Utjecaj duhovnosti na subjektivni osjećaj zdravlja

/ Influence of Spiritual Life on the Subjective Perception of Health

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Cilj ovog rada bio je istražiti utječe li duhovni život na subjektivni osjećaj zdravlja pojedinaca i je li taj utjecaj značajan. *Metode:* Anketom SF-36 istražili smo mišljenje o vlastitom zdravlju pripadnika molitvene zajednice u odnosu na one koji to nisu. Anketiran je 51 član molitvene zajednice i isto toliko ljudi u kontrolnoj skupini. *Rezultati:* Analiza je pokazala da molitvena zajednica pokazuje više vrijednosti u svim ljestvicama zdravlja u odnosu na kontrolnu skupinu i hrvatsku populaciju. Statistički značajne razlike molitvena skupina pokazuje u odnosu na kontrolnu skupinu u ljestvici općeg zdravlja, vitalnosti, emocionalnog ograničenja, psihičkog zdravlja i zbirnog mentalnog zdravlja. U odnosu na hrvatsku populaciju molitvena grupa pokazuje statistički značajne razlike u svim ljestvicama osim u socijalnom funkcioniranju. *Zaključak*: Istraživanje je ukazalo na kvalitetu vjerskog života kao bitnog čimbenika u percepciji osobe svog mentalnog i fizičkog zdravlja.

/ The goal of this study was to investigate whether spiritual life influences the subjective feeling of health in individuals and whether this influence was significant. Methods: We used the SF-36 questionnaire to investigate the opinions of a religious prayer group on their personal health in comparison with participants who were not members. The questionnaire was completed by 51 members of the prayer group and as many participants in the control group. Results: The analysis showed that the prayer group had higher ratings in all scales on subjective health perception in comparison with the control group and the general population in Croatia. There were statistically significant differences in the prayer group in comparison with the control group on the scales for general health, vitality, emotional limitations, mental health, and mental component summary. In comparison with the Croatian population, the prayer group had statistically significant differences in all scores except social functioning. Conclusion: The study indicates that the quality of religious life is an important factor in a person's perception of their own mental and physical health.

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UVOD

Istraživanja čimbenika duhovnosti u zdravlju i kvaliteti življenja dovelo je do cjelovitijeg razumijevanja ljudskog zdravlja koje uključuje i nematerijalnu dimenziju, drugim riječima odnos duhovnog, psihičkog i somatskog (1-3). Otavska povelja definirala je unaprjeđenje zdravlja kao proces kojim ljudi preuzimaju kontrolu nad svojim zdravljem i tako ga unaprjeđuju (4). Unaprjeđenje zdravlja ima za cilj da se pojedincima i zajednicama omogući povećana kontrola nad čimbenicima koji uvjetuju zdravlje. Brojni čimbenici utječu na zdravlje: naslijeđe, radno mjesto, obitelj, okolina, socioekonomski uvjeti, demografski uvjeti (5,6). Svjetska zdravstvena organizacija uključila je proteklih godina preko 30 međunarodnih centara u svoju studiju kvalitete življenja, koja je definirana sa šest sljedećih dimenzija: tjelesno i psihičko zdravlje, osobna neovisnost, socijalni odnosi, okoliš, te duhovnost i religijski običaji (7). Cilj ovog rada bio je istražiti utjecaj duhovne dimenzije na zdravlje pa smo glede toga analizirali mišljenje o vlastitom zdravlju kod ljudi prepoznatljive duhovne orijentacije, kao što su članovi karizmatske katoličke molitvene zajednice.

Važnost duhovne dimenzije ljudskog bića najčešće dolazi do izražaja prigodom teških iskušenja, kao što su sučeljavanja s bolešću i smrću. Opće je poznato da je psihijatar Viktor Frankl, otac treće bečke psihoterapijske škole, logoterapije, tijekom II. svjetskog rata proveo tri godine kao zatočenik Auschwitza i Dachaua i o tom svojem iskustvu je kazivao: "Istina je da među onima koji su preživjeli strahote koncentracijskih logora, broj onih kojima se vjera probudila unatoč užasu kojem su bili izloženi, uvelike prelazi broj onih koji su vjeru izgubili» (8).

Tijekom posljednjih godina života Hudolin je govorio o uvođenju antropološke spiritualnosti, a posebno njene vjerske dimenzije u klubove liječenih alkoholičara (9). Pitanje holističke

INTRODUCTION

Research into the effects of spirituality on health and quality of life has led to a more holistic understanding of human health that also includes the non-material dimension, i.e. the relationship between the spiritual, mental, and physical (1-3). The Ottawa Charter for Health Promotion defined health promotion as the process of enabling people to increase control over and to improve their health (4). Health promotion has the goal of allowing individuals and communities to exert more control over factors that influence health. Numerous factors can influence health: hereditary elements, the workplace, family, the environment, socioeconomic conditions, and demographic conditions (5,6). Over the last few years, the World Health Organization has included over 30 international centers in its study on quality of life, which is defined through the following six dimensions: physical and mental health, personal independence, social relationships, environment, and spirituality and religious customs (7). The goal of this study was to investigate the influence of the spiritual dimension on health, which lead us to analyze the subjective opinion on personal health in people with a recognizable spiritual orientation such as members of a Catholic charismatic prayer group.

The importance of the spiritual dimension of human beings usually comes to the fore during difficult challenges, such as facing disease and death. It is well-known that the psychiatrist Victor Frankl, the father of logotherapy, the third Viennese school of psychiatry, spent three years as a prisoner in Auschwitz and Dachau in World War II and said of his experience: "The truth is that among those who survive the horrors of the concentration camps, the number of those who had an awakening of faith despite the horrors they were exposed to was much greater than the number of those who lost their faith" (8).

In his final years, Hudolin spoke of the introduction of anthropological spirituality and its religious dimension in particular into clubs for

zdravstvene skrbi u onome što obuhvaća moderni hospicijski pokret odnosi se upravo na promicanje duhovne skrbi (10).

Razvijajući u sebi religijski pogled na život mnogi ljudi postaju otporniji na stresove, njihovo je psihičko zdravlje stoga manje ugroženo, a od toga društvo nesumnjivo ima velike koristi (3). Istraživanje sila koje mnogima nesumnjivo pomažu voditi svrhoviti život, a takve djeluju u duhovnom aspektu života, unatoč objektivno neizdrživim pritiscima životnih nesreća, može biti za društvo od daleko veće koristi od mnogih etabliranih modela primarne prevencije bolesti i poremećaja i to kako somatskih, tako i onih psihičkih (11).

Duhovnost se često uzima kao širi pojam od religioznosti. Prema tome duhovnost obuhvaća u sebi i sve koncepte religioznosti (12). Od početka 21. stoljeća nastoji se povući jasniju granicu duhovnosti prema religioznosti kao kategoriji koju je lakše definirati u odnosu na širi pojam duhovnosti (13-15). Religioznost se odnosi na klaster religioznog ponašanja i vjerovanja, koji je institucionaliziran i organiziran, dok je duhovnost okrenuta doživljaju više razine sebstva i nad-materijalnog unutar sebe (16, 17).

CILJ

Cilj studije bio je istražiti postoje li razlike u mišljenju o vlastitom zdravlju, koristeći se psihometrijskim instrumentom SF-36, kod ljudi koji su uključeni u molitvenu zajednicu u odnosu na one koji to nisu.

ISPITANICI I METODE

Ispitanici

Istraživanje je provedeno standardiziranom anketom SF-36 (18) kod 54 člana molitvene zajednice koji su bili prisutni na evangelizacijskom seminaru. Svi anketirani članovi trebali

recovering alcoholics (9). The issue of holistic healthcare in the modern hospice movement specifically relates to the promotion of spiritual care (10).

When developing a religious view of life, many people become more resistant to stress, resulting in less endangered mental health, which is certainly very useful to society as a whole (3). Study of the forces that indubitably help many in leading meaningful lives, which act in the spiritual aspect of life despite objectively unbearable pressures of life's misfortunes, can be much more useful to society than many established methods of primary prevention models for diseases and disorders, including both physical and mental ones (11).

Spirituality is often considered a wider concept than religiousness. According to this view, spirituality also encompasses all religious concepts (12). Since the start of the 21st century, there have been attempts to draw a clearer distinction between spirituality and religiousness, with religiousness as a category that is easier to define in relation to the wider concept of spirituality (13-15). Religiousness refers to a cluster of religious behaviors and beliefs that are institutionalized and organized, whereas spirituality is the experience of a higher level of the self and the supra-material within oneself (16,17).

AIM

The goal of the present study was to investigate if there are any difference in subjective opinion of personal health based on the SF-36 tool in people who were part of a prayer group compared with people who were not.

PARTICIPANTS AND METHODS

Participants

The study was conducted using the standardized SF-36 questionnaire (18) on 54 members of a prayer group that attended an evangeliza-

su zadovoljiti uvjete da su u zajednici duže od godinu dana i da su stariji od 18 godina. Uz SF-36 priložen je upitnik o socioekonomskom statusu ispitanika koji je sadržavao: dob, spol, stručnu spremu, bračno stanje, radni status, obitelj, stambeno pitanje, posjedovanje automobila, primanja po članu obitelji, stambeno okruženje i zadovoljstvo sa svojom socioekonomskom situacijom. Zbog nepotpunih podataka na upitniku, tri ankete nisu obrađene.

Ista anketa provedena je na kontrolnoj skupini koja je izabrana među zdravstvenim osiguranicima upisanima u dvije ordinacije opće medicine iz mjesta Sveti Ivan Žabno, Hrvatska. Kriteriji za izbor kontrolne skupine bili su dob, spol, stručna sprema, radni odnos, bračno stanje i obitelj, odgovarajući ispitanicima molitvene zajednice.

Svim ispitanicima je u detalje objašnjena svrha i postupak istraživanja i svi su dragovoljno iskazali suglasnost za istraživanje. Istraživanje je bilo potpuno usklađeno s etičkim standardima postavljenim Helsinškom deklaracijom iz 1964. godine.

Struktura ispitanika i kontrolne skupine prema karakteristikama iz upitnika prikazana je u tablici 1.

U nekoliko slučajeva nije se moglo u potpunosti zadovoljiti istovjetnost svih kriterija za odgovarajući par u kontrolnoj skupini (npr. osoba u kontrolnoj skupini odgovarala je onoj u molitvenoj zajednici u značajkama da je rastavljena, nezaposlena i ima djecu, ali nije odgovarala po godinama ili stručnoj spremi). Zato u skupini molitvene zajednice i kontrolnoj skupini nisu potpuno identične značajke po dobnoj strukturi i stručnoj spremi.

Metode

Anketa SF-36 je najčešće upotrebljavani upitnik zdravlja u studijama za evaluaciju tretmana različitih bolesti, praćenju subjektivnog osje-

tion seminar. All participants had to fulfil inclusion criteria that consisted of being in the prayer group for over a year and being older than 18 years of age. In addition to SF-36, participants also received a questionnaire on their socioeconomic status that included information on: age, sex, education, marital status, employment status, family, living arrangements, car ownership, income per family member, living environment, and satisfaction with their socioeconomic situation. Due to incomplete data in the questionnaire, three participants were excluded from the study.

The same questionnaire was used in the control group which was chosen among people with health insurance who were registered at two general medicine clinics in Sveti Ivan Žabno, Croatia. The criteria for enrollment in the control group were age, sex, education, employment status, marital status, and family, which were matched to participants in the prayer group.

All participants received a detailed explanation of the goal and methods of the study and all of them voluntarily agreed to participate. The study was fully in line with the ethical standards established by the Declaration of Helsinki of 1964.

The demographic data on the prayer group and the control group that was gathered using the additional questionnaire is shown in Table 1.

In a few cases it was not possible to fully match all criteria to a corresponding member in the control group (i.e. a person in the control group matched the person in the prayer group in being divorced, unemployed, and having children, but did not match in age or education). As a result, not all data are completely identical between the control and prayer groups regarding age structure and education.

Methods

The SF-36 questionnaire is the most widely used health questionnaire in studies evaluating the treatment of various diseases, monitoring the

TABLICA 1. Struktura ispitanika i kontrolne grupe
TABLE 1. Demographic data for the prayer group and the control group

	Struktura ispitanika / Demographic data	Molitvena / Prayer group	Kontrolna / Control group
Spol / Sex	Muški / Male	18	18
	Ženski / Female	33	33
Dob (god.) / Age (years)	18-35	18	18
	36-45	18	16
	46-55	11	12
	56-65	3	4
	65+	1	1
Stručna sprema / Education	OŠ / Primary school	4	5
	SSS / Secondary Education	33	33
	VŠS / Bachelor degree	11	9
	VSS / Master degree	3	4
Bračno stanje / Marital status	Oženj./Udane / Married	24	24
	Neož./Neud. / Unmarried	19	19
	Rastavljeni / Divorced	4	4
	Udovice / Widowed	2	2
	Žive u vanbr. zajednici / Domestic partnership	2	2
Obitelj / Family	S djecom / With children	29	29
	Bez djece / Without children	22	22
Radni status / Employment status	Zaposleni / Employed	30	30
	Studira / Student	7	11
	U mirovini / Retired	3	3
	Domaćica / Housewife	1	1
	Nezaposleni / Unemployed	10	6

ćaja zdravlja različitih kliničkih i sociodemografskih uzoraka, te u studijama zdravlja na nacionalnoj razini. Ona reprezentira teorijski utemeljenu i empirijski provjerenu operacionalizaciju dvaju generalnih koncepata zdravlja: fizičko i psihičko zdravlje, te dviju njegovih općenitih manifestacija: funkcioniranje i dobrobit. Na manifestnoj razini svaka od čestica ankete odnosi se na jedno od osam različitih područja zdravlja unutar dva općenita koncepta zdravlja: fizičkog i psihičkog. Na taj način anketa SF-36 sadrži osam različitih ljestvica zdravlja, a ukupne rezultate prikazuje u obliku profila (18).

Pojedini odgovori na svaku od čestica različito se boduju prema unaprijed utvrđenim empirijskim normama. Pojedine ljestvice ili manifestacije zdravlja obuhvaćene su različitim brojem čestica, pa se broj bodova zabilježen na svakoj ljestvici upitnika transformira u standardne vrijednosti i baždari na jedinstvenu ljestvicu čiji teorijski minimum iznosi 0, a maksimum 100 bodova. Na taj je način moguće

subjective perception of health in various clinical and sociodemographic populations, and in health studies on the national level. The questionnaire represents a well-founded and empirically tested operationalization of two general concepts of health – physical and mental health – and two of its general manifestations: functioning and well-being. Each unit in the questionnaire refers to one of the eight different health scores classified under the two general concepts of health: physical and mental. Thusly, the SF-36 questionnaire has eight different health scores and represents the total score in the form of a profile (18).

Individual answers for each unit are scored according to previously established empirical norms. Individual scores or health manifestations are determined by different numbers of units, and the number of points on each scale of the questionnaire is transformed into standard values and calibrated to a single score with a theoretical minimum of 0 and a maximum of 100. This allows quantitative comparison of different manifestations of health that the

kvantitativno uspoređivati različite manifestacije zdravlja koje upitnik mjeri, interpretirati ukupnu razinu i diferenciranost osam točaka profila (18).

Anketa obuhvaća osam područja zdravlja, uz dodatak dva zbirna, dakle ukupno deset.

1. Fizičko funkcioniranje
2. Ograničenje zbog fizičkih tegoba
3. Tjelesni bolovi
4. Opće zdravlje
5. Vitalnost
6. Socijalno funkcioniranje
7. Ograničenje zbog emocionalnih tegoba
8. Psihičko zdravlje
9. Zbirno fizičko zdravlje
10. Zbirno mentalno zdravlje

Pet ljestvica (područja) ankete (*Fizičko funkcioniranje, Ograničenje zbog fizičkih tegoba, Tjelesni bolovi, Socijalno funkcioniranje, Ograničenje zbog emocionalnih tegoba*) definiraju zdravlje kao odsutnost ograničenja i nesposobnosti kontinuirane su jednodimenzionalne mjere zdravlja. Tri ljestvice (*Opće zdravlje, Vitalnost, Psihičko zdravlje*) ocjenjuju kompleksniji doživljaj pojedinca, koji je rezultat utjecaja više aspekata zdravlja (18). Maksimalnih 100 bodova na svakoj od navedenih ljestvica postižu ispitanici koji ne primjećuju bilo kakva ograničenja ili nesposobnosti.

Statistika

Rezultate iz ankete SF-36 uobičajeno je prikazivati u obliku profila, ovdje definiranog s 10 točaka. One prezentiraju prosječne rezultate prema područjima zdravlja. Viši rezultat ukazuje na bolji doživljaj zdravlja (18).

Podatci su obrađeni standardiziranom statističkom obradom za SF-36 anketu. U analizi značajnosti razlika koristio se t-test. Razina značajnosti α postavljena je na 0,05.

questionnaire measures as well as interpretation of the total level and differentiation of the eight points in the profile (18).

The questionnaire has eight health scores and two additional general scores, for a total of ten.

1. Physical functioning.
2. Physical role limitations.
3. Bodily pain.
4. General health.
5. Vitality.
6. Social functioning.
7. Emotional role limitations.
8. Mental health.
9. Physical component summary.
10. Mental component summary.

Five scores in the questionnaire (physical role limitations, physical functioning, bodily pain, social functioning, emotional role limitations) define health as the absence of limitations and disability and represent continuous one-dimensional health scores. Three scores (general health, vitality, mental health) score the more complex subjective experience of the individual that is the result of influence from multiple aspects of personal health (18). The maximum of 100 on all of the above scores is achieved by respondents who perceive no limitations or disabilities.

Statistics

Results from the SF-36 questionnaire are usual presented as profiles, which we defined using 10 scores. They represent average results in health scores. Higher results indicate a better perception of personal health (18).

Data were analyzed using standardized statistical analysis for SF-36 questionnaires. The T-test was used to analyze statistical significance in score differences. The significance level α was set at 0.05.

REZULTATI

U istraživanje je bio uključen 51 član karizmatske molitvene zajednice i isti broj ispitanika u kontrolnoj skupini izabranih prema upitniku o socioekonomskom statusu. Članovi molitvene zajednice morali su ispuniti uvjet da su u zajednici duže od godinu dana i da su stariji od 18 godina. Bitna je značajka članova molitvene zajednice da su naglašeno aktivni u organiziranim aktivnostima unutar katoličke crkve, što uključuje i redovno sudjelovanje u evangelizacijskim seminarima, te da se redovito tjedno sastaju u zajedničkoj molitvi, što se nastavlja u slavlju euharistije. U anketi je sudjelovalo više žena nego muškaraca, većina je bila mlađa od 45 godina i pretežito su bili sa srednjom i višom stručnom spremom u odnosu na osnovnu školu i visoku stručnu spremu.

U tablici 2. prikazane su značajke obih skupina glede primanja po članu obitelji i zadovoljstvu vlastitom materijalno-financijskom situacijom.

U obim skupinama jednak je broj zadovoljnih s vlastitom materijalno-financijskom situacijom, po približno petina ispitanika. Ostali su srednje zadovoljni i nezadovoljni, s tim da je nešto veće nezadovoljstvo u kontrolnoj skupini. Prema primanjima po članu obitelji većina je u skupini od 1 000 do 3 000 kn, nešto više ispitanika u kontrolnoj skupini ima primanja iznad 3 000 kn po članu obitelji.

U tablici 3. prikazani su odgovori kontrolne skupine na pitanja o vjeri.

Od 51 ispitanika kontrolne skupine 46 se izjasnilo vjernikom, od toga 13 ide u crkvu redovito nedjeljom, a nikada 20. Kod kuće moli svaki dan 23,

RESULTS

The study included 51 members of a charismatic prayer group and the same number of participants in the control group chosen based on a questionnaire on socioeconomic status. Members of the prayer group had to fulfil the inclusion criterion of being members of the prayer group for more than one year and being older than 18 years of age. An important characteristic of the members of the prayer group was that they were especially active in organizational activities within the Catholic Church, including regular participation in evangelization seminars and regular weekly group prayer meetings which continued in eucharistic celebration. More women than men participated in the study, and most participants were younger than 45 years of age, predominantly with secondary and graduate education in comparison with primary and postgraduate education.

Table 2 shows characteristics of both groups with regard to income per family member and satisfaction with their personal material-financial situation.

The number of participants who were content with their personal material-financial situation was the same in both groups, representing approximately a fifth of the participants. The rest were moderately satisfied and unsatisfied, with slightly higher dissatisfaction in the control group. Regarding income per family member, most participants were in the 1000 to 3000 HRK group, with somewhat more participants in the control group reporting income above 3000 HRK per family member.

TABLICA 2. Socioekonomske karakteristike grupa
TABLE 2. Socioeconomic characteristics of the groups

	Socioekonomske značajke / Socioeconomic characteristics	Molitvena / Prayer group	Kontrolna / Control group
Primanja po članu obitelji / Income per family member	ispod 1000 kn / Below 1000 HRK	10	8
	1000-3000 kn / 1000-3000 HRK	30	27
	iznad 3000 kn / Above 3000 HRK	11	16
Zadovolj. materijal. situacijom / Satisfaction material-financial situation	zadovoljno / Satisfied	11	11
	osrednje / Moderately satisfied	25	20
	nezadovoljno / Unsatisfied	15	20

TABLICA 3. Struktura odgovora kontrolne grupe na pitanja o vjeri
TABLE 3. Responses on questions about religion in the control group

Struktura odgovora kontrolne grupe o vjerskom životu / Responses on questions about religion in the control group		
Vjernik / Religious beliefs	da / Yes	46
	ne / No	5
Ide u crkvu / Attends church	redovito nedjeljom / Occasionally on Sundays	13
	povremeno / Occasionally	18
	nikada / Never	20
Moli kod kuće / Prays at home	svaki dan / Every day	23
	povremeno / Occasionally	16
	samo u teškim situacijama / Only in difficult times	2
	nikada / Never	10
Zdravlje i vjera su povezani / Health and religiousness are related	da / Yes	30
	nije siguran/na / Not sure	16
	ne / No	5

a 30 smatra da su vjera i zdravlje povezani. Odgovori ukazuju da ispitanici iz kontrolne skupine također sebe većinom doživljavaju vjernicima.

U tablici 4. prikazani su rezultati ankete SF-36 provedeni u molitvenoj zajednici i kontrolnoj skupini.

Rezultati su prikazani u 10 područja zdravlja. Dobivene vrijednosti prikazane su bodovima. Prikazane su statističke razlike, a gdje je p-vrijednost manja od 0,05 pretpostavili smo postojanje statistički značajne razlike.

U svim manifestacijama zdravlja dobivene su veće vrijednosti u molitvenoj zajednici. Statistički značajne razlike pokazale su se u korist

Table 3 shows responses on questions about religion in the control group.

Out of a total of 51 participants in the control group, 46 reported having religious beliefs and 13 reported regularly attending church on Sundays, whereas 20 reported that they never attend church services. Praying at home every day was reported by 23 participants, and 30 participants believed that faith and health are related. The answers indicated that participants in the control group also mostly saw themselves as religious.

Table 4 shows the results of the SF-36 questionnaire in the prayer and control groups.

TABLICA 4. Rezultati ankete SF-36 u molitvenoj zajednici i u kontrolnoj grupi prikazani u 10 manifestacija zdravlja i P-vrijednost
TABLE 4. Results of the SF-36 questionnaire in the prayer and control groups shown as 10 health scores and P-value

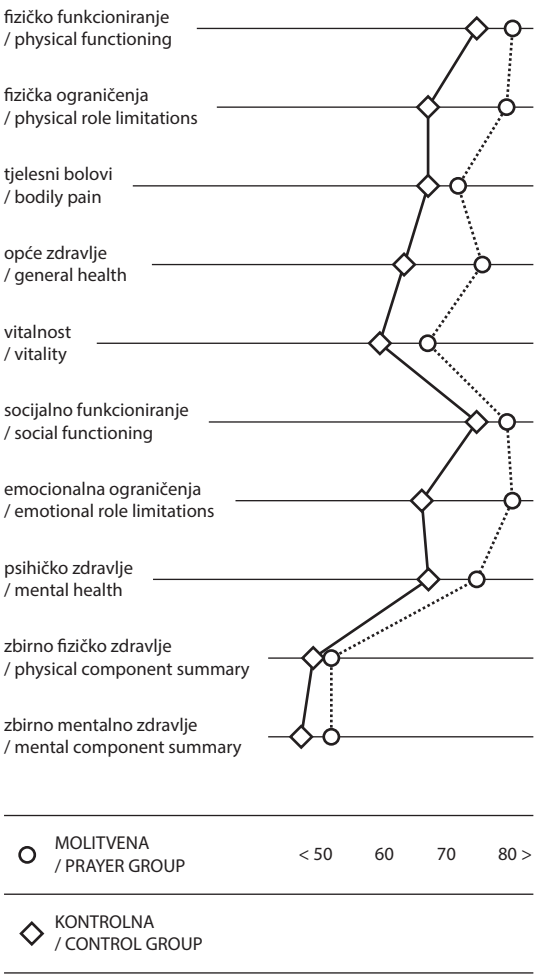
Manfestacija zdravlja / Health score	Molitvena / Prayer group	Kontrolna / Control group	P-vrijednost / P-value
Fizičko funkcioniranje / Physical functioning	80,490	74,510	0,2302
Fizička ograničenja / Physical role limitations	79,902	67,157	0,0627
Tjelesni bolovi / Bodily pain	72,157	67,059	0,2669
Opće zdravlje / General health	75,431	62,686	0,0004
Vitalnost / Vitality	67,255	58,725	0,0129
Socijalno funkcioniranje / Social functioning	80,000	74,510	0,1577
Emocionalna ograničenja / Emotional role limitations	81,046	66,667	0,0322
Psihičko zdravlje / Mental health	74,588	67,137	0,0145
Zbirno fizičko zdravlje / Physical component summary	50,799	48,192	0,1656
Zbirno mentalno zdravlje / Mental component summary	50,562	46,029	0,0199

molitvene zajednice kod općeg zdravlja, vitalnosti, emocionalnih ograničenja, psihičkog zdravlja i zbirnog mentalnog zdravlja.

Na sl. 1. prikazan je profil rezultata u molitvenoj zajednici i kontrolnoj skupini u 10 točaka.

Na svim ljestvicama su viši rezultati u molitvenoj zajednici nego u kontrolnoj skupini. U fizičkom funkcioniranju, fizičkim ograničenjima, tjelesnim bolovima, socijalnom funkcioniranju i zbirnom fizičkom zdravlju razlika postoji, ali je statistički nesignifikantna, premda sva u korist molitvene zajednice. U zbirnom fizičkom zdravlju rezultat je gotovo identičan u obje skupine.

Važna je činjenica da je 2003. godine ista anketa SF-36 provedena na hrvatskoj populaciji (12). U tablici 5. prikazani su rezultati te an-



GRAF 1. Profil rezultata molitvene zajednice i kontrolne grupe.
FIGURE 1. Result profile for the prayer and control groups.

Results are shown based on the 10 health scores. The score values are shown as numbers. Statistical differences are presented as well, and where the P-value was lower than 0.05 we assumed the existence of a statistically significant difference.

All health scores were higher in members of the prayer group. Statistically significant differences were in favor of the prayer group in general health, vitality, emotional role limitations, mental health, and mental component summary.

Figure 1 shows the result profile for the prayer and control groups for 10 scores.

The results for all health scores were higher in the prayer group than in the control group. A difference was observed for physical functioning, physical role limitations, bodily pain, social functioning, and physical component summary, but it was not statistically significant despite being in favor of the prayer group. For physical component summary, the score was nearly identical in both groups.

It is important to note that the same SF-36 questionnaire was used on a Croatian population in 2003 (12). Table 5 shows the results of that survey in comparison with the results from our prayer group.

Statistically significant differences were in favor the prayer group in all health scores except social functioning.

Figure 2 shows a profile of the results of the 2003 SF-36 survey in the Croatian population and the prayer group results from the present study.

In such profile comparisons, two data points are generally considered the most important: (1) the total profile level; (2) the shape of the profile. We can see that the total profile level of both the control group and the Croatian population in 2003 is lower than the profile of the prayer group. The control group and the 2003

TABLICA 5. Rezultati ankete SF-36 u Hrvatskoj 2003. godine i u molitvenoj zajednici te P-vrijednost
TABLE 5. Results of the 2003 SF-36 questionnaire Croatian survey in comparison with our prayer group with P-values

Manifestacija zdravlja / Health score	Molitvena / Prayer group	HZA 2003* / CHS 2003	P-vrijednost / P-value
Fizičko funkcioniranje / Physical functioning	80,490	70,198	0,0143
Fizička ograničenja / Physical role limitations	79,902	62,734	0,0004
Tjelesni bolovi / Bodily pain	72,157	65,509	0,0452
Opće zdravlje / General health	75,431	55,474	<0,0001
Vitalnost / Vitality	67,255	53,985	<0,0001
Socijalno funkcioniranje / Social functioning	80,000	74,569	0,0565
Emocionalna ograničenja / Emotional role limitations	81,046	70,659	0,0289
Psihičko zdravlje / Mental health	74,588	63,243	<0,0001
Zbirno fizičko zdravlje / Physical component summary	50,799	46,102	0,0043
Zbirno mentalno zdravlje / Mental component summary	50,562	45,667	0,0029

*HZA 2003 – Hrv. zdravstvena anketa 2003.
/ *CHS 2003 – Croatian Health Survey 2003

kete, usporedno s rezultatima naše ankete u molitvenoj zajednici.

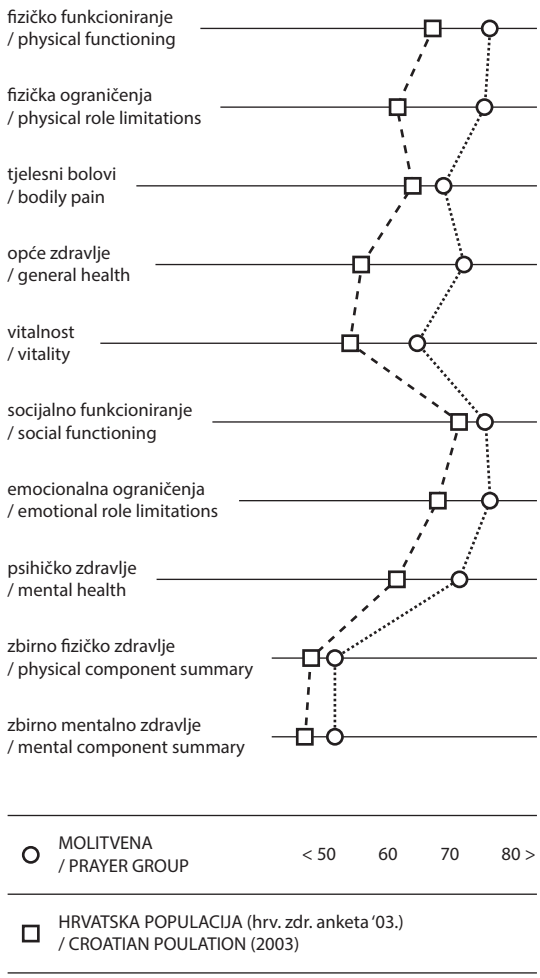
Statistički značajne razlike pokazale su se u korist molitvene zajednice u svim područjima zdravlja osim u socijalnom funkcioniranju.

U obliku profila na grafu u sl. 2. prikazani su rezultati ankete SF-36 u Hrvatskoj i u molitvenoj zajednici.

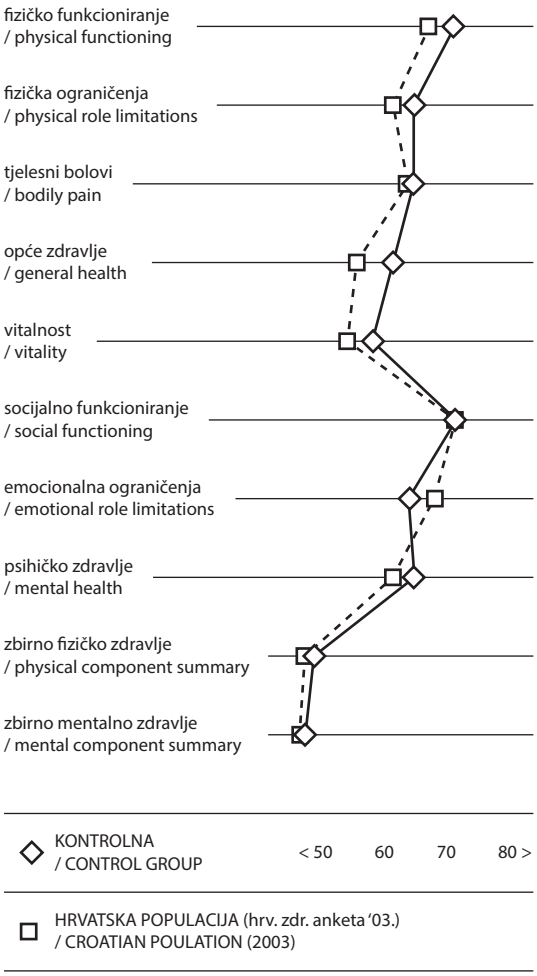
U ovakvim usporedbama profila općenito se najvažnijim smatraju dva podatka : 1. ukupna razina profila, 2. njegov oblik (18). Tako uočavamo da je ukupna razina kako profila kontrolne skupine, tako i hrvatskog profila, niža od profila molitvene zajednice. Na svim ljestvicama kontrolne skupine i hrvatskog profila zabilježeni su niži rezultati nego na ljestvicama molitvene zajednice.

Oblik krivulje molitvene zajednice ne prati trend kontrolne skupine i hrvatske populacije. Profil molitvene zajednice ne pokazuje pad u fizičkim ograničenjima, u općem zdravlju ima snažniji trend porasta u odnosu na druga dva profila te ne pokazuje trend pada u emocionalnim ograničenjima, koji je vidljiv u profilu kontrolne skupine.

Sl. 3. prikazuje profil kontrolne skupine i hrvatske populacije. Očito je da je razina profila tu



GRAF 2. Profil rezultata molitvene zajednice i hrvatske populacije 2003. godine.
FIGURE 2. Profile of the results from the prayer group and the Croatian population in 2003.



GRAF 3. Profil rezultata kontrolne grupe i hrvatske populacije 2003. godine.
FIGURE 3. Result profile for the control group and the Croatian population from 2003.

gotovo podjednaka, te i oblik profila u kontrolnoj skupini prati trend profila hrvatske populacije. Rezultati na ljestvicama zbirnog fizičkog i zbirnog mentalnog zdravlja su podjednaki, s tim da su rezultati na ljestvicama općeg zdravlja i vitalnosti u prosjeku najniži.

RASPRAVA

Kvaliteta i intenzitet duhovnog života u odnosu na različite aspekte doživljaja zdravlja mora biti tema od interesa za javno zdravstvo (19,20). Važno je zamijetiti da je unutar okvira duhovnog života u velikom broju studija ove vrste naglasak na vjerskom životu, budući da je

Croatian population had lower results in all scores than in the prayer group.

The shape of the curve for the prayer group does not follow the trends of the control group and the 2003 population. The profile of the prayer group does not show a reduction in physical role limitations, it shows a stronger increase in general health in comparison with the other two profiles, and does not show a reduction in emotional role limitations that can be observed in the control group profile.

Figure 3 shows the profile of the control group and the Croatian population from 2003. It is clear that the profile levels are almost identical, as are the shapes of the profiles, with the control group profile following the trends of the 2003 profile. Results on the physical component summary and mental component summary scales were almost identical, whereas the scores for general health and vitality were the lowest on average for both profiles.

DISCUSSION

The quality and intensity of spiritual life in relation to different aspects of subjective health perception should be a topic of interest to public health (19,20). It is important to note that many of these studies on spiritual life emphasize religious life, since it is possible to precisely define religious life within the broader spectrum of spirituality using established measurement tools (21,22), such as DUREL (The Duke University Religion Index) and RCOPE (Religious Coping Scale). Using these instruments, it is possible to correlate the intensity and quality of religious life with various aspects of subjective perception of personal health, which can also be quantified (23). No quantification of the quality and intensity of spiritual life was performed in the present study due to the increase in technical complexity this would have resulted in, but we attempted to ameliorate this

unutar spektra duhovnosti vjerski život moguće precizno definirati za što postoje etablirani mjerni instrumenti (21,22), kao što su DUREL (The Duke University Religion Index) i RCOPE (Religious Coping Scale). Koristeći mjerne instrumente moguće je postaviti u korelaciju intenzitet i kvalitetu vjerskog života s različitim aspektima doživljaja zdravlja, koji se također mogu kvantificirati (23). U ovom istraživanju kvantifikacija kvalitete i intenziteta duhovnog života nije učinjena zbog usložnjavanja tehničkih zadaća istraživačima, pa se dizajnom studije nastojalo ublažiti ovaj nedostatak izborom ispitanika za koje se može pretpostaviti s dostatnom razinom sigurnosti da predstavljaju skupinu intenzivnog i naglašeno kvalitetnog vjerskog života kakva je karizmatska molitvena zajednica. Intenzivan vjerski život pretpostavlja često sudjelovanje u organiziranom životu crkve kao i u osobnim vjerskim aktivnostima. Članovi molitvene zajednice trebali bi imati, osim intenzivnijeg vjerskog života od članova kontrolne skupine, i drugačiju kvalitetu religijskog života od članova kontrolne skupine, iako se i ta sastoji gotovo u cijelosti od vjernika (24,25). Drugačija bi kvaliteta vjerskog života kod članova molitvene zajednice podrazumijevala višu razinu intrinzične religioznosti u odnosu na članove kontrolne skupine, što je usmjerena prije svega prema ispunjenju vjerom svake životne aktivnosti (21,23). Za članove kontrolne skupine pretpostavka je da su vjerske aktivnosti dominantno ekstrinzične, dakle korištene su kao medijator što pomaže ostvarenju nekih drugih važnih životnih ciljeva, npr. osjećaju pripadnosti, postizanju socijalnih i ekonomskih ciljeva (21,26).

Drugim riječima, cilj se ovog istraživanja može postaviti kao odgovor na pitanje postoje li razlike u doživljaju vlastita zdravlja u skupini ljudi intenzivnog i naglašeno intrinzičnog vjerskog života u odnosu na kontrolnu skupinu kod koje je intenzitet vjerskog života znatno niži i više ekstrinzičan.

limitation by selecting participants who could be reasonably assumed to represent a population with intensive and higher quality religious life that would be expected from a charismatic prayer group. Intensive religious life implies regular participation in organized church activities as well as personal religious activities. Prayer group members were assumed to have more intensive religious life than members of the control group but also a different quality of religious life than members of the control group, although participants in the control group were also almost all religious (24,25). Different quality of religious life in the prayer group would include a higher level of intrinsic religiosity in comparison with members of the control group, primarily manifesting as faith permeating every activity in the members' lives (21,33). Members of the control group were assumed to engage in religious activity as a predominantly extrinsic activity, i.e. using them as a mediator that facilitates the achievement of other important life goals such as a feeling of belonging and other social and economic goals (21,26).

In other words, the goal of this study was to answer the question whether there were differences in the subjective perception of personal health in a sample population with an intensive and decidedly intrinsic religious life in comparison with the control group in which the intensity of religious life was significantly lower and more extrinsic.

The results of the SF-36 survey in the prayer group found nominally better results in all 10 health scores in comparison with the control group and the Croatian population. There was a statistically significant difference between participants from the prayer group and participants in the control group in scores on general health, vitality, emotional role limitations, mental health, and mental component summary, whereas there was a statistically significant difference between the

Rezultati ankete SF-36 u molitvenoj zajednici pokazuju u svih 10 ljestvica zdravlja nominalno bolje rezultate u odnosu na kontrolnu skupinu i hrvatsku populaciju. Statistički značajna razlika između ispitanika molitvene skupine i ispitanika kontrolne skupine postoji kod manifestacija općeg zdravlja, vitalnosti, emocionalnih ograničenja, psihičkog zdravlja i zbirnog mentalnog zdravlja, dok se između ispitanika molitvene zajednice i ispitanika hrvatske populacije pronašla statistički značajna razlika u svim manifestacijama zdravlja osim u socijalnom funkcioniranju. S druge strane, statistički značajne razlike nema između molitvene i kontrolne grupe u fizičkim ograničenjima, fizičkom funkcioniranju, tjelesnim bolovima, socijalnom funkcioniranju i zbirnom fizičkom zdravlju. Dakle, unatoč tome da se doživljaj fizičkog zdravlja i socijalnog funkcioniranja kod pripadnika molitvene zajednice statistički značajno ne razlikuje od kontrolne skupine, pripadnici molitvene zajednice osjećaju se emocionalno i mentalno zdravijima, vitalnijima, vezujući uz vlastito zdravlje očito pozitivniju percepciju od pripadnika kontrolne skupine, kao i hrvatske populacije (18). Podatak da je u molitvenoj zajednici ukupno mentalno zdravlje statistički značajno bolje u odnosu na kontrolnu skupinu i hrvatsku populaciju možemo objasniti time da fizički bolovi u njenih pripadnika manje utječu na opći osjećaj dobrog bivstvovanja (27-29).

Između ispitanika molitvene zajednice i hrvatske populacije statistički značajna razlika postoji u svim ljestvicama zdravlja osim u socijalnom funkcioniranju. Pronašlo se da ni hrvatska populacija nema jednaki profil u svim dijelovima države. Najpovoljniji profil pokazala je zapadna Hrvatska (18), iz koje upravo potječu članovi kontrolne skupine u ovom istraživanju. Kako nema statistički značajne razlike u socijalnom funkcioniranju niti molitvene, niti kontrolne skupine prema hrvatskoj populaciji, nameće se zaključak da socijalno funkcioniranje ovisi u manjoj mjeri o duhov-

prayer group and the Croatian population in all health scores except for social functioning. On the other hand, there were no statistically significant differences between the prayer and control groups in physical role limitations, physical functioning, bodily pain, social functioning, and physical component summary. Therefore, despite the fact that general health and social functioning were not statistically significantly different in comparison with the control group, members of the prayer group felt emotionally and mentally more healthy, more vital, and clearly had a more positive perception of their personal health in comparison with both the control group and the Croatian population (18). The fact that the mental component summary score was statistically significantly better in the prayer group in comparison with the control group and the Croatian population can be explained by physical pain in the members of the prayer group having less of an impact on the general feeling of wellbeing (27-29).

There was a statistically significant difference in all health scores except social functioning when comparing members of the prayer group with the Croatian population. We also found that the Croatian population does not have the same profile in all parts of the country. The best profile was found in western Croatia (18), which is where the control group participants were from in our study. As there was no statistically significant difference in social functioning when comparing the prayer and control group with the Croatian population, we are led to conclude that social functioning depends on the spirituality of the individual only to a lesser extend and is more influenced by other factors such as general societal conditions, the influence of family, career satisfaction, and membership in some social groups. According to the available literature, spiritual life could also influence the success of social adaptation, which was not confirmed in the

noj usmjerenosti pojedinca, koliko o drugim čimbenicima npr. općim društvenim uvjetima, utjecaju obitelji, profesionalnom zadovoljstvu, pripadnosti nekim društvenim skupinama. Prema dostupnoj literaturi duhovni život bi mogao utjecati i na uspješnost socijalne adaptacije, što u ovom istraživanju nismo potvrdili (30,31). Na ograničenja vezana uz socijalni život i ostvarenje životnih uloga očito je vrlo teško utjecati. Razvijen duhovni život, iako nije značajnije promijenio socijalno funkcioniranje moguće je povezati sa smanjenjem negativnog utjecaja ograničenog "socijalnog blagostanja" na psihičko zdravlje. Kod hrvatske populacije i kontrolne skupine vitalnost i opće zdravlje (uz zbirno mentalno i zbirno fizičko zdravlje) imaju najnižu razinu na profilu. Prema literaturi to je karakteristično za opću i ne-kliničku populaciju (18). U molitvenoj zajednici osjećaj vitalnosti i općeg zdravlja su značajno pozitivniji nego što su u kontrolnoj skupini i hrvatskoj populaciji, s time da je razina tjelesnih bolova u molitvenoj zajednici ispod razine općeg zdravlja u profilu rezultata, za razliku od kontrolne skupine i hrvatske populacije gdje je osjećaj općeg zdravlja negativnije percipiran od osjećaja tjelesnih bolova. Može li se to objasniti ispunjenijim duhovnim životom? Negativno formuliran odgovor na ovo pitanje donosi glavno ograničenje istraživanja da nađene razlike u subjektivnom osjećanju zdravlja između promatranih skupina, detektirane upitnikom SF-36, moguće nisu povezane s kvalitetom duhovne usmjerenosti članova, već s nekom drugom značajkom koja razlikuje promatrane skupine.

ZAKLJUČCI

Ovim istraživanjem pokazalo se da unatoč tome što je od 51 ispitanika u kontrolnoj grupi čak 46 vjernika, od čega 30 vjeruje u povezanost vjere i zdravlja, 23 redovito moli, a 13 ide redovito u crkvu, postoji statistički značajna razlika u percepciji zdravlja, odnosno postoji

present study (30,31). Limitations concerning social life and achieving life roles are obviously very hard to influence. A developed spiritual life, despite not significantly changing social functioning, can be associated with a reduction in the negative effect of limited "social wellbeing" on mental health. In both the Croatian population and the control group, the scores for vitality and general health (in addition to mental and physical component summary) were the lowest in the profile. According to the literature, this is characteristic for the general and non-clinical population (18). In prayer group members, the feelings of vitality and general health were significantly more positive than in the control group and the Croatian population, with the bodily pain score in the prayer group being below the level of general health in the results profile, in contrast to the control group and Croatian population where the general health was perceived more negatively than bodily pain. Can this be explained by a more fulfilled spiritual life? A negative answer to this question highlights the main limitation of the study, which is that the differences found in the subjective feeling of health between the observed groups using the SF-36 questionnaire might not be associated with the spirituality of participants but may instead be associated with some other factor that differentiates the observed groups.

CONCLUSIONS

This study has shown that despite the fact that 46 out of 51 participants in the control group expressed religious beliefs, of which 30 believed in a connection between faith and health, 23 prayed regularly, and 13 attended church regularly, there was a statistically significant difference in health perception, i.e. there was a significant difference in general health, vitality, emotional role limitations, mental

značajna razlika u percepciji općeg zdravlja, vitalnosti, emocionalnog ograničenja, psihičkog zdravlja i zbirnog mentalnog zdravlja između te skupine i skupine molitvene zajednice. Istraživanje ukazuje na kakvoću vjerskog života kao bitnog razlikovnog čimbenika između skupina, što dovodi do zamijećene razlike.

health, and mental component summary between the control group and the group formed from members of a prayer group. Therefore, this study indicates that the quality of religious life was a significant differentiating factor between the groups that resulted in the observed differences.

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