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Theoretical Considerations of Resilience in Caregivers

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Opinion

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Abstract

Resilience requires a dynamic interaction between the physical, emotional, cognitive and social dimensions of self, marshaled to confront adversity, meet specific associated challenges, recover and rebound to achieve personal growth. Caregivers encounter adversity repeatedly over time such that these experiences become routine creating an unusual circumstance for personal growth. Oversights in methodologies such as failing to evaluate subtle differences in intra-personal domains and adversity ratings prior to encountering the impact of stressors during a care giving assignment, at targeted intervals over the course of the assignment and sometime after completion may result in missed opportunities to appreciate valuable data that reveals the complexity of the resilience construct. Components of motivation, socialization, cognition, emotion and physical domains in caregiver research have not been clearly explicated. There has been no unifying qualitative or quantitative theory of resilience proposed addressing the dynamic interaction within and between the intra-personal dimensions and the environmental stress over the care giving assignment that considers underlying caregivers' motivations. This article attempts to identify the intrinsic and extrinsic factors involved in understanding and measuring resilience among caregivers. A hypothetical model is proposed conceptualizing resilience as a continuous experience in care giving measured by intrinsic and extrinsic components incorporated in to a newly developed dependent measure to be administered at specified intervals before, during and after subjects accept new assignments. The factor structure of this new instrument may serve to capture subtle individual differences based on demographic factors, motivation, physical, emotional, and/or cognitive set, recovery, rebound, and personal growth. In this way, resilience may be considered a continuous factor capturing both positive and negative impact of the care giving experience.

Keywords: Caregivers; Environmental Stress; Motivation

Abbreviation: PTSD: Post Traumatic Stress Disorder.

Introduction

Theoretical Considerations of Resilience in Caregivers

Resilience has emerged as an important, albeit controversial research topic in recent decades. Investigators have failed to reach consensus on a definition of resilience despite ongoing debate. In this context, resilience refers to the experience of organizing and applying pro-social behaviors required to assume responsibilities for care of another human being, and overcome the adversities encountered over the course of an entire assignment [1-4]. Resilience requires a dynamic interaction between the physical, emotional, cognitive and social dimensions of self, marshaled to confront adversity, meet specific associated challenges,

recover and rebound to achieve personal growth. Adverse events often present and are reported as solitary events by researchers. From this view, resilience has been measured as the effects of stress on one or more of these intra-personal dimensions. Statistical models have typically investigated such intra-personal dimensions as independent components of resilience, measured separately as dependent variables. This approach has produced conflicting results. Caregiver research poses unique challenges to the understanding and measuring adverse experience. Caregivers encounter adversity repeatedly over time such that these experiences become routine as a matter of course. Caregivers may not have time to reflect, recover and rebound before being challenged again. The duration of assignments can be hours or years. In case of the latter, caregivers are vulnerable to a host of related and unrelated adversities, both intra-personal and extra-personal, potentially introducing extraneous variability into data sets. In such circumstances, dependent measures may record a caregiver's reaction to stressful events occurring outside the work environment which are more appropriately attributed to stressors unrelated to care giving. Adversity is not easily reduced to dimensions of care giving responsibility corresponding to specific aspects of resilience described above using cross sectional research and current dependent measures. For example, there have been reports of familial caregivers visiting loved ones in ICU, later presenting with delayed onset of Post-Traumatic Stress Disorder (PTSD) [5-7]. Such situations may result in spurious outcomes should the dependent variables be administered prior to the onset of PTSD. The full effects of adversity may not be captured when resilience measures are administered prior to the onset of symptoms. Measuring resilience may be complicated by the likelihood that some individuals are more capable of recovering and rebounding from stress on some intra-personal dimensions to a greater extent or faster than others. Older adults are less likely to recover physically, rebound as quickly or efficiently as younger adults. Conversely, younger adults are usually less adept cognitively and emotionally at recovering from adverse experiences caring for others than older, more experienced counterparts. In such circumstances, statistical manipulation of demographic considerations may only further obfuscate important dynamics underlying the nature of resilience within the sample investigated. Expectations for personal growth varies based on intra-personal considerations, and the demands of the care giving responsibilities assigned. Such important dynamics may be lost using current research models where dependent measures are limited to specific factors and administered only once. If the dependent variable is administered at the end of an assignment, the timing of data collection may occur prior to recovery and rebound, the researcher may miss the opportunity to capture the effects of stress on personal growth which may occur at a later time [8-10]. Social opportunities and social resources appear to moderate resilience outcomes among caregivers such that social isolation of subjects has been linked to lower resilience scores, and greater socialization behaviors are related to higher resilience outcomes. Caregivers with higher needs for social affiliation are more likely to utilize social support or informal caregiver backup resources than caregivers with lower need for social affiliation. Oversights in methodologies such as failing to evaluate subtle differences in intra-personal domains and adversity ratings prior to encountering the impact of stressors during a care giving assignment, at targeted intervals over the course of the assignment and sometime after completion may result in missed opportunities to appreciate valuable data that reveals the complexity of the resilience construct including recovery, rebound and personal growth [11-14].

Sometimes used interchangeably with resilience, wellbeing technically represents health status across the intra-personal dimensions considered above. Researchers are challenged to view wellbeing as important component of resilience following the adverse experience as the outcome measures assessing wellbeing may not assess recovery, rebound and personal growth. The outcomes measures often employed to consider wellbeing do not assess the range of intra-personal domains outlined above, and often target negative or positive behaviors, attitudes, attributes, emotions, or perceptions. In such cases, caregiver research may well be subject to confirmation bias. Investigators rarely include dependent measures designed to assess positive and negative aspects of all intra-personal dimensions potentially impacted. It has been argued that dependent measures are too frequently entitled or worded with negative connotations, ignoring the opportunity to examine the positive aspects of personal growth reported by many caregivers. Investigators rarely employ dependent measures designed to assess effects of positive and negative stress on intra-personal domains included as part of outcome research in resilience. The growth aspect of resilience discussed by investigators may be difficult to assess in the caregiver population, particularly in absence of a control group. Some researchers have chosen to exclude control groups for comparison, limiting potential for generalization of findings, and potential for drawing inferences to demographically matched caregivers. As previously suggested, the continuous demands of care giving responsibilities may well preclude existential introspection known to be an important aspect of psychological growth. It is certainly possible that some caregivers experience a delayed sense of growth well after assignments are completed, where caregivers encounter stress resulting in a temporary negative impact on physical, emotional or cognitive status. As such, a longitudinal methods using repeated measures of resilience merits further consideration. This strategy may reveal latent effects of care giving stress on recovery, rebound and personal growth demonstrating what appears

to be a continuous nature of resilience in care giving. Use of control groups would help optimize realization of the unique impact of care giving on resilience [15-18].

One important question among researchers investigating resilience has been motivators of caregivers' decisions to pursue this experience. Motivation research has largely been pursued by psychologists, and nurses seeking to better understand the nature of this construct and predictors of caregiver retention. Some consider motivation as a trait behavior. Motivation has been considered as a uni-dimensional and multidimensional construct. Researchers have entertained arguments for and against these approaches. Incorporating motivational factors in caregiver research has been limited by the large proportion of qualitative data published, making generalization of interpretations difficult. Some have suggested caregiver motivation involves a complex relationship between intrinsic vs. extrinsic rewards, and attributional constructs. Others have identified cultural traditions, familial commitment, and/or reciprocal social expectations as specific motivators. Altruism, ambition, hope, and spiritual beliefs have also been reported to motivate caregivers and impact the recovery, the rebound and personal growth aspects of resilience. Conceptual models suggest motivation serves as the impetus for allocating executive routines orchestrated toward success and personal growth [19-21]. As part of the motivational structure, some have argued modified beliefs, new attributions, or alterations in cognitive sets occur after being rewarded for previous resilient responses effectuated or observed when exposed to similar situations. Components of resilience, particularly recovery and rebound are rewarded when approximations of the desired outcome have been achieved. Not all caregivers respond to adversity in a similar fashion, recovery or rebound alike. Notwithstanding the inherent challenges of motivational research, there has been no unifying qualitative or quantitative theoretical model of resilience proposed addressing the dynamic interaction within and between the intra-personal dimensions and the environment over the care giving assignment that considers underlying motivations of caregivers. Similarly, researchers have been relatively silent when contemplating theories that may provide a comprehensive understanding of the existing data involving the impact of motivation and stress on intra-personal domains, and components of resilience among caregivers.

A theoretical model conceptualizing the nature of resilience should account for motivations of the caregiver and the reciprocal effects of adversity on various dimensions of intra-personal experience over time such that resilience is seen as a continuous multifactorial construct. A more reductionalistic approach would include the neuropsychological and neurophysiological aspects the caregiver functioning and their relationship to motivation and resilience. Although probably necessary to fully understand resilience and motivation, these issues are beyond the scope of this paper. Many investigators now view motivation as a multifactorial construct. Motivation squarely falls on the intra-personal side of the equation, impelling executive functions required to organize and maintain care giving behavior. Moreover, motivation produces the rudimentary drive behind care giving behavior; influences skill acquisition and application, yields psychological and physical preparedness for acceptance of responsibilities, actuates vigilance, commitment and endurance required, catalyzes the potential for recovery and rebound from unavoidable stressors. Stressors encountered during the care giving assignment will interact with motivation, intra-peronsal domains, potential for recovery, rebound and personal growth to create the ongoing process of behavior change. Any statistical model of resilience should incorporate this theoretical hypothesis. Components of health status vulnerable to interpersonal stress such as sleep, appetite, energy level, joint pain, myalgia, headaches, respiratory and GI symptoms are important to monitor. Appraisal of self-worth, self-efficacy, sense of purpose, goal orientation, patience, flexibility in adaptation, cognitive strategies for stress tolerance, and endurance at baseline and at prescribed intervals over the course of an assignment are indicated to consider the process of recovery, rebound and growth. Caregivers' pre-exisiting proclivities toward sorting for negative versus positive outcomes should also be measured at baseline and periodically thereafter. Cognitive expectations of positive outcomes is a feature of optimistic individuals worth consideration. Conversely, pessimistic individuals tend to sort for negative outcomes. Optimism, positive sorting, goal setting, self-expectancy for success and routine appraisal of goals are cognitive behavioral strategies known to predict positive outcomes. Pessimism, negative sorting, absence of goal setting and limited self-monitoring for achievements have been linked to depression and anxiety [22,23]. Optimism and pessimism have predicted components of resilience. Optimism has been associated with higher recovery and rebound rates. Whereas, pessimism has been inversely related to resilience. Individual differences in specific aspects of cognitive sets may offer useful insights into potential for recovery, rebound and personal growth. The purpose of care giving is typically addressed among investigators seeking to understand motivations of caregivers. Differences in reasons a caregiver pursues the experience may provide predictive value toward recovery and rebound; however, motivation may not change after encountering adversity as easily as some other factors discussed. Caregivers' purpose are linked to self-efficacy, self-esteem, and expectations of personal growth outcomes. The potential for personal growth should be measurable across several intra-personal domains (motivation, physical,

emotional, cognitive, and social components of self-efficacy including skill set, and coping strategies, recovery, and personal growth). A theoretical model of resilience should include a multifactorial instrument designed to captures change in the caregiver's response sets across the assignment [24]. The resilience measure should include motivation, intra-personal domains, mastery of skills, caregiver load, caregiver rebound, recovery and growth. If properly developed, such an instrument could be applied as an indicator of resilience across various target populations. When administered at the outset of research, intermittently over the course of the assignment, and sometime after completion of assignment researchers would be enabled to evaluate the continuous nature of resilience among caregivers stratified by demographic status. Repeated measures and comparison to control groups will be necessary to evaluate the interaction of caregiver stress with motivation over time while considering the unique changes in intra-personal domains of functioning attributable to recovery and rebound behavior, and personal growth. Sophisticated statistical models such as path analysis may then be employed to consider potential causal relationships between specific independent variables, and latent variables within a new dependent comprehensive resilience measure to gain a more omnibus view. In recent years, there have been a small number of attempts to develop comprehensive measures of resilience conceptualized as a multifactorial construct using factor analysis, including several of the dimensions discussed above. To this end, researchers have appreciated an enriched viewpoint, creating the opportunity to examine the inter-correlated effects of positive and negative stress on resilience among caregivers. Investigators have yet to design studies conceptualizing resilience as a continuous process as outlined above. Future studies following similar lines of research using strategic methodology, an enhanced dependent measure of resilience, incorporating positive and negative responses to stress, using longitudinal methods may well prove efficacious.

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