



Is religiosity a protective factor against suicidal behavior in bipolar I outpatients?



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ABSTRACT

Background: Several risk factors have been associated with suicidal behavior (SB) in bipolar disorder (BD), but little is known regarding possible protective factors. Religiosity has been related to favorable outcomes in mental health and to a reduction in the risk of SB, although the relation between BD, religiosity and SB remains under-investigated. The objective of this study was to evaluate the association between religiosity and SB in euthymic bipolar I outpatients.

Method: In this study, 164 outpatients with BD type I with and without a history of suicide attempts were assessed and compared using a questionnaire to collect clinical and sociodemographic characteristics, the Structured Clinical Interview for DSM-IV, the Hamilton Depression Rating Scale, the Young Mania Rating Scale, the Duke Religious Index, and the Barratt Impulsivity Scale.

Results: The suicide attempters (SA) group had more psychiatric comorbidity ($p=0.007$), more rapid cycling ($p=0.004$), higher levels of impulsivity in all domains ($p=0.000$), and less religious affiliation ($p=0.006$) compared with the non-SA group. In the multivariate analysis, after controlling for covariates, non-organizational religious activities (OR, 0.66; 95% CI, 0.50–0.86) and intrinsic religiosity (OR, 0.70; 95% CI, 0.60–0.81) were associated with less SB.

Limitations: A small sample size, the cross-sectional design that precluded the possibility of assessing cause and effect relationships, and the infeasibility of determining the time lapse between the last suicide attempt and the period when the patients were evaluated.

Conclusion: Non-organizational religious activities and intrinsic religiosity dimensions exert a protective effect against SB in bipolar I outpatients, even when controlling for variables that may affect the outcome in question.

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1. Introduction

Suicide is a major public health issue that results in approximately one million deaths per year worldwide (Pompili et al., 2013; Wasserman et al., 2012). It is estimated that there are 10–40 attempted suicides for each completed suicide (Bertolote et al., 2006). Despite the complexity of this issue and the need for the interaction of multiple factors for suicidal behavior (SB) to

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manifest, the presence of mental illness is one of the most important factors in the occurrence of this outcome (Randall et al., 2014).

Among mental illnesses, bipolar disorder (BD) is one of the illnesses that is most frequently associated with suicide attempts and suicide (Chesney et al., 2014). In the Epidemiological Catchment Area study (ECA), 29% of individuals with BD in the general population made at least one suicide attempt during their lifetime (Chen and Dilsaver, 1996). In clinical samples, 25–56% of patients with BD report at least one suicide attempt during their lives, and 10–19% die by suicide (Costa et al., 2015; Parmentier et al., 2012). For the most part, the focus of research on SB aims to understand the risk factors; however, little attention has been devoted to

investigating the protective factors against SB in bipolar patients (Latalova et al., 2014).

In recent decades, researchers have become more interested in scientifically studying the relationships between religiosity and mental health (Caribé et al., 2015; Moreira-Almeida et al., 2006). Most of the studies that have been conducted to date show that greater religious involvement is positively associated with indicators of psychological well-being and better health (Dein et al., 2012; Koenig et al., 2001). In fact, level of religious involvement tends to be inversely related to depression, SB, drug misuse, impulsivity, and pathological gambling (Casey et al., 2011; Ronneberg et al., 2014; Caribé et al., 2012). With regard to SB, the studies entailed heterogeneous samples of patients presenting with several mental illnesses (Wu et al., 2015). However, what little research there is on patients with mood disorders suggests that religiosity bestows a protective effect against SB in this population (Mosqueiro et al., 2015).

Although the existence of links between religiosity and health appear to be established, much less is known about how these aspects of religious involvement translate into health outcomes. Many mechanisms have been proposed to account for these relationships, with those most commonly mentioned including health behaviors, social support, coping, a sense of meaning in life, hope, positive affect, compassion, and locus of control (Park, 2007). However, the relationship between religiosity and BD continues to be under-investigated, and the hypothesis that religiosity can be relevant both in terms of providing a protective effect and as a provocative element in SB, depressive or manic/hypomanic phases in BD has not been fully supported (De Fazio et al., 2015). Moreover, some studies on BD have included non-homogeneous patient samples, such as BD type I and II, and have used various methodologies, making it difficult to compare the results (Bonelli and Koenig, 2013; De Fazio et al., 2015). Therefore, the objective of this study was to evaluate whether there is an association between religiosity and SB in bipolar I outpatients evaluated only in a euthymic state.

2. Methods

2.1. Participants

The sample was composed of outpatients aged 18 years or older with BD type I according to DSM-IV criteria. All were included during the 2012–2014 period at four specialized centers for the treatment of BD in Brazil: 1-Program of mood and anxiety disorders of the Federal University of Bahia-CETHA-(UFBA), Salvador-Bahia; 2-Interdisciplinary Laboratory of Clinical Neurosciences, Federal University of São Paulo- (UNIFESP)-São Paulo-São Paulo; 3-Laboratory of Molecular Psychiatry, INCT for Translational Medicine, Federal University of Rio Grande do Sul (UFRGS), Porto Alegre- Rio Grande do Sul; 4-Department of Mental Health of the Federal University of Minas Gerais (UFMG), Belo Horizonte, Minas Gerais.

Inclusion criteria were as follows: being in a euthymic state, defined as having scores lower than 7 on both the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960) and the Young Mania Rating Scale (YMRS) (Young et al., 1978) and no mood episodes in the previous two months. The exclusion criterion was difficulty in understanding the questionnaires.

After administering the protocol, the patients were divided into two groups: suicide attempters (SA) and non-suicide attempters (non-SA). The SA group was composed of patients who reported at least one suicide attempt during their lifetime. The information on history of suicide attempt(s) is collected in the questionnaire of clinical and sociodemographic data, which includes presence or

absence thereof, number of attempts and method. A suicide attempt was defined as any act of self-inflicted injury with the intention of causing one's own death.

This study was approved by the local Medical Review Ethics Committee and performed in accordance with the ethical standards established in the 1964 Declaration of Helsinki. In addition, all patients provided written informed consent prior to their inclusion in the study.

2.2. Instruments

This was a cross-sectional study in which data were collected using the same instruments at all centers. Face-to-face interviews were conducted simultaneously with the scale application. The interviews were conducted individually or, when necessary, in the presence of family members. The data gathered from the patients' reports were complemented by the data in the medical chart, as appropriate. The evaluations were performed by psychiatrists who had been trained in using the referred instruments and had more than 5 years of experience in the field. The instruments used are described as follows:

(1) a questionnaire to collect clinical and sociodemographic characteristics; (2) a structured clinical interview with DSM-IV axis I (SCID-I) for the diagnosis of mental illnesses (First et al., 1997); (3) the Duke Religious Index-DUREL-(DRI), a five-item self-report scale that assesses three domains of religiosity: organizational religious activities (ORA), non-organizational religious activities (NORA), and intrinsic religiosity (IR). The ORA domain is measured by one item and defined as the frequency with which one attends formal religious services. The NORA domain is measured by one item and defined as the amount of time spent in private religious activities such as prayer or meditation. The IR domain is measured by three items and conceptualized as the degree to which one integrates one's religion into one's life. Response options were on a 5- or 6-point Likert scale (Lucchetti et al., 2012); and (4) the Barratt Impulsivity Scale (BIS-11), a 30-item self-report measure of impulsivity that includes three subscales: (i) attentional (AI) (problems related to concentrating and/or paying attention), (ii) motor (MI) (fast reactions and/or restlessness), and (iii) non-planning (AP) (orientation toward the present rather than the future) and total impulsivity (TI) (von Diemen et al., 2007). All instruments were validated in Brazilian Portuguese.

2.3. Statistical analysis

The collected data were recorded using the Statistical Package for Social Sciences (SPSS Win, v. 16) and were analyzed in the statistical program Stata v. 9.0. The simple frequencies and percentages of the categorical variables were obtained as well as measures of central tendency (mean) and dispersion (standard deviation) of the numerical variables.

To verify the possible differences in clinical and socio-demographic characteristics between the two groups (SA and non-SA), the chi-square test and Student's *t*-tests were used when appropriate. After this initial analysis, the variables that showed a more significant difference ($p < 0.20$) between the two groups were adjusted in the multivariate regression, apart from religious affiliation, seeing as it is also a religious variable.

In the bivariate analysis, the measure of association (odds ratio [OR]) was estimated using a logistic regression model with a respective confidence interval (CI) of 95% between the religiosity domains (ORA, NORA, and IR) and the outcome variable (suicide attempts). By using a multivariate logistic regression, an adjusted measure was obtained with the variables sex, employment, presence of partner, having children, psychiatric comorbidity, rapid

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