



The Perceived Value of Religious Coping as a Predictor of Caregiving Outcomes in Mexican-American Families

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Abstract

Using interview data from 47 Mexican-American filial caregivers, this study explored the extent to which the perceived value of religious coping predicted both positive and negative caregiving outcomes. Religious coping included participation in religious services/activities, and the practice of prayer and/or meditation. Caregiving outcomes included perceived benefits derived from caregiving and subjective burden. Covariates included caregiver age and income, co-residence with the care receiver, cultural orientation, the extent of the care receiver's functional impairment, restrictions on the caregiver's social activities, and the caregiver's sense of mastery and competence in caregiving. Use of prayer/meditation was predictive of perceived personal gains, whereas participating in religious services and activities was predictive of lower levels of subjective burden.

Rationale

- There is increasing evidence that religious coping is an important factor in the experience of caring for a loved one who is frail and dependent (Pearce, 2005). Nevertheless, the effects of religious and spiritual coping are still unclear, particularly in different ethnic and racial groups (Hebert, Weinstein, Martire, and Schulz (2006).
- There has been a substantial increase in the elderly Hispanic population (Angel & Whitfield, 2007) and there is a cultural preference for 'la familia' as the primary caregiver setting (Herrera, Lee, Palos & Torres-vigil, 2008).
- Hispanic caregivers are more likely to be in more intense and/or more time-consuming caregiving circumstances than non-Hispanic caregivers.

Purpose

The purpose of the study was to contribute further understanding to the role that religiosity may play in Hispanic caregiving by examining whether religious coping was associated with positive and/or negative outcomes of filial caregiving in Mexican-American families.

Value of Religious Coping

- The use of religion and/or spirituality as a means of coping with stress has been documented in a number of studies wherein the findings link religious involvement with improved mental and physical health outcomes, including, lower psychological distress, faster illness recovery time, reduced mortality, and lower rates of physical and mental illness (Levin, 2006; Levin, Chatters, & Taylor, 2010; Stuckey, 2003).
- Benefits of religious coping manifest in three ways: (1) facilitation of cognitive re-structuring via the individual's belief system, (2) social support via their chosen religious community, and (3) a sense of control over applicable stressors (Tix & Frazier, 1998).
- Religion and spirituality may impact individual well-being through supportive social networks and facilitation of positive emotions (Carver, Scheier, & Weintraub, 1989)

Religious Coping and Caregiving

- Several studies have documented the benefits of religious coping in response to caregiver stressors (see Pargament, 1997, for a review)
- Religious and spiritual practices have been reported as effective coping mechanisms for persons caring for loved ones afflicted with Alzheimer's disease (Stuckey, 2001; Kail & Cavanaugh, 2000)
- Caregivers frequently turn to religion as a means of coping with the stressors they face (Murray et al., 2006)
- A high percentage of caregivers (64-72%) reported use of prayer ($r=.89$, $p=.01$) and religious service attendance as effective coping mechanisms for caregiving (Stolley, Buckwalter, & Koenig, 1999)

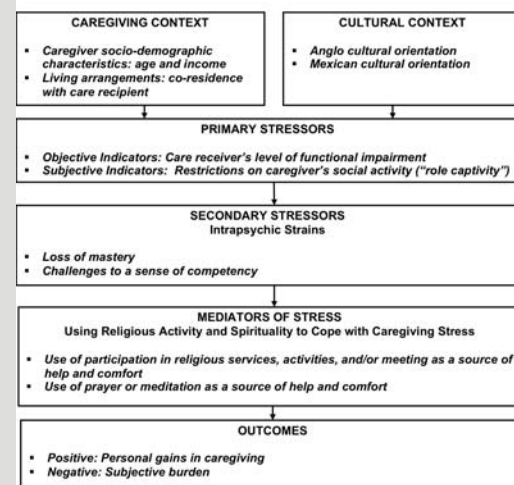
Hypotheses

- The help and comfort that a caregiver derives from participating in religious services and activities will be predictive of both perceived personal gains in caregiving and subjective burden.
 - The help and comfort that a caregiver receives from prayer and meditation will be predictive of both perceived personal gains in caregiving and subjective burden.
- Measures of religious coping were hypothesized to be positively associated with positive gains, and negatively associated with subjective burden.

Conceptual Model

The conceptual model undergirding the study was adapted from a theory of caregiver burden initially proposed by Barber (1989) and subsequently revised based on work by Pearlin, Mullan, Semple, and Skaff (1990) for use in a study of differences in the caregiving experience between Hispanic and non-Hispanic White caregivers (Barber & Vega, 2004). The model is illustrated in Figure 1, and depicts caregiving outcomes (both positive and negative) as being a product of four domains of variables: those associated with the context of caregiving, cultural factors, primary stressors, secondary stressors, and mediating factors.

Figure 1. Conceptual Model: Predictors of Positive and Negative Caregiver Outcomes for Hispanic Caregivers



Methodology

Recruitment and Data Collection

Caregiving families were recruited via referrals from churches, hospitals, congregate meal sites, and other human service agencies in Colorado. All were providing at least weekly assistance to an elderly parent in the form of help with two or more activities of daily living (e.g. grooming, meal preparation, dressing, etc.). Although 54 of the 113 families were Mexican American, only 47 were included for the analyses presented in this poster. Data were collected via face-to-face interviews. About one-third of the caregivers elected to have the interview conducted primarily in Spanish.

Respondent Characteristics

- Filial caregiver mean age of 46 (SD = 12.65, range = 30-74).
- Average age of parent receiving care 76.6 (SD = 11.7, range = 60-96).
- 83% of caregivers were female, had at least a high school education (76.6%), were employed full-time (59.6%), had a modal annual household income of between \$30,000-\$50,000 and had been providing help with at least two ADL's to a parent for a modal period of 4 years.
- All of the respondents were of Mexican lineage; 21% were born in Mexico, 28% were first generation in the United States, 15% second, 13% third, and 23% fourth generation.

Measurement of Variables

Caregiving context: Caregiver age and income, and whether the care recipient was co-residing with the caregiver.

Cultural context/orientation: Scale 1 of the revised Acculturation Rating Scale for Mexican Americans [ARMSA-II] (Cuellar, Arnold, & Maldonado, 1995).

Care recipient impairment: Measured using the Katz Activities of Daily Living scale (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963), and the Lawton Instrumental Activities of Daily Living scale (Lawton & Brody, 1969). The higher the score, the greater the impairment.

"Role captivity": Scale developed for the REACH project (Rubert & Ory, 1998). The higher the score, the fewer the restrictions (i.e. the less the role captivity) in the caregiver's social activities as a result of caregiving.

Loss of mastery: Scale developed by Pearlin and his colleagues (Pearlin & Schooler, 1978; Skaff, Pearlin, & Mullan, 1996). Scale items are summed to derive a total score; higher scores are indicative of greater perceived mastery and control in the context of caring for a loved one who is frail and dependent.

Perceived sense of caregiving competency: Caregiving Competence Scale created by Skaff (reported in Pearlin et al., 1990). 7 items in scale are summed. Higher scores are indicative of greater feelings of competency in fulfilling the caregiving role.

Religious coping: Measured using two items from the REACH project: "To what extent has participation in religious services, meetings, and/or activities been a source of help and comfort to you in providing help to (care recipient)?" and "To what extent has prayer or meditation been a source of help and comfort to you in providing care to (care recipient)?" The response set is: Not at all; Some; Quite a bit; A great deal. Higher scores are indicative that the caregivers derives help and comfort from these sources.

Personal gains in caregiving: Measured using a 4-item scale wherein are listed some benefits of caregiving: "How much have you become more aware of your inner strengths from taking care of ____?" "How much have you become more self-confident?" "How much have you grown as a person?" and "How much have you learned to do things you didn't do before?" Reported alpha for this scale is .76 (Pearlin et al., 1990). The higher the score, the greater the personal gains perceived by the caregiver.

Subjective burden: Measured using 10 items from a caregiving appraisal instrument developed by Lawton et al. (1989). Higher scores are indicative of greater subjective burden.

Findings

Correlations Between Religious Coping and Outcome Measures

Table 1: Bivariate analysis of religiosity measures with measures of caregiver well-being

	Positive Gains Derived from Caregiving	Subjective Burden	Help and Comfort from Participation in Religious Services, Meetings, & Activities	Help and Comfort from Use of Prayer/Meditation
Positive aspects of caregiving	1.0	--	--	--
Subjective burden	-.066	1.0	--	--
Help and comfort from participation in religious services, meetings, & activities	.048	-.412**	1.0	--
Help and comfort form use of prayer or meditation	.305*	-.079	.525**	1.0

***p < 0.001 **; p < 0.01; *p < 0.05

Religious Coping As A Source of Help and Comfort in Caregiving

Table 2: Standardized regression coefficients of religious coping as predictors of caregiver well-being

	Personal Gains Derived from Caregiving β	Subjective Burden β
Contributions of religiosity to the caregiving experience		
Participation in religious services, meetings, and activities as a source of help and comfort in caregiving	.197	-.413**
Use of prayer or meditation as a source of help and comfort in caregiving	.254*	.089
Covariates		
Caregiver age	-.135	-.102
Caregiver income	.149	-.292
Living arrangements: Co-residing with care recipient	-.097	.040
Acculturation: Anglo cultural orientation	-.201	.004
Acculturation: Mexican cultural orientation	.320*	-.061
Care receiver's functional impairment	.278	.227
Restrictions on social activities ("role captivity")	.057	-.164
Caregiver mastery	.064	.111
Caregiver competence	.787***	-.297
R2	.746	.437
Adjusted R2	.646	.216

***p < 0.001 **; p < 0.01; *p < 0.05; β = standardized coefficient

Findings and Discussion

Table 1 displays the correlation coefficients among measures of caregiving outcomes and measures of religious coping. Regression models for measures of religious coping with caregiving outcomes as dependent variables are shown in Table 2. Treated as covariates in these models are other contributing factors from the conceptual model.

Hypothesis 1: Participating in religious activities was moderately predictive of lower levels of subjective burden, but was not predictive of personal gains derived from caregiving.

- Social support afforded by participating in faith-based communities may lessen perceived costs of caregiving.
- Those who attend religious services and activities may feel less isolated.

Hypothesis 2: Use of prayer or meditation was slightly predictive of personal gains perceived to be derived from caregiving, but was not predictive of subjective burden.

- Prayer/meditation may be a means of deriving intrinsic benefits, such as meaning or purpose, in the caregiver predicament.
- Prayer/meditation may allow individuals to view or reframe caregiving in a broader and more positive context.
- The focus of prayer/meditation may be such that it cultivates inner strength and helps focus on the benefits rather than the costs of caregiving.

Other: Caregivers with a predominantly Mexican orientation derived greater perceived personal gains from caregiving than did those with a predominantly Anglo orientation

- Consistent with findings reported by Barber and Vega (2004), Hispanic caregivers who have a strong Mexican orientation may embrace a perspective that emphasizes caregiving as a source of pride, and consequently may be more likely to derive personal gains, fulfillment, and/or satisfaction.

Limitations

- Religiosity was not distinguished from religious coping.
- Religious coping was narrowly defined in terms of participation in religious activities and the use of prayer and meditation.
- The measure of religious coping should have been multi-dimensional, and included both coping techniques and the functions of prayer.
- The study design was cross-sectional, and as such unable to capture the role of religious coping over the caregiving trajectory.
- Participants included only Mexican-Americans, and may not represent other groups of Hispanic caregivers residing in the United States.

Implications and Directions for Future Research

- Culturally sensitive interventions targeting Mexican-American caregivers should include the use of religious coping strategies.
- Future studies should closely examine the role of prayer and religious activities on caregiver outcomes using more precise, multidimensional measures; these studies should not preclude the potential negative influence of religiosity or religious coping.
- Given the potentially powerful role that religious communities may play amongst ethnic groups, they may present a culturally sensitive venue through which social programs could work to facilitate well-being interventions for caregivers and care recipients. Efforts aimed at collaboration between these two groups could present a valuable and cost-effective means of intervention.