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Self-Reported Health-Promoting Behaviors of Black and White Caregivers[1]

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The purpose of this study was to describe the behaviors that caregivers report carrying out to maintain their own health, and to compare the health-promoting behaviors of Black and White caregivers. Although many studies have examined health-promoting behaviors, few have examined health promotion among caregivers. Reported studies of caregivers' health-promoting behaviors have not compared cultural groups. The sample for this study was selected by random digit dialing, and included 136 Black and 257 White caregivers of frail elders. Content analysis of respondents' answers to the open-ended question, "In general, what do you do to stay healthy?" was used to address the research questions. Most caregivers reported specific behaviors they engaged in for the purpose of staying healthy. Although most of their behaviors addressed physical health, caregivers also mentioned behaviors that contribute to mental and spiritual health. Both differences and similarities were found in Black and White caregivers' self-reported health behaviors, which have important implications for nursing practice and research in the future.

Home care is both preferred by elders and their families and is cost-effective for society. Caring for a frail elder, however, places the caregiver at high risk for impaired health. When compared with the general population or with age-matched peers, caregivers have more stress, disability, chronic illness, and mental health problems (Jutras & Lavoie, 1995; Schulz, Visintainer, & Williamson, 1990). Caregivers also use more prescription drugs, make more health care visits, and have higher death rates (George, 1991; Haley, Levine, Brown, Berry, & Hughes, 1987). Although health risks of

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caregiving are well documented, few studies have examined health-promoting behaviors of caregivers. The goal of this study was to describe the behaviors that people caring for frail elders carry out to promote their own health and to compare the behaviors reported by Black and White caregivers.

This study focused on actions caregivers take to protect and enhance their health, rather than on whether they carry out behaviors that professionals think are health promoting. Health-promoting behaviors may postpone or prevent the onset of health problems or decrease the debilitating effects that result from the chronic illnesses many caregivers face. Poor health of the caregiver is frequently a factor in the decision to place a frail elder in an institution. Therefore, increased knowledge of health-promoting behavior will both improve care for the caregivers themselves and enable them to continue providing care to the elder.

CAREGIVER'S HEALTH-PROMOTING BEHAVIOR

Several recent studies have investigated health behaviors of caregivers providing care for frail elders. A high proportion (79.5%) of caregivers in Connell's (1994) study reported using exercise as a health-promotion behavior. Moreover, O'Brien (1993) found that behaviors that foster positive self-esteem and interpersonal support were most frequently reported in her pilot study of 20 spousal caregivers of persons with multiple sclerosis. Less frequently reported health behaviors dealt with health monitoring, exercise, and stress management (O'Brien, 1993). Another study of health behaviors of Alzheimer's disease spousal caregivers found that the majority abstained from alcohol and tobacco and exercised weekly (Bergman-Evans, 1994).

In contrast to positive health behaviors, a trend toward less healthy practices exist for most caregivers of frail elders. For example, although not many caregivers smoked, Connell (1994) found that half of the smokers reported an increase in their smoking. When caregivers were questioned about coping strategies, 63.8% indicated that they ate when they were stressed by caregiving, 52.3% slept more, 34.1% used medications, and 34.1% used alcohol. Negative health behaviors were also apparent when 52 male spouse caregivers were compared with 53 demographically matched controls (Fuller-Jonap & Haley, 1995). Male caregivers reported greater difficulty sleeping, less regular exercise, and greater use of over-the-counter medications. Use of alcohol or tobacco did not differ between the caregivers and the comparison group.

Killeen (1989) examined a convenience sample of 120 caregivers of frail elders living in the community and found that older caregivers who had been providing care longer reported greater participation in health-promoting behaviors. These older caregivers were less likely to work outside the home and less likely to have child care responsibilities. When a subsample (every fifth caregiver of 120 participants or roughly 24 participants) was interviewed and asked what they did and did not do for their own health, half of the women (ages ranging from 27 to 93 years) responded by saying they did not have time to be "worried" about their own health and were unable to specify any particular activities that they did to maintain or promote their health. These findings may be reflective of women deferring personal needs to focus instead on extrapersonal demands of caregiving, their jobs, and their families. The majority of participants were White (85%) and female (79%), and comparisons were not made between Black and White participants.

Most studies of health-promoting behavior have used a quantitative approach in which participants indicated whether they carry out specified behaviors. Harris and Guten (1979), in an effort to look beyond the practices recommended by health professionals, inquired about self-defined behaviors undertaken to protect, promote, or maintain health by a random sample of adults, 32% of whom were 55 or older. Five clusters of behaviors were identified including personal health practices, safety practices, preventive health care, avoidance of environmental hazards, and avoidance of harmful substances. If health is a culturally determined construct, then it is particularly important when comparing Black and White caregivers not to impose the researchers' definition. What the caregiver does to stay healthy will be determined in part by the caregiver's own definition of health. Caregivers' responses to open-ended questions can enrich our understanding of caregivers' health-promoting behaviors.

Montgomery and McGlinn-Datwyler (1990) have suggested that caregiving, which adversely affects caregiver health, may vary by race. For example, Belgrave, Wykle, and Choi-Jung (1993) found that Black elders are currently admitted to nursing homes at between half and three quarters the rate of White elders. Moreover, Black elders may need care and assistance at a younger age in the family's life cycle when attention is still focused on the care of younger members. The tendency to have lower incomes, poorer housing, education, and physically demanding jobs in labor-intensive or domestic settings pose higher risks of injury, and a greater likelihood of minority elders having more chronic diseases, poorer health

habits, and higher levels of disability at younger ages. Most Black caregivers, by necessity, work outside the home (Butler, 1987), and coupled with the demands of providing care to another person, they may neglect their own health to a greater extent than White caregivers.

Although health promotion and preventive health measures have received increased attention in the past decade, there has been little research done on health promoting behaviors of Blacks. Because Black people have a lower life expectancy, poorer health, more chronic diseases, and higher levels of disability at younger ages, it is important to study their health behaviors. A descriptive study of Black men found that participants were not very health conscious. A large proportion (68%) of these men ate high-fat foods, did not pay attention to physical changes in their bodies (56%), and few (4% to 9%) carried out self-monitoring for signs of cancer (Millon-Underwood & Sanders, 1990). Comparisons of Black participants with Whites have found that Blacks report less use of nutritional behaviors and exercise, are more likely to smoke and are more likely to be overweight, but are also more likely to carry out health screening examinations (Ahijevych & Bernhard, 1994; Duelberg, 1992; Weitzel & Waller, 1990). Foster (1992) examined relationships among life satisfaction, use of tobacco, and health-promoting behaviors in elderly Black adults and found that those with high life satisfaction were less likely to smoke and more likely to engage in other health-promoting behaviors.

A comparison of 24 Black and 29 White caregivers of older adults with dementia (Wykle, Taylor, Belgrave, & Namazi, 1991) showed that caregivers in general did not take care of their own health and were reluctant to see themselves as needing help. Black caregivers in this study had poorer health, more sickness, more distress, and more depression than White caregivers. This discrepancy in health status suggests that health promotion behaviors differ for these two groups, but the differences have not been fully explored. Similarly, Scharlach, Midanik, Runkle, and Soghikian (1997) found that poorer health practices were associated with non-White groups from low-income levels who were employed part-time and experienced health limitations. Their sample, however, was predominantly White (85.6%) with only 3% of the caregivers reported as Black. The descriptive study reported here addressed the following research questions: What actions or behaviors are carried out by caregivers of frail elders for the purpose of maintaining or enhancing their own health? Are there differences in the types of behaviors reported by Black and White caregivers?

METHOD

Data for this research came from the first wave of data collection, and was part of a larger longitudinal study of caregivers' use of informal and formal services (Wykle, 1992). The sample of 136 Black and 257 White caregivers was recruited from a large midwestern metropolitan area through random digit dialing, and data were collected in face-to face interviews. All respondents were English speaking and provided unpaid assistance or care for a minimum of 5 hours weekly to an impaired adult 60 years of age or older living in the community. The study reported here analyzed the open-ended interview question, "In general, what do you do to stay healthy?" Test-retest reliability was established for this question in a convenience sample of 20 participants. Of the responses, 65% were reproduced during a 2- to 4-week interval.

Data Analysis

Verbatim answers to the question on activities to stay healthy were typed for coding and analysis. Individual health-promoting behaviors were the unit of analysis. These individual behaviors were independently categorized by the first and second author with 88% agreement. Upon discussion, agreement was reached on 16 inductively coded categories that emerged from the data and 100% agreement in coding was then achieved. Miles and Huberman (1994) describe the components of an interactive model of data analysis as data collection, data reduction, data display, and drawing/verifying conclusions. Counting forces the investigator to examine all the data, not just those data supporting investigator bias. To facilitate this counting, the health behavior categories were entered in SPSS for Windows (Release 6.1), to examine frequency distributions and to compare percentages of each group reporting a particular type of behavior.

The goal of the study was to identify all of the categories of health-promoting behaviors that caregivers reported, not to quantify the frequency or amount of specific types of behaviors. Therefore, for each participant, the categories of health-promoting behaviors were analyzed, not the number of specific behaviors within a category. For example, if a caregiver reported taking short walks and riding a stationary bicycle, this was coded as engaging in exercise or sports. Similarly, a caregiver who reported "trying to watch what I eat" and trying not to eat too much high-fat food, was credited with healthy nutrition. Caregivers who made only negative statements such as "I don't exercise," "I don't eat right," and those who said, "I don't do

anything to stay healthy" were coded as reporting no health-promoting behaviors for the respective category.

RESULTS

Description of the Sample

The sample included a total of 393 caregivers, 63 (16%) males and 330 (84%) females. The sample was 34.6% Black and 65.4% White. Roughly, 5% were Black males, 30% Black females, 11% White males, and 54% White females. The ages of the caregivers ranged from 20 to 91 years, with a mean age of 51.8 years (SD = 12.99). White caregivers were, on average, 3 years older than Black caregivers (t = 2.30, df = 392, p = .05). White caregivers also reported higher incomes than Blacks, and twice as many White caregivers as Blacks had graduated from college.

Nearly 6l% of the caregivers worked for pay or volunteered. Most of these caregivers worked less than 40 hours per week. Blacks and Whites did not differ significantly in employment. The majority of White caregivers were married, and a higher percentage of Black caregivers were widowed, separated, divorced, or never married. The majority of the sample, regardless of race, were adult children caring for parents.

The age of the impaired elders, ranging from 60 to 108 years, did not differ significantly in the two groups, $t(233.26) = 1.56$, p =.12. A higher proportion of Black care recipients were aged 90 years and older in contrast to the White group. Although a higher percentage of Black impaired elders required assistance in activities of daily living (ADLs), the two groups did not significantly differ in ADL scores.

Major Categories

Table 1 lists the 16 categories of health-promoting behaviors that emerged from the data and the number of participants who mentioned activities in each category. The average number of categories of health-promoting behaviors reported for the 393 participants was 2.3, and the range was from 0 to 5. Only 5% of the caregivers reported doing nothing to stay healthy. The proportion of caregivers reporting they did nothing to stay healthy was approximately the same in Black and White caregivers (4.4% and 5.4%, respectively).

TABLE 1: Health Promoting Behaviors Identified by Caregivers

Categories	*All Caregivers (N = 393)* N *(%)*	*Blacks (n = 136)* N *(%)*	*Whites (n = 257)* N *(%)*
Nutrition/supplements	266 (67.7)	95 (70.0)	171 (66.5)
Exercise and sports	166 (42.0)	54 (39.7)	112 (43.2)
Cognitive strategies	85 (21.5)	31 (22.8)	54 (20.8)
Keeps active/stays busy	84 (21.3)	21 (15.4)	63 (24.5)
Rest and relaxation	83 (21.0)	27 (19.9)	56 (21.6)
Recreation and socializing	57 (14.4)	17 (12.5)	40 (15.4)
Spiritual activities	34 (8.6)	20 (14.7)	14 (5.4)
Seeks/follows professional health advice	30 (7.6)	17 (12.5)	13 (5.0)
Avoids harmful practices	46 (11.7)	18 (13.2)	28 (10.9)
Unspecified	12 (3.1)	7 (5.1)	5 (1.9)
Drinking	13 (3.3)	6 (4.4)	7 (2.7)
Smoking	17 (4.3)	5 (3.7)	12 (4.6)
Drugs	4 (1.5)	0 (0.0)	4 (1.5)
Volunteers/doing for others	16 (4.1)	4 (2.9)	12 (4.6)
Uses moderation/common sense	11 (2.8)	3 (2.2)	8 (3.1)
Seeks help	6 (1.5)	1 (<1.0)	5 (1.9)

NOTE: Caregivers identified multiple behaviors; therefore, totals are greater than 100%.

The majority of caregivers said that they tried to eat right (67.7%), and almost half tried to exercise (42.0%). Black and White caregivers reported similar strategies for promoting their own health with regard to nutrition, exercise, cognitive coping strategies, rest and relaxation, recreation and socializing, and the use of moderation or common sense. Black caregivers were more than twice as likely as White caregivers to mention that they followed professional health advice, and twice as likely to report abstinence or moderate drinking behavior and avoiding harmful health practices in general. On the other hand, White caregivers were twice as likely to mention keeping busy or staying active, seeking help, and avoiding drugs as Black caregivers.

Only 34 of the 393 caregivers in the study reported spiritual activities as a means of promoting health, and Black caregivers were much more likely to report religious faith than their White counterparts. In the current study, volunteering or doing for others was mentioned by 16 (4.1%) caregivers, who found time to do for others in spite of their caregiving demands and responsibilities, and believed that involvement promoted their own health. Some

caregivers also managed to take considerable time for themselves; for example, one caregiver reported, "I ride my bicycle about 150 miles a week." Risk-avoidance behaviors were also mentioned. Although Black caregivers were almost twice as likely as White caregivers to report abstinence or moderate drinking, and almost three times as likely to avoid harmful health practices in general, White caregivers more often reported not smoking or not doing drugs.

DISCUSSION

Caregivers' responses to the open-ended question on what they did to stay healthy indicated that the caregivers in this study were interested in both promoting and protecting their health. They were concerned about their physical health, and for some, emotional, psychological, and spiritual health were also important. Responses such as "take time for mental relaxation," "usually having a good disposition helps me," "manage stress by harmonizing," and "I have a very active spiritual life" suggest that a general sense of well-being was important to these caregivers as well as physical health status.

Segall and Wykle (1989) found that Black caregivers of all ages used religious faith as a way of coping with the stresses of caregiving. A higher proportion of Black than White caregivers reported spiritual activities as a way to stay healthy in the present study. This response to an open-ended question must, however, be interpreted with caution. In a previous study, Black caregivers were more likely to mention religion in response to open-ended questions, but Black and White caregivers were equally likely to select religious faith as a means of coping with stress in questions in which they were asked to select from listed options (Wykle & Segall, 1991). This suggests that religious faith was important to both races, but Black caregivers may be more likely to openly discuss the importance of spiritual practices. Similar cultural-response issues may affect other findings such as White caregivers' greater tendency to report staying busy and seeking help. Overall, the small number of caregivers in both groups who mentioned seeking help as a means of promoting their own health should be of concern to nurses who work with caregivers and care recipients. Failure to seek help may result from a lack of knowledge or personal values. Nurses in both primary care and long-term care are in a position to help caregivers identify resources and methods of seeking help that are consistent with their personal values.

When the reported health behaviors of caregivers in this study are compared and contrasted with those of other adult populations, many more similarities than differences were observed. A parallel, for example, was noted with both Brown and McCreedy's (1986) and Brody's (1985) work, in which spiritual, mental, psychological and social well-being, physical exercise, nutrition, and visits to health professionals were frequently mentioned. Previous research has shown that adults do incorporate health-oriented behaviors in their lifestyles (Heidrich, 1998). Our study suggests that this is true even when faced with the stresses of caregiving.

A major contribution of this study is the fact that the data give us information about what actions caregivers take to protect and enhance their health. Harris and Guten (1979) used a similar approach in an effort to look beyond the practices recommended by health professionals. Safety practices such as seat belts in automobiles, smoke detectors, and avoidance of environmental hazards that were reported by Harris and Guten (1979) were not mentioned in this study. This difference may result from the fact that their participants were younger and less homebound. However, it also suggests that home and/or environmental safety issues may need to be addressed with caregivers.

Research on health-promotion behaviors of caregivers is in its infancy, and examination of caregiver race in relation to health-promoting behaviors is even more rudimentary. Only one other published study has compared health behaviors of Black and White caregivers. Haley and colleagues (1995) found significant differences between Black and White participants, but no significant differences within each ethnic group between caregivers and noncaregivers. Nonspouse caregivers in each ethnic group had the higher number of unhealthy behaviors. Further research is needed to understand the uniqueness and similarities of diverse groups in order to foster more affordable, culturally sensitive programs to promote caregiver health. Given and Given (1998) also contend that a focus on health-promoting activities for caregivers has been absent and suggest that nurse researchers are well-suited to address this gap.

This study provides a beginning exploration of lifestyle practices of Black and White caregivers and suggests that practicing nurses need to assess and intervene to help caregivers enhance their health-promoting behaviors. Strategies that promote physical health, mental health, and well-being must be incorporated into the busy lifestyles of caregivers. Plans to promote the well-being of caregivers must consider their experience and lifestyle in a holistic manner. The rewards of caregiving should be considered as well as the burdens. Given the importance of spirituality in previous

studies of caregivers (Segall & Wykle, 1989; Wykle & Segall, 1991), religious faith as a way of promoting well-being should not be overlooked.

Nurse practitioners who provide primary care to older adults and their caregivers are in a unique position to assess caregiver needs and help other health care providers to design an individualized plan. As the number of elders maintained in the community with functional dependencies continues to increase, the role of the nurse is vital in maintaining the health of these older adults and their caregivers.

NOTE

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