



## Original article

# Differences in religiosity among cognitively intact, mildly cognitively impaired, and mildly demented elderly, and its possible relationship with depressive mood



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## ABSTRACT

**Introduction:** According to literature, religious attitudes can enhance cognitive functioning in elders, because it gives the sense of purpose in life. Therefore, due to the controversy among studies, it is of great importance to identify whether religiosity levels are greater in cognitively intact elders compared to participants with MCI as well as in patients with mild dementia irrespective etiology.

**Objective:** This study aims to examine possible differences with regards to religiosity levels between controls, MCI and patients with mild dementia.

**Methodology:** Religiosity was measured using the Systems of Belief Inventory (SBI-15R, Holland, et al., 1998), which was standardized in Greek population.

**Results:** According to the ANOVA test, significant main effect was found for group by means of SBI-15R score  $F(2, 400) = 5.624, p = .004, \eta^2 = .027$ . Post-hoc comparisons showed that MCI participants had significantly higher total religiosity scores ( $M = 35.48, SD = 9.67$ ) compared to the healthy controls ( $M = 31.73, SD = 4.11$ ),  $p = .002$ . Additionally, patients with mild dementia had also increased religiosity scores ( $M = 35.13, SD = 9.09$ ) compared to controls ( $M = 31.73, SD = 4.11$ ),  $p = .010$ . Additionally, Pearson correlation showed significant relationship between GDS with SBI-15R score ( $r = -.221, p = .023$ ) and Religious beliefs & practices subscale ( $r = -.260, p = .007$ ) in patients with mild dementia.

**Conclusion:** Results suggested that MCI participants as well as patients with mild dementia demonstrated higher religiosity levels compared to the healthy controls. Moreover, the total religiosity levels were related with depressive symptomatology only in patients with mild dementia unlike to the other two groups.

## 1. Introduction

Spirituality and religiosity have recently become of particular interest in mental health. Despite these two concepts being strongly associated with each other, they are not the same (Hill & Pargament, 2008). Religiosity involves mainly the belief system and relevant religious behaviors, whereas spirituality is related to a general meaning of life (Popescu, Ghiuru, Spiru, & Stroe, 2013). Nevertheless, most studies about this topic have measured religiosity rather than spirituality (Williams & Sternthal, 2007).

Religiosity is a multidimensional term that is not easy to define (Hackney & Sanders, 2003) because it incorporates differential sub-categories such as emotional, cognitive and behavioral parameters (Hackney & Sanders, 2003). Despite being a vague term, religiosity

constitutes an integral issue among elders, and is used to support themselves and enhance their psychological state (Koenig, McCullough, & Larson, 2001; Koenig, Moberg, & Kvale, 1988; Nelson-Becker, 2005). Taking religiosity as a multifactorial variable, we can make an initial distinction between extrinsic, which involves taking part in organized religious activities and intrinsic, which includes private religious practices such as prayer (Bjarnason, 2007). Additionally, trying to conceptualize religiosity, Bjarnason (2007) states three different religiosity features that is, religious affiliation e.g. Catholic, Christianity, religious activities, such as religious attendance, and religious beliefs, such as believing in the presence of God. Furthermore, other studies (Chaaya, Sibai, Fayad, & El-Roueiheb, 2007; Levin, Chatters, & Taylor, 1995) divided religiosity in three domains, organizational, which involves participating in religious services, non-organizational, including

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praying and fasting, and subjective which depicts how significant is religion for the individual.

However, clinicians usually consider these features to be highly personal and consequently avoid relevant discussions on them with patients, despite the observation that patients often welcome the opportunity to talk about their religiosity.

Lawrence (2003) demonstrated that religiosity constitutes a cornerstone among elderly, giving a deeper purpose in life and a sense of healing because it supports them psychologically (Haugan, 2014), and promotes their well-being (Fry, 2000). Additionally, previous studies have found that religiosity has also a great impact on health outcome (Chaaya et al., 2007; Kaufman, Anaki, Binns, & Freedman, 2007; Popescu et al., 2013). More in detail, religiosity has a protective role in elders suffering from mental disorders, mainly reducing the risk for depression and suicide (Braam et al., 2001; Clements & Koenig, 2014; Nisbet, Duberstein, Conwell, & Seidlitz, 2000). Additionally, taking part in religious activities is positively associated with enhanced cognitive levels in ageing (Fung & Lam, 2013). Lin et al. (2015) proved also that Christianity affiliation protects from dementia risk, mainly in women population and those exercised regularly. Authors also focus on the great value of women's involvement in religious activities.

In line with the previous studies, a longitudinal study conducted by Boyle, Barnes, Buchman, and Bennett (2009) showed that, among community-dwelling elders, having a purpose in life is related to a lower risk of suffering from Alzheimer's Disease (AD) or Mild Cognitive Impairment (MCI). Complementary, Coin et al. (2010) found that higher religiosity levels are correlated with slower cognitive and behavioral decline in patients with Alzheimer disease. Additionally, Agli, Bailly, and Ferrand (2015) refer that increased levels of religiosity and spirituality in dementia enhance the cognitive abilities, or at least keep them stabilized, while at the same time strengthening their coping strategies, which leads to improvement in quality of life.

The fact that there are no previous studies to measure the levels of religiosity among MCI population, except from the study of Boyle et al. (2009) mentioned previously, and taking into account that religiosity in dementia is yet an under-researched field (Doherty, 2006), the current study aims to identify whether cognitively intact elders have indeed higher levels of religiosity, as it was proven by the majority of previous studies, compared to patients with mild dementia, and participants with MCI.

Secondly, the next aim is to study whether there is a relationship between religiosity and depression. According to literature (Chaaya et al., 2007), depression, which is widely associated with memory loss both in MCI and dementia (Panza et al., 2010; Saczynski et al., 2010) is lower in those who have increased religiosity levels. Additionally, Fountoulakis, Siamouli, Magiria, and Kaprinis (2008) found that religiosity levels are associated with lower depressive symptoms in elderly. Therefore, it is worthwhile to identify whether we can repeat this relationship in the three groups of our study.

## 2. Hypotheses

It is expected that patients with mild dementia will demonstrate lower religiosity levels than the other two groups controlling for age. This hypothesis has arisen due to the fact that higher religiosity levels were associated with lower progression of Alzheimer's disease according to various studies (Coin et al., 2010; Kaufman et al., 2007). Conclusively, we intend to find differences between cognitively intact elders and MCI population with patients with mild dementia on religiosity, because there is relevant research that supports this line of reasoning. However, to our knowledge, there are almost no previous studies evaluating religiosity in MCI participants.

Another scope of the current study is to find whether religiosity levels can be related with the demographic profile (age, gender and education status), in each group of our sample. According to literature, demographics, such as higher age (Taylor, Mattis, & Chatters, 1999),

female gender (Meisenhelder, 2003), as well as low education level (Taylor, Chatters, & Jackson, 2007), are increased in elderly. Therefore, we expect to identify whether the findings mentioned above would be replicated in the current study, irrespective of the group which someone belongs.

Secondarily, it is hypothesized that higher religiosity levels will be associated with lower depression scores in the three groups of our sample, as it is supported by the large corpus of the literature mentioned previously.

## 3. Method

### 3.1. Participants

Four hundred and four individuals were included in the study being divided in three groups, cognitively intact elders, elders with MCI, and patients with dementia. Participants were excluded if they had other psychiatric disorders, except from depressive mood/disorder, because this was beyond of the scope of the study, or because they did not complete the questionnaires or the neurological and neuropsychological assessment.

### 3.2. Material

Religiosity was measured using the Systems of Belief Inventory (SBI-15R, Holland et al., 1998), which was standardized in the Greek population by Assimakopoulos et al. (2009). The SBI-15R consists of 15 items rated on a 4 point scale. Ten items assess religious beliefs and practices, and five items measure social activity, in accordance with the purposes of this study. To control for other social activities participants may have been involved in (e.g. volunteering), we asked the participants to report the religious activities they took part, to ensure that effects are indeed religiosity related and not confounded by other types of social engagement.

All participants of the study underwent a neurological examination and neuropsychological assessment by the neurologist and the neuropsychologists of the research team during their clinical visit. Specifically, the diagnostic process included two steps (a) a complete medical evaluation was conducted by a neurologist based on the fMRI and specific laboratory tests (b) neuropsychological examination that was conducted from the neuropsychologist of the team, and included the following tools: the Mini Mental State Examination (MMSE, Folstein, Folstein, & McHugh, 1975; Fountoulakis, Tsolaki, Chantzi, & Kazis, 2000) (cut off score 23/24), the Montreal Cognitive Assessment (MoCA, Nasreddine et al., 2005) (cut off score  $\geq 26$  points), the Functional Rating Scale of Symptoms of Dementia (FRSSD, Hutton, 1990), and the Neuropsychiatric Inventory (NPI, Cummings et al., 1994; Politis, Mayer, Passa, Maillis, & Lyketsos, 2004). Depression levels were measured with the Geriatric Depression Scale (GDS, Yesavage & Sheikh, 1986; Fountoulakis et al., 1999) (cut off score 6/7), and other neuropsychological tests which are included in the neuropsychological evaluation protocol of Greek Alzheimer Association. All these data from each patient were gathered and assessed overall by the members of the team and therefore diagnosis was assigned according to DSM V criteria (American Psychiatric Association, 2013), whereas, the group of MCI participants, specifically amnesic MCI (single- or multidomain) met the diagnostic criteria of Petersen et al. (1999). Afterwards, participants were divided in the three groups.

### 3.3. Procedure

The participants of our sample were recruited at the Greek Alzheimer Association, a day care center in Thessaloniki, Greece. In detail the participants were residents of Thessaloniki who had initially come to the Greek Alzheimer Association to be evaluated as regards their cognitive abilities, either preventively or because they had

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