Broadening Research and Practice Approaches to Assessing Religiosity in African American Older Adults

Historically, religiosity, medicine, and health care have been interconnected (Koenig, 2012). Religiosity reflects religious beliefs and behaviors related to the participation in non-organized religious activities (e.g., private prayer), organized religious involvement (e.g., attending church), and having an intrinsic connection with a higher being (Koenig & Bussing, 2010; Murguia, 2011). Over time, religiosity (e.g., religious beliefs, practices, faith, relationships) has become somewhat disjointed from health care, often leading to conflicts in the understanding and receipt of medical care for individuals (Sevensky, 1983). Thus, religiosity is an important concept to explore as it can influence a person’s decisions and outlook on their options related to seeking out and receiving medical care (Pattison, 2013). Health care providers and researchers must consider the role of religiosity for those they serve to provide holistic care and improve health outcomes (Pattison, 2013; Sulmasy, 2009). This need for a more intentional survey of religiosity may be especially true for highly religious populations, such as African American older adults (Chatters et al., 2008). Although different racial and ethnic groups express religiosity in distinct ways, African American adults have been found to interpret religiosity and spirituality as similarly related concepts (Chaney, 2008), while also relying heavily on religious and spiritual beliefs, practices, and communities in their day-to-day lives and decisions (McAdoo, 2007; Taylor et al., 2004).

The influence of religion in African American communities can be traced back to slavery, a period when religious practices provided brief respite from the harsh realities of servitude (McAdoo, 2007). Although all ethnic groups report a decreased reliance on religious practices in comparison to prior decades (Waters & Bortree, 2012), approximately three fourths of African American individuals continue to report religiosity is very important to them (Pew Forum, 2015). Research also shows that the African American community often uses religious practices for support (Chatters et al., 2008; Cone, 2002; Hamilton, 2013). Various dimensions of religiosity can serve as a resource for stressful situations, and research shows that African American adults may use religious practices, such as prayer and reading the Bible, to cope with diseases that disproportionately affect people of color (Chatters et al., 2008; Cooper et al., 2014; Koenig et al., 2012). In addition, sermons, scriptures, and the lyrics of religious songs serve as a form of communication of God’s words for guidance, instruction, comfort during illness, and promise for an afterlife free of pain and suffering (Cone, 2002; Hamilton, 2013). These religious practices and activities have multiple meanings for individuals and can promote a spiritual connectedness to God and to each other, thereby enhancing one’s mental and physical health (Epps et al., 2016; Rabinowitz et al., 2009).

Studies on African American communities often capture religious influence with simplistic, global indices of religiosity, including church attendance and denominational affiliation (Taylor et al., 2004). Although such measures may help establish positive and negative outcomes associated with religious involvement, they do little for understanding the nuances of religiosity and spirituality (Pargament & Raiya, 2007). The Duke University Religion Index (DUREL) is an example of a valid and reliable global religiosity measurement. However, the correlation amongst the dimensions of religiosity (i.e., organizational, non-organizational, and intrinsic) are cancelled out when examining for correlation between the subscales on the DUREL (Koenig & Bussing, 2010). In addition, Koenig et al. (2015) explain many existing measures of religiosity are subject to ceiling effects that underestimate the true influence of religiosity in the lives of highly religious groups, which include African American communities.
The field of religiosity, spirituality, and health is still growing and advancements are needed to fully appreciate the impact of religiosity on health (Zimmer et al., 2016). Furthermore, given the salience of religiosity in African American communities, there exists a need to broaden research and practice-based approaches to understanding how religiosity impacts African American families and their health outcomes. It is necessary to develop effective ways to capture religiosity for the African American community, by revisiting how it is being operationalized and measured with existing measures. Although the common practice of assessing religiosity through surveys or other self-reported measures can be a limitation, asking probing, open-ended questions could help researchers and practitioners “discover the meanings and motivations that drive those persons whose outcomes are most significantly impacted by religion” (Marks & Dollahite, 2011, p. 182). Further, because African American older adults may limit their engagement in organized religious activities due to health issues (Koenig et al., 2012), simply capturing data on measures such as church attendance would do little for understanding how and why religion influences their decisions and behaviors. As such, developing qualitative approaches to assessing religiosity over the life course may be needed to fill this gap.

Intraracial differences also exist in religiosity. Examples include African American older adults self-identifying as more religious than younger adults and African American women reporting higher rates of prayer than their male counterparts (Greer & Abel, 2017; Skipper et al., 2018). Therefore, a greater depth of knowledge in assessing how African American older adults express their faith and religion is needed. By understanding the role of religion for African American older adults via qualitative approaches, health care professionals could better describe the health care wishes and needs of African American families more appropriately. These efforts can assist future researchers and health care professionals in developing culturally appropriate, evidence-based interventions that take into consideration the role of religiosity in medical decisions and health-related behaviors. In addition, attempts to engage African American older adults in honest, transparent conversations about religious influences can help researchers and practitioners disentangle religiosity from other influential factors, such as culture, socioeconomic status, education, personality, family, and philosophical views.

Health care professionals should explore the religious histories of those they care for and be thoughtful to religious practices that are important to these individuals. Such consideration might allow for certain religious practices and activities, particularly those found to be positively related to recovery (Koenig et al., 2012), to be incorporated into treatment and discharge plans. Although the multidimensional nature of religiosity may make the construct challenging to empirically study, the impact of religious beliefs and practices has been shown to influence society’s belief systems, regardless of the types of religion (or faith denominations) involved (Arli & Pekerti, 2017). As one of the most religious ethnic groups, when religion matters for African American families, it often matters significantly. Capturing and understanding the religiosity of African American older adults assists practitioners and researchers in providing culturally sensitive, person-centered care that builds on the strengths of those they serve.

REFERENCES


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The authors have disclosed no potential conflicts of interest, financial or otherwise.

doi:10.3928/19404921-20200617-01