AN ANALYSIS OF CULTURAL VALUES, RELIGIOSITY AND FAMILY MEMBER'S CAREGIVING ON THE POSITIVE APPRAISAL OF CARING FOR THE ELDERLY

DISSERTATION PROPOSAL

presented to

the Faculty of the Graduate School

Southern University and Agriculture and Mechanical College

---

in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

in Nursing

---

by

Fayron Recha Epps

May 2012

CERTIFICATE OF APPROVAL

DOCTORAL DISSERTATION

This is to certify that the Doctoral Dissertation of

Fayron Recha Epps

has been approved by the Examining Committee for the dissertation

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Dedication

This dissertation is dedicated to my family. I appreciate all of the love, words of encouragement, support and understanding that you all have given me through this long journey. First, a special feeling of gratitude to my mother, Artimese Epps, who was my backbone, encouraging me and always being there for my children and me. Even when I was ready to give up, she believed in me. I am truly bless to have a mother like you.

Secondly, this dissertation is dedicated to my darling little prince and princess (Malachi and Shai). Mommy loves you all so much. I know at times you all didn't understand why I needed so much time alone or why you all were spending a lot of time by Maw Maw; but I love you both and thank you all for loving me back unconditionally.

Lastly, this dissertation is dedicated to my Aunt, the late, Albertha L. Molo. Aunt Bert you assisted my mom in raising me and instilled in me the value of an education. From early childhood, continuing your education after high school was not an option in your book and I thank you for pushing me and believing in me at a young age. Even though you passed away while I was pursuing my undergraduate degree, I never gave up and I kept going because you told me the sky was the limit and I know you are one of those bright stars shining on me. Although, I do not see you, I know your spirit is with me. Thank you so much, I love and miss you.

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worked with me from the access sites and all the participants in this study. Without their efforts, this study would not have been possible.

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ABSTRACT

Epps, Fayron Recha, Ph.D., Southern University and A & M College, May 2012
Title of Dissertation: AN ANALYSIS OF CULTURAL VALUES, RELIGIOSITY AND FAMILY MEMBER'S CAREGIVING ON THE POSITIVE APPRAISAL OF CARING FOR THE ELDERLY
Major Professor: Sharon Hutchinson, PhD, MN, RN, CNE

The stress and burden experienced by the family caregiver during the caregiving experience has been widely researched and established among the literature. Limited research exists on the impact of cultural values, religiosity and family caregiving on the caregiver's positive appraisal of caring for a dependent elderly family member. Therefore, the purpose of this study was to examine the influence of cultural values and religiosity on the positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members. A predictive correlational study design was employed to examine the relationship amongst variables for 69 African-American, Hispanic and Caucasian family caregivers that reside in southeastern Louisiana.

Two theoretical frameworks served as the paradigm for this study, providing direction in concepts selected, formulation of six hypotheses, and the study design. The first is Roy Adaptation Model (Roy & Andrews, 1999), describing individuals as holistic adaptive systems that are capable of responding to internal and external environmental stimuli. The second is Lazarus (1991) Structural Model of Appraisal, which explains how the interpretation of a situation determines the person's appraisal of the situation.

Study participants completed a demographic tool and four instruments the: (1) *Katz Index*, (2) *Obligation Scale*, (3) *Duke University Religion Index*, and (4) *Positive Appraisal of Care Scale*. Pearson's r, ANOVA and multiple regression analyses were used to test hypotheses in determining relationships, differences and predictions among African American, Hispanic and Caucasian family caregivers.

An overall significant moderate correlation was found between cultural values and positive caregiver appraisal as measured by the Obligation Scale and Positive Appraisal of Care Scale ($p < .001$). A significant correlation did not exist between the religiosity score and positive caregiver appraisal among the family caregivers. Overall, there was a not a significant difference in cultural values, religiosity, and positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers as a whole. However, analysis revealed cultural values and religiosity was a significant factor in predicting the positive appraisal of caregiving for African Americans ($p = .002$). Findings from this study indicate that more research is needed in order to plan and organize culturally sensitive interventions (inclusive of religious beliefs) to assist not only the elderly family member, but the family caregiver also.

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CHAPTER I

INTRODUCTION

The United States (U.S.) population is aging, with the overall population of Americans age 65 and over projected to double by the year 2050 (U. S. Census Bureau, 2011). Existing data indicates the greatest population increase are in races other than Caucasian, with more than half of the growth between 2000 and 2010 due to an increase in the Hispanic population (U. S. Census, 2011). Projections indicate that the African American elderly population will quadruple and the Hispanic elderly population will increase to 6.5 times its current size by 2050 (U.S. Census Bureau , 2011). Furthermore, 23.6% of the households within the United States include one or more people age 65 and over (U.S. Census Bureau, 2011). These statistics suggest there is the potential for family members to become informal care providers and provide caregiving for their elderly family members residing in their home.

Caregiving provided by a family member is a life-altering experience involving changes and sacrifices of the family caregiver to meet their own needs along with the needs of the dependent family member (Vroman & Morency, 2011). The caregiving experience can elicit beneficial aspects to include feeling useful, adding meaning to one's sense of self, strengthening caregivers' relationship with their relative, and gaining satisfaction (Shirai, Silverberg & Kenyon, 2009). Negative aspects associated with

caregiving includes stress, strain, and burden (Van Den Wijngaart, Vernooij-Dassen & Felling, 2007; Jensen, Ferrari & Cavanaugh, 2004). Hunt (2003) refers to caregiving as a mulidimensional construct which includes both positive and negative appraisal of caregiving experience (Coon et al., 2004;Haley et al., 2004; Harwood et al., 2000). However, a caregiver's motivation for taking responsibility in caring for another person may have positive consequences on their satisfaction finding gratification and meaning in their role as caregiver and the appraised caregiving experience (Andren & Elmstahl, 2005).

Caregiver appraisal is the process by which an individual estimates the amount or significance of caregiving; it denotes a neutral term that indicates positive, neutral, or negative feelings about the caregiving situation (Lee, Yoo & Jung, 2010). As a natural psychological process for reducing stress, caregivers reinterpret the meaning of caregiving resulting in positive, neutral, or negative appraisal (Lai, 2010). Gender and culture are often overlooked in exploring caregiving for dependent and elderly family members. However, Hunt (2003) recommends additional attention be given to gender and cultural differences as it relates to caregiving for dependent elderly family members. Culture guides the behavior of family members and their roles within the family (Yarry, Stevens & McCallun, 2007), including providing care for loved ones. Relevant to the African American and Hispanic cultures is the provision of care for its elderly family members. "Older ethnic minority individuals are more likely to be part of a larger extended family context than are older European American individuals, influencing who provides care. Older African American and Hispanic individuals frequently live in single-parent families and multigenerational homes, which include a broader range of

family members than is typically found in households with nuclear structure" (Yarry et al., p.24). Among Hispanics, cultural values and norms have been shown to affect the provision of care as well as feelings of burden and depression (Harwood et al., 2000).

Another relevant cultural value of African American and Hispanic cultures is religion. Providing care for the elderly is biblical and often linked to religious values or more specifically religiosity (Picot, Debanne, Namazi & Wykle, 1997; Haley et al, 2004). Religious belief systems foster a character of responsibility and care for others serving as an important resource when one is faced with realities of responsibility and care (Chang, Noonan & Tennstedt, 1998; Haley et al., 2004). Furthermore, it has also been found that particular religous beliefs are connected to family member's motivation to provide care for frail elders (Chang, Noonan & Tennstedt, 1998; Dilworth-Anderson, Boswell & Cohen, 2007).

Statement of Problem

Existing literature emphasizes the poor health outcomes and experiences of family caregiving (Lee & Singh, 2010;Yamamoto-Mitani, Ishigaki, Kuniyoshi & Kawahara-Maekawa, 2004; Sander, Davis, Struchen, Atchison, Malee & Nakase-Richardson, 2007). Research on family caregiving also examines the stress and burden experienced by caregivers who provide care for family members (Van Den Wijngaart, Vernooij-Dassen & Felling, 2007; Jensen, Ferrari & Cavanaugh, 2004; Sander et al., 2007). Furthermore, the literature also examines stress and burden associated with caregiving is a matter of subjective appraisal (Lawton, Kleban, Moss & Rovine, 1989). Negative caregiving consequences remain the primary focus of family caregiving research despite the recent

positive literature that indicates the beneficial aspects of caregiving (Shirai, Silverberg, & Kenyon, 2009).

The cultural values and perceptions of caregivers have an impact on their appraisal of being able to meet the demands of caregiving (Montoro-Rodriguez & Gallagher-Thompson, 2009). Research on cultural differences in caregiving is also limited, eventhough the nation is becoming increasingly diverse, warranting additional research to focus on gender and cultural differences in caregiving (Anngela-Cole & Hilton, 2009; Hunt, 2003). Guinta, Chow, Scharlach and Dal Danto (2004) studied the relationship of racial and ethnic differences in family caregiving that showed "minority caregivers have more intensive caregiving responsibilities and use fewer formal services to assist them. However, there is a dearth of literature which examines the effects of caregiving among specific cultures thus warranting additional research to understand the impact of culture on caregiver appraisal (Harwood et al., 2000).

Therefore, Knight and Sayegh (2009) developed a revised sociocultural stress and coping model for caregivers to describe cultural influences on stress and the coping process. Cultural values is used in this model as an additonal element to consider in comparisons of ethnic group differences in caregiving. Familialism is a good measure of an individual's ranking on the individualism to collectivism dimension and confirmed the commonly perceived differences on the dimension among ethnic groups (Knight & Sayegh, 2009). Moreover, Knight and Sayegh (2009) defines familiasm as a cultural value that refers to strong identification and solidarity of individuals with their family as well as strong normative feelings of allegiance, dedication, reciprocity and attachment to their family members. Within the construct of culture, filial piety is evident in many

ethnic cultures as a very important value that gives representation of a cultural value. Filial piety leads to respecting parents and taking good care of them in their old age (Lee & Singh, 2010).

Vroman and Morency (2011) conducted a study showing a relationship with a higher being was identified on how religiosity effected how they viewed and coped with the caregiver role and how culture positively influenced caregivers' beliefs and perceptions of caregiving. The use of religion for coping has been associated with a more positive outlook in relation to caregiving, serving as a source of comfort buffering the effects of stress (Yarry et al., 2007). "A growing body of research indicates that involvement in religious activities may enhance various aspects of well-being by providing social integration, support, a relationship with a higher power, and systems of meaning and existential coherence. People who attend organized religious activities have the opportunity to establish reliable informal social networks from which they derive support in times of stress" (Coon et al., 2004, p. 332).

Despite the aforementioned studies, most research has ignored racial diversity among caregivers as it relates to well-being, appraisal and religious coping (Haley et al., 2004). In addition, religion and well-being among caregivers of dependent adults have been unexplored (Hebert, Weinstein, Martire & Schulz, 2006). A knowledge gap in literature exist in examining cultural values, religiosity and it's affects on the postive appraisal of caregiving for dependent elderly family members.

Statement of Purpose

This study assess the influence of cultural values and religiosity on the positive appraisal of caregiving among African American, Hispanic and Caucasian family

caregivers. This study also examine the relationship among cultural values, religiosity, and the positive appraisal of caregiving in African American, Hispanic and Caucasian caregivers for dependent elderly family members. The variables address in this study are cultural values, religiosity and the family caregiver's positive appraisal of caregiving. The independent variables are cultural values and religiosity with the intercept variable as family caregiving. The dependent variable is the positive appraisal of caregiving.

Significance of the Study

Family caregivers are an integral part of our health care system; attending to their needs is a crucial nursng responsibility and often leads to improvement of outcomes for both the care recipient and caregiver. "Caregivers are a vulnerable population worthy of attention equal to that of the care recipient" (Anngela-Cole & Hilton, 2009, p. 60). Serving as a caregiver is stressful, but the nurse that is well informed understands the relationship between cultural values, religiosity and family caregivng will be able to approach the caregiver and care recipient in a positive manner. Understanding and having an accurate measurement of positive appraisal of care by family caregivers is important for nurses to better plan and organize interventions to assist not only the elderly family member, but the caregivers also.

In response to the increasing social diversity of health care recipients, it is important that nurses and other healthcare providers understand how caregivers from distinct cultural background impact caregiving for an elderly family member. The expected increase in the older population means there is a critical need for resources and research to support caregivers. However, the number of family unpaid caregivers will increase as the population continues to age (U.S. Census Bureau, 2011). This increase in

unpaid family caregivers is parallel to the increasing diversity of the United States' population.

As the quality and longevity of life expands, it is important for nurses working with the elderly to have a better understanding of the needs of family members serving as caregivers. Additionally, the values and beliefs of the caregivers shape decisions regarding who provides care and the resources used in caring for their elderly family members (Guinta et al., 2004).

Investigating cultural differences and the impact of care among ethnic minority caregivers is critical given the dramatic increase and diveristy shift of the U.S. The nursing profession needs to recognize the cultural values and acknowledge its connection with religiosity in their practice in order to promote positive outcomes and healthy behaviors in accordance with Healthy People 2020.

Research Hypotheses

The independent variables are cultural values and religiosity. The dependent variable is the positive appraisal of caregiving. In order to explore the relationships among the independent and dependent variables, the following research hypotheses were addressed in this study.

H_1: There is a positive relationship between cultural values and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_2: There is a positive relationship between religiosity and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_3: There is a significant difference in cultural values, religiosity, and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_4: Cultural values and religiosity will predict the positive appraisal of caregiving of African American caregivers for dependent elderly family members.

H_5: Cultural values and religiosity will predict the positive appraisal of caregiving of Hispanic caregivers for dependent elderly family members.

H_6: Cultural values and religiosity will predict the positive appraisal of caregiving of Caucasian caregivers for dependent elderly family members.

Definition of Terms

The following terms have been defined to assist the reader in comprehending this study:

Acute Illness

Conceptual: An acute illness is characterized by severe symptoms that are of relatively short duration and affect functioning in any dimension (Potter & Perry, 2009).

Operational: Acute illness of a dependent elderly will be identified on the demographic questionnaire under care recipient information by the family caregiver as having an acute illness that will resolve within six months.

African American

Conceptual: African American is a person that has origin of any Black racial groups of Africa, including those individuals that identify as Kenyan, Nigerian or Haitian (U. S. Census Bureau, 2011).

Operational: The family caregiver's self-reported response as African American/Black (non-Hispanic origin) on the demographic questionnaire.

Caucasian

Conceptual: Caucasian is a person that has origin of any original peoples of Europe, the Middle East or North Africa, including those that identify as White, Irish, German, Italian, Lebanese, Arab or Moroccan (U.S. Census Bureau, 2011).

Operational: The family caregiver's self-reported response of Caucasian/White (non-Hispanic origin) on the demographic questionnaire.

Chronic Illness

Conceptual: "A chronic illness persists, usually longer than six months and can also affect functioning in any dimension" (Potter & Perry, 2009, p. 79).

Operational: Chronic illness of a dependent elderly will be identified on the demographic questionnaire under care recipient information by the family caregiver as having a chronic illness that will last six months or greater.

Cultural Values

Conceptual: Leininger and McFarland (2002) defines culture values a "the powerful internal and external directive forces that give meaning and order to the thinking, decisions and actions of an individual" (p. 49). Categorizing caregivers by their ethnicity to describe culture values will limit the study by not fully capturing values and attitudes of the caregiver. "Family obligation is a factor that reflects cultural values that demand caregiving for family members in need" (Knight & Sayegh, 2009, p. 7). It is recommended that filial piety, more specifically filial obligation, be utilized for the evaluation of the contributions of specific cultural characteristics (Lee et al., 2010). Filial

obligation is the degree of a person's expression for a cultural value that modifies the effect of caregiving appraisal and perceived obligation to provide material and emotional support to the family (Lee et al., 2010; Anngela-Cole & Hilton, 2009).

Operational: The scores obtained using the Obligation scale assessed the cultural values of family caregivers. The Obligation scale is composed of seven items on a 5-point Likert scale designed to measure family caregivers' general feeling about obligation towards helping a parent (Cicirelli, 1991).

Dependent Elderly

Conceptual: The ageing process is a biological reality, which has its own dynamic. However, it is also subject to the constructions by which each society makes sense of old age. The age of 60 or 65, roughly equivalent to retirement ages is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant. Contrast to the chronological milestones which mark life stages, old age for many is seen to begin at the point when active contribution is no longer possible (Randel, German & Ewing 1999). A dependent elderly is a person that has aged, often with a chronic illness and their self-sufficiency in mobility, occupation, personal care and leisure activities has decline, many make transiton from independent living to some form of dependent living (National Alliance for Caregiving, Executive Summary, 2009).

Operational: A dependent elderly was identified on the demographic questionnaire under care recipient information by the family caregiver as a person age 65 and over, which receives some form of assistance with activities of daily living (bathing,

dressing, toileting, transferring continence and feeding) from a family member, diagnosed with chronic illness and does not reside in a nursing home. In addition, the family caregiver on the Katz index identified the elderly's dependent activity of daily living. Katz Index assessed the functional status as a measurement of the elderly family member's ability to perform activities of daily living as either independent or dependent (Wallace & Shelkey, 2008).

Family Caregiver

Conceptual: A family caregiver is a person who provides care for an ailing family member, such as elderly parents, sisters, brothers or children. The family caregiver ultimately becomes the sole decision maker regarding the family member's health status and exerts a great deal of time and energy performing certain task to ensure that the family member maintains optimal health. Primary caregivers have the highest level of responsibility regarding care (providing majority of care) compared to secondary caregivers having a lesser level of responsibility (providing minimum care) (National Alliance for Caregiving, Executive Summary, 2009).

Operational: Self-reported on the investigator developed demographic questionnaire as being a family member and primary or secondary caregiver for the elderly individual who is the recipient of care; and provides a minimum of 20 hours of care per week.

Family Caregiving

Conceptual: The National Alliance for Caregiving (2009) defines caregiving as the provision of unpaid care to a relative or friend with special needs in order to help the individual take care of himself or herself.

Operational: Self-reported information provided on the investigator developed demographic questionnaire indicating the family caregiving provides an elderly family member with at least 20 hours of care per week and assist their dependent elderly family member with activities of daily living (bathing, dressing, toileting, transferring, continence and feeding).

Hispanic

Conceptual: Hispanics are American of Cuban, Mexican and Puerto Rican, and South or Central American family origin (U. S. Census Bureau, 2011).

Operational: The family caregiver's self-reported response of Hispanic American or Latina (of any race) on the demographic questionnaire.

Positive Appraisal of Caregiving

Conceptual: "Appraisal represents an evaluation of what those circumstances imply for the individuals' personal well-being given his or her unique configuration of needs, goals, values, abilities, and the like" (Contrada & Baun, 2011, p. 200). Positive appraisal of caregiving is the extent in which the caregiving role experience is affectively appraised resulting in a positive return to the caregiver describing the experience as good and comfortable (as cited in Hunt, 2003). Positive appraisal of family caregiving includes the concepts of caregiver esteem, uplifts of caregiving, caregiver satisfaction, and caregiver gain.

Operational: The caregiver's positive appraisal of family caregiving measured using the Positive Appraisal of Care scale that explores relationship satisfaction, role confidence, consequential gain and normative fulfillment of the caregiver (Yamamoto-Mitani et al., 2004).

Religiosity

Conceptual: Religiosity reflects behaviors that include participation in religious activities (organizational), religious involvement (non-organizational) and subjective (intrinsic) reports of having a relationship with a higher being (Picot et al., 1997). Religiosity and spirituality were treated as the same construct.

Operational: Duke University Religion Index (DUREL) was used to assess religiosity in family caregivers. This scale contains five items that examine three dimensions of religiosity under the categories of organizational, non-organizational and intrinsic (Koenig & Bussing, 2010).

Theoretical Framework

Two theoretical frameworks support this study. The first is Roy's Adaptation Model (Roy & Andrews, 1999), describing individuals as holistic adaptive systems that are capable of responding to internal and external environmental stimuli. The second is Lazarus (1991) Structural Model of Appraisal, which explains how the interpretation of a situation determines the person's appraisal of the situation.

The purpose of Roy's Adaptation Model (RAM) is to understand and explain how people adapt to life situations, including description of individuals and group coping process, methods of adaptation to environmental stimuli and explanations of the relationship between adaptation and health (Roy & Andrews, 1999). Findings from RAM are based on philosophical claims, adaptation claims, scientific assumptions and philosophical assumptions for the person and environment. The phenomena of interest identified by Roy and Andrews as cited in Fawcett (2005) include the study of basic life processes and how nursing maintains or enhances adaptive responses or changes

ineffective responses. These specific inquiries represent focal, contextual and residual stimuli. Within the context of basic nursing science, RAM identifies a particular person or group of interest as an adaptive system, which includes coping processes for the individual and a stabilizer and innovator for groups. The adaptive system may be an individual, family or other group, community or society (Fawcett, 2009) (see Figure 1).

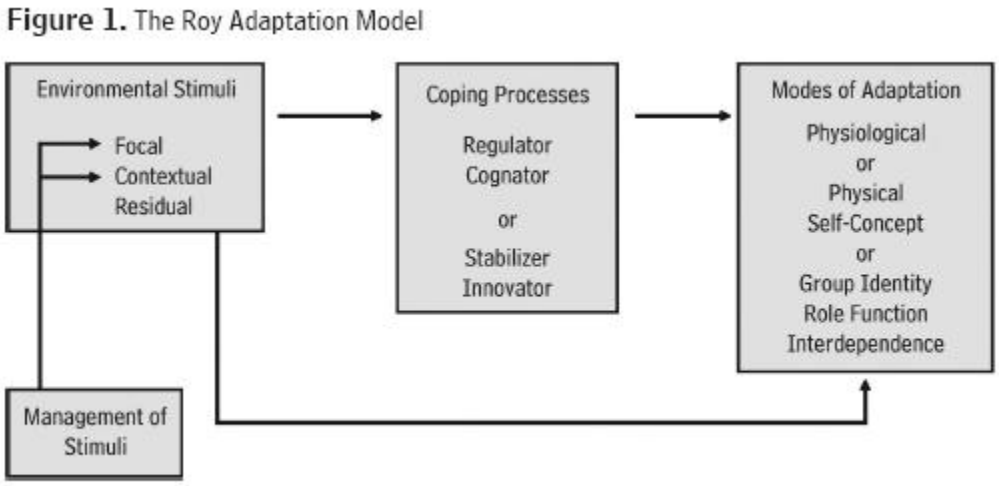

Figure 1. Example of the Roy Adaptation Model (Fawcett, 2009). Reprinted with Permission.

According to Roy and Andrews (1999), the main concepts of the Roy Adaptation Model include:

- The person is viewed as an open adaptive system in constant interchange with environment.
- Adaptation is both a process and a state that involves the person and environment
- Three classes of stimuli (focal, contextual and residual) are derived from the person and environment.

- Focal stimulus is what immediately confronts the individual.
- Contextual stimuli are factors that contribute to the focal stimulus.
- Residual stimuli are the unknown environmental factors that can influence the situation.
- Stimuli are filtered through the cognator and the regulator coping mechanism (subsystems).
- The cognator subsystem includes emotion, perceptions, information processing and judgment.
- The regulator subsystem involved the automatic neuroendocrine response.
- System effectors are recognized in the form of four adaptive modes: physiologic, self-concept, role function, and interdependence.
- Physiologic mode adaptation is achieved when the need for oxygen, nutrition, elimination, activity, and rest are met.
- Self-concept mode focuses on the beliefs and feelings that one holds about one ’s self at a given time, encompasses physical and spiritual self.
- Role function mode identifies social integrity and knowing who we are in relationship to others.
- Interdependence mode involves a close relationship with others and the ability to love, value, and respect.
- Behavior involves internal or external actions and reactions under specified circumstances.

Moreover, Lazarus's (1991) Structural Model of Appraisal examines and evaluates the cognitive appraisal process and how different appraisals influence emotions. There are two types of appraisals which are primary and secondary (Hogg & Cooper, 2003). The construct of primary appraisal establishes the significance of an event for a person by examining goal relevance, goal congruence or incongruence and type of ego involved (Lazarus, 1999). In primary appraisals, a situation is perceived as being either irrelevant, benign-positive or stressful. A stress-relevant situation is appraised as challenging when it mobilizes physical and psychological activity and involvement. In the process of appraisal of caregiving, family caregivers may see an opportunity to prove themselves, anticipating gain, mastery or personal growth from the caregiving experience. Therefore, the situation is experienced as pleasant, exciting and interesting and the person is hopeful, eager and confident to meet the demands.

Secondary appraisal involves the person's evaluation of their resources and options for coping by examining self-accountability, other-accountability, problem-focused coping potential, emotional-focused coping potential and future expectancy (Contrada & Baun, 2011). Within the construct of the secondary appraisal, Lazarus addresses of individual's coping resources.

Lazarus and Folkman (1984) maintain that appraisals of the person-environment relationship are in constant flux as people gain feedback about emotional and instrumental consequence of their coping efforts. Therefore, meaning caregivers are involved in a continuous process of evaluating how well their coping efforts advance their goals as they determine the cost of caregiving to themselves and others. The family caregiver evaluates social support and material or other resources in order to readapt to

the circumstances and to reestablish equilibrium between person and environment. Overall, the Structural Model of Appraisal provides guidance on how to examine a person's appraisal of a situation and then predict the emotion of experiences of that person based upon their view of the situation. (Hogg & Cooper, 2003).

However, stressors are situations perceived and appraised by individuals as personally relevant to their well-being, but also taxing (Picot et al., 1997). Roy and Andrews (1999) implies studying family approaches to spiritiuality provides insight into factors which may influence the family's response to environmental stimuli. Family caregiving is a well documented stressful experience. Within this study, the influences of cultural values and religiosity on the positive appraisal of caregiving for dependent elderly family members were examined by utilizing Roy's Adaption Model (1999) and Lazarus's Structural Model of Appraisal (1991). The relatedness of study variables to Lazarus's and Roy's model follows:

Focal stimuli are represented by the family caregiving variable, which is the stimulus that immediately confronts the family. The demographic variables represent the contextual stimuli in this study, factors that contribute to family caregiving. Residual factors are classified as unknown, as recommend by Roy's Adaptation Model (Roy & Andrews, 1999) which allows for unknown environmental factors. According to the Roy Adaptation Model, individuals respond to their changing envrinomental stimuli through regulator and cognator coping subsystems (Roy & Andrews, 1999). The cognator coping subsystem was used in this study to explore the involvement of religiosity and cultural values on caregiving.

These theorists identifies positive appraisal of caregiving as a continous process of evaluating coping mechnasims to help restablish stability between person and environment. African American, Hispanic and Caucasian caregivers, along with the independent variables of cultural values and religiosity are affected directly by the environmental stimuli of family caregiving, demographic and unknown variables. Overall, the envorimental stimuli examined the affect of independed vaariables upon the expected outcome. Cultural values within each ethnic group was evaluated to determine each caregiver's positive appraisal of caregiving. Also, religiosity was examined to determine it's impact on the positive appraisal of caregiving. Additionally, the evaluation of cultural values, religiosity and positive appraisal of caregiving was examined overall among African American, Hispanic and Caucasian family caregivers (See Figure 2).

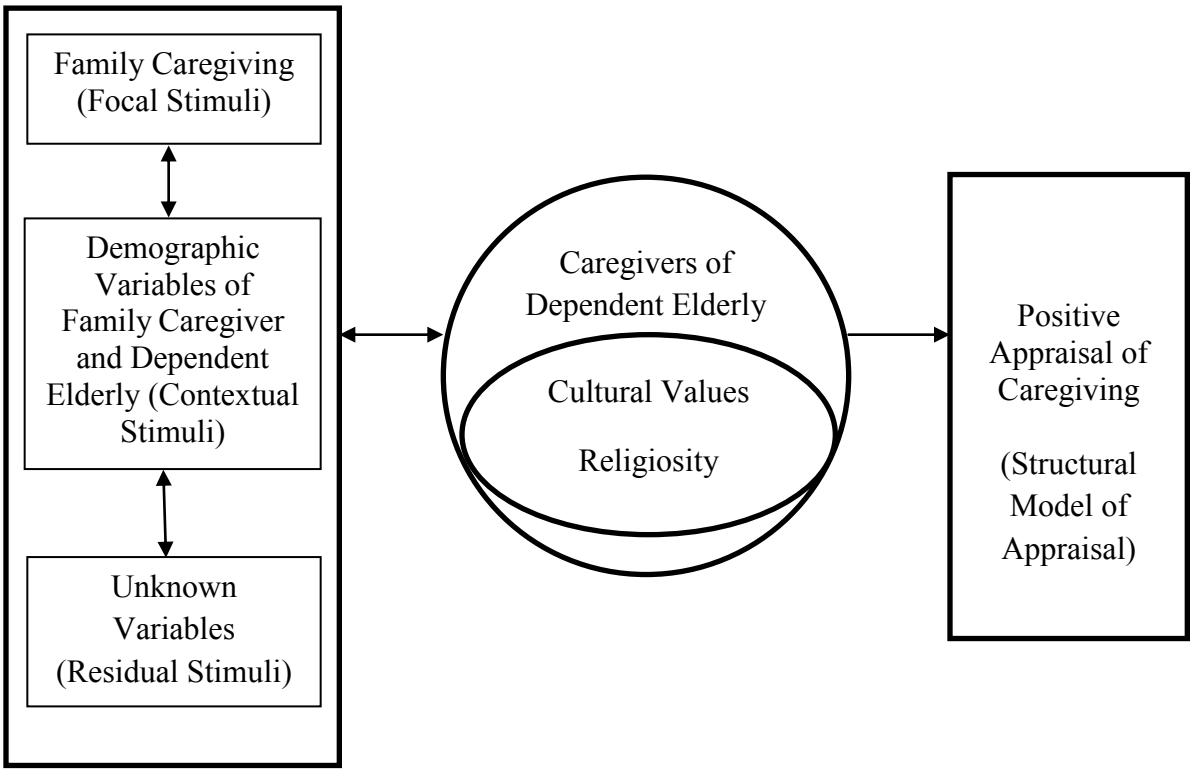

Figure 2. This path model, adopted from Roy's Adaptation Model and Lazarus's Structural Model of Appraisal, describes the relationship of stressors (stimuli), cultural values and religiosity on the positive appraisal of caregiving (Structural Model of Appraisal).

Assumptions

According to Burns and Groves (2001), assumptions are statements taken for granted or considered true, even though they have not been scientifically tested. The following assumptions were made for this study.

1. There is a relationship between culture and caregiving provided by family members.
2. Family caregivers for dependent elderly family members who are from different cultural backgrounds treat their elderly dependent family members differently.

3. The family caregivers participating in this research were honest in responding to surveys and questionnaires.
4. Family caregivers participating in this research were representative of the population of African American, Hispanic, and Caucasian family caregivers for southeastern region of Louisiana.

Summary

Family caregivers, such as spouses, adult daughters, adult sons, and other relatives, are identified as being dependable sources of caregiving to ailing family members. Taking on the role of a caregiver can be stressful and/or rewarding. Family caregivers play an important role within their family and culture. The diversity within the United States is increasing and the number of family caregivers will increase as the population continues to age (Hebert, Weinstein, Martire & Schulz, 2006). Caregiving appraisal may be different by diverse values or beliefs. Therefore, different and individualized interventions should be planned and implemented (Lee et al., 2010). The overall goal of this study is to expand the limited amount of research findings available on the positive appraisal of family caregiving among African Americans, Hispanics and Caucasians.

CHAPTER II

REVIEW OF LITERATURE

Included in the review of literature are studies which address family caregiving, positive caregiving appraisal, cultural values and religiosity. The findings from these reviews illuminate the knowledge gaps in studies of cultural values and religiosity on the positive appraisal of caregiving among dependent elderly family members in the African American, Hispanic, and Caucasian population.

Family Caregiving

Guinta, Chow, Scharlach and Dal Danto (2004) studied the relationship of racial and ethnic differences in family caregiving among 1,643 individuals who were providing care to someone age 50 and over. Andersen and Newman's model of health behavior and utilization served as the theoretical paradigm to conceptualize the influence of race and ethnicity on the family caregiving experience. The study examined how the family caregiving experience differs among racial and ethnic groups as it relates to caregiver characteristics, service utilization, caregiver strain, and coping mechanisms. Data were collected through English and Spanish versions of a telephone household survey of California caregivers over a five month period. The questionnaire was constructed to elicit information in six areas: the demographic characteristics of caregivers and care recipients, care recipient health and functioning; level of care provided to the care

recipient, assistance provided by the caregiver, services provided to caregiver, unmet needs of the caregiver, and the impact of caregiving on work, emotional health, and physical health. Five questions adapted from the Cultural Justifications Caregiving Scale were included in the questionnaire to explore the appraisal of the caregiving experience and the effects of the caregiving situation on the family. Validity and reliability was not reported for the questions adapted to use within the study. The sample size of 1,643 caregivers had an accuracy rate of plus/minus 2.4% at a 95% level of confidence yielding a response rate of 19%.

Study findings revealed differences in self-reported health status, financial strain, perceived emotional support, religiosity, formal service use, and barriers to formal services emerged across different ethnic groups. Similarities were also noted within the caregiver experience that transcended race and ethnicity included feelings around family unity, family contribution and emotional strain. A significant finding from the study resulted African American caregivers exhibiting the highest proportion (92.6%) of caregivers ever attending church ($X^2 = 56.4$; $p < .001$). There were no significant racial or ethnic differences among caregivers who claimed that caregiving was a hardship on the family. Formal caregiver service utilization significantly differed by ethnicity, as African American and White caregivers were significantly more likely to use formal services than other counterparts were. In addition, significantly Latina and African American caregivers were more likely that other groups to report barriers related to poor service quality. The responses to the positive aspects of caregiving and effects of the caregiving situation were mostly similar across all race and ethnic groups. The investigators report that the findings of the study support previous findings that minority

caregivers have more intensive caregiving responsibilities and use fewer formal services to assist them (Guinta et al., 2004).

Vroman and Morency (2011) conducted a qualitative exploratory study that examined the caregivers' perceptions of informal caregiving for older adults in Belize. The purpose of this study was to identify the characteristics of the informal caregivers of older family members, achieve an understanding of caregivers' perceptions of caregiving, and to recognize the socio-cultural factors that shaped their caregiving. A theoretical framework was not identified. Their study utilized a convenience sample of 29 informal caregivers of functionally dependent elders. Semi-structured interviews used open-ended questions to elicit information by utilizing a thematic content analysis approach. Participants described their experiences of caregiving, how they perceived and managed the role, and what critical resources they needed. These caregivers provided unpaid, in-home care to older adults that were unable to live independently or care for themselves. Three main themes that were identified in the interviews were the experiences of caregivers, the rewards of caregiving and navigating the caregiver role. The researchers coded the interviews for meaningful data representing key issues and information related to caregivers' perspectives and experiences of caregiving. To ensure trustworthiness and credibility of the data, the National Council on Aging and others working with elders in Belize conducted a peer review process in the development of the study and review of the findings. Overall, the caregivers within this study identified positively with the role of a care provider and did not report any burden or role strain. Furthermore, a relationship with a higher being was identified with the effects of religiosity on the views and coping mechanisms of the caregiver and on the positive influence of caregiver's beliefs and

perceptions. An intergenerational ethos of caregiving was observed within an environment constrained by a lack of resources. The investigators found caregivers coped by reducing the tension between what they have and might have with an acceptance of the present, a perspective that reflected the central role with Christian beliefs playing a significant role in how they construed life and an appreciation for the privilege and blessing found in reciprocity, human connectedness, and family values (Vroman & Morency, 2011).

Positive Appraisal of Caregiving

Family caregivers expereince both positive and negative reactions in caregiving situations (Andren & Elmstahl, 2005). The aim of this study was to explore a previously devleoped instrument to study rewards gained by caregivers and to determine the factors associated with satisfaction in family members caring for patients with dementia living at home. Patients with dementia were recruited consecutively for four years. Of the 207 patients that fulfilled the inclusion criteria, a final number of 153 participated in the study. The patients with dementia was asked to nominate a family caregiver, a relative who has the main responsibility in caring. There was no theoretical framework identified within this study. Several instruments were used to assess the different aspects of the caregivers' sense of satisfaction and dissatisfaction, and the nature of the disease and its severity in the person being cared for among 153 family members. The level of the patient's loss of function was assessed by Katz Index; the level of social dependency was assessed by the Berger Scale; the severity of dementia and symptoms was assessed by the Gottfries-Brane-Steen Scale; the level of caregiver's satisfaction was measured by the Carers' Assessment of Satisfaction Index ($\alpha = .76$); the level of dissatisfaction was

measured by the Caregiver Burden Scale (κ-values in the range of .89 to 1.00); the subjective experience of health was measured by the Nottingham Health Profile Scale and the Sense of Coherence Scale (α = .82 to .95) was used to describe the individual resource or a personality characteristic. Registered nurses were used to perform assessment of Katz Index, Berger scale and Gottfries-Brane Scale in the person's home. Caregivers completed the rating themselves in their own home.

Spearman correlation coefficient was used to examine the relationship between the instruments assessing satisfaction and health; burden; individual resources and modigying effects related to severity of illness and relationship. A multiple regression analysis was done to idientify factors that influence satisfaction and variablew with univariate association with any of the factors of satisfaction ($p < .05$) were included. Significant positive finding were noted between satisfaction factors, increasing age and deteriorated functions as assessed by Gottfries-Brane-Steen scale and Berger scale. However, a negative association was noted for the relationship variables; the more distant the relationship, the lower the satisfaction. In addition,no significant association was noted between satisfaction and the subjective health of the caregiver. Overall, a major finding of this study was high proportion of caregivers express satisfaction, despite caregiver burden or the health of the caregiver. The investigators concluded an important finding of this study resulted caregivers experience one or more kinds of satisfaction irrespective of health and degree of burden suggesting the need to decrease caregiver burden to enhance their sense of satisfaction (Adren & Elmstahl, 2005).

A convenience sample of 40 family caregivers were studied to examine the positive and negative apprasial among Cuban American caregivers of Alzheimer's

disease patients (Harwood et al., 2000). The researchers reference the work of Lazarus and Folkman in regard to stress and adaptation but a theoretical framework is not identified specifically for this study. This cross-sectional study was conducted among 40 Cuban American family caregivers of patients diagnosed with probable or possible Alzheimer's Disease at a universiy affiliated outpatient memory disorders clinic. In order to be incuded in the study, the family caregiver had to be self-identified as both Hispanic and Cuban American. Within this study, several instruments were used to assess the Alzheimer's disease patients and caregivers. The Caregiving Burden Scale ($\alpha = .89$), Caregiving Satisfaction Scale ($\alpha = .69$), Perceived Emotional Support Scale ($\alpha = .89$) and the Short Form-36 Health Survey-General Health Index ($\alpha = .88$) were the instruments used to assess the caregivers.

A hierarchical multiple regression analysis were used to identify the predictors of caregiving and burden. The hierarchical multiple regression predicting satisfaction among Cuban American caregivers showed that perceived emotional support and older caregiver age were significant predictors of caregiving satisfaction. On the other hand, the hierarchiacal multiple regression predicting burden among Cuban American caregivers revealed patient behavioral disturbances, female gender and perceived emotional support significantly predicted burden. Pearson correlation coefficients were also used to investigate the association of acculturation with positive and negative appraisal. The results indicated that the caregiver's length of residence in the United States was not related to burden ($r = -.22$, $p = .19$) or satisfaction ($r = -.11$, $p = .53$). The investigators suggest that Cuban American family members may benefit from the

development of culutrally congruent treatment starategies that address the distinct needs of this caregiving population (Harwood et al., 2000).

Within another study, positive and negative appraisal of care was examined in relation to the caregiver's subjective quality of life (Yamamoto-Mitani, Ishigaki, Kuniyoshi, & Kawahara-Maekawa, 2004). Positive appraisal was conceptualized from literature review and qualitative interviews with Japanese caregivers as any cognitive and affective evaluation of one's caregiving experience that describes caregiving as good and comfortable. There was no theoritical framework identified within this study. The hypotheses for this study examined each domain of positive appraisal as having a significant positive relationship with physical and psychological quality of life. The subjects for this research were family caregivers providing home-based care for elderly relatives aged 65 or more. Caregivers were selected from 21 visiting nurse organizations in various areas of Japan-Tokyo metropolitan area. Each organization determined how many caregivers could be selected and 381 caregivers were sampled for this study.

A questionnaire was developed for this research to collect data for appraisal of care, subjective quality of life as well as demographic variables of caregiver and care recipient. Nurses collected data for questionnaires in approxiamtely two weeks with all quesitonnaires forwared to the primary investigator. This study used a newly developed multi-dimensional scale that was subcategorized as Negative Appraisal of Care Scale (α = .87) and Positive Appraisal of Care Scale (α = .92) which included the domains of relationship satisfaction (α = .84), role confidence (α = .83), consequential gain (α= .84), normative fulfillment (α = .74), role exhaustion (α = .82), isolation (α = .74), relationship difficulty (α = .76) and symptom management difficulty (α = .68). Altogether 337

Japanese family caregivers participated in this survey. Stepwise multiple regression analyses revealed that 'role confidence', 'normative fulfillment' and 'role exhaustion' had a significant independent impact on physical quality of life, while 'role confidence' and 'role exhaustion' on psychological quality of life. The association of 'normative fulfillment' with physical quality of life was negative while that of 'role confidence' was positive, despite the positive correlation between the two domains. The investigators suggest the results underline the importance of considering positive as well as negative appraisal of care when examining subjective quality of life of the family caregivers (Yamamoto-Mitani et al., 2004).

A study conducted in southern Arizona among 63 family caregivers used a mediation model of total socio-emotional support to predict caregiver feelings of gain via caregiving mastery (Shirai, Silverberg, & Kenyon, 2009). Based on Bandura's Social Cognitive Theory, the researchers proposed a mediation model translating how socio-emotional support predicts caregiver feelings of gains with an association mediated by a sense of caregiving mastery. Caregiver feelings of gain was measured by the revised Positive Aspects of Caregiving Scale. Socio-emotional support was measured by four items devloped by Walen and Lachman. Caregiver mastery was measured by a revised version of the Caregiving Mastery Scale. Reliability was not reported on any instruments used in this study.

Questionnaire packets were sent to a total of 78 caregivers with 63 responding and returning questionnaires. A series of structural equation modeling analyses was applied. The results indicated that overall the predictors accounted for approxiamtely 42% of the variance in caregiver feelings of gain ($r^2 = .418$). Family socio-emotional

support and partner socio-emotional support were positively associated with caregiver feelings of gain ($p < .01$). As a result of this study, socio-emotional support from family members was found to be an important resource for caregiver's feeling of gain. In addition, the investigators report the mechanisms by which socio-emotional support influences caregiver feelings of gain vary depending on the source of support (Shira et al., 2009).

Jensen, Ferrari, and Cavanaugh (2004) conducting a study to assess satisfaction and well-being in elder care. Utilizing the Caregiving Satisfaction Scale ($\alpha = .79$), the Center for Epidemiologic Studies Depression Scale ($\alpha = .84$), the Caregiver Well-Being Scale ($\alpha = .79$), and the Caregiving Uplifts Scale ($\alpha = .77$); 100 interviews were conducted to expore the benefits of caregiving. Participants of this study were caregivers that self-identified themselves as the primary caregiver for a relative, been providing care for the past threee months. The care recipients in this study inclusion criteria were: (1) a probable or definite diagnosis of cognitive or physical impairment; (2) at least 60 years of age and (3) living in own home or caregiver's home.

A multivariate analysis of variance was conducted to test the proposed hypothesis using care recipient imapirment and caregiver relationship as the fixed factors and the scales as the dependent variables. Significant differences based on the care recipient impairment werer found for the Caregiver Well-Being Scale, Caregiver Satisfaction Scale and the Caregiver Uplifts Scale ($p < .01$). Overall, this study concluded caregiver satisfaction was significantly higher for caregivers for elders with a primarily physical impairment as compared to an elder with a cognitive impairment. "These findings advance previous research by indicating that caregivers experience satisfaction in their

role and the potential for personal fulfillment even when faced with challenging circumstances" (Jensen et al., 2004, p. 88).

A mixed study conducted by Jervis, Boland, and Fickenscher (2010) explored the negative and positive aspects of providing elder care among American Indian family members. A theoretical framework is not identified in this study but the stress-coping model is referenced in relation to the negative and burdensome aspects of caregiving. This study used data collected in a larger study where an culturally modified cognitive assessment was administered to 140 elders. Permission was asked of the elders to contact their caregiver and 53 elders provided permission. The investigators of this study chose 20 family members but one interview was not retained due to missing data, thus resulting in a sample size of 19 caregivers. Each caregiver participated in a structured interview and an audiorecorded ethnographic interview.

The quantitative part of this study involved a structured interview where funcitonal status, caregiving burden, and caregiving reward was evaluated using Activities of Daily Living and Instrumental Activities of Daily Living measure, Burden Inventory, and Positive Aspects of Caregiving measure. It is reported within the study that analyses were restricted to percentages, range,mean and standard deviation of caregiver responses due to small sample size. All of the caregivers reported that caregiving made them feel needed and enabled them to appreciate life more. However, only 75% of the caregivers respond to caregiving enabling them to develop a more positive attitude. The qualitative component involved a semi-structured ethnographic interview that examined family lives, exchanges of assistance between the caregiver and the elder, problems helping the elder and both the difficult and the positive aspects of

caregiving. The investigators concluded the results of this study of family members reported low levels of caregiving burden and high levels of reward attributable to cultural attitudes toward elders and caregiving, collective care provision, strong reciprocal relationships with elders, enjoyment of elders, and relatively low levels of care provision (Jervis et al., 2010).

Cultural Values

A descriptive cross-sectional survey was conducted among 242 Korean family caregivers to examine the expression of cultural roles and individual values on the caregivers' quality of life (Lee, Yoo, & Jung, 2010). A theoretical framework was not identified as being used in this study. Permission to conduct the study was obtained from the Institutional Review Board of participating institutions. Data was collected over a two year period from outpatient stroke centers at three hsopitals and two home health agenies located in Korea. The Revised Caregiving Appraisal Scale was used to measure caregiving appraisal with an acceptable Cronbach's alpha of .78. Filial obligation was used in this study to measure cultural values with an understanding that these values can be influenced by personal characteristics and the caregiver's relationship to the care recipient. Cicirelli's Obligation Scale was used to assess the cultural values of caregivers. The reported reliability with family careivers ranged from .71 to .88 and the construct validity of the scale showed a correlation of .62 with the Filial Responsibility Expectation Scale. This study resulted that caregiver distress significantly correlated with age ($r = .151$, $p = .022$), the number of caregiving hours per week ($r = .198$, $p = .003$) and the filial obligations ($r = .336$, $p = .000$) with caregiver appraisal showing a significant difference based on the relationship between the caregiver and the recipient.

Caregiving appraisal scores did not differ by gender, education or income. The investigators report the results indicate the shifting family structure in Korean society from an extended family to a nuclear family, where the traditional caregiving responsibility is being carried out by spouses more frequently than by adult children (Lee et al., 2010).

A study examining the effects of filial piety on the appraisal of caregiving burden was conducted among Chinese-Canadian family caregivers (Lai, 2010). Lawton's two-factor model is used by the researcher to explain the relationships between different predictors of positive and negative caregiving outcomes. The primary focus of this study was to explore the effects of cultural values on the appriasal of caregiving by family caregivers. Filial piety showed to be a strong motivational force behind family caregiving, providing caregivers with the strength and endurance to meet the challenges of caregiving.

This was a quantitative telephone survey where 339 Chinese-Canadian famly caregivers were randomly selected by Chinese surnames with listed telephone numbers. A limitation was identified of this sampling method by excluding households that did not have a telephone or a landline and it also excluded unlisted numbers. The structured questionnarie used consisted of questions regarding demographic information of the caregivers and their elderly family member, such as health status of elderly family member and types of caring tasks provided. The Zarit Burden Interview was used to measure caregiver burden, reporting a split-half correlation coefficient of .81. Perceived caregiving gains were measured by six questions from the caregiving satisfaction dimension of Lawton's caregiving appraisal scale. Two dimensions of the Cost of Care

Index was also incorporated in the questionnaire to measure perceived values and economic cost. Filial piety was measured by including six questions that asked how much one whould agree or disagree with the obligation to look after, assist, respect, obey, please and maintain contact with elderly parents. The caregivers' health was measured by reporting yes or no to a list of 14 health problems. Caregiving task were measured by the level of assistance the caregivers provided to the care recipient in a range of activities of daily living and instrumental activities of daily living.

Descriptive statistics were calculated for all variables within this study. A hypothesized model denoting both the direct and indirect effects of filial piety on caregiving burden was tested using a structural equation model. This study revealed filial piety indirectly affects caregiver burden by altering the appraisals of the caregiver role, thus enhancing the positive effect of appraisal factors. Caregivers identified with the concept of filial piety interpreted family caregivng as rewarding. Direct positive effect of the stressors was moderated by the appraisal factors, which reduced the level of caregiving burden (Lai, 2010).

In contrast, a research study on the role of attitudes and culture in family caregivers was conducted by Angela-Cole and Hilton (2009) surveyed 98 Japanese American and 86 Caucasion American family caregivers caring for frail elders. The study participants were family members 18 years of age or older who cared for an elderly person at home that was 60 years of age or over, assisting in at least three activities of daily living and unpaid. The purpose of this study was to examine cultural differences in attitudes toward caregiving and wheher mainstream findings on the stresses of caregiving and whether mainstream findings on the stresses of caregiving apply to a

minority population. The dependent variable was caregiver stress which was operationally defined as the level of depression and life satisfaction. The independent variables that were studied were caregiver employment, time spent in caregiving, formal servie use, functional ability of the care recipient, emotional support, health of the caregiver, and attitude toward family care. A theoretical framework was not identified in the study.

Functional ability of the care recipient was measured by using the Adult day Care Assessment Procedure with alpha reliability estimates of .89 to .91. A subscale from the Inventory of Socially Supportive Behaviors was used to measure emotional support. Construct validity and reliability (.84 and .95) were reported, respectively, for this scale among Japanese, Chinese, and Hawaiian ethnic groups. Additionally, the attitude toward family care was measured by a modified version of the Attitude Toward the Provision of Long-Term Care Scale with a documented construct validiy and reliability (α =.88) when used with caregivers of elderly family members.

Analysis using multivariate analysis of variance (MANOVA) and multiple regression analyses revealed Caucasian caregivers had more positive attitudes and provided more hours of care than the Japanese caregivers but both groups had elevated levels of caregiver stress. Caucasian caregivers scoring higher on the variables of spending more time in caregivng (mean = 12.60) and having stronger beliefs and more positive attitude about the obligation of the family to provided care for the elderly (mean = 50.08). The study explains the results being based on the sample of Causcasian Americans used for this study represent a self-selected sample of volunteer caregivers who do not represent the attitudes of most Caucasians. In addition, the results were also

effected by the sample of Japanese caregivers who may of felt pressure into the caregiver role, thus does not embrace the role as part of their definition of self (Angela-Cole & Hilton, 2009).

Haley et al. (2004) used findings from the Resources for Enhancing Alzheimer's Caregiver Health (REACH) multi-site study to compare well-being, appraisal, and religious coping in African American and Caucasian caregivers. The study sample was a subset of the REACH Study and comprised 720 family caregivers with data being collected during in-home interviews. The family caregivers has to be at least 21 years of age, be a family member of the care recipient, have a telephone, plan to remain in the area for the duration of the study, have been caregiving for at least six months, and provide at least four hours of care per day. Inclusion criteria was also given for the care recipients to be diagnosed with dementia and unable to perform one or more activities of daily living according to the Katz Index.

Demographic characteristics, caregiving stressors, caregiver mental helath, caregiver physical health, appraisal, and religious coping and behavior were measured in this study. The researchers assessed caregiver stressors by assessing their responsibilities and report of disturbing behaviors of the care recipient by utlizing Activities of Daily Living Scale ($\alpha = .84$) and the Revised Memory and Behavior Problems Checklist, which also measures appraisal my quantifying how much the care recipient's problem behaviors bother the caregiver. Depression was assessed among the caregivers with the Center for Epidemiological Studies Depression scale ($\alpha = .888$). The caregiver's physical health and perceived physical health measure ($\alpha = .715$) consisted four items to assess perceived physical health. This study also used the Positive Aspects of Caregiving Scale ($\alpha = .906$)

to measure the the caregiver's perception of benefits associated with the caregiving experience. Caregivers were asked how much they agree with statements on a five-point scale with higher scores indicating more positive appraisal. Religious coping and behavior was assessed by querying the importance of religious faith, attendance at religious services and the frequency of prayer. No theoretical framework was identified.

Comparisons among Caucasian and African American caregivers was compared using demographic characteristics, patient characterisitcs, and objective stressors. Analysis of variance, logistic regression and polytomous logistic regressions was used to measure the remaining variables. Consistent with the researchers predictions, African American caregivers showed the highest appraisal of positive aspects of caregiving and lower levels of psychological distress in comparison to Caucasian caregivers. Results of this study showed African American caregivers reported lower anxiety, better well-being, less use of psychotropic medications, more benign appraisals of stress and perceived benefits of caregiving, and greater religious coping and participation, than Caucasian caregivers (Haley et al., 2004).

Religiosity

Morgan, Gaston-Johansson and Mock (2006) conducted a pilot study to explore the spiritual well-being, religious coping and the quality of life of African American women during the breast cancer treatment phase. A convenience sample of 11 African American women from hospital oncology centers and medical oncology physician offices within the mid-Atlanticand southeastern U.S. was used. The researchers used Roy Adaptation Model as the theoretical framework for this pilot study. The psychosocial mode of Roy Adaptation Model was the focus area to explore the components of quality

of life. A descriptive cross-sectional design was used to examine the relationships of spiritual well-being, religious coping and quality of life. Questionnaires were mailed out and took approximately 40 minutes to complete, requiring one follow-up phone to remind participants to complete questionnaires and address any concerns.

The Brief RCOPE is one instrument that was used to measure religious coping that had a Cronbach's alpha coefficient estimated at .87 for the positive scale and .69 for the negative scale. The other instrument used in this study was the Functional Assessment and Cancer Therapy Scale that measured how individuals are managing a chronic illness. This researcher reported adequate reliability and validity among the subscales of the Functional Assessment and Cancer Therapy Scale with Cronhbach's alpha coefficient ranging from .63 to .90. Data were analyzed utlizing descriptinve statistics and the Spearman rho correlational analysis. The results showed significant relationships between spiritual well-being and the quality of life domains of physical, emotional and functional well-being. The investigators concluded that African American women rely positively on religiousness as a coping resource with moderate to strong positive correlations found between spiritual well-being and other domains of quality of life, physical, emotional and functional well-being (Morgan et al., 2006).

Dilworth-Anderson, Boswell and Cohen (2007) conducted a qualitative study that examined 303 African American caregivers on how and if religious affiliation, involvement, and spiritual beliefs helped in providing care to an older relative. This study was approached from a grounded theory perspective utilizing Berger's ideas on social order and constructing reality. Majority of the caregivers studied were middle-aged daughters of the care recipients who were selected from the Duke Established

Populations for Epidemiological Studies of the Elderly (EPESE). The criteria for selecting from EPSE includes provided information on sociodemographic characteristics, physical health status, level of cognitive impairment, the inability to perform two or more basic activities of daily living and scoring of three or higher on the Short Portable Mental Status Questionnaire.

Interestingly, caregiver types were distinguished by primary, secondary and tertiary. Primary caregivers had the highest level of responsibility regarding care and identified secondary and tertiary caregivers. Secondary caregivers performed tasks at a level similar to the primary caregiver but did not have the same level of responsibility. Tertiary caregivers have minimum responsibility and performed specialized task such as grocery shopping, yard work or paying bills.

Qualitative data were collected using open-ended questions to assess caregivers' views, beliefs, and values on the role of spirituality as support and help in providing care to family caregivers. Results supported that seven to 22% of all groups of caregivers reported receiving help from their place of worship with emotional support being mostly provided. Majority of the caregivers (78% to 86%) indicated that their spiritual beliefs helped them considerably with caregiving. In addition, four domains of spiritual beliefs were patterned to include the strength to endure, a sense of duty and reciprocity toward who had cared for them, faith for encouragement, inspiration and gratification to foster positive feelings about giving care. Findings revealed religiosity and spirituality have a vey strong presence among African Americans and this particular ethnic group may experience more perceived benefits of caregiving than found among Caucasian caregivers (Dilworth-Andderson et al., 2007).

Another study explored the extent to which religiosity variables function as mediators of the effects of situation/demographic factors on perceived caregiver rewards (Picot, Debanne, Namazi, & Wykle, 1997). The researchers used Lazarus and Folkman's stress and coping conceptual framework with additional underpinnings from Reed's transcendent paradigm. Reed's Choice and Social Exchange Theory proposed caregivers' situational and demographic factors may be influenced by the caregivers' appraisals of perceived rewards directly and indirectly through the intersessions of religiosity.

Face-to-face interviews were conducted among 391 caregivers with descriptive statistics showing 65.2% White and 34.8% Black. Caregiver perceived rewards were assessed by18 items out of the 24 item Picot Caregiver Rewards Scale which measures the positive feelings and outcomes of caregiving. In the 18 items used, respondents were asked to rate their feelings about caring for their relative on a 5-point Likert scale. The Cronbach's alpha for this scale was .82 in Blacks and .81 in Whites. Deficits in activities of daily living was assessed by using the Activities of Daily Living Scale with researchers reporting a Cronbach's alpha of .86 for Blacks and .82 for Whites. The Instrumental Activities of Daily Living scale was used to obtain the caregiver's estimate of the care receiver's need for help with meal preparation, shopping, light housework, heavy house work and managing money. In this study, the Cronbach's alpha for the Instrumental Activities of Daily Living scale were .63 for Blacks and .63 for Whites. In measuring religiosity, three items was used based on dimensions of religiosity, organizational non-organizational, and subjective.

Through regression analysis, this study revealed that African American caregivers perceive higher levels of reward than Caucasians and the relationship between race and perceived rewards was determined by comfort from religion and prayer. The investigators suggest from the findings, the idea of all the dimensions of religiosity function as mediators in the stress appraisal process. Separate analyses of the dimensions of religiosity revealed while comfort from religion and prayer functioned as mediators between race and perceived caregiver rewards for both Black and Whites. Furthermore, attendance at services and self-rated religiosity may function differently as resource variables among Black and White caregivers. In addition, it was reported that the caregivers within this study with more education reported less perceived rewards of caregiving than those caregivers of lower education levels (β = -.18, p < .01) (Picot et al., 1997).

Chang, Noonan, and Tennstedt (1998) conducted a study to examine religious and spiritual coping related to specific conditions of caregiving and psychological distress among 127 informal caregivers to community residing disabled elders. The researchers hypothesized that religious and spiritual coping would affect psychological distress indirectly through quality of relationship between elders and caregivers. A conceptual model was developed based on the stress process models of Lazarus and Folkman. The conceptual model included the components of stressor (health status, disability, impairment and problem behaviors), coping (religious and spiritual), interventing variable (quality of relationship) and outcomes (depression and role submersion). Functional disability was based on whether the elderly had problem performing two acitivity of daily living items. Cognitive impairement was identified by

the score on the Short Portable Mental Status Questionnaire. Elder problem behaviors was assessed by asking caregivers questions relating to the elder wandering off, loud outburst, hiding objects, false accusations and rummaging through others' belongings. The degree of religious and spiritual coping was measured by a single item (α = .47) from the Meaning in Caregivng scale (α=0.88). The quality of relationship between the elders and caregivers was measure by five items from the positive affect measure of the University of Southern California Longitudinal Study of Three-Generation Family (α = .78). Depression was measured by a version of the Radloff's Center for Epidemiolgic Studies-Depression scale (α = .73). Role submersion was measured by the sum of two scales, role capitivity and loss of self which revealed high internal consistency among items (α = .88).

Data was collected via telephone interviews that were being conducted for a larger project, Massachusetts Elder Health Project. The majority of caregivers within this sample were White (99%). Path analysis was used to test the conceptual model and the hypothesis with path regression coefficients estimated by a series of ordinary least squares. Results showed caregivers who used religious or spirtiual beliefs to cope with caregiving had a better relationship with care recipients ($\beta = .24$, $p < .01$), which was associated with lower levels of depression ($\beta = -.30$, $p < .01$) and role submersion ($\beta = -.40$, $p < .01$) (Chang, Noonan, & Tennstedt, 1998).

Herrera, Lee, Nanyonjo, Laufman, and Torres-Vigil (2009) studied religious coping and caregiver well-being in Mexican-American families. The purpose of this study was to explore the association of religious and spiritual coping with multiple measures of well-being in Mexican-American family caregivers caring for older relatives

with long-term disability. A conceptual framework was developed by the researchers to examine specific dimensions of religiosity and religious coping and their association with perceived burden, physical and menatal health and depression among the studied population. It was hypothesized in this study that some constructs of religiosity and spirituality would have a protective effect on caregivers' health and well-being, while others would impact well-being negatively. A convenience sample of 66 Mexican-American family caregivers gave consent to be interviewed in their homes or at a community site in San Diego County. Participants were recruited by word of mouth and flyers. In order to participate in this study, participants had to be caregivers, related to the care recipients and currently providing assistance that included help with at least one activity of daily living or instrumental activity of daily living. Participants received educational materials on health and aging and caregiving. The Institutional Review Board of Loma Linda Univeristy gave approval before the study was implemented.

Several tools were used to measure the variables within this study. Duke University Religion Index was used to assess caregivers' intrinsic, organizational, and non-organizational religiosity. Religious coping was measured using the short form of the Brief Religious Coping Scale. Caregiver well-being was assessed using three instruments: (1) *Zarit's Burden Inventory*, (2) *Center for Epidemiological Studies Depression Scale* and (3) *TSF-8 Health Survey*. Caregivers described the functional status of their care recipient with Katz Index of Activities of Daily Living and the Instrumental Activities of Daily Living Scale. In addition, familism and acculturation was measured by a Familism Scale and an Acculturation Rating Scale for Mexican Americans. All tools that were unavailabe in Spanish were translated for the family

caregivers. The reliabilty and validity of these instruments were not mentioned within this study.

Using regression analysis, sociocultural factors were controlled for along with forms of formal and informal support, care recipients' functional status and characteristics of the caregiving dyad. Intrinsic and organizational religiosity was significantly associated with lower perceived burden (β = -.23, p < .05), while non-organizational religiosity was associated with poorer mental health (β = -.20, p < .10). Furthermore negative religious coping predicted greater depression (β = .21). The investigators concluded their research supports the notion that religious and spiritual beliefs of caregivers are pertinent to their ability to adapt to physical and mental health problems (Herrera et al., 2009).

Summary

This review of literature has expanded on the variables of family caregiving, positive caregiver appraisal, cultural values and religiosity among various ethnicities. Despite the recent literature on the positive appraisal of care, additional research is warranted to examine the multi-dimensional variables of cultural values and religiosity among specific ethnicities. The aim of this study is to explore and examine the relationship among cultural values, religiosity, and positive appraisal of caregiving in African American, Hispanic, and Caucasian caregivers for dependent elderly family members. Investigating cultural differences and the impact of care among ethnic minority caregivers is critical given the dramatic shift in diveristy of the U.S population.

CHAPTER III

METHODOLOGY

This study assessed the influence of cultural values and religioisty on the positive appraisal of caregiving among African American, Hispanic and Caucasian family caregivers. Independent variables of this study are cultural values and religiosity. The dependent variable is the positive appraisal of caregiving. Therefore, this chapter describes the methods and procedures used to examine the relationship among cultural values, religiosity and positive appraisal of caregiving in African American, Hispanic and Caucasian caregivers for dependent elderly family members. Also discussed are the study design, sample size, instruments, procedure and the data analysis plan that was used to complete the study.

Research Design

A predictive correlational design was used in this study to examine the relationship among the study variables. Burns and Grove (2011) indicate the purpose of using this design is to predict the values of the dependent variable based on values obtained from the independent variables. The independent variables that are most effective in prediction are highly correlated with the dependent variable but not highly correlated with other independent variables used in the study. (Burns & Grove, 2011). Therefore, this study tested a theory-based mathematical hypothesis that

proposed the independent variables expected to predict the dependent variable effectively. Within this study, the predictive correlational study design was used to determine the causal relationships among African American, Hispanic and Caucasian cultural values and religiosity on the positive appraisal of caregiving (see Figure 3).

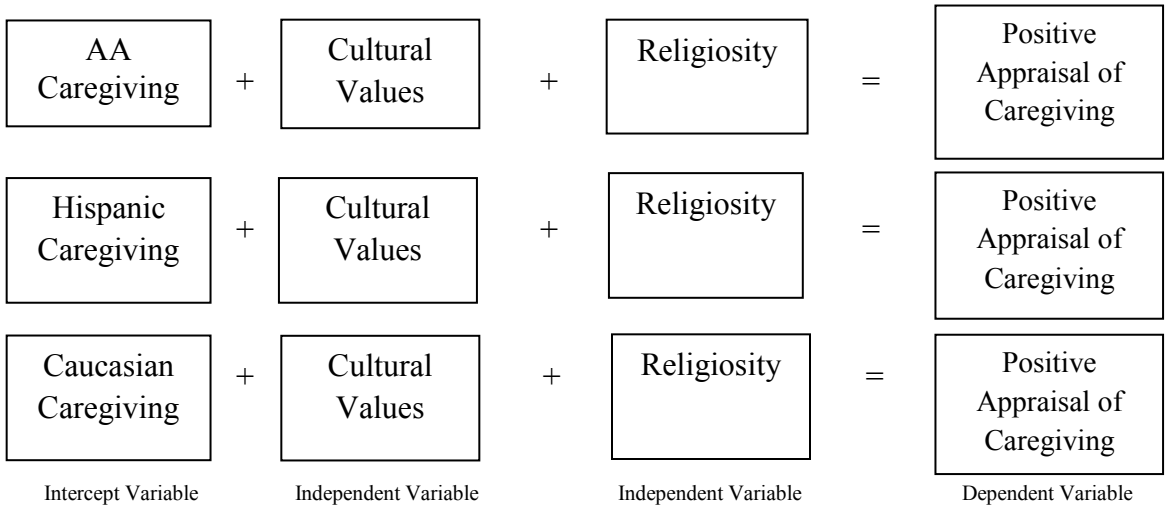

Figure 3. Predictive Correlational Study Design for Cultural Values and Religiosity on the Positive Appraisal of Caregiving for a Dependent Elderly Family Member among African American, Hispanic and Caucasian Populations.

Research Hypotheses

The following research hypotheses were tested.

H_1: There is a positive relationship between cultural values and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_2: There is a positive relationship between religiosity and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_3: There is a significant difference in cultural values, religiosity, and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

H_4: Cultural values and religiosity will predict the positive appraisal of caregiving of African American caregivers for dependent elderly family members.

H_5: Cultural values and religiosity will predict the positive appraisal of caregiving of Hispanic caregivers for dependent elderly family members.

H_6: Cultural values and religiosity will predict the positive appraisal of caregiving of Caucasian caregivers for dependent elderly family members.

Population and Sample

The population for this study were African American, Hispanic, and Caucasian family caregivers of dependent elderly family members from the Southeastern regions of Louisiana. In order to particpiate in this study, the following inclusion criteria was met: (1) individuals who identified themselves with the definitions provided as either African American, Hispanic or Caucasian; (2) those at least 18 years of age; (3) individuals who were able to speak, write, read and understand the English language at the eighth grade level; (4) those that provided unpaid care and assistance with a minimum of one activity of daily living according to the Katz Index; and (5) individuals who provided at least 20 hours per week of care and assistance to an noninstitutionalized family member that is over the age of 64 diagnosed with chronic illness. In addition, the following individuals were excluded from this study: (1) family care providers whose dependent elderly family member resided in a nursing home or diagnosed with an acute illness; (2) caregivers under the age of 18; (3) caregivers that cared for a family member screened as

independent on the Katz Index; and (4) caregivers who reported receiving compensation for caring for a family member.

According to Gillis and Jackson (2002), sampling identifies or detects real differences among variables to determine the probability that an inferential statistical test detects a significant difference that is real or correctly rejects a null hypothesis. A non-probability quota sampling technique was used in this study. Quota sampling uses a convenience sampling technique, where available subjects are entered into the study until the desired sample size is reached, with an added feature of strategizing to ensure inclusion of subject types that are likely to be underrepresented in a convenience sample (Burns & Groves, 2009). Additionally, this method was used to ensure adequate numbers of subjects in each stratum for the planned statistical analysis (Burns & Groves, 2009). Quota sampling was used in this study to increase the representiveness of the sample by maintaining equal cell sizes for the planned statistical analyis.

Newton & Rudestam (1999) suggests the following formula in determining sample size: $N \geq 50 + 8$ times the number of independent variables. Calculated by this method, 66 participants were required. According to Tabachnick & Fidell (2001), a case-to-independent variable ratio of 40 to 1 yielded a sample size of 80 participants. However, G* Power 3.1 calculates a sample size of 68 using a power of 0.80, medium effect size of .15, and alpha of .05 (Faul, Erdfelder, Buchner, & Lang, 2009). The investigator used an overall sample size of 69. This sample size was divided into three equal groups of 23 according to African Americans, Hispanics and Caucasians to ensure adequate subjects in each stratum for statistical analysis to decrease potential biases (Burns & Groves, 2009).

The sample consisted of 69 male and female family caregivers from the southeastern region of Louisiana. The participants were between 24 and 79 years of age, with a mean age of 47.88 ± 13.275. A total of 14.5% were males and 85.5% were females. The percentage of African American, Hispanic, and Caucasian family caregivers equaled to 33.3% within each racial group for this study. The ages ranged from 26 to 79 with a mean age of 49 ± 13.236 and 8.7% male and 91.3% female for African American family caregivers. Among the Caucasian family caregivers, the mean age was 40 ± 12.023 with ages ranging from 24 to 67. The mean age for Hispanic family caregivers was 54.65 ± 10.525 with ages ranging from 28-74. The percentages within each group of Hispanic and Caucasian male family caregivers were 17.4 % and 82.6% female (see Table 1).

Table 1
Race, Age and Gender Demographics

Variables	N(n)	M	SD	%
Age (overall)		47.88	13.275	
Gender (overall)				
Male	10			14.5
Female	59			85.5
Total	69			100
Race				
AA/Black (non-Hispanic)	23			33.3
Age		49	13.236	
Gender				
Male	2			8.7
Female	21			91.3
Hispanic/Latino (of any race)	23			33.3
Age		54.65	10.53	
Gender				
Male	4			17.4
Female	19			82.6
Caucasian/White (non-Hispanic)	23			33.3
Age		40	12.02	
Gender				
Male	4			17.4
Female	19			82.6

The study was conducted in settings that family caregivers utilize, Adult Day Health Care Centers, Churches, and caregiver support groups located in the southeastern region of Louisiana. Adult Day Health Care Centers sample of family caregivers were from the greater New Orleans area (Site 1 and 2). The churches (Site 3, 4, 5, 6 and 7) utilized in this study to obtain and interview family caregivers were located in Metairie, River Parishes and the Baton Rouge area. These churches included approximately 300 to

400 members of multiple faiths. In addition, family members were obtained from caregiver support groups (Site 8) located in Metairie (see Table 2).

Table 2
Data Collection Sites

Site	Participants(n)	%
1	9	13.1
2	11	15.9
3	3	4.3
4	10	14.5
5	14	20.3
6	8	11.6
7	5	7.2
8	9	13.1
Total	69	100.0

Human Subjects Protection

Prior to data collection, written approval to conduct the study was obtained from Southern University and A & M College's Institutional Review Board (IRB) (see Appendix C). Additionally, approval from the data collection sites was obtained according to their protocol. Written informed consent was obtained from all participants. Participants were informed participation in the study was voluntary and would not influence any access to care for them or their family. Participants were informed the potential risks associated with participating in the study were minimal. Potential risks include: (1) a feeling of personal apprehension concerning the content of the

questionnaires; (2) a feeling by the participants that their personal responses on the questionnaire were shared with others; and (3) possible fatigue as it relates to time needed to complete questionnaires.

Completed questionnaires were placed in sealed envelopes with a three-digit bar code stamped to the questionnaire. Questionnaires were kept separate from signed informed consents in order to ensure anonymity. All data collected was secured in a locked file cabinet and security locked electronic files. The principal investigator was the only person with access to the data.

Instruments

In order to measure cultural values, religiosity and positive appraisal of caregiving; the following four instruments and a demographic questionnaire were used to collect data in this study: (1) *Katz Index*, (2) the *Obligation Scale*, (3) *Duke University Religion Index* (DUREL) and (4) *Positive Appraisal of Care Scale* (see Appendices E-1, F-1, F-2, and F-3). Written permission was obtained prior to using these four instruments (see Appendix G-1, G-2, G-3, and G-4). In addition to these four instruments, a demographic tool designed by the researcher was utilized in this study (see Appendix E-2). Completion of the surveys took approximately 20 to 30 minutes.

Katz Index

The Katz Index of Independence in Activities of Daily Living is reported as the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently (Wallace & Shelkey, 2008). The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding by judging the degree of independence.

Clients are scored yes/no for independence in each of the six functions with a score of six indicating full function, four indicating moderate impairment, and two or less indicating severe functional impairment. The Katz Index has shown good reliability, as evidenced by reliability coefficients ranging from .87 to .94 (Cisesla, Shi, Stoskopf, & Samuels 1993). Despite that there was formal reliability and validity reports found in the literature, Wallace and Shelkey (2008) reports that the Katz Index consistently demonstrates its utility and accuracy in evaluating functional status in the elderly population. The reading level of the Katz Index is 6.0 with a 71.7 Flesch Reading Ease score. The Katz Index was used as a screening tool in this study to determine the elderly family member as dependent or independent.

The Obligation Scale

Cicirelli (1991) develped a seven-item scale to measure general feelings about obligation in relation to an elderly relative. This scale assesses global feelings about obligation that reflect general cultural norms (Cicirelli, 1993). Each item on the scale consist of a five-point Likert-type response that ranges from strongly agree (5) to strongly disagree (1). The respondents were asked to indicate how important each statement is as a reason for helping their family member with the higher score indicating higher obligation. (Items included "I feel a sense of obligation to help"; "It's a child's duty to help"; "I feel that I should do my part in helping"; "I'm the one in the family who should help"; "I was raised to believe I should help"; "I would feel guilty if I didn't help"; and "I would feel ashamed if I didn't help") The reported reliability was .71 (Cicirelli, 1993). This study paralleled with Lee et al.'s (2010) study which uses the Obligation Scale to assess the cultural values of caregivers. The reading level of the Obligation Scale is 8.4

with a 59.6 Flesch Reading Ease score. In this study, the Cronbach's alpha for the Obligation Scale was .83 showing internal consistency.

Duke University Religion Index

The Duke University Religion Index (DUREL) is a five-item measure of religious involvement that assesses three major dimensions of religiosity (Koenig & Bussing, 2010). The three dimensions of religiosity are organizational religious activity, non-organizational religious activity, and intrinsic or subjective religiosity. The DUREL measures each of these dimensions by subscale to assess particular aspects of religious practice or religion devotion. Subscale number one is the first question in the DUREL that asks about frequency of attendance at religious services (organizational). Subscale number two is the second question that asks about frequency of private activites (non-organizational). Subscale number three consists of the final three items that assess intrinsic religiosity. In order to obtain the overall religiosity, scores are to be reversed and summed. It is recommended for each subscale to be summed independently when examining their relationships to health outcomes. The overall scale has a high test-retest reliability (intra-class correlation) of a .91 and a high convergent validity with other measures of religioisty (r's = .71 to .86) (Koenig & Bussing, 2010). The reading level of DUREL is 8.2 with a 58.2 Flesch Reading Ease Score. This instrument was used in this study to measure the religiosity of family caregivers with a Cronbach's alpha of .85 showing internal consistency.

Positive Appraisal of Care Scale

The Positive Appraisal of Care Scale was developed to evaluate positive appraisal of care among family caregivers within the framework of caregiver adaptation

(Yamamoto-Mitani et al., 2001). This scale consist of 21 items, relationship satisfaction (five items), role confidence (five items), consequential gain (six items), and normative fulfillment (five items). Participants were instructed to rate "how you have been in the previous 2 weeks" using a four-point Likert scale: (0) not at all applicable, (1) not very applicable, (2) somewhat applicable and (3) very much applicable. In order to calculate the overall score, item scores within each domain was summed, and divided by 3, then the sum was divided by the number of items and multiplied by 100 (Score = [Σ {item rating/3}$\div$ # of items $\times$ 100]). The range of possible scores is 0 to 100, with the higher the score indicating more positive appraisal. Yamamoto-Mitani et al. (2001) reports Cronbach alphas of the domains and total scales as follows: .84 (relationship satisfaction), .83 (role confidence), .84 (consequential gain), .74 (normative fulfillment), and .92 (total of the Positive Appraisal of Care Scale).

The principal investigator (Epps, 2006) conducted a pilot study to examine the applicability in regard to utilization in determining the quality of care given to the elderly population. In addiiton, the purpose of this pilot study was to determine the feasibility of a major study, identify problems in the research design, examine the reliability and validity for the Positive Appraisal of Care Scale, determine time allocation for completion of scale and allow the investigator an initial experience with subjects, methodology and instrument. The following research questions were addressed in this study: (1) Is the Positive Appraisal of Care Scale relaible? (2) Is the Positive Appraisal of Care Scale valid? and (3) What is the appraisal of care among family caregivers of the eldelry population? The target population for this pilot study were caregivers of dependent elderly among African American, Hispanic and Caucasians. A sample size of

20 was used in this study. The intended population for this instrument were family caregivers of elderly Japanese care recipients. Originally, the Positive Appraisal of Care Scale was a Japanese-language scale, however, the English version was used in this pilot study. Reliability of the Positive Appraisal of Care Scale for this pilot study was a Cronbach's alpha of .63. Within statistical literature, it has been mentioned that if a Cronbach's alpha falls below .7, that it is not necessarily a "bad test", in fact the test might measure several attributes and dimensions (Nunnally, 1978). The Positive Appraisal of Care Scale is categorized into four domains: (1) relationship satisfaction (α = .02), (2) role confidence (α = .11), (3) consequential gain (α = .91) and (4) normative fulfilllment (α = .34). In addition, the researcher reviewed the actual scores of the scale from each caregiver participant. The overall goal of the pilot study was not to receive any scores below 67, which would indicate a negative score. Data analysis revealed that the mean score of the collected scales was 83.72, indicating a positive appraisal (Epps, 2006).

The Positive Appraisal of Care Scale was used in this study to measure the positive appraisal of caregiving and had an overall Cronbach's alpha of .87. Reading level for this instrument is 2.8 with a 85.6 Flesch Reading Ease score.

Demographic Questionnaire

A demographic questionnaire, developed by the investigator, was based on literature. Face validity for the demographic tool was established with two master's prepared nurses and two doctoral prepared nurse, with one of the doctoral prepared nurses being an expert in gerontology. The questionnaire consisted of 15 questions to identify selected background information and characteristics of the caregiver and care

recipient. The characteristics included age, race, gender, religion, caregiver income, relationship to care recipient, type of caregiver, amount of time per week spent providing care, and if compensated for care provided. In addition, the participant responded to questions in regard to the care recipient's age, gender, place of residence, and type of illness. The reading level for this instrument is 8.0 with a 49.5 Flesch Reading Ease score.

Within the demographics, the majority of the care recipients were female 78.3% (n = 54), lived at home 62.3% (n = 43), had Catholic family caregivers 40.6% (n = 28) and received caregiving from their child 69.6% (n =48). It was also observed that 8.7% (n = 6) of the family caregivers were nephews and neices providing care to an elderly family member. Additionally, several participants did not identify with provided religious preferences and selected other, designating their religion as Pentecostal and Christianity 10.1% (n = 7). Overall, the demographic tool allowed for a greater description of the sample of family caregivers who participated in the study (see Table 3, 4 and 5).

Table 3
Caregiver Demographics

	AA/Black (non-Hispanic)		Hispanic/ Latino (of any race)		Caucasian/White (non-Hispanic)		Total	
Caregiver Variables	**n**	**%**	**n**	**%**	**n**	**%**	**N**	**%**
Education Level								
Elementary	0	0	2	8.7	0	0	2	2.9
High/GED	4	17.4	7	30.4	8	34.8	19	27.5
Some College	8	34.8	7	30.4	5	21.8	20	29.0
College Grad	6	26.1	5	21.8	7	30.4	18	26.1
Grad Degree	5	21.7	2	8.7	3	13.0	10	14.5
Annual Income								
0-25,999	9	39.1	14	60.9	7	30.4	30	43.5
26-35,999	5	21.8	5	21.8	6	26.1	16	23.2
36-45,999	2	8.7	1	4.3	2	8.7	5	7.2
46-55,999	1	4.3	1	4.3	2	8.7	4	5.8
56-65,999	5	21.8	0	0	2	8.7	7	10.1
66-75,999	1	4.3	0	0	3	13.0	4	5.8
>76,000	0	0	2	8.7	1	4.3	3	4.3
Religion								
Baptist	15	65.2	5	21.8	4	17.4	24	34.8
Methodist	0	0	0	0	3	13.0	3	4.3
Other	1	4.3	6	26.1	0	0	7	10.1
Catholic	5	21.8	12	52.2	11	47.8	28	40.6
Non-denominational	2	8.7	0	0.0	5	21.8	7	10.1
Relationship								
Child	18	78.3	14	60.9	16	69.6	48	69.6
Grandchild	1	4.3	6	26.1	4	17.4	11	15.9
Sibling	0	0	1	4.3	1	4.3	2	2.9
Spouse	0	0	0	0	2	8.7	2	2.9
Other relative	4	17.4	2	8.7	0	0.0	6	8.7
Caregiver Type								
Primary	18	78.3	15	65.2	12	52.2	45	65.2
Secondary	5	21.7	8	34.8	11	47.8	24	34.8

Table 4
Care Recipient Demographics

	AA/Black (non-Hispanic)		Hispanic/Latino (of any race)		Caucasian/White (non-Hispanic)		Total	
Care Recipient Variables	**n**	**%**	**n**	**%**	**n**	**%**	**N**	**%**
Gender								
Male	3	13.0	6	26.1	6	26.1	15	21.7
Female	20	87.0	17	73.9	17	73.9	54	78.3
Total	23	100	23	100	23	100	69	100
Living Arrangements								
Own home	12	52.2	14	60.9	17	73.9	43	62.3
Someone else's home	4	17.4	3	13.0	4	17.4	11	15.9
With caregiver	7	30.4	6	26.1	2	8.7	15	21.7

Table 5
Demographic Mean and SD

Variables	N(n)	Min	Max	Mean	SD
Race					
AA/Black (non-Hispanic)	23				
Caregiver age		26	79	49.00	13.24
Years as caregiver		1	15	4.70	3.67
Hrs/wk		20	168	65.61	51.55
Care recipient age		65	96	77.30	9.12
Hispanic/Latino (of any race)	23				
Caregiver age		24	67	40.00	12.02
Years as caregiver		1	40	7.13	8.85
Hrs/wk		20	150	49.09	39.83
Care recipient age		65	97	76.13	10.57
Caucasian/White (non-Hispanic)	23				
Caregiver age		28	74	54.65	10.53
Years as caregiver		1	30	7.74	7.52
Hrs/wk		20	168	41.13	41.07
Care recipient age		65	99	79.65	8.32
Overall	69				
Caregiver age		24	79	47.88	13.28
Years as caregiver		1	40	6.52	7.06
Hrs/wk		20	168	51.94	44.987
Care recipient age		65	99	77.70	9.358

Recruitment

Recruitment, also an element of the overall sampling plan, began after receiving permission to proceed from the Institutional Review Board of Southern University and A&M College and receiving permission from Adult Day Health Care Centers, caregiver support groups, and churches located in southeastern Louisiana. Gaining access to

suitable sites is key, along with the ongoing process of establishing relationships and rapport with the gatekeepers (Polit & Beck, 2008). The principal investigator contacted individuals in charge at Adult Day Health Care Centers, caregiver support groups, and churches to assist in identifying adequate volunteer participation from family caregivers. Flyers of the proposed study were posted among the facilities and sent home with care recipients, caregivers, and church members (see Appendix H). The principal investigator's contact information was included on the flyers for potential participants to be screened by telephone using the Katz Index and demographic questionnaire.

The screening packet consisted of Katz Index and demographic questionnaire. Each screening packet contained a one to three-digit number to identify the number of potential subjects screeened. The one to three-digit number was followed by three blank spaces for the assignment of the pre-numbered questionnaires. A total of 83 family caregivers were screened. There was a total of 14 family caregivers that did not meet the inclusion criteria and their screening packets were filed away. However, once inclusion criteria was met for the remaining family caregivers, the questionnaire packet was opened and the three-digit code from the questionnaire packet was assigned to the Katz Index and demographic tool, which was then placed with remainder of questionnaires. In order for the potential participants to participate in the study, arrangements were made to meet and complete the remainder of the questionnaires. A removable note was attached to the questionnaire packet indicating the time and place of meeting. Polit and Beck (2008) recommends that effort be made to collect data at a time and location that is convenient for participants. Arrangements were made with the potential participants to meet at the access sites or at local community site (e.g. coffee shops and public libraries). "Gifts and

monetary incentives have been found to increase participation" (Polit & Beck, 2008, p. 352). Therefore, all participants received a Wal-Mart gift card valued at $10 as an incentive for participating in the study.

Procedure

Potential participants were asked if they are willing to participate in a study that is investigating the influence of cultural values, religiosity and family caregiving on the positive appraisal of caring for a dependent elderly family member. The consent form was then administered, allowing for questions to be asked before signing. Once all questions were satisfactorily answered and participants voluntarily agreed to participate in the research study, the informed consent was collected (see Appendix B). A copy of the informed consent was provided to all participants for their records. Study participants were given a pen and envelope containing the Katz Index screening tool, demographic questionnaire, DUREL, the Obligation Scale and the Positive Appraisal of Care Scale to review and complete. They were instructed to review the Katz Index screening tool and demographic questionnaire for accuracy, to answer each question on the remaining questionnaires, and to review all of them for completeness before turning them into the principle investigator. Completion of the surveys took approximately 20 to 30 minutes total. The principle investigator reviewed each questionnaire for completeness.

Questionnaires were placed in sealed envelopes with a three-digit code stamped to them. Questionnaires were kept separate from the signed informed consents and did not contain the three-digit code in order to assure anonymity. All data was secured in a locked fireproof file cabinet. The principal investigator was the only person with access

to the data. Participants were given the opportunity to withdraw from this study at any time without any penalty.

Statistical Analysis

Data was analyzed using the Statistical Package for the Social Sciences for Windows software. Descriptive statistics including frequency distributions, means, modes, medians, standard deviations, ranges and percentages were used to summarize demographic variables. Pearson's r was used to determine correlations among cultural values, religiosity and positive caregiver appraisal. An analysis of variance (ANOVA) was used to test the difference in family cultural values, religiosity, and positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers. In addition, multiple regression was used to evaluate the predictive means of cultural values and religiosity for family caregivers who provide care for dependent elderly family members the different cultures (see Table 6). A level of significance was established ($\alpha = .05$).

Table 6
Analysis Plan—Positive Appraisal of Caregiving

Research Hypotheses	Statistical Test
$H_{1:}$ There is a positive relationship between cultural values and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.	Pearson's r
$H_{2:}$ There is a positive relationship between religiosity and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.	Pearson's r
$H_{3:}$ There is a significant difference in cultural values, religiosity and positive appraisal of caregiving among African American, Hispanic, and Caucasian caregivers for dependent elderly family members.	ANOVA (analysis of variance)
$H_{4:}$ Cultural values and religiosity will predict the positive appraisal of caregiving of African American caregivers for dependent elderly family members.	Multiple Regression
$H_{5:}$ Cultural values and religiosity will predict the positive appraisal of caregiving for Hispanic caregivers for dependent elderly family members.	Multiple Regression
$H_{6:}$ Cultural values and religiosity will predict the positive appraisal of caregiving for Caucasian caregivers for dependent elderly family members.	Multiple Regression

Summary

Limited research exists on the influence of cultural values, religiosity and family caregiving on the positive appraisal of caregiving among African American, Hispanic and

Caucasian family caregivers. Therefore, the purpose of this study was to assess the influence of cultural values and religiosity on the positive appraisal of caregiving among African American, Hispanic and Caucasian family caregivers. This study also examined the relationship among cultural values, religiosity, and positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers of the dependent elderly. A predictive correlational design was used to examine the impact amongst the variables for African American, Hispanic and Caucasian family caregivers in the southeastern region of Louisiana. The research hypotheses were analyzed by using ANOVA, correlation and regression analyses. In addition, the predictive validity and reliability of the Katz Index, Obligation Scale, DUREL and Positive Appraisal of Caring Scale were examined.

CHAPTER IV

RESULTS

This chapter presents the results from data analysis, which examined the variables and relationships among the independent variables cultural values, religiosity and the dependent variable positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers of the dependent elderly. Hypothesis and corresponding results from statistical analysis occurs separately in this chapter.

Cultural Values, Religiosity and Positive Appraisal of Caregiving

All participants completed the Obligation Scale, DUREL, and Positive Appraisal of Care Scale. Results from data analysis are as follows:

Overall scores on the Obligation Scale for all family caregivers ranged from 14 to 35. The maximum possible score was 35. The mean score was 29.88 ± 5.10. Greater Obligation scoress were associated with a greater feeling of filial obligation as it relates to cultural values. Likewise, comparison of the Obligation Scale scores among the studied ethnic groups revealed similar results. African American family caregivers' scores ranged from 14 to 35 with a mean score of 30.13 ± 6.15. Hispanic family caregivers' scores ranged from 19 to 35 with a mean score of 30.00 ± 4.34. Caucasian family caregivers' scores ranged from 18 tio 35 with a mean score of 29.52 ± 4.85.

Overall scores on the DUREL ranged from five to 27. The maximum score was 27. The mean score was 22.00 ± 4.49. Greater religiosity scores were associated with a greater sense of religiosity. African American family caregivers' scores ranged from 16 to 27 with a mean score of 22.43 ± 3.13. Hispanic family caregivers' scores ranged from 5 to 27 with a mean score of 22.48 ± 5.33. Caucasian family caregivers' scores ranged from 10 tio 27 with a mean score of 21.09 ± 4.77.

Overall scores on the Positive Appraisal of Care Scale ranged from 38 to 100 among the family caregivers. The maximum score was 100. The mean score was 86.11 ± 13.43. A greater positive appraisal of care score indicated a more positive appraisal among family caregivers. Furthermore, the positive appraisal of caregiving scores revealed African American family caregivers of having a higher mean of positive appraisal of caregiving (90.04) in comparison to Hispanics (84.86) and Caucasians (83.42).

Hypotheses Testing

Hypotheses H_1

H_1: There is a positive relationship between cultural values and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

Pearson product-moment correlation coefficient (r) was computed to assess the relationship between cultural values and the positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers. The Pearson Product-Moment Correlation Coefficient (r) test revealed an overall significant moderate correlation between cultural values and positive caregiver appraisal as measured by the Obligation

Scale and Positive Appraisal of Care Scale (r = .432; N =69; $p < .001$) (see Table 7). Statistical evidence supports H_1.

Table 7
Correlation between Cultural Values and Positive Appraisal of Caregiving (Overall)

Variable	N	Sig. (2-tailed)	Pearson	Mean	SD
Cultural Values (Obligation Scale)	69	< .001	.432**	29.88	5.10
Positive Appraisal of Care	69	< .001	.432**	86.11	13.42

Note: **Correlation is significant at the .01 level (2-tailed)

However, when examining the relationship of cultural values and the positive appraisal of caregiving separately among African American, Hispanic and Caucasian family caregivers; only African American and Caucasian family caregivers revealed a significant correlation between cultural values and the positive appraisal of caregiving (African Americans' r = .647; n = 23; $p < .01$ and Caucasians' r = .455; n = 23; $p < .05$) (see Table 8).

Table 8
Correlation between Cultural Values and Positive Appraisal of Caregiving within African American, Hispanic and Caucasian Family Caregivers

Variables	n	Sig. (2-tailed)	Pearson	Mean	SD
AA/Black (non-Hispanic)					
Cultural Values (Obligation Scale)	23	.001	.647**	30.13	6.15
Positive Appraisal of Care	23	.001	.647**	90.04	11.45
Hispanic/Latino (of any race)					
Cultural Values (Obligation Scale)	23	.407	.181	30.00	4.34
Positive Appraisal of Care	23	.407	.181	84.86	12.96
Caucasian/White (non-Hispanic)					
Cultural Values (Obligation Scale)	23	.029	.455*	29.52	4.85
Positive Appraisal of Care	23	.029	.455*	83.42	15.25

Notes: **Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (2-tailed).

Hypothesis H_2

H_2: There is a positive relationship between religiosity and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members

Pearson product-moment correlation coefficient (r) was computed to assess the relationship between religiosity and the positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers. The Pearson Product-Moment Correlation Coefficient (r) test revealed that there is not a significant correlation between religiosity and positive caregiver appraisal as measured by the DUREL and Positive Appraisal of Care Scale (see Table 9). Statistical evidence does not support H_2.

Table 9
Correlation between Religiosity and Positive Appraisal of Caregiving (Overall)

Variable	N	Sig. (2-tailed)	Pearson	Mean	SD
Religiosity (DUREL)	69	.128	.185	22.00	4.49
Positive Appraisal of Care	69	.128	.185	86.11	13.42

Furthermore, when examining the relationship of religiosity and the positive appraisal of caregiving separately among African American, Hispanic and Caucasian family caregivers; there was no association between the variables for the different racial groups (see Table 10).

Table 10
Correlation between Religiosity and Positive Appraisal of Caregiving within African American, Hispanic and Caucasian Family Caregivers

Variables	N	Sig.(2-tailed)	Pearson	Mean	SD
AA/Black (non-Hispanic)					
Religiosity (DUREL)	23	.270	-.240	22.43	3.13
Positive Appraisal of Care	23	.270	-.240	90.04	11.45
Hispanic/Latino (of any race)					
Religiosity (DUREL)	23	.057	.402	22.48	5.33
Positive Appraisal of Care	23	.057	.402	84.86	12.96
Caucasian/White (non-Hispanic)					
Religiosity (DUREL)	23	.470	.158	21.09	4.77
Positive Appraisal of Care	23	.470	.158	83.42	15.25

An analysis of the relationship between the subscales of DUREL and the positive appraisal of caregiving revealed no direct association between the variables among African American, Hispanic and Caucasian family caregivers. However, data analysis also revealed a significant negative correlation between the non-organizational dimension of religiosity and positive appraisal of caring in the African American family caregivers ($r = -.451$; $n = 23$; $p < .05$). This finding indicated as African American family caregiver's religious involvement in private activities increases, their positive appraisal of caregiving decreases. Additionally, a positive correlation was found between organizational dimension of religiosity and positive appraisal of care among the Hispanic family caregivers ($r = .458$; $n = 23$; $p < .05$) (see Table 11).

Table 11
Correlation of DUREL Subscales with Positive Appraisal of Caregiving

Variables	N(n)	Pearson	Sig. (2-tailed)
Total (overall)	69	199	.101
Organizational			
Non-organizational		-.064	.602
Intrinsic		.161	.185
AA/Black (non-Hispanic)	23		
Organizational		-.137	.534
Non-organizational		-.451*	.031
Intrinsic		-.114	.605
Hispanic/Latino (of any race)	23		
Organizational		.458*	.028
Non-organizational		.327	.127
Intrinsic		.365	.087
Caucasian/White (non-Hispanic)	23		
Organizational		.233	.284
Non-organizational		.037	.867
Intrinsic		.158	.470

Note: *Correlation is significant at the 0.05 level (2-tailed).

Hypothesis H_3

H_3: There is a significant difference in cultural values, religiosity, and positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members.

A one-way between subjects ANOVA was conducted to compare the differences in cultural values, religiosity, and positive appraisal of caregiving among African American, Hispanic, and Caucasian family caregivers. Overall, there was not a significant difference in cultural values, religiosity and positive appraisal of caregiving for African American, Hispanic and Caucasian family caregivers (see Table 12). Statistical evidence does not support H_3.

Table 12
Effects of Cultural Values, Religiosity, and Positive Appraisal of Caregiving

Variables	Mean Square	F	Sig.
Cultural Values (Obligation Scale) Between Groups	2.36	.088	.915
Religiosity (DUREL) Between Groups	14.39	.709	.496
Positive Appraisal of Care Between Groups	279.36	1.58	.214

Hypotheses H_4, H_5, and H_6

H_4: Cultural values and religiosity will predict the positive appraisal of caregiving of African American caregivers for dependent elderly family members.

H_5: Cultural values and religiosity will predict the positive appraisal of caregiving of Hispanic caregivers for dependent elderly family members.

$H_{6:}$ Cultural values and religiosity will predict the positive appraisal of caregiving of Caucasian caregivers for dependent elderly family members.

Multiple regression analysis of variance was conducted using the stepwise regression procedure to evaluate whether cultural values and religiosity were predictors of the positive appraisal of caregiving in African American, Hispanic and Caucasian caregivers for dependent elderly family members. The predictor (independent) variables were cultural values and religiosity, and the criterion (dependent) variable was positive appraisal of caregiving. The backward solution in the stepwise regression procedure was performed to include all of the predictor variables in the regression at one time. Results from the backward solution in the regression procedure resulted in the removal of the least important variables and calculations continued until only significant variables remained. The linear combination of cultural values (Obligation Scale) and religiosity (DUREL) was statistically significant and related to the positive appraisal of caregiving for African American [F (2, 20) = 8.27] family caregivers (p = .002). In contrast, the linear combination of cultural values (Obligation Scale) and religiosity (DUREL) on the positive appraisal of caregiving was not statistically significant among Hispanic and Caucasian family caregivers (see Table 13). Therefore statistically, evidence does not support H_5 and H_6, but provides statistical evidence supporting H_4.

Table 13
Multiple Regression of Cultural Values and Religiosity on the Positive Appraisal of Caregiving

Variables	B	Std. Error	R^2	F	Sig.
AA/Black (non-Hispanic)	69.89	17.26	.453	8.27	.002**
Hispanic/Latino (of any race)	50.69	20.56	.182	2.23	.133
Caucasian/White (non-Hispanic)	40.72	20.29	.208	2.62	.098

Note: a. Predictors: Religiosity and Cultural Values
b. Dependent Variable: Positive Appraisal Caregiving
**Correlation is significant at the 0.01 level (2-tailed).

Summary

The testing of six hypotheses occurred in this study. Pearson's r was used to test hypotheses H_1 and H_2. A one-way between subjects ANOVA was used to test H_3. Multiple regressions were used to tests H_4, H_5, and H_6. Hypotheses one and four were supported and statistical evidence did not support hypotheses two, three, five, and six. The findings supported H_1, indicating a significant correlation between cultural values and positive appraisal of caregiving ($p < .001$). Data analysis revealed that as the level of filial obligation (cultural values) increases, so did positive appraisal of caregiving among the family caregivers. Additionally, findings revealed only African American ($p = .001$) and Caucasian ($p = .029$) family caregivers have a significant correlation between cultural values and positive appraisal of caregiving. Hypothesis H_4 was supported by using a multiple regression analysis revealing a statistically significant linear combination of cultural values and religiosity on the positive appraisal of care for African American

family caregivers (p = .002). There was no relationship between the family caregiver's religiosity and positive appraisal of caregiving overall when testing H_2. However, when the three dimensions of religiosity were measured separately, it was determined that there is a positive relationship between positive appraisal of caregiving and religiosity (non-organizational) for African Americans (p = .031) and religiosity (organizational) for Hispanics (p = .028). A one-way between subjects ANOVA statistically revealed evidence that did not support H_3. There was not a statistical difference in cultural values, religiosity, and positive appraisal of care for the family caregivers within this study. Finally, statistical evidence did not support H_5 and H_6, revealing no linear combination of cultural values and religiosity on the positive appraisal of caregiving in Hispanic and Caucasian family caregivers.

CHAPTER V

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

This chapter is a discussion of the results in relation to the theoretical framework and existing literature. Also addressed are the implications for nursing education, practice, policy, and research.

Roy's Adaptation Model addresses an individual's or group's response to internal and external environmental stimuli. Furthermore, Roy and Andrews (1999) identify the person as an adaptive system, which includes coping processes to respond to environmental stimuli through regulator and cognator coping subsystems. As such, the statistically significant linear combination, which exists for cultural values and religiosity influence on the positive appraisal of caregiving in African American family caregivers, supports the establishment of behaviors through internal and/or external actions and reactions to stimuli. The stimuli in this study are family caregiving and the demographics of caregivers and dependent elders, which influences the positive appraisal of caregiving through the influence of cultural values and religiosity. Furthermore, Roy's Adaptation Model supports a positive correlation between the level of filial obligation (cultural values) and positive appraisal of caregiving among family caregivers through the beliefs and feelings that encompasses one's spiritual self.

Findings, also indicate only African American (p = .001) and Caucasian (p = .029) family caregivers have a significant correlation between cultural values and positive appraisal of caregiving. Moreover, results reveal a significant relationship between positive appraisal of caregiving and non-organizational religiosity for African Americans and organizational religiosity for Hispanics. This relationship aligns with Roy's Adaptation Model and supports the assertion that spirituality provides insight into factors, which may and can influence a person or family's response to environmental stimuli (Roy & Andrew, 1999).

Lazarus's Structural Model of Appraisal, the second theoretical paradigm explains how family caregivers interpret and appraise family caregiving. When predicting the emotion of experience, scores reveal African American family caregivers in this study have a higher mean positive appraisal of caregiving in comparison to Hispanics and Caucasians. Indicative of this study, family socio-emotional support is positively associated with caregiver feelings. This finding is consistent with Shira, Silverberg and Kenyon (2009), who also reported socio-emotional support from family members is an important resource for caregiver satisfaction.

Existing literature indicates dependent elderly recipients of care and their family caregivers are typically greater than 84 (care recipient) and 52 (caregiver) years of age (Dilworth-Anderson, Boswell & Cohen, 2011; Vroman & Morency, 2011). However, an inconsistent finding of this study is the reportedly lower mean ages for both the care recipient and caregiver. This finding could possibly be attributed to the majority of family caregivers classifying themselves as children of the care recipient. Additionally, the lifestyle of elders (unhealthy eating, medication noncompliance, fixed income and

etc.) can contribute to poor health outcomes and increased dependency at an early age. Also, inconsistent with the literature is the Katz Index score revealing participants exhibit a greater need for assistance with their activies of daily living (Vroman & Morency, 2011).

Overall, the family caregivers within in this study express a positive appraisal of care along with an increase sense of filial obligation (cultural values). Other studies report caregivers who identify with the concept of filial piety to interpret family caregiving as rewarding (Lai, 2010; Lee, Yoo & Jung, 2010). Angela-Cole and Hilton (2009) reports Caucasians to have stronger beliefs and more positive attitudes about filial obligation. However, when the family caregivers were examined separately by race, African Americans and Caucasians are the only family caregivers showing a significant positive correlation between cultural values and positive appraisal of caregiving.

Literature expounds on how religion and spiritual beliefs are coping mechanisms used to help with the stressors of family caregiving (Dilworth-Anderson, Boswell, & Cohen, 2011; Coon et al., 2004; Yarry, Stevens, & McCallun, 2007). For this study, there is no association between the total religiosity score and positive appraisal of caregivng among family caregivers. However, this finding is inconsistent with previous research. Prior studies describe how family caregivers' religiosity positively influences their perception of caregivng (Haley et al., 2004; Dilworth-Anderson et al., 2011; Vroman & Morency, 2011). Additionally, studies report African American family caregivers as a having higher level of religiosity resulting in experiencing perceived benefits of caregiving compared to Caucasians (Haley et al., 2004; Picot et al., 1997; Dilworth-Anderson et al., 2011; Guinta, Chow, Scharlach, & Dal Danto, 2004).

Moreover, religiosity reflects behaviors that include participation in religious activities (organizational), religious involvement in private activities (non-organizational) and subjective (intrinsic) reports of having a relationship with a higher being (Picot et al., 1997). These behaviors were examined separately according to race, exhibiting a significant correlation in the religiosity subscales of organizational (Hispanic) and non-organizational (African American) with the positive appraisal of caregiving. Existing literature reports Mexican-American family caregivers with greater levels of organizational religiosity are less likely to perceive their caregiving role as burdensome (Herrera et al., 2009), a finding consistent in this study. Surprisingly, for African American family caregivers, a significant negative correlation exists between the non-organizational dimension of religiosity (private prayer, meditation and etc) and the positive appaisal of caregiving (p = .031). None-the-less, a unique finding of this study is as African American caregivers' religious involvement in private meditation activity increases, their positive appraisal of caregiving decreases. Findings from Picot et al. (1997) suggest African American family caregivers use private prayer and meditation to cope with the stressors of caregiving allowing them to positively evaluate and appreciate the caregiving experience, but for this study, this finding supports a negative correlation. Another possibility exist that the more time African American family caregivers spend in meditation and prayer raises their expectations, which in turn leads to holding themselves to higher standards that are not easily obtainable.

An overall average of the positive appraisal of caregiving using the Positive Appraisal of Care Scale correlates with the pilot study conducted by the principal investigator (Epps, 2006). Guinta and colleagues (2004) also found that the positive

aspects of caregiving were similar across all race groups within their study, African American, Latina and Casucasian family caregivers. However, when examining racial groups separately in this study, African American family caregivers reveals the highest appraisal score in comparison to Hispanic and Caucasian family caregivers This finding supports published studies reporting African Americans having higher levels of reward in comparison to Caucasian family caregivers (Picot et al., 1997; Haley et al., 2004).

Despite the aforementioned studies and current findings, the majority of research ignores racial diversity as it relates to cultural values, religiosity, and caregiver appraisal. Additionally, limited research exists which utilizes Hispanics to explore family caregiving and related variables (Haley et al., 2004). There continues to be a need for research studies to investigate the influence of cultural values, religiosity on the positive appraisal of family caregiving among different cultures due to the increasing diversity within the United States.

Limitations

Despite adding considerably to exisiting literature, several limitations for this research exist. The first limitation is the sampling technique used. Data was collected by using a quota sampling technique recruiting from a convenience sample of African American, Hispanic and Caucasian family caregivers in the southeast region of Louisiana. Therefore, the study participants are not representative of African American, Hispanic and Caucasian family caregivers in general, hence study findings are not generalizeable to the entire population of these racial groups in the U.S.

Additionally, acculturation of African American and Hispanic caregivers is not measured or controlled for within this study. Thus, attitudes regarding care of the elderly

would be more traditional among first-generation African and Hispanic caregivers than among third-generation (Harwood et al., 2000). The influence of acculturation on caregiver's attitudes and behaviors is an important factor to consider in future studies.

Recruitment of study participants from faith-based organizations also limits the generalizability of study findings resulting in potential bias for the religiosity score. Furthermore, the use of surveys with self-reported data is a limitation for this study. Study participants were asked to respond to questions regarding demographics, cultural values, religiosity, and appraisal of caregiving. Self-reported responses by the participants lend to recall bias and a possible unintentional distortion of the facts (Burns & Grove, 2011). Lastly, self-reporting of religion preferences was a limitation due to the selection option of "other religion", which can lead to a bias response.

Implications

Findings from this study have relevant implications for nursing research. The expected increase in the older population indicates a critical need for resources and additional research to support caregivers. This research supports the notion that cultural values and some dimensions of religiosity are pertinent to the family caregiver's ability to adapt positively to the caregiving experience. Nurses not only provide direct care services, but also provides opinions and research for the formulation of health policies.

First, there is a need for future studies designed to explore confounding variables that could have affected the results of this study. Second, there is a need for research, which explores African American, Hispanic and Caucasian relationships with the dimensions of religiosity by using the DUREL subscales versus other religiosity scales to improve the conceptualization of religiosity. A larger representative sample from within

other states, including Asian would enhance the external validity of the study. Also, performance of secondary analysis to determine relationships between the caregiver demographic variables, such as marital status of caregiver, relationship to care recipient and type of caregiver on the positive appraisal of caregiving is an additional implication for future research.

This study did not examine correlations amongst caregivers of dependent family members who are eighty years or greater. Correlation amongst positive appraisal of caregiving and acute disease versus chronic disease processes in caregivers 65 years of age or greater would also support the existing body of literature. Future studies need to be done to examine the impact of living arrangements of care recipients and cultural values prediction on the positive appraisal of caregiving. Additionally, there is a need for future studies examining religiosity among family caregivers in relationship to the different levels of dependent elderly care and length of care provided. Finally, findings from this study indicate more research is necessary to plan and organize culturally responsive and sensitive interventions, inclusive of religious beliefs, thereby assisting not only the elderly family member recipient of care, but also the family caregiver.

Recommendations

Based on research findings from this study, there are several recommendations for nursing practice, nursing education and policy. As the quality and longevity of life expands, it is important for nurses working with the elderly to have a better understanding of the needs of the family members serving as caregivers. To improve family outcomes currently and in the future, it is important for an evidence-based approach to be used in the development of the plan of care by utlizing culturally sensitive

interventions. Findings from this study reveal that a sense of filial obligation has a positive impact on the positive appraisal of caregiving, specifically among African Americans and Caucasians. Eventhough, there is not an overall significant correlation between religiosity and positive appraisal of caregiving; nursing professionals need to recognize ethnic group differences in the relationship of cultural values and religiosity by incorporating it into practice to promote positive outcomes and healthy family behaviors. Nurses working with family caregivers in providing support services should assist caregivers with connecting the positive aspects of the caregiving experience. Additionally, nurses can facilitate appropriate culturally sensitive interventions with the hope of alleviating potential stress. For example, based on the findings from this research study, the nurse should recommend for Hispanic family caregivers to increase attendance at church (organizational religiosity) in order to obtain positive appraisals of caregiving.

Nursing education includes holistic assessments of patients. These assessments should consider every patient's need, requiring nurses to learn how to be sensitive and aware of cultural and religious needs of every patient. Culturally relevant content should be incorporated throughout nursing curricula to reflect the increasing diversity within the community.

Furthermore, it is vital for federal monies to continue to be allocated within all local states in the effort of funding non-profit organizations that support family caregivers. The assertion of caregiving being a stressful event lends to the need for education and support for family members in the hopes of making caregiving a positive experience for the family caregiver. Policy makers should consider the limitations and challenges faced by caregivers and provide adequate support and tangible resources to

prevent potential feelings of "burn out". Programs should be developed for nurturing filial obligations and responsibilites in caring for dependent elderly family members. Policy initiatives at local, state, and federal levels are essential in order to meet the challenges of family caregiving and to prevent negative experiences associated with the caregiving expereince. These recommendations have the potential for positively influencing nursing practice, education and policy in providing a better understanding of factors that affect caregiving for family members. Nurses, policy makers, and researchers need to continue to work together to develop culturally appropriate, evidence-based interventions to address the needs of family caregivers and the increasing diversity in the population of the U.S.

Summary

This predictive correlational research study was conducted to: (1) predict the causal relationships between cultural values and religiosity on the positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members; and (2) explore the relationship between cultural values and religiosity on the positive appraisal of caregiving among African American, Hispanic and Caucasian caregivers for dependent elderly family members. Data analysis reveals as the level of filial obligation (cultural values) increases, so does the positive appraisal of care among family caregivers. In this study, the mean Obligation Scale score is 29.88, parallel to the mean of 29.83 reported in Lee et al.'s study (2010). Additionally, findings reveal only African American (p = .001) and Caucasian (p = .029) family caregivers have a significant correlation between cultural values and positive appraisal of caregiving. Overall, there is no association between the family caregiver's religiosity and positive

appraisal of caregiving. However, when the three dimensions of religiosity is measured separately, it is determined there is a negative correlation between positive appraisal of caregiving and non-organizational religiosity for African Americans, but a positive relationship with organizational religiosity for Hispanics. There is not a statistical difference in cultural values, religiosity, and positive appraisal of care for the family caregivers within this study. This study also reveals a statistically significant linear combination of cultural values and religiosity on the positive appraisal of care for African American family caregivers (p = .002). Findings reveal no linear combination of cultural values and religiosity on the positive appraisal of care in Hispanic and Caucasian family caregivers.

Information obtained from this study reveals an understanding of family caregivers' appraisal of caregiving, thereby providing nurses with the means of enhancing multidisciplinary plans of care. Family caregivers within this study spent an average of six years providing care to their family member. Whereas, the family caregivers within the study conducted by Dilworth-Anderson et al. (2011) reported an average of nine years of providing care suggesting further exploration of this factor that may influence positive appraisal of caregiving in African American, Hispanic and Caucasian family caregivers. Future studies will provide nurses and healthcare providers with a greater awareness of family caregiving and influential factors of positive appraisal of family caregiving.

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Yamamoto-Mitani, N., Ishigaki, K., Kuniyoshi, M., & Kawahara-Maekawa, N. (2004). Subjective quality of life and positive of care among Japanese family caregivers of older adults. *Quality of LifeResearch, 13*, 207-221.

Yarry, S., Stevens, E., & McCallun, T. (2007). Cultural influences on spousal caregiving. *Generations, 31*(3), 24-29.

APPENDICES

APPENDIX A

IRB APPROVAL FORM

SOUTHERN UNIVERSITY
Agricultural & Mechanical College

Office of Research
and Strategic Initiatives
Post Office Box 9272
(225) 771-3890 (voice)
(225) 771-5231 (fax)

**Institutional Review Board (IRB)
for the Protection of Human Subjects**

Federal Wide Assurance # 00002518 **IRB Registration # 00002445**

Initial Approval Form for Non-Exempt Research

Investigator(s): Fayron Ward Epps Unit: Nursing

Project Title: An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on Positive Appraisal of Caring for the Elderly

Project Number: SU-BR IRB 2011 – 47NE

I certify that the above research project was reviewed and approved by the SU-BR IRB for the Protection of Human Subjects in accordance with the Code of Federal Regulations, Title 45 Public Welfare Part 46 Protection of Human Subjects, on December 29, 2011 – Expedited Review Research Category Title 45 CRF 46.110(F) and 110 (F) (7). However, before any changes to approved proposed protocols (e.g., subject selection or category, consent, risks, benefits, procedures, subject anonymity and confidentiality, etc.), the principal investigator is to present the proposed changes to the Chairperson of IRB for the Protection of Human Subjects for review and approval prior to implementation of these changes.

Signature: _____ Date: 12/29/11

Name: Reginald Rackley, Ph.D.
Department of Psychology
Southern University – Baton Rouge
Baton Rouge LA 70813
reginald_rackley@cxs.subr.edu
(V) 771-2990 / (F) 771-2082

We certify that this institution applies Title 45 CRF 46 subparts A, B, C, and D to all research involving human subjects regardless of the source of support.

Chairperson of the SU-BR Institutional Research Oversight Committee

Signature: _____ Date: 1/10/12

Name: Patrick Carriere, Ph.D.
(V) 771-5870 / (F) 771-4320
patrick_carriere@cxs.subr.edu

Authorized Institutional Official

Signature: _____ Date: 1/10/2012

Name: Michael Stubblefield, Ph.D.
Office of Research and Strategic Initiatives
(V) 771-3890 / (F) 771-5231

APPENDIX B

CONSENT FORM

Consent to Participate in a Research Study

Title of Research Study: An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly

Principal Investigator: Fayron Epps
Southern University and A & M College
Graduate Nursing Student
P. O. Box 11794
Baton Rouge, LA 70813
Phone: (504) 201-2658
Email Address: fayron_ward_00@subr.edu

Faculty Advisor: Dr. Sharon Hutchinson
Southern University School of Nursing
P. O. Box 11794
Baton Rouge, LA 70813
Phone: (225) 771-2663
Email Address: sharon_hutchinson@subr.edu

Purpose of Research Study:

Family caregiving is a life-altering experience that involves many sacrifices from the family caregiver, which can be appraised by the caregiver as a negative or positive experience. The stress and burden experienced by the family caregiver during the caregiving experience has been widely researched and established among the literature, but limited research exists on the impact of cultural values, religiosity, and family caregiving on the caregiver's positive appraisal of caring for a dependent elderly family member. In addition, minimum research has been conducted in comparing the positive appraisal of caregiving among minority populations that include Caucasian, African American and Hispanic family caregivers. Therefore, the purpose of this study is to examine the influence of cultural values and religiosity on the positive appraisal of caregiving among Caucasian, African American and Hispanic family caregivers for dependent elderly family members.

Eligibility Criteria:

Sixty-nine Caucasian, African Americans and Hispanic family caregivers will be recruited for this study from the Southeastern regions of Louisiana Participants will also meet the following inclusion criteria in order to participiate in this study: (1) be able to identify themselves with the definitions provided as either Caucasian, African American, or Hispanic; (2) be at least 18 years of age; (3) be able to speak, write, read and understand the English language at the eighth grade level; (4) provide unpaid care and assistance with a minimum of one activitiy of daily living according to the Katz Index; and (5) provide at least 20hours per week of care and assistance to an noninstitutionalized family member that is over the age of 64 diagnosed with chronic illness. In addition, the following individuals will be excluded from this study: (1) family care providers whose dependent elderly family member reside in a nursing home or diagnosed with an acute illness; (2) caregivers under the age of 18; (3) caregivers that are caring for a family member screened as independent on the Katz Index; and (4) caregivers that are being compensated for caring for a family member.

Procedures:

All participants will complete a screening packet, consisting of the Katz Index and demographic questionnaire, which will take 10-15 minutes to complete. Before you can participate in this study, you will be asked to read and sign the consent. Each participant will be asked to complete three remaining questionnaires that will take 20-30 minutes. The questionnaires are the Obligation Scale, Duke University Religion Index, and Positive Appraisal of Caring Scale. Questions must be completed individually. As the principal investigator for this research study, I will be the only person collecting data from persons agreeing to participate in the study.

Benefits and Risk:

Persons agreeing to participate in the study will receive information on family caregiving. Risks related to participation in this study are considered to be minimal. These risks include: (1) a feeling of personal apprehension about the content of the questionnaire; (2) a feeling by the participant that their personal responses on the questionnaire will be shared with others; and (3) possible fatigue as it relates to time needed to complete questionnaires.

Costs:

There are no costs to participate in this study.

Incentives:

Persons agreeing to participate in this research study will receive a $10.00 Wal-Mart gift card upon completion of all five questionnaires.

Confidentiality:

Any information obtained about the participants in this research study will be strictly confidential. All surveys will be coded to protect the confidentiality of each participant. No identifying information, other than an assigned code will be placed on individual surveys. The investigator under double lock and key will keep signed consents separate form completed questionnaires. Only aggregate or group data will be used in publications, presentations or reports.

Right to Withdraw:

Participants have the choice at any time not to participate in the study and can withdraw (quit) without penalty. Also, the principal investigator may terminate the participation of subjects at any time due to participant's inability to complete all questionnaires. Additionally, failure of the participant to complete all surveys completely may result in data not being used in the study. Significant new findings that may relate to the participant's willingness to continue participation in the study will be disclosed.

If you should have any questions related to the study, you may call the following persons:

Principal Investigator: Fayron Epps
Southern University and A & M College
Graduate Nursing Student
P. O. Box 11794
Baton Rouge, LA 70813
Phone: (504) 201-2658
Email Address: fayron_ward_00@subr.edu

Faculty Advisor: Dr. Sharon Hutchinson
Southern University School of Nursing
P. O. Box 11794
Baton Rouge, LA 70813
Phone: (225) 771-2663
Email Address: sharon_hutchinson@subr.edu

If you should have any questions or concerns about their rights as a research volunteer in this research study or if you want to report a research-related injury, you should contact:

Patrick Carriere, Ph.D., Chairperson
Institutional Research Oversight Committee
P. O. Box 11241
Southern University-Baton Rouge
Baton Rouge, LA 70813-1241
Voice 225-771-5870
Facsimile 225-771-4320
E-mail – patrick_carriere@cxs.subr.edu

A federal regulation known as the Privacy Rule gives you certain rights concerning the privacy of your health information. The Privacy Rule was issued under a law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Researchers covered by this regulation are required to get your authorization (permission) to use and disclose (share with others) any health related information that could identify you.

If you sign this consent form, you are giving permission for the use and disclosure of your health information for the purposes of this research study. You do not have to give this permission. However, if you do not, you will not be able to participate in this study.

Voluntary Consent:

The study has been discussed with me and all my questions have been answered. I understand that additional questions regarding the study should be directed to the study researcher(s)/investigator(s). I agree with the terms above and acknowledge that I have been given a copy of the consent form. I understand that I have not waived any of my legal rights by signing this form.

With my signature, I grant authorization (permission) for the use and disclosure of my health information for the purposes of this research study.

_____	_____
Signature of Volunteer (or mark, if unable to sign)	Date
_____	_____
Signature of Person Administering Informed Consent	Date
_____	_____
Signature of Principal Investigator/Researcher	Date

APPENDIX C

HUMAN PARTICIPANT PROTECTIONS EDUCATION FOR RESEARCH TEAMS

CERTIFICATE

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Fayron Epps-Ward** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 06/20/2011

Certification Number: 704324

APPENDIX D

AUTHORIZATION TO ACCESS DATA COLLECTION SITES

DESTINY CHRISTIAN CENTER

STEVE O. ALLEN, PASTOR

612 Main Street, LaPlace, LA 70068 | PH: (985) 653-9006 | FAX: (985) 653-8444
www.destinychristian.org | P.O. Box 2108, LaPlace, LA 70069

January 4, 2012

Fayron Epps RN, MSN

Dear Ms. Epps,

The abstract for your study ***An Analysis of Cultural Values, Religiousity and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly*** has been received. After review of your document, we approve your use of our facility as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University and A&M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our facility as a data collection site to meet with family caregivers for dependent elderly family members who are affiliated with our congregation.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Grace and peace,

Brittany Allen
Executive Administrator

Crescent City Adult Day Health Care
51 Holmes Blvd. Suite D
Terrytown, La 70056
504.367.3580/504.367.3579 phone
504.367.3578 fax
1.877.412.3580 toll-free
crescentcityadhc@yahoo.com

December 05, 2011

Fayron Epps, RN, MSN

Dear Ms. Epps:

The abstract for your study *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly* has been received. After review of your document, we approve your use of our facility, **Crescent City Adult Day Health Care**, as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University and A&M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our facility, **Crescent City Adult Day Health Care** as a data collection site to meet with family caregivers for dependent elderly family member who is affiliated with our agency.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Sincerely.

Nichole M. Turner, RN, BSN
Owner/Director

IGLESIA NUEVA JERUSALEM
418 Maine St.
Jefferson, LA 70121
(504) 344-6529 or (504) 628-1619

January 7, 2012

Fayron Epps RN, MSN

Dear Ms. Epps:

The abstract for your study *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly* has been received. After review of your document, we approve your use of our church, IGLESIA NUEVA JERUSALEM, as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University & A&M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A &M College Institutional Review Board (IRB), you may proceed with using our church, IGLESIA NUEVA JERUSALEM as a data collection site to meet with family caregivers for dependent elderly family member who maybe members of our church.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Sincerely yours,

Pastor Henry Cardamo
Pastor Jose Guzman

Mount Olive Baptist Church
Of
Caddoville, Louisiana
27320 Hwy 405- P. O. Box 901
Plaquemine, LA

Rev. Joseph Jones-Pastor

December 16, 2011

Fayron Epps R N, MSN

Dear Ms Epps:

The Abstract for your study, An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly has been received. After review of your document, we approve your use of our church, Mount Olive Baptist, as a data collection site to fulfill your dissertation requirement for Ph D in Nursing with Southern University and A & M Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our church, Mount Olive Baptist as a data collection site to meet with family caregivers for dependent elderly family member who may be members of our church.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this endeavor to better understand and meet the needs of family caregivers.

Sincerely Yours,

New Pilgrim Baptist Church
107 Pilgrim Dr. Reserve, La 70084
(985)-536-2693
Rev. Dr. Forell Bering Sr., Pastor
newpilgirmbaptistchurch.org

December 21, 2011

Fayron Epps RN, MSN

Dear Ms. Epps:

The abstract for your study *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly* has been received. After review of your document, we approve your use of our church, New Pilgrim Baptist Church, as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University & A&M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our church, New Pilgrim Baptist Church as a data collection site to meet with family caregivers for dependent elderly family member who maybe members of our church.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Sincerely,

Rev. Forell Bering Sr., Pastor

January 25, 2012

Fayron Epps RN, MSN

Dear Ms. Epps:

The abstract for your study *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly* has been received. After review of your document we approve your use of our facility, Day Haven Adult Day Health Care, LLC, as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University & A&M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our agency, Day Haven Adult Day Health Care, LLC as a data collection site to meet with family caregivers for dependent elderly family member who is affiliated with our agency.

Please feel free to contact me at 504-361-1203 for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Sincerely,

Cedric B Miller, Sr.
Associate Director

ST. LUKE FAMILY CHRISTIAN CENTER

HOLY BIBLE

Bishop Sam Butler, Jr.
Pastor

Church:(225) 687-1912
Fax: (225) 687-0282
Pastor's Office: (225) 687-1955
Pastor's Home: (225) 356-5924

December 16, 2011

Fayron Epps RN, MSN

Dear Ms. Epps:

The abstract for your study *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly* has been received. After review of your document, we approve your use of our church, St. Luke Family Christian Center, as a data collection site to fulfill your dissertation requirement for the PhD in Nursing with Southern University & A & M College School of Nursing Graduate Nursing Programs. Upon approval from Southern University and A&M College Institutional Review Board (IRB), you may proceed with using our church, St. Luke Family Christian Center as a data collection site to meet with family caregivers for dependent elderly family member who maybe members of our church.

Please feel free to contact me for further assistance or if anything else is needed. We look forward to assisting you in this great endeavor to better understand and meet the needs of family caregivers.

Sincerely,

Bishop Samuel Butler, Jr.

P.O. Box 445 • 58615 Hoover Street • Plaquemine, Louisiana 70764

January 12, 2012

Fayron R. Epps, Ph.D., MSN, BSN

EJGH

Louisiana's First Nurse Magnet Hospital

Re: (New Protocol – interview questionnaire study)
An Analysis of Cultural values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly
Fayron Epps, RN, MSN, Ph.D., Nursing, Principal Investigator

* Study Protocol - Informed Consent on pages 15-18
* Southern University-Baton Rouge IRB Approval Documentation
* Curriculum Vitae for Ms. Epps

Dear Ms. Epps:

This is to inform you that at its January 10, 2012 meeting, the East Jefferson General Hospital Institutional Review Board received the above referenced study and has decided that since no direct patient action is involved, no IRB approval or oversight is required for this study.

The IRB is appreciative of your efforts and lauds your efforts in conducting this study. Since there is no IRB oversight, an annual report is not required. However, the IRB would like to request a copy of your final report at the conclusion of your study.

If you have any questions or if I may be of assistance, please do not hesitate to call. Thank you.

Sincerely,

Hildreth B. McCarthy, MD
EJGH IRB Chairman

HBM/dp

cc: Barbara Bihm, Ph.D.

East Jefferson General Hospital
Medical Staff Services
4200 Houma Blvd. • Metairie, LA 70006 • 504-454-5641 • Fax: 504-454-5667 • www.ejgh.org

APPENDIX E

SCREENING PACKET

APPENDIX E-1

KATZ INDEX

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) NO supervision, direction or personal assistance	**Dependence** (0 Points) WITH supervision, direction, personal assistance or total care
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity	(0 POINTS) Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	(1 POINT) Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	(0 POINTS)Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

Total Points: _____

Score of 6 = High, Patient is independent.
Score of 0 = Low, patient is very dependent.

**Slightly adapted. Katz S., Down, TD, Cash, HR, et al. (1970) progress in the development of the index of ADL. *Gerontologist* 10:20-30.

APPENDIX E-2

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

To be completed after screening as dependent on the Katz Index

(Please mark the correct answer or fill in the correct responses where appropriate)

Caregiver Information

1. **Gender:** _____Male _____Female
2. **Caregiver's age** _____(in years)
3. **Highest Level of Education**
   _____Elementary School _____Some College _____Graduate Degree
   _____High School/GED _____College Graduate+/or some graduate school
4. **Annual Caregiver Income**
   _____0-25,999
   _____26-35,999
   _____36-45,999
   _____46-55,999
   _____56-65,999
   _____66-75,999
   _____>76,000
5. **Race/ethnicity**
   _____African American/Black (non-Hispanic origin) _____Caucasian/White (non-Hispanic origin)
   _____Hispanic American or Latino (of any race) _____Other Race_____
6. **Religious Preference**
   _____Baptist _____Catholic
   _____Methodist _____Non-denominational
   _____Other Religion_____
7. **Relationship to care recipient**
   _____Child _____Spouse
   _____Grandchild _____Other Relative_____
   _____Sibling (sister/brother)
8. **Which of the following do you consider yourself?**
   _____Primary (regular caring responsibilities)
   _____Secondary (minimal caring responsibilities)
9. **How long have you been serving as the caregiver for the recipient?** _____ (in years)
10. **How many hours per week to do you provide care and assistance for your dependent elderly family member?** _____
11. **Do you receive any type of financial payment for providing care and assistance to your elderly dependent family member**? _____Yes _____No

Care Recipient Information

12. **Elderly family member's age** _____(in years)
13. **Gender:** _____Male _____Female
14. **Living Arrangements**
    _____Own home _____With caregiver _____Assisted living
    _____Someone else's home _____Nursing home _____Other
15. **Type of illness**
    _____Acute (will resolve < 6 months)
    _____Chronic (will last > 6 months)

APPENDIX F

QUESTIONNAIRE PACKET

APPENDIX F-1

OBLIGATION SCALE

– – –

Obligation Scale

Please indicate how important each statement is to you as a reason for helping.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1. I feel a sense of obligation to help	1	2	3	4	5
2. It's a child's duty to help	1	2	3	4	5
3. I feel that I should do my part in helping	1	2	3	4	5
4. I'm the one in the family who should help	1	2	3	4	5
5. I was raised to believe I should help	1	2	3	4	5
6. I would feel guilty if I didn't help	1	2	3	4	5
7. I would feel ashamed if I didn't help	1	2	3	4	5

APPENDIX F-2

DUKE UNIVERSITY RELIGION INDEX

DUREL: Duke University Religion Index

Directions: Please answer the following questions about your religious beliefs and/or involvement.

Please indicate your answer with a checkmark.

(1) How often do you attend church or other religious meetings?
1. More than once/wk
2. Once a week
3. A few times a month
4. A few time a year
5. Once a year or less
6. Never

(2) How often do you spend time in private religious activities, such as prayer, meditation or Bible study?
1. More than once a day
2. Daily
3. Two or more times/week
4. Once a week
5. A few times a month
6. Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

(3) In my life, I experience the presence of the Divine (i.e., God).
1. Definitely true of me
2. Tends to be true
3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

(4) My religious beliefs are what really lie behind my whole approach to life.
1. Definitely true of me
2. Tends to be true
3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

(5) I try hard to carry my religion over into all other dealings in life.
1. Definitely true of me
2. Tends to be true
3. Unsure
4. Tends *not* to be true
5. Definitely *not* true

Koenig H. Meador K., & Parkerson G. (1997) Religion index for psychiatric research: A 5-item measure for use in health outcome studies. *American Journal of Psychiatry, 154,* 885-886. *Reprinted with permission from the American Journal of Psychiatry, (Copyright © 1997). American Psychiatric Association,*

SCORING of DUREL

Subscale 1
Reverse score item 1 to obtain frequency of religious attendance subscale score

Subscale 2
Reverse score item 2 to obtain frequency of private religious activity subscale score

Subscale 3
Reverse score items 3-5 and total to obtain intrinsic religiosity subscale score

Overall Score
For overall religiosity, sum up reversed scores for items 1-5 (NOT RECOMMENDED)

Points:

- Be sure to reverse score items before analysis
- Examine each dimension (subscale) in a separate regression model when examining health outcomes
- Don't recommend including all subscales in a single model due to strong multiple collinearity between subscales
- Don't recommend using the total score, since subscale scores may cancel out the effects of each other.

APPENDIX F-3

POSITIVE APPRAISAL OF CARE SCALE

Positive Appraisal of Care Scale

Please rate "how you have been in the previous two weeks" for each item using the following scale: Replace the word "elder" with the name of the care recipient.
Mark an "X" in the appropriate box.

	0	1	2	3
	Not at all applicable	**Not very applicable**	**Somewhat applicable**	**Very much applicable**
Relationship Satisfaction				
(elder) cares for me.				
I do not want to lose (elder).				
I care for (elder).				
I respect (elder).				
I get along with (elder) well.				
Role Confidence				
I am confident about taking care of (elder).				
I am satisfied with my way of taking care of (elder).				
I can give the best care for (elder).				
I know all about (elder).				
I can deal with (elder)'s difficulty behaviors well.				
Consequential Gain				
I found a new meaning in my life through taking care of (elder).				
I have grown as a person in taking care of (elder).				
I am happy about my getting to know many people through taking care of (elder).				
I am happy about gaining caregiving skills through taking care of (elder).				
My family has become closer because of taking care of (elder).				
Taking care of (elder) is a source of my purpose in life.				
Normative Fulfillment				
I am just doing what I am expected to do.				
It is my role to take care of (elder).				
Religious or other belief supports my effort in taking care of (elder).				
Taking care of (elder) is a repayment to (elder).				
I am glad that (elder) does not have to go to an institution because I take care of (elder).				

Used by permission and adopted from: Yamamoto-Mitani, N., Sugishita, C., Ischigaki, K., & Maekawa, N. (2001). Development of instruments to measure appraisal of care among Japanese family caregivers of the elderly. *Scholarly Inquiry for Nursing Practice An International Journal, 15* (2), 113-135.

APPENDIX G

AUTHORIZATION TO USE INSTRUMENTS IN RESEARCH STUDY

APPENDIX G-1

AUTHORIZATION FOR KATZ INDEX

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Oct 31, 2011

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Licensed content title	Progress in Development of the Index of ADL
Licensed content author	Sidney Katz, Thomas D. Downs, Helen R. Cash, Robert C. Grotz
Licensed content date	Spring 1970
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Institution name	
Title of your work	An Analysis of Cultural Values, Religiosity, and Family Caregiving on the Positive Appraisal of Caring for the Elderly
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From: vcicirel@psych.purdue.edu [vcicirel@psych.purdue.edu] **Sent:** Mon 11/7/2011 4:38 AM
To: Fayron Ward (Student)
Cc:
Subject: Re: Permission Request
Attachments:

Hi Fayron:

Yes, you have my permission. Good luck on your work

Dr. Cicirelli

Quoting "Fayron Ward (Student)" <fayron_ward_00@subr.edu>:

> 168 W. Lakeview Dr.
>
> Laplace, LA 70068
>
> November 6, 2011
>
> Purdue University
>
> Victor Cicirelli, PhD
>
> Department of Psychology Sciences
>
> 703 Third Street
>
> West Lafayette, IN 47907-2004
>
> Dear Dr. Cicirelli
>
> I am a doctoral student at Southern University A & M College in
> Baton Rouge, LA. I am requesting permission to utilize the
> Obligation Scale for my dissertation work titled An Analysis of
> Cultural Values, Religiosity, and Family Member's Caregiving on the
> Positive Appraisal of Caring for the Elderly. An abstract for my
> proposal dissertation work is enclosed. I anticipate data

> collection in the spring as my expected date of completion for this
> research is May 2012 .
>
>
>
> For further questions you may contact me at 504-201-2658; Email:
> fayron_ward_00@subr.edu <mailto:fayron_ward_00@subr.edu> . My
> Dissertation Committee Chairperson is Dr. Sharon W. Hutchinson. Dr.
> Hutchinson's telecommunication contact information is as follows:
>
> Sharon_hutchinson@subr.edu <mailto:Sharon_hutchinson@subr.edu> or
> 225-771-2798.
>
>
>
> Thanks in advance for your time and attention in these matters.
>
> Sincerely,
>
> Fayron Epps MSN, RN
>
> Doctoral Candidate
>
>
>
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From: Harold G. Koenig [koenig@geri.duke.edu] **Sent:** Tue 11/8/2011 8:24 AM
To: Fayron Ward (Student)
Cc:
Subject: Re: Permission Request
Attachments: 0-DUREL English version.doc(41KB) DUREL paper - Religions 2010.pdf(190KB)

Fayron -- you have permission. See attached. HK

At 12:22 AM 11/7/2011, Fayron Ward (Student) wrote:

168 W. Lakeview Dr.

Laplace, LA 70068

November 6, 2011

Center for Spirituality, Theology and Health

Box 3400 Duke University Medical Center

Busse Building, Ste 0505

Durham, NC 27710

Dear Dr. Koenig,

I am a doctoral student at Southern University A & M College in Baton Rouge, LA. I am requesting permission to utilize the **Duke University Religion Index (DUREL)** for my dissertation work titled *An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly.* An abstract for my proposal dissertation work is enclosed. I anticipate data collection in the spring as my expected date of completion for this research is May 2012 .

For further questions you may contact me at 504-201-2658; Email: fayron_ward_00@subr.edu . My Dissertation Committee Chairperson is Dr. Sharon W. Hutchinson. Dr. Hutchinson's telecommunication contact information is as follows:

Sharon_hutchinson@subr.edu or 225-771-2798.

Thanks in advance for your time and attention in these matters.

Sincerely,

Fayron Epps MSN, RN

Doctoral Candidate

Harold G. Koenig, M.D.
Professor of Psychiatry & Behavioral Sciences
Associate Professor of Medicine
Director, Center for Spirituality, Theology and health
Box 3400 Duke University Medical Center
Durham, NC 27710
919-681-6633 (voice mail)
1-888-244-5517 (FAX)
919-383-6962 (P) (private line to his desk)
FEDEX address: 415 Clarion Dr., Durham, NC 27705

To obtain training on research related to religion, spirituality and health -- go to: http://www.spiritualityandhealth.duke.edu/education/summer-research/research-workshop.html

Fayron Ward (Student)

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Professor and Nurse Theorist

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TEL: 617-552-4250 FAX: 617-552-0745 WEB: www.bc.edu/nursing

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Author:	Lazarus, Richard S.
Publication:	American Psychologist
Publisher:	American Psychological Association
Date:	Aug 1, 1991

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Contact person Fayron Epps MSN, RN
Principal Investigator

**** A gift will be provided to eligible participants ****

This research study is being conducted by:
Fayron Epps MSN, RN
Doctoral Candidate in Nursing
Southern University and A&M College
Baton Rouge, LA

VITA

CURRICULUM VITAE

Fayron Epps RN, MSN, PhDc

I. EDUCATION & PROFESSIONAL HISTORY

A. EDUCATION

Dates Attended	*Degree*	*Field of Study*	*Institution*	*Location*
May, 2000	BSN	Nursing	Tuskegee University	Tuskegee, AL
May, 2003	MSN	Health Care Systems Management	Loyola University New Orleans	New Orleans, LA
Currently Enrolled (expected completion date May, 2012)	PhD	Nursing	Southern University and A&M College	Baton Rouge, LA

Dissertation

An Analysis of Cultural Values, Religiosity, and Family Member's Caregiving on the Positive Appraisal of Caring for the Elderly

B. LICENSURE/CERTIFICATION

Dates	*Organization*
2000-present	Louisiana State Board of Nursing, RN licensure
2003	Resident Assessment Coordinator-Credentialed (RAC-C)
Current	Advanced Cardiac Life Support (ACLS)
Current	Basic Life Support (BLS)

HONORS/AWARDS

Dates	*Honor, including organization*
2004	Induction to Southern University and A&M College Nursing Honor Society
2004	United Who's Who Empowering Executives & Professionals
2011	Nominee: Our Lady of the Lake "Emerging Faculty Award"
2011	Nominee: Our Lady of the Lake "Collegial Spirit Award"

C. PROFESSIONAL EXPERIENCE

1. Teaching Experience

Dates	*Position*	*College/University Location*	*Focal Area*
2004	Clinical Adjunct Faculty	Our Lady of the Lake College Baton Rouge, LA	Nursing
2005-2006	Instructor	Our Lady of the Lake College Baton Rouge, LA	Nursing
2007-2010	Clinical Adjunct Faculty	Our Lady of the Lake College Baton Rouge, LA	Nursing
2010-present	Instructor	Our Lady of the Lake College Baton Rouge, LA	Nursing

2. Clinical Experience

Dates	*Position*	*Institution/Location*	*Area*
2000-2001	Staff Nurse	Ochsner Clinic Foundation New Orleans, LA	Cardiac Intermediate Care Unit
2001-2002	Charge Nurse	Laplace Rehabilitation Hospital Laplace, LA	Med-Surg Rehabilitation
2002-2003	Unit Manager	Twin Oaks Nursing Home Laplace, LA	Long-term Care
2003-2004	Director of Nursing	St. James Parish Hospital Lutcher, LA	Executive Management
2006-2007	Staff Development Coordinator	Touro Infirmary New Orleans, LA	Clinical Education
2007-2009	Case Manager/Nurse Liaison	Gulfstates Health System Baton Rouge, LA	Case Management Admissions
2009	Director of Nursing	Specialty Rehabilitation Hospital of Laplace Laplace, LA	Executive Management
2009	Director of Nursing	New Iberia Rehabilitation Hospital New Iberia, LA	Executive Management
2010-Present	Quality Improvement Specialist	Coventry Health Care of Louisiana Metairie, LA	Managed Care

II. SCHOLARSHIP

A. Areas of Interest

My career goal as a nurse scholar is to promote health across the life span by increasing the quality of life for family caregivers and recognizing the multidimensional complexities of supporting older adults through nursing research and teaching. My developing area of research is on family caregiving and family caregivers of African American, Hispanic and Caucasian elders. I have worked with local churches, support groups, hospitals, and adult day health care centers to reach family caregivers with the opportunity of providing positive support and education.

B. Research and Clinical Presentations

2005 April. Epps, F. *Intervention Research*. Poster. Southern University 5th Annual Research Day

2012 February 2. Epps, F. *The Advantages of Nursing Accelerated Curricula.* Presentation. Loyola University New Orleans, Department of Biological Sciences Career Seminar. Invited presentation

III. SERVICE

A. Professional Service

1. **Professional Organizations**

2003-Present American Nurses Association
2003-Present Louisiana Nurses Association
2004-Present Sigma Theta Tau International
2004-2005 Louisiana Organization of Nurse Executives
2012-Present Gerontological Society of America
2012-Present Louisiana Geriatrics Society

2012-Present Association of Nurses Working for our Patients

2. Reviewer

2006-Present McMaster Online Rating of Evidence (MORE)

B. Collegiate and University Service

1. School of Nursing, Our Lady of the Lake College

2005	Member: Admissions and Progression Committee
2005-2006	Member: Curriculum Committee
2005-2006	Member: Information and Learning Committee
2010-2011	Member: Curriculum Committee
2011-Present	Member: Admissions and Progression Committee
2011-Present	Member: Assessment and Evaluation Committee

C. Community Service

2010	Volunteer. American Cancer Society. *Making Strides Against Breast Cancer*
2012	Volunteer. Louisiana Center for Health Equity. *Celebrating Wellness and Culture.*

IV. TEACHING

A. Course Instruction

Dates	*College/University*	*Level of Program*
2004	Our Lady of the Lake College	Associate Degree Registered Nurse • Medical Surgical Nursing I o Practicum
2005-2006	Our Lady of the Lake College	Associate Degree Registered Nurse • Medical Surgical Nursing I o Course Coordinator o Didactic/Practicum • Medical Surgical Nursing III o Practicum
2007-2010	Our Lady of the Lake College	Associate Degree Registered Nurse • Medical Surgical Nursing I o Practicum
2010-present	Our Lady of the Lake College	Associate Degree Registered Nurse • Fundamentals of Nursing o Course Coordinator o Didactic/Practicum • Medical Surgical Nursing I o Didactic/Practicum • Medical Surgical Nursing II o Course Coordinator o Didactic/Practicum • Medical Surgical Nursing II o Didactic/Practicum BSN • Leadership in Nursing o Online Course Development

Approval for Scholarly Dissemination

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Author_____

Date _____