



The relationship between religious coping, psychological distress and quality of life in hemodialysis patients

Susana P. Ramirez ^a, Danielle S. Macêdo ^b, Paulo Marcelo G. Sales ^a, Saharoff M. Figueiredo ^a, Elizabeth F. Daher ^a, Sônia M. Araújo ^a, Kenneth I. Pargament ^c, Thomas N. Hyphantis ^d, André F. Carvalho ^{a,*}

^a Department of Clinical Medicine, Federal University of Ceará, Fortaleza, CE, Brazil

^b Department of Physiology and Pharmacology, Federal University of Ceará, Fortaleza, CE, Brazil

^c Department of Psychology, Bowling Green State University, Bowling Green, OH, USA

^d Department of Psychiatry, Medical School, University of Ioannina, Ioannina, Greece

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ABSTRACT

Objective: No studies have evaluated the relationship among religious coping, psychological distress and health-related quality of life (HRQoL) in patients with End stage renal disease (ESRD). This study assessed whether positive religious coping or religious struggle was independently associated with psychological distress and health-related quality of life (HRQoL) in hemodialysis patients.

Methods: This cross-sectional study recruited a random sample of 170 patients who had ESRD from three outpatient hemodialysis units. Socio-demographic and clinical data were collected. Patients completed the Brief RCOPE, the Hospital Anxiety and Depression Scale (HADS) and the World Health Organization Quality of Life instrument—Abbreviated version (WHOQOL-Bref).

Results: Positive or negative religious coping strategies were frequently adopted by hemodialysis patients to deal with ESRD. Religious struggle correlated with both depressive ($r = 0.43$; $P < .0001$) and anxiety ($r = 0.32$; $P < .0001$) symptoms. These associations remained significant following multivariate adjustment to clinical and socio-demographic data. Positive religious coping was associated with better overall, mental and social relations HRQoL and these associations were independent from psychological distress symptoms, socio-demographic and clinical variables. Religious struggle was an independent correlate of worse overall, physical, mental, social relations and environment HRQoL.

Conclusion: In ESRD, religious struggle was independently associated with greater psychological distress and impaired HRQoL, while positive religious coping was associated with improved HRQoL. These data provide a rationale for the design of prospective and/or intervention studies targeting religious coping in hemodialysis populations.

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Introduction

When end-stage renal disease (ESRD) is diagnosed, a patient requires renal replacement therapy, which includes hemodialysis (HD) treatment. Although HD has become a life-prolonging therapy for patients with ESRD, HD patients deal with unique existential dilemmas [1,2]. For instance, ESRD patients on HD might experience conflicts about life and death concerning withholding and withdrawal of dialysis treatment [2,3]. HD patients face major psychological distress [5–7], and the prevalence of depression in the dialysis population is high and is associated with increased mortality [8]. ESRD patients were found more likely to commit suicide than the general population [9]. Furthermore, hemodialysis is associated with a high

prevalence of anxiety symptoms and disorders [5]. Several lines of evidence indicate that patients with ESRD treated with hemodialysis have compromised health-related quality of life (HRQoL) measures when compared to general population norms [9,10].

Individuals coping with the limitations and burden imposed by serious medical illnesses often find hope, meaning and support in their connection to the transcendent [11–13]. Evidences relating religion and spirituality to clinical outcomes are accumulating in the medical literature [12,13]. Most studies point to a positive influence of religion on physical health [13]. In the past decade, several studies have investigated the influence of religiousness and spirituality in ESRD [14–17]. Religious and spiritual beliefs have been shown to be conducive to better HRQoL and satisfaction with life and medical care [14,15]. However, some studies have not revealed a positive association between religious beliefs and religiosity with HRQoL in patients undergoing hemodialysis [16,17]. A recent study suggests that the existential domain of spirituality was moderately associated with several HRQoL domains, whereas only negligible correlations were verified between religiosity

* Corresponding author at: Department of Clinical Medicine, Faculty of Medicine, Federal University of Ceará; Rua Prof. Costa Mendes, 1608, 4º andar, 60430-040, Fortaleza, CE, Brazil.

E-mail address: andrefc7@terra.com.br (A.F. Carvalho).

and HRQoL [18]. Therefore, these mixed findings might be related to the assessment of different religiousness/spirituality constructs.

Distinct from the general concept of religiousness, religious coping refers to how a patient makes use of his or her system of religious beliefs and practices to understand and adapt to stress [19–22]. Patients who use religion to cope with their illness most often rely on positive religious coping, which is characterized by a constructive reliance on faith to promote healthy adaptation (e.g., through “seeking God’s love and care”). Conversely, some patients experience a period of existential turmoil, namely religious struggle [19,20]. Religious struggle refers to tension, question, and conflict about spiritual issues within oneself, with other people, and with the Divine. Religious struggle has been associated with psychological distress, worse HRQoL and increased mortality in patients with a wide range of chronic medical conditions [23–25]. Positive religious coping and religious struggle are not mutually exclusive; use of positive religious coping does not indicate absence of spiritual struggle or vice versa. Negative religious coping and religious struggle refer to the same underlying concept and will be used interchangeably throughout this manuscript.

Although several studies have investigated the influence of religiousness and spirituality in ESRD, no study has investigated the impact of religious coping strategies on psychological distress (i.e., anxiety and depressive symptoms) or HRQoL in ESRD patients in hemodialysis. Furthermore, most investigations on the role of religiousness/spirituality in hemodialysis have been performed in North American samples. Therefore, studies from samples with different cultural backgrounds are needed. Brazil is a predominantly Catholic country in which 94% of the population has a religious affiliation and 84% considers religion very important [26]. The present study investigated the associations of positive religious coping and religious struggle with psychological distress and HRQoL in a Brazilian sample of HD patients. Two specific hypotheses were addressed: (1) positive religious coping would be associated with lower levels of psychological distress symptoms and better HRQoL independently of socio-demographic and clinical variables, and (2) religious struggle would be an independent correlate of anxiety and depressive symptoms and impaired HRQoL.

Methods

Participants and survey

This observational cross-sectional study enrolled a randomly (i.e., through simple random sampling with a computer random number generator) selected sample of participants from three outpatient HD units in Fortaleza, Brazil (these HD units provide treatment for approximately 650 patients). We had added such recruitment process in order to avoid potential selection bias. The sample was recruited between December, 2009 and June, 2010. The study protocol was approved by the ethics committee of Hospital Universitário Walter Cantídio. Following careful explanation of the experimental protocol, each participant signed a written informed consent. Exclusion criteria were hearing impairment, inability to comprehend study instruments (e.g., history of mental retardation and dementia) and unwillingness to participate. Out of the 190 initially approached, 170 patients agreed to participate (response rate: 89.5%). Twelve subjects declined to participate; 5 had history of dementia and 3 had hearing deficits. No information is available for those 20 individuals who did not participate in the study procedures. A final sample of 170 participants answered paper and pencil study measures while at the clinic. The experimental protocol took approximately 1–1.5 h to be completed.

Measures

Socio-demographic and clinical data

Socio-demographic data, namely age, gender, marital status, ethnicity, religious affiliation, educational level (years of education)

and gross monthly income (in US\$ dollars) were accessed at baseline. The underlying etiology of the ESRD was determined by clinical criteria. Kt/V was determined using a second-generation Daugirdas’ formula [27]. Three sequential monthly Kt/V and predialytic creatinine, hemoglobin and albumin concentrations were collected prior to enrollment, and the mean was determined for each parameter. The medical records were checked for a diagnosis of type II diabetes mellitus. Each participant was asked for current smoking status.

Psychological distress symptoms

Anxiety and depressive symptoms were assessed with the validated Brazilian Portuguese version of the Hospital Anxiety and Depression Scale (HADS) [28,29]. An extensive review of more than 700 studies using HADS indicates that it demonstrates good psychometric properties, as it has adequate internal consistency reliability (mean Cronbach’s alpha values across studies >0.80 for both the anxiety and depression subscales) and effectively screen both anxiety and depressive disorders (sensitivity and specificity of approximately 0.80 across studies) among medical samples with a wide range of pathological conditions and from different cultural backgrounds [30]. The HADS consists of 14 items equally distributed between anxiety and depression subscales. Each item is rated on a scale from 0 to 3. A score of eight or more was considered indicative of anxiety and depression, respectively [29]. In our sample, Cronbach’s alpha values for the HADS were 0.81 and 0.83 for the anxiety and depression subscales, respectively.

Religious coping

Pargament and colleagues developed and validated an elaborate questionnaire on types of religious coping [21]. Brief versions of this instrument are currently available [22]. Such measures have been extensively employed in medical research [23–25]. Patients completed the validated Brazilian Portuguese version of the Brief RCOPE [22,31]. This is a 14-item questionnaire that assesses religious coping. The extent to which patients engage in 7 types of positive religious coping and 7 types of negative religious coping was rated on a 4-point Likert scale from 1 (‘never’) to 4 (‘very often’).

Health-related quality of life

HRQoL was assessed with the World Health Organization Quality of Life instrument-Abbreviated version (WHOQOL-Bref) which is a generic instrument composed of 26 items, two of them measuring overall HRQoL [32]. The other 24 items are divided into 4 domains: physical, mental, social relations and environment HRQoL. More specifically, the psychological domain (6 items) includes items such as negative emotions like despair, believing that life is meaningless, and feeling psychologically incapacitated (e.g., inability to concentrate); the social relations domain (3 items) includes items on dissatisfaction with personal relationships, social support, and sexual life; the physical dimension (7 items) includes the experience of physical pain, incapacity to work and get around, and problems with energy and sleep; the environment domain (8 items) includes feeling that one’s environment is unsafe or unhealthy, lack of financial resources and lack of leisure opportunities; finally, the overall HRQoL score asks subjects to rate their general HRQoL and to estimate their satisfaction with their health [32]. Each item is rated on a 5-point Likert interval scale and the scores are transformed on a scale from 0 to 100. A higher score indicates better HRQoL. The validated Brazilian Portuguese version of the WHOQOL-Bref was used [33]. The WHOQOL-Bref has been shown to be a reliable and valid HRQoL measure in HD samples [34]. For instance, the WHOQOL-Bref had good internal consistency reliability in our sample. The Cronbach’s alpha was 0.81 for the entire instrument. The coefficients for each of its domains were: physical 0.78, mental 0.81, social relations 0.76 and environment 0.83.

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