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The influence of religious affiliation on time to first treatment and hospitalization

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Abstract

Longer duration of untreated psychosis (DUP) has been associated with treatment-refractory illness, significant cognitive decline, and poorer long-term outcomes. There are many factors, including social and cultural, that promote longer DUP. To date, there have been no studies to evaluate religion's effect on DUP. In this study, we evaluated the effect of certain religious affiliations and degree of religious practice on the DUP.

Methods: A total of 195 patients were recruited aged 18 to 45 years with the presence of at least 1 psychotic symptom (delusions, hallucinations, or prominent thought disorder). Patients were evaluated on their religious practice prior to the index episode using a Likert-style scale. Using a similar scale, patients were asked about their religious affiliation categorized as Catholic, Protestant, or neither.

Results: Correlational analysis revealed that the time to first treatment and time to first hospitalization were both was negatively related to degree of religious practice ($r = -0.15$, $N = 161$, $p < 0.05$ and $r = -0.18$, $N = 161$, $p < 0.05$, respectively). Between-group comparisons revealed longer DUP in the Protestant group compared to the no affiliation and Catholic groups ($p = 0.05$).

Conclusion: From our results, it appears that the degree of religious practice does not affect length of time to treatment in psychotic patients. However, having a Protestant religious affiliation is strongly associated with having a greater delay in treatment seeking for psychosis. Factors contributing to a longer DUP in this group warrant further study.

Keywords: Schizophrenia; Psychosis; Religious affiliation; Protestant; Catholic

1. Introduction

Psychosis is a component of a number of psychiatric and medical syndromes, although is commonly linked to schizophrenia. As an example, in the United States, schizophrenia, carries a significant financial burden of $30 billion to $40 billion annually (Rice,

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1999). People with psychotic disorders are more likely to be homeless, attempt and complete suicide, and have greater social isolation than the general population (Brown, 1997; Folsom et al., 2005; Lauber et al., 2004).

In psychiatric practice, psychotic patients often present weeks, months, or years after the first onset of symptoms. Recently, the mental health community has given considerable attention to the effects of the duration of untreated psychosis (DUP). Studies have shown that the DUP often ranges from 4 to 12 months, but can be much longer (e.g., years) (Yamazawa et al., 2004; Chong, 2005; Drake et al., 2000). Researchers have associated longer DUP with certain patient-related factors, such as poor insight, poor integration, and avolition. Those who avoid treatment longer may have poorer work, social, and global functioning with more insidious onset of symptoms (Larsen et al., 1996). In schizophrenia, longer DUP is a primary predictor of negative symptom severity (Meagher et al., 2004). Addington et al. (2004) found that DUP was associated with high levels of positive symptoms and poor social functioning. Some investigators have speculated that treatment refractory psychotic illness may be linked to longer DUP. Patients with extended DUP have a lower level of recovery, longer time to remission, and increased risk of relapse (Sheitman and Lieberman, 1998). In short, the DUP prior to treatment adversely affects long-term outcome in schizophrenia (Bottlender et al., 2003). With these prognosticators known, it becomes important to identify factors contributing to a longer DUP. Interestingly, studies have described preserved coping as one factor contributing to longer DUP (Drake et al., 2000). Drake et al. also found that DUP may be shortened if patients are more overtly symptomatic, i.e. demonstrate preoccupation with internal stimuli or display hostile behavior.

Religion or spirituality, like many cultural factors, affects the course of mental illness. There have been various studies looking at that influence, but the results have varied. Some studies demonstrated that religion promotes recovery from mental illness (Koenig et al., 1998; Braam et al., 2004), lower rates of depression (Milstein et al., 2003), and provides another method of coping (Abernethy et al., 2002). Other studies demonstrated that religious affiliation is associated with less suicidal behavior (Dervic et al., 2004). In treatment, there has been a possible chasm between the religious community and mental health. In non-white religious groups, there is evidence of a community stigma associated with mental illness. These groups may prefer other coping strategies than seeking mental health services (Cinnirella and Loewenthal, 1999). Studies have also shown that some Protestant groups are apprehensive with the interface of their beliefs and seeking mental health services (McLatchie and Draguns, 1984). In contrast Catholic patients may have a greater acceptance of seeking psychological help (Halter, 2004). These findings suggest that certain religious affiliations may delay seeking mental health services, thereby increasing DUP.

With these considerations in mind, we retrospectively examined the time to first treatment and hospitalization in psychotic inpatients who reported no religious affiliation, Catholic (Christian) affiliation, or Protestant (Christian) affiliation. We predicted that DUP would be significantly increased for religiously affiliated individuals, particularly Protestants.

2. Methods

2.1. Subjects

Adult patients were randomly selected for recruitment from consecutive admissions to the University of Cincinnati Hospital from January 1, 1998 through May 31, 2001. To be included, patients were required to meet the following inclusion criteria: (1) aged 18 to 45 years (the upper age limit was incorporated to minimize the likelihood that psychotic symptoms were secondary to medical problems); (2) presence of at least 1 psychotic symptom (delusions, hallucinations, or prominent thought disorder); (3) no history of mental retardation or IQ$<$70; (4) ability to communicate in English; and (5) ability to understand study procedures and provide written informed consent as determined by study personnel and clinicians participating in the patients' care. Patients were excluded from this study if their symptoms appeared to be secondary to drug or alcohol intoxication or withdrawal or medical illness. This work was carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of