THE CONTRIBUTION AND INFLUENCE OF SPIRITUALITY AND RELIGION ON FILIPINO CAREGIVERS’ MOTIVATIONS AND SERVICES

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THE CONTRIBUTION AND INFLUENCE OF SPIRITUALITY AND RELIGION ON FILIPINO CAREGIVERS’ MOTIVATIONS AND SERVICES

A Project

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This qualitative study examines the narratives of 14 caregivers (13 Filipinos and a Honduran) around Sacramento County regarding the contribution and influence of spirituality and religion on their motivations and quality of service. Purposive sampling with snowballing referrals led to the selection of the participants. Face to face interviews yielded interview data that was coded by themes. The findings of the study centered on six themes: caregiver motivations, caregiver stress or burden, cultural factors, the personal and ideological relationship between spirituality and religion, coping strategies and the rewards of caregiving, and the influence of spirituality and religion on wellness and quality of life. The caregivers were moved to take on the caregiving responsibilities for financial reasons and to reciprocate the love of the elderly parents or family members. Cultural values also characterized the Filipino style of caregiving. Spirituality and religion helped them handle their job to find meaning to
their life and promote their own wellness. Implications for further research and social work practice are explored.

________________________, Committee Chair
Andrew Bein, PhD, LCSW

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Date
DEDICATION

To Angela St. James who, with her deep faith, humble ways, self-effacing devotion, and sincere care for her loved ones and all others sent across her path, became my inspiration and motive to celebrate with joy in being a wounded healer, a caring love-giver, and a messenger of hope, especially to those whose roads in life seemed to lead nowhere and who in believing hope against hope (Rom 4:18), this project is lovingly dedicated.
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To our late parents who always taught us to have preferential love for the marginalized in society, to the Cistercian monks of New Melleray Abbey (Iowa) for the space and atmosphere of contemplation, to my close friends and prayer partners in the Philippines, to Becky Fernando, the Arana family, the care homes staff and residents, and to all whose paths I crossed and had the privilege of serving and being served;

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Most of all, to the God of love who desires the best for all of us, may my every work of service be Eucharistic gestures in faith, hope, and love.
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Chapter 1

THE PROBLEM

Introduction

The baby boomers of the post-war generation (1946-1964) are again taking the center stage in society. This time, they represent the inevitably marked ‘graying of America’ (Cutler, 1977; Rogers 2000; Hayes-Bautista, Hsu, Perez & Gamboa, 2002; Wright, 2005) as they come of old age. Providing care for older persons and helping them promote their well-being remains one of the nobler aspirations of individuals, families, groups, communities, and our society. At the same time, it is one of the more challenging tasks, especially in a profit-oriented and results-driven culture typical of developed nations, like the United States. Care providers themselves often remain invisible and marginalized just like the recipients of their care.

To provide care for older persons is one of the major objectives of our society and government. Social policies on health care and the budget allocations for the needs and care of older persons express how much the government emphasizes this issue. Unfortunately, it is also among the first items in the economic and political agenda to be shelved, in case other perceived social needs surface. Care for older parents or relatives could turn either into a blessing or a curse among family members in their efforts to be cohesive.

One may acknowledge that caregiving for an older person is very challenging. Some may argue that it is not a productive endeavor, and that not everyone is meant to fulfill his role. Basic to the responsibility of caregiving is the sincerity of the caregiver. It is
founded on noble motivations. Behind the commendable gestures of caregiving on behalf of those in the field, we want to know the coping ways and strategies that caregivers adopt to fulfill their tasks. We tend to believe that just like any task, activity, or career, providing care for the older persons is a skill that is learned, practiced, and mastered. A lot of its success would depend on the mentoring received, the tools employed, and the personal adaptation of the skills learned in the actual practice.

In my lifelong engagement in the helping profession, I am continuously inspired by the commitment and dedication of those who help others (either their kin or their clients) help themselves, particularly in the field of caregiving. I know of friends back in the Philippines who were thrust into caregiving tasks, perhaps reluctantly at the start, yet they found that phase of their life to be very rewarding. Here in the United States, I have met fellow Filipinos who take up caregiving as their new career or means of livelihood. I have seen quite a few who despite the burdens of caregiving maintain their sanity and good health in this challenging job. What could be their secrets behind carrying out this unpopular task? What are some of their coping skills in addressing the stressors and distress in their job?

As I engage further in the helping profession, I would like to understand the role that spirituality and religion play in the life of caregivers, particularly the contributions of spirituality and religion on the motivation and services provided by caregivers. Inasmuch as spirituality and religion touches on metaphysical aspects of life, I would like to know whether these realities exert an influence in the life of caregivers to live up to the demands of their duties or calling as care providers.
Background of the Problem

The aging population shows dramatic demographic changes. In 2006, around 37 million people age 65 and over comprised a little over 12 percent of the total American population. In 2030, the older population is projected to double from the year 2000 statistics of 35 million to 71.5 million (Federal Interagency Forum on Aging-Related Statistics, 2008).

The population of family caregivers in the country (those who provide care for their older and frail parents and/or relatives with disabilities) numbers more than 50 million. However, the rate of increase of people over 65 is at 2.3%, while the number of available formal caregivers increases at a rate of 0.8% (National Family Caregivers Association, 2008). There is a rising need then for formal caregivers or long-term care workers. A 2005 study by Montgomery, Holey, Deichert & Kosloski found that in the United States, about 90% of these workers were middle-aged, and female, more than 50% were non-White, and about 20% were foreign-born (cited in Browne, & Braun, 2008). Of these foreign-born caregivers, the most researched resource supply nation is the Philippines. In Los Angeles, California, about 75% of providers of in-home eldercare comprise of Filipina migrant workers. In Hawai’i, about 95% of care home operators are Filipina immigrants (Browne, & Braun, 2008).

Providing care to others, including the older persons, is wrought with numerous challenges that impact the caregiver’s bio-psycho-social aspects of life. Accompanying the motivations to provide care for others are the sacrifices involved in caregiving. Coping strategies and skills are needed for survival and effectiveness. Social work
researchers have found that caregivers have resorted to various resources and coping ways in order to manage caregiving burdens effectively (e.g., National Alliance for Caregiving and AARP, 2004; Pinquart, & Sorensen, 2005b). Quantitative and qualitative research studies have been conducted on the role of spirituality and religion as coping means for the individual’s well-being. Study results have shown mixed relationships between spirituality and religion and the different health and wellness indicators among multiple ethnic caregivers. With the increasing number of Filipino caregivers, both formal and informal ones, in the United States, it is interesting to know and understand how they manage with their caregiving burdens and stress, and particularly to focus on the contribution of spirituality and religion. A research study of this ethnic group could yield helpful results and information for the helping professionals in their social work practice.

Statement of the Research Problem

There is paucity of exploratory and descriptive studies made on the contribution of spirituality and religion on the motivation and services of caregivers. This study will examine the narratives of Filipino male and female caregivers, be they formal or informal ones, on their caregiving experiences and the influence of spirituality and religion in coping with the stress of providing care to older patients.

In addressing this problem, I hope to become more familiar with the coping strategies and skills of Filipino caregivers and learn from them. This present study could shed light on the significant stories of these ethnic minority group members who undergo the challenges of caregiving for their older family members or clients and have
learned to cope through the use of spirituality and religion. The results of the study could have implications on the policies and social work practice related to health care, immigration, and the promotion of well-being of all those involved in the care of older persons.

Purpose of the Study

Our present study aims to explore and describe the phenomenological experiences of Filipino caregivers, both formal and informal ones, in providing care to older persons. The study particularly focuses on the caregiver’s use of spirituality and religion in coping with the burdens of caregiving. The formal caregivers work mainly in different care home facilities in the Sacramento area. The informal caregivers experienced caregiving for their loved ones, either back in the Philippines or in the United States. I had the opportunity of knowing them through friends and/or encountering them anew in the Sacramento area. The commonality between these two types of caregivers lies in their culture of origin as Filipinos. There are interesting values in the Filipino culture that may or may not facilitate the use of spirituality and religion in coping with life’s challenges.

The results of this study could help the caregivers themselves to understand their own experiences in perceiving their needs and in discerning which tools and strategies to apply in their caregiving job or calling. The care home operators should in turn be more receptive to the conditions and needs of their direct caregivers. Helping professionals who are nurses, therapists, and social workers could be encouraged and inspired to consider a spiritual approach for themselves and to appreciate the
importance of spirituality for caregivers. Aspirants or students to the social work services should also be given the opportunity through their academic formation and field internship to appreciate the nature of spirituality and religion in their personal and professional life in order to maximize the resources available to them in reaching out to their clients. It is hoped that this limited study will unveil new insights to enrich lives and promote the well-being of people.

*Theoretical Framework*

With the development of spiritual sensitivity in the social work practice, the profession is recovering its soul from a collective loss (Canda, 1999). The retrieval of the soul of social work stems from the emergence of major nonsectarian spiritual perspectives that grew out of humanistic intellectual developments in Europe and the United States. Industrialization and the threats of global disasters through wars and environmental catastrophes gradually have created conditions ripe for an emerging sense of meaninglessness among individuals, societies, and the global communities. However, such absurd situations of global proportions led to alternative ways of understanding the meaning of life that considered the value of the spiritual dimension in human beings (Canda & Furman, 1999).

Transpersonal theories and existentialism provide us with a fitting theoretical framework. These theories draw on various religious and philosophical views as they are nonsectarian, multicultural, and transreligious in orientation. They apply to different disciplines, such as philosophy, mental health professions, medicine, religious studies, and social work. They aim to address the person’s search for meaning and the capacity
for self-transcendence. In the quest for meaning in the face of adversities and absurdities in life, they direct us to focus on the spiritual and religious dimensions of human existence.

There are many representative theorists to these theories, such as Maslow, Jung, Assagioli, Tart, Grof, and Wilber for transpersonal theories, and for existentialism, Kierkegaard, Nietzsche, Heidegger, Husserl, Buber, Sartre, Camus, Frankl, and Marcel represent this theory. To understand our theoretical framework better, I will present Abraham Maslow’s Theory of Self-Actualization and Self-Transcendence, and Viktor Frankl’s Logotherapy. Then I will indicate the relevance of these theories for social work practice.

*Transpersonal theories.* Transpersonal theories concern with the highest aspirations, potentials, and needs of human beings, such as love, meaning, creativity, and communion with others and the universe (Robbins, Chatterjee, & Canda, 2006). It is by going deep into ourselves that we begin to understand ourselves and our truer nature, realize our full potential, and transcend the ego (the “persona”, or the ego-bounded self-identity) into the trans-egoic phase of life. No longer do we experience our state of separateness and distinctness, but we move into a state of being united with others and the universe. We attain the peak of unity when we experience the so-called unitive consciousness, union with the divine or oneness with the ground of being.

Transpersonal theory is also known as the “fourth force” of psychology (named as such by Maslow) in response to the inadequacies of the previous three intellectual fields of Freudianism, behaviorism, and humanistic psychology. Freudianism reduced human
behavior into determinism mainly by unconscious, instinctual, and selfish impulses in
search of pleasure and avoidance of tension and conflict. Behaviorism viewed people to
be mechanically controlled by their environmental forces and deprived of the capacity
to choose freely and spontaneously. Humanistic psychology notes that people have the
capacity for self-transcendence, which is essential for a sense of self-fulfillment. But
what makes transpersonal theory to be considered the “fourth force” lies in its focus on
the altered states of consciousness, the spiritual aspects of human experience and
therapeutic techniques which facilitate transpersonal awareness (Canda & Furman,
1999; Robbins, Chatterjee, & Canda, 2006).

Abraham Maslow’s theory of self-actualization and self-transcendence. Maslow
(1908-1970) is credited with the naming of two foundational concepts of self-
actualization and self-transcendence. He began by outlining the hierarchy of needs in
every human being on five broader layers: the physiological needs, the needs for safety
and security, the needs for belonging and love, the need for esteem, and the need for
self-actualization (growth motivation or being needs). In its fullest potential, self-
actualization becomes self-transcendence.

To illustrate concrete models of self-actualization, Maslow studied around 20
successful historical figures and unknown individuals and analyzed their biographies.
He deciphered ten major values in their lives, namely, love for solitude, deeper personal
relations, autonomy, resisting enculturation, healthy sense of humor, acceptance of self
and others, spontaneity and simplicity, sense of humility and respect, appreciation with
wonder, and the ability to be creative inventive and original (Boeree, 2006).
Existentialist theory. In the late 19th to the mid-20th century, particularly in Europe, social and spiritual crises were triggered by the impersonalized state of urbanization, rapid industrialization resulting in mass production of commodities, and the rise of destructive and oppressive social movements (Robbins, Chatterjee, & Canda, 2006). The traditional structures of constructed meaning and order broke down. People lost their solid foothold and experienced crises related to life’s meaning.

Such situation of meaninglessness led intellectual theorists, like Camus, Sartre, Kierkegaard, Dostoyevsky, Buber, Heidegger, and Frankl, to search for the meaning of existence, in its immediacy to its absolute reality (Crowell, 2008). The existentialists encouraged the need to confront absurdity in human existence, such as in the face of injustice, failure, suffering, and mortality, in order to find meaning, purpose, and motivation to life. Existentialism as a theory then is a critique of social conformism and a revolt towards trans-personalism. It asserts the values of human freedom and dignity, the essence of human personal relationships, the discovery and knowledge of truth through intimate personal experiences, and the growth in the determination of meaning through loving (I-Thou) interpersonal relationships. Through caring, people are affirmed in courage to find meaning in the face of varying degrees of human malaise and suffering. They are able to transcend themselves and relate to others and to the God, the eternal Thou, or the Universe from whom essential meaning is derived (Canda, & Furman, 1999).
**Viktor Frankl’s logotherapy.** Viktor Frankl’s logotherapy is relevant for addressing social work concerns and issues related to family and professional caregivers. Frankl (1905-1997), a renowned Austrian psychiatrist, was a Nazi survivor who experienced first-hand the meaninglessness of the war and life in the concentration camps. It was his prison experiences, together with the loss of his loved ones, which made his search for meaning to existence more real. Later on, he developed his existential approach called logotherapy, or healing by way of discovering the “word” (*logos*), or meaning to one’s existence (Boeree, 2006). Nietzsche’s words (“He who has a why to live for can bear with almost any how”, quoted in Frankl, 1963, p. 121) became his motivating inspiration in his works. His more famous writings are Man’s Search for Meaning, The Unconscious God (his doctoral dissertation), and Man’s Search for Ultimate Meaning (updated version of his dissertation).

Logotherapy emphasizes a will to meaning in contrast to Freud’s will to pleasure as the root of all human motivation (Boeree, 2006). For Frankl, conscience as a sort of unconscious spirituality is the core of our being from which personal integrity springs. He discusses how the wisdom of the heart is involved with our discovery of meaning. When meaninglessness seeps in, an existential vacuum is created of which boredom is a sign. Such existential vacuum could lead to neurotic vicious cycles, such as anticipatory anxiety, hyperintention, and hyperreflection. Depression, addiction, and aggression constitute the mass neurotic field. Through therapy, these neuroses (and psychoses) are countered by the quest for meaning.
The gradational approaches to search for meaning take place through experiential values (including the peak experiences and aesthetic experiences in admiring art works or the beauty of nature), creative values (by engaging in art, music, or writing), attitudinal values (in compassion, courage, good sense of humor, or even through suffering), and the supra-meaning or transcendence (pertaining to God and spiritual meaning). To break down the vicious neurotic cycles through therapy, Frankl applies the techniques of paradoxical intention, dereflection, and self-transcendence. From the last technique, one experiences self-actualization (of Maslow) and discovers meaning (Boeree, 2006).

*Theoretical framework in relation to the research problem.* Basic to coping with the challenges of life is the quest for meaning and self-transcendence. Transpersonal theories, such as Maslow’s self-actualization and self-transcendence theory, and the existentialist perspective, such as Frankl’s logotherapy, could fittingly serve as theoretical frameworks in the helping profession. They provide the key to addressing the stressors of life with the use of spirituality and religion. Caregiving as an act of service to others leads to self-transcendence in relation to others, to humanity, to the universe, and to God or the Ultimate Ground of Being. Despite the sufferings of providing care to others, with immense sacrifices, a caregiver endures for the sake of the other. It is the motive of love, which propels service and gives meaning to one’s actions and transforms them towards one’s self-actualization and self-transcendence.
On the part of the helping professional, knowledge of the dynamics of caregiving and the use of spirituality and religion among caregiver coping strategies is important in dealing with caregiver challenges.

Definitions of Terms

Key words or terms that are often used in this study are defined here:

**Caregiving** pertains to the acts and services rendered to another individual who needs assistance due to some degree of incapacity. The help extended could refer either to *activities of daily living or ADLs* (i.e., the basic functions, such as eating, bathing, dressing, getting to and from the bathroom, getting in and out of bed, and walking) or to *instrumental activities of daily living or IADLs* (such as keeping track of money, doing, light household chores, taking medicine, and running errands). (Quadagno, 2008).

**Caregiver** is a person who provides assistance to another person. One is identified either as an *informal caregiver* (which ensues from a natural relationship that exists in one’s environment, such as the family, friends, church, and organizations) or *formal caregiver* (such as the health care professionals, staff members in hospitals, day care centers, nursing homes, and home care facilities). The former are not professionals and not paid for their services. The latter are professionals or paraprofessionals and are paid for their caregiving (Hillier & Barrow, 2007). At times, one may assume both formal and informal caregiving roles in varying degrees at different times, depending on the demands of the moment. The term **caregiver** in our study often pertains to the one who provides care to older persons.
Caregiver burden refers to the negative stresses of providing care, which includes role strain, subjective perception of the strain (or caregiver stress), depression, anxiety, hostility, and other cumbersome emotions (Hillier & Barrow, 2007). Coping in terms of strategies or skills pertains to the response to the demands of particular stressful situations.

Filipino caregiver is a male or female caregiver of ethnic and cultural ascendancy from the Philippines. He/she may live in the Philippines or in the United States, exercising the role of formal caregiving to older persons or informal caregiving to family members.

Spirituality and religion as referring to transcendental entities are often understood in a continuum, although they are distinct from each other. Basically, spirituality pertains to harmonious relationship or connections with self, others, neighbors, or a higher being (who is called God, Allah, or by other names) that draws one beyond oneself (Fehring, Miller, & Shaw, 1997). It operates beyond the tangible realities into the realm of the “spirit” in contrast to what is “material.” Religion pertains to the organized systems of beliefs, practices or rituals.

Care Home or Residential Care Facility for the Elderly (RCFE) is a specialized institution with government license from the Department of Social Services to care for the needs of older persons on a long-term basis.

Motivation for caregiving refers to the rationale for the caregiver’ action in rendering care and in attending to the needs of the care recipients. It could be influenced by several factors, including family and cultural backgrounds, financial or
spiritual/religious reasons. One’s motivation is normally translated into one’s actions, behavior, or services to others.

Assumptions

There are four basic assumptions in undertaking this research work, namely, (1) that caregivers go through caregiving burdens to which they respond by way of coping strategies which they skillfully employ in their life; (2) that caregivers are open, willing and honest to share the richness of their caregiving experiences and life-stories; (3) that spirituality and religion are one of the coping mechanisms that some caregivers use to meet and overcome the challenges they face in their career or calling; and (4) that to properly understand the coping skills of Filipino caregivers demands viewing it from cultural perspective.

Justification

This research project could significantly assist practitioners, particularly social workers and gerontologists, in assessing the needs and applying the available resources to help caregivers in coping with the caregiving burdens and stress. Additionally, the study illuminates the use of spirituality and religion as a protective factor for caregivers.

Limitations

There are two perceived limitations in this study. The first limitation concerns the limited number of participants that is inherent in the nature of a qualitative research. The other limitation factor pertains to the interviewer’s bias against which the researcher must always take precaution and strive to overcome.
This research project deals with the personal narratives of fourteen formal and informal caregivers, with a focus on the use of spirituality and religion in coping with their caregiving burdens. The study limits the participants mainly among Filipino formal caregivers within the Sacramento area. Majority of them worked at two residential care facilities for the elderly (RCFEs) in Rancho Cordova and Carmichael. The other caregivers work with older persons in various types of care home settings, as in a bigger care facility, in group home care and in-home service care. The informal caregivers cared their family members, a spouse, sister, or parents. Two of them were Filipinas, and the third as a negative case sample was a Honduran but married to a Filipina. With the limited number of participants and mainly with Filipino ethnic origins, the caregiving experiences of the participants could not be generalized as equal to the global (universal) experiences of caregivers, regardless of their ethnic origins. This limitation of generalization likewise applies to other Filipino caregivers who would have variant experiences in providing care to others. However, certain elements in the experiences of our participants could resonate with the related responses and coping strategies in others of varying backgrounds.

Another perceived limitation is my role as volunteer chaplain in two RCFEs and the possibility of the interviewer’s bias on the topic of the study and of the interviewee’s perception of the researcher in the chaplain’s role. Most caregivers knew and related to me in that capacity for more than two years already. However, having been properly debriefed for credibility check by my advisor, I was constantly aware of this limitation in my interviews with the participants. I prefaced my interviews with the clause of
confidentiality and the need for openness in their thoughts, sentiments, and way of relating with me as the researcher. Despite this possible limitation, my volunteer works at the facilities enabled me also to observe the caregivers’ services and relationships with one another and the residents with some depth. I would consider this observational mode to be a useful complementary tool with the open-ended interviews I did with the participants (Patton, 1990). The caregivers who worked in other facilities knew me more as an MSW student preparing this study. Some informal caregivers have always related to me as their friend and spiritual adviser, especially in their trying times of caregiving. Nonetheless, by participating in the study, they did not feel constrained by the debt of gratitude (utang na loob), but were glad to revisit their experiences and share them with others who would benefit from the study. Often in my interview with the other caregivers, the formal ones and the family caregivers, I expressed my desire to know more of their family and experiences by taking extra conversation times with them, while I observed and inquired more in active curiosity on their life and coping skills. Relating with me as their friend, they gladly responded to my questions. They even generously shared their stories and other experiences in life.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

It is expected that by 2045 the percentage of the over 65 population would increase to 22% from the current 13%. Consequently, there will be an increase in the number of poor, homeless, and uninsured elderly people. The inverted pyramid of the older population and the increased dependency ratio on caregivers is an emerging phenomenon (Wright, 2005). The pressures on informal and formal caregivers continue to mount as they are impacted by the physical, psychological, social, and spiritual dimensions. The financial strain on the care recipients and the family caregivers add up to the caregiving burdens. The crisis in health care with respect to caregiving lies in the shrinking pool of qualified formal caregivers (Kietzman, Benjamin, & Matthias, 2008).

One of the objectives of social work practice is to assist not just the care recipients but also the caregivers. Caregiver’s self-care is a significant factor for healthy caregiving and assistance of the care recipient. Knowledge of the caregiver coping mechanisms and the available resources for these strategies is helpful for the social work practitioners. Among the different means for coping, spirituality and religion are presumed to be helpful.

Prior to undertaking our research study on the impact of spirituality and religion on caregivers’ motivation and services, we begin by looking into the results of previous related studies on our problem. We review what other studies have learned.
The review of literature pertinent to our problem covers four general themes. First, we examine the theme of caregiving, specifically, caregiving motivation, burdens, and benefits. Second, inasmuch as the targets of this study are male and female Filipino caregivers, both formal and informal ones, the theme of Filipino cultural values, such as filial respect and piety, and the sense of gratitude, is taken up as influential bases in their caregiving roles. Third, we look into the definitions of, and the relationship between, spirituality and religion. Lastly, we study the coping usefulness of spirituality and religion on caregiving. There are presumed relationships and associations between spirituality and religion and the bio-psycho-social and cultural aspects of life. Of these relationships, our focused query pertains to how spirituality and religion relate with the caregivers’ health, motivations, and services.

**Nature and Challenges of Caregiving**

The terms “caregiving” and “caregiver” are relatively new words in the dictionary, entered mainly around 1966 (Merriam-Webster Online Dictionary, 2009). As terminologies on health care, they refer to providing care, such as for children, people who are elderly or chronically ill. Called a “carer” in England, New Zealand, and Australia, one who provides care is called “caregiver” or “care provider” in the United States. Operationally defined, a caregiver is one “who is involved in helping someone else manage to carry out the tasks of living” (Anna Zimmer, cited in Berman, 2001, p. 8). The tasks of caregiving include both the activities of daily living (or ADLs) which pertain to personal care, such as helping the care recipient in/out of bed and chairs, dressing, bathing, toileting, feeding, and changing diapers, and the instrumental
activities of daily living (or IADLs) which concern management of everyday living, such as assistance in transportation, grocery shopping, housework, managing finances, preparing meals, giving medicines, and arranging services. Amy Horowitz, director of Lighthouse Research Institute further qualifies the caregiving behavior into four categories of “emotional support, direct service provisions, mediation with formal organizations and providers, and financial assistance” (Berman, 2001, p. 9). Care provision encompasses all activities when the caregiver shares the household with the care recipient.

Caregiving is rendered *informally* when a natural relationship exists between the caregiver and the care recipient, such as family, friends, church or organizations that are not professional or government-funded. Informal caregivers are also known as “volunteer caregivers” because of their unpaid services due to the existing natural bond with the care recipient. On the other hand, *formal* caregivers render paid services. They are also called “care workers,” “professional caregivers,” “health care assistants (HCA)” or “Direct Support Professional.” Formal caregivers include health care professionals in hospitals, day care centers, and nursing homes (Hiller & Burrow, 2007). In our study, these include the caregivers in residential care facilities for the elderly (RCFEs), group homes for the elderly, and in-home care services. Kietzman, Benjamin & Matthias (2004) conceptualize formal caregivers into three groups according to the consumer-directed model of care, namely, family members who are related to the care recipient by blood or by law; friends who are unrelated but known to the client before they provided care, such as neighbors, workmates, and acquaintances;
and strangers who are unrelated and not known to the client before any caregiving arrangement.

In 2004, the National Alliance for Caregiving and AARP conducted a qualitative survey of 1,247 caregivers of which 600 equally belonged either to African-American, Hispanic or Asian-American ethnic groups. The study found that the typical informal caregiver in the U.S. is a 46-year old female, had college education, is employed, and spends more than 20 hours of caregiving to her mother. Moreover, female caregivers provide more hours of care and a higher level of care than male caregivers. Male caregivers who are husbands, sons or relatives are more likely to be working full or part-time (66%) than female caregivers (55%). This statistics corresponds to the tendency of sons-caregivers to engage in fewer and less intense tasks. Aside from their reason of employment, sons feel less obliged to care for their parents and attribute caregiving to be women’s work and part of the women’s traditional role in society (Montgomery & Kamo, 1989). In 1993, a study by Harris (Hillier & Barrow, 2007) identified four types of caregiving services of husbands or male caregivers, namely, the work role (performed in an organized manner with work plans and schedules), the labor of love (out of devotion, and not duty), sense of duty (commitment, responsibility, and in reciprocal expectation), and the crossroads phase (an experience of transitional crisis). In a later study in 1997, Harris and Bichler noted a fifth type of providing care by male caregivers called “going it together”. It uses the team approach in which the husbands include their wives in the process of decision making for the latter’s health care (Micka, 2004).
The sense of filial responsibility or filial maturity is one motive for providing care as expressed in intergenerational literature. Gender differences are present in this motive factor. Moreover, geographical distance becomes a relevant factor in the intergenerational contact (Adams, 1968). With geographical proximity of the adult children to their parents, the task of caregiving becomes imposed. As the geographical distance widens, the contact becomes limited and discretionary. From this relationship between filial maturity and intergenerational contact, geographical distance becomes a determining element in the motives of providing care. Particularly for daughters or women in the family, the reasons for caregiving could be obligatory and/or discretionary (Walker, Pratt, Shin, & Jones, 1989). Obligatory caregiving is imposed as responsibility often on the women (such as the daughters or daughters-in-law) due to their socialized role as nurturers and their easily negotiable availability for employment (Varona, Saito, Takahashi, & Kai, 2007). Discretionary caregiving is based on compassion and interdependence. Walker, Pratt, Shin, & Jones (1989) found that mothers think more of the discretionary motives of their daughters’ caregiving services. However, daughters feel both the obligatory and discretionary motives in providing care for their parents.

The task of providing care for someone else generates pressure and burdens, beginning with the reality of taking responsibility for the care recipient’s well-being. Caregiving bears on one’s time, finances, physical health, emotions, and relationships (Olvera, 1999; Delehanty & Ginzler, 2005; Pinquart, & Sorensen, 2005b; Lee, 2008; Montoro-Rodriguez, Kosloski, Kercher, & Montgomery, 2009). Practically, it includes
role strain from the demands of other tasks and the need for respite. Strains in intersibling relations and the stress in arranging outside help and coping with bureaucratic complications are also present (Hillier & Barrow, 2007).

Caregiving distress arises in an attempt to control a situation that could be beyond one’s control. Address and Person (2003) sum up the struggles or conflicts for caregivers on three fronts. First, there is the conflict of independence versus dependence. As the caregiver strives to be independent, there is the growing dependence of the parents on the family caregiver, and the latter’s eventual dependency. Second, there is the conflict of moral understanding and standards. As the parents decline in health, one’s religious and societal values may conflict in understanding how to care for them, from which a sense of guilt ensues (Koenig, 2002). Third, there is the conflict of integration and isolation. As parents reached their own search for personal, professional, and intellectual integration, they become more isolated due to aging. In the course of providing care for them, the caregiver begins to fear one’s isolation from partners and family, friends, and meaningful activities.

With the multiple stressors in caregiving, it is not surprising that since female caregivers provide more intensive care with higher levels of burden, they report more emotional stress and its consequent toll on their physical health than the male caregivers (40% versus 26%) (National Alliance for Caregiving, 2004). Furthermore, because of the intimacy of the relationship between spouses, caregiver spouses experienced higher levels of depression than any other caregivers (Eisdorfer, 1996; Smerglia, & Deimling, 1997; Berg-Weger, McGartland, & Tebb, 2000; Seeno, 2000). Aside from the physical
and emotional strains in caregiving, the high level of burden and stress on the spouse caregiver or the female informal caregiver arises from the feeling of obligation or duty to assume the caregiving role. The survey by the National Alliance for Caregiving (2004) indicated that nearly four in ten caregivers (39%) say they feel that they had no choice, and that this forced situation caused much emotional stress. Of those who felt they had a choice in becoming caregivers, around 25% of them reported experiencing stress at the highest levels.

According to the Caregiving Statistics Fact Sheet on Family Caregivers and Family Caregiving issued by the National Family Caregivers Association (2008), the impact of providing care takes a great toll on the caregiver’s health and well-being. It is worthwhile to note the following findings: (1) that elderly spousal caregivers with a history of chronic illnesses, themselves, have a 63% higher mortality rate than their non-caregiving peers; (2) that the immune system of caregivers for dementia patients is affected for up to three years after their caregiving is completed with the increased chance of developing chronic illnesses themselves; (3) that the symptoms of depression or anxiety are six times higher for spouses and twice as high for those caring for a parent than for the non-caregivers; (4) that the husband who cares for his wife’s hospitalization increases his mortality risk in one month by 35%, and that the wife providing care for the hospitalized husband risks a 44% higher mortality rate; (5) that in cases of extreme caregiving stress, the caregiver tends to age prematurely, thus taking off as much as 10 years from the family caregiver’s life.
The pervasive stress factor in caregiving impacts informal caregivers to the degree that they often hire the services of formal caregivers. With the increasing number of aging baby boomers that need care, it is expected that by 2050, the ratio of caregivers to care recipients will be only four to one (AARP, 1998). Moreover, six social trends affect the supply of caregivers by the middle of the 21st century. The trends include: (1) the increase in divorce and remarriage rates; (2) the decrease in the number of available family caregivers because of more geographical dispersal and fewer single adults; (3) the decreasing number of children per household and the increase in childless household; (4) more women who are the traditional caregivers becoming employed; (5) the women bearing children at later age, thus, creating the “sandwich generation” phenomenon (Riley, & Bowen, 2005) and dividing their attention on the care of their children and their aging parents; and (6) extended life-expectancy beyond 85 years of age due to medical advances (Feinberg, 1997; Olvera, 1999). The supportive contribution of formal caregivers, especially those coming from ethnic minority groups, does not meaningfully affect the levels and intensity of caregiving burden on the informal caregivers. Despite the assistance of formal caregivers, the greater responsibility to provide care to older parents and other family members, which includes decision-making and planning out effective care, ultimately rests on the family caregivers. The next section discusses the caregiving role of Filipino caregivers. We will examine the added elements of distress affecting them.

There are not only negative outcomes or detrimental effects of caregiving, but there are benefits or gains for the caregiver as well. Caregivers feel more useful, feel needed,
learn new skills, and add new meaning to their sense of self (Koemer, Kenyon, & Shirai (2009). Though providing care could be motivated by a sense of obligation, the caregiver feels fulfilled and may enjoy the companionship of the care recipient. Often, the negative effects and positive benefits of caregiving go hand in hand in the life of the caregivers. However, the practical goal is to minimize the burdens or stress of caregiving and maximize the gains or benefits of this human task in order to enhance the well-being of the caregiver and the care recipient as well (Kietzman, Benjamin, & Matthias, 2008).

What is a coping mechanism? What are the types of coping mechanisms which caregivers employ to adjust and effectively perform their caregiving role? How do caregivers cope with the challenges of their work?

The 2004 survey of 1,247 caregivers conducted by the National Alliance for Caregiving and the AARP surveyed caregivers on their coping strategies. The most common coping strategy involved the use of praying by the caregivers (73%), followed by talking with or seeking advice from friend or relatives (61%), reading about caregiving (44%), exercising or working out (41%) and going on the Internet to find information (33%). Less frequently caregivers talk to a professional or spiritual counselor (27%) and take medication (12%). Women resort to praying (80%) and talking with friends or relatives (67%) more often than men (61% and 51%, respectively). Those who are more prone to use the Internet to download information on coping include Asian American caregivers (43%), those who had college education
(41%), earn higher income (44% of those earning $100,000), and those who provide care to someone with Alzheimer’s or dementia (42%).

Hillier and Barrow (2007) highlight the importance of having a social support network which includes support groups, educational groups, and problem-solving groups for caregivers and care recipients. Recourse to individual and family counseling, and visits by social workers and/or family consultants help address the psychological stress of caregivers. Taking time off or availing of respite care is advised to be more effective than psychological interventions (Varona, Saito, Takahashi, & Kai, 2007).

Taking a cue from the 12-step program of the Alcoholic Anonymous, Morris (2004) presents in his manual on caregiving of aging parents a 12-step Caregiver’s Anonymous Program. The 12 steps are the following courses of action: (1) Taking a break, vacation or free time; (2) Making friends for social support; (3) Staying calm, breathing, and meditating; (4) Setting worries aside; (5) Strengthening one’s immune system through laughter; (6) Reading papers, or watching TV or movies to get new perspectives of the world; (7) Advocating for control and solution; (8) Avoiding the “coulda-shoulda-woulda” and focusing on what is/can be; (9) Pursuing other interests, hobbies, sports, and crafts; (10) Getting spiritual support as in praying; (11) Relaxing, meditating, and doing taichi to relieve stress; and (12) Indulging on some necessities, like taking a hot bath, going on a shopping spree, having an exquisite dinner, getting a new hairstyle, star-gazing or taking the afternoon to rest under the sun. These steps help the caregiver develop self-care in order to recompose oneself for the demanding task of providing care for others.
A study involving 63 caregivers examined whether the individual’s personality and interpersonal traits were conducive for experiencing personal benefits and gains in caregiving (Koemer, Kenyon, & Shirai, 2009). This study was unique in focusing less on the extrinsic activities and more on the intrinsic qualities for coping. The finding showed that the personality traits of agreeableness and extroversion and the socio-emotional support from family spouse/partner were positively related with caregiving benefits or gains. On the other hand, “neuroticism” in the individual made one to feel anxious and vulnerable, to be easily irritated and worried, and be sensitive to criticism and guilt, and to experience higher level of stress as well as negative health and mental conditions. The caregiver with higher neuroticism tends to be more negative in outlook regarding the caregiving situation, more reactive and enjoys less the task of providing care to others. The study results highlighted the importance of the emotional support from family and spouse/partner. With the use of educational and counseling groups for caregivers and their family system, those who provide care gain insights in understanding the dynamics of their role and assist them better in fulfilling their tasks.

Overall, caregiving is a complex activity that generates positive and negative outcomes on caregivers affecting the bio-psycho-socio-cultural and spiritual dimensions of their life. It is important that coping strategies are in place for the caregiver to benefit from the caregiving works and to promote his/her own well-being.

*Filipino Cultural Values and Relationship with Caregiving Role*

With the increasingly marked shortage of informal caregivers to provide care for the aging population, 37 states identified caregiver recruitment and retention as a priority
(Kietzman, Benjamin, & Matthias, 2008). However, to address the increasing needs of the older population, the current number of formal caregivers must be doubled just to maintain the present ratio of caregiving workforce (Friedland, 2004, cited in Kietzman, Benjamin, & Matthias, 2008). Research studies now focus not just on the common grouping of Latin-Hispanic, African American, and Caucasian American caregivers (Ayalong, 2004; Kietzman, Benjamin, & Matthias, 2008), but also on various minority ethnic groups, such as the Chinese, Filipinos, Koreans, Native Americans, Russians, and Vietnamese (Scharlach, Kellam, Ong, Baskin, Goldstein, & Fox, 2006). Redfoot & Houser (2005) mention Jamaica, Mexico, Puerto Rico and the Philippines to be the primary supply nations for direct long-term care (DLTC) workers in the United States. Because of the diverse ethnic/race groups who require caregiving and who provide formal and informal labor, the cultural variants of caregiving should be considered.

Culture has been defined as “shared values, norms, beliefs, and practices that guide the thinking, behaviors, and decisions of the group” (Ayalong, 2004, p. 131, in citing Pickett, 1993). From the cultural perspective, caregiving is the product of multiracial/or multiethnic interactions and it progresses within the historical and social contexts. Four major theories are relevant in exploring the race/ethnicity interface with the caregiving experience: (1) theories of cultural pluralism, which acknowledges ethnic group differences within the majority culture; (2) the assimilation perspective, or the acculturation or assimilation of the values of the ethnic group into the values held by the majority group; (3) the double jeopardy theory which points to the dual disadvantage of age and race on ethnic minority caregivers; and (4) the ethnic compensation theory
which emphasizes the strengths and benefits of being a member of an ethnic minority
group (Ayalong, 2004).

In a qualitative study of eight family caregivers (three Latinos, two African
Americans, and three Caucasian Americans), findings showed that caregiving is a
culture that employs common values, traditions, customs, beliefs and behaviors
(Ayalong, 2004). Likewise, caregivers across various race/ethnicity groups face similar
challenges. Differences occurred in their types of care recipients, levels of care being
given, and in the employed coping strategies.

Filipino caregivers abound in Europe (Italy, Greece, Germany, Spain, and United
Kingdom), in the Middle East (Saudi Arabia, mainly as nurses), and in the United Arab
Emirates, Kuwait, Bahrain, and Israel (Leteller, 2006; Ayalon, Kaniel, & Rosenberg,
2008), in Asia (Malaysia, Singapore, Taiwan, Korea, Japan, and Hong Kong) (Chang,
& Ling, 2003), in Australia, New Zealand, and Canada. There is no precise number of
Filipino caregivers in the United States (Go, 2002). However, it is estimated that there
are 2.14 million Filipino workers in different capacities of work. The U.S. Bureau of
Census reported that already in 1990, Filipinos comprise the largest Asian group in the
country (Cimmarusti, 1996). In certain parts of the United States, Filipino caregivers are
a majority group. For example, in Los Angeles, Filipino migrant workers undertake
75% of in-home elder care (Browne, & Braun, 2008). In Hawai’i, Filipinos operate 95%
of care homes (RCFE) (Browne, Braun, & Arnsberger, 2006). Though many Filipino,
especially female, migrants engage in caregiving, quite a few are “unaffiliated
providers” (Abel, & Nelson, 1990, cited in Tung, 2000, p. 62) because their work
arrangement is done “under the table” or “off the books”. They also offer varied services, aside from caregiving, such as housekeeping, gardening and/or companionate. Since many are undocumented and overstaying, it is difficult to have an accurate number of Filipino caregivers in the United States.

In a study of cultural attitudes and caregiver service use involving eight racial/ethnic-specific populations, including Filipinos (Scharlach, et al., 2006), three cross-cutting constructs indicated the following: (1) on familism: the decision to become caregivers fulfills cultural norms, maintains cultural continuity, and strengthens family ties; (2) on group identity: the social history of adversity brings the people together, making them more aware and sensitive to others’ needs, and more committed to providing care; moreover, the task of providing care for others may be an element of stability for an ethnic culture that experiences transition in another culture; and (3) on the barriers in the use of service resources: that with the lack of knowledge of available services, the lack of available resources or their inappropriateness (such as language barrier, lack of monetary support, training services, or respite care), minority ethnic caregivers rely greatly on informal support services network than on formal services. The study revealed that on this last item, Asian Pacific caregivers are the least likely to use formal support services.

In my visits to countries where most Filipinos are employed as caregivers or helping professionals (e.g., Italy, Germany, Israel, Hong Kong, Australia, Canada, and the United States), the common places for their socializing support are the churches, cultural centers or social halls. Muslim countries, especially Saudi Arabia, are
exceptions, since congregating for worship other than Islam is legally banned. In such cases, the private residences, apartments, or common halls in their workplace become meeting points for socialization and mutual support. The preferred support system among Filipino caregivers stems from the cultural value system.

Geographically, the Philippines, which equals more or less the land area of the state of California, is located in Southeast Asia bordering the western end of the Pacific Ocean. Culturally, it shares the neighboring Eastern values of harmony, close family ties, and sense of honor and shame. Politically, it had been under Spain’s rule for more than 300 years (1565-1898), under the United States after the Spanish-American War for 40 years (1900-1946), and under the Japanese regime for three years during World War II (1942-1945). Economically, it engaged in trade with China, with Spain through the galleon trades, with the United States, which imported much of the modern Western goods, values, and influence, and with Japan. The majority of Filipinos are Roman Catholics (83%) due to Spanish influence. Some are Protestants (9%) with the advent of the Americans (Natividad, 2000; Hermalin, 2002). In the South, in the Mindanao region, Muslims (6%) have strong political backing from the neighboring Malaysia, Indonesia, and other Islamic nations. Then there is the mixture of minority groups of Buddhists, Hindus, Shintoists, and indigenous faiths. Economically, the Philippines was rich in natural resources and had economic advantages over other Southeast Asian nations in the 1960s. But its history of successive dominations by imperialist rulers has brought about a politics of kinship which resulted into practices of graft and corruption in the government. Such sad state of events left the country in economic shambles and
the people in dire poverty. Nonetheless, its people as a labor force with its distinct

culture and spirit of resiliency remains as the precious commodity for export, out of

necessity, to different nations all over the world.

There is a confluence of various factors in the life of the Filipino people. The culture

that facilitates caregiving is characterized by these elements: (1) primacy of the family

in social life (shown also in bayanihan, from the word, bayan, which means, town or

community); (2) maintenance of smooth interpersonal relations (SIR) (manifested in

pakikisama, or the show of unity out of deference for authority and brotherhood); (3)

sense of debt of gratitude (utang na loob) especially towards the parents and the family,

and those from whom one receives favors; and (4) avoidance of behaviors that bring

shame (hiya) to the individual and to the family (Natividad, 2000). There is a bilateral

kinship system that extends to the next generations. Older persons (elder siblings,

parents, and grandparents, or other relatives, including neighbors and friends) can rely

upon this kinship system for social, economic, and emotional support. At the base of

this system lies the reciprocal bonding marked by obedience, respect, and compassion.
Children hope to gratefully return the favor of being reared by their parents (or

guardians) to adulthood and independence by taking care them in their old age. Refusal

to fulfill this tradition of filial piety could mean a strong sanction of hiya (sense of

shame).

Gossip (tsismis) is frowned upon because it is considered as a treacherous and

cowardly act. It destroys social relationships. However, there could be positive cultural

outcomes of gossiping (Cimmarusti, 1996). It is used as a coping tool at the lack of
sense of duty by a member in the family. It helps rectify negative behaviors through the use of go-betweens, especially an older person, without directly confronting the person concerned. As a result, the person talked about can still save his/her face and self-esteem, while the gossipers who remain anonymous are spared from direct confrontation and revenge by the other party. Unfortunately, the sense of betrayal, lack of honesty and courage, and the possible malicious motives by the gossipers adversely affects relationships and divide the community.

Older parents may need help in care, but they do not expect elderly care to be their right. It is embarrassing (nakakahiya) to ask and invoke upon this favor as a right. However, they appreciate the voluntary gestures by their children who take care of their older parents. Caregiving is done through direct care provision, regular visits, or giving money to their parents which serves as their major source of income (Natividad, 2000). At the same time, especially in the United States, the phenomenon of Filipino American grandparents assuming the caregiving role to their grandchildren expresses the bilateral kinship system. They understand that their caregiving work is not a burden but a normative process of mutual reciprocity in terms of favors and responsibility among family members (Kataoka-Yahiro, Cerla, & Yoder, 2004).

Notably, the cultural values of Filipinos support caregiving in families (McBride & Parreno, 1996; Braun & Browne, 1998; Tyner, 1999, cited in Browne & Braun, 2008; Perez, 2006). This partially explains why migrating Filipinos easily fit into caregiving employment (Chang, & Ling, 2003; Browne, Braun, & Arnsberger, 2006; Ayalon, Kaniel, & Rosenberger, 2008). However, there are other motivating reasons for their
involvement in caregiving. One reason is the structural barriers to other employment due to lack of skills in the English language, low educational attainment, lack of job opportunities due to their immigration status, and the imagined or real discrimination in employment (Browne, Braun, & Arnsberger, 2006). Another significant reason is the high level of poverty in the Philippines. This economic condition of the Philippines, which impacts caregiving motivation, is affected by three global trends of world poverty and economic inequalities, feminization and colorization of labor, especially in long-term care, and feminine empowerment and women’s rights (Browne, & Braun, 2008; Go, 2002). These extrinsic factors often add up to the burden or challenges of caregiving for the Filipino migrant workers.

In addition to the usual caregiving stress and burden, Filipino caregivers go through various challenges. In a study of 173 Filipino care home operators in Hawai’i, findings showed that the parent-caregivers who are first generation immigrants do not recommend this kind of job to their children for the following reasons: (1) it is a 24-hour job; (2) dealing with the residents’ difficult health and behavior issues is too demanding; (3) there are conflicts with other family members/ others involved in the resident’ care; (4) government offices’ demand to inspect and license care homes is stressful; and (5) the pay is inadequate (Browne, Braun, & Arnsberger, 2006). What adds up to these challenges are the following: the caregivers’ difficulties in communication and in confronting discriminatory attitudes among fellow caregivers of different ethnic groups, and the lack of organizational response to their concerns (Browne, & Braun, 2008).
In a study of focus groups of Filipino caregivers working in Israel, the participants summed up their stressors into four areas, namely, (1) cultural differences, (2) legal struggles regarding immigration, (3) social conflicts; and (4) economic difficulties (Ayalon, Kaniel, & Rosenberg, 2008). In the documentary film, “Paper Dolls,” about Filipino transgender women-caregivers in Israel for elderly Orthodox Jews, the daily struggles of these care providers included confronting racism, homophobia, culture clash, and violence (Leteller, 2006). On a global context in a feminist perspective, there is the overlooked part of women’s migration as response to the globalization strategies of developing nations. Most of the in-home caregivers working with older persons are undocumented and often taken for granted (Tung, 2000). Not only do they provide care, but also companionate. Their extra works include light medical care, housekeeping, cooking, and grocery shopping. Some men also do gardening. Filipino women caregivers are prone to be natural nurturers providing caring relationships. These invisible workers are undervalued in their labor since they invest on the factors of sacrifice and emotion to do their job. “Emotional labor” is defined as “the conscious and unconscious induction and suppression of feelings in order to fulfill the psychological, physical, and monetary needs of the workers and employers” (Tung, 2000, p. 65) and involves the caregiver treating the clients as family members in love or compassion. However, their uncommon situation in the labor force easily warrants their loss of empowerment and human rights, and their lower place in the salary scale.

Given the history of adverse circumstances that characterize the Filipino way of life, their resiliency is symbolically portrayed on the qualities of a bamboo tree. No amount
of strong winds or typhoons can topple down this pliant tree as it sways to the direction of the impacting forces. After the adversity, in no time does it regain momentum and strength. This natural metaphor relates to traits of patience, perseverance, and compassion as cultural coping traits of Filipinos.

In a study of 63 family caregivers in southern Arizona as to which traits are helpful for them to benefit most from their caregiving tasks (Koemer, Kenyon, & Shirai, 2009), the personality traits of agreeableness, conscientiousness, and extroversion led to more gains for the care provider in terms of satisfaction in their job. Furthermore, the interpersonal factors of family and spouse/partner support, and the socio-emotional support were beneficial to the caregiver’s well-being. Considering the emotional labor that Filipino caregivers expended, despite the possible inadequate compensation they received according to the wage scale, it was the motive of mothering from afar, or caring to uplift their families’ living conditions that enabled them to make sacrifices in their work. Their savings, which were remitted overseas via moneygram or through a coworker who went home for a family visit, helped them to send the children to school, and assist the family to build or buy a house, car, furniture, appliances or other equipment. To sustain them emotionally, they communicated with their family members through emails, making phone calls, or sending packages (or balikbayan boxes). For social, emotional, and spiritual support, religious organizations or churches served as means for socialization and networking (Kataoka-Yahiro, Cerla, & Yoder, 2004).

Whenever possible, Filipinos socialized with others during fiestas (commemorating the feasts of their hometown’s patron saints or marking other religious feasts), or in
community events, and joined social clubs for dancing, recreation or companionship. Through these coping strategies, Filipinos, in particular the caregivers, were able to maintain their well-being in the face of life’s stressors.

*Spirituality and Religion: Definitions and their Relationships*

In a 2004 survey sponsored by the National Alliance for Caregiving and the AARP showed that the use of prayer (73%) ranked first among coping strategies for caregivers. As noted earlier, Filipino caregivers also cope through joining religious organizations and becoming active in their churches to gain social, emotional, and spiritual support (Kataoka-Yahiro, Cerla, & Yoder, 2004). In general, the use of prayer and religious organizations help caregivers to address the challenges they face in life and in their caregiving role (Stolley, Buckwalter, & Koenig, 1999; Perez, 2006). From the layman’s point of view, spirituality and religion are used interchangeably (Yoon, & Lee, 2006; Sinnott, 2002; Moberg, 2005; Cohen, Thomas, & Williamson, 2008). Nonetheless, from the perspective of diversity among the traits of caregivers and their use of coping skills, spirituality and religion may be distinct, but they are considered related in sense and scope.

In order to start defining spirituality and religion, examining their etymology or developmental origin of the terms will help us define the differences between spirituality and religion. The word ‘spirituality’ denotes the realm of the spirit in contrast to the realm of the body or matter, of the incorporeal versus the corporeal. Spirit pertains to what exists beyond mere human sight or touch into what is metaphysical. It refers to what is imperceptible with the sensory aspects of the body, and yet
real and credible. The wind is a good metaphor of the spirit (Hebrew, *ruach*; Greek, *pneuma*; Latin, *spiritus*). It is free and unforeseeable yet determined, felt and heard but not seen, active and life-giving (John 3:8, in The New American Bible, 1987). With the holistic composite nature of the human person as consisting of body and spirit, spirituality touches on the transcendental, metaphysical aspects and experiences of the individual’s life (Elkins, Hedstrom, Hughes, Leaf, & Saunders, 1988). Address & Person (2003) trace the sacred sense of “spiritual” by relating it to the Hebrew word, “*kadosh*” which is translated as “holy, sacred, nonphysical”, and referring to what is “separate, unique, other than the ordinary” (p. 63). This uniqueness or distinction denotes “the other.” In the Jewish faith, the *Kadosh*, or the Great Other (with a capital ‘O’), is God or Yahweh (Leviticus 19:1, in The New American Bible, 1987). In the sense of Hebrew “*Kadosh*” for the ‘spiritual’, and of the individual’s capacity to relate or connect with the “Other” that encompasses the universe, spirituality is the binding or relating of “the self of the I with the Self of the universe” (Rabbi Lawrence Kushner, cited in Address, & Person, 2003).

The word ‘religion’ comes from the sense of “collecting (Lat., *legere*), or binding (Lat., *ligare*) again (prefix, *re-*).” It pertains to one’s connection or relationship with divine or supernatural powers as expressed in systems of beliefs, worship or ritual, ethical values, and conduct (Webster’s New World Dictionary, 1986).

Understandably, in scientific investigations that seek empirical proofs or evidences, spirituality and religion are initially frowned upon, disregarded or neglected by researchers and helping professionals (Edgar, 1996; Betton, 1997; Sinnott, 2002;
Silvestri, Knittig, Zoller, & Nietert, 2003; Heyman, Buchanan, Marlowe, & Sealy, 2006). But what clients attest to as contributive factors to their healing, practitioners should not deny or take for granted (Seeno, 2000; Chevraux, 1998). There is now a renewed interest in spirituality even in social work (Jacobs, 2006), which, as Canda (1999) affirms, is “in the process of recovering from collective soul loss” (p. 1).

Possibly, in an effort to reconcile spirituality with empirical sciences, Elkins, Hedstrom, Hughes, Leaf, & Saunders (1988) attempted to understand spirituality in a humanistic way. Their premise was that it is a human phenomenon that potentially exists in people. Using psychological terminologies, the authors defined spirituality as consisting of nine major components (cited also in Hickson, & Phelps, 1998). These are: (1) the transcendent dimension; (2) quest for meaning and purpose in life; (3) a sense responsibility to life, or a mission to accomplish; (4) sacredness of life evoking a sense of we and wonder; (5) material values (money and possessions) are needed, but the ultimate satisfaction in life lies in spiritual realities; (6) commitment to social justice and altruism; (7) sense of idealism; (8) awareness of human tragedy, suffering and death; and (9) the fruits of spirituality in one’s life. Then, in a related approach to positive spirituality, the psychological and existential mechanisms of positive spirituality were use to set the directions in one’s search for meaning and purpose in the face of changes, transitions, and the unknown (Hill, & Pargament, 2003; Sadler, & Biggs (2006).

From a social work perspective, five core components of spirituality were identified (Ortiz & Langer, 2002; Sadler & Biggs, 2006). They pertained to: (1) connectedness
with others; (2) relationship with a transcendent presence in life; (3) possessing a power for living, such as faith and love, with coping strategies in moments of adversity and change; (4) meaning-making ability in persons, through personal reflections on ultimate concerns; and (5) varied expressions of one’s spirituality in public and private ways.

Canda (1988, 1990), Carroll (1998), and Hugen (2001b) clarified what spirituality was by distinguishing its broader sense as ‘spirituality-as-essence’ from its narrow sense as ‘spirituality-as-one-dimension’. The broader sense refers to the wholeness of humanity in all its components (biological, mental, social, or spiritual), while the narrow sense pertains to one’s “search for meaning and morally fulfilling relationships between oneself, other people, the encompassing universe, and the ontological ground of existence” (Canda, 1990, p. 13). Spirituality-as-essence is a state of interconnectedness with existence and the energy that enables such linkage, while spirituality-as-one-dimension points to actions and experiences that promote developing meaning and relationship with the divine, transcendent, or ultimate reality (Carroll, 1998).

With this insight on interconnectedness, Carol Ochs founded a theoretical perspective in 1986 called “relational spirituality” as a helpful tool in social caregiving (Favre, 2004). Spirituality in this sense is a process of broadening one’s sense of reality through love and openness to other people, perspectives, and to the transcendent Other. Love helps one to view others as subjects, and not as objects. It results into joy and vitality, which sustain one’s capacity to care for others and the world.
Ingersoll (1995) and Munk (2005) outlined seven dimensions of spirituality. They included: (1) one’s conception of the divine or the absolute which is greater than one’s self; (2) a sense of the beautiful, worthwhile, and meaningful; (3) one’s relationship with the divine and other beings; (4) one’s tolerance or capability for mystery; (5) peak and ordinary experiences (including rituals or spiritual exercises) which enhance spirituality; (6) spirituality as play; and (7) a systemic, integrative force on all the dimensions of one’s life.

Positive responses to the spiritual experiences result in faith, which helps one in the journey of interconnectedness with the various aspects of reality (Miller, 1985, cited in Betton, 1997; Hugen, 2001b). Fowler (1981) outlined seven stages of faith that could guide the practitioner in the spiritual assessment of the clients. They paralleled Erikson’s psychosocial stages (Edgar, 1996) and were akin to Kohlberg’s moral development model (Munk, 2005). The stages included: (1) undifferentiated faith (infancy); (2) intuitive-projective faith (early childhood); (3) mythic-literal faith (school years); (4) synthetic-conventional faith (adolescence); (5) individuative-reflective faith (young adulthood); (6) conjunctive faith (mid-life); and (7) universalizing faith (late life or old age).

Erikson’s theory of psychosocial development was critiqued for its linear concept of human developmental stages which seemed not to allow for digression. Moreover, it used a biased population sampling. Similarly, Fowler’s faith-stages model which was based on a limited sample population tended to fall under the same criticism. Ninety-seven percent of his samples were white and of Judeo-Christian tradition (Munk, 2005).
Nevertheless, Fowler points to events in life concerning identity development and developmental crises which could trigger or serve as impetus towards dynamism or growth in spirituality. The crises could include: (1) one-time predictable crises (as in migration, moving from home, birth of a baby), (2) one-time traumatic crises (as in the loss of a loved one, sexual assault, tragedy), and (3) chronic trauma or adversity (child abuse, domestic violence, illness, racism, sexism, addiction). In this last category, shame (or social embarrassment, Montoro-Rodriguez, Kosloski, Kercher, & Montgomery, 2009) could play a major role towards disconnection and isolation. From the perspective of relational-cultural theory, a healthy practice of spirituality and religion could help in overcoming the crisis towards connectedness and well-being (Munk, 2005; Fox, 1986; Edgar, 1996).

From the review of literature on the meaning of spirituality, we take note of the inherent potential in every human being to integrate all the various dimensions, aspects, and relationships in life, the capacity to search for meaning by way of transcendent perspective, and the energy to move towards a holistic lifestyle and way of living (Wright 1998; Address, & Person, 2003). Spirituality orients the person towards interiority, relies on internal authority, and empowers the individual to be the expert in directing one’s life through the personal insights and individual experiences gained in the course of life (Buchanan, Dzelme, Harris, & Hecker 2001, cited in Munk, 2005). It is the individual’s belief system that guides one to manage through life amidst the complex challenges being encountered.
Religion, on the other hand, serves as the complementary aspect to spirituality. It is oriented towards the external sphere. One’s faith system finds organized expression in actions (rituals), teachings (beliefs), and way of living (ethics) (Koenig, McCullough, & Larson, 2001; Hillier, & Barrow, 2007). It tends towards institutionalization in a communal-societal context for stability in the tradition of the religious culture and for social networking and support (McFadden, 2008). The scriptures, the religious institutions, and their leaders serve as pillars of stability and consistency (Van Hook, Hugen, & Aguilar, 2001; Munk, 2005). Affiliations and membership in the religious organizations sharpen the perception of one’s identity and the understanding of one’s responsibility for others. In doing so, one is described as ‘religious’ depending on the extent and degree of involvement in the works of the establishment. (Hugen, 2001b; Heyman, Buchanan, Marlowe, & Sealy, 2006; Yoon, & Lee, 2006).

Interestingly, with the social and political forces inherent in religious institutions, religion helps form cultural notions of self (Cohen, Hall, Koenig, & Meador, 2005; Delgado, 1996). Hugen (2001b, pp.11-12) summed up the ambivalence of religion in the lives of individuals. Positively, for its social and communal traits, (1) it integrates norms and values, thus helping the person form moral character and establish relationship with others; (2) it fosters order, discipline, and authority; (3) it provides emotional support when needed; (4) it confers self-identity; and (5) it contributes to positive physical and mental health. Negatively, religion (1) may promote fanaticism, intolerance, and prejudice; (2) it could be socially disruptive in its pluralism, categorizing people into believers and nonbelievers; and (3) it could condone policies
and acts of social injustice, directly or indirectly, thus perpetuating them. These divergent traits of religion could impact the clients in terms of strengthening or oppressing them. It is important then for the social work practitioner to know and understand these dynamics in order to maximize the assistance that can be extended to the clients and minimize or eliminate the pitfalls of their clients’ religion (Netting, Thibault, & Ellor, 1990; Porter, 2002).

Religiousness has three major dimensions in terms of one’s involvement in activities on religion (Koenig, George, & Titus, 2004). The dimensions of religiosity include the following: (1) ORA, or the organizational religious activity, which involves going to a church, synagogue, mosque or temple, attending religious functions, and participating in prayer or scriptural study groups; it is other-directed, and socially-oriented; (2) NORA, or non-organizational religious activity, is more private-oriented, involving personal religious behaviors, such as, praying, meditating, reading the Bible or religious literature, listening to religious radio programs, or watching religious TV programs (Lowis, Edwards, Roe, Jewell, Jackson, & Tidmarsh, 2005); (3) IR, or intrinsic religiosity, is also subjective in orientation, whereby one understands religion as a motivational factor in one’s life towards decision-making and behavior. Intrinsic religiosity closely overlaps with the realm of spirituality in its broader sense. A professed atheist may disdain the use of the word religion or religiosity, but the commitment to a cause or ideals beyond oneself could indicate signs of the subjective religiosity in the person, or ‘spiritual instinct’ (Address, & Person, 2003, p. 63). A sure guide that the religious experience is viable is that it should be “philosophically

Cohen, Hall, Koenig, and Meador (2005) distinguished religiousness into two, instead of three, dimensions, mainly, the IRO (intrinsic religious orientation) and the ERO (extrinsic religious orientation). The distinction was based on the orientation in one’s motivations, either individual or social. Applying this criterion on some religious institutions, the authors identified the American Protestant and fundamentalist religions with IRO leaning, while the Jews and Catholics tended to be more on ERO side.

Evidently, spirituality and religion are two distinct concepts, though overlapping at times. Since they both touch on transcendental realities, they are related to each other. Spirituality encompasses all transcendental relationships of the individual beyond oneself. Religion is more focused on the expressions of spirituality, particularly in communal context, by way of systems of beliefs (faith), teachings (dogmas), rituals (in worship or liturgy) and ethics (values and conduct). There is a relational aspect in the two entities. Spirituality integrates the horizontal aspect (one’s positive self-concept in connectedness with others and environment) and the vertical aspect (in one’s transcending union with God, a higher power, or creator experience) of relationships (Britto, 1998). Religion brings together individuals in the common spiritual experience and communally expresses in teachings, rites, and ethics their relationship with the self, others, universe, and transcendent Being, Power, or Reality which mutually impact one another for the person’s well-being.
Considering the innate relationship between spirituality and religion in a continuum, spiritually-competent social work practice demands care, sensitivity, courage, and confidence in working to promote the well-being of the clients. In this regard, the practical insights of Bein (2008) on tapping the treasure field of spiritual and religious experiences of clients evoke due interest. He writes:

It makes little sense to say that we will inquire about spirituality but we will not talk about religion. The dualism between religion and spirituality is artificial when it comes to the world of our clients. Obviously, people have all kinds of combinations regarding the manifestations of their religious and spiritual lives. Some people start with the formality of religion and become more spiritual over time. Some people start with some religious training, leave their place of worship to develop their own sense of spirituality, then return to place of worship to gain community and structure. (pp. 155-156).

*Spirituality and Religion as Tools for Coping with Life’s Challenges*

Research studies on the helping professionals, particularly in social work practice, have been conducted with spirituality and religion as variables in relation to the individual’s physical and mental health, and their coping skills with life’s challenges. In the field of health care, stressors and burden are inherent in providing care for others, especially the elderly, the children, or those with disabilities. The literature review on this theme could shed light in understanding the role of spirituality and religion on the motivations and services of caregivers in the demanding task of caregiving.
On the challenges of the aging process and caregiving, Koenig, George, & Titus (2004) observed in their study that religious activities, personal religiosity, and spiritual experiences brought about multiple benefits to care recipients themselves (Gallego, 1988; Heyman, Buchanan, Marlowe, & Sealy, 2006), such as, warding off depression, improving cognitive function and physical health, enhancing readiness to help others, and in maintaining positive attitudes toward self-care, compliance, and recovery (Moberg, 2005; Hill, 2006). This is significant for the caregivers to know and realize so that as they provide care to others, their works would be less burdensome and effective both for the care recipients and themselves.

The report of Choi, Tirrito, & Mills (2008) on the role of religion and spirituality in helping caregivers decide for their loved ones on the institutionalization of their elderly parents or relatives presents a useful list of research findings on the benefits of these coping tools in promoting caregivers’ well-being. Some of the findings they mentioned confirmed other related results: (1) that having religious beliefs and religiosity, and employing them to cope with caregiving stress minimized the strain of the task (Jacobsen, 1988; Lowis, et al., 2005; Leblanc, Driscoll, & Pearlin, 2004), increased positive psychological well-being (Forbes, 1994; Leetun, 1996; Chang, Noonan, & Tennstedt, 1998; Olvera, 1999; Stuckey, 2001; Hillier, & Barrow, 2007), and lessened the rate of depression (Koenig, McCullough, & Larson, 2001; Koenig, George, & Titus, 2004; Jacobs, 2006); (2) that having the network of informal support from the religious group (church or communities) lessened the need for formal support in providing care; and (3) that active religious involvement related positively to physical and mental health.
(Van Hook, & Aguilar, 2001), optimism, and longevity (or “successful aging”, Sadler, 2006, p. 268; Rowe & Kahn, 1997). The study of Choi, Tirrito, and Mills (2008) showed that by participating in faith-based organizations and interacting with the members the anxieties of caregivers were reduced and they felt less need to institutionalize their elderly care recipients.

In relation to solving ethical dilemmas, Koenig (2005) found that in the interview of 13 female caregivers, they used spirituality as a philosophy of life, as help in decision-making, and as a way of transcending dilemmas that they face. Kaye and Robinson (1994) observed in their study of 17 female caregivers whose husbands suffered dementia that they used spiritual behaviors to compensate for their perceived lack of caregiving support. They prayed, watched religious TV programs, read spiritual materials, talked to friends or family about spiritual matters and their blessings, and shared their problems too.

In times of hardships in life, including caregiving burdens, addiction, and the aging process, spirituality and religion play a key role towards resiliency and recovery (Ramsey, & Bliezner, 1999; Greene, & Conrad, 2002; Abbott, 2008). With resilient attitude, one can cope well with the various stressors in life, which positively impact one’s health. In a report by the Fetzer Institute and National Institute of Aging Working Group (FI/NIAWG) (1999), certain domains of religion and spirituality that most likely impact health included: “daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious and spiritual coping, religious support,
religious and spiritual history, commitment, organized religion, and religious preference” (p. 411).

Studies on the impact of spirituality and religion on caregivers’ health and their coping skills revealed that different ethnic groups have varied levels of employing them and manifest different results in their relationship with the care recipients and on their well-being. Hebert, Weinstein, Martire, & Schultz (2006) found that spirituality and religion helped caregivers in positively reappraising their role and promoted positive results in their services. Moreover, their study showed that ethnic minority caregivers, such as African Americans and Hispanics, had higher religious and spiritual scores and frequent religious behaviors. Gardner, Tripp-Reimer, & Simpson (2007) found that in a qualitative study of African American female caregivers in Arkansas Delta, spirituality, faith, and religion played important roles in their coping with caregiving responsibilities and enhancing their sense of identity (Miltiades, & Pruchno, 2002).

The church historically served as a liberating sign of their freedom from the grim past of slavery. Prayer was the most common coping tool in their time of adversities to relinquish problems to God, reduce emotional stress, and, as one participant noted, “lift(s) my burden” (p. 369). Notably, African American caregivers who resided in large urban areas found less need for spirituality and religion in their caregiving role (Fox, Hinton, & Levkoff, 1999, cited on p. 369). In another study, Dilworth-Anderson, Boswell, & Cohen (2007) made a qualitative study of 303 African American caregivers and observed that emotional support and spiritual beliefs greatly helped caregivers in providing care for their older relatives. The respondents indicated that their spiritual
beliefs enabled them to endure and cope well. They helped deepen their sense of duty and relationship toward the care recipients. Faith provided them with encouragement and inspiration in life. Likewise, they felt satisfied in their caregiving works.

A study of Puerto Ricans in Springfield, Massachusetts by Delgado (1996) considered the culturally competent setting of the older persons in Puerto Rico on the provision of care and other social services. It involved 244 older persons with disabilities and 194 primary caregivers. This culture-sensitive approach facilitated the promotion of their well-being. Acculturated religious institutions, such as the fundamentalist groups, helped to meet the needs of their congregations with the use of Spanish language, holidays, and food (Diaz-Stevens, 1993). Their churches were conveniently located. They offered various activities for involvement, such as adult education and recreational programs, including the leadership possibility in the church. Although the Puerto Rican fundamentalist churches were less involved in responding to social and economic justice, they helped the members to adjust to the mainland life in the United States. In contrast, the African American churches assume cohesive roles for their members. They generate community social actions, business ventures, and charity works (Blackwell, 1985, cited by Delgado, 1996).

In a meta-analytical review of 116 studies of ethnic differences in stressors, resources, and psychological outcomes of family caregiving, Pinquart and Sorensen (2005) compared the minority ethnic groups of African American, Hispanic, and Asian American caregivers with the White caregivers. Inasmuch as we deal with Filipino caregivers in the present study, we focus on the survey results related to the Asian
American caregivers. The review study on the Asian American caregivers in relation to White caregivers showed the following trends: (1) that the number of their caregiving tasks was higher; (2) that they had poorer physical health, with possible causes, like, restricted access to good health care plans, lower level of insurance coverage, and racial discrimination; (3) that they experienced higher levels of depression, which could stem from cultural differences and choosiness in caregiving often resulting in poor relationship quality with the care recipients; (4) that they used the emotion-focused coping style (Riley, & Bowen, 2005) rather than the objective, instrumental style of coping; and (5) that they used less formal support (Scharlach, et al., 2006), due to language barriers or differences in acculturation, and mistrust of formal service providers. The barriers generate other outcomes, such as lack of knowledge of available services, and lack of available and appropriate services for their needs.

In the 2004 survey by the National Alliance for Caregiving and AARP, 73% of the 1,247 caregivers said that praying was their primary coping strategy. Of this percentage, African American (84%) and Hispanic (79%) caregivers used this coping mechanism with greater frequency compared to the White (71%) and Asian American (50%) caregivers. With the Spanish cultural and Catholic religious background of Filipinos compared to the contexts of the neighboring Asian countries, spiritual coping through active involvement in churches and their religious activities assumed primary importance for them (Scharlach, et al., 2006). This could have a carry-over in the coping strategy of caregivers (Ramirez, 2003), especially when they emigrate away
from their loved ones in search of permanent residency and/or employment overseas to provide better for their families.

Summary

Our review of the literature pertinent to our study reveals interesting insights about caregiving and the burdens that go with it, the use of coping strategies, particularly the use of religion and spirituality, and the socio-cultural contexts in which Filipino caregivers provide care and cope with the challenges they face.

Previous studies indicated that caregiving creates different relational levels and categories of care. It impacts family members and creates stress in their relationships. Family caregivers are able to render either obligatory or discretionary caregiving for their older parents. The caregiving task could become intergenerational and affected by gender and race factors.

At the base of this responsibility of providing care to older parents is the sense of filial devotion. Among Filipino families, care for older persons is also determined by the cultural values of the importance of the family or clan (in the spirit of bayanihan), the sense of reciprocal gratitude (utang na loob), harmony in one’s relationship with others (pakikisama), and shame (hiya). With the people’s history of waves of foreign occupation through the centuries, resilience is manifested in flexibility and gentleness of character, which count a lot in the quality of providing care to others. In general, Filipino migrants carry over this cultural frame of mind to their work of formal caregiving even in other countries.
Social networking is important for coping with the demands of providing care. The family becomes the primary resource for coping against the burden and stress of caregiving. Then, by joining social clubs and participating in cultural activities among their countrymen even in other countries, caregivers are able to cope with the difficulties of their work. However, either as an added tool or as a fundamental mechanism for coping, spirituality and religion become significant coping strategies used. This is done through praying, deepening their faith in God, attending church services, joining religious organizations, reading religious materials, and listening to or watching religious programs. While spirituality and religion are distinct in their scope, they are often used interchangeably.

One cannot take for granted the immense challenges that Filipino formal caregivers face in doing their job. The burden of caregiving is compounded by other challenges in their personal or family life, such as the financial needs of their own families, the emotional strain of being away from their loved ones who reside in their home country, such as the Philippines, and the threats to their physical and mental health. The culture of love and respect for older persons by the caregiver helps mitigate the emotional angst of separation from one’s family. It helps channel the need to relate with others through service and find satisfaction in the emotional labor being expended in one’s work. Social support through family connections, friends, and cultural and religious affiliations are experienced as good coping ways. Formal caregivers cite the use of spirituality and religion for its positive impacts on the various aspects of their life.
The presentation of the methodology and the findings of our study in the next chapters will provide interesting insights on the approach used and the experiences and opinions of the participants in their caregiving works.
Chapter 3

METHODOLOGY

Introduction

This chapter describes the methodology employed in this research study. It presents the study design, sampling and data collection procedures, and the approach in analyzing the data. With sufficient care done in protecting the human subjects of this study, I likewise indicate the procedures taken to safeguard the participants’ safety.

Study Design

This study examined the role and use of spirituality and religion in relation to caregiver motivations and caregiving services. The research design is exploratory and qualitative in nature. Narratives were obtained from participants regarding their experiences and perspectives of caregiving.

Moberg (2001, cited in Cohen, Thomas & Williamson, 2008) observed that the majority of studies on the elderly and on spirituality and religion are quantitative in design. Qualitative studies may be weak in presenting objective empirical data and in the ability to generalize the results of the findings. However, they lead to deeper understanding of the subject’s perspectives and insights on particular topics, situations, and events (Rubin, & Babbie, 2008). Because of this topic and the “highly personal and individual nature of religious and spiritual beliefs,” (J. C. Stuckey, 2001, p. 83), the qualitative study is better undertaken. Though spirituality and religion defy finer empirical norms for scientific evaluation, they provide meaning to life and enable the
individuals to transcend their physical limitations, relate comprehensively beyond themselves, and discover their self-identity (Canda, & Furman, 1999).

**Sampling Procedures**

Our study involves the participation of formal and informal caregivers to older persons. Since the focus of the research is on the experiences of Filipino caregivers, I employed purposive sampling in the selection of the subjects (Rubin, & Babbie, 2008). Initial selection of the subjects began with the request made to the administrator of two RCFEs (residential care facility for the elderly) in the Sacramento area to allow interviews of willing formal caregivers who are all Filipinos from the said facilities. There were eight qualified subjects from this first round of selection. The second round of selection involved snowball sampling of two more subjects.

On the selection of informal caregivers, I was able to interview two friends of mine to talk about their caregiving experiences. A third one, a male person from Central America, was chosen as a negative case sampling. He was referred to me one formal caregiver.

For our study then, there are thirteen Filipino caregivers and one Central American male informal caregiver who participated. Three other Filipinos were considered as potential participants but, in the final analysis, they did not qualify according to the established criteria due to distance and their lack of availability for interview.

**Protection of Human Subjects**

To protect the safety of the participants, multiple steps were taken at every phase of the study. The application submitted for approval by the Committee for the Protection
of Human Subjects of the Division of Social Work at the California State University, Sacramento, detailed the process in ensuring the safety of the participants.

When the topic for research has been ascertained with the help of the project advisor, a letter from the administrator of two RCFEs was addressed and presented to the Committee chairperson indicating the approval of the request to interview willing participants among the caregivers. The application included a copy of the informed consent form (Appendix A), which the participants would read and sign to express their consent to participate in the project and the interview to be audio recorded for accuracy in reporting the subjects’ responses during the interview session. Likewise, a sample copy of the interview questions was attached indicating the general logical movement of the interview session (Appendix B). Appendix C in this project lists possible names of resource agencies for counseling whose service a concerned participant could avail of, should the need arise as a result of one’s participation in the research study.

The approval by the Committee for the Protection of Human Subjects of the Division of Social Work was issued on May 18, 2009 with the approval number of 08-09-129 (Appendix D). The research project was classified to involve minimum risk. Although there was potential psychological harm due to questions that could involve intrusion into the subject’s privacy, the risk was expected not to cause more stress than would be experienced through the course of regular activities in daily life.

Data Collection Procedures

The data used in this study were gathered mainly through face-to-face interviews with the participants. The respondents were caregivers, either in formal or informal
capacity. The formal caregivers worked at two RCFEs or in in-home support services in different homes. The informal caregivers have provided care to their older family members, either a spouse, an older sister, or parents-in-law.

The participants were initially notified about the project study during an earlier visit made to them. After they signified their willingness to participate and be interviewed, dates were set for the actual interviews. Using the guide interview questions (Appendix C), the interviews were done either at the facilities or at their home. One informal caregiver was interviewed in a coffee shop. The interview lasted from one hour to one hour and a half each. The questions were asked in English. The respondents had the option to respond either in English, Tagalog (the official Filipino language), or in Pampango (a regional language used in a province mainly, some 70 miles north of Manila, of Indo-Malayan roots). The researcher engaged with the respondents in either of these languages, in interpreting or elaborating the question, and later in translating the responses for analysis on the project findings. In this report, some native words are enclosed in parentheses to savor their linguistic and cultural nuances.

The important elements in the study process included the confidentiality clause in the research process, the safeguard on the anonymity in the use and presentation of the findings, and the care in ensuring the safety of the participant’s well-being. Pseudonyms were used to identify the participants. The collected materials with the recorded data, such as the letters of informed consent, the recorded interviews, and the written notes, were securely kept in custody in a locked file cabinet. At the conclusion of the study,
coinciding with the end of the academic year 2009-2010, the notes and taped interviews of the participants were disposed.

In order to report accurate information on the responses of the participants, the interviews were audio taped. The participants initialized their names on the line provided on the letter to express their consent for audio recording. At the end of the letter, opposite the signature of the researcher, the participants signed and dated the letter.

The responses to the questions were audio recorded by the researcher. At the same time, scribbled notes were made to facilitate the review of the main ideas or insights shared by the participants. After the interview, the significant points in the conversation were noted down, some of them were written verbatim on a notebook, for appropriate use in reporting the findings in the study. In the course of data collection process, the researcher underwent debriefing with the project advisor to help maintain the methodological rigors in conducting qualitative research (Padgett, Mathew, & Conte, 1990; Rubin, & Babbie, 2008).

*Instruments Used*

The basic tool used to draw information from the responses of the participants in the open-ended interview was a set guide of 22 interview questions. With the differences in the situation of the informal caregivers from the formal care providers, the beginning and ending questions for each group have been modified accordingly. The set basically consisted of six sections detailing different areas relative to the development of the topic. The six sections pertained to the caregiver’s work situation, religious preference
and history, the meaning and relevance of spirituality, relationship between work and sense of spirituality/religion, narratives and observations in caregiving works, and the rewards and benefits of caregiving.

In conducting the interview, a digital audio recorder was used to record the interview session. A ball pen and a notebook were used to record the main points of the interviews in order to facilitate the search for the actual segment of the interviews for verbatim transcription of the responses. Meanwhile, for security purpose, the gathered materials were always kept in safe custody in a locked cabinet in my room, far from the reach of other individuals.

Data Analysis

Analysis of the data followed soon after the data collection. The recorded notes were reviewed, and emerging themes and patterns were identified. The interview responses were then classified according to the themes earlier identified. With the related themes grouped together, emerging patterns were discovered and organized (Luborsky, 1994). To highlight the nature of the participants’ responses, quotes from the subjects and examples from their experiences were added.

Summary

In this chapter, the methodology in our research process was presented in an overview. After the Division Committee approved the human subjects protocol for the study, interviews were conducted involving purposive sampling of fourteen caregivers, eleven had formal caregiving roles, and three provided care for their family members. All were Filipinos, except one Honduran informal caregiver. Care and caution were
duly taken to ensure the methodological rigors in the research, especially in the

collection and the analysis of the data. The significant findings of the study will now be

presented in the following chapter.
Chapter 4

THE FINDINGS

Introduction

The personal face-to-face interviews with the participants were an intimate exploration of the interviewees’ perspectives and distinct lived experiences. Steinar Kvale (1996) highlights the idea of mutually enriched sharing between the interviewer and the respondent. He makes use of two metaphors for interviewers, that of a “miner” and a “traveler”.

A miner diligently digs out the field in search of the treasures buried in it. Having been given the prerogative to venture into another’s hallowed ground (the participant’s experiences shared in the life-narrative), the interviewer needs to proceed with caution, respect, and admiration. He has an idea of what to look for, but he should be ready for surprises in his discoveries (Padgett, 1990), aware that the experience itself would be enriching.

A traveler is open to the beauty of the place he visits, but more importantly, the unique life-culture of the other that would enrich him. The idea of a “pilgrim” or “sojourner” becomes a more fitting metaphor for the interviewer, especially when the notion of the sacred (kadosh) is understood in the interrelational dialogue with the participant. One treads on sacred ground where one’s cultural protective gear, shoes or sandals (preconceptions, prejudgments, and biases) must be taken off out of respect for and openness to the culture and perspective of the proprietor of the land. An important evaluation law of Halcolm which was quoted by Patton (1990) stressed that “qualitative
inquiry cultivates the most useful of all human capacities – the capacity to learn from others” (p. 7).

In this chapter, the significant findings of the study based on the interviews with the participants are presented. It begins with the demographic information gathered in the study. Then, in relation to the themes found in the literature review and from the interviews made, the findings of our study are presented in six sections: (1) motivations for caregiving, (2) caregiving situations and the associated burdens or stress, (3) the cultural factors in caregiving, (4) definition and relationship between spirituality and religion, (5) coping strategies in caregiving and the rewards of caregiving, and (6) the influence of spirituality and religion for wellness and quality of life.

Demographics

The fourteen participants in this study were caregivers, either as formal or informal ones. All of them exercised their caregiving works in the Philippines and in California, especially in Sacramento. Thirteen participants were Filipinos born in the Philippines, and one informal caregiver was born in Honduras. As first generation immigrants from different countries, the participants had their caregiving experiences prior to their migration to the United States. Eleven of our participants were formal caregivers, and three of them cared for their family members. Of the formal care providers, eight were female, and three were male. The informal caregivers consisted of two females, a spouse and a sister, and the male caregiver was the adult son of his parents. To give personal identity to our caregivers, we use code names in reporting their narratives or comments. The eight female formal caregivers were Jane, Odette, Joyce, Remy, Karen,
Cora, Lina, and Ana. The three male counterparts were Neal, Leo, and Edbert. Our family caregivers were Talitha, Julia, and Jorge. An elaborate description of the latter three is presented below. For the sake of confidentiality, generic reference is made only when the information shared was rather sensitive. Otherwise, we acknowledge the merits of the comments given and the unique worth of their caregiving experiences.

The ages of the fourteen participants ranged from 26 to 67 years old. The ages of the formal caregivers averaged 45.6 years old (n=11), while the average age of the informal caregivers was 61.6 (n=3) years old. They assisted their loved ones for an average period of 9.3 years. The three informal caregivers lived with their care recipients throughout their caregiving period. Their age range of the caregivers is distributed thus:

Table 1
*Age Distribution of the Caregiver-Participants*

<table>
<thead>
<tr>
<th>Age Range of the Respondents</th>
<th>Number (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 and under</td>
<td>2</td>
</tr>
<tr>
<td>31 – 40</td>
<td>1</td>
</tr>
<tr>
<td>41 – 50</td>
<td>3</td>
</tr>
<tr>
<td>51 – 60</td>
<td>6</td>
</tr>
<tr>
<td>61 – 69</td>
<td>2</td>
</tr>
</tbody>
</table>

Except one female formal caregiver who finished high school and vocational studies in the Philippines, all the 14 participants had a college degree, and had worked professionally in the home country Philippines in different capacities as high school and college teachers, business person, financial consultant, supervisor in a car dealership,
information technology engineers, biologist, chemical laboratory engineers, nurse, senior bank teller, and executive legal officer in a national financial company. This finding resonates with the results in the study of Ramirez (2003). However, the sample from Quinlan (1988) was comprised of a majority of paid caregivers possessing a high school education or less (Ramirez, 2003).

The majority of the formal caregivers (8 out of 11) worked mainly in two RCFEs. Two rendered in-home care support services. Another one assisted at a bigger suburban facility. Their average years of services as caregivers were 6.5 years.

Concerning the family caregivers, the first one Talitha, 67, cared for her spouse (aged 70) for six years. Her husband had a complicated heart bypass operation. He became confined to a wheel chair and was unable to walk. However, he continued his spiritual and social life. He had time to continue his updating his books in the legal field, albeit in a reduced way.

The second informal caregiver, Julia by name, 60, cared for her older sister (aged 81) for a period of twenty months, that is, from the time of her diagnosis till her death. The sister was diagnosed with stage 4 lung cancer. It soon metastasized to her bones, and later spread to her spine, cervix, and brain.

The last informal caregiver among our participants, known as Jorge, 58, was born in Honduras. He lived as single from the time of his separation and eventual divorce from his wife until he married his neighbor who was a Filipina widow fifteen years earlier. As a young adult, he moved to Sacramento with his parents and lived with them. His eight siblings lived mainly in Honduras and other parts of California. Since he lived
with his parents, the task of caregiving fell on him. He first cared for his father who was sick of leukemia for ten years and died at the age of 87. His mother had broken ribs due to repeated falls. Towards the end, her chronic pains were exacerbated by pneumonia which led to her death at the age of 89.

Motivations for Caregiving

Behind every human action, there are motives and motivations, be they on the conscious or subconscious levels. Motive(s) could refer to the specific reason(s) for an action or a behavior. It points to “some inner drive, impulse, intention, etc. that causes a person to do something or act in a certain way” (Webster’s New World Dictionary, 1986). Motivation, though synonymous to motive, pertains more to a prolonged rationale for a sustained behavior or lifestyle. Different and contrasting motivations could coexist in the individual. They may have varying moral characters as neutral, good, or bad, which could evolve in nature and intensity, depending on circumstances or factors affecting the person.

The formal caregivers were asked: “What led you to become a care provider?” (Question #3). The question curiously asked for the circumstances and the motivations in their role as caregivers. In their responses, the common rationale was the financial need to earn a living for their families. However, as one listens to the specific circumstances of the participants, there are ramifications to their responses. All of the eleven formal caregivers, except three, entered the country with tourist visas. The three exceptions had their immigration papers in order and later they became naturalized citizens. They subsequently applied for caregiving jobs to supplement their income,
together with other motives. Joyce did extra babysitting times, but with irregular schedule. In becoming a caregiver, she commented, “I had no choice. I don’t like the job because there is too much responsibility.” Odette worked in a money remittance agency. She saw caregiving as a “good source of income.” Lina was married to an American citizen. She said that in one of her visits to an older neighbor who lived in a big care facility for the elderly, she felt compassion for the older people. “I saw their need for care and companionship,” she noted. “I love older people, and I thought I could help them as caregiver.”

The rest of the formal caregivers came to the United States with no legal papers, but they needed to support their family in the Philippines (5 out of 8 respondents). However, secondary motivations led the caregivers to stay in their caregiving works. As undocumented immigrants, caregiving became the only available job open for them. In the course of doing their jobs, the concerned participants enjoyed their work because of the benefits of free board and lodging for live-in caregivers (8 out of 8 respondents). Four of the 8 respondents said that caregiving was part of their nature to help others, particularly the older adults whom they treated as their parents or grandparents. Two of the 8 respondents indicated that their work was related to their educational formation or work experience, either as nurse or parish volunteer, back in the Philippines. The majority of the formal caregivers expressed satisfaction in their caregiving job (10 out of 11 respondents).

The family caregivers were not explicitly asked why they became care providers to their loved ones. But their dedication and commitment to provide care showed deeper
motivations. Talitha responded that caregiving was rewarding for her, especially “that I was able to provide care and comfort to the one in need….that I was instrumental in making life a little better for someone I cared for very deeply.” Julia shared, “My sister has been very good to me. She was not only a sister, but a mother and father when both passed away. I was determined to serve her to reciprocate the care and love she showered on me during my entire life.” When I interviewed Jorge, his mother recently died a couple of weeks earlier. The signs of his grieving for the loss of his mother were still evident in his responses. He provided care for his parents till their deaths. He said, “I am lucky to have taken care of my parents because I was most available among my siblings. But I never regretted it. I enjoyed giving care to them. Now I miss those days when Mama was around with us. I loved Papa and Mama a lot.” The closeness of the family caregivers to their relatives whom they care for is understandable because of their blood relationships. However, for the formal caregivers, their closeness with the older adults whom they serve was not lacking. Their filial attitude to older people even became a sustaining factor for them to find satisfaction in their job.

*Caregiving Situation and the Associated Burdens or Stress*

On the caregiving situation and its associated stress, the participants were asked these three related questions: (Q #1) “As caregiver, what is the nature and scope of your responsibilities?”; (Q #13) “What has been the greatest challenge in your life?”; (Q #14) “What is (has been) most challenging in your caregiving work? What are the difficulties you encountered?”
The formal caregivers described their work in terms of the care recipient’s activities of daily living (ADL), that is, those pertaining to basic functions, such as personal care and hygiene. They helped care recipients go to the bathroom, gave them showers, made them presentable by combing their hair, helped them get dressed, prepared their food and medications, and then at night, assisted them to their beds, and made sure that everyone was safe. The caregiver-nurse even regularly checked the vital signs (blood sugar, blood pressure, pulse rate, and respiratory rate) of the residents under her care. Services for instrumental acts of daily living (IADL) were also rendered, such as helping the older persons do their grocery or mall shopping, run errands for the care recipients, mail letters for them, assist them go to banks, or for their doctor’s and/or dental appointments. Remy, the care home administrator, oversaw these different tasks and ensured that everything went on smoothly. Lina who was with the Activity Department organized individual and group activities for the residents. She even went around and visited the frail ones, talked to them, listened to their stories, sang and danced for them, as needed, to cheer them up. At the two RCFEs, the administrator planned the yearly, monthly, weekly, and daily programs, and the caregivers assisted in implementing them as they took turns in leading the activity programs of physical exercises, intellectual activities (solving puzzles, scrabbles, finding the word games, etc.), cultural events (watching July 4 parades, doing the Easter egg hunt, summer festival, Christmas gift exchanges, etc.) and common games (including bingo, karaoke singing, dancing, etc.).
The three family caregivers summed up their caregiving tasks in two ways, namely, to make the life of their care recipients comfortable, and to keep them company. Aside from attending to the ADL’s of their care recipients, including their medical adherence and injecting insulin, they helped their family members in their other needs, the IADLs. This work involved typing letters for them, preparing the supporting documents for reimbursement of medical expenses by the insurance company, and reading the latest news of the day and portions of books of interest. Julia also accompanied her sister to the daily 6:00 A.M. Mass in their nearby parish church.

The formal caregivers attest to the caregiving stress in their work. These add up to the other stressors they experience in their lives. The burdens of caregiving begin with the struggle to carry the patients physically when they had to move from and into their beds. Edbert mentioned that for one resident, a heavy-set European woman, he had to use a mechanical lifter to move her between the bed and the wheelchair. As she was hoisted, she would routinely cuss at anything and anybody. Joyce complained of being scratched on her arms by a stubborn care recipient while she had to endure the cusses directed at her.

Most caregivers understand that the care recipients with dementia and Alzheimer’s disease were more challenging in their behaviors (Ramirez, 2003). These could be violent at times, and they had to be ‘restricted’, either to contain them or to prevent them from falling off their beds. Jane recalled that in one facility where she worked, the administrator often took her to drive around the neighborhood in search of some able but lost and wandering residents. Neal noted that aside from having had a long day, he
lacked sleep during the night because while a resident kept shouting throughout the night, another one had to go to the bathroom at least seven times in the night. Some residents had come to the point of playing with their feces, or throwing it against the wall. Some caregivers euphemistically called this action as “painting on the wall.” Ana noted that she was able to handle difficult residents, but there were times when her patience was tested, especially when she felt that a resident did not respect her when she introduced Ana to her family as “my servant.” Her ears turned red as she felt discriminated and hurt, but she gently corrected her saying, “I am caregiver for all of the home residents.” Remy shared her experience of getting racial derogatory remarks in one facility from a male care recipient who was arrogant and repulsive. The recipient once saw TV footages about the Philippines’ infamous Smoky Mountain (a dumping ground for garbage in Tondo, Manila until the mid 90s where destitute families of slum-dwellers and scavengers made their living by dwelling on or around the mountain of garbage trash and incinerating the huge amount of garbage openly looked like a perpetual smoking garbage furnace. As Remy attended to him, he reacted with his usual abusive words and said, “You, Filipinos, eat only trash, don’t you?” She felt hurt, but she humbly and maturely responded, “No, we eat lots of good delicious food!” She noted that such an incident was a test of patience for her.

Seven of the eleven formal caregivers mentioned that the physical and emotional stress in caregiving tested their patience a lot. Some live-in caregivers indicated that the stress was aggravated by their situational confinement in the facility, even on their days-off, with a feeling of suffocation. Instead of going elsewhere on their free days, they
preferred to stay-in and get more time to rest (Bedini, & Estes, 2002; Ramirez, 2003). Often they had to deal not just with the residents, but also with other caregivers, the families of residents, and the facility administrators. The relationship strain added up to the personal problems for the caregivers, including the anxiety of “staying without legal papers,” family and marital problems, difficult relationship with a daughter, death of family members and grieving over the loss, aggravated financial difficulties as fraud victims, kin’s demand to support poor siblings living in the home country, and crisis of faith.

Among family caregivers, their stress included the state of frustration and helplessness at the challenging condition of the spouse. Talitha mentioned that one of “my most challenging roles as caregiver happened when my mother died, and I had to provide care for my Dad who lived in another province that required a long bus trip of three hours to the province almost weekly until his death.” Her other siblings lived in the United States and she was left alone to care for her Dad. Jorge’s burden of providing care to his parents was aggravated by the illness of his sister who lived in Honduras but was suffering with multiple sclerosis for forty years. This trying situation made him question his faith in God and why and for what purpose he had to suffer. As he cared for his parents, he felt helpless to provide care to his ailing sister.

Julia’s struggle concerned her guilt when her caregiving commitment to her sister conflicted with her volunteer works with her church which meant her commitment to God. She desired to be “completely selfless” in wanting to serve God through her commitment to her church although she “felt unappreciated in what I have been doing
for them (personalities in the church hierarchy).” At the same time, she felt divided when she had to attend to her sister whose days became more and more limited. To assist her church, she gave up her job. In assisting her sister, she had to make more personal sacrifices because “my sister had been very good to me.” Her sister “was not only a sister, but a mother and father when both passed away. I was determined to serve her to reciprocate the care and love she showered on me during my entire life.” Julia’s love for her sister helped her endure more stress.

The participants were not explicitly asked about the impacts of caregiving on their health. They seemed physically healthy and did not mention anything related to their physical well-being. However, their stories indicated the impact that emotional stress played in their lives. Nonetheless, the caregivers were able to cope in their job or commitment. The theme of coping skills is discussed in the section below. It is the basic attitude of the caregivers which helped them manage the multiple stressors in their life. “I do things one day at a time,” confessed Neal in handling stress. “After all, it will pass,” he continued as he referred to the temporality of the hardships he went through in his life. Talitha shared an important insight when she said, “I notice that love for the patient is one sustaining factor in being able to cope.” Julia echoed this message as she said, “If you really love a person, you will never resent doing a lot of sacrifices for her sake.”
Cultural Factors in Caregiving

In the interviews with the formal caregivers, I posed an extra question to them which pertained to the cultural factors in caregiving. The question (#23) was: “Do you think that Filipinos do well as caregivers? Why?”

Foremost among the responses given by the participants, they noted that Filipinos are patient (mapagpasensiya). This trait is understood as the ability to endure pains and hardships in order to achieve a goal. It relates well with persevering (matiyaga), being kind (mabait), or being gentle with people, especially the disadvantaged. Patience also relates to being accommodating (mapagbigay) without any expectation of extra compensation. A male caregiver was quick in making ethnic comparison with the actions of his former coworkers. He said, “Yes, Filipinos fit well into caregiving! The Indians (from Asia) did not want to deal with the residents, but only with their mops.”

Odette was rather fair in her comments as she said, “Well, it depends upon the person. But in our culture, we love our elders.” Right away, some cultural traits surfaced in their responses. Filipinos are said to be patient, ready to endure hardships for the sake of others. Such traits stem from the desire to succeed in life. Cora, a caregiver-nurse who came from a family of nine children mentioned that her relatives from each parental side were well-to-do, and that these relatives looked down upon her immediate family. “Because of the way they treated us, I resolved to study hard and succeed in order to show them that I can do well too,” she confessed. “Since I live more comfortably than my other siblings and their families back in the Philippines, I presently help my other relatives financially, and even plan for their migration to the U.S.”
Apparent in this study is that related to patience or perseverance, kindness, and gentleness to people is the love for the family, especially the elders. The majority of the formal caregivers’ stories of prior caregiving experiences related to caring for their parents, grandparents, or other family members. They indicated a sense of duty but it was done out of love for them. Edbert, one of the male caregivers, admitted that in providing care for the residents in a facility, “I was seeing my grandpa (Lolo) in them.” Odette expressed that what she missed doing for her parents, “I want to do well with the older people here. I feel deep compassion for them.” Karen confessed, “It is like the extended love for my parents in caring for the old people.” Lina, a veteran caregiver, emphasized the “extra mile” of love for the care recipients as she said, “When I visit some residents, especially those who were hardly visited by their families, I would drop by to bring them flowers and let them taste some Filipino food. That already made them happy.”

Interestingly, one of the caregivers who had been working since her youth and was getting tired in her caregiving job noted that it was painful to be told of her last day with one care recipient because the recipient’s family moved her to live with them. This caregiver, Joyce, felt sad because she cared for the older person a lot. At the old lady’s previous residence, Joyce cleaned her place beyond what was expected of her, so the lady could live comfortably. She said, “There were times when I feel hurt because Mrs. A would embarrass me before others, but I became sad when I saw her new place. It was not that organized and clean. I even had to clean the bathroom which the family used.” Further on, she shared, “I wonder whether her daughter and the husband would
have time for her because most of the time they are out for work. The grandson who lived in the house was not also into maintaining a clean house.”

Karen mentioned that aside from the love for the elderly, a good Filipino trait is the fear of God. She said that she did her work not just out of love for older persons, but out of love for God. In the previous caregiving experiences of Talitha who cared for her husband, she showed her love for her Dad in caring for him despite the long distances she had to travel and the concurrent multiple tasks she had to do for her family and with her job at that time. Her inherent religiosity behind caregiving was evident when she said, “Thinking and caring for others is the best way of expressing one’s Christianity.” Jorge from Honduras showed his love for his parents through of providing care for them during their old age and illnesses.

The debt of gratitude (utang na loob) which is another cultural trait among Filipinos is veiled behind the extended love for parents and grandparents shown to the care recipients by the caregivers. This association is clearly expressed by Julia when asked whether she would provide care to others, should another occasion arise (Q #19). She said, “By nature I have the immediate reaction to provide care to others when needed, but the degree of intensity may vary from person to person depending on how much they have touched my life.” Julia considered her eldest sister as her surrogate parent. When her sister got sick, she gave her the best care in reciprocity of love.
Definitions and Relationship between Spirituality and Religion

Our findings in this study on the themes of spirituality and religion cover two sections of the research instrument, that of “Religious Preference and History” (Qs #4-8), and “Spirituality – Meaning and Relevance” (Qs #9-12).

On the topic of religion, the questions were: Q #4: “What is your religious preference?”; Q #5: “Could you share with me the history of your religious preference?”; Q #6: “How do you practice your religion? (such as, going to church, reading any religious book, listening to or watching a religion program, alone or with other worshippers); Q #7: “Where do you practice your religion?”; Q #8: “What is the core teaching you find in your religion?”.

Then pertinent to spirituality, the guide questions were: Q #9: “How do you understand the word ‘spirituality’?”; Q #10: “Would you find it important in your life? How?”; Q #11: “What is the relationship between spirituality and religion?”; and Q #12: “What do you consider most important in life? Give concrete examples.”

All the fourteen participants in the study professed a Christian religious preference. Eight were Catholics from birth. Three were baptized Catholics as infants, but upon adulthood, they affiliated to other Christian religions. Of those three, two moved to a non-denominational Christian religion, and one joined the Iglesia ni Cristo (INC) (Church of Christ), a Philippine-based religion. Two others were members of the Iglesia ni Cristo from birth. The last caregiver was baptized Methodist Christian, then he was confirmed Catholic as an adolescent, and in college, he became a born-again (Pentecostal) Christian. He was a member of a non-denominational religion which
focused on the primacy of the Bible. For an overview of the participants’ religious affiliations, the list goes:

Table 2

*Religious Affiliations of the Caregiver-Participants*

<table>
<thead>
<tr>
<th>Religious Affiliations</th>
<th>Number (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholics since birth</td>
<td>8</td>
</tr>
<tr>
<td>Non-Catholic Christians</td>
<td>6</td>
</tr>
<tr>
<td>Catholics, later turned non-denominational Christians</td>
<td>2</td>
</tr>
<tr>
<td>Catholic, later turned Iglesia ni Cristo (INC)</td>
<td>1</td>
</tr>
<tr>
<td>Iglesia ni Cristo since birth</td>
<td>2</td>
</tr>
<tr>
<td>Non-denominational (Born Again) Christian</td>
<td>1</td>
</tr>
</tbody>
</table>

From this list, one sees the diversity of the participants’ religious preferences and the progression of their choices through the various phases of their life. Affiliation as Catholic is represented as the majority group here, similar to the representation of the Roman Catholic religion in the Philippines (82%). Other Christian denominations, including the mainline Protestant groups and the non-denominational Christian (Born-Again, or Pentecostal) groups, come next in majority number. Having been born into the family tradition as Catholics, some changed their preferences later to other (Christian) religious denominations. Others were born already into another religious tradition and lived their religion with devotion. Jorge, our Honduran participant, underwent developmental process in his religious history. Born a Catholic, he later preferred not to affiliate to any church, but professed to be close to God and actively practicing his faith.
With the Spanish occupation of the Philippines for more than three centuries (1521-1898), the majority of Filipinos are Catholics (82%). As they grow into adolescence and adulthood, they make their particular choices of religion, such as, maintaining their Catholic faith, moving into another Christian denomination or local religion, or professing to be free from any religious affiliation.

The participants who professed to be Catholics or Roman Catholics believe in a Trinitarian God, the Father, the Son, and the Holy Spirit (Catechism, 1997). They believe that God the Father is the creator of the world, and that Jesus Christ is the Son of God, the Savior of the world. Going to Mass on Sundays, going to confession, and receiving Communion are significant elements of the Catholic practice. They concur that faith in God should be manifested in one’s daily life – based on “the golden rule of doing unto others what I would want others do unto me”. Further on, Talitha, a family caregiver, said, “I try to find opportunities to share what I have with others and look out for those in need.” These words echo Christ’s core teaching in the “love of God and of neighbor, as of oneself.” For her, God is “a merciful but a just God.” She added, “In the end, one reaps what one sows; as one lives, so does one die….I think the most important in life is to set a good example to others of the life you live and model the right values…. Hopefully, we can inspire others to do the same.” In saying these words, Talitha also put them into practice. She started a Medical Fund in their office to help her coworkers defray the staggering costs of medical care. After four years, the Funds’ worth more than doubled because of others’ contributions. It has helped a good number of coworkers and their family members in need.
Devotion to Christ is done, aside from going to church, through visits to the Blessed Sacrament in churches or devotion to the Sacred Heart of Jesus or Christ the King. On devotion to Mary or the Blessed Virgin Mary, most of the eight Catholic interviewees believe in her as the mother of Jesus, or the Mother of God. With their experience and relationship of support (through answered prayers) from the Virgin Mary, they reported that they expressed their devotion to her by saying the rosary (individually or as a family), praying the novenas to her, and beholding her image, painting, and/or statue (such as Our Lady of Lourdes, Our Lady of Fatima, or Our Lady of Guadalupe) in order to express their love for her in appreciation of her maternal love to them as her children in Jesus.

Some of the caregivers mentioned that in their younger days when they had more time available, they joined Bible study groups. Some continued to read the Bible privately or other religious materials for their inspiration and guidance. Prayer was an essential part of the daily lives of the caregivers at different parts of the day. Some said that they prayed before they started the day or before going to bed.

It happens that while the family members belonged to one religious tradition, individual members, beginning with the parents, exercised their religiosity in distinct ways, not necessarily according to the exact rituals of the church they belonged to. The testimony of Julia gives us an idea of the complexity and diversity of religiosity. She said, “My mother was a very devout Catholic, always going to mass. Although my father never went to mass or to the church, he prayed religiously in the morning and at night in front of the sacred images in their bedroom. My father, a very principled man,
was a true practicing Catholic in action – not by Catholic rituals like processions, etc., but in his fair and kind dealings with everyone. Also, he was the one who insisted that the family prayed the rosary together every evening.’”

The other caregivers, three of them, who moved to non-denominational religions focused on the Bible as point of reference for their beliefs. One who became a member of the Methodist church, and later of a non-denominational born-again church, professed in the Triune God, and in Jesus Christ as the Son of God. He read the Bible regularly at home, in their worship services, over the church’s website, or through audio tapes while driving. Another one believed in Jehovah as God, since she became a member of the Jehovah’s Witness. Later on, like Jorge, she opted not to belong to any church. They believed that faith in Jesus Christ was best shown in practice in daily life by being good to everyone.

Three of the caregivers belonged to the *Iglesia ni Cristo* (Church of Christ). One became a member of this church from being a Catholic. Two of them were baptized *Iglesias* from birth. This church was locally founded in the Philippines by a self-proclaimed messenger of God’s word named Felix Manalo on July 27, 1914. It was the date when World War I broke out. Known for its highly centralized government with executive leadership roles handled by Manalo’s clan, and strong emphasis on tithing its members, their church designs follow a common architectural style and are financed centrally (Santiago, 2005). They use the Bible to guide their interpretation of God’s Word. Although they believe in Jesus as the son of God, he is understood more as God’s special prophet, a very extraordinary man, but not God. Meanwhile, Bro. Felix
was God’s messenger (*sinugo*, Tagalog word for “sent”) from the east (Far East) commissioned to proclaim the divine message (*pasugo*) at a crucial world event, thus fulfilling the prophecies of Isaiah 46:11 and Revelation 7:1-4 (Aromin, 2008). The *Iglesias* do not celebrate Christmas as the birth date of Jesus. Instead of the Holy Eucharist (among Catholics), they have the Holy Supper in March or April, different from the Catholic or Jewish calculations of the date of the Last Supper. Upon the death of the founding father Brother Felix, his son Eraño took over the leadership of the church as its Executive Minister with the other kin of Brother Felix heading the corollary executive roles, such as the financial and construction departments. Brother Eraño died on August 31, 2009. He was succeeded by the Deputy Executive Minister, Brother Eduardo V. Manalo, his son. In July 2009, its 95th foundation anniversary coincided with the 41st year of its anniversary in the West (including, the United States). The members estimated to range from 3 to 10 million worldwide (inexact in figures because they claim not wanting to know their numbers) come for their worship services twice a week, preferably on Thursdays and Sundays. They organize bible missions in the homes of the members on a rotation basis. Aside from the teachings of the pastors, that are bible-based, their official publication is the monthly “*Pasugo – God’s Message*.” This magazine serves as the official teaching guide and bulletin for the members.

When the participants were asked about how they understood the word “spirituality,” there was often a pause of varying lengths as they tried to express what it meant. Different elements surfaced in their responses. The common element that was
mentioned as pertinent to spirituality was “God,” “Higher Being,” “belief in God,” “relationship with God,” or “connection with God’s Spirit.” From this transcendent relational element, the respondents (6 out of 9) saw the immanent aspect of spirituality in their person that enabled them to find meaning to their life and the events that transpire in life. In effect, they become inspired to be better persons and reach out to others in doing good works to people. Julia sums up the meaning of spirituality in these words: “It is turning one’s Faith into action. I used to believe for some time that spirituality means living a life of prayer, feeling holy….I now understand it as putting action what we believe and value in life.”

Interestingly, most of the participants also mentioned ways of nurturing spirituality in religious ways, such as prayers, going to church, doing novena prayers, etc. In this connection, the question was asked as to the relationship between spirituality and religion. Two responded saying, “I don’t know.” However, after some reflection, one replied in a concise way, “Spirituality through religion.” Other responses elaborated the basic relationship between the two concepts. They acknowledge that spirituality and religion are “interrelated,” and “interchangeable, hardly different” in use. However, the differences between the two concepts have been expressed by some participants in these words: “Spirituality is belief in God; religion is the outward expression,” or “Religion is the way to express one’s spirituality”; “Spirituality is deeper and personal, while religion concerns practices”; and “Religion is the base out of which spirituality springs forth or spirituality may come as part of one’s interaction with one’s fellowmen and with the beauty of creation, irrespective of one’s religious bent.” This last statement was
elaborated further by Talitha, a family caregiver when she said, “One cannot look around at the splendor of Nature without being touched to the core of one’s soul and find affinity in the beauty and majesty of Nature….Even without any organized religion this feeling and awareness will translate into sensitivity, thoughtfulness and kindness which I believe are the core elements of any spiritual human being.”

Two related questions were subsequently asked in the interviews. One dealt with the importance of spirituality in their life. We will present the responses to this question in the last section on quality of life. The other question solicited the participants’ views on what they considered most valuable in their life. Notably, their common response focused on relationships, particularly with themselves, their families, others, and with God. Three formal caregivers emphasized their effort “to give good life to my family” in order for them to have “peace of mind.” Three respondents indicated the close connection between their love of God, their families, and other fellowmen. One noted that this love is “made concrete through good examples and modeling right values.”

“Prayer is most important,” professed one family caregiver. She understood it that as a relationship with God and a “devotion to the Blessed Mary,” it is an effective tool in coping with life’s “pains and sorrows” and other challenges.

**Coping Strategies in Caregiving and the Rewards of Caregiving**

In the earlier section on “Caregiving Situation and the Associated Burdens or Stress,” the participants shared the challenges they encountered in their caregiving duties that compounded with the difficulties they experienced in their personal and familial lives. In this section, their coping skills are outlined, together with the rewards
or benefits they accrue in providing care to others. The guide questions posed to them were: (Q #15) “How do you cope with these challenges? Is the facility administrator aware of this, and how has it helped you cope with them?”; (Q #17) “What are some of the striking (inspiring) stories and experiences you have as a caregiver?”; (Q #18) “Based on your observations, what are the ways in which the elderly people cope with their challenges in life, especially in aging?”; (Q #19) “How do you find satisfaction in your work as caregiver? For your family? In your relationship with your fellow caregivers? In your relationship with the elderly?” (Q #20) “What are your future plans in life? Would you continue to be a caregiver, if circumstances permit?”; and (Q #21) “What are the rewards and benefits of being a caregiver?”

Among the different coping strategies which the caregivers employed in their duties, prayer occupied a prime position in their list. The fourteen respondents mentioned it as an important coping tool. They admitted to praying to God to ask for strength in fulfilling their tasks and/or thanking God for the many blessings received. Jane said, “I prayed to God in order to lighten the burdens of my work. My prayer was this, “Lord, help us, give us kind residents.”” Coping through prayer for others meant also being grateful for the “gifts received from God.” The gifts referred to could mean the caregiving job itself, good health of the caregivers, their families and their safety and comfort, their faith in God, and the helps to cope with life’s problems through patience, perseverance, and humility.

For the family caregivers, family support was very important. This did not necessarily mean one member taking over the caregiving job, but being appreciated for
the efforts to provide care to their loved ones. Being able to share their difficulties through listening ears and helping hands from the other family members lightened the burdens of the caregiver. For the formal caregivers, being able to connect with their families, especially those living overseas or in other states (through phone calls, emails, or visits) for whom they made sacrifices in their jobs as caregivers helped them cope well. Through communication with their loved ones and receiving help from them, the participants became emotionally recharged.

Support from the administrators of care homes and from fellow caregivers helped the caregivers also in managing the burdens of their caregiving tasks. The administrative support came in terms of bonuses or salary increases, certificates of appreciation, recognition during celebrations of the care homes, or positive affirmations to them. Cora proudly shared her experience that with her dedication to her work, she gained the recognition as “Employee of the Month” just in her third month at a facility. Remy narrated one incident during her work at a major Sacramento facility. She shared her rewarding experience in these words:

One time one of the facility residents was dying. There was no one with him in the room, no family member, no personnel. What I did was to stay beside his bed and talk to him hoping to console him in his last moments while I held his hand. My weakness is that when one of our residents passes away, I could not control my tears at the thought of bidding farewell to them. I was happy also at the thought that up to the final moments, we were able to help them live more meaningfully. The resident I was talking about died shortly after that. His family
members soon came, but they missed his final moments. To comfort them, I said that their Dad was not alone because I was there up to his last moment. I described to them how I stayed by his side and held his hand. They were grateful for what I did. I did not realize that the resident owned a big publishing company somewhere.

Then unexpectedly, in one of the caregivers’ meetings, the administrator of the facility told our group that a family commended the facility for the sincere care provided to their father. In appreciation for the facility’s services, they donated $300,000 to the facility. The administrator then asked who among us assisted the concerned resident and suggested that she would raise her hand. I was surprised to hear the story. When asked to come forward, I was even embarrassed to raise my hand in front of everybody. Soon I had the courage to acknowledge what I did. Everybody applauded at the recognition. On that occasion, the administrator gave me a certificate of recognition for the incident. That was very encouraging for me. I felt happy knowing that I was able to help someone and it made his family also happy. At least, the facility received a hefty donation too.

The administrative support, such as the story showed, was also rewarding for the caregivers in encouraging them, at least with the appreciation being given on their performance. Fellow caregivers provided support by way of guidance on the caregiving procedures, physical and moral support in handling the residents, and/or assisting one
another in emergency cases or covering for each other in times of personal appointments.

The use of self-care by the caregivers is another important coping skill noted by the participants. This is done with the use of centering techniques, that is, being mindful of what they were doing or about to do. Deep breathing also proved to be very useful. Some have a favorite motto to guide them in their daily life. Jane said, “I always remind myself to persevere amidst the hardships I experience with the words, ‘one day at a time’.” She challenged herself with a self-talk of “If others can cope with their problems, why can’t I?” Karen, a young caregiver learned from the coping style of some older adults who gave themselves occasional treats, such as eating her favorite food, or buying herself some stuff (clothes, shoes, or i-Pod).

Maintaining a positive attitude through a healthy sense of humor also helped the caregivers in their coping skills. Neal, a male caregiver told the story of his difficulty in dealing with a stubborn and ever-complaining resident who was a former history teacher in high school. He said that instead of being too serious with him, the caregiver used the resident’s language and perspective. Joe, the resident had the habit of going to the toilet several times in the morning without accomplishing anything. So Neal devised a coded science phrase to refer to his toileting routine. He told Joe one time, “Why don’t you just follow the law of gravity?” He did not hear any reaction from Joe. Later on, while Joe was seated on the toilet seat, he called on Neal and said, “Hey, the law of gravity is now at work!” Neal later happily shared the story with his partner caregiver for his accomplishment in helping Joe make light of the situation. The other participants
had their own stories of humor which helped them cope with the humdrum of their work.

The participants acknowledged that by performing group activities, such as physical exercises, scrabble game, bingo, or other intellectual games for the older persons at the facilities reinvigorated them too and helped them enjoy their work. Ana who was a former college teacher became creative in preparing the group activities, including vocabulary and math exercises. Lina always came in with her contagious smiles to the rooms of some facility residents who hardly received any family visit. She cheered them up by singing songs to them. Other caregivers would join some residents by taking turns in singing some karaoke songs with them. They acknowledged that such activity was very relaxing and refreshing to the vocal chord and the spirit.

All the participants mentioned that appreciation from the care recipients and/or their families propped them up a lot in their caregiving works. Even only being able to dialogue with the care recipients and make them laugh and respond well gave the caregivers encouraging moments. Responsive care recipients were often appreciative and grateful to their care providers. “I get inspired in my work when the older people, especially those who have developmental disabilities, could still recognize me, call my name, and say thank you,” confessed Karen. “When one resident spoke of me to her family and said, “Cora is very good”, I felt very happy,” Cora said with a smile. Ana felt delighted whenever one resident introduced her to her family members as “my special sister,” and not just as a caregiver. “There is nothing like being treated with respect and care too,” she said.
Not to be missed among the coping strategies by the participants was the sincere love of the caregivers for the care recipients. Talitha said, “I notice that love for the patient is one sustaining factor in being able to cope.” This reality of love is equivalent to what Karen mentioned as “TLC or tender loving care for the recipients.” The others expressed this insight as “loving your job makes the work easy.” In the context of the cultural values as Filipinos, it meant “treating the recipients as one’s own family members, as parents, or grandparents (Lolo or Lola).” Some of them noted that it was also a subconscious recompense to the debt of gratitude (utang na loob) to their own elders whom they have not served as well before.

The notions of satisfaction in the work as caregivers, rewards, and/or future plans in life showcase into the motivations of caregivers to continue their work or calling and find self-fulfillment in their tasks. On the question of sources of satisfaction in providing care to others, the majority of the participants emphasized the value of being appreciated in their work by the care recipients themselves or by their families. Most caregivers claimed that the simple words of gratitude or an encouraging smile by the older persons or by the care recipients with developmental disabilities were more than sufficient to uplift them from their burdensome day. Cora who administered a group home expressed her inner joy when the residents said that they wanted to stay with her and be under their care till their death. Joyce confessed that she was already feeling tired in working and simply looked forward to her retirement days, but each time her care recipient introduced her to her family as “my favorite caregiver” and gave her a hug, she got inspired to do her work well. Neal mentioned that in one facility, the
appreciation by the care recipients was done through tips “to buy some food” given on Christmas or their birthdays. They were careful in receiving material gifts, but with the administration’s knowledge and according to norms, these were happily received. Remy said, “As administrator and owner of the care homes, I feel happy when the residents recommend our place to their friends or the referral centers take us in priority. We give our best in caring for the residents, and such instances make us feel inspired, not just for the incomes we receive but in making a difference in the lives of others.” Julia shared her satisfaction as she said, “I know my sister appreciated what I did because she told a number of people…Our family appreciated what I did and tried to find ways to help me to lessen my burden.”

The insights of the caregivers on their work made them happy in doing their jobs or tasks. Janet acknowledged her joy in “the consoling thought of having helped others till their last moment.” This joy was among her intangible rewards as care provider. Talitha’s response to the question of rewards was, “The best reward for me is the knowledge that I was able to provide care and comfort to one in need…that I was instrumental in making life a little better for someone I cared for very deeply. Being able to prolong his life and provide him with a better quality of life are more than enough rewards for me.” Edbert’s satisfaction in caregiving was expressed in the bond of friendships he built with the residents. Although he secured another job, he regularly visited with them on the facility’s special events and greeted the residents on their birthdays. “A caregiver is always a caregiver,” he said, making these words his guiding motto on the rewarding role of caregiving.
Surely, the caregivers admit to the benefits of their incomes as caregivers to sustain their personal and family’s needs, to pay for their housing mortgages or related debts, and to secure relative comforts in their life. However, the majority refer to intangible rewards in their work (Kietzman, Benjamin, & Matthias, 2008; Koemer, Kenyon, & Shirai, 2009). “I enjoy being with the elders and build friendships with them. I also begin to understand my own aging and provide me with coping skills,” replied Odette. In the future, she said, “I plan to have my own care home.” Remy said, “As care home operators, having happy residents and being able to help caregivers are sources of joy for us already. We hope to make a difference in their life. My husband and I hope that this tradition of caregiving continues in our family.”

There are skills learned in caregiving too. Leo acknowledged that he learned to cook by being at the facility. Karen planned to continue her studies towards a degree in nursing which is an advanced level of caring for others. Cora expressed her plan to found her own home care facility and engage in paratransit business related to transporting consumers with disabilities and the older persons. Julia shared the different insights she gained in providing care for her sister. She said, “Now I have better understanding of their (caregivers’) responsibilities. I learned a lot of medical terms and procedures. (Caring for the sister) becomes a shared journey in this life on earth. Man’s mortality is an eye-opener…As to my future plans, I have to make very good use of my remaining years on this earth to prepare myself in meeting my Creator.” Interestingly, Lina summed up the rewards of caregiving for her in these words, “God is my reward….I am happy already in serving older people for it is like serving my parents.”
Influence of Spirituality and Religion for Wellness and Quality of Life

The question on the influence of spirituality and religion on caregiver’s wellness and quality of life was posed to the participants in these words: (Q #16) “Would you say that your spirituality/religion helps you in your coping skills in life, and in your work? How?” This query served more to cap the questions on the given theme. Pertinent responses also surfaced in other related questions, such as in: (Q #10) “Would you find it (spirituality) important in your life? How?”, and in (Q #12) “What do you consider most important in life? Give concrete example.” In most interviews, especially when it touched on the aspects of challenges in life, caregiving burdens, and other difficulties, the participants spontaneously referred mostly to their coping tools in relation to their spirituality and religion.

Recalling the participants’ responses on what mattered most to them, the priorities in their list mentioned “God”, “love for my families,” “my religion,” “peace of mind,” “good health,” “faith,” and “prayer.” There was an indirect reference to self in terms of achieving peace, good health, and salvation. The use of faith and prayer, seen in a relationship with God, facilitated their coping with the challenges in life and in their work. The object of prayer was not just one’s self and their families, but also their caregiving work and the recipients of their caregiving.

The reference to God was in the context of the Judeo-Christian notion of one God, Father-Creator. As Christians, the participants understand God as Trinitarian, namely, Father, Son (Christ) and Holy Spirit. However, the responses mentioned the generic term, “God” as the focal point of their relationships in life. Three of the participants
used references in the Holy Bible to highlight the primacy of God and faith in their life. When asked on the coping value of spirituality and religion, Neal replied, “My only recourse for help is God. We live only once.” Then he paraphrased the passage from Matthew 4:4 (on the temptation of Jesus, quoted from Deuteronomy 8:3) in these words, “We cannot live by bread alone. We look for eternal life.” Cora expressed the supremacy of God in her life by saying, “100%, I depend on it (spirituality).” She followed her response with these words, “If I have the world but without the Spirit, there is no sense to life.” The phrase echoes a combination of Mark 9:36 (on gaining the whole world but forfeiting one’s life) and I Corinthians 13:1-3 (on the value of love over all other attributes in life). She indicated that the relationship with God needed to translate into practice in one’s life. Edbert emphasized the value of faith in his life, saying, “Without faith, life is useless and meaningless,” which echoed the main theme of St. Paul’s letter to the Romans. He added, “From the love of God, everything follows from it,” and mentioned the “Golden Rule” (“Do to others whatever you would have them do to you,” Matthew 7:12).

For the participants, spirituality and religion is relational, beginning with love of God and translating into love of others, such as the family, the fellow caregivers, and the care recipients. Love of self is hardly mentioned but obliquely noted in their quest for salvation, peace of mind, and good health. Talitha and Odette indicated the sense of accompaniment of God in her life which provides her the strength, courage, and confidence to go through the challenges of life. “This made my burden lighter and
certainly a blessing in the end,” Talitha further professed. Joyce speaks of her “religion (as)…my only riches in my life to attain salvation.”

Another key element in the use of spirituality and religion as coping strategy is the use of prayer. It is relational in many directions. It is a way of relating to God, or to the Blessed Mary. It is a way to bring others and self into this bind as the objects of one’s prayer.

The participants mentioned in their responses who and what they prayed for. Here are some of their comments. Jane spoke of praying for her family and for the residents in the facility and their families. Odette confessed, “Prayer helped me cope when my mother died and let go of her.” Julia experienced the alleviating power of prayers on her pains and sorrows. Moreover, she noted the effectiveness of her devotional prayers to the Blessed Mary. There were concrete virtues asked for in prayer. Odette said that she prayed always for wisdom and patience to do her work well. Remy spoke also of the petition for patience and being accommodating in her prayers for the residents.

The responses of the participants clearly presented a broader picture on the influence of spirituality and religion on their coping skills in life and particularly in their work of providing care to others. All the respondents, male and female, formal and informal caregivers, young and older ones, mainly Filipinos and one Hispanic, affirmed the significant contribution of these transcendental factors in making better sense of their life.

One thing was common in their responses. When they were asked whether spirituality and religion helped them in their coping skills to face the challenges in their
life and work, the participants responded affirmatively, even with confidence, as seen in some responses: “Yes, it extends in my whole life!”, “Yes, it is a great help.”, “Yes, it is 100%!”; “Surely, it helps a lot!” From their immediate response, smiles of confidence and sincerity expressed deep commitment to their work and joy of life.

Summary

As the findings of this qualitative study are presented, the researcher served as the miner and the sojourner with the participants. Interviews through questions were conducted in a spirit of respect and curiosity on the theme of the influence of spirituality and religion on the caregivers’ motivations and services. Respondents revealed the nature of the works of the caregivers, the challenges and stress they faced not just on their work, but also in their lives, the rich cultural background they brought with them in their migration and in their work, their understanding of spirituality and religion as it applied in their life, their coping skills, and the use of spirituality and religion as coping means in their caregiving works and life. The study unearthed significant findings that are relevant to social work research and practice. Moreover, it helped the researcher to understand better the life lived specifically by Filipino caregivers and the usefulness of the coping skills they employed.

The final chapter of this study presents the conclusions and recommendations that are relevant to social work practice and research.
CONCLUSIONS

Summary of Findings and Comments

This qualitative study of 14 caregivers focused on the influence or contribution of spirituality and religion on caregivers’ motivations and services in terms of their coping skills. Through face to face interviews, the researcher obtained significant findings on the nature of providing care to older adults, either as a paid job or a work rendered to a care recipient who was a family member.

Six themes pertinent to providing care to older adults by formal and informal caregivers emerged as categories in the study. In select areas, insights from the literature review are discussed as they pertain to the findings.

Motivations for caregiving. The literature review showed that the Philippines is an economically poor country, and the labor force of Filipinos is among the country’s major exports to other countries all over the world. The overseas workers earned a comparatively good income abroad than what they could possibly earn at home. At the same time, they remitted bountiful taxes for the government. Overseas caregiving by Filipinos in the USA helps add to the income of the Philippine government.

From the findings in the study, the formal caregivers were motivated by the need to provide financially for their families. They expressed their love for their families through an enhanced income and the consequent standard of living for the family. In this endeavor, caregivers render much sacrifice for the sake of their families, including being away from home. Although most Filipino caregivers have had good educational
background to do other jobs, caregiving was the more feasible and available job for them. However, being undocumented workers, they could become easy prey for labor abuse (Abel, & Nelson, 1990, cited in Tung, 2000). Nonetheless, their love for the family makes them take the risks and engage in immense sacrifices. Their undocumented status does not jeopardize their commitment to their work. In fact, part of their motivation in their job is reflected in their dedication and love for the older care recipients as an extension of their love for the older parents or grandparents (Lolo and Lola). This attitude stems from the Filipino cultural value of filial piety.

The informal caregivers took the duty of caring for their family members out of love for them. They wanted to provide care and comfort to their loved ones in need of their service. Furthermore, the family caregivers aimed to reciprocate the care and love they received from their loved ones, either as their parents, spouses or surrogate parents.

_Caregiving situation and the associated stress or burden._ In this study, the family caregivers stated that they made life for their care recipients comfortable, and kept them company. In fulfilling these objectives, the caregiver stays with the care recipient, through the entire day. What is often taken for granted is the underlying stress and burden which a caregiver experiences.

Caregiving stress arises not only from the physical burden of carrying or lifting the care recipient but also from the emotional reactions to the situation of providing care. In the helping profession, there are the unpredictable behaviors of care recipients due to the pains and stresses they themselves undergo in their own ailing conditions (Ramirez, 2003). Unless the caregiver is prepared for the unexpected and ready to cope with it, the
level of stress and perception of burden in caregiving could increase. The caregiver can become stressed by the irrational demands of care recipients or the undeserved racial and discriminatory remarks that can really test their patience. For the formal caregivers, the stressors could further include situational confinement in a facility, even during days off, the anxiety of being an undocumented alien, marital and family problems, financial difficulties, grief at the loss of a loved one, the perceived need to support siblings and their families, frustration and sense of helplessness at the degenerating condition of an ailing spouse, and/or the compounded and extended caregiving for the parents.

Providing care for the loved one can also impact one’s faith in God and trigger a crisis which leads one to question God and the meaning of suffering. At times, there was a feeling of divided loyalties, e.g., one’s commitment to a church and the family, and a resultant sense of guilt.

In our literature review, providing care for others, be they family members or non-relatives, can be distressing because it impacts: the caregiver’s time, career or plans in life, financial situation, physical and psychological health, relationships, and other aspects of life (Pinquart, & Sorensen, 2005b; Lee, 2008; Montoro-Rodriguez, Kosloski, Kercher, & Montgomery, 2009). The personal and relational aspects in the life of formal caregivers often compounded the burden of caregiving. Although two of the informal caregivers who participated in this study secured the assistance of other helping professionals, like a nurse or a caregiver, such an arrangement did not minimize their stress in providing care for their loved ones. The care recipient often preferred the care from the family caregiver because of trust and ease with the family relationship.
Cultural factors involved in caregiving. When the formal caregivers were asked as to the fitness of Filipinos in caregiving, the cultural values of this ethnic group pertinent to providing care were enumerated. Generally, Filipino caregivers are patient (mapagpasensiya), persevering, and accommodating. As a people that have been through tremendous sufferings and struggles for survival, they see themselves like bamboo trees for being resilient, pliant, and strong.

Belonging to the Asian Eastern heritage, Filipinos nurture close family relationships and sense of community. In situations of need, they extend help to one another for being part of the family or community (the spirit of bayanihan). They are ready to sacrifice themselves for each other, even to the point of being ready to sacrifice family closeness in favor of job opportunities overseas with the goal of enhancing living standard of the family. Filial piety is another important trait among Filipinos. Parental care and sacrifices to rear their children to maturity and give them good life are acknowledged later on through reciprocal care by the children for their elderly parents in a sense of debt of gratitude (utang na loob) (Natividad, 2000). Family caregivers devote part of their life in caring for a family member out of this cultural value of love for older people. On the part of the formal caregivers, one of their coping skills in being away from their family lies in considering and treating the older care recipients as their older parents or grandparents.

From this perspective, this type of providing care is seen as labor of love (in the study of Harris, 1993, cited in Hillier, & Barrow, 2007). The formal caregivers acknowledged that their caregiving work to the older care recipients compensated for their missed
opportunities to express or reciprocate the love their parents gave them in their childhood and growing years. Although their caregiving was a job, most formal caregivers manifested emotional concern when their care recipients seemed not to enjoy proper care and attention by their own families.

The caregivers expressed that providing care to others stemmed from their love of God. The participants professed diversity in their religious preferences, but mainly they followed the Christian tradition of loving one’s neighbor as an expression of love of God. Their spirit of resilience stems from the belief in a loving God who guides them in living their life. This faith is expressed in the love for others, those of their families and outside the family circle.

*Definitions and relationship between spirituality and religion.* The participants in this study openly expressed their understanding of the definitions of spirituality and religion, and the relationship between the two. They may not have the technical expressions to articulate their experiences, but they shared significant insights on the given theme. From their discussions and revelations, the following points surfaced:

(a) The participants were reared in the Christian traditions. However, there was complexity and diversity in their religious preferences. The majority of the respondents were Catholics (11 out of 14), either from birth, or at a certain stage in their life; two were members of the *Iglesia ni Cristo* (INC), and one was a member of a non-denominational Protestant church.

(b) Since life is a journey, the participants have gone through an evolution in their life of spirituality and religion. It indicates that although initially they take on the faith
and practices of their parents at birth, they gradually evolve in their understanding and practice of spirituality and religion. Transition to different phases and types of spiritual and religious experiences often takes place in adolescence and continues through adulthood. Three of the 14 participants were born Catholics, but later on turned to another religion, such as INC and non-denominational Christian (e.g., Born-Again).

(c) The religious devotions learned in childhood continued to be practiced by the participants, including going to church. However, when the job conflicted with church practice, the latter gave way to the work duty (see Ramirez, 2003). Nonetheless, participants professed to continue their practice of prayer and other religious devotions, such as reading the Bible or saying novena prayers.

(d) The participants clearly understood that their religious faith should find expressions in their practical life, including the quality of their caregiving services and devotional care to the care recipients.

Prior to the interviews, the participants were not clear about the definitions and distinction between spirituality and religion. When they were asked about these notions, they were able to clarify their own concepts of the two terms. The respondents generally referred to spirituality as a relationship with God, or the Transcendent Being, or other related divine names. The presence of God was understood in a comprehensive way, both in his transcendence beyond the individual self (which could be in Nature, in the “Heavens”, in other people, in a noble humanitarian cause) and his immanence (indwelling) in persons.
As to the relationship between spirituality and religion, the participants noted that whereas spirituality signified one’s beliefs, religion was their outward expression in the various aspects of life, including the social or communitarian dimension. It was clear to them that it was not enough to have a good relationship with God alone, but this should be expressed in one’s love for others. The use of prayer was mentioned by the respondents as the effective means to relate with God and connect with others (families, community, and society).

Interestingly, on this theme of spirituality and religion, the findings in this study aligned the literature review on the definitions of the two terms which are used interchangeably from the laymen’s point of view (Yoon, & Lee, 2006; Sinnott, 2002; Moberg, 2005; Cohen, Thomas, & Williamson, 2008), and their relational and integrative nature on the various aspects of life (Wright 1998; Address, & Person, 2003; Koenig, McCullough, & Larson, 2001; Hillier, & Barrow, 2007). As in the 2004 survey made by the National Alliance for Caregiving and the AARP, the participants of this study ranked the use of prayer as most important in their life, especially among their coping skills. The use of coping skills by caregivers is further discussed in the next section.

_Coping strategies in caregiving and the rewards of caregiving._ Considering that caregiving entails burdens and generates multiple stresses, the participants employed coping strategies to promote their wellness and quality of life also. It was to preserve themselves and achieve their life goals so the caregivers used different mechanisms to address the challenges they encountered in their life and in their work of providing care
to others. Foremost among their coping mechanisms was the use of prayer by the participants. They reported that they prayed for strength, for physical health and safety, for their families, and other needs. Furthermore, they prayed thanking God for their job and the consequent positive impacts on their life, for answered prayers, and for their various relationships, beginning with their families, relatives, and their care recipients.

The participants also acknowledged the importance of the support systems in their life. For the informal caregivers, family support eased the burden of their assumed task of providing care to the ill or older family members. This support happened by way of appreciation by other family members of their works and sacrifices, listening ears and helping hands extended to them, and family communication and visits. Formal caregivers recognized that a letter, an email, or a phone call to them from their families, distant they may be, lifted up their spirits and inspired them to keep their caregiving job and do it well amidst great personal sacrifices. Care providers also found the support from the administrators of care homes and from their fellow caregivers to be helpful. Employer rewards, recognition, guidance, salary increases and bonuses, and moral support help boost their confidence and sense of meaning with their job. Positive support from the old-time caregivers facilitated their introduction and orientation to their new job.

Although it was expected that due to their ailments or old age, care recipients were not ready to appreciate the sacrificial efforts of their caregivers, nonetheless, words of appreciation or little acts of thoughtfulness from the care recipients or their families helped boost the caregivers’ delivery of services. Behind these unsolicited gestures, the
The work demands and the nature of caregiving also became useful coping strategies because of the benefits accrued in providing care itself. The salaries (and bonuses) received by the caregivers become material incentives for them to sustain themselves and to provide comfortable life standard for their families, especially those living in their native country. However, the participants were aware that material or financial benefits alone did not satisfy the longing for happiness and the quest for meaning to their job. They reported that aside from a good salary, the participants always hoped for favorable work conditions and enriching working relationships. In addition to the financial compensations received by the participants, they mentioned that the goal of learning skills in their work, such as cooking, baking, knitting, and the dynamics of going through the bureaucratic processes to fulfill the policy requirements in caregiving, helped them cope with their job’s demands. A couple of caregivers who began to understand the bureaucratic processes reported wanting to venture also into care home managements in the future. Group activities, such as physical exercises, dancing, intellectual games, word games, math exercises, and singing the karaoke, became sources of inspiration for most caregivers. They acknowledged that they always learned something new, and by interacting with the care recipients and other caregivers, they became close with one another.
A number of items already mentioned above, such as learning skills and group activities, pertain to the use of self-care by the caregivers. Either through in-service training for the staff, the insights gained in their personal readings or from sharing by others, the participants noted the importance of self-care, which included exercises, such as centering of thoughts and emotions, breathing exercises, or taking respite from their stressful work.

The participants in this study recognized the value of developing positive attitudes in life as an effective coping mechanism. For the Filipino caregivers, the cultural trait of resilience was likewise shown through a good sense of humor. In humor, one is able to make light of the situations that tend to be burdensome or painful. One clear case is how some (young) Filipino caregivers, especially the girls, tend to giggle slightly while covering their mouth when they commit mistakes. A non-Filipino might misconstrue this coping behavior as lack of contrition for the wrong deed done or lack of seriousness in dealing with the act. It is more to shield the guilty individual from the emotional pains and the embarrassment for the mistake committed.

The participants mentioned that by helping the recipients of their care, they manifested their love for God in their relationship with others. Consequently, they felt closeness to their care recipients, and it made their work lighter.

*Influence of spirituality and religion for wellness and quality of life.* The respondents said that most important to them were God, love for family, religion, peace of mind, good health, faith, and prayer. They referred to spiritual and religious values. Valuing good health may pertain to physical wellbeing, but in the context of life’s
meaning, this value was meant to promote other goals in life, either in relation to oneself or to others.

The relationship with God was indicated by all the participants as a primary value in their life. This relationship with the Divine Being was understood to translate into their practical life. Underlying their invocation of the Golden Rule (“Do unto others whatever you would have them do unto you”) is the belief in God which expresses in one’s positive relationship with others. Hence, their core values were seen as relational with respect to God, others (family, community, and society), and self. Even the love of self through self-care is understood in view of one’s effective ability to help others. A significant spiritual and religious value as a coping strategy for the caregivers was the use of prayers. Prayer was also seen as relational on different levels of relationship, that is, with God, others, the environment (Nature), and with self. Aside from the petitions for material favors, including the alleviation from pains, when the participants prayed, they also asked for spiritual values, such as wisdom and patience. These qualities assisted them both in the manner of handling their personal challenges and in responding to the needs of others through service and caregiving.

Related to the question of primary values in life, the participants were also asked as to the use of spirituality and religion as coping means in their life. All the participants in the study affirmed the use of spirituality and religion in their life. They found these transcendental realities to greatly contribute and positively influence their life, particularly in their duty of providing care as informal caregivers to members of their families or as formal caregivers to those to whom they had no relations, either by blood
or by law. The participants professed that the use of spirituality and religion gave them a sense of meaning for their life and work (Shaw, Patterson, Semple, Grant, Yu, Zhang, et al., 1997; Ramirez, 2003). It generated in them a deep commitment as well as joy.

Limitations of the Research Study

Among the limitations of this qualitative research study, the first one is the limited number of participants (n = 14). The study focused primarily on Filipinos mainly working in Sacramento County. Findings from this study could not be readily generalized to other populations.

Secondly, the recruited participants and their places of work could also be a limiting element. Fifty percent of the respondents (7 out of 14) worked in two residential care facilities for the elderly (RCFEs) where the researcher provided regular voluntary chaplaincy services to the residents and the staffs of the care homes. There is a possibility that social desirability affected the responses to the interview questions out of deference to the researcher’s role in the facilities.

This qualitative study describes the narratives of the caregivers on their actual experiences of caregiving with all the challenges they encountered and their trait of resiliency to cope with them. Multiple approaches to obtain a deeper picture of the caregivers’ narratives were employed by the researcher. The responses of the participants during the interviews were supplemented by the researcher’s observations of the caregivers’ service performances and their personal sharing of their life challenges and basic attitudes on their caregiving work. Furthermore, the three years’ voluntary work of the researcher in the facilities and the ensuing friendships with the
residents and the staff members enabled them to establish a trusting relationship with him. The referrals made to recruit the other participants likewise facilitated a trusting encounter and dialogue with the researcher.

**Implications for Further Research**

This study focused on the contribution and influence of spirituality and religion on caregivers’ motivations and quality of services in providing care. In the process, secondary but significant issues related to the theme of caregiving have been encountered but not fully researched and discussed. Here are a few items that might be helpful to look into and understand through future research.

The current study focused on Filipino caregivers who, as adults, migrated to the USA in search of livelihood. The cultural values, particularly of sense of community (*bayanihan*), filial piety (respect and love for the elderly), debt of gratitude (*utang na loob*), religiosity, and resiliency, remain actively alive and practiced in their consciousness even in their newfound home. The church or bible study groups become the common venues to nurture their Filipino heritage. As first generation migrants, the mode of survival remains that of maintaining the predominant cultural values and practices in their home country. This study did not explore the opinions, attitudes, and behaviors of second-generation Filipino immigrants whose parents are in the caregiving business or occupation. Further studies on the cultural aspects of Filipino caregiving could focus on two points. One study could deal with the cultural traits, and attitudes of the second-generation Filipinos (those who migrated as children with their parents or were born already in the USA) whose parents worked or are working as caregivers.
Another study could focus on a particular regional group of Filipinos who are in the work or business of providing care. The present study dealt mainly with Pampango- and Tagalog-speaking participants who bear the sub-cultural traits of their regions in Pampanga (70 miles north of Manila) and the Tagalog regions around Central Luzon. Considering the presence of around 17 major Filipino languages in the home country whose speakers are spread out in three main islands in over 7,000 islands, the diverse and complex cultural characteristics of the Filipino people already envision a throve of cultural richness and subject matter for research.

This study examined the stressors of caregiving on various aspects in the life of caregivers and their impacts on their wellness and quality of life. Interviews with the caregivers did not focus on the adverse impacts of the job or duty on the physical wellbeing of the care providers. Considering that the health care system in the USA is a luxury commodity which only those with stable jobs and sufficient savings could afford, getting sick, especially as an undocumented immigrant or as a materially poor legal migrant or citizen could be equally stressful and taxing on one’s physical health. A further study could focus on the way of life of caregivers haunted by occasional health problems and the risk of not having any medical benefits. What is their recourse, considering the tremendous sacrifices they made for the subsistence of their families back home? How do care home operators strive to handle such eventuality, if there is any effort at all, as they aim for the welfare of their staff members and the profitability of their business operations? What are the coping ways of caregivers to keep themselves physically fit or age successfully?
One of the touchy aspects of formal caregiving by ethnic minority groups who do not belong to the mainstream white American or African American groups is the question of immigration. Similar to the issue of labor migration in the vineyards and citrus fields of California, caregiving by the ethnic minorities with roots from other countries is a great service to the people of the USA. In their desire to find a means of livelihood for themselves and sustain their families overseas, the caregiving recruits agree to “under the table” arrangements for work. Despite the financial compensation package they receive which is beneficial for them and their families, the undocumented caregivers are not educated regarding their lack of medical health benefits and possible subjection to human rights abuse. As the advent of the baby boomers brings about collateral concerns on caregiving and immigration, the country should be prepared to address these inevitable issues in the spirit of justice for all persons concerned.

Implications for Social Work Practice

There are a number of ways that this study could positively impact social work practice. This study affirms the importance of spirituality and religion in social work as well as the contribution and influence of these transcendental realities in ennobling the motivations of caregivers and in improving the quality of their services to care recipients. Considering the cultural and spiritual values of people should engender a feeling of respect for people’s faith systems. This is what makes social work inspiring because it deals with people and their worth and dignity as persons with the capacity to reach out beyond themselves and relate to others, to noble causes, to nature and the universe, and to God or Divine Being or a Supreme Reality.
By recognizing and utilizing the values of spirituality and religion for the promotion of the person’s dignity, social work becomes a sacred calling. It participates in the role of re-creating people amidst their brokenness and of re-integrating them in unity to various elements in life which restlessly seeks for wholeness. For a social work practitioner, this study implies a challenge to search for one’s spirituality and to understand it in the context of people’s expressions of *their* spirituality in religion. “You cannot give what you do not have” is an ancient Latin adage which spurs the practitioner to search for the spiritual treasures in one’s life (soul) and to discover the links that lead to effective outreach to others whom one is called to serve. A social work practitioner need not cower in venturing into the potential power of spirituality and religion during the assessment of a client or in attentive listening to the client’s narratives of coping with the use of these metaphysical realities.

Students or interns in social work practice, especially those in the fields of gerontology and geriatrics, should consider the value and transforming role of spirituality and religion in a client’s life. It is significant that academic preparations and field work should be open to the benefits which these transcendental realities offer to individuals, families and groups. Focus should be made not on the politicization of religion, but on its expressive role for spirituality and the vehicle for the existential search for meaning in life. The vulnerability of clients to meaning or lack of meaning should be directed towards enriched understanding of life in its transpersonal dimension. This risky but enriching venture could benefit not just the client but even the social work practitioner.
Since spirituality and religion is the specialty field of churches or faith communities, the social work practitioner should be more familiar with the great resources which the churches of different faiths offer both in their creeds and in their outreach programs. Coordination work with the leaders of the different congregational or denominational churches could impact the clients with physical, emotional, and mental ailments more positively in their journey towards wellness, recovery and transformation.

An aspect of social work practice is advocacy for human rights. A significant role of the practitioner also includes the readiness to advocate for the rights of the older adults before the operators and administrators of care home facilities, such as the RCFEs, assisted care living facilities, and nursing homes. Social workers should assist their clients by nurturing their clients’ spiritual and religious welfare. Doing so would mean promoting a holistic understanding of the noble dignity of the residents and giving the needed respect and care that is due to them. It also means assisting caregivers in enhancing their coping skills through the use of spirituality and religion. The investment placed on caregivers’ metaphysical values has impact for the well-being of the residents and for the fulfillment of the facilities’ objectives.
APPENDIX A

Informed Consent Form
Informed Consent to Participate in Research  
(On Caregiving and Caregivers)

Dear ____________________:

You are being asked to participate in research which will be conducted by Crisostomo Yalung, a graduate student in Social Work at California State University, Sacramento. The study will investigate the impact of spirituality and religion on caregivers’ motivation and services.

You will be asked to complete an interview about your perception, understanding, and practice of spirituality and religion, and their impact on your motivation and services as caregiver. The interview may require up to an hour of your time.

Some of the items in the interview may seem personal to you. You may experience discomfort regarding the personal nature of some of the interview questions. If you feel discomfort, or believe that the questions invade your privacy, you are welcome to not answer them. Should you need counseling assistance, you may contact any counseling agency on the attached list.

You may gain additional insight into the impact of spirituality and religion on your motivation and works as caregiver or you may not personally benefit from participating in this research. It is hoped that the results of the study will be beneficial to other caregivers and for programs designed to help caregivers in coping with the challenges of their works.

You are assured that the information you share in the interview will be kept confidential. The interview will be audio taped to preserve the accuracy of the
information and insights you share. But your identity will be kept confidential and anonymous. The audio tapes will be disposed of on May 31, 2010. By then, the needed information would have been integrated into the research project. Until that time, they will be stored in a secure location. To indicate your consent on audiotaping the interview, kindly initialize your name on the line provided:_________________

You will not receive any compensation for participating in this study. However, I will send you a letter of gratitude for your participation.

If you have any questions about this research, you may contact me by phone at (916) 854-7375 or by e-mail at sanitor22@aol.com. You may also contact the Project Advisor, Prof. Andrew Bein at (916)-278-6170 or by e-mail at abein@csus.edu.

Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page, understand its contents, and you willingly consent to participate in the research.

___________________________                               __________________________
Signature of Researcher                               Signature of Participant

__________________________
Date                                           __________________________
Date
APPENDIX B

Semi-Structured Guide Interview Questions
Guide Interview Questions

I thank you for agreeing to participate in this study. I have a few questions to ask you on the topic of spirituality and religion and their contribution and influence on your motivation and work as care provider. In case you find some questions difficult to answer, you may refrain from responding. Also, feel free to answer the questions as you feel sharing for they are all important to this study.

A. Work Situation:
1. As caregiver, what is the nature and scope of your responsibilities?
2. How long are you working now as caregiver in the USA?
3. Where else and when have you served as caregiver in USA?
   What led you to become a care provider?

B. Religious Preference and History:
4. What is your religious preference?
5. Could you share with me the history of your religious preference(s)?
6. How do you practice your religion? (such as, going to church, reading any religious book, listening to or watching a religious program, alone or with other worshippers)
7. Where do you practice your religion?
8. What is the core teaching you find in your religion?

C. Spirituality – Meaning and Relevance
9. How do you understand the word “spirituality”?
10. Would you find it important in your life? How?
11. What is the relationship between spirituality and religion?
12. What do you consider most important in life? Give concrete examples.
D. Relationship between Work and Sense of Spirituality/Religion:
13. What has been the greatest challenge in your life? How did you cope with it?
14. What is (has been) most challenging in your caregiving work? What are the difficulties you encountered?
15. How do you cope with these challenges? Is the facility administration aware of this, and how has it helped you cope with them?
16. Would you say that your spirituality/religion helps you in your coping skills in life, and in your work? How?

E. Narratives and Observations in Caregiving Works:
17. What are some of the striking (inspiring) stories and experiences you have as caregiver?
18. Based on your observations, what are the ways in which the elderly people cope with their challenges in life, esp. in aging?
19. How do you find satisfaction in your work as caregiver? For your family? In your relationship with your fellow caregivers? In your relationship with the elderly?

F. Rewards and Benefits of Caregiving:
20. What are your future plans in life? Would you continue to be a caregiver, if circumstances permit?
21. What are the rewards and benefits of being a caregiver?
22. To other or future caregivers, what lessons or message would you like to share with them?

Do you have any questions about the study research I am conducting?

Thank you very much for your participation. Good luck!

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For Researcher’s Use only:
1. Interview # _______  2. Date: ________  3. Gender: [ ] Male  [ ] Female
APPENDIX C

Resource Agencies for Counseling Services
Counseling Agencies

Asian Pacific Community Counseling
Free services provided to the Asian/Pacific Islander community. Located on Power Inn Road, call (916) 383-6783.

California State University, Sacramento - Center for Counseling and Diagnostic Services
Provides for fee counseling and diagnostic testing to the community. Fees are based on services provided. Counseling is provided by graduate students. For information call (916) 278-6252.

La Familia Counseling Center
La Familia offers free short and long term counseling for all ethnicities. Located on 34th Street in Sacramento. Call (916) 452-3601

New Pathways (formerly Catholic Social Services)
Provides counseling for children, adults and families of all denominations. Their standard fee is $70, but they also offer a sliding fee based on income. They are located on Newman court in Sacramento and can be reached at (916) 452-1218.

Sacramento County Mental Health
Offers mental health services, support and referrals for adults and children. Call (916) 875-7070.

Southeast Asian Assistance Center (SAC)
Located on 24th Street in Sacramento. Call (916) 421-1036.
APPENDIX D

Approval by the Committee for the Protection of Human Subjects from the Division of Social Work
TO: Crisostomo A. Yalung

FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “_

_X_ approved as _____EXEMPT ____NO RISK ___MINIMAL RISK.

Your human subjects approval number is: 08-09-129. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Tania Alamed-Lawson, Jude Antonyappan, Maria Dinis, Francis Yuen, Andy Bein, Ron Boltz, Joyce Burris, Serge Lee, Sue Taylor

Cc: Andrew Bein
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