SOCIALIZATION, DEMAND APPRAISAL, AND COMPASSION SATISFACTION: PRESERVING AND PROTECTING CAREGIVER MENTAL HEALTH

by

ORIANA MESSER

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Melissa Graboyes

Caring for others is an integral part of participating in human society. Some individuals pursue caregiving professionally, assuming roles as nurses, counselors, teachers, among other helping professions. While these careers are often deeply rewarding, they can also draw upon personal resources, leaving caregivers burnt out and unable to provide the care for their charges. However, caregivers can employ strategies to support their health, and possibly the health of those that they work with including revising how they think about stressful events and turning to supportive individuals. This project examines the intersection of caregiver event appraisal (whether someone appraises an event as a challenge, with the potential for positive results, or a hindrance, without that possibility), socialization (engagement in social relationships), and religious practices, and compassion satisfaction (the feeling of happiness that one gets from helping others). It asks the question, "To what extent, does challenge event appraisal protect caregiver mental health? In what ways do social networks and socialization influence caregiver mental health? To what extent do caregivers link these two factors to religion and their religious practices? The work reported here answers this question through analysis of caregiver interviews, which are presented in a series of profiles highlighting themes that correspond to the research questions. The findings of this thesis support the hypothesis, indicating that socialization, compassion satisfaction and religion support event appraisal, which in turn facilitates positive coping strategies and maintains caregiver positive mental health.

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Table of Contents

Introduction

Everyone, at some point in their life, engages in caregiving, whether it is the informal caregiving of friendship, where individuals can support each other emotionally, the explicitly needs-based relationship of parent and child, or in a professional setting such as counseling or nursing. All caregivers, but especially those who work professionally, can experience detrimental side effects of this resource-intensive work, which can include mental and physical health problems. These potential health problems can also negatively impact the person being cared for in these relationships, highlighting the wide-reaching implications of caregiving and caregiver health.

This project focuses on caregivers working in orphanages around the globe, in Kenya, Ethiopia, Cambodia, and India. This thesis examines the positive side of caregiver mental health; that is, it considers the techniques that caregivers use to maintain their positive mental health. Using 15 caregiver interviews, this thesis examines how caregivers' religious practices, socialization, and appraisal of stressors as challenges or hindrances influences their mental health. It profiles five caregivers based in five different locations whose interviews highlight the intersection of the themes outlined above, which in turn provide insight into how caregivers can simultaneously operate in resource-strapped settings and experience positive mental health.

It is important to note that this thesis does not deal with the presence or absence of mental illness in these caregivers, because the absence of mental illness does not equate to the presence of mental health. The WHO defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the

normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO 2014). They emphasize that mental health "is not merely the absence of disease or infirmity." While the definition of mental health does include the absence of mental illness, the concepts in the definition are quite difficult to measure, and interpretation of these concepts may vary greatly from person to person and across cultures. In fact, this was demonstrated throughout the project, as caregivers who were interviewed often had entirely different definitions of mental health from one another, and some seemed to misunderstand the questions that framed mental health from a Western perspective.

The complications surrounding definitions of mental health raise broader questions about mental health research, and the validity of frameworks and concepts developed by Western researchers and implemented in the global South. These questions highlight the need for both greater sensitivity in developing research projects that take place in the global South, and reconciling what "mental health" means in different locations and cultures in relationship to the frameworks with which researchers approach such sensitive topics. Additionally, it is important to emphasize the difference between an absence of mental illness and a presence of mental health. As a result, this project focuses on how caregivers maintain positive mental health, rather than simply considering the detrimental effects that caregiving can have on individuals' mental health. In doing so, it attempts to fill a gap in the existing literature on the mental health of caregivers.

This thesis found that caregivers utilize a combination of socialization and religious practice to appraise events as challenges, and subsequently implement

productive coping mechanisms. It found that compassion satisfaction also functioned reciprocally with event appraisal, which is to say that compassion satisfaction helped to produce challenge event appraisal, which in turn produce greater compassion satisfaction and positive mental health symptoms and practices.

Background

The work of caregiving, whether for an aging relative, a sick child, or in an institutional setting like a nursing home or hospital, can take an immense toll on an individual's mental, physical and emotional resources. Excessive depletion of these resources can have a variety of negative impacts on the caregiver's quality of life, such as burnout, compassion fatigue, and mental and physical health problems (Branch, 2015; Sprang, 2007). More specifically, research has demonstrated that caregivers experience higher instances of depression, sleep disturbance, elevated biomarkers for cardiovascular disease, and increased hypertension (Alzheimer's Association, 2014; Gouin et al., 2012, Shulz et al., 1995, Shaw et al., 1999). Chronic stress has been repeatedly demonstrated to negatively impact health, and stress derived from caregiving correlates with these outcomes as well (Herbert & Cohen, 1993; Chandola, Brunner, & Marmot, 2006).

Thus far, the majority of research on the mental health of caregivers has focused on the negative outcomes of caregiving described above; that is, the existing research operates from a deficit perspective, focusing on what can go wrong with caregiving. What research has not sufficiently examined, however, is the ways in which caregivers utilize the resources that are available to them to maintain a healthy mental state, cope well with stressors, and gain satisfaction and fulfillment from caregiving.

The word "caregiving" can bring to mind a wide range of individuals in a variety of professions— those working in nursing/ assisted living facilities, individuals caring for family members, nurses working in hospital environments, and people who care for children, especially children with special needs. This project deals with

caregivers working in orphanages. The orphanages in this project are organized by a variety of organizations, such as the state, by churches or other religious groups, by another NGO, or by individual families or communities.

This project focuses on caregivers working in orphanages, in five different regions (Hyderabad, India; Nagaland, India; Bungoma, Kenya; Addis Ababa, Ethiopia; and Battambang, Cambodia). These caregivers come from a wide range of backgrounds— some grew up at the facility in which they now work, some came to it for purely economic reasons, and others felt a calling to work with children, to name a few. Additionally, the workload that caregivers experience varies widely from location to location: many spend all of their time there, working seven days a week, while others spend three or four nights a week at the facility but also have the opportunity to spend time in their own homes.

Some key words and phrases that must be defined for greater clarity in this thesis read as follows: A caregiver, as stated above, is an individual working in institutional childcare settings. Socialization is defined as engaging in meaningful social relationships and interactions with others, both in and out of the workplace. I use the WHO definition of mental health in this thesis, which is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his [sic] community (WHO 2014). Additionally, I define compassion satisfaction and compassion fatigue. Compassion satisfaction is defined as "the happiness or pleasure that caregivers can derive from their work experiences (Decker, Brown, Ong, & Stiney-Ziskin, 2015; Stamm, 2002), and compassion fatigue is defined as "frustration and

exhaustion as a result of prolonged exposure to care-receiver problems (Figley, 2002). Finally, I utilize the Challenge- Hindrance Stressor Framework developed by Lazarus and Folkman (1984), which will be further discussed in the literature review. Briefly, though, it refers to how the way that a person perceives an event—either as a challenge, with potential positive results, or as a hindrance, with potential negative results—impacts the way that they subsequently cope with that event, which in turn informs their mental health.

For six weeks during the summer of 2017, I interned at the Center for Health Policy and Inequalities Research at the Global Health Institute at Duke University. During that time, I worked on several different projects, but spent the majority of my time working on the Caregiver Flourishing Project. It is on the Caregiver Flourishing project that I developed the questions and hypothesis for this thesis.

The Caregiver Flourishing Project is "an interdisciplinary, cross-cultural study to understand pathways for sustaining flourishing mental health (FMH) while caring for people who are suffering" (Proeschold-Bell 2016, 1). The research "[spans] four countries (India, Kenya, Ethiopia, and Cambodia) and four religious traditions (Christianity, Islam, Hinduism, and Buddhism)" (Proeschold-Bell 2016, 1). The project seeks to contribute to existing theoretical conceptions of stress, coping, and inform the measurement of virtue, and provide practical guidance on how caregivers in challenging contexts can flourish. The project asks the question, "How do caregivers who work in the context of suffering sustain emotional engagement, derive satisfaction, and maintain FMH." The project distinguishes between Flourishing Mental Health and Low Mental Health; the first being defined as "the absence of mental illness and the presence of high

levels of emotional, psychological, and social well-being (Keyes, 2002, 2005)," and the second as "levels of emotional, psychological, or social well-being that are low almost every day, regardless of the presence of mental illness."

An additional concept that merits some discussion is "religion." In this thesis, religion refers to several things, depending on the caregiver and their particular practices and coping mechanisms. Religion can refer to an individual's belief systems—that is, their relationship with God, and how that relationship can function as a resource when stressors arise. Additionally, religion can intersect with socialization, in that worship spaces can also function as spaces of social support *through* religious practices. And, "religion" can refer to an individual's meditative religious practices, such as prayer, meditation, or reading scripture. All of these different contexts for religion function as instruments for coping, and these instances are specifically pointed out. However, they are most often referred to as "religion" or as "religious practice."

My part in the Caregiver Flourishing Project involved helping to develop the codebook, and coding caregiver interviews. Although the broader project focuses on the way that religion and religious practices can protect or otherwise influence caregiver mental health, I also noticed other themes surfacing in the interviews that I was coding. Specifically, I noticed caregivers who mentioned turning to social networks as a means to process stressful or challenging life events, as well as caregivers who had meaningful instances of appraising life events as challenges. While all of the themes that I noticed were addressed in the broader project (that is, there were codes that related to these themes), they were were not directly addressed in the interview questions, which made their consistent appearance and reappearance more interesting. While analyzing data for

this project, however, I realized that the importance of religion as an influencer of caregiver mental health could not be ignored, as religion appeared repeatedly as one of the most important features in caregivers' lives.

In order to address the themes that appeared during coding, this project asks the following questions: In what ways, and to what extent, does challenge event appraisal protect caregiver mental health? In what ways do social networks and socialization influence caregiver mental health? And, to what extent do caregivers link these factors to religion and their religious practices?

I hypothesized that caregiver socialization, that is, participation in social networks, and the appraisal of stressors as challenges, would be associated with better mental health. In this case, "social networks" refers to meaningful relationships, either with other caregivers or friends outside the institution, as well as membership in broader communities, such as religious groups. Additionally, I hypothesized that religion and religious practices would also act as protective factors for caregiver mental health, both in dealing with stressors and through social networks organized through religious practice.

Literature Review

The literature reviewed for this project covered a variety of topics, ranging from the impact of stress on a person's physical and mental health, to reciprocal relationships between caregiver and receiver-of-care health. Several themes ran throughout the majority of the literature that are key to this thesis. First, the literature highlights the importance of coping in mental health, specifically in terms of the challenge-hindrance stress appraisal framework proposed by Lazarus and Folkman. Second, much of the literature expands on this framework, demonstrating the ways in which context and individual disposition can determine the way an individual copes with a stressor. In turn, the literature about event appraisal points towards how appraisal impacts mental health, and emphasizes the importance of studying mental health, as opposed to mental illness.

I draw in large part on literature from social psychology. This body of literature offered valuable perspectives and theories on mental health, wellbeing, and mental illness. However, the majority of this literature, with the exception of a few studies, take place in the United States. The research subjects and the researchers exist in the same context, meaning that they likely view things through similar lenses. This literature review does not consider anthropological literature. As a result, the literature reviewed here does not consider how research functions in non-Western settings, or seek to define local conceptions of mental health or stress.

Researchers have widely investigated the impact of stress on the body, ranging from the psychological impact of being in a lower position on the social hierarchy (Link and Phelan, 2005; Marmot, 2006; Wilkinson and Picket, 2006), to the impact of stress

caused by racism (Geronimus et al 2006; Gravley 2009), to stress caused by resource-depleting employment. Although short-term, resolvable stress can have a neutral or even positive effect on the human body, chronic stress has been linked to a myriad of physical and mental health problems (Pearlin 1989, 2010). This can include increased risk of depression, sleep disturbances, elevated biomarkers for cardiovascular disease, and increased risk for hypertension (Alzheimer's Association, 2014; Gouin et al., 2012, Schulz et al., 1995; Shaw et al., 1999).

To expand on the impact of stress on an individual, the stress produced by caregiving is uniquely impactful, in that it affects both the caregiver and the person receiving care. Ice et al (2012) examined the relationship between perceived stress and physical markers for stress among Kenyan Luo elders caring for young children. The study found, first, that cultural context is important in discussing mental health issues, which will be further discussed later on in this review. The study also found that higher perceived levels of stress correlated with elevated biomarkers for stress, specifically cortisol levels, a finding that has been reinforced across other studies (Pearlin 2010; 1990). In addition to physical manifestations of stress, caregivers and related professionals often also experience adverse psychological effects, like burnout. Burnout is defined as a "psychological syndrome that develops in response to chronic emotional and interpersonal stress and is characterized by three features: emotional exhaustion, depersonalization (a defense mechanism for caregivers and service providers to gain emotional distance) and feelings of ineffectiveness or lack of personal accomplishment" (Thompson 2014, 58). The presence of burnout in caregivers eventually has an adverse

effect on the quality of the care that they can deliver to those they care for, which in turn has health implications for receivers-of-care.

Caregiver health and the health of the recipient-of-caregiving have also been linked. Thielman et al explored the relationship between caregiver and child health in "Correlates of poor health among orphans and abandoned children in less wealthy countries: the importance of caregiver heath" (2012). The study found that orphans and abandoned children whose caregivers reported symptoms of poor health were more likely to also report symptoms of poor health. This does not make a causal claim; rather, it focuses on the correlation between the two variables. Nonetheless, it is an important observation to make in terms of the implications of studies on caregiver mental health, in that the health of caregivers seems to be reciprocal and can have a broader impact than on the caregiving individual alone. Additionally, it is important to note that this study focuses on the detrimental affects of caregiver *health* on receiver-of-care health, whereas the Caregiver Flourishing study, and this thesis, examines the positive side of caregiver mental health, which has the potential to inversely impact receiver-of-care health, where a caregiver with positive mental health could promote better receiver-of-care health. Additionally, Sales et al determined that "children's behavioral problems are related to mothers' caregiving strains, which then is related to greater maternal mental health symptomatology." This is to emphasize that there research has indicated a reciprocal relationship between the mental health of the child and the mental health of the caregiver.

This project draws on the stress and coping theoretical framework proposed by Lazarus and Folkman. The authors propose that the ways in which individuals respond

to stressors, that is, what their emotional and later physical response they have to stress, is in large part determined by their appraisal of that stressor. That is, "it is the perception that the event is stressful, rather than the event itself, that determines whether coping strategies are initiated and whether the stressor is ultimately resolved" (Biggs, Brough, & Drummond 2017, 350). This theoretical work is key in considering caregiver mental health, because appraisal can play a large part in determining caregivers' attitudes towards their jobs, and subsequently affect caregiver mental health. Specifically, burnout, a common symptom of overstressed and under-resourced caregivers (and similar professionals) both detrimentally impacts the quality of the caregiver's life and the quality of care that their charge receives.

The coping strategies individuals employ are either problem-focused coping (PFC) or emotion-focused coping (ECP) (Biggs, Brough, & Drummond 2017). When using PFC, an individual seeks to resolve the stressor itself, or otherwise find a way to mitigate the problem. Contrastingly, EFC involves the individual regulating their emotional and psychological response to the stressor. It should be noted that neither strategy is across-the-board superior to the other; rather, both are quite effective when employed under appropriate circumstances. For example, an individual utilizing EFC when it is apparent that they can do nothing about the stressor itself implements the appropriate strategy, whereas an individual facing a stressor head-on and dealing with the source of the problem appropriately uses PFC (Biggs, Brough, & Drummond 2017).

Initially, Lazarus and Folkman's framework was interpreted as a dichotomy, where in which researchers assumed that an individual would either respond to a

stressor based on their situation, or they would respond based on their disposition (Smith and Kirby 2009). However, these initial models proved ineffective, in that people in the same situation responded differently to the same stressor, and that the same person would respond differently to the same stressor at two different times. Smith and Kirby proposed a "relational model of appraisal and emotion" in order to address this inconsistency (Smith & Kirby 2009). The relational model of appraisal and emotion affirms that emotion-eliciting appraisal are a product of what the stressor means to an individual, as it relates to their disposition, as well as their needs and resources available at that time (Smith and Kirby 2009). This lends credence to the idea that emotional responses to stressors are logical and functional. They argue for three components to develop a relational appraisal model: the motivational relevance (how important the stressor is to the individual); problem-focused coping potential (the individual's ability to actually reduce the stress of the situation); and emotion-focused coping potential (an individual's ability to emotionally adjust to the stressor) (Smith and Kirby 2009). The authors conclude by suggesting that knowledge of these patterns can potentially impact the way that an individual reacts to these stressors, perhaps allowing for more efficient or effective coping mechanisms. This paper could be can be applied to caregiving in that caregivers implement this model of appraisal, when facing stressors in their work. For example, if an event occurs, the caregiver in question can first appraise the event as either a challenge or a hindrance based on the resources that they have available to them, and then cope with the situation using those resources, with either negative or positive results.

Paskador, LePine, and LePine (2007) investigated how different appraisals of stressors (either challenge or hindrance) affected individuals' job attitudes and performance. They specifically examined job attitudes, turnover intentions, and actual turnover in jobs. They found that hindrance appraisal tended to produce worse attitudes towards jobs, whereas challenge stressors tended to produce positive relationships with job satisfaction and organizational commitment. These findings are important because caregivers need to like their jobs in order to keep doing them and also to perform them more effectively.

One reason for considering the mental health and wellbeing of caregivers, rather than simply identifying whether or not they might have mental illness, is that the absence of mental illness does not equate to positive mental health. Keyes (2002) advocates for a reconceptualization of mental health and mental illness, placing them on two separate continua. Keyes affirms that protecting the *flourishing* mental health of individuals, rather than simply responding to illness, would best serve populations in the long-term. In "The mental health continuum: From languishing to flourishing in life," (1998), Keyes outlines variations in mental health status in individuals who do *not* have mental illness. Consideration of mental health *in addition to* mental illness is important for the wellbeing of the caregivers, and for those in similar professions, because the absence of mental illness does not equate to someone flourishing in their profession or in their life. If we are concerned about the wellbeing of individuals, the active presence of mental health, and measure to cultivate and protect that health, are necessary. Consideration of the presence or absence of mental illness is beyond the scope of this project, although some mental illness measures were implemented by the Caregiver

Flourishing Project. Rather, this project focuses on how caregivers perceive their own mental health, and maintain their positive mental health. This project does not use the same terminology that Keyes outlines in his paper; rather it simply discusses caregiver mental health, using "good" and "positive" interchangeably, and "negative," or "low." Nonetheless, Keyes' paper is key to this project in considering the importance of the presence of mental health in caregivers.

Thompson, et all al., (2014) considered the different predictors for the burnout, or lack thereof, of mental health counselors. Using the transactional theory of coping proposed by Lazarus and Folkman, they examined the ways in which counselor context *and* use of coping strategy predicted incidence of compassion fatigue and burnout. The study determined that counselors' perception of stressors and their use of different coping strategies was a major predictor of compassion fatigue and burnout. To elaborate, they found that organizational factors, that is, a lack of sufficient resources and an excessive workload, can increase counselors' risk of burnout. More important, however, is the the counselor's individual personal perception and subsequent utilization of helpful or maladaptive coping strategies. More specifically, the most common helpful, though not exhaustive, strategies (not all are named here) that counselors used involved things like seeking emotional support, instrumental social support, use of humor, physical activity, talking with friends and family, and engaging in spiritually oriented activities. They also found that use of maladaptive coping, such as substance abuse, denial, distraction, and self-blame, correlated with increased compassion fatigue and burnout. Additionally, perception, an important step in the transactional coping theory, was enormously important in how counselors dealt with

stress. This is to say that counselors who interpreted the stressor as challenges, with the potential for personal growth, and effectively identified resources available to them, such as relationships, and the presence of compassion satisfaction, employed more effective coping strategies and were more protected from burnout. This study was oriented towards mental health counselors, but its findings are relevant to this thesis in that: counselors and caregivers both fulfill emotionally taxing roles requiring a high degree of empathy and personal investment, so that perception and coping strategy, particularly the identification and utilization of available resources, are equally important to caregivers and counselors.

In a discussion of resources that are available to caregivers, Decker, Brown, Ong, and Stiney-Ziskind (2015) examined how mindfulness affected compassion fatigue and satisfaction in social work interns. This study focused on social work interns, because, as noted previously, social workers and other caring professionals tend to have very a high risk of compassion fatigue and burnout due to the heightened exposure to the trauma of others found that "mindfulness significantly positively increased positive affect, self-compassion, global functioning, overall wellbeing, and decreased depression, anxiety, and stress" (29) This study focused on mindfulness rather than clear religious practice, but the results are nonetheless promising.

Pargament, Smith, Koenig, and Perez (1998) *did* focus specifically on religious beliefs and practice, and determine that religious coping is enormously helpful in coping with major life events. The authors examined positive and negative patterns of religious coping after major life events, finding that individuals who used positive coping, that is, patterns that strengthened their relationship with their religion and

viewed the life event as an opportunity for growth, tended to fare better than those who used negative coping, viewing the event as a punishment from God or proof that God had abandoned them. They also found that "religious coping cannot be 'reduced' to nonreligious forms of coping," because the religious aspect, and the additional resource of a relationship with God, reinforced already positive coping techniques so that religious coping was even more effective. Moreover, Kendler, et al., (2003) found that religiosity decreased risk for both externalizing and internalizing psychiatric disorders in the general population. Overall, this religion-focused literature suggests that religion acts as a resource for appraisal and coping, such that religious practices can actively improve and protect individuals' mental health.

Keyes also writes on the importance of social wellbeing and its determinants, which is of great importance to this thesis (Keyes 1998). Social wellbeing is one of the determinants of mental health that Keyes identified. Keyes outlines the 5 elements of social well-being, which are as follows: social integration, or the extent to which an individual feels like they fit into their society and community; social acceptance, or the belief that people are generally good (this trait is often characterized as the societal piece of self-acceptance); social contribution, or the belief that an individual is an important member of their community or society; social actualization, or the belief that society is improving for you and others; and social coherence, or that an individual thinks that the world is generally good, that they care about the world they live in and they know what is going on around them. Keyes' paper emphasized the ways in which an individual's educational status influenced their social wellbeing, which somewhat distances it from this thesis' topic, but one of the findings of the paper is consistently

relevant to the topic. Keyes determined that, overall, social wellbeing improved with age, and that increased social involvement correlated with improved social wellbeing, particularly on the axis of social contribution. Social wellbeing will be addressed much more generally in this thesis; that is, it will not discuss findings on a statistical scale, but rather consider the ways that each caregiver reported their own social wellbeing, and take Keyes' findings into account.

It should be noted that a significant proportion of the research reviewed above took place in the United States, unless explicitly noted otherwise. For example, the study examining perceived stress in Kenyan Lou elders took place in Kenya; and the Thielman et al article had several study sites around the globe. However, the majority of the other studies discussed Western conceptions of mental illness and mental health. In the study discussing stress among Kenyan Luo elders, Ice (2012) affirmed that, for international research on mental health and stress, researchers need to determine the "local idiom of stress" that can effectively communicate how stress is conceived in different places.

Patel (2001) addresses some of the complications of performing psychiatric and mental health research in cross-cultural settings. Patel argues that "cross-cultural psychiatry" ignores already-existing non-Western conceptions of mental health and mental illness. Additionally, Patel argues that fraught histories surrounding mental health/ illness and the associated community reactions or treatments— for instance, an individual may associate mental illness with asylums and social stigma— may affect a person's likelihood to name their symptoms as mental illness, or omit descriptions of symptoms commonly associated with mental illness (Patel 2001). As a result, so-called

"cross-cultural psychiatry" is often ineffective, failing to address the nuanced causes of mental health problems in non-Western locations. While this thesis in particular does not contend with psychiatry and mental illness research, the themes that Patel points to with regards to cross-cultural research are relevant to this thesis as well. In the interviews, caregivers were asked to define mental health and describe any times that they may have had mental health problems, which makes Patel's arguments quite salient.

Some additional problems that accompany cross-cultural research is the implementation of mental health measures. Pence (2012) determined that although mental health measures such as the PHQ-9 can be implemented in non-Western regions, it has very low sensitivity for diagnosing depression in patients. This suggests that the language used in diagnostic measures cannot may not be easily translated into different cultures, languages, and modes of thinking outside American or European conceptions of mental illness and mental health. Moreover, number-based scales (for example, on 0-10), have also been demonstrated to be ineffective in non-Western contexts, which further points to the need for more fully developed and localized measures to determine mental health across cultures.

Generally, the existing literature supports my hypothesis that socialization, compassion satisfaction, and challenge event appraisal intersect to positively influence caregiver mental health. However, the literature also contains gaps that need to be filled with further research. The Caregiver Flourishing project seeks to fill many of these gaps, given that it addresses the positive mental health practices of caregivers. Additionally, it seeks to identify protective factors and practices that may contribute to

caregiver positive mental health. This could help facilitate or encourage a continuation or expansion of these practices. Ultimately, the impact on quality of life, as well as the impacts of caregiver health on the health of their charges, emphasizes the importance of this kind of research. To reiterate the research questions of this project, and to distinguish its questions from those of the larger project, this thesis asks, "in what ways, and to what extent, does challenge event appraisal protect caregiver mental health? In what ways do social networks and socialization influence caregiver mental health? And, to what extent do caregivers link these two factors to religion and their religious practices?

Methods

Caregiver Flourishing Project

This project uses data obtained from the Caregiver Flourishing. The project collected a variety of data, which included qualitative data collection in the form of interviews, and quantitative data in the form of surveys, various mental health measures, and a daily activity diary.

The Caregiver Flourishing Project received approval from Duke University and Emory University IRBs. Access to data was restricted to those who had undergone human subjects research training, and the data was stored on a protected drive only accessible through a VPN with multi-factor authentication, from an encrypted computer. Additionally, this project was granted research approval from all of the nations participating in the study, and received research endorsements from the local organizations that they collaborated with. Moreover, the research team at Duke made a commitment to be receptive to the needs and recommendations of the local individuals working on the project. This allowed the project to be sensitive to local norms and needs, and attempted to address issues of cultural difference in data collection and interpretation (Proeschold-Bell 2016).

The sites used for this study are orphanages already linked to a CHPIR study. Caregivers were recruited by study site PIs, who have had more than ten years of experience performing this kind of research. Very little information was available to me about the study sites; however, the sites were selected because caregivers working in those orphanages lacked many of the structural protections that were available in the US

and other affluent countries (Proeschold-Bell 2016). This suggests that the working conditions for these caregivers are quite limited. Additionally, there are differences between the sites themselves. Four of the five studies sites are located in different countries, with different sociopolitical histories and contexts, not to mention the religious variation that occurs both within and between sites. Four religious traditions were present in the caregiver study: Christian, Muslim, Buddhist, and Hindu. The orphanages themselves are run by a variety of organizations. Some are run by the state, some by NGOs, some by individual families, and some by religious groups. This influences the kind of person that could be hired there, as well as the ways that employees are expected to deal with challenges or complications that arise with their charges.

All data from caregivers was anonymized: Caregivers were assigned an ID number, and that ID number was the only piece of information available to distinguish caregivers from one another during data analysis. The ID numbers were coded such that they indicated the region that the caregiver was from, but otherwise all identifying information was excluded from analysis. The interviews themselves were conducted in a private space, where the caregiver was able to speak freely, and the caregivers were made aware of the fact that their disclosures during the interview were entirely confidential.

As addressed in the literature review, assessing a person's mental health status across cultures is quite difficult, due to differences in mental frameworks about mental health and illness, issues in translation, and the effectiveness, or lack thereof, of measures to evalutate mental health. The Caregiver Flourishing Project attempted to

address these issues by implementing the Mental Health Continuum-Short Form (MHC-SF). This measure was selected because it is not culture-bound, that is, it can be used with good results in a variety of different cultural settings, and it assesses mental health on a scale of "flourishing," "moderate," and "low," which corresponds to the framework that the project uses to evaluate caregiver mental health (Keyes 2009).

For this thesis, I used the interviews that I coded over the summer while working on the Caregiver Flourishing project. During that time, the interviews were double-coded by another Duke intern. The program used for coding, NVivo, allows coders to merge two separate documents and compare the agreement of the different documents. This is to say, the programs allows two coders to compare how similar or different their results were. This encourages consistent interpretation of the codebook, and was part of why these 15 interviews were selected for inclusion. Additionally, these interviews were selected because the caregivers in question tended to give longer, more detailed answers. One potential limitation of this criterion for inclusion is that the caregivers who spoke more freely about religion and their social lives may indicate that these factors are more important to them, and thus skew the data.

I revisited the coding that I had already done, and re-coded the interviews, looking for the themes that I had identified as central to my project. These included: event appraisal, mentions of compassion satisfaction or compassion fatigue, mentions of happiness or wellbeing in their work, and mentions of the importance of religion. Following this coding, I evaluated which caregivers had positive mental health, which had low or negative mental health, and which had mental health that was not clearly either positive or negative. Following this evaluation, I selected five interviews that best

exemplified the themes that appeared during coding, and present them as case studies. That said, I do acknowledge that prioritizing the amount of data, and the degree to which it spoke to my research question and hypothesis, generates a considerable risk of confirmation bias in the selection of the case studies.

Qualitative Data Collection:

Interviews were conducted at each study site, by a local resident collaborating with Duke. A total of 69 interviews were conducted: 24 in Kenya; 18 in Cambodia; 6 in Nagaland, India; 9 in Hyderabad, India; and 12 in Ethiopia. They were conducted with using the same interview guide across all study sites, in the native language of both the interviewer and the caregiver. The interviews consisted of 45 questions. The exact length of interview varied from caregiver to caregiver, as some caregivers spoke more freely and shared more personal anecdotes, which took more time, and others were less forthcoming. Follow-up interviews were conducted if any important information was missing from the interviews, or if any clarification was necessary. No official follow-ups were conducted with the caregivers unless clarification was necessary.

The interviews covered a wide range of information about each caregiver, ranging from information about their institution (how many children they work with, how many hours they work per week), to more abstract questions such as their motivations to remain in the caregiving profession. Although the interview questions were consistent across all sites, they were open-ended enough to encourage caregivers to share personal anecdotes about their lives and experiences. Additionally, interview

questions were often accompanied by a "probe" follow-up question, in order to obtain a more in-depth and rich answer from the caregiver being interviewed.

Interviews were recorded, then transcribed, and translated into English by the interviewers. The interviewers were all proficient in English, and conducted the interviews in their and the caregivers' first language, which allowed for both an accurate and nuanced translation of the interviews. Additionally, the fact that the interviewers were typically of the culture of the caregivers allowed the interviewers to account for cultural difference when translating the interviews, and add notes for clarification if necessary.

The case studies presented in the results section are those that I determined had the most meaningful data— that is, the caregiver spoke about their mental health, religious practices, and socialization in such a way that information could be gleaned from their comments. The case studies presented in the results represent interviews in which the participant spoke about the intersection of their religion, socialization, and subsequent even appraisal and coping, which in turn contributes to their overall mental health. While many interviews spoke to this intersection, the interviews that I selected contained the clearest illustrations of these themes. One consequence of this approach is that is it can skew analysis, because caregivers who talk more about their religion may have a stronger relationship with it, thereby producing a non-representative relationship of the group at large. That being said, I took into account those who indicated that the above factors were *not* important to them, and incorporated that them into my overall consideration of the themes that appeared in the interviews.

Coding

Following transcription, the interviews were coded using NVivo software. The interviews were coded by myself and others working on the Caregiver Flourishing project, using a codebook designed by the investigators, and contributed to by those coding the interviews. The codebook was designed to follow the flow of the interview, and included codes that pertained to specific questions as well as codes that corresponded to overarching or general themes that appeared throughout the interview. Codes that related to specific answers were subsumed under broader thematic "holding nodes," which helped to organize and streamline the codebook.

The overall codebook is quite expansive, and with topics ranging across a wide variety of information about the caregivers. For my analysis, I focused on a small section of these codes, those that pertained directly to event appraisal, compassion satisfaction, mentions of overall wellbeing and happiness in work, and importance of religion. However, the number of mentions per code for each caregiver became largely unimportant, because the *amount* of information conveyed in each mention of a topic varied widely from caregiver to caregiver. The coding process eventually became a way to look briefly at the key points about a caregiver's mental health, and the quotes that were stored in each particular coding node became the primary sources for analysis of that caregiver's mental health and mental health practices.

Results and Analysis

A total of 15 interviews were coded for this project. Of these interviews, two were from Hyderabad, India; three were from Nagaland, India; five were from Ethiopia; two were from Kenya; and three were from Cambodia. Four of the caregivers were Orthodox Christian; two were Catholic; three were Protestant Christian; two were Christian but did not specify a denomination; two were Buddhist; and two were Hindu. Nearly half of the caregivers demonstrated positive mental health— they reported that they were happy in their jobs, they expressed considerable compassion satisfaction, and they tended to appraise events as challenges, and subsequently utilize effective coping methods in the face of stressors. Two of the caregivers whose interviews were coded had demonstrably low mental health— They expressed negative attitudes towards their jobs, shows showed less compassion satisfaction and in many cases expressed compassion fatigue and burnout, and they appraised events as hindrances. The mental health of the remaining six caregivers was more unclear. In many ways they exhibited traits of positive mental health, and many were happy in their jobs and personal lives. However, they also talked about the ways in which they were struggling with various challenges in their lives. The large proportion of caregivers who couldn't be determined to have positive mental health *or* negative mental health underlines the ambiguous nature of this type of research.

Case Studies

The profiles presented below are representative of themes that arose in the interviews coded for this thesis. They are separated into two groups, each of which

highlights different themes and overarching patterns of behavior and mental health. The first set of these profiles highlights certain trends that appeared in many interviews. They include caregivers who tended to appraise stressors as challenges rather than hindrances, and subsequently engaged in productive coping processes. These were tied to key resources available to these caregivers, such as religious practice, social networks either through work or through their place of worship, as well as a combination of contextual and personal factors that contributed to coping.

The second set of profiles highlights a different, but equally important set of themes that arose in interviews. Specifically, they emphasize the importance of individual agendas in caregiving, potential implications of resource-strapped settings in conjunction with hindrance appraisal of stressors, and the implications of the confluence of these factors in terms of caregiver mental health. The profiles included in this selection were chosen because the caregivers in question shared more meaningful anecdotes about topics that related to their mental health, or because their interview emphasized a particular theme.

These case studies attempted to showcase consistent information about the caregivers; specifically, their background in caregiving, their religious denomination and religious practices, as well as more nebulous concepts such as their appraisal of stressors and the way that they perceive socialization and their work. However, some information was missing from some interviews, and as a result the case studies are not entirely consistent in the information that they present. In the cases where a specific piece of information was missing, i.e., a caregiver's religion, I provided more general information that pertained to the same topic. For example, in many cases the caregivers

stated that they were "Christian," and did not elaborate on a specific denomination of Christianity.

Profiles—High-functioning Coping

Esttha

Esttha is a Hindu man who has worked at an orphanage in Hyderabad, India, for the past 3 years. His orphanage serves 46 children, with 2 caregivers that supervise them. He lives at the orphanage, typically starting work at 4:30 AM and finishing at 11 PM.

When the interviewer asked how Esttha came into this work, he answered with the following anecdote of a conflict between a local village leader, Esttha and his "Nethaji Youth club," a community organization oriented around youth education and empowerment. Esttha's club began raising money for village causes, including the reconstruction of a derelict temple, leading to a rivalry between his group and "Mohan Dora's." Over the course of the conflict, both actors destroyed several pieces of each the other's farming equipment, which eventually led to a legal battle to exile Dora from the community. Although Esttha's "side" technically won the conflict, he still felt as though he had committed a sin. One of Esttha's teachers, "a person who is our relative and lecturer by profession… he advised me that doing things like serving the old and aged people or serving orphans can help you to overcome the mistakes you have made… my guru advised me to do service to children to get rid of my sins or mistakes knowingly or unknowingly committed. It is not my own idea or knowledge but on the advice of my known person."

Esttha indicates that his initial motivations to become a caregiver were religious, almost contractual: in order to overcome his mistakes and atone for the sins he had committed over the course of the aforementioned conflict, Esttha must work in the service of others. He repeatedly asserted that he *must* serve, which underlines the importance of this work. He also said that Hinduism teaches "to help the needy and poor, help them in all means… this [service] to these poor and disadvantaged will relieve us from sins and help us get to bliss."

Esttha's religion has considerably shaped his conceptualization and initial motivation to become a caregiver. Throughout the interview, he explicitly stated that religion was the reason he became a caregiver in the first place, and that religion plays a major part in his day day-to to-day life. He participates in religions services and practices several times each day, and religion helps him conceptualize why children were orphaned in the first place.

Despite this strong motivation, however, Esttha also described an initial period of difficulty at work, where he felt angry and frustrated. He said that the support of other staff members— the secretary and treasurer of his orphanage— helped him overcome this challenge and gain patience and endurance. He said "at [the beginning] I thought that this work was not suitable to me… it felt like I was stuck in the jail, I thought of leaving the job several times. [They] convinced me to wait for some time to taste the success of my job." After this initial period of difficulty, Esttha experienced considerable satisfaction and happiness in his work, and said that now he enjoys every aspect of his job very much.

Esttha's job, involves very long hours and a considerable amount of work; as a result, employee turnover at the institution is very high. Esttha's 3-year tenure at the orphanage makes him exception in this particular role. As a result, he acts as a source of comfort and support for other staff members, because he has settled into the routine of the job and said that he no longer feels stress from it. When he does experience stress, however, Esttha said that he "[takes] every issue [easily] and [handles] it cautiously. It reduces stress," and that in order to keep himself "peaceful," he participates in "morning prayer and Harathi." He also said that the secretary and treasurer at his orphanage continue to be sources of support for him.

Esttha's conceptualization of "mental health" was quite difficult to interpret from the interview. The interviewer repeatedly asked him what it meant to be mentally healthy or unhealthy, and Esttha either misunderstood the question, or answered in a way that was unintelligible to both the interviewer and the coders. The exchange reads as follows:

> I: This type of work is stressful for the caregivers, because they of unlimited working hours, less time for rest, dealing with different type of children will give stress. According to you how do you say one person is mentally healthy?
>
> E: Sir my way of dealing things is that if some subject is there we should talk here and forget here so there will not be any issues. Taking every issue easy and handling it cautiously. … Avoid too much thinking will keep mentally healthy.
>
> I: So you mean to say one has to keep their mind calm and peaceful?
>
> E: Yes
>
> I: "Okay what if someone has mental health [problems]?
>
> E: Mental?
>
> I: It doesn't mean mentally ill? Having mental health problem?

E: If they have mental health problems it affects health like high blood pressure, diabetes, etc.

First, Esttha's answer to the initial question about being mentally healthy is quite convoluted. The interviewer interprets his response and reframes it to be more clear, although the interviewer's interpretation of his response doesn't align exactly with what Esttha said. This may suggest a problem with translation, or indicate a miscommunication between the two. Additionally, as the conversation moved to mental health problems, the evidence of some kind of miscommunication continues. Esttha's response "Mental?" to the interviewer's question about mental health problems, and the interviewer's response "It doesn't mean mentally ill? Having mental health problems?" suggests that the actual word that the interviewer used doesn't actually mean "mental health problems" as Esttha conceives of them. This further underlines the difficulty of conducting research on such nuanced topics of mental health, where local idioms of stress and mental health can vary so much from location to location.

Despite the confusion, Esttha did, however, repeatedly assert that he is entirely happy in his role, and did not have any tasks that he did not enjoy completing. Esttha's was the only interview where the caregiver emphasized so heavily that he enjoyed all tasks and all aspects of caregiving, which suggests that his response does not indicate a broader theme of compliance with perceived expectations on the part of the interviewer.

Nyala

Nyala works at an orphanage in Addis Ababa, Ethiopia. Her institution serves 25 children between 10 caregivers working on a shift basis. She has worked at her orphanage for nearly 10 years.

Nyala found this job through a neighbor, and starting working at the orphanage "just to see what it was like." She did not report having any particular motivation to work there, but discovered that working with children made her very happy, and that she "never wants to be separated" form them. Nyala was very aware of the important role that she plays in the children's lives. That which continues to motivate her to be a caregiver is that the children "don't have a mother or a father on their side and when they see us as their parents, that's what makes us stick with the job. All you want to do is take care of those children." She also described the considerable emotional strain of having such close relationships with the children puts on her and her co-workers. She said, "When a baby girl came to this institution, I was here. When the person who brought her left, the girl ended up with me. She hugged me tight and asked 'Would you be my mother moving forward?' She was about four years old when she came [CG tears up] and I said to her 'yes, don't worry, I will be your mother." I was on a day shift and I had to leave clandestinely. She was following me. I left clandestinely and they told me that she asked my whereabouts and cried. When I got here the following day, she said 'my mom is here.' After that, even when I have days off, she doesn't want me to leave. I would talk to her on the phone, from home. [CG tears up and sits in silence for a minute] These kinds of experiences make me want to stay here."

In addition to feeling a familial obligation to the children that she cares for, Nyala said that the relationship between herself and the other staff members was very close, also comparing them to family members. She said, “It does not feel like a work environment… we help each other in our tasks but also in terms of sharing ideas.” She suggested that these close relationships help foster a healthier work environment, given that caregivers are able to socialize and talk together outside of work-related issues, and that rapport ensures that caregivers *do* help each other when problems arise.

In order to cope with the strain of being a caregiver, Nyala turns to her religious practices. She tries to pray every day, and said that her religion is very important to her, and inspires her work with the children. Nyala expressed frustration with the fact that she can’t fully share her religion with the children, as she is not allowed to take them to services with her.

Although Nyala acknowledged that her work could be emotionally taxing, she also emphasized how happy her work makes her. She said, “caring for the children makes me happy. When they are happy, I become happy form the inside. When they are content with what I do for them, I also become joyful. That’s why I enjoy all tasks.” Nyala defined mental health in the following way: “Being mentally healthy is very important. It’s when you are mentally healthy that you are able to raise children that are mentally healthy. If you are not mentally healthy… if you experience minor health problems, you would not have a good relationship with children, you easily become angry. When they come hear you, you may push them away an make them distant… In my opinion, to have mental health problems means not being able to calm down, being disturbed, being capricious and preferring to be alone.” She says that she hasn’t

experienced such a time, and generally finds herself to be mentally health. She established being mentally health as "you feel happy from the inside. It makes you very productive. It helps you communicate well with others. It makes your overall activity good." When Nyala is enthusiastic towards her work, and doesn't feel too tired, she knows that she is mentally healthy.

Sarah

Sarah is a Christian caregiver at a government-run orphanage in Western Kenya. She has been caring for children for over 10 years, since 2007. Her institution serves 70 children, and she works with 10 other caregivers.

Although Sarah knew that she loved children, and loved taking care of them, she never imagined that she would be a caregiver. Sarah began working at her institution after a period of unemployment, during which she told herself "any job that comes first, I will do it," and accepted a position at the orphanage after a neighbor told her about an opening. In a broad sense, Sarah reported that she really enjoyed the work of caregiving, and that "it's a job I enjoy doing because I love these children and love taking care of these kids."

Although Sarah's religion did not act as a primary motivator for her to become a caregiver, she does connect the two. She said, "[I] became a caregiver because of my religion, it inspired me to care for the orphan children… I love to take care of children and was given an opportunity to serve God by looking after orphans." Sarah also elaborated, saying "I love children this is what gives me motivation, even if it is difficult but I enjoy being with children and serving God in that way as my religion encourages us to do." The encouragement that she got from her religion helped bolster

the enjoyment that she has in caring for children, enabling her to continue to be motivated at work even when difficulties are present.

Sarah directly stated that "[religion] has helped me overcome many challenges in life… through… words of encouragement from the scriptures." Sarah felt that overcoming these challenges helped make her a "better person," and that she was able to overcome these difficulties through God's help. Additionally, Sarah illustrated that she views her religion, and her relationship with God, as a resource to draw upon. In addition to considering why God may have sent a particular difficulty or life event, Sarah was able to draw on her religion, saying "God is my deliverer and… gives me strength to carry on in the midst of all the challenges." Religion played a major part in helping Sarah overcome major live events.

That being said, Sarah also spoke about overcoming challenges independent of her relationship with her religion. In these cases, she rationalizes confronting an event by realizing/ noting that she is the only one available to complete that task, and that it is her job, so she has no other option. In these cases, she referenced the close relationship that she has with m any children, adding that she is their caregiver before anything else. She said, "I just do [the tasks] because there is nobody else who will do it, it just forces you to do it. The kids need someone to look after them… you can't choose which times you want to be around your children." Sarah demonstrated her commitment to caregiving and to being a reliable caregiver, using that commitment to overcoming her disinclination to perform particular tasks.

Sarah's commitment to caregiving and the relationship that she fosters with her children encourages/ allows her to remain largely happy in her work at the institution.

Sarah repeatedly said that she "loves working with the children," and that spending time with them makes her happy. She said, "I love children and taking care of them gives me satisfaction… that is what gives me motivation, even if it is difficult." Sarah goes so far to suggest that feeling needed by the children is equally as important, and makes her equally as happy, as the feeling she has when spending time with them.

Sarah did not describe particularly close relationships with the other caregivers at her institution, but she did identify socialization as an important factor in how she maintains positive mental health. Caregivers did tend to support one another in difficult situations, although she also indicated that

Additionally, although Sarah acknowledged that she has had "mental problems" in the past (episodes where she did not feel mentally healthy), the most significant way that she recovered was by being social with people, and said that she can feel sad when she is alone. This indicates that, for Sarah, socialization represents an extremely important resource that enables her to implement positive coping strategies.

Analysis—High-functioning Coping

The preceding case studies highlight themes that were particularly important to caregiver mental health. First, these studies demonstrate stressor challenge appraisal, and the subsequent coping process. More specifically, they illustrate the ways in which caregivers identified resources available to them in order to healthily cope with stressors. The majority of these resources involved religious practice and social involvement, and emphasized the importance of relationships, both with other caregivers/ friends, with the children they work with, and with their religion. Additionally, these three interviewees had more *meaningful* mentions and anecdotes

regarding event appraisal, which provided valuable insight into *how* they appraise, and with which resources they cope with stressors.

Although the majority of caregiver interviews examined for this project identified religion as an important aspect of their lives, these caregivers were particularly tied to their religious practices, and drew upon their religious practices in order to maintain positive mental health. This was exemplified in a variety of ways, ranging from religion providing a social space for caregivers to escape to when necessary, to giving advice and praying over the issue, and reading scripture together.

These case studies are included not because these caregivers held easier jobs, or were paid better, but rather because they employed more effective coping strategies in the face of life events or demands. Organizational factors, such as longer work hours and fewer resources available, can negatively influence caregiver mental health; however, a caregivers' perception of these resources was quite important as well (Thompson 2014). These case studies demonstrated the caregivers' perception of events overcoming any structural problems that may have detrimentally impacted them in their work.

Caregivers either drew upon resources that were already available to them, or they utilized relationships and practices that existed in their lives so that they became useful resources. For instance, when Esttha experienced difficulties at the beginning of his time working at his institution, he actively sought out the help of the secretary and treasurer at his institution. The expectation that the work *would* become more rewarding and satisfying as time went on eventually came to fruition, such that Esttha currently expresses a high degree of compassion satisfaction and exhibits positive mental health.

Additionally, the attitude with which he addressed that first challenge, knowing that his work would become more enjoyable, set him up to continue to appraise life events as challenges, with the continued expectation of rewards in his work, and in terms of his religious motivation. Other caregivers also expressed similar motivation to Esttha with regards to redeeming past sins and ensuring that their actions in this life led to improved circumstances in the next life. Interestingly, Christian caregivers did not discuss the possibility of heaven or hell in their rationale for being caregivers; rather, they tended to discuss their work in terms of service to God and to the children they work with.

A consistent trait of caregivers who exhibited good mental health, or were best able to cope with stressful circumstances, was their ability to flexibly identify and utilize resources available to them. A remarkably effective resource that caregivers utilized was their religion and religious practices. A particularly poignant example of a caregiver effectively utilizing this resource is Sarah. She demonstrated that her religion, and religious beliefs, allowed her to implement challenge-oriented event appraisal in the face of difficulties. Specifically, Sarah suggested that there was a greater purpose to the life events that she experienced. She said, "[religion] has helped me overcome many challenges in life… through… words of encouragement from the scriptures like you are not alone and everybody gets trials and passes through temptations, and God cannot give you a burden you cannot overcome." Sarah repeatedly connected God to the challenges that she faces in her life and in her day-to-day work, treating them as challenges *from God* that she works *with him* to overcome. The result of this work, then, is that Sarah becomes "good… less judgmental, [more] kind, forgiving, and grateful." The mindset that Sarah implements of working through a particularly challenging life

event because God has sent her that challenge, with the knowledge that she will overcome it, allows her appraise these life events as challenges that have greater purpose and utilize her religion as a resource to overcome them. In this case, religion both enables the more effective coping, and acts as a resource for the caregiver to draw upon as they work through that life event. Sarah's initial appraisal of a life event as a challenge, which was in part prompted by her relationship with God, allowed her to subsequently cope with those events in a more productive way, which in turn contributes to her overall positive mental health.

The majority of the caregivers who demonstrated positive mental health described having social relationships and networks, and utilizing those networks to protect their mental health. Caregivers often described social support taking place between caregivers at work. Nyala described particularly healthy inter-caregiver relationships in her interview, comparing them to family members. She said, "It does not feel like a work environment… we help each other in our tasks but also in terms of sharing ideas. We support each other in all aspects… We have close relationships." Nyala suggested that these close relationships contribute to a healthier work environment, which in turn contributes to her positive mental health. The support that Nyala describes suggests that, in environments where caregivers are able to form close relationships, those relationships acted as yet another resource for caregivers to draw upon to preserve their mental health.

Esttha, on the other hand, described relatively distant relationships with other caregivers. He suggested that because the turnover rate at his orphanage was so high, close relationships were not able to form. This was not necessarily detrimental to his

attitude, because it was standard practice at his orphanage and not something out of the ordinary (he did not feel excluded from caregiver relationships in the way that other caregivers could). As a result, Esttha did not think about relationships as an important aspect of his work or personal life, instead focusing on other elements of his job to maintain his wellbeing.

As an interesting intersection between the last two examples, Sarah described an environment that was simultaneously supportive and competitive among different groups of caregivers. She said that, in times of crisis, caregivers would support one another, with the exception of certain caregivers who seemed to reject forming relationships with the others. It was unclear in the interview if she was referring to individuals who were isolated from the larger group, or if there were cliques at her institution, but the disparity between different groups was interesting.

Taken together, these three examples suggest that relationships between workers can be influential in establishing and protecting caregivers' positive mental health. Social networks within work environments acts as a direct, immediate resource to caregivers when they experience stressors at work. Other caregivers can empathize more closely with these caregivers, given that they work under the same conditions and often with the same children. Indeed, the immediacy of the support that they can provide is quite important as well— several caregivers mentioned calling on their co-workers for help with emergencies, and stated that the knowledge that they had other caregivers to go to for support when necessary helped them work through problems more calmly.

However, the interviews simultaneously demonstrated that strong relationships among co-workers are not always necessary if the caregiver has other resources in their lives to draw upon. Esttha did not describe close relationships with his coworkers; rather, he emphasized the importance of his religious practice and his individual commitment to serving the children as a resource for his mental health. Additionally, he repeatedly mentioned the importance of his relationship with the treasurer and secretary of his orphanage, which suggests that even though relationships with other caregivers are not so important to his mental health, he does recognize the value of social support.

Independent of relationships with other caregivers in their institutions, social networks outside of work were equally if not more important. Caregivers tended to have better mental health when they engaged in meaningful social relationships, or had rich social networks in their lives to draw upon. Many of the caregivers identified socialization, though, as demonstrated prior, not necessarily socialization with other caregivers, as an important avenue to establishing healthy mental health practices and coping mechanisms. All of the caregivers described going to other individuals for support in times of difficulty, or for general advice on their work or their lives.

One caregiver, not featured in these case studies, particularly emphasized the importance of these relationships. She is a nun, and works at an orphanage near her convent. This caregiver repeatedly communicated how she would return to her convent several times throughout the week, and on her days off, to get support from the sisters there. This both helped her de-stress from daily work, and also provided support and guidance during major life events or particularly stressful times, such as a sickness at the orphanage. This caregiver also highlights the importance of support at the

intersection of socialization and religion. Additionally, Sarah described bringing her worries and stresses to a religious group where they talk the issue over together, and pray on it. In this case, social support and religious practice overlapped, creating an intersection of resources that enables caregivers to confront events more effectively.

Another theme that was prevalent throughout the interviews of caregivers was the feeling of mutual attachment to the children that they cared for. Caregivers who had more positive mental health often described close relationships to the children that they worked with, as well as a feeling of commitment and obligation to those children. Feeling happy being and working with children was an important factor for caregivers who expressed higher degrees of compassion satisfaction, obviously. On one hand, having close, family-like relationships with the children that a caregiver works with produces this compassion satisfaction, which enables them to be more engaged and happy in their work. For instance, Sarah pointed to her obligation to the children as a motivator to work through challenging situations at her work. She said, "I just do [the tasks] because there is nobody else who will do it, it just forces you to do it. The kids need someone to look after them… you can't choose which times you want to be around your children." In these cases, Sarah simultaneously implements PFC and EFC, in that she confronts the problem head-on, and regulates her own emotional response to it. This both contributes to positive caregiver mental health, but also creates a great deal of tension between the caregivers *as caregivers* and the caregivers as individuals, with separate lives and obligations.

Nyala exemplified this tension in her interview, in which she formed a very close connection with a young girl at her institution, but that close connection resulted

in internal conflict between Nyala's work at the orphanage and her need to be able to leave her work behind at the end of the day. She said, "I was on a day shift and I had to leave clandestinely. She was following me. I left clandestinely and they told me that she asked my whereabouts and cried… Even when I have days off, she doesn't want me to leave. I would talk to her on the phone, from home." Nyala simultaneously wants to be an effective caregiver, and supply the emotional support for the children at her orphanage, but also recognizes her personal need to connect with others outside of the orphanage and have space from her work. As a result, her time away from work was both a source of relief and a source of stress, which made maintaining mental health more difficult.

Caregivers tended to divide their conceptualization of challenges into two categories: major life events and day-to-day difficulties to overcome. Sarah, for example, tended to utilize her religious practices when faced with major life events, treating the event as a learning opportunity that will bring her closer to God by overcoming it. Day to day life events, however, she approached very pragmatically, with the attitude that if she does not deal with the issue, then no one else will. In this case, Sarah drew upon the feeling of commitment and the motivation that she had to continue providing care to the children at her institution. Additionally, she utilized her social networks to relieve daily work-related stress, speaking with friends or with other church members.

Although religion may have been more meaningful when used as a resource for coping with major life events, religion was also used as a daily resource for these caregivers. Prayer, meditation, and conversation with other church members all

functioned as healthy mental health practices, allowing caregivers to decompress and process daily stressors. The contrast between the two situational uses of religion as a mental health support emphasizes the importance of coping with and processing these daily stressors as well as using it to deal with major life events.

An interesting contrast within the case studies featured here appears in their respective definitions of mental health. As noted previously, Esttha struggled with understanding the interviewer's question about mental health and mental illness, and provided an unclear answer to the two questions. This highlighted potential problems with translation, as well as different frameworks for conceiving of mental health. Contrastingly, Nyala immediately provided a clear and succinct definition of mental health and illness in her interview, talking about the importance of mental health both for herself and for the children that she cares for. The difference between these two further underlines the ambiguity of discussing mental health in international research, and points to a further need to investigate better methods for doing this research.

Profiles—Limited-functioning Coping

Arvind

Arvind is a young man working at an orphanage in Nagaland, India. His institution serves 45 children, with responsibility shared between among 5 caregivers. He has worked at this orphanage for 5 years, and was brought up there.

Arvind's path to caregiving was quite different from man that of the other caregivers interviewed. His family founded the orphanage, and he spent time with the children there when he himself was a child, and continued on to assist in care taking

when he got older. Arvind says, “I was born and brought up… here so I have been working the whole time. Even as I was studying I was looking after the children. After I joined my college whenever I [had vacations] I used to come and help the children.” As a result of this familial connection, Arvind consistently feels obligated to work at the institution and continue to support his family.

Additionally, Arvind shared that his Christianity motivated him to continue working with children as well. He linked this to the idea of sharing in the good fortune that he felt that he has had, saying “I feel so privileged like… being born in a Christian family or in a good family so I thought… since God has given me this privilege let me use this and help… the children.” In addition to utilizing his privilege to help others, Arvind said that “religion… has… helped me become a caregiver because that is what I find in my Christ. I see that he loves children and that he has humbled himself so much in spite of being a God… it has influenced me so much.” Arvind explicitly identified his connection to God as a motivator to care for children.

Another layer of meaning that Arvind’s religion holds for him is that it helped him maintain his overall sense of wellbeing, and in his ability to work through difficult life events. A particularly poignant example came when Arvind relayed this story:

> “When I was… 16, my dad passed away, and during that time I was really young and even my brothers and sisters… are also quite young. So I was lost and I was thinking, how come? How am I going to live my life? Where will my help come from? I think that was the question I had in my life, where will my help come from, that has been answered by God from his bible. So I think it has really helped me with such… questions that [came] into my mind with that struggle [but] I was able to overcome it. I think that was [through] God, it was through my religion, through the bible that I read. It was in psalms. So as I kept reading the bible it keeps talking to me time and again, time and again, and then I encouraged myself. There [were] no people that are and told me “it’s ok,

> it will be all right." Nobody came and comforted me. It was me and me alone, it was between me and my lord with whom I had these talks, so it has really strengthened me, and today it has really made me who I am. I am confident in the life I am living today, working with the children, and I am enjoying it [when] I think it was all because of the lord. God has [a] different purpose and plan for me. I believe in that."

Even when the interview questions did not directly pertain to religion, Arvind continually connected his practice and motivation as a caregiver to his religious upbringing and current practices. If he has time, he reads the scriptures. In order to improve or maintain his mental health, Arvind prays.

Despite reporting his motivation to be a caregiver, Arvind also expressed frustration with his work, because he feels there are too few caregivers to sufficiently work with the number of children at his institution. He said "when it comes to 10 [or] 15 children… one caregiver cannot look [after] so many children." To elaborate on this, Arvind said, "when we do something it is not well done, it… has been done [just for its] name sake, and it is not good. [Take] the example of their [studies]… when we don't check the paper… they take it for granted and then [they] skip their [studying]… so cheating takes place." The stress of caring for so many children, as well as the added challenge of trying to ensure that they completed their studies properly, exhausted him.

When asked about how he defined mental health, Arvind answered with the absence of stress, and the ability to make proper decisions. When the interviewer asked specifically about his mental health, he answered with

> "I don't only work here but I help with my church as well, looking after the children so… and then working in school… [there is] so much work load sometimes, it…. Just [comes] in one day and I cannot handle all the tasks at one go [and] feel really depressed."

He also described his specific symptoms of being mentally unwell as "mood swings… [shifts] in moods. Sometimes… I will burst out and later on I realize [there was nothing] to burst out [about]." In both of these examples, Arvind links feeling mentally unwell to feeling overworked and burnt out. Additionally, he characterized his supervisor as "dumping" responsibility onto him and the other caregivers.

All this being said, Arvind did indicate that he feels passionate about the work that he does, and that spending time with the children makes him feel happy and satisfied. Interestingly, although he did mention that he often prays when feeling stressed or depressed, Arvind did not mention that religious practices produce any happiness.

Lai

Lai has worked at her orphanage in Cambodia for the past 16 years, and had lived there as a child before that. She was orphaned in the Cambodian Civil war, and came to the orphanage in 1994. Her institution serves upwards of 100 children, with the work shared between 20 caregivers.

Unlike many other caregivers, Lai did not express any particular motivation to become a caregiver. She said, "I didn't have any job to do after I didn't pass the exam of nursing school and teacher school. And I didn't know where I could work because I didn't have a house to live, [and] the institution here didn't have enough caregivers, so the director suggested [that I] do this job and I took [it]." Lai's work as a caregiver arose as a result of practicality on her part— she needed a job, and took the first opportunity.

Lai admitted that she remains at this institution because she does not have another job to do, and that the orphanage helps her support her children and husband. She said, “I will not stay here for my whole life… I would leave when my children graduate from school and get a good job. Honestly I can say I stay to work here because [of] my own benefits more than the orphans.” This attitude of doing what was best for her and her family pervaded Lai’s interview, which was underlined by a marked absence of the deeper motivations that other caregivers described.

The majority of concerns, motivations, and problems that Lai discussed centered around practical issues rather than religious or idealistic issues. Her worries involved financial matters, the future of her children, and the future of the children that she takes care of. Additionally, Lai is not religious, which set her apart from the majority of the other caregivers. She said that she doesn’t identify with any particular religion, but listens to Buddhist dharma teachings on the radio and TV. Religion rarely appeared in her discussion of her life at the orphanage. Lai characterized this absence of religion as something due to her childhood in the orphanage, as her parents were not able to teach her. Additionally, she suggests that she *can’t* be religious because she doesn’t know much about Buddhism and Buddhist practices. She did, however, say that a friend of hers is “a great… teacher [who teaches] me to stay calm, she knows well about Buddhism.”

Lai said that she did not have a very close relationship with the majority of the other caregivers at her orphanage, and that their relationships were primarily competitive. She said, “when someone does the job well and is [admired] by the boss, [the other caregivers] are jealous but they don’t try to do their job better.” This suggests

that socialization is not an important element of Lai's life, or that it is a resource that she often draws upon. That being said, Lai did say that she had a friendly relationship with two other caregivers, one of whom worked at the institution at the time of the interview, and the other who had left. She said that the two of them provide emotional support for her when she had any problems.

Lai defines mental health as "something inside us, in our mind... I think if a person has mental health, they are always happy and not frustrated in their mind and don't speak impolite words." She said that people with mental health problems "would have short temper, frustrated, and furious feeling. I cannot think about others." She said that she has had mental health problems in the past, related to family strife. Lai feels mentally healthy when she doesn't think about anything.

Analysis—Limited-Functioning Coping

These two case studies were included because they highlighted different, yet equally important themes that arose in the interviews. In particular, I found that these two caregivers tended to express less compassion satisfaction and happiness in their job overall. Additionally, they either had fewer social, religious, or mental resources available to them, or they did not effectively identify and utilize these resources in order to overcome life events, and tended to appraise stressors as hindrances rather than as challenges. As a result, they tended cope more poorly with day-to-day life stressors, and expressed that they felt overworked and more stressed than other caregivers did.

Both Arvind and Lai were unique in how they perceived and utilized religion, in that Lai was not religious at all and Arvind's religion was an important part of his life. Arvind demonstrated that his religion was very important to him, sharing an anecdote,

described in his profile, in which he coped with his father's death through his relationship with God. One thing that differentiated Arvind from the other religious caregivers, though, is the way in which he utilized his practice to overcome life events, or not. Throughout the course of his interview, Arvind simultaneously illustrated that while he felt led to be a caregiver, and that taking care of children made him happy, the heavy workload and stress that he experienced through his job was fairly extreme. His interview had a tone of frustration and unhappiness. Even when he discussed the most satisfying part of his work, Arvind focused more on motivation and the necessity of his work rather than feeling actually happy doing it, which set him apart from many of the other caregivers.

Lai was a distinctive caregiver, given that, compared in contrast to the majority of the other caregivers, she was not religious at all. Her concerns as a caregiver were primarily pragmatic and related to herself and her family. She was concerned with feeding her family, and the children she cared for, and being able to afford to send her children to school. Lai exemplifies the influence that personal agendas can have on a person's event appraisal and subsequent mental health. Lai prioritized her children and her financial status rather than focusing on the "greater good" of the work that she does, and as a result expresses lower compassion satisfaction, lower social wellbeing, and generally has lower mental health.

Additionally, it appeared as though Lai tended to perceive events, even small ones, as hindrances rather than as challenges. A small but telling examples read, "I try my best to cook… delicious food… when I hear [the children and my husband] say it is delicious, I feel happy. But sometimes it is not delicious and I don't know why I [spent]

a lot of money to cook it but it is still not delicious." Lai's tone here conveys a sense of frustration that seems disproportionate to the event itself. Lai's emphasis on a small setback in her personal life may be indicative of a tendency to focus on the negative side of an event in other parts of her life as well.

As mentioned above, Arvind did demonstrate that he could utilize his religion to work through major life events, particularly as it related to the death of his father. He characterized this time as one where he was working *with* God to understand and process his father's death, and that a large part of his comfort came from the scriptures. However, although the scriptures continue to be a primary way that Arvind deals with stress associated with his work, he does not talk about using them to deal with day-to-day stressors in the same way that he dealt with the death of his father. He characterized the administration at his orphanage as "dumping" work on himself and the other caregivers, and didn't really describe ways that he dealt with the stress associated with this work, other than reading the scriptures.

Additionally, Arvind conveyed that the stress that he feels at work eventually becomes a feeling of hopelessness about the amount of work that needs to get done at the orphanage. This demonstrates an absolute lack of resources for the institution where he works, and illustrates the way that Arvind struggles to cope with that lack of resources. He said, with regards to his mental health, "I don't only work here but I help with my church as well, looking after the children so… and then working in school [there is] so much work load sometimes, it… just [comes] in one day and I cannot handle all the tasks at one go [and]… feel really depressed." Arvind described accumulation of stressors, and suggested that he lacked sufficient mental, physical (such

as enough caregivers to distribute the workload), or social (relationships to rely on to decrease stress) to cope with the accumulation. According to Arvind, he experienced depression and other mental health issues as a result. As a counterpoint, Esttha works at an orphanage with a very high child-caregiver ratio, but is apparently able to cope with the additional challenges presented by this workload. This difference emphasizes the importance of individual perception in contrast to contextual factors in determining a person's mental health. Both caregivers here work in fairly resource-poor environments, but Esttha's perception allows him to maintain positive mental health, whereas Arvind perceives this context as a hindrance, and as a result expresses lower mental health. Of course, this is not to say that their situations are entirely comparable, but the difference with which they interpret their individual stressors is markedly different.

Lai also did not describe any particularly healthy or effective ways that she overcame day-to-day challenges at work. She did describe "playing on her smartphone" and going on Facebook, as distractions and ways to de-stress at the end of the day. However, studies have suggested that distraction is a maladaptive coping technique, which tends to make individuals more vulnerable to burnout (Thompson 2014). Indeed, when considered in conjunction with Lai's overall attitude towards both her work and non-work life, this finding suggests that distraction may be an ineffective coping method for her.

Another interesting aspect that distinguished Lai's interview from others is her total ambiguity about socialization and relationships that she has formed at the institution where she works. Lai mostly talked about rivalries and jealousy between caregivers at her institution, and that collaboration was not really present. This feeling

of competition coupled with a slight sense of overall dissatisfaction with the other caregivers and her relationship with them, and combined with stress from her family which produced an overall sense of dissatisfaction and detachment from the caregivers that she worked with. However, she did describe a relationship with a former carver from her orphanage, who now provides emotional support from afar. This suggests that although Lai did not describe close relationships with other caregivers, and as a result did not use this resource to maintain positive mental health, it could be due to a lack of sufficient resources or social capital available at the institution for Lai to tap into.

Also, Lai and Arvind both expressed less internal motivation to work at their respective institutions. Lai grew up in the orphanage at which she works at, and her parents were killed in the Civil War, so she reports not having anywhere else to go. Working at the orphanage is a very practical, seemingly necessary choice for her to make because it provides for her and her family. She has a job, she doesn't have to pay rent or for food, and can send her children to school for free. She hardly talked about stress at her work itself at all. She did not describe her caregiving as a "calling" or something that she feels that she was meant to do at all. She stated, explicitly, that once her children graduate from school she plans to pursue another profession.

Arvind, also, has a familial obligation to work at his institution. His family runs the orphanage, and he grew up there, so it makes sense that he returns home and works on his school breaks and works here after graduating college. His familial ties to the institution also provoke some problems for Arvind, in that it appears as though he feels like he can't complain "up the ladder" to improve the shortcomings that he identified in his institution, because his supervisors are his family members.

Overall, Arvind and Lai's interviews indicate several differences between the other case studies described in this study. They did not describe more overtly stressful work environments, or work longer hours than other caregivers. Rather, their interviews were characterized not by the presence of stressors, but by an absence of happiness and sense of fulfillment that many other caregivers described. These differences highlight the critical nature of individual event appraisal in caregiver mental health, as well as the identification and utilization of resources that further support positive coping techniques.

Discussion

A major logistical complication of this project is the small sample size of interviews that I worked with. I do not anticipate that the 15 interviews included in this thesis are representative of the entire sample. However, the themes that arise in the interviews are consistent with findings described in more extensive studies on mental health and wellbeing. Moreover, this thesis does not seek to be prescriptive or make any definitive claims about the nature of mental health in caregivers; rather, it describes themes that *did* appear within and across interviews.

A complication that arose in research is cultural difference in conceptions of mental health. Specifically, the ways in which caregivers defined mental health varied considerably from place to place, which illustrated the complications of conducting research in such culturally variable settings. Additionally, many caregivers had trouble even understanding what the question was asking— many requested that the question be repeated several times, and the interviewer sometimes had to reword the questions considerably. For example, in one interview, the interviewer had to repeatedly reword the question about how they define mental health several times. An excerpt from the interview reads:

> "I: What does it mean to have mental health problems?
>
> CG: I have no much answers…
>
> I: Ok… if you are mentally unhealthy, if you are having mental health problems, what kind of problems will it be? If your mind is not sound, not ok…
>
> CG: I cannot give good service to children, I cannot guide [them].
>
> I: Yes you cannot guide because you are… not ok in your mind?
>
> CG: [no response]

I: If you are disturbed and if you are going through a lot of emotions… then your mind is not ok…. You understand what I'm trying to say?

CG: [no response] laughs

I: When you are emotionally— in your mind not ok you will not be able to do your job properly right?

CG: yes

I: you are not yourself, you cannot concentrate, you are always disturbed, you can't do you work properly.

The excerpt above demonstrates both the difficulty of translating concepts such as "mental health" into other conceptual frameworks, as well as the ambiguity of reading and interpreting interviews done by someone else, which is quite common in all qualitative research. The caregiver never fully answers the question posed by the interviewer, and the interviewer eventually words the question in such a way that the caregiver can just confirm what they said, rather than speaking for themselves.

Moreover, the definitions that caregivers provided for the question "what does mental health mean to you" varied considerably from place to place. For example, one caregiver might say, "having good mental health means being in a good mood," and another might say "having good mental health means having your mind in the proper order." That said, caregivers all did have answers to this question, demonstrating that they are cognizant of mental health and mental health problems, but there was no single, shared definition of mental health either within the same location or between locations. None of the interviews that I coded included aspects of the Western biomedical conceptions of mental health. This is to say that although there are working conceptions of mental health and mental illness in the US and much of the Western world, these conceptions of mental health do not necessarily translate well, either in terms of language or in terms of mental frameworks.

The fact that so many caregivers struggled with the original question, regardless of what their answer ultimately was, indicates that many individuals may not even define "mental health" as "mental health," or may be hesitant to discuss the topic, if mental illness is stigmatized in their community. Ice, et al., (2012) argued for a need identify a "local idiom of stress" as a basis for culturally specific scales of stress and mental health. Additionally, Patel (2001) argues that "cross-cultural psychiatry" ignores the fact that conceptions of mental illness and mental health may already exist in the local context. Furthermore, the idea that non-Western cultures don't already have their definitions of mental health and illness only impedes the development of culturally competent research. Given that standardized questions were used across all interview sites, so that there was no opportunity to determine the local "idiom of stress" and shape questions towards that idiom, the questions regarding mental health may not actually correspond with how caregivers conceive of mental health.

Furthermore, caregiver interviews, although rich in anecdotal and personal evidence, capture a snapshot of how a caregiver feels about their work and their mental health *on that particular day*. As a result, that caregiver's mood could affect how they present their attitudes about work, their own mental health, and their overall wellbeing, either to the positive or to the negative. Additionally, participants may have been telling interviewers what they thought that they wanted to hear, a form of response bias, which could skew results. My determination is not an absolute judgment on their mental health, and the project did not investigate cultural norms around compliance and confirmation bias. Nonetheless, these complications are an element to consider when reading and interpreting interviews.

Despite the complications listed above, the interviews and caregivers' anecdotes provide valuable insight into their perceptions of stress, work, mental health, and wellbeing, among other topics. As a result, while things that caregivers did *not*s mention also merited consideration, analysis significantly privileged the information that they directly conveyed through the interviews.

It should be emphasized that "mental illness" as a diagnosis, or as a category, does not appear in this project. I focus on the mental *health* of caregivers, or relative absence thereof. While measures used to detect mental illness were employed for the Caregiver Flourishing study, they were not considered at all for this thesis. As emphasized in Keyes' articles, mental health, rather than simply an absence of mental illness, merits consideration in research and in intervention.

Conclusions

Generally, caregivers who appraised stressors and events as challenges rather than as hindrances exhibited better mental health, and utilized more effective coping mechanisms. Additionally, these caregivers expressed more, and more meaningful, mentions of compassion satisfaction. Consistent with Thompson (2014), compassion satisfaction simultaneously functioned as a resource that caregivers can identify and draw upon when coping with stressors, and was product of event appraisal and coping strategies. Caregivers who expressed compassion satisfaction in their jobs—that is, simply enjoying the work of caring for children—often described that enjoyment as part of the reason that they were able to overcome stressors in their work. Prior investment in their work encouraged them to regard stressors as challenges rather than hindrances. Treating these stressors as challenges in turn led to more productive coping mechanisms, which reinforced the compassion satisfaction that caregivers experienced in their employment.

This project found that with regards to caregiver mental health, religion and spirituality is of the utmost importance for those caregivers who are religious or engage in other spiritual practices. Religion functioned as a resource for caregivers to draw on when confronted with stressful life events, from the death of a parent to the day-to-day stressors of working in an emotionally, physically, and mentally taxing environment, which corresponds with findings presented by Pargamet (1998). Caregivers would often describe stressors as opportunities to learn and improve as individuals, with the stressors sent from God to teach them something about themselves or about their faith. While this ties in to overall appraisal of challenge stressors or hindrance stressors,

caregivers often emphasized the religious component of their appraisal and subsequent coping to the extent that, as Pargamet et al stated, religious appraisal could not be reduced to non-religious forms of appraisal and coping. Thus, religion and religious practices represent a vital resource for caregiver mental health, given that it contributed to caregivers' positive mental health.

Several caregivers who exhibited the highest degree of positive mental health used religion to help cope with the amount of work that they had to do in their positions. For example, Sarah often referenced service to God as one of the things that kept her motivated as a caregiver. The idea that caregivers are completing their work in service of/ in response to the call of a higher power, encourages caregivers to interpret the stressors presented in this work as challenges to continue answering this call to serve. Caregivers tended to tie this idea to a "calling" from God that either motivated them to become caregivers in the first place, or to remain in the profession. Additionally, the belief that caregiving work helps make the world a better place falls along dimensions of social wellbeing as outlined by Keyes, which in turn may improve the caretakers' social wellbeing (Keyes 1998).

Individual religious practices also contributed to caregiver positive mental health, in accordance with findings of Decker et al (2015). These included things like prayer, meditation, the reading of scripture, and listening to recordings of religious teachings. Caregivers often described turning to such resources to deal with daily stressors. Esttha, for instance, described a rigorous prayer and meditation schedule that he pointed as a significant part of his mental health maintenance, and Nyala said that she turned to prayer more than once per day to re-center herself in her work. These practices also

assisted caregivers in coping with major life events. As Arvind described in his interview, when his father died, he turned inward, to his relationship with God. He said,

> "I think that was [through] God, it was through my religion, through the bible that I read. It was in psalms. So as I kept reading the bible it keeps talking to me time and again, time and again, and then I encouraged myself. There [were] no people that are and told me "it's ok, it will be all right." Nobody came and comforted me. It was me and me alone, it was between me and my lord."

These lines illustrate with particular saliency the importance of Arvind's individual relationship with his religion. He emphasized "it was me and me alone, it was between me and my lord." Arvind conveyed the strongest sense of positive mental health when he discussed his religious practice, which further underlines the extent to which individual religious practice can protect caregiver mental health.

Along similar lines, religious practices appeared to protect caregiver social wellbeing, and as a result, promote positive mental health and coping practices (Keyes 1998). Sarah, for example, described turning to her church community to help her deal with both daily stressors and major life events. Religious groups provided social space for caregivers to process and react to life stressors, and members of religious groups were also able to provide social support to caregivers that appealed to their spirituality, such as praying for a caregiver or praying over a problem.

More generally, social networks and social support acted as a protective factor for caregiver mental health, also as suggested by Keyes (1998). Caregivers who indicated that they had meaningful relationships, either with other caregivers inside their institution, or with individuals outside of their institution, tended to have better mental health, and many suggested that this provided them with more resources to support them when necessary. Nonetheless, positive mental health flourished even in very

under-resourced settings, demonstrating the importance of personal affect and coping strategies. Esttha, for example, works extremely long hours caring for many children with only a few other caregivers and staff to help support him. Nonetheless, he expressed a great deal of positivity towards his work, and emphasized how satisfied he is both in his profession and in his personal life. This occurred even in situations where he did not have particularly strong social support from other caregivers, precisely because the work that they engage in is so stressful that many do not spend much time in his position. Esttha's ability to overcome the material challenges that he experienced in his workplace demonstrates the importance of personal affect and perception in mental health, in accordance with Thompson (2014).

Personal agendas also played a part in caregiver mental health: for example, Lai prioritized her marital and financial agendas over her caregiving work, wanting stability in her personal life rather than working towards a larger goal. This was reflected in her interview, in that she didn't experience compassion satisfaction from her work. Different agendas contributed to different types of appraisal among caregivers. Many caregivers who expressed that they felt they were contributing to a greater good, or responding to a call for service, appraised events as challenges in order to continue working towards the greater good that they identified as a motivator. Caregivers whose agendas were largely personal often also utilized challenge event appraisal; however, they also tended to express more frustration with their work environments and appraised more day-to-day stressors as hindrances.

A major conclusion to draw from these claims is the need for additional research on caregiver mental health. The importance of flourishing mental health, rather than simply

the absence of mental illness, is an understudied topic that merits further investigation. Furthermore, research on how individuals *maintain* mental health is very much lacking. A large portion of the existing literature has focused on effects of negative mental health, emphasizing the ways in which individuals fall short in maintaining or facilitating their own mental health, as well as the external factors that contribute to poor mental health. As a result, there is a need for asset-focused research that identifies how people use the resources that are available to them.

Further research on positive mental health practices has broader implications as well. Greater knowledge on the determining factors of mental health could contribute to interventions designed to improve mental health of those who work in draining professions. A major factor that differentiated Lai and Arvind's mental health was their failure to identify and utilize resources available to them, which prevented them from flourishing to the fullest capacity. Interventions aimed at enabling caregivers to identify and utilize resources available to them in coping with stressors could contribute to an overall increase in mental health.

Emphasis on mental health is a critical element in assisting and facilitating the overall health of caregivers, and of their charges. The stress that caregivers and those working in similar professions experience is related to day-to-day stressors and events. Specifically, caregivers often described smaller, daily stressors as the source of stress that they experienced in their work, rather than to major life events that occurred in discrete situations. The prevalence of daily stress in caregiver interviews highlights the gap in research on coping with day-to-day stressors, given that much of the existing research has focused on how individuals respond to major life events.

The response to this gap in research carries significant implications not only for caregivers the caregivers described in this project, but also for those who work in caregiver professions across all fields.

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