
A Study of Religion, Ministry, and Meaning in Caregiving among Health Professionals in an Institutional Setting in New York City*

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The clinical staff of a large metropolitan nursing home was surveyed about their religious practices, the degree to which they saw their work as a ministry, and the meaning they obtain from being caregivers. Age, race, gender, education, and various other measures were also taken. As hypothesized, religiosity made a significant positive contribution to participants' belief their work was a ministry to those in need. Multiple regression revealed that African American and older staff scored significantly higher on both dependent variables, whereas Caucasians were significantly less likely to view their work as ministry. Staff who worked with long-term patients derived significantly more meaning from their work, but they were no more likely to see it as ministry. Religiosity appears to enhance the meaning caregivers get from their work, and this may be beneficial to patients. Further research may identify other factors that enhance the meaning caregivers get from their work.

Many people rely heavily upon their religious faith to deal with stressful situations¹ and this is especially true for family caregivers as they deal with the burden of providing care to loved ones. For example, Guberman and his colleagues found that religious belief is directly related to the personal motivation to provide care for frail elderly and mentally ill relatives.² Religious involvement can lower the risk of depression and caregiving strain,³ which are common and troubling problems

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¹Kenneth I. Pargament, *The Psychology of Religion and Coping* (New York, NY: Guilford Press, 1997).

²Nancy Guberman, Pierre Maheu, & Chantal Maille, "Women as Family Caregivers. Why Do They Care," *The Gerontologist*, 1992, Vol. 32, pp. 607-617.

³Sandra J. Picot, Sara M. Debanne, Kevan H. Namazi, & May L. Wykle, "Religiosity and Perceived Rewards of Black and White Caregivers," *The Gerontologist*, 1997, Vol. 37, No. 1, pp. 89-101.

among family caregivers.^{4,5,6} The more critical the situation, the more frequently caregivers report reliance on religion.⁷

Several studies indicate that caregivers receive positive feelings and a sense of purpose and meaning from taking care of a family member,^{8,9,10} and it has been suggested that religious faith enhances this sense of meaning.¹¹ In light of this research, we were interested in learning the extent to which religiosity plays a role in the meaning that professional caregivers obtain from their work in institutional settings.

A study by Davidson and Caddell¹² provides fascinating findings on the relationship between religiosity and the meaning religious people accord to their work. The study, which surveyed over 3,400 members from more than thirty Protestant and Catholic congregations, was specifically designed to test the hypothesis that the more religious an individual was, the more they would see their work as a calling or ministry, as opposed to seeing it as a career or just a job. In all, 15% of those surveyed agreed with the statement: "My work has special meaning because I have been called to do what I'm doing regardless of how much time it takes or how little money I earn; I was put on earth to do what I am doing."

After controlling for income, education, social class, and several variables pertaining to employment, Davidson and Caddell¹³ found that religiosity and belief in social justice were the most prominent predictors of who saw their work as a calling. Involvement in religious activities and the importance of religion made significant, independent contributions to the model's predictive ability. Given these findings, we hypothesized that professional caregivers who were more religious would be more likely to: (1) see their work as a calling or ministry, and (2) find greater meaning in their work.

Methods

Study Site

The study was conducted at the Florence Nightingale Health Center and The Rehab Institute of New York (FNHC), a 561-bed nursing home facility in New York City. Over 60% of the patients suffer from Alzheimer's disease or some other form of dementia and reside on both long-term and sub-acute units.

⁴Jason Dura, Karl Stukenberg, & Janice Kiecolt-Glaser, "Chronic Stress and Depressive Disorders in Older Adults," *Journal of Abnormal Psychology*, 1990, Vol. 99, pp. 284-290.

⁵Donna L. Hoyert and Marsha M. Seltzer, "Factors Related to the Well-Being and Life Activities of Family Caregivers," *Family Relations*, 1992, Vol. 41, pp. 74-81.

⁶Richard R. Schulz and Scott R. Beach, "Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study," *Journal of the American Medical Association*, 1999, Vol. 282, pp. 2215-2219.

⁷Judy Kaye and Karen Meier Robinson, "Spirituality Among Caregivers," *Image: Journal of Nursing Scholarship*, 1994, Vol. 26, pp. 218-221.

⁸Anne E. Noonan and Sharon L. Tennstedt, "Meaning in Caregiving and Its Contribution to Caregiver's Well-being," *The Gerontologist*, 1997, Vol. 37, No. 6, pp. 785-794.

⁹Sandra J. Picot, "Rewards, Costs and Coping on Black American Caregivers," *Nursing Research*, 1995, Vol. 44, pp. 147-152.

¹⁰Picot, *et al.*, 1997, *op. cit.*

¹¹Harold G. Koenig and Andrew J. Weaver, *Counseling Troubled Older Adults: A Handbook for Pastors and Religious Caregivers* (Nashville, TN: Abingdon Press, 1997).

¹²James C. Davidson and David P. Caddell, "Religion and the Meaning of Work," *Journal for the Scientific Study of Religion*, 1994, Vol. 33, No. 2, pp. 135-147.

¹³*Ibid.*

Procedure

A questionnaire was distributed to the 354 full-time clinical staff and 76 part-time agency personnel (N = 430 staff), attached to their paychecks, along with a cover letter and a postage-paid, self-addressed return envelope. The letter explained the purpose of the study and contained instructions for completing the questionnaire and returning it to the Research Department of The HealthCare Chaplaincy. A sealed collection-box was also located near the chaplain's office for those who chose to deposit their surveys there. The anonymity of all surveys was assured in the cover letter.

The questionnaire was divided into three parts. The first part collected demographic and work-related data from staff, including age, gender, race/ethnicity, religion, education, job classification, number of years of work in the health-care field, number of years of work at FNHC, and whether they cared for long-term or short-term patients. The second part contained six items to measure various aspects of religiosity. The third part contained items to measure the two primary dependent variables: (1) meaning obtained from caregiving, and (2) seeing work as a calling or ministry.

Measures

Except for age and education, the data collected in the first section of the questionnaire was on a nominal scale. Level of education was measured on a 6-point scale, ranging from elementary school (scored as 1) to doctoral degree (scored as 6). Work unit was converted to numerical scale to measure the extent to which staff worked with long-term patients, with 0 = no-long-term patients, 1 = long-term and short-term patients, and 2 = only long-term patients.

Religiosity was operationally defined by six questions adapted from previously published research.^{14,15,16} The first four questions were designed to measure organizational and non-organizational religious practices, in accordance with Levin and Chatters¹⁷ schema. These were: (1) How often do you attend religious services? (2) How often do you pray? (3) How often do you read religious materials? (4) How often do you watch or listen to religious programs on the TV or radio? Each of the four questions had eight response categories, ranging from 1 (never) to 8 (every day).

The last two questions, which were intended to measure subjective religiosity, were: (5) How religious are you? (6) How important was religion in your home when you were growing up? Each question had four response categories, ranging from 1 (not at all religious/important) to 4 (very religious/important).

The third section of the survey instrument contained the *Meaning in Caregiving Scale*,¹⁸ and an item about seeing work as a calling: "I view my

¹⁴Harold G. Koenig, Kenneth I. Pargament, & Julie Nielson, "Religious Coping and Health," *Journal of Nervous and Mental Disease*, 1998, Vol.186, No. 9, pp. 513.

¹⁵Jeffrey J. Levin and Linda M. Chatters, "Religion, Health, and Psychological Well-being in Older Adults," *Journal of Aging and Health*, 1998 Vol. 10, No. 4, pp. 504-531.

¹⁶Jeffrey J. Levin, Linda M. Chatters, & Robert J. Taylor, "Religious Effects on Health Status and Life Satisfaction among Black Americans," *Journal of Gerontology: Social Sciences*, 1995, Vol. 50B, No 3, pp. S154-S163.

¹⁷Levin and Chatters, 1998, *op. cit.*

¹⁸Anne E. Noonan and Sharon L. Tennstedt, "Meaning in Caregiving and its Contribution to Caregiver Well-being," *The Gerontologist*, 1997, Vol. 37, No. 6, pp. 785-794.

work as a ministry to those in need." The wording of the Noonan and Tennstedt¹⁹ items were modified somewhat to make them applicable to caregiving in this context. The 12 items are provided in the appendix. The response categories for all items were: 1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree.

Data Analysis

Pearson's product-moment correlation coefficient was used to determine the strength of association among the religiosity measures, and age, education, and the two dependent variables (*i.e.*, meaning and ministry). Cronbach's alpha's was calculated to determine the internal reliability of the religiosity and meaning measures.

Gender differences were analyzed using the *t*-test and ethnic differences were analyzed by analysis of variance (ANOVA). Hierarchical multiple-regression was used to determine the degree to which religiosity and other variables predicted the meaning staff obtained from their work and the extent to which they saw their work as a ministry. Three sets of variables were entered into the model in order: (1) demographic, (2) work-related, and (3) religiosity. The first set of variables consisted of age, gender (dummy coded as 1 or 0), education, and ethnicity. Two ethnicity variables were created: African-American (coded as 1 or 0), and Caucasian (coded as 1 or 0). The second set of variables included years in the healthcare field, years at FNHC, and long-term (equals 1) or short-term care (equals 0). A composite religiosity score was entered into the model as the third set, which was created by summing the responses to the six religiosity questions.

Results

The return rate for full-time staff was 43.8% (155/354), with more than three-quarters of the professional staff of several departments completing the survey, including social workers (8/10 = 80.0%), physicians/psychologists (10/13 = 77.0%), recreation staff (9/12 = 75.0%), and rehabilitation staff (23/26 = 88.5%). The registered nurses, licensed professional nurses, and certified nursing assistants who comprise over 80% ($n = 352$) of the full-time clinical staff had a return rate of 42.3% (149/352). Of the 76 questionnaires distributed to part-time agency personnel, 25 were completed for a return rate of 32.9%. In all, then, the total sample size was 210 clinical staff.

Just over 84% of the sample was female, which is roughly proportionate to the actual make-up of the clinical staff. The respondents ranged from 19 to 67 years of age, with a median age of 40 years and a mean age of 40.9 years. On average, respondents had worked at the facility for 6.3 years (median = 3.0) and had worked in the health-care field for 11.6 years (median = 8.0).

African-Americans comprised the largest percentage (48.6%) of the sample, followed by Caucasians (21.4%), Asians (12.4%), and Hispanics (8.1%). The remaining 9.5% of staff identified themselves as Native Americans, Pacific Islanders, or other. Most of the sample was Protestant (41.9%), Catholic (31.4%), or Jewish (7.1%), in addition to a small number of staff who were Buddhist (1.4%), Hindu (1.0%), and Muslim (1.0%). The remainder had other religious denominations (5.2%) or had no religious affiliation (11.0%).

¹⁹*Ibid.*

Table 1 shows that our sample was quite religious. On average, staff members attended religious services almost every month, they prayed between several times a week to daily, and they read religious materials and watched or listened to religious programs several times a month. In general, staff members viewed themselves as being fairly religious. Factor analysis indicated that the six religiosity measures formed a single common factor, so, their responses were summed to create a single composite measure of religiosity, which had a Cronbach alpha of .81.

TABLE 1
Mean Responses of Participants to the Questions about Religion

Measure	Mean	SD
How often do you:		
Attend religious services?	3.2	1.6
Pray?	6.3	2.3
Read religious materials?	4.5	2.5
Watch/listen to religious programs?	3.6	2.4
How religious are you?	3.0	1.0
How important was religion in your home when you were growing up?	3.6	0.9

Table 2 presents the survey participants' mean religiosity, meaning, and ministry scores, broken down by key demographic variables. Age was divided into four groups, and education was collapsed into three groups solely for presentation purposes. The Cronbach alpha for the Meaning in Caring Scale was .87.

TABLE 2
Mean Religiosity, Meaning and Ministry by Four Major Demographic Variables

Variables	Religiosity ¹		Meaning ²		Ministry ³	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Gender						
Men	19.9 ^{**}	7.9	37.8	5.2	2.9	0.8
Women	24.8	8.1	39.4	5.5	3.2	0.8
Education						
High School or less	26.6 [†]	7.3	40.5 [†]	5.7	3.3 [†]	0.8
Associate or Bachelor's	24.4	7.8	38.1	5.1	3.3	0.7
Master's or Doctorate	17.8	7.8	37.9	5.0	2.7	0.9
Age in Years						
Less than 30	20.8 [†]	7.6	38.7 [†]	5.3	3.1 [†]	0.8
31-40	22.4	8.2	38.9	5.2	3.1	0.8
41-50	27.4	7.4	38.4	4.9	3.2	0.8
More than 50	25.4	8.2	40.9	6.6	3.4	0.8

Ethnicity ^a						
African-American	27.4 [*]	6.2	40.3 ^{**}	5.6	3.4	0.7
Asian	22.3	9.4	37.3	4.4	3.1	0.7
Hispanic	23.0	7.6	39.2	4.5	3.2	0.8
Caucasian	16.5	7.2	36.3	4.7	2.7	0.9
Other	26.6	7.0	38.5	6.4	3.1	0.8

^aSix item composite religiosity score: maximum = 40

^bMeaning in Caregiving Scale: maximum = 48

^c"I view my work as a ministry to those in need:" maximum = 4

* $p < .05$

** $p < .01$

† $p < .001$

Male and female staff were found to differ significantly in terms of their religiosity [$t(208) = 3.19, p < .01$] but not in terms of the meaning they obtained from their work as caregivers, or their belief that their work was a ministry. In all, 42.4% (142/430) of the staff agreed that they viewed their work as a ministry to those in need and another 38.6% (166/430) strongly agreed with this statement.

Statistically significant negative correlations were found between education and religiosity [$r(208) = -.40, p < .001$], meaning in caregiving [$r(208) = -.17, p < .05$], and viewing work as a ministry [$r(208) = -.26, p < .001$]. Age, on the other hand, was positively correlated with all three variables: religiosity [$r(208) = .31, p < .001$], meaning [$r = .17, p < .05$], and ministry [$r(208) = .19, p < .01$].

ANOVA found significant differences among ethnic groups with respect to religiosity [$F(4,205) = 19.74, p < .001$], meaning [$F(4,205) = 6.15, p < .01$], and ministry [$F(4,205) = 8.14, p < .001$]. African-Americans were significantly higher than all other groups and Caucasians were significantly lower than all other groups on all three measures.

A significant positive correlation was found between years worked at FNHC and the meaning and ministry measures, with $r(208) = .15, p < .05$ in both cases. There was a non-significant trend in the same direction for years worked in the healthcare field. There also was a tendency for staff who worked with long-term patients to derive more meaning from their work, but this effect was not statistically significant.

Table 3 shows the variables that were found to significantly predict the meaning staff obtained from caregiving and their opinion that their work was a ministry to those in need. As seen in the table, meaning was higher among African-American staff members, those who worked with long-term patients, and those who were more religious. Age, ethnicity and religiosity also made statistically significant contributions to staff members' belief that their work was a ministry. While African-Americans were significantly more likely to see their work as ministry, Caucasians were significantly less likely to do so. The type of patients that staff cared for did not affect their views about the ministerial nature of their work.

TABLE 3
Variables Contributing to Meaning and Ministry on a
Hierarchical Multiple Regression Models

Variables	Parameter Estimates	Percent of Variation Accounted for	<i>t</i>	<i>p</i> <
<i>Meaning in Caregiving</i>				
Age	+0.076	2.97%	2.12	.05
African-American	+2.002	3.57%	2.81	.05
Care for Long-Term Patients	+0.998	1.56%	2.35	.05
Religiosity	0.181	5.72%	3.69	.001
Total for <i>Meaning</i>		13.82%		
<i>Belief that Work is a Ministry</i>				
Age	+0.011	3.74%	2.13	.05
African-American	+0.255	7.60%	3.16	.01
Caucasian	-0.455	5.12%	2.27	.05
Religiosity	+0.031	7.04%	4.26	.001
Total for <i>Ministry</i>		23.5%		

Discussion

Given that the average meaning score of our sample was 39.1 out of a possible score of 48, the results clearly indicate that the clinical staff we surveyed obtained considerable meaning from their work as caregivers. This level of meaning is higher than that which Noonan and Tennstedt²⁰ found among caregivers, many of whom were relatives caring for elderly family members.

As hypothesized, religiosity was positively and significantly related to the meaning participants derived from their work as caregivers. However, since religiosity accounted for less than 6% of the variation in participants' scores, most of the meaning participants obtained from caregiving was largely unrelated to their religious beliefs and practices. The regression analysis indicated that some of the other factors that influenced the level of meaning for staff were their ethnic background, their age, and the type of patients they cared for (long-term or short-term). The finding that staff who worked with long-term patients found greater meaning in their work suggests that long-term relationships between patients and staff enhance the meaningfulness of the work.

The sense of meaning was higher among African-American and older staff, as was religiosity. The higher level of religiosity among the African-Americans in our sample was consistent with other research showing that

²⁰ *Ibid.*

African-Americans are more religious than European-Americans.^{21,22,23} The relationship between age and religion has been well established in national polls Gallup & Lindsay,²⁴ especially among African-Americans.^{25,26,27}

Our second hypothesis was also confirmed, in that religiosity was positively related to staff members' views that their work was a ministry to those in need. Once again, a positive effect of age was found, as well as ethnicity effects. African-Americans were significantly more likely to view their work as a ministry to those in need and Caucasians were significantly less likely to do so. Despite such differences, 42.4% of the staff agreed that they saw their work as a ministry to those in need and another 38.6% strongly agreed with this statement. Among Davidson and Caddell's²⁸ sample of over 3,400 church parishioners, just 15% saw their work as a calling. Some of the factors that they examined help to account for the high percentage we found in our sample. First, there is a relatively high level of religiosity in our sample. Second, all the people in our sample work directly with people, and Davidson and Caddell²⁹ found that people who worked with people rather than with things, as they described it, were twice as likely to see their work as a calling. A third factor that influenced "calling" in that study and would tend to increase it here, is having permanent employment.

Whereas, Davidson and Caddell³⁰ found that more educated people were more likely to see their work as a calling, we found the opposite effect. The religiosity of our sample also was negatively correlated to education. The inverse relationship between education and religiosity appears to be less well established.³¹ That the women in the sample were significantly more religious than men is a common finding, as well.^{32,33,34}

Although the questions asked were intended to tap three different dimensions of religiosity (organizational, non-organizational, subjective) examined by Levin and Chatters,³⁵ all of the items were positively correlated with one another and factor analysis showed that they formed a single

²¹Jeffery S. Levin and Robert J. Taylor, "Age Differences in Patterns and Correlates of the Frequency of Prayer," *The Gerontologist*, 1997, Vol. 37, No. 1, pp. 74-88.

²²Jeffery S. Levin, Robert J. Taylor, & Linda M. Chatters, "Race and Gender Differences in Religiosity among Older Adults: Findings from Four National Surveys," *Journal of Gerontology*, 1994, Vol. 49, No. 3, pp. S137-S145.

²³Robert J. Taylor, Linda M. Chatters, Rukmalie Jayakody, & Jeffrey S. Levin, "Black and White Differences in Religious Participation: A Multi-sample Comparison," *Journal for the Scientific Study of Religion*, 1996, Vol. 35, No 4, pp. 403-410.

²⁴George H. Gallup and D. Michael Lindsay, *Surveying the Religious Landscape: Trends in U.S. Beliefs* (Harrisburg, PA: Morehouse Publishing, 1999).

²⁵Jeffery S. Levin, Linda M. Chatters, and Robert J. Taylor, "Religious Effects on Health Status and Life Satisfaction Among Black Americans," *Journal of Gerontology: Social Sciences*, 1995, Vol. 50B, No. 3, pp. S154-S163.

²⁶Levin and Taylor, 1997, *op. cit.*

²⁷Robert J. Taylor, Jacqueline Mattis, & Linda M. Chatters, "Subjective Religiosity among African Americans: A Synthesis of Findings from Five National Samples," *Journal of Black Psychology*, 1999, Vol. 25, No. 4, pp. 524-543.

²⁸Davidson and Caddell, 1994, *op. cit.*

²⁹*Ibid.*

³⁰*Ibid.*

³¹Robert J. Taylor, "Religious Participation Among Elderly Blacks," *Gerontologist*, 1986, Vol. 26, No. 6, pp. 630-636.

³²Levin, *et al.*, 1995, *op. cit.*

³³Jeffery S. Levin and Robert J. Taylor, "Gender and Age Differences in Religiosity among Black Americans," *The Gerontologist*, 1993, Vol. 33, No. 1, pp.16-23.

³⁴Levin and Taylor, 1997, *op. cit.*

³⁵Levin and Chatters, 1998, *op. cit.*

common factor. This may have occurred, in part, because the sample was fairly religious.

The present findings do not allow us to conclude that religiosity directly enhances the meaning people find in caregiving, but there is a clear association between the two. Rabins and colleagues^{36,37} have found that greater religiosity leads to more rapid adaptation to the caregiver role, perhaps by increasing meaning and providing a sense of ministry. Prospective studies would be needed to demonstrate that an increase in staff religiosity actually leads to such things as greater purpose or meaning in their work, increased satisfaction, less turnover, or better patient care. However, until these types of studies are done, being aware that greater religiosity and the belief that work is a ministry are both connected to increased meaning and purpose will be encouraging for those staff members who are religious. Finally, should future studies find that religiosity actually increases a sense of meaning and purpose among health professionals working in these settings, nursing homes and chronic care facilities may decide to allocate time to nourish the spirituality of the staff and/or to help them see their work as ministry. This may result in staff members being more satisfied and happy at their jobs, which surely would improve the quality of the care that they deliver.

Why are these findings on the connection between religiosity and the meaning that professional caregivers ascribe to their work important? First, one of the most challenging and difficult places for health professionals to work is in a chronic care, nursing home setting.³⁸ The pay is modest and the physical and emotional demands are high.³⁹ Patients typically have progressive, disabling health problems that lead to dependency and death. In these settings patients are often depressed and many times feel abandoned by their loved ones.⁴⁰ As a result, patients may be dissatisfied and irritable, frequently complaining and having difficulty showing appreciation for care received.⁴¹ Because of inadequacies of care in some nursing homes in the 1970's, federal and state governments have mandated regulations that are ever increasing, along with volumes of documentation of dubious worth. Stress from lawsuits by family members or pressure from regulating agencies is ongoing. Thus, health professionals in these settings are required to give a lot of themselves, often with little recognition and modest pay.⁴² Finding meaning in one's work may help to prevent burnout, which is a signif-

³⁵Levin and Chatters, 1998, *op. cit.*

³⁶Peter V. Rabins, Melinda D. Fitting, James Eastham, & John Fetting, "The Emotional Impact of Caring for the Chronically Ill," *Psychosomatics*, 1990a, Vol. 31, pp. 331-336.

³⁷Peter V. Rabins, Melinda D. Fitting, James Esatham, & James Zabora, "Emotional Adaptation over Time in Care-givers for Chronically Ill Elderly People," *Age and Aging*, 1990b, Vol. 19, pp. 185-190.

³⁸Robert J. Newcomer, Patrick J. Fox, & Charlene A. Harrington, "Health and Long-Term Care for People with Alzheimer's Disease and Related Dementias: Policy Research Issues," *Aging and Mental Health*, 2001, Vol. 5, Suppl. 1, pp.S124-S137.

³⁹Paula R. Mobily, Merdean L. Maas, Kathleen C. Buckwalter, & Lisa S. Kelley, "Staff Stress on an Alzheimer's Unit," *Journal of Psychosocial Nursing and Mental Health Services*, 1992, Vol. 30, No. 9, pp. 25-31.

⁴⁰Newcomer, *et al.*, 2001, *op. cit.*

⁴¹A. Srikumar Menon, Ann L. Gruber-Baldini, Richard Hebel, Bruce Kaup, David Loreck, Sheryl Itkin Zimmerman, Lynda Burton, Pearl German, & Jay Magaziner, "Relationship Between Aggressive Behaviors and Depression Among Nursing Home Residents with Dementia," *International Journal of Geriatric Psychiatry*, 2001, Vol. 16, No. 2, pp. 139-146.

⁴²Newcomer, *et al.*, 2001, *op. cit.*

icant problem⁴³, that may contribute to the high turnover rate of staff in nursing homes.⁴⁴ The level of meaning we found among the professional caregivers in our sample may help to account for the relatively high average length of employment at FNHC, which was 6.3 years.

Second, if caregivers are emotionally stressed, it is difficult for them to deliver high-quality care. Depressed, anxious, or stressed caregivers have difficulty meeting the emotional needs of those who require their care.⁴⁵ They simply do not have the psychological energy necessary for compassion and caring. With less time to do their work and fewer psychological reserves, how can caregivers provide good care to patients? Again, this can result in burnout and low morale, with a high turnover of staff and less continuity of care. High turnover means that staff never really gets to know patients as persons, therefore having greater difficulty providing personalized care. New staff are under the stress of "learning the ropes," and this can distract them from meeting the emotional needs of patients and their families.

Having meaning and purpose in one's work helps to counter the negative aspects of caregiving because they provide a reason for giving good care.⁴⁶ Meaning and purpose can provide psychological rewards that help offset the increased physical and emotional stress that caring for elderly, chronically ill and dying patients causes. This study offers evidence that being religious and seeing one's work as a ministry is a contributing factor in imbuing the difficult work of caregiving with meaning. It appears that religiosity has the potential to offset the stress experienced by health professionals in these settings.

Appendix

1. I feel that it is important to me that I have been involved in caregiving.
2. Since becoming a caregiver of patients, I feel differently about what things in life are worth extra effort.
3. I have learned a lot about myself as a result of caring for patients.
4. My caregiving experience has changed my idea of what is important in a relationship.
5. My caregiving experience has led me to think of myself as more skillful and able.
6. Since becoming a caregiver, I don't worry as much about the little things in my life.
7. After going through some of the stress of caregiving, I feel that I can handle just about anything.
8. I take satisfaction in doing things the way my patients like.
9. My religion or spiritual beliefs have helped me handle my caregiving of patients.
10. I feel I have become a stronger person since becoming a caregiver of patients.

⁴³Mobily, *et al.*, 1992 *op. cit.*

⁴⁴Larry D. Grieshaber, Patricia Parker, & Judy Deering, "Job Satisfaction of Nursing Assistants in Long-term Care," *Health Care Supervisor*, 1995, Vol. 13, No. 4, pp. 18-28

⁴⁵Richard Schulz, Alison T. O'Brien, Jamila Bookwala, & Kathy Fleissner, "Psychiatric and Physical Morbidity Effects of Dementia Caregiving: Prevalence, Correlates, and Causes," *The Gerontologist*, 1995, Vol. 35, No. 6, pp. 771-791.

⁴⁶Rita S. Monahan and Susanne McCarthy, "Nursing Home Employment: The Nurse's Aides Perspective," *Journal of Gerontological Nursing*, 1992, Vol. 18, No.2, pp. 13-16.

11. I feel less afraid now of other things that might come along in the future.
12. I am better able to accept my role as a caregiver because I feel that my patients need me. ✎

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