African Journal of Social and Behavioural Sciences (AJSBS)
Volume 14, Number 3 (2024) ISSN: 2141-209X

IMPACT OF DEPRESSION ON PSYCHOLOGICAL WELL-BEING OF PATIENTS CAREGIVERS IN FEDERAL NEURO-PSYCHIATRIC HOSPITAL IN BARNAWA, KADUNA STATE

Magdaline Gajere Adamu[1], David Markus Shekwolo[2*], Denis Atafo[3] & Jerry James Doka[4]

[1,2,3]Department of Psychology, Nigerian Defence Academy, Kaduna, Nigeria

[4]Department of Psychology, Nasarawa State University, Keffi, Nigeria

*davoe80@yahoo.com, dmshekwolo@nda.edu.ng

ABSTRACT: The caregiving role is often associated with various challenges, and understanding the psychological consequences is crucial for developing effective support systems. Therefore, this study investigated the influence of depression and stress on the psychological wellbeing of caregivers providing support to patients at the Federal Neuro-Psychiatric Hospital in Barnawa, Kaduna. A total of one hundred and twenty mental health patient care givers in FNPH Barnawa, caregivers (males = 54 and females = 57) aged between 18 and 58 years, with a mean age of 36.16 years and an average age of 9.457 years, were selected. Two instruments were used in this study: the Self-Rating Depression Scale (SDS) developed by Zung (1965) and the Brief Psychological Wellbeing Scale developed by Ryff (1995). The descriptive statistics used and inferential statistics were used to test the hypothesis. The Pearson correlation results revealed a statistically significant negative relationship (r(109)= -0.583, P < 0.05) between depression and psychological well-being among caregivers. The study concluded that there is a significant negative relationship between depression and the psychological well-being of patients' caregivers and recommended that the ministry of health should establish caregiver support groups within the hospital where caregivers can share their experiences and receive emotional support from others facing similar challenges.

Keywords: Depression, Psychological Wellbeing, Caregivers, Patients

INTRODUCTION

Care giving and care receiving can occur at any point in the life course and are typically associated with chronic illnesses or disabilities, which can result in a loss of independence and functioning. The literature on the psychological well-being of mental health caregivers has shed light on the psychological challenges this population faces (Balfe et al., 2016). Often, caregivers of patients with mental health issues experience the same or more psychological distress (i.e., anxiety and depression) than the patients they care for (Matthews, 2003; Ross, 2010). Patient caregivers have experienced distress and bear increasingly heavy responsibilities. Moreover, they are riddled with endless worry and horror about the future, resulting in a psychological struggle. Caregivers have also been found to suffer from anxiety and depression, which are correlated with each other. A patient's worsening condition may lead to the deterioration of his or her mental health and quality of life, and he or she is more likely to feel anxious and depressed due to the increasing burden of care (Zhang et al., 2021). While caring for a patient with psychological distress significantly impacts the caregiver's health, the literature has documented this increase.

Concern about caregivers' wellbeing with respect to their psychological and physical health. Caregivers have been reported to experience psychological distress and burden during the care of family relatives with mental disorders or disabilities (Ogunmodede et al., 2019). Researchers have therefore come to define caregiver burden of care as unwanted and negative experiences that caregivers encounter as a result of taking care of their mentally ill relative (Romito et al., 2013). Their role is multifaceted and constantly changing as patients' medical and emotional needs change (Romito et al., 2019). As a result of the demanding nature of caregiving, caregivers face many psychological challenges (Romito et al., 2019). The challenges they face are often associated with lower quality of life and higher levels of distress (Printz, 2021). Nevertheless, due to limited community health services and heavy economic burdens, most patients choose to be rehabilitated at home with family caregivers providing care after discharge, and care is provided by family caregivers (Li et al., 2021).

The WHO Mental Health Gap Action Programme data (2019) indicate that mental illness has a negative impact on family dynamics, causing stress and depression, even though the intensity of distress may vary from person to person based on various psychosocial factors, including the personality of the patient, caregiver, and nature of the illness (WHO Mental Health Gap Action Programme data). However, it is true that everyone experiences negative feelings that come and go over time, but when these feelings become more intense and leave caregivers totally drained of energy, crying frequently or easily angered by their loved one or other people, it may well be a warning sign of depression. Hence, there is a need to identify psychological factors that protect families from the stress of caring for mentally ill patients. Mental health professionals need to help care-giving families make choices to improve their challenging situations, identify rewards of giving care and advocate for increased systemic support to ease caregivers' stress (Mental Health Call for Action data, 2001). Caregiver burden and psychological well-being need to be assessed to develop strategies to aid in caregiving (Chakraborty, 2023).

Depression is more frequently reported by caregivers of patients with chronic mental illness. Caregivers who have persistent high stress levels are more likely to have a lower quality of life and greater physical health risks than are those in the general population. Depression is a leading cause of disability and disease burden worldwide and in the United States, affecting millions of individuals worldwide, particularly women. Women have a high risk of experiencing depression, with an estimated lifetime risk of 10–25% (Kessler et al., 2003). This increased vulnerability to depression starts in puberty and continues through menopause (Kessler et al., 2003). Depression is a public health concern because of its short- and long-term detrimental effects on women and their families. Individuals with depression experience high rates of anxiety, suicidality, substance use, and poor spouse/child relations (Zbozinek et al., 2014); depression is also highly related to prevalent health outcomes such as cardiovascular disease, one of the five major causes of death in the United States (Elderon & Whooley, 2018).

A study conducted by Hong & Stephens (2019) in Italy showed an increase in depressive symptoms among caregivers of patients with dementia (using the Zung Self-Rating Depression Scale) with a high burden level (using the Caregiver Burden Inventory). In Korea, a study showed a clear association between being a caregiver of a patient with dementia and an increased risk of depression, especially in women and low-income families. Their aim was to assess depressive symptoms in caregivers of patients with dementia, taking into consideration variables such as the severity of dementia, sex, age, and the financial status of the patient. To improve the satisfaction and quality of life of the caregiver, they assessed depressive symptoms to increase awareness within the health community to build a management plan that included the caregivers along with the patients with dementia and to offer adequate assistance to the caregiver, particularly to groups that showed a higher level of depressive symptoms (Dudek et al., 2019). A total of 222 caregivers of patients with dementia participated in the study and completed the questionnaire. More than half were women (60%, n = 133). Half of them were cohabitating with the patients (51%, n = 112), and 60% of them were sons or daughters of the patient with dementia (n = 134). The prevalence of clinical depression (measured by the PHQ-9 and based on the DSM-IV diagnostic criteria for depression) among the caregivers of patients with dementia was 14.9% (n = 33). The mean PHQ-9 score of the caregivers was 7.98 ± 5.23 (maximum = 27). Minimal symptoms of depression were experienced by 96 caregivers (43.2%), moderate by 45 (20.3%), moderate-severe by 15 (6.8%), and severe by 8 (3.6%). The mean BLS-D score of patients with dementia was 9.73 ± 5.03 (maximum = 17). The caregivers were caring for 46 patients with mild dementia (22%), 73 with moderate dementia (34.9%), and 90 with severe dementia (43.1%). In addition, being responsible for the patient’s financial obligations was significantly associated with depression (P = .002). No statistically significant associations were found between depression and caregiver sex (P = .391), age (P = .105), or marital status (P = .387). Depression was more prevalent among caregivers who were sons or daughters of patients with dementia, with a borderline significant association (P = .05).

Moreover, a study performed at King Abdulaziz Medical City in Riyadh, Saudi Arabia, showed that the depression rate in the general population was 12.6%.15 Moreover, a study conducted in Sharurah, Saudi Arabia, reported a 12% rate of depression (Kennedy, 2018). Depression seems to be more prevalent in caregivers of patients with dementia due to the burden and difficulties that they face while caring for a patient with dementia. They found that 73.9% of caregivers had, to some degree, symptoms of depression: 43.2% had minimal symptoms, 20.3% had moderate symptoms, 6.8% had moderate-severe symptoms, and 3.6% had severe symptoms. Parents as caregivers reported greater well-being than did spouses but less than did siblings, whereas some studies reported that spouses reported significantly greater psychological well-being than did parents.

Notwithstanding the positive aspects of caregiving, including feelings of affection and closeness within these relationships and the sense of personal satisfaction and purpose in life that may be derived from it (Litwin et al., 2014), caregiving tends to have negative implications for caregivers’ mental health (Savage & Bailey, 2004). To a large extent, however, research in this area tends to focus on care recipients who are older and, consequently, on adult child caregivers to older parents. As a result, questions arise as to whether findings regarding the negative implications of caregiving reflect the specific experiences of this group but differ from those in other types of caregiving relationships.

On the one hand, stress process models (Aneshensel et al., 1995), social role theory, and associated notions of role strain, role conflict, and role overload (Stephen's et al., 2001) have suggested that. In contrast, caregiving in general is stressful, caring for an older parent is particularly stressful and consequently has a more negative impact on care receivers’ mental health and wellbeing than caregiving for an older spouse or other family member or non-member. It has been noted, for example, that adult child caregivers “view caregiving as extra work (role overload) and experience the burden of role reversal” (Chappell et al., 2014). This study aims to explore the correlation between depression and psychological well-being among caregivers in a neuro-psychiatric setting.

Statement of the Problem

Medically and financially, caregivers are another population at high risk for experiencing the negative effects of caregiver burden and stress. When the demands of the caregiving role exceed the emotional capacity of the caregiver, caregivers may experience caregiver burden (Given et al., 2004). The primary challenges associated with caregiver burden include sleep disturbances, psychological distress, financial distress, and potential cognitive impairment (Nightingale et al., 2019). Early research conceptualized caregiver burden through cognitive stress theory, also known as the transactional model of stress. Many investigations have reported that caregivers have greater levels of perceived stress, anxiety, and depressed mood than non-caregivers (Okamoto et al., 2019).

However, less research is available on the independent influence of depression and psychological well-being among patients’ caregivers, especially in psychiatric hospitals. In addition, there is a lack of evidence on how the appraisal of stress might independently contribute to caregiver burden among these caregivers. Most caregiver research focuses on how to avoid negative outcomes (physical and psychological) rather than how to create positive experiences (Coons, 2020). Additionally, the Nigerian view of caregiving as the sum of responsibility values and reciprocity is missing in the literature. Caregivers experience significant psychological distress, yet there is limited research on how depression specifically affects their well-being, particularly in psychiatric settings. It is on this note that this study addresses this gap.

Objective of the Study

The study examined the following objectives.

i. To examine the correlation between depression levels and psychological wellbeing among caregivers at the Federal Neuro-Psychiatric Hospital Kaduna.

Statement of Hypothesis

The following hypothesis was tested in the study.

i. There is a significant negative relationship between depression levels and psychological well-being among caregivers.

METHODS

Design

This study adopted a cross-sectional survey design to investigate the influence of depression on the psychological well-being of patients' caregivers at the Federal Neuro-Psychiatric Hospital Barnawa Kaduna. The cross-sectional survey design was most appropriate as it was used to collect data that enabled the researcher to describe systematically the characteristic features of the population and it is only interested in describing the variables of interest in relation to the participants. There was no attempt to manipulate the variables since a survey design presumes that the data are collected after the events of interest have occurred. The two independent variables used in this study were depression and stress, while the dependent variable was the psychological well-being of the patients' caregivers at the Federal Neuro-Psychiatric Hospital Barnawa Kaduna.

Participants

There were 205 caregivers at the Federal Neuro-Psychiatric Hospital Barnawa Kaduna during the period of investigation. The relevant socio-demographic information, including age, marital status, and religion, was obtained. For participants, the study details were explained, anonymity was ensured, and informed consent was obtained to encourage the participants to take part in the research for free. Participants were recruited through convenience sampling at the Federal Neuro-Psychiatric Hospital, with informed consent obtained prior to participation.

The inclusion criteria were as follows: caregivers aged 18 years and older who were family members (first-degree relatives such as parents, siblings, offspring, or spouses) who assisted the patient in their daily functions, performed medical monitoring and treatment, met their needs and looked after the patient as a priority.

The exclusion criteria were as follows: the main patients were not qualified for the study, and only their caregiver and any caregiver younger than 18 years were selected for the study.

Sampling size/technique

The sampling technique that was employed in this research was purposive sampling. This enabled the selection and collection of data from the participants in the field, and it involved the collection of relevant information from the given participants to obtain information about them in the setting through the administration of research instruments (questionnaires), which include information about depression, stress, and psychological well-being.

To obtain the required sample for this study, Yamane's formula was used (Yamane, 1967).

Yamane's formula is: $\mathrm{n} = \frac{N}{1+N(e)2}$

Were

n= desired sample size

N=the population size

e=error

In this study, the population size was

$n = \frac{205}{1+205(0.5)2} = 120$

n=120

The sample size for this study was one hundred and twenty (120) mental health patient care givers in FNCH Barnawa.

Instruments

Two instruments were employed for this study and were divided into sections. The Self Rating Depression Scale (SDS) and Brief Psychological Wellbeing Scale.

Section A: Demographic characteristics.

Section B: Self-Rating Depression Scale (SDS): This psychological instrument was developed by Zung (1965) and has 20 items with four (4) response options ranging from 1= some or a little of the time, 2 = some of the time, 3 = good part of the time and 4 = most or all of the time. The Zung Self-Rating Depression Scale has fairly good reliability. Zung reported a split-half reliability of 0.73. An alpha coefficient of 0.68 was obtained by DeForge and Sobal (1988); however, 0.82 was reported by DeJonghe & Baneke (1989). The correlation between the ZSDS and the physician's global rating was 0.69. In addition, the ZSDS has a strong correlation with the Hamiliton Rating Scale and the Beck Depression Inventory for assessing self-criticism, hysteria, and hypochondriasis, and the Paranoia SDS has demonstrated good internal consistency, with reported Cronbach's alpha coefficients typically ranging from 0.70 to 0.90 (DeForge & Sobal, 1988). This suggests that the items in the scale are strongly correlated with each other, indicating good reliability.

Section C: Brief Psychological Wellbeing Scale: This scale was developed by Ryff (1995). The scale consists of an 8-item brief version with 7 response options ranging from **7-**Strongly Agree, 6-Agree, 5-Slightly Agree, 4-Neither Agree nor Disagree, 3-Slightly Disagree, 2-Disagree, and 1-Strongly Disagree. All items are phrased in a positive direction. Scores can range from 8 (strong disagreement with all items) to 56 (strong agreement with all items). High scores signify that respondents view themselves in very positive terms in diverse areas of functioning. Ryff (1989) reported internal consistency coefficients ranging from 0.86 to 0.93 and six-week test-retest reliability coefficients for a subsample of participants. (0.81-0.88). The six dimensions of the scale had Cronbach's alpha values of .72, .66, .78, .69, .72 and .70 for autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance, respectively (Ryff, 1989). Sunday and Okhakhume (2017) conducted a pilot study on the scale using ninety–seven (97) police officers in the Otupko Area Command, Benue State, and obtained a Cronbach's alpha of .87 and a total variance of 67.506, indicating that the test items are highly reliable and valid measures of psychological well-being. For the Nigerian environment, Nwankwo et al. (2015) reported an overall coefficient of internal consistency of 0.87 for the psychological wellbeing scale and a coefficient ranging from 0.71-0.74 for individual items. The authors also obtained a Cronbach's alpha reliability of .89. For reliability, the researcher carried out a pilot study on the scale using forty (40) adolescents (male =19, female = 21, mean age =19.65) drawn from Federal Polytechnic, Nekede. The researcher correlated the scale with the life satisfaction scale developed by Neugarten et al. (1961), which yielded a Cronbach's alpha of .40.

Procedure

An introduction letter was given to the ethical committee of the hospital, and participants were free to withdraw at any point. The participants of the study were drawn to Federal Neuro Psychiatric Hospital Kaduna in Kaduna using purposive sampling. The inclusion criterion was male or female caregivers aged 18 years or older who were currently in the hospital. The purpose of the study was explained to the participants, and as such, the participants who voluntarily agreed to participate in the study were subsequently given the questionnaire. Then, at the completion of the questionnaire, they were returned for further analysis.

Statistical Technique Used.

The data collected in this study were submitted to the Statistical Packages for Social Sciences (SPSS version 26.0). The data collected on the demographic characteristics of the participants were fully analysed using descriptive statistics, such as frequency, simple percentage, mean and standard deviation. The Pearson product-moment correlation was employed as an inferential statistic to test the hypotheses and to determine the relationships between the variables.

Ethical considerations

The study adhered strictly to ethical provisions for conducting research with humans based on the Declaration of Helsinki:

The study gave the participants ample opportunity to participate in the study voluntarily without force or intimidation. After briefing the participants about the aim of the study, the researcher obtained informed consent from the participants. Upon providing consent, the questionnaire was administered to the participants. Participants were assured of their confidentiality and right to withdraw from the study at any time without adverse consequences. The benefits of the study to the participants were discussed in two ways. The study provided opportunities for participants who needed more counselling services for stress related to drug abuse.

The participants were debriefed about the essence of the research. These include sharing information related to the purpose of the research with the participants. Again, if any of them had any misconceptions about the study, the researcher took reasonable steps to correct those misconceptions. Additionally, if the participants are deceived during the study in any way, the debriefing will explain the true objective of the study. The debriefing was performed equally to help the participants know that if any one of them was physically or emotionally harmed in any way, the researcher identified and addressed such issues. Finally, the participants were informed of their right to withdraw from the study at any time. The study did not constitute any physical harm to the participants.

RESULTS

Demographic Variables

Table 1: Demographic Characteristics of Participants

Demographic Factors		Frequency	Percentage
Gender:	Male	54	48.6
	Female	57	51.4
	Total	**111**	**100%**
Age:	18-30 years	38	34.2
	31-40 years	34	30.6
	41-58 years	39	35.1

	Total	**111**	**100%**
Religion:	Christianity	69	62.2
	Islam	42	37.8
	Total	**111**	**100%**
Marital Status:	Single	48	43.2
	Married	51	45.9
	Divorced	12	10.8
	Total	**111**	**100%**
Education:	Secondary	32	32.2
	Tertiary	73	65.8
	Total	**111**	**100%**

Table 1 presents the demographic characteristics of the 111 patients' caregivers (n=54 males and 57 females) aged between 18 and 58 years, with a mean age of 36.16 years and an average age of 9.457 years. Age was further categorized into 18-30 years (N= 38; 48.6%), 31-40 years (N= 34; 30.6%) and 41-58 years (N= 39; 35.1%). Religion: Christianity (N= 69; 62.2%) and Islam (N= 42; 37.2%). Marital status: single (N= 48; 43.2%), married (N= 51; 45.9%) and divorced (N= 12, 10.8%). Education: secondary (N= 32; 32.2%) or tertiary (N= 73; 65.8%).

Test of Hypothesis

This section presents the analysis of the variables tested and their corresponding interpretations.

Hypothesis 1: There will be a significant relationship between depression and psychological wellbeing among patients' caregivers. This hypothesis was tested using Pearson product moment correlation in

Table 2: Table 2: Relationship between Depression and Psychological Well-being among Patients' Caregivers

Variables	M	SD	df	r	Sig.
Depression	79.39	19.995	109	-.583	.000
Psychological Wellbeing	32.29	6.740			

r(109) = -0.583, P < 0.05

Table 2 shows the relationship between depression and psychological wellbeing among caregivers. The mean depression score was 79.39 (SD = 19.995), and the mean psychological wellbeing score was 32.29 (SD = 6.740). A significant negative correlation was found (r(109) = -0.583, p < 0.05), indicating that higher depression levels are associated with lower psychological wellbeing."

DISCUSSION

This study investigated the influence of depression on the psychological well-being of patients' caregivers at the Federal-Neuro Psychiatric Hospital Barnawa Kaduna, Kaduna State.

Hypotheses were postulated, and the data collated in the study were analysed and interpreted. The data collected on the demographic characteristics of the participants were fully analysed using descriptive statistics, such as frequency, simple percentage, mean and standard deviation. The Pearson Product Moment Correlation was employed to analysed the hypothesis in the study.

The hypothesis was that there would be a significant relationship between depression and psychological wellbeing among mental health caregivers. Hypothesis one was confirmed to be statistically significant; therefore, we concluded that there is a significant negative relationship between depression and psychological wellbeing among patient caregivers. Care giving is associated with all the features of a chronic stress experience and challenge. These challengeable tasks, chronic stress, daily hassles and negative caregivers perception bring profound objective and/or subjective burden that involves psychosocial, physical, and financial impact on the caregivers of individuals with severe mental illness which is comparable to that of persons with other illnesses such as Alzheimer’s disease or cancer, especially after deinstitutionalization movement began more than five decades ago because there was transferring of responsibility and day-to-day care to family members. Supporting the findings of this study, a study conducted by Hong & Stephens (2019) in Italy showed an increase in depressive symptoms among caregivers of patients with dementia (using the Zung Self-Rating Depression Scale) with a high burden level (using the Caregiver Burden Inventory). In Korea, a study showed a clear association between being a caregiver of a patient with dementia and an increased risk of depression, especially in women and low-income families. Their aim was to assess depressive symptoms in caregivers of patients with dementia, taking into consideration variables such as the severity of dementia, sex, age, and the financial status of the patient. To improve the satisfaction and quality of life of the caregiver, they assessed depressive symptoms to increase awareness within the health community to build a management plan that included the caregivers along with the patients with dementia and to offer adequate assistance to the caregiver, particularly to groups that showed a higher level of depressive symptoms (Dudek et al., 2019). A total of 222 caregivers of patients with dementia participated in the study and completed the questionnaire. More than half were women (60%, n = 133). Half of them were cohabitating with the patients (51%, n = 112), and 60% of them were sons or daughters of the patient with dementia (n = 134). The prevalence of clinical depression (measured by the PHQ-9 and based on the DSM-IV diagnostic criteria for depression) among the caregivers of patients with dementia was 14.9% (n = 33). The mean PHQ-9 score of the caregivers was 7.98 ± 5.23 (maximum = 27). Minimal symptoms of depression were experienced by 96 caregivers (43.2%), moderate by 45 (20.3%), moderate-severe by 15 (6.8%), and severe by 8 (3.6%). The mean BLS-D score of patients with dementia was 9.73 ± 5.03 (maximum = 17). The caregivers were caring for 46 patients with mild dementia (22%), 73 with moderate dementia (34.9%), and 90 with severe dementia (43.1%). In addition, being responsible for the patient’s financial obligations was significantly associated with depression (P = .002). No statistically significant associations were found between depression and caregiver sex (P = .391), age (P = .105), or marital status (P = .387). Depression was more prevalent among caregivers who were sons or daughters of patients with dementia, with a borderline significant association (P = .05). Moreover, a study performed at King Abdulaziz Medical City in Riyadh, Saudi Arabia, showed that the depression rate in the general population was 12.6%.15 Moreover, a study conducted in Sharurah, Saudi Arabia, reported a 12% rate of depression (Kennedy, 2018). Depression seems to be more prevalent in caregivers of patients with dementia due to the burden and difficulties that they face while caring for a patient with dementia. They found that 73.9% of caregivers had, to some degree, symptoms of depression: 43.2% had minimal symptoms, 20.3% had moderate symptoms, 6.8% had moderate-severe symptoms, and 3.6% had severe symptoms. Parents as caregivers reported greater well-being than did spouses but less than did siblings, whereas some studies reported that spouses reported significantly greater psychological well-being than did parents.

Notwithstanding the positive aspects of caregiving, including feelings of affection and closeness within these relationships and the sense of personal satisfaction and purpose in life that may be derived from it (Litwin et al., 2014), caregiving tends to have negative implications for caregivers' mental health (Savage & Bailey, 2004). To a large extent, however, research in this area tends to focus on care recipients who are older and, consequently, on adult child caregivers to older parents. As a result, questions arise as to whether findings regarding the negative implications of caregiving reflect the specific experiences of this group but differ for those in other types of caregiving relationships. On the one hand, stress process models (Aneshensel et al., 1995) as well as social role theory and associated notions of role strain, role conflict, and role overload (Stephen's et al., 2001) have led to suggestions that whereas caregiving in general is stressful, caring for an older parent is particularly stressful and consequently has a more negative impact on care receivers' mental health and wellbeing than caregiving for an older spouse or other family member or non-member. It has been noted, for example, that adult child caregivers "view caregiving as extra work (role overload) and experience the burden of role reversal" (Chappell et al., 2014).

Conclusion

This study investigated the influence of depression on the psychological well-being of patients' care givers at the Federal-Neuro Psychiatric Hospital Barnawa Kaduna, Kaduna State. The study confirmed that there is a significant negative relationship between depression and the psychological well-being of patients' caregivers. Patient caregivers have experienced distress and bear increasingly heavy responsibilities. Moreover, they are riddled with endless worry and horror about the future, resulting in a psychological struggle. Caregivers have also been found to suffer from anxiety and depression, which are correlated with each other. At times, caregivers feel guilty and helpless which is further confounded by social stigma, ignorance and lack of knowledge. As caregivers struggle to balance work, family and care giving, their own physical and emotional health is often ignored. As a result of this and lack of personal, financial, emotional resources and stigma, many caregivers often experience significant physical and mental distress but physical effects of care giving are generally less intensive than the psychological effects.

Recommendations

At the end of this study, we recommended the following:

ii. Caregiver Support Groups: Establish caregiver support groups within the hospital where caregivers can share their experiences and receive emotional support from others facing similar challenges.
iii. Counselling Services: Provide access to counselling services specifically tailored to caregivers to help them cope with the emotional toll of caregiving.
iv. Education Programs: Develop educational programs to help caregivers better understand the conditions their loved ones are facing, which can reduce feelings of helplessness.

REFERENCES

Aneshensel, C.S., Pearlin, L.I., Mullan, J.T., Zarit, S.H., & Whitatch, C.J. (1995). *Profiles in caregiving:*The unexpected career. San Diego, CA: Academic Press.

Balfe, D.W., Barusch, A.S., & Spaid, W.M. (2016). Gender differences in caregiving: Why do wives report greater burden? *Gerontologist*, 29(5), 667-676.

Chakraborty, R., Jana, A., & Vibhute, V.M. (2023). Caregiving: a risk factor for poor health and depression among informal caregivers in India- A comparative analysis. BMC *Public Health*. 23(1),42. doi: 10.1186/s12889-022-14880-5. PMID: 36609312; PMCID: PMC9817300.

Chappel, A.S., Dujela, J., & Smith, O. (2014). What are the brain mechanisms on which psychological processes are based? *Perspectives on Psychological Science, 4 (1)*, 10-20.

Coon, D.W. (2020). Resilience and family caregiving. *Annual Review of Gerontology & Geriatrics,* 32(1), 231-249.

Dudek, D., Zieba, A., Jawor, M., Szymaczek, M., Opila, J., & Dattilio, F.M. (2019). The impact of depressive illness on spouses of depressed patients. *Journal of Cognitive Psychotherapy*.15:49–57.

Elderon, F. A., & Whooley, J. U. (2018). Prevalence and correlates of posttraumatic stress disorder among Kuwaiti military men according to level of involvement in the first Gulf War. *Depression and Anxiety, 25,* 932-941.

Given, B., Wyatt, G., Given, C., Sherwood, P., Gift, A., DeVoss, D., & Rahbar, M. (2004). Burden and depression among caregivers of patients with cancer at the end of life. *Oncology Nursing Forum,* 31(6), 1105-117.

Hamaideh, S.H., Al-Omari, H., & Al-Modallal, H. (2017). Nursing students' perceived stress and coping behaviours in clinical training in Saudi Arabia. *Journal of Mental Health* 26(3), 197–203.10.3109/09638237.2016.1139067

Hong, P., & Stephens, R.J. (2019). Depression in patients with lung cancer: prevalence and risk factors derived from quality-of-life data. *Journal of Clinical Oncology,* 18(4):893–903.

Kennedy, S.H. (2018). Core symptoms of major depressive disorder: relevance to diagnosis and treatment. *Dialogues Clinic of Neuroscienc*e. 10(3),271-279. doi: 10.31887/DCNS.2008.10.3/shkennedy. PMID: 18979940; PMCID: PMC3181882.

Kessler, R.C., Berglund, P., Demler, O., et al. (2008). Epidemiology of major depressive disorder: Results from the national comorbidity survey replication (NCS-R). *Journal of the American Medical Association*, 289, 3095-3105. http://dx.doi.org/10.1001/jama.289.23.3095

Lin, E., & Jonathan. D. (2012). *Caregivers in decline: A close-up look at the health risks of caring for loved one.* Retrieved from http://www.EvercareHealthPlans.com/Caregiver

Litwin, M.L., Kolt, G.S., & Matheny, J. (2014). Eustress, distress and their interpretation in primary and secondary occupational stress management interventions: which way first?. *Journal of Managerial Psychology.* 21(6), 547–565. doi:10.1108/02683940610684391.

Mathews, M. A. (2003). *Coping in caregivers of family member with traumatic brain injury and the effects in the caregivers' quality of life.* A thesis presented in partial of requirements for the degree of Doctor of Clinical Psychology at Massey University Albang, New Zealand. http://hdl.handle.net/10179/3321.

Mugenda, H. (2003). Psychological distress in patients with head and neck cancer: review. *British Journal of Oral and Maxillofacial Surgery*, 39(1), 67-70.

Nightingale, R., & Abdulrazak, W. (2019). *Psychological stress and psychopathology*. New York: McGraw-Hill Book Company; 18882.

Nwankwo, C. B., Okechi, B.C., & Nweke, P. O. (2015). Relationship between perceived self-esteem and psychological wellbeing among Student athletes. *Academic Research Journal of Psychology and Counselling* 2(1), 8-16.

Obiora, L.I. (1995). Conceptual strategies for the study of caregiver stress. In W. Light, G. Niederehe, & B.D. Lebowitz (Eds.), *Stress effects on family caregivers of Alzheimer's patients, research and interventions* (pp. 3-21). New York: Springer.

Ogunmodede, A.J., Abiodun, O., Makanjuola, A.B., Olarinoye, J.K., Ogunmodede, J.A, & Buhari, O.I. (2019). Burden of care and psychological distress in primary caregivers of patients with type -2 diabetes mellitus in A tertiary hospital in Nigeria. *Ethiopian Journal of Health Science.* 29(6),697-708. doi: 10.4314/ejhs.v29i6.6. PMID: 31741640; PMCID: PMC6842725.

Okamoto, E., & Doyle-Portillo, S., (2019). *What is Psychology*? 2nd Ed. Belmont, CA: Thompson Higher Education.

Printz, S.L. (2021). *Spouse caregiving: The impact of stressors and perceptions on well-being*. Unpublished doctoral dissertation, University of Michigan.

Romito, D., Daniel, Y., & Roy. C. (2019). Adaptation model: A conceptual framework for nursing. *Nursing Outlook*, 18(3), 42-45.

Ross, R.W. (2010). Clinical assessment of family caregivers in dementia. *Gerontologist*, 32(6), 813-821.

Ryff, D. (1989). Race differences in the effects of multiple roles on health: Longitudinal evidence from a national sample of older men. *Journal of Health & Social Behaviour,* 33(2), 126-139.

Ryff, D. (1995). An explication of the philosophical assumptions of the Roy adaptation model. *Nursing Science Quarterly,* 2(1), 26-34.

Savage, L. T., & Badiley, J. R. (2004). Parental divorce and college students: The impact of family unpredictability and perceptions of divorce. *Journal of Divorce and Remarriage, 50,* 248-259.

Stephen, D., Adam, J., Smart, T., & Samuel, G. (2001). The UCLA loneliness scale (version 3). Reliability, validity, and factor structure. *Journal of Personality Assessment, 66,* 20-40.

Zbozinek, A. M., Tang, C.S., & Kwok, T. C. (2014). Self-efficacy, health locus of control, and psychological distress in elderly Chinese women with chronic illnesses. *Aging and Mental Health, 8(1),* 21-28.

Zhang, H. H., Zhao, Y. J., Wang, C., Zhang, Q., Yu, H. Y., Cheung, T., et al. (2021). Depression and its relationship with quality of life in frontline psychiatric clinicians during the

COVID-19 pandemic in China: a national survey. *International Journal of Biological Science.* 17, 683–688. doi: 10.7150/ijbs.56037

Zung, M. (1965). Measuring readiness to change and locus of control belief among male alcohol consumers dependent patients in Taiwan: Comparism of the different degree of alcohol dependence. *Psychiatry and Clinical Neuroscience, 1(62)*,533-539.