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Research report

Religious involvement in major depression: Protective or risky behavior? The relevance of bipolar spectrum

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ABSTRACT

Background: Religiosity has been reported to be inversely related to depression and to suicide as well, but there is a lack of studies on its impact on bipolar disorder and especially, on depressed patients belonging to the bipolar spectrum.
Methods: As part of the EPIDEP National Multisite French Study of 493 consecutive DSM-IV major depressive patients evaluated in at least two semi-structured interviews 1 month apart, 234 (55.2%) could be classified as with high religious involvement (HRI), and 190 (44.8%) as with low religious involvement (LRI), on the basis of their ratings on the Duke Religious Index (DRI).
Results: Compared to LRI, HRI patients did not differ with respect to their religious affiliation but had a later age at onset of their affective illness with more hospitalizations, suicide attempts, associated hypomanic features, switches under antidepressant treatment, prescription of tricyclics, comorbid obsessive compulsive disorder, and family history of affective disorder in first-degree relatives. The following independent variables were associated with religious involvement: age, depressive temperament, mixed polarity of first episode, and chronic depression. The clinical picture of depressive patients with HRI was evocative of chronic mixed depressive episodes described in bipolar III patients within the spectrum of bipolar disorders.
Limitations: Retrospective design, recall bias, lack of sample homogeneity, no assessment of potential protective and risk factors, and not representative for all religious affiliations.
Conclusions: In depressive patients belonging to the bipolar spectrum, high religious involvement associated with mixed features may increase the risk of suicidal behavior, despite the existence of religious affiliation.

1. Introduction

There is mounting evidence showing that religion may serve as a protective factor against mental health concerns, although potential negative effects were also mentioned in literature (Ellison and Levin, 1998; Nelson et al., 2012). A systematic review on religion and depression found that inverse relationships between religiosity and depression were reported for the majority of the studies, whereas few demonstrated positive relationships (Koenig et al., 2001). Similarly an inverse relationship was generally reported between religiosity and suicide (Colucci and Martin, 2008). This relationship is likely to concern religious affiliation as well as religious commitment, despite some controversial findings in literature (Dervic et al., 2004). Thus far very few studies have addressed the impact of religiosity on bipolar disorder (Gallemore et al., 1969; Mitchell and Romans, 2003; Cruz et al., 2010; Dervic et al., 2011). Gallemore et al. (1969) found no major differences between the religious lives of bipolar patients and those from controls, although the former reported more conversion experiences. The study by Mitchell and Romans (2003) highlighted the salience of religio-spiritual ideas to many bipolar patients and how these ideas may shape the ways in which patients think about their illness. Cruz et al. (2010) reported that, in bipolar I patients, religious commitment was the most pronounced during mixed episodes, but did not assess its potential effect on the suicidal risk which is known to be high during those mood states (Valtonen, 2007). Finally, Dervic et al. (2011) found that, in depressed bipolar patients, suicidal behavior was associated to higher levels of aggression and lower levels of moral or religious objections to suicide.

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The current study was designed to (1) assess the prevalence of religious involvement in a large sample of unipolar and bipolar spectrum patients during an index depressive episode, (2) examine the main characteristics of patients with high religious involvement (HRI) in this population, and (3) determine the positive effects as well as potential risks associated with religious involvement in the latter.

2. Methods

2.1. EPIDEP design and general findings

EPIDEP involved 48 specially trained psychiatrists working in 15 different centers in France. It was scheduled in two phases. In phase 1, 537 patients with major depressive episode (MDE) were recruited by using a semi-structured interview based on DSM-IV subtypes on clinical grounds. Intensity of depression was assessed by the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960) and mood disturbances were self-reported by assessing the Multiple Visual Analog Scales of Bipolarity (MVAS-BP) (Ahearn and Carroll, 1996; Hantouche et al., 2001a).

Religious involvement was assessed with the Duke Religious Index (DRI), (Koenig et al., 1997). The DRI is a 5-item scale that captures information on respondents' involvement in the three major dimensions of religiousness. The first item measures public dimension, the second private dimension, whereas items 3–5 measure subjective or intrinsic religiosity. For items 1 and 2, responses range from 1 (rarely or never) to 6, whereas items 3–5 are rated on a scale from 1 to 5. In phase 2, scheduled an average of four weeks after the first visit, a systematic search for DSM-IV hypomanic episodes was made by using a semi-structured interview. Sociodemographic characteristics, illness course, family history, psychiatric comorbidity and information on affective temperaments were also recorded during the second visit. Family history for mental disorders was assessed according to the Research Diagnostic Criteria family history version (Andreasen et al., 1977). Lifetime comorbidity for anxious, substance use and eating disorders was recorded by using a semi-structured interview based on DSM-IV criteria. Further information on comorbid anxiety disorders was obtained by means of specific interviews (for obsessive compulsive disorder, see Lensi et al., 1996). Self-reporting of affective temperaments (hyperthymic, depressive, cyclothymic and irritable) with four questionnaires was filled out by the patient (Hantouche et al., 2001b).

From the 537 patients included at visit 1, 493 returned at visit 2. Among the latter, 256 were classified as unipolar (UP), 41 as bipolar (BP) I and 196 as BP spectrum (including 144 patients with spontaneous hypomanias and 52 whose hypomanias were associated with antidepressant treatment).

For further details on the methodology and previous findings of EPIDEP, the reader is referred to Hantouche et al. (1998, 2003a), Akiskal et al. (2003a, 2003b).

2.2. Patient selection for the present study

Patients were judged to show "High Religious Involvement" (HRI) when their involvement was found to be high in at least one of the three accepted major dimensions of religiousness, i.e., when they fulfilled at least one of the following criteria on the DRI: item $1 \geq 5$, item $2 \geq 5$, one among items $3–5 \geq 4$. When this was not the case, they were classified as "Low Religious Involvement" (LRI) (Koenig et al., 1997).

2.3. Statistical analyses

For categorical variables, we used χ^2 or Fisher exact test for comparison between groups. For continuous variables with normal distribution, we used a 2-sample *t*-test for comparison between groups; where assumptions of normality were not adequately met, differences between groups were tested using a Mann–Whitney test.

A stepwise logistic regression model was then used to identify factors associated with religious involvement. Based on the results of univariate analyses and literature data, the following variables were entered into the model as independent variables: age, education, religious affiliation, hospitalization, guilt feelings, social desinhibition score, comorbid obsessive compulsive disorder, any religious obsession, any religious compulsion, diagnosis, depressive temperament, comorbid other substance abuse, age at onset, first episode polarity, total number of hypomanic episodes, hypomanic switches with antidepressants, chronic depression, suicide attempts in lifetime, tricyclics in lifetime, valproate in lifetime, unipolar depression and bipolar disorder in first degree relatives.

3. Results

3.1. Patients

From the 493 patients re-examined at visit 2 in EPIDEP, only 424 were included in the current study. The 41 BPI patients were excluded from the present analyses and for 28 patients, religious involvement was not documented. The mean age of the current study population was 46.15 ± 12.50 years. Seventy-two percent were female. The mean number of prior episodes was 6.52 ± 8.85. Multiple hospitalizations were recorded in 31.4%.

3.2. Prevalence

Two hundred thirty-four patients (55.2%) were classified as HRI, the remaining 190 (44.8%) as LRI.

3.3. Sociodemographic aspects

Sociodemographic characteristics of HRI and LRI patients are summarized in Table 1. Compared to LRI, HRI patients were older and showed lower educational levels, whereas they did not differ in regard to gender, marital status, socioeconomic status, employment and religious affiliation.

3.4. Clinical features

Table 2 summarizes the clinical features of the two groups. In comparison to LRI, HRI patients were more frequently hospitalized and showed more suicide attempts during their current depressive episode, whereas they did not differ with respect to psychotic features. They scored higher on the following items of the HDRS: depressed mood, guilt feelings, somatic anxiety and obsessive compulsive symptoms. However, they were comparable on the HDRS total score. They also scored higher on the Social Desinhibition component of the MVAS-BP, but had comparable scores on the other components of this scale, as well as on the total score. As regards comorbidity, HRI patients had higher rates of comorbid obsessive compulsive disorder (OCD), but did not differ from LRI for the other anxious disorders, as well as for comorbid eating or alcohol abuse disorders, despite showing lower rates of comorbidity for other substance abuse. The frequency of religious obsessions and compulsions seen in