Research Article

Depression, Religious Coping and Quality of Life in Chronically Ill Patients

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Abstract

The present study examined the relationship among depression, religious coping activities and quality of life in chronically ill patients suffering from type II diabetes, cancer and coronary heart diseases. Study also investigated whether the chronic illness is the predictor of quality of life, depression and religious coping. It was hypothesized that, there is relationship among quality of life, depression and religious coping in chronically ill patients, there is likely to be negative relationship between quality of life and depression, there is likely to be positive relationship between religious coping and quality of life, Quality of life is likely to predict religious coping activities and depression in patients, there are likely to be differences between three groups of patients (diabetes, cancer and cardiac) on depression, religious coping and quality of life. A sample of 90 patients (30 each from cancer, heart and diabetes groups, 15 men and 15 women) was taken from Sir Gangaram hospital. Their age ranged from 35 to 58 years and mean score for men was 49.00 (SD=6.81) and for women was 47.36 (SD=6.81). Quality of life scale (Flanagan, 1982), brief RECOPE and Center for Epidemiological Study Depression Scale, was used for assessment. Urdu version of scales was used. Cross sectional research design was used. e. Result analyzed using descriptive statistical analysis, correlation, MANOVA and Hierarchical Regression. The result showed that depression effect religious coping and quality of life in chronic patients as when depression high the quality of life will be low. The result also showed that quality of life is the predictor of positive religious copings and depression. The multiple analyses of variance showed that there are differences between three groups of patients on depression and quality of life but not on religious coping. ***ASEAN Journal of Psychiatry, Vol. 23(8), August, 2022; 1-8.***

Keywords: Depression, Religious Coping, Quality of Life, Chronically Ill Patients

Introduction

Dejection and unusual sadness are characteristics of emotional state which is known as depression [1]. A range of associated behavioral, physical, cognitive and emotional symptoms, low mod and absence of a positive affect characterize a wide range of mental health problems which are referred by depression. It is problematic to differentiate the mood changes between those occurring 'normally' and clinically important degrees of depression. On a continuum of severity, symptoms of depression can be best considered [2]. Through certain medications, exercise and diet, some illnesses can be cored but chronic sickness is a condition that cannot be cured totally and lasts for a very long time. Multiple sclerosis, lupus, HIV/AIDS, kidney disease, diabetes, arthritis and heart disease are examples of chronic sickness [3].

Depression was caused and aggravated not only by chronic physical health problems but depression can also cause chronic physical health problems in reverse direction [4]. There was an interaction between physical health problems and major depression [5]. Physical health problems

risk factors such as sedentary lifestyle, smoking and fatness were linked with childhood adversity and major depression. Burden of the disease was increased by poorer self administration of chronic physical health problems related to depression. Physical illness had an association with the functional impairment. Similarly, risk of worsening and emerging depression may be increased with oblique path physiological factors e.g. cytokine levels or other inflammatory factors. Approximately 20% new onsets of anxiety and depression were linked with first hospitalization with a heart attack and the year after the diagnosis of cancer in clinical population [5]. Depression would be triggered by any illness in which hopelessness and helplessness of an individual increased (Kisch, 2011). It was easy to overlook depression because chronic illnesses were impersonated by change in energy levels or fatigue which was symptoms for depression [6].

Many studies have been conducted to find out the relationship among depression and chronic diseases. In a study conducted by Erin and colleagues (2008), found that quality of life in diabetic patients noteworthy worsening was seen due to the existence of depression. Studies conducted by Jacobson, Alan, Weinger, and Katie, 1998; Prince and colleagues, 2007 explored the relationship between chronic diseases like heart, diabetes and depression and found that a higher rate of diabetic complications and poorer blood glucose control is associated with depression and in this way stroke andcoronary heart disease was persistent physical health problems which were developed due to constant evidence for depression.

Among Muslim populations more than a few studies on religious coping have been reported. A comparison between Swedish and Egyptian people was made for the use of religious coping, God will help them is a belief of 37% of Swedish and 92% of Egyptian patients having cancer. Few respondents showed that their headaches were controlled by reciting verses of Quran [7]. A study conducted by Fitchett et al, (2004) on cancer, heart and diabetes patients. The aim of this study was to examine the prevalence and correlates of religious struggle in three groups of medical patients, diabetic outpatients, congestive heart failure and oncology inpatients. Half of the total sample (52%) reported no religious struggle, while 15% reported moderate or high levels of religious struggle, while those who attended worship most frequently had lower levels of religious struggle.

The worth of every form of religious activity in coping with depression was believed less strongly by any other belief groups than Muslims. This was shown in an analysis made for depressed people among Muslims, Christians, Hindus, Jews, the non-religious and, followers of other religions by Loewenthal and colleagues (2001). There is a connection between less depression and religious attachment and stronger perception of the significance of faith [8]. In disaster, bodily communal and the psychological amendment of people could be affected by religious/spiritual methods of coping, was proved by a large body of empirical support [9]. As number of factors have been associated with psychological health of every person either male or female as well as normal or patients revealed by literature [10]. So the current study is a significant contribution by exploring the relationship among quality of life, depression and religious coping in chronically ill patients. The study also highlighted the differences in three groups of patients heart, cancer and cardiac patients regarding depression, religious coping activities and quality of life.

Hypotheses

HI: There is likely to be relationship among quality of life, depression and religious coping in chronically ill patients.
HII: There is likely to be a negative relationship between quality of life and depression.
HIII: There is likely to be a negative relationship between religious coping and depression.
IV: There is likely to be positive relationship between religious coping and quality of life.
V: Quality of life is likely to predict religious coping activities and depression in patients.
VI: There are likely to be differences between three groups of patients (diabetes, cancer and cardiac) regarding depression, religious coping and quality of life.

Method

Research Design and Participants Description

Cross sectional research design was used to explore the relationship among depression, religious coping and quality of life in chronically ill patients.The sample size comprised of 90 middle age men and women with chronically ill diseases. Their age ranged from 35 to 58 years and mean score for men was 49.00 (SD=6.81) and for women was 47.36 (SD=6.81).

Participants were taken from Sir Ganga Ram hospital, Lahore [11].

Assessment Measures

The quality of life scale

American Psychologist Flanagan developed the quality of life scale (1970). It consisted of 16 items. It is a Likert type seven point scales. The seven responses are "overjoyed" (7), "happy" (6), "mostly contented" (5), "miscellaneous" (4), "mostly discontented" (3), "sad" (2), "horrible" (1) are seven responses of this scale. For all work undertaken to adapt the scale for use in American chronic illness populations, the 7-point delighted-terrible scale was used to measure contentment with an item [12]. The reliability of this scale is 0.78 to 0.84. This scale was translated into Urdu from source English language. The procedure of the translation of scale was according to the instruction and procedure described in Linguistic validation methodology by MAPI (2008) institute.

Center for epidemiological studies depression scale

CES-D has 20 items which measure the depression for the past 7 days. The response options are from not at all (0) to very severe (3). The reverse items of this scale are 4, 8, 12 and 16. The Urdu translation version of the scale was used done by (Naz&Rukhsana, 2012). The cut off score of CES-D is 16. The reliability of this scale has been reported from .85 to .90 across studies (Radloff, 1977).

Brief RECOPE Scale

It contains 21 subscales which include a inclusive, functionally oriented measure of religious coping and each subscale consisting of five items (105 items total). It is brief form of RECOPE scale which consisted of seven positive points and seven negative points. Subjects point out the scope to which they use particular religious methods of coping with a negative event on a four-point Likert scale ranging from 0 "not at all" to 3 "a great deal." . Cronbach's alpha coefficient estimates were .90 and .87 and .81 and .69 for the positive and negative scales. This scale was translated into Urdu from source English language [13].

Procedures

A formal permission was taken from the authors for using the questionnaire to obtain the data.To formally commence the study an authority letters was taken from the department of Applied Psychology and signed by the supervisor to collect the data [14]. After getting the official permission, data collection was started. Consent form was prepared and finalized to obtain individuals willingness to participate in the study. In this form it was clarified that information obtained from the participant would be used only for research purpose and the purpose of the research study was explained in detail to the participants. Multiple visits were paid by the researcher to the hospitals to collect the data. After the lengthy process of data collection, the questionnaire was scored and quantitatively coded [15].

Ethical Considerations

The permission was taken from authors to use scales. The consent form was given to the participants.The nature as well as the purpose of the study was explained to the participants before administration of the questionnaires.The information which gained from the participants was not disclosed by the researcher [16].

Results

The study explored the relationship among depression, religious coping activities and quality of life in chronically ill patients (hear, diabetes and cancer (Table 1). Pearson product moment correlation was run to find out the relationship among study variables [17].

Table 1. Correlation between depression, positive religious coping, negative religious coping and quality of life

Variables	CESD	RC(p)	RC(n)	QOL
CEDS		-.31**	.36**	-0.52**
RC(p)				.34**

RC(n)				-.21*
QOL				

Note: *p<.05, **p<0.01: CSED = Centre for epidemiological depression scale, RC (p)=Positive religious coping, RC (n)=Negative religious coping, QOL=Quality of life.*

Result shows highly negative correlation between depression and positive religious coping (Table 2). Result also shows positive relationship between depression and negative religious coping [18]. Result show negative correlation between depression and quality of life which means if depression high the quality of life will be low (Table 3). Negative religious copings show negative relationship with quality of life. The study also examined the prediction and association among different variables. For this Hierarchical Regression Analysis was used [19].

Table 2. Hierarchical Regression Analysis for Quality of Life in Chronically Ill Patients (N=90)

Predictors		R^2	ΔR	**B**
Step 1	**Constant**			
	Age in years	0.11	0.08	0.07
	Gender			-.31**
	Education			-0.05
Step 2	Constant			
	Age range of all groups	0.25	0.2	0.03
	Gender			-.35***
	Education			0.02
	Totalnegative R.C			-0.07
	Totalpositive R.C			.35***
Step 3	Constant			
	Age range of all groups	0.4	0.35	0
	Gender			-.30***
	Education			0.05
	Totalnegative R.C			0.04
	Totalpositive R.C			.26**
	Depressiontotal			-.43***

Note: **p<0.01,***p<0.001 RC=Religious Coping*

Result indicated that quality of life shows significant association with gender F (3, 86)= 3.595, p<0.01, 0.01. The result also showed that quality of life is the predictor of positive religious copings F(5, 84)=5.60, p<0.01, 0.01 and depression F (6, 83)=9.29., p<0.01, 0.01.

Table 3. MANOVA for Depression, Religious Coping and Quality of Life in Cancer, Heart and Diabetes patients (N=90).

Predictors		R^2	ΔR	**B**
Step 1	**Constant**			
	Age in years	0.11	0.08	0.07
	Gender			-.31**
	Education			-0.05

Step 2	Constant			
	Age range of all groups	0.25	0.2	0.03
	Gender			$-.35^{***}$
	Education			0.02
	Totalnegative R.C			-0.07
	Totalpositive R.C			$.35^{***}$
Step 3	Constant			
	Age range of all groups	0.4	0.35	0
	Gender			$-.30^{***}$
	Education			0.05
	Totalnegative R.C			0.04
	Totalpositive R.C			$.26^{**}$
	Depressiontotal			$-.43^{***}$

Note.****p<0.001,SS=sum of squares: DF=degree of freedom: MS=mean square: Positive religious coping, RC(n)=Negative religious coping, QOL=Quality of life.*

Results show there is statistically significant difference between cancers, heart and diabetes patients on depression and quality of life and there is no significant difference regarding to negative and positive religious copings [20]. Post hoc analysis shows that there was significant difference between diabetic and heart patients on depression $p<0.05$ but result show no significant differences between heart and cancer patients $p>0.05$. On quality of life there were significant differences between diabetic and heart patients $p<0.05$. There were significant differences between diabetic and cancer patients $p<0.05$, but there were no significant differences heart and cancer patients $p>0.05$.

Important Findings

There is highly negative correlation between depression and positive religious coping and positive relationship between depression and negative religious coping. It is also finding that there is negative correlation between depression and quality of life which means if depression high the quality of life will be low.

There is positive relationship between positive religious coping and quality of life according to result. Negative religious copings show negative relationship with quality of life. It is also find out that negative religious coping has significant association with depression while it is not predictor of quality of life, as well depression has significant association with quality of life and negative religious coping while it is not a predictor of positive religious coping. According to MANOVA analysis there is significant difference between cancers, heart and diabetes patients regarding to depression and quality of life and there is no significant difference regarding to negative and positive religious copings.

Discussion

The study highlighted the relationship among quality of life, depression and religious coping in chronically ill patients and to see the association of depression and quality of life with chronically ill patients. Furthermore the research will explore differences in three groups of patients (heart, cancer and cardiac patients) regarding depression, religious coping activities and quality of life. According to results there is negative correlation between depression and positive religious coping.

It means the positive religious coping high the depression will be low. A study conducted by Jeffrey and John (2007) to investigate the potential moderating effects of positive and negative religious coping patterns on the relationship between negative life events and psychological functioning supported the both findings as they found negative events were related to increased use of positive and negative religious coping and decreased psychological functioning. Moreover, negative events and positive religious coping produced an interaction effect on depression, such that the high use of

positive religious coping buffered the deleterious effects of negative events. Negative religious copings show positive correlation with depression which means if negative religious coping high than depression will be high in patients. In oncology patients, diabetic outpatients and Coronary Heart Failure (CHF) outpatients, higher level of depressive symptoms and emotional distress were related to negative religious coping. Indeed, those who used positive religious coping had a lower level of distress, while participants with negative feelings toward God had a higher level of distress. The findings of this study are consistent with previous research indicating a positive relation between well-being and positive religious coping methods.

There is positive relationship between positive religious coping and quality of life according to result. Several results indicated religious involvement to be modesty but meaningfully associated with psychosocial adjustment, various dimensions of health related quality of life and beneficial strategies in cancer patients.

According to findings of this research there is significant difference between cancer, heart and diabetes patients regarding to depression. Different researchers conducted researches on cancer, heart and diabetes patients and conclude prevalence of depression among people with diabetes ranges from 8.5% to 32.5%, Clinically significant depression was present in 21.5% of heart failure patients, depression is a co morbid disabling syndrome that affects approximately 15% to 25% of cancer patients. But there is significant difference between cancer, heart and diabetes patients regarding to quality of life.

Health related quality of life measures the effects of an illness or a treatment from the patient's perspective. Cancer, heart and diabetes affect the patient quality of life in different way. According to me economic background also affects the patient’s quality of life in different way. The patients who are economically low having poor quality of life and who are economically high have better quality of life. In this way that there is no significant difference between cancer, heart stressful life events. Different peoples have different level of religious coping in their illness. Some peoples have very strong religious beliefs and face their illness with patience and humble. If the physicians handle the patients according their way of religious coping it can be make their treatment very effective.

and diabetes patients regarding to positive and negative religious coping. Because according to me Muslims everywhere in the world use positive religious coping in chronic illness and avoid negative religious coping as being a Muslims. Previous researches also support this result, a study conducted by Taylor (1999) on religious coping in which he compared the responses of different patient groups to an open ended question. He asked 120 participants with cancer, diabetes or severe mental illness to list up to five ways in which they currently coping with their illness. Overall 35 (29.2%) of the participants spontaneously indicated at least one religious coping responses.

Limitations/suggestions/recommendations for future research

The permission process was very lengthy and time consuming. Time was too short to conduct this type of research. Sample was too small, include uneducated people and less cooperative. I take very short sample for my thesis which includes both educated and uneducated peoples. Because of uneducated sample it is very difficult for me to fill my questionnaire. If the sample of my thesis is large and all peoples are educated the results will be better.

The result of this thesis can be very useful in the medical field e.g. physicians can be used at the time of assessment and treatment of the patients. The physicians should know about the effect of quality of life on patient’s diseases or the effect of illness on patient’s standard of life so they can treat or handle the patients accordingly. The result thesis can force to know about the economic issues of the patients.

Depression has very deep effect on patient’s illness and it is mostly present in chronic illness. If the physicians know about the intensity of depression in patients they can treat the patients in better way and I hope the result of this thesis help the physicians to know how depression can affect the quality of life and religious beliefs of the patients. Religion plays very important role in the way of coping in chronic illness and other

Implications of the findings

The findings from the present research are important for patients to understand that depression will lead toward low quality of life. The findings are also important for patients to

understand that more the more the depression they less think about religion and as a result their depression will be high and quality of life will be low. The findings are also important to help us understand that lower the life satisfaction the more will be depression among cancer, heart and diabetes patients. The findings also help the caregivers of the patients how to care them according to their level of depression and their religious coping. The findings also help the authority of hospitals how to deal patients and their caregivers.

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