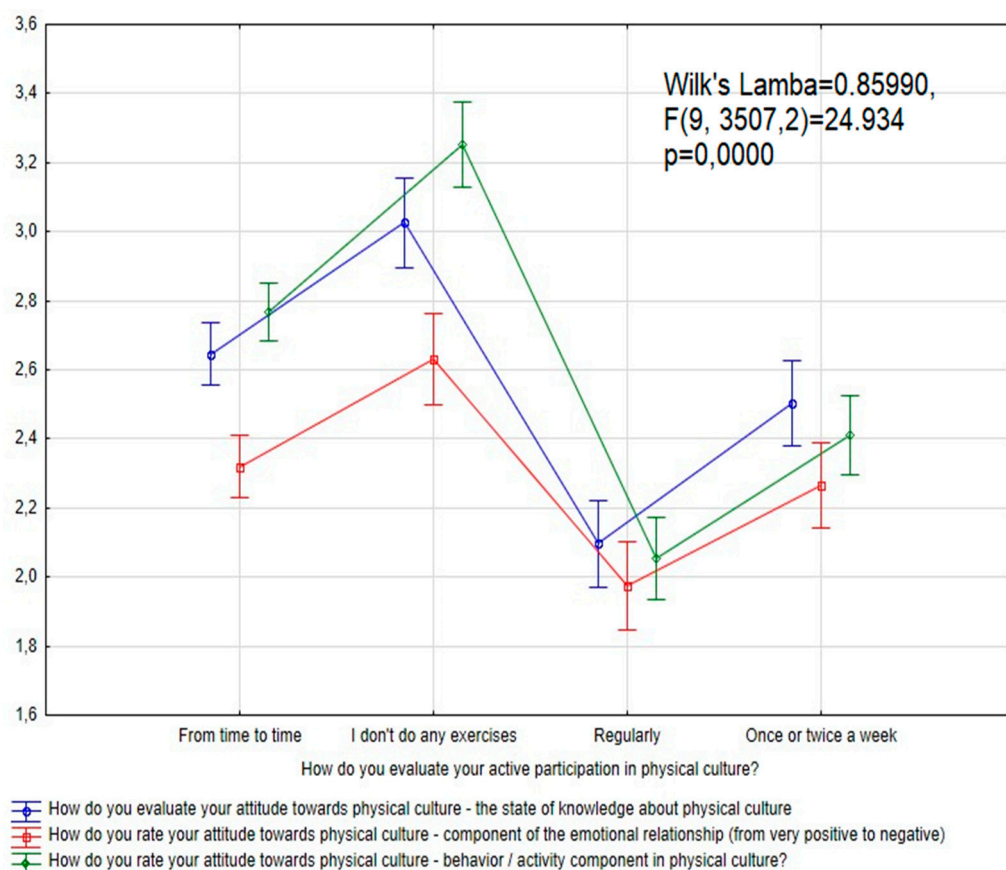


**Figure 5.** Attitude toward physical culture by religiosity (source: authors' research).

The attitudes of the respondents toward individual components of physical culture differed significantly depending on the frequency of practicing physical culture. The highest self-esteem was demonstrated by the respondents who did not practice physical culture, at the same time indicating the highest attitudes towards being active and toward physical culture, with a mean of  $3.24 \pm 1.1$ . The self-esteem decreased in all components with increasing physical activity of the respondents. Occasional practitioners rated the individual components from 2.33 to 2.76, in people training once or twice a week—from 2.26 to 2.50, and in regular practitioners—from 1.97 to 2.09. In general, the emotional relationship to physical culture was rated the lowest, and participation was the highest, with the details illustrated in Figure 6. Analysis of individual components using one-way ANOVA (Table 10) revealed separate effects, with significant differences for joint effect presented in Figure 6. The calculated effect size was the strongest for attitudes toward physical culture, while the weakest yet considerable effect size was found for the emotional component.

**Table 9.** Descriptive statistics of attitudes toward physical culture by religiosity.

How do you rate your attitude toward physical culture? (the state of knowledge about physical culture)									ANOVA		
Are you a practitioner (Holy Mass or other church services)?	count	mean	SD	min	25%	50%	75%	max	F	p-value	Effect size
I don't practice	214	2.64	1.16	1	2	2.5	3	5	4.852	0.008	0.0856
Yes, but irregularly	590	2.67	1.12	1	2	3	3	5			
Yes, regularly	649	2.48	1.11	1	2	3	3	5			
How do you rate your attitude toward physical culture? (component of the emotional relationship—from very positive to negative)											
Are you a practitioner (Holy Mass or other church services)?	count	mean	std	min	25%	50%	75%	max	F	p-value	Effect size
I don't practice	213	2.36	1.15	1	1	2	3	5	2.117	0.120	0.0575
Yes, but irregularly	590	2.35	1.16	1	1	2	3	5			
Yes, regularly	650	2.23	1.08	1	1	2	3	5			
How do you rate your attitude toward physical culture? (behavior/activity component in physical culture)											
Are you a practitioner (Holy Mass or other church services)?	count	mean	std	min	25%	50%	75%	max	F	p-value	Effect size
I don't practice	213	2.83	1.17	1	2	3	4	5	8.332	0.000	0.1112
Yes, but irregularly	589	2.71	1.09	1	2	3	3	5			
Yes, regularly	650	2.52	1.07	1	2	3	3	5			

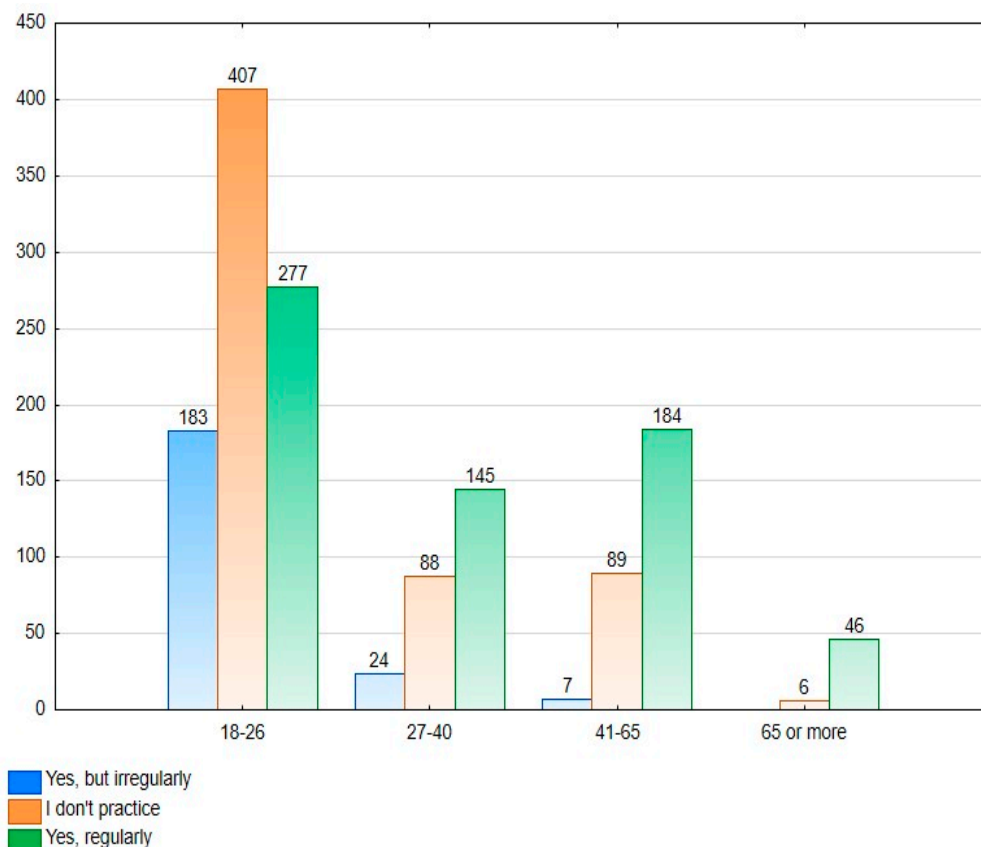


**Figure 6.** Attitudes toward physical culture by physical activity (source: authors' research).

**Table 10.** Descriptive statistics of attitudes toward physical culture by active participation in physical activity.

How do you rate your attitude toward physical culture? (the state of knowledge about physical culture)									ANOVA		
How do you rate your active participation in physical culture?	count	mean	SD	min	25%	50%	75%	max	F	p-value	Effect size
I don't do any exercises	276	3.03	1.092	1	2	3	4	5	35.813	0.00	0.2803
I exercise once or twice a week	306	2.50	1.117	1	2	2	3	5			
I practice some form of physical culture by exercising regularly	287	2.1	1.251	1	1	2	3	5			
I practice something from time to time	585	2.64	0.976	1	2	3	3	5			
How do you rate your attitude toward physical culture? (the component of the emotional relationship, from very positive to negative)											
How do you rate your active participation in physical culture?	count	mean	SD	min	25%	50%	75%	max	F	p-value	Effect size
I don't do any exercises	276	2.62	1.09	1	2	3	3	5	16.271	0.00	0.1898
I exercise once or twice a week	306	2.26	1.15	1	1	2	3	5			
I practice some form of physical culture by exercising regularly	287	1.98	1.22	1	1	2	2.5	5			
I practice something from time to time	585	2.32	1.03	1	1	2	3	5			
How do you rate your attitude toward physical culture? (behavior/activity component in physical culture)											
How do you rate your active participation in physical culture?	count	mean	SD	min	25%	50%	75%	max	F	p-value	Effect size
I don't do any exercises	276	3.24	1.10	1	2.75	3	4	5	71.294	0.00	0.3864
I exercise once or twice a week	306	2.41	0.92	1	2	2	3	5			
I practice some form of physical culture by exercising regularly	287	2.05	1.20	1	1	2	3	5			
I practice something from time to time	584	2.77	0.95	1	2	3	3	5			

Despite the overrepresentation of the 18–26 age group, in which the distribution of the religiosity of the respondents contained the highest percentage of non-practitioners, there was a noticeable change in these proportions correlated with the age of the respondents. In each age category, people who practiced their religion irregularly constituted a small percentage of the respondents. Furthermore, as the age category increased, the number of non-practitioners decreased while the percentage of religious people increased. Cumulatively, as age increased, at some point in the age category of 41 to 65 years, regular practitioners accounted for over 50% of respondents, and 88% of people over 65 were religious. The analysis of Spearman's rank correlation in the distribution of the two-way table revealed a weak relationship between the age of the respondents and religiosity at  $r = 0.348$ , with details presented in Figure 7.



**Figure 7.** Correlation of religiosity with the age of respondents (source: authors' research).

### 3. Materials and Methods

#### 3.1. Participants

Participants in the study consisted of  $N = 1458$  people from southeastern Poland and western Ukraine. Using Cochran's Sample Size Formula with a 5% margin of error and confidence level of 95%, the required sample size was 375 participants for every population (Polish students, Ukrainian students) (Bartlett et al. 2001). The survey was conducted between January and April 2022. An open label cross-sectional study using a convenience sampling was used because the questionnaire was intended for a group of available people. However, the respondents can be considered average individuals who are typical of the population. The minimum age of 18 years and consent to participate in the study were inclusion criteria, whereas refusal to complete the questionnaire or incomplete completion were exclusion criteria. The entire survey was conducted by the authors of the paper after prior agreement and standardization of the rules. Most of the respondents were women (72.4%), and the majority of men were of Polish nationality. Almost 60% of the respondents were young people in the 18–26 age group, not in long-term formal relationships with any other people. Many participants indicated having completed undergraduate studies (38.8%), while almost half of the respondents indicated studying at universities. Over 90% of respondents professed faith in God. Among the respondents, a similar yet slightly larger proportion reported regular religious practice (44.9%) compared to those who reported irregular, sporadic practice (40.5%). More people of Polish nationality practiced regularly, while irregular practice was reported more often by people of Ukrainian nationality. For further analysis, the  $N$  was reduced to 1456, due to the exclusion of two cases, one of a divorced woman and another of a person identifying as Muslim. We conducted a snowball non-probability sampling survey. The sampling approach utilized the network of Lviv State University of Physical Culture. Researchers collaborated with students' trade unions and student government organizations to invite students to participate in the study. The invitation was distributed by Facebook groups, Viber groups, and Telegram channels.

The survey was disseminated using self-reported Google Forms to allow respondents to participate via mobile devices.

A detailed list of participants is presented in Table 11.

**Table 11.** Quantitative statistics of the answers provided by the respondents (N = 1458).

	Answer	Polish (% of N)		Ukrainian (% of N)		General (% of N)	
Gender	female	409	28.10%	647	44.40%	1056	72.40%
	male	272	18.70%	130	8.90%	402	27.60%
Age	18–26	274	18.80%	593	40.70%	867	59.50%
	27–40	165	11.30%	93	6.40%	258	17.70%
	41–65	191	13.10%	89	6.10%	280	19.20%
	65 or more	51	3.50%	2	0.10%	53	3.60%
Marital status	single	322	22.10%	590	40.50%	912	62.60%
	married	308	21.10%	179	12.30%	487	33.40%
	widow/widower	51	3.50%	7	0.50%	58	4.00%
	divorced	0	0.00%	1	0.10%	1	0.10%
Education level	elementary education	43	2.90%	0	0.00%	43	2.90%
	secondary education	253	17.40%	198	13.60%	451	30.90%
	vocational education	81	5.60%	89	6.10%	170	11.70%
	bachelor degree	162	11.10%	404	27.70%	566	38.80%
	master's degree	142	9.70%	86	5.90%	228	15.60%
Employment	part-time job	61	4.20%	56	3.80%	117	8.00%
	university student	206	14.10%	507	34.80%	713	48.90%
	full-time job	277	19.00%	184	12.60%	461	31.60%
	school student	14	1.00%	0	0.00%	14	1.00%
	unemployed	26	1.80%	28	1.90%	54	3.70%
	retired	67	4.60%	0	0.00%	67	4.60%
	pensioner	30	2.10%	2	0.10%	32	2.20%
Do you believe in God?	no	45	3.10%	90	6.20%	135	9.30%
	yes	636	43.60%	687	47.10%	1323	90.70%
Are you a practitioner?	I don't practice	96	6.6%	118	8.1%	214	14.7%
	Yes, but irregularly	203	13.9%	387	26.5%	590	40.5%
	Yes, regularly	381	26.1%	273	18.7%	654	44.9%

### 3.2. Measurement Methods

The diagnostic survey method was used, with the questionnaire technique and questions about faith in God versus atheism, and in the case of professing faith in God, further questions concerning the type of religion and the extent to which the respondents participated in religious practices. The applied research method illustrates the phenomenon of the relationship between two indicated realities—religious faith and health, based on the statements of a large group of respondents (the results are not representative of the entire population of the region). The questionnaire contained 16 items in its main part and 7 record-related questions. The questions of the main part concerned religiosity, attitudes toward physical culture (in terms of its basic components), and self-rated health status, both physical and mental, including, *inter alia*, test questions and indirect questions. Questions regarding self-esteem and attitudes toward physical culture were assessed on a Likert scale of 1 to 5 points, where 1 was the most negative result and 5 was the most positive result. Other questions contained single-choice answers, assigning the variables according to the categorical order (yes/no answers, choice of the appropriate category or frequency range). The model of this research tool can be found in the Supplementary Material.

### 3.3. Statistical Analysis

Statistical analysis of the collected material was carried out in the Statistica v 13.3 program (StatSoft, Kraków, Poland). Basic descriptive statistics were calculated as arith-

metric means with standard deviation. One-way ANOVA was used to verify statistically significant differences between the tests. The choice of this test was due to meeting the assumption of normality of the distribution of variables, which was verified using the Shapiro–Wilk test. Due to the specificity of the questionnaire, Spearman’s rank correlation was used to assess dependence. The level of statistical significance was set at  $p < 0.05$ .

#### 4. Discussion

In light of the results of the present research, Roman Catholics practice religion the most frequently, followed by Greek Catholics and Orthodox Christians. This may be due to the larger population of believers who were Roman Catholics. Respondents identifying with other religious affiliations tended to practice irregularly or not at all. Poles, most often Roman Catholics, are slightly more active in terms of the frequency of their religious practices, i.e., they practice religion more regularly.

Professing faith in God is associated with significantly lower self-esteem. Similar conclusions were noted by [Ashton and Lee \(2021\)](#), who claimed that general religiosity shows little positive association with personality factors. It is interesting to note how the individual components of health (i.e., spiritual, moral, mental, physical) are perceived. Practitioners evaluated all these components of health as significantly worse. In contrast, [Cummings et al. \(2014\)](#) argued that religion and spirituality have a potentially powerful therapeutic influence on human mental health. Lower results occurred in men and respondents with lower education. The findings revealed a downward trend correlated with age, which is obviously to be anticipated. In general, a lower self-assessment of health was reported by Catholics and Jehovah’s Witnesses, and the highest by respondents reporting no specific religious affiliation.

A number of studies have analyzed the global relationship of religion with health and physical fitness in the context of religiosity. The analysis of these studies shows that the relationship between religiosity and health depends on the nationality of the population studied. Positive associations of religiosity and health have been demonstrated in studies conducted in the United States, Western Europe, and the United Kingdom. In contrast, weaker indicators of the relationships between religiosity and health concerned former and current communist countries in Asia and Eastern Europe ([Diener et al. 2011](#); [Elliott and Hayward 2009](#); [Lun and Bond 2013](#)). Furthermore, in the context of faith, the purpose and meaning of life for health are pondered by those living in countries with significant government restrictions. Religious participation promotes positive well-being in countries with a significant degree of religious diversity. It can be surmised that this is related to the freedom to practice religion without fear or shame, and religious practice is a personal choice there, often for practical reasons ([Zimmer et al. 2019](#); [Inglehart 2010](#)).

This study equates religiosity with the intensity/frequency of religious practice. As for all self-rated components of health, the results were lower for practitioners. This finding raises the question as to whether physical culture could be misunderstood as a substitute for religious practice or religious practice as a substitute for physical culture. Unlike the student youth group, older adults are more religious and practice more regularly, with up to 88% in the 65+ age category. Over the past three decades, numerous studies have shown that religious involvement promotes lifelong health and longevity. Faith-based health promotion programs such as those helping people improve their diets and exercise habits are common, especially in underserved populations where health disparities are most pronounced ([Koenig et al. 2012](#)). Other publications have confirmed the effectiveness of interventions conducted in religious communities to improve screening for early disease detection and promote health through education in specific cultural contexts ([Whisenant et al. 2014](#)). Researchers studying the relationships between religion and physical health are increasingly focusing on indicators of biological functioning ([Seybold 2007](#); [Hill 2010](#)). The resurgence of interest in the effect of religion and spirituality on health is also considered in the context of the holistic and historical paradigm. This approach shows that religious involvement promotes health and longevity across the life cycle ([Page et al. 2020](#)). In terms

of physical health, the beneficial effects of religious involvement extend to self-rated health and physical functioning (Hill et al. 2016; Idler et al. 2009). There is also evidence to suggest that there is no relationship or that religious involvement is associated with poorer physical functioning (Hayward and Krause 2013).

If older adults experience worse health and are more religious, their attitudes toward physical culture may result from these conditions. Human aging or disease, coupled with reflection on the inevitability of death, can attract human attention to timeless, especially religious, values. Scientists have repeatedly identified the relationships between the role of religion and the aging process (Cohen and Koenig 2003; Malone and Dadswell 2018). The problem of mental health is important for the analysis of aging from the perspective of psychology. There is relative agreement as to the fact that religion gives a sense of meaning in life, strengthening older adults and the terminally ill (Fromm 1995; Levin 2001; Woźniak 2012). Moreover, in another civilization region, namely China, similar regularities have been reported (Pan et al. 2022).

Compared to the findings of the Public Opinion Research Center (CBOS) in Poland, the present study obtained a slightly lower index concerning the declaration of faith in God, with 90.7% compared to 92% in Poland (preponderantly Roman Catholics). Regular practice (e.g., visiting the house of worship at least once a week) was also reported by fewer respondents—44.9% compared to 50% in Poland and 56.4% in the Podkarpacie region of Poland (Boguszewski 2017; Portal Przemyski 2018).

The novelty of this research is (a) the comparison of attitudes toward religion/religiosity, health, and physical culture jointly, and (b) looking at the research topic from the perspective of different faiths and two nationalities.

#### *Limitations of the Study*

The limitations on making generalizations in this study result from the fact that these two regions have their own specificity. It is likely that in other regions of the countries studied (i.e., Poland and Ukraine), the results would differ, at least slightly. The deliberate overrepresentation of the student youth group in this study will cause its results to differ from those conducted for the entire society. However, these results can be used for comparisons with research involving young people from other countries, which would be one of the possible objectives for further research. Research would also include studies of other regions, where historical/cultural conditions and the current impact of mass culture may have resulted in the consolidation of other attitudes towards religion, health, and physical culture. In addition, the small effect sizes indicate the limited practical application of this study.

## **5. Conclusions**

An interesting finding of this study is that non-practitioners rated their moral health as the lowest and their mental health as the highest. Students, who constituted a significant percentage of the respondents, were often people looking for their path in life. This age group (18–26 years) includes usually many left-wing voters, people who contest the status quo, and those who prefer freedom from all restrictions. Hence, there may be slightly fewer indications of faith and regular religious practice, as compared to the research on the entire population of adult Poles.

In all components of health, Poles showed lower average values than Ukrainians. Poles assessed their moral health as the lowest (mean:  $2.07 \pm 1.07$ ), and their physical health as the highest (mean:  $2.39 \pm 1.17$ ). This finding may result from the mental attitude or health care that is widespread in society. However, the only thing that can be stated based on the results obtained here is the dependence of self-esteem on nationality.

The main conclusions of the study are as follows:

1. The faith of the inhabitants of southeastern Poland and western Ukraine is largely related to their regular religious practice; however, irregularity is a dominant characteristic of this practice.



2. Respondents self-rated their faith and/or practice and health status, with more religious respondents reporting statistically lower health status.
3. Health status (in terms of individual components) was self-rated higher by respondents from Ukraine.
4. In general, the respondents evaluated their attitudes toward physical culture and their active participation in physical culture positively.
5. The variable that determined the answers of the respondents to the greatest extent was their age.

**Supplementary Materials:** The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/rel15070756/s1>.

**Author Contributions:** All authors contributed to the study's conception and design. Material preparation, data collection, and analysis were performed by W.J.C., S.D. and J.W. The first draft of the manuscript was written by W.J.C., S.D., K.K., Ł.R., D.M., I.P., J.-H.Y. and T.A. All authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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**Institutional Review Board Statement:** This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of the Idokan Poland Association, Committee of Scientific Research, in accordance with the Declaration of Helsinki (Opinion No. A1/2022).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the study.

**Data Availability Statement:** The original contributions presented in the study are included in the article/Supplementary Materials, further inquiries can be directed to the corresponding author.

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