POPULATIONS AT RISK

Losing Faith and Using Faith: Older African Americans Discuss Spirituality, Religious Activities, and Depression

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BACKGROUND AND OBJECTIVES: Older African Americans are often under diagnosed and under treated for depression. Given that older African Americans are more likely than whites to identify spirituality as important in depression care, we sought to understand how spirituality may play a role in the way they conceptualize and deal with depression in order to inform possible interventions aimed at improving the acceptability and effectiveness of depression treatment.

DESIGN: Cross-sectional qualitative interview study of older African American primary care patients.

PARTICIPANTS AND SETTING: Forty-seven older African American patients recruited from primary care practices in the Baltimore, MD area, interviewed in their homes.

MEASUREMENTS: Semi-structured interviews lasting approximately 60 minutes. Interviews were transcribed and themes related to spirituality in the context of discussing depression were identified using a grounded-theory approach.

MAIN RESULTS: Participants in this study held a faith-based explanatory model of depression with a particular emphasis on the cause of depression and what to do about it. Specifically, participants described depression as being due to a "loss of faith" and faith and spiritual/religious activities were thought to be empowering in the way they can work together with medical treatments to provide the strength for healing to occur.

CONCLUSIONS: The older African Americans in this study described an intrinsically spiritual explanatory model of depression. Addressing spirituality in the clinical encounter may lead to improved detection of depression and treatments that are more congruent with patient's beliefs and values.

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INTRODUCTION

African Americans are more likely than whites to seek help for depression from primary care clinicians than from specialty mental health providers[1,2] but are less likely to be identified as depressed[3]. While prevalence rates of depression are thought to be similar among African Americans and whites[4,5], older African Americans are less likely to be prescribed antidepressants than others[6]. The low rate of identification and treatment of depression among African Americans may be due to a number of factors. Physicians may not readily recognize the symptoms of depression among African Americans[7]. Furthermore, African Americans may be more likely to delay treatment for depression[8]. While structural and financial barriers of access to mental health care for ethnic minority patients have been described[9], cultural beliefs and preferences may contribute to differentials in health care as well. For example, African Americans may be skeptical about the biological basis of depression and wary of becoming addicted to antidepressants, preferring counseling and prayer as treatments for depression[10] and perceiving intrinsic spirituality (spirituality of a private and introspective nature) as an important aspect of treatment[11]. Given these findings, cultural beliefs and preferences relevant to spirituality and religion may be particularly critical to understand with regard to older African Americans and depression.

Research linking religious involvement with psychological well-being among African Americans indicates that prayer is an important means of coping with serious personal problems[12]. Older African Americans may experience and attribute a unique meaning to religious faith which gives them the strength to confront race-related problems that may adversely impact their mental health[5,13]. This unique experience of religion and spirituality among older African Americans may contribute to overall life satisfaction[14] and make them more likely to reap the benefits of religious involvement such as church based social support as compared to whites[15]. Religious or spiritual beliefs may have an impact on the experience and help-seeking behaviors of older African Americans. Physicians may feel that spiritual African Americans will be less

likely to accept a diagnosis of or treatment for depression or they may miss depression in an African American patient who has a spiritual viewpoint.

In order to understand whether and how spirituality may play a role in the conceptualization of depression among older African Americans, we used the notion of the personal explanatory model as a guiding framework. By focusing on the aspects of spirituality within older African Americans' explanatory models of depression, we hoped to gain insight into the process of help seeking and the identification and treatment of depression among older African Americans in primary care.

METHODS

Study Overview

Data for this study were derived from a mixed methods study consisting of two linked studies: Spectrum I, a quantitative study, and Spectrum II, a qualitative and quantitative study (described in detail below). Spectrum I was designed to describe depression in late life which may not meet standard criteria for major depression[16–18]. Participants were screened for depression in their primary care doctors' offices: 2,560 older adults (ages 65 years and greater) were screened, 773 were asked to participate, 355 agreed to participate and completed a baseline in-home assessment. Standard scripted interviews were used to assess depression, anxiety, hopelessness, daily functioning, cognition, medical conditions, religiosity and personality (measures are described below).

Spectrum II was designed to give respondents an opportunity to express their views about depression and to integrate respondents' views with the structured responses they gave to the fixed-answer questions in Spectrum I[18,19]. Participants for Spectrum II were identified from the older adults who participated in Spectrum I and who agreed to be contacted and interviewed again. For the Spectrum II study, we used a purposive sampling strategy in order to include a population of persons from the Spectrum I sample who had high and low depression scores and to achieve an equal number of African American and white participants. Permission to re-contact and interview Spectrum I participants was granted by the University of Pennsylvania Institutional Review Board. A Certificate of Confidentiality was obtained from the Department of Health and Human Services as an additional confidentiality safeguard. In all, 102 persons from the Spectrum I study were the basis for the Spectrum II investigation, 47 of whom were African American. In order to explore ways in which religion, spirituality and depression might intersect for African Americans, we focused only on the semi-structured interviews of the subsample of African Americans who participated in Spectrum II (n=47). We did not look at the whole sample of 102 because we wanted to focus on the viewpoints of the African Americans and how religion and spirituality may play a role in the beliefs about depression and help-seeking behavior related to these beliefs. The semi-structured interview guide is available on request from the first author.

Semi-structured Interviews

Spectrum II interviews consisted of a series of open ended questions designed to obtain each individual's explanatory model for depression[20]. In addition to the semi-structured interview guide consisting of questions related to the experience of depression, the perceived causes of depression, and what to do about depression, we used two vignettes describing depressed people to elicit participants' explanatory models for depression. Vignettes are a common and useful method for eliciting explanatory models of illnesses in community samples[21,22]. Our vignettes described an older person with common symptoms of depression including lack of sleep, decreased weight, appetite loss, and a lack of interest in usual activities. The gender and the age of the vignette character were matched to the gender and age of the participant. The two vignettes (in their female versions) are as follows:

> Mrs. A is a (participant's age)-year-old woman who was deeply religious and was active in her church her whole life. She believed that God wasn't going to give you more than you could bear. She took pills for her heart three times a day and insulin injections every morning. She usually handled things okay, but recently she told her pastor she felt "weighed down by the world." She found that she did not enjoy her food, and lost weight. Others noticed that she was forgetful and no longer fixed her hair or put make-up on. Her doctor examined and tested her thoroughly and found her health to be the same. Nevertheless, Mrs. A did not feel well.

> Mrs. B is a (participant's age)-year-old woman whose husband died 8 years ago. They raised three children who are now all married with families of their own and living in different states. She has good visits with them about once a year. She used to play cards with friends every Wednesday. Lately, though, she can hardly drag herself out of bed in the morning, let alone get herself dressed and out to a card game. She has no energy and lost 12 pounds. Her doctor examined her thoroughly and found her health to be the same. Nevertheless, Mrs. B does not feel well.

In order to ascertain participants' beliefs about the cause and treatment of depressive symptoms, after hearing each vignette participants were asked three questions: (1) What do you think is the matter with Mrs. A (or Mrs. B)? (2) What should be done about it? (3) Who could help?

In all, 47 African American older adults took part in semi-structured interviews in their homes. Professional interviewers were trained and supervised by two of the project co-investigators (MW and FB). Interviews were recorded, transcribed, and entered into QSR-N6 for coding and analysis[23,24]. We used the constant comparative method, moving iteratively between codes and text in order to derive themes related to religion, spirituality and depression[25,26]. Originally developed for use in the grounded theory methodology of Glaser and Strauss[26], the constant comparative method is a discovery-oriented method that involves taking one piece of data (e.g. one theme) and comparing it with all others that may be similar or different in order to develop conceptualizations of the possible relations among various pieces of data. Initial coding and theme generation was carried out by two members of our team (MW and JJ). Coders were blinded to clinical and demographic characteristics. A third author (LL) independently coded the data to check for convergence and consistency of theme analysis. We discussed and resolved any discrepancies by

consensus. Additionally, we compared the transcripts of men and women as well as the transcripts of individuals with and without significant depressive symptoms (based on the Centers for Epidemiologic Studies Depression scale, described below) with respect to discussion of spirituality, religion and depression.

Spirituality and Religion

Important distinctions have been made between the terms "religion" and "spirituality". Harold Koenig defines religion as "an organized system of beliefs, practices, rituals and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and (b) to foster an understanding of one's relation and responsibility to others in living together in a community"[27]. In contrast, Koenig defines spirituality as "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community"[27]. In this paper we incorporate components of both spirituality and religion as discussed by older African Americans, and we employ both terms throughout this paper.

Data Collected in Spectrum I

Data collected in Spectrum I included participant age, gender, ethnicity, marital status, level of educational attainment, as well as several measures that assessed psychological and physical health. In addition, frequency of attending formal religious activities and intrinsic spirituality (the involvement of religion in all of one's dealings in life) was assessed using the Duke Religious Index[28]. The Duke Religious Index is a five-item measure of religious involvement[29] and contains three statements regarding intrinsic religiosity: "My religious beliefs are what really lie behind my whole approach to life," "In my life I experience the presence of the Divine," and "I try hard to carry my religion over into all other dealings in life." Respondents were asked to respond to these statements with "strongly agree," "agree," "neither agree nor disagree," "disagree," or "strongly disagree." For our analyses we dichotomized participants into those who agreed with the statement ("agree and "strongly agree") and those who did not agree (all other answers). Depression was assessed using the Centers for Epidemiologic Studies Depression (CES-D) scale. The CES-D was developed by the National Institute of Mental Health for use in studies of depression in community samples[30–32] and has been employed in studies of older adults[33,34]. In the Spectrum study, we employed an established threshold of 17 or above as indicative of significant depressive symptoms[35].

RESULTS

Sample Characteristics

The majority of the sample were women (79%); the mean age of the sample was 78.3. The mean CESD score was 15.3, and 45% of the participants had a CESD score equal or greater than 17, corresponding with a significant level of depressive symptoms. With regard to their religious involvement, 70% of the sample said they attended church at least once per week and 70% practiced a religious activity at least once per day. With regard to measures of intrinsic religiosity, 96% agreed that their religious beliefs are what really lie behind their whole approach to life, 96% agreed that they "experience the presence of the Divine", and 91% agreed with the statement "I try hard to carry my religion over into all other dealings in life."

A Faith-Based Explanatory Model of Depression

The African American older adults in our study brought up the term "faith" frequently when discussing depression. In all, 40 out of 47 participants (85%) discussed faith, God, or religion when discussing depression. In particular, the notion of faith came up with respect to two main components of participants' explanatory model of depression: the cause of depression and what to do about depression. There was no difference in the frequency with which participants discussed faith-based notions of depression based on CES-D score or gender.

Depression as a Loss of Faith. Participants talked about depression as a loss of faith. When they were presented with a scenario that included a description of an older adult with common symptoms of depression, participants commented:

> "Well he might have lost faith in a lot of things. You did say he was a church man…"

> "She's lost a little bit of her faith. … When you believe in God, God can do anything but fail. When you don't believe, really believe in God, you've lost some of your faith.

> "Only thing I know, he's just losing his faith and his strength. He's losing his faith and strength."

> "To some extent I feel that she lost out in believing in Christ because I feel that Christ in my life is the answer and I feel that this person lost the touch with Christ."

One 72-year-old woman discussed the reason why someone might be depressed despite taking care of her physical health: *"I think she could have been depressed because she could be losing faith in God… because if she took the pills for heart three times a day and insulin injections every morning and yet she still felt weighed down… somehow she lost something and it's probably her faith."*

"Getting Faith" is the Cure and the Foundation for Healing. Many respondents believed that "getting faith" is the cure. Some said that faith provides hope and moral strength in the face of hardship. A 72-year-old woman said: *"You got to put your faith in the Lord. If you don't you're going to feel bad and you're not going to get up and do anything but just lay there and complain…"*. The same woman described her own battle with depression, noting that she takes antidepressants, but credited her faith with helping her to get better: *"I mean I know I take [depression] pills but then… I just stopped worrying] …because I knew God was going to take care of me."*

Faith was seen as an all-encompassing framework which involves the physicians and the treatments they offer. A 79-

year-old woman said the following when discussing what she does if she gets depressed: *"I believed in God and I still believe in Him…– it's not the doctors or nobody else doing anything for me, it's the Lord that's doing it, giving them the strength and the understanding to do it with Him."* A 77-year-old woman talked about how God works through medicine: *"God works through that medicine – that medicine don't do nothing for you. You can take that medicine and if you don't have faith in God and know that God can heal you through that medicine, you'll be taking that medicine the rest of your life because you're putting your trust in that medicine. You see, God works through that medicine and if you believe that you could be healed through that by God, then it will work."*

Religious Activities Used for Dealing with Depression. In addition to discussing the healing value of faith, the participants in our study talked about the therapeutic value of specific religious coping methods. Respondents told us that spiritual coping methods could be used directly to relieve depression and that spiritual coping can enhance conventional medical treatments.

Prayer. Participants described prayer as an active strategy of seeking guidance and of helping oneself. A 79-year-old man said: *"Well truthfully I think his answer to the question of what to do about depression would be praying, asking God to enlighten him and show him the way, what he should do, how he should act, what to do with his life."* Most of the respondents described prayer as a basic form of helping oneself which is done independently or with others and can be complementary to other forms of help-seeking: *"See it can be a pastor, a nurse, a doctor – all of this has helped… [but] this man can help himself by praying more. Pray more and he can believe he is going to be all right."*

Talking to the Pastor. Participants in our study also said that speaking with a pastor or religious leader would help with the symptoms of depression. The pastor was talked about as a member of their community who is trustworthy, caring and ensures confidentiality. One 82-year-old man stated: *"If you talk to your pastor … he always is more or less private and just knowing that you can talk with somebody who has had dealings with people like that or know that they aren't just telling you things just for making you think 'I can help you' but really help you."* A minister was seen not just as a hopeful listener but as providing a link to the spiritual or religious realm. *"It makes them feel better because they feel that they're going to pray to God when they go to the minister and tell them about it and talk it over with them. And that's how they want or think they can get rid of it."* While doctors and ministers might both be people who can help with depression, only the minister has "God in them": *"First you got to have some part of Jesus in you. You can be a doctor but the doctor don't have the sympathy and that feeling that they need to give you. They have to have some of God in them. You can go to your minister and you can go to the hospital but I prefer the minister."*

Going to Church. Participants frequently brought up church as a place to go for strength, comfort and support in times of crisis. *"I have some very good friends and my church members are very important in my life. They are my sisters and brothers because I didn't have any real sisters and brothers."* Going to church was also seen as a way to bolster strength and restore lost faith. An 83-year-old woman talked about restoring faith in the following way: *"Church helps you a whole lot. And since I've been going, it has helped me a whole lot. My faith is beginning to restore. But the more you stay out of church, the more you lose your faith. You're not strong like you used to be. I could move mountains when I go, you know. If you don't go to church and receive the word of God, you just get weak."*

DISCUSSION

Older African Americans in our study presented an explanatory model of depression which is inherently spiritual. Depression was seen as a spiritual crisis characterized by a loss of faith. Consistent with their explanatory model, regaining faith and using religious activities such as prayer, talking to a pastor or going to church, were discussed as ways in which depression can be relieved. In addition, religious activities were seen as methods to activate the patient. The participants in our study did endorse seeking help from a physician and taking medications; however, the effectiveness of medical treatments was seen as being dependent upon a person's faith.

Religious belief significantly influences how African American elderly view the nature of depression and how they engage in treatment. Some physicians may feel that persons with high salience of religion in daily life will have a passive and fatalistic orientation toward their health[36–39]; however, recent studies suggest that religious and spiritual beliefs are associated with active coping methods rather than avoidant or passive methods[36,40]. Our respondents told us that spiritual beliefs can provide strong coping skills and methods which can be either primary or adjunctive in depression treatment. Respondents in our study talked about how prayer and spiritual practice can be empowering. Although previous research has couched spiritual beliefs and religiosity among African Americans as a barrier to depression treatment seeking, using faith in the way it was discussed by older African Americans in our study is compatible with using "positive spirituality" to promote overall wellness and health among elders as was set forth by Crowther and colleagues[41]. Positive spirituality, the notion of "developing an internalized personal relation with the sacred or transcendent" may foster active engagement in life through religious and/or community activities, prayer, meditation, and other practices. Older African Americans with strong spiritual relationships with God may experience a heightened capability or self-efficacy to manage difficult health situations and overcome barriers to health promoting activities[42,43]. Moreover, spiritual explanatory models of depression need not be seen as antagonistic towards a biomedical explanatory model.

In a previous analysis from the Spectrum II study, we found that participants identified as depressed by their physicians incorporated both medical and experience-based ideas about depression into their own models for depression, saying depression was how their physicians defined it, *in addition to* their personal experiences of its causes and feelings[44]. Patients appear comfortable incorporating biomedical and personal knowledge into their explanatory models for depression and may not see the coexistence of spiritual and biomedical models for depression as problematic. In our study, a spiritual

explanatory model of depression did not exclude help-seeking in primary care. Many of the African American respondents in our study describe medicine and faith as working synergistically, although those who endorse a spiritual explanatory model believe faith is the indispensable element for healing.

For African Americans, discussion of spirituality appears to be particularly important in the context of depression care[11]. The majority of the older African Americans in our study (85%) used a spiritual explanatory model to describe depression based on how they described the cause and treatment of depression. Specifically, they described depression as a loss of faith and talked about religious or spiritual activities that were helpful in dealing with depression. They discussed ways in which spiritual coping methods can be self-motivating and enhance biomedical treatments. People who choose to use non-medical therapies instead of medical treatments typically do so not because of dissatisfaction with medical treatments but because they find non-medically based therapies to be more congruent with their own values, beliefs, and philosophical orientations toward health and life[45]. Given that the spiritual element is absent from the biomedical account of depression, there is a risk that a person with a spiritual explanation of depression may feel like an outsider. The main coping strategy and way of finding meaning may go unacknowledged by physicians when in fact spiritual beliefs may enhance biomedical treatments for some African American patients. Discordant perceptions between physicians and patients regarding the meaning of depression may increase the risk of miscommunication and under-diagnosis, and it may result in lack of adherence to medical treatment.

Before discussing the clinical implications of our findings, we need to first consider some potential limitations. First, while the majority of the sample were women, we found that the men we interviewed were equally likely to discuss faith in the context of talking about depression. Second, because the majority of African Americans in our sample held strong opinions on the importance of religion in dealing with depression, questions that dealt more directly with spirituality had the potential to trigger respondents to discuss religion and spirituality out of a moral sense of social desirability. However, we found that most respondents discussed the relationship of religious beliefs and depression spontaneously rather than in response to direct questioning by the interviewer. Third, although respondents were recruited from primary health care settings, interviews occurred in the home, where older adults may be more comfortable discussing the role of religious beliefs in depression than they would be if such discussions occurred in a doctor's office. Finally, this sample of older African Americans appears to identify themselves primarily as Christians; this may reflect the region from which the sample was drawn. Older African Americans with other religious beliefs might discuss depression and religion in very different ways.

In the clinical encounter, discussing a patient's faith might make older African American patients more likely to express depressive symptoms, especially if depression is seen not as a medical problem but rather a "loss of faith." Given the under-diagnosis and treatment of depression among older African Americans, an important next step to make depression treatment more acceptable and effective might be to test treatment strategies that incorporate spirituality and religion. Several previous studies have shown that patients want physicians to consider their spiritual needs and discuss them[46–48], and several screening tools have been developed for use in clinical care[49–51]. Future studies might elucidate whether the incorporation of a spiritual perspective into depression care will encourage discussion and detection of depression as well as continued engagement in treatment. The patient's world extends beyond the offices of primary care and mental health care providers. A public health perspective that extends to places of worship may lead to new ways of addressing the role of faith in depression in ways that support and link communities with existing services.

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