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Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Intrinsic religiosity, resilience, quality of life, and suicide risk in depressed inpatients

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ARTICLE INFO

Article history:

Received 27 December 2014

Accepted 12 March 2015

Available online 21 March 2015

Keywords:

Intrinsic religiosity

Resilience

Depression

Suicide risk

Quality of life

ABSTRACT

Background: Religiosity is inversely related to depression and is directly associated with positive psychological outcomes. Nonetheless, there is no consensus on whether or how religiosity could impact and protect against depression. The present study evaluated the association between intrinsic religiosity and resilient psychological characteristics in depressed inpatients.

Methods: A sample of 143 depressed patients was prospectively evaluated in an inpatient psychiatric treatment in South Brazil. High Intrinsic Religiosity (HIR) and Low Intrinsic Religiosity (LIR) patients were compared across socio-demographic information, clinical measures, religiosity, resilience and quality of life. A linear regression model was used to evaluate the association between intrinsic religiosity and resilience, and the Cohen *d* test was utilized to assess effect sizes.

Results: At admission, HIR patients showed higher HAM-D ($p=0.05$), BPRS ($p=0.02$), GAF ($p=0.02$), and CGI ($p=0.03$) scores, lower educational levels ($p=0.04$), higher social support ($p=0.05$), and fewer previous suicide attempts ($p=0.05$). At discharge, HIR patients showed higher quality of life ($p=0.001$) and higher resilience ($p=0.000$), with a large effect size difference between groups (1.02). Based on a linear regression model (adjusted $r=0.19$, $p=0.000$), intrinsic religiosity was associated with resilience, controlling for covariates.

Conclusion: In a sample of depressed inpatients, intrinsic religiosity was found to be associated with resilience, quality of life, and fewer previous suicide attempts. These findings support the relevance of religiosity assessments in mental health practice and support the hypothesis that resilient psychological characteristics may mediate the positive effects of intrinsic religiosity in depression.

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1. Introduction

The relationship between religiosity and depression remains a challenging issue in psychiatry. Religiosity has been described as a protective factor for major depression (Miller et al., 2012), suicide (Huguelet et al., 2007; Moreira-Almeida et al., 2006) and is positively associated with psychological health (Rosmarin et al., 2013), and quality of life (Panzini et al., 2011). Nonetheless, to date, there is no consensus on religiosity influences on mental health and the pathways that mediate benefits of religiosity on depression (Blazer, 2012).

In a systematic review, 67% of the most methodologically rigorous studies identified inverse relationships between religiosity and depression (Bonelli et al., 2012). A meta-analysis of 147 studies

identified a weak but inverse association between religiousness and depression; a stronger association was found in people undergoing stressful life events (Smith et al., 2003). Intrinsic religiosity, more specifically, predicted shorter time to remission in older depressed inpatients (Koenig et al., 1998) and was associated with less depressive symptomatology and higher quality of life in bipolar disorder patients (Stroppa and Moreira-Almeida, 2013).

Resilience is defined as the capacity to “bounce back” or recover in the context of trauma or adversity (Rutten et al., 2013; Southwick et al., 2011). Religiosity is thought to be a resource of resilience in adversities and traumatic events (Feder et al., 2012). In United States, after the September 11th terrorist attacks, for example, turning to religion represented the second most used coping strategy to deal with stress based on 90% of community interviewed individuals (Schuster et al., 2001). Spirituality, likewise, was identified as a key independent predictor of resilience in patients with depression (Min et al., 2012).

Depressed inpatients represent a population with severe symptomatology and at a high risk of suicide (Seemüller et al., 2010). To our knowledge, no previous studies have directly assessed how intrinsic

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religiosity is related to resilience in this population. The aim of present study was to evaluate intrinsic religiosity, resilience, suicide risk, quality of life and clinical characteristics of depressed inpatients. The hypothesis of the present study was that intrinsic religiosity is positively associated with psychological resilient characteristics, representing a possible pathway to mediate more favorable clinical outcomes in depression.

2. Method

2.1. Study sample

This study evaluated a prospective cohort of psychiatric inpatients in *Hospital de Clínicas de Porto Alegre*, a tertiary care general hospital in South Brazil. Information regarding religiosity and resilience of depressed inpatients was collected from May 2011 to August 2013. Assessments were performed in the first 72 h of admission and in the 48 h before hospital discharge. Informed consent was obtained according to the ethical committee's requirement. Patients with cognitive deficits which prevented comprehension or patients with acute substance use disorder as a primary diagnosis were not included in the study.

2.2. Assessments

2.2.1. Diagnostic, socio-demographic and clinical data

Trained psychiatrists or psychiatry residents evaluated diagnostic and clinical measures. Diagnosis of depressive episodes and comorbidities were assessed using the Mini International Neuropsychiatric Interview (Amorim, 2000) in a semi-structured interview performed within the first 72 h of admission. Clinical measures scales were used at admission and before discharge, including Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960), General Assessment of Functionality (GAF) (Smith et al., 2011), Clinical Global Impression (CGI) (Lima et al., 2007), and Brief Psychopathological Rating Scale (BPRS) (Crippa et al., 2002).

Trained interviewers (medicine or psychology students and psychologists) independently evaluated socio-demographic data and the Brazilian versions of the following instruments: World Health Organization Quality of Life abbreviated form instrument (WHOQOL-BREF) (Berlim et al., 2005), Duke University Religion Index (DUREL) (Moreira-Almeida et al., 2008), Resilience Scale (RS) (Pesce et al., 2005), Medical Outcomes Study's Social Support Scale (MOS) (Griep et al., 2005), and Cumulative Illness Rating Scale (CIRS) (Salvi et al., 2008). Socio-demographic information was structured in a protocol completed with the best information available (patient interview or medical records) within the first 72 h of admission, including age, sex, ethnicity, marital status, occupation, education, and socioeconomic level, number of previous psychiatry hospitalizations, suicide attempts, and illicit drug use. Trained psychologists used the Wechsler Adult Intelligence Scale (WAIS) Brazilian adapted version to estimate IQ (Wagner et al., 2010). Religiosity and resilience measures were evaluated before patient discharge. Researchers were not strictly blinded to religiosity and resilience instruments, but the clinical data and the main protocol information were collected independently and before religiosity and resilience instruments were used.

2.2.2. Religiosity measures

Religiosity was evaluated using Duke University Religion Index (DUREL) (Lucchetti et al., 2010; Moreira-Almeida et al., 2008). DUREL is a 5-item Likert scale measure with three dimensions of religiosity. The first question evaluates organizational religiosity (including church, temple, or institutional attendance), the second evaluates non-organizational religiosity (religion activities performed in private, such as prayer, readings, and meditation), and the last three

questions evaluated intrinsic religiosity dimensions (subjective beliefs and motivation related to religiosity involvement). Intrinsic religiosity was chosen as the main religiosity dimension to study its relationship to resilience. According to previous research, DUREL can be used as a continuous score in each domain or as a categorical division. High intrinsic religiosity was defined by an overall score in the last three questions of more than 10 points (Stroppa and Moreira-Almeida, 2013).

2.2.3. Social support

Medical Outcomes Study's Social Support Scale (MOS) was used to quantify social support (Griep et al., 2005). The instrument was developed and applied in an epidemiological study with chronic diseases, such as hypertension, diabetes, cardiovascular diseases, and depression in three centers in the United States. Social support was defined as the individual perception of available social resources in a needed situation. MOS instrument is composed of 19 questions in a 5-item Likert scale format. A higher overall score reflects greater social support (Griep et al., 2005).

2.2.4. Quality of life

Quality of Life was evaluated using the World Health Organization Quality of Life abbreviated instrument (WHOQOL-BREF) (Rocha et al., 2012). The instrument is composed of 26 items in a Likert scale. WHOQOL-BREF is based on the full version WHOQOL-100, developed in a worldwide perspective which included 15 international field centers. WHOQOL-BREF is composed of physical, psychological, social, and environmental domains. It has been developed and validated based on the concept of quality of life proposed by WHO as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (Fleck et al., 1999)."

2.2.5. Resilience

Resilience is defined as a process of adaptation in the face of trauma, stress, or adversity. Psychological characteristics associated with resilience were studied using the Brazilian Portuguese version of Resilience Scale (RS) (Pesce et al., 2005). Resilience Scale scores are positively correlated with well being (Cloninger and Zohar, 2011), life satisfaction, morale, and health (Wagnild and Young, 1993) and negatively correlated with depression (Abiola and Udofia, 2011; Hasui et al., 2009; Wagnild and Young, 1993). The instrument includes 25 items with a 7-point Likert scale. Measures were analyzed as global score ranging from 25 to 175 and a two-domain division identified by Wagnild and Young in factorial analysis (Hasui et al., 2009; Wagnild and Young, 1993; Windle et al., 2011). The first domain is called personal competence and represents self-reliance, independence, determination, invincibility, mastery, resourcefulness and perseverance. The second reflects adaptability, flexibility, and a sense of peace in the face of adversity, as well as a balanced perspective of life and acceptance of life circumstances. Higher scores on RS indicate greater resilience.

2.2.6. Statistical analysis

Analyses were performed using SPSS software. The Kolmogorov–Smirnov test evaluated the normality distribution of the sample. A Student's *t* test was used to compare continuous normally distributed variables, a Chi-Square test was used to evaluate categorical variables, and a Mann–Whitney test was used to compare non-parametric distributions. High intrinsic religiosity (HIR) and Low intrinsic Religiosity (LIR) groups of depressed inpatients were compared across socio-demographic data, clinical variables, resilience, and quality of life. The Cohen's *d* test evaluates the effect size of differences in resilience between LIR and HIR groups. The relationship between resilience and socio-demographic, clinical data, and religiosity was

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