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Social Support, Religious Commitment, Hardiness and Psychological Well-Being of Psychiatric Patients' Caregivers: A Nigerian Study

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1. Abstract

Research evidence indicates that religious commitment and social support has impact on mental health across diverse population, Impact of social support and religious commitment of Psychiatric patients' caregivers has been give little research attention in Nigeria. The present study examined the association of social support, hardiness and religious commitment on psychological well-being of psychiatric patients' caregivers. Participants were 420 patients' caregivers drawn from a neuro-psychiatric hospital in eastern Nigeria. Data was collected by means of self-report measures translated into the local dialect of the caregivers. Multiple regression results showed that social support and religious commitment positively predicted psychological well-being in total sample.

2. Introduction

Caregivers experiences distress in offering needed care to patients [1, 2] and are at risk to physical and mental exhaustion (Wissing & Temane, 2008). These individuals are exposed to various forms and intensities of stress that are associated with various ailments [3, 4]. Nigerian studies on psychiatric patients' caregivers is scare in comparism with other patients caregivres (eg cancer, diabetics, sickle cell, caesarian, HIV/AIDS, elderly, Orthopedic). Caregivers of individuals in mental health care are faced with continuous physical and mental strain [5-7]. Thus caring for Psychiatric patient may be super stressful and demanding, These stressors can impact on social support [8], religious commitment [9, 10], mental well-being [11]. and presence of a social support and or religious commitment may increase or decrease impact of stressors on caregivers [11].

Social support is the comfort given to one by one's family, friends, coworkers and others. This comfort can be in the form of resources provided by others to assist one (Bodla, Saima & Ammara, 2012). It has contributed to adverse mental health in other contexts such as depression in physically challenged (Oyeleke & Pius, 2013) and among vulnerable adolescents[12] (Cheng, Li, Lou, et al, 2014), geriatric mental health [13, 14]and maternal health [15,16] .However, little is known on mental well-being implications of social support in psychiatric patients' caregivers using Nigerian samples. In addition, knowledge of possible associations of religious commitment and caregivers' psychological health is very limited within Nigerian context. Religious commitment is the adherence to the practices and beliefs of an organized church or religious institution. It simply refers to religious faith in a power beyond oneself whereby the individual seeks to satisfy the demands of life through acts of worship and service. It indicates the degree to which a person may be identified as religious (Shafranske & Maloney, 1990). Religious commitment has been indicated to have an effect on mental health across varied population such as among widows [17,18] coping with trauma [19] among orthopaedic patients' caregivers [20] among pediatric caregivers [21, 22] and among cancer patients' caregivers [23-25]. Studies has indicated that individuals that are religiously committed experiences more

psychological health [11].

Hardiness is a predisposition that allows an individual to accept the challenges and changes in life with good humor and resilience, which in turn influences behavior that prevents illness. Hardiness is also the pattern of attitudes and strategies that helps in turning life's ongoing stresses from potential disasters into growth opportunities. The hardy attitudes involve commitment (importance of staying involved), control (importance of trying to have an influence), and challenge (recognition that life is normally stressful). These attitudes give the courage to do the hard work of turning stresses to advantage by the hardy strategies of problem-solving (rather than avoidance) coping, socially-supportive (rather than conflict) interactions, and beneficial (rather than over-indulgent) self-care (Sabri & Abdkhodai, 2010). Hardiness is the ability to perceive external conditions and desirable decision – making quality about self (Bartone, 2006). Hardiness has been indicated to have an effect on mental health across varied population such as among students [26] retirees [27]; depressed patients (Schellenberg , 2005). studies has indicated that individuals that are high in hardiness experiences more psychological health [28], also, some studies indicated that are low in hardiness experiences lesser psychological health [27].

Table 1: The result of the correlations matrix of the predictor variables religious commitment, social support and hardiness and the control variables Gender and Age on the criterion Variable Psychological well-being

Variables	Mean	SD	1	2	3	4	5	6
Psychological Wellbeing	59.41	16.7	1					
Religious Commitment	36.18	8.86	.103*	1				
Social Support	26.25	3.97	.100*	0.026	1			
Hardiness	40.69	3.11	-0.005	0.055	0.004	1		
Age	26.45	9.08	.113*	0.021	0.013	-0.05	1	
Gender	1.63	0.48	-0.069	-0.024	0.07	-.006	.009	1

*. Correlation is significant at the 0.05 level (2-tailed).

Table 2: Multiple regression table showing the model summary, Beta (β) coefficient and significant levels of religious commitment, social support and hardiness on Psychological well-being.

Model	B	Std. Error	Beta (β)	t	Model summary		
					R	R^2	AR^2
Religious Commitment	0.2	0.09	0.1	2.18*			
Social Support	0.43	0.2	0.1	2.11*			
Hardiness	-0.05	0.26	-0.01	-0.22	.14	.21	.14

a. Dependent Variable: Psychological Wellbeing. **Note * p < .05**.

As a rationale for this study, more differential information on effects of social support and religious commitment on mental health are needed and it will lead to tailored and specific strategies to enhance social support and religious commitment which in turn, could potentially effectively reduce psychological distress and contribute to better quality of life for both caregivers and psychiatric patients. Also, the study seeks to replicate among psychiatric patients' caregivers, extant findings on impacts of social support and religious commitment on health as established in other populations. It will add to the caregiving literature and the findings may be relevant to practitioners in mental healthcare. The specific objectives of this study are to examine whether: 1) Social support predicts psychiatric caregivers' psychological well-being; 2) Hardiness predicts psychiatric caregivers' psychological well-being and .3) Religious commitment predicts psychiatric caregivers' psychological well-being.

3. Participants and Procedure

Participants were 420 patients' caregivers (35% males and 65% females; Age range = 19-38 years, mage = 26. 45 years) drawn from a neuro-psychiatric hospital in eastern Nigeria, using a purposive sampling technique. Data was collected by means of questionnaires in the local dialect of the caregivers. Translation and back translation of the questionnaire from English to the local Igbo language was carried out by two expert translators. Semantic problems shown by the translation into Igbo were resolved through discussions between the experts, the researchers and 5 caregivers who were native Igbo speakers with good knowledge of English. Following ethical approval by the Institutional Review Board of the Hospital, caregivers were approached by trained research assistants (attending nurses) in the Hospital wards, and asked to participate in this study. The purpose and procedures of the study, the kinds of questions that would be asked, confidentiality of data, and participants' rights were explained to them. Caregivers who gave informed consent were recruited for the study. Non-literate participants were assisted by the research assistants. It took approximately 10 min to answer the questionnaire. Nine participants whose data were missing for >25% of items within any of the scales were not included in the analysis, giving rise to a final sample of 420 caregivers.

3.1. Measures

Data was collected using four self-report measures, namely, Religious Commitment Inventory (RCI), Multidimensional Scale of Perceived Social support (MSPSS), Hardiness scale and Brief Inventory of Thriving (BIT). Participants provided data on their age and gender by indicating them on the questionnaire. To assess Religious commitment, we used the Religious Commitment Inventory (RCI) (Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry, Bursley and O'Connor, 2001). RCI has been shown to be reliable, in terms of internal consistency (α = .92) and test-retest reliability over five months period (.87), and has good convergent validity with other measures of religiosity. In the current study, we obtained α of .70. To measure social support, we used the Multidimensional Scale of Perceived Social support (Zimet, Dahlem, Zimet & Farley,1998). MSPSS has been shown to be reliable, in terms of internal consistency (α = .70 -.78) and test-retest reliability three months period (.76), and has good convergent validity with other measures of social support. In the current study, we obtained α of .70. To measure for hardiness, we use Hardiness scale [29]. Hardiness scale has shown to be reliable in terms of internal consistency(α=.83), andtest-retest reliability over two weeks interval (α=.70). To measure psychological well-being, we used the Brief Inventory of Thriving (Sue, Tay and Diener, 2014). BIT has been shown to be reliable in terms of internal consistency (α=.90) and test-retest reliability over two weeks interval (α=.63), and has good convergent validity with the Satisfaction with Life Scale (SwLF), having a strong positive correlation with the SwLF (r=.29, P < .001). In the current study, we obtained α of .60

4. Data Analysis

We used multiple regression to analyse the data.

5. Results

The correlation result in Table1 above shows that psychological well-being was significantly and positively related to religious commitment (r =.10, p > .05). Result indicated that psychological well-being was positively related to social support (r =.10, p > .05). Result also indicated that hardiness has no relationship with psychological well-being. Result further indicated psychological well-being to be negatively associated with age (r =.11, p >.05).

Table 2 above indicates that religious commitment positively and significantly predicted psychological well-being of psychiatric inpatient caregivers (β=.10, t=2.18, p<.05). Result also shows that social support positively and significantly predicted psychological well-being of psychiatric inpatient caregivers (β=.10, t= 2.11, p< .05). The result further shows that hardiness has no relationship with psychological well-being. It implies that social support plays a significant role on psychological well-being of psychiatric inpatient caregivers. The result of the model summary as shown by R (.14), R2 (.21) and AR2 (.14) showed the strength of the relationship between the three independent variables; religious commitment, social support and hardiness on psychological well-being of psychiatric inpatient caregivers. The results indicate that 14% of the variation in psychological well-being of psychiatric inpatient caregivers was due to the contributory influence of religious commitment, social support and hardiness.

6. Discussion

Findings of this study indicated that social support was a positive predictor of psychological well-being for the total sample and it indicates that as caregivers are provided with more social support, they may experience more psychological well-being. This finding supports previous studies which reported that social support positively predicts mental well-being (Oyeleke & Pius, 2013; Taylor, 2011; Chambers, 2010). Caregivers may have received empathy, concern, love, encouragement, financial aid and guidance from significant persons that may have bust their interpersonal relationship and this in turn increase their psychological well-being. Also, Hardiness was not a significant predictor of psychological well-being. This finding is consistent with findings that did not significantly predict hardiness mental wellbeing (Jindal, 2013). The finding is consistent with studies that significantly predict hardiness to mental well-being (Shakarami, Davarniya, & Zahrakar, 2014). The likely explanation to this could be explained by Lazarus & Folksman (1984) transactional model of personality. This model has its premises that events in an individual's life do not cause ill-health but how the situation is appraised. With this theory it could be posits that Hardy individuals tend to view change as a natural event in life. They see change as an opportunity or challenge, rather than a threat or a negative event. Hardy individuals not only expect change in their lives, they welcome it. They view change as having the potential for positive outcomes, even if the change was initially unwanted or resulted in loss or sadness. In addition, hardy individuals tend to be committed in work and activities that interest and motivate them. They let their decisions flow from their priorities and tend to organize their time and energy around these commitments. Because of these tendencies, hardy individuals are often more content with their obligations than other people might be. They give maximal attention and effort to their commitments and generally regard them in a positive light. Again, individuals who exhibit hardiness believed that they have the ability to direct the course of their lives. They do feel that the decisions they make can help determine their success and satisfaction in given situations. Hardy individuals have a strong sense of initiative and a high sense of personal influence. They feel that they have a choice in how they react to life's challenges and opportunities. They believe in their ability to accomplish their goals and steer events.

The findings also indicated that religious commitment was a positive predictor of psychological well-being for the total sample and it indicates that as caregivers experience religious commitment, more psychological well-being they will have. This findings sup-

ports previous studies which reported that religious commitment positively predicts mental well-being (García-Alandete & Bernabé-Valero, 2013; Koenig & Titus, 2004). Religious commitment may have exposed caregivers on better ways of controlling their fears, stress, anxiety and other negative emotions and this in turn may have increased their psychological well-being. Effective programmes to improve psychological well-being of psychiatric patients' caregers in Nigeria could benefit from tailored and specific strategies to improve their social support and religious commitment. This study has some limitations including cross-sectional design and limited male subsample, which demands caution in interpretation. Apart from age and gender, other patient and caregiver characteristics (e.g. illness duration, length of stay in the hospital) may influence mental health outcomes. Such variables were not included as control variables due to the unavailability of such data and it is one of this study's weaknesses. In conclusion, despite these limitations, findings point to the study as a modest effort to highlight the relevance of recognizing social support religious commitment and age differential when designing and implementing caregiver mental health interventions.

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