

# Supporting Caregivers Who Care for African American Elders: A Pastoral Perspective

Wanda L. Collins & Altonette D. Hawkins

*This article focuses on how social workers and African American congregations could respond to the increased needs of informal caregivers (e.g., family, neighbors, or friends) to provide care to elderly African Americans. With support from aging and caregiver literature, two pastors offer reflections regarding the challenges of caregiving based on their perspectives from providing pastoral care in a rural and an urban setting. A case scenario is included that illustrates the increasing need of caregivers for physical and emotional support as elder care needs increase, both in the number of hours required and in the demands of providing daily care. The authors discuss barriers that may hinder access to caregiving resources and offer suggestions regarding activities that African American churches and pastors can incorporate to reduce caregivers' burdens.*

**A**CCORDING TO AGING RESEARCH, THE PROPORTION OF OLDER PEOPLE (65+) in society continues to increase (Administration on Aging, 2014; U.S. Census Bureau, 2014). The U. S. Census Bureau (2014) reports, "The percentage of the population aged 65 and over among the total population increased from 4.1 percent in 1900 to 13.0 percent in 2010 and is projected to reach 20.9 percent by 2050" (p. 3). African American elders reached 4 million in 2014 and the number is projected to grow to 12 million by 2060. In 2014, African Americans made up 9% of the older population. By 2060, the percentage of the older population that is African American is projected to grow to 12% (Administration on Aging, 2014). Parallel to this population increase, African American elders are expected

to be in poorer health due to chronic illnesses related to arthritis, diabetes, heart disease, cancer, and other diseases (Administration on Aging, 2014; U. S. Census Bureau, 2014). The most frequently occurring conditions among older African Americans in 2011-2013 were: hypertension (85% in 2009-2012), diagnosed arthritis (51%), diagnosed diabetes (39% in 2009-2012), all types of heart disease (27%), and cancer (17%). The comparable figures for all older persons were: hypertension (71% in 2009-2012), diagnosed arthritis (49%), all types of heart disease (31%), diagnosed diabetes (21% in 2009-2012), and cancer (25%) (Administration on Aging, 2014; U. S. Census Bureau, 2014).

The societal challenge to meet the physical, mental, spiritual, and social needs of older adults underscores the need for social work professionals to not only understand factors that affect aging and living but the needs of the primary caregivers as well. The role of a caregiver to the elderly can be burdensome and debilitating to one's own well-being if intentional self-care and support from other sources are not accessible and utilized. The caregiver has greater physical and mental strain due to caring for an elder (Bauer, & Sousa-poza, 2015) who in most cases has lost or is losing functionality in some activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Kim, Chang, Rose, & Kim, 2012). In addition to caring for the elder, caregivers tend to experience stress and strain from functioning in multiple roles such as spouse or partner, parent, working professional or business owner, and community leader while providing caregiving to elderly parents or a family member.

With support from aging and caregiver literature, the purpose of this article, is to offer the pastoral perspectives of two Central Kentucky pastors regarding formal providers (e.g., professional helpers) and informal support and care relationships (e.g., family, neighbors, or friends) that African American churches could utilize to lessen the burden of African American caregivers. One contributor is a senior pastor in an urban metropolitan setting and the other is a social work educator and an associate pastor in a rural location. We share caregiver barriers from the literature and offer reflections regarding the challenges of caregiving based on our experience in pastoral care. The illustration of a married female age 55 years old who provides the majority of the caregiving to her elderly parents is included as a case study. The urban-based case scenario that follows highlights the increasing need of caregivers for physical and emotional support that often goes unrecognized as elder care needs increase, both in the number of hours required and in the demands of providing daily care.

### **The Case of Mrs. C**

Mrs. C is a 55-year-old African American woman who is the primary caregiver for her two elderly middle-class parents. She lives within five

minutes of their home. Her 90 year-old father, Mr. B., is married to his wife of more than 60 years. Mr. B is diagnosed with prostate cancer and has other health problems. Mrs. B., her mother, is 92 years of age and has been living with Parkinson's disease for more than 20 years. In addition to Parkinson's, Mrs. B was recently diagnosed with liver cancer. She tries to be supportive of her husband while addressing her own health challenges. Living also in the home with both parents is Mrs. C's 59-year-old brother. His health conditions, resulting from several major surgeries, prevent him from being able to provide adequate caregiving support to his parents. Therefore, Mrs. C is faced with being the primary caregiver for her father. At the same time, she gingerly cares for her mother but tries not to take away her independence since she is still able to perform daily life activities.

Mrs. C is a high-profile public servant who has been married for 23 years and has two young adult sons. In addition to her roles as wife, mother, and caregiver, she also served in lay leadership positions in her church for more than 15 years (i.e., in a metropolitan setting). She attends Bible study, worship services, and church meetings. She was reared and married in the same Christian church in which her parents were married, and has brought her children up in this religious setting as well. Their family represent several generations that have attended the church even prior to Mrs. C's birth. For example, as a couple, Mr. and Mrs. B were actively involved in the church for many years, holding various leadership positions. Despite being homebound for more than 10 years, Mr. B, a devout man of faith, remains an avid reader of the scriptures. With this strong religious influence, religion and spirituality play important roles in Mrs. C's life and daily orientation. For example, it is her religious and spiritual belief that as a Christian it is her moral responsibility to take care of her parents since they cared for her when she was young.

Mrs. C maintains a full plate as a church leader, wife, mother, professional worker, and caregiver. Her caregiving responsibilities include ensuring that her father goes to doctors' appointments, obtains and takes medications as prescribed, eats healthy meals, and receives follow-up care, as required. Over time, Mrs. C's caregiving responsibilities increased and spilled over to caring for her mother as her health began to deteriorate. For Mrs. C, the load was too great and ultimately affected her health. Due to the strain of serving as her parents' caregiver and a number of other stressors, Mrs. C began to encounter major health challenges, which resulted in a heart attack. Additionally, she dealt with marital issues, the hospitalization of her oldest son due to serious injuries from an assault, participation in college tours for her youngest son as a part of his college selection process, and requests from her nieces and nephews for financial assistance with legal issues related to family conflict. The heart attack and other family stressors signaled for Mrs. C the importance of having support in the caregiving process and making time for her own self-care and renewal. The urban

pastor made an intentional connection with Mrs. C in the space and time of each worship service by asking her to verbalize her weekly self-care plan.

However, during pastoral visitations, the church's support of this family was primarily directed toward Mr. B, with the permission and oversight of Mrs. C. The only people who had direct contact with Mr. B were his wife, Mrs. C., other family members, the pastor, and deacons of the church. The deacons visited once a month to serve communion until the family requested only the pastor for visitations. It was the family's wishes to maintain the total responsibility of caregiving and not subject their loved one to service providers or visitors who caused Mr. B to become weary and possibly overwhelmed. As Mr. B's health challenges escalated to multiple surgeries and hospitalizations, the family made the decision to use formal support services. Eventually, the family accepted the reality that Mr. B required more skilled and attentive care than they could provide at home. As a last resort, Mr. B was admitted to a long-term nursing care facility. In this case, the family also followed through with doctors' appointments, physician referrals to specialists, and hospitalization. They were not receptive to community resources that gerontology or generalist social workers would recommend to minimize their caregiving burden and stress. The strain on the caregiver, Mrs. C, did not become easier because it required her to make frequent visits to the nursing home. The weight of caregiving, combined with her other roles, eventually gave way to other unforeseen consequences. The marital problems eventually led to Mrs. C's divorce. While Mrs. C carried most of the caregiving load for her father, she received some assistance from her two young adult sons and adult niece but little to no support from her brother, who lived in the parents' home.

The church's support of the caregiver during her own health challenges was limited to the pastor and members of the family who were also church members. Due to stress and chronic overload, Mrs. C became the care recipient needing care and support. The pastor offered pastoral care to the caregiver/care recipient through hospital visits, prayers, and gentle reminders of personal stewardship to make self-care a priority so that she could effectively care for others.

Shortly after Mrs. C's discharge from the hospital, she established a walking routine as a part of her self-care. The urban pastor went on walks with her to model the principles of self-care, to be a source of encouragement and offer the ministry of presence in a non-traditional way that met Mrs. C's needs. In addition, the pastor continued to attend to the pastoral needs of her father, Mr. B, up until his death in the hospital. Although Mrs. C no longer had the demands of caring for her father, shortly after his death her brother died unexpectedly. Mrs. C made the decision to relocate her mother to a long-term assisted living facility to address her need for ongoing caregiving support in a more stable environment. Placing her mother

in a facility was a weight off her shoulders because she could share the caregiving responsibilities with trained professionals. This arrangement allowed her more flexibility to take care of herself and to remain a loyal and supportive daughter to her mother.

### **Challenges of Caregiving**

According to National Alliance for Caregiving (NAC) and AARP Public Policy Institute (2015), nearly half of caregivers care for someone age 75 years or older and 39 percent care for someone age 50 to 74 years old. The typical care recipient is female (65%) and 69.4 years of age. The report reveals that a large majority of caregivers provide care for a relative (85%), with 49 percent caring for a parent or parent-in-law (NAC/AARP Public Policy Institute, 2015). Additionally, on average, caregivers spend 24.4 hours a week providing care to their loved one. While nearly one-quarter provide 41 or more hours of care a week (23%) caregiving for a spouse/partner averages 44.6 hours a week (NAC/AARP Public Policy Institute, 2015). The data show that among employed caregivers, six in ten who provide care to someone 50+ work full time (57%), and another 15% work between 30 and 39 hours. On average, employed caregivers work 34.8 hours a week (NAC/AARP Public Policy Institute, 2015, p. 37).

Furthermore, because of time spent on caregiving, more than half of employed women caregivers have made changes at work, such as going in late, leaving early, or working fewer hours (Family Caregiver Alliance, 2015; Office on Women's Health, 2012). Caring for older adults who are often chronically ill or disabled can be demanding and emotionally and physically tiring (Litzelman, Skinner, Gangnon, Nieto, Malecki, & Witt, 2014). Research indicates that caregivers often experience negative physical, financial, and psychological stress, including anxiety, depression, and worry (Foley, Tung, & Mutran, 2002; Garlo, O'Learly, Van Ness, & Fried, 2010). With a greater percentage of the population living longer and managing chronic ailments (U. S. Census Bureau, 2014), more families will be faced with decisions to provide care for elderly family members. Outside help may or may not be available due to economic constraints, eligibility requirements for services, or the degree of functional disability of the older adult (Bullock, Crawford, & Tennstedt, 2003).

Stress and decreased time for personal needs are two major challenges that caregivers face. Stress may be constant as caregivers adjust to frequent or sudden changes in meeting their caregiver responsibilities that can cause them to sacrifice vacations, hobbies, or other activities (Epstein-Lubow, 2014). Primary caregivers frequently must balance providing care under complex circumstances that can result in the lack of a routine schedule, long drives to and from medical facilities, juggling doctors' appointments,

or devoting less time to their own personal needs, which can leave them feeling, physically exhausted and emotionally drained (U. S. Department of Health and Human Services, 2012).

### **Cultural Influence on Caregiving**

As the United States population becomes increasingly more ethnically and culturally diverse, there is a greater need to understand the cultural determinants of caregiving responsibilities (Scharlach, Kellam, Ong, Baskin, Goldstein, & Fox, 2006). Despite the increased demand for caregiving, minority caregivers tend to use informal support services more than their non-Hispanic White counterparts (Dilworth-Anderson, Williams, & Gibson, 2002; Dunlop, Manheim, Song, & Chang, 2002). The difference is largely due to longstanding cultural traditions that define family obligations such as mutual support and reciprocity that is expressed in giving back love and support to family members who have given the same (Bennett, Sheridan, & Richardson, 2014; Gallant, Spitze, & Grove, 2010; Lindauer, Harvath, Berry, & Wros, 2015; Scharlach et al., 2006). This cultural tradition is also made known by honoring filial obligations and showing respect for an older relative's worthiness and authority.

Ethnographic research documents that, as a group, African American cultural norms are family-centered with defined roles for the caregivers (Pharr, Francis, Terry, & Clark, 2014; Taylor & Chatters, 1986). The communal aspect of caregiving in African American families is traditionally ascribed to the cultural precept of "caring for their own" rather than placing elderly family members in alternative care facilities (Anderson & Turner, 2010; Pharr, Francis, Terry, & Clark, 2014). Caring for their own or a family first mentality is the premise by which African American caregivers operate to make the sacrifice of time, resources, and self before considering any other options (Lindauer, Harvath, Berry, & Wros, 2015; Pharr, Francis, Terry, & Clark, 2014). Rather than seeing caregiving as a burden, African American caregivers most often describe caregiving as a source of personal satisfaction and emotional fulfillment (Bennett, Sheridan, & Richardson, 2014; Hargrave, 2006). This outlook often results in helping family members in their time of need, fulfilling cultural norms, and bringing family members closer together (Scharlach et al., 2006). Despite the fact that family-centered norms strengthen the bond between the caregiver, family members, and the elder caregiving recipient, these cultural norms act as a boundary for keeping outsiders at bay. Thus, the cultural norms of African American caregivers can impact their attitudes and the caregiving process (Gallant, Spitze, & Grove, 2010; Scharlach et al., 2006; Qualls & Zarit, 2009).

For instance, sometimes those outside the sanctity of the family might include the pastor and church members. This dilemma may create undue

stress and strain on the caregiver who is trapped between honoring the traditions of the family and maintaining a sense of connectedness to the beloved church community (Bennett, Sheridan, & Richardson, 2014). The hospitalization of an elderly care recipient provides an example of this type of caregiving process.

It is our observation as pastors, that when an elderly care recipient is hospitalized, whether for a short- or long-term stay, family members are designated to cover the morning, afternoon, and evening shifts. Other family members are expected to perform supplementary activities such as preparing meals, doing laundry, or cooking meals, as needed (Carlton-LaNey, Hamilton, & Alexander, 2001). This practice is meant to ensure the care recipient is never left alone solely in the care of the hospital personnel and enables the primary caregiver to continue to work and maintain a work/life balance as long as possible. Sometimes this caregiving network may extend beyond the family under special circumstances. Those special circumstances may be due to the unavailability of a family member, but the 'family first' rules of engagement are usually in play. The caregiver acts on behalf of the care recipient and serves as a gatekeeper to ensure the wishes of the care recipient are not violated. Overseeing the rotational schedule of responsibilities and honoring the traditions of the family can produce undue stress and strain on the caregiver.

However, in the informal support network of caregiving to elderly African Americans, the church is often involved in the provision of emotional support and comfort by arranging pastoral visits, praying for prayer concerns, providing tapes of sermons or special musical events, and hospital visits. Though atypical, in the case of Mrs. C, the urban pastor arranged brief walks at a nearby park following Mrs. C's heart attack. It was a way for the pastor to model her own method to reduce stress and to provide gentle motivation and encouragement to raise Mrs. C's awareness of self-care.

### **Barriers that Hinder Access to Caregiving Resources**

In the African American culture, as in other ethnic groups, there are service barriers, cultural norms, attitudes, and beliefs that may impact African American caregivers and thwart access to beneficial caregiving resources. A few of these barriers, supported by the literature, are included in the paragraphs below and observed from our pastoral experiences.

### **Reliance on Informal Support Networks Rather Than Formal Services**

Care and support from family members, friends, and neighbors during times of need or crisis is typically referred to as informal social support. Formal support is caregiving help provided by professionals, paid helpers, or companies and is not characterized by social and emotional bonds

(Williams & Dilworth-Anderson, 2002). Although formal services and resources are available, African American families can be reluctant or wary about utilizing community services (Ayalon & Young, 2005). This stance is frequently due to perceptions that service providers are biased, insensitive, or will minimize their cultural experiences. In reality, both are losers since there is a disconnection from the intended recipients, African American caregivers. Consequently, reliance on an informal support network of family, who are primarily women, close friends, and the African American church tends to be more valued than formal support within the African American culture (Pickard, Inoue, Chadiha, & Johnson, 2011; Williams & Dilworth-Anderson, 2002).

Some formal caregiver services may include long-term care, home health, adult day care, referral services, support groups, transportation services, community services, and even caregiver defined church supported ministries. Although African American caregivers tend to use informal support networks, they consistently express a greater need for formal support services and higher levels of unmet social and mental health needs than do non-Hispanic White caregivers (Chadiha, Portia, Biegel, Auslander, & Gutierrez, 2004; Ho, Weitzman, Cui, & Levkoff, 2000; National Alliance for Caregiving (NAC) and the AARP Public Policy Institute (2015). There appears to be a disconnect between the use of informal support networks, the expressed need for formal support, and the actual use of formal support to more effectively meet the needs of African American caregivers.

Historically, the African American church has been responsive to the needs of its community members, whose access to traditional social institutions and services has been restricted (Pickard, Inoue, Chadiha, & Johnson, 2011; Samuels, 2011; Taylor & Chatters, 1988). Hence, limited access to formal services may have altered help seeking patterns over time and contributed to African Americans becoming more self-reliant and intentional about utilizing informal support services (Williams & Dilworth-Anderson, 2002).

### **Mistrust of Formal Service Providers**

On the flip side, African-American caregivers may be knowledgeable about available services but may elect not to use them due to social factors that may influence disparities or issues related to mistrust (Barnes & Bennett, 2014; Buser, 2009; Chatters, Mattis, Woodward, Taylor, Neighbors, & Grayman, 2011). Due to the communal nature of the African American culture, the key to accomplishing anything is through relationship building. Relationships build trust and trust builds involvement. The African American church is a trusted source of support in the African American culture. It is both community and spiritually based (Hardy, 2014). For some African American caregivers, it is often difficult to trust agencies and service

providers who request personal information regarding finances, the names of relatives who have used similar services, and the disclosure of personal assets during the initial intervention.

As a result, families can be opposed to utilizing formal interventions when agencies or organizations fail to understand the value in first cultivating genuine relationships during the helping process or lack sensitivity to structural barriers to service utilization such as lack of transportation, negative prior experiences, language barriers, or culturally sensitive-services (Scharlach et al., 2006).

For example, in the case of Mrs. C, the family relied on limited formal service providers initially because of a perception that these types of services are intrusive. Mrs. C's family was more open to the pastoral visits and occasional visits from the deacons to serve communion because they had established commonality. The development of culturally appropriate services can only be achieved through knowledge of the culture and the involvement of culturally competent social or human service professionals who understand the nuances of the culture (Briscoe, 2000; Hardy, 2014).

### **Spiritual Implications of Faith Beliefs**

African Americans have relied on the centrality of their religious faith as a source of support; it is also a resource and a source of coping when providing elder care (Dilworth-Anderson, Boswell, Cohen, 2007; Dilworth-Anderson & et al., 2002; Sheridan, Burley, Hendricks, & Rose, 2014). In the caregiving role, some caregivers see God in the image of healer, provider, and sustainer (Gibson & Hendricks, 2006; Mast, 2014). From a theological perspective, one's personal spirituality is connected to one's faith (Bennett, Sheridan, & Richardson, (2014; Chaney, 2008). James 2:14-17, one of the well-known passages regarding the lifelessness of claimed faith unsubstantiated by works, says, "faith without works is dead" (NKJV). In essence, it means that people act in accordance to their faith. For some African American caregivers this scripture may mean that faith is demonstrated by their actions, not the actions or support of others (Jang & Johnson, 2004; Wittnik, Joo, Lewis, & Barg, 2009). Unfortunately, as caregiving demands increase, attendance at religious services often decreases. Nonetheless, many African American caregivers seem strengthened by their belief that God is in control (Bennett, Sheridan, & Richardson, 2014; Thornton & Hopp, 2011).

Religion and spirituality, faith in God, and prayer are honored and important religious practices within African American families (Coogle, 2004; Hamilton, Sandelowski, Moore, Agarwal, & Koenig, 2013; Neal, 2004; Sheridan, Burley, Hendricks, & Rose, 2014). Historically, these elements of faith have served as a source of support when African American families faced various challenges ranging from the adversity of systemic oppression

and racism to familial stressors. Jones-Cannon and Davis (2005) point out that religion, faith, and prayer helped African American daughters involved in caregiving roles to cope. These researchers report that spirituality was a theme that predominated throughout focus group discussions in their study. It was also the belief of many in the focus group that without prayer and God they would not have had the strength to continue their caregiving role. In addition, taking care of an aging parent was for most a commitment to the commandment in the Scripture to honor one's father and mother (Ephesians, 6:2-3, NIV).

Our experience attests that whether caregivers draw on organized religion, spiritual resources, or develop their own practices, some form of religious (e.g., organized religion) or spiritual (e.g., connection to a higher power) support is beneficial. This support might be in the form of clergy or others within the religious institution connecting with caregivers, encouraging the practice of Christian meditation, engaging in prayer, reading scriptures (demonstrated in the rural church), or creatively embracing journaling (practiced in the urban church). Actions such as these are positive coping practices that help caregivers manage challenges in their lives. Prayers were positively received by caregivers in the rural pastor's church and often elicited feelings of hope, gratitude, and compassion. Conversely, journaling classes in the urban pastor's church helped caregivers to find meaning in their hardship and become resilient in spite of their caregiver burden or associated responsibilities.

African American churches, in collaboration with social workers, are in prime positions to tap into the spiritual practices of some caregivers to reduce the psychosocial burden experienced from caring for elderly adults. For instance, in the rural congregation served by the social worker/pastor, caregivers are comfortable using the telephone for devotional and prayer support. A number of congregational members report calling various 1-800 numbers for diabetes and cancer advice. Adopting a similar approach, social workers connected with faith communities can use organizational skills to set up 1-800 caregiver hotlines to help caregivers to feel connected during difficult times. A 1-800 number would offer confidentiality, a convenient and timely resource, and most likely an opportunity to reduce immediate stress (Ramsay, Reisinger, Ramsay, Compton, & Thompson, 2012). Implementation of this suggestion might support caregivers in providing care a little longer based on their faith in God and access to another form of supportive care.

African American congregations could also work in partnership with social workers to provide brochures regarding services in the community to increase congregants' awareness of, and links to, community resources. The informational pamphlets could be located in a centralized area of the church close to religious literature for easy access and increased visibility. Therefore, when devotional literature, prayer booklets, and other forms of

religious or spiritual materials are retrieved, community information would be available and accessible in a familiar place.

### **The Church's Role in Lessening Caregiver Burden**

The real challenge for the church is to identify creative ways to support the caregiver that does not violate the familial norms and offer care recipients and their family members a sense of rest and comfort. Ultimately, the church's goal is to be a trusted source of healing and care for both the caregiver and the care recipient that creates a renewed sense of vitality, strength, and community.

With a greater percentage of the population living longer and managing chronic ailments, more families will be faced with decisions to provide care for elderly family members. Given the many demands and responsibilities that caregivers must face, support from congregational church members who share a common faith would be a real benefit. For example, the African American church and the pastor together form a sustaining source of support and strength for those who practice and share their faith. The congregational support could undergird the caregiver, the care recipient, and affirm the congregational/pastoral mission of being a life-giving transformational resource. In this light, the African American church is a place of community that embraces wholeness through inspired faith, ongoing support, and spiritual direction that may possibly champion the caregiving journey of its worshippers.

The church's ministry of service to caregivers within the congregation can be both spiritual and practical (Underwood & Powell, 2006) and it can be conducted either at church or as a special ministry in the residences of elderly adults receiving care. In its historical role as a kind of extended family, the African American church is in a unique position to play a vital role in mitigating caregiving stress due to the emphasis on Christian faith and service (Coogler, 2004; Underwood & Powell, 2006). African American churches can support congregational caregivers in their need for information, resources, and assistance in several areas that may include both formal (e.g., professional helpers) and informal social support (e.g., friends, neighbors, family) (Avent, Cashwell, & Brown-Jeffy, 2015; Williams & Dilworth-Anderson, 2002).

### **Organize Pre-Arranged Visits or Calls to Reduce Social Isolation**

The challenges of caregiving are often compounded by caregivers' tendencies to become isolated and experience lack of emotional and social support. Both the urban and rural pastors organized pre-arranged visits to the homes of caregivers to ensure some sort of contact from the church and to break social isolation. Various church members participated in visiting

on a rotating basis to minimize burnout and overload of a few congregants. The courtesy of arriving at times recommended by the caregiver, respecting boundaries by not asking invasive medical or personal questions, and giving attention to not staying too long, were behaviors appreciated by those engaged in caregiving activities.

Additionally, putting together a caregiver phone support group (Smith, Toseland, Rizzo, & Zinoman, 2005) or e-mail list to establish ongoing contact with church members who have minimum opportunity to worship regularly is an alternative way that these pastors expressed care and concern. Building on the importance of spirituality and religion among African Americans in general, caregivers from the rural church received taped sermons, Bible Study lessons, inspirational e-mails, devotionals, or other contacts via social media to enhance spiritual uplift.

Church members can further take advantage of the communal nature of African American families by intentionally offering help to caregivers by sitting with the sick, shopping, visiting during deaths, bringing food, giving financial assistance, cooking, cleaning, or offering other types of social support (Carlton-LaNey, 2006; Carlton-LaNey, Hamilton, & Alexander, 2001; Williams & Dilworth-Anderson, 2002). These are acts of service that congregational members, missionary groups, or Family Care Ministers could offer caregivers as an outworking of their faith beliefs of giving and helping others without the expectation of pay (1 Peter 4:10, NLT). By continuing with these forms of informal helping practices, African American congregations can become significant and essential sources of help for caregivers experiencing social isolation as well as promote community uplift (Carlton-LaNey, 2006).

### **Promote the Utilization of Community-Based Service**

As the elderly increase in numbers, reliance on caregivers (Family Caregiver Alliance, 2015) will most likely increase due to chronic illnesses related to arthritis, diabetes, stroke, heart disease, and other diseases (Family Caregiver Alliance, 2015; National Council on Aging, 2014). Additionally, many elderly adults might find it gradually more difficult to maintain their independence and to keep up with everyday tasks such as shopping, preparing meals, cleaning the house, doing laundry, paying bills, or keeping up with the maintenance of a house and yard. Increasing difficulty with daily activities such as eating, taking a bath, or driving to appointments are yet other issues that might interfere with independent living that could be addressed by greater use of community-based services. While there are agencies that offer excellent services, frequently they are not well-known by caregivers. Therefore, many times, community agencies such as the Visiting Nurses Association, United Way, or Meals on Wheels have expanded-based services for the elderly that are underused.

One study shows that a typical church provides financial support, volunteers, space, and in-kind donations to six community programs each year (Ammerman, 2001). Adult day care is an example of a community-based program that provides a beneficial service to caregivers. It is considered as an important community-based service for adults who need supervision and assistance with basic needs. In an ethnographic study exploring day care centers, Nelson (2002) states that such service provision is particularly important for African American families in whom the placement of family members in institutions has traditionally been viewed as an unacceptable option. Nelson (2002) reports that actual utilization of adult day care services depends on the creation of a caring milieu in the centers, and one important element is the opportunity for spiritual expression.

African American churches are then ideal culturally sensitive settings that could offer contractual or in-house services to caregivers and their families seeking quality care that is adaptable to ethnic and cultural frameworks. Outreach programs that partner with helping professionals (e.g., area neighborhood clergy, community nurses, psychologists, social workers, mental health practitioners, universities, etc.) to train volunteers who can provide respite care while a caregiver takes a needed break away from the home are another vitally important response to community needs (Rizzo, Gomes, & Chalfy, 2013; Coogle, 2004).

Similarly, short-term nursing homes or day hospitals could provide medical care for care receivers when caregivers need overnight or weekend assistance when they must leave town (U. S. Department of Health and Human Services, 2012).

Moreover, an added benefit would entail either generalist social workers on staff or on-site licensed or clinical social workers serving neighborhoods on designated days at select African American churches to provide brief solution-focused counseling to help caregivers resolve family conflicts or unresolved feelings of anger and resentment they might experience related to lack of support from other family members.

African American churches could also be valuable neighborhood resources for congregational caregivers desiring to use computer labs to research medical, community, and organizational services to reduce the time and cost of actually traveling to agencies to seek information. Access to high-speed Internet and computer access in this digital age is especially critical to households in rural areas and blighted urban neighborhoods unable to afford a computer or computer services. Using church computers with Internet access, social workers could teach individual volunteers within congregations who express a degree of comfort or computer savvy how to research agency criteria for service eligibility, investigate the types of insurance doctors accept, or to look up confusing medical terms. Once trained, a core group of church volunteers could be attuned to the ongoing needs of caregivers and care receivers and assist with information sharing as an act

of service and kindness to bolster congregants' sense of connectedness with church members.

Identifying community geriatric social workers who are specially trained professionals skilled in working with older adults and caregivers can provide a tremendous service to congregants experiencing caregiver fatigue. Geriatric social workers are proficient in working with family members to find long-term care plans and other appropriate services (Tompkins & Rosen, 2007). Such networking could allow congregational members to discuss potential city resources and options within the familiar and comfortable environment of the church. Working with a community-oriented focus, geriatric or generalist social workers could pool their expertise with doctors, nurses, psychiatrists, and other helping professionals to link caregivers to people with skills to help lessen their caregiver burden (Young, Griffith, & Williams, 2003). Since social workers are experienced as resource brokers (Hepworth, Rooney, Rooney, & Gottfried, 2013) they could play a vital role in facilitating the identification of a range of service providers such as Area Agencies on Aging, Alzheimer's Associations, Diabetes Self-Management Programs, Health Promotion Programs, or fall prevention and physical activity programs for instance.

### **Provide Space for Professional and Lay Volunteers to Conduct Support Groups**

Support groups are perceived as benefits to caregiving families by enhancing caregivers' coping mechanisms (Biegel, Shafran, & Johnsen, 2004; Jones-Cannon & Davis, 2005; Ramsay, Reisinger, Ramsay, Compton, & Thompson (2012). Congregations can form caregiver support groups for caregivers as a form of help and type of social support. A caregiver's support group could provide opportunities for caregivers to have a safe and caring place to get counsel, receive feedback, listen for helpful tips, and to share experiences with other caregivers in the congregation (Toseland, 2004). Social workers could volunteer to either lead groups or provide general coaching to promote and schedule support group meetings. Understanding the erratic schedule and time-consuming demands of some caregivers, group leaders should demonstrate sensitivity to time restraints by offering flexible times to host meetings.

Religious, spiritual, and faith-based venues could consider creative ways to initiate and mitigate caregiver burden by promoting partnerships with social workers, social service agencies, or mental health providers to conduct support groups. Social workers and mental health professionals are both adept at offering emotional and practical support to caregivers and their families in addition to helping caregivers cope with feelings of stress. However, social workers offer complementary skills and knowledge in understanding community resources and the referral process to assist

individuals in qualifying for appropriate social services (Hepworth, Rooney, Rooney, & Gottfried, 2013).

Within religious and spiritual settings, support groups are viewed as extensions of caring ministries that provide comfort, compassion, and support for people dealing with a wide range of life situations. In support groups, family caregivers of older adults can reduce stress and anxiety by sharing their experiences with others in similar situations where people giving care can feel connected, understood, and sustained. Jones-Cannon and Davis (2005) noted that African American caregiving daughters felt that attending support groups and knowing that their parents needed them influenced their caregiving experiences in positive ways.

In addition to social workers, African American churches could utilize lay people to provide one-on-one support to individuals dealing with various caregiving issues by using the training recommendations of Stephen's Ministry. Based in St. Louis, Stephen's Ministry equips church members to provide one-to-one Christian care to people who are hurting (Stephen's Ministry, 2015). For example, the social worker/pastor serving in the rural church participated with lay leaders in the congregation in starting a support group for caregivers. Utilizing Stephen's Ministry training as a foundation, the pastor and lay members provided a safe and caring space for those giving care to meet socially and to learn ways to cope with stressful situations.

### **Conclusion**

Cultural attitudes, mistrust of formal organizations, and religious or spiritual beliefs, often result in reduced utilization of formal supports and services that could help to lessen the demands of elderly caregiving among African American families. The reflections noted in this article can help equip African American congregations and social workers to provide an empowerment approach to minimize caregiver stress and burden (Bennett, Sheridan, & Richardson, 2014). African American religious organizations and pastors are positioned to be catalysts for increasing involvement, acceptance, and utilization of formal services (Chaney, 2008; Samuels, 2011) to lessen caregiver strain. Additionally, the generalist practice of social work provides practitioners with ways of thinking critically about the client's identified concerns and placing those issues in the context of the client's environment. Hence, social workers' skill-sets and generalist knowledge allow them to refer, assist, and coordinate community resources with congregations. Therefore, alliances between African American pastors, social workers, and other human service professionals could allow for easier and more supported dissemination of services to care recipients and caregivers. ❖

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**Wanda L. Collins, Ph.D., ACSW, Professor and Distinguished Teaching Scholar, is Director of the BSW Program, University of Louisville, Louisville, KY. Phone: (502) 852-0428. Email: wanda.collins@louisville.edu.**

**Altonnette D. Hawkins, D. Min., CPC, Senior Pastor, Open Door Christian Church, Louisville, KY. Phone: (502) 366-6306. Email: drtoni@takecarewithselfcare.com.**

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