Is Religiosity a Protective Factor for Mexican-American Filial Caregivers?

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Using interview data collected from 47 Mexican-American families, this study explored whether two measures of religiosity—prayer and/or meditation, and participation in religious services—predicted caregiving outcomes in filial caregivers. Dependent variables included the perceived benefits derived from caregiving, and the subjective appraisal of caregiving as burdensome. Treated as covariates were caregiver age and income, care receiver co-residence, cultural orientation, 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 and/or meditation was predictive of the perception that caregiving resulted in perceived benefits, and participating in religious services/meetings/activities was predictive of lower levels of subjective burden.

KEYWORDS eldercare, filial caregiving, Mexican-American caregivers, religiosity

Data collected during the 2010 U.S. Census reveal that the Hispanic population now numbers around 50.5 million and constitutes 16% of the total population. Based on the current growth trajectory, this percentage will increase to 25% by 2025, and to 33% by 2050 (Ennis, Rios-Vargas, & Albert, 2011). Because the Hispanic population is relatively young, often overlooked is the fact that the number of older Hispanics is also rising. In 2010, there were 2.9 million Hispanic elderly. By 2050, this figure is projected to be 17.5 million, at which time the proportion of the Hispanic population age 85 and older will have increased from 5% to 15% (Vincent & Velkoff, 2010).

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An important impact of this demographic trend is that Hispanic families are becoming increasingly involved in eldercare at home, even more than is the case in the general population. A national survey of caregivers, for example, reported that 36% of Hispanic households have at least one family member caring for an elderly loved one, compared to 21% of all U.S. households (National Alliance for Caregiving & Evercare, 2008).

**POSITIVE APPRAISAL AND SOCIAL SUPPORT AS PROTECTIVE FACTORS**

Caring for an elderly family member can have consequences that may negatively impact the well-being of caregivers. Indeed, several studies have reported that Hispanic caregivers are at disproportionate risk of developing physical and mental health problems (Markides, Eschbach, Ray, & Peek; 2007). Consequently, it becomes important to identify protective factors that may buffer the negative impacts of caregiving.

Among the findings often reported in studies comparing the appraisal of caregiving by Hispanic versus Caucasian family caregivers is that the former report deriving greater gains and benefits from caregiving, and are less likely to describe the caregiving experience as bothersome, despite devoting more hours to caregiving each week, and having lower levels of income (Barber & Vega, 2004; Coon et al., 2004). Collectively, these findings have prompted some researchers to conclude that Hispanic caregivers embrace a cultural worldview of caregiving centered more on the positive outcomes and gains (Barber & Vega, 2004). In discussing findings from a study involving Hispanic versus Caucasian female caregivers of family members with dementia, Coon et al. (2004) observed that caregiving is generally viewed more positively by Hispanics because it is framed as a process that strengthens family relationships and supports social continuity. Harwood et al. (2000) have suggested that Hispanic caregivers’ perceptions of available support by family may be an important factor contributing to a positive appraisal of the caregiving experience, and consequently serve as a protective factor against the negative impacts of caregiving.

The research reported in this article centers on religiosity as a protective factor related to both positive appraisal and social support. In studies comparing Hispanic and Caucasian caregivers, a frequently reported finding is that Hispanic caregivers are more likely to report using prayer and involvement in religious activities as a means of coping with caregiving (Adams, Aranda, Kemp, & Takagi, 2002, Calderon & Tennstedt, 1998). In this context, Coon et al. (2004, p. 341) observed that “religious and spiritual activities may serve as particularly important coping strategies for Latinas to help buffer against the daily stress of caregiving through their promotion of social integration, social support, and relationship with God.”
The purpose of this study was to explore the association between measures of religiosity and caregiving outcomes among Mexican-American filial caregivers. Specifically, the study investigated the extent to which the organizational and nonorganizational dimensions of religiosity reported by Mexican-American adult children affected the perceived benefits derived from caring for an elderly parent, and their appraisal of the caregiving as burdensome.

RELIGION, SPIRITUALITY, AND RELIGIOSITY

Religion, spirituality, and religiosity are often used interchangeably in the Hispanic caregiving literature, but there are subtle conceptual differences. Religion is conceptually defined as a discrete set of beliefs, practices, ideas, and language embraced by a community in search of sacred or transcendent meaning (Hebert, Weinstein, Martire, & Schulz, 2006; Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009). Spirituality is often conceptually framed as a belief in (or a search for) the transcendent, or that which positively affirms human life (Herrera et al., 2009).

By contrast, religiosity is defined as a multidimensional concept involving (a) the internalization of basic faith or belief principles, (b) the organized, public practice of religious rituals, such as attending and/or participating in religious services and activities), and (c) the nonorganized, private practice of religious rituals, such as prayer, meditation, studying sacred texts and writings (Pearce, 2005). The focus of this study was on the organized and nonorganized dimensions of religiosity: Attending and participating in religious services and activities, and the use of prayer and/or meditation.

RESEARCH QUESTION AND HYPOTHESES

The general question guiding this study was: To what extent is religiosity perceived by Hispanic filial caregivers to be a source of help and comfort in coping with the stresses associated with caring for an elderly parent? In answering this question, two hypotheses were addressed:

1. As a measure of the organized dimension of religiosity, attending church services and participating in religious activities will be predictive of caregiver well-being. Caregivers reporting that attending church services and participating in religious activities is a source of help and comfort in caregiving will be more likely to perceive the benefits derived from caregiving, and will report lower levels of subjective caregiving burden.
2. As a measure of the nonorganized dimension of religiosity, prayer, and/or meditation will be predictive of caregiver well-being. Caregivers who report
that prayer and/or meditation is a source of help and comfort in caregiving will be more likely to perceive the benefits derived from caregiving, and will have lower levels of subjective caregiving burden.

CONCEPTUAL MODEL

The variables measured in the study were derived from a conceptual model initially proposed by Barber (1989), and subsequently revised based on the work of Pearlin, Mullan, Semple, and Skaff (1990). The model is illustrated in Figure 1, and depicts both positive and negative caregiving outcomes as being the product of four domains of variables: those associated with the context of caregiving, primary stressors, secondary stressors, and factors that mediate or buffer the impact of stressors on caregiving outcomes.

CAREGIVING CONTEXT
- Caregiver sociodemographic characteristics: age and income; living arrangements: co-residence with care
- Cultural orientation (Anglo and Mexican) recipient

PRIMARY STRESSORS
- Objective: Care receiver’s level of functional impairment
- Subjective: Restrictions in social activity (“role captivity”)

SECONDARY STRESSORS – INTRAPSYCHIC STRAINS
- Loss of mastery
- Challenges to a sense of competency

RELIGIOSITY AS A MEDIATOR OR BUFFER OF STRESS
- Use of participation in religious services, activities, and/or meeting as a source of help and comfort in caregiving
- Use of prayer or meditation as a source of help and comfort

CAREGIVING OUTCOMES
- Positive: Personal gains derived from caregiving
- Negative: Subjective burden (appraisal centered on the perceived personal “costs” of caregiving)

FIGURE 1 Conceptual model: Predictors of positive and negative caregiver outcomes for Hispanic caregivers.
The Context of Caregiving

The context of caregiving includes such factors as caregiver characteristics (e.g., age and income) and living arrangements (i.e., whether the care recipient is co-residing with the caregivers). Context also includes such factors as ethnicity and measures of acculturation, such as cultural orientation. Although not diagrammed as such in Figure 1, contextual factors exert their influence throughout the caregiving process.

Primary Stressors

Primary stressors are both objective and subjective in nature. Objective stressors center on the care receiver’s level of impairment. This includes both the ability to perform activities of daily living (ADL) as well as cognitive status. The range and difficulty of caregiving activities and the ability of caregivers to manage their relationships with their impaired relatives are directly impacted by a loved one’s ADL capacity, memory loss, communication deficits, and recognition failures, and problem behaviors such as wandering. Subjective indicators of stress include such factors as role overload, role captivity (feelings of entrapment and confinement), and relational deprivation (the loss caregivers feel as their relationship with the care recipient becomes more distant and unfamiliar).

Secondary Stressors

Secondary stressors represent the concept of “secondary appraisal” reported by Lawton, Moss, Kleban, Glicksman, and Rovine (1991). These stressors are viewed as secondary, not because they are less significant than primary stressors, but because they are an outgrowth of the ongoing process of caregiving (Whitlatch & Noelker, 1996). Among secondary stressors are intrapsychic strain; challenges to a caregiver’s sense of mastery/control, and the erosion of feelings of competency and self-esteem.

Mediating or Protective Factors

Over time, as the care recipient’s condition worsens, primary and secondary stressors proliferate. This can often produce negative caregiver outcomes such as depression, anger, anxiety, and compromised physical health. Mediating or protective factors, such as religiosity, have the potential to limit or buffer this proliferation by lessening the negative effects of the multiple domains of stress. In the present study, both the organizational and nonorganizational dimensions of religiosity are framed as mediating or protective factors.
Caregiving Outcomes

The experience of caring for an elderly parent involves both positive and negative outcomes. The negative outcomes of caregiving, however, have received far more attention in the literature than have positive outcomes. Common measures of negative outcomes include depression, anxiety, and declines in physical health. Since family caregiving is performed for an individual with whom the caregiver has had a form of emotional attachment, some of the outcomes of caregiving are likely to be positive, and there are personal gains or benefits to be derived from caring for a loved one. This may be particularly true for Hispanic caregivers given the importance of *la familia* and the cultural value of *familismo* (Sabogal, Marin, Otero-Sabogal, Vanoss-Marin, & Perez-Stable, 1987).

**METHODS**

**Data Collection**

A total of 113 caregiving families were recruited via referrals from churches, hospitals, congregate meal sites, and a variety of human service agencies. 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, and dressing). Among those interviewed were 47 Hispanic caregivers, who constitute the focus of this article.

The interview protocol was such that only one filial caregiver could serve as the primary respondent for each family, and one elderly parent could serve as the referent for the questions specifying the recipient of care. In instances where two or more siblings were providing care, the sibling who had provided the most care and support to the parent during the 12 months preceding the interview was selected as the primary caregiver. Although some siblings “took turns” caring for a parent, there was little disagreement regarding who had provided the majority of care during the year preceding the interview. In families where more than one elderly parent was receiving care, the parent who had received the most care (defined as receiving the most help with activities of daily living) during the year preceding the interview was selected as the “care recipient” referent.

Data were collected via face-to-face interviews that lasted, on average, about two hours. Consent to participate in the study was verbally solicited during the initial phone contact, and again at the outset of the interview in the form of signed consent. Contact information (including names) was not recorded on interview booklets. The majority of the interviews were conducted at the caregiver’s place of residence. In most instances of co-residency, the care-receiving parent was not present during the interview. For Hispanic participants, interviews were conducted in Spanish or English,
depending on the caregiver’s preference. About one-third of the Hispanic caregivers elected to have the interview conducted in Spanish.

Measures

Most of the measures were derived from the REACH project (Wisniewski et al., 2003). Additional measures were gleaned from a large NIMH (National Institute of Mental Health) study of caregivers in California (Pearlin et al., 1990), from the National Study of Households and Families (Sweet, Bumpass, & Call, 1988), and from a study of work-family conflict among employed caregivers (Neal, Ingersoll-Dayton, & Starrels, 1997). The selection of variables for this investigation was guided by the conceptual model presented in Figure 1. They are presented below in the order in which they appear in the model.

Caregiving context. Variables in this domain included caregiver age and income, and whether the care recipient (a parent or parent-in-law) was co-residing with the caregiver.

Cultural context. There are several salient variables in the domain of cultural context that influence caregiving outcomes. Selected for this study was cultural orientation, measured using Scale 1 of the revised Acculuration Rating Scale for Mexican Americans (ARSMA-II) (Cuellar, Arnold, & Maldonado, 1995). The ARSMA-II contains 30 items, and consists of two subscales: the Mexican orientation subscale (MOS), and the Anglo orientation subscale (AOS). Both subscales use a 5-point response set described as Not At All; Very Little or Not Very Often; Moderately; Much or Very Often; Extremely Often or Almost Always. Items address language usage and preference, ethnic identity, and ethnicity of social relations. For this study, items for each scale were summed, with higher MOS scores being indicative of greater Mexican orientation, and higher AOS scores being indicative of greater Anglo orientation. The ARSMA-II subscales have evidenced good internal consistency (Cronbach’s $\alpha = .83$ for the AOS and .88 for the MOS) and stability across a two-week period (.94 and .96, respectively; Cuellar et al., 1995). In the current study, coefficients of reliability for the AOS and the MOS were .88 and .89, respectively.

Objective indicator of primary stress: Care recipient impairment. The degree of care recipient impairment was measured using items from 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 ADL/IADL sections assessed care recipient’s ability to perform tasks of day-to-day importance (activities of daily living: ADLs), and to live independently in the community (instrumental activities of daily living: IADLs). ADL and IADL items are summed to derive an overall measure of impairment or functional capacity. The higher the score, the greater the impairment.
Subjective indicator of primary stress: “Role captivity.” The notion of role captivity is based on the perception of being restricted in social activities due to caregiving involvement (Aneshensel, Pearlin, & Schuler, 1993). The scale used to measure role captivity was derived from the Social Activities measure developed for the REACH project (Rubert & Ory, 1998). The scale consisted of six items designed to assess how satisfied the caregiver is—in the context of caregiving responsibilities—with the frequency that they have engaged in activities such as spending quiet time by oneself and taking part in hobbies over the past month. There was a seventh summary item which is worded “Over the past month, how satisfied are you with the amount of time you have been able to spend in activities that you enjoy?” Response options to this item matched the others in the scale: Not at all; A little; A lot. A score for this scale is derived by summing the seven items. 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.

Secondary stressors: Mastery and competence. Caregiving mastery was measured using seven items developed by Pearlin and his colleagues (Pearlin & Schooler, 1978; Skaff, Pearlin, & Mullan, 1996). This scale measures the extent to which a caregiver feels she or he can exercise some degree of control over caregiving experiences and circumstances. Response categories are set on a 4-point Likert scale (strongly disagree to strongly agree). Responses to 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 caregiving competency was measured using a 4-item scale requesting participants to rate the perceived adequacy of their performance as caregivers (alpha = .74). The Caregiving Competence Scale was created by Skaff (reported in Pearlin et al., 1990). Sample items include: “How much do you believe that you’ve learned how to deal with a very difficult situation?” and “How much do you feel that all in all, you are a good caregiver?” Response set categories are Very much; Somewhat; Just a little; Not at all. A total scale score is obtained by summing items. Higher scores are indicative of greater feelings of competency in fulfilling the caregiving role.

Religiosity. The role of religiosity in coping with caregiving was 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 the organizational and nonorganizational dimensions of religiosity.

Personal gains and benefits derived from caregiving. The positive outcomes of caregiving were 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). Response categories were Very much; Somewhat; Just a little; Not at all. The higher the score, the greater the personal gains perceived by the caregiver.

Subjective burden. The negative outcomes of caregiving on caregiver well-being was measured using 10 items from a caregiving appraisal instrument developed by Lawton et al. (1989). The reported alpha coefficient is .87 (Lawton, Kleban, Moss, Rovine, & Glicksman, 1989). For the current study, the coefficient of reliability was .83. A sample item is the extent to which caregivers feel they have lost control of their life as a result of caregiving. Items 1–7 are scored on a 5-point scale described as Never; Rarely; Sometimes; Quite Frequently; Nearly Always. Items 8–10 use the following response set: Agree a Lot; Agree a Little; Neither Agree nor Disagree; Disagree a Little; Disagree a Lot. Some items are reverse-scored so that higher scores are indicative of greater subjective burden.

RESULTS

Caregiver Characteristics

Filial caregivers who participated in the study had a mean age of 46 (SD = 12.65, range = 30–74); the average age of the parent receiving care was 76.6 (SD = 11.7, range = 60–96). Most caregivers were female (83%), 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 some level of support (i.e., help with at least two more activities of daily living) to a parent for a modal period of four years. About 4 in 10 caregivers co-resided with the parent receiving care. 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.

Religiosity and Caregiving Outcomes

Table 1 displays the correlation coefficients among measures of positive and negative caregiving outcomes and two dimensions of religiosity. As hypothesized, the measure of organized religiosity—participating in religious services/meetings/activities—was negatively correlated with subjective burden, whereas prayer and meditation—representing the nonorganizational dimension of religiosity—was positively correlated with perceived benefits derived from caregiving.
Regression models for measures of religiosity with the two dependent variables, caregiving benefits/gains and subjective burden, are shown in Table 2. Treated as covariates are other contributing factors from the conceptual model presented in Figure 1. As sources of help and comfort for Mexican-American caregivers interviewed in this study, the two measures of religiosity were slightly predictive of caregiver outcomes. Use of prayer or meditation was predictive of the perception that caregiving resulted in personal gains and benefits, and participating in religious services, meeting, and activities was predictive of lower levels of subjective burden.

**DISCUSSION**

Based on a comprehensive review of 84 studies, Hebert et al. (2006) report that three mechanisms may link religion/spirituality to caregiver well-being: Supportive social networks, coping resources (i.e., cognitive restructuring and appraisal), and positive emotions that improve relationship quality. In this study, the finding that Hispanic caregivers who reported higher levels of organized religious participation also reported lower levels of subjective burden might be explained by the fact that such participation affords them higher levels of social support, and consequently, lower levels of burden. In comments to open-ended questions at the conclusion of the interviews, a number of caregivers observed that associations with members of their faith-based communities was a source of strength during difficult times in caregiving. They would seek the advice of other church members, and share caregiving experiences with others who were also involved in caregiving.
TABLE 2 Standardized Regression Coefficients of Religious Coping as Predictors of Caregiver Well-being

<table>
<thead>
<tr>
<th>Contributions of religiosity to the caregiving</th>
<th>Personal Gains Derived From Caregiving</th>
<th>Subjective Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in religious services, meetings, and activities as a source of help and comfort in caregiving</td>
<td>.197</td>
<td>−.413**</td>
</tr>
<tr>
<td>Use of prayer or meditation as a source of help and comfort in caregiving</td>
<td>.254*</td>
<td>.089</td>
</tr>
</tbody>
</table>

Covariates

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Personal Gains Derived From Caregiving</th>
<th>Subjective Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver age</td>
<td>−.135</td>
<td>−.102</td>
</tr>
<tr>
<td>Caregiver income</td>
<td>.149</td>
<td>−.292</td>
</tr>
<tr>
<td>Living arrangements: Co-residing with care recipient</td>
<td>−.097</td>
<td>.040</td>
</tr>
<tr>
<td>Acculturation: Anglo cultural orientation</td>
<td>−.201</td>
<td>.004</td>
</tr>
<tr>
<td>Acculturation: Mexican cultural orientation</td>
<td>.320*</td>
<td>−.061</td>
</tr>
<tr>
<td>Care receiver’s functional impairment</td>
<td>.278</td>
<td>.227</td>
</tr>
<tr>
<td>Restrictions on social activities (“role captivity”)</td>
<td>.057</td>
<td>−.164</td>
</tr>
<tr>
<td>Caregiver mastery</td>
<td>.064</td>
<td>.111</td>
</tr>
<tr>
<td>Caregiver competence</td>
<td>.787****</td>
<td>−.297</td>
</tr>
</tbody>
</table>

$R^2$ | .746 | .437 |

Adjusted $R^2$ | .646 | .216 |

*p < .05; **p < .01; ***p < .001.

Note. β = standardized coefficient.

With regard to the nonorganized dimension of religiosity, caregivers engaging in prayer and/or meditation were more likely to perceive the benefits and gains derived from caregiving. It is likely that this finding is a product of cognitive restructuring and appraisal.

In addition to prayer, the present study also examined the impact of meditation on Hispanic filial caregiving. While there is little research on meditation among Hispanic caregivers, Waelde, Thompson, and Gallagher-Thompson (2004) introduced dementia caregivers (eight Hispanic women and four Caucasian women) to a meditation intervention intended to facilitate an ability to detach from negative cognitive patterns, reduce depression, and increase self-efficacy in controlling distressing thoughts and negative thinking patterns related to caregiving. Results were promising, showing a statistically significant reduction in depression and anxiety and in increase in self-efficacy.

While the findings reported in this article contribute to the literature, there are some important limitations. As with many Hispanic caregiving studies involving religion and/or spirituality, no differentiation was made between religiosity and religious coping. A notable exception is a study by Herrera et al. (2009) involving a sample of 66 Mexican-American caregivers, for whom well-being was measured in terms of perceived burden,
depression, and subjective mental and physical health. Intrinsic, organizational, and nonorganizational religiosity were measured using the Duke Religiosity Index (Storch et al., 2004). Religious coping (both positive and negative dimensions) was measured using the Brief Religious Coping Scale (Pargament, 1999). After controlling for sociocultural factors and other forms of formal and informal support, the general finding was that both religiosity and religious coping were related to the mental health and burden of caregivers, but not to self-rated physical health. Hispanic caregivers reporting higher levels of both intrinsic and organizational religiosity were less likely to perceive caregiving as burdensome, while caregivers with higher levels of nonorganizational religiosity (e.g., prayer and meditation) reported worse mental health.

In offering an explanation for the finding that nonorganizational religiosity was associated with poorer mental health, Herrera et al. (2009) observe that poorer mental health may be more prominent among caregivers who are unable to participate in public religious rituals (i.e., church attendance) as a result of increased caregiving responsibilities and burden, which may lead them alternatively to seek relief through prayer and meditation.

REFERENCES


Religiosity as a Protective Factor in Filial Caregiving


