Journal of
Novel Physiotherapies
ISSN: 2165-7025

Research Article Open Access

The Prevalence of Symptoms of Psychiatric Disorder and the Interface with Religious/Spiritual Coping in Brazilian Cross-Cultural Missionaries

Michael Morillas*

Department of Psychiatric Disorder, Brazilian University, Brazil

Abstract

Background: Some studies identify cross-cultural christian missionaries as humanitarian agents or community service developers in different areas. Cultural adaptations, demands for a flawless life, constant availability, financial difficulty, and work overload can be a risk factor for the development of psychiatric disorders, low quality of life and burnout. Despite the importance of the missionary work, few studies have investigated the mental health and the interface with spirituality in this group.

Aim: To investigate the prevalence of symptoms of psychiatric disorders, burnout and quality of life and their relationship with spirituality in Brazilian cross-cultural missionaries.

Method: 327 Brazilian missionaries living in various parts of the world answered: Ministerial Inventory, Self-Report Psychiatric Screening Questionnaire, Beck Depression Inventory II, State-Trait Anxiety Inventory, Maslach Burnout Inventory, Medical Outcomes Study 36 and Brief Religious Coping Scale.

Results: The absolute and relative frequencies found to develop symptoms of Common Mental Disorder were 29.4%; Depression Disorder 22.3%; anxiety disorder 35.5% and Burnout Syndrome 16.5%.

Conclusion: The high frequencies of mental disorder found, revealed that missionaries are part of the risk group for psychiatric disorders. However, it was confirmed that the higher the positive religious coping is, the greater protective factor against the incidence of mental disorders is developed.

Keywords: Psychiatric disorder; Depression; Anxiety; Burnout; Quality of life, Spirituality; Religious cope

Introduction

Some studies identify cross-cultural Christian missionaries as "humanitarian agents" or community service developers in the fields of education, sport, chaplaincy, and public health. In addition, due to the scarcity, in some parts of the world, of qualified people to deal with psychiatric disorders or because of psychophobia, perceptible in some cultures, the missionaries are also considered agents or guardians of the mental health services of the frontline. However, cultural adaptations, demands for a flawless life, constant availability, lack of social recognition, financial difficulty, work overload, exposure to very strong emotions in a short period of time to be elaborate, among others, can be risk factors for the development of mental disorders, low quality of life and burnout.

The interface between the religiosity/spirituality (R/E) dimension and physical health has been systematically studied, but only in the last 20 years has the scientific literature increasingly, consistently and relevantly described the importance and the relationship between R/E and physical and mental health, especially regarding the attribution of meaning to the suffering caused by chronic diseases, and also as a resource for coping and hope in the face of changes in health [1].

In fact, the reference to religion and spirituality as a coping strategy for dealing with diseases is not something that can be considered new. Nevertheless, few studies have examined the key person in religious matters: clergy and even fewer the transcultural missionaries, who leave their homes, families of origin and countries to settle in other cultures, facing, among others, environmental and cultural stressors that can interfere with their quality of life [2].

Religious/Spiritual Coping (RCOPE) can be understood as the application of spirituality, religion, or faith to stress management. RCOPE strategies, according to the consequences they cause for those who use them, can be listed as positive or negative, being generally related, respectively, to better or worse physical/mental health and quality of life results. Evidence shows that people use RCOPE more in crisis situations and also more positive than negative. Therefore, Positive RCOPE can be defined as involving strategies that generate beneficial/positive effects for the individual who practices them, such as seeking love and protection from God, greater connectivity with transcendental forces, comfort in religious literature, seeking forgiveness, praying for the welfare of others, solving problems by sharing them with God, redefining the stressor as beneficial. Negative RCOPE is defined as strategies that produce detrimental/negative results to the person, such as questioning God's existence, love, deeds, or transferring to God the resolution of problems, feeling dissatisfaction with God and others, redefining the stressor as divine punishment or evil forces.

Considering these factors, this study aimed to verify the prevalence of symptoms of Common Mental Disorders (CMD), Major Depressive Disorder (MDD), Anxiety Disorder (AD), Burnout Syndrome (BS), Quality of Life (QoL) and the interface with religious/spiritual coping among Brazilian cross-cultural evangelical/protestant missionaries who carry out their work outside Brazil.

***Corresponding author:** Michael Morillas, Department of Psychiatric Disorder, Brazilian University, Brazil, E-mail: michael.morillas.8520@gmail.com

Received: 02-Dec-2023, Manuscript No: jnp-23-119089; **Editor assigned:** 04-Dec-2023, Pre-QC No: jnp-23-119089 (PQ); **Reviewed:** 18-Dec-2023, QC No: jnp-23-119089; **Revised:** 25-Dec-2023, Manuscript No: jnp-23-119089 (R); **Published:** 01-Jan-2024, DOI: 10.4172/2165-7025.1000670

Citation: Morillas M (2024) The Prevalence of Symptoms of Psychiatric Disorder and the Interface with Religious/Spiritual Coping in Brazilian Cross-Cultural Missionaries. J Nov Physiother 14: 670.

Materials and Methods

Study design and population

Since the beginning of the study, 16 missionary agencies and the Brazilian Transcultural Missions Association (AMTB) were contacted, who referred 935 missionaries to the research by providing their e-mails. From the e-mails given, 65 (6.95%) returned for containing some error in their email address; thus having 870 confirmed addresses; of which 390 (44.83%) missionaries digitally signed the Free Informed Consent Form agreeing to participate in the study, in spite of it, 8 (0.86%) did not return the scales sent, 54 (6.21%) partially answered the scales and were consequently removed from the study; 1 (0.92%) refused to answer the scales, remaining 327 (327/870; 37.59%) missionaries at the end of the studies who completed all psychological assessments.

After signing the Informed Consent Form, 7 links were sent to them: 1) MI (Ministerial Inventory) in which Sociodemographic data were collected, and stress situations were tracked; 2) SRQ-20 (Self-Report Psychiatric Screening Questionnaire); 3) BDI-II (Beck Depression Inventory II); 4) Inventory of State-Trait Anxiety; 5) MBI (Maslach Burnout Inventory); 6) SF-36 (Medical Outcomes Study 36-Item short form health survey) and 7) Brief RCOPE (Brief Religious/Spiritual Coping Scale).

The eligibility criteria were age ≥ 18 years old, Brazilian, Protestant or Evangelical Christian, Portuguese speaking, have at least two years of residence in a foreign country, perform some kind of missionary work, and sign the Informe Consent.

All participants who met the eligibility criteria responded to the MI and underwent evaluation for: symptoms of psychiatric disorder Burnout Syndrome, QoL and Religious Coping. For this study the definitions of psychiatric disorders were based on DSM-5 [3], the definition of QoL by WHO (1998) and the definition of R/E according to Pargament.

Ethical approval

The study was approved by the research ethics committee at Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo (Protocol FMUSP 13866; CAAE 47940415.7.0000.0065) and was conducted in accordance with the Declaration of Helsinki. The researchers guarantee that individuals provided written consent and that all documentation will be kept confidential.

Statistical analysis

The baseline characteristics were compared with the increased odds of the presence of CMD symptoms by SRQ-20, with cutoff ≥ 5 for women and ≥ 7 for men [4]; MDD symptoms by BDI-II with a cutoff point from 0 to 13, no depression; from 14 to 19, mild depression; from 20 to 28, moderate depression and from 29 to 63: severe depression; symptoms of AD by STAI State-Trait with cutoff ≤ 32 without symptomatology or mild anxiety, between 33 and 49 moderate symptomatology and ≥ 50 high symptomatology; BS by MBI with cutoff: Exhaustion-Low from 0-16, Moderate from 17-26, High ≥ 27; Cynicism or Depersonalization-Low from 0-6, Moderate from 7-12, High ≥ 13; Professional Efficacy-Low ≥ 39, Moderate 32-39 and High 0-31 [5]; QoL by SF 36 evaluated by transforming responses into scores, on a scale of 0 to 100, for each component, with no single value summarizing the entire assessment, resulting in a better or worse general state of health [6] and Religious Coping by BRIEF-RCOPE Scale with Cutoff: None or Minimal (1.00 to 1.50), Low (1.51 to 2.50), Medium (2.51 to 3.50), High (3.51 to 4.50), Very High (4.51 to 5.00), by Chi-square test (categorical variables), and by corresponding test for continuous variables, depending on the distribution sample by Shapiro normality test [7]. Associations between CMD and other disorders were also made considering age, sex, education, marital status, self-reported ethnicity, education, profession, mission time, continent, country status at religious persecution level, body mass index (BMI), physical inactivity, hypertension, diabetes, and history of disorders. All descriptive analyses of the instruments used to track psychiatric disorders were performed continuously, as well as dichotomous according to previously mentioned sections previously established in the literature. Finally, logistic regression was performed for each adopted scale adjusted for potential significant factors associated with the adopted scales. Through the acquired logistic models, the odds ratios (OR) were calculated with their respective 95% confidence intervals (95% CI). For all analyses performed results were considered as statistically significant to those with p values $p<0.05$. We considered statistical significance in two-tailed $p < 0.05$ and for all of them were performed with SPSS version 20.0.

Results

Assessment of symptoms of psychiatric disorders during the study:

The baseline characteristics of all 327 participants in the study were described according to with or without symptoms of CMD through SRQ 20.

The Absolute and relative frequencies of CMD symptoms by SRQ-20 were 29.4%, being the most significant frequencies for women compared to men (84.4% vs 15.6%, p= 0.000), with a 6.7 times increased OR; the not ordained pastor opposed to the ordained (84.4% vs 15.6%, p= 0.000); with a 3.4 times increased OR; the sedentary lifestyle compared to the non-sedentary (77.1%vs 22.9%, p=0.000), with a 2.6 times increased OR.

The Depressive symptoms were assessed by BDI-II with relative and absolute frequencies of 22.3%. The highest frequencies were among the females compared to the males (78.1% vs 21.9%, p= 0.000), with a 3.6 times increased OR; the not ordained pastor as opposed to the ordained (76.7% vs 23.3%, p= 0.008); for those with missional formation (31.5%, p=0.040); the sedentary lifestyle in relation to the non-sedentary (72.6% vs 27.4%, p=0.002), with a 2.0 times increased OR; no previous diagnosis of anxiety (57.5% vs 42.5%, p=0.001), with a 2.0 times increased OR.

The Anxiety symptoms were tracked by the STAI-State-Trait with the relative and absolute frequencies of 35.5% for both the STAI-State (SE) and STAI-Trait (ST).

The highest symptom frequencies were found for the ages between 31 and 40 years SE (37.3%, p=0.002) and ST (35.5%, p=0.003); for females compared to males SE (62.3% vs 37.3%, p= 0.002) and ST (61.3% vs 35.5%, p= 0.000), with a 2.9 and 2.6 times increased OR, respectively; for those with stable relationship compared to those without SE (57.5% vs 42.5%, p= 0.004) and ST (57.4% vs 42.6%, p= 0.002); for not-ordained pastor as opposed to the ordained SE (73.4% vs 26.6%, p= 0.000) and ST (72.3% vs 27.7%, p= 0.001), with a 2.0 times increased OR for ST.

The Burnout Syndrome and the stress profiles were assessed by MBI with absolute and relative frequencies for burnout 16.5%; Disengaged 24.5%; Overextended 0.9%; Ineffective 28.7%; and Engaged 29.4%.

The most significant frequencies found by MBI were for the Emotional Exhaustion subscale related to the female-population

compared to the male Moderate (p= 0.027), for the time spent in the mission field from 6 to 10 years (p= 0.000), and for those with no previous depression diagnosis (p= 0.000).

Significant frequencies were found for the SF36-Functional Capacity domain related to the age (p= 0.021) and sedentary lifestyle (p= 0.005).

Likewise, there were significant frequencies for the SF-36-Limitation by Physical Aspect domain regarding mission time (p= 0.000); other types of illness (p= 0.014); and with or without previously diagnosed psychiatric disorder (p= 0.004).

Religious coping was evaluated by the Brief RCOPE Scale, which obtained significant frequencies for the Negative RCOPE related to missionaries, with and without previous diagnosis of depression (p= 0.036); as well as among those with or without previous diagnosis of psychiatric disorder (p= 0.034),.

Regarding to Positive RCOPE, significant frequencies were obtained for the married group compared to the single group (p= 0.032), for those without hypertension compared to those with hypertension (p= 0.007),.

For the RCOPE-Factor 1, the significant frequencies were for the married compared to the single (p= 0.016), for those without stable relationship (p= 0.016); for the not-ordained pastor (p= 0.035%) and for those with a history of family depression (p= 0.019).

For the RCOPE Factor P2, significant frequencies were associated with BDI II (p= 0.030 and p= 0.016), IM-Emotional Exhaustion (p= 0.000) and for the stress profiles (p= 0.002).

Similarly, significant frequencies were found for RCOPE-Factor P3 associated with SRQ 20 (p= 0.008), BMI (p= 0.023 and p= 0.050) and SF36-Functional Capacity domain (p= 0.050).

Significant frequencies for RCOPE-Factor P4 were found in relation to marital status (p= 0.020), for the stable relationship (p= 0.003) and for those with diabetes mellitus (p= 0.004).

Equally important, frequencies were found for the RCOPE-Factor P5 associated with marital status (p= 0.034) and stable relationship (p= 0.044).

For the RCOPE-Factor P6, significant frequencies were found for the not-ordained pastor (p= 0.025) and for those with a history of family depression (p= 0.024).

The Quality of Life were verified according to the global assessment of the 8 domains screened by the SF36 for Poor/Fair with the absolute and relative frequencies for: Functional Capacity (6.7%), Limitation due to Physical Aspects (19.3%), Pain (40.4%), General Health (14.7%), Vitality (17.7%), Social Aspects (17.4%), Emotional Aspects (30%) and Mental Health (13.1%).

Discussion

The prevalence of CMD symptoms found in this sample of Brazilian cross-cultural evangelical/protestant missionaries were 29.4%, and although high, it is in accordance with literature data. In Brazil, the prevalence of the general population, according to some studies, ranges from 17% to 35% [8]. This sample also found a high prevalence of depressive symptoms 22.3%, of which 10.7% suggest Major Depressive Disorder (MDD).

Lotufo Neto (1996) found the frequency of 16.4% of MDD in his sample [9] and PG Deus (2009), states that in his clinical practice he has attended a significant number of pastors with MDD [10].

The prevalence of MDD symptoms found in this study is higher compared to the general population. According to WHO (2017) the prevalence of Depression Disorder worldwide is 4.4% and in the Brazilian population is 5.8%. Placing Brazil with the highest prevalence of depression in Latin America and the second most prevalent in the Americas, behind only to the United States, which has 5.9% [11]. Therefore, it can be stated that there is a significant impairment in this group.

Similarly, a high prevalence of Anxiety Disorder (AD) symptoms was found in the sample; 35.5% of the missionaries scored for moderate/severe anxiety symptoms for both the State and the Trait analysed (by the STAI). Although Brazil has the highest rate of AD in the world, 9.3%, the frequencies identified in this sample, were much higher than those recorded in general population studies [12], revealing that there is also a relevant impairment in this group studied.

Burnout Syndrome (BS) also obtained high and significant frequencies in this sample. 16.4% of the missionaries scored for the syndrome. In addition, high frequencies were found for the subscales: Exhaustion 17.4%, Depersonalization 41.0%, and Professional Efficacy 63.6%. These results suggest that the work performed by this group is a source of high stress, and, that, if not properly cared for, can lead the individual to develop Burnout Syndrome. The high frequencies for Depersonalization, and low Professional Efficacy, reveal that most of the missionaries surveyed has some difficulty in connecting with the local population, and do not feel proficient with the work being done [13].

Regarding stress profiles, the high prevalence found in the sample suggests that 70.6% of the missionaries had some profound impairment of negative emotion processing related to their ministry, as only 29.4% scored for Engaged.

The high prevalence found among the missionaries could be explained by the stress-generating factors surveyed through the Ministerial Inventory (IM): the need to be available 24/7, the demands from the mission agency and/or sending church, the pressure for results (expressed in number of conversions, baptisms, discipleships), feeling helpless in the field, loneliness, constant field changes, feeling unsuccessful, low salaries, lack of resources (human, financial, and equipment) for the projects, adapting to new culture (language, cooking and customs), lack of mentors, lack of proper training and spiritual preparation, lack of ability to mediate conflicts, alternation of strong emotions (elicited by having to perform funerals, marriages, baptisms, visits to the sick, visits to prisons etc.), within a short period of time, consequently making it difficult to process all these emotions [14].

The high frequencies found for the female population, such as 6.7-fold increased OR for symptoms of CMD (p= 0.000); 3.6 times for depressive symptoms (p= 0.00); 2.9 times for anxiety symptoms (p= 0.000) compared to the male population, do not differ from the literature [15].

The high prevalence of mental disorders found among the not-ordained pastors (OR increased 3.4 times for CMD and 2.8 times for AD) who had only a missional preparation may indicate that theological seminaries and college in some ways prepare missionaries to better cope in the field, as subjects such as pastoral psychology, counselling, family life cycle, spirituality, and conflict resolution favour self-knowledge and more positive management of difficulties.

The high prevalence of symptoms identified among sedentary individuals, (OR increased 2.6-fold for CMD; 2.0-fold for MDD; and 1.2-fold for AD) is widely studied, and is in agreement with the literature. Morilha (2014), in his study, found that people with sedentary lifestyle are 2.5 more likely to develop depressive symptoms than non-sedentary ones [16]. Lemos (2008) found frequencies similar to those observed in a prospective study with 168 patients divided into three groups: male and female, aged 35 to 65 years, investigated through BDI-I for both sedentary lifestyle and current smoking [17].

The poor/fair quality of life observed in the 8 domains of the SF 36 can be explained by the difficult conditions that some of the missionaries face in their cross-cultural fields.

Regarding Religious Coping, significant frequencies were found for association with Negative-RCOPE and the development of symptoms of CMD, MDD, AD, and Burnout.

Furthermore, the association of Factor N3 (Negative Meaning Revaluation) with SRQ-20 revealed a 3.9-fold increased OR for developing symptoms of CMD, and 4.3-fold increased OR for MDD. In contrast, missionaries with Positive-RCOPE revealed a protective factor against developing MDD with a 3.4-fold increased OR, and a 3.9-fold increased OR to feel Self-Fulfilled. Likewise, according to the Positive-RCOPE, Factor P2 and P7, a 2.24-fold increased OR and a 2.0-fold increased OR, respectively, for non-development of MDD, was identified [18].

Therefore, considering the results found, it could be stated that the lower the negative-RCOPE is, the lower the possibility of developing psychiatric disorders, and the higher the Positive-RCOPE is, the greater protective factor against the incidence of mental disorders is developed.

Limitations

To evaluate the symptoms of CMD, MDD, and AD, the SRQ20, BDI-II, and State-Trait STAI instruments were used. Despite being sensitive, specific for the tracking of symptoms of mental disorders and being validated in Portuguese and supported by the literature, these scales are not considered as gold standard as SCID.

Difficulties in accessing the Internet in some countries and closed country security protocols for Christianity have made it difficult to respond to the health inventories.

Conclusion

High frequencies of symptoms of CMD, MDD, AD, and BS were found among the missionaries revealing that this people group is part of the risk group for the development of psychiatric disorders, especially among the female, not-ordained pastors, those who are overseas for a period of 31 to 40 years, the overweight, the sedentary lifestyle, and those without previous diagnosis of psychiatric disorder, depression and/or anxiety.

However, it was confirmed by the Brief Religious/Spiritual Coping Scale that the lower the Negative RCOPE is, the lower the possibility of developing mental disorders and the higher the Positive RCOPE is, the greater protective factor against the incidence of mental disorders is developed.

References

1. Lucchese FA, Koenig HG (2013) Religion, spirituality and cardiovascular disease: research, clinical implications, and opportunities in Brazil. Rev Bras Cir Cardiovasc 28: 103-128.
2. Almeida-Moreira A, Sharma A, Rensburg VJB, Verhagen JP, Cook CHC (2018) Posicionamento da Associação Mundial de Psiquiatria Sobre Espiritualidade e Religiosidade em Psiquiatria. Revista debates em psiquiatria.
3. Lourenço IA (2004) A espiritualidade no processo terapêutico. Coimbra: Editora Quarteto.
4. Koenig HG, Larson D, Larson S (2001) Religion and coping with serious medical illness. Ann Pharmacother 35: 352-359.
5. Johnstone B, Franklin KL, Yoon DP, Burris J, Shigaki C (2008) Relationships among religiousness, spirituality, and health for individuals with stroke. J ClinPsychol Med Settings 15: 308-13.
6. Samano EST, Goldenstein PT, Ribeiro LM, Lewing F, Valesin ESF, et al. (2004) A Praying correlates eight higher quality of life: Results from a survey on complementary/alternative medicine use among a group of Brazilian cancer patients. Sao Paulo Med J 112: 60-63.
7. Steffen PR, Hinderliter AI, Blumenthal JA, Sherwood A (2001) Religious coping, ethnicity, and ambulatory blood pressure. Psychosom Med 63: 523-530.
8. Koenig HG, King D, Carson VB (2012) Handbook of Religion and Health. New York: Oxford University Press.
9. Kessler C (1998) Trends in Alternative Medicine Use in the United States, 1990-1997: (1998). Results of a Follow-up National Survey. JAMA 280: 1569-1575.
10. DSM 5 (2014) American Psychiatric Association. Referência rápida aos critérios diagnósticos do DSM-5. 5. ed. Porto Alegre: Artmed.
11. World Health Organization (2018) Division of mental health and prevention of substance abuse. WHOQOL and spirituality, religiousness and personal beliefs (SRPB). Genève (Report on WHO consultation).
12. Pargament KI (1997) The psychology of religion and coping: theory, research, practice. New York: Guilford Press.
13. Pargament KI, Koenig HG, Perez LM (2000) The many methods of religious coping: development and initial validation of the RCOPE. J Clin Psych 56: 519-543.
14. Harding TW, del Arango MV, Baltazar J, Climent CE, Ibrahim HH, et al. (1980) Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. Psychol Med 10: 231-241.
15. Mari JJ, Williams PA (1986) Validity study of a Psychiatric Screening Questionnaire (SRQ-20) in primary care in the city of Sao Paulo. Br J Psychiatry 148: 23-26.
16. Wang YP, Andrade LC, Gorenstein C (2005) Validation of the Beck Depression Inventory for a Portuguese-speaking Chinese community in Brazil. Braz J Med Biol Res 38: 399-408.
17. Paranhos ME; Argimon IIL, Werlang BSG (2010) Propriedades psicométricas do Inventário de Depressão BECK-II (BDI-II) em adolescentes. Avaliação Psicológica 9: 383-392.
18. Spielberg CD, Gorshuch RL, Lushene RD (1970) STAI: manual for the State-Trait Anxiety Inventory. Palo Alto, CA: Consulting Psychologists Press.