Mechanisms Underlying Religious Involvement & Health among African-American Christian Family Caregivers

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Aging and Caregiving

- Number of persons 65+ projected to be 79 million by 2050.
- African American elders will quadruple by 2050, with 1 to 1.4 million estimated in poor health by 2030.
- In 2005, 2 trillion dollars spent on health care (16% GDP); will reach 4 trillion (20% GDP) in next decade.
- Primary caregivers are family; 50 million in any given year
- Economic value of “free” family caregiving is 306 billion dollars annually; almost more than twice as much as homecare and nursing home services combined.

Sheridan, 2009
Caregivers at increased risk of poor health
- Increased blood pressure/hypertension
- Increased cardiovascular disease
- Increased insulin levels
- Altered endocrine function
- Sleep disturbances
- Depression, anxiety, other mental health problems
- Increased mortality

Sheridan, 2009

Previous Paradigm of Caregiving Health Outcomes

“Stress-Adaptation” Model

Chronic stressors of caregiving positively mediated by:
- Social support
- Active coping mechanisms
- Positive attitudes toward caregiving

More recent conceptualizations focus on “caregiving rewards”
- Caregiving as reward, blessing, opportunity vs. burden, obligation or role overload

Sheridan, 2009
Previous studies on African Americans
- More positive caregiving attitudes
- Less perceived stress
- Less negative health outcomes, especially mental health

Multiple Stressors
- Higher percentage caring for children
- Higher unemployment levels
- Higher caregiving intensity
- Racism and discrimination

Role of Religion and Spirituality

Established link between religion and positive health outcomes in general population

African Americans:
- Consider God to be part of informal support to same extent as family, friends, and neighbors
- God reported as most helpful source of support, even more than help with physical care
- Prayer, faith, religion, and divine trust used more than any other coping mechanism
- Connection to faith related to caregiver reward
**Hypothesized Pathways between Religious Involvement & Health Based on “Spiritual-Adaptation-Stress Model of Caregiving”**

- Religious/Spiritual Involvement
  - Enhanced Spiritual Aspects of Caregiving Rewards: Meaning, Purpose, Connection
  - Reduced Caregiving Stressors
  - Increased Supports for Caregiving
  - Increased Positive Coping Strategies

- Physical Health
- Mental Health

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**Sampling**

- **Nonprobability Sample: DC Metro Area**
  - African Americans 18 or older
  - Providing unpaid care for elderly relative or friend, 50 or older
  - Drawn from caregiver service agencies, health agencies serving older people, and A.A. networks

- **Today’s presentation preliminary findings on:**
  - Quantitative results on $N = 147$
  - Final sample: 300 quantitative; 30 qualitative

Sheridan, 2009
**Measurement**

- **Religious/Spiritual Involvement**
  - Organized Religion (3 items)
  - Private Religious/Spiritual Practices (4 items)
  - “Intrinsic Religious Motivation Scale”

- **Spiritual Caregiving Rewards**
  - “Finding Meaning Through Caregiving Scale” *(Meaning)*
  - “Life Engagement Test” *(Purpose)*
  - “Measure of Attachment Quality” *(Connection)*

Sheridan, 2009

- **Caregiving Stressors**
  - “Caregiving Burden Inventory”
  - “Caregiver Reaction Assessment: Finances Subscale”
  - “Caregiving Distress Scale”

- **Social Support**
  - “Duke Social Support and Stress Scale: Social Support Subscale”

- **Coping**
  - “Brief Cope: Active Coping”

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Physical Health
– “Charlson Index of Comorbidity”
– “CDC (Un)Healthy Days – Physical Items”

Mental Health
– “CES-Depression Scale”
– “CDC (Un)Healthy Days – Mental Items”

Demographic Characteristics:
African-American Christian Caregivers (N = 147)

Sex:
– 91% Female
– 9% Male

Caregiver Age:
– 24 to 84 (M = 56.24; SD = 11.12)

Care Recipient Age:
– 58 to 102 (M = 81.30; SD = 8.99)

Marital Status:
– 34% Single, never married
– 34% Separated/Divorced/Widowed
– 32% Married/Partnered

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Educational Status:
- 10% less than high school
- 24% high school
- 29% some college/technical school
- 23% college graduate
- 14% graduate school

Employment:
- 40% full-time or part-time employment
- 35% retired
- 10% unemployed due to disability
- 8% unemployed and looking for work
- 6% homemaker/caregiver
- <1% student

Income:
- 21% less than $20,000
- 14% $20,001 to $30,000
- 14% $30,001 to $40,000
- 10% $40,001 to $50,000
- 6% $50,001 to $60,000
- 7% $60,001 to $70,000
- 28% over $70,000

– Median Income between $30,001 - $40,000

Sheridan, 2009
Caregiving Profiles

- Duration of Caregiving
  - \( M = 5 \text{ years, 9 months} \) (SD = 5 years, 3 months)
  - \( Range = 2 \text{ months to 25 years} \)

- Hours per week of Caregiving
  - \( M = 70 \text{ hrs} \) (SD = 53 hours)
  - \( Range = 4 \text{ to 168 hours (24/7)} \)

- Care Recipient Proximity to Caregiver
  - 73% living with caregiver
  - 22% living within 30 minutes
  - 5% living between 30 minutes and 1 hour

Main Reason for Caregiving

- 43% Alzheimer’s, other dementia
- 14% Stroke
- 8% Mobility issues
- 8% Arthritis
- 6% Heart disease
- 4% Blindness, vision loss
- 3% Cancer
- 2% High blood pressure, hypertension
- 2% Diabetes
- 2% Amputee
- 2% Mental illness, depression
- < 1% each mental retardation; lung disease/emphysema; Parkinson’s disease, paraplegia

Sheridan, 2009
**Level of Care Index**

- Caregiving intensity score based on number of ADLs and IADLs care recipient needs assistance with and number of hours of care per week.

  - 2%  Level 1
  - 6%  Level 2
  - 12% Level 3
  - 46% Level 4
  - 35% Level 5

- Median score = Level 4

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**Religious/Spiritual Identity**

- Religious Affiliation
  - 50% Baptist
  - 12% Catholic
  - 10% Nondenominational
  - 8% Pentecostal
  - 7% Methodist
  - 4% AME
  - 3% Holiness
  - 1% Seventh Day Adventist
  - 4% Other

- Self-Identification
  - 77% Both religious and spiritual
  - 20% Spiritual, but not religious
  - 2% Religious/not spiritual
  - 1% Neither religious or spiritual

Sheridan, 2009
Relationships Between Religious Involvement and Spiritual Aspects of Caregiving Rewards

7 of 9 hypothesized relationships statistically significant

Organized Religious Activities (3 items) → Purpose (LET) \( (r = .19) \)
Connection (MAQ) \( (r = .18) \)

Private Religious/Spiritual Activities (4 items) → Meaning (FMTCS) \( (r = .35) \)
Connection (MAQ) \( (r = .15) \)

Intrinsic Religiosity/Spirituality (IRMS) → Meaning (FMTCS) \( (r = .38) \)
Purpose (LET) \( (r = .27) \)
Connection (MAQ) \( (r = .34) \)

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7 of 9 hypothesized relationships statistically significant

Reduced Caregiving Stressors

Meaning (FMTCS) → Stressors: (CBS) \( (r = -.27) \)
(CDS) \( (r = -.32) \)

Purpose (LET) → Stressors: (CBS) \( (r = -.39) \)
(CRA-F) \( (r = -.31) \)
(CDS) \( (r = -.37) \)

Connection (MAQ) → Stressors: (CBS) \( (r = -.32) \)
(CRA-F) \( (r = -.31) \)
(CDS) \( (r = -.46) \)

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Relationships Between Spiritual Caregiving Rewards and Caregiving Supports and Positive Coping

- Enhanced Spiritual Aspects of Caregiving Rewards: Meaning, Purpose, Connection
- Increased Supports for Caregiving
- Increased Positive Coping Strategies

4 of 6 hypothesized relationships statistically significant

Meaning (FMTC5) → Social Support: (Duke SS) \( r = .21 \)
Coping: (Brief COPE) \( r = .16 \)

Purpose (LET) → Social Support: (Duke SS) \( r = .20 \)

Connection (MAQ) → Social Support: (Duke SS) \( r = .15 \)

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Relationships Between Caregiving Stressors & Mental and Physical Health

- Reduced Caregiving Stressors
- Physical Health
- Mental Health

8 of 12 hypothesized relationships statistically significant

Stressors: (CBI) → Physical (Un)Healthy Days (CDC-HD) \( r = .52 \)
Stressors: (CDS) → Physical (Un)Healthy Days (CDC-HD) \( r = .39 \)
Stressors: (CBI) → Mental (Un)Healthy Days (CDC-HD) \( r = .59 \)
Depression (CES-D) \( r = .55 \)
Stressors: (CRA-F) → Mental (Un)Healthy Days (CDC-HD) \( r = .21 \)
Depression (CES-D) \( r = .20 \)
Stressors: (CDS) → Mental (Un)Healthy Days (CDC-HD) \( r = .52 \)
Depression (CES-D) \( r = .46 \)

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Relationships Between Caregiving Supports & Mental and Physical Health

4 of 4 hypothesized relationships statistically significant

Social Support : (Duke SS) → Physical Health Status (CIC) \( r = -0.15 \)
Physical (Un)Healthy Days (CDC-HD) \( r = -0.16 \)

Social Support : (Duke SS) → Mental (Un)Healthy Days (CDC-HD) \( r = -0.20 \)
Depression (CES-D) \( r = -0.17 \)

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Relationships Between Positive Coping & Mental and Physical Health

2 of 4 hypothesized relationships statistically significant

Coping: (Brief COPE) → Physical Health Status (CIC) \( r = -0.15 \)

Coping: (Brief COPE) → Mental (Un)Healthy Days (CDC-HD) \( r = -0.18 \)

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Observed Pathways between Religious Involvement & Health Based on Spiritual-Adaptation-Stress Model of Caregiving

- Religious Involvement
- Enhanced Spiritual Aspects of Caregiving Rewards: Meaning, Purpose, Connection
- Reduced Caregiving Stressors
- Increased Supports for Caregiving
- Increased Positive Coping Strategies
- Physical Health
- Mental Health

Study Limitations

- Nonprobability Sample of African Americans in DC Metro Area
- Cross-sectional study – correlational, not causal
- Multiple bivariate analyses increase chance of results due to chance
**Implications for Social Work Practice**

- Increased awareness and knowledge regarding:
  - Caregiving intensity and areas of caregiving stress
  - Potential of caregiving for spiritual rewards (meaning, purpose, and connection)
  - Influence of spiritual rewards as mediator of negative impacts (stressors) and positive impacts (social support and coping)
  - Influence of spiritual rewards on both physical and mental health

  Sheridan, 2009

- Attention to caregiver as well as care recipient
  - Assess caregiver’s physical and emotional health
  - Assess involvement in both organized religion and religious/spiritual practices as possible resources for caregivers
  - Assess caregiving rewards as well as stressors

  Sheridan, 2009
Use practice approaches that are holistic and spiritually-sensitive

- Include interventions that help facilitate exploration of the spiritual rewards of caregiving (meaning, purpose, and connection)

- Recognize religious/spiritual resources as potential sources of social support and positive coping

- Collaborate with religious/spiritual resources to support continued involvement if these deemed important

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