Can Faith Protect From Emotional Distress After Stroke?

Salvatore Giaquinto, MD; Cristiana Spiridigliozzi, MSc; Barbara Caracciolo, MSc

Background and Purpose—Emotional distress is common in the aftermath of stroke and can impact negatively on the outcome. The study was aimed at evaluating whether religious beliefs can protect from emotional distress.

Methods—Data were collected from 132 consecutive inpatients who were hospitalized for stroke rehabilitation and met the research requirements. At admission all study participants received a semi-structured interview on religious beliefs (Royal Free Interview for religious and spiritual beliefs) and were assessed on their mood with the Hospital Anxiety and Depression Scale. The relationship between religious beliefs and mood was explored, adjusting for possible confounders.

Results—Subjects with over-threshold Hospital Anxiety and Depression Scale scores had significantly lower Royal Free Interview scores (odds ratio, 0.95; CI, 91 to 98). The direction and magnitude of the association did not change after adjusting for possible confounders (odds ratio, 0.95; CI, 91 to 98). The same pattern was observed when analyzing separately Hospital Anxiety and Depression Scale anxiety and depression subscales. The other significant variable was functional dependence.

Conclusions—The strength of religious beliefs influences the ability to cope after a stroke event, with stronger religious beliefs acting as a possible protective factor against emotional distress. (Stroke. 2007;38:993-997.)

Key Words: rehabilitation ■ stroke

Emotional distress is a relatively frequent complication after stroke. In particular, poststroke depression has been the topic of many studies. The pooled estimate is 33% (95% CI, 29% to 36%). Differences in the case mix, inclusion criteria, and methods of assessment can make results different across studies.1,2 A recent Italian study found poststroke depression in 36% of stroke survivors.3 The small population size which is usual in this strand of literature does not allow reliable models and only stroke severity is associated with depression.2,4,5 However, female gender and previous cerebrovascular or depressive episodes, but not site, were also associated variables.3 According to the Swedish national quality assessment register Risk-Stroke, antidepressant medication is used by 22.5% of men and 28.1% of women who experienced a stroke.6

Poststroke depression negatively affects outcome either during hospitalization or after discharge.7,8,9 Therefore, this issue is important in rehabilitation and deserves a deeper insight. So far, physical variables as well as health history were considered in the literature, whereas faith has never been studied. Faith is an overall concept. Spirituality and religiosity are more focused concepts, but they are not synonymous. Spirituality is concerned with the transcendent with addressing ultimate questions about life’s meaning, assuming that there is more than what can be seen or understood.10 The concept is generally taken to mean believing, valuing, or being devoted to some high power outside the corporeal world. By contrast, religiosity involves a doctrinaire system that is shared by other people. Religious participation rather than spirituality may account for beneficial effects on health and survival, because religiousness is linked to a group of worshippers sharing doctrine, communication, control, and habits. Therefore, social participation, rules, style of life, dietary restrictions, and moderation can explain the benefits.

Regarding inpatients after stroke, there have been no systematic investigations and no studies of managed care networks. Yet religious experience is not only part of multiculturalism but also consistent with the overall direction of postmodern culture.11 It is surprising that only a few articles on stroke are found,12 mainly addressing the question of benefit mechanisms of attending religious services. Yet some articles already outlined the role of religion and spiritual beliefs in rehabilitation units.10,13 According to the authors, spiritual and religious beliefs are probably important to many rehabilitation patients because life satisfaction and quality of life can be positively influenced.

When a patient is referred to a rehabilitation center, a stressful occurrence takes place, ie, an event or a series of events or life conditions that demand adjustment. The complex of stimuli, perception, and reactions to internal and external demands challenge the organism’s adaptation resources. In Pargament’s model,14 people appraise stress-producing events using primary appraisal (“Is the event...}
potentially harmful?”) and secondary appraisal (“Can I cope with it?”). A stress reaction may ensue depending on various mediators such as social support, personal hardiness, and problem-solving style. Empirical research on the role of religion in counseling has increased considerably. Religious and nonreligious people tend to experience the same amount of stress, but religion may help people deal better with negative life events and the attendant stress. Religious community is like a shelter where prevention, promotion, and mutual collaboration foster coping strategies against negative events of life.

More than 40% of hospitalized medically ill elderly people spontaneously reported that the religious faith was the most important factor that enabled them to cope. Recent articles have emphasized the importance in medicine of religion and spiritual involvement in better health outcome, including greater longevity and coping skills even during terminal illness, and anxiety, depression, and suicide attempts decrease. The results endorse the view in the field of mental health that religion has a positive role. Although religiosity appeared to be unrelated to stress among caregivers of patients with dementia, one stressor, namely feelings of role overload, was correlated with greater levels of self-perceived religiosity. Spirituality positively influenced recovery after acute myocardial infarction and improved survival in women with breast cancer. People who attended church once per week presented a 32% reduction in the risk of mortality as compared with those who never attended religious services. Successful aging is also considered to be influenced by positive spirituality, the so-called forgotten factor, and leaders in gerontology are criticized when they fail to consider its growing evidence. The previous research leads to conclude that faith has a positive influence in several fields of medicine. However, the issue of poststroke emotional distress was never considered. Thus, our research was aimed at verifying whether emotional distress is less in people with strong religious and spiritual beliefs.

Materials and Methods

Subjects
One hundred sixty-two consecutive Italian patients were enrolled after their first stroke in the time period 2004 to 2005. They were referred to the rehabilitation center from district hospitals. The mean interval between the stroke and the admission was 9 days (SD, 2.3). General and neurological examination, routine tests, CT scan, and/or MRI were executed in all patients to confirm diagnosis before the rehabilitation program. Exclusion criteria were: (1) a previous stroke, but a previous transient ischemic attack was accepted; (2) subarachnoid hemorrhage; (3) admission for rehabilitation >3 weeks after stroke; (4) severe comorbidity; (5) mental impairment; and (6) comprehension impairment. The patients were treated only with those drugs that were strictly necessary. No psychoactive drugs were used. Data were collected from eligible 132 inpatients, with 60 men (57.5%) and 72 women (42.5%). Mean age was 70.0 years (SD, 10.3). The mean education was 7.6 years (SD, 3.9). The stroke was ischemic in 108 cases (81.8%) and hemorrhagic in the others. The median Scandinavian Stroke Scale score was 41 (range of the scale 0 to 58, with lower scores indicating worse status). The lesion site was in the right hemisphere in 72 patients and in the left in 44. Patients with language comprehension were not included. The middle cerebral artery territory was involved in 80.2% of cases, whereas the anterior and the posterior cerebral artery territories were involved in 6.3% and 13.3%, respectively.

History of depression is an important issue, but the data collection can be biased by either underestimation or overestimation. We applied the criteria to check medical prescription in the time period before the stroke and found that only 5 patients had been treated with antidepressants (3.78%).

Scales
The Mini Mental State Examination was used to measure cognition. Subjects scoring at least 24/30 were considered nondeteriorated and therefore were enrolled in the study.

Comorbidity was assessed by means of the Cumulative Illness Rating Scale, which is an ordinal scale, in which each item is scored from 1 (normal) to 5 (life-threatening situation). Patients scoring >3 in any item and those having a comorbidity index > 3 were not included.

Dependence was assessed by means of the Functional Independence Measure scale. The worst disability is scored 18, whereas a score is 126. We applied no cut-off score for selection. Table 1 shows the distribution in our population sample.

With regard to aphasia, we used a scale adapted to the Italian population. According to this scale, patients scoring <18 in auditory comprehension were not enrolled. The instrument is brief, simple, and can be administered even in the acute stage. Scoring is adjusted for age and education on the basis of values obtained from 103 control subjects.

Spiritual and religious beliefs were assessed by means of the Royal Free Interview (RFI). The instrument has high criterion validity, predictive validity, internal consistency, and test-retest reliability. A translated and validated version into Italian was used. High scores indicate strong religious and spiritual belief. The scale consists of a section for demographic data and a second section for the clinical assessment. The third section follows a branching format and has questions about religious and spiritual beliefs and philosophical understanding. After a paragraph of instructions, there are 20 questions. Two scales are derived from the survey, a scale measuring spiritual and religious belief and a philosophical scale.

The Hospital Anxiety and Depression Scale (HADS) is a self-assessment scale to measure both anxiety and depression. Higher scores mean higher psychological distress. The cut-off scores are fixed at 5 for the partial scores and at 10 for the total score. Equivalent or higher scores classify subjects as psychologically distressed. The subscales are also valid measures of severity of the emotional disorder.

Variables
For all analysis, HADS total score and anxiety and depression subscores were dichotomized according to the recommended cut-offs. RFI score was entered as a continuous variable, with higher scores indicating higher levels of reported religious beliefs and engagement in religious activities. Variables considered as possible confounders were: age (attained years), education (number of years of formal education completed), marital status (married versus not or no longer married), living conditions (living alone versus living with

<table>
<thead>
<tr>
<th>TABLE 1. Patient Sociodemographic Characteristics and Baseline Scores on FIM, CIRS, and MMSE</th>
</tr>
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<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Age</td>
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<tr>
<td>Education</td>
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<tr>
<td>FIM</td>
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<td>CIRS</td>
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<td>MMSE</td>
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CIRS indicates Cumulative Illness Rating Scale; FIMS, Functional Independence Measure; IQR, interquartile range; MMSE, Mini Mental State Examination.
TABLE 2. Distribution of Scores on RFI Among Patients With Over-Threshold and Under-Threshold HAD Scores

<table>
<thead>
<tr>
<th>RFI</th>
<th>Median</th>
<th>IQR</th>
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<tbody>
<tr>
<td>HAD ≥10</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>HAD &lt;10</td>
<td>32</td>
<td>15</td>
</tr>
</tbody>
</table>

HAD indicates Hospital Anxiety and Depression; RFI, Royal Free Interview.

In this model, the other significant variable was functional dependence, as measured by Functional Independence Measure (odds ratio, 0.96; 95% CI, 0.91 to 0.98; P<0.001).

As shown in Table 3, the analysis of HADS subscales “anxiety” and “depression” gave similar results, with a 4% and 5% decrease in HADS scores, respectively, for each unit increase in RFI scores.

Among the 5 patients who were using antidepressant therapy, poststroke depression developed in 3 of them.

TABLE 3. Adjusted and Unadjusted Logistic Regression Models Exploring the Association between RFI and HAD Scale

<table>
<thead>
<tr>
<th>HAD ≥10</th>
<th>OR</th>
<th>CI</th>
<th>P</th>
<th>OR</th>
<th>CI</th>
<th>P</th>
<th>OR</th>
<th>CI</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1*</td>
<td>0.95</td>
<td>0.93–0.98</td>
<td>&lt;0.005</td>
<td>0.97</td>
<td>0.94–1.0</td>
<td>&lt;0.05</td>
<td>0.97</td>
<td>0.94–1.0</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Model 2†</td>
<td>0.96</td>
<td>0.93–0.99</td>
<td>&lt;0.01</td>
<td>0.97</td>
<td>0.94–1.0</td>
<td>&lt;0.05</td>
<td>0.96</td>
<td>0.93–0.99</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Model 3‡</td>
<td>0.95</td>
<td>0.91–0.98</td>
<td>&lt;0.005</td>
<td>0.96</td>
<td>0.93–1.0</td>
<td>&lt;0.05</td>
<td>0.95</td>
<td>0.92–0.99</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

*Unadjusted models with RFI as the unique predictor.
†Models adjusted for age, gender, education, and baseline MMSE score.
‡Models adjusted for age, gender, education, and baseline MMSE score, marital status, cohabiting status, comorbidity, and FIM score.

In the acute phase of stroke, between day 3 and 7 after admittance, HADS showed that 26.4% of stroke patients had anxiety symptoms, with 14.0% from depressive symptoms and 7.9% from both. At a 6-month follow-up of stroke survivors, 16% had scores >10 on the anxiety subscale and 12% on the depression subscale. Patients with physical disability were more likely to be depressed, whereas the correlation between disability and anxiety was less strong.

Explanations for the depression damping effect of spirituality and religious beliefs are only partially identifiable. IL-6, cardiovascular control mechanisms, and lowering of blood pressure are some possible organic mechanisms. A better coping with stress, motivation, optimistic drive, inner strength, and peace can control depression generated by psychological factors. Prayer appears to be the most common form of religious coping and even nonreligious people often turn to prayer in the throes of suffering. Prayer is a common coping strategy among elderly individuals with persistent pain. Several themes focus on how prayer is used for...
emotional distress, which is a multifactor process negatively
studied. However, 25% of the no-meditation group had died.45 Other
subjects. Half of them were assigned to a daily meditation and
research was performed in Italy, a country where the majority of inhabitants are Catholic, and
is also unknown. Our research was performed in Italy, a
community have a peak of mortality just
on that day.46
It is very difficult to state that one’s faith has a more
powerful influence than psychotherapy. A meta-analysis
study has revealed that significant albeit small improvement
is known. For example, transcendental meditation was exam-
meditation and
half were not. After 3 years, none in the meditation group
died, but 25% of the no-meditation group had died.45 Other
observations that go beyond science are collected from both
Chinese and Japanese American Communities, in which the
fourth day of the month is considered unlucky. Yet statistics
indicate that those communities have a peak of mortality just
been considered, because they have a weight in such
complication.

The limitations of the study are the following: (1) it is still
unknown whether faith fosters recovery after stroke; (2)
differences are not clear between spirituality and religiosity
in coping with poststroke emotional distress; (3) it is still
unknown whether skeptic people may acquire faith after a
dramatic event such as stroke; and (4) the extension of our
results to other cultures and/or to other form of religiousness
is also unknown. Our research was performed in Italy, a
country where the majority of inhabitants are Catholic, and
more particularly in Rome, a city where the Pope resides.
However, religious coping mechanisms have been identified in
non-Catholic people. They should be considered in post-
stroke rehabilitation, and spiritual assistance should be pro-
vided to those patients who overtly or silently call for it.

Acknowledgments
The authors thank Astrid van Rijn, who revised the English.

Disclosures
None.

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*Stroke*. 2007;38:993-997; originally published online February 15, 2007;
doi: 10.1161/01.STR.0000257996.26950.59
*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
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