

Commentary on: *Self-care self-efficacy, religious participation and depression as predictors of post-stroke self-care among underserved ethnic minorities*

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Robertson *et al.*¹ investigated self-care self-efficacy, religiosity/spirituality (specifically, religious participation) and depression in a sample of 52 ethnic minority under-served stroke survivors, in the context of stroke self-management.¹ They used data from a randomized controlled pilot study,^{2,3} and exploited logistic regression for constructing models able to predict health behaviors and outcomes. They found that programs empowering the patients and enhancing their involvement in religious activities as well as interventions focused on depression treatment could be particularly useful for improving patients' health behaviors.

Since cardiovascular diseases have a tremendous burden and represent an important target in the field of Public Health, it is very important to have an integrated bio-psycho-social model which could serve as a translational framework for designing and implementing *ad hoc* psycho-social interventions.

Under-served ethnic minorities are particularly vulnerable since they experience disparities and inequities in accessing health services, and have a susceptible genetic and biological makeup.⁴ Moreover, ethnic minority patients have particular beliefs about their own diseases and a knowledge of these health-related beliefs as well as of perceived barriers could constitute an advancement in the field. Edelman *et al.*⁵ found a correlation between acculturation and traditional cardiovascular risk factors and health behaviors. In particular, some health beliefs were considered as an obstacle in adopting protective behaviors and having regular preventive screening and routine check-ups. Other scholars have confirmed these findings and shown further correlations between acculturation and quality of life, perceived well-being and health locus of control (LOC).⁶

Depression, another variable studied by Robertson *et al.*, is typically encountered among ethnic communities and could be associated with acculturation, deriving from the feeling of isolation or discrimination, and from a lack of integration in the new social context. Other explanations could be difficulties in

speaking a new language and communicating with the others, poor economic conditions, psycho-social distress and the generational gap.⁷

Summarizing, a typical aspect of non-Western patients is their attitude to conceive diseases as a holistic concept and to embed and incorporate spiritual and religious components in the nursing and health-care delivery. For example, prayer is deeply rooted among ethnic communities and is used by most patients suffering from chronic diseases, such as cancer and chronic heart failure (CHF).^{8,9} But religiosity does not reduce only to prayers. Religiosity and spirituality, indeed, are very broad categories which include the creeds, the rituals, the transcendental conceptions, as well as their inner incorporation and personalized ways of living and practicing them, and spiritual inclinations.

These categories can be used as predictors of well-being and health outcome in patients with CHF.¹⁰ Moreover, spirituality has been found to modulate insulin resistance, inflammatory proteins such as TNF, interleukins (namely, IL6, IL10 and their ratio), metabolism (glucose plasma level and blood lipids), physiological parameters like blood pressure and heart rate.^{11,12} Since ethnic minorities are particularly vulnerable, exhibiting higher lipoprotein(a) levels, tissue-type plasminogen activator, high prevalence of diabetes mellitus and overweight/obesity and other metabolic disorders,⁹ interventions which incorporate spiritual practices for motivating patients to adopt health behaviors are particularly clinically relevant.

Spirituality modulates not only biological variables, but also psychological ones, such as depression and psychological acculturative distress.^{13,14} Religiosity could make patients more reflective about their diseases and could have an impact on their illness cognitions, perception of symptoms burden and quality of life.^{15,16} For all these reasons, incorporating spiritual interventions is useful and meaningful also because taking into account patients' explanatory models could enable physicians to modulate psychosocial, behavioral aspects besides physiological ones and thus result more effective than traditional approaches.⁹ Moreover, as Robertson *et al.* have shown in their article, there is a strong need of culturally sensitive and tailored programs,¹⁷ specifically targeted for under-served ethnic minorities.¹⁸

References

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