Geriatric Palliative Caregiving Among Caregivers in Metro Manila: Experiences and Assessment of Health Identity and Life Satisfaction

Wilfred Luis Clamor
De La Salle University, Philippines, wilfred.clamor@dlsu.edu.ph

RESEARCH BRIEF

Geriatric Palliative Caregiving Among Caregivers in Metro Manila: Experiences and Assessment of Health Identity and Life Satisfaction

Wilfred Luis Clamor
De La Salle University, Philippines
wilfred.clamor@dlsu.edu.ph

Around the world, caregiving is known to be an in-demand health occupation. It is needed most by the elderly population because, according to Sakakibara, Kabayama, and Ito (2015, p. 1), there is a "rapid increase in the number of elderly people" globally. Also, it is found that the population of the terminally ill or individuals who need palliative care at the age of 75 is seen to be increasing (Hickey, 1980). Caregivers are indeed needed to tend to the elderly population most especially those who are under the geriatric palliative care and were left-behind in nursing homes or caregiving institutions. However, it is seen that the number of caregivers is not enough to cover this drastic increase in elderly population that needs caregiving. It is presumed that it may be caused by the caregiver's experiences and their effects on the current health of caregivers that make them leave their job. Also, it is seen that even the idea of what health workers experienced in caregiving becomes problematic more so hinders individuals to enter the health occupation. Caring for an individual is very challenging in the part of caregivers. In fact, it is seen to be a difficult job. More so is geriatric palliative caregiving which is tending to elderly individuals who needs intensive care because it is more holistic in terms of approach and requires much effort to prolong the life of the patient.

Geriatric Palliative Caregiving

Caregivers tend to do geriatric palliative care when they are tending to elderly patients who has a certain disease that is hard to heal. This kind of caregiving is increasingly studied because of its complex features. Specifically, it is studied through experiences of different healthcare individuals.

Through different approaches, various literature defined geriatric palliative caregiving as tending to elderly individuals that "goes beyond traditional pain relief to encompass the emotional, social, and spiritual needs of patients who are not terminally ill, as well as those who are" (Lamberg, 2002, p. 943). In that sense, it is a more holistic kind of care given to elderly individuals. Geriatric palliative caregiving aims to relieve elderly individuals the pain and suffering they experience through a biopsychosocial-spiritual approach (Dane & Moore, 2006; Chandrana, Corbina, & Shillamb, 2016). It follows an approach that specializes on the following elements: open and good communication towards illness prognosis and trajectory; healthcare management; psychosocial and spiritual support; and pain or symptom management (Durepos et al., 2017). Caregivers witness and experience different situations doing geriatric palliative

care. Experiences such as health management strategies, challenges, and success in caregiving are the core of geriatric palliative caregiving among healthcare professionals (Durepos et al., 2017; Corless, Germino, & Pittmann, 2006; LeSeure & Chongkham-ang, 2015).

Caregiving Practices

Caregiving involves day-to-day practices such as feeding, moving the patient safely around, ensuring proper nutrition, bathing, and many more. However, doing geriatric palliative caregiving involves a more specialized and complex health management strategy. It includes a biopsychosocial-spiritual approach in reducing the suffering of elderly individuals to improve quality of life (Durepos et al., 2017). In this approach, the caregiver holistically cares through physical, psychological, social, and spiritual health management strategies to lessen the suffering and pain that their elderly patients experience. For the biological well-being of their patients, caregivers manage a large amount of pharmacological treatment based on the condition of their patient. Treatments focus on pain management most especially to patients with cancer, dementia, Alzheimer's disease, and other diseases that fall under intensive care (Van de Steen, Radbruch, & Hertogh, 2014).

Geriatric palliative caregiving involves interventions and strategies to treat psychosocial problems experienced by elderly patients. Health strategies such as music therapy, aromatherapy, validation therapy, multisensory practices, and light therapy are the most frequently used by caregivers to calm the mind of elderly patients (Durepos et al., 2017). However, there are some strategies that include treatments on aggression and agitation with antipsychotics when patients manifest harmful behaviors (Abbey, Palk, & Carlson, 2008). There are also strategies that focus on the social health of patients. Practices that decrease social isolation such as community day programs are very popular in nursing homes to help patients interact more with other patients (Durepos et al., 2017).

Compared to other types of care, geriatric palliative caregiving emphasizes in improving the quality of life through spiritual interventions and strategies. This strategy is not mostly used by other kinds of caregiving.

This approach is used in palliative care because it prepares elderly patients for the end of life (Amano, Morita, & Tatara, 2015). Moreover, this health management strategy is mostly used by nursing homes run by religious organizations. According to studies, it is found that giving importance to the spiritual dimension of an individual helps the coping process across until the end of life (Coward, 1997; Plante & Sherman, 2001). In a study by Dane and Moore (2006, p.64), "improving spiritual well-being can bolster immune functioning, reduce cardiovascular risk associated with stress and anxiety, and foster enhanced psychological well-being." Health management strategies in the spiritual context involve praying, meditation, reading of religious scriptures, and life review. These strategies are known as coping resources and can foster inner peace and relaxation to improve the quality of life of elderly patients (Hill & Pargament, 2003; Helminiak, 1998). Also, it is found that spiritual health practices provide relief from pain and makes patients hope for a peaceful death (Peraklya, 1991).

Experienced Rewards

Geriatric palliative caregiving is a job that requires a lot of effort and time in caring for elderly patients which can be burdensome to most healthcare workers. However, it is also found that geriatric palliative caregiving can also be rewarding to most caregivers. According to LeSeure and Chongkham-ang (2015), caregivers experienced a high level of satisfaction in tending to their elderly patients which is in contrast to the idea that geriatric palliative caregiving is very challenging and burdensome. Geriatric palliative caregivers experience happiness when they care for their patients. Providing holistic care to their patients also makes them feel accomplished (Coronel, Chua, Constantino, & Cordova, 2009). Most studies found that caregivers feel successful because of the intrinsic rewards that they experience which makes them forget the burdensome nature of caregiving (Reineck & Furino, 2005). Moreover, caregivers experience success and rewards by being appreciated, respected, and trusted by their elderly patients. In that sense, caregivers gain a lot of experience working in nursing homes to grow and develop their personal and work-related life.

Experienced Challenges

With a specialized and complex approach in dealing with elderly patients, geriatric palliative caregivers experience many challenges. According to Corless, Germino, and Pittman (2006), caregiving involves physical, psychological, and emotional burdens experienced by healthcare workers. Moreover, caregivers experience undesirable situations; uncertainty for the nature and all in all progression of the disease; difficulty in managing their personal life; and problems in handling issues of elderly patients (Brinkley, 1983). Being a caregiver means to be on call most of the time tending to their patients. According to recent literature, most caregivers are at risk of being drained and stressed out because of their job (Kahn, 1993). In that sense, geriatric palliative caregivers experience job burnout. It is defined as a "syndrome of physical and emotional exhaustion, involving the development of a negative self-concept, negative job attitudes, and a loss of concern and feelings for clients" (Pines & Maslach, 1978, p. 233). According to Coronel et al. (2009), problems in the institution are a challenge in doing caregiving duties. Inadequacies in finance, facilities, medicines, and human resource are significant struggles caregivers experience. In that sense, geriatric palliative caregiving is a difficult job that may affect the health or well-being of caregivers.

Geriatric Palliative Caregiving as Influence of Health Identity and Life Satisfaction

Geriatric palliative caregiving is seen to be a job that involves a complex approach compared to other kinds of caregiving. Also, it is found that geriatric palliative caregiving is perceived by healthcare professionals to be challenging and rewarding at the same time. With various experiences, previous literature states that caregiving behavior lead to different health outcomes specifically on health identity and life satisfaction of caregivers (Staight & Harvey, 1990).

In recent studies, the health of caregivers is mostly seen to be problematic because of the nature of their work. It is seen that the biopsychosocial model is frequently used to explain the deterioration of the health conditions of caregivers. According to Rogers (1999, p. 2), "caregivers frequently experience psychological,

social, and physical losses that include deterioration of health, reduction or loss of employment, loss of personal freedom and privacy, and deterioration of social relationships." For physical health, it is found that caregivers are at risk of biological illnesses (Schulz & Beach, 1999). In a study by Elmore (2013), it is found that caregivers have deficits in antibody responses to vaccination, extremely high levels of stress hormones, and poor quality of sleep. All in all, healthcare workers experience exhaustion because of handling elderly patients, most especially those very difficult to be cared for. According to Coronel et al. (2009), tending to elderly patients is an energy-consuming job because of unexpected mood changes, specifically patients who have cognitive impairments and degenerative diseases. With these kinds of experiences, caregivers cope with unhealthy behaviors. A study by Vitaliano, Zhang, and Scanlan (2003) stated that healthcare workers also engage in risky health behaviors such as smoking, poor nutrition, substance abuse, and sedentary lifestyle because of the nature of the job.

Geriatric palliative caregiving can also lead to different benefits (Schulz & Beach, 1999). Using the biopsychosocial approach, this style of caregiving can lead to better well-being towards the caregivers themselves. In a study by Brissette, Scheier, and Carver (2002), high levels of optimism among caregivers are associated with low levels of emotional stress and depression. Moreover, it is also found that with high levels of optimism present, caregivers tend to have reduced risk of having a disease and faster recovery from various illnesses (Kivimaki et al., 2005).

Health Identity

The concept of health identity is seen to be poorly conceptualized. Literatures are seen to have the gap in defining this concept. However, it can be defined using its etymology. Health identity is composed of two words. Health concerns the total well-being of an individual. Identity means the essence of who an individual is. Therefore, health identities are health-related aspects of one's identity (Fox & Ward, 2008). However, it is not easy to define an individual's health identity. Identity itself emerges from an assemblage of relations with the material and social world. Also, according to Bond, McCrone, and Brown (2003,

p. 371), "identities are never prior or essential, but are constituted in relation to the social environment that an individual inhabits." In that sense, health identities in recent literatures can be related to the philosophy of social identity.

It means that our health identity can be defined by the "I" and the "Other." On the one hand, the "I" creates a personal identity based on self-experiences. The self creates a personal reality (Bogue, 1989). On the other hand, the "Other" is based on the collective thought that influences and molds an identity (Delgado, 2015). In relation to health, according to Fox and Ward (2008), health identity is never fixed, and may alter due to different experiences. In relation to caregiving, the "I" may see their health identity to be in a positive outlook because of good health conditions and absence of certain kinds of diseases. However, the "other" may prove otherwise. They may see an individual to be sick due to caregiving burden and struggles. Therefore, health identities are seen in two ways: through the self and through other social forces.

The self identifies one's health. According to the philosophy of Friedrich Nietzsche on the will-to-power, only the self creates the reality that they want (Bogue, 1989). In this philosophy, Nietzsche explained that for an individual to master the "I," one must not give in to the "herd" and create one's identity based on the self. Relating it to health identity, an individual has the power to see the capacity of the self by looking at their own physical or biological, psychological, and social well-being and capacity. A study by Fox and Ward (2008) described health identities among individuals by looking at pharmaceutical products, specifically, anti-obesity regimens. It is seen that individuals are using pharmaceutical products to sustain a low body weight due to self-control and self-affirmation. These findings echo the idea that health identities are controlled by the self. An identity of being pro-anorexia comes up due to their health behavior. In caregiver's perspective, they tend to do self-medication when they perceive themselves incapable of working due to their job or when they face a specific disease.

In contrast, another notion of the genesis of health identities is that individuals perceive themselves based on the "other." The philosophy of Foucalt (1980) about power and knowledge describes powerful social forms

that shape the health identity of an individual. Another study by Fox and Ward (2008) found that people sought validation of their decisions on health based on social forces such as biomedical expertise and cultural norms. Caregivers tend to manifest health-seeking behavior when peers and colleagues perceive them to be unhealthy. Moreover, they seek medical attention from biomedical and sometimes traditional health expertise to counter certain illnesses.

However, health identity can be recognized by the dialogue of both the self and social forces. In the *logic of sense* and *difference and repetition*, philosopher Gilles Deleuze (1990, 1994) explained the concept of subjectivity in defining one's identity. This subjectivity comes from a discourse confluence between the social world and the engagement of the living body. This relationship then affects the whole well-being of an individual and how the self is being identified.

Life Satisfaction

Alongside the health conditions and health identity of caregivers, their life satisfaction is also found to be affected by various experiences in doing geriatric palliative care. According to Sumner (1996, p.145), "it is a positive evaluation of the conditions of [one's] life, a judgement that at least on balance, it measures up favorably against one's standards or expectation." A study by Staight and Harvey (1990) found that more than half of the caregivers in their study were not very satisfied with their lives. In addition, the study found that caregivers are even more depressed and lonely compared to their elderly patients. Also, it is found that the decline of health due to the experiences of palliative caregiving can lead to lower levels of life satisfaction (Pruchno, Kleban, Michael, & Dempsey, 1990). With lower life satisfaction, the overall well-being of caregivers is being affected.

However, there are also studies that caregivers feel satisfied with their lives due to their experiences in their job. With geriatric palliative caregiving, healthcare workers feel satisfied with their life because of being an agent of happiness to their elderly patients (Coronel et al., 2009). Moreover, caregivers become satisfied with life because of spiritual and personal fulfillment that they experience in doing geriatric palliative caregiving (Elmore, 2013). All in all, it is seen that life satisfaction

among caregivers is affected due to various experiences in geriatric palliative caregiving.

This study describes the experiences of professional caregivers in doing geriatric palliative care and how these experiences influence their self-assessment of their health identity and life satisfaction. Specifically, this study seeks to answer the following questions:

1. What are their experiences in geriatric palliative care?
2. What is their self-assessment of their current health identity and life satisfaction?
3. How does their self-assessment of their current health identity and life satisfaction vary based on their geriatric palliative caregiving experiences?

Methods

This study used a qualitative-descriptive research design. It involved key informant interviews of caregivers as a research method. In addition, this involved a face-to-face interview as a research technique. The population of this study involved professional caregivers employed by organizations in Metro Manila. This study involved 12 key informants as a sample. This study utilized a non-probability sampling technique. Key informants are chosen through a purposive-convenient sampling.

The voice-recorded in-depth interviews were transcribed, and the data gathered were sorted according to the research problems they addressed.

Content analysis was used as data evaluation through an assessment of the interview transcriptions. The information was analyzed and presented based on the similarities and differences of the themes.

Results

Caregivers mentioned different experiences in doing geriatric palliative care towards their patients. This refers to their experiences of doing holistic care for elderly individuals who need intensive care. These experiences are determined through their caregiving practices, challenges experienced, and perceived rewards in caregiving.

Geriatric Palliative Caregiving Experience

Caregiving practices. In geriatric palliative caregiving, caregivers are expected to do the basic as well as holistic care to their patients. Caregivers cited various caregiving practices. These practices focus on the healthcare management of patients. The identified caregiving practices are classified according to biological/physical approach (e.g., bathing & feeding), psychological approach (e.g., psychological therapies), social approach (e.g., leisure & social gathering), and spiritual approach (e.g., praying & yoga). Various practices were enumerated by the caregivers (see Table 1).

Elderly individuals under palliative care are in a situation that requires basic as well as holistic care. Elderly individuals in the nursing home require medical and care-related approach as a way of tending to their needs due to the current situation of patients. In that

Table 1
Caregiving Practices Among Caregivers

Themes	Sub-themes	Mentioned Examples
Physical Caregiving Practice	Basic Practices	Feeding, bathing, clothing, etc.
	Medical Practices	Checking vital signs, and giving medicines
Psychological Caregiving Practices	Emotional Practices	*Lambing*, emotional boosting, and genuine care
Social Caregiving Practices	Leisure Activities	*Lambing*, talking, and entertaining patients
Spiritual Caregiving Practices	Traditional Religious Practices	Attending Sunday mass with patients and praying

sense, it is expected that caregivers tend to the physical well-being of their patients. Basic practices such as feeding, bathing, checking vital signs, clothing, giving medicine, and putting diapers are part of the daily routine of caregivers. According to a caregiver,

By 6 a.m., we let our patients take their breakfast. After that, they will take a bath. By 10 o'clock, we will give them snacks to eat. Their lunch is scheduled on 11:30 then afterwards, by 1 or 2 in the afternoon, they will have their "siesta". By 3 in the afternoon, we will give our patients snacks and by 5pm, they will take their dinner. By 6 in the evening, they will go to bed.

The patients of the caregivers are seen to undergo psychological problems because of their current situation. Elderly individuals feel depressed because of the feeling of angst and grief due to the longing for their families. More so, elderly patients experience forgetfulness due to their old age. Some patients also have Alzheimer's disease which requires psychological caregiving practices such as emotion management practice. These kinds of practices intend to supervise the psychological well-being of elderly patients. Majority of the caregivers responded that they use the practice of *lambing* to maintain the psychological health of their patients. According to these caregivers, *lambing* is an act of giving love and affection to their patients. The concept of *lambing* refers to the behavior of giving another individual intimate time. As one caregiver said,

There are times that you need to love your patients for them to be happy. If they want someone to be beside them, I will stay and they will talk about their life until they become peaceful.

Emotional boosting is also seen to be a significant psychological caregiving practice manifested by caregivers. The patients of caregivers are seen to experience different kinds of psychological suffering due to their current situation. These patients tend to become depressed and seen to have suicidal thoughts. Also, psychological distress is seen to affect the overall

well-being of patients. Caregivers are then urged to encourage and maintain good emotions in the nursing homes. Health care providers tend to talk to their patients about their problems, giving the love their patients deserve, and emotionally encourage them by making their patients smile. One caregiver said that,

Every caregiver must give their patients genuine care. This refers to showing and giving love or care to patients. We give this kind of care because our patients do not experience the care that their family must give to them.

To maintain the social well-being of patients, caregivers also mentioned *lambing* as a caregiving practice. Caregivers admitted that *lambing* also boosts the social well-being of the patients. It is seen that patients need to experience the "warmth" that other people give. Caregivers tend to be "always there" to encourage and care for their patients. This kind of behavior can also come from fellow patients. Caregivers manage practices that make patients manifest the behavior of *lambing* with other patients. Patients are often seen to socialize with one another. Caregivers facilitate these socialization practices and that the behavior of *lambing* must be manifested by patients. It would be very beneficial to the caregivers because patients would not hate and show unruly behavior with other patients.

In other leisure activities, patients are expected to talk to other patients to maintain their social well-being. This kind of practice helps patients not to feel any sense of solitude inside the nursing home. This also sets the mood in bonding with other patients. This lifts the patients from any ideation that makes them feel that they are alone. Bonding with other patients enhances their well-being which decreases any chances of depression and suicidal behavior. Caregivers facilitate this socialization process by making their patients talk about their history. Caregivers responded that this is an effective approach because of the concept of *libang* [To entertain]. Patients talking about their past hinders any chance of thinking about depressive and suicidal thoughts. This is also seen to control and calm patients if they are feeling any chance of anger

and inappropriate behavior. According to a female caregiver,

> *By 3 or 2 in the afternoon, all of our patients are taken outside. They then would talk to each other about their past. This serves as their leisure time with other patients. We also talk to them about their past. They even feel happy and excited when they talk about their life before entering the nursing home.*

Spiritual caregiving practices are seen to be significant health management strategies among caregivers. This kind of approach is found to be neglected by most caregivers. However, informants in this study responded that this kind of practice encourages and helps the maintenance of having good quality health or well-being. A spiritual approach is seen to be an effective approach to enhance the total well-being of elderly patients. This practice encourages keeping faith which is seen to decrease tendencies in thinking of suicidal thought among elderly patients. Some caregivers tend to pray alongside their patients as a spiritual practice. Being one with caregivers, patients have faded any tendency of loneliness and solitude.

In these kinds of institutions, having masses every Sunday is a weekly routine. Caregivers and their patients assemble in a formation center for the Sunday mass because all are required to attend for spiritual needs and fulfillment. Sunday masses also grants the opportunity for patients to be "closer to God." In this way, patients are seen to be spiritually fulfilled. This practice makes the patients avoid any idea of dread and longing.

Rewards in caregiving. Caregivers tend to experience different encouraging situations that uplift their morals and makes challenging experiences bearable. The identified rewards in caregiving are classified into two categories: patient-to-caregiver rewards and institution-to-caregiver rewards (Table 2).

Caregivers admitted that their patients are the most significant source of stress and tension. However, caregivers also responded that elderly patients could also be seen as a significant source of encouragement and rewards. Majority of the caregivers interviewed responded that their patients play a significant role in terms of inspiration and support. Moreover, caregivers undergo positive experiences when patients appreciate their healthcare provider. It is seen that caregivers undergo stressful situations; however, these circumstances are diminished when patients appreciate the work of their caregivers. According to most informants, a simple "thank you" from their patients makes their day. This manifestation of appreciation makes the caregivers feel that their job is worth the stress. These experiences boost the fulfilling attitude among caregivers which also urges them to work more. These are the actual experiences by the majority of caregivers interviewed.

Some caregivers also admitted that they do geriatric palliative care because of altruism. Altruistic behavior refers to a manifestation of helping behavior to a certain individual without any form of compensation or payment. Majority of the caregivers responded that the idea of helping elderly patients is a fulfilling experience. Caring for the abandoned elderly is seen to be a rewarding experience for most caregivers. According to one middle-aged informant,

> *There are times that I tend to not care about the payment I receive here in the nursing home. I just want to help them because I already fell in love caring for my patients.*

Table 2

Experienced Rewards in Caregiving

Themes	Sub-themes	Mentioned Examples
Patient Based Rewards	Emotional Gain	Appreciation from patients and altruistic fulfillment
	Cognitive Gain	Gaining caregiving knowledge
Institution Based Rewards	Monetary Gain	Salary increase

In addition to altruistic fulfillment, caring for the abandoned elderly is seen to be a rewarding experience for most caregivers. According to one female informant,

It is also a rewarding experience for us caregivers tending to our patients. More so if we are to give the love they deserve which they did not experience with their families. It is fulfilling for us because we are the ones giving them happiness.

Caregivers mentioned that a salary increase is a rewarding experience according to most informants. This experience is classified under the institution-to-caregiver rewards. A salary increase occurs if the superiors of the nursing homes agreed to increase the monetary incentive due to the good quality performance of a caregiver. This is a significant, rewarding experience on the part of the caregivers due to the small amount of salary they receive. With that, caregivers are seen to be recognized for their performance in the nursing home. Caregivers admitted that they are encouraged and fulfilled if such rewarding experience occurs.

Challenges in caregiving. Another experience of caregivers in geriatric palliative care is a certain occurrence of different challenges and burdensome situations. Caregivers tend to have difficulties in handling patients due to health situations. Geriatric palliative care involves intensive practices and complex health management strategies because patients are seen to have problematic health conditions (e.g., patients having an Alzheimer's disease). The identified challenges in caregiving are classified into two: patient-to-caregiver challenges and institution-to-caregiver challenges (Table 3).

Caregivers experience various challenges in terms of tending to elderly patients under intensive care. Before entering the nursing homes, caregivers are trained to manage these kinds of patient-to-caregiver challenges to cope up. However, caregivers cannot avoid these challenges because it is a natural experience for every worker when tending to patients. Majority of the caregivers responded that the most challenging experience is living through the undesirable behavior of elderly patients. Caregivers go through different unruly behaviors every day when tending to patients. Most of the informants are seen to experience having patients who exhibit and manifest stress to manage behaviors. Patients in the nursing homes show hyperactive behavior that is found to be difficult to manage. These hyperactive behaviors refer to patients shouting, crying, and mood swings. Caregivers tend to manage these behaviors; however, it is seen to be a very challenging experience. This is true for most caregivers. As one caregiver quipped,

There are times that they go out of control or they become very hyperactive or they would not listen to you. It is very difficult to handle these kinds of situations. There are also times that they would fight one another. It is so stressful on the part of caregivers.

Most caregivers said that their patients tend to become unruly to the point of physical infliction of pain towards their caregiver. These abusive behaviors

Table 3

Experienced Challenges in Caregiving

Themes	Sub-themes	Mentioned Examples
Patient Based Challenges	Behavioral problems of patients	Patient hurting caregivers and hyperactive behavior of patients
	Cognitive impairment of patient	Forgetfulness patients
	Functional disabilities of patients	Sickly patients
Institution Based Challenges	Monetary Deduction	Salary deduction

become uncontrollable because of the health condition of elderly patients. These behaviors include pinching, punching, and slapping the caregivers. These unruly behaviors are manifested most of the day as disclosed by most of the informants.

Cognitive impairment of patients is also seen as one of the major challenges and concerns experienced by most caregivers. With older age, patients are found to be always forgetting in most circumstances in the nursing homes. Also, some elderly patients have Alzheimer's disease which is natural to have a weak cognition and memory. Majority of the caregivers treat this phenomenon as a challenge. Caregivers admitted that handling elderly patients are very difficult to manage because there are times that their patients suddenly manifest abusive behavior due to forgetfulness. One informant responded,

> *It is very difficult for us to manage our patients because there are times they forget. They sometimes ask you, "haven't we eaten yet?" They sometimes fail to recall that have eaten already. They would become mad at you because they feel that you did not feed them.*

Caregivers are also seen to experience difficulties and challenges due to the management of the institution. Majority of the caregivers admitted to experiencing salary deduction because of institutional punishments. This is seen to be a difficulty among caregivers because a salary deduction can cause a significant amount of monetary loss. Most caregivers are seen to have a small salary, and a salary deduction would be very stressful on their part. Salary deduction is due to institutional punishment. Caregivers are challenged not to violate these institutional rules and regulation to avoid any chance of salary deduction.

Self-Assessment on Health Identity and Life Satisfaction

With different experiences in doing geriatric palliative care, caregivers tend to mention various self-assessments in terms of health identity and life satisfaction. This self-assessment examines the overall well-being of caregivers in terms of the identification of perceived health and fulfillment in life.

Health identity. The self-assessment on health identity of caregivers are labels and description given by the self and from other people on their current health condition. This health identity is based on the "self" and "other" interactions of the caregiver in terms of characterization of health. Responses are classified into two health identities: biological health identity, and psychosocial health identity (Table 4).

It is found that majority of the caregivers interviewed have different descriptions and labels in terms of their current health condition. For the biological health identity, it is seen that most caregivers identify themselves to be physically healthy. In that sense, caregivers doing geriatric palliative care described their health identity in good quality. It can be said that caregivers have a good health condition as they have no health problems experienced while working in nursing homes. Caregivers also responded to having a normal health condition when tending to elderly patients.

Table 4
Health Identity of Caregivers

Themes	Mentioned Examples
Physiological Health Identity	Physically healthy
	Being fit
	Getting thinner
Psychosocial Health Identity	Emotionally and socially stable
	Depressed
	Burnt out

Caregivers also admitted having changes in terms of body shape while doing geriatric palliative care. On the one hand, some caregivers responded to having a biological health identity of stronger built or "being fit." According to the informants, the caregivers themselves and other people noticed the physical changes in terms of being muscular in shape. This is so because caregivers are seen to carry patients and do other physical activities as caregiving practices in the nursing home. On the other hand, some caregivers responded to having a biological health identity of "getting thinner." Caregivers responded that most people noticed the manifestation of weight loss as a significant bodily change. This is so because caregivers experience difficulties when tending to their patients. Also, caregivers are required to pay full attention to their patients which makes these healthcare providers forget about caring for themselves.

For the psychosocial health identities, caregivers also stated different responses. Majority of the caregivers labeled their psychosocial health to be considerably good. Moreover, caregivers responded to have "emotionally and socially stable" health identity. This means that most caregivers have no psychosocial health problems encountered while working in the institution.

Some caregivers are seen to have a problematic description of their psychosocial health. Some caregivers stated to have a "depressed" health identity. This is so due to the experiences of caregivers tending to their elderly patients. These caregivers felt sorry for the situations of their patients. These are seen to affect the cognition and behavior of some caregivers. According to one health care provider,

There are times that I become very depressed while working. I may be always smiling but deep inside, I feel very sad most especially because of the situation of my patients.

Life satisfaction. In terms of life satisfaction, caregivers mentioned various attitudes and perspectives on having a fulfilling life. Responses in the interview are classified into two: perceived ideal life and present life of caregivers (Table 5).

Caregivers cited different perceptions on an ideal life. Majority of the caregivers interviewed answered that having a "carefree life" is a perfect or ideal kind of life. Most caregivers responded to having a "carefree life" as an ideal life probably because they are seen to work whole day caring for their patients. Caregivers must always look after the well-being of their patients. Every day, caregivers worry about elderly patients due to their problematic health condition.

Making a living is seen to be an ideal life based on the responses of caregivers. It is found that caregivers do not receive a high amount of monetary payment, hence, perceiving having a high paying job would be ideal. Also, making a living as a response to ideal life shows that caregivers tend to hope for a financially stable life.

The current situation of the informants measures if caregivers are close to their ideal life and if they

Table 5
Life Satisfaction of Caregivers

Themes	Mentioned Examples
Ideal Life	Having a carefree life
	Making a living
	Balanced life
	Finishing a degree
Present Life	Satisfied as a caregiver
	Earning money
	Problematic life

are satisfied with life. Most caregivers responded to being satisfied in caring for elderly patients. This is probably because of the experienced fulfillment in doing geriatric palliative care. Also, caregivers are satisfied with the monetary incentives they receive in working at the nursing homes.

However, caregivers also admitted to having a problematic life compared to their ideal life. Problems in the family, friends, and other difficulties in life are mentioned by caregivers. Caregivers admitted that their ideal life is far from their current life which is seen to be problematic.

Geriatric Palliative Caregiving and Self-Assessment of Health Identity and Life Satisfaction

Self-assessment of caregivers on health identity and life satisfaction vary based on their experiences in geriatric palliative care. Experiences such as caregiving practices, challenges, and rewards in caregiving are seen to be influencing the phenomenon on the variation of self-assessments on health identity and life satisfaction among caregivers.

Most caregivers have regular health, whether physically or emotionally, regardless of their caregiving practices. However, some caregivers doing physical and psychological caregiving practices are seen to have an abnormality in terms of health identities. For the physical approach, it is seen that some caregivers have health labels of being fit, getting thinner and being depressed. In terms of doing a psychological caregiving practice, some caregivers are seen to have a health identity of being depressed (Table 6).

In terms of life satisfaction, most caregivers are satisfied with their life regardless of their caregiving practices. However, it is also seen that some caregivers doing physical and psychological caregiving practices are found to have problematic life satisfaction. Some caregivers categorized in such caregiving practice are found to have certain problems they experience in their present life.

Most caregivers are seen to have regular well-being regardless of their experienced rewards and challenges. However, some caregivers mentioned of having peculiar health identities and unsatisfied with life.

Table 6

Caregiving Practices and Self-Assessment on Health Identity and Life Satisfaction

	With Physical Approach	With Psychological Approach	With Social Approach	With Spiritual Approach
Mentioned Health Identity Themes	– Physiological Health Identities (e.g., physically healthy, being fit, & getting thinner)	– Physiological Health Identities (e.g., physically healthy)	– Physiological Health Identities (e.g., physically healthy)	– Physiological Health Identities (e.g., physically healthy)
	– Psychological Health Identities (e.g., emotionally healthy and depressed)	– Psychological Health Identities (e.g., emotionally healthy)	– Psychological Health Identities (e.g., emotionally healthy)	– Psychological Health Identities (e.g., emotionally healthy)
Mentioned Life Satisfaction Themes	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)
	– With life problems (e.g., family problems)	– With life problems (e.g., family problems)		

Patient-based rewards and challenges lead to peculiar health identities. Moreover, caregivers experiencing caregiver challenges and rewards tend to be dissatisfied with life (Table 7).

Discussion

Caregivers vary in experiences on geriatric palliative care. These include their caregiving practices such as physical, psychological, social, and spiritual health management. Caregiving rewards were also mentioned to be part of the experiences of caregivers. Rewards encompass patient-to-caregiver rewards such as being appreciated by their patients and altruistic fulfillment and institution-to-caregiver rewards such as monetary gains. In terms of challenges experienced, caregivers mentioned patient-to-caregiver challenges such as the manifestation of unruly behavior and institution-to-caregiver such as salary deduction.

With further examinations, it is found that these experiences such as caregiving practices, rewards, and challenges in caregiving influence the variation of self-assessment on health identity and life satisfaction.

In terms of caregiving practices, it is examined that caregivers are most likely to have good health identification and is satisfied with life. This finding is a reflection on the study of positive effects of caregiving towards the total well-being of caregivers (Schulz et al., 1997; Brown, 2007).

However, there are some instances that caregivers assess themselves to having peculiar health identities and life satisfaction. Caregivers doing a physical caregiving practice and psychosocial caregiving practice tend to have a biological health identity of being fit, and getting thinner, and depressed.

Changes in the body, specifically having health identities of being fit, are found to be a significant effect of handling patients by doing physical caregiving practices. This is because of the physical burden that caregivers experience in doing physical health practices such as carrying, washing, and cleaning patients (Vitaliano et al., 2003). Physiological changes are expected in doing geriatric palliative care. This type of care requires caregivers to have intensive attention to their patients. With this kind of approach, caregivers can be doing physically challenging practices which

Table 7

Rewards and Challenges Experienced and Self-Assessment on Health Identity and Life Satisfaction

	With Patient-Based Rewards	**With Institution-Based Rewards**	**With Patient-Based Challenges**	**With Institution-Based Challenges**
Mentioned Health Identity Themes	– Physiological Health Identities (e.g. physically healthy, being fit, & getting thinner)	– Physiological Health Identities (e.g., physically healthy)	– Physiological Health Identities (e.g., physically healthy, being fit, & getting thinner)	– Physiological Health Identities (e.g., physically healthy)
	– Psychological Health Identities (e.g., emotionally healthy and depressed)	– Psychological Health Identities (e.g., emotionally healthy)	– Psychological Health Identities (e.g., emotionally healthy and depressed)	– Psychological Health Identities (e.g., emotionally healthy)
Mentioned Life Satisfaction Themes	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)	– Satisfied with life (e.g., making a living)
		– With life problems (e.g., family problems)		– With life problems (e.g., family problems)

can lead to a change in physique and a label of being fit.

In geriatric palliative care, caregivers are required to give full attention in tending to their patients. Caregivers must check from time to time the well-being of their patients because geriatric palliative care requires several hours of care provision. This means the care providers have irregular time for themselves, specifically a time for eating. An irregular eating habit affects the physique of an individual. Moreover, caregivers are seen to skip food due to the nature of their job, which is to give full attention to their patients. This then leads to a significant weight loss and physical health changes among caregivers (Shaw et al., 1997).

"Depressed" and "not satisfied with life" are also mentioned in the assessment of caregivers. Being depressed and having problems with life are mentioned by caregivers who practice physical and psychosocial health management strategies. According to Schulz, O'Brien, Bookwala, and Fleissner (1995), caregivers tend to be depressed and dissatisfied with life because of the care recipient's functional abilities.

Caregivers are found to have a normal health condition based on their health labels and are satisfied with life due to their experienced rewards in caregiving. This is true in most literature stating that caregiving is a rewarding experience (House, Landis, & Umberson, 1988; Brown, 2007). However, there are some instances that caregivers assess their well-being to have certain changes, whether physical or psychosocial adjustments, due to the rewards experienced and received.

In terms of challenges experienced, the majority of the caregivers are seen to have a normal health identity and good quality of life satisfaction regardless of such experiences. Yet, there are some instances that caregivers experience different health identities and dissatisfaction in life. Some caregivers who cited patient-based challenges also mentioned that they experience peculiar health labels (e.g., being fit, being depressed, and getting thinner) and problematic life satisfaction.

Some of the caregivers having patient-based challenges mentioned having a peculiar physiological health identity. This is because patient-based stressors lead to physical strains and physiological changes (Shaw et al., 1997). The functional impairments of patients are found to be significant indicators of stressors among caregivers which leads to physiological changes. The stress that caregivers experience sometimes relates to metabolic changes which alter the physique of the caregivers drastically (Vitaliano et al., 2003). Hence, caregivers identify themselves as having unusual health labels such as being fit, getting thinner, or experiencing drastic weight loss.

Having patient-based challenges also leads to a health identity of being depressed according to some caregivers. Patients are most likely to be a stressor among caregivers since full attention is given to them. Experiencing patient-based stressors lead to depressive attitude and behavior among caregivers. According to a study of Schulz et al. (1995), caregivers experiencing greater degrees of depression are related to the behavioral problems, cognitive impairment, and functional disabilities of patients. These kinds of stressors are most likely experienced by caregivers doing geriatric palliative care. Hence, some caregivers tend to have peculiar psychosocial health identity, specifically being depressed.

Regardless of the kind of rewards and challenges experienced, caregivers tend to be satisfied with life. These workers mentioned making a living out of their profession as satisfying. With a right amount of payment, workers can send their children to schools, and have proper access to different high-quality resources (Bolante, 2014).

Geriatric palliative caregiving is found to influence the health identity and life satisfaction of caregivers. Generally, caregivers are seen to have a good quality health identity and life satisfaction. However, there are some tendencies that caregivers cite some out of the ordinary assessments of their health identity and life satisfaction. Caregivers doing physical caregiving practice, psychosocial caregiving practice, and experiencing patient-based rewards and challenges are precedent to health identities such as being fit, getting thinner, and being depressed.

Ethical clearance:

The study was approved by the institution.

Conflict of interest:

None.

References

Abbey, J., Palk, E., & Carlson, L. (2008). *Clinical practice guidelines and care pathways for people with dementia living in the community*. Retrieved from http://eprints.qut.edu.au/17393/1/17393.pdf

Amano, K., Morita, T., & Tatara, R. (2015). Association between early palliative care referrals, inpatient hospice utilization, and aggressiveness of care at the end of life. *Journal of Palliative Medicine, 18*, 270–273.

Bolante, M. (2014). Master and servant: Contradictory roles of migrant Filipina domestic worker. *Asia-Pacific Social Science Review, 14*(2), 162–167.

Bond, R., McCrone, D., & Brown, A. (2003). National identity and economic development: reiteration, recapture, reinterpretation and repudiation. *Nations and Nationalism, 9(3)*, 371–391.

Bogue, R. (1989). *Deleuze and Guattari*. London: Routledge.

Brinkley, D. (1983). Emotional distress during cancer chemotherapy. *British Medical Journal, 286*, 663–664.

Brissette, L., Scheier, M., & Carver, C. (2002). The role of optimism in social network development, coping, and psychological adjustment during a life transition. *Journal of Personality and Social Psychology, 82,* 102–111.

Brown, S. (2007). Health effects of caregiving: Studies of helping behavior needed. *Alzheimer's Care Today, 8(3),* 235–246.

Chandrana, D., Corbina, H., & Shillamb, C. (2016). An ecological understanding of caregiver experiences in palliative care. *Journal of Social Work in End-of-Life & Palliative Care, 12*(1-2), 162–182.

Corless, I., Germino, B., & Pittman, M. (Eds.). (2006). *Dying, death, and bereavement: A challenge for living* (2nd ed.). New York, NY: Springer.

Coronel, R., Chua, K., Constantino, M., & Cordova, E. (2009). The success and struggles of Filipino geriatric nurses in nursing homes. *Educational Gerontology, 35*(4), 358–377.

Coward, D. (1997). Constructing meaning from the experience of cancer. *Seminars in Oncology Nursing, 13*, 248–251.

Dane, B., & Moore, R. (2006). Social workers' use of spiritual practices in palliative care. *Journal of Social Work in End-of-Life & Palliative Care, 1(*4), 63–82.

Deleuze, G. (1990) The Logic of Sense. New York: Columbia University Press.

Deleuze, G. (1994) Difference and Repetition. London: Athlone Press.

Deleuze, G. (1990). *The Logic of Sense*. New York: Columbia University Press.

Deleuze, G. (1994). *Difference and Repetition*. London: Athlone Press.

Delgado, D. (2015). Discourse, identity, and international development cooperation: China, Africa and FOCAC. *Asia-Pacific Social Science Review, 15*(2), 1–18.

Durepos, P., Wickson-Griffiths, A., Hazzan, A., Kaasalainen, S., Vastis, V., Battistella, L., & Papaioannou, A. (2017). Assessing palliative care content in dementia care guidelines: A systematic review. *Journal of Pain and Symptom Management*, *54*(4), 804–813.

Elmore, D. (2013). The impact of caregiving on physical and mental health: Implications for research, practice, education, and policy. In Talley, R., Fricchione, G., & Druss, B. (Eds.), *The challenges of mental health caregiving: Research • Practice • Policy (*pp. 15–31). New York, NY: Springer.

Foucault, M. (1980). "The eye of power". In Gordon, C. (ed.), *Power/Knowledge*. Brighton: Harvester.

Fox, N., & Ward, K. (2008). What are health identities and how may we study them? *Sociology of Health & Illness, 30*(7), 1007–1021.

Hickey, T. (1980). *Health and aging*. Belmont, CA: Wadsworth.

Hill, P., & Pargament, K. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58,* 64–74.

Helminiak, D. (1998). Sexuality and spirituality: A humanist account. *Pastoral Psychology, 47*(2), 119–126.

House, J, Landis, K., & Umberson, D. (1988). Social relationships and health. *Science, 241(4865)*, 540–545.

Kahn, W. (1993). Caring for the caregivers: Patterns of organizational caregiving. *Administrative Science Quarterly, 38*(4), 539–563.

Kivimaki, M., Vahtera, J., Elovainio, M., Helenius, H., Singh-Manoux, A., & Pentti, J. (2005). Optimism and pessimism as predictors of change in health after death or onset of severe illness in family. *Health Psychology, 24(4)*, 413–421.

Peraklya, A. (1991). Hope work in the care of seriously ill patient. *Qualitative Health Research, 1*(4), 407–433.

Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital and Community Psychiatry, 29,* 233–237.

Pruchno, R., Kleban, M., Michael, J., & Dempsey, N. (1990). Mental and physical health of caregiving spouses development of a causal model. *Journal of Gerontology, 45(5),* 192–199.

Sakakibara, K., Kabayama, M., & Ito, M. (2015). Experiences of "endless" caregiving of impaired elderly at home by family caregivers: A qualitative study. *BMC Research Notes, 8(827),* 1–11.

Sumner, L. W. (1996). *Welfare, happiness and ethics*. New York: Oxford University Press.

Lamberg, L. (2002). "Palliative care" means "active care." *Journal of American Medical Association, 288*(2), 943–944.

LeSeure, P., & Chongkham-ang, S. (2015). The experience of caregivers living with cancer patients: A systematic review and meta-synthesis. *Journal of Personal Medicine, 5*, 406–439.

Plante, T., & Sherman, A. (2001). *Faith and health: Psychological perspectives.* New York: The Guilford Press.

Reineck, M., & Furino, A. (2005). Nursing career fulfillment: Statistics and statements from registered nurses. *Nursing Economics, 23*(1), 25–30.

Rogers, N. (1999). Caring for those who care. *Adaptation & Aging, 24*(1), 1–12.

Schulz, R., & Beach, S. (1999). Caregiving as a risk factor for mortality: The caregiver health effects study. *Journal of American Medical Association, 282*(23), 2215–2219.

Schulz, R., Newsom, J., Mittelmark, M., Burton, L., Hirsch, C., & Jackson, S. (1997). Health effects of caregiving: The caregiver health effects study: An ancillary study of the Cardiovascular Health Study. *Annual Behavioral Medicine, 19*(2), 110–116.

Schulz, R., O'Brien, A., Bookwala, J., & Fleissner, K. (1995). Psychiatric and physical morbidity effects of dementia caregiving: Prevalence, correlates, and cause. *Gerontologist, 35*(6), 771–791.

Shaw, W., Patterson, T., Semple, S., Ho, S., Irwin, M., & Haugler, R. (1997). Longitudinal analysis of multiple indicators of health decline among spousal caregivers. *Annals of Behavioral Medicine, 19,* 101–109.

Staight, P., & Harvey, S. (1990). Caregiver burden: A comparison between elderly women as primary and secondary caregivers for their spouses. *Journal of Gerontological Social Work, 15*(1/2), 89–101.

Van der Steen, J., Radbruch, L., & Hertogh, C. (2014). White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care. *Palliative Medicine, 28*, 197–209.

Vitaliano, P., Zhang, J., & Scanlan, J. (2003). Is caregiving hazardous to one's physical health? A meta-analysis. *Psychological Bulletin, 129*(6), 946–972.