An investigation of the importance of spirituality and afrocentricity among African American caregivers: Implications for the mentally ill

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AN INVESTIGATION OF THE IMPORTANCE OF SPIRITUALITY AND AFROCENTRICITY AMONG AFRICAN AMERICAN CAREGIVERS: IMPLICATIONS FOR THE MENTALLY ILL

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Myron Damon Lilley
June 2000
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ABSTRACT

This paper explored how much Spirituality and Afrocentricity played a part in the primary caregiver's willingness to care for a relative or client who suffers from mental illness. For the purpose of this study primary caregiver was defined as a person who provided financial, emotional, and psychological support. Implications were addressed for African American caregivers. Subjects were African American males and females ranging from the age of 20 to 70 years old. These subjects were the primary caretakers for a mentally ill relative or client. Education of the subjects ranged from a high school diploma to 6 years of college study. Results indicated a significant correlation between Spirituality and the willingness to care for the mentally ill. Afrocentricity was shown to have no significant correlation. Based on the results spirituality was a key component to increase the willingness of caretaking. This result would indicate a need to incorporate more spiritually based treatment plans with African American clients, and the caregivers who provide for them.
ACKNOWLEDGEMENTS

I have been very fortunate in the course of writing this research project to have had the help and support of many wonderful people from different agencies and walks of life. The first of these is my wife, Sheila Jones-Lilley, who gave freely of her support, help, and editing expertise throughout the process. She brings the meaning of helpmate to a new level. I have also been aided by two special people, Bill Newell, my mentor for the last two years, and Delia Lang, MA, my supervisor for this project. My special thanks to Dr. Majorie Hunt, who assisted me early on with the conceptual stages of this project.

During the writing process I have learned the real meaning of "extended family" and have had the encouragement and help of two agencies. Both the Center for Individualized Development, and Mesa Counseling Services, who are a part of the San Bernardino County Behavioral Health Department, have been very helpful to me. I would also like to acknowledge my in-laws, Mr. and Mrs. Clarence Jones who provided their time and energy to interview participants from out of state. I would like to thank Mr. Erick McCrady for lending me his artistic talents for my research project during Celebrate Social Work week.
Finally I would like to thank Dr. Robert Jager for allowing me to utilize his research questionnaire which was my guide in my own research.
DEDICATION

To my Lord and Savior, Jesus Christ, and my grandmother, Mrs. Lovie D. Gardner, may she rest in peace.
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Introduction

In recent years there has been increasing literature on the subject of spirituality, and how it can help individuals and families improve their ability to cope with life stressors. Schulz (1991) conducted several studies on the mentally ill and their family members. He concluded that families exhibited low tolerance toward their mentally ill family member, and often the family suffered at a considerable price. Schulz also believes that deinstitutionalization has led to a greater burden on families today because many clients who would have been hospitalized in the past are now treated primarily in community based programs. In addition, because length of hospitalization has shortened, many clients with severe psychological problems are returning to the community, and to their families, thus creating a higher stress level for the caretaker.

In 1993 U.S. Bureau of Census predicted that in 50 years, almost 50% of Americans will be of non-European ancestry, of which 20% will be of African American descent. In addition to the normal stressors of everyday life, these individuals may face additional stressors including racism, and poverty, which are likely to affect how they deal with problems in their lives (Serafica, Schwebel, Russel, Issac & Myers 1990).
Overcash (1996) discussed the impact of stressful and traumatic events and the methods individuals use to cope. Results indicated that spirituality is considered an important part of the lives of many Americans, especially African Americans. Overcash believes that understanding the role of spiritual beliefs of clients remains vital to their overall mental health and coping process. When one considers the client’s family, spiritual beliefs play a greater role across all situations, especially in response to difficult events.

Clay (1990) studied the different ways people use religion to cope with major life stressors ranging from mental illness, to war, to the Oklahoma City bombings. She stated, “When you look more closely, you find there are certain types of religious expressions that seem to be helpful and certain types that seem to be harmful.” In her studies involving hundreds of subjects, she found that people who embrace what could be called “the sinners in the hands of an angry God” model do indeed have poorer mental health outcomes. Such people feel God is angry and that they are being punished for their sins. In contrast, people who embrace the “loving God” model see God as a partner who works with them to resolve their problems. They view difficult situations as an opportunity for spiritual growth and the development of stronger resiliency. Most African
AmeriGans have relied on the scriptures in the bible for their source of strength and survival throughout African American history.

Kirkpatrick (1996) supports Clay’s findings as well. He concluded that mental health outcomes depend on the way people view their relationship with God. People who classified their attachment to God as secure scored much lower on loneliness, depression, and anxiety and higher on general life satisfaction.

Neighbors (1990) provided pivotal history on African Americans and Mental Health Services. Neighbors stated that African Americans do not take full advantage of traditional mental health services. They do not seek professional assistance due to the inability of the therapist to understand the black culture. This information was crucial because it implied that other and different methods should be incorporated to reach certain populations and to keep them in treatment.

As part of this study it was important to explore the characteristics of the caregiver. Brown (1998) identified elements such as: financial means, adequate social support, and personal forms of religious expression (e.g. prayer, bible readings) as being important for caregiving. Other scholars like Clipp (1990), identified social and recreational outlets as important characteristics of
caregivers. Harris (1997), in her study of 30 male caregivers revealed that a commitment to caregiving, and the establishment of a structured regime was a vital characteristic of the caretaker.

During this study it was vital to explore how African Americans defined Spirituality and Afrocentricity. Studies by Boyd-Franklin (1990), stated that Black African American family's first observation is that religion or spirituality permeated every aspect of the African's life. Spirituality is such an integral part of man's existence that it and he were inseparable. Spirituality accompanies the individual from conception to long after death. Boyd-Franklin continued by saying that spirituality is the non-material or invisible substance that connects all elements of the universe. Spirituality in the form of faith is the substance of things hoped for and the evidence of things not seen.

Jager (1996) defined spirituality as the belief that all elements of reality contain a certain amount of life force. It entails believing and behaving as if non-observable and non-material life forces have governing powers in one's everyday affairs. Thus, a continuous sensitivity to core spiritual qualities takes priority in one's life. Indeed, it goes beyond church affiliation. Moreover, it connotes a belief in the transcendence of
physical death and a sense of continuity with one's ancestry.

Jager (1996) provided data on spirituality from an Afrocultural perspective. Sixty-eight African American college students completed the Spirituality Scale and indices of internal, external and religious motivation. Results revealed spirituality to be a central cultural tenant for most people of African ancestry. Other findings from Jager revealed spirituality not to be counted among the core orientations of Anglo-American culture.

Boykin, Jager, Howard (1999), published a follow-up study in which they developed a spirituality scale that measured an individual's coping process. In this research, attention was given to the systematic study of spirituality from an Afrocultural perspective. A conceptual definition and a pool of preliminary items were generated and validated by a panel of subject matter experts. The test was a Likert Scale which yielded twenty items. Five filler items were implemented to minimize errors. The final 25 items were administered to several samples of adult age African Americans. Results indicated the spirituality scale to have adequate psychometric qualities. Findings suggested that the cultivation of this spiritual quality is thought to enhance psychological well-being.
Asante (1988) addressed issues of treatment for African American women and their families as it related to drug and alcohol dependency. Asante points out how alcoholism and drug abuse is often the cause of, or greatly contributes to mental illness. In his research, African Americans have been shown to have greater success with an Afrocentric treatment regime than what is commonly being offered through general counseling. Asante described a program which uses an Afrocentric perspective as its chief philosophy and treatment orientation. This program, named Iwo San (which is Swahili for "House of Healing") is a multistage treatment program for alcohol abusive women and their families. Following the residential component, a continuing care phase is offered that allows the women and their families to return to Iwo San for individualized counseling, group therapy, and family therapy. The Iwo San focuses on the values of spirituality, community, respect for tradition, harmony with nature, and the creation of self-identity and dignity. Asante considered that spirituality continues to be the corner stone of Afrocentric activity. Spirituality hinges on the belief that the spirit is invested in everything. The clients and their families in the program are taught that the Creator exists in everything, and everything can give meaning to the person's life. Clients are taught that they are entrusted with the
knowledge and wisdom of their Creator that is greater than themselves. The discharge of a client is determined by the elders in accordance with agency polices and procedures. If a client and their family leave prematurely, it is not considered a failure but viewed as a turning point for their treatment, and the client would not be banned from the program.

Potts (1990) discussed the importance of spirituality in understanding and treating alcoholism in African American communities. He noted that it is vital to mental health treatment because 65 to 70% of African American clients who seek treatment have abused alcohol, therefore contributing to more severe mental health problems.

Potts contends that the components of spirituality can be divided into two primary categories—"vertical" and "horizontal." The vertical dimension refers to one’s relationship with or experience of the Ultimate or God. The horizontal dimension refers to one’s sense of meaning, purpose or mission in life. Potts believes that having these two dimensions in one’s life will influence positive treatment outcomes.

Potts’ information highlights the inner strength of survival that has been prevalent since Africans were brought to this country as slaves. This power of faith and belief continues to manifest itself with African Americans today.
O’Rourke (1997) reported a study which examined spirituality and religious issues among adults suffering from mental illness. This research explored how group psychotherapy as treatment modality can assist mentally ill adults and their families in resolving spiritual and religious conflicts by identifying spiritual resources as agents in the healing process. O’Rourke looked at twelve clients, along with their family members, in a psychiatric day treatment program who participated in a weekly spiritual issues group. It provided individuals with an opportunity to examine their spiritual beliefs and to explore religious conflicts and doubts as well as the positive dimensions of their religious experiences. O’Rourke’s treatment program tried to accomplish two goals: 1. spiritual guidance should function as a transitional space for clients between family support and community support, 2. the group should provide members the opportunity to encounter religious and emotional experiences. These clients experienced more success with this treatment than other groups.

Walsh (1995) looked at the impact of schizophrenia on clients’ religious beliefs and its implications for families. In his study, he defined two goals for families who are the primary caretakers of relatives suffering from schizophrenia: 1. promoting members’ growth and
individuation, and 2. providing socialization, stability, and support functions.

Walsh used theories from the family systems approach, in which the social worker helped persons explore family dynamics and facilitated problem resolutions by searching for a common set of loyalties and values with which members can communicate their needs. Religious aspects provide families with a set of rituals and symbols that reflect a shared value system. Religion serves as a resource for families disrupted by schizophrenia. As the client with schizophrenia becomes increasingly worse, religion may help family members share meaningful experiences.

Walsh's perspective dealt specifically with mental illness, religion and its implications for family coping. It defined how spirituality can be incorporated in the family treatment process in order to maintain a sense of cohesion through the many difficulties that may arise. Furthermore, Walsh suggested that, in his view social workers, psychologists, and health care professions are reluctant to implement spiritual principles in their client's treatment. Boyd-Franklin (1990) conducted a survey of 328 Virginia social workers, psychologists, and counselors and found that many respondents valued religious and spiritual dimensions in their own lives, but addressed reluctance to implement religious principles in clients'
treatment. They expressed concern about the potential for imposing their beliefs on clients.

Schiele (1994) noted in his findings that spirituality is the central component of the African American culture. He strongly encouraged the social work profession to move more rapidly to an Afrocentric World View, instead of providing services from an Eurocentric World View. Schiele’s definition of Afrocentricity is based upon interdependency, collectivity, spirituality, cultural values, similarities and inclusiveness, and a belief that the welfare of the group takes precedence over the welfare of the individual. Kinship ties make up what is perhaps one of the most enduring and important aspects of black African Heritage. This sense of family survival has persisted through the centuries and these survival skills are some of the most lasting strengths of Afro-American families today (Boyd-Franklin 1990).

Research has been introduced on how spirituality can provide a means for coping with difficult life circumstances, and stressors that impede normal life functioning. This study addressed if spirituality and Afrocentricity could enhance the willingness of caretakers to care for the mentally ill. Literature suggests that spirituality and Afrocentricity are important components in dealing with life stressors within the African American
community. This study addresses the elements of spirituality and Afrocentricity among African American caregivers, while caring for relatives or clients who suffer from a mental illness. It is expected that spirituality and Afrocentricity will increase individual willingness to care for the mentally ill.

Method

Subjects

Subjects consisted of 33 participants, fourteen males (42.4%) and nineteen females (57.6%), who provided caregiving for mentally ill relatives or clients. Participants were selected from two behavioral health clinics, Mesa Counseling Services, and the Center for Individualized Development. Other participants were volunteers from various communities in and out California. All subjects were African Americans. The age of respondents ranged from 20 to 70 years (mean = 41.48; sd = 13.50). The average time length of caregiving was ten years and eight months. Level of education ranged from a high school diploma to 6 years of college study. Participants were able to participate if they met two criteria: 1. if they were the primary caretaker of a relative or client who suffers from a mental illness, and 2. if they were of African American descent.
Materials

Materials used for this study consisted of a questionnaire of 30 items which asked questions related to spirituality, afrocentricity, and caregiving. Items on the questionnaire were adopted from Jager’s article on spirituality which used a Likert Scale format. The questionnaire used a single rating scale. Under each statement there was a scale ranging from 1 to 6 (1= strongly disagree; 2= mostly disagree; 3= somewhat disagree; 4= somewhat agree; 5= mostly agree; 6= completely agree). Using this scale participants circled the number which best represented the degree to which the statement was agreed or disagreed upon. Some questions from Jager’s (1996) original test were deleted and others added to make it more suitable, practical, and time efficient for this study. Demographic questions were implemented for possible comparison of results. Demographic questions included age, sex, level of education, identification of relative or non relative, and the total number of months the care had been provided.

Procedures

Each participant was given a worksheet with 30 questions to be answered in pen. Each worksheet was given an identification number to maintain confidentiality. The researcher distributed an informed consent and debriefing statement to be read and kept by the participants.
Results

Data were screened before proceeding with statistical analyses to insure that the proper assumptions were met. Histograms indicated that the majority of variables were approximately normally distributed. Afrocentricity was slightly negatively skewed and outliers were detected. Similarly the number of years of caretaking was slightly positively skewed and two outliers were detected. Due to the small sample size and the variables described above, it was decided that all subjects would be retained as part of statistical analyses.

There were thirty questions designed to assess Afrocentricity, spirituality, and caregiving. Numbers 1 through 8 and 18 through 30 measured spirituality, numbers 8, 10 through 13 measured Afrocentricity, and numbers 9, 14 through 18 measured caregiving. Subjects’ responses on each of the above subscales were added to arrive at a total score for Afrocentricity, spirituality, and caregiving respectively. For the caregiving subscale a possible total score ranged from 6 to 36, for Afrocentricity a total score could range from 5 to 30, and for spirituality a total score could range from 19 to 114. The current sample’s mean score for caregiving was 28.64(SD=4.67). The mean score for Afrocentricity was 24.84(SD=4.69) and the mean score for spirituality was 88.6(SD=12.2).
Bi-variate correlations were conducted to assess the degree to which the three variables were associated. Caregiving and afrocentricity were not significantly correlated ($r = .092, p = .306$). Caregiving and spirituality were significantly correlated ($r = .351, p = .022$), indicating that increased spirituality is associated with increased willingness for caregiving. Afrocentricity and spirituality were also significantly correlated ($r = .701, p = .0001$), indicating that increased afrocentricity is associated with increased spirituality.

A stepwise linear regression was conducted to determine the degree to which afrocentricity and spirituality predicted a willingness to care for the mentally ill. Spirituality was the only significant predictor of the willingness to care for a mentally ill relative or client ($p = .045$). Spirituality accounted for 12.3% of variance in the willingness to be a caregiver for the mentally ill. Afrocentricity was not significant in predicting the willingness to care for the mentally ill ($p = .201$).

Stepwise linear regressions were also conducted for males and females. For males neither spirituality or afrocentricity were significant predictors of caregiving for the mentally ill. For females spirituality was a significant predictor ($p = .043$), and it accounted for 21.9% of
Afrocentricity was not a significant predictor ($p = .335$).

Afrocentricity was not a significant predictor in any analyses. This may be due to its high correlation ($p = .701$) with the spirituality variable, indicating that the two variables may be assessing the same construct. In other words, spirituality is a major component of Afrocentricity.

**Discussion**

The results of the study show that spirituality is a significant predictor of willingness to care for the mentally ill. This suggests that when working with African American clients, caregivers or family members, it is vital for the clinician to utilize a spiritual component within their treatment modalities.

One of the limitations of the study was its small sample size. Ideally a sample of 100 subjects or more might have proven to be more convincing. On the other hand, the current sample was quite diverse with subjects from different backgrounds, various regions of the country, and diverse socioeconomic groups.

Another aspect of the study that could be viewed as a limitation is the fact that a comparison of how other ethnic groups value spirituality in their willingness to care for a mentally ill relative or client was not conducted. It is possible to believe that people of other ethnic groups would
also have shown some correlation between spirituality and willingness to care for the mentally ill. It is possible that such a correlation would not be as strong as that of African American subjects, simply because spirituality itself is such a strong component of Afrocentricity and the African American culture.

One of the reasons why Afrocentricity did not show a strong significance in the willingness to care for the mentally ill, may be that many African Americans do not even recognize their own afrocentricity. They may view afrocentricity in its outward and most superficial form in terms of knowing African history, collecting African art or even wearing African style clothing. However, most African Americans possess the most inward or subconscious attributes and characteristics of Afrocentricity, including a strong sense of spirituality, interdependency, inclusiveness, and the belief that the welfare of the group takes precedence over the individual.

Practitioners must come to recognize the great significance of spirituality in their treatment and interactions with African American caregivers for the mentally ill. It has been proven that African Americans do not take full advantage of traditional mental health services (Neighbors, 1990). This information is crucial because it should indicate to clinicians that other and
different methods must be incorporated to reach African Americans in order to keep them in treatment.

Based on the results of this study, future research would need to be conducted in order to find other elements which make a difference in the willingness to care for the mentally ill. It would be most interesting to learn the results if a study was conducted which measured the effects that spirituality has on the coping skills of caretakers for the mentally ill. One can suspect that the caretakers who have a strong sense of spirituality are better equipped to handle the difficulties of caring for the mentally ill. Further studies need to be done to assess the long term effects on the caregiver. In other words, after several years have gone by, are they still able to cope and provide quality care.
APPENDIX

1. strongly disagree
2. mostly disagree
3. somewhat disagree
4. somewhat agree
5. mostly agree
6. completely agree

1. I believe in a higher power.
   1 2 3 4 5 6
2. I believe a higher power has influence over my life.
   1 2 3 4 5 6
3. I call on a higher power in times of turmoil or a crisis.
   1 2 3 4 5 6
4. To me, every object has some amount of spiritual quality.
   1 2 3 4 5 6
5. I believe that God will provide for my needs.
   1 2 3 4 5 6
6. I strongly support my family during a crisis, but I also pray for help.
   1 2 3 4 5 6
7. Without some form of spiritual help, there is little hope in life.
   1 2 3 4 5 6
8. Knowing about my African American culture is an important part of my life.
    1 2 3 4 5 6

9. If need be I would gladly agree again to care for a mentally ill relative or client.
    1 2 3 4 5 6

10. My African heritage, culture, and traditions are important to me.
    1 2 3 4 5 6

11. I agree that African Americans, as a people are empowered by the history, culture, and traditions of their ancestors.
    1 2 3 4 5 6

12. I believe that we are all interconnected and mutually dependent on each other for existence.
    1 2 3 4 5 6

13. I believe in the African Proverb that says it takes a village to raise a child.
    1 2 3 4 5 6

14. I have extreme difficulty being a caregiver for a mentally relative or client.
    1 2 3 4 5 6

15. My primary reason for caring for my mentally ill relative or client is to receive monetary compensation.
    1 2 3 4 5 6
16. I feel that caring for my mentally ill relative or client is too demanding on my time and energy.

17. Caring of the mentally ill only involves providing food, shelter, and clothing.

18. I have never regretted becoming a caregiver for the mentally ill.

19. To have faith in each other is to have faith in God.

20. I believe that the world is not under our control but is guided by a greater force.

21. The most important part of me is the inner force which gives me life.

22. Though I may go to the doctor when I am ill, I also pray.

23. I feel life is made up of spiritual forces.

24. Just because I have faith and beliefs does not mean I live that way all the time.
25. I act as though unseen forces are at work.
   1 2 3 4 5 6

26. I pray before taking a trip.
   1 2 3 4 5 6

27. I pray before eating a meal.
   1 2 3 4 5 6

28. To me, it is impossible to get in touch with the
    spiritual world.
   1 2 3 4 5 6

29. I pray before making an important decision.
   1 2 3 4 5 6

30. If I had more money, life would be happier.
   1 2 3 4 5 6

Demographics

1. Age________

2. Sex   M or F

3. For how long have you taken care of a mentally ill person
   Years________   Months_______

4. Level of education________

5. Is this person a relative of non relative
   please specify______________
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