Geriatric Nursing xx (2017) 1–6

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

Spiritual/religious coping and depressive symptoms in informal caregivers of hospitalized older adults

Luciano Magalhães Vitorino, PhD, RN Post-doctoral research fellow at Faculty of Medicine [a,*], Laryssa Souza Marins, MD student [b], Alessandra Lamas Granero Lucchetti, MD, PhD [c], Ana Eliza Oliveira Santos, RN [d], Jonas Prepossi Cruz, PhD, BSN. [e], Paulo José Oliveira Cortez, PhD [b], Giancarlo Lucchetti, MD, PhD Associate Professor [c]

[a] Federal University of Juiz de Fora, Brazil
[b] Faculty of Medicine of Itajubá, Brazil
[c] School of Medicine, Federal University of Juiz de Fora, Brazil
[d] Federal University of São Paulo, UNIFESP, São Paulo, Brazil
[e] Nursing Department, College of Applied Medical Sciences, Shaqra University, Al Dawadmi, Saudi Arabia

ARTICLE INFO

Article history:
Received 24 January 2017
Received in revised form
30 May 2017
Accepted 2 June 2017
Available online xxx

Keywords:
Depression
Religion and medicine
Spirituality
Caregiving
Coping

ABSTRACT

This aim of this study was assess whether positive and negative spiritual/religious coping (SRC) strategies are associated with depressive symptoms (DS) of informal caregiver (IC) of hospitalized older adults. A cross-sectional study was conducted among 98 IC of hospitalized older adults in the medical clinic of a Brazilian School Hospital. The functionality, Positive and Negative SRC strategies and DS were evaluated. The IC had high average use of SRC, with Positive SRC being more used than Negative SRC. In the unadjusted regression model, Positive and Negative SRC were associated with DS. However, when adjusted for confounding factors, only Negative SRC remained associated with DS. The IC had used their religious and spiritual beliefs as a way to cope with the stress that comes from caring for hospitalized older adults. Although the positive strategy use of these beliefs was more common, only the negative strategies were associated with a higher DS.

Introduction

With the decreased fertility and advances in medicine and health technology, the world population is aging quickly.[1,2] This demographic phenomenon, which is associated with a growing number of chronic diseases and frailty of the older adults, has a direct impact in healthcare.[3,4] Consequently, there is an increase in the number of dependent older adults and an increasing demand for continuous caregivers to assist with daily living activities.[5] These caregivers, mostly informal (e.g., unpaid caregivers who attend a relative or friend who requires supervision or assistance in a state of incapacity),[6] end up suffering a physical,[7] and mental overload,[8] due to the time spent caring for these patients.

These are also important problems in the Brazilian scenario. According to the federal legislation of the Brazilian Ministry of Health, every person hospitalized and having 60 years old or more, is allowed to have a caregiver during all the time of hospitalization, except in cases of medical recommendation or if the patient is in the intensive care unit.[9] This informal caregiver is usually responsible to keep family members and friends informed about the patient's condition, collaborates with health care professionals providing accurate information, perform basic and permitted care within the hospital environment and promote safety and psychological comfort for the hospitalized older adult.[10,11] According to previous studies, these inpatient caregivers are usually middle-aged women with a mean caregiving time of 14 h a day, most often with a relationship with the care-receiver (i.e. son/daughter or wife/spouse) and often exposed to great physical and psychological demands such as, stress and caregiving overload.[12]

In fact, there is a strong association between work overload and a higher incidence of depressive symptoms among informal

Funding sources: Minas Gerais Research Foundation – FAPEMIG, Process Number: 45/2014.
Conflict of interest: Neither of the authors has any conflict of interest.
Addresse of the institution where the work was carried out: Faculty of Medicine of Itajubá, Brazil. Renó Júnior Av., 368, São Vicente, Itajubá, Brazil. Zip code: 37502-138.
* Corresponding author. Luciano Magalhães Vitorino. Olegário Maciel Av., 255, Itajubá, Brazil. 37.550-030
E-mail address: lucianoenf@yahoo.com.br (L.M. Vitorino).

0197-4572/$ – see front matter © 2017 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.gerinurse.2017.06.001

caregivers of older adults,[13,14] a group with higher rates of depression symptoms when compared to the general population.[15] Particularly in the Brazilian context, Neri and colleagues (2011), detected that 20% of the informal caregivers of the older adults had depressive symptoms,[16] while Oliveira et al. (2014) identified that depressive symptoms were associated with quality of life impairment and more hours of care in hospitalized older adults caregivers.[11]

Several factors are associated with distress in caregivers, which include confinement, lack of leisure, lack of help from other family members, poor knowledge of caregiving, caregiver age and guilt for denying patient complaints.[17–19] In addition, spiritual and religious beliefs seem to minimize the distress of caregiving and are often used to address situations of stress.[20–24] In a previous study, spirituality was associated with better psychological adjustment and well-being among 157 family caregivers of Korean older adults with chronic illness.[25] Moreover, religious attitudes were associated with lower caregiving burden in 407 family caregivers of Iranian older adults with stroke,[26] while religious attendance was associated with lower anxiety in 100 caregivers of Brazilian older adults.[11,26]

Within this context, spiritual/religious coping (SRC) stands out. SRC is defined as the process by which the individual, through his spirituality, belief or religious behavior, faces and deals with stressful situations in his/her life.[27,28] SRC may have positive strategies (e.g. search for help and spiritual knowledge and positive attitude towards God) or negative strategies (e.g., dissatisfaction with a religious representative, negative revaluation of God or meaning).[27,28] The literature shows a growing number of studies that strengthens the association of Positive SRC strategies with better outcomes in the physical and mental health of people of all ages.[22,23,28–31] On the other hand, there is also evidence of the association of Negative SRC with major depressive symptoms, anxiety, loneliness, health impairment and quality of life.[23,32–34]

A critical review has shown a high prevalence of the use of SRC strategies among informal caregivers of patients with different types of chronic and critical illnesses.[35] Several studies have shown that caregivers use spiritual and religious beliefs to deal with stressful situations and, when used in a positive way, which occurs most of the time, religiosity is associated with better mental health,[35,36] better quality of life,[11] wellbeing,[35] fewer burdens,[35,36] better caregiver adaptation,[37] and less receipt of mental health services.[35,36] However, if used in negatively way, it can increase levels of depression and worse outcomes among informal caregivers,[35,36]

Despite this evidence, most studies in this field of research are held in North American and European countries, with few studies conducted in the hospital context. Even with these international studies, we have an interest in verifying this association among Brazilian informal caregivers, since Brazil is a very religious country (eight out of ten adults define religion as a very important aspect of everyday life)[38] and little is known about the relationship between SRC strategies and depressive symptoms among informal caregivers of older adults, especially when the older adults are hospitalized. Therefore, the objective of this study was to assess whether Positive and Negative SRC strategies are associated with depressive symptoms of informal caregivers of hospitalized older adults in Brazilian context.

Methods

Study design

An observational and cross-sectional study was conducted between August and November 2014 with informal caregivers of hospitalized older adults in the medical ward of a Brazilian School Hospital. This is a general teaching hospital with approximately 150 beds (35 beds in the medical ward). The main reasons for hospitalization of older adults in the hospital were neurodegenerative, oncological and cardiological diseases. This study was approved by the Research Ethics Committee of the Medical School of Itajubá, in the state of Minas Gerais, under the approval number 523.814. All participants signed an Informed Consent Term.

Eligibility criteria

The study included informal caregivers aged 18 or older who were responsible for most of the care of hospitalized older adults for at least six months; caring for dependent older adults according on the classification of Katz Index with degrees D to G.[39] This means that the care recipient is minimally dependent to bathing and dressing. Informal caregivers where the older adults were independent or partially dependent, or in a serious state of health (hemodynamic instability that prevented the caregiver's attention at the interview), were excluded from the study.

Sample size

Sample size was calculated by using G*Power 3.1.9.2 software,[40] aiming to perform a multiple regression between Beck Depression Inventory and 9 independent variables with a medium effect size ($f^2 = 0.15$), $\alpha = 0.05$ and a power of 0.75. For that purpose, the sample needed was 98 informal caregivers.

To reach the minimum sample required by the sample calculation (n = 98), 133 informal caregivers of older adults hospitalized in the medical ward were invited to participate in this study (response rate = 73.6%). From this total, sixteen were excluded because they were less than 6 months as an informal caregiver, four because they were very psychologically affected by hospitalization or physically exhausted; nine because they did not care for older adults in the degrees D to G by the Katz index,[39] one caregiver for being under 18 and five who had no interest in participating in the study.

Data collection

Data collection was performed while the older adults were asleep or did not need the informal caregivers. The selection of informal caregivers of the older adults was by simple random sampling. Older adult's informal caregivers were selected and invited to participate in this study if patient's medical record number was even. One of the authors collected the data, which was performed on pre-established days in the medical ward. The researcher who was responsible for collecting data searched for the even numbers of all medical records and evaluated if the patient was 60 years old or older and if the care receiver had an informal caregiver. Before interviewing the informal caregivers, the hospitalized older adults were assessed for the degree of dependency. All the caregivers present in the medical ward were evaluated until the desired number was reached based on the sample size (described above). The questionnaires used for data collection lasted 15 to 20 min.

Measures

A questionnaire of Socio-demographic and health characterization of the older adults' informal caregivers was used, which included age, gender, religious attendance (regular - at least once a week; irregular - at least once a month; never), self-reported family income (sufficient for family or not) and time as a caregiver (< 1 year; 1 to 3 years; > 3 years).