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Role of spirituality and religiosity in clinical practice: problem conceptualization

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The concepts of spirituality and religiosity are studied in the context of cardiac disease and prevention. In psychology, psychosomatics, psychocardiology, spirituality is studied as a feature of human experience, attributed to certain transcendental ideas. Religiosity is a part of a person's self-identification, influencing his experience of interaction with medicine, and more broadly, in general, his worldview and conceptualizations. Spirituality and religiosity are culturally specific, in particular, in Russia, where society has historically formed stereotypes of attitudes on God and other inaccessible ideas. Thus, the Russian society is characterized by lay religiosity, which includes Eastern Orthodox metaphysics along with paganism. In practical cardiology, the concepts of spirituality and religiosity can be realized explicitly (manifestation of faith by a patient and a doctor) and implicitly, without manifestation. Spirituality and religiosity can influence patient adherence, decision making, and more complex psychosomatic processes. Spirituality and religiosity can be a salutogenic factor, which promotes health, improves the psychological and physical state. But they can also mediate morbid effects if a doctor incorrectly addresses them during communication with a patient. Spirituality and religiosity are a part of complex downward system of somatic manifestation of cultural and social factors, the study and consideration of which is obvious in practice.

Key words: psychosomatics, upward communication, downward communication, experience, risk factors, patient-centered care, communication, spirituality, religiosity.

Relationships and Activities: none.

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Cardiovascular disease is a strong example of psychosomatic interrelationships of human physiology, relations of social life and somatics. Lifestyle and stress are risk factors for noninfectious pathology that depend directly on the motivation, emotions, mood, as well as personality traits, accentuations, and stable features of the social self.

Human is biosocial. This means that biological and physiological structure through mental functions manifests itself in the form of social behavior, and life in society leaves a stamp on the physiology and then the pathomorphology of the body. Psychosocial risk factors are culturally dependent. Stress is the result of comprehending and experiencing socially significant events, and the way of life is closely related to the requirements that society makes to the individual, and to the opportunities that it provides.

Working with cardiovascular disease requires taking into account the sociocultural aspects involved in the disease development, as well as those positively effecting, promoting rehabilitation and secondary prevention. The concepts of disease picture and illness narrative, existential issues associated with the disease include cultural constructs — ideas developed historically. Among these constructs, religiosity and spirituality (RS) are important concepts for explaining the inexplicable and dealing with the inevitable. Illness and death are certainly the first to raise the questions that people seek answers to.

Definitions

The concepts of religiosity and spirituality are quite new (or well overlooked old) in the complex of attitudes towards their own health.

The concepts of RS are one of the most difficult to define in psychology. The general main feature of RS is the fact of recognizing the existence of the transcendent as fundamentally inaccessible to the experience of perception of our external senses. A person with such an experience feels like a part of something larger, which, despite its influence on the psyche and somatics of the experiencer, remains in his perception as something inaccessible to experience. Many researchers designate this as a determining factor, however, it seems to us more adequate to recognize the immanent as an important part of religious and mystical experience. Rituality is the most important aspect of this social phenomenon. The importance of immanent experience is also confirmed by studies on influence of prayers, meditations and religious participation as factors preventing the cardiovascular pathology.

Spirituality is not tied to social institutions and rituals, which distinguishes it from religiosity. Comprehension of one's attitude to the transcendental is often associated with spirituality. Thus, the psychologist Sinnott JD (professor at Towson University, Maryland, USA) believes that spirituality is more related to a person's attitude to the sacred or transcendent, while religiosity more refers to practices and beliefs related to a particular dogma system [1]. However, the separation of concerns can be quite controversial. Spirituality is also associated with the inner mystical experience, which has a somatic effect similar to religiosity. For religious thinkers and texts, spirituality is, on the contrary, an integral part of the religious experience of life. This, in turn, means that for religious people, whose self-identification is significant in interviewing for empirical research, spirituality is realized in the same non-opposing way. Accordingly, a significant number of empirical studies do not reveal not only opposition, but also a demarcation of these phenomena.

Quantitative studies in Russia [2] and abroad [3-5] show the positive influence of religiosity and supernatural belief on the prevention of cardiovascular diseases. The nature of this association is not completely clear, but the effect turns out to be positive and diverse. Various studies have shown that religiosity has a multifaceted effect on a person's life, reducing the likelihood of excessive alcohol consumption, smoking, promiscuity. It also improves the condition of blood vessels and diet. The positive influence of certain religious practices on blood pressure is shown. All this allows us to consider RS as significant factors in the dynamics of cardiovascular disease development in an individual patient. It is obvious that despite the absence of any evidence of the supernatural nature of RS effect on the cardiovascular health, the nature of this influence lies in the complex biopsychosocial relationship of the somatics and complex external factors. The difficulties of describing this issue are largely determined by two closely related problems: 1) formulation of abstract and culturally overloaded definitions; 2) the subject studied is equally an intersection of factors, most of which go beyond biomedical science, involving economic factors, cultural norms and social institutions. Figures proving this connection in numerous publications are reliable and representative, but by themselves they are hardly applicable to medical therapeutic practice [6].

RS are one of the significant factors in a doctor-patient relationship, but the direction of this influence, as well as specific communicative advice, turn out to be difficult to interpret and have been little studied. In addition to psychological and psychosomatic (cultural-somatic [7]) relationships, one should remember about the patient's decision-making and signing an informed consent. In fact, in the specifics of working with psychosocial risk factors for noncommunicable diseases, the transdisciplinary

competence of physician and his understanding of cultural relations turn out to be more important. In addition, despite the similar results of studies on the RS correlations, it remains unclear whether there is any significant specificity of Russian religiosity.

Historical and cultural specificity

The issue of significant specificity in the religiosity of Russians, represented primarily in Orthodoxy, is ambiguous. It is worth saying that we see more evidence of the importance of individual factors than belonging to a particular religion. In the case of social factors, this means being included in a certain community. The group factor is quite clear and consists in helping a person to perceive his identity, and also realizes the social nature of our biological species. Naturally, loneliness is a known risk factor for noncommunicable diseases.

In the case of non-specific individual factors, the presence of mystical experience and prayer can be distinguished. As neurophysiologic studies show, the former is usually described as a strong inner feeling of being part of something larger and is mainly associated with the work of inferior parietal lobule [8]. The study by Italian cardiologists that examined the effect of pronouncing Ave Maria in Latin or the Tibetan Buddhist mantra (in the original language) on the sensitivity of arterial baroreceptor reflex. Reduced baroreceptor reflex is known to be associated with future coronary artery disease and heart failure. Results have shown an increase in baroreceptor reflex in both forms of meditation [9]. The salutogenic nature of some factors, while not yet sufficiently conceptualized in biomedicine, is a kind of antagonist of the pathogenic (morbidogenic) factor, positively influencing the dynamics of cardiovascular disease development [2].

The positive effect of RS is associated with the patient's satisfaction with his personal life and his external environment. To date, parameters of stress extend to illness or death of loved ones, family conflicts, marital status, difficulties at work, lack of rest [10], that is, the relationship of an individual with his environment. It does not affect the person's inner attitude to himself or his personal ideas about the world.

With the development of Freudian thought, the concept of norm and their deviations entered the social culture, which is associated with the psychosis. Now anyone who has seen, heard or felt something supernatural will say, perhaps these are manifestations of the disease — delusion and hallucinations. Identifying parameters of RS is associated with another negative view: all unexplained phenomena and sensations fall under the well-established definitions adopted in psychiatry and describing a tendency to psychosis. Delusions, hallucinations, perceptual disorders, disorganized speech or non-normal behavior [11] can be regarded as clinical signs of psychosis. Therefore, even a positive, short, but inexplicable experience that a person can go through turns out to be carefully hidden.

The factor of RS can positively influence a patient [2]. At the same time, the perception of illness as punishment and injustice is a negative inner experience. "I have never drank alcohol or smoked in my life — why am I punished?" — the patient can ask a question to the doctor who announced the severe diagnosis. At this moment, mistrust may arise in the medicine, which "made a mistake" in the diagnosis or prescribed treatment. The cognitive dissonance experienced by the patient does not lead to acceptance of the disease, but to reflections on guilt: either he is to blame or someone else.

Lifestyle modification should include not only dietary changes, weight loss, increased physical activity, but also balancing the internal psychological state and perception of the external world. Religiosity allows to receive "support" from some external figure who personifies a powerful force, and spirituality increases the amount of positive emotions experienced by an individual.

"Crisis of sacrality"

In Russia, the relationship between society and church is affected by several crises. One of them is the "crisis of sacrality", when the church is perceived as a social organization (or corporation) separated from the religious personality, designed to provide "religious services" and "services" in the field of charity [12].

"Popular religiosity" in Russia is considered an ethnographic sign of everyday consciousness, which is supported by the mass media and has nothing to do with religion. Such religiosity is a mixture of pagan and Christian concepts and is often deeply rooted in human consciousness [12]. Therefore, any question related to the concept of religiosity, first of all, will be perceived by the patient precisely from the standpoint of the correctness of ritual performance, and not deeply immerse him in the contemplation of his selfhood.

However, religiosity is not only what a person believes and considers himself a part of any religious institution, but also how mysticism (attitude to the supernatural), spirituality (inner experiences and sensations) and the transformation of his selfhood (Where I came from? Where will I go?) are combined. When a person thinks, responses to external factors or begins to conduct an internal dialogue, then all these questions constitute the integrity of his thought process.

The theory that personal relationship with God is just a product of the human psyche was put forward by Sigmund Freud a hundred years ago. Before this theory firmly began to enter human culture, everyone knew: there is I and there is "something" that affects me from the outside. A thousand years ago, a person firmly believed that his main purpose was to correctly live this real life and receive as a reward a "different" life, full of love and pleasure.

Spiritual experiences are considered to be the internal responses of the human psyche to external influences (for example, the sense of beautiful, satisfaction from favorite occupation) or to conditions that are felt inside the body, but produce an additional sensory response (for example, love, tenderness, delight).

The concept of mystical religious experience (MRE) appeared long ago and was actively developed among American sects and religious societies [13]. It was associated with using hypnosis or narcotics. More recent research of the Presbyterian church among parishioners [14] suggests that additional external stimuli should be discarded and that MRE is viewed in the context of faith or participation in religious practice. However, there is a terminological mixture in the meaning of MRE. In Orthodoxy, this concern is a specially organized practice aimed at achieving exclusive states (communion with God, deification) [15]. For modern research, it is important to interpret the concept of MRE as some exceptional state, an intense experience that is perceived (interpreted) by an individual as a collision with transcendental reality [16]. It is proposed to use not a questionnaire related to bodily sensations in parallel with conscious changes in the psyche, but the neutral formulation of A. Hardy known as 'The Hardy Question' [17]: "Have you ever been aware of or influenced by a presence or power, whether you call it God or not, which is different from your everyday self?". A classification of possible variants of interpersonal relations in the context of the MRE has been developed [18]: 1. A person intuitively notes the existence or presence of God as a partner in interpersonal interaction. 2. Man realizes and accepts the mutual character of the relationship between him and God. God is perceived as an "entity" and a partner aware of the presence of human. 3. Awareness of mutual presence is replaced by an emotional relationship, akin to love or friendship. 4. Human feels himself to be a "confidant" of God, an equal participant in their relationship.

The survey of women from 23 to 62 years old studied spirituality and spiritual quest [19]. It has been shown that modern Russian women are implicit in the attitude to spirituality and participate in "spiritual" (non-religious) practices. Since the author did not provide clear criteria for spirituality for their respondents, they were unable to distinguish between spiritual experience and MRE, limiting themselves to listing common elements: "A complex gamut of conflicting experiences, a sense of belonging to a supernatural reality, ideas about the transcendental foundations of everyday life, the interpretation of any objects and events of one's own life as sacred phenomena". The author points out that the subjects gained experience by immersing themselves in spiritual practices that combine elements of different cults and beliefs. But for a real assessment of RS factor, which could be applied in everyday medical practice in Russia (except for counseling psychology), these classifications are unacceptable.

Practical aspects

As for the direct interaction with the clinician (cardiologist, therapist), in addition to the favorable picture of the disease course, it is known that mainly spiritual/religious patients are more prone to adherence, trust in the doctor and greater involvement in research [5]. At the same time, a value dissonance (a doctor of another religion or an atheist) articulated by a doctor may, on the contrary, turn out to be a significant obstacle. This case rather describes interaction with radical Orthodox Christians, who are in a statistical minority, but a similar scenario is possible in the case of a combination of other factors (age, sex and area of residence). And although more spiritual/religious patients trust doctors, the activity of interaction with the patient can be reduced on his part along with a decrease in the salutogenic factor, which is replaced by the feeling of "deserved punishment". For example, in Russian studies, the deservedness of punishment turned out to be a common explanation for the myocardial infarction that occurred [2]. Curiously, patients who identified themselves as not very religious blamed fate for the punishment. Rural African Americans also tended to treat illness as divine punishment [20]. Elderly Englishmen from Durham actually illustrated similar responses, but in addition to punishment, there was also an interpretation of what happened as an ordeal. All this suggests that the happened myocardial infarction in the interpretation of events by the patient is often described as punishment, regardless of the region of residence.

It can be assumed that the feeling of deserving punishment may not only be a barrier for doctor, but in general, rather negatively affect the general attitude. Internal acceptance of the happened myocardial infarction as an ordeal looks more beneficial and can be recommended to the patient by the therapist in order to improve his inner self-consciousness.

It should also be noted that in order to gain better medical adherence and emotional response in a situation of feeling deserved punishment, a priest may be more proper than a doctor. In Russian medical practice, priests are frequent visitors to hospitals, but they are far from always in demand even among spiritual/religious patients. Perhaps a more universal tool for resolving such problems, independent of spiritual and religious preferences or their absence, is psychotherapy, however, unfortunately, the patient's attitude to communication with a psychotherapist causes a noticeable negative response [21].

An important point in communication is the fact that although RS factor can favorably affect the disease course, the doctor should not increase it. Inappropriate advice (for example, "go to church") can negatively affect the patient's general attitude towards the doctor. Phrases such as "people will pray for you" or an invitation to pray for a patient will not only not calm him down, but may also negatively affect treatment. In 2005, the randomized study was conducted where patients were divided into three groups: those received intercessory prayer and was not informed about it; those received intercessory prayer and was informed about it, and control group [22]. The highest incidence of atrial fibrillation was revealed in the second group. This may be due to the frame inconsistency: in a hospital where people are to be treated, a patient after a very dangerous disease (myocardial infarction) is told that he is being prayed for, which makes prayer feel like a last resort.

All this leads to the fact that it is not a doctor who should initiate conversations about God, but he can bring to them and in no way impose either his position or his recommendations on actions related to RS. Not initiative, but support, will be the best strategy for interaction. In the case of atheistic views of a doctor, he should perceive the RS factor as a necessary part of evolution and society, which naturally has certain positive functions, including for health.

Based on evidence of the positive effects of RS, can an atheist be encouraged to think about increasing his own RS? There are reasons to give a negative answer. Focusing on this factor is not favorable for an atheist: instead of believing with further healing, a patient is more likely to get stuck in the frame of faith as a missed opportunity, which, like any other strong negative experience, negatively affects the treatment. Thus, discussing religious issues with a patient-atheist can be fraught, and the initiative to increase the RS factor is not only difficult, but also dangerous.

An individual spiritual quest necessarily leads to a group with similar interests or to a group that can satisfy this need with their ideas. In the case of a patient, these may be neighbors in the hospital ward. Very often this factor escapes the attention of a doctor, since he is observing a patient, and not a group of people gathered in one place and united by a common problem. In a hospital, a person breaks out of the familiar environment and social circle, becoming more vulnerable to the effects of the new environment and more in need of a positive attitude. A doctor can contribute to the creation of a salutogenic environment" by establishing the correct settings — the patient is not alone, is under close care, the treatment regimen is selected correctly, family members support and await recovery.

However, the attending physician cannot perform the functions of a personal psychologist, but can refer them to the "health schools". If the patient talks about individual discomfort (dissatisfaction with life, work, etc.), then group trainings aimed at personal growth are suitable.

Therefore, it seems important for a doctor to assess the medical adherence of patient and to change not only the lifestyle, but also the attitude towards the disease. Spirituality can be maintained by listening to favorite music, watching movies, reading books, or visiting places that the patient would like to see, but did not dare. The need for mysticism and receiving "reinforcement" in the form of dreams and revelations is solved through intellectual and creative work on oneself and exercise. General religiosity, the basic need of which is the absence of loneliness and a feeling of love, is achieved by rethinking the patient's life attitudes, but this process does not occur simultaneously.

In day-to-day life, there are several vectors in our country that people try to separate from each other and even hide from their loved ones. This attitude is determined by the socially accepted criteria of "shame" and "punishment" — natural constraints within any society. Therefore, the degree of plain-speaking depends not only on the personality of a doctor, but also on the guarantee of confidentiality.

The RS factor depends significantly on sex and differs in various generations. People who are immersed in everyday life problems tend to forget about RS, they psychologically isolate themselves, trying not to think. Therefore, memories of spiritual quest beginning in adolescence can be a kind of trigger. Or some tragic event (for example, the death of a loved one), after which a person dramatically changes his life. A rarer option is love, since this feeling is not so clearly understood in modern society in a spiritual sense.

Negation, or repression, is based on the natural unwillingness of a person to experience painful questions: how should I live? "Here and now" or is there life after death? These are two opposite

paradigms. However, the next question is why live: if reality does not suit you, and I don't believe in the afterlife? All personality crises can be explained by depression and childhood traumas, and the meaning of life is found in creativity or work. Disease is a factor that changes everyday life, that is, when the attitude "bad reality — there is no other life," a negative scenario is inside a person. Therefore, initially the doctor should be concerned only with two aspects: does the patient have a desire to change his life? And second, no less important, does the patient realize that well-being in his life depends only on himself? Not from a doctor, government, family, or bad weather forecast.

Conclusion

Conceptualization of RS concerns for scientific and practical cardiology is necessary due to the powerful culturally-specific influence of the factors described by these concepts on the patient. This influence is realized in at least two ways: through psychosomatic experiences that create both salutogenic and morbidogenic effects, and through behavioral components — lifestyle, stress, medical adherence, trust in medicine, decision-making, and communication.

In clinical practice, there are many questions that do not imply an exact answer, but are included in the clinical performance, the world picture of both a patient and a doctor. The individual response to them depends on the worldview and experience of a person. Not only psychology, but philosophy and cultural studies will make it possible to operationalize the concepts of RS and their individual elements for a more effective inclusion in clinical practice.

Relationships and Activities: none.

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