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Social Support from Church and Family Members and Depressive Symptoms among Older African Americans

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Abstract

Objectives—This study examined the influence of church and family based social support on depressive symptoms and serious psychological distress among older African Americans.

Methods—The analysis is based on the National Survey of American Life (NSAL). Church and family based informal social support correlates of depressive symptoms (CES-D) and serious psychological distress (K6) were examined. Data from 686 African Americans aged 55 years or older who attend religious services at least a few times a year are used in this analysis.

Results—Multivariate analysis found that social support from church members was significantly and inversely associated with depressive symptoms and psychological distress. Frequency of negative interactions with church members was positively associated with depressive symptoms and psychological distress. Social support from church members remained significant but negative interaction from church members did not remain significant when controlling for indicators of family social support. Among this sample of church goers, emotional support from family was a protective factor and negative interaction with family was a risk factor for depressive symptoms and psychological distress.

Conclusions—This is the first investigation of the relationship between church and family based social support and depressive symptoms and psychological distress among a national sample of older African Americans. Overall, the findings indicate that social support from church networks was protective against depressive symptoms and psychological distress. This finding remained significant when controlling for indicators of family social support.

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Keywords

Depression; Religion; Extended Family; Congregation Support

Introduction

Depression and depressive symptoms are a major concern among older African Americans. While estimates vary across studies, among older African Americans the lifetime prevalence of major depression is roughly 5%[1-2] and 2.4% for 12-month depression.[2] Clinically significant depressive symptoms without a diagnosis of depression range from 5.4% to 12.8% among community samples and 6 to 33% among clinical samples.[3] Depression and depressive symptoms among older African Americans frequently occur in conjunction with other mental and physical disorders[1,3] and are associated with poorer functioning.[4] In addition, among those with 12 month major depressive disorder, older African Americans are less likely than non-Hispanic whites to seek help from psychiatrists and family doctors but more likely to receive help from a religious or spiritual advisor.[1]

Research indicates that social support may be protective of depression and depressive symptoms. The vast majority of research only investigates social support from family members, but there is an emerging body of research on church based informal social support networks. This research is mostly found in religious studies and social gerontology, with little work in geriatric psychiatry. Church based social support may be particularly important for older African Americans given their extremely high rates of religious service attendance and overall religious participation.[5]

The current study examines the influence of church and family informal support networks on depressive symptoms and serious psychological distress among older African Americans. This study builds upon previous research by investigating both the positive and negative aspects of church support networks. Further, in order to identify the unique associations between church support networks and depressive symptoms and psychological distress, this study controls for the impact of informal social support from family networks.

Church-based social support networks are of particular interest in understanding the link between religion and depressive symptoms among older African Americans for several reasons. First, involvement in church-based networks is a primary social outlet for older African Americans who are major constituents of religious congregations.[6] The majority of African Americans receive some form of assistance from church support networks[6-8] and comparatively speaking, older African Americans are more likely to be involved in church support networks than older non-Hispanic whites.[9] Furthermore, individuals who have more extensive church based ties and involvement (e.g., formal membership, regular attendance) appear to benefit most from church support networks. Church members may also function as surrogate family members[6-7] for older African Americans who are without families or have limited contact with family (e.g., due to geographic distance or estrangement).

Church-based support networks provide a variety of benefits to congregants including psychological (e.g., positive self-regard, self-esteem), social (e.g., perceived and objective

social support) and material resources (e.g., money, services, goods). Prior research and theory on church-based support networks indicates that they are effective in coping with life problems, including providing concrete strategies and approaches to deal with problems, assisting in problem definition (i.e., reframing) and resolution, regulating emotional responses to these difficulties, and bolstering self-perceptions (e.g., self-esteem, control) that are often eroded in the face of stressors.[10-14] Furthermore, support from church members is associated with several positive health and well-being outcomes including self-rated health,[11] life satisfaction,[15] fruit and vegetable intake,[16] health care use,[17] and lower mortality rates.[12] In many instances support from church members is a more important protective factor for older African Americans than older whites.[11] Additionally, Chatters et al. found that church support networks were protective against both suicidal ideation and attempts.[18]

It is important to note that despite the positive and protective features of church support, specific aspects of church support networks may undermine mental health. In particular, negative interactions such as gossip, petty disagreements, insults, and criticisms are features of all interpersonal relationships including those involving church members.[14] A rather substantial body of research indicates that these types of negative interactions are associated with higher levels of psychological distress and depressive symptoms.[19] In order to take into account the dual nature of social interactions, our analysis includes indicators of both positive and negative aspects of church support networks.

A limitation of the literature on church support and mental health is that the majority of studies fail to control for the influence of family support networks. To address this, the analysis also includes measures of family support as covariates. Further, we include measures of both positive and negative aspects of family support networks.

Methods

Sample

The National Survey of American Life: Coping with Stress in the 21st Century (NSAL) was collected by the University of Michigan's Institute for Social Research from 2001 to 2003. A total of 6,082 interviews were conducted including 837 African Americans aged 55 years or older. The overall response rate was 72.3%. It is important to note that the church support network questions were not asked of respondents who indicated that they attend religious services less than once per year. Consequently, the analytic sample for this study is older African Americans who attend religious services at least a few times a year (n=686). Design and sample characteristics of the NSAL are described in more detail elsewhere.[20] This study has been approved by the University of Michigan Institutional Review Board.

Measures

Two dependent variables are examined in this analysis: 1) depressive symptoms as measured by the CES-D, and 2) serious psychological distress as measured by the Kessler 6 (K6). Depressive symptoms were assessed using the 12-item version of the Center for Epidemiological Studies-Depression scale (CES-D).[21] This abbreviated CES-D has been

found to have acceptable reliability and a similar factor structure compared to the original version. Item responses are coded 1 (“hardly ever”) to 3 (“most of the time”) and focus on experiences in the past 30 days. These 12 items measure the extent to which respondents: had trouble keeping their mind on tasks, enjoyed life, had crying spells, could not get going, felt depressed, hopeful, restless, happy, as good as other people, that everything was an effort, that people were unfriendly, and that people dislike them. Positive valence items were reverse coded and summed resulting in a continuous measure; a high score indicates a greater number of depressive symptoms (M = 5.14, SD = 4.48) (Cronbach's alpha = 0.77). Research on the psychometric properties of the CES-D on older African Americans finds this scale to be reliable with good internal consistency.[22]

Serious psychological distress (SPD) was measured by the K6. This is a 6-item scale designed to assess non-specific psychological distress including symptoms of depression and anxiety in the past 30 days.[23-24] Specifically, the K6 includes items designed to identify individuals with a high likelihood of having a diagnosable mental illness and associated limitations. The K6 is intended to identify persons with mental health problems severe enough to cause moderate to serious impairment in social and occupational functioning and to require treatment. Each item was measured on a 5-point Likert scale ranging from 0 (none of the time) to 4 (all of the time). Positive valence items were reverse coded and summed with higher scores reflecting higher levels of psychological distress (M = 2.70, SD = 3.15) (Cronbach's alpha = 0.83). The K6 also has consistent psychometric properties across major socio-demographic sub samples;[23] however, there are very few measurement studies or other research using the K6 among older African Americans.

Two aspects of church-based support networks are assessed in this study: 1) emotional support from church members, and 2) frequency of negative interactions with church members. These measures were created by the Program for Research on Black Americans for use in the second wave of the National Survey of Black Americans (1987-88) (see Taylor et al., 2005) and the NSAL. They are an adaptation of measures that have been historically used for family support networks. Emotional support from church members is measured by the item: How often do the people in your church make you feel loved and cared for? Response categories range from “very often” to “never” with higher values on this index indicating higher levels of emotional support. Negative interaction with church members is measured by an index of 3 items. Respondents were asked “How often do your church members: 1) make too many demands on you? 2) criticize you and the things you do? and 3) try to take advantage of you?” The response categories for these questions were “very often,” “fairly often,” “not too often” and “never.” Higher values on this index indicate higher levels of negative interaction with church members (Cronbach's alpha =0.72).

Frequency of religious service attendance is measured by the question: “How often do you usually attend religious services?” The categories for this variable are: *attend nearly everyday*, *attend at least once a week*, *a few times a month*, and *a few times a year*. In the regression analysis, service attendance is a categorical variable with at least once a week being the comparison category.

This analysis also contains measures of supportive relationships with extended family members. Emotional support from family members is measured by the item “Other than your (spouse/partner) how often do your family members make you feel loved and cared for?” Response categories range from “very often” to “never” with higher values on this index indicating higher levels of emotional support. Negative interaction with extended family members is also measured by an index of 3 items. Respondents were asked “Other than your (spouse/partner) how often do your family members: 1) make too many demands on you? 2) criticize you and the things you do? and 3) try to take advantage of you?” The response categories for these questions were “very often,” “fairly often,” “not too often” and “never.” Higher values on this index indicate higher levels of negative interaction with family members (Cronbach's alpha =0.75).

The demographic variables used in this analysis include age, gender, marital status, education, and family income. Physical health, measured by respondents' reports of doctor-diagnosed physical health conditions, is a potential confounder in these relationships; it was included as a covariate in multivariate analyses. The distribution of the study variables is presented in Table 1.

Analysis Strategy

An examination of the univariate distribution of our dependent variables indicated that they were not normally distributed. In particular, the variance exceeded the mean which indicated overdispersion. Consequently, instead of linear regression we used negative binomial regression. This is the appropriate technique for this type of nonnormal distribution. Both standardized and unstandardized regression coefficients and standard errors are presented. For each of the dependent variables three regression models are presented. All models control for the demographic variables and the number of chronic health problems. The first model includes only service attendance and the control variables. The second model includes service attendance and adds the two church support variables. The third model adds the family support variables with the two church support variables and service attendance. To obtain results that are generalizable to the older African American population all statistical analyses accounted for the complex multistage clustered design of the NSAL sample, unequal probabilities of selection, nonresponse, and post-stratification to calculate weighted, nationally representative population estimates and standard errors.

Results

Descriptive characteristics of the sample (N=686) are presented in Table 1. Overall respondents indicated that they attended religious services at least once a week, received a fair amount of emotional support from church members and rarely had negative interactions (arguments, criticisms) with their church members. Respondents also indicated that they received a fair amount of emotional support from their family members and that they rarely had negative interactions with family members. The average age of the respondents is 66 years, respondents age ranged from 55 to 93 years of age and 38.52% are male. The average household income is $32,695 and 1out of 6 respondents have less than 9 years of formal

education. Around 40% of the respondents are married or living with a partner and respondents averaged 2.61 physical health problems.

Table 2 contains the negative binomial regression analysis of the church and family support variables on depressive symptoms (CES-D). Service attendance was not significantly associated with depressive symptoms in any of the three models. In Model 2 emotional support from church members was negatively associated with depressive symptoms, whereas frequency of negative interactions with church members was positively associated. In Model 3, emotional support from church members remains significant despite the addition of the two family support variables. Emotional support from family members is negatively associated whereas; negative interaction with family members is positively associated with depressive symptoms. An examination of the standardized coefficients for Model 3 indicates that the magnitude of the coefficient for emotional support from church members is similar to that of the number of chronic health problems.

The results of the negative binomial regression analysis of the church and family support variables on serious psychological distress (K6) are presented in Table 3. Service attendance was significantly associated with serious psychological distress with respondents who attended services nearly every day having less psychological distress (Table 3, Model 1). Emotional support from church members was negatively associated with serious psychological distress and frequency of negative interaction with church members was positively associated with serious psychological distress (Model 2). The addition of the two family support variables in Model 3 did not substantially alter the impact of service attendance and emotional support from church members on serious psychological distress. Respondents who attended religious services nearly every day had less psychological distress, emotional support from church members was protective of serious psychological distress while negative interaction with church members was no longer significantly associated with serious psychological distress (Table 3, Model 3). Receiving emotional support from family was protective of serious psychological distress, whereas negative interaction with family members was positively associated with serious psychological distress.

Discussion

This study contributes to a small, but emerging literature on church support and mental health (e.g., Chatters et al., 2011). This analysis has several notable strengths including: 1) focusing on African Americans, an underserved and under studied segment of the older adult population, 2) examination of both positive as well as negative aspects of church support networks, 3) investigating the role of both church and family support networks, 4) controlling for health and demographic variables, 5) and utilizing data from a national sample. Overall, this analysis found that among older African Americans who attended religious services at least a few times a year: a) emotional support from church members protected against depressive symptoms and serious psychological distress, b) controlling for family support did not mitigate the significant impact of church member support on both depressive symptoms and serious psychological distress, c) emotional support from extended family members was protective of depressive symptoms and serious psychological

distress and d) negative interaction with family members was associated with an increase in both depressive symptoms and serious psychological distress. Religious service attendance was related to the K-6 but not the CES-D among this population. In addition to these broad points, more detailed discussion of the findings provides insight regarding how church-based social support functions.

First, emotional closeness from church members was inversely associated with depressive symptoms and serious psychological distress, indicating that it is a protective factor. Theoretical perspectives on religion-health connections[10, 25-26] emphasize that religious communities provide a sense of belonging and social integration which, in turn, has positive impacts on health and psychological well-being. The present finding is consistent with other research indicating that church based informal social support has important protective influences on physical and mental health,[11-12,15-17] as well as suicidal ideation.[18] Additionally, research indicates that church support networks are particularly beneficial for older African Americans given their higher rates of religious service attendance relative to older white adults.[14,27]

Previous research indicates that frequency of service attendance is inversely associated with depressive symptoms,[28] major depression,[29] and mood disorders.[30] Our analysis found that service attendance was not associated with depressive symptoms but was inversely associated with serious psychological distress. Consistent with previous research, respondents who attended services nearly every day had lower levels of psychological distress than those who attended at least once a week.

Negative interaction with church members was positively associated with both depressive symptoms and serious psychological distress. These relationships, however, did not remain significant when controlling for the family variables. Although there are extremely few studies on the impact of church support on mental health, even fewer examine the impact of negative interactions with church members on depressive symptoms. The findings of this study are consistent with the few previous investigations in this area. For instance, studies of Presbyterians[31] and older Mexican Americans[32] found that negative interaction with church members is associated with higher levels of psychological distress. The current analysis confirms that negative interactions with church members have deleterious impacts on mental health, but that these relationships fail to maintain significance when controlling for the impact of family support.

Several significant family support findings were found controlling for the two church support variables. First, emotional support from family was negatively associated with both depressive symptoms and serious psychological distress. Previous research on the impact of emotional support from family members among African Americans is inconsistent, with some research showing no effects[33] and other research demonstrating the importance of family support as a protective factor for a variety of mental health problems.[34] Second, negative interaction with family was positively associated with both depressive symptoms and serious psychological distress. This is consistent with research among African Americans showing that negative interaction with family members is positively associated

with depressive symptoms,[35] mood and anxiety disorders,[36] and suicidal ideation and attempts.[34]

We find that for older African Americans, emotional support from church members is important for their mental health. Further, the standardized coefficients for emotional support from church members on depressive symptoms and serious psychological distress are comparable in size to the coefficients for number of chronic health problems on depressive symptoms and serious psychological distress (Tables 2 and 3). This comparison is important because health problems are one of the strongest and most consistent correlates of depression and depressive symptoms.[37] The relative size of these coefficients indicates that the importance of church networks to the mental health of African Americans is not trivial.

One of the strengths of this analysis is that it investigates both church and family networks. The vast majority of research investigates only one source of support. Future research should explore the complementary roles of several types of support including family, church members, friends and spouses. Research on older African Americans indicates that although in some cases some of the support networks may overlap, respondents can clearly discern the different types of support that they received from these groups.[38] Additionally, although it is impossible to determine causality with our data, we believe that overall support networks are protective of mental health problems. Effective support networks prevent loneliness, provide guidance to reduce risky behaviors which may cause stress, and mobilize to help individuals when they are in distress. Alternatively, the inverse relationship between church support and psychological distress could suggest that individuals with symptoms of depression may not be able to garner support from church members. Church networks may have difficulty in extending support due to social stigma and fears about mental illness, victim blaming, and problems in communication.

These results bolster previous findings about the importance of positive social support and the potentially deleterious effects of negative interactions including, but not limited to, family networks. Older African Americans suffering from depression may be encouraged to limit their exposure to negative exchanges, but this is not always practical. When negative interactions during church activities, avoiding those exchanges may also effectively cut the individual off from church members who provide supportive relationships. Previous research suggests that individuals' feelings of mastery mediate the relationship between negative interactions and depressive symptoms.[39] Thus, a more fruitful approach may be to help individuals develop skills to increase mastery and deal with interpersonal problems at the root of the negative interactions. While research exists on developing mastery in older adults in relation to areas such as negative reminiscence and psychological distress[40] and daily functioning,[41] relatively little examines mastery and interpersonal relationships and no studies focus specifically on culturally appropriate interventions for older African Americans.

This study has several limitations. First, study findings are not generalizable to segments of the population such as institutionalized and homeless individuals who were not represented in this sample of older African Americans. Second, given the cross-sectional nature of the

data, causal inferences regarding the relationships between church-based support on depressive symptoms and serious psychological distress (i.e., protective effects) are only suggestive and await confirmation with prospective data.

Nonetheless, the significant advantages of this study include: 1) the use of indicators of church and family support, 2) examination of both positive and negative aspects of church and family support networks, 3) controls for demographic and physical health factors, and 4) the use of a national sample. In sum, the study provides the first opportunity to systematically investigate the influence of church and family support networks on depressive symptoms and serious psychological distress among older African Americans and contributes to an emerging literature on the mental health of older African Americans.[42,43,44]

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Table 1

Demographic Characteristics of the Sample and Distribution of Study Variables*

	%	N	Mean	S.D.	Range
Service Attendance					
Nearly Everyday	8.11	56			
At Least Once a Week	49.80	346			
A Few Times a Month	26.43	183			
A Few Times a Year	15.67	101			
Church Emotional Support		684	3.55	0.65	1-4
Negative Interaction with Church Members		686	4.46	1.57	2-12
Family Emotional Support		677	3.62	0.56	1-4
Negative Interaction with Family Members		676	4.85	1.77	2-12
Age		686	66.48	7.19	55-93
Gender					
Male	38.52	229			
Female	61.47	457			
Education		686	11.58	2.99	0-17
Income		686	32695.68	29399.43	0-450,000
Marital Status					
Married/partnered	41.51	216			
Not Married	58.49	470			
No. of Chronic Health Conditions		686	2.61	1.58	0-11
CES-D		677	5.14	4.48	0-33
K-6		680	2.70	3.15	0-23

*Data are given as weighted means and weighted standard deviations for continuous variables and unweighted frequencies and weighted percentages for categorical variables.

Table 2

Negative Binomial Regression Analysis of Church and Family Support on Depressive Symptoms (CES-D) among Older African Americans

	Model 1				Model 2				Model 3			
Independent Variable	**B**	**b**	**S.E.**	**t-value**	**B**	**b**	**S.E.**	**t-value**	**B**	**b**	**S.E.**	**t-value**
Service Attendance												
Nearly Everyday	-0.03	-0.11	0.03	-0.87	-0.02	-0.10	0.03	-0.76	-0.03	-0.11	0.03	-0.95
At Least Once a Week	Ref	Ref			Ref	Ref			Ref	Ref		
A Few Times a Month	0.04	0.11	0.04	1.08	0.01	0.02	0.04	0.25	0.00	0.00	0.04	0.05
A Few Times a Year	0.01	0.02	0.05	0.13	-0.02	-0.08	0.04	-0.57	-0.03	-0.08	0.05	-0.56
Emotional Support from Church Members	--				-0.13**	-0.20**	0.04	-3.28	-0.11*	-0.17*	0.04	-2.67
Negative Interaction with Church Members	--				0.09*	0.06*	0.04	2.38	0.05	0.03	0.03	1.58
Emotional Support from Family Members	--				--				-0.09*	-0.15*	0.03	-2.72
Negative Interaction with Extended Family	--				--				0.09*	0.05*	0.04	2.43
# of Chronic Health Problems	0.14***	0.09***	0.04	3.87	0.14**	0.09**	0.04	3.68	0.14**	0.09**	0.04	3.48
Gender - Female	-0.04	-0.10	0.05	-0.86	-0.04	-0.09	0.05	-0.77	-0.03	-0.08	0.05	-0.69
Age	-0.08	-0.01	0.05	-1.64	-0.06	-0.01	0.05	-1.30	-0.04	-0.01	0.05	-0.75
Income	-0.12	-0.02	0.06	-2.03	-0.11	-0.02	0.06	-1.86	-0.12	-0.02	0.06	-1.94
Education	-0.15**	-0.05**	0.05	-3.10	-0.16**	-0.05**	0.05	-3.54	-0.15**	-0.05**	0.05	-3.33
Marital Status – Married	-0.03	-0.08	0.04	-0.77	-0.03	-0.08	0.05	-0.75	-0.01	- 0.03	0.05	-0.31
Intercept	1.58***	2.84***	0.05	32.58	1.56***	3.24***	0.04	35.77	1.55***	3.25***	0.04	35.48
F	6.75***				13.76***				11.82***			
Complex Design df	33				33				33			
N	677				675				667			

Abbreviations: B= standardized regression coefficient; b=unstandardized regression coefficient; SE=standardized error; df = degrees of freedom.

* p < .05;

** p< .01;

*** p < .001

Degrees of freedom associated with the F statistic are (9, 25) for Model 1 (11, 23) for Model 2 and (13, 21) for Model 3.

Table 3

Negative Binomial Regression Analysis of Church and Family Support on Serious Psychological Distress (K6) among Older African Americans

	Model 1				Model 2				Model 3			
Independent Variable	**B**	**b**	**S.E.**	**t-value**	**B**	**b**	**S.E.**	**t-value**	**B**	**b**	**S.E.**	**t-value**
Service Attendance												
Nearly Everyday	-0.11*	-0.49*	0.04	-2.60	-0.11*	-0.48*	0.04	-2.60	-0.11*	-0.46*	0.04	-2.45
At Least Once a Week	ref	ref			ref	ref			ref	ref		
A Few Times a Month	0.06	0.16	0.05	1.14	0.01	0.04	0.06	0.24	0.01	0.02	0.06	0.15
A Few Times a Year	-0.05	-0.15	0.06	-0.72	-0.10	-0.33	0.06	-1.88	-0.10	-0.31	0.05	-1.81
Emotional Support from Church Members	--	--			-0.19**	-0.30**	0.05	-3.71	-0.18**	-0.27**	0.06	-2.95
Negative Interaction with Church Members	--	--			0.12*	0.08*	0.05	2.43	0.07	0.05	0.04	1.71
Emotional Support from Family Members	--	--			--				-0.09*	-0.17*	0.04	-2.11
Negative Interaction with Extended Family	--	--			--				0.12*	0.07*	0.05	2.27
# of Chronic Health Problems	0.24***	0.15***	0.05	5.06	0.24***	0.15***	0.05	5.07	0.23***	0.15***	0.05	4.91
Gender - Female	-0.06	-0.15	0.06	-1.01	-0.06	-0.14	0.06	-0.94	-0.05	-0.13	0.06	-0.87
Age	-0.17**	-0.02**	0.06	-2.76	-0.16*	-0.02*	0.06	-2.43	-0.11	-0.02	0.07	-1.71
Income	-0.16	-0.03	0.09	-1.74	-0.17	-0.03	0.09	-1.78	-0.18	-0.03	0.10	-1.88
Education	-0.14*	-0.05*	0.06	-2.30	-0.16*	-0.05*	0.06	-2.73	-0.15**	-0.05**	0.05	-2.76
marital status – not married	-0.02	-0.04	0.06	-0.26	-0.01	-0.03	0.06	-0.23	0.01	0.03	0.06	0.20
Intercept	0.88***	2.86***	0.08	10.97	0.85***	3.63***	0.08	10.88	0.83***	3.43***	0.08	10.82
F	6.85***				8.30***				9.11***			
Complex Design df	33				33				33			
N	680				678				669			

Abbreviations: B= standardized regression coefficient; b=unstandardized regression coefficient; SE=standardized error; df = degrees of freedom.

* p < .05;

** p< .01;

*** p < .001

Degrees of freedom associated with the F statistic are (9, 25) for Model 1 (11, 23) for Model 2 and (13, 21) for Model 3.