



## Spiritual/religious coping in patients with epilepsy: Relationship with sociodemographic and clinical aspects and quality of life



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### ABSTRACT

One hundred and ten patients with epilepsy with a mean age of 45.9 were assessed by a clinical-neurological evaluation, Quality of Life in Epilepsy Inventory-31 (QOLIE-31), and the Spiritual/Religious Coping (SRCOPE) Scale. The objective of this study was to evaluate if patients with epilepsy used positive and/or negative spiritual/religious coping and the relationships between this type of coping and the sociodemographic and clinical aspects of epilepsy and the QOLIE-31. A greater use of positive coping ( $3.0 \pm 0.7$ ) than negative coping ( $2.3 \pm 0.7$ ) was found. The use of the positive factor was greater in mesial temporal lobe epilepsy (MTLE) than in other types of epilepsy. The ratio of negative/positive coping was associated with lower scores in the QOLIE-31 ( $-0.222$ ;  $p = 0.036$ ). Patients with epilepsy appear to use spiritual/religious coping, especially those with MTLE, and a predominance of negative coping was associated with a reduced quality of life. Future studies should evaluate interventions considering the knowledge of spiritual/religious strategies by the patients.

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### 1. Introduction

The implications of spirituality and religiousness (SR) are being studied and scientifically documented, but the mechanisms by which SR acts on health have still not been completely established [1], and the subject is still a matter of controversy in literature [2].

Spirituality and religiousness are related but are not synonymous. Spirituality is a human propensity to search for significance in life by way of concepts that transcend the tangible and transmit vitality and significance to events in life. Religiousness involves a doctrine system shared by a group and, therefore, has behavioral, social, and specific value characteristics [3].

Spirituality and religiousness studies related to epilepsy have been historically marked by contradiction and conflicts. Despite the relevance of the subject, studies on the relationship of SR with the clinical aspects of epilepsy and their contribution to quality of life (QoL) are rare [4,5].

The search for religious support is considered to be an important resource to deal with stressful situations. Cultural aspects can influence

how people live with SR, and, according to the type and use, religious beliefs can provide greater acceptance, firmness, and capacity to adapt to difficult situations or they can generate guilt, doubt, sadness, and insecurity [2,6].

Spiritual/religious coping is considered to occur when people turn to religion and spirituality in order to deal with stress or use their faith to deal with problems [7,8], and, depending on how people use the spiritual/religious coping strategies, they can be classified as either positive or negative [8]. Positive coping covers strategies that provide a beneficial effect, such as “solve one’s problems in collaboration with God” and “search for help and comfort in religious literature”, whereas negative coping involves strategies that promote consequences that prejudice the individual, such as “the belief in a punitive God” and “delegate God to solve one’s problems” [8].

The measurement of SR is highly complex and has its limitations. On the other hand, some authors suggest that the scales that evaluate spiritual/religious coping strategies are better predictors when touching on specific aspects of the relationship between SR, health, and stressful situations [8,9].

The Spiritual/Religious Coping (SRCOPE) Scale is the Brazilian version of the RCOPE scale [10] and was validated in Brazil in 2005 by Panzini and Bandeira [9]. This instrument allows for the multidimensional evaluation of the use of positive and negative aspects in the facing-up process and contributes to finding solutions for ambiguities in the relationship between SR and health [9]. There are no normative studies on the use of spiritual/religious coping for health reasons by the Brazilian population [9].

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Our hypothesis was that spiritual/religious coping may frequently be used by patients with epilepsy and that it may interfere with their quality of life.

No studies were found in the literature that evaluated the use of spiritual/religious coping in patients with epilepsy.

Thus, the objective of this study was to evaluate if patients with epilepsy used positive and/or negative spiritual/religious coping and the relationships between this type of coping and the sociodemographic and clinical aspects of epilepsy and QoL.

## 2. Method

### 2.1. Participants

One hundred and ten consecutive patients were included in this study, aged above 14 and diagnosed with epilepsy according to the international classification of epilepsy and epileptic syndromes (ILAE) [11,12]. All were referred by the outpatient department of the PUC-Campinas Neurology Clinic.

The mean age of the patients was 45.9 ( $\pm 16.4$ ) years, 55.5% were females, mean duration of formal education was 6.1 ( $\pm 3.7$ ) years, and the age at the first epileptic seizure (ES) was 27.3 ( $\pm 19$ ) years.

At the time of the evaluation, 47 (42.7%) of the individuals were employed, 8 (7.3%) were unemployed, and 34 (30.9%) were students or housewives. Leave and/or retirement was referred to by 21 (19.1%) patients.

The research was approved by the Ethics Committee for Research with Human Beings of PUC-Campinas.

Patients with cognitive deficiencies or who had difficulty in understanding the instruments were excluded.

### 2.2. Procedures

The patients were submitted to the following procedures:

- Clinical evaluation to obtain sociodemographic (age, gender, educational level, marital status, and employment situation) and clinical (age at onset of epilepsy, type and frequency of epileptic seizures (ES), duration of the epilepsy, alterations in the neurological examination, use of antiepileptic drugs (AEDs), and the diagnosis of an epileptic syndrome) data, neurological and psychiatric antecedents, and also aspects related to religiousness, that is, ictus-related religious experiences, declared religion, and whether the individual practiced his/her declared religion.
- Digital electroencephalogram (EEG) – Abnormal EEG background activity and the location and side of the epileptiform activity were assessed.
- Quality of Life in Epilepsy Inventory-31 (QOLIE-31) [13]: this is the specific inventory used to evaluate QoL in epilepsy and was validated in Brazil in 2007 [14]. It consists of the total score and the following 7 dimensions: seizure worry, overall quality of life, emotional well-being, energy/fatigue, cognitive function, medication effects, and social function. The scores vary from 1 to 100 with a higher score indicating a better quality of life. The scoring indicated by the authors [13] was used to analyze the questionnaire.
- Spiritual/Religious Coping (SRCOPE) Scale [9]: this is composed of 87 items rated on a 5-point Likert scale from 1 – “not at all” to 5 – “very much so”. The individual should mark the response that indicates how much he/she uses religious confrontation in each situation. The following indexes were used in the analysis: positive spiritual/religious coping (SRC), negative SRC, and the negative/positive SRC ratio. Positive SRC indicates the level of spiritual/religious confrontation practiced by the person being evaluated using the mean of 66 questions. It is composed of 8 factors (P1: “transformation of himself and/or his life”; P2: “actions in the search of spiritual help”; P3: “offer of help to another person”; P4: “positive position before God”;

P5: “personal search for spiritual growth”; P6: “actions in search of the other institution”; P7: “personal search for spiritual knowledge”; and P8: “withdrawal by way of God from religion and/or spirituality”). Negative SRC is the mean of 21 questions and is composed of 4 factors (N1: “negative reevaluation of God”; N2: “negative position before God”; N3: “negative reevaluation of the significance”; and N4: “lack of satisfaction with the other institution”). For the positive and negative SRC indexes, the higher the value, the greater is the use. For the negative/positive SRC ratio and the percentage of negative SRC used in relation to the positive value, the greater the value, the greater is the use of negative SRC. The mean application time was 30 min.

Among the patients with symptomatic focal epilepsy, a subgroup with mesial temporal lobe epilepsy with hippocampal sclerosis (MTLE-HS) was formed, characterized by clinical aspects of this epilepsy syndrome and by the presence of hippocampal atrophy by magnetic resonance imaging and not submitted to any surgical procedure.

The diagnosis of psychiatric comorbidity was carried out by the psychiatric service according to the CID-10 criteria and the DSM-IV. The patients were classified into two groups: with and without psychiatric comorbidity.

### 2.3. Data analysis

The relationships of the SRCOPE Scale scores with the sociodemographic and clinical aspects of epilepsy and with the QOLIE-31 data were studied.

With respect to the clinical aspects, the SRCOPE Scale scores obtained by the patients with MTLE-HS were compared with those obtained by patients with other epileptic syndromes (idiopathic generalized epilepsy, probable symptomatic focal epilepsy, and symptomatic focal epilepsy of other etiologies).

Parametric and nonparametric statistical tests were applied according to the situation under study with the use of the Statistical Package for the Social Sciences program (SPSS, version 20.0) with a level of significance of  $p < 0.05$ .

## 3. Results

With respect to religion, 58 (52.7%) patients declared that they were Catholic, 39 (35.5%) were evangelical, 4 (3.6%) had other religions, and 9 (8.2%) declared that they had no religious affiliation. Regular religious practice was referred to by 68 (61.8%) individuals. Ictus-related religious experiences were not referred to by any of the patients.

Nineteen (17.3%) patients had idiopathic generalized epilepsy, 30 (27.3%) had probable symptomatic focal epilepsy, and 61 (55.5%) had symptomatic focal epilepsy according to the ILAE criteria [12]. Mesial temporal lobe epilepsy with hippocampal sclerosis was observed in 32 cases with sclerosis of the right and left hippocampi in 16 cases each. The ES were under control in 54 (49.1%) cases.

On the SRCOPE Scale, the patients attained higher scores on the positive SRC index than on the negative one (respectively,  $3.0 \pm 0.7$  and  $2.3 \pm 0.7$ ; Mann-Whitney  $U$  test,  $p < 0.000$ ). The negative/positive SRC ratio was 0.7 ( $\pm 0.2$ ), and there was a positive correlation between the positive and negative SRC indexes (Spearman test: 0.416,  $p < 0.000$ ).

There was also a positive correlation (Spearman test: 0.258;  $p = 0.007$ ) between patient age and the factor related to “personal search for spiritual growth” (positive factor 5).

It was shown that individuals with less formal education presented a significantly higher score for the positive SRC index (Spearman test:  $-0.274$ ;  $p = 0.004$ ) and for the positive factors “P2” ( $-0.315$ ;  $p = 0.001$ ), “P5” ( $-0.292$ ;  $p = 0.002$ ), “P6” ( $-0.205$ ;  $p = 0.032$ ), “P7” ( $-0.317$ ;  $p = 0.001$ ), and “P8” ( $-0.252$ ;  $p = 0.008$ ).

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