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The Paradoxical Impact of Companionship on the Mental Health of Older African American Men

Jamie A. Mitchell,[1] Tamara Cadet,[2] Shanna Burke,[3] Ed-Dee Williams,[4] and Daniel Alvarez[5]

[1]School of Social Work, The University of Michigan, Ann Arbor. [2]Simmons College School of Social Work, Boston, Massachusetts. [3]Robert Stempel College of Public Health and Social Work, Florida International University, Miami. [4]The University of Michigan School of Social Work, Ann Arbor. [5]Florida International University, Robert Stempel College of Public Health and Social Work, Miami.

Address correspondence to: Jamie A. Mitchell, PhD, School of Social Work, The University of Michigan, 1080 South University Avenue, 3847 SSWB, Ann Arbor, MI 48109. E-mail: Mitchj@Umich.edu

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Abstract

Objectives: African Americans comprise 9% of the 46 million U.S. adults over age 65. Two thirds of older African American men (AAM) reside with companions. This study investigated the assumption that frequent contact with companions confers mainly health-related benefits for AAM.

Methods: Utilizing secondary data from the National Alzheimer's Coordinating Center, the relationship between older AAM's mental health and related conditions (depression, anxiety, and sleep disturbances), companion living arrangements, and frequency of contact with the participants for 3,423 older AAM and their 1,161 companions, was examined.

Results: The mean age of participants and companions was 74 years and 90% of AAM lived in a private residence. Logistic regression models indicated that an increased risk for anxiety was found when companions lived in (OR = 1.66), called daily (OR = 1.089), or visited daily (OR = 1.079). Finally, AAM had an increased likelihood of nonmedical sleep disturbances when companions lived in (OR = 1.67), called daily (1.105), or visited daily (1.078).

Discussion: The frequency of contact with companions may be consequential for select mental health outcomes and associated physiological conditions for older AAM; the timing of contact requires further investigation.

Keywords: African American, Caregiving, Disease, Men, Mental Health, Social Determinants of Health

African Americans comprise approximately 9% of the more than 46.2 million Americans aged 65 years and older with an expected growth to 12% by the year 2060 (Administration on Aging, 2014). African American elders experience persistent disparities in physical and mental health care access and outcomes, with African American men bearing a disproportionate burden of poor health (Hammond et al., 2011; Thompson, Mitchell, Johnson-Lawrence, Watkins, & Modlin, 2015). Older African American men also experience an increased risk of dementia, leading to significant disparities in the prevalence of Alzheimer's disease when compared to older White men (Chin, Negash, & Hamilton, 2011). This increased dementia prevalence may be attributed to variations in health conditions such as cardiovascular disease, diabetes, and depression that increase the risk of Alzheimer's development, as well as socioeconomic risk factors such as lower educational attainment; all more common among older African Americans broadly (Alzheimer's Association, 2015; Burke, Maramaldi, Cadet, & Kukull, 2016a, b; Hamilton et al., 2014; Turner, Capuano, Wilson, & Barnes, 2015; Williams et al., 2007).

Mental health is an important aspect of wellbeing for African American men and is deeply consequential for healthy aging. Prevalence rates of depression for older

African American men range from 5% to 10% (Lincoln, Taylor, Watkins, & Chatters, 2011; Skarupski et al., 2005). Although depression and anxiety are not synonymous, evidence indicates that older African American men with depression often display symptoms of anxiety as well (Mitchell, Watkins, Shires, Chapman, & Burnett, 2015; Watkins, 2012). An empirical review by Ward and Mengesha (2013) identified 19 studies over a span of 25 years (1985–2010) addressing African American men's experiences with depression and concluded that extant knowledge largely focuses on the relationships between stress, discrimination, and depression for older African American men (Banks, Kohn-Wood, & Spencer, 2006; Hammond, 2012; Watkins, 2012). Research also indicates that older African American men's depression is more likely to be under-diagnosed than men and women of other racial/ethnic groups. This is partially the result of differently expressed symptoms of irritability, anger, and feelings of isolation that do not align with current depression symptom criteria (Mitchell et al., 2015). When health care providers are not attuned to culturally specific manifestations of symptoms for anxiety, depression, mood disorders, and other mental health conditions affecting older African American men, mental health disparities are amplified for a population already less likely to seek mental health treatment (Mitchell et al., 2015).

An oft-overlooked correlate of untreated mental health issues is sleep disturbances, the most common being insomnia. Insomnia is characterized by difficulty falling asleep, staying asleep, or getting adequate recuperative rest (Anderson & Bradley, 2013). Sleep disturbances become more common as people age, and are a distinct marker of poorer quality of life among older adults (Reid et al., 2006). A comprehensive review of empirical research found that African Americans experience a higher prevalence of sleep disturbances than Whites in general (Durrence & Lichstein, 2006). Despite what is known about the role of sleep disturbances as an influence on and risk factor for both mental health issues and neurodegenerative conditions (Anderson & Bradley, 2013), and evidence that older African American men experience an increased risk for dementia, disordered sleep, and mental health misdiagnosis, few studies have examined the interface of these conditions for this population in particular. Gaps clearly remain in our collective understanding of older African American men's mental health needs and experiences; therefore it is critical to investigate the availability and utilization of supportive resources in the daily lives of older African American men, such as the friends, family members, and caretakers they come into contact with most often.

A growing body of evidence establishes the primacy of strengthening mental health-related support and resources accessible to older African American men in order to potentially moderate some of the disparities they face (Chatters, Taylor, Woodward, & Nicklett, 2015). For example, one commonly examined source of support for older men broadly, is marriage. Much has been written about how marriage in particular, and nonspousal companionship generally, confers protective health benefits for older men such as a lower relative risk of mortality, improved self-rated health (Zheng & Thomas, 2013), and fewer depressive symptoms (Watkins, Wharton, Mitchell, Matusko & Kales, 2015). Research also confirms that older men who bring companions to their primary care medical visits experience longer visits, more task-focused information exchange with physicians, and greater comprehension of and engagement in medical decision making compared to older men who visited the physician unaccompanied (Wolff, Clayman, Rabins, Cook, & Roter, 2015). However, marital satisfaction and the associated benefits vary widely among subgroups of African American men. For example, higher education has been negatively associated with marital satisfaction in at least one large nationally representative sample of African American men (Bryant, Taylor, Lincoln, Chatters, & Jackson, 2008). This finding indicates that older African American men do not experience certain health advantages connected to marriage to the same degree as their non-Hispanic White and Hispanic counterparts. In a study of the effects of social ties on levels of depression for older adults, older African American men's social ties including marriage, were found to have no impact on their abnormally high levels of depression (Mair, 2010). Regardless of marital status, African American men tended to have lower rates of life satisfaction and higher rates of physical and mental health issues (Mair, 2010; Barker, Morrow, & Mitteness, 1998; Ball & Robbins, 1986).

Considering that approximately 55% of older African American men report living with a spouse, 13% with a relative, 5% with a non-relative, and 27% living alone (Administration on Aging, 2014), it is imperative that we have a greater understanding of how a range of companionate relationships influence mental health outcomes of older African American men. This investigation is guided by elements of the theoretical framework of Schaefer, Coyne, and Lazarus (1981) who focused on the multidimensionality of social support functions (e.g., tangible, emotional, and informational) for older adults. This framework also emphasizes the need to more subtly investigate the supportive value of social or companionate relationships and networks for this population. Findings from this investigation will contribute to the literature on the varying types of support companions provide that are consequential for the mental health of older African American men.

Methods

Data Source and Study Sample

Utilizing a secondary data analysis of baseline data from the National Alzheimer's Coordinating Center Uniform Data Set (NACC UDS), the current investigation examined the relationship between older African American men's (AAM) mental health outcomes (depression, anxiety, and sleep disturbances), and companion characteristics (living arrangements, frequency, and type of contact between AAM and their study informants). The NACC UDS provides researchers a novel opportunity to examine relationships between a relatively large sample of African Americans and their companions, in addition to a range of psychosocial, physiological and cognitive health outcomes for participants. NACC was first established through funding from the National Institutes on Aging in 1999, and the UDS began data collection in 2005. The NACC UDS contains data collected from 33 Alzheimer's Disease Centers (ADC) across the United States since 2005 (Beekly et al., 2004). The current study includes initial annual visits by study participants and their companions to ADCs in the United States between 2005 and December 2015. The parent study from which the current study data is drawn, includes observations from over 35,000 participants who enrolled on a voluntary or referral basis (National Alzheimer's Coordinating Center, 2016). Each ADC establishes their own recruitment and, as such, methods varying by the specific ADC protocol. Participants present to the ADC on a yearly basis for an evaluation. A sample of all African-American men and their companions, for whom complete data was available, was derived from the total participant pool, yielding an analytic sample of 3,423 older AAM and their companions at baseline. Note that the term "informants" is used in the original parent study to describe any formal or informal companion, caregiver, relative or other adult accompanying participants to their ADC visits, and 61.3% of informants were spouses. Hereafter, we use the term "companion" to describe any adult (in whatever role or capacity) associated with and providing complimentary data for the older African American men in this study. Companion participation is required by the Alzheimer's disease Centers to enable accurate reporting even as the participant's cognitive status may decline, thus yielding the information analyzed in the current study.

Outcome Variables

Anxiety and sleep disturbance were assessed using the Neuropsychiatric Inventory Questionnaire (Cummings, 1997), an assessment instrument. This tool is completed by trained health professionals who are certified as interviewers through a training mechanism administered by the University of California, Los Angeles and the NACC. All respondents were asked to indicate anxiety and sleep disturbance with a simple "yes" or "no" response. Depression was assessed through clinician judgment as to whether the participant's symptoms met DSM (American Psychiatric Association, 2013) criteria and were asked to indicate a categorical yes/no response to this effect.

Independent Variables

Companions were classified by their relationship to participants (categorical: spouse/partner, child, sibling, other relative, friend/neighbor, paid caregiver, or other), and whether or not they lived together (categorical: yes or no). Demographic information, such as a companion sex (categorical: male and female), birth year (continuous: 1906–1994), and years of education (continuous: 1–26 years were also collected. The frequency of a companion's visits and calls to the participant were recorded on a six-point Likert scale ranging from daily contact to less than monthly. Clinicians gathered information at yearly visits when companions joined participants for observations and also subjectively assessed whether there was a reason to question the reliability of the information companions provided (categorical: yes or no).

Control Variables

Model 2 controls for age and model 3 controls for age and cognitive status. Age is a continuous variable and the coding matches the participants' age with a range of 38–98 years of age. Cognitive status is coded into four categories, which are (a) normal cognition; (b) impaired, not mild cognitive impairment; (c) mild cognitive impairment; and (d) dementia.

Analytic Approach

Descriptive statistics were analyzed for participants (Table 1) and their respective informants (Table 2) through a univariate analysis of means and *SDs* for continuous variables, and sample sizes and percentages for categorical variables. Logistic regression was performed utilizing Stata version 14 (StataCorp, 2015), and p values of <.05, <.01, and <.001 were reported. Outcomes were presented as odds ratios. The main effects were reported in Model 1, followed by a second model controlling for age, and a third model controlling for age and cognitive status. The decision to control for certain specific variables was decided by their statistically significant relationship to the outcome variables. Both age and cognitive status are theoretically, pragmatically, and statistically related to the mental health outcomes of interest in this population. As a result, we controlled for these variables to remove their effects from the equation as is standard in studies examining outcomes in older adults.

Findings

The mean age of both participants and companions was 74 years old and 90% of participants lived in a private residence. The mean educational attainment was 13.5 years for participants, and 14.5 years for companions. Companions and participants knew each other for 33 years on average (*SD* 16.79 years), and 85% of companions were females (n = 2,773). Most often, the companion was a spouse (61.3%), child (16.38%), or friend/neighbor (7.75%). In 67% of cases, participants and their companions lived

Table 1. Distribution of a Sample of 3,423 African-American Men in the National Alzheimer's Coordinating Center's Uniform Data Set

Variables	Means	*SD*
Age	X = 74.16 (Range: 38–98 years)	9.00
Birth year	X = 1937 (Range: 1911–1972)	10.24
Education	13.55 (Range: 0–25 years)	3.77

Variables	Sample sizes	%
Marital status		
Married	*N* = 2,278	67.24
Widowed	*N* = 409	12.07
Divorced	*N* = 379	11.19
Separated	*N* = 87	2.57
Never married	*N* = 186	5.49
Domestic partner	*N* = 49	1.45
Living situation		
Lives alone	*N* = 804	23.54
Lives with spouse/ partner	*N* = 2,222	65.05
Lives with relative/ friend	*N* = 313	9.16
Lives with group	*N* = 37	1.08
Other	*N* = 40	1.17
Cognitive status		
Normal cognition	*N* = 1,373	40.11
Impaired not MCI	*N* = 197	5.76
MCI	*N* = 741	21.65
Dementia	*N* = 1,112	32.49

MCI = mild cognitive impairment.

Table 2. Distribution of a Sample of 3,423 Informants in the National Alzheimer's Coordinating Center's Uniform Data Set

Variables	Mean	*SD*
Birth year (Range: 1906–1994)	1947	13.55
Education (Range: 1–26 years)	14.55	2.88
Number of years known to participant (Range: 1–66 years)	33	16.79

Variables	Sample sizes	%
Sex		
Male	*N* = 480	14.76
Female	*N* = 2,773	85.24
Relationship to participant		
Spouse	*N* = 1,994	61.30
Child	*N* = 553	16.38
Sibling	*N* = 181	5.56
Other relative	*N* = 163	5.01
Friend, neighbor	*N* = 252	7.75
Paid caregiver	*N* = 33	1.01
Other	*N* = 97	2.98
Lives with participant		
Yes	*N* = 2,187	67.23
No	*N* = 1,066	32.77
Frequency of visits[a]		
Daily	*N* = 177	5.44
At least three times per week	*N* = 289	8.88
Weekly	*N* = 270	8.30
At least three times per month	*N* = 120	3.69
Monthly	*N* = 111	3.41
Less than once per month	*N* = 99	3.04
Frequency of telephone contact[a]		
Daily	*N* = 392	12.05
At least three times per week	*N* = 293	9.01
Weekly	*N* = 186	5.72
At least three times per month	*N* = 60	1.84
Monthly	*N* = 52	1.60
Less than once per month	*N* = 83	2.55
Question of reliability of informant		
Yes	*N* = 150	4.61
No	*N* = 3,103	95.39

[a] Of those not living together.

together. For those not living with participants, most companions visited one (8.3%) or three (8.88%) times per week, and called daily (12.05%) or at least three times per week (9.01%). In 95% of cases, the clinician subjectively assessed the companion as a reliable source of information. The majority of participants were of normal cognition (*n* = 1,373, 40%), however 32.5% had dementia or and 21.65% of men were diagnosed with mild cognitive impairment. Anxiety was reported by 16.39% of the older African American men, sleep disturbance was reported by 21.33% others, and clinician-verified depression was endorsed in 11.86% of the sample. In all, 256 respondents experienced both sleep disturbance and anxiety within the last 30 days, 122 respondents experienced both depression and anxiety, and 148 experienced both sleep disturbance and depression.

Logistic regression models indicated that the odds of a non-medical sleep disturbance were statistically significant when companions lived with (OR = 1.38, 95% CI 1.12–1.69), or called less than once per month (OR = 2.40, 95% CI 1.29–4.47). When frequency of visits were less than once per month, a protective odds ratio emerged (OR = 0.434, 95% CI 0.198–0.952), signifying a reduction in risk. Participants experienced an increased likelihood of anxiety when companions lived in (OR = 1.34, 95% CI 1.07–1.68), called daily (OR = 1.65, 95% CI 1.01–2.71), or called less than once per month (OR = 2.46, 95% CI 1.48–3.42). Call frequency was statistically related clinician-verified depression in all scenarios aside from monthly calling, including daily phone contact (OR = 2.05, 95% CI 1.14–3.68), weekly (OR = 3.45, 95% CI 1.82–6.51), at least three times per month (OR = 2.83, 95% CI 1.18–6.79), and less than once per month (OR 5.06, 95% CI 2.49–10.26). Living together also resulted in a statistically significant relationship with clinician-verified depression (OR = 1.85, 95% CI 1.10–3.09).

Interestingly, certain relationship types were related to a reduction of risk. For instance, sibling companions were related to a reduced odds of sleep disturbance (OR = 0.189, 95% CI 0.090–0.397), and anxiety (OR = 0.142, 95% CI 0.062–0.325) among older African American male participants. Adult children acting as companions of the participants were similarly related to a decreased likelihood of sleep disturbance (OR = 0.537, 95% CI 0.313–0.919) and anxiety (OR = 0.308, 95% CI 0.173–0.550). Spousal companions were only related to a reduction in anxiety (OR = 0.512, 95% CI 0.305–0.862). Paid caregiver companions (such as home health aides) were not statistically associated with any of the examined conditions. The relationship of the companion did not influence clinician-verified depression. Table 3 displays the results of the logistic regression analysis.

Discussion

The current investigation considers the possibility that certain aspects of companionate contact are negatively associated with specific mental health outcomes among older African American men, while others appear to confer protective benefits. Again, we utilize the term companion as inclusive of all of the potentially overlapping roles that supportive adults play in the lives of older African American men, including but not limited to formal and informal caregiving. Utilizing a large secondary sample of older African American men and their companions, we extracted careful distinctions in their relationships that broaden our understanding of the mental health impact of supportive companionship on older African American men. There is evidence in this study, for example, that the companion's relationship to the participant, frequency and timing of contact, and residential status, are all significant factors that contextualize the mental health experiences of older African American men.

Companionate Burden

The narrative surrounding companionate care, particularly for elders with cognitive impairment or dementia (54% of this sample), tends to predominantly focus on burden for the companion, who often also serves in a role as caregiver (Braun et al., 2009). Caregiver burden has been defined as the persistent chronic psychological and physiological stress and related adverse health issues that often accompany intensive informal caregiving (Adelman, Tmanova, Delgado, Dion, & Lachs, 2014; Bevans & Sternberg, 2012). The literature is replete with risk factors for this phenomenon, such as living with the recipient of care, being a female caregiver, and the number of hours spent caregiving among others (Braun et al., 2009; Bevans & Sternberg, 2012). Indeed, the demographic profile of companions in this study reflect those risk factors in that the majority are women who reside with the men in this study, most often as spouses. The toll of such care not only affects the health and wellbeing of caregivers, but may also contribute to gaps in identifying and managing serious health conditions for care recipients. We utilize the term "care paradox" due to the counterintuitive nature of this relationship such that well-intentioned care delivered by a companion could lead to an increased likelihood of poor mental health for older African American men.

Sleep Disturbances

Our findings provide insight into potential mental health repercussions of being cared for by a live-in companion or spouse, namely, an increased likelihood of sleep disturbances. The timing of such effects are unclear and on the surface, they seem inconsistent with extant research detailing how supportive social and marital relationships confer at least minimal health advantages and increased access to health resources and health behavior promotion for African American men (Green, Doherty, Fothergill & Ensminger, 2012). However, we readily acknowledge that sleep disturbances among older African American men could also be influenced by a multitude of social and environmental conditions that were beyond the scope of this study, acting alone or intersecting with the presence of a companion to shape mental health outcomes. For example, residing in unsafe and/or economically disadvantaged neighborhoods that lack access to adequate goods and services for health and quality of life has been identified as psychosocial stressors that exacerbate poor health for African American men (Xanthos, Treadwell, & Holden, 2010; Yen, Michael & Perdue, 2009).

Of interest, 54% of the men in this study were diagnosed with at least mild cognitive impairment and one interpretation of this finding could be that in the overwhelm of supporting older adults with cognitive impairment in particular, less discernable conditions such as mental health concerns potentially go unchecked by live-in companions and or spouses. Sleep disturbances are also common among older adults, and highly prevalent among individuals with cognitive impairments. Our finding that the likelihood of non-medical sleep disturbances increased among African American men when companions lived-in, may reflect the fact that companions of older adults with sleep disturbances also experience disrupted sleep, and reduced quality of life as a consequence (Lee & Thomas, 2011). What is known is that poor sleep among companions for individuals with cognitive impairment has been linked to poor physical and psychosocial health among care recipients (McCurry, Gibbons, Logsdon, Vitiello, & Teri, 2009).

Anxiety as an Unnoticed Corollary of Companionate Care

This study was motivated by a concern that the narrative of supportive companion care has been unilateral in assuming

Table 3. Logistic Regression Analysis for Variables Predicting Sleep Disturbance ($n = 677$), Anxiety ($n = 520$), and Depression ($n = 406$) Among African-American Men

	Sleep disturbance			Anxiety			Depression		
Predictor	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
Age	0.995 (0.986–1.00)	-	0.980 (0.970–0.990)	0.993 (0.983–1.00)	-	0.977 (0.966–0.987)	0.983 (0.972–0.995)	-	0.973 (0.962–0.985)
Cognitive Status	1.82 (1.68–1.96)	1.87 (1.7–2.03)	-	1.97 (1.80–2.16)	2.04 (1.86–2.24)	-	1.48 (1.36–1.61)	1.53 (1.40–1.68)	-
Relationship to participant									
Spouse	0.876 (0.548–1.40)	0.870 (0.544–1.39)	0.660 (0.401–1.09)	0.725 (0.447–1.18)	0.720 (0.444–1.17)	0.512 (0.305–0.862)	0.737 (0.418–1.30)	0.725 (0.410–1.28)	0.593 (0.331–1.06)
Child	0.681 (0.412–1.13)	0.707 (0.425–1.18)	0.537 (0.313–0.919)	0.423 (0.247–0.727)	0.438 (0.255–0.753)	0.308 (0.173–0.550)	0.799 (0.436–1.47)	0.879 (0.477–1.62)	0.736 (0.394–1.37)
Sibling	0.24 (0.118–0.489)	0.230 (0.113–0.470)	0.189 (0.090–0.397)	0.187 (0.085–0.413)	0.180 (0.081–0.399)	0.142 (0.062–0.325)	0.796 (0.394–1.61)	0.719 (0.354–1.46)	0.665 (0.323–1.37)
Other relative	0.498 (0.265–0.936)	0.501 (0.266–0.941)	0.492 (0.254–0.952)	0.451 (0.232–0.876)	0.453 (0.233–0.880)	0.441 (0.219–0.888)	0.679 (0.325–1.42)	0.679 (0.325–1.42)	0.688 (0.325–1.46)
Friend/neighbor	0.425 (0.237–0.765)	0.416 (0.231–0.748)	0.453 (0.245–0.838)	0.317 (0.168–0.599)	0.310 (0.164–0.587)	0.338 (0.173–0.661)	0.629 (0.317–1.25)	0.596 (0.300–1.18)	0.653 (0.325–1.31)
Paid caregiver	1.74 (0.741–4.10)	1.74 (0.740–4.10)	1.57 (0.634–3.87)	2.23 (0.949–5.24)	2.23 (0.948–5.24)	2.07 (0.825–5.19)	0.754 (0.231–2.46)	0.759 (0.232–2.48)	0.657 (0.198–2.18)
Lives with participant	1.67 (1.38–2.03)	1.67 (1.37–2.02)	1.38 (1.12–1.69)	1.68 (1.35–2.09)	1.68 (1.35–2.09)	1.34 (1.07–1.68)	1.03 (0.821–1.29)	1.01 (0.809–1.27)	0.860 (0.681–1.09)
Frequency of visits									
Daily	1.14 (0.710–1.83)	1.16 (0.723–1.87)	1.05 (0.641–1.71)	1.14 (0.676–1.92)	1.16 (0.686–1.95)	1.07 (0.626–1.82)	0.997 (0.566–1.76)	1.03 (0.580–1.81)	0.958 (0.537–1.71)
Weekly	0.647 (0.405–1.03)	0.657 (0.411–1.05)	0.702 (0.433–1.14)	0.706 (0.423–1.18)	0.716 (0.428–1.20)	0.758 (0.450–1.28)	1.01 (0.613–1.67)	1.05 (0.635–1.74)	1.14 (0.681–1.90)
At least three times/ month	0.805 (0.449–1.45)	0.800 (0.445–1.44)	0.997 (0.545–1.82)	0.328 (0.135–0.795)	0.325 (0.134–0.790)	0.379 (0.155–0.926)	0.854 (0.435–1.67)	0.846 (0.431–1.66)	1.04 (0.521–2.06)
Monthly	0.708 (0.380–1.32)	0.694 (0.372–1.29)	0.957 (0.503–1.82)	0.608 (0.293–1.26)	0.599 (0.288–1.24)	0.763 (0.362–1.61)	0.696 (0.333–1.45)	0.676 (0.323–1.42)	0.877 (0.413–1.86)
Less than once/month	0.434 (0.198–0.952)	0.445 (0.203–0.978)	0.603 (0.269–1.35)	0.757 (0.362–1.58)	0.774 (0.088–1.59)	0.991 (0.466–2.11)	0.878 (0.429–1.80)	0.934 (0.454–1.92)	1.19 (0.571–2.49)
Frequency of telephone calls									
Daily	1.23 (0.785–1.92)	1.24 (0.793–1.94)	1.05 (0.662–1.66)	1.63 (0.993–2.67)	1.65 (1.01–2.71)	1.39 (0.832–2.31)	2.16 (1.21–3.85)	2.27 (1.27–4.06)	2.05 (1.14–3.68)
Weekly	0.987 (0.563–1.73)	0.998 (0.570–1.75)	1.01 (0.567–1.80)	0.888 (0.457–1.73)	0.902 (0.463–1.75)	0.906 (0.458–1.79)	3.12 (1.67–5.84)	3.31 (1.76–6.21)	3.45 (1.82–6.51)

Table 3. *Continued*

Predictor	Sleep disturbance			Anxiety			Depression		
	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3	Model 1	Model 2	Model 3
At least 3 times/month	1.69	1.70	1.59	1.29	1.30	1.17	2.87	2.94	2.83
	(0.822–3.49)	(0.826–3.51)	(0.752–3.37)	(0.532–3.13)	(0.535–3.15)	(0.469–2.91)	(1.21–6.78)	(1.24–6.97)	(1.18–6.79)
Monthly	1.65	1.64	1.66	1.19	1.18	1.17	0.649	0.633	0.638
	(0.735–3.70)	(0.729–3.67)	(0.717–3.83)	(0.433–3.28)	(0.428–3.25)	(0.410–3.31)	(0.146–2.90)	(0.142–2.83)	(0.142–2.87)
Less than once/month	3.32	3.38	2.40	2.40	2.46	1.61	5.86	6.43	5.06
	(1.84–6.01)	(1.87–6.13)	(1.29–4.47)	(1.20–4.81)	(1.23–4.93)	(0.785–3.31)	(2.93–11.69)	(3.21–12.90)	(2.49–10.26)
Lives together	2.15	2.16	1.63	2.24	2.25	1.62	2.24	2.29	1.85
	(1.50–3.10)	(1.50–3.11)	(1.12–2.37)	(1.47–3.40)	(1.48–3.42)	(1.05–2.49)	(1.35–3.71)	(1.38–3.80)	(1.10–3.09)

Note: Model 1 is unadjusted, Model 2 controls for age, Model 3 controls for age and cognitive status. For informant relationship, "other" is the reference category. For living with participant, not living together is the reference group. For frequency of visits, visitation three times per week is the reference group. For frequency of telephone calls, calling three times per week is the reference group.

only benefits to the health of older African American men, and particularly those with cognitive impairment. It is therefore unsurprising to see that an increased likelihood of anxiety exists for older African American men when their companions lived in the home; another indication of a paradoxical outcome. Interestingly, participants' levels of anxiety increased on both ends—with too little or too much contact from companions; an effect reflected in prior research with older adults (Newsom & Schulz, 1998). This finding is instructive; insomuch as it highlights how little is known about how a sense of balance is negotiated and established in supportive care relationships regarding the frequency and degree of companion engagement. Qualitative research on the health of older African American men reveals that traditional gender roles and perceptions of gender identity (i.e., hegemonic masculinity) continues to powerfully shape the health behaviors and mental health of African American men in later life (Hooker, Wilcox, Burroughs, Rheaume, & Courtenay, 2012). One potential interpretation of the anxiety-related findings in this study are that as older African American men, particularly those with cognitive impairment, become increasingly care-dependent, and as their sense of self-sufficiency is imperiled, the progressive loss of control and independence as evidenced by too frequent contact with caregivers could be associated with an increase in anxiety. While the secondary data utilized in this study does not allow for testing such a hypothesis, it certainly necessitates further research into the mechanisms by which engendering predominant cultural norms of masculinity are consequential for mental health outcomes of older African American men.

These findings also revealed that too infrequent contact with companions increased the odds of anxiety for men in this study. There is an abundant knowledge base on social isolation as an indicator of social wellbeing among older adults. Social isolation, and relatedly—loneliness, indicates a lack of regular social engagement and the absence of satisfying social relationships. Social isolation in particular has been reliably and independently associated with an increased risk for mortality, dementia, hospital readmissions, and biological processes associated with cardiovascular disease, mainly by way of the impact of social isolation on health behaviors among older adults (Nicholson, 2012; Shankar, McMunn, Banks, & Steptoe, 2011). It is a reasonable extrapolation from this literature to the current findings to infer that when companions exhibited less engagement in the form of infrequent contact, this increased the likelihood of anxiety in care recipients. In the current study, companions were most often close members of older African American men's social networks, possibly compounding a sense of loss, loneliness, or isolation when those companions stayed away too long. While we are unable to resolve these tensions through additional analyses at this time, it is clear that the proportionality of companionate contact is consequential for older African American men, and is an understudied aspect of their experience as a care recipient.

Limitations and Conclusions

This study utilized a secondary analysis of rich existing data to inject nuance into a commonly one-sided narrative on caregiving for an understudied population, older African American men. Inherent in using existing data are important limitations to the application of our findings. First, given the retrospective reporting of study participants and their informants, it is not possible to formulate causal inferences. For instance, it is currently unknown whether the frequency of contact caused the higher hazard in sleep disturbance, or whether the sleep disturbance issue was somehow related to, or even influenced the frequency of contact by others. As such, reverse causation is a possibility. The UDS is not a nationally representative sample of the U.S. population with regard to dementia, ethnicity, and race. Care should be taken not to derive associations between the role nor the impact of race based on this analysis. Given that African-American men and women constitute less than 13% of the overall sample (*N* = 33,900), the results described herein should not be generalized to all African-American men who did not participate in an Alzheimer's Disease Center. Future research could replicate this study where possible, in a national data set to examine whether these trends are upheld.

These limitations notwithstanding, in the present study we extended the research on older African American men's caregiving experiences in a number of important ways. Namely, this study identified significant associations between characteristics of companions and caregiving relationships, and mental health outcomes for older African American men, more than half having a form of cognitive impairment. We assert the essentiality of additional research into these dynamics given the lack of clinical assessment for anxiety and social isolation targeting older care-recipients, and caregiver burden for companions, available in primary care where the health of most community-dwelling older African American men is managed (Mitchell et al., 2015; Nicholson, 2012). Above all, we encourage scholars and clinicians to continually challenge the notion that all caregiving is without consequence for the care recipient, particularly for vulnerable care recipients such as those with mild cognitive impairment. We endeavor to spark new dialogue and research that considers cultural and gendered interpretations of being a care recipient, and more thoroughly interrogates potential pathways through which this care paradox may translate into missed opportunities to support the health and longevity of older African American men.

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T. C. and S. B. conceived the study concept and design. J. A. M. supervised implementation and with T. C., S. B., and E. W., drafted the manuscript. S. B. conducted the analyses and completed revisions alongside J. A. M. All authors read and approved the final manuscript.

Conflict of Interest

The authors declare no conflict of interest.

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