Familism Beliefs and Psychological Distress Among African American Women Caregivers

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Purpose: Drawing from stress and coping models, we examined heterogeneity in the expression of familism (i.e., beliefs about the caregiving role) and its impact on psychological distress among African American women caregivers. Design and Methods: We relied on data from the Black Rural and Urban Caregivers Mental Health and Functioning study, a cross-sectional study of 521 midwestern African American women family caregivers. First we used the ordinary least squares regression method to examine the factors predicting caregiving beliefs. Subsequently, using hierarchical linear regressions, we regressed caregivers' depressive symptoms and perceived stress on their familism beliefs while controlling separately for interpersonal, personal, and situational contextual factors. Results: Wife caregivers, caregivers with lower levels of education, and caregivers with lower levels of mastery held significantly more traditional caregiving beliefs. Also, having poor caregiving relationships; being younger; being unemployed; and having lower levels of education, self-rated health, and mastery were all associated with higher levels of depression and perceived stress in caregivers. Traditional caregiving beliefs were also significant predictors of higher levels of depression and perceived stress. Implications: Although familism is culturally and socially popular, traditional beliefs in the caregiving role can lead to negative psychological consequences for African American women caregivers. Policies that support the realistic involvement of caregivers are needed to prevent negative consequences for caregivers.

Key Words: Familism, Psychological distress, African Americans, Caregiving contexts

Defined as “the subordination of individual interests to those of the family” (Rogers & Sebald, 1962, p. 26), familism not only appeals as a cultural belief to one’s sense of familial obligations and duties but also is congruent with American cultural norms (Olson, 2003). Familism refers to the “reliance on family for support, obligation towards family members, and use of relatives as referents” (Magaña, 1999, p. 466). Surprisingly, researchers have not extensively examined caregivers’ cultural beliefs about their caregiving roles as possible explanations for caregiving outcomes—this despite indications of the importance of the influence of people’s beliefs on their mental health (Pearlin, 1994; Simon & Marcussen, 1999).

Simon and Marcussen (1999) defined beliefs as “cognitions that involve understandings and convictions about some aspect of reality” (p. 113). In their study examining the effect of people’s beliefs about marriage on marital transitions and depression, Simon and Marcussen found that people who held more traditional beliefs of marriage (i.e., as permanent, desirable, and important) experienced less depressive feelings upon getting married and more depressive feelings upon getting divorced. Hence, it is necessary to examine the influence of sociocultural beliefs on psychological distress for ethnic minority women caregivers to further researchers’ understanding of their caregiving experiences (Aranda & Knight, 1997; Dilworth-Anderson et al., 2005; Dilworth-Anderson, Goodwin, & Williams, 2004).

In this study, we investigated the relationship between familism, as specified by caregivers’ beliefs about their caregiving role, and psychological distress in a sample of African American women family caregivers. Our interest stems from three conceptual

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frameworks that highlight the importance of beliefs in influencing caregiving outcomes as well as from feminist concerns about potential psychological consequences of familism for family caregivers. The latter reflects a critical understanding of family caregiving policies that are predicated on an expectation that families will continue to play a crucial role in meeting the long-term-care needs of their frail relatives (Olson, 2003).

**Theoretical Framework**

In our examination, we draw from three approaches: Pearlin’s (1989) stress and coping model, Dilworth-Anderson and Anderson’s (1994) contextual model, and Aranda and Knight’s (1997) sociocultural model. The latter two approaches represent researchers’ efforts to expand consideration of the influence of race/ethnicity on the caregiving experience and outcome.

**Stress and Coping Model.**—The stress and coping model examines the influence of caregiving stressors, which are considered recurring problematic life circumstances, on psychosocial outcomes for caregivers. Its utility lies in its attention to the intervening variables that may influence the relationship between stressors and psychological outcomes for caregivers (Pearlin, 1994). Pearlin (1989) suggested that values and beliefs affect to some degree the extent to which people feel threatened by certain stressors and, therefore, offer an explanation as to why well-being outcomes vary among people exposed to similar stressors.

**Contextual Model.**—In addressing the shortcomings of the original stress and coping model in explaining racial/ethnic differences, Dilworth-Anderson and Anderson (1994) argued that contextual factors of caregiving, which are treated as background variables in Pearlin’s model, must be brought to the forefront. In their revised model, caregiver beliefs about their familial obligations are a part of the sociocultural context, signifying the importance of the influence of shared values and traditions on caregivers’ experiences and outcomes (Dilworth-Anderson & Anderson, 1994).

**Sociocultural Model.**—Aranda and Knight (1997) proposed that both ethnicity and culture can influence the caregiving experience, in that racial/ethnic and cultural differences can result in differential morbidity experiences in both caregivers and their care receivers. According to the sociocultural model, culture refers to commonly held values and beliefs (Aranda & Knight, 1997), such as caregivers’ beliefs about their caregiving role, which can be viewed as “their culturally endorsed role as care providers” (John, Hennessy, Dyeson, & Garrett, 2001, p. 211). In sum, these conceptual models provided us a framework and impetus for our examination of the influence of caregiving beliefs on psychological outcomes for African American caregivers.

**Cultural Beliefs About Caregiving.**—In their examination of the impact of cultural beliefs about caregiving on well-being, Dilworth-Anderson and colleagues (2004) operationalized familism using the Cultural Justifications for Caregiving scale. Items on that scale reflect caregivers’ beliefs, values, traditions, and motivations pertaining to their caregiving role. In their prospective study of 107 African American primary caregivers, Dilworth-Anderson and colleagues (2004) found that cultural justifications for caregiving had a curvilinear relationship with caregivers’ psychological well-being over time. Measuring psychosocial health at each of three waves of data collection, the researchers observed that caregivers who reported either very strong or very weak cultural justifications for giving care also reported significantly lower psychosocial well-being than those who reported moderate to strong justifications. In another study examining the relationship between race and gender and cultural justifications for caregiving, Dilworth-Anderson and associates (2005) found that African Americans had higher cultural justification ratings than Whites and that African American women scored the highest in their cultural justification scores.

In addition to familism, we were interested in another type of belief (i.e., mastery). Pearlin and Schooler (1978) defined mastery as “the extent to which one regards one’s life-chances as being under one’s own control in contrast to being fatally ruled” (p. 5). Given this definition, mastery represents the belief one has in one’s ability to influence his or her external environment. However, unlike beliefs about the caregiving role, mastery is a psychological belief. Noonan and Tennstedt (1997) found that in a sample of 131 caregivers of community-dwelling, disabled elders, caregivers reporting higher levels of mastery also reported lower levels of burden in the caregiving role. Using a larger sample (n = 204) drawn from the same data set, Yates, Tennstedt, and Change (1999) examined the potential mediating effects of certain variables between caregiver stressors and psychological well-being. Their research showed that, controlling for primary stressors, high levels of mastery were associated with lower risk of depression (Yates et al., 1999). Neither study included race as an independent variable in the descriptive statistics; therefore, it is unknown whether these findings would also be true for racial/ethnic minority caregivers.

**Focus of the Study**

Studies using large, exclusively White samples have rarely focused on the impact of familism on
caregivers’ psychological outcomes. When past studies have included some form of measurement of caregiver beliefs and well-being in samples of African American caregivers, researchers have typically interpreted findings in comparison with those of White caregivers (Dilworth-Anderson et al., 2005; Lawton, Rajagopal, Brody, & Kleban, 1992). Due to the individualistic and personal nature of beliefs (Simon & Marcusen, 1999), a comparative approach ignores the heterogeneity that exists within racial/ethnic and gender groups. Furthermore, these studies have tended to rely on relatively small convenience samples of African Americans. Perhaps because of this, findings have been somewhat inconsistent. Hence, a within-gender and within-race focus using a sample of family caregivers that is systematically drawn from the community will allow us to examine the contextual heterogeneity that exists for African American women caregivers.

Guided by the abovementioned conceptual models, this study examines the influence of caregivers’ sociocultural beliefs on their psychological distress while controlling for their personal, interpersonal, situational, and psychological contexts. Specifically, there are three aims: First, we examine the factors that predict the heterogeneity in caregivers’ sociocultural beliefs about their caregiving. Second, we test the relationship between caregivers’ sociocultural factors (caregiving beliefs) and their depressive symptoms and perceived stress while controlling for personal context (demographics), interpersonal context (relationship between the caregiver and care receiver), situational context (caregiving demands and geographic location), and psychological context (mastery).

Third, and finally, we examine whether mastery moderates the relationship between caregivers’ beliefs about their caregiving role and psychological distress. Few examples exist from the literature looking at the moderating effects of mastery in models in which depression and perceived stress are measured as outcomes. When this moderating role has been tested, however, significant findings have resulted (Bookwala & Schulz, 1998; Jang, Haley, Small, & Mortimer, 2002).

**Methods**

**Research Design, Sample, and Data Collection**

The Black Rural and Urban Caregivers Mental Health and Functioning Study was a cross-sectional study of 521 urban and rural midwestern African American female caregivers of older African Americans (aged 65 and older). With the approval of the Institutional Review Board of Washington University in St. Louis, the data collection for the study was done between July 1999 and August 2002 in the state of Missouri.

Drawn from rural and urban locations, the sample of African American caregivers was obtained using the reverse screening methodology of Picot, Samonte, Tierney, and Connor (2001) that began with a list of Medicare enrollees that was obtained from the then Health Care Financing Administration. The researchers screened older Medicare enrollees to determine if elders and their family caregivers were eligible for study inclusion. The sampling method is further described in previously published works (Chadiha et al., 2004).

Eligible elders or their proxies were asked for contact information for up to two unpaid African American women who provided help—one of whom they considered helped them most and another who helped in their care. Eligible caregivers (i.e., those who self-identified as African American women, 18 years or older, and currently providing unpaid help to the older person) were contacted for their participation in the study.

Using a computerized structured questionnaire, trained African American women interviewers conducted in-home interviews with caregivers that lasted about 2.5 hr. Of the 592 eligible caregivers who had given oral consent, 521 caregivers completed interviews, thus yielding an overall response rate of 88%. Caregivers were compensated $15 for their participation in the study.

**Measures**

**Dependent Variables.**—In our study, we operationalized psychological distress in terms of depressive symptoms and perceived stress. We measured depressive symptoms with the 20-item Center for Epidemiologic Studies–Depression scale, which was designed to measure a person’s current level of depressive symptoms, with an emphasis on the person’s affect (Radloff, 1977). Responses to the items ranged from 0 (rarely or none of the time) to 3 (most or all the time). Some items were reversed scored before obtaining a summary score. Higher scores reflect higher levels of caregivers’ depressive symptoms.

We operationalized perceived stress with the 10-item Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983). The Perceived Stress Scale was developed as an outcome variable to measure the subjective impact of stressful events in the lives of the respondents (Cohen et al., 1983). Respondents were asked about their feelings and thoughts in relation to their experience of an unexpected or uncontrollable stressful event in the past month. Responses for the items ranged from 0 (never) to 4 (very often), and six items were reversed scored. Higher scores indicate higher perceptions of stress, thus reflecting more negative outcomes.
Independent and Control Variables.—For our examination of the sociocultural context, we operationalized caregivers’ beliefs about their caregiving role using four items: “I was picked by my family as a child to provide care for all my family members,” “I honestly never thought about doing anything else with my life other than working and providing care for others in my family,” “... all my choices about life revolve around my responsibilities to provide care,” and “My family expected me to provide care for them.” Items for the scale derived from themes that emerged from Burton’s (1996) qualitative study on the relationship between age norms, family role transitions, and caregiving responsibilities of women in multigenerational African American families. These items reflect Aranda and Knight’s (1997) definition of culture as values and beliefs in measuring cultural caregiving beliefs. Respondents were asked to rate how well each item fits with their beliefs about their caregiving situation, from 1 (definitely false) to 4 (definitely true). Summary scores ranged from 4 to 16, with higher scores indicating more traditional beliefs about the caregiving role. The Cronbach’s alpha for this scale was .581.

Caregiver mastery was measured with the 6-item Mastery subscale of the Caregiver Appraisal Scale (Lawton, Kleban, Moss, Rovine, & Glicksman, 1989). Respondents were asked to rate, among other things, the degree of certainty they felt about their caregiving, the degree of assurance they had that they were providing proper care, and the degree to which they felt they could be doing better. Each item was rated from 1 (never) to 5 (nearly always), and some items were reversed scored. Summary scores ranged from 6 to 30, with higher scores indicating a higher sense of caregiving mastery.

In line with our conceptual framework, we were also interested in examining the influence of interpersonal, personal, situational, and psychological contextual factors on caregiver well-being outcomes. We identified these contextual variables because previous studies have linked them to caregivers’ psychological distress (Dilworth-Anderson, Williams, & Cooper, 1999; Pinquart & Sorensen, 2003).

For the interpersonal context, we were interested in the type of kinship relationship between the caregiver and care receiver, along with the caregiver’s perception of the quality of that dyadic relationship. The type of kinship relationship between caregivers and their care receivers was measured categorically. In our model, we dichotomized caregiver relationship, with non-wife caregivers as the reference group. The quality of the relationship between caregiver and care receiver was measured with three items (Andrus Gerontology Center, 1997): “... how close do you feel is the relationship between you and (your elder)?” “How good is your communication between you and (your elder),” and “How well do you get along with (your elder)?” Responses ranged from 1 (not at all close/good/well) to 6 (extremely close/good/well). Scores on all three items were added together for summary scores that ranged from 3 to 18, with higher scores referring to better quality of the dyadic relationship between caregivers and their care receivers. The Cronbach’s alpha for this scale was .836.

Following the lead of Dilworth-Anderson and colleagues (1999), we used caregivers’ age, education, and employment status as measures of the personal context. Caregivers’ age and education level were measured in years and were treated as continuous variables in our model. Employment status was a dichotomous variable that was based on questions about primary caregivers’ current employment status, with 1 referring to caregivers who were working full or part time and 0 to those who had never worked, were unemployed, were a homemaker, or were retired. Scharlach (1994) identified employment as a potential positive resource or a competing demand for caregivers.

We used the care receivers’ activity of daily living (ADL) and instrumental ADL (IADL) functioning, the number of years of caregiving to the care recipient, and the geographical location of the caregiving as measures of the situational context. The level of the care receiver’s functional impairment has been linked to the caregiver’s distress (Pearlin, Mullan, Semple, & Skaff, 1990; Pinquart & Sorensen, 2003). Consequently, we measured the physical functioning of the care receivers with the Older Americans Resources and Services instrument (Duke University, 1978). Caregivers were asked to rate the functional dependency of their elders in seven ADLs and seven IADLs. Unsummed scores ranged from 0 (no help needed) to 2 (unable to do the task). We summed scores across the 14 ADL and IADL areas to create a measure of the care recipient’s functional dependency, with a range from 0 to 28. Higher scores represented greater functional dependency. Although measured in years, we treated duration of caregiving ordinally for purposes of the multivariate analyses. Wood and Wan (1993) identified rurality as a predictor for increased objective needs and decreased availability of formal services. Hence, we controlled for geographical location, which we dummy coded as 1 = rural and 0 = urban.

Analyses

In addition to the descriptive statistics, we computed a correlation matrix to examine the bivariate relationships between the variables of interest. To test our first aim, we regressed caregiving beliefs on the personal, interpersonal, and geographic variables using the ordinary least squares regression method. Next, using hierarchical
In examining the correlations of the variables of interest (matrix not presented here), we found that beliefs about one’s caregiving role were positively related to being a wife ($r = .131$, $p = .003$) and negatively associated with level of education ($r = -.138$, $p = .002$). Depressive symptoms were positively related to beliefs about one’s caregiving role ($r = .165$, $p < .001$) and negatively related to caregivers’ perceived quality of the dyadic caregiving relationship ($r = -.166$, $p < .001$), employment status ($r = -.102$, $p = .025$), mastery level ($r = -.204$, $p < .001$), educational level ($r = -.116$, $p = .008$), and self-rated health ($r = -.254$, $p < .001$). We observed an identical pattern of bivariate relationships between perceived stress and these same variables. Hence, caregivers with higher levels of depressive symptoms and perceived stress were more likely to have more traditional caregiving beliefs, poorer quality of relationship, lower mastery, lower levels of education, and poorer self-rated health and were more likely to be unemployed.

Tables 2, 3, and 4 present findings from the multiple regression models addressing the key aims of the study. When we regressed caregivers’ beliefs about their caregiving on the personal, interpersonal, situational, and psychological contexts, we found that the model was significant, $F(10, 467) = 2.191$, $p = .017$ (see Table 2). There were only three significant predictors of traditional caregiving beliefs: type of kinship ($b = 0.855$, $p = .034$), educational level ($b = -0.118$, $p = .030$), and mastery ($b = -0.075$, $p = .043$). Wife caregivers, caregivers with lower levels of education, and those with lower levels of mastery were more likely to endorse more traditional beliefs about their caregiving role.

In the hierarchical regression model with depressive symptoms as the dependent variable (see Table 3) and with interpersonal variables (i.e., type of kinship relationship and quality of caregiver–care receiver relationship) entered, we found that the model was significant, $F(2, 475) = 7.301$, $p = .001$, and that caregivers’ perceptions of higher quality of the dyadic relationship were significantly predictive of higher perceived health.

### Notes
- $p < .05$.
of lower depressive symptoms \((b = -0.499, p < .0001)\). All four variables in the block of personal contextual factors were significantly negatively related to depressive symptoms: caregiver’s age \((b = -0.430, p = .001)\), employment status \((b = -2.275, p = .007)\), educational level \((b = -0.347, p = .013)\), and self-rated health \((b = -1.947, p < .0001)\). The explained variance increased significantly by 11.0%, \(F(6, 471) = 12.8, p < .001\), in comparison with the first model. Caregivers who were older, were employed, had a higher educational level, and had better self-rated health reported lower levels of depressive symptoms after we controlled for interpersonal contextual factors. The situational variables were not significantly related to depressive symptoms, nor did the inclusion of these variables significantly increase the amount of variance explained. Geographic location was negatively related to depressive symptoms, with rural caregivers reporting significantly lower depressive symptoms \((b = -1.85, p = .022)\). Although the variance explained increased by 1%, it was significant. Caregiver mastery was significantly related to depressive symptoms \((b = -0.338, p = .001)\), in that a unit increase in caregiver mastery was predictive of lower depressive symptoms. Furthermore, caregivers’ sociocultural beliefs were also significantly predictive of their depressive symptoms, such that traditional caregiving belief was related to more depressive symptoms \((b = 0.394, p = .002)\). The latter two blocks of variables did significantly increase the variance explained.

Table 3. Hierarchical Regression for Depressive Symptoms

<table>
<thead>
<tr>
<th>Variable</th>
<th>(b)</th>
<th>SE (b)</th>
<th>(\Delta R^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to elder (wife = 1)</td>
<td>-0.909</td>
<td>1.002</td>
<td></td>
</tr>
<tr>
<td>Quality of relationship</td>
<td>-0.499</td>
<td>0.132</td>
<td></td>
</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver’s age</td>
<td>-0.149</td>
<td>0.031</td>
<td></td>
</tr>
<tr>
<td>Employment status (\text{employed} = 1)</td>
<td>-2.275</td>
<td>0.839</td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td>-0.347</td>
<td>0.14</td>
<td></td>
</tr>
<tr>
<td>Self-rated health</td>
<td>-1.947</td>
<td>0.361</td>
<td></td>
</tr>
<tr>
<td>Block 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elder’s functional abilities</td>
<td>0.002</td>
<td>0.064</td>
<td></td>
</tr>
<tr>
<td>Duration of caregiving</td>
<td>0.010</td>
<td>0.041</td>
<td></td>
</tr>
<tr>
<td>Block 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic location (\text{rural} = 1)</td>
<td>-1.851</td>
<td>0.803</td>
<td></td>
</tr>
<tr>
<td>Block 5</td>
<td></td>
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</tr>
<tr>
<td>Mastery</td>
<td>-0.338</td>
<td>0.101</td>
<td></td>
</tr>
<tr>
<td>Block 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiving beliefs</td>
<td>0.394</td>
<td>0.125</td>
<td></td>
</tr>
<tr>
<td>Total (R^2)</td>
<td></td>
<td></td>
<td>.432***</td>
</tr>
</tbody>
</table>

Note: \(* p < .05; ** p < .01; *** p < .001. ns = not significant.\)

Table 4. Hierarchical Regression for Perceived Stress

<table>
<thead>
<tr>
<th>Variable</th>
<th>(b)</th>
<th>SE (b)</th>
<th>(\Delta R^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to elder (wife = 1)</td>
<td>0.359</td>
<td>0.632</td>
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</tr>
<tr>
<td>Quality of relationship</td>
<td>-0.398</td>
<td>0.083</td>
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</tr>
<tr>
<td>Block 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver’s age</td>
<td>-0.106</td>
<td>0.019</td>
<td></td>
</tr>
<tr>
<td>Employment status (\text{employed} = 1)</td>
<td>-1.173</td>
<td>0.525</td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td>-0.315</td>
<td>0.087</td>
<td></td>
</tr>
<tr>
<td>Self-rated health</td>
<td>-1.192</td>
<td>0.226</td>
<td></td>
</tr>
<tr>
<td>Block 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elder’s functional abilities</td>
<td>-0.002</td>
<td>0.040</td>
<td></td>
</tr>
<tr>
<td>Duration of caregiving</td>
<td>-0.009</td>
<td>0.025</td>
<td></td>
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<tr>
<td>Block 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic location (\text{rural} = 1)</td>
<td>-0.491</td>
<td>0.505</td>
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<tr>
<td>Block 5</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mastery</td>
<td>-0.193</td>
<td>0.064</td>
<td></td>
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<tr>
<td>Block 6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiving beliefs</td>
<td>0.270</td>
<td>0.079</td>
<td></td>
</tr>
<tr>
<td>Total (R^2)</td>
<td></td>
<td></td>
<td>.456***</td>
</tr>
</tbody>
</table>

Note: \(* p < .05; ** p < .01; *** p < .001. ns = not significant.\)

Table 4 reveals a pattern of significant relationships similar to that found in Table 3. In the first block, perceived quality of the relationship was negatively related to perceived stress \((b = -0.398, p < .0001)\), in that one unit increase in the perceptions of higher quality in the dyadic relationship resulted in a decrease in perceived stress for caregivers. When we added the second block of variables, there was a significant \(R^2\) change of 12%, \(F(4, 471) = 16.091, p < .001\). All of the personal contextual factors that were significantly related to perceived stress had negative relationships; older caregivers \((b = -0.106, p < .001)\), employed caregivers \((b = -1.173, p = .026)\); caregivers with more education \((b = -0.315, p < .001)\), and caregivers with better self-rated health \((b = -1.192, p < .001)\) reported lower perceived stress. None of the situational contextual variables were significantly predictive of perceived stress, and unlike in the earlier hierarchical model with depressive symptoms as the dependent variable, geographical location was not significantly related to perceived stress. When we added mastery and caregivers’ beliefs about their caregiving role to the model separately, both variables were significantly related to perceived stress and significantly improved the \(R^2\) in the final model \((R^2 = .21), F(11, 466) = 11.112, p < .0001\). Whereas mastery was negatively related to perceived stress \((b = -0.172, p = .007)\), caregivers’ beliefs about their caregiving role were positively related to perceived stress \((b = 0.270, p = .001)\).

To examine the third aim of this study, we included mastery and caregiver beliefs as interaction terms in our models, with depressive symptoms and
perceived stress as dependent variables in separate models. We did not find any significant interaction relationships between mastery and caregiver beliefs in predicting either depressive symptoms or perceived stress.

Discussion

Drawing from three conceptual frameworks, we examined the impact of sociocultural context on psychological distress for African American women family caregivers. For our first aim, we examined among African American women the predictors of familism, which we operationalized as sociocultural beliefs of caregiving, to highlight the heterogeneity of contexts for them. To this end, we found that, on average, African American women caregivers were at the midpoint in terms of their beliefs about their caregiving role, which supports the notion of the heterogeneity of sociocultural beliefs about caregiving in the sample. This descriptive finding differs from that of a prior study documenting limited variance in and higher levels of traditional sociocultural caregiving beliefs among a sample of African American caregivers and non-caregivers (Dilworth-Anderson et al., 2005) and may be explained by differences in sampling methods.

Our findings converge with a prior study (Dilworth-Anderson et al., 2005) in documenting a significant association between caregivers’ educational level and their cultural caregiving beliefs. Caregivers with more education were more likely to report lower levels of familism than those with less education. Contrary to the prior work, in our sample being a spouse to the care receiver was predictive of holding more traditional caregiving beliefs. We posit that wife caregivers have social obligations regarding caring for their frail husbands that stem from the differences in their interpersonal and temporal contexts in comparison with other kinship caregivers.

In addressing our second aim, we did not find familism to be protective of caregivers’ depressive symptoms and perceptions of stress when we controlled for interpersonal, personal, and situational contextual variables. Rather, having strong beliefs of familism predisposes caregivers to higher levels of psychological distress. Our finding dovetails with that of Knight and colleagues (2002), who found that familism led to poorer mental health and physical health outcomes among caregivers of people with dementia in some ethnic groups. There are some similarities with Dilworth-Anderson and associates’ (2004) findings, though they found a curvilinear relationship between caregivers’ cultural justification for caregiving and general health. Specifically, caregivers reporting weak cultural justification experienced the highest level of distress, those with strong cultural justification experienced the next highest level of distress, and those with moderate to strong cultural justification reported the lowest level of distress.

It appears that when African American women caregivers report having better relationships with their care receivers, they are more likely to report lower levels of psychological distress. We speculate that a better caregiving dyadic relationship might lead to greater satisfaction in the caring relationship or receipt of emotional support from the care receivers. Furthermore, we also found that employment outside the home was protective for caregivers, in that being employed was related to lower psychological distress (Scharlach, 1994). Consistent with other studies (Bookwala & Schulz, 1998; Yates et al., 1999), mastery was significantly predictive of lower levels of depressive symptoms in the current study, possibly indicating that caregivers with high mastery are more likely to perceive greater control over their caregiving situations. Contrary to these other studies (Bookwala & Schulz, 1998; Jang et al., 2002), and in examination of our third aim, we found that having high caregiving mastery was not a significant moderator between caregiver beliefs and psychological distress.

In considering this study’s overall findings, it could well be that caregivers who profess traditional familism values about their caregiving role may undertake the sole responsibility in meeting the needs of their older relatives. In doing so, they might experience a discrepancy between the demands of their caregiving tasks and the resources from which they can draw. In fact, Dressel and Clark (1990) pointed to the emotive dissonance that women caregivers commonly experience between the disjuncture of their acts of caring and their feelings. Indeed, Simon and Marcussen (1999) argued that people who experienced a consistency between their behaviors and beliefs were more likely to enjoy better mental health outcomes. This argument is important in that it highlights the fact that caregiving tasks go beyond just meeting the physical needs of the care receiver; they also include meeting the person’s emotional and psychological needs (Piercy, 1998). Thus, when caregivers profess to be the people chosen by the family for the caregiving role, they might be more motivated by their cultural sense of filial obligation than by their affection, which can sometimes lead to frustration in their caregiving experience (Knight et al., 2002). From a cultural standpoint, familism beliefs may serve the function of resistance to the “depersonalization and exploitation of a capitalist society” among ethnic minorities (Wallace & Facio, 1992, p. 219) as well as the cultural endorsement of the caregiving role (John et al., 2001).

Although our sample of African American caregivers endorsed varying levels of familism beliefs, which may represent their sense of cultural obligation to provide care for their frail elders, the
expression of these beliefs can have “important policy and programming implications for the design and delivery of long-term care services” (John et al., 2001, p. 211). Indeed, higher levels of familism beliefs about their caregiving role might intrude in caregivers’ help-seeking behaviors because of their sense of shame in not managing well on their own in caring for their elder relative and because of their sense of loyalty or obligation to their family. More important, policies and programs that emphasize the role of families might inadvertently reinforce the value that families should rely on their own limited resources in meeting the needs of their frail elders (Olson, 2003), thus legitimizing the low demand and supply of government services (Wallace & Facio, 1992).

Limitations and Strengths

One needs to consider a few caveats regarding this study’s findings. This study’s cross-sectional design did not allow us to examine the causal links between caregivers’ sociocultural caregiving beliefs and their psychological distress or to examine the dynamic nature of these beliefs. Because beliefs shape and are shaped by the caregiving experience, more research is needed to illuminate such causal links. Despite use of a probability sampling method to draw the sample of caregivers, findings are limited as regards generalizability to African American caregivers living in other regions of the United States and to male caregivers. From a contextual standpoint, it is necessary to consider geographical and neighborhood differences because such ecological differences may influence caregivers’ objective need and the availability of formal and informal support (Wood & Wan, 1993). Finally, although our interest in the sociocultural aspects of the caregiving role was conceptually similar to that of Dilworth-Anderson and her colleagues, we did not use the same scale to operationalize the construct, which in turn limits the comparability of our findings.

Despite these limitations, this study’s findings remain important in furthering researchers’ understanding of the influence of sociocultural beliefs on psychological distress among a sample of African American women caregivers. In emphasizing the contextual approach, we have shown the importance of the sociocultural context in shaping caregiving outcomes for African American women caregivers. More important, we have documented the negative psychological consequences (Olson, 2003) that caregivers experience when they hold traditional beliefs about their caregiving roles. Although this negative impact might stem from caregivers’ sense of obligation or shame, the economic, social, ideological, and political structures coupled with the retrenchment of government responsibilities might play a role in perpetuating and reinforcing familism among caregivers (Olson, 2003), thus contributing to poorer psychological outcomes among certain groups of caregivers. Hence, there is a need to shift the goals of existing family caregiver programs to be truly supportive of family caregiving efforts that can assist these programs to realistically meet the demands of their roles. Finally, the contextual approach allowed us to account for the heterogeneity of experiences among African American women caregivers and unmask the differences that exist within gender and race.

References


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