

Original Article



Quality of Life of Filipino Caregivers of Children in Need of Special Protection: Correlations with their Role Overload and Role Distress

Ian Christopher Naungayan Rocha^{1*}, Myla Marcellana Arcinas²¹School of Medicine, Centro Escolar University, Manila, Philippines²Behavioral Sciences Department, College of Liberal Arts, De La Salle University, Manila, Philippines**Article Info****Article History:**

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Corresponding Author:Ian Christopher N. Rocha,
Email: ianchristopherrocha@gmail.com**Abstract****Introduction:** The quality of life (QOL) of the caregivers who attend to children in need of special protection (CNSP) influences their effectiveness in rendering care to their care recipients. This study aimed to determine the QOL of caregivers with their levels of role overload (RO) and role distress (RD).**Methods:** A total of 130 caregivers, identified through a convenience sampling technique, from 17 child-caring institutions from the Philippines' National Capital Region (NCR) participated in this descriptive correlational study. The survey method was used to gather the data using a structured self-administered questionnaire. Data were processed and analyzed using Statistica 13.0 and Spearman's rho test.**Results:** The study found a significant inverse moderate correlation between the level of QOL of the caregivers and their level of RO. A significant inverse strong correlation was also found between the level of their QOL and their level of RD.**Conclusion:** The findings confirm that as the levels of RO and RD of the caregivers decrease, their level of QOL increases. Conversely, their level of QOL decreases as their levels of RO and RD increase. Recommendations were provided to improve the QOL of the caregivers of CNSP in the Philippines.**Introduction**

In 2017, the United Nations Children's Fund (UNICEF) reported 140 million children worldwide who were abandoned, orphaned, and neglected.¹ Sadly, 123 million of the orphaned and abandoned children came from the deprived, developing, and most under-resourced countries.¹ There is an increased vulnerability for children in less developed nations because of poverty, morbidity, and mortality.² Asia accounts for 61 million orphans worldwide.¹ Another report also stated that there are around 150 million street children in different cities worldwide.³ These vulnerable children are among the most physically noticeable of all poor children because they live and work in the streets. These children are not only orphans, but many of them have run away from home because of psychological, physical or sexual abuse, violence, family collapse, socio-economic breakdown, or a natural disaster.¹⁻⁶

In the Philippines, there are 3.3 million working children⁷ and 1.8 million abandoned children.⁸ Around 250,000 of them live in the streets all over the country, and the estimation of 30,000 street children is in Metro Manila, the National Capital Region (NCR) of the Philippines.⁹ These vulnerable populations are children in need of special protection (CNSP). In the Philippines, CNSP

refers to children below 18 years of age and are unable to take care of themselves because of physical and mental disability and those who are victims of abuse, neglect, exploitation, cruelty, discrimination, and violence.¹⁰ The Department of Social Welfare and Development (DSWD) is responsible for CNSPs in the country. Aside from the DSWD centers, some institutions are willing to care for these children.¹¹ Many institutions, such as orphanages and non-governmental organizations which started of love by concerned people, have been the most usual form of custody and support for abandoned and orphaned children.¹²

Their parents or family left these children out of desperation with the hope that they will have a better life. A better life means giving the physiological support needed by a child, such as food and shelter. However, the issue of love and care from a parent or a family is absent. These children long for love and affection from their caregivers in the institution. These caregivers are doing their best to love, protect, and support these children.¹²⁻¹⁴

CNSP caregivers provide routine care in child-caring centers to meet the holistic health and functional care needs of their care recipients. They engage in many support activities, including monitoring the child's condition, ensuring others know how to deal with the child, working

with children to provide appropriate boundaries and reinforcements, giving rewards, and preparing a balanced diet.¹⁵ In addition to the medical responsibility of the care providers for the children they are caring for, caregivers with sick care recipients also have to help them keep up with the school's academic demands if the child is studying and support the child in playing with other children. Studies characterized institutional caring by rotational shifts of different care providers, high child to caregiver ratios, and limited social and psychological stimulation. Nevertheless, the quality of care varies among the caregivers and within different settings and environments.^{16,17} Previous studies showed that most of the caregivers in CNSP are middle-aged women who did not finish college, and from the low social class.^{18,19}

Many caregivers of CNSP often experience a multitude of stressors and distress associated with providing care to their care recipients and the myriad of other hardships of daily life.²⁰ Often, caregivers experience high levels of role overload (RO) and role distress (RD), which can result in negative consequences and may affect their caregiving role.

RO happened when caregivers simultaneously commit themselves to several social role positions and tasks. Different role obligations may force a caregiver to allocate resources, such as time, for the consummation and fulfillment of all the roles and duties as a caregiver.²¹ RO pressures enough time and energy to fulfill various and multiple role commitments.²² It is also defined caregiver RO as a feeling of being exhausted before sleeping at night, having more things to do than they can handle, having no enough time for themselves, and unable to finish what needed to be done.²⁰ In some studies, the level of RO is measured through daily hours of care. When RO increases, caregiver burden is likely to increase. RO influences the caregiver's choices as well as the capacity to provide care resulting in decreased quality of life (QOL) and, subsequently, an erosion of the quality of care to their care recipients. As RO increases, the quality of caring role suffers.²³ A high level of RO also contributes to depression and anxiety disorders found in many caregivers. Depressed caregivers who experience a high degree of RO are most likely to have a worse QOL.^{24,25} Caregivers who tolerate a high level of RO face a higher risk of a low QOL compared to the caregivers who have less RO. This situation is consistent in all QOL domains but with a more significant effect on the physical and psychological health domains.²⁶ Additionally, CNSPs are dependent on their caregivers which can cause perceived burden associated with the daily demands of care, impaired capacity, and reduced QOL.²⁷

RD is defined as the physiological, emotional, societal, and economic issues and problems that can also burden the caregivers.²⁸ It is also characterized by a feeling of difficulty and stress in fulfilling role obligations, commitments, and duties of a caregiver.²⁹ In caregiving, RD can be easily seen as an outcome of a series of stressors and factors. These

stressors affect the caregiver's level of RD.²³ The tasks were viewed as a prime determinant of the caregiver's RD.³⁰ Studies reported caregivers who experience a higher level of RD to suffer inadequate sleep, ineffective self-care,³¹ depression, emotional, and mental problems.^{32,33} An increased level of RD thus negatively impacts the QOL of the caregiver,^{19,34} and this affects the quality of caregiving role.¹⁸ Additionally, RD may wear down the subjective experience of the health of caregivers.³⁵

Caregivers of CNSP need to maintain a good QOL to give quality care to their care recipients. QOL is defined as a good and well-lived life, as reflected in the following domains: physical health, psychological, level of independence, social relations, environment, spirituality, religion, or personal beliefs.^{36,37} Previous studies found that low level of QOL of caregivers is found to be associated with their work situation, that is caregivers who tolerate a high level of RD, and high level of RO face a higher risk of the low QOL.^{18,26} Additionally, the measurement of the QOL of caregivers offers vital understanding into the degree to which a condition interferes with daily life activities and depletes psychosocial factors.²⁷ Although caregiving role can be rewarding, care providers experience physical, psychological, and financial stressors which impact their QOL.¹⁵ Caregivers are tasked with the essential duty of providing support and encouragement to their care recipient; thus, protecting them from too much work overload and work distress will not compromise their QOL, which can affect the quality of care that they give to their care recipients especially for the case of CNSP. Professionalizing their work as a caregiver is also needed to protect the CNSP. To care and to protect those who provide care and protection to CNSP is a way to uplift caregiving as a profession.

This study primarily aimed to determine the level of QOL of 130 caregivers of CNSP from 17 residential child-rearing institutions in 8 cities within the NCR, Philippines. This study also examined the levels of their RO and RD as caregivers of CNSP in residential child-rearing institutions. Overall, the study determined the correlations of the QOL of caregivers of CNSP in residential child-rearing institutions with their levels of RO and RD.

Materials and Methods

This is a cross-sectional study aimed at determining the correlations of the level of RO and level of RD with the level of QOL of caregivers attending to CNSP in child-rearing institutions in NCR, Philippines.

From a total of 150 caregivers in the 17 child-rearing institutions, a sample size of 122 was the required sample size under a 99% level of significance and a 5% margin of error. A total of 130 caregivers gave consent and answered the survey questionnaire. Data cleaning was done, and all the 130 accomplished questionnaires were valid and thus included in the data processing.

They were selected through convenience sampling and were selected based on the following criteria: (1) 18

years of age and above, which is the legal maturity age in the Philippines, (2) working as a caregiver in a child-rearing institution based in NCR for at least a year to establish familiarity to the role and tasks of a caregiver in a child-rearing institution, and (3) directly attending and providing care and support to CNSP for a minimum of a year. Those who did not qualify in the above-mentioned criteria were prohibited in joining the study.

In gathering the data, a structured questionnaire was constructed, comprised of four sections: demographic characteristics, RO and RD, and QOL. The first part of the questionnaire generated their personal and work-related characteristics, the second part measured their levels of RO, and the last part measured their level of QOL. To measure their level of RO, an established 13-item RO Scale (ROS) of Reilly³⁸ was used with a Cronbach's alpha value of 0.89.³⁹ Their level of RD was measured based on the established 17-item Caregiving Distress Scale (CDS) of Cousins et al.,⁴⁰ with Cronbach alpha value of 0.87. Their level of QOL was measured based on the established 26-item World Health Organization (WHO) QOL questionnaire (WHOQOL-BREF)⁴¹ with a Cronbach alpha value of 0.76.⁴² All the scales were measured using Likert scale with scales from 1 to 5. Mean scores and standard deviations were generated to identify their levels of RO, RD, and QOL. Permissions were asked from all the authors in using them in this study.

In the data collection, permissions from the administrators of the 17 NCR child-caring institutions were sought. Then, the schedule of visits to the institutions was set. Before the caregiver participated in the study, the researchers thoroughly explained to each one of them the purpose of the study. They were fully informed that participation was voluntary as no incentive will be given to them, and they could withdraw at any stage of the survey with no repercussions. Also, assurance was given that the collected data will be kept confidential and that their identity will be protected. Only after the above process that informed consent was asked of them, which was signed by each of the respondents. During the conduct of the survey, the researchers remained present as the respondents accomplish the questionnaire. When the survey was accomplished, the researchers double-checked the questionnaire to check if there were errors or if the respondents missed any items.

The collected data were processed and analyzed using Statistica 13.0. Descriptive statistics were used, such as frequency, mean, median, and standard deviation in presenting the respondents' profile and their levels of RO, RD, and QOL. The scores for the levels of RO, RD, and QOL were interpreted into three degrees: high (mean score of 3.68-5.00), moderate (mean score of 2.34-3.67), and low (mean score of 1.00-2.33).⁴³ Spearman's rho was used in assessing the correlation of the RO and RD with the QOL. The significance level was set at 95% or $P < 0.05$. The basis of the strength of correlation used an absolute value of four levels: 0.00 to 0.30 for very weak/negligible correlation, 0.30 to 0.50 for weak/low correlation, 0.50 to

0.70 for moderate correlation, 0.70–0.90 for high/strong correlation, 0.90 to 1.00 for very high/strong to perfect correlation.⁴³

Results

Profile of the Caregivers

Of the 130 caregivers who participated in the study, half of them (50%) were of middle age (36-55 years old), about half (47.7%) were single, about three-fifths (58.5%) were non-college graduates, and above the majority of them (56.2%) have 1 to 4 dependents. About two-thirds (63.8%) were working as a caregiver for 1 to 5 years, about three-fifths (59.2%) attended 1 to 5 work-related trainings, and more than two-fifths (42.3%) were earning ₱9,001 to ₱12,000 (\$170 to \$230) a month. About three-fifths of them (58.5%) were living in the institution, more than half (51.5%) served as house parents to the CNSP, less than half (47.7%) were assigned in day shift, two-fifths (40%) were rendering 9 to 16 hours of care to their care recipients, another two-fifths (40%) were handling abandoned and orphaned children, and about two-fifths (36.2%) were caring for 6 to 10 care recipients (Table 1).

The Level of Role Overload the Caregivers

The 13-item Reilly's ROS was used to measure if the caregivers experience RO based on three domains, namely duties and responsibilities, energy, and time. Table 2 shows that seven out of the 13 items assessed reflected high work overload, but overall, the caregivers assessed their tasks in the institution (RO) to be at a moderate level with a total mean (SD) score of 3.51 (0.52), with all the domains also rated as moderate or average (duties and responsibilities with $x = 3.53$, energy with $x = 3.53$, and time with $x = 3.48$). Their level of RO was high. They felt that: 1) their duties and responsibilities would require them to prepare a priority list to do their work, 2) they could not meet everyone's expectations in the institution, and 3) they have to cancel their commitments outside to meet work demands. They also felt that they have to overextend their energy level to finish their tasks, and thus they felt that they needed more hours to accomplish their tasks, given too many work tasks/demands.

The Level of Role Distress of the Caregivers

Their RD level was measured using the 17-item Cousins and colleagues' CDS based on five domains, such as social impact, care recipient's demands, personal cost, emotional, and relationship distress. Overall findings showed that they experienced a moderate level of RD with a total mean (SD) score of 2.88 (0.55). All domains generated an average mean score, except for relationship distress, which got a low mean score. Table 3 shows that the respondents strongly agreed that they have less time to visit their family and friends. On the other hand, they reflected low mean scores on items such as caring for care recipients, which made them nervous, felt helpless in caring for care recipients, the relationship with care recipients no longer

Table 1. Frequency and percentage distributions of the personal and work-related characteristics of the caregiver - respondents (n=130)

Personal and work-related characteristics	No. (%)
Age group	
Young adult (18-35)	55 (42.3)
Middle adult (36-55)	65 (50.0)
Old adult (56 and above)	10 (7.7)
Monthly income	
₱3,000 and less	9 (6.9)
₱3,001 – ₱6,000	23 (17.7)
₱6,001 – ₱9,000	10 (7.7)
₱9,001 – ₱12,000	55 (42.3)
₱12,001 – ₱15,000	28 (21.5)
₱15,001 – ₱18,000	4 (3.8)
₱18,001 and more	1 (0.8)
Civil status	
Single	62 (47.7)
Married	52 (40.0)
Cohabitation	7 (5.4)
Separated	7 (5.4)
Widowed	2 (1.5)
Highest educational attainment	
Elementary level	1 (0.8)
High school level	13 (10.0)
High school graduate	23 (17.7)
Vocational graduate	18 (13.8)
College level	21 (16.2)
College graduate	50 (38.5)
Post-graduate level	4 (3.1)
Number of dependents	
None	40 (30.8)
1 to 4	73 (56.2)
5 to 8	16 (12.3)
9 to 12	1 (0.8)
Living arrangement	
Living in the institution	76(58.5)
Living with family outside the institution	43(33.1)
Living with friends outside the institution	7(5.4)
Living alone outside the institution	4(3.1)
Number of Training	
None	24 (18.5)
1 to 5 trainings	77 (59.2)
6 to 10 trainings	26 (20.0)
11 trainings and above	3 (2.3)
Years of service in the institution	
1 to 5 years	83 (63.8)
6 to 10 years	26 (20.0)
11 to 15 years	9 (6.9)
16 to 20 years	10 (7.7)
21 years and above	2 (1.5)
Types of care recipients	
Abandoned/orphaned children (AOC)	52 (40.0)
Abused/exploited children (AEC)	6 (4.6)
Children with special needs (CSN)	6 (4.6)
AOC and AEC	7 (5.4)

AOC and CSN	7 (5.4)
AEC and CSN	2 (1.5)
AOC, AEC, and CSN	50 (38.5)
Number of care recipients	
1 to 5 children	8 (6.2)
6 to 10 children	47 (36.2)
11 to 15 children	20 (15.4)
16 to 20 children	29 (22.3)
21 children and above	26 (20.0)
Work shift schedule	
Day shift	62 (47.7)
Night shift	22 (16.9)
24 hours	46 (35.4)
Hours of care	
Less than 9 hours	32 (24.6)
9 to 16 hours	52 (40.0)
More than 16 hours	46 (35.4)
Position in the institution	
Houseparent	67 (51.5)
Care provider	57 (43.8)
Nurse	6 (4.6)

₱ : Philippine peso (1\$ = 48.52 Peso).

Table 2. Mean scores and standard deviations of the level of role overload of the caregivers (n=130)

Level of role overload (RO)	Mean (SD)	Interpretation
Duties and obligations	3.53 (0.57)	Moderate
I find myself having to prepare priority lists to get all the things I have to do	4.19 (0.84)	High
There are times when I cannot meet everyone's expectations	3.95 (0.76)	High
Many times I have to cancel commitments outside to meet my work demands	3.82 (1.02)	High
I seem to have more commitments to overcome than some other caregivers I know	2.85 (1.18)	Moderate
I cannot ever seem to catch up with work assigned to me	2.84 (1.28)	Moderate
Energy	3.53 (0.38)	Moderate
I seem to have overextended myself in order to be able to finish everything I have to do	3.98 (0.84)	High
I just cannot find the energy to do all the things expected of e	3.57 (0.78)	Moderate
I have to do things less carefully in order to get everything done	3.04 (1.10)	Moderate
Time	3.48 (0.54)	Moderate
I need more hours to do all the things which are expected of me	4.10 (1.03)	High
There are too many demands on my time	3.90 (1.15)	High
Sometimes, I feel like there are not enough hours in the day for me to complete my tasks	3.68 (1.03)	High
I have things to do which I do not have time for	3.08 (1.00)	Moderate
I do not ever seem to have time for myself	2.65 (1.05)	Moderate
Total role overload	3.51 (0.52)	Moderate

Legend: 3.68 to 5.00 for high; 2.34 to 3.67 for moderate; 1.00 to 2.33 for low.

give them pleasure, and the relationship with the care recipients restrained. The results implied that they care for their care recipients and they like their work. All the other items generated a moderate assessment. While working in the institution may give them less time to their family and friends, they care for their children in the institution, as reflected in their low mean scores on the items above. Overall, the results showed that both the RO and RD levels of caregivers were at a moderate level.

Quality of Life of the Caregivers

Table 4 presents the level of QOL of the caregivers based on four domains, namely: physical health, psychological health, social health, and living condition. Their QOL was measured based on the 26-item WHOQOL-BREF. Their total QOL generated a mean (SD) score of 3.35 (0.52).

Table 3. Mean scores and standard deviations of the level of role distress of the caregivers (n=130)

Level of role distress (RD)	Mean (SD)	Interpretation
Social impact	3.50 (0.37)	Moderate
I visit my family and friends less	4.01 (1.29)	High
I take part in other social activities less	3.33 (1.05)	Moderate
I take part in organized activities less	3.15 (1.01)	Moderate
Care recipient demands	3.25 (0.82)	Moderate
My care recipients try to manipulate me	3.35 (1.05)	Moderate
My care recipients make more requests than necessary	3.25 (1.14)	Moderate
I feel pressured between giving care to my care recipients and my family or significant others	3.15 (1.13)	Moderate
Personal cost	3.25 (0.24)	Moderate
I feel that my care recipient/s can only depend on me	3.52 (1.05)	Moderate
I feel that my health has suffered because of my care recipients	3.29 (1.12)	Moderate
I feel that my personal life has suffered because of my care recipients	2.93 (1.12)	Moderate
Emotional burden	2.50 (0.27)	Moderate
I feel overwhelmed by caring for my care recipients	2.96 (1.20)	Moderate
I feel frustrated with caring for my care recipients	2.45 (0.94)	Moderate
Caring for my care recipients has made me nervous	2.32 (0.87)	Low
I feel helpless in caring for my care recipients	2.27 (0.91)	Low
Relationship distress	2.24 (0.13)	Low
I feel resentful towards my care recipients	2.39 (0.83)	Moderate
My relationship with my care recipients depresses me	2.35 (0.92)	Moderate
My relationship with my care recipients no longer gives me pleasure	2.12 (0.85)	Low
My relationship with my care recipients is strained	2.11 (0.93)	Low
Total role distress	2.88 (0.55)	Moderate

3.68 to 5.00 for high; 2.34 to 3.67 for moderate; 1.00 to 2.33 for low.

Results showed that of the four QOL domains, their social health got a high rating with a mean (SD) score of 3.70 (0.64), and all three domains got a moderate rating. Only eight out of the 24 items in the QOL got a high rating.

Their social health condition generated a high mean (SD) score of 3.70 (0.64), with two out of three items, obtained high mean scores, and the other obtained a moderate mean score. The only question that obtained a moderate mean score was the satisfaction of support they got from their friends and colleagues, while their satisfaction with sex and personal relationships got high mean scores. Results implied that their longing for their friends outside of the institution. Their workload in the institution deprived them of having more time with friends. All the other three domains got a moderate rating. They rated physical health conditions moderate with a mean (SD) score of 3.25 (0.49). They reported a low mean score in the satisfaction of sleep, which means they suffer from sleep deprivation. Their psychological health obtained a moderate mean (SD) score of 3.45 (0.78). They reported high mean scores in items such as the extent of feeling life as meaningful, enjoying life, accepting their bodily appearance, and being satisfied with themselves. However, they revealed a low mean score on the item that they do not feel negative, which means that they have adverse feelings such as blue mood, despair, anxiety, and depression. Their living condition also got a moderate mean (SD) score of 3.22 (0.35). Only one out of the eight items obtained a high mean score that they felt safe in their daily life. The rest of the items generated a moderate rating. Overall, the caregivers of CNSP in child-rearing institutions in the NCR only had a moderate level of QOL.

Correlations of the Caregiver's QOL with RO and RD

Overall, findings revealed significant inverse correlations of their levels of RO and RD with their QOL. Table 5 shows that, there was a significant inverse moderate correlation between their level of RO and QOL ($r = -0.519, P < 0.01$). On the other hand, a significant inverse high/strong correlation was found between their level of distress and their level of QOL ($r = -0.782, P < 0.01$). These results imply that as their levels of RO and RD decrease, their level of QOL escalates. Furthermore, conversely, the level of their QOL decrease as their level of RO and RD increase. The strong inverse correlations between their level of RO and level of QOL are alarming as they reinforce that their level of QOL decreases, or they suffer more with the increase in RD level.

Looking at the specific domains of QOL, findings also showed significant inverse low correlations between the QOL domains and their level of RO, such as physical health ($r = -0.484, P < 0.01$), living condition ($r = -0.468, P < 0.01$), psychological health ($r = -0.379, P < 0.01$), and social health ($r = -0.261, P < 0.01$). On the correlations between the level of RD and QOL domains, significant inverse moderate correlations were likewise found: the living condition ($r = -0.689, P < 0.01$), physical health (r

Table 4. Health-related quality of life of the caregivers (n=130)

Health-related quality of life (QOL)	Mean (SD)	Interpretation
Social health	3.70 (0.64)	High
How satisfied are you with your relationships?	3.75 (0.84)	High
How satisfied are you with your sex life?	3.69 (0.83)	High
How satisfied are you with the support you get from your friends and colleagues?	3.65 (0.95)	Moderate
Psychological health	3.45 (0.78)	Moderate
To what extent do you feel your life to be meaningful?	4.06 (0.76)	High
How much do you enjoy life?	3.95 (0.83)	High
Are you able to accept your bodily appearance?	3.92 (0.88)	High
How satisfied are you with yourself?	3.75 (0.95)	High
How well are you able to concentrate?	3.23 (0.95)	Moderate
How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1.81 (0.92)	Low
Physical health	3.25 (0.49)	Moderate
How well are you able to get around?	3.81 (0.86)	High
How satisfied are you with your capacity for work?	3.59 (0.96)	Moderate
To what extent do you feel that physical pain prevents you from doing what you need to do?	3.48 (0.95)	Moderate
How satisfied are you with your ability to perform your daily living activities?	3.28 (0.98)	Moderate
How much do you need any medical treatment to function in your daily life?	3.22 (1.09)	Moderate
Do you have the energy for everyday life?	3.22 (1.00)	Moderate
How satisfied are you with your sleep?	2.16 (1.13)	Low
Living condition	3.22 (0.35)	Moderate
How safe do you feel in your daily life?	3.77 (0.76)	High
How healthy is your physical environment?	3.48 (0.94)	Moderate
How available to you is the information that you need in your day-to-day life?	3.39 (0.90)	Moderate
How satisfied are you with your access to health services?	3.24 (1.01)	Moderate
How satisfied are you with your transport?	3.22 (1.02)	Moderate
How satisfied are you with the conditions of your living place?	3.16 (1.01)	Moderate
To what extent do you have the opportunity for leisure activities?	3.02 (1.04)	Moderate
Do you have enough money to meet your needs?	2.47 (1.01)	Moderate
General quality of life (GQOL)		
How would you rate your quality of life?	3.33 (0.73)	Moderate
General health (GH)		
How satisfied are you with your health?	3.33 (0.77)	Moderate
Total quality of life (TQOL)	3.35 (0.52)	Moderate

3.68 to 5.00 for high; 2.34 to 3.67 for moderate; 1.00 to 2.33 for low; * Scores were reversed during the analysis.

= -0.685, $P < 0.01$), and psychological health domain ($r = -0.617$, $P < 0.01$). On the other hand, a significant inverse low to almost moderate correlation was found between QOL social health domain and their RD ($r = -0.499$, $P < 0.01$) (Table 5).

Discussion

Caregiving to orphaned and abandoned children is not an easy task. The caregivers need to have a good QOL to carry the load of work and challenges of giving quality care to the children under their care in the institutions. This study shows that the caregivers' QOL was found to have a significant moderate inverse correlation with their level of RO and a strong inverse correlation between their level of QOL and their level of RD. These results suggest that as their RO and RD levels increase, the level of their QOL decreases. Similarly, their QOL increases with decreased RO and RD. More attention needs to be given to their RD as a strong inverse correlation was found between the two variables. Managing their level of RO is essential, but what is more crucial to their QOL is their level of RD. Their high level of RO could increase their level of RD that could have a high negative effect on their level of QOL.

Previous studies regarding the relationship between levels of RO and QOL have proven that caregivers who endure a high level of RO, such as with longer hours of care, and exert more energy face a higher risk of a low level of QOL than the other caregivers who have a low level or no RO at all.²⁶ Also, several caregivers consistently reported the negative consequences of increased RO to their QOL, especially to their mental health domain.⁴⁴ Thus, an increase in the level of RO makes the level of QOL lower. Additional role obligations added to their role of caregiving can post an extra task to fulfilling role obligations, which eventually can make their level of QOL lower.²⁹ Similarly, a high level of RO contributes to depression and anxiety disorders found in many caregivers. Depressed caregivers who experience a high degree of RO are most likely to have a worse QOL.^{24,25} Another previous study found out that the demands of high-level RO in caregiving could be responsible for the higher burden among caregivers.⁴⁵ Too much RO could also harm well-being and leads to a low level of QOL when their health and personal lives suffer as a consequence, and when they cannot perform other essential activities aside from caregiving, such as having time for themselves and visiting their loved ones.⁴⁶ Therefore, the level of RO is an excellent indicator of the level of QOL based on previous studies and the findings of this study. The results suggested that a high level of RO leads to a low level of QOL among the caregiver. Statistically, this also follows that a low level of RO leads to a higher level of QOL. Previous studies found out that addressing the RO of caregivers can enhance their QOL. Introducing trainings on how to deal with RO situations can prevent a high level of RO among caregivers. Careful scheduling of all activities a caregiver needs to accomplish facilitated productivity, which simultaneously decreased

Table 5. Correlations of the quality of life of the caregivers with their levels of role overload and role distress (n=130)

	Physical health	Psychological health	Social health	Living conditions	Total quality of life
Level of role overload	-0.484**	-0.379**	-0.261**	-0.468**	-0.519**
Level of role distress	-0.685**	-0.617**	-0.499**	-0.689**	-0.782**

Correlation is significant at the 0.01 level (2-tailed).

Interpretation: 0.00 to 0.30 = very weak/negligible correlation; 0.30 to 0.50 = weak/low correlation, 0.50 to 0.70 = moderate correlation, 0.70–0.90 = high/strong correlation, 0.90 to 1.00 = very high/strong to perfect correlation.⁴³

their RO. Also, reducing the number of items on their to-do lists to essential priorities helped reduce their RO level.^{47,48}

Meanwhile, the study results showed that a high level of RD also harms caregivers' QOL, which is proven by previous studies. The different domains of QOL are affected if the level of their RD increases, confirming that their QOL and RD levels are strictly and inversely associated.²⁶ The caregivers who have a higher level of RD may experience a higher risk of a low QOL. Additionally, a high level of RD, covering the caregiver's burden and strain, harms the emotional, social, and physical functions of the caregivers.^{33,49-51} Also, previous studies reported that most caregivers have symptoms of depression, a negative facet of psychological health because of the high level of RD.³³ Caregivers who experience a high level of RD have low psychological and physical health such as high levels of anxiety, symptoms of depression, inadequate sleep, and ineffective self-care and activities of daily living.^{31,38} They also found out that many caregivers consistently report negative consequences to their level of QOL especially to their mental health domain as a direct result of the high level of RD.⁴⁴ In relation, the relationship between social health and mental health expressed statistically and inversely significant compared to the level of RD, which means if social and mental health domains are good, the level of RD decreases.¹⁹ This is also proven by one study that coping resources such as social support, a facet of social health, maybe an essential factor for improving the QOL of an individual.⁵⁰ Similar with the psychological health, if psychological interventions, such as psychological counseling, are set up, the level of RD will eventually decrease and may result to an enhanced level of QOL. Some studies have reported using interventions to lower the level of RD and subsequently enhance the level of QOL. Caregivers who undergone stress management and relaxation techniques reported spending less time feeling depressed, guilty, or angry, while instead experiencing more periods of calm and peacefulness.⁴⁴ Also, managers of institutions who sought ways to help their caregivers managed to improve the level of QOL of caregivers by addressing their problems such as high level of RD.⁴⁸ This, therefore, means that caregivers who learned to address and manage their low level of RD have improved QOL.

Therefore, an increase in the levels of RO and RD negatively influence the level of QOL of the caregivers and may impair the caregivers' effectiveness in rendering care to their care recipients.²⁶ Due to the vital and indispensable role played by the caregivers; studies proved that RO

specifically duties and obligations, energy, and time, and RD specifically social impact, demands of care recipients, personal cost, emotional burden, and relationship distress significantly affect the QOL of caregivers.^{44,52-56} Thus, managing their tasks to avoid high levels of RO and RD would improve their level of QOL. Therefore, the results of this study corresponded with the findings of the previous related literature.

Conclusion

The RO and RD of the caregivers significantly correlate with the QOL of the caregivers. The study concludes that as their levels of RO and RD increase, their QOL decreases. And conversely, as their levels of RO and RD decrease, their QOL escalates. Thus, their levels of RO and RD significantly influence their level of QOL. Managing their level of RO is important, but what is more crucial to their QOL is their level of RD. Their high level of RD has a high adverse effect on their level of QOL.

The findings of the study are essential to professionalizing the work of caregivers. The DSWD should revisit and review the role descriptions of caregivers attending CNSP to appraise their workload level. The management of the child-caring institution should find ways to lessen the RO and RD levels of caregivers to improve their health-related QOL. Hosting and institutionalizing trainings on how to manage their levels of RO and RD are important support mechanisms to the caregivers. Giving them the skills to manage stress (RO) and instituting a peer support system in the institution can avert a high level of RO among caregivers. These caregivers are the primary workers of a child-caring institution; improving their QOL will positively influence the quality of support they give to them under their care and protection.

For further research, the researchers recommend that a qualitative study be pursued to give depth and appreciate the stories of the caregivers attending to CNSP. Also, caregivers in other regions of the country may be studied to see parallelism of their conditions and their levels of RO, RD, and QOL.

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Research Highlights

What is the current knowledge?

The QOL of the CNSP caregivers influences their effectiveness in rendering care to their care recipients.

What is new here?

The QOL of the CNSP caregivers decreases with the high levels of RO and RD.

Ethical Issues

This descriptive correlational study was reviewed and approved by the Faculty of the Behavioral Sciences Department of De La Salle University (DLSU) and the Research Ethics Office of DLSU with accession number dlsu.b1387986.

Conflict of Interest

The authors declare no conflict of interest.

Authors' Contributions

ICNR: Conceptualization and formulation, writing of the review of literature, data collection, data analysis and processing, and manuscript writing and revision. MMA: Conceptualization and formulation, writing of the review of literature, data analysis and processing, and manuscript writing and revision.

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