

Spiritual growth, sense of coherence and self-efficacy of family caregivers of people with disabilities

Crecimiento espiritual, sentido de coherencia y autoeficacia de las cuidadoras familiares de personas con discapacidad

Crescimento espiritual, senso de coerência e autoeficácia de cuidadores familiares de pessoas com deficiência

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ABSTRACT

Objective: Analyze the spiritual growth of family caregivers of people with severe disabilities who reside in the Metropolitan District of Quito and identify the cognitive-affective factors, bio-sociocultural characteristics and care characteristics that model it.

Method: Cross-sectional study, carried out during the second semester of 2021, probabilistic sample of 223 caregivers residing in Quito-Ecuador. Descriptive statistics, correlation coefficients and regression were applied.

Results: 49.8% perceived a high spiritual growth. This correlated with the manageability dimension of the sense of coherence and with the self-efficacy of care. Some cognitive-affective factors, bio-sociocultural characteristics and care characteristics explained 25% of its variation.

Conclusion: The results showed a frequent practice of actions that promote spiritual growth, self-efficacy of care is highlighted as an important protective factor, these results can serve as a basis for planning interventions towards the evaluation and development of spiritual growth in search of a healthy lifestyle. in this vulnerable population.

Keywords: Caregivers. Spirituality. Sense of coherence. Self efficacy. Life style. Health promotion.

RESUMEN

Objetivo: Analizar el crecimiento espiritual de las cuidadoras familiares de personas con discapacidad severa que residen en el Distrito Metropolitano de Quito e identificar los factores cognitivo-afectivos, características bio-socioculturales y características del cuidado que modelen el mismo.

Método: Estudio transversal, realizado durante el segundo semestre del 2021, muestra probabilística de 223 cuidadoras residentes en Quito-Ecuador. Se aplicó estadística descriptiva, coeficientes de correlación y regresión.

Resultados: El 49,8% percibieron un alto crecimiento espiritual. Este correlacionó con la dimensión manejabilidad del sentido de coherencia y con la autoeficacia del cuidado. Algunos factores cognitivo-afectivos, características bio-socioculturales y características del cuidado, explicaron el 25% de la variación del mismo.

Conclusión: Los resultados mostraron una práctica frecuente de acciones promotoras del crecimiento espiritual, se destaca la autoeficacia del cuidado como factor protector importante, estos resultados pueden servir de base para planificar intervenciones hacia la evaluación y desarrollo del crecimiento espiritual en busca de un estilo de vida saludable en esta población vulnerable.

Palabras clave: Cuidadores. Espiritualidad. Sentido de coherencia. Autoeficacia. Estilo de vida. Promoción de la salud.

RESUMO

Objetivo: Analisar o crescimento espiritual dos cuidadores familiares de pessoas com deficiência grave que residem no Distrito Metropolitano de Quito e identificar os fatores cognitivo-afetivos, as características bio-socio-culturais e características do cuidado que o modelam.

Método: Estudo transversal, realizado durante o segundo semestre de 2021, amostra probabilística de 223 cuidadores residentes em Quito-Ecuador. Foram aplicadas estatísticas descritivas, coeficientes de correlação e regressão.

Resultados: 49,8% perceberam um alto crescimento espiritual. Isso se correlacionou com a dimensão gerencial do senso de coerência e com a autoeficácia do cuidado. Alguns fatores cognitivo-afetivos, características bio-socio-culturais e características do cuidado explicaram 25% de sua variação.

Conclusão: Os resultados mostraram uma prática frequente de ações que promovam o crescimento espiritual, a autoeficácia do cuidado é destacada como importante fator de proteção, esses resultados podem servir de base para o planejamento de intervenções voltadas à avaliação e desenvolvimento do crescimento espiritual em busca de uma vida saudável estilo de vida nesta população vulnerável.

Palavras-chave: Cuidadores. Espiritualidade. Senso de coerência. Autoeficácia. Estilo de vida. Promoção da saúde.

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■ INTRODUCTION

Worldwide, estimates indicate that more than a billion persons have some form of disability⁽¹⁾. This number tends to grow, and, as the number of persons with disabilities (PWD) and dependent persons increases, the need to have someone responsible for care at home also increases. Social contributions to family care is valuable not only for the person who receives the care or their family, but also for the health system and the national economy⁽²⁾, and for a caregiver to provide optimal care, it is essential to promote their health.

Ecuador pushed forth social programs for the attention of PWD that divided responsibility between state and the population. The Joaquín Gallegos Lara Bonus (BJGL) is a redistributive mechanism which transfers 240 USD a month to those responsible for the care of a person with severe disability who lives in a critical condition of poverty⁽³⁾. This contribution must be used for food, transport, supplies, rehabilitation, and caring for the PWD. Although this is a relatively stable program, we could not find evidence about the impact of this program on the lives of PWDs and their caregivers.

Although caring for a dependent relative is associated with negative effects and low quality of life⁽⁴⁻⁶⁾, the experience of care can also generate positive emotions and behaviors, such as spiritual growth (SG). SG is one of the dimensions of a health-promoting lifestyle (HPLS) proposed by Pender⁽⁷⁾. It is defined as the development of internal resources, such as: transcendence, connection, and development, through which we can achieve: inner peace, feelings of harmony, plenitude, and connection with the universe, in addition to finding a meaning that motivates working towards goals in life⁽⁸⁾. SG is a dimension of HPLS that can help dealing with the daily burden and stress of caring for dependent relatives. This resource could shield one's health or soften negative impacts of care.

The support provided by spirituality to the cultivation of physical and mental health has been recognized, and it is possible to see and measure its beneficial effect on mental structures and in attitudinal and behavioral changes⁽⁹⁾. The participation or lack thereof of caregivers in healthy behaviors regarding SG can be explained considering the health promotion model (HPM), according to which individual characteristics and experiences, as well as knowledge and specific affections associated with behavior, lead to a behavioral result⁽⁷⁾. Specific cognitive-affective factors from one's conduct are categories with an enormous motivational importance that are critical for an intervention, since they are subject to change through nursing actions⁽⁷⁾. Therefore,

this study analyzed the sense of coherence (SOC) and the self-efficacy of care (SEC).

The SOC expresses the point to which a person has a generalized, long-lasting, and dynamic feeling of trust on the fact that the course of life is structured, predictable, and explainable, that they have the resources to satisfy the demands of these incentives; and that these demands are challenges one must commit themselves to⁽¹⁰⁾. In family caregivers, SOC has been understood as an important protective effect against the native impact of care and it has been said that caregivers with a high level of SOC can use coping strategies such as more communication in the family, search for support, guidance towards the future, and the belief in a higher power⁽¹¹⁾.

Self-efficacy, in turn, has a regulatory function over behaviors, since it determines beliefs regarding personal capacity, based on which one organizes and executes actions to reach the desired outcomes⁽¹²⁾. Self-efficacy varies according to the domain of the activity, the demands of the tasks and the characteristics of the situation⁽¹³⁾. When applied to family care, it is focused on the beliefs of caregivers about their ability to care for themselves and have some space to breath when needed, their ability to deal with disturbing behaviors from the person cared for, and other issues related with care, as well as the ability to control uncomfortable thoughts and negative feelings activated by the activity as a caregiver⁽¹³⁾.

Participating in a healthy lifestyle is a challenging task for most people⁽¹²⁾, but even more in family caregivers as they have to cope with growing demands for care, experimenting multiple transitions, emotional concerns, losses and grief, where the search for meaning becomes evident⁽¹⁴⁾ here, spiritual growth can have an important adaptive role. This is why the guiding question of this investigation with family caregivers of persons with severe disabilities who received the BJGL and lived in the metropolitan area of Quito – Ecuador, was: What is the SG level of these family caregivers and what are the cognitive-affective factors, biosociocultural characteristics, and health care factors that determine this SG?

The SOC has been recognized to contribute for the positioning of individuals in the health-disease continuous, facilitating successful and adaptive personal results⁽¹⁵⁾, and SEC beliefs have shown strong predictive validity regarding health conditions in the domains of health behaviors⁽¹²⁾; as a result, evaluating their effects on SG as part of the HPLS of caregivers has practical implications on the promotion of health.

To promote and facilitate health-promoting behaviors, we must understand the variables that impact on the decision to

adopt these behaviors. This is why the goal of this study was to analyze the SG of family caregivers of persons with severe disabilities who live in the metropolitan district of Quito, and to identify the cognitive-affective factors, biosociocultural characteristics, and care characteristics that model the SG.

■ METHOD

This is a descriptive, correlational study, carried out in Quito, the capital city of Ecuador, one of the most populous cities in the country. Ecuador is in the northwest of South America. It is a sovereign, pluri-national country. The study population included 1804 relatives of persons with severe disabilities who received the BJGL. Sample size was calculated to detect statistical associations with a correlation coefficient of at least 0.20, with 95% reliability and 80% strength. The resulting sample size was of 223 participants, selected with stratified probabilistic sampling with proportional limits per zone of residence (urban or rural to the north, center, or south of the city). Data collection took place in the second semester of 2021. Inclusion criteria were: having cared for a person with severe disability permanently, in a private home, for at least six months, 6 hours a day; receiving BJGL; living in the limits of the metropolitan district of Quito; and being 18 years old or older. Exclusion criteria were: being occasional caregivers, or having some form of cognitive issue that prevented responding to the instrument.

The instrument used to collect information was formed by: a semistructured questionnaire, designed by the authors, including 28 questions about sociodemographic and cultural data of the caregiver, and about the characteristics of the care provided. We also used the spiritual growth subscale, which is part of the questionnaire of health-promoting lifestyle HPLP II⁽¹⁶⁾. It consists of 9 items which evaluate the frequency of health behaviors, requiring 4-point Likert responses. The range of the score varies from 9 to 36 points, with higher scores indicating more common practices. The HPLP II has good psychometric properties ($\alpha=0.943$) which is why it is frequently used in research⁽⁸⁾. The questionnaire of guidance for life (OLQ-13) evaluates three dimensions of SOC: significance, intelligibility, and manageability. It includes 13 items with 7 Likert-type response options, and its total score ranges from 13 to 91 points. Questions 1,2,3,7 and 10 are written negatively and, therefore, are codified inversely, as they sum all elements to reach the total. Worldwide, there has been an alpha coefficient from 0.70 to 0.92⁽¹⁷⁾. The revised self-efficacy scale for self-care (RSCSE) includes 15 items, evaluates the reliability (0-100 points) of caregivers in

regard to: have a break, deal with disruptive conducts, and control disturbing thoughts⁽¹³⁾. The internal consistency was found to be strong, from 0.82 to 0.85⁽¹³⁾.

For this investigation, questionnaires HPLP II, OLQ-13, and the RSCSE scale were culturally adapted into Ecuador, and the content of the adapted version was submitted to five experts in community nursing and psychology.

Data collection took place in interviews in the home of the caregiver, which lasted from 45 minutes to one hour, approximately. This contact with the potential participants was carried out through a technician of the Ministry of Economic and Social Inclusion (MIES). The participants were contacted via phone by the researcher. During the call, the characteristics of the study were briefly explained and an interview was scheduled for those who accepted participating. Before the interview, all participants were informed about the confidentiality of the data collected and asked to sign a free and informed consent form. During the interview, the researcher read the instrument questions one by one, and the caregiver responded to each. To facilitate the process, we elaborated a form with the response options, so the caregiver could mark the correct one. Once the process was finished, we recorded and digitized the information collected.

Data found was organized, processed, and analyzed in the software Statistical Package for the Social Sciences (SPSS)[®] 25. The analysis was carried out considering the goals of the investigation and the measurement levels of the variables, considering descriptive and inferential statistics (correlation coefficient, multiple regression, and regression trees for multivariate modeling). The statistical significance was $p<0.05$.

The investigation was based on the main universal bioethical principles, adopted by international agreements that promote freedom of investigation and the maximum guarantees of respect to the rights and safety of the subjects who participate. This study was submitted for the approval of the Research Ethics Committee of the Nursing Department at the Universidad de Concepción (Resolución N° 064-19), to the Ethics, Bioethics, and Biosecurity Committee of the Vice-rectory of Investigation and Development of the Universidad de Concepción (CEBB 521-2019), and to the Sub-committee of Ethics in Investigations with Human Beings of Universidad Central del Ecuador, which is credited by the Public Health Ministry of Ecuador, which certified the ethical viability of the study in the ordinary session No. 002-SEISH-UCE-20.

To guarantee the confidentiality of information, primary participant data was only accessed by the authors. The anonymity was maintained through the use of indirect identifiers

in the data collection instrument (using codes instead of the name of the participant).

RESULTS

This investigation included 223 participants and its goal was to analyze the SG of the family caregivers of persons with severe disabilities who live in the metropolitan district of Quito, and to identify which cognitive-affective factors, biosociocultural characteristics, and characteristics of the care provided that model the SG. No participant fit our exclusion criteria.

Table 1 shows the sociodemographic characteristics and the characteristics of the care provided.

The mean SG score was 28.1 ± 5 points, and almost half the caregivers presented a high SG. To analyze the frequency of conducts regarding SG, we categorized the means of the answers in a Likert scale from 1-4, where 1 represented the lowest frequency of health behaviors (never), 2 meant "some times", 3 meant "often", and 4 meant "consistently". The mean value was 3.13 ± 0.61 , that is, caregivers stated that they carried out activities that contribute to the SG frequently or consistently (Table 2).

Regarding the evaluation of cognitive affective data, SOC and SEC, the mean SOC score in the family caregivers was 59.4 ± 12.8 points, where 50.7% presented a high level of SOC. An important difference was found in the means of the dimensions: the "significance" regarding the dimensions "intelligibility" and "manageability" (Table 3). The mean total score of RSCSE in the caregivers was 61.6 ± 15.9 points, with 52.9% of caregivers presenting high SG levels. There was a 30-point difference between the dimension "having a break" and the others. The dimensions "dealing with disruptive conducts" and "controlling disturbing thoughts" showed no great differences between themselves with means above 70. Therefore, the caregivers showed a relatively low SG when it comes to "having a break", and a high self-efficacy in regard to "dealing with disruptive conducts" and "controlling disturbing thoughts" (Table 3). These differences were statistically significant (Friedman, $p < 0.001$).

Regarding the association between the dimensions of the sense of coherence and SG, "manageability" stood out, with a significant, positive, and weak correlation to SG, that is: the higher the manageability, the higher the SG of the family caregivers (Table 3).

Regarding the association, concerning the dimensions between SEC and SG, we found a significant, positive, and weak correlation between SG and "having a break", "dealing with disruptive conducts", and "controlling disturbing thoughts". (Table 3).

Regarding biosociocultural characteristics of the caregivers, characteristics of the care provided and of the person cared for, Table 4 shows those which had an association with the SG of the family caregiver.

The age of the family caregiver ($r = -0.239$ $p = 0.000$) and the time working as a caregiver ($r = -0.171$ $p = 0.010$) had a significant, negative, and weak correlation with the SG. The educational level of the caregiver ($r = 0.231$ $p = 0.000$) and the family income ($r = 0.173$ $p = 0.009$) had a significant, positive, and weak correlation with the SG.

The motivation for providing care was related with the SG ($p = 0.017$), in the sense that caregivers that care to fulfill a duty or obligation had a lower SG than those who do it for reciprocity or gratitude, because they want to aid selflessly, or due to responsibility.

Whether the person receiving care has a chronic disease also led to differences in the SG, meaning that the caregivers of PWD who also have chronic diseases had a higher SG than those who cared for PWD who did not have further chronic diseases.

In the analysis above, we found variables with significant associations, which were incorporated to a linear regression model. The final model presented a determination coefficient R^2 of 25.0%, that is, its capacity to explain was moderate. The model obtained was:

$$CE = 3.126 + 0.246 \times (\text{presence of chronic disease in the person receiving care}) - 0.291 \times (\text{Motivation for the care: duty or obligation}) + 0.279 \times (\text{Motivation for the care: reciprocity or gratitude}) + 0.031 \times (\text{Motivation for the care: selfless desire to help}) + 0.004 \times (\text{have a break}) + 0.024 \times (\text{Educational level}) + 0.001 \times (\text{Family income}) + 0.0002 \times (\text{Management of disruptive conducts}).$$

The scale in which the variable "spiritual growth" is expressed goes from 1 to 4, while the scale which expresses "have a break" and "manage disruptive conducts" goes from 0 to 100. The presence of chronic diseases and the motivation to care have the value of 1 in the cases determined by the model.

The interpretation of coefficients is as follows: The base level of "spiritual growth" is 3.126 and the mean score of "spiritual growth":

Grows 0.246 if the person receiving care has a chronic disease. Decreases in 0.291 if the motivation to care is that it is a duty or obligation. Increases in 0.279 if the motivation to care is reciprocity or gratitude. Increases in 0.031 if the motivation to care is a selfless desire to help. Increases in 0.04 for every 10 points of the score for "having a break". Increases in 0.024 for each extra year of study of the caregiver. Increases in 0.010 for each 10 increase in the family income. Increases 0.002 for each 10 points increased in the score for "Management of disruptive conducts".

Table 1 – Family caregivers (n=223) according to their sociodemographic and care characteristics. Quito, Ecuador, 2022

Characteristics		
Age (years)*		49.3(13.95)
Years of formal education*		9(4)
Family income (USD)*		398(180)
Time as a caregiver (years)*		16.5(11.3)
Number of hours dedicated to care per day*		19(5)
Sex	Female	206(92.4)
	Male	17(7.6)
Marital status	No partner	112(50.2)
	Has a partner	111(49.8)
Religion	Catholic	171(76.7)
	Evangelical	36(16.1)
	Other	9(4.2)
Motivation for the care	Responsibility	112(50.2)
	Other	45(20.1)
	Duty or obligation	31(13.9)
	Selfless desire to help	19(8.5)
	Reciprocity or acknowledgment	16(7.2)

Source: research data, 2021.
 Data expressed in absolute number and percentages; *data expressed in mean ± standard deviation
 USD: American dollars.

Table 2 – Characteristics of the spiritual growth of family caregivers (n=223). Quito, Ecuador, 2022

Variable	Min	Max	Mean (SD)	Median	Mode	Coef. of variation	Range	%< Mean	%≥ Mean
Score									
Theoretical	9	36	28.1(5.5)	-	-	-	-	50.2	49.8
Empirical	15	36		-	-	-	-		
Frequency of SG conducts from 1 to 4 points	1.67	4.00	3.13(0.6)	3.22	3.89	19.49%	2.33	-	-

Source: research data, 2021.
 Min: minimum; Max: maximum; SD: standard deviation; Coef.: coefficient; 1 point: never; 4 points: consistently.

Table 3 – Correlation between spiritual growth, feeling of coherence, and self-efficacy of family caregiver care (n=223) Quito, Ecuador, 2022

Variable	Dimension	\bar{x}	Spiritual Growth	
			Correlation	P-value
Sense of coherence	Manageability	5.01	0.152	0.023
	Intelligibility	4.77	0.116	0.083
	Significance	3.87	0.099	0.142
Care self-efficacy	Control of disturbing thoughts	73.64	0.203	0.002
	Management of disruptive conducts	73.46	0.231	0.002
	Having a break	43.06	0.197	0.003

\bar{x} : mean score
Source: research data, 2021.

Table 4 – Correlation between the spiritual growth of family caregivers (n=223), biosociocultural characteristics of the caregivers, characteristics of the care provided, and characteristics of the person receiving care. Quito, Ecuador, 2022

Variable	Correlation	P-value
Age	-0.239*	0.000
Educational level	0.231*	0.000
Family income	0.173*	0.009
Time as a caregiver	-0.171*	0.010
Motivation for the care	0.017 †	-
Presence of chronic diseases in the person receiving care	-	0.005 ‡

*Spearman; †Kruskal Wallis; ‡Mann Whitney's U.
Source: research data, 2021.

In summation, the SG of the family caregivers increased when the person receiving care had a chronic disease; when the motivation to care is reciprocity, gratitude, or the selfless desire to help; when the caregiver had more self-efficacy in the ability to have a break or dealing with disruptive conducts; when the educational level of the caregiver was higher; and when the caregiver had a higher income. On the other hand, the SG was lower when the motivation to care was the fact it was a duty or obligation.

The regression tree (Figure 1) explains the variations of SG, according to the presence of chronic diseases in the PWD. The SG, in general, was high (\bar{x} =3.1), that is, the caregivers reported to “often” carry out actions to support their SG. Caregivers for persons with chronic diseases applied practices to improve their SG from often to consistently, while caregivers of persons who do not have chronic diseases only support their spiritual growth “often”.

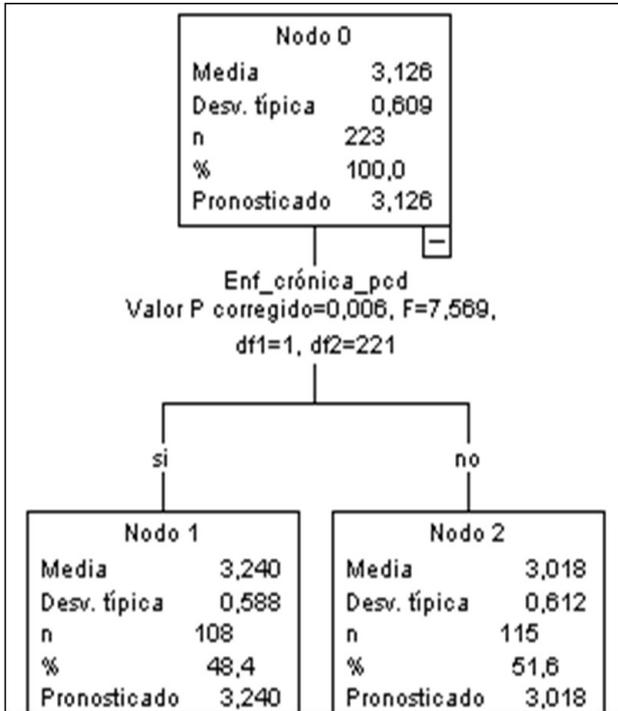


Figure 1 – Regression tree for the spiritual growth of the family caregiver of persons with severe disabilities. Quito, Ecuador, 2022
Source: research data, 2021.

DISCUSSION

This investigation found that nearly half caregivers (49.8%) informed a high SG. The frequency of behaviors tending to SG was from frequent to consistently ($\bar{x}=3.13$). This is in accordance with another study⁽¹⁸⁾, where the SG dimension was found to be the most practiced by the caregivers. In the context of family care, we have observed a strong inclination towards spirituality as the main way of coping⁽¹⁹⁾. Spiritual beliefs appear as sources for consolation and hope, which helps to better accept the condition. Furthermore, the SG is an accessible resource, since activities that are needed to support it are not physical and, as a result, require no commuting nor leaving the person receiving care unattended, not to mention that these activities can be shared⁽¹⁸⁾, facilitating their application.

Regarding the relationship between SOC and SEC, there was a positive relationship of the dimension of manageability of SOC with the three dimensions of SEC. This is due to the fact that caregivers with more manageability have more trust and self-efficacy to complete challenging challenges of care. Caregivers with a positive perspective, with disposition and

the ability to cope with stressing situations by themselves or involving members of their social network, can keep hope in harsh times, which, in the end, increases their satisfaction with life⁽²⁰⁾.

It is noteworthy that, in this study, caregivers revealed low significance, indicating that the evaluation of stressing stimuli and the choice of actions considering their role can be affected, since the significance is an element that motivates caregivers. According to the salutogenic theory, there are different types of life experiences that contribute to the process of developing the elements that are part of the SOC. Significance, for example, is boosted by the participation of the person in the configuration of results, that is, by the role they performed in choosing their own destiny⁽²¹⁾. Therefore, low significance in caregivers can be related with the lack of options that are frequently experimented at the time of choosing to enter or remain in the world of family care. Significance is also developed in the emotional relationship and through being attached to others. In the case of family care, some authors state that a strong emotional attachment in the dyad conducts to the formation of an affective bond created on solid, truthful, and unbreakable pillars, which will remain throughout one's life, even when dealing with adversity. This close relationship increases the chance for caregivers to see care as a significant and spiritual experience^(22,23). The spiritual growth implies a meaning of connection and belonging⁽⁸⁾.

It is equally worrying that caregivers presented a relatively low SEC when it comes to having a break. Literature has informed that low scores reported in the dimension of self-efficacy in having a break are associated with a perception of less available social support⁽¹³⁾. It can sometimes be related with the belief on the part of the caregivers that asking for help is embarrassing or somehow indicative of their inability to care for the PWD by themselves⁽²⁴⁾. High levels of self-efficacy in having a break are associated with the reduction of adverse results for health^(25,26). The possibility of obtaining relief is related with the maintenance of the quality of life of the caregiver and of the care itself. This allows the continuation of attention at home, since, if they receive support in the provision of care, they can have some time to rest and deal with their own health⁽²⁷⁾. This reiterates the importance of addressing this cognitive resource within the interventions for the caregivers.

The regression model showed that the spiritual growth of family caregivers is higher when the person receiving care had a chronic disease; when the motivation to care is reciprocity, gratitude, or the selfless desire to help; when the caregiver had more self-efficacy in the ability to have a break

or dealing with disruptive conducts; when the educational level of the caregiver was higher; and when the caregiver had a higher income. On the other hand, the SG was lower when the motivation to care was the fact it was a duty or obligation. In this model, we can observe the influence of modifiable and non-modifiable factors. Regarding educational level, the mean among participants was 9 years of formal education, meaning they did not finish their high school. The low educational level has an impact not only on their lifestyles, but also in the economic future of the caregivers⁽⁴⁾. Concerning the family income, most participants reported an income of 240 USD, which is due to the fact that most participants have no income other than the BJGL, which provides exactly this value. The money should be destined, basically, to food, medicine, and expenses of the PWD⁽³⁾, but, in reality, is used to cover the basic needs of the family, considering that the PWD requires full-time care, meaning that the caregivers have no access to paid jobs, which significantly reduces their income, their social interactions, and their time for rest⁽⁴⁾. This situation can prevent them from having plans for the future and seek new challenges in life, which, finally, has an impact on their spiritual growth.

Another relevant aspect is the relevance of the familism model and the feminization of filial obligations, which mean that the care is assumed and consolidated as a moral obligation for women⁽⁵⁾. The familism common to Latin American countries is based on attachment, feelings of loyalty, reciprocity, and solidarity between the members of a family household⁽⁵⁾. In this study, half the caregivers (50.2%) stated that their main reason for caring for their relative is responsibility. A minor portion (13.9%) stated they do it because it is a duty or obligation, while others mention altruistic reasons (35.8%). This reiterates the fact that, when the care is motivated by positive feelings, such as gratitude, reciprocity, love, and affection, caregivers find ways to care that overcome difficulties and are the product of a deficit in the specific qualification for the care. They provide the necessary care with patience, ability, and stability, developing conducts and attitudes necessary for continuous care⁽⁶⁾. This contributes to feelings of peace and satisfaction with oneself. This perspective regarding care is reflected in new values in their personal lives, such as the feeling of having done the right thing by taking on the responsibility of caring, and that becoming caregivers made them better people⁽²⁸⁾.

On the other hand, the pressure from social forces in determining the choice of this role puts the caregiver at risk, since, as has been reported, caregivers which provide care due to social expectations and/or in response to practical

needs show a lack of control and seek less active solutions to challenges⁽²⁹⁾. It has also been described that caregivers mainly motivated by social expectations expressed less control over the situation, more unresolved tension, and were more likely to deal with conflicts by using temporary solutions, which did not address the roots of the issues at hand⁽²⁹⁾.

In this study, we would like to highlight the role of self-efficacy, both in the case of having breaks and in that of managing disruptive conducts. The self-efficacy in the management of disruptive conducts contributes for the SG, since reacting calmly to disruptive behaviors can be related with the ability of caregivers to regulate emotional responses such as anger⁽¹³⁾. A better development of self-efficacy allows managing this type of issue⁽²⁵⁻²⁷⁾, since it makes caregivers more capable of identifying positive aspects of the care included in negative situations⁽²⁷⁾.

Similarly, being able to have some time for herself contributes to the SG of caregivers. This ability to take a break is influenced by their perception of social support⁽²⁴⁾, meaning that, if the caregiver is to be relieved from her role, she must count on a support network she trusts and uses. Social support is a valuable form of support which also has an influence on their self-esteem and on their feeling of belonging to the community⁽²⁸⁾. When the caregivers receive sufficient support, their ability to deal with challenges is increased; on the other hand, when support is absent, they deal with the problems using less constructive strategies⁽²⁸⁾. Therefore, helping the caregiver to benefit from the experiences, family bonds, and the close support relationships will give meaning to the challenges and contribute to their inner strength, so they can deal with the demands of care.

Reformulating the challenge of care as a spiritual experience has a positive effect on coping. Nonetheless, caregivers are likely to develop in a positive direction, towards a life goal⁽²³⁾, and, if this happens, they can show more interest in self-care, which is necessary for them to continue helping the relative who needs them.

When the philosophy of life of caregivers evolves and they understand that the essential aspect of caring for a person is love, they reevaluate their priorities of life and give more value to human relations than to material considerations⁽²³⁾, caring with love transforms their legacy in a mutual interchange, giving meaning to the life of both and no expectations of getting something in return⁽²²⁾.

Self-regulating mechanisms can be apprehended or strengthened, since there is evidence that caregiver self-efficacy is a modifiable characteristics that can be addressed through interventions directed at the family caregivers, such

as: training the caregiver, online multimedia programs, psychoeducation, and training in problem-solving^(26,30), all cases in which a nurse can have an important role.

The findings of this study provide guidance for the development of interventions for caregivers that emphasize the promotion of health in the areas of growth and spiritual meaning. To overcome the negative emphasis often associated with investigations of family care, a more optimistic focus regarding the strength of the caregivers for an HPLS can be a positive intervention in families of the community. Future research would benefit by exploring in depth the needs for spiritual growth and the actors that contribute to it.

Study limitations that are worth considering when interpreting this study include the fact that the sample was formed by caregivers in a condition of vulnerability due to poverty, meaning that our results may be unable to represent the experience of women in different environments. Furthermore, the data was obtained in personal interviews, which may lead to some level of social desirability bias.

■ CONCLUSION

Almost half the caregivers informed a high SG and reported to carry out activities that contribute to it often or consistently. The SG is influenced by educational level, income, motivation for the care, by the presence of chronic diseases in the PWD, and by the self-efficacy of the caregiver to find time for a break and manage disruptive conducts. Among these, cognitive-affective resources can be taught or strengthened through interventions directed at the development of psychosocial abilities focused on improving cognition, emotion, and positive behavior. Practices that tend to develop SG are valued by their positive influence on the health of caregivers. Improving the HPLS of caregivers implies supporting them with sustainable and culturally receptive interventions that can strengthen their SG, so they can pay closer attention to the multifaceted experience of providing care, instead of focusing solely on its negative aspects.

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