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HEALTH PROBLEMS RELATED TO ISOLATION AND POSSIBILITIES OF THEIR RELIGIOUS AND SPIRITUAL OVERCOMING

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Abstract

Epidemics, natural disasters, serious illness and life misery are a serious test for human mental and physical well-being. Studies have shown significant benefits of religious or spiritual life for people's health and welfare. There is evidence that religious and spiritually oriented patients are more stress resistant, tolerant of pain, less prone to depression, and more committed to on-going treatment and a healthy lifestyle. However, the number and quality of studies performed are limited. This is due to a frequent distinction lack between concepts of religiosity and spirituality (R/S), patients' attitude heterogeneity, unexplored mechanisms of religious and spiritual influence on human health and insufficient research method standardisation. Very promising is introducing spiritually oriented techniques in the healthcare system. It is advisable to train outpatient medical personnel and clergymen in such technique intervention. More R/S impact research on human well-being and health is needed as it is the basis for this kind of practice further improvement.

Keywords: religiosity, spirituality, health, epidemics, natural disasters

1. Critical situations and post-traumatic disorders in a person's life and opportunities for spiritual overcoming

Critical situations, such as illness, natural calamities, epidemics and misfortunes are a serious challenge for a person's mental and physical well-being. Currently, the COVID19 pandemic has been a difficult ordeal, accompanied by general isolation, emergence of severely ill patients and fear. It should be noted that prolonged isolation leads to post-traumatic stress disorders (PTSD) in 25-30% of people [1, 2]. They include depression, aggression, anxiety

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disorders, addictive and suicidal behaviour. Children, the elderly, people with chronic disease and socio-economic problems are particularly subject to PTSD [2, 3]. There is evidence that the chronic pathology course worsens in isolation, due to physical inactivity, frequent dietary disorders, alcohol and psychoactive substances abuse and depression [4, 5].

Currently, available data allow us to conclude that people who classify themselves as religious and spiritual showed significantly better stress resistance and health, compared with a group of people without these qualities [6, 7]. Convincing data have been obtained that spiritually oriented techniques in medical practice can improve treatment outcomes for various pathologies and increase psychological and physical well-being level [8-10]. In this regard, works aimed at studying religious and spiritual life influence on a person's mental and physical condition during isolation and self-isolation are particularly relevant [3, 11]. But many aspects of this interaction are still not fully understood.

2. Isolation effect on psychological health

Quarantine has been used with certain success for centuries to contain cholera, plague and leprosy outbreaks. Moreover, quarantine measures were accompanied by political and social instability, general fear, aggression, lack of understanding, discrimination of certain population groups and economic difficulties [1]. Although quarantine severe psychosocial effects had been known for a long time, a scientific basis for studying social exclusion psycho-traumatic effects appeared about 20 years ago mainly in Severe Acute Respiratory Syndrome (SARS) epidemic studies [1]. It was at this time that it became clear that prolonged isolation was accompanied by various PTSD and depression in approximately 30% of people [1]. The most vulnerable to quarantine-related PTSD are those with concomitant diseases (cardiovascular disease, lung diseases, diabetes mellitus, obesity), the elderly with cognitive and behavioural problems, stigmatization and/or socio-economic difficulties [3].

The literature provides evidence that post-traumatic mental disorders are four times more likely to occur in quarantined children and their parents, compared with non-quarantined ones. So, PTSD during quarantine are observed in 30% of children and 25% of parents [2]. Various studies report a significant increase in quarantined individuals` psychopathological symptoms [12], such as depression [1], low moods [13], anxiety [14], emotional instability [15], irritability [13] and insomnia [13]. Among quarantined respondents` psychiatric disorders the most common are depression (73%) and irritability (57%) [13]. A Canadian study's results of 1,057 quarantined individuals are interesting in connection with their possible contact with SARS-infected ones. The vast majority of such people experience negative emotions associated with quarantine: a feeling of boredom (62.2%), a sense of despair (58.5%), irritation (54.3%), anxiety (40.2%), loneliness (31.7%), bitterness (28.6%) and fear (22.4%). Only 5% of respondents showed positive emotions [12]. Numerous

modern studies also confirm a high occurrence frequency of various negative emotions in forcibly isolated people [16-19]. It should be noted that among medical workers in isolation occurrence frequency of negative emotion was two times lower than among non-medical respondents, which is explained by the former's better awareness of the need for measures taken [12]. One of the studies testifies to the fact that the respondents' mental state returns to normal 4-6 months after the quarantine is lifted and the negative emotion level in such individuals approaches the control group [20]. However, a significant proportion of people who have been quarantined for many months continue to have a behaviour focused on isolation: avoiding crowded and closed places (25%), coughing and sneezing people (53.7%) [12]. Long-term isolation is a stress factor and can cause harm to both mental and physical health, especially in older people. It is associated with physical inactivity harmful effects, leading to sarcopenia and senile asthenia, which result in chronic disease manifestation [4, 5, 21].

3. Religiosity, spirituality and health

In recent years, spirituality and religion have gained great importance in health research. In 1984 the 37th WHO session proposed including a spiritual component in the definition of health, in addition to physical, social and mental ones. However, to date, spirituality, as a health integral part, has not been fixed by WHO in the health definition, which is caused by this concept heterogeneity and association with religion. Nevertheless, WHO considers it necessary to assess health in the context of welfare, in other words, in the context of human values. It emphasises that, despite the fact that health is the most powerful factor affecting well-being, there are equally important additional things, which include philosophical understanding of life, nature of self-perception, sense of life, spirituality and religious faith [World Health Organization, 2012, http://www.euro.who.int/__data/assets/pdf_file/0004/197113/EHR2012-Eng.pdf]. At the same time, well-being can extend life by 7-10 years [22].

R/S are believed to have a positive effect on people's mental and physical health [21, 23-25] and positive religious experience is associated with happiness, optimism, satisfaction, and emotional vitality [26]. Until today, there is no clear distinction between R/S concepts. Some authors avoid giving definitions to spirituality and religiosity [23], others do not distinguish between these concepts [27]. The third group of authors distinguishes between these concepts, defining religiosity as an organized system of principles that a person believes, follows, professes, and which are aimed at ensuring proximity to the sacred [21]. Typically, these religious beliefs affect how people strive to live their lives and their relationships with loved ones [28]. Spirituality is partly separated from the concept of religiosity, acquiring a broader meaning of personal desire to find answers to the most important questions about life, its meaning and attitude to the sacred or transcendental [21]. This concept may include a "personal search for meaning and purpose in life, which may or may not be associated with

religion " [29]. At the same time, R/S role separation is considered justified for scientific research, since respondents often consider themselves to be spiritual, but not religious [21, 29].

R/S role in physical and mental health is widely covered in the scientific literature. Available literature data mainly relate to the best health indicators of people who consider themselves to belong to the R/S category [30]. Studies prove the importance of combining collective participation in worship, rituals and prayers. R/S significantly correlate with a healthy diet, non-smoking status, physical activity [31], which can reduce severe somatic pathology incidence. For example, a Danish cohort study involving 10,800 Baptists and Adventists showed a decrease in cancer risk by 40% in this group, including a 72% reduction in lung cancer. Incidence of chronic lung disease, ischemic heart disease and certain mental disorders has also a clear tendency to decrease [32]. The study reported that life expectancy for women attending church is on average 2.6 years longer than for those who do not [33]. It emphasized that religious or spiritual adolescents have on average a 9-30% smaller number of health complaints [34].

According to the literature, religiosity negatively correlates with depression, which often develops in people who are in self-isolation. So, in a meta-analysis it was shown that in 61-67% of the studies conducted an inverse relationship was observed between religiosity and depression [21]. 63% of studies showed significantly better treatment outcomes for depression in religious people [21]. According to the same meta-analysis 75% of studies found a negative relationship between suicidal thoughts and behaviour, suicide and religiosity. 73% of studies indicated a positive relationship between hope and religiosity and 81% - between optimism and religiosity. An earlier meta-analysis found positive correlations between religiosity and a sense of well-being (79% of studies), hope and religiosity (86% of studies), sense of life and religiosity (94% of studies) [35]. In religious or spiritual patients over 50 years of age suicide risk was 4 times lower than in the control group [36].

It has been proved that R/S and involvement in spiritual practices often arise in a personal crisis due to illness or another difficult life circumstance. At the same time, R/S as a system of values different from other systems play an important role for people in crisis [30]. The R/S dominant importance for these individuals is determined by faith in a higher principle, God or power that goes beyond human life and can provide help, comfort and give hope for a successful outcome.

The R/S impact on a person`s well-being in a crisis situation largely depends on what place they occupy in the system of values. Therefore, one can expect that R/S importance for a person will contribute to spiritual and religious psychotherapy success. This is due to the fact that R/S is associated with a higher adherence and belief in treatment. In some cases this is crucial in achieving a positive effect of intervention and treatment outcomes [37].

There is noteworthy evidence that R/S can affect feelings of pain and fatigue. Thus, in a large cohort of 30859 people aged 15 years and older it was demonstrated that people with chronic pain and fatigue more often use prayer and seek spiritual support as a way to overcome difficulties compared to people who consider themselves to be spiritual, but non-religious [38]. Both people professing religion and non-religious but spiritual ones, suffering from pain more often demonstrate psychological well-being. Religious people are much more likely to use positive strategies to overcome their illnesses (for example search for the bright side of life, absence of bad habits, fight against physical inactivity, acceptance of one's illness), which is explained by a greater degree of social interaction. People who consider themselves to be non-religious but spiritual often resort to negative strategies believing that the disease can be God's anger. They often develop addictive behaviour that worsens health indicators.

In general, chronic pain, depression and fatigue are more associated with spirituality and prayer to God or Higher power, than with religiosity [38]. Presumably this may be due to poor health and difficulty of attending worship services. The number of people with chronic pain, depression, and fatigue who consider themselves non-religious and non-spiritual was the same as on average in the population [38]. Other publications confirm this evidence and suggest that people with chronic pain are more likely to associate themselves with spirituality and religiosity [9]. Another large meta-analysis based on 147 independent studies of stress levels, religiosity and depressive symptoms showed that stress levels are related to depression and religiosity. In addition, it is emphasized that religiosity helps to overcome serious life stress (loss of a child) through gaining hope and social support.

Relation to religiosity is also maintained in a study of patients with chronic pain. Such patients often report greater spiritual experience and better mental health. A stronger correlation is observed between spirituality and mental health in individuals with a higher level of pain [39].

However, these studies have certain limitations, since they do not take into account the nature of a person's faith, since people of the same faith can have different worldviews. This can be a significant factor, because a worldview that emphasizes God's punishing nature can be associated with a greater sense of pain and fatigue. This conclusion comes from Whitford et al, who interviewed 449 Australians with pain and fatigue symptoms [40]. Their study showed that the group with a low religiosity degree is more prosperous than the highly religious group whose adherents focus on God's punishing nature, impossibility of forgiveness, being god-forsaken and escape responsibility for solving existing problems. Rippentrop et al., who interviewed 122 people with chronic musculoskeletal pain and other researchers, came to similar conclusions [41]. Their research suggests that negative spiritual experience, including prayer aimed at relieving a person of responsibility for solving a problem, can worsen a feeling of well-being and treatment outcomes [9, 42, 43]. Noteworthy is the evidence that negative religious experience in the group of elderly people is

associated with a 19-28% higher mortality rate than in the group of people with positive religious experience [44]. Nevertheless, all sources of literature claim that positive spiritual practice (focusing on faith, hope, prayer, trust in God and intention to overcome existing problems with God) has, of course, a positive value and negatively correlates with helplessness, hopelessness, fatigue, anxiety, preoccupation, and depression [9; D.B. Berg, 2011, https://www.researchgate.net/publication/216841438_Spirituality_Existentialism_and_Psychotherapy_Moving_Forward]. Thus, the above data indicate that prayer can be considered a positive strategy to overcome difficulties.

An interesting study showed that among patients with chronic pain, older people and women have a greater degree of religiosity [45]. At the same time, a negative correlation is noted between religiosity and the level of education. The level of trust in God is more associated with Christian denominations [45]. It turned out that a feeling of insecurity and uncertainty decrease with an increase of trust in God [46]. Besides, spirituality is significantly more often associated with understanding of suffering, adaptation to crises ($p = 0.038$) [47], and a lesser degree of aggression ($p = 0.001$) [48].

Thus, moderate religious and spiritual resources use is a fairly effective tool for treating pain and depression, if a certain form of self-efficacy is maintained in the treatment process and responsibility for the process is supported by God or higher powers [49-51].

4. Spiritually integrated treatment

In the past 20 years, R/S are increasingly considered an important human life component, which can be successfully used to improve both mental and physical health [52]. Spiritual help to people who are in a stressful situation and lost hope is carried out through a strategy called coping. The concept of coping includes cognitive, emotional and behavioural strategies aimed at coping with stressful situations. One of its forms is a system for integrating R/S into psychosomatics, psychiatry and psychotherapy. Their integration is based on the bio-psychosocial model [8]. Five steps are suggested to provide spiritual support. At the first stage, the medical institution must initiate an R/S support program. At the second stage, the medical organization provides training for medical personnel in R/S with an emphasis on their impact on human health and well-being. The medical organization must always be very highly patient-centred, especially since this is required by the Joint International Commission (JCI), which prescribes providing care, respecting the patient`s personal values and beliefs and responding to requests related to religious/spiritual beliefs [http://www.jointcommissioninternational.org/assets/3/7/Hospital-5E-Standards-Only-Mar2014.pdf]. Moreover, the patient's spiritual satisfaction affects the treatment outcome itself, which, of course, also has economic benefits.

Upon admission to hospital, patients should be informed of their rights and available resources for spiritual support. The basic infrastructure to meet these needs should include personal space for contemplation and reflection (e.g.

hospital chapel, holy books, electronic media, icons, electronic candles) [53, 54]. Nosocomial policy adjustment should also be made to ensure pastoral interventions, which include assessing the patient's needs and spiritual abilities, ministry, counselling and rituals. It is necessary to discuss with the patient the possibility of bringing a priest in advance. Pastoral counselling must be carried out by certified clergymen [54].

To involve the patient in a bio-psychosocial-spiritual model, it is necessary to clarify the R /S and disease role in the patient's life. It is necessary to analyse his spiritual resources and the disease severity. If R/S is really important for the patient, then there is a need to find out how his worldview can affect understanding the role of the doctor and the treatment. It is important that spiritual goals (the purpose of life, hope, restoration of connection with God) help to cope with the existing mental or somatic problem and do not contradict the treatment. In this case spiritual goals should be discussed in an interdisciplinary team, where the counsellor is a full member [8]. Noteworthy is the fact that religiosity can be considered as a religiously oriented patient's personal resource, and that this resource activation can support therapeutic intervention and improve its results [55]. Successful implementation of the bio-psychosocial-spiritual model improves the patient's well-being and reduces pain [8, 9].

The role of spiritually oriented treatment of patients with depression, chronic pain and severe somatic diseases is a subject of continuous study [10, 56]. The goal of spiritually-oriented treatment should be healthy spirituality development because of its serious role in the course and outcome of the disease and human well-being. When diagnosing negative emotional, existential, or spiritual condition a specialist should help the patient develop self-identity, hope, a sense of piety and unity and find the purpose of life [57]. In this instance there are spiritually-oriented solutions to existential problems, such as loss of self-identity and purpose of life, despair, guilt, isolation, which are certainly associated with depression, a low level of well-being and self-efficacy. There are also recommendations to integrate spiritual practices into cognitive-behavioural psychotherapy, humanistic psychotherapy, to use transpersonal psychotherapy, spiritual guidance (pastoral counselling), pastoral psychotherapy for medical purposes [10, 57-59] (Table 1).

Of particular interest is the work of A. Darvishi, convincingly proving that spiritual psychotherapy (12 sessions of 60 minutes 2 times a week) significantly improves spiritual health, self-esteem and self-efficacy in patients with haemodialysis who are limited in mobility [60]. Pastoral counselling improves well-being in 84.4% of patients with palliative care [61]. Pastoral counselling can reliably reduce pain in people with burns compared to the control group [62]. It also significantly reduces depression in people with chronic pain and impaired mobility [63]. A large meta-analysis shows that it takes 1 month to reduce general symptoms of anxiety ($p < 0.001$), and from 1 to 6 months to reduce those of depression ($p = 0.05$) with the help of R/S intervention. R/S interventions reduce stress, alcohol addiction and depression [7]. Another large

meta-analysis demonstrates that religious/spiritual activity has a statistically significant effect on improving life quality, normalizing body weight, increasing physical activity, rationalising nutrition and pain tolerance [6]. At the same time, effective chronic disease treatment is significant protection from medical workers' emotional burnout, which is a statistically significant positive effect associated with job satisfaction. The study concludes that patients experience a high level of confidence in the R/S intervention protocols used [6]. Besides, it proposes using psycho-synthesis methods to awaken spirituality in people with existential problems. It also proves that psycho-synthesis methods make it possible to reveal spiritual abilities in 30% of people who previously considered themselves to be non-spiritual and non-religious, needing spiritual help [64]. This in turn allows one to apply R/S intervention methods and improve such individuals' treatment results. The literature provides evidence that 12-stage psychotherapy with spiritually oriented intervention can reduce alcohol and psychoactive substance abuse [65], which tends to increase in self-isolation.

Table 1. Relationship of spiritually oriented interventions with depression problems (according to J.R. Peteet [57] with additional).

Existential sphere	**Depression-associated conditions**	**Healthy spiritual status**	**Spiritually oriented intervention**
Self-identity	Doubt/disorientation	Involvement, interest development	Humanistic psychology, 12-stage psychotherapy, spiritual guidance/pastoral counselling
Hope	Despair/mistrust	Transformation, integration into the social environment	Psychodynamic cognitive-behavioural therapy
Sense/purpose	Loss of sense/purpose	Harmonization through mystical insight	Spiritual guidance/pastoral counselling, interpersonal psychotherapy, mindfulness, meditation, making sense
Moral	Guilt	Moral growth, reconciliation	Promoting forgiveness, positive psychology
Authority autonomy	Isolation, non-recognition	Acceptance, love	Psychodynamic cognitive-behavioural therapy, spiritual guidance/pastoral counselling

5. Conclusions

Critical situations, such as epidemics, natural phenomena, major diseases and life adversities are a serious threat to mental and physical well-being of mankind. Today, great benefits of religious/spiritual life for human health and well-being are becoming apparent. There is compelling evidence that religious/spiritual patients are more resistant to stress, more tolerant of pain, less at risk of depression, and more committed to treatment and a healthy attitude and behaviour. However, there is a serious lack of the number and quality of studies performed. This is often due to a blurred distinction between R/S concepts, heterogeneity of patients` religious/spiritual attitudes, poor understanding of R/S influence on human health, and insufficient standardisation of research methods. Very promising is further R/S practice introduction in the healthcare system, which will improve treatment results for various patient profiles. It is justified to train outpatient medical workers and clergymen in R/S intervention techniques. There is a need for further research of the R/S influence on human health and well-being, which is important for further improvement of spiritually oriented intervention methods.

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