Attending Religious Services, Depression and Health-Related Quality of Life in Parkinson's Disease Patients

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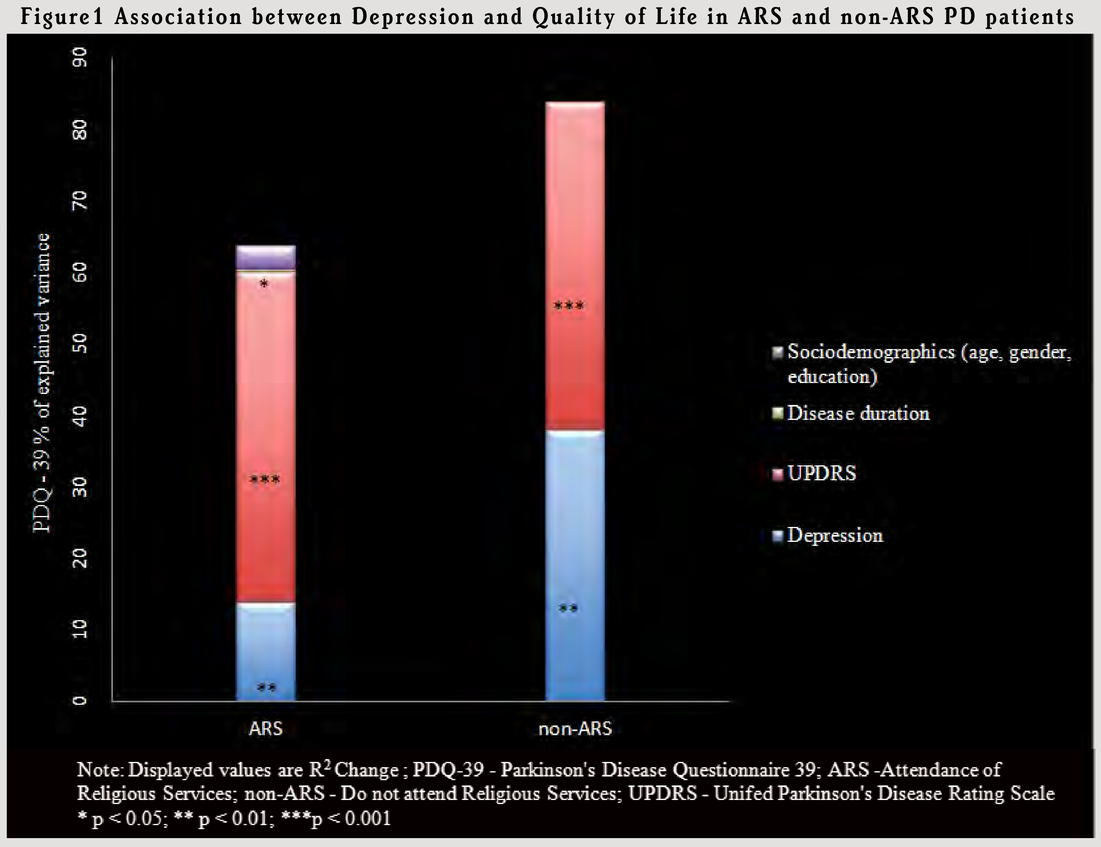
People, who attend religious services, have generally lower levels of anxiety and depressive symptoms and better quality of life than non-religious ones, with buffering effects of religious service attendance on the relationship between psychological problems and quality of life (1, 2). Furthermore, in hands with religiosity, social support provides a buffer against psychological distress and the effect of religiosity may be mediated by social support (3, 4). The aim of this study was to explore how depression is associated with health-related quality of life (HRQOL) in patients with Parkinson's disease (PD) who attend religious services (ARS) and in those who do not (non-ARS).

RESULTS

Age, education, disease duration, disease severity and depression explained 64% of the total variance of PDQ-39 in the ARS group of PD patients, of which 14% was explained by depression. In non-ARS, the same model explained 80% of the total variance of PDQ-39, of which 38% was explained by depression.

Figure1 Association between Depression and Quality of Life in ARS and non-ARS PD patients



Note: Displayed values are R^2 Change ; PDQ-39 - Parkinson's Disease Questionnaire 39; ARS -Attendance of Religious Services; non-ARS - Do not attend Religious Services; UPDRS - Unifed Parkinson's Disease Rating Scale
* p < 0.05; ** p < 0.01; ***p < 0.001

CONCLUSION

The association between depression and quality of life differs between PD patients who attend religious services and those who do not. Patients who do not attend religious services suffer from more depression. Our results underline very recent research findings showing that attendance of such premises may play a significant role in collaborating in the management of depressive symptomatology among elderly patients.

DESIGN AND METHODS

SAMPLE

124 patients (47.6% female; 68.1±8.4); disease duration 6.3±5.5 yrs.

MEASURES

- gender
- education (elementary, secondary, university)
- disease duration (in years)
- disease severity *(UPDRS - Unified Parkinson's Disease Rating Scale)*
- depression *(HADS - Hospital Anxiety and Depression Scale)*
- HRQOL *(PDQ-39 - Parkinson's Disease Questionnaire-39)*

STATISTICAL ANALYSIS

- hierarchical linear regression model
- independent variable: depression
- dependent variable: PDQ-39
- controlled for: age, gender, disease duration, UPDRS

PRACTICE IMPLICATIONS

For practice, considerable attention should be paid to map the psychosocial aspect of patient's well-being with an emphasis to encourage patient for social participation, for example, to attend religious service and to share problems and experience with a wider social environment.

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ABSTRACT SUPPLEMENT

Guest editors: **Julian Mamo, Dineke Zeegers Paget**

CONTENTS

This publication arises from the conference "5th European public health conference" which has received funding from the European Union in the framework of the Health Programme.

Background
Multiple sclerosis (MS) is a chronic inflammatory disease of the central nervous system that causes high levels of distress for patients. The aim of this study was to analyse the associations between coping strategies used to be related to MS, and to the physical and mental components of health-related quality of life (HRQoL).
Methods
The study comprised 109 MS patients (response rate 78.4%) from Eastern Slovakia (78% women, mean age 40.0 ± 9.2). Patients filled in the Short-Form Health Survey (SF-36) measuring HRQoL and the Coping Self-Efficacy Scale (CSE) measuring three coping strategies: problem-focused coping, getting support from family and friends and stopping unpleasant emotions and thoughts. Disability was assessed using the Expanded Disability Status Scale (EDSS). The associations between EDSS, CSE and SF-36 were analysed with linear regression using the both components of the SF-36, the Physical Component Summary (PCS) and the Mental Component Summary (MCS).
Results
EDSS and age were significantly associated with PCS, but not with MCS. All three types of coping strategies showed a significant association with MCS: problem-focused coping ($\beta^2 = 0.58$, $p < 0.05$), coping focused on getting support ($\beta = 0.53$, $p < 0.05$), and coping focused on stopping unpleasant emotions and thoughts ($\beta = 0.62$, $p < 0.05$), but not with PCS. The regression models for all three coping types explained 30%, 24% and 36%, respectively, of the MCS total variance. PCS was explained predominantly by EDSS and age. Other variables did not show any significant association with PCS or MCS.
Conclusions
An association between three types of coping and MCS was found. Stopping unpleasant emotions and thoughts explained most of the variance in the MCS. Thus patients, their caregivers and health professionals might be educated about effective coping strategy like decreasing negative emotions and thoughts. This could improve the mental quality of life of MS patients.

The benefits of nature-culture interplay on health, environment and wellbeing-Three evaluation studies

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Introduction
Researchers have investigated the potential of nature-culture-health activities in terms of their health-promoting properties. The shaping of health-promoting settings at work, in hospitals, in schools, and in local communities has therefore been significantly supported by the WHO.
Aim
To present results from three evaluation studies focusing on how art, music, nature and culture have a beneficial impact on health and wellbeing.
Method
The first evaluation study describes the subjective experiences of people partaking in nature-culture-health activities at the National Centre for Nature-Culture-Health (NaCuHeal) in Asker, a municipality west of Oslo. The second evaluation study highlights the way that music can act as a sort of folk-medical practice in our contemporary culture to maintain, improve, or change health status, though it is administered in a non-professional setting. The third evaluation paper presents results from a study conducted by Eastern Norway Research Institute [ENRI] in collaboration with the Fron Rehabilitation Centre, Norway in 2008–2009. Qualitative methods were used. Patterns, tendencies, and main characteristics have been explored. A total number from the three evaluations consists of ninety ($n = 90$) in-depth ethnographic interviews and open narratives from men and women (age, 23–79) with long-term illnesses or diseases.
Results
A common theme, and hence a major finding, is that nature-culture-health experiences may, from a salutogenic perspective, help participants to construct a meaning, to identify coping mechanisms, and to revitalize the energetic and resourceful parts of the self. Through participation in Nature-Culture-Health activities, hidden resources and creativity are awakened. Participants feel good about themselves and what they do is appreciated. In this way, one can strengthen the salutogenetic factors in a person's life.
Conclusion
These evaluation studies indicate how art, music, and nature-culture- health activities may have a beneficial impact on health and wellbeing, and hence be useful for rehabilitation. A salutogenic approach could create a solid theoretical framework for health promotion and it may counteract events leading to sickness absence.

Attending religious services, depression and health-related quality of life in Parkinson's disease patients

Radka Ghorbani Saeedian

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Background
Recent studies have shown a significant inverse association between attending religious services and depressive symptoms across the general population and in clinical samples. Religious acts rather than religious orientation seem to dominate the relationship between religiosity and psychological well-being. We aimed to explore how depression is associated with health-related quality of life (HRQOL) in patients with Parkinson's disease (PD) who attend religious services and in those who do not.
Methods
The sample consisted of 124 patients (47.6% female; mean age 68.1 ± 8.4years; mean disease duration 6.3 ± 5.5 years). Attending religious services was obtained from a self-report sociodemographic questionnaire (Do you attend a religious service? Yes ($N = 81$)/No ($N = 43$)). Disease severity was measured using the Unified Parkinson Disease Rating Scale (UPDRS), depression with the Hospital Anxiety and Depression Scale (HADS; subscale HADS-D) and HRQOL with the Parkinson's Disease Questionnaire-39. Data were analysed using multiple linear regression.
Results
The model consisting of age, education, disease duration, disease severity and depression explained 64% of the total variance of HRQOL in PD patients attending religious services, of which 14% was explained by depression. The above model explained 80% of the total variance of HRQOL in the group of PD patients who did not attend religious services, of which 38% was explained by depression.
Conclusions
It seems that the association between depression and HRQOL differs between Parkinson disease patients who attend religious services and those who do not. Our results underline a very recent research finding showing that an extrinsic orientation to religion might protect or might delay the onset of depression.