



Resilience and spirituality in patients with depression and their family members: A cross-sectional study

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Abstract

Objective: The degree and quality of resilience in patients with depression have never been investigated in the context of remission status, spirituality/religiosity, and family members' resilience levels, which was addressed in this study.

Methods: This cross-sectional study recruited Japanese outpatients with depressive disorder according to ICD-10 and cohabitant family members who were free from psychiatric diagnoses. Resilience was assessed using the 25-item Resilience Scale (RS). Other assessments included the Montgomery-Asberg Depression Rating Scale (MADRS); the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT) and Kasen et al.'s (2012) scale for spirituality/religiosity; and the Rosenberg Self-Esteem Scale (RSES).

Results: One hundred outpatients with depression (mean \pm SD age, 50.8 \pm 14.5 years; 44 men; MADRS total score 9.8 \pm 9.0) and 36 healthy family members (mean \pm SD age, 56.5 \pm 15.0 years; 18 men) were included. Symptom severity, attendance at religious/spiritual services, and self-esteem were significantly associated with RS scores in the patient group. RS total scores were significantly higher in remitted patients compared to non-remitted patients (mean \pm SD, 112.3 \pm 17.1 vs. 84.8 \pm 27.7, $p < 0.001$). No correlation was found in RS total scores between patients and their family members ($p = 0.265$), regardless of patients' remission status.

Conclusions: Resilience may be influenced by individual characteristics rather than familial environment; furthermore, self-esteem or spirituality/religiosity may represent reinforcing elements. While caution is necessary in extrapolating these findings to other patient populations, our results suggest that resilience may be considered a state marker in depression.

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1. Introduction

Resilience refers to a person's ability to successfully adapt to adverse life events or psychological stress, recover, and maintain one's healthy mental state [1,2]. Resilience is reported to play an important role in both the prevention and treatment of various psychiatric disorders, including depression [3–5]. One cross-sectional study of 810 middle-aged

and older adults showed that a higher resilience level was associated with a lesser degree of depressive symptomatology [6]. However, it remains unclear whether resilience is a state or trait marker in patients with clinical depression [7], and to the best of our knowledge, no studies have evaluated the degree of resilience in association with remission status. In addition, data is scarce regarding the impact of spirituality and religiosity on resilience in depression. While recent scholarship has recognized the positive influence of religious involvement on the prevention of depression in Judeo-Christian countries [8], we are unaware of any studies that have tackled this issue in non-Judeo-Christian countries. The attention to other religious backgrounds is crucial in light of potential differences in the role religion plays in different

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cultural contexts. For example, in Japan, although Buddhism and Shintoism are still common, practitioners are relatively secular compared to Christians in Western countries. Given this difference, the impact of religion and spirituality on resilience levels may be lower.

Family environment is also expected to play a role in patients' resilience levels. Three studies have investigated resilience levels in the family members of patients with mixed psychiatric diagnoses [9–11], but no study has focused on the associations between patients' and family members' resilience levels specifically in depression. In addition, previous studies have focused solely on self-rated scales to assess illness severity [5,12,13]. In light of potential discrepancies between self-rated (subjective) and observer-rated (objective) symptomatology, it would be ideal to compare both perspectives to identify elements relevant to resilience levels in depression.

To fill this gap in the literature, we conducted a cross-sectional study to investigate characteristics and correlates of resilience in patients with depression and their family members. The primary objective was to examine the degree and quality of resilience in patients with depression in association with their illness severity and spirituality/religiosity. The secondary objective was to examine the association of resilience levels between patients and their family members.

2. Materials and methods

2.1. Study design and participants

This cross-sectional study was conducted at ten psychiatric hospitals and clinics in Tokyo and Saitama, Japan (Ohizumi Hospital; Komagino Hospital; Ongata Hospital; Inokashira Hospital; Ohshima Medical Center; Ohizumi Mental Clinic; Asakadai Mental Clinic; Aoyama Shibuya Medical Clinic; Azumabashi New Tower Clinic; and Sakano Clinic). This study was approved by the institutional review board at each participating site, and all subjects provided written informed consent after receiving detailed information about the protocol.

Subjects were eligible if they were outpatients 18 years of age or older, who fulfilled the criteria for a depressive episode (F32) or recurrent depressive disorder (F33) according to the International Classification of Disease and Related Health Problems, 10th Revision (ICD-10) and were capable of providing informed consent. Patients with a history of epilepsy or organic mental disorders, mental retardation, active substance abuse, or those judged to have active suicidal ideation or severe physical impairments by their treating psychiatrists were excluded.

The primary assessment scale in this study was the 25-item Resilience Scale (RS) [6,14]. All items are scored on a 7-point scale with a total score ranging from 25 to 175; higher scores indicate greater levels of resilience. Subjects were further evaluated with the Montgomery-Asberg

Depression Rating Scale (MADRS) [15,16]; the Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR) [17,18]; the WHOQOL-BREF instrument (QOL) [19,20]; the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT-Sp) [21,22]; the assessment of daily religious practice (two items that evaluate the attendance item, or the attendance at any religious or spiritual services, and the importance item, or the importance of religion or spirituality, respectively) [8]; the Perceived Deficits Questionnaire (PDQ) [23]; the state-trait anxiety inventory (STAI) [24,25]; the NEO-Five Factor Inventory (NEO-FFI) [26,27]; the Rosenberg self-esteem scale (RSES), [28,29]; and the Multidimensional Scale of Perceived Social Support (MSPSS) [30,31]. Descriptions of these scales are summarized in Supplementary Table 1. The PDQ was translated into Japanese by two authors (CO and YM) and then back-translated into English by another two (EBR and HU), who were not aware of the content of the original English version. The scale's developer (M. J. Sullivan) confirmed the back-translated version with regard to accuracy and context.

In cases where subjects lived together with family members or other individuals, cohabitants were also asked to participate in the study. If patients cohabitated with two or more individuals, the patient determined who should be approached. Family members or other significant others were eligible for this study if they were 18 years of age or older, capable of providing informed consent, and had no history or presence of psychiatric disorders, mental retardation, substance abuse, epilepsy, organic brain disease, or severe physical impairments. Following written informed consent, cohabitants were asked to complete the following self-rated assessments: QIDS-SR, RS, QOL, PDQ, STAI, NEO-FFI, RSES, and MSPSS. Additional information collected from patients and family members included age, sex, duration of illness, occupation status (student, paid employment, retired, or unemployed), religious denomination, years of education, marital status, presence of cohabitants (family members or other individuals), and prescription medications.

2.2. Statistical analysis

Multiple linear regression analysis (forced entry model) was performed to identify factors that were associated with RS total score in the patient group. The following factors were included as independent variables: age, sex, duration of illness, item scores in the attendance at any religious or spiritual services (attendance) and the importance of religion or spirituality (importance), RSES total score, MSPSS mean score, and either the MADRS or QIDS total score.

Next, RS total and FACIT-Sp scores were compared between patients who were remitted and those who were not, where remission was defined as a total score of 9 or less on the MADRS [32] or a total score of 5 or less on the QIDS [33], using a Student's *t*-test. These patients were referred to as MADRS-remitted and QIDS-remitted patients, respectively.

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