

# Sources of strength perceived by females caring for relatives diagnosed with cancer: an exploratory study from India

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## Abstract

**Goals of work** The aim of the study was to explore sources of strength in the process of caregiving from the perspectives of Indian women caring for relatives suffering from cancer. In addition, it aimed at exploring self-reported occurrence of positive moments and personal changes experienced during the care-giving process.

**Materials and methods** Twenty female caregivers participated in two to four interview sessions. The average caregiver was about 40 years old. Spouses and children as caregivers had the highest representation in the sample. The care recipients had heterogeneous cancer diagnoses and were undergoing active treatment.

**Main results** Religious beliefs and practices and positive appraisal of the caregiver role in terms of “value” emerged as the most frequently cited intrapersonal sources of strengths. Religious beliefs and practices were linked with positive appraisals of care-giving demands and experience of hope. The participants also described several interpersonal sources of strengths, e.g., family, medical fraternity, and care recipients themselves. The narratives of the participants indicated the occurrence of positive moments as well as perceptions of positive personal changes during the care-giving process.

**Conclusions** The findings have implications for further research on positive aspects of caregiving as well as for devel-

opment of intervention components that may help caregivers maintain and enhance their well-being.

**Keywords** Cancer · Oncology · Care-giving experience · Strength perspective · Support

## Introduction

Although caring and being cared for are important aspects of day-to-day interactions in close relationships; the term family caregiving refers to the situation wherein one or more family members aid or assist other family members beyond what is required as part of normal everyday life [50]. There is a substantial body of empirical literature on the process of caregiving for an ill/disabled family member and its effects on the care providers. Specifically, the deleterious psychosocial outcomes associated with being a family caregiver (such as burden, strain, depression, and poor physical health) have attracted a lot of attention from researchers [9, 35, 38, 57]. The stress process model [36] proposes that components such as context of care, including background characteristics of care giver and care recipients, duration since caregiving and objective care demands associated with disease stage, available resources and subjective stressors interact with each other to influence caregiver outcomes. In contrast to research on burden and other negative outcomes, there is a relative paucity of research studies that examine factors that facilitate caregivers in managing care-giving demands and are associated with positive psychosocial outcomes [1, 11, 22]. Researchers [31] have proposed a framework to describe positive adaptation to stressful experiences. Similarly, a model of the health effects of caregiving [26] proposed that the impact of objective care-giving demands may be mediated

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by their subjective appraisals and incorporated the possibility of both positive and negative outcomes of caregiving.

Although there is a growing number of research endeavors that focus on positive aspects of care-giving experience such as satisfaction, positive appraisal of the care-giving experience, gratifications, meaning, and purpose in caregiving and personal gains [2, 5, 10, 18, 33]; there is a dearth of research on the processes and contexts that may accompany generation and maintenance of positive affective states as well as experience of personal gains during caregiving. In a longitudinal study of AIDS caregivers, three kinds of coping related to the occurrence and maintenance of positive affect were identified namely; positive reappraisal, goal-directed problem-focused coping [32], and the infusion of ordinary events with positive meaning [13]. It was noted by these researchers that positive affect states co-occurred with distress during the care-giving experience. Another study findings [24] indicated that positive responses to caring for a family member (e.g., “I want to give care”) can moderate emotional distress of care givers.

The strengths perspective [41] upholds the belief that people are capable of growth and change, particularly when empowered to gain insight into their own assets, strengths, and resources [42]. In this context, it becomes important to allow caregivers to narrate their own perceptions of the resources they draw upon in coping with stressful situations. The findings that emerge from such studies may help in generating hypotheses for further studies as well as in developing mental health promotive interventions or modifying existing psychological interventions by incorporating potentially useful components.

In the above background, the present study attempted to qualitatively explore sources of strengths and positive experiences as reported by females caring for relatives suffering from cancer. Despite advancements in the diagnostic and treatment procedures, cancer experience is often described to be a highly stressful one for the patients as well as their caregivers [14, 56]. The present study focused on females as caregivers. This focus was influenced by the available research data on gender issues in caregiving. Research indicates that the majority of family caregivers are women [46, 47] and that women who assume a care-giving role tend to be provided with less supplemental support from other network persons than men caregivers [19]. Although there is a relative lack of consistency in results across studies, the preponderance of evidence suggests that women experience more burden and psychological distress in the care-giving role than men do [30]. A study on caregivers of cancer patients [34] indicated the need to separately examine gender issues and to fully explore care-giving appraisals that may result in positive outcomes such as enhanced self-esteem.

On the whole, a scan at the available research literature suggests that very few studies [e.g., 22, 32, 33] have focused on exploration of various sources of strengths that may facilitate coping with care-giving demands from the family caregiver’s perspective. Relatively speaking, the literature is silent on what may make the care-giving role a meaningful and fulfilling one and result in the occurrence of positive states of mind in the midst of experience of distress. The present study was designed to be a one small step in the direction of bridging research gaps in the field of psychology of cancer caregiving. Although care-giving experiences are likely to be influenced by cultural values and not just individual differences in dispositions, the published literature shows preponderance of studies from the West [20] and a virtual absence of studies on these issues from India. Indian families are characterized by strong emotional ties that encourage sharing and mutual dependence [17]. Despite globalization influences and the rise in the number of nuclear families, links with extended families and wide kinship networks are common in India, and families continue to be a source of strength for a majority of Indians especially during sickness and death [40, 45]. In this context, it becomes important to understand the resources that Indian caregivers draw upon while managing to provide care for a family member suffering from a major medical illness.

The study aimed at exploring the sources of strength in the process of caregiving, as perceived by female caregivers of individuals suffering from cancer in India. It also aimed at exploring self-reported occurrence of positive moments and personal changes during the care-giving process. Caregiving has been described as a dynamic process that may be influenced by the changing nature of illness demands over time [16]. The first year after cancer diagnosis poses its own unique demands on the patients and their significant others, such as coming to term with the diagnosis, overcoming demoralization, managing stress related to unfamiliar problem situations, and living with uncertainty while attempting to re-gain some sense of control. The present study limited its breadth of inquiry to include caregiving in the context of a recent cancer diagnosis.

## Method and procedures

The study was cross-sectional and qualitative in nature. The term “strengths” in the present study context referred to all the intrapersonal and interpersonal factors that are perceived by the caregivers as being helpful in managing distress and maintaining well-being. The term “female caregiver” in the present study referred to a female family member of the patient who spent maximum time with the

patient and was actively involved in providing day-to-day care for the patient at home and during hospitalization.

### Sample selection

The study was carried out at a cancer hospital situated in a metropolitan city of south India after obtaining clearance of the protocol on methodological and ethical aspects by the protocol review committee of the Department of Mental Health and Social Psychology of the concerned Institute. All the female caregivers of cancer patients available in the hospital during the data collection phase of the study were considered for inclusion. Those who fulfilled the study criteria (described below) and gave written informed consent were finally enrolled. The data were collected between November 2004 and April 2005. Although 30 caregivers initially gave informed consent, due to practical constraints, only 20 of them could be contacted for conducting the interviews during the study period.

### Criteria for sample selection

Inclusion criteria: females who were 20 years or older and were providing care for relatives undergoing active treatment for cancer were considered for the study. Only those caregivers whose relatives were diagnosed with cancer less than a year ago were included. Exclusion criteria: female caregivers of patients with cancers adjudged by the treating oncologist to have poor prognosis as well as those with recurrence of cancer were excluded. Female caregivers who were not fluent in either English/Kannada (regional language) were also excluded. The above criteria were applied to reduce the heterogeneity of the sample with respect to specific care-recipient characteristics such as duration since diagnosis, current phase of treatment, and nature of prognosis, which are likely to impact on the caregiving experiences [e.g., 27].

### Description of the sample recruited

The age of the 20 study participants ranged from 20 to 67 years. The average caregiver was about 40 years old. Spouses (nine) and children (six) as caregivers had the highest representation in the sample, followed by mothers (four). Majority of the caregivers (14) had completed at least 15 years of formal education that included 3 years of college education. Six out of 20 were employed; three were students, whereas 11 were housewives. Majority of the caregivers (17) were Hindu by religion, were married (15), and belonged to a nuclear family set-up (15).

Care-recipient characteristics have a bearing on the caregiving process [36], and hence, may influence the sources

of strength that caregivers are able to mobilize. This necessitates understanding the care-recipient characteristics in the present study sample. Age of the care recipient/patient varied widely, the distribution ranging from 3 to 86 years. There were two care recipients within 3 to 16 years range; 13 were middle-aged (32 to 55 years), and five were older adults (55 to 86 years). The duration since cancer diagnosis was short, as the sample selection criteria permitted inclusion of only those cases wherein the duration since cancer diagnosis was 1 year or less. The mean duration since cancer diagnosis in the present study was 3 months, the maximum duration being 7 months, and the minimum being 1 month. There were 13 male patients and seven female patients. Half of the patients had at least post-graduate level qualification obtained after 17 years of formal education. Slightly more than a quarter (six) had a first university degree obtained after 15 years of formal education, and slightly less than a quarter (four) had 10 years or less of formal education. A large proportion of the care recipients (12) consisted of salaried professionals, whereas a quarter consisted of housewives. The two most common sites of cancer were genitourinary (six) and breast (five) cancers, respectively. The prognosis of cancer was operationalized in terms of the absence of poor prognosis, as opined by the treating team of oncologists in the present study setting. The oncologists took into account the stage of the disease as well as other medical factors for arriving at this decision. None of the patients (care recipients) had poor prognosis. All were recently diagnosed and undergoing active treatment (radiation/chemotherapy) during the time frame of the study.

### Measures

*Basic data sheet* This was to record the respondents' socio-demographic details and the relationship with the patient. It also included a data sheet with details of patient's age, sex, education, occupation, diagnosis, and duration since diagnosis, etc.

*Qualitative interview* General questions and guidelines for the interview were developed in the pilot phase of the present study. The interviewer allowed a free flow of narration by the use of general, open-ended questions at the beginning of the interviews. This part of the interview was aimed at allowing the participants to narrate their personal experiences and emotions after cancer diagnoses in their loved ones. It also aimed at understanding the current life contexts of the caregivers. The subsequent portion of the interview used follow-up questions that were specifically geared to fill gaps in the above narrations to directly cover the following grounds: (a) to obtain a subjective account from the caregivers as to what helped them in their attempts to manage their distress and maintain well-being during

caregiving. This involved asking questions aimed at understanding the caregivers' mobilization of intrapersonal (e.g., beliefs and cognitive frameworks) as well as interpersonal (e.g., social support, help seeking from medical fraternity) resources. Leading questions tapping specific domains of distress and sources of strength were avoided, as the aim was to obtain a spontaneous report of strengths. (b) In addition, open-ended, albeit specific, questions were asked to explore the occurrence of positive moments and perceptions of personal changes during the care-giving process. It was left to the participants to interpret the phrases "positive moments" and "personal changes" in their own ways. This was meant to help in capturing these experiences from the participants' perspectives.

### Procedure

Twenty female caregivers of patients suffering from cancer, who fulfilled the specified sample selection criteria and provided informed consent, were interviewed. The second author conducted all the interviews. A minimum of two and a maximum of four sessions were held with each participant within a span of 6–8 days. The focus of the initial sessions was on building rapport and initiating the qualitative interviews. The subsequent sessions were used to complete the qualitative interviews. The last segments of the interviews were devoted to seeking clarifications, if any, as well as providing opportunities to reflect on the interviews and summarizing. The duration of each session ranged between 30 min to 1.5 h. More than a single interview with each participant allowed a deepening of rapport. It also provided space between sessions for the researcher to record reflections, check for consistency of themes across sessions, and seek opportunities for obtaining clarifications and elaborations. Audio taping of the interview sessions was considered during the pilot phase of the study. However, it was observed that it was not feasible in the present study context due to reservations about the same in the participants as well as the practical constraints in the study setting. Although audio taping provides rich data while ensuring that problems related to fallibility of recollection and selective attention of the researcher are minimized, it is also recognized that sometimes, participants might find it uncomfortable that the interviews are taped and that tense or hostile participants may not provide very useful narratives [52]. The field work by the authors suggest that the source of this difficulty in obtaining consent for tape-recording the interviews stemmed not from a fear of technology per se but from an attempt to maintain a sense of privacy by talking about distress in a naturalistic context. Prior experience of the first author also seems to suggest

that participating in audio-taped research interviews may not be a comfortable and natural process for several Indian participants in oncology settings and influences their willingness to give consent for studies. In the present study, the second author, who conducted the interviews, listened and took brief notes during the sessions and wrote down the extensive session notes and her reflections immediately after the completion of each session. She positioned herself in an open stance so as to permit expressions of distress as well as perceived strengths and positive experiences. The interview session notes were content-analyzed [51] by coding for emergent themes, which were integrated across 20 protocols. Similar themes were then put together to form broader themes. The first five protocols were jointly coded by the first and the second author to arrive at a shared understanding of the process of content analysis for this study. The second author independently coded the remaining protocols, and any new themes that emerged were coded after consultation with the first author. Both the authors jointly carried out the grouping of similar themes into broad themes.

### Results and discussion

The qualitative interviews provided the participants opportunities to describe the sources of strength in the care-giving process, as perceived by them. Religious beliefs and practices, appraisal of caregiver role, and prior experience of caregiving emerged as three spontaneously reported sources of strength. In addition, five broad themes, namely family, medical fraternity, and hospital staff, friends, care recipients, and fellow caregivers, emerged as interpersonal sources of strength. It needs to be noted at this juncture that although the paper focuses more or less exclusively on the sources of strengths, the narration of it was interwoven with themes of distress. This is understandable, as research suggests co-occurrence of distress and positive states of mind during periods of prolonged stress [12]. Not surprisingly, several factors that reportedly served as sources of strength in some instances were the same as those that apparently contributed to distress in other instances, the positive/negative impact being determined by the quality of such factors. For example, support from the hospital staff was reported to be a highly valued source of strength, and the perception of such support being absent/inadequate added to the experience of distress. All the broad themes and subthemes that were unraveled under intrapersonal and interpersonal sources of strength are described below. In addition, reports about the occurrence of positive moments and personal changes during the care-giving process are described in the subsequent sections.

### Intrapersonal sources of strengths

These reflect strengths that primarily involved within-subject resources. Content analysis revealed that participants spoke about three intrapersonal sources of strengths, namely, religious beliefs and practices, perception of care-giving role, and prior care-giving experiences.

#### *Religious beliefs and practices*

Religious issues were spontaneously mentioned during the interviews. Thirty percent of the participants (6 out of 20) in the present study spontaneously reported that the diagnosis of cancer in the significant other had triggered the distressing question of meaning [48] such as “why did it happen to me/my dear one?” The narrations indicated that their global beliefs were being challenged by the diagnosis of cancer and its consequences. However, most of these participants reported this questioning phase to be a transient one during which they experienced varying degrees of anger towards god or fate and a sense of injustice and anguish. Almost all narratives indicated a subsequent shift to being more hopeful and optimistic about God’s benevolence, indicating the probable operation of cognitive restructuring/attempts at rebuilding or strengthening religious beliefs. All the participants (100%) noted religious beliefs and practices as a source of strength. Most of the participants reflected on the singular belief that “God will not let us down”. The recurrent expression of strong hope (that the patient would recover) often occurred, along with expression of faith in God, in the participants’ narrations. On the whole, it appears that in the present study sample, the experience of hope was significantly connected to the subjects’ religious frameworks. Empirical evidence indicates that religion is widely used in coping with stressful life situations ranging from chronic illness to bereavement and disability [21, 28]. A variety of cognitive mechanisms of coping that stem from religious belief frameworks emerged during the qualitative phase of the study. Some participants appraised their current difficult situation as “being tested by God”, which, in turn, reportedly meant that they needed to hold on to their faith and do their best in the given context. This reappraisal of difficulty as “being tested by God” provided a sense of meaning to the care-giving tasks and motivated them to do their best. “Everything that happens, happens for the good” and “It is all a part of God’s plan” were a few other statements that reflected cognitive coping through religious beliefs. Participants also reported using self-talk strategies: talking to god to help them as means of dealing with the stress. Mental simulation processes (deriving solace by comparing one’s current situation with a hypothetically worse situation) were also

tied to thoughts about God’s benevolence, and this, in turn, strengthened the hope for positive outcomes in future. In work with accident victims, researchers [7] have reported that religion offered meaning and helped in viewing the place of a stressful event in an overall plan or purpose. Eastern religions support beliefs that stressful events are the plan of the universe and part of “karmic” relationships from infinite past lives [39]. Other scholars [15] report that religious belief frameworks ensure that beyond the surface of seemingly unfathomable occurrences of life, there is a basic meaning. The role of religiosity was indicated in the cancer experience of a sample of African-Americans [37] who spoke about the belief in God as a source of healing, value of prayer, and the use of a strategy named “turning it over to the Lord”. Along parallel lines, while some participants in the present study felt the need to “accept what God gives”, some others in the present study also reported bargaining with God for the life of their loved one. Several participants, during the narratives, spoke in detail about various religious practices they performed, e.g., prayers, visits to places of worships, special worship rituals, chanting mantras (holy verses), charity, etc. to support their faith in God and to improve the chances of positive outcomes. Researchers [29] suggest that people use prayers to foster feelings of control because of the belief that such activity might change the course of events. On the whole, religious beliefs and practices appeared to be a hallmark source of strength for the study participants, as they relied frequently on it for distress management through reappraisals and maintenance of hope during coping with the care-giving demands.

#### *Appraisal of caregiver role*

In the present study, caregivers saw their roles in terms of “duty”/expectations from others and themselves or as a “value” in terms of opportunity to serve. The description in terms of “duty” tended to emphasize the “demand” aspect of their role in terms of “needing to do” what was expected of them in a given situation. However, some participants expanded their interpretation beyond a sense of duty and went on to elaborate how they saw the care-giving role as valuable. These participants’ narratives frequently reflected their tendency to appraise the current situation as opportunity to “return to others/reciprocate” by “giving” and returning care to those who have cared for/provided for them at some point of time in the past. Along similar lines, a study on family caregivers [43] listed family loyalty/payment of previously accumulated debts as a method of managing stress. For some participants in the present study, “giving” was also linked with expectations to be cared for sometime in the future, in times of need. The subjective

benefits of transforming extrinsically motivated activities (obligations/“shoulds”) into intrinsically motivated valuable activities (wants) have been examined earlier [3]. Parallel to such observations, 25% (five) of the participants in the present study appeared to manage the care-giving tasks through complete absorption in their role, and they reported that living their role of caregivers fully provided them a sense of fulfillment. The present study data raise the hypothesis that appraisal of the care-giving role in the frame of reference of one’s value system (giving/returning) has the potential for reducing the subjective sense of burden and enhancing positive states of mind during the caregiving in contrast to its appraisal as an “imposition”. In addition, some participants cited caregiving as being an inherent part of their helping nature that came to them effortlessly and that provided them a sense of meaning. Earlier research from India, in the context of caring for people with dementia, suggests that attitudes towards caregiving can be quite varied such as perceiving oneself as trapped in the situational demand, seeing it as one’s fate, accepting it as one’s duty, or deriving a sense of personal satisfaction from caring and doing one’s best [44]. Future studies need to explore these differences in appraisals of care-giving roles and their impact on mental health.

#### *Prior experience of caregiving*

Personal experience of caregiving in the past also appeared to help caregivers’ process of coping. The information or knowledge that they possessed while engaged in caregiving to significant others in the past reportedly enhanced their preparedness related to dealing with hospitalization and related issues and caring for the sick person while managing other demands. It appeared to endow them with the readiness to take on the caregiver role. In the present study, participants’ reports suggest that past personal experiences may facilitate current coping with care-giving demand through an enhanced sense of personal control and tolerance of uncertainties.

#### *Interpersonal sources of strengths*

These include sources of strengths that are interpersonal in nature. The broad themes that emerged were: family, medical fraternity, friends, care recipients, and fellow caregivers.

#### *Family*

For a large proportion of participants (75%), family accounted for a significant source of strength. As per the participants’ narrations during the interviews, several factors associated with family emerged as sources of strength. Several studies have indicated that people who solicit help

usually look for comfort, reassurance, and advice and initially tend to turn to family and friends for support [4, 25, 53]. The participants of the current study reported that the following factors within the families provided strength to caregiving: (a) provision of emotional support (of staying together during procedures, discussing important issues, sharing difficulties; (b) instrumental support in terms of assuming the caregiver’s routine role and responsibilities back at home, providing financial aid, arrangements for medication was crucial to caregivers in relieving some of their preoccupation with day-to-day chores and multiple other demands; (c) instances of family members providing informational support regarding illness and treatment were also mentioned by a few participants; (d) spiritual support was also obtained through other family members undertaking prayers for the well-being of the care recipient.

#### *Medical fraternity*

The medical fraternity was spontaneously cited to be an important source of strength by as many as 45% (nine) of the participants. In the present study, participants have listed some of the features of interactions with the medical fraternity that were helpful: (a) the doctors’ style of communication that emphasized optimistic ways of looking at problems and possible solutions; (b) their clarity in the provision of information regarding treatment; (c) personal care of the doctor reflected in following up of patient status after treatment procedures, regular visits to the family and patient, and “being there”, not necessarily for “doing” something. All of the above mentioned factors (optimistic style, clarity, and care) were reported to help the caregiver in feeling cared for and attended to. In a study on psychosocial needs of cancer patients and spouses [49], the participants reported the importance of communication with the doctors. In the present study, apart from medical professionals, the hospital staff (inclusive of nurses, aides, security personnel) was also reported by participants as being important sources of strength during the hospitalization period. The caring attitude of the staff reflected in being helpful when the caregiver needed practical assistance in small but meaningful ways and supporting the caregiver emotionally was perceived as very valuable aid enhancing the coping of the caregivers.

#### *Friends*

Friends, as a source of strength, were spontaneously mentioned by 30% (six) of the participants. An earlier study [6] on the role of confiding relationships in coping with a variety of life events and role strains observed that friends were most commonly selected by 75% of the urban adult sample as providing a confiding relationship. In the

present study, friends provided similar forms of emotional, instrumental, informational, and spiritual support as the family. Another form of support from friends came in terms of unexpected help (arranging for donations of blood, finances).

#### *Care recipients*

It was noted that when inquired about sources of strength, 40% (eight) of the participants spontaneously reported that care recipients/patients themselves were a significant source of strength. They enabled the care-giving process by providing support to the caregiver through their personal optimism that “things will improve”, thereby strengthening the hope of the caregiver. Acceptance of diagnosis by the patient helped in facilitating the adaptation process more effectively, and thereby, reducing the caregiver distress. The study participants reported that the care recipients’ affect state in terms of feeling positive and cheerful despite the illness and treatment helped in relieving the caregiver’s emotional stress. Patient’s encouragement of caregiver’s return to normalcy, motivating family members to pursue their activities of daily living, reportedly led to decreased subjective sense of burden. Emotional sharing with the care recipient about difficulties, discussing problem areas, past memories, as well as future plans also appeared to help the caregivers in coping. A positive relationship between the caregiver and the care recipient has been linked to higher levels of satisfaction and meaning/sense of purpose in caregiving [23]. As to how coping mediates the effect of optimism on distress in women with early stage breast cancer has been the subject of examination [8]. The qualitative analyses in the current study raises a hypothesis that the patient’s optimism may also have an impact on the caregiver’s optimism, coping, and well-being.

#### *Fellow caregivers*

In the present study, 3 out of 20 (15%) participants spontaneously reported the role of fellow caregivers during hospitalization. The fellow caregivers contributed in facilitating management of emotions (sharing their experiences and coping), sharing burden and providing instrumental support (buying amenities for the others, taking care of the patient in the absence of the caregiver), and sharing problem-solving strategies (resources they utilized to deal with crisis, knowledge of available means to deal with difficulties).

#### Positive moments during caregiving

Several participants, in the course of their narratives, spontaneously or, upon inquiry, mentioned about positive/good moments experienced by them during the process of

caregiving. These included (a) events related to care recipients’ health that fostered hope, e.g., getting a normal report of a blood investigation; (b) interactions with significant others resulting in feelings of being cared for, e.g., talking to a friend who listened to their difficulties and provided emotional support; (c) temporary respite from caregiving and opportunities to engage in positive distraction, e.g., being able to take a few hours off from the caregiving role through soliciting others’ help and engaging in another inherently pleasurable activity, e.g., gardening; and (d) recollection of positive memories of the past or positive aspects of current life situation and planning for future, e.g., talking with others about good times in the past, realizing how things are not as bad as they could have been, and visualizing good things in future such as celebrating a festival. Participants also reported that they were learning to appreciate simple joys of life such as taking a walk. This observation is in keeping with the review of literature on coping processes that generate positive affect in general and the role of infusing ordinary events with positive meanings in particular [12]. It is observed that in the present study, pleasant moments, as reported, tended to occur very often in interpersonal contexts (sharing experiences and emotions, doing things together, etc.).

#### Personal changes

Seventy five percent (15) of the participants reported personal changes as being a positive fallout of the care-giving role. Many reported caregiving to be a testing time that facilitated discovering their hidden potential for patience, strength to handle novel and difficult situations, and deal with multiple demands. Awareness and appreciation of support received resulted in the knowledge that there were people who could be relied upon and enhanced a sense of belonging and being cared for. Some participants spontaneously reported learning to tolerate minor irritations/hassles. They reported experiencing a perspective shift in terms of being more accepting of each day and also being able to prioritize their life issues. Some reported experience of feeling closer to God, of being “cared for and supported by Him” while being “tested by Him” at the same time. The narratives of the present study participants resonate with themes similar to those described in another study [43]. It needs to be noted here that these descriptions of positive changes are not based on responses obtained to a questionnaire or a checklist. Rather, they were reported spontaneously in response to an open-ended question asking them to describe the changes that they may have perceived in themselves as a result of the care-giving experience. Positive personal changes (after major stress) in the form of post-traumatic growth have been reported in patients’ as well as caregivers’ samples [54, 55].

## Conclusions

The study highlights the perspectives of females caring for relatives diagnosed with cancer in India in terms of the intrapersonal and interpersonal resources that they draw upon to maintain their well-being during the process of caregiving for relatives suffering from cancer. Religious beliefs and practices, positive appraisal of the care-giving role, prior experience, and care received from family, hospital staff, friends, patients themselves, as well as fellow caregivers were cited as important sources of strength by the study participants. In addition, the participants also described occurrence of positive moments as well as positive personal changes during the care-giving process. It may be argued that positivity and hope that underlie the narrations in the present study may be attributable to the fact that none of the care recipients had poor prognosis, and the duration since caregiving was relatively short. However, this argument does not capture the complete essence of what emerged from the data. The expressions of hope in the present study were closely intertwined with disclosures regarding religious beliefs. Also, it needs to be reiterated that positive themes emerged in the background of narration of distress, dilemmas, and struggles. The fact that no direct and leading questions were asked regarding specific sources of strengths or the nature of personal changes experienced lends credence to the emergent themes.

The themes that emerged are bound by the context of the study that gave space to the voices of a small sample of females caring for relatives diagnosed with cancer. These caregivers were in the early phase of the cancer care-giving trajectory for a family member recently diagnosed to be suffering from cancer with a prognosis opined to be fair to good. The cross-sectional nature of the inquiry has limitations in understanding the dynamic nature of the phenomena explored, and prospective studies are needed to better capture the process of caregiving as it evolves over time. Rigorous qualitative analyses of the data could not be carried out due to non-feasibility of audio taping the interviews.

Although the present study has limitations as indicated above, this is the first research account in the Indian context that qualitatively explores the experiences of females caring for relatives diagnosed with cancer from a strength perspective. The study findings have several research and clinical implications. The themes related to intrapersonal sources of strength highlight the potential utility of meaning-based interventions for cancer caregivers. The participants viewed the medical fraternity and hospital staff as a highly valuable interpersonal source of strength. The narrations of the participants in the present study contain implications for development and testing of educational modules for sensitizing cancer care staff in India that focus on (a) enhancing awareness of the powerful impact of the

interactional stance of the doctors and staff on the experience of caregivers providing care for their ill relatives and (b) discovering small and yet meaningful ways in which they may be able to support the psychological needs of the caregivers. The important role of family members, friends, as well as fellow caregivers in contributing to perceived strengths during caregiving is probably at least partly rooted in the collectivistic nature of Indian society wherein “giving” and being there for each other are intrinsically valued aspects of life. As a corollary, the failures or deficiencies in such systems of support are likely to have a deleterious impact on the caregivers’ coping. The study findings highlight the need for examining the utility of developing orientation material for sensitizing individuals who form the informal support networks of the primary caregivers about responding sensitively to the latter’s emotional needs. The reports of positive moments and positive personal changes during caregiving highlight the need for further studies to understand the processes that are involved in the generation and maintenance of positive affect states and experience of positive personal changes during stressful times. On the whole, the study findings suggest that research, using a strength perspective in caregiving, holds promise for development of intervention models that empower caregivers with a broader range of approaches for managing distress, meaning making, remaining attuned to positive affective and growth experiences, and maintaining their subjective well-being.

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