

# Coping Strategies and Resiliency of Informal Caregivers

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## ABSTRACT

This quantitative study determined the associations among the demographic variables, the extent of coping strategies, and the degree of resiliency of the informal caregivers. By using standardized instruments as well as profile sheets and checklists, 103 informal caregivers who are full-time provincial government employees provided data for this study. By using descriptive statistics, Pearson  $r$ , and eta correlation in analyzing the results, findings showed no significant relationship among the demographic variables and the extent of coping strategies and the degree of resiliency. However, relationships revealed between age and problem-focused coping strategy and between resiliency and emotion-focused coping strategy. Furthermore, resiliency could be attributed to both internal and external sources and associated with a coping strategy. It could also predict the extent of coping used by informal caregivers. Moreover, caregiving had both positive and negative effects on their health and well-being.

**Keywords:** Psychology, Resiliency, Coping Strategies, Descriptive, Correlational, Negros Occidental, Philippines

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## 1.0. Introduction

Caregiving is a complex process involving multiple tasks (Spillman, Wolff, Freedman, & Kasper, 2014). In many underdeveloped countries, family caregiving is the most common and often the only care that patients received due to unaffordable clinic-based care and clinic, which is far away from home (Kipp, Tindyebwa, Rubaale, Karamagi, & Bajenja, 2007). With its increasing demand, societies are being forced to

develop strategies to provide a sufficient supply of informal care; thus, creating home-based informal caregivers (Bauer & Sousa-Poza, 2015).

Culturally, in a Filipino setting, a family is recognized as the primary caretaker of the elderly, especially of unmarried women living nearby—not providing is a grave social offense. Respect for elderly and “*utang na loob*” were reasons that increase pressure on young women to take care of their parents (Margarida, 2012). The majority of the caregivers were daughters living with frail older parents (Varona, Saito, Takahashi, & Kai, 2007; Sharma, Chakrabarti, & Grover, 2016). They also found out that adopting the role of a family caregiver was more of a societal and cultural demand. The demands of work and caregiving are both tedious and arduous; thus, committing to a caregiver role is an individual decision.

Though caregiving is fulfilling, the toll of it is more significant (Bauer & Sousa-Poza, 2015). One advisement is that the care provider needs to know how to deal with difficulties through a range of coping strategies (Sequiera, 2013). The findings of Fraser and Pakenham (2009) proved that some resiliency could make a difference between adjustment and caregiving. It is essential to know that the interaction of various factors found in the person, family, and social environment influenced resiliency, as well as the assistance one received in coping and how he found meaning in his adversity (Wasner, 2008). Moreover, critical factors also influence resiliency and that coping interact to enhance resiliency (Bennett, 2015). Feldman (2011) further added that the individual degree of resilience helps in psychological recovery.

In the provincial government, some female employees assume the role of informal caregivers. They have to juggle between the role of public servants and being informal caregivers. As government employees, they perform crucial roles in the implementation of public service. The researcher opines that in balancing their roles and responsibilities as government employees and informal caregivers, their whole well-being may be affected because both responsibilities entail much stress unless they cope effectively.

Previous studies have assessed on caregiving (Sequiera, 2013; Dettinger & Clarkberg, 2002; Marks, Lambert & Choi, 2002; Haley, Roth, Howard, & Stafford, 2010), but few studies have focused on the relationship between resiliency and coping strategies of caregivers who perform dual roles such as that of a family caregiver and public servant at the same time. Hence, the conduct of this study is imperative.

The study aimed to determine the degree of resiliency and extent of coping strategies of the informal caregivers when taken as a whole and when grouped according to the demographic variables such as sex, age, civil status, position category, work station, duration of care, and nature of care recipient. The findings of this study will be the basis for a coping and resiliency intervention program for government employees who assume the role of informal caregivers. Aside from the informal caregivers, their families and care recipients will also benefit from this study.

## **2.0. Framework of the Study**

The Trait Theory (Allport, 1937) provided the theoretical framework of this study. According to him, one’s personality is made up of the traits one possesses and is rooted very much within the person. In the context of his theory, he considered

resilience as a common personality trait that is central to an individual. Such trait determines an outcome of well-being, but to be demonstrated, a challenge or adversity is required. For Zausniewski, Bekhet, and Suresky (2010), resilience is a process consisting of positive adaptation when facing significant hardship or adversity.

On the other hand, Simpson and Jones (2012) define it as a dynamic set of skills utilized when facing a difficult situation. For Rutter (2010), resilience is a complicated process that concretely manifests itself at specific moments to face certain circumstances. In the theory of resiliency, resiliency is determined by both risk and protective factors (Greff, Vansteenwegen & Ide, 2006; Zausniewski et al., 2009).

Relative to the theory of resilience is the Positive Adaptation Model of Goldstein (2006), where resilience is encompassed within a wellness framework characteristic of positive adaptation. Within this model, human growth is regarded to be driven by a need to cope, adapt, and develop. This model is anchored on the concepts of Folkman and Lazarus (1980), who define coping as strategies such as specific efforts, both behavioral and psychological, that people employ to master, tolerate, reduce, or minimize stressful events. As to what type of coping to use will depend on the person's cognitive appraisal of the situation and his emotional status.

According to Folkman and Moskowitz (2000), people use both types of strategies- the problem-solving strategies, which are efforts to do something active to lessen stressful circumstances while emotion-focused coping strategies involve efforts to regulate the emotional consequences of potentially stressful events to combat most stressful events. Stress and coping mechanisms go together, and which approach to use depends on the type of stress and individual needs. In this theoretical context, resilience, therefore, is a positive adaptive process.

Another theory that is related to coping is the psychological stress theory of Lazarus (1966). He defines psychological stress as a "particular association between the person and environment that is assessed by the person as overloading or surpassing his or her sources and endangering his or her well-being" (Lazarus & Folkman, 1984). According to him, the effects of stress on a person are likely based more on that person's feelings of threat, vulnerability, and ability to cope than on the stressful event itself. The individual's perspective of the psychological situation is a critical factor. Thus, this theory emphasizes a coping process in which individuals appraise potential stressors and, based on these appraisals, develop adaptive and maladaptive coping strategies to deal with them.

Furthermore, the self-regulation theory of Carver and Scheier (1981) is likewise related to coping in which they claimed that the desire to reduce an aversive state of discomfort drives behavioral regulation. This adjustment involves persistence or disengagement. In this theoretical context, in the presence of a stressful situation, an individual has the innate motivation to adjust or to remove from that stressful or uncomfortable situation.

The above concepts only show that coping and resiliency are related. According to Bennett (2015), some factors interact to enhance resiliency. These critical factors influence and facilitate resiliency, such as outlook in life, optimism, spirituality, family, social support, and participation. For Fraser and Pakenham (2009), some resiliency could make a difference between adjustment and caregiving. Wasner (2008) further

added that caregivers receiving assistance in coping and finding meaning might be helpful for their resilience.

Some studies reveal that demographic variables shape or influence one's resiliency and coping strategies used by informal caregivers. In Alnazly's (2016) findings, older caregivers used confrontive coping and accepting responsibility (problem-focused) than the younger ones. Moreover, distancing was used commonly by males than females. Furthermore, the longer the caregivers provided care, the more they used accepting responsibility and positive reappraisal as coping strategies.

Gage-Bouchard, Devine, and Heckler (2013) examined the relationship between caregivers' sociodemographic characteristics and coping strategies. Their findings revealed that mothers and fathers cope with their child's cancer differently. Mothers used more active coping, instrumental support, religious coping, social, and emotional support than men. Men with lower education opted to use substance use coping and lower planning frequently.

On the other hand, in the study of Dias, Simões-Neto, Santos, Barroso de Sousa, Baptista, Lacerda, Kimura, and Dourado (2016), their findings revealed there was no relationship between caregivers' resilience and the socio-demographic and clinical characteristics of people with dementia. In this study, resiliency is the independent variable, while coping is the dependent variable. As the informal caregivers faced the physical and psychosocial challenges in providing care to their family members, a peril to their physical, emotional, mental, and spiritual well-being may occur. They demonstrated distinct degrees of resilience and extent of coping based on their characteristics such as sex, age, civil status, position category, work station, duration of care, and nature of care recipient. The researcher designed a resiliency and coping strategy intervention for these informal caregivers as an output of this study.

### **3.0. Methods**

By utilizing the quantitative research design, particularly the descriptive-correlational approach, this study determined the degree of resiliency and extent of coping strategy of the 103 informal caregivers coming from the 18 offices, including the 11 district hospitals under the Provincial Government of Negros Occidental (PGNO). These caregivers were full time permanent and casual employees who worked at least eight hours per day and performed regular functions in their offices and involved in projects or programs.

Aside from being regular employees of PGNO, they also acted as informal caregivers to their loved one/family member and spent at least an hour per day taking care of their care recipient for a month or longer and lived with them or separately. In the performance of their dual roles, it was inevitable that they experienced physical and psychological challenges and concerns.

Thirty of them were chosen through the lottery method random sampling to answer the two standardized instruments which were subject to reliability testing. The remaining 73 informal caregivers were taken in as participants for the study proper. The majority of them were females, married, and older. These variables acted as indicators of varying degrees of resiliency and the extent of coping strategies in some studies. To cite, older caregivers used the problem-focused coping strategy, and the males utilized

distancing mostly in the study of Alnazly (2016). Women used more emotion-focused coping than men, and men opted to use substance-use coping and lower planning frequency in Gage-Bouchard, Devine, and Heckler's study (2013). Married caregivers seemed to cope best with the caregiving burden in Bauer and Sousa-Poza's (2015) study. The findings only revealed that females and males cope differently. However, in the study of Dias, Simões-Neto, Santos, Barroso de Sousa, Baptista, Lacerda, Kimura, and Dourado (2016), results showed no significant relationship between caregivers' resilience and the socio-demographic characteristics.

As to data collection, profile sheets, checklists, the Brief Resilience Scale (BRS) by Smith et al., 2008 and Brief Coping Orientation to Problems Experienced (COPE) by Carver et al., 1989 were used to gather data with the assistance and approval of the provincial administrator, department heads, and administrative officers.

The results were then subjected to statistical computation and were analyzed using descriptive statistics such as frequency, percentage, mean, and standard deviation. For inferential data analysis, Pearson  $r$  and eta correlation were used to determine relationships among the degree of resiliency, the extent of coping strategies, and the demographic variables such as sex, age, civil status, position category, work station, duration of care, and nature of care recipient.

#### **4.0. Results and Discussion**

##### ***Degree of Resiliency of Informal Caregivers***

The degree of resiliency of informal caregivers when taken as a whole ( $M=3.55$ ,  $SD=0.60$ ) and when grouped according to the demographic variables was normal except for the separated who had high resilience ( $M=4.33$ ,  $SD=0.24$ ) as shown in Table 1.

##### ***Extent of Coping Strategies of Informal Caregivers***

As shown in Table 2, the use of the problem-focused strategy of the informal caregivers when taken as a whole and when grouped according to the demographic variables ( $M=5.98$ ,  $SD=0.91$ ) was average while the use of the emotion-focused strategy ( $M=4.56$ ,  $SD=0.71$ ) was low except for the widowed ( $M=5.21$ ,  $SD=1.11$ ) and the informal caregiver who had a month duration of care ( $M=5.43$ ,  $SD=0.00$ ) had an average use of the emotion-focused coping strategy.

**Table 1. Degree of Resiliency of Informal Caregivers**

<b>Variable</b>	<b>M</b>	<b>SD</b>	<b>Interpretation</b>
<b>Sex</b>			
Male (n=13)	3.42	0.65	Normal Resilience
Female (n=60)	3.57	0.59	Normal Resilience
<b>Civil Status</b>			
Single (n=29)	3.46	0.61	Normal Resilience
Married (n=40)	3.56	0.60	Normal Resilience
Separated (n=2)	4.33	0.24	High Resilience
Widowed (n=2)	3.67	0.24	Normal Resilience
<b>Age</b>			
Younger (n=18)	3.77	0.62	Normal Resilience
Older (n=55)	3.47	0.58	Normal Resilience
<b>Position Category</b>			
1st Level (n=35)	3.43	0.55	Normal Resilience
2nd Level (n=38)	3.65	0.63	Normal Resilience
<b>Work Station</b>			
Capitol Based (n=49)	3.59	0.61	Normal Resilience
Hospital Based (n=12)	3.25	0.49	Normal Resilience
Field Worker (n=12)	3.67	0.58	Normal Resilience
<b>Duration of Care</b>			
1 month (n=1)	3.00	0.00	Normal Resilience
less than six months (n=4)	3.46	0.80	Normal Resilience
more than six months (n=8)	3.38	0.52	Normal Resilience
1 year (n=2)	4.17	0.24	Normal Resilience
more than one year (n=58)	3.56	0.60	Normal Resilience
<b>Nature of Care Recipient</b>			
Aged/Elderly (n=36)	3.43	0.60	Normal Resilience
Young Disabled (n=2)	3.58	1.06	Normal Resilience
Old Disabled (n=21)	3.69	0.49	Normal Resilience
Psychological Problem (n=1)	4.17	0.00	Normal Resilience
Special Needs (n=6)	3.56	0.81	Normal Resilience
Chronic Disease (n=3)	3.67	0.67	Normal Resilience
Heart Ailment (n=3)	3.39	0.82	Normal Resilience
Oncological Disease (n=1)	4.17	0.00	Normal Resilience
<b>As a Whole (n=73)</b>	<b>3.55</b>	<b>0.60</b>	<b>Normal Resilience</b>

Note: Score interpretation:

1.00-2.99 Low Resilience	Low ability to bounce back/weak capacity to recover
3.00-4.30 Normal Resilience	Average ability to bounce back/moderate capacity to recover
4.31-5.00 High Resilience	High ability to bounce back/strong capacity to recover

**Table 2.** *Extent of Coping Strategies of Informal Caregivers*

Variable	Problem Focused			Emotion-Focused		
	M	SD	Int	M	SD	Int
<b>Sex</b>						
Male (n=13)	5.87	0.96	Average	4.54	0.76	Low
Female (n=60)	6.00	0.90	Average	4.56	0.70	Low
<b>Civil Status</b>						
Single (n=29)	6.11	0.76	Average	4.68	0.77	Low
Married (n=40)	5.86	1.02	Average	4.45	0.65	Low
Separated (n=2)	6.71	0.20	Average	4.43	0.00	Low
Widowed (n=2)	5.64	0.10	Average	5.21	1.11	Average
<b>Age</b>						
Younger (n=18)	6.38	0.50	Average	4.75	0.86	Low
Older (n=55)	5.85	0.97	Average	4.50	0.65	Low
<b>Position Category</b>						
1st Level (n=35)	6.06	0.90	Average	4.68	0.73	Low
2nd Level (n=38)	5.91	0.92	Average	4.45	0.67	Low
<b>Work Station</b>						
Capitol Based (n=49)	5.87	0.91	Average	4.54	0.72	Low
Hospital-Based (n=12)	6.55	0.57	Average	4.88	0.70	Low
Field Worker (n=12)	5.88	1.01	Average	4.31	0.55	Low
<b>Duration of Care</b>						
1 month (n=1)	5.00	0.00	Average	5.43	0.00	Average
less than 6 months (n=4)	5.93	1.21	Average	4.57	1.06	Low
more than 6 months (n=8)	5.73	1.01	Average	4.46	0.75	Low
One year (n=2)	6.21	0.30	Average	4.07	0.10	Low
more than one year (n=58)	6.03	0.90	Average	4.57	0.69	Low
<b>Nature of Care Recipient</b>						
Aged/Elderly (n=36)	6.10	0.79	Average	4.63	0.79	Low
Young Disabled (n=2)	6.14	0.40	Average	4.50	0.71	Low
Old Disabled (n=21)	5.74	1.26	Average	4.50	0.66	Low
Psychological Problem (n=1)	6.57	0.00	Average	4.43	0.00	Low
Special Needs (n=6)	5.88	0.64	Average	4.45	0.53	Low
Chronic Disease (n=3)	6.19	0.30	Average	4.24	0.58	Low
Heart Ailment (n=3)	5.90	0.79	Average	4.57	0.94	Low
Oncological Disease (n=1)	6.00	0.00	Average	4.86	0.00	Low
<b>As a Whole (n=73)</b>	<b>5.98</b>	<b>0.91</b>	<b>Average</b>	<b>4.56</b>	<b>0.71</b>	<b>Low</b>

*Note: Score interpretation:*

- 0-4 Low            Less use of a particular coping strategy  
Low tendency to implement the corresponding coping strategies.
- 5-6 Average      Average use of a particular coping strategy  
Average tendency to implement the corresponding coping strategies
- 7-10 High        Great use of a particular coping strategy  
A high tendency to implement the corresponding coping strategies

**Relationship between the Demographic Variables and Resiliency**

In Table 3, Pearson r was used to determine the significant relationship between sex, age, position category, duration of care, and resiliency. There was no significant relationship between sex ( $r=0.096$ ,  $p=0.419$ ), age ( $r=-0.214$ ,  $p=0.068$ ), position category ( $r=0.181$ ,  $p=0.125$ ), duration of care ( $r=0.111$ ,  $p=0.350$ ) and resiliency, therefore, the null hypothesis was accepted.

**Table 3.** Relationship between Sex, Age, Position Category, Duration of Care, and Resiliency

Variable	r	df	p
Sex	0.096	71	0.419
Age	-0.214	71	0.068
Position Category	0.181	71	0.125
Duration of Care	0.111	71	0.350

Note: the correlation is significant when  $p < 0.05$

**Relationship between Demographic Variables and Coping Strategies**

Pearson r was used to determine the association between sex, age, position category, duration of care, and coping strategy. Regarding the problem-focused strategy, Table 4 shows that there was no significant relationship between sex ( $r=0.058$ ,  $p=0.626$ ), position category ( $r=-0.082$ ,  $p=0.492$ ), duration of care ( $r=0.125$ ,  $p=0.293$ ) and extent of coping strategy; therefore, the null hypothesis was accepted. However, there was a negative association between the level of coping strategy (problem-focused) and age ( $r=-0.254$ ,  $p=0.030$ ).

As to emotion-focused strategy, it had no significant relationship with sex, age, position category, and duration of care. Therefore, the null hypothesis was accepted.

**Table 4.** Relationship between Sex, Age, Position Category, Duration of Care, and Extent of Coping Strategies

Variable	df	Problem Focused (PF)		Emotion-Focused (EF)	
		r	p	r	p
Sex	71	0.058	0.626	0.014	0.906
Age	71	-0.254*	0.030	-0.158	0.181
Position Category	71	-0.082	0.492	-0.167	0.158
Duration of Care	71	0.125	0.293	-0.022	0.852

Note: \*the correlation is significant when  $p < 0.05$

**Relationship between Coping Strategies and Resiliency**

Pearson r was used to determine the significant relationship between coping strategies and resiliency, which Table 5 presents. There was no significant relationship between problem-focused coping strategy ( $r=-0.103$ ,  $p=0.386$ ) and resiliency; therefore, the null hypothesis is accepted. However, there is a significant negative relationship between resiliency and emotion-focused coping strategy ( $r=-0.249$ ,  $p=0.034$ ). Therefore, it rejected the null hypothesis.

The results showed that informal caregivers were most often the family who assumed the tasks of the daily care of their care recipients (Kipp et al., 2007; Margarida, 2012). The finding also showed that the majority of the informal caregivers (82%)



**Table 5.** *Relationship between Coping Strategies and Resiliency*

Variable	R	df	P
Resiliency x Problem focus	-0.103	71	0.386
Resiliency x Emotion focus	-0.249*	71	0.034

Note: \*the correlation is significant when  $p < 0.05$

were females (Varona et al., 2007; Sharma et al., 2016; Alvarez et al., 2017; Kipp et al., 2007; Sequeira, 2013 & Qiu et al., 2017). It appears that both in developed and underdeveloped countries, women/girls do most of the caregiving jobs. Caring is predominantly associated with femininity, although the consequences of caregiving affect both genders.

Moreover, most of the informal caregivers within the sample were married (54%) (Sequeira, 2013). Bauer and Sousa-Poza's (2015) study revealed that married caregivers seemed to cope best with the caregiving burden because they received more social support and had a better financial situation.

On the other hand, some single caregivers (40 percent) were also acting as informal caregivers. According to Margarida (2012), this is typical in a Filipino setting where unmarried women usually take care of their parents and elderly as a sign of respect and "utang na loob." Society and culture seemed to demand women to adopt the role of family caregivers (Sharma et al., 2016).

Furthermore, informal caregivers were mostly old or senior women (75 percent), and only 25 percent were young (Kipp et al., 2007; Donnellan, 2017; Alvarez et al., 2017; Haley et al., 2010; Marks et al., 2002). This can be attributed to the positivity bias of older caregivers (Donnellan, 2017), positive coping (Haley et al., 2010), and caregiver's gain (Marks et al., 2002).

Culturally speaking, the informal caregivers in this present study and the above-cited studies had a family-centered view. This finding is similar to that of the Chinese, where they hold values of familialism and regard caring for older family members as an individual's family responsibility. Belonging in a collectivist culture, a Filipino caregiver would take care of an elderly family member as personal responsibility and a form of self-sacrifice. This finding only shows that an individual is embedded with values and beliefs profoundly, and adherence to such values and beliefs seem obligatory as part of one's culture.

The normal degree of resiliency of the informal caregivers when taken as a whole and when grouped according to the demographic variables meant they had an average or sufficient ability to bounce back or moderate capacity to recover from a stressful event. As carers and employees, their moderate resilience served as protective factors (Zhao et al., 2016) that buffer the physical and psychological demands of both jobs.

Moreover, they had sufficient capacity to appraise their potential stressors and develop adaptive or maladaptive coping strategies in dealing with them (Lazarus, 1966). With this challenge, informal caregivers should make a conscious effort to strengthen these factors to increase their resiliency and promote emotional and mental health.

It is worthy to note that regarding the degree of resiliency, only the separated informal caregivers achieved high resilience. Aside from the assumption that resiliency

is an inherent factor and that each person has unique and essential qualities (Allport, 1937), this can be attributed to the assistance in coping that they receive and how they find meaning in their adversities that enhance their resiliency (Wasner, 2008). Thus, how the caregivers interpret their situation, what strategies they adopt to deal with it, as well as their features and personalities are all crucial variables for the development of their varying levels of resilience (Dias et al., 2016).

As to coping, the use of the problem-focused strategy of the informal caregivers as a whole was average while the emotion-focused strategy was low. This only showed that they were more inclined to use the problem-focused coping strategy rather than the emotion-focused coping; thus, they were more likely to take actions to minimize the stress brought about by caregiving and work responsibilities. Since most of the caregivers in this study were old adults, they tend to adopt problem-solving coping strategies (Hamarat et al., 2001).

Likewise, age was found to be one of the significant determinants of stress coping in Chaturvedi and Purushothaman's (2009) study where women in the age range of 40-60 years scored significantly higher in terms of stress-coping than the women in the younger age range. Additionally, Stevenson et al. (2012) study revealed that older adults had lower levels of dysfunctional coping strategies than younger adults.

Moreso, there was no significant relationship between resiliency and the demographic variables. However, there was a negative relationship between problem-focused coping strategy and age. This finding is in line with Chen et al. (2018); Charles, Leger, and Urban (2016); and Navaie-Waliser et al. (2002), having older adults to use less likely the problem-focused coping strategy. This may be due to the increased physiological vulnerabilities that affected their brain functions, resulting from a decline in mental cognitions (Charles, Leger & Urban, 2016). Navaie-Waliser et al. (2002) added that caregiving demands might tax their health and physical abilities and compromise their immune response systems.

Additionally, the stress associated with caregiving can exacerbate existing chronic health conditions. Due to these factors, a rational approach to cope with stressors was less likely to happen, as indicated in their minimal use of the problem-focused coping strategy. This finding only shows that age correlated with the coping strategy and a factor to predict the type of coping strategy to use.

Furthermore, their normal degree of resiliency attributed their moderate use of problem-focused coping strategy. This finding means that as resilient caregivers, they tend to solve problems more efficiently by using their mental faculties. On the other hand, their inclination to use the emotion-focused coping strategy was low. This finding means that they were less likely to use external strategies to manage stress or to execute actions aimed to prevent, minimize, or reduce the emotional anguish caused by the stressful situation.

Another finding in this study is that there was a significant relationship between resiliency and the emotion-focused coping strategy. As their resiliency increases, the use of the emotion-focused coping strategy decreases. Resiliency being a protective factor (Zhao et al., 2016) and associated with psychological factors as well (Bekhet, 2013), their moderate resilience helped them respond to stress or strain positively using more of their positive cognitions; thus, increasing their inclination to use the problem-

focused coping strategy rather than the emotion-focused coping. Therefore, moderate or high resiliency is associated with frequent use of problem-focused coping.

Generally, caregiving can be rewarding, but the toll of it is significant (Bauer et al., 2015). Positive outcomes seem to be dominated by ill effects. In the study of Panganiban-Corales and Medina (2011), caregivers were susceptible to strain or experienced severe strain and were either averagely or severely dysfunctional. Despite the negative impacts of caregiving and working, the informal caregivers claimed positive benefits of caring. In Haley, Roth, Howard, and Stafford's study (2010), many caregivers were fulfilled with their jobs and even considered it as a positive coping.

## 5.0. Conclusion

Coping strategies are associated with resiliency, and it predicts the degree of resiliency of the informal caregivers. More so, the demographic variables are not significantly related to the extent of coping strategies and the degree of resiliency of the informal caregivers. Therefore, one's resiliency may be a characteristic or a trait that is unique to an individual, and the demographic variables do not define or determine one's degree of resiliency. However, some variables, such as age and resiliency, are associated with coping strategy.

Furthermore, resiliency could be attributed to both internal and external sources and associated with coping strategy and predict the extent of coping used by informal caregivers.

Whether resilience is viewed as a trait and an outcome of one's circumstance, one's resilience can buffer adversities, personal stress, and challenges. It is an influential factor in the achievement of work care balance.

Various strategies can be employed, such as problem and emotion-focused strategies to cope with the strains associated with the complex physical and psychological demands involved in caregiving and in the assumption of dual roles.

It is recommended, therefore, that human resources agencies should formulate policies to address the issues and concerns pertaining to the health and welfare of their employees. Likewise, the administration should make mindful effort to promote emotional and mental health to their employees by providing developmental dialogues, counseling, therapy, and lectures on stress management, burnout coping, compassion fatigue, and psychological first aid to be conducted by helping professionals.

Moreover, an intervention program that will enhance resiliency and help employees adopt healthy coping strategies is recommended.

Future studies should also be conducted to assess further the relationship and influence of sociodemographic variables on resiliency and types of coping.

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