Vulnerabilities, depression, and religiosity in the elderly hospitalised in an emergency unit

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Vulnerabilidades, depressão e religiosidade em idosos internados em uma unidade de emergência

Vulnerabilidades, depresión y religiosidad en ancianos internados en una unidad de emergencia

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ABSTRACT

Objectives: To identify vulnerabilities and the association between religiosity and depressive signs in the elderly hospitalised in an emergency unit.

Methods: This cross-sectional study was conducted with 140 elderly patients admitted to a public hospital in the Federal District, Brazil, between May and October 2016. Data were collected using a semi-structured health questionnaire, the Duke University Religion Scale (DUREL), and the Geriatric Depression Scale (GDS).

Results: The elderly patients were vulnerable in terms of schooling, place of residence, and life habits, and 37.3% exhibited signs of depression. A weak association was found between religiosity and the development of depressive signs ($p \leq 0$, $R = 0.12$; $p = 0.02$ and $r = 0.06$).

Conclusion: The results showed isolated religiosity is not an effective protective factor, but it strengthens resilience in the face of disease and serves as a support network for the elderly.

Keywords: Aged. Religion. Depression. Health vulnerability. Spirituality.

RESUMO

Objetivos: Identificar vulnerabilidades e a associação entre religiosidade e a presença de sinais depressivos presentes em idosos internados em uma unidade de urgência e emergência.

Métodos: Estudo transversal, realizado com 140 idosos internados em um hospital público do Distrito Federal, entre o mês de maio a outubro 2016, realizado por meio de questionário semiestruturado sobre dados de saúde, escala de religiosidade de DUREL e de depressão geriátrica.

Resultados: Os idosos estudados são vulneráveis em relação a escolaridade, local de residência, a hábitos de vida, 37,3% dos idosos apresentavam sinais depressivos, e que existe uma associação fraca de proteção entre religiosidade e desenvolvimento de sinais depressivos ($p \leq 0{,}00$ $r = 0.12$) e ($p = 0{,}02$ e $r = 0{,}06$).

Conclusão: Observou-se a religiosidade isolada não apresenta fator protetor eficaz, mas apresenta papel importante no desenvolvimento de resiliência diante da enfermidade e uma fonte construtora de rede de apoio ao idoso.

Palavras–chave: Idoso. Religião. Depressão. Vulnerabilidade em saúde. Espiritualidade.

RESUMEN

Objetivos: Identificar vulnerabilidades y la asociación entre religiosidad y la presencia de signos depresivos presentes en ancianos internados en una unidad de urgencia y emergencia.

Métodos: Estudio transversal, realizado con 140 ancianos internados en un hospital público del Distrito Federal, entre el mes de mayo a octubre de 2016, realizado por medio de un cuestionario semiestructurado sobre datos de salud, escala de religiosidad de DUREL y de depresión geriátrica.

Resultados: Los ancianos estudiados son vulnerables en relación a la escolaridad, lugar de residencia, a hábitos de vida, el 37,3% de los ancianos presentaban signos depresivos, y que existe una asociación débil de protección entre religiosidad y desarrollo de signos depresivos ($p \leq 0\ ,00$ $r = 0.12$) y ($p = 0{,}02$ er $= 0{,}06$).

Conclusión: Se observó la religiosidad aislada no presenta un factor protector eficaz, pero presenta un papel importante en el desarrollo de resiliencia ante la enfermedad y una fuente constructora de red de apoyo al anciano.

Palabras clave: Anciano. Religión. Depresión. Vulnerabilidad en salud. Espiritualidad.

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INTRODUCTION

The Brazilian population and world population are aging rapidly, and this demographic transition, according to estimates of the World Health Organization (WHO), represents a leap in the elderly population. The estimated population of elderly people over 60 is 1.2 billion in 2025 and around 2 billion in 2050[1].

Aging is usually accompanied by a series of organic changes with the subsequent decline of functional capabilities and alterations in the physiological functioning of organs and systems. Consequently, the elderly are more prone to chronic diseases and vulnerabilities, which affects the ability of organic systems to perform functions regarding changes to the internal medium. As time passes and the organism gets naturally older, it tends to exhibit some faults[2].

Senility, associated with many aging-associated diseases, can increase the frequency of disabilities. One of the diseases that can affect the elderly is depression and the clinical symptoms of this disease can be underdiagnosed and undertreated[3-4].

Depressive symptoms may cause the elderly to become more vulnerable and aggravate any chronic diseases, thus increasing the risk of morbidity and the need for support from health workers to effectively minimise or prevent these problems[3].

During a hospital stay, the elderly may be more sensitive and vulnerable, and they often seek religion to cope with disease and feel confident they will be protected and possibly cured[5].

Religiosity and spirituality are common phenomena in the lives of Brazilians, especially in old age, when people are more likely to seek answers to the meaning of life. In the elderly population, religiosity and spirituality provide a sense of well-being, reduce anxiety and helplessness, and boost resilience to problem situations and difficulties associated with aging, such as emotional and physical limitations, leading patients to believe disease is a positive process they must endure, while also increasing their understanding of the meaning of life and positive life experiences[5-7].

Spirituality is considered a philosophical guide capable of producing sympathy and specific behaviours, such as hope, love, and faith, and of providing a sense of meaning to people's lives. Religion is the belief of a higher power with the supernatural capacity to create and control the universe[5-6]. It can serve as a path through which individuals express their spirituality based on values, beliefs, and ritual practices, thus enabling the search for transcendence, self-reflection, and thought regarding existential relationships beyond the objective world[6-7].

In this sense, religion often serves as a refuge for the chaos caused by illness and as comfort for the fears and insecurities triggered by the feeling of death. Through religion, patients attribute meaning to their illness and may find an explanation for their impossibility to control the situation. Therefore, religion serves as an illusionary control over the imponderable, represented by the illness[7].

For this reason, the hypotheses of this study is that religiosity is a protective factor that allows the elderly to be more resilient. It is defined as the ability to adapt to stressors, challenges or adversity, enabling people to fight and interact traces of their personalities with environmental factors to increase or decrease resiliency throughout life and face aging-associated vulnerabilities and the related social context[8].

The aim of this study was to identify the vulnerabilities and association between religiosity and depressive signs in elderly inpatients in an emergency unit.

METHODS

It is a descriptive, exploratory, cross-sectional study with a qualitative approach conducted at a public hospital in the Federal District - DF, Brazil.

A convenience sample was obtained through data collected over a period of six months. The inclusion criteria were elderly people, i.e. 60 years or older, admitted for over 24 hours in the emergency unit, with the cognitive and communicative capacity to understand and participate in the study, with no clinical instability or in any imminent risk of death.

The study site was the emergency room (ER) because it allows the combined observation of emergency care and hospitalisation. Patients with cognitive alterations or in any other condition that prevented them from answering the interview questions were excluded.

An interview was conducted with the elderly people between May and October 2016, after they agreed to sign an informed consent statement. The semi-structured script consisted of sociodemographic variables (name, sex, age, marital status, education, household income, place of residence) and health data (Manchester scale classification, tobacco and alcohol use, physical activity, and the continued or habitual use of medication).

The depressive symptoms were screened using the Geriatric Depression Scale, 15-item version (GDS-15). The scale was validated for use in Brazil in 1999(9). It contains questions with yes and no answers with a maximum score of 15, in which "0 to 5" means no depression, "6 to 10" means mild to moderate depression, and "11 to 15" means severe depression[9-10].

The instrument chosen to evaluate the index of religiosity of the elderly was the Duke University Religion Index (DUREL), validated for the Brazilian population. The scale comprises three dimensions of religiosity: organisational religious activity (ORA) with one question, non-organisational religious activity (NORA) with one question, and intrinsic religiosity (IR) with three questions in three levels[6,11].

To determine the associations and correlations between the DUREL and the GDS, the items in the latter scale were divided into items with a positive association to religiosity and items with a low association, as shown in the flowchart below (Figure 1).

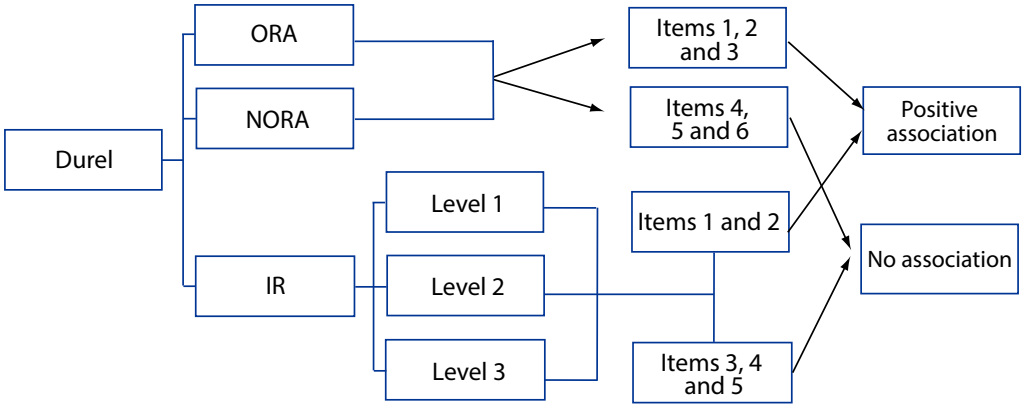

Figure 1 - Flow chart of positive and negative association between religiosity and depression

Source: Authors

ORA: organisational religious activity; NORA: non-organisational religious activity; IR: intrinsic religiosity

Organisational religious activity is the frequency people attend temples, churches, and other locations. This item was associated with the answers of items one, two, and three of organisational religious activity classified as positive association. The answers to items four, five, and six, however, mean no association or low association.

Non-organisational religious activity refers to how often people engage in religious activities and items one, two, and three were also classified as having a positive association, while items four, five, and six were classified as no association.

The dimension of intrinsic religiosity is divided into three levels, which were analysed individually and separately. The first level assesses how people experience the presence of God in their lives; the second assesses how beliefs govern their approach to life; and the third level assesses efforts to carry religion into life at all levels. The items with a score of one and two were classified as having a positive association with religiosity, and the answers to items three, four, and five represented low or no association.

For statistical analysis, Microsoft Excel® version 2013 was used to present the sociodemographic and health data descriptively through the distribution of absolute frequencies and percentage. STATA® version 12 was used to analyse the association between depressive signs and religiosity. The GDS was summarised using absolute frequency, percentage, average, and standard deviation. The measure of association was the prevalence ratio (PR), and the Chi-square test was used to analyse the dichotomous variables between the DUREL and the GDS, with a significance level $p = 0.05$ and a confidence interval of 95%. The Pearson correlation coefficient (r) (the closer to one, the greater the association between variables and the closer to zero, the lower the association) was used for the analysis between the results of depressive signs and the participants' level of religiosity[12].

The research was submitted to the research ethics committee of the Fundação de Ensino e Pesquisa em Ciências da Saúde (FEPECS) of the Federal District and approved under protocol number CAAE 54603216.3.0000.5553.

RESULTS

In all, 140 elderly inpatients were interviewed. They had a homogenous sociodemographic profile in relation to sex since 50% were women and 50% were men. In terms of distribution by age group, most of the elderly were 60-64 years old (25.7%), and 20% of the inpatients were octogenarians (Table 1).

In relation to marital status, 34.3% were married and 28.6% were widowed. Most of the elderly had studied for up to four years (80.7%) and 36.4% were illiterate. Only nine (6.4%) had studied eight or more years or the equivalent to finishing primary school (Table 1).

Most of the elderly inpatients (82.9%) were retired, with a family income of one minimum wage (54.3%), which in many cases came from their retirement and was the only source of income for the family (Table 1).

In terms of residence, 76.4% lived within the hospital coverage area defined by the government of the Federal District and 14.3% lived in other states outside the so-called integrated development region of the Federal District (RIDE-DF) and surrounding areas, such as southeast Bahia and northeast Goiás.

Table 1 - Absolute frequency and percentage of the sociodemographic data of the elderly inpatients who participated in the research, Federal District, 2016 (n = 140)

Sociodemographic profile	n	%
Sex		
Male	70	50
Female	70	50
Age group		
60-64	36	25.7
65-69	35	25
70-74	21	15
75-79	16	11.4
80-84	20	14.3
85-89	8	5.7
90-95	4	2.9
Marital status		
Married	48	34.3
Single	17	12.1
Widowed	40	28.6
Separated	21	15
Other	14	10
Education		
Illiterate	51	36.4
Up to 4 years of schooling	62	44.3
4 to 8 years of schooling	18	12.9
8 years or more of schooling	9	6.4
Retired		
No	24	17.1
Yes	116	82.9
Family income		
1 minimum wage	76	54.3
2 minimum wages	40	28.6
3 minimum wages	16	11.3
4 minimum wages	4	2.9
5 or more minimum wages	4	2.9
Place of residence		
Planaltina - DF	107	76.4
RIDE-DF*	13	9.3
Other	20	14.3

Source: Research data, 2016.

*RIDE-DF: Integrated development region of the Federal District and surroundings consisting of the Federal District and the municipalities of Abadiânia, Água Fria de Goiás, Águas Lindas de Goiás, Alexânia, Cabeceiras, Cidade Ocidental, Cocalzinho de Goiás, Corumbá de Goiás, Cristalina, Formosa, Luziânia, Mimoso de Goiás, Novo Gama, Padre Bernardo, Pirenópolis, Planaltina, Santo Antônio do Descoberto, Valparaíso de Goiás, and Vila Boa, in the state of Goiás, and Unaí, Buritis, and Cabeceira Grande in the state of Minas Gerais.

Table 2 - Absolute and relative frequency of health-related data of the elderly participants in the study. Federal District. 2016 (n = 140)

Profile of heath data	n	%
Manchester*		
Not classified	68	48.6
Blue	0	0
Green	4	2.9
Yellow	29	20.7
Orange	34	24.2
Red	5	3.6
Smoker		
No	74	52.9
Yes	66	47.1
Frequently	29	20.7
Rarely	14	10
Stopped smoking	23	16.4
Alcohol use		
No	91	65
Yes	49	35
Frequently	19	13.6
Rarely	13	9.3
Stopped drinking	17	12.1
Trouble sleeping		
No	62	44.3
Yes	78	55.7
Delayed	50	35.7
Wake up the night	27	19.3
Wake up early	0	0
Sleepy	1	0.7
Difficulties of locomotion		
No	72	51.4
Yes	68	48.6
Human aid	8	5.7
Canes or crutches	11	7.9
Walker	1	0.7
Wheelchair	3	2.1
More than one option	8	5.7
None	37	26.5
Physical activity		
No	120	85.7
Yes	20	14.3
Inpatient clinic		
General medicine	96	68.6
General surgery	26	18.6
Orthopaedics	18	12.8

continue...

...continuation

Profile of heath data	n	%
Amount of continued-use medication		
None	18	12.8
One	17	12.1
Two	25	17.8
Three	23	16.4
Four	20	14.3
Five or more	37	26.6

Source: Research data, 2016.

* Risk classification - Manchester protocol.

Table 3 – Relationship between average, standard deviation, and prevalence ratio between the GDS and the DUREL. Federal District, 2016 (n = 140)

GDS	n (%)	A	SD	DUREL				
				ORA	NORA	IR		
				PR (CI95%)	PR (CI95%)	PR (CI95%)	PR (CI95%)	PR (CI95%)
Normal	88 (62.7%)	3.09	1.26	0.93 (0.71 - 1.21)	0.75 (0.55 - 1.02)	0.61 (0.54 - 0.70)	**0.65 (0.53 - 0.81)**	0.93 (0.63 - 1.37)
Mild	47 (33.7%)	7.51	1.47	0.75 (0.55 - 1.02)	1.91(0.53 - 6.87)	**0.43 (0.31 - 0.59)**	1,74 (0.61 - 4.93)	1.00 (0.47 to 2.14)
Severe	5 (3.6%)	11.2	0.44	0.31(0.05 - 1.80)	x	x	x	x

Source: Research data, 2016.

Data: GDS - Geriatric Depression Scale, DUREL - Duke University Religion Index, ORA - organisational religious activity, NORA - non-organisational religious activity, IR - intrinsic religiosity, n (%) number of participants and percentage, A - average, SD - standard deviation, PR - prevalence ratio, CI - confidence interval.

As for the health-related data, 48.6% of the elderly in the emergency unit had not been assessed for risk and 24.2% had an orange risk classification, which is used for emergencies and when there is a significant risk of progressing to death. General medicine had the highest admission rate after screening in the ER, totalling 68.6% of cases, mostly involving acute complications of chronic noncommunicable diseases (Table 2).

In relation to the habits of the elderly, 47.1% reported they smoked and 16.4% were not currently smoking. Among the smokers, 17.1% of the elderly inpatients had been smokers for more than 40 years and 30% smoked an average of 10 cigarettes per day. The consumption of alcoholic beverages was reported by 35% of the patients and 9.3% had been drinking for more than 40 years. Most drinkers (10.7%) preferred fermented beverages (Table 2).

Around 55.7% of the elderly had some trouble sleeping, considering 35.7% stated they took some time to fall asleep and 19.3% said they woke up at least once during the night. Almost one third (26.6%) of the inpatients were using five or more medications per day and 12.8% did not use medication on a daily basis (Table 2).

The habit of practicing physical activity was reported by 14.3%, and walking was the most common activity. Walking difficulties were stated by 48.6% of the patients, of which 26.5% did not need a walking aid (Table 2).

In relation to the signs and symptoms of depression based on the GDS, 62.7% of the elderly did not have signs of depression, with an average score of 3.09 points, 33.6% had mild depressive symptoms, with an average of 7.51 points, and 3.6% had severe depressive symptoms, averaging 11.2 points (Table 3),

The prevalence ratio of organisational religious activity was 0.31 and the confidence interval was CI95% 0.05-1.80. It was not possible to establish an association with the remaining variables of the GRS in the elderly with severe signs and symptoms of depression because there was no positive control in the sample for this variable (Table 3).

Table 4 - P-value (Chi-square) and Pearson's correlation coefficient (r) between the GDS and the DUREL, Distrito Federal, 2016 (n = 140)

Level	DUREL Questions	GDS-15					
		Normal		Mild		Severe	
		p*	r **	p*	r**	p**	r**
ORA	How often do you attend church or other religious meetings?	0.62	0.13	0.18	0.13	0.50	0.12
NORA	How often do you spend time in private religious activities, such as prayer, meditation or Bible study?	0.18	0.00	0.26	0.01	0.50	0.00
IR-1	In my life, I experience the presence of the Divine (or God).	0.11	0.11	**≤ 0.00**	**0.12**	0.69	0.12
IR-2	My religious beliefs are what really lie behind my whole approach to life.	**0.02**	**0.06**	0.24	0.05	0.43	0.07
IR-3	I try hard to carry my religion into all other dealings in life.	0.74	0.02	0.98	0.05	´ x	0.03

Source: Research data, 2016.

Data: DUREL - Duke University Religion Index, ORA - organisational religious activity, NORA - non-organisational religious activity, IR-1 - intrinsic religiosity level 1, IR-2 – intrinsic religiosity 2 level, IR-3 - intrinsic religiosity level 3.

* p-value= X^2 test (Chi-square).

** r = Pearson's correlation.

In all the dimensions of the GRS, the prevalence ratio (PR) was relatively low, suggesting a low protective factor among the elderly with a strong association with religion in relation to those with low or no religiosity (Table 3).

The association between depressive signs and religiosity was determined by statistically analysing the distribution of Chi-square ($\chi 2$) for a descriptive level of significant p-value ≤ 0.05. Significant differences were observed in relation to depression and the level of religiosity in two associations; between the absence of signs of depression and the presence of intrinsic religiosity in the second level (p = 0.02) and between the presence of depressive signs and the absence of intrinsic religiosity in the first level (p = 0.00) (Table 4).

The Pearson correlation coefficient (r) showed a tiny positive correlation (r = 0.06) in relation to the second question of intrinsic religiosity and the absence of signs of depression, and a weak positive correlation (r = 0.12) for the presence of mild signs of depression and intrinsic religiosity in the first question. This data corroborates the results obtained with the prevalence ratio shown in Table 3, in the same associations where the p-value was significant, which showed weak association ratios (PR 0.43 CI 0.31-0.59 and PR 0.65 CI 0.53 to 0.81) demonstrating that religiosity has a low beneficial effect on the appearance of signs of depression in the elderly who were part of this research.

DISCUSSION

Results show that approximately 50% of the elderly in the unit were not assessed for risk, mostly because the protocol is not applied from 00:00 to 07:00 a.m. Moreover, patients referred from the orthopaedics and surgery units are not usually classified for risk at the institution.

The National Policy of Humanisation ("HNP") of the Ministry of Health established the use of this protocol so hospitals could determine risk classification on patient arrival to provide care according to the severity of the case rather than order of arrival(13). Consequently, the study revealed a correlation between classification and the patient admission outcome, showing the efficiency of this protocol.

The general clinic of the emergency unit has the largest number of elderly inpatients, primarily due to aggravations

of chronic noncommunicable diseases. Similar studies also found that age, schooling, chronic multimorbidities, and residence away from the urban centres increases the level of vulnerability of this population and consequently increases the prevalence of admissions and readmissions[14-15].

Admissions and readmissions may be associated with the process of senility, which leads to a decrease or loss of mobility, diminished physical capacity, and sarcopenia and syndromes of weaknesses. These conditions make the elderly more vulnerable to aggravations of chronic diseases and subsequent hospital admissions, also considering they are often sensitive to nursing interventions in primary healthcare[15].

Nursing plays an important role in the prevention of hospital readmissions because it promotes healthcare and education for patients in treatment or outpatient care.

Studies have found an association between increased religiosity and the number of incapacitating morbidities in the elderly since they may require the comfort and compensation of religion[16]. This positive association with religiosity found in studies may improve the physical and mental well-being of elderly patients and reduce the aggravation of morbidities[15-16].

In this study, 47.14% of the elderly people were exposed to the harmful effects of smoking and 35% were exposed to the effects of alcohol. In general, studies show religions encourage the adoption of a healthy lifestyle and have strict rules regarding the use of alcohol, tobacco, drugs, specific diets, and sexual behaviours. They also discourage certain behaviour that can pose a risk to morbidity and mortality, thus suggesting the absence of religiosity can people more prone to unhealthy practices[16].

A relevant factor among the elderly in situations of vulnerability is the presence of signs of depression, often associated with advanced age, low education, use of toxic substances, insomnia, and noncommunicable diseases. These vulnerabilities are highly deleterious in the lives of the elderly, as found in the data obtained in this study revealing 37.57% exhibited mild signs of depression and 4.79% exhibited severe signs, totalling 42.36% of patients with depressive symptoms.

These data, however, diverge from that of other research using the same depression screening instrument. In a study conducted in the city of Bagé, Rio Grande do Sul, the prevalence was 18%, while in a study of the city of Montes Claros, Minas Gerais, the prevalence was 34.8% for very old people and 26.3% for the 60 to 79 age group. In another study conducted in the city of Alfenas, Minas Gerais, 88% of the elderly had depressive signs and 5% had severe depressive signs. All three studies, however, were conducted in the elderly population of a community, which could explain the divergence with this study, conducted with hospitalised elderly patients who are weakened by disease[17-19].

As for religion, this study revealed significant association values ($p = 0.02$) between the second level of intrinsic religiosity, suggesting a search for the internalisation of religious belief as a full life goal, and the absence of depressive symptoms. Moreover, the indexes showed a positive association between religiosity and a negligibly associated Pearson's correlation.

In the elderly with a high degree of religiosity, this religiosity was not strongly linked to the absence of signs of depression. In fact, the association was positive but the Pearson correlation was weak in intrinsic religiosity and feeling of the presence of God. In similar studies also with the DUREL, no association was found between religiosity and the absence of depressive signs ($p = 0.522$)[20].

The study has limitations regarding the perception of spirituality by the elderly since the religiosity scale does not include important factors, such as the existential domain and human essence. The weak association between religiosity and absence of depressive signs may be correlated to how the elderly understand religiosity. Furthermore, some authors claim hope and spirituality are stronger constituents of a resilient self and englobe broader meanings than religiosity[8]. Other limitations are inherent to the surveying of data, such as the real perception of religion with the practiced religion, the hospital setting, the admission process, and nursing complications that can increase depressive signs or trigger the perception of finiteness and approximation with God.

Spirituality is something innate that promotes well-being, health and stability, and an individual and personal perception that arouses feelings of hope, love, and faith. It also allows transcendence and provides an explanation for personal facts, thus enabling people to restructure their lives[20].

CONCLUSION

In this study, it was found that the vulnerabilities inherent to aging make the elderly more fragile and often trigger depressive symptoms.

Religiosity contributed to their social and personal well-being, although no association was observed between levels of religiosity and absence of signs of depression in the studied population. However, religion should be stimulated since the elderly tend toward isolation and the internalisation of their religiosity can make them more resilient to cope with the adversities of life.

Some of the benefits of nursing research includes strategies to help the elderly adhere to religiosity and build su-

pport networks and the development of strategies to optimise user assistance, improve internal screening protocols for the elderly, and reduce their vulnerabilities, therefore enabling health workers to intervene in health determinants that are sensitive to health education measures.

In this context, this study can provide the support nurses need to understand the vulnerabilities of elderly patients and the context of religiosity as a support tool. It can also encourage the development of new studies on religiosity and spirituality in the context of healthcare for the elderly.

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