








Strengthening Cultural Resilience of Caregivers: Implementing Coaching Programs based on the Angelic Model of Caregiver Competence for Individuals with Serious Mental Illness

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Abstract. Supporting and assisting individuals with serious mental illness (ISMI) is challenging. They may display aggressive behavior, engage in disorganized speech, or harshly criticize those around them. Caregivers need specific skills to connect with them through a specialized approach. This study aimed to explore the types of caregiver competencies and attitudes that can serve as a model for strengthening the cultural resilience of caregivers in maintaining relationships with ISMI. Purposive sampling was used to select participants, with 32 individuals in the ISMI group and 11 caregivers meeting the eligibility criteria. An inductive qualitative method was employed, using primary and secondary data collection through semi-structured interviews. The results showed that non-technical competencies—such as self-development (30%), spiritual maturity (40%), and skills and interactive experience with ISMI (20%)—were more influential than technical skills (10%) in enhancing caregivers' cultural resilience, driven by compassionate hearts. The study concludes that Angelic's Coaching Programs, based on the Angelic's Model of Caregivers Competence, are recommended, particularly for newcomers in psychiatric care. The study's implications include the development of the Angelic's Model of Caregiver Competence, addressing misconceptions, and providing a solution to knowledge gaps in psychiatric care for ISMI.

Keywords: Cultural resilience, competence, serious mental illness.

1 Introduction

The abnormal behavior exhibited by individuals with serious mental illness (ISMI) significantly impacts those around them. ISMI are characterized by severe mental illnesses that involve dynamic mental states, leading to unstable conditions. Their actions are often driven by unconscious behavior, and they frequently act against their own will. Instances of ISMI engaging in unconscious suicide have been documented (Mott, 2023). They struggle to distinguish between reality and delusion, with their behaviors and emotions frequently influenced by hallucinations or delusions. Most ISMI experience communication difficulties, and their interactions are shaped by symptoms such as aggression, erratic behavior (Smith, 2022) rudeness, violence, or harassment (Rueve & Welton, 2008)

Families caring for ISMI often find themselves in states of exhaustion, confusion, fear, significant emotional distress, and overwhelming frustration as their lives are turned upside down (Iseselo, 2016) They may feel unsafe and unable to relax, as their emotional turmoil persists. With families in such distress, professional psychiatric caregivers are essential. To address these challenges effectively, it is important to consider the following:

1.1 The Complexity of Psychiatric Care

The complexity faced by families lacking adequate knowledge of psychiatric care is substantial. Misconceptions and miscommunications between individuals with serious mental illness (ISMI) and their families are common (Vashist & Kaur, 2018). Misunderstandings, divergent perceptions, and communication difficulties often exacerbate the condition of ISMI, further deteriorating their mental health. Family members, already preoccupied with their own responsibilities, often lack the time or resources to educate themselves on psychiatric issues.

Simultaneously, the condition of ISMI worsens due to the absence of a supportive environment. In many cases, families are unaware that a member is suffering from mental illness, as they do not recognize the signs. For instance, one father harshly blamed, slapped, and scolded his son for what he perceived as dishonesty, not realizing his son's behavior was a manifestation of hallucinations or unconscious actions. Over time, these misunderstandings lead to increasingly strained relationships. It is only when ISMI exhibit harmful behavior or damage their surroundings that families begin to realize something is seriously wrong, identifying it as abnormal behavior. This realization often brings significant emotional distress and feelings of burden for the family (Cham, et al., 2022)

The resulting tensions at home create a complex situation that is difficult to manage, particularly for those without psychiatric knowledge. These challenges are compounded when they occur in low-income families. Many individuals with serious mental illness resist seeking psychological or psychiatric help, believing they are fine and not recognizing their symptoms. The situation escalates when families enter a state of panic, particularly when ISMI engage in disorganized speech, talk to themselves, exhibit public nudity, or show suicidal tendencies. Overall, these families experience intense emotions such as sadness, anger, and frustration as they struggle to cope with the

pervasive impact of these symptoms on their daily lives (N.N., 2024). Addressing this psychiatric complexity requires professional intervention from trained caregivers.

1.2 The Burning-Out of Human Ecology

The complexity of psychiatric care for individuals with serious mental illness (ISMI) is profound, and families often bear the burden of this challenge. Psychologically, they experience significant limitations, with their cultural resilience being undermined by the abnormal behaviors exhibited by ISMI. For these families, coping with the demands of psychiatric care becomes an overwhelming source of suffering. They often feel intense stress, anxiety, and fatigue, as the illness is typically chronic and requires constant attention. Over time, this can lead to burnout and emotional exhaustion, manifesting in heightened irritability, moodiness, and increased sensitivity (Chadda, 2014).

The situation is far from easy. From the perspective of human ecology, the complexity of psychiatric care not only affects the immediate family but also has a broader impact on others who must interact with ISMI. Given the wide-reaching effects of these challenges, a crucial question arises: would placing ISMI in a supportive care facility be a viable solution to alleviate these burdens?

1.3 The Competence of Caregivers

We considered the significant challenges involved in assisting ISMI and their families in addressing the complexities of psychiatric care. It became evident that professional caregivers were essential to navigating these issues. However, the question arises: how do caregivers perceive such complexity, and what competencies are required of them? We hypothesized that caregivers must possess the ability to manage ISMI, particularly in psychiatric emergencies, when the ISMI may pose a danger to those around them. Professional caregivers need to demonstrate both medical (Gnanapragasam, Paul, Sebastian, & Sathiyaseelan, 2021) and non-medical skills (Roughead, Westaway, Procter, & Sluggett, 2017) as well as technical (Sheikhbaaeddinzadeh, Ashktorab, & Ebadi, 2022) and non-technical competencies (Prineas, Mosier, Mirko, & Guicciardi, 2021). A professional caregiver should exhibit patience, friendliness, and compassionate care for ISMI (Gilbert, 2010), coupled with a solid foundation of psychiatric knowledge. When both technical and non-technical competencies are prioritized (Maj, 2014) better outcomes for ISMI can be achieved.

It is evident that ISMI's abnormal behavior impacts all those around them, including professional caregivers, and disrupts the broader human ecological system. Consequently, the research question then becomes: how resilient are caregivers in the face of such cultural challenges?

To answer the above question, caregiver's competencies must be constructed through a multidimensional, sociocultural lens. In doing so, it must take into account the cultural and historical context, including the medical history of ISMI and the psychological distress the patients experience (O'Connor et al., 2021).

1.4 Cultural Resilience of Caregivers

Caring for individuals with serious mental illness (ISMI) is a highly challenging task, especially for those living in nonrural areas, where meeting treatment needs is even more difficult due to various exacerbating factors. Research indicates that 52% of ISMI face situational barriers, 46% encounter financial barriers, and 45% experience a lack of treatment effectiveness. A common issue is that 72% fail to seek treatment, and 52% discontinue treatment, often due to a belief that they can solve the problem on their own (Kessler, et al., 2001). Family burnout is exceedingly high, making it difficult for families to continue caring for ISMI. In some cases, families may employ uncooperative treatment strategies or hold differing views from professional caregivers, largely due to their lack of psychiatric care knowledge. Additionally, families frequently experience significant emotional distress, anxiety, frustration, depression, or even PTSD (Post-Traumatic Stress Disorder).

Caregivers themselves also bear a substantial burden when caring for ISMI, often experiencing stress. As human beings, it is challenging to cope with such demands. Specific attitudes, such as patience, friendliness, and empathy, are necessary but difficult to maintain without strong cultural resilience. This highlights the fact that professional caregivers must also contend with the complexities of this burden (Buanasari, Rahman, & Gannika, 2023). Therefore, it is essential for caregivers to strengthen their own cultural resilience over time to effectively manage these challenges. With strong cultural resilience, caregivers will be better equipped to endure the long-term demands of caring for ISMI.

1.5 Gap Phenomenon

This study seeks to address two significant gaps in the current understanding of caregiving for ISMI. The first gap involves the discrepancy between the need for ISMI to be readmitted for treatment and the financial constraints preventing this, including transportation and other associated costs. Limited budgets, family ignorance regarding psychiatric care, and the stigma surrounding mental illness have often resulted in ISMI being confined to their homes. The second gap pertains to misconceptions about mental illness treatment, existing between ISMI and mental health services, among psychiatrists, and between psychiatrists and specialists from other disciplines.

Given these challenges, the key issue for caregivers lies in managing psychiatric emergencies and providing care amidst complex circumstances. Caregivers must rely on their own cultural resilience to navigate these difficulties, and perseverance in developing their competencies is crucial.

The aim of this study is to investigate the competencies that can enhance caregivers' abilities and strengthen their cultural resilience, enabling them to better manage interactions with ISMI. Using inductive methodology, this research seeks to develop a model of competence that can fortify caregivers' cultural resilience.

2 Methodology

2.1 Research Design

The study was conducted in accordance with the ethical guidelines established by the relevant national and institutional committees on human subjects. All participants provided written informed consent prior to their involvement. Two distinct groups of participants were included: the first group comprised ISMI, and the second group consisted of caregivers. Data triangulation was employed to confirm and cross-validate findings between the two groups. An inductive qualitative approach was utilized to explore the competencies that could enhance caregivers' cultural resilience, enabling them to better interact with ISMI. The research design is illustrated in Fig 1 below.

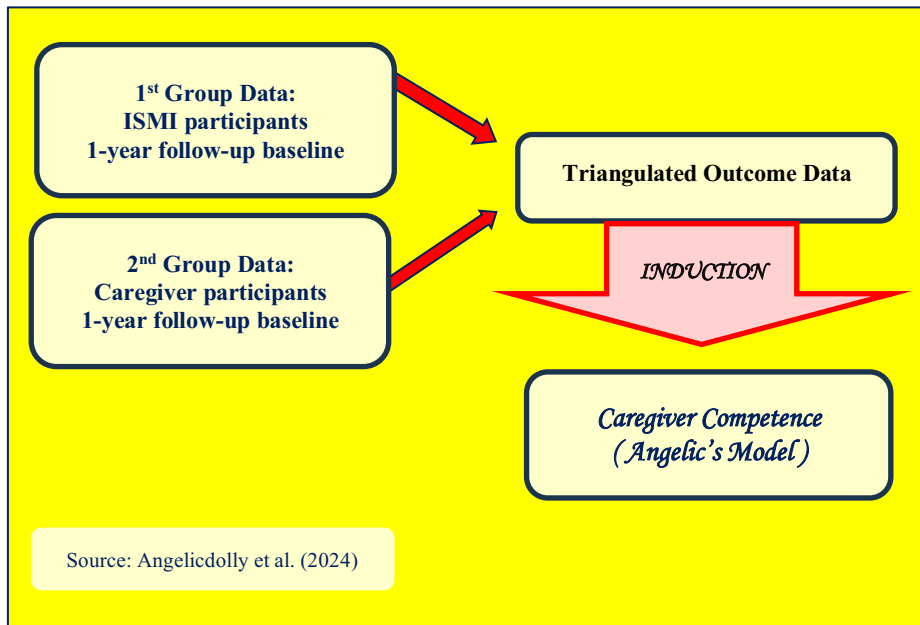


Fig. 1. Research Design

2.2 Data Collection

Purposive sampling was employed for data collection, with participants selected based on specific inclusion and exclusion criteria. The first group of participants had to meet the following eligibility criteria: a history of serious mental illness at baseline, either sex, age ≥ 17 years, under treatment by YGM for ≥ 12 months, returned to their family but still receiving care from YGM, fluent communication in Indonesian, honesty, and cooperativeness with the researcher. The second group of participants, consisting of caregivers, had to meet the following criteria: a good assessment on the MMPI-2 (Minnesota Multiphasic Personality Inventory-2), either sex, age ≥ 25 years, ≥ 2 years of

experience as a YGM caregiver, fluency in Indonesian, have honesty, and cooperativeness with the researcher.

The ISMI participants in the first group provided feedback on the competencies of the caregivers who had been responsible for their care. Data was collected through semi-structured interviews to explore their perspectives. The second group of caregiver participants was also interviewed to gain insight into the dynamics of their experiences in managing ISMI daily. Semi-structured interviews were conducted with this group as well. Additionally, a Focus Group Discussion (FGD) (O'Nyumba, Wilson, Derrick, & Mukherjee, 2018; Wong, 2008) was facilitated by the researcher among caregivers to explore their cultural resilience in dealing with the complexities of psychiatric care.

2.3 Data Analysis

A triangulation analysis was conducted to confirm the consistency between the outcome data from the first group (ISMI participants) and the second group (caregiver participants). Since this research followed an inductive approach, the triangulated data were analyzed through coding to develop a framework identifying the specific competencies required by caregivers and to assess the strength of their cultural resilience. This process aimed to establish a comprehensive model of caregiver competence, as well as to determine the factors that contribute to strengthening the cultural resilience of caregivers.

3 Finding and Discussion

The study was conducted at the Supporting House of *Yayasan Griya Malaikat* (YGM), a rehabilitation and aftercare facility for individuals with mental illness located in Purwokerto, Indonesia over the course of one year, from July 2022 to August 2023. Purposive sampling was employed to select participants with serious ISMI, resulting in 32 eligible ISMI participants who provided feedback on the competencies of 11 caregivers. The demographic characteristics of the first group (ISMI participants) are presented in Table 1, while those of the second group (caregiver participants) are shown in Table 2. The tables are as follows:

Table 1. Demographic characteristics of first group's participants

Characteristics of ISMI Participants	Baseline n = 32	One Year Follow-up n = 32
	N (%)	N (%)
<i>Average Age (years):</i>	32 (35.50)	32 (36.50)
Teenager (≤ 25)	5 (15.625)	5 (15.625)
Young age (26-45)	22 (68.75)	22 (68.75)
Middle age & elderly (> 45)	5 (15.625)	5 (15.625)
<i>Average age at first-onset (years, first getting ill as ISMI)</i>	32 (20.25)	-

<i>Gender:</i>		
Female	16 (50)	16 (50)
Male	16 (50)	16 (50)
<i>Education:</i>		
Undergraduate	23 (71.88)	23 (71.88)
Postgraduate	9 (28.12)	9 (28.12)
<i>Diagnostics of ISMI by psychiatrist</i>	32 (100)	32 (100)
<i>Family history of ISMI:</i>		
With family history of ISMI	8 (25)	8 (25)
No family history of ISMI	24 (75)	24 (75)

Source: Primary data, Angelicdolly, 2023

Table 2. Demographic characteristics of second group's participants

Characteristics of Caregiver Participants	Baseline n = 11	One Year Follow-up n = 11
	N (%)	N (%)
<i>Average age (years):</i>	11 (56.09)	11 (57.09)
Young age (26-45)	2 (18.18)	2 (18.18)
Middle age (46-60)	4 (36.36)	4 (36.36)
Elderly (≥ 60)	5 (45.46)	5 (45.46)
<i>Average age at first caregiving ISMI (years):</i>	11 (13.82)	-
Children (< 12)	1 (9.09)	-
Young age (26-45)	5 (45.46)	-
Middle age (46-60)	4 (36.36)	-
Elderly (> 60)	1 (9.09)	-
<i>Experience in caring of ISMI (years):</i>		
1. Stage of Come and See (< 3 months)	-	-
2. New comer caregiver (< 1)	1 (9.09)	1 (9.09)
3. Early experience (1-2)	1 (9.09)	1 (9.09)
4. Short experience (3-5)	1 (9.09)	1 (9.09)
5. Assisted experience (6-10)	2 (18.18)	2 (18.18)
6. Middle experience (11-15)	3 (27.28)	3 (27.28)
7. Advanced experience (16-20)	-	-
8. Long experience (21-30)	2 (18.18)	2 (18.18)

9. Outstanding of experience (> 30)	1 (9.09)	1 (9.09)
<i>Gender:</i>		
Female	5 (45.45)	5 (45.45)
Male	6 (54.55)	6 (54.55)
<i>Education:</i>		
Undergraduate	4 (36.36)	4 (36.36)
Postgraduate	7 (63.64)	7 (63.64)
<i>Family history of ISMI:</i>		
With family history of ISMI	1 (9.09)	1 (9.09)
No family history of ISMI	10 (90.91)	10 (90.91)

Source: Primary data, Angelicdolly, 2023

Based on Table 1, the demographic characteristics of the first group (ISMI participants) revealed an equal gender distribution, with 50% male and 50% female participants. The average age at baseline was 35.5 years, increasing to 36.5 years at the one-year follow-up. A significant proportion (68.75%) of participants were between the ages of 26 and 45, while the average age of first onset of serious mental illness occurred during adolescence (≤ 25 years), with a mean age of 20.25 years. The majority of ISMI participants (71.88%) had completed undergraduate education. All participants (32; 100%) had been diagnosed with ISMI by a psychiatrist, and most (75%) had no family history of ISMI, while a smaller proportion (25%) reported a family history of the condition.

Table 2 outlines the demographic characteristics of the second group (caregiver participants), showing a nearly balanced gender distribution, with 45.45% female and 54.55% male caregivers. The average age at baseline was 56.09 years, which increased to 57.09 years at the one-year follow-up. At baseline, most caregivers were either elderly (45.46%; ≥ 60 years) or middle-aged (36.36%; 46–60 years), a trend that persisted at the one-year follow-up. The average age at first caregiving experience was 13.82 years, falling within the adolescent age range (12–25 years). A significant proportion of caregivers (45.46%) began caregiving during young adulthood (26–45 years), while 36.36% started during middle age (46–60 years). Caregiving experience varied, with 27.28% of caregivers having 11–15 years of experience, classified as moderate experience, while others had more than 15 years or fewer than 11 years of caregiving experience. Most caregivers (63.64%) had attained postgraduate education. Additionally, 90.91% of caregivers reported no family history of ISMI, while 9.09% had a family history of the condition.

3.1 Caregiver Competence

The results of this study yielded data on caregiver competencies and the factors that strengthen their cultural resilience. The findings revealed that caregiver competence

can be categorized into two main areas: technical and non-technical competencies, which are described as follows:

3.1.1 Technical Competence

The technical competence (TC) of caregivers encompasses tangible skills and abilities. Empirical data from this study, which is evidence-based, identified key aspects of caregiver's competence, including foundational psychiatric knowledge, proficiency in psychiatric care, the ability to manage psychiatric emergencies, and the capacity to make informed decisions regarding symptom dynamics. The study found that technical competence accounted for 10% of the overall caregiver's competence. This competence can be developed through a six-month Angelic's Professional Growth and Care (PGC) program and a three-month YGM live-in program designed for novice caregivers. Additionally, caregivers can participate in advanced coaching sessions led by senior caregivers and psychiatrists. Figure 2 illustrates a caregiver engaging in a discussion on advanced psychiatric care dynamics with a psychiatrist as part of the Angelic's Advanced Growth Coaching (AGC) program.



Fig. 2. Angelic's Advance Growth Coaching led by psychiatrist

3.1.2 Non-Technical Competence

The term "non-technical competence" (NTC) is recommended over alternative terms such as "behavioral" or "human skills," which have been deemed inaccurate and potentially confusing (O'Connor & O'Dea, 2024).. NTC has been shown to significantly enhance caregiver performance, particularly when compared to those with insufficient NTC (Patey, 2015). The NTC aspects identified in this study represent intangible competencies and were found to constitute 90% of the overall competence framework: 30% for self-development, 40% for spiritual maturity, and 20% for skills and experience in interactions with ISMI (Individuals with Serious Mental Illness).

The evidence from this study demonstrates that self-development is a fundamental attitude for caregivers. This encompasses several key dimensions. First, caregivers should exhibit positive attitudes, including kindness, gentleness, patience, friendliness, thoughtfulness, a compassionate heart, and wisdom. Second, caregivers should display

a strong desire for continual learning, including acquiring psychiatric knowledge, humbly learning from senior caregivers, and gaining insights from both positive and challenging experiences. Third, effective communication skills are crucial, including knowing when to provide or request information and being empathetic listeners. Lastly, self-awareness is essential for caregivers to understand their own strengths, weaknesses, challenges, and struggles.

Spiritual maturity emerged as the most significant factor in fostering resilience and enabling caregivers to bear the challenges of caring for ISMI. It provides the emotional strength required to cope with the complexities of psychiatric care, accept the risks of altruistic caregiving, and persevere under stress. Cultural resilience, supported by spiritual maturity, contributes to caregiver well-being (Redublo, Paul, Joshi, Arbour, & Murray, 2024) and enables optimal performance. Spiritual adaptation in the face of psychiatric emergencies and discernment in navigating difficult situations were key factors in strengthening caregivers' cultural resilience.

This study also highlighted the importance of skills and experience in caring for ISMI. Caregivers' daily interactions with ISMI enabled them to develop an understanding of symptom manifestations and to acquire unique skills in psychiatric care. These experiences were highly personal and contributed to their ability to manage ISMI's abnormal behaviors. Caregivers learned how to cope with ISMI's aggression, navigate challenges with uncooperative family members, endure burnout, and maintain resilience in the face of rejection, humiliation, and misunderstandings from ISMI, their families, and others.

The findings of this study emphasize the value of caregiver competence in achieving professional growth, enhancing performance, and enriching their skills. This competence also fostered deep motivation in caregivers, transforming their work into a mission to restore the dignity of ISMI. Evidence-based results suggest that caregivers who engage in continuous learning, both professionally and personally, can attain higher levels of competence, as depicted in Fig. 3.



Fig. 3. A caregiver offering his compassionate heart

3.2 Competence Model for Caregivers

In conclusion, through inductive reasoning, a framework termed the Angelic's Model of Caregiver Competence was established, as illustrated in Fig. 4. The findings indicate that non-technical competence (NTC), comprising 90% of the overall competence, is significantly more influential than technical competence, which accounts for only 10%. The integrity of caregivers is primarily cultivated through NTC rather than technical skills, with personal integrity in caregiving stemming from the ability to adapt to the complexities associated with psychiatric care.

The competence weight attained by each caregiver serves as a robust foundation for enhancing their cultural resilience. This resilience is particularly essential for caregivers, especially in contexts where they face humiliation or underestimation, which poses a risk of burnout within the human ecological framework. The positive attributes and various aspects of NTC competence exert a beneficial effect, not only fortifying the cultural resilience of caregivers but also promoting the functional recovery ISMI.

This recovery is evidenced by improvements in Activities of Daily Living (ADL), whereby caregivers report that individuals with ISMI have begun to achieve a state of well-being. These individuals exhibit acceptance of their conditions, maintain positive interpersonal relationships, and demonstrate an optimistic outlook for the future. They have initiated personal recovery processes, managing their journeys toward health, while still requiring ongoing support from caregivers and family members.

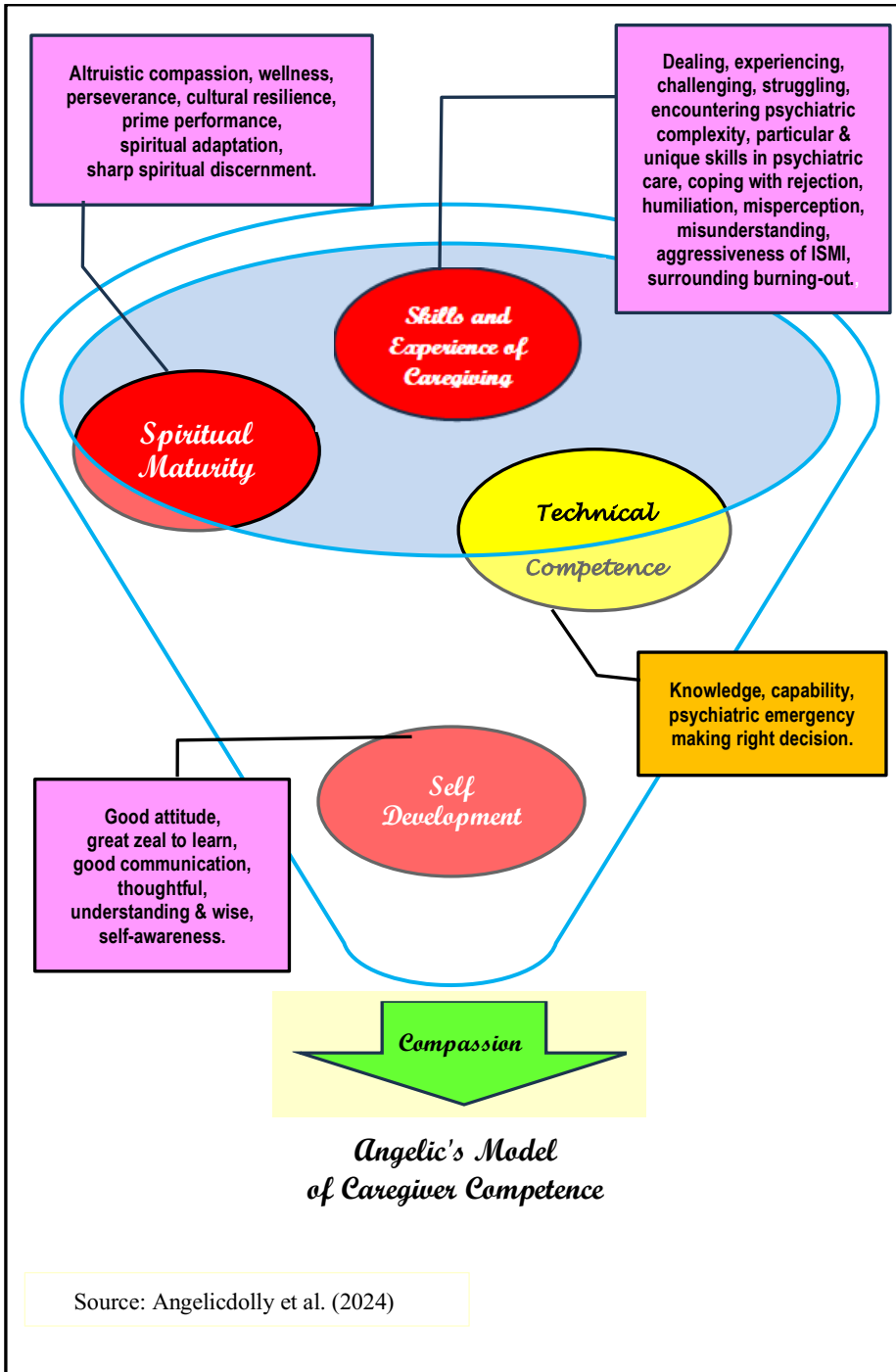
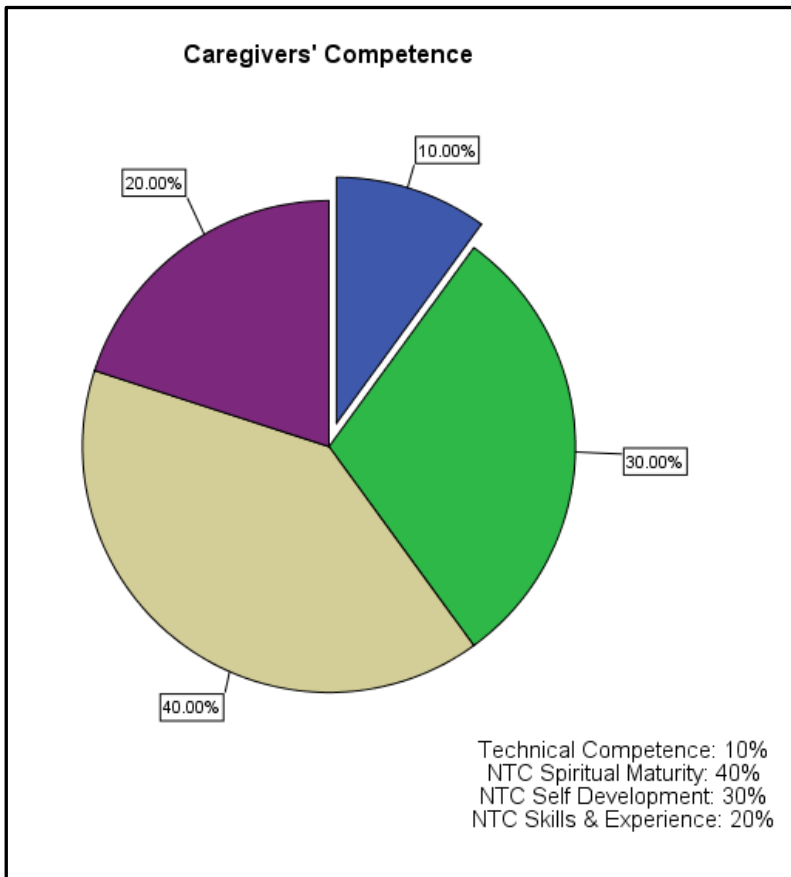


Fig. 4. Angelic's Model of Caregiver Competence

3.3 Angelic’s Personal Growth Coaching and Angelic’s Advance Growth Coaching

This study identified two caregiver programs implemented by YGM: Angelic’s Personal Growth Coaching (Angelic’s PGC) and Angelic’s Advance Growth Coaching (Angelic’s AGC). These programs are instrumental in cultivating valuable integrity within the caregiving profession, thereby enhancing the competencies of caregivers. Notably, this competence is predominantly influenced by non-technical competence (NTC), which comprises 90% of the overall competence weight, as illustrated in Fig. 5.



Source: Angelicdolly et al. (2024)

Fig. 5. Competence weight of caregivers

The Angelic’s Personal Growth Coaching (Angelic’s PGC) program is designed for caregivers at various stages of experience, including those in the initial phase of "come and see" (less than 3 months), newcomers (4-12 months), and caregivers with early (1-

2 years), short (3-5 years), assisted (6-10 years), and middle (11-15 years) experience, as illustrated in Fig. 6.



Fig. 6. A caregiver giving an ISMI an early Angelic's PGC

In contrast, the Angelic's Advance Growth Coaching (Angelic's AGC) program caters to caregivers with advanced experience (16-20 years), long-term experience (21-30 years), and those with exceptional experience (over 30 years). Both programs are instrumental in enhancing caregivers' sense of compassion, as depicted in Fig. 7.



Fig. 7. A compassionate caregiver fed ISMI her meal

The Angelic's Personal Growth Coaching (Angelic's PGC) and Angelic's Advance Growth Coaching (Angelic's AGC) programs resulted in caregivers demonstrating exemplary performance in providing compassionate care to individuals with serious mental illness (SMI). Despite the complexities associated with psychiatric care, these caregivers emerged as authentic and empathetic individuals who willingly shouldered the burdens of those they served. This indicates that both Angelic's PGC and Angelic's AGC have the potential to significantly enhance the cultural resilience of caregivers.

Furthermore, this study revealed that each caregiver is accompanied by a Spiritual Director, a religious leader who plays a crucial role in fostering the caregivers' cultural resilience through spiritual guidance and psycho-spiritual support. The Spiritual Director's influence is essential in enhancing caregivers' spiritual discernment and providing emotional and spiritual sustenance. Overall, both coaching programs, in conjunction with the Angelic's Model of Caregiver Competence, spiritual guidance, and psycho-spiritual support, contribute to strengthening and enhancing the cultural resilience of caregivers. As illustrated in Fig. 8, a Spiritual Director provides psycho-spiritual support to a caregiver in her efforts to care for SMI and their families.



Fig. 8. A Spiritual Director gave psycho-spiritual support to enhance the cultural resilience of caregivers

4 Conclusion

This study presents the Angelic's Model of Caregiver Competence (Angelic's MCC) as a novel framework designed to enhance the cultural resilience of caregivers. The findings indicate that non-technical competence (NTC), with a weight of 90%, significantly outweighs the technical competence (TC), which accounts for only 10%. Furthermore, spiritual guidance and psycho-spiritual support have been identified as essential contributors to bolstering the cultural resilience of caregivers. Consequently,

this study recommends the implementation of both Angelic's Personal Growth Coaching (Angelic's PGC) and Angelic's Advance Growth Coaching (Angelic's AGC) programs utilizing this novel model to further strengthen caregivers' cultural resilience.

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