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Influence of Social Support and Percived Resilience on Depressive Symptoms among Caregivers.

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ABSTRACT: *Health is not merely the lack of illness ; it encompasses a state of balance across psychological, physical, and medical dimensions. To this end, the study sought to investigate the role of social support and perceived resilience in depression. The survey research involved a convenient selection of 199 participants, consisting of 65 males and 134 females. The variables in the study were assessed utilizing three standardized instruments, specifically the Multidimensional Scale of Perceived Social Support (MSPSS), the Brief Resilience Scale (BRS) and the Depression Status Inventory (DSI). The study tested three hypotheses, revealing that participants with low social support exhibited significantly higher levels of depression compared to those with high social support, t (197) = 2.347, p<.05. The findings indicated that resilience did not serve as a significant predictor of depression, with F (1, 197) = .464 and p > .05. Ultimately, the findings indicated that the duration of admission is a significant predictor of depression in caregivers, F (1, 197) = 6.694, p<.05. The findings were examined in relation to existing literature and pertinent theoretical frameworks. It was suggested that strategies including early intervention, fostering a positive social and familial environment, enhancing self-esteem and support, as well as providing social and life skills/vocational education, should be implemented in hospitals to improve mental and emotional outcomes.*

KEYWORDS- *Social Support, Perceived Resilience, Depression, Caregivers*

I. INTRODUCTION

Illness affects not only the patient's life but also that of their family members. The management of disorders or diseases may necessitate either short-term or long-term therapy and care. Patients require both psychological and physical care, particularly during the last phase of disease, when they depend on others for tasks of daily living due to incapacitation or partial impairment. The incapacity to execute daily ordinary duties and the requirement for assistance necessitates the involvement of caretakers. A caregiver is defined as a spouse, adult child, family, partner, or friend who has a personal relationship with and offers a wide array of unpaid support to an adult with a serious disease (Osaro, 2012).

Caregivers have a key role in society, with considerable ramifications in economic, social, and human dimensions. This caregiver is susceptible to psychological disorders and may experience a breakdown due to stress or overload, exhibiting symptoms such as stress, impatience, diminished social contact, anxiety, sadness, and lowered self-esteem, among others. These elements may result in physical, psychological, emotional, social, and economical issues. Engaging with patients and their families is a process designed to furnish the informal caregiver with essential support and guidance, thereby encouraging both the patient and caregiver to actively participate in the therapeutic process, ultimately enhancing the quality of life for both the patient and family. Numerous research (e.g. Adams, 2008) indicate that cancer patients and their partners experience elevated psychological discomfort relative to the general population.

Caregiving responsibilities are typically classified into three categories: physical, emotional, and financial. These requests may impose a significant load on the caregiver. The notion of caregiver burden encompasses both objective and subjective aspects. Objective dimensions encompass the duration of caregiving, the nature of caregiving services rendered, and the financial resources allocated for the patient (Sung &Kyin, 2016). Subjective dimensions pertain to an individual's thoughts, assumptions, and emotions regarding the caregiver role. Caregivers must manage physical, emotional, social, and economical challenges, perhaps leading to the neglect of their own needs. Scott & Rende (2002) reported that caregiver burden is a risk factor for depression. Anxiety and depressive moods in caregivers may negatively influence their assessment of their current circumstances.

Positive social support is a crucial social predictor of health and wellbeing for caregivers, as it correlates with enhanced coping mechanisms regarding chronic stress, depression, and mental illness, all of which are substantial health concerns for caregivers (AIHW, 2012). The literature has largely overlooked social network theories in the caregiving context; however, a limited yet diverse body of research on social support among patient populations offers insights into the relationships formed and sustained by caregivers in hospital settings. Research indicates that numerous patients originate from socially isolated environments, frequently possessing restricted social support networks (Gayer-Anderson & Morgan, 2013). Upon entering the hospital, caregivers may encounter shock and stress due to the disruption of established social support networks, which complicates coping mechanisms (Biggam and Power, 1997; Hobbs and Dear, 2000).

Illnesses result in progressive and irreversible cognitive and functional deficits, renderingaffected individuals reliant on caretakers, typically family members (Putri &Riasmini, 2013). The adverse health implications of caregiving for an ill family member, especially regarding mental and physical well-being, are extensively established (Rosario, Greuther&Nuem, 2009). Individuals afflicted with illnesses may exhibit a variety of neuropsychiatric symptoms, including mood

disorders, delusions, hallucinations, vegetative signs, and psychomotor abnormalities. Neuropsychiatric symptoms are the primary contributors to caregiver burden (Hoopman et al, 2000). Jones & Peters (2009) noted that while caregivers of individuals with illnesses encounter several challenges, they may also have good emotional responses, potentially linked to resilience and, subsequently, to favourable feelings regarding caregiving.

1.1 Statement of the Problem

Family members caring for their loved ones often narrate the caregiving experience as ‘‘enduring stress and frustration’’ (Etters, Debbie, & Barbara, 2008). Emotional anxiety amongst family caregivers impacts their health and also affects the relationship between them and care recipients (Etters et al., 2008). Several studies reported that poor quality of life affects family caregivers of hospitalised patients (Schulz, Boerner, Shear, Zhang, & Gitlin, 2006). According to Schulz and colleagues (2006), caregiving stress is linked with poor outcomes for caregivers such as depression, illness, and decreased quality of life. Schulz and colleagues (2016) specified that stressed caregivers experienced a 63% greater risk for mortality when compared to non-caregivers.

Further, family caregivers suffer from increased depression when compared to non-caregivers (Given, Given, Stommel, & Azzouz, 1999). Similarly, caregivers for spouses with terminal diseases such as cancer experience greater risks of emotional stress, depression, and other health related problems or issues (Adams, 2008). Higher levels of depression and distress among caregivers are associated with care recipients’ functional and behavioural features such as need for assistance with personal care and status of cognitive or behavioural impairment (Oikonomou, Gkintoni, Halkiopoulos, &Karademas (2024).

The ability to bounce back from stressful and emotional demanding situations and the degree of help received by caregivers may help to buffer against experience of depression and lead to positive emotional and social outcomes. This study is poised to investigate the role of social support and resilience in mitigating the experience of depression among caregivers.

1.2 Objectives of the Study

The broad objective of this study is to assess social support and resilience as predictors of depressive symptoms among caregivers. Specifically, the study seeks to:

i. Find out the influence of social support on depressive symptoms among caregivers of patients in health facilities.
ii. Investigate the role of resilience as a buffer or amplifier of depression among caregivers of patients in health facilities.
iii. Find out whether length of admission will significantly influence level of resilience and experience of depression among caregivers of patients in health facilities.

1.3 Significance of the Study

Extensive researches have been carried out among different population on the factors promoting the experience of perpetual blue moments (Silletti & colleagues 2024). This study however proposes to investigate the experience of depressive symptoms in an under- researched population i.e caregivers. The study also has as its merits the simultaneous investigation of social support and resilience as they influence depression among caregivers. Findings from this study will help in broadening people's understanding of the role of social support and resilience in experience of depressive symptoms. This study will also be useful to clinicians and counsellors who help clients recover from adverse emotional issues and cope with hassles of daily living. Finding from this study will also add to existing body of literature on the study of depression and also open doors for further researches on the study of caregiving and the attendant emotional implications associated with being on the ward without falling sick in Nigeria.

II. METHODS

2.1 Research Design

The research for this study is survey research. It is survey research because a fraction of the population was selected and copies of questionnaires were used to gather their opinion on the variables of interest. Also, the independent group design makes it possible to compare the groups on the variables of interest.

2.2 Participants

The population of this study consisted of people who help patients who are admitted in the hospital with activities of daily living (caregivers). These caregivers were selected from Ekiti State University Teaching Hospital, Ado-Ekiti and Federal Teaching Hospital, Ido-Ekiti. The researcher conveniently selected 199 caregivers from among caregivers on the ward of the health facilities mentioned above. The sample comprised of 65 males and 134 female caregivers

2.3 Measures

Questionnaire comprising of four sections was used for this study. Section A consisted of personal bio data e.g. Sex, Age, Religion etc. Section B consisted of the Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet, Dahlem, Zimet and Farley (1988, 1990). The MSPSS is a self-report containing 12 items rated on a seven point Likert-format scale. The scale is meant to measure an individual's perception of how much support he or she receives from people. The authors reported a cronbach alpha coefficient of .82 among 222 urban and local African American adolescent samples. The scale has been subjected to rigorous validity analysis over time, for example, Mogaji (1997) correlated the MSPSS with family caring scale to ascertain the divergent validity coefficient of .75 using an exclusive student population. All items on the scale are direct scored.

Section C of the questionnaire comprised the Brief Resilience Scale (BRS) established by Smith, Dalen, Wiggins, Tooley, Christopher & Bernard (2008). The scale has six items designed to assess resilience as the capacity to recover following a stressful event. The response scale is as follows: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = highly agree. The authors validated the scale on four distinct samples, with each sample demonstrating a one-factor solution that accounted for 55–67% of the variance (Samples 1–4 = 61%, 61%, 57%, 67%, respectively). Assessments of the scale's dependability have produced favorable outcomes, with loadings between .68 and .91. The internal consistency was satisfactory, with Cronbach’s alpha values between .80 and .91 (Samples 1–4 = .84, .87, .80, .91, respectively). The BRS was administered twice across two samples, yielding a test-retest reliability of .69 over one month for 48 participants in Sample 2, and .62 over three months for 61 participants in Sample 3.

Convergent Validity: The BRS exhibited a positive correlation with resilience metrics, optimism, and life purpose, while demonstrating a negative correlation with pessimism and alexithymia. In addition, it was positively connected with social support and adversely correlated with unpleasant interactions. Ultimately, it exhibited a constant positive correlation with active coping and positive reframing, while demonstrating a negative correlation with behavioral disengagement, denial, and self-blame.
With relation to health-related outcomes, the BRS was consistently adversely connected with perceived stress, anxiety, depression, negative affect, and physical symptoms. Furthermore, it had a positive correlation with positive affect in three out of four samples and with weekly exercise frequency in the cardiac rehabilitation cohort. It had a negative correlation with fatigue in the cardiac sample and a negative correlation with both fatigue and pain in the cohort of middle-aged women.

Section C of the questionnaire comprised the Brief Resilience Scale (BRS) developed by Smith, Dalen, Wiggins, Tooley, Christopher & Bernard (2008). The scale is a 6-item scale developed to measure resilience simply as the ability to bounce back after a stressful situation. The response format 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree.” The scale was validated on four different samples by the authors and results for each sample revealed a one-factor solution accounting for 55– 67% of the variance (Samples 1–4 = 61%, 61%, 57%, 67%, respectively). Tests regarding the reliability of the scale have also yielded positive results with loadings ranging from .68 to .91. Internal consistency was good, with Cronbach’s alpha ranging from .80–.91(Samples 1–4 = .84, .87, .80, .91, respectively).

Section D comprised the Depression Status Inventory (DSI) developed by Zung (1974). The DSI is a self-report instrument based on the symptoms described by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which makes measuring depressive severity possible. The inventory consists of 20 items, in which four response options are presented on a scale of 1(None) to 4(Severe). Each item on the scale measures the presence of one symptom of depression. For example, item one measures Depressive mood with this statement (Do you feel sad or depressed?), item 14 measures “Emptiness” etc. The DSI has been subjected to various reliability tests by researchers and clinicians over the years. , Jegede (1976) reported an excellent Cronbach alpha reliability coefficient of .72 . Its content validity is ensured because most of its items are equivalent to the DSM-IV criteria for depression. Zung (1976) reported a split half reliability of 0.81 on a sample of 225 patients. Its concurrent validity has also been tested successfully by comparing scores with other measures for depression. For example, the original version, Zung (1965) was compared with the MMPI and a correlation of .70 was obtained.

2.4 Procedure for data collection

Permission was sought from hospital authorities before data is collected. The researcher personally administered the questionnaire with the help of a research assistant (a staff in the hospital) in each hospital and also retrieved the questionnaires from the respondents in order to ensure compliance with instructions. In all, two hundred and twenty (220) copies of questionnaire were administered, however only two hundred and six (206) were retrieved and one hundred and ninety-nine (199) used for analysis.

III. DATA ANALYSIS

Three hypotheses were tested in the study and independent t-test was used to test hypothesis one while hypothesis two and three were tested using regression analysis. Significance level was set at the 0.05.

IV. RESULTS

Table 1: t-test Summary Table showing influence of social support on depression

	Social support	N	Mean	SD	Df	t	P
Depression							
	High	99	41.82	11.53	197	2.347	<.05
	Low	100	46.66	17.02			

From table 1, the result shows that caregivers who reported high social support were significantly different from caregivers who reported low social support in depression t(197)= 2.347,p<.05. Therefore, hypothesis one is supported.

Table 2

Simple Linear Regression summary table showing the predictive influence of resilience on depression

Model	R	R^2df	F	p	
			1		
Resilience	.048	.002	197	.464	>.05

DV: Depression

The table shows that resilience did not significantly predict depression F(1, 197)= .464,p>.05 with an R^2 of .002. Hypothesis two is not supported.

Table 3

Simple Linear Regression summary table showing the predictive influence of duration of admission on depression

Model	R	R^2	df	F	p
			1		
Duration of admission	.181	.033	197	6.694	<.05

The table shows that duration of admission significantly predict depression among caregivers F(1, 197)= 6.694,p<.05 with an R^2 of .033. This means that an increase in length of admission predicts an increase in experience of depressive symptoms.

V. DISCUSSION CONCLSION AND RECOMMENDATIONS

5.1 Discussion

Hypothesis one suggests that social support plays a crucial role in affecting depression levels among caregivers. An in-depth analysis of impact direction indicates that caregivers with limited social support exhibited more significant depressive symptoms compared to those who received substantial support from family, friends, and significant others. Pössel, Burton, Cauley, Sawyer, Spence, and Sheffield (2018) found that different sources of perceived social support from family and friends, as opposed to a significant other, were negatively associated with symptoms of depression. Family and peer support seemed to affect depression through different pathways, with self-esteem acting as a mediator in the association between family support and depressive symptoms, although this was not applicable to peer support. This discovery may indicate the differential impacts of perceived social support on personal characteristics and may be developmentally contingent. The perception of social support from peers might not influence a young adult's self-esteem, as this type of assistance is frequently regarded as stable, significant, and anticipated during this phase of development (Walen and Lachman, 2000). The dynamics of relationships with parents and family during college can significantly influence the continuity or re-establishment of familial support, which is not a given for all young adults. The depression-buffering theory has been validated; nonetheless, the indirect effect of social support on depression via self-esteem is influenced by the levels of perceived stress. This aligns with the finding that perceived social support does not reduce depression in individuals (Panayiotou and Karekla, 2013). People experiencing increased stress require significant perceived social support to achieve the protective benefits of that support against depressive symptoms, as shown by the indirect effect regression slopes. People experiencing elevated stress levels may struggle to maintain close social relationships, occasionally isolating themselves from others as their stress impacts their social networks (Coyne and Downey, 1991). The lack of social connections during times of heightened stress hinders individuals from finding meaning, which may help them address symptoms of depression (Ioannou, Kassianos, &Symeou, 2019). In this context, differentiating between perceived and actual social support, individuals experiencing high levels of perceived stress may underestimate the social support available to them and/or may find it challenging to effectively leverage that support to enhance their self-esteem and psychological well-being. The enhancement of self-esteem might be influenced by specific contexts and may not straightforwardly lead to a reduction in depressive symptoms. This could be attributed to cognitive limitations or distortions associated with increased stress, such as selective attention, intolerance of uncertainty, worry, rumination, catastrophizing, and a tendency to attribute support and improved self-esteem to external rather than internal factors.

Hypothesis two suggests that resilience did not significantly predict depressive symptoms in caregivers. To the best of their knowledge, no local study has examined the effect of resilience on depression in caregivers. Some studies have shown that resilience plays a partial mediating role in the relationship between stress and psychological health (Laubach, 2009). In addition to its mediating role, resilience might exert both direct and moderating effects on the connection between stress and the experiences of depression and anxiety. This study utilized a statistical model to examine the impact of resilience and implemented a hierarchical linear regression model to evaluate its moderating effect. The mediation study shown that resilience had more than three times the impact on depression than on anxiety, suggesting that resilience is more critical than anxiety in explaining depression. Ridley, Rao, Schilbach, and Patel (2020) noted in their study that the linear regression model indicated a diminished effect of stress on the depression levels of grassroots civil servants with high resilience scores, whereas individuals with low resilience scores exhibited a significantly stronger relationship between stress and depression. The scores of participants in the high resilience group demonstrated a decreased correlation between stress and anxiety relative to those in the low resilience group. The analysis of moderating and mediating factors reveals that resilience has a direct impact on the relationships between stress, depression, and anxiety, while also showing an indirect influence on these connections. The ability to bounce back can effectively mitigate the negative impacts of stress on mental well-being, acting as a safeguard in challenging situations. The interplay among stress, depression, and anxiety underscores the notions of resilience as both compensatory and protective mechanisms. This is consistent with previous research on resilience models, suggesting that elevated resilience scores are associated with an increased ability to endure stress and improved psychological well-being (West, 2019). Divergences in results may be ascribed to variations in individuals, countries, and other factors. Resilience can serve as a natural safeguard, as individuals with higher resilience tend to be more adept at positively evaluating stressful circumstances, even when confronted with the same stressors. They systematically modify the interplay between the environment and humans, enhance and amplify potential, optimize resource utilization, tackle challenges, and achieve an advantageous state of adaptation and growth. Thus, resilience is an element that ought to be incorporated into intervention programs designed to improve psychological well-being, especially for informal caregivers.

5.2 Conclusion

Depression is a psychological disorder that frequently receives insufficient care in Africa. Depression ranks among the most common mental disorders encountered by mental health professionals (Antai-Otong, 2006). Depression is an emotional condition defined by melancholy, feelings of powerlessness, worthlessness, and guilt, social isolation, and disturbances in appetite, sexual desire, and sleep patterns. Depression operates on a spectrum, with severe forms being notably prevalent (Australian Institute of Health and Welfare [AIHW], 2004). In the last five decades, the incidence of depression has increased, positioning mood disorders as significant contributors to disability (AIHW, 2004).

The prevalence of depression has risen over the last five decades, with mood disorders identified as leading contributors to disability (AIHW, 2004). However, based on the findings of this study, it can be concluded that social support did significantly influence depression. The degree of access caregivers have to family members, loved ones, and significant others influences the likelihood of experiencing depressive symptoms. This finding may result from the significant role of familial relations in human psychological well-being. It can be concluded that level of resilience did not predict depression among caregivers. Moreover, it is concluded that the duration of admission significantly affects depression. Anecdotal evidence indicates that individuals who undergo prolonged involuntary separation from family often express regret regarding their limited contact with loved ones, which may contribute to depressive symptoms

5.3 Recomendations

Based on the finding of this study, it recommended that:

1. Since this study discovered that there is significant influence of social support on depression, hospital authorities should endeavour to extend visiting hours in order to give patients and caregivers more access to their loved ones with a view to reducing experience of depression among them.

2. Strategies such as early intervention, positive social and familial climate, self-esteem and support building, social and life skills/ vocational education should be made available in hospitals to enhance positive mental and emotional outcomes among caregivers.
3. Psychiatric–mental health nurses are well positioned to facilitate resilience strategies for caregivers as supporting people who are depressed toward enhancement of resilience qualities can be achieved through core practices of the psychiatric–mental health nurse, such as counselling and psychosocial education.

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