Acceptance of family caregiving in the older adults: A validation of theory through a descriptive correlational study

Alfredo Z. Feliciano [1, 2], Evelyn E. Feliciano [1, 2, *], Joan Russel D. Feliciano [1], Sharifa Al-Asiry [3], Ma. Corazon M. Tanhueco [1], Debbie Q. Ramirez [1], Anna Lyn M. Paano [1], Jennie C. Junio [1], Doroteo S. Dizon [1]

[1]College of Nursing, Angeles University Foundation, Angeles, Philippines
[2]Graduate Studies, Angeles University Foundation, Angeles, Philippines
[3]Department of Nursing, College of Applied Medical Sciences, Majmaah University, Al Majmaah, Saudi Arabia

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ABSTRACT

This descriptive correlational study on theory validation aimed at validating one of the propositions of the theory that states, "Family caregiving trajectory is influenced by factors such as resources" with a purposive sample of 304 family caregivers in Pampanga. To facilitate the validation of the proposition, the study aimed to determine the correlation between the older adults and family caregivers' characteristics with family caregiver burden using an instrument composed of the socio-demographic profile, Barthel Index (BI) of independence, caregiving self-efficacy scale, and Zarit burden interview scale. Caregiver burden was predicted by the identified older adults' and caregivers' characteristics by 28.1% with respect to the R square value of 0.281. Of all identified characteristics of the older adults and family caregivers, co-morbidity presence (p=.027; B=-3.641), lack of financial support (p=.009; B=5.539), decreasing level of independence (p=.000; B=-0.134) and low efficacy in the control of upsetting thoughts (p=.000; B=-2.359) were predictive of caregiver burden. The negative connotation related to aging and "everlasting caregiving" showed a relative interest in understanding caregiver burden experience. The resources, while infused on older adults' and family caregivers' characteristics showed a good prediction of older adults' independence level, financial support and presence of co-morbidities, and family caregivers' self-efficacy towards caregiver burden. Therefore, resources come from various forms, and they play an integral part in impacting a successful family caregiving trajectory.

1. Introduction

The burden of adult care translating into a long-term process is a potential consequence of a rapidly aging population. As a global health concern, limited family and professional caregivers are faced with an obligation to look after their older adults which emanates from widespread cultural expectations and strong intergenerational family solidarity (Harvath et al., 2020; Paguirigan, 2019; Sakakibara et al., 2015). Around 85 to 95% of all older adults receive care from their family members on a global scale (Gaugler et al., 2018), and the family caregivers' predicament is thought to be related to their need to balance personal and social roles. Assumption of caregiving roles in the care of older adults can be as sudden or carefully planned depending on various factors such as family dynamics, and required care timing, duration, and transitions.

Caregiving trajectory is the term that involves family caregivers' pathway to care processes inclusive of sequential stages of role awareness, the emergence of responsibilities, increase in care demands, and end of life (Schulz and Eden, 2016). Requisites to meeting each stage of caregiving is a certain degree of acceptance of role assumption (Feliciano et al., 2022a). The assignment of primary caregiver is based on factors that are reflective of existing relationships, gender, societal norms, geographical proximity, and caregiving capability. As a process, caregiving requires resources because the increasing dependence and functional decline can overwhelm the caregivers' capacity to successfully meet complex health demands. Inadequate preparation relating to problem-solving and

communication skills, poor role acceptance, limited resources, and foreseeable conflicts with familial, social, and employment responsibilities can adversely lead to poor quality care for older adults and caregiver burden of the family member.

For a successful caring process to ensue, the acceptance theory of family caregiving goes beyond mere acceptance of the role in the face of existing familial commitment and expectations endured through generations (Gaugler et al., 2018). As one of the propositions of the theory, resources influence family caregiving trajectory which explains the occurrence of caregiver burden in the context of inadequate preparedness, limited resources, and reduced self-efficacy. Burnout related to caregiving has been explored in studies that ultimately point to the imperative role of adaptation. The interaction of the person in a changing environment influences health and caring dimensions and for the person to balance despite external pressures of the environment, acceptance of the change is pivotal.

Imperative to this understanding, family members' planned behavior of caring is based upon integration of acceptance with concretized measures to ensure accessibility of needed resources in the caregiving process (Feliciano et al., 2022a). It is in this regard that the acceptance theory of family caregiving's proposition, family caregiving trajectory is influenced by factors such as resources, is validated through a quantitative descriptive correlational study.

2. Methods

2.1. Study design

A quantitative correlational design was employed to validate one of the propositions of the accepted theory of family caregiving that states, that family caregiving trajectory is influenced by factors such as resources. Consistent with the objective, the study aimed at understanding the factors that predict caregiver burden, a serious consequence of family caregiving trajectory. As these resources influence through prediction of the family caregiving process, a dependent variable in the form of caregiver burden was included to highlight how the caregiving process is impinged by a significant lack of resources.

2.2. Sample and setting

Three hundred four (304) older adults and their family members were chosen via nonprobability purposive sampling in Pampanga. In the context of this study, family caregivers are those who live with their older adults at home and are mainly responsible for health decision-making matters. While there are several members in the family where the older adult lives in a particular household, the study included the following eligibility criteria: At least a year of living together with the older adult established by familial relationship (e.g., spouse,

children, grandchildren, niece, nephew, and equivalent in-laws) and the older adult whom the caregiver lives with is 60 years old and above regardless of the co-morbidity presence, cognitive function, and level of independence. Exclusion criteria included those who refuse to participate in the study, had less than a year of being with the older adult and were without an established familial relationship. Caregivers established through friendship or neighborhood were not allowed to participate in the study. Estimation of the required sample was obtained through G Power analysis. The respondents of the study were determined through purposive sampling.

2.3. Measurement/instrument

The study utilized a research instrument that was divided into (1) socio-demographic information of the older adults and family caregivers, and (2) standardized questionnaires to measure the older adults' level of independence (Barthel Index, BI), and the family caregivers' self-report of caregiver burden (Zarit Burden Interview Scale, ZBI), and self-efficacy in caregiving (Revised Caregiving Self-Efficacy).

The BI is a 10-item observer rating scale that is widely used internationally to rate older adults' level of independence in ten (10) daily tasks into two to four levels. The score for the Barthel index ranges from 0 to 100 points with a greater score indicating an increasing level of independence. It has an intraclass-correlation-coefficient for the older adults at 0.89. From an original pool of 29 items, the popular ZBI scale is a 22-item self-report Likert scale to measure the caregiver's burden. Response options range from 0 (never) to 4 (nearly always) to measure negative health outcomes among caregivers. Based on a summative score for all the 22 items (0 to 88 points), an appropriate interpretation of caregiver burden is suggested namely little to no burden (0-20 points), mild to moderate burden (21-40 points), moderate to severe burden (41 to 60 points), and severe burden (61 to 88 points).

The Revised Caregiving Self-Efficacy Scale is a 15-item Likert scale that measures three domains of caregiving self-efficacy:

1. Obtaining respite,
2. Responding to disruptive patient behaviors, and
3. Controlling upsetting thoughts.

Self-efficacy is a measure of the person's ability to organize and execute courses of action to manage a given situation. Two-week test-retest reliability shows an acceptable range making it a practical instrument for research and clinical purposes. Within the subscales and the items of this scale, a rating of 0 to 100 is required where higher scores indicate a higher level of perceived self-efficacy. Meanwhile, low scores on self-efficacy indicate that family members tend to focus on the negative aspects of caregiving inclusive personal deficiencies,

demands of the work, and the negative consequences of failed caring.

2.4. Data collection procedure

Upon approval, data were collected from October to November 2021 with which eligible respondents voluntarily participated in this study for at least 15-20 minutes. All authors, the principal, and co-principal investigators validated all returned questionnaires for completeness and admissibility for the data process. Authors, the principal, and co-principal investigators dispersed, retrieved, and validated all returned questionnaires for completeness and admissibility for data processing.

2.5. Data analysis

The quantitative data were tabulated into a matrix and were prepared for data analysis. The Statistical Package for Social Sciences version 25 was used. Multiple regression analysis was utilized to determine whether the independent variables predict the value of the dependent variable. The study also determines the presence or absence of a significant relationship between variables through Pearson r product moment correlation after the assumption of normality of data. Categorical variables, on the other hand, were computed through a Chi-Square of association.

3. Results

3.1. Respondents' socio-demographic profile

Table 1 illustrates older adults and their family caregivers' sociodemographic profiles. The 304 older adults were mostly between 73 and 74 years old ($\bar{x}$=73.11 years-old; SD=±8.377), female (202 or 66.4%), married (139 or 45.7%) or widow/ widower (139 or 45.7%) with an average of five (5) children (SD=±2.481) and completed secondary level of education (95 or 31.3%). Additionally, most were with co-morbidities (235 or 77.3%), had health insurance (210 or 69.1%), and regularly received financial support from family or through pension (269 or 88.5%). More so, it showed that the family caregivers were between 31 and 32 years old ($\bar{x}$=31.20; SD=±14.066), female (226 or 74.3%), and the older adults' grandchild (140 or 46.1%). They were most commonly without children (215 or 70.7%) as they were single (205 or 67.4%) and had a tertiary level of education (174 or 57.2%). Lastly, most were unemployed (226 or 74.3%) and belonged under class E (171 or 56.3%) of estimated monthly income.

3.2. Older adults' level of independence activities and their scores

Utilizing BI, the level of independence among older adults in activities and according to scores is

presented in Table 2. The older adults were described in terms of their level of independence across ten (10) daily activities inclusive of feeding, bathing, grooming, dressing, bowel, and bladder elimination, toilet use, bed and chair transfer, level-surface mobility, and stairs. Based on the results, most of the older adults exhibited independence in these activities of daily living.

Table 1: Respondents' socio-demographic profile (n=304)

Older adults	Family caregivers
Age $\bar{x}$=73.11 years old (SD=±8.377)	Age $\bar{x}$=31.20 years old (SD=±14.066)
Sex: f (%) Male: 102 (33.6%) Female: 202 (66.4%)	Sex: f (%) Male: 78 (25.7%) Female: 226 (74.3%)
Marital status: f (%) Single: 11 (3.6%) Married: 139 (45.7%) Widow/widower: 139 (45.7%) Separated: 15 (4.9%)	Civil status: f (%) Single: 205 (67.4%) Married: 82 (27.0) Widow/widower: 5 (1.6%) Separated: 12 (3.9%)
Educational attainment: f (%) Never been to school: 6 (2.0%) Elementary level: 76 (25.0%) Secondary level: 95 (31.3%) Tertiary level: 85 (28.0%) Post-graduate level: 42 (13.8%)	Educational attainment: f (%) Elementary level: 3 (1.0%) Secondary level: 88 (28.9%) Tertiary level: 174 (57.2%) Post-graduate level: 39 (12.8%)
Comorbidity/ies: f (%) With: 235 (77.3%) Without: 69 (22.7%)	Relationship to the older adult: f (%) Spouse: 7 (2.3%) Child (equivalent in-law): 133 (43.8%)
Number of children $\bar{x}$=5.0 (SD±2.481)	Grandchild: 140 (46.1%) Nephew/niece: 24 (7.9%)
Health insurance: f (%) With: 210 (69.1%) Without: 94 (30.9%)	With own children: f (%) Yes: 89 (29.3%) No: 215 (70.7%) Employment status: f (%) Employed: 78 (25.7%) Unemployed: 226 (74.3%) Estimated monthly income: f (%) Class A (100,000 and up): 11 (3.6%)
Recipient of pension/financial support from family Yes: 269 (88.5%) No: 35 (11.5%)	Class B (50,001 to 99,999): 21 (6.9%) Upper C (30,001 to 50,000): 39 (12.8%) Broad C (15,001 to 30,000): 41 (13.5%) Class D (8,001 to 15,000): 21 (6.9%) Class E (8,000 or less): 171 (56.3%)

In addition, Table 2 showed the older adults' independence in the activities according to scores and the mean scores in each activity demonstrated above-median scores indicating higher independence in the performance of these activities. From the highest possible score of 100 points, the obtained average was 85.54 points (SD=±24.100) which indicated greater independence.

3.3. Family caregivers' self-efficacy and burden

Table 3 presents the family caregivers' self-efficacy and their burden. In terms of family caregiving self-efficacy, family caregivers exhibited greater confidence in all three subscales namely, obtaining respite ($\bar{x}$=82.38; SD=±19.15), responding

($\bar{x}$=85.13; SD=±16.20, and controlling upsetting thoughts ($\bar{x}$=85.55; SD=±15.11). As to high self-efficacy for obtaining respite, it showed that the caregivers reported greater availability of help from family and other means of social support. High self-efficacy scores on responding to disruptive behaviors and controlling upsetting behaviors decrease the likelihood of anger and anxiety,

respectively. Likewise, there is a greater likelihood of the use of behavioral coping strategies such as relaxation, and replacement of distorted and negative thoughts through cognition. Such findings also reinforced the older adults' high independence level which did not call for a demanding caregiving situation.

Table 2: Older adults' level of independence activities and their scores (n=304)

Activities	Level of Independence	f	%	$\bar{x}$	SD (±)
Feeding	Unable	9	3.0		
	Needs help cutting, spreading butter, and the like, or requires a modified diet	46	15.1	8.95	2.378
	Independent	249	81.9		
Bathing	Dependent	53	17.4	4.13	1.900
	Independent (or in shower)	251	82.6		
Grooming	Needs help with personal care	54	17.8	4.11	1.914
	Independent face/hair/teeth/shaving	250	82.2		
Dressing	Dependent	27	8.9		
	Needs help but can do about half unaided	40	13.2	8.45	3.133
	Independent (including buttons, zippers, laces, and the like)	237	78.0		
Bowels	Incontinent (or needs enema to pass out stool)	19	6.3		
	Occasional accident	25	8.2	8.96	2.694
	Continent	260	85.5		
Bladder	Incontinent, or catheterized and unable to manage alone	11	3.6		
	Occasional accident	31	10.2	9.13	2.329
	Continent	262	86.2		
Toilet Use	Dependent	38	12.5		
	Needs some help, but can do something alone	238	78.3	8.45	3.159
	Independent (on and off, dressing, wiping)	28	9.2		
Transfers (Bed to Chair, and Back)	Unable, no sitting balance	9	3.0		
	Major help (one or two people, physical), can sit	23	7.6	13.03	3.774
	Minor help (verbal or physical)	47	15.5		
	Independent	225	74.0		
Mobility (on level surfaces)	Immobile or less than 50 yards (40 meters)	23	7.6		
	Wheelchair independent, including corners, more than 50 yards (40 meters)	6	2.0		
	Walks with the help of one person (verbal or physical), more than 50 yards (40 meters)	47	15.5	12.89	4.300
	Independent (but may use any aid, for example, stick), more than 50 yards (40 meters)	228	75.0		
Stairs	Unable	35	11.5		
	Needs help (verbal, physical, carrying aid)	86	28.3	7.43	3.470
	Independent	183	60.2		
	Highest possible score: 100 points			85.54	24.100

3.4. Relationship between older adults' characteristics and family caregiver burden

Presented in Table 4 is the correlation between the older adults' characteristics (socio-demographic profile and level of independence) and family caregiver characteristics (socio-demographic profile and self-efficacy), and caregiver burden. As shown, caregiver burden was likely if the older adults had co-morbidities (p=.000; coefficient=-0.207), were without financial support (p=.001; coefficient=0.195), with fewer children to share responsibilities with the appointed caregiver (p=.031; coefficient=-0.124), and with a lower level of independence (p=.000; coefficient=-0.233). Meanwhile, the older adults' age, sex, civil status, educational attainment, and the presence of health insurance did not provide a statistically significant relationship (p>.05).

The relationship of family caregivers' characteristics (socio-demographic profile and self-efficacy) to their caregiver burden can likewise be seen in Table 4. As revealed, a higher likelihood of

caregiver burden is statistically correlated if the family caregivers had children of their own (p=.034, coefficient=-0.121). Lower caregiver burden scores were correlated with higher self-efficacy among family caregivers in all subscales namely, obtaining respite (p=.000; coefficient=-0.199), responding to disruptive behaviors (p=.000; coefficient=-0.252), and controlling upsetting thoughts (p=.000; coefficient=-0.369). Caregivers' age, sex, educational attainment, relationship to the older adult, employment, and economic status did not display a significant relationship to caregiver burden (p value>.05).

3.5. Older adults and family caregiver characteristics and their prediction of caregiver burden

Table 5 shows the predictors of family caregiver burden from the older adults' and caregivers' characteristics. The regression model summary that showed an R (multiple correlation coefficient) of 0.530 demonstrated a good fit of the data. In a

summary, the dependent variable was predicted by the identified independent variables by 28.1% with respect to the R square value of 0.281. It is shown according to B values that family caregiver burden could be predicted if the older adults had co-morbidities (p=.027; B=-3.641), without financial support (p=.009; B=5.539) and displayed a lower level of independence to activities (p=.000; B=-0.134); and when family caregivers could not demonstrate adequate control of upsetting thoughts related to caregiving situation (p=.000; B=-2.359). The other characteristics were not shown to be predictive of caregiver burden.

Table 3: Family caregivers' self-efficacy and burden (n=304)

Category	Subscales and statements	x̄	SD (±)
Self-efficacy	**Subscales†**		
Obtaining respite: Confidence that you can…			
1. Ask someone to cover for your older adult for a day when you must visit a doctor.		86.7	19.20
2. Ask someone to cover for your older adult for a day when you have errands to run.		86.5	19.12
3. Ask someone to run errands for you.		79.5	22.44
4. Ask someone to cover for your older adult for a day when you feel that you need a break.		82.1	22.03
5. Ask someone to stay with your older adult when you need time for yourself.		77.0	26.87
	Average	82.38	19.15
Responding to disruptive behaviors: Confidence that you can…			
6. Answer the older adult's repetitive questions without raising your voice.		84.3	19.39
7. Calm yourself down in response to the older adult's repetitive questioning.		86.3	16.48
8. Respond without arguing back when the older adult complains about you.		85.3	17.27
9. Answer without raising your voice when the older adult asks 4 times in the first hour after lunch when lunch is.		84.8	16.92
10. Answer without raising your voice when the older adult interrupts you for the fourth time while making dinner.		84.9	17.52
	Average	85.13	16.20
Controlling upsetting thoughts: Confidence that you can…			
11. Control thinking about unpleasant aspects of older adult care.		86.2	16.12
12. Control thinking about how unfair it is that you must put up with this situation.		86.1	17.71
13. Control thinking about what a good life you had before the older adult's illness and how much you've lost.		86.6	18.24
14. Control thinking about what you are missing or giving up because of time spent in caregiving.		85.8	18.02
15. Control thinking about future problems that might come up with the older adult.		83.00	17.76
	Average	85.55	15.11
Burden	**Statements††**		
1	Asks for more help than he or she needs.	1.33	1.006
2	Not having enough time for yourself.	0.83	0.885
3	Feel stressed between caring for your older adult and trying to meet other responsibilities for your family or work.	1.18	1.041
4	Feel embarrassed over your older adult's behavior.	0.48	0.820
5	Feel angry when you are around your older adult.	0.42	0.680
6	Feel that your older adult currently affects your relationship with other family members or friends in a negative way.	0.49	0.792
7	Afraid about what the future holds for your older adult.	1.99	1.210
8	Feel your relative is dependent on you.	1.14	1.038
9	Feel strained when you are around your older adult.	0.72	0.847
10	Feel your health has suffered because of your involvement with your older adult.	0.36	0.707
11	Feel that you do not have as much as privacy as you would like, because of your older adult.	0.70	0.916
12	Feel that your social life has suffered because you are caring for your older adult.	0.50	0.792
13	Feel uncomfortable about having friends over because you are caring for your older adult.	0.39	0.732
14	Feel that your older adult seems to expect you to take care of him or her, as if you were the only one, he or she could depend on.	0.96	1.107
15	Feel that you do not have enough money to care for your older adult, in addition to the rest of your expenses.	0.83	1.068
16	Feel that you will be unable to take care of your older adult much longer.	0.64	0.922
17	Feel that you have lost control of your life since your older adult's illness.	0.38	0.721
18	Wish you could just leave the care of your older adult to someone else.	0.41	0.739
19	Feel uncertain about what to do about your older adult.	0.71	0.864
20	Feel you should be doing more for your older adult.	1.82	1.171
21	Feel you could do a better job than in caring for your older adult.	1.57	1.164
22	Feel burdened in caring for your older adult.	0.64	0.816
	Total (88 points)	18.47	12.389

†Scale of 0-100 points; ††0=never to 4=nearly always

4. Discussion

As older adults are faced with age-related physical and cognitive changes, increasing reliance on others to accomplish previously abled activities becomes imminent. The responsibility of the family members to watch over their older adults as they age is often based on societal expectation, suggesting family solidarity (Paguirigan, 2019) and has endured several generations implicating those older adults

receive care from their families as they age (Gaugler et al., 2018).

Table 4: Relationship between older adults' characteristics and family caregiver burden (n=304)

Characteristics	Caregiver burden	
	p-value	Correlation coeficient
Older adults		
A. Socio-demographic profile		
Age	.245	0.067
Sex[†]	.886	-0.008
Civil status[††]	.723	-0.020
Educational attainment[††]	.342	0.055
Co-morbidity presence[†]	.000*	-0.207
Number of children	.031	-0.124
Health insurance[†]	.799	0.015
Financial support[†]	.001*	0.195
B. Level of independence	.000*	-0.233
Family caregivers		
A. Socio-demographic profile		
Age	.195	0.075
Sex[†]	.561	0.033
Civil status[††]	.108	0.052
Educational Attainment[††]	.368	0.052
Relationship with older adult[††]	.082	0.100
Presence of children[†]	.034*	-0.121
Employment status[†]	.357	-0.053
Economic status[††]	.131	-0.087
B. Caregiving self-efficacy		
Obtaining respite	.000*	-0.199
Responding to disruptive behaviors	.000*	-0.252
Controlling upsetting thoughts	.000*	-0.369

*Correlation is significant when the p-value is < 0.05; [†]determined by point-biserial correlation (dichotomous independent variables); [††]determined by chi-square association (categorical variables)

Table 5: Characteristics of the older adults and family caregivers and their prediction of caregiver burden (n=304)

Regression Model Summary	R	R square	Variability of caregiver burden by the independent variables (%)	
	0.530	0.281	28.1%	
Statistical significance of the independent variables			p-value	B
Older adults' characteristics				
A. Socio-demographic profile				
Age			.772	-0.28
Sex			.581	0.794
Civil status			.864	-0.182
Educational attainment			.632	0.322
Co-morbidity presence			.027*	-3.641
Number of children			.155	-0.453
Health insurance			.445	1.119
Financial support			.009*	5.539
B. Level of Independence			.000*	-0.134
Family caregivers' characteristics				
A. Socio-demographic profile				
Age			.321	-0.083
Sex			.675	-0.652
Civil status			.071	2.585
Educational attainment			.871	0.164
Relationship with older adult			.087	2.180
Presence of children			.193	-3.015
Employment status			.985	0.035
Economic status			.845	-0.105
B. Caregiving self-efficacy				
Obtaining respite			.264	0.477
Responding			.218	-0.662
Controlling upsetting thoughts			.000*	-2.359

R=multiple correlation coefficient; R square=coefficient of determination; B=unstandardized coefficient; *regression is significant when p-value is < 0.05

The care for older adults stems from the various needs that they need to cope with and become resilient to the challenges of aging (Feliciano et al., 2022b). The rapidly aging population becomes an urgent health concern due to the crucial need for competent healthcare providers while maintaining the safe nursing practice for patient safety outcomes (Feliciano et al., 2021; 2020; 2019; CDC, 2019) and the risk for co-morbidities among older adults is implied along with the concept related with "everlasting caregiving" (Sakakibara et al., 2015).

The adoption of the word "aging" often connotes negative consequences of the process (Moyle et al., 2014) and this is associated with a decline in functions. Referred to as the study's dependent variable, family caregiver burden is a multi-dimensional concept that comprises social, emotional, and financial issues (Haji Assa and Umberger, 2022; Tamizi et al., 2019). The relative risk factors, as attributes possessed by assigned caregivers and older adults, were regarded as the

independent variables or predictors to cause caregiver burden.

In the light of the validation of one of the propositions of the accepted theory of family caregiving, the family caregiving trajectory requires resources. As revealed in one of the findings of the study, increasing physical dependence of older adults overwhelms family resources and the degree of dependence in terms of activities of daily living has been a consistent predictor of caregiver burden (Bekdemir and Ilhan, 2019). The scope of caregiving responsibilities is associated with the older adult's capacity to perform activities of daily living impacting the caregiving situation (Schulz and Eden, 2016). The ability of the older adult to perform activities with a greater level of independence can be seen as an important resource that can reduce the likelihood of caregiver difficulties.

With increasing physical dependency, the help of other family members becomes crucial. Consistent in literature, it is a family member's predicament to balance personal and social roles in the face of older adults' complex needs (Kumagai, 2017). As older adults enter the phase of life where increasing demands for care emerge, the trajectory of caregiving becomes more challenging than ever (Schulz and Eden, 2016) utilizing every available resource. Additional strain on the caregiver develops when the recipients' needs increase and result in a conflict of multiple responsibilities (Liu et al., 2020). The need to adjust to the changing environment and demands of the older adults across phases of the caregiving trajectory is well-emphasized to ensure that balance is achieved evidenced by the tolerable experience of caregiving adversities. Work-life conflict in family caregiving poses challenges in family domains and responsibilities (Kayaalp et al., 2021). Being able to obtain respite or help through family engagement and other forms of social support has been associated with the challenges of older adult care (Assa et al., 2021). As it was seen in the study's findings, the caregiver burden is less likely when there are more family members who can share responsibilities. Family engagement becomes an important resource to address the adversities of caregiving.

The process involved with caregiving is faced with challenges such as the lack of competent care providers (Harvath et al., 2020). Transitioning to meeting care demands can be overwhelming but redefining what is normal in the care of the older adult in the face of other roles and relationships can be achieved by coming to terms with the situation and connecting with others (Duggleby et al., 2017). While substantial evidence indicates that family members are at higher risk of adverse effects brought about by caregiving (Schulz and Eden, 2016), increasing their self-efficacy and competence is vital. Tackling negative thoughts in improving self-efficacy is demonstrated to reduce caregiver burden (Grano et al., 2017). Having the adequate confidence to control upsetting thoughts of caregiving is challenging but becomes fulfilling in every phase of trajectory caregiving. Greater self-efficacy is maintained to ensure that caregiving transitions even to the end-of-life phase of the trajectory are an opportunity to find meaning in this experience (Duggleby et al., 2017). Since the primary domain of the caregiving role is related to health and medical care, family caregivers need to establish effective communication and interprofessional education with healthcare professionals (Assa et al., 2021; Krutter et al., 2020). The uncertainty of older adult care is addressed by allowing the family members to process all related information (Haji Assa and Umberger, 2022). Understanding the positive and negative feelings of the caregiving process is a requisite for self-perception and self-efficacy (Liu et al., 2020). The study has shown that a higher level of self-efficacy allows for making confident decisions relating to older adult care without the fear of negative consequences. This implies that the need to strengthen the family caregivers' confidence to deal with the negative thoughts and demands of caregiving through health education, social support, and counseling is of clinical relevance and an essential resource.

Consistent with the current findings, financial stress has also been implicated as a predictor of caregiver burden (Adelman et al., 2014) and resource availability and accessibility are crucial to sustaining the process. For instance, the presence of co-morbidities requires constant coordination of care, physician communication, and even hospitalization. Financial support is so vital in this process because a lack of it not only compromises care but strains the caregiver's emotional and psychological status. This is where financial capacity, an important resource, becomes relevant to addressing the cost of health-related interventions as it has been proven in the study to be predictive of caregiver burden.

As implied, careful assessment of their needs is vital because only appropriate care plans can provide an in-depth perspective of the older adults' quality of life (Olbrisch et al., 2001) requiring needed interventions.

The health of both the caregivers and the older adults are affected by the experience of caregiver burden (Dawood, 2016; Rha et al., 2015; Sanuade and Boatemaa, 2015), thereby necessitating the relevant roles successful caregiving trajectory. To do this, acknowledging strengths and resources that greatly impact the successful care of older adults is imperative (Moyle et al., 2014). Both intrapersonal and interpersonal characteristics of caregivers can act to buffer the adverse effects of caregiver burden (Dawood, 2016). Unfortunately, caregivers often neglect their own health needs (CDC, 2019) in the face of the caregiving process. Consequently, care provision decreases, quality of life diminishes, and deterioration of physical and psychological health (Lee et al., 2017; Liu et al., 2020). It is therefore essential that access to high-quality and evidence-based interventions is established among family caregivers (Schulz and Eden, 2016).

5. Limitations

The study did not proceed without limitations. As the term caregiving refers to the delivery of care to an older adult that has significant physical dependency or cognitive decline, this study included older adults regardless of their level of independence. The context of family caregiving was applied only to family members who lived with their older adults and the study recommends including caregivers established by social relationships.

6. Conclusion

Resources come from many forms, and they can play an integral part in the family caregiving trajectory. As the older adult's health condition advances through the presence of co-morbidities and physical dependency, the demands for resources in the form of financial support and self-efficacy are established predictors of caregiving challenges.

Compliance with ethical standards

Ethical consideration

Consistent with the ethical guidelines, an informed consent was secured from the respondents of the study. The informed consent detailed the subject status, purpose, type of data, nature of commitment, subject selection, procedures, and potential risks and benefits. Moreover, an emphasis on subject confidentiality was maintained throughout the course of the study.

Conflict of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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