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DEPARTMENT OF SOCIAL STUDIES

THE INFLUENCE OF SOCIAL SUPPORT ON PHYSICAL EXHAUSTION AND EMOTIONAL DISTRESS: A CASE STUDY OF FAMILY CAREGIVERS OF THE AGED 70-100 YEARS IN THE METHODIST CHURCH - ACCRA DIOCESE.

BY

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DECLARATION

I, Deborah Odartsoo Benjamin-Addy, hereby declare that this thesis is as a result of my personal research and has not been presented by anyone for any academic award in thls or any other university. All references used in this thesis have been fully acknowledged.

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DEDICATION

I dedicate this work to the Almighty God for enabling me to successfully complete this study and the entire programme.

I also dedicate this work to my husband who always encouraged me to strive for higher heights in education and to my elder sister Ms. Giftina O. Mills for her selfless commitment in taking care of our aged mother.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AARP	-	American Association of Retired Persons
AD	-	Activities of Daily living
EMSC	-	European-Mediterranean Seismological Centre
JCCP	-	Joint Community Care Planning
NCB	-	National Commercial Bank
PD	-	Parkinson Disease
QOL	-	Quality of Life
UK	-	United Kingdom
UN	-	United Nations
WHO	-	World Health Organization

ABSTRACT

This study examined the influence of social support on physical exhaustion and emotional distress among family caregivers and also explores the relationship between caregiver burden and social support on physical exhaustion and emotional distress. A survey methodology was used to sample 120 family caregivers from a population of 240 in the Accra Diocese of the Methodist Church. The findings revealed that the most influential social support relief physical exhaustion is that in the past 4 weeks, the majority feel that everything was an effort. The study also found that the most influential burden of family caregivers is that they feel they are positively influencing other people's lives through their work. Also, the study found out that the most influential social support duke inventory is feeling useful to the family. A linear regression test revealed that social support has influence and therefore affect the physical exhaustion and emotional distress. This study revealed that social support influences physical exhaustion and emotional distress. It is recommended that there should be family commitment, education, counselling given to social caregivers and further research must be done to contribute more to this area future.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Ageing is inevitable and for as long as one does not die at a young age, he or she would definitely grow old. The concept 'elderly' refers to a category of adults who have attained advanced ages. The demographic understanding of the concept refers to persons aged 60 years and above. In the developed countries where life expectancy is high (more than 70 years) and the age of retirement from active public economic activity is 65 years, the elderly is defined as persons aged 65 years and above (Population Reference Bureau, 2012). In developing countries on the other hand, since life expectancy at birth is lower, the age of retirement is 60 years and the elderly are considered as persons aged 60 years and above. At the international level, age 60 is now being used as the cut-off age for defining the elderly (United Nations Population Fund and Help Age (UNPFA), 2012).

The elderly is also referred to as the 'aged' or 'older people'. Ageing is an associated word that refers to the process by which persons or adults are attaining chronological ages that are classified as old ages. Ageing also refers to a process by which the elderly or older persons constitute a higher proportion of the total national population than at an initial period (Weeks, 2012). UN tabulations provided figures for both 60 and 65 years of age and older (United Nations, 1999), making possible more detailed estimates and projections for older people in most countries. The WHO uses categories starting at the age of 65 as elderly or older persons and 80 as oldest-old (WHO, 1999).

Globally, the population is ageing and the demand for health and home care services has become vital (Joint Community Care Planning Framework (JCCP), 2012). For instance, the average age of the United Kingdom (UK) population has increased. The proportion of people aged 65 and over in the UK population increased from 15% in 1985 to 17% in 2010, an increase of 1.7 million people. It is projected that by 2035 people aged 65 and over will account for 23% of the total population (Office for National Statistics (ONS), 2012). It is estimated that in England there are more than 400,000 older people living in care homes. This includes people receiving care in residential and nursing accommodation funded by Councils with Adult Social Services Responsibilities and people who either partially or fully fund their own care (Care Quality Commission, 2012).

Populations worldwide are ageing, leading to a dramatic increase in the numbers of people living into their seventies, eighties and nineties (World Health Organization-WHO, 2011). According to the World Health Organization (WHO), there are about 600 million people aged 60years and above and this number is expected to double by the year 2025- the vast majority of them in developing countries like Ghana.

In Ghana, the 2010 Population and Housing Census estimated that the population of the aged has increased seven-and-half times from 1960 to 2010 namely from 213,477 and 1,643,381 respectively constituting 6.7 percent of the total national population in 2010 compared with 4.5 percent in 1960. Over two-thirds of all the elderly (68.2%) are aged 60-74 years, and approximately one-tenth (9.6%) are very old (85 years and above) (Ghana Statistical Service, 2013). These increases in the aged population are also likely to increase the demand for home care services.

As demographic trends change, reflected in the growing proportion of the population in the older age categories, and in the rising proportion of women in paid employment, the need for publicly provided eldercare services has also grown. For example, women are no longer available, to the extent they have been in the past, to provide eldercare services. At the same time, life expectancy levels have increased and as a consequence, the need and demand for public, voluntary and private market-based care services have grown (Barry, 2010).

Whilst the public sector has an important role to play in promoting health and well-being, supporting self-care and preventing ill-health, it is recognized that there are many other private organizations, particularly in the voluntary, community and independent sector, who may be better placed to provide these services (JCCP, 2012) as one of the most significant changes in- home care in the last 30 years.

Family caregivers significantly contribute to the provision of health care for their family members. In 2009, approximately 65.7 million people in the United States served as informal caregivers (National Alliance for Caregiving & AARP, 2009). As increased health care costs prompt earlier transitions from acute care facilities to the home, families will continue to serve a primary caregiving role for family members with chronic disease. Currently, family caregivers contribute a large portion of unpaid care for those with chronic disease who are aged (Feinberg, Houser & Chouta, 2011).

In addition to the large volume of care provided by family members, the duration and intensity of caregiving duties are often unpredictable, creating stress that can result in the negative outcomes of caregiver burden and compassion fatigue. When assuming the responsibility for and providing care to an elderly person, caregivers generally do it in an uninterrupted fashion, that is, without rest. The caregiver works for many hours in a row, mainly with activities related to bodily care, feeding, elimination, environment, health control and other situations, which leads caregivers to experience stressful situations and burdens (Sabo, 2008).

Burdens generated in caregivers can lead to the development of psychiatric symptoms, fatigue, the use of psychotropic medication, in addition to a worsened health condition, depleting a caregiver's suitable condition to care for elderly individuals. The caregiver activity can also affect the caregivers' social and economic spheres, hurting all aspects of their lives. The conception of the term 'burden' includes emotional distress, physical, psychological, or emotional, social or financial problems experienced by family caregivers, represented by both subjective and objective aspects, arising from the caregiver role. Burden can be expressed by physical problems such as multiple somatic complaints, among them mechanical pain in the limbs, tension headaches, asthenia, chronic fatigue, changes in the sleep-wake cycle, as well as psychological problems manifested by disorders such as depression, anxiety and insomnia, which are routes through which emotional discomfort manifests (Sabo, 2008).

Although research exists regarding the burdens family caregivers face and interventions aimed at reducing those burdens, this research mainly accounts for the negative aspects of the caregiving experience such as the emotional distress and physical exhaustion. It is also recognized that the care family caregivers provide can result in positive outcomes, such as enhanced health, improved well-being, personal growth (Jones, Winslow, Lee, Burns & Zhang, 2011) satisfaction, sense of fulfilment, and feeling good about caring (Greenwood, Mackenzie, Cloud & Wilson, 2009). Therefore, current research is often polarized, focusing on either the positive or negative aspects of caregiving. To better understand the family caregiver experience and empower caregivers to continue to provide care to chronically ill individuals, it is necessary to examine the impact of social support on physical exhaustion and emotional distress of family caregivers of the aged 70-100years.

1.2 Statement of the Problem

A recent report (Feinberg et al., 2011) indicated that family caregivers provide a substantial amount of unpaid care for chronically ill family members. It is critical to the health care system that family members continue to provide this care. Although caregiver burden among family caregivers is an important area of inquiry, it provides a perspective that is limited in scope due to its conceptual lack of clarity (Bastawrous, 2013) and its incomplete view of the experience by focusing on only negative outcomes. Family caregivers are believed to play an important role in promoting the quality of life of the aged ones. In the view of Wistow et al. (2003), well-being is an important component of successful ageing and call for a greater focus on promoting older people’s quality of life and their engagement in the community. Unfortunately, it has also been noted that social support for family caregivers has been the least visible area of activity in most communities in Africa (Age Concern, 2006). Similarly, studies suggest that in Ghana the role and the well-being of older persons have long been ignored by social scientists (Ayisi, 2013). Researchers, therefore, have made a call for the well-being of family caregivers to be considered paramount in future studies (Luff, Ferreira & Meye, 2011).

More so, services provided by family caregivers have a beneficial impact on wellbeing, quality of life, morbidity and mortality (Age UK, 2011). However, very few studies have specifically evaluated the impact of social support on quality of life of family caregivers, hence this study to examine the impact of social support on physical exhaustion and emotional distress of family caregivers of the aged 70-100years.

1.3 Purpose of the Study

The purpose of this study is to examine the influence of social support on physical exhaustion and emotional distress among family caregivers and also to explore the relationship between caregiver burden and social support on physical exhaustion and emotional distress.

1.4 Research Objectives

The specific objectives of this research include the following:

1. To assess how social support relief physical exhaustion and emotional distress in family caregivers.
2. To assess the burden of family caregivers of the aged 70-100years.
3. To examine whether background context factors (age, gender, ethnicity, employment status, caregiver education, caregiver relationship, and income) contribute to differences in social support on physical exhaustion and emotional distress scores.
4. To ascertain caregiving demands, length of time caregiving and caregiver burden contribute to the prediction of social support on physical exhaustion and emotional distress in family caregivers.
5. To assess caregiving demands, length of time caregiving and caregiver burden contribute to social support in family caregivers.

1.5 Significance of the Study

The significance of this study is to create awareness on the impact of social support on physical exhaustion and emotional distress. This study also is of great significance to health analysts since it assists in analyzing the impact of social support on physical exhaustion and emotional distress.

1.6 Organization of the Study

This study is organized into five chapters as follows:

Chapter one is an introduction and covers background to the study, statement of the problem, objectives of the study and significance of the study.

Chapter two presents a conceptual framework to explain the theoretical framework of the study. A review of selected literature is also reviewed in this chapter.

Chapter three discusses the research methodology, including research design, target population, sample size, sampling technique, procedure for the study, ethical consideration and data management and analyses.

Chapter Four include the analysis of data.

Chapter Five comprises discussions, summary of findings, conclusion and recommendations for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter covers theories and related literature pertinent to the study.

2.2 Theoretical Framework

2.2.1 Watson's Caring Theory

This study was based on Watson's Caring Theory (1999), developed as a framework for the professional development of nurses. Since caregiver spouses choose to care for their spouse at home and this decision transforms them into the role of informal caregiver, Watson's ideas are pertinent to this study. Watson and Smith (2002) wrote that "Caring knowledge and practices affect all health, education, and human service practitioners" (p. 455) and this includes the caring role of the caregiver spouse. The practice role of nursing includes helping people cope with problems of daily living that are related to their health problems (California Scope of Practice Act, 2004), and so transcends the boundaries of clinical nursing and fits well the challenges faced by EMSC.

Watson and Foster (2003) believed that each thought and choice that individuals make carries energy into their lives and into the lives of others, so that a care-provider's presence makes a difference for a patient, separate from any medical intervention or supervision, and that caring and compassionate acts of love cause healing for the patient but also for the caregiver. This transpersonal conception of caregiving applies to health professionals but also to informal caregivers, such as spousal caregivers. As partners in the care-recipient/care-provider dyad, both the ill individual and his or her care provider can feel emotional healing and support through the transpersonal nature of the caregiving act. For example, nine male caregiver spouses interviewed by Knutsen and Raholm (2009) noted that caring for their wives was a central role in their lives and that proficiency in that role gave the caregivers a sense of fulfilment and satisfaction. These men said that they were proud of their caregiving work and they enjoyed mastering the skills needed to care for their wives.

Watson and Foster (2003) identified four components of her caring model, which she called The Four Cs; these are, collaboration, conflict resolution, change management, and construction of a new identity. Collaboration is manifest in a caregiver's realization that caring is done with a care recipient, not to her. Conflict resolution is a necessary skill because, in the midst of the collaborative nature of caring, differences of opinion about the goals and methods of care inevitably arise between the caregiver and the care recipient, and it is the caregiver's responsibility to resolve this conflict amicably. The condition that led to the need for care inevitably changes the life of the care recipient and the life of the caregiver as well, especially the life of a spousal caregiver, so that change management is part of a caregiver's work and includes helping the care recipient adjust to change and accepting a shared life experience that is in many ways diminished at least different from what it was. Finally, Watson and Foster (2003) assigned to the caregiver the task of assisting the care recipient in constructing a new identity in the face of changes that have occurred and will occur in the future. These changes occur in the life of the caregiver as well, as he or she grows and adjusts to new roles and new realities.

The salience of Watson's Four Cs has been verified in subsequent research (Pihl et al, 2010; Scotto, 2003). Spouses of heart failure patients (Pihl et al, 2010) whose main task was to keep the care recipient's disease managed, demonstrated their acceptance of the role of caregiver by making changes in their social life and also by expressing a need for care themselves to adjust to the changes that their spouse's health had triggered in their own lives. Individuals who assume the role of informal nurse must care for themselves physically and emotionally in addition to being proficient in nursing duties (Scotto). Failure to make these personal adjustments led informal caregivers to report the greatest burden in terms of poor mental and physical health (Buyck et al., 2011). Outside support for the caregiver role is essential for the health and well-being of both the care-recipient and the caregiver (Cao et al., 2010), and this need may be highest among those least familiar with traditional caregiving roles, including male spousal caregivers (Scotto, 2003).

Although Watson and Foster (2003) caring theory relate to caregiver spouses similarly to its relevance to professional nurses, the caregiver inhibits also the role of one who needs care. The EMSC is unprepared for the functional and emotional burden associated with giving care and for the impact the illness and the need to provide care has on his emotional connection to the care recipient, his wife. The male spousal caregiver is an authentic presence to his spouse and in the dimensional role as a spouse and caregiver hopes to assist the care recipient to live her life and their life as a couple to its fullest degree. However, caregiving has no timetable and the responsibilities change depending on the needs of the care recipient (Savundranayagam, Montgomery, Kosloski & Little, 2011). The caregiver spouse needs ongoing support and education to improve health outcomes for the care recipient and for him.

The Watson's theory of human caring is linked to the study because the theory states that human caring is the process between the caregiver and the receiver and emphasized the wholeness of nursing (Watson, 2005). In the study, the caregiver is acted as the nurse who supports how social support relief physical exhaustion and emotional distress in family caregivers which makes the aged better and this is linked to objective one. Also, the theory talks about how the caregiver can reduce the burden of the aged which is linked to the objective two. This helps to develop self- healing capacity, high level of consciousness and harmony in the life of the person.

The theory is chosen because it is people-oriented that accepts the integrity of people with a clear mindset and the love that must be given by the caregiver when caring for the aged.

2.2.2 Stress Process Model

The Stress Process Model examines the development of negative outcomes from primary subjective and objective stressors plus secondary stressors. The objective and subjective measures specifically address the physical and emotional stressors that accompany caregiving. Mediators, including support and the caregiving context, can impact this process and resultant outcomes (Gaugler, Anderson, Zarit, & Pearlin, 2004). An important element in this model is the focus on the *process* of stress, examining the relationships among concepts that vary and change over time. The model examines four domains of the stress process: background and context of stress, the stressors, the mediators of stress, and the outcomes and manifestations of stress (Pearlin, Mullan, Semple, & Skaff, 1990).

In application to family caregivers, Pearlin et al. (1990) stated that the background and context of the stress for caregivers included individual caregiver characteristics such as age, gender, ethnicity, educational, occupational, and economic characteristics. Additional components important to the caregiver context include caregiving history, family and network composition, and access to and use of resources. The stressors are conceptualized as those “conditions, experiences, and activities that are problematic for people; that is, that threatened them, thwart their efforts, fatigue them, and defeat their dreams” (Pearlin et al., 1990, p. 586), Stressors are divided into primary and secondary stressors which are interrelated. Caregiving is conceptualized as the primary stressor recognizing that other stressors related to life and daily hassles will play a secondary role.

Effective coping and social support are viewed as mediators. Interest in these mediators is based on trying to determine if differences in how one responds can be attributed to coping mechanisms or social support (Pearlin et al., 1990). Pearlin, Lieberman, Menaghan, and Mullan (1981) referred to coping in relation to its function, which includes “the modification of the situations giving rise to stressful problems; the modification of the meaning of problems in a manner that reduces their threat; and the management of stress symptoms” (p. 341). Additionally, Pearlin and Skaff (1996) perceived coping behaviours as evolving over time and focused on the meaning of the situation rather than managing or changing it. Similarly, Garwick et al., (1998) deemed coping as adaptive, using cognitive and behavioural strategies to alter the meaning of the situation as a way to reduce and/or manage their demands.

Social support is a concept not clearly defined in the literature. Pearlin et al. (1981) noted that the presence of social support is dependent on the depth of relationship and frequency of interaction between individuals and, further, that being part of a social network does not necessarily equate to social support (Pearlin et al., 1981). However, social support is reported to be a buffer to stressors by preventing or inhibiting the development of secondary stressors (Pearlin et al., 1990).

The theory is linked to the study because it establishes how age, gender, ethnicity, employment status, caregiver education, caregiver relationship, and income contribute to the social support which is the third objective of the study. To the caregiver, the context includes caregiving history, family and network composition, and access to and use of resources. Also, the theory is relevant to the study it helps to access the burden of caregiver on social support which is the fourth objective of the study.

2.3 Caregiver

A caregiver or carer is an unpaid or paid member of a person's social network who helps them with activities of daily living (Mosher, Bakas, & Champion, 2013). Caregiving is most commonly used to address impairments related to old age, disability, a disease, or a mental disorder. Typical duties of a caregiver might include taking care of someone who has a chronic illness or disease; managing medications or talking to doctors and nurses on someone's behalf; helping to bathe or dress someone who is frail or disabled; or taking care of household chores, meals, or bills for someone who cannot do these things alone.

With an increasingly ageing population in all developed societies, the role of caregiver has been increasingly recognized as an important one, both functionally and economically. Many organizations which provide support for persons with disabilities have developed various forms of support for carers as well.

2.3.1 Caregiver Burden

Caregiving, in either a professional or informal role, places caregivers at risk for physical and emotional problems (Aneshensel et al., 1995). Caregiver stress levels are particularly high when the care happens not as part of a job but at home (Salin, Kaunonen & Astedt-Kurki, 2009). Those who care for family members at home cannot escape to a less stressful environment. This is especially true for caregivers who provide care full time, including men who are retired. One study screened 6,806 adults and found a strong negative effect associated with being an informal caregiver, on home life, work responsibilities and on caregivers' own health status (National Alliance for Caregiving in Collaboration AARP, 2009).

Caregivers were found to be more likely to report fair or poor health the longer they had been in their role as a caregiver, according to the National Alliance for Caregiving (2009). This finding of failing health was also reported in a meta-analysis of caregiver stress and health effects (Pinquart & Sorenson, 2006), and among elderly couples in which the care recipient had end- stage kidney disease (Wilson-Genderson, Pruchno, & Cartwright, 2009). Similarly, both male and female caregivers of those afflicted with lung cancer found that caregivers' mental and physical health were lower than population averages (Mosher, Bakas, & Champion, 2013). One- third of the caregivers in that study reported adverse physical effects of caregiving, including body pain, emotional upset and decreased vitality.

Social isolation is another problem facing caregivers, who experience the role captivity that leads to limited social engagement (Aneshensel et al., 1993). A study of 49 caregivers in Turkey of those ill with multiple sclerosis found that caregiver exhaustion increased with social isolation (Akkus, 2011). Similar outcomes were found in a study of caregivers for persons with dementia (Andren & Elmstahl, 2008). Male spousal caregivers caring for demented wives feel lonely due to the inability to converse with their wives about the future that they had formerly shared (Knutsen & Raholm, 2009). Feelings of role captivity decreased for elderly caregivers when care-recipients were moved to a nursing home and when the care-recipients' health declined precipitously with institutionalization (Aneshensel et al., 1993). The threat of triggering the death of a spouse by abandoning one's caregiver role seems to epitomize the very notion of role captivity.

Caregiver stress can be alleviated with support. For example, 400 caregivers of spouses afflicted by dementia participated in a program of family counselling sessions, enrollment in a weekly caregiver support group and unlimited counselling by telephone, while a similar number in a control group received information about Alzheimer's disease and assistance upon request but no formal support program (Mittelman, 2002). The caregivers in the treatment group experienced significantly less depression than the caregivers in the control group. Additional studies (Emanuel, Fairclough, Slutsman, & Emanuel, 2000; Sameroff et al., 2004) of caregivers caring for family members with serious or life-threatening illnesses discovered that when caregivers were given the information, they seek related to physical care and disease progression, the caregivers experienced less depression and a better quality of life.

Caregivers of elderly spouses are usually older too. Caring for a spouse with a chronic debilitating condition can stress the caregiver to a greater extent than might be felt by a younger family member who is less intimately connected to the care recipient. A caregiver spouse may have physical limitations himself that also add to the burden of caring for his spouse (Family Caregiver Alliance, 2013).

Members of older caregiver/care recipient dyads made the decision in a happier time to live in an adult community. The purchase of their home promised a lifestyle of activity and adventure, as portrayed in promotional materials distributed by at least one developer (Del Webb, 2013). However, drastic lifestyle changes occur when one marital partner falls ill or is no longer able to get around without assistance. These changes contribute to stress, in the infirm partner but also in the partner who suddenly must deliver care. In an ethnographic study of men caring for wives with dementia, Black, Schwartz, Caruso, and Hannum (2008) found that "the isolation of caregiving may lead to increased mental and physical health problems in an ageing body and at a time of diminishing resources" (p. 180). This care entails many tasks for which a caregiver, including an elderly male caregiver, maybe unprepared, including mastery of new knowledge and skills. The need to learn new things may contribute to caregiver stress.

2.3.2 The Consequences of Informal Caregiving

Being a caregiver is associated with many negative physical and mental health outcomes. Caregivers are at increased risk of cardiovascular disease, of higher levels of stress, anxiety, and depression, and of lower levels of subjective well-being and physical health compared to non- caregivers (Chan, Malhotra, Malhortra, Rush, & Ostbye, 2013). Caregiving also is linked with an increased risk of mortality. Schulz and Beach (1999) found that spousal caregivers who provided care and experienced caregiving strain had a 63% higher risk of mortality than non- caregivers. The study found caregiving to be an independent risk factor for death. Caregiving also is associated with positive outcomes for caregivers. Caregivers report developing a closer relationship with the individual requiring care, experiencing personal growth, developing a sense of mastery over caregiving skills, and feeling useful and like they could give back to other caregivers (Cheng et al., 2016).

The provision of care to an ill family member creates a closer bond between the caregiver and his or her ill relative. Caregivers spend an increased amount of time with the individual requiring care, enabling the caregiver to know their family member in a new way and to gain a deeper appreciation for their relationship (Cheng et al., 2016; Li et al., 2013). Spousal caregivers also report that caregiving is a way to show their love for their ill spouse, deepening the relationship bond (Li et al., 2013). As well, caregiving provides caregivers with the chance to learn more about themselves, leading to personal growth. Examples of personal growth include learning how to cope with difficult situations, and showing more patience and tolerance while providing care (Cheng et al., 2016; Peacock et al., 2010). A sense of mastery over caregiving skills enables caregivers to feel more competent while providing care. Mastery also results in caregivers being able to adapt and to cope better with the challenges of caregiving (Peacock et al., 2010). Reciprocity is another positive aspect of caregiving. Reciprocity means that caregivers are able to give back to other caregivers by sharing their knowledge and experiences and providing comfort to other individuals in similar situations (Cheng et al., 2016). Giving back cultivates a sense of usefulness and purpose. Although caregiving has positive benefits for caregivers, it is important to reiterate that caregivers are at a higher risk of negative physical and mental health outcomes than non-caregivers (Chan et al., 2013). Accordingly, this literature review focus on the negative health outcomes of caregiving, specifically depression, in order to gain an understanding of how to improve caregiver health.

2.3.2.1 Caregiver Depression

Caregiver depression is a negative health outcome requiring attention because it is a predictor of functional decline and poor health status (Shao et al., 2017). Poor physical and mental health can compromise a caregiver's ability to assist his or her family member, which can lead to the provision of poor-quality care. Poor quality care refers to caregiver behaviour that can potentially cause psychological or physical harm onto the individual requiring care (Beach et al., 2005). Examples of potentially harmful behaviour include screaming and yelling, threatening to relocate a family member into a nursing home, withholding food, and economic abuse, among others. Studies show that a link exists between depression and potentially harmful behaviour exhibited by the caregiver. Beach et al. (2005) found that caregivers who were at-risk for clinical depression were more likely to engage in potentially harmful behaviour. As well, in a longitudinal study on the associations between caregiver stressors, caregiver depression and quality of care, Smith, et al (2011) reported that caregivers who were more depressed provided less respectful care and reported more potentially harmful behaviour. Caregivers in the study who reported increases in depressive symptoms also reported more occurrences of potentially harmful behaviours (Smith, Williamson, Miller, & Schulz, 2011).

Consequentially, caregiver depression has implications for both the caregiver and for the individual to whom he or she provides care. Depression affects a caregiver's health, which in turn affects his or her ability to provide care. Caregivers' depression impacts the care and quality of life of the individual requiring assistance, increasing the risk of institutionalization for the care-recipient (Czaja et al., 2009).

2.3.2.2 Predictors of Depressive Symptoms in Caregivers

Depression has an impact on the well-being of the caregiver and the individual to whom she/he provides care. It is important to examine the predictors of depressive symptoms in caregivers to understand how to improve caregivers' mental health. Selected demographic characteristics of informal caregivers are predictors of depressive symptoms. Age and gender influence depression risk for caregivers. Younger caregivers and female caregivers report more depressive symptoms compared to older caregivers and male caregivers, respectively (Won et al., 2017; Young et al., 2008).

Younger caregivers, such as adult children, may have competing roles and responsibilities for caregiving compared to older caregivers such as spouses (Bastawrous, Gignac, Kapral, & Cameron, 2015). Adult-children may be caring for their own children while also caring for an ageing parent. Adult-children caregivers also are more likely to be employed than spouse caregivers and maybe balancing employment with caregiving duties (Sinha, 2013). Multiple roles in a caregiver's life may limit the time a caregiver has to engage in desired activities, increasing vulnerability to depressive symptoms.

Women's social roles and the role strains they face may contribute to higher rates of depression compared to men. Many women are employed full-time and also are expected to care for their own children and ageing parents. Women are more likely to provide more care and assist with personal care tasks compared to men (Sorensen, Duberstein, Gill & Pinquart, 2006). The responsibilities of multiple role identities can lead to role overload and strain, increasing the risk of depression (Bastawrous, Gignac, Kapral, & Cameron, 2015). The gendered differences in social roles and expectations may contribute to depression. Unlike women, men are not socialized to take on more nurturing roles such as caregiving, decreasing the risk of experiencing role overload and developing depressive symptoms. In addition, women are more likely to report depressive symptoms than men (Sorensen, Duberstein, Gill & Pinquart, 2006). As a result, women may be overrepresented in the depression literature compared to men.

Income and living arrangement are other significant demographic predictors of depressive symptoms. Lower-income is associated with higher rates of depressive symptoms (Arai et al., 2014). Income influences an individual's ability to access resources. Caregivers with lower income may be unable to afford access to resources needed to lessen stress and to improve well- being, such as home care, respite care, or counselling services. This may explain why lower income is associated with a higher risk of depression. Caregivers who live with the individual for whom they are caring experience higher amounts of depressive symptoms compared to caregivers who do not co-reside with the individual requiring care (Arai et al., 2014). Caregivers who live with the individual requiring care may experience caregiving stressors more frequently than caregivers who do not co-reside with the individuals for whom they provide care. A caregiver who lives with an ill family member may spend more time providing care and may provide more intensive care compared to a non-co-residing caregiver. Caregivers who live with the individual requiring care may have less time for respite and may experience more chronic stress compared to caregivers who do not share a household with the individual for whom they care.

Kinship is another predictor of caregivers' depression. Studies show that spouses are more likely to report higher levels of depressive symptoms than non-spousal caregivers, such as adult- children (Cummings & Kropf, 2015). The level of depression risk also is influenced by the gender and marital status of the spousal caregiver. Wives are at a greater risk of depression and experience more depressive symptoms compared to husbands (Bookwala & Schulz, 2000; Cummings & Kropf, 2015). Caregiver health is another predictor of depressive symptoms. Poor caregiver health and a higher number of health problems are associated with higher depression scores (Luchsinger et al., 2015).

Along with demographic characteristics, factors related to caregiving itself can impact caregivers’ level of risk for depression. The characteristics of the individual requiring care can influence depressive symptoms in caregivers. These characteristics include the severity of cognitive impairment of the individual requiring care and problem behaviours. Dementia severity impacts depression for caregivers providing care to an individual with dementia. More severe levels of dementia in the individual requiring care are associated with higher amounts of depressive symptoms in caregivers (Arai et al., 2014; Williams, 2005). As well, the dementia type of the individual requiring care influences caregiver depression. Caregivers of individuals living with frontotemporal dementia report significantly higher amounts of depressive symptoms than caregivers of individuals living with Alzheimer’s disease (Mioshi, Bristow, Cook & Hodges, 2009). More behavioural problems, such as agitation or wandering, of the individual for whom the caregiver is caring, are associated with higher depression scores (Williams, 2005).

As well, physical limitations of the individual requiring care impact caregivers’ vulnerability to depressive symptoms. Peyrovi et al. (2012) investigated the relationship between perceived life changes and depression in caregivers of stroke survivors. Study findings revealed that the functional disability of the stroke survivor predicted caregiver depression. More severe disability of the stroke survivor was associated with caregivers exhibiting higher levels of depressive symptoms (Peyrovi, Mohammad-Saied, Farahani-Nia & Hoseini, 2012). Lau and Au (2011) conducted a meta-analysis on the correlates of caregiver distress in caregivers of individuals living with Parkinson 's disease (PD). The review found that the severity of the individual with PD's motor symptoms and level of limitation in activities of daily living (ADL) predicted caregiver distress. More severe motor symptoms and more limitation in ADLs were related to higher levels of caregiver distress (Lau & Au, 2011). Higher levels of caregiver distress increase susceptibility to experiencing depressive symptoms.

Factors specific to caregiving, such as the cognitive and physical limitations of the individual requiring care, can affect how a caregiver appraises his or her caregiving situation. Personal appraisals of the caregiving situation can influence depression. Negative appraisals such as being upset by the problem behaviours of the individual requiring caring are linked with more depressive symptoms than more positive appraisals (Aggar, Ronaldson & Cameron, 2010; Williams, 2005). Williams (2005) found that caregivers who reported feeling more bothered by the problem behaviours of their ill family member had more depressive symptoms than those who were less bothered by problem behaviours. Peyrovi et al. (2012) determined that positive perceptions of life changes associated with caregiving were related to lower depression scores.

The amount of burden experienced by a caregiver while providing care also can predict depression. Caregiver burden focuses on the impact of the physical, psychological, social and financial demands of caregiving on the caregiver (Pinquart & Sorensen, 2003). Caregivers with higher amounts of burden reported more depressive symptoms compared to caregivers with lower amounts of burden (Schulz et al., 1995; Song, Biegel & Milligan, 1997; Young et al., 2008). In their study on depression in family caregivers of cancer patients, Young et al. (2008) found that caregivers who felt burdened faced six times greater risk of depression than caregivers who felt less burdened.

Social variables, such as social support and social participation, are other predictors of depressive symptoms in caregivers. The amount of perceived social support plays an important role in predicting depressive symptoms. Lower perceived social support is related to higher levels of depressive symptoms (Kim et al., 2011; Losada et al., 2010).

The type of social support a caregiver receives also can influence depression. A study by Miller et al. (2001) revealed that lower levels of informal instrumental and emotional support are linked with higher levels of depressive symptoms. Instrumental informal support refers to the amount of assistance a caregiver receives from family or friends with tasks such as household chores (Miller et al., 2001). Social network size is another factor associated with depressive symptoms. A larger social network is related to lower amounts of depressive symptoms (Haley et al., 2003; Piercy et al., 2013; Williams, 2005). Social participation also can influence the risk of developing depressive symptoms. Lower levels of social participation are associated with higher depression scores (Croezen et al., 2015; Ghosh & Greenberg, 2012; Li et al., 1997; Loucks- Atkinson et al., 2006; Mausbach et al., 2008). Two aspects of social participation related to caregiver depressive symptomology include the frequency of social participation and perception of leisure time. Wakui et al. (2012) found that weekly engagement in-home or social activities by Japanese family caregivers were significantly related to lower depression scores. A study on leisure and distress in caregivers of older adults found that caregivers who perceived they had more leisure time reported lower depression scores (Losada et al., 2010). Engagement in social and leisure activities aids in alleviating the negative psychological health outcomes of caregiving.

The experience of depressive symptoms by caregivers can be influenced by demographic characteristics, stressors related to caregiving, and social variables. Accordingly, it is important to gain a deeper understanding of the caregiving context and the factors that influence depression in caregivers. The caregiving and stress process model is one theoretical construct that can be used to explain why caregivers are susceptible to developing depressive symptoms.

2.3.3 Stress and the Health of a Caregiver

Caregivers in several studies described a decline in their own personal health (Buyck et al., 2011; Ducharme et al., 2007; Pihl et al., 2010). Such a decline negatively affects both marital partners. If a caregiver’s health declines to the point that he or she can no longer give care, the care recipient is in danger of nursing home placement. Male caregiver spouses who were asked who would care for their wives if they themselves became ill admitted that their children were too busy with their own lives and their wives would have to go to a nursing home (Sanders & Power, 2009). The knowledge of his responsibility for his wife’s future care places even more pressure on the male spousal caregiver and amplifies the importance of his own health (Sanders & Power, 2009). Yet no research was found demonstrating that male spousal caregivers recognize the consequences of neglecting their own health care while fulfilling their caregiver role. Depression as a result of caregiving is well documented in several studies (Adams, McClendon & Smyth, 2008; Buyck et al., 2011; Ducharme et al., 2007).

Depression of the caregiver is directly related to "role captivity," which is the feeling of being trapped in a particular role with no way out except through changes that are even worse than the current situation (Ducharme et al., 2007). One gentleman reported exercising once or twice a day just to avoid depression, and others admitted to self-medicating with alcohol to cope with the demands of caregiving (Calasanti & King, 2007). Caregivers with the highest reported burden score described poorer mental and physical health than individuals not caring for an older adult (Buyck et al., 2011). The level of measured burden is correlated to perceived caregiver health so that caregivers with lower stress burden reported a higher measure of perceived personal health (Andren & Elmstahl, 2008).

Sleep plays an essential role in good health. An adequate supply of quality sleep can help protect mental health, physical health, and well-being (National Heart Lung and Blood Institute, 2014). However, individuals caring for a spouse with Alzheimer's disease reported poor sleep and were at increased risk for poor mental health (WilletteMurphy, Todero & Yeaworth, 2006). No sleep differences between caregivers and noncaregivers were found in older women caring for persons with osteoporosis but caregivers who were clinically depressed reported more sleep problems than noncaregivers who were depressed; caregiving represents an added risk to depressive individuals (Kochar, Fredman, Stone & Cauley, 2007). This is significant because depression is common among elderly caregivers, so the risk of sleep-deprivation and accompanying health problems among caregivers is strong (Kochar et al., 2007).

Caregiving represents an independent risk factor for elderly caregivers (Schulz & Beach, 1999). Elderly who provide support for another and who report role strain are 63% more likely to die within 4 years than those who either are not providing care or who report no strain in the caregiver role. The level of patient suffering may contribute to a decline in the health of the caregiver since working so hard “to provide help that then fails to enhance the quality of a care recipient's life may lead to frustration, resignation, and negative health effects for the caregiver” (Koerner et al., 2010, p. 110-111). Psychological and physical symptoms in caregivers are more likely on days when care recipients were especially needful and when social supports are absent or perceived negatively (Koerner, Shirai & Kenyon, 2010).

The potential to positively affect the sleep quality of caregivers of individuals with dementia and reduce their depressive symptom scores can be realized through a treatment program that combined relaxation techniques, control of stress triggers, and education in good sleep habits along with personal goal setting (Simpson & Carter, 2010). But overall, the intensity of caregiver strain can lead to a myriad of negative health effects, including the early death of the caregiver. Simpson and Carter (2010) suggest that social support is valuable in maintaining a caregiver’s mental and physical well-being but that the perceptions of an elderly caregiver about his situation and the situation faced by the marital dyad may be significant. The effect of stress on a married couple may undermine this most intimate form of social support.

2.3.4 Support Needs of the Caregiver

Since caregiving for a spouse is an unexpected career without orientation or position description, many caregivers seek support (Salin, Kaunonen & Astedt-Kurki, 2009; de Leon Arabit, 2008; Sussman & Regehr, 2009). Nearly all participants feel invigorated by a respite care period (Salin, et al., 2009). The respite care offered in Finland consists of time in an institution for the care recipient (Salin et al., 2009), yet de Leon Arabit found that none of the caregivers in a United States study of caregiver coping strategies sought formal interventions, perhaps because they were unaware of local resources. Spousal caregivers' involvement with community services is poor as well in a Canadian study (Sussman & Regehr, 2009). The caregiver spouses found that with the exception of adult daycare, available services did little to reduce their level of stress burden. The lack of perceived value of community-based social services found in these studies suggests that elderly caregivers may look to friends and family for support. It appears that support from friends and family may also be inadequate.

Caregivers of people with Parkinson's disease have reported they undertook this role with minimal information and with little support from family and friends (McLaughlin et al., 2010). In fact, spouses often feel that their caregiving efforts were ignored by friends and family (Pihl et al., 2010). Caregiver spouses feel that their loneliness was increased by their friends' disregard for their needs as a caregiver. Caregivers need encouragement in their caregiver role and social support in order to continue in the role of caregiver (White et al., 2008). Caregivers with lower social support perceive the role of the caregiver as more burdensome (Hwang et al., 2011).

Caregiver spouses need the information to care for themselves as well as for their wives. Educational programs to support caregivers and assist them with self-care have been described in studies by Elliott, Burgio, and De Coster (2010), White et al. (2008) and Peeters et al. (2010) among others. An intervention group, receiving services under the Resources for Enhancing Alzheimer’s Caregiver Health program, reported reductions in caregiver burden and better self- rated caregiver health at the end of six months (Elliott, Burgio & De Coster, 2010). A six-week program for caregivers that provided education and support for informal caregivers increased emotional comfort and improved caregiving skills (White et al., 2008). Individuals caring for a spouse with dementia were found to need more emotional support and relief care than caregivers who were sons or daughters of the care recipient (Peeters et al., 2010). Researchers (Elliott, Burgio & De Coster, 2010; Peeters et al., 2010) have recommended that agencies assess the extent of social support existing for elderly caregivers, which aligns with the focus of my study.

There are numerous studies related to female caregiver spouses, but I have identified only seven articles devoted to understanding the male caregiver spouse. This limited research has focused on men’s desire to keep their home lives as normal as possible despite their evolving caregiver role (Sanders & Power, 2009; Black et al., 2008), their struggle to integrate caregiving into traditional attitudes about masculinity (Baker et al., 2010), and men’s ways of approaching caregiving tasks that differ from the typical approaches of female caregivers (Calasanti & King, 2007). EMSCs were found to become more vulnerable to emotional distress, physical decline, and counter-productive ways of managing stress as their caregiving role extended over time and was recognized by the men to describe a limited future without hope of improvement (Ducharme et al., 2007).

All of these studies stated that existing interventions need to be more inclusive of male caregiver spouses; the development of male support groups, separate from support groups for women or intended for both sexes, may be beneficial. More research and understanding of the plight of the EMSC are needed. Male caregiver spouses are a growing group that needs and deserves more attention.

2.4 Social Support

Sarason, Levine and Basham (1983) defined social support as the existence or availability of people who let an individual know that they care about, value, and love them. It can also be referred to as the process by which various forms of assistance is provided to others and is a member of a supportive social network. This support may come from different sources such as family, friends, teachers, community, or any social groups to which one is affiliated. Social support can be said to be the key to many human accomplishments, including the successful caregiving.

Social support is also viewed as the actuality and perception that one is being cared for, has support, thus the psychological and material available from other people. There are three main types of resources that often show difference in social support. They include instrumental, informational, and emotional. Instrumental support involves the provision of material aid, financial assistance or help with daily tasks.

In relation to Informational support, it denote the provision of significant information intended to assist the individual cope with present difficulties and typically take the form of advice or guidance in dealing with one’s problems and emotional support involves the expression of empathy, love, caring, reassurance and trust which provides opportunities for emotional expression and venting (Cohen, Doyle, Turner, Alper, & Skoner, 2003).

Also, according to Malecki, Demaray, & Elliott (2000) explained perceived social support as person’s views of social support from people in their social network, which increases their functioning and may safeguard them from negative outcomes. Cared given to help individual to experience a better life is termed as social support according to Yasin & Dzulkifli, (2010).

Additionally, Pearlin et al. (1981) defined social support as “the access to and use of individuals, groups, or organizations in dealing with life’s vicissitudes” (p. 340). Social support, in contrast to social networks, refers to the resources used in dealing with life’s problems. Whereas social networks are the total resources available to someone under stress, the effect of social support often depends on the context of the relationships from which it is obtained. As a result, perceived support is reported to have a buffering effect on stress (Pearlin, 1989).

In an analysis of the term social support, Finfgeld - Connett (2005) reported that two types of social support exist: emotional and instrumental. Emotional support includes those activities or behaviours viewed as comforting, aimed to decrease levels of uncertainty, anxiety, hopelessness, and depression. Instrumental support includes activities or services that are tangible, such as the provision of food or supplies. Antecedents to social support include need, social network, and social climate, all of which contribute to the interpersonal process influenced by the context and the reciprocal exchange of information (Finfgeld-Connett, 2005). Expanding this individual, or micro, perspective, Chappell and Funk (2011) added Meso-level views, which included social institutions such as families, and macro-level views of social support in relation to gender and ethnicity. In a study of family caregivers, social support was conceptualized within functional, structural, and appraisal dimensions. The functional dimension characterizes the tangible aspects of support provided, the structural dimension refers to social networks, and the appraisal dimension represents the perception of social support provided (Sit, Wong, Clinton, Li, & Fong, 2004). Therefore, although social support is described differently in these studies, similar characteristics are exhibited in all of them that contribute to its conceptual meaning.

Social support has been reported to result in beneficial outcomes, including the reduction of distress, stress, loneliness, depression, cognitive decline, and biological risk. Additional positive effects include increased life satisfaction, psychological health, physical health, functional ability, survival, cognition ability, and adjustment to institutionalization (Chappell & Funk, 2011). In the caregiving literature, Bainbridge et al. (2009) found that higher levels of program accessibility and social support predicted less caregiver burden. Social support was also found to be the one predictor that contributed to both caregiver strain and caregiver satisfaction (Wakefield et al., 2012). Similarly, the availability of social support and satisfaction with it were positively correlated to adjustment and negatively correlated to distress (Fitzell & Pakenham, 2010). Chen and Greenberg (2004) also found that increased social support contributed to more reported positive outcomes of caregiving.

In addition, Garlo et al. (2010) and Burton et al. (2012) found that the need or desire for more help was associated with higher caregiver burden. Overall, in a study of caregivers of stroke patients, Sit et al. (2004) found that caregivers often perceived more social support than actually present and that those with more tangible and social companionship had fewer health problems. However, in a meta-analysis of 35 studies of social support in caregiver research, no association was found between the type of support (perceived or received) and caregiver adjustment. Additionally, no association was found when support was conceptualized as instrumental and socio-emotional (Smerglia, Miller, Sotnak, & Geiss, 2007). In this analysis, Smerglia et al. (2007) reported that 61% of caregivers did not find that social support had a positive impact on adjustment. Findings on the impact social support have on family caregivers are inconsistent. Therefore, questions exist as to whether these differences could be attributed to the caregiving outcome measured or the instrument used to measure social support.

2.4.1 Constriction of a Caregiver's Social Life: The Impact on Social Support and Social Participation

The caregiving and stress process can be used to understand how stress manifests itself in caregivers and why caregivers are at risk of developing depression. One of the contributing stressors to caregiver depression as outlined in the model is the construction of a caregiver's social life. The constriction can be related to the concept of social support. Social support can be divided into structural and functional support. These two types of support serve different purposes in an individual's life. Structural support refers to the connection and degree of integration one has with a social network. It can be measured by examining the number of social relationships a person has or how integrated an individual is within their social network (Cohen & Wills, 1985). Social participation is a type of structural support because participating in activities such as sport or recreation, or belonging to organizations and clubs contributes to and creates social integration. Social participation refers to participating in social, leisure, recreational, cultural, and spiritual activities in the community and with family. Participating in social activities presents individuals with the opportunity to become involved in their community and to maintain or create new social relationships (World Health Organization, 2007). Social participation can be seen to access functional social supports. Functional support focuses on the purposes interpersonal relationships serve in an individual's life, such as the provision of emotional support, companionship, and affection (Cohen & Willis, 1985).

Social support and social participation have important implications for an individual's health. Low levels of social support and social participation are associated with an increased risk of mortality (Nyqvist, Pape, Pellfolk, Forsman, & Wahlbeck; 2014). A strong relationship exists between social participation and mortality risk. Nieminen et al., (2015) analyzed the relationships among social support, social participation, trust, and all-cause mortality risk using population-level data from a national health survey administered in Finland. Social participation was the strongest predictor of mortality. Low levels of social participation were associated with higher mortality rates. The mortality rate of individuals with low levels of social participation was double the mortality rate of individuals with high levels of participation (Nieminen et al., 2015). Similarly, a meta-analysis by Nyqvist et al., (2014) revealed that higher levels of social participation were associated with a decreased risk of mortality. The significant relationship between social participation and mortality remained regardless of age and gender. Low levels of social support and social participation may exacerbate the mortality risk caregivers face already, given that caregiving puts an individual at an increased risk of death (Schulz & Beach, 1999). Therefore, examining how social support and social participation influence caregiver stress and susceptibility to negative health outcomes is crucial.

According to the caregiving and stress process, social support is a mediator of caregiver stress and stress outcomes. One of the ways in which social support mediates against stress is through buffering effects. Social support acts as a buffer and protects an individual against negative outcomes such as physical illness or depression. Social support is most beneficial and can protect against negative outcomes during times of stress (Cohen & Willis, 1985). The buffering effects of social support can be related to caregiving as caregiving is characterized by the experience of chronic stress. Studies show social support is associated with a reduction in negative health outcomes in caregivers. Emotional support buffers against depression in a wife- and daughter- caregivers who experience medium or high levels of stress (Li et al., 1997). Caregivers with higher perceived social support and more perceived leisure time reported lower levels of burden, and significantly lower depression scores versus caregivers who reported lower levels of perceived social support and leisure time (Losada et al., 2010). Schuz and colleagues (2015) found participation in affiliation groups, such as sports clubs or religious clubs, to be associated with a reduction in anxiety scores. The findings from studies on social support and caregiving demonstrate that caregivers benefit from experiencing both structural and functional forms of social support.

The provision of emotional support to a caregiver can help alleviate negative emotions, such as anxiety, and can also assist the caregiver in appraising his or her situation more positively (Pearlin et al., 1990). For example, reassurance and encouragement from close friends about the support caregivers are providing to their family members can enable caregivers to realize that they are doing well in their role. This realization causes the caregiver to perceive him or herself and his or her situation more positively. However, caregiving also can lead to a perception of diminishing social support. The increasing dependency of the individual requiring care may limit the time a caregiver has to spend with friends and family, decreasing his or her access to social support and leading to feelings of depression (Pearlin et al., 1990).

Caregiving also can constrain the caregivers' abilities to engage in social activities. Caregivers may not always be able to access the opportunity for involvement and socialization associated with participating in social activities because of the stresses and demands associated with caregiving. Growing caregiving duties can limit the amount of time a caregiver has to engage in other activities. Limited time for other activities leads to decreased social participation which increases the risk of depression (Loucks-Atkinson et al., 2006). It is important to understand how poor social support and low levels of social participation impact depressive symptoms in caregivers. The activity restriction model of depressed affect (Williamson & Shaffer, 2000) provides a framework to guide insight into the relationship between social participation and depression among caregivers.

2.4.2 Effects of Lack of Social Support

Social support is an important factor that may buffer the ill effects of stress on mental and physical health. In a cross-sectional study of 707 older adults, it was found that a positive association existed between social support and recovery from depression (Hay, Steffens, Flint Bosworth & George 2001). Social support has been shown to moderate the effects of health- related strain on mental health in 410 elderly individuals (Hagerty & Williams 1999). Lack of social support affects the overall health of an individual. According to Rook (1985), the absence of social support has been linked to a decline in cognitive function.

Social support, social exchange and social network are related constructs which may be powerful and potentially modifiable determinants of cognitive health and mortality in the elderly population (Jordan-Marsh & Harden 2005). Absence or disruption of contact with significant others, which frequently occurs when one age or is ill, has been linked to several physical and mental health indices including increased mortality after myocardial infarction (Berkman, et al. ,1992). These same researchers found that those with little social support were at increased risk of institutionalization.

In a cross-sectional study by George Blazer, Hughes and Fowler (1989), a decrease in social support over a one-year interval was found to be associated with increased psychiatric symptoms, including depression, in a sample of old people. Furthermore, it was found that quality, not quantity, of the support, was the most important factor. This makes it clearly important to further investigate the effect of quality of each type of social network in the elderly. In a study by Adams et al. (2004), receiving fewer visits from friends, and having less extensive social network predicted loneliness. In addition, individuals with less adequate social relationship possess reduced immunological functioning (Uchino, Caccioppo, & Kiecolt- Glaser, 1996). Wilmoth (2001) suggested that unbalanced social exchanges contribute to changes in living situations and “are a central part of the death process” for older adults.

In addition, older adults with low social engagement have increased glucocorticoid production, which has been shown to be associated with hippocampal damage resulting in decreased learning and memory function (Seeman, Singer, Rowe, Horwitz & McEven 1997). Mac-Arthur studies on successful ageing have validated the linkage of social relationship to longevity (Rowe & Kahn, 2002). Social support and its many variant forms, including exchange, have long been recognized as influencing immunological functioning (Jordan-Marsh & Harden. 2005). Lack of social support in nursing homes can lead to a decrement in psychosocial health.

Some experts suggest that social support provides a sense of connectedness to one’s social group, which results in feelings of wellbeing (Ryan, 1995). More social support was related to positive cognitive functioning in old people and that quality, not quantity, of support, was the most important factor (Ryan). Furthermore, disruptions in the make-up of social networks such as change of residence or death of close friends or family members may lead to increased loneliness in this age group, especially when it has been found that older adults form new social connections less easily than younger persons. This may be a problem for those in age-segregated communities where individuals have left their traditional neighborhoods to obtain services and amenities. Social support, defined as both structural characteristics of a social network and perceived availability of resources, has been proposed to affect the onset, course, and outcome of depression (Billings & Moos, 1984; Conyne & Downey 1991). It has been hypothesized that this occurs as a direct effect or as a buffering effect during stress conditions (Dooley, 1985). In summary, a lack of social relations has been found to be related to loneliness, and loneliness can lead to a serious mental condition of depression.

2.5 Review of Related Studies

Research on social relationships and health often mention the benefits of social support (Weisz, Quinn & Williams, 2015; Poortinga, 2012). Successful coping during stressful situations and reducing caregiver burden are some of the benefits to caregivers associated with social support (Rodakowski, Skidmore, Rogers & Schulz, 2012). For older adults, late-life is full of significant life changes, such as the deaths of friends and family, retirement, loss of independence, and moving. These changes can be softened by the instrumental, emotional, and informational support provided by community members, such as caregivers, family, and friends (Francis, Worthington, Kypriotakis & Rose, 2010).

Additionally, satisfaction with social support has also been linked to better self-reported health status (White, Philogene, Fine & Sinha, 2009). Seminal work by House (as cited in Glanz, Rimer & Viswanath, 2008) explained social support as the interaction of four types of supportive behaviours that result in a functional relationship, including: 1) Emotional support (e.g., provision of empathy, love, caring); 2) Instrumental support (that is, tangible services); 3) Informational support (example, advice, suggestions); and 4) Appraisal support (example, information for self-evaluation and improvement). The importance of instrumental and emotional support and its benefits on overall health have been widely documented (Berkman & Glass, 2000). Reciprocal relationships have been shown to have a positive impact on the mental and physical health of older adults, improvements in cognitive functioning, a sense of personal control and meaning, and later onset of disease, disability, and mortality (Berkman, Glass, Brissette & Seeman, 2000).

Lifestyle preference in older adults choosing to live in active retirement communities are becoming more popular (Glass & Skinner, 2013) and the majority of older adults prefer to age in place (Feldman, Oberlink, Simantove & Gursen, 2004). The “Village” model is a non- governmental approach to combat the rising costs of formal care and provide affordable strategies to support ageing in place. This grassroots organization provides community-dwelling older adults with a wide range of resources, including emotional and instrumental support (NCB Capital Impact, 2009). In reference to social support, Barker (2002) analyzed the social interactions between friends, neighbours, and non-kin available to ageing caregivers. The findings highlight that the quality of emotional connectedness, associations with informal caregivers, and assistance with tasks performed influence the naturally occurring care relationships in community-living older adults. The findings suggest that these relationships are paramount for sustaining community living for nearly 10% of frail older adults. Further, variances in caregiver burden were significantly associated with the quality and quantity of social support available (Rodakowski, Skidmore, Rogers & Schulz, 2012). In addition, a sense of value, ability to care, and caregiver satisfaction were associated with caregiver optimism; higher levels in optimism was also associated with higher social support (Brand, Barry & Gallagher, 2016). Moreover, Abamfo-Atiemo (2018) conducted a research on church- related social support and health and wellbeing of social support of the elderly in Achimota Accra Metropolitan Assembly. The researcher used a purposive sampling method. Findings of the researcher indicated that churches provide spiritual support, financial support, health support, visitation, material support and socialization to elders. He further revealed that the abovementioned support makes the elderly feel better, comfort and cared for. Again, studies on social support, mood and relationship satisfaction at trait and social levels was investigated by Willianmson (2015). The researcher adopted a multiple sample to obtain his results. The results of his research show that women received more support than men and that recipient who were younger, more extraverted, and more open to new experiences also received more support. The research results further showed that individuals received more social support from their romantic partners and less from their family and friends. The results of the research again point out that females provide more social support than their male counterparts. The researcher finally found out that individuals who mostly receive more social support also experienced more negative mood.

2.5.1 Statement of Hypothesis

The following hypotheses were tested in the study:

H1 Social support significantly predicts emotional distress H2 Social support significantly predicts physical exhaustion H3 Emotional distress influences physical exhaustion

H4 Gender significantly predicts social support, emotional distress and physical exhaustion”

H5 Physical exhaustion and emotional distress of caregivers influences years of caregiving

2.6 Operational Definition

Social support: is the perception and actuality that one is cared for, has assistance available from other people, and most popularly, that one is part of a supportive social network. These supportive resources can be emotional (example, nurturance), tangible (example, financial assistance), informational (example, advice), or companionship (example, sense of belonging) and intangible (example, personal advice).

Exhaustion: a state of extreme physical or mental tiredness.

Emotional distress**:** a highly unpleasant emotional reaction (as anguish, humiliation, or fury) which results from another's conduct and for which damages may be sought.

A caregiver or carer**:** is an unpaid or paid member of a person's social network who helps them with activities of daily living. Caregiving is most commonly used to address impairments related to old age, disability, a disease, or a mental disorder.

Typical duties of a caregiver might include taking care of someone who has a chronic illness or disease; managing medications or talking to doctors and nurses on someone's behalf; helping to bathe or dress someone who is frail or disabled; or taking care of household chores, meals, or bills for someone who cannot do these things alone.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter of the research deals with the research design, target population, sample size and sampling techniques, instrument, scoring, procedure for the study, ethical consideration and data management and analyses.

3.1 Research Design

This study employed a survey research design. Surveys are useful in that a researcher is able to gather the information that is not likely to be available from another source and the information gathered usually provides an unbiased representation of the target population. The design enabled the researcher to reach many respondents to obtain the representative sample of the population. Surveys also provide a means of standardizing the data collection because the same data is collected from every respondent. Survey methodology was employed because it aids the collection of quantitative data from the field for analysis using a questionnaire.

3.2 Target Population

Although the entire population usually does not participate in a research study, the results from the study are generalized to the entire population. The target population was two hundred and forty (240). The population was the family caregivers of the aged 70-100 years in the Methodist Church of the Accra Diocese. The researcher used the aged because, between 70-100 years, the aged need support in all their endeavors. Therefore, the caregivers were in a better position to respond effectively to the questionnaire.

3.3 Sample Size and Sampling Techniques

Fowler (2014) posited that responses and findings of the sample size are usually projected to reflect the entire population as such the sample size should be representative of the population. In selecting the sample size for the study, the researcher used simple random sampling technique for the selection of the respondents because each individual in the population was given equal chances of being selected. Also, it gives a fair representation thereby preventing bias in selecting respondents. Also, simple random sampling technique is a type of probability sampling that makes it easy to interpret data collected. The sample size of one hundred and twenty (120) was selected for the study on Fraenkel and Wallen (2006) proposal of sampling size based on the proper representation of the entire population. Respondents were selected from twelve (12) circuits among the twenty-three (23) circuits in the Accra Diocese of the Methodist Church. These were as follows; Mamprobi Circuit 20, Korle Gonno Circuit 20, Kaneshie North 20, Abossey Okai 20, Lartebiokorshie 10, Dansoman 20 and Kaneshie 10.

3.4 Measures and Instruments

A questionnaire is used as the data collection instrument. The questionnaire is made up of both open and close-ended questions which respondents would be asked to tick the appropriate answer.

The questionnaires would be divided into various sections to capture the critical areas spelt out in the objectives for the study. Also, the study used the following measuring instruments to collect the data. Background information data was collected about the type of caregiver, duration of caregiving, relationship with aged, age, gender, marital status, and education.

3.5 Scoring

3.5.1 The Kessler Psychological Distress Scale (K10)

The K10 scale involves 10 questions about emotional states each with a five-level. Each item is scored from one ‘none of the time’ to five ‘all of the time’. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50. Low scores indicate low levels of psychological distress, and high scores indicate high levels of psychological distress (Kessler, 2003).

2.5.2 Dukes social support inventory (DSSI)

Social support was measured by the DSSI (Koenig et al., 1993), which is 23 items in three subscales: Social Interaction (SIS, 4 items), Subjective Social Support (SSS, 7 items) and Instrumental Social Support (ISS, 12 items). One example is, “How many family members could this person depend on or feel close to?” SIS and SSS subscales are answered on a 3-point Likert format; the ISS subscale is dichotomous. The DSSI total score is the sum of scores of SIS, SSS, and SIS, and it can range from 11 to 45, which a higher score of DSSI means more social support.

2.5.3 Maslach Burnout Inventory (MBI)

It contains 22 items, making up 3 subscales: emotional exhaustion, depersonalization, and personal achievement concerning occupational burnout. On the Emotional Exhaustion (EE) subscale, a subject was considered to have a low score if the aggregate of the different scores was between 0-16. This projected that the subject experienced a low level of emotional exhaustion. Likewise, on the Depersonalization (DP) subscale, a subject was considered to have a low score if the entirety of the different score was between 0-8. This was also understood as a low level of depersonalization. On the Personal Achievement (PA) subscale, scoring is in reverse trend to EE and DP subscales. When the totality of the different scores was between 0-30, the subject was considered to have a high score, and inferred as having a high level of personal accomplishment. When the sum of the individual scores was between 31-36, the subject was considered to have a moderate score, suggesting a moderate level of personal accomplishment. A total score of 37 and above was considered a low score and interpreted as a low level of personal accomplishment (Amosun & Dantile, 1996).

3.6 Data Collection Procedure

An introductory letter was collected from the psychology department and sent to the churches to seek permission. The questionnaire was a self-administered questionnaire to the family caregiver to ensure high response. The researcher explained to the respondents the purpose and importance of the study. Respondents who had difficulties reading and understanding some of the items on the questionnaires was explained to them to obtain the desired response. The administration of the questionnaire took 3 weeks, and each respondent used a maximum of twenty minutes to complete the questionnaire.

3.7 Ethical Consideration

Some ethical issues were considered for this study. These ethical issues include: the researcher sent a letter of introduction to churches to seek permission to gather data from the various churches. Respondents were made aware of the essence of the research and a written consent was sought from them. In other words, respondents' participation in the research was voluntary and respondents could leave anytime they wanted to discontinue in taking part in the study.

Respondents were assured of the confidentiality of the information they gave out to the researcher. Plagiarism of other authors' works were curtailed by the researcher through the acknowledgement of the use of other authors' works. The University of Ghana code of ethics was adhered to.

3.8 Data Management and Analyses

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 23. SPSS and excel was used because it makes analysis easy and are also reliable. It is also easier to define variables, input data and generate output or reports. Variables were coded in the variable view and the answered questionnaires (data) also were entered in the data view to generate the required reports in a form of frequency tables. All data collected for the purpose of this study is safely kept. The quantitative data (completed questionnaires, hard copies) are kept safely in a locked compartment provided by the researcher's supervisor in the Department of Psychology. Also, electronic copies of the quantitative data are safely kept in the researcher's computer that is encrypted with a password known by the researcher only. The researcher has ensured that all data is kept safely to ensure confidentiality and to avoid possible access by any third party to the data.

CHAPTER FOUR

ANALYSIS OF DATA

4.1 Introduction

This chapter presents the analysis of data gathered from family caregivers of the aged in the Accra Diocese of the Methodist Church. This section was divided into three main sections, namely: background information, hypotheses and summary of findings. The details of the results are presented below.

4.2 Background Information

The background information contains the statistical data and data was collected about the type of caregiver, duration of caregiving, relationship with aged, age, gender, marital status, and education. The summary of the background information is given in Table 4.1:

Table 4.1: Demographic Table

A table showing summary of demographic information for respondent

Variable	Response	Frequency	Percentage
Type of Caregiver	Informal	71	59.2
	Formal	47	39.2
	Nurse	2	1.6
	Total	120	100
Duration of Caregiver	Less than 5 years	77	64.2
	5-10 years	27	22.5
	11-15 years	8	6.6

	16-20 years	7	5.8
	More than 20 years	1	0.8
	Total	120	100
Education	Tertiary	56	46.6
	SSS / O-Level	26	21.6
	JSS / Middle School	21	17.5
	Primary	7	5.8
	None	10	8.3
	Total	120	100
Relationship	Relative	53	44.2
	Parent	49	40.8
	Other	10	8.3
	Friend	8	6.6
	Total	120	100
Age	Less than 20years	6	5
	20-40 years	25	20.8
	41-60 years	45	37.5
	61-80 years	25	20.8
	More than 80 years	19	15.8
	Total	120	100

Source: Field data, 2020

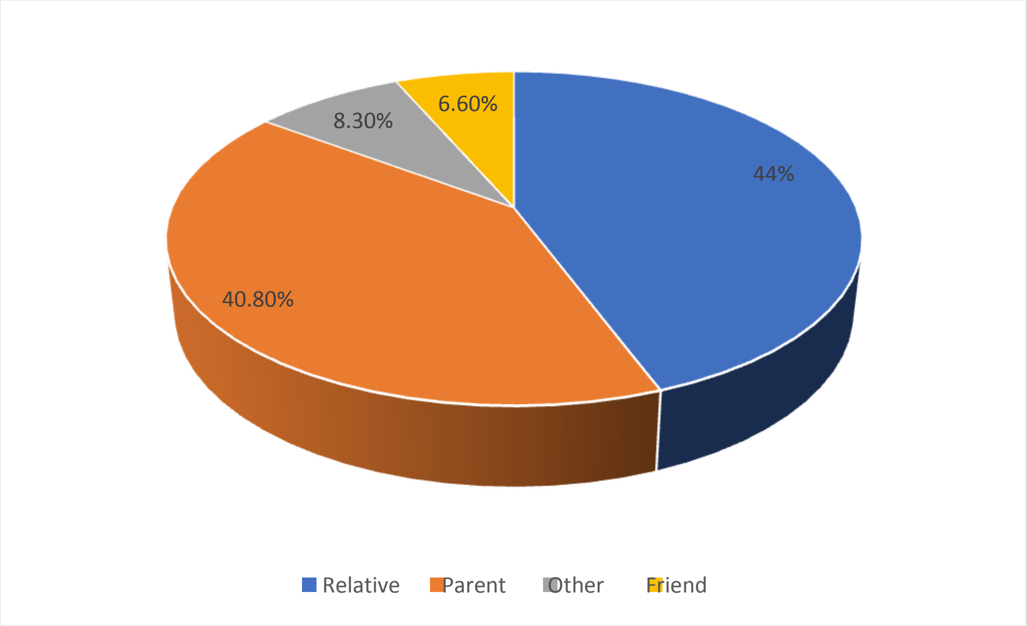

Figure 4.1: Relationship with Aged of Respondents

Source: Field data, 2020

Majority of the caregivers in this study (44.2%) are relatives of the aged, 40.8% are parents while 8.3% and 6.6% belong to the others and Friend category.

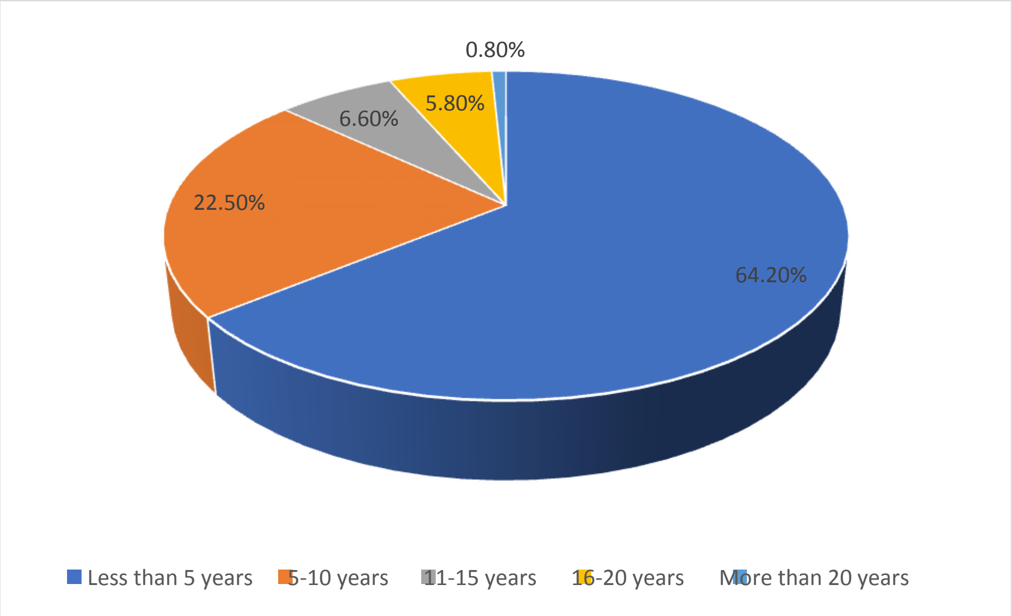

Figure 4.2: Duration of Caregiving

Source: Field data, 2020

The duration spent by the caregivers in this study indicated 64.2% of the respondent have spent less than five years with the aged, 22.5% have been with the aged for 5-10 years followed by 6.6% giving 11-15 years of caregiving. 5.8% and 0.8% were recorded for 16-20 years and more than 20 years of duration for caregiving.

4.3 Hypothesis Testing

4.3.1 Hypothesis One

The first hypothesis states that "social support significantly predict emotional distress". The result is presented in the Table 4.2.

Table 4.2: Linear Regression Test Result showing whether social support significantly predicts emotional distress

Model	B	SEB	Β	t	P
Constant	32.914	4.156			
Social support	.329	.131	.234	2.509	.064

a. Dependent Variable: emotional distress

Table 4.2 shows the R (regression) coefficient (r = 0.234) and the p-value at 0.064, which means that the relationship between social support and emotional distress scores is positive. Thus, high social support increases the tendency of people making positive decisions concerning their emotional distress. At 5% level of significance, social support significantly predicts emotional distress in this study. Thus the hypothesis is accepted.

4.3.2 Hypothesis Two

The second hypothesis states that “social support significantly predicts physical exhaustion.” The result is presented in Table 4.3.

Table 4.3: Linear Regression Test Result on whether social support significantly predicts physical exhaustion

Model	B	SEB	β	t	P
Constant	53.943	10.432			
Social support	.039	.330	-.211	.119	.015

b. Dependent Variable: Physical exhaustion

Table 4.3 shows the R (regression) coefficient (r = - 0.211) and p-value at 0.015, A regression correlation coefficient (r = - 0.211) means there is a negative relationship between social support and physical exhaustion. With a p-value = 0.015, the null hypothesis is rejected (at the 5% level). Hence social support as an independent variable could not significantly predict physical exhaustion.

4.3.3 Hypothesis Three

The third hypothesis states that “emotional significantly predicts physical exhaustion.” The result is presented in Table 4.4.

Table 4.4: Linear Regression Test Result on whether emotional distress significantly predicts physical exhaustion

Model	B	SEB	β	t	P
Constant	47.132	5.627			
Emotional distress	.246	.233	.101	1.060	.292

c. Dependent Variable: Physical exhaustion

Table 4.4 shows that the linear regression analysis was used to test whether emotional distress influences physical exhaustion. The result shows a correlation coefficient (r = 0.101) and a p-value at 0.292 (at the 5% level). Which means that there is a relationship between emotional distress and physical exhaustion scores. Hence emotional distress significantly predicts physical exhaustion.

4.3.4 Hypothesis Four

The fourth hypothesis states that “Gender significantly predicts social support, emotional distress and physical exhaustion” Result is presented in Table 4.5.

Table 4.5: Linear Regression Test Result on whether Gender significantly predicts Social support, emotional distress and physical exhaustion

Model	B	SEB	β	T	P
Constant	1.579	.178			
Gender	.002	.002	.122	1.283	.202

a. Dependent Variable: Social support, emotional distress, and physical exhaustion

In Table 4.5, linear regression was used to test whether gender influence social support, emotional distress and physical exhaustion. The result indicates a correlation coefficient (r = 0.122) and p-value = 0.202. Which means that there is a positive relationship between gender on social support, emotional distress, and physical exhaustion (at the 5% level). This implies that gender has an influence on social support, emotional distress, and physical exhaustion in this study.

4.3.5 Hypothesis Five

The fifth hypothesis states that "physical exhaustion and emotional distress of caregivers influences years of caregiving." The result is presented in Table 4.6.

Table 4.6: Linear Regression Test Result on whether physical exhaustion and emotional distress influences years of caregiving

Model	B	SEB	β	t	P
Constant	1.533	1.581			
Physical exhaustion and emotional distress	.038	.020	.178	1.894	.061

a. Dependent Variable: Years of caregiving

In Table 4.6, linear regression analysis was used to examine whether physical exhaustion and emotional distress influences years of caregiving. The result shows the R (regression) coefficient (r = 0.178) and a p-value at 0.061, Hence we accept the null hypothesis (at the 5% level). This implies that there is a positive relationship between duration of years on physical exhaustion and emotional distress. Hence physical exhaustion and emotional distress significantly predicts years of caregiving.

4.4 Summary of Findings

The study tested five hypotheses. Linear regression was used to test all the five hypotheses. The first hypothesis indicated that social support significantly predicts emotional distress. The second hypothesis established that social support has a negative correlation with physical exhaustion was rejected. The third hypothesis was supported and established that emotional distress influences physical exhaustion. The fourth hypothesis established that social support, emotional distress, and physical exhaustion significantly predicts gender was supported. The fifth hypothesis was accepted, and it established that physical exhaustion and emotional distress influences duration of years.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings from the stated hypotheses, summary of findings, conclusion, and recommendations.

5.2 Social support and emotional distress

The data collected and analyzed on the first hypothesis states that "social support has a positive correlation with emotional distress". Thus, social support significantly predicts emotional distress. This implies that the higher social support increases higher the tendency of people making positive decisions concerning their emotional distress. The finding is in line with Fitzell and Pakenham (2010) because they stipulated that the availability of social support and satisfaction with it were positively correlated to adjustment and negatively correlated to distress. Also, Chen and Greenberg (2004) found that increased social support contributed to more reported positive outcomes of caregiving. On the contrary, the finding is inconsistent with the study by Miller and colleagues (2001) who revealed that lower levels of informal instrumental and emotional support are linked with higher levels of depressive symptoms. This means the type of social support a caregiver receives also can influence emotional distress. Wakui and colleagues (2012) found that weekly engagement in home or social activities by Japanese family caregivers was significantly related to lower depression scores.

The Stress Process Model attempted to explain effective coping and social support as mediators. Interest in these mediators is based on trying to determine if differences in how one responds can be attributed to coping mechanisms or social support (Pearlin et al., 1990). Pearlin, Lieberman, Menaghan, and Mullan (1981) referred to coping in relation to its function, which includes "the modification of the situations giving rise to stressful problems; the modification of the meaning of problems in a manner that reduces their threat; and the management of stress symptoms" (p. 341).

5.3 Social support and physical exhaustion

The data collected and analyzed on the second hypothesis states that "social support has a negative correlation with physical exhaustion." The analysis reveals that social support does not influence physical exhaustion in this study. The result is inconsistent with the findings of Kim et al. (2011) and Losada et al. (2010). They indicated that the amount of perceived social support plays an important role in predicting depressive symptoms thus lower perceived social support is related to higher levels of depressive symptoms.

This finding can be explained by Stress Process Model which indicates that the process of stress, examining the relationships among concepts vary and change over time. This examines four domains of the stress process: background and context of stress, the stressors, the mediators of stress, and the outcomes and manifestations of stress (Pearlin, Mullan, Semple, & Skaff, 1990).

5.4 Emotional distress and physical exhaustion

The data collected and analyzed on the third hypothesis states that "emotional distress has a positive correlation with physical exhaustion." The result from the analysis indicates that emotional distress significantly predicts physical exhaustion. This clearly implies that the increase in emotional distress has influence on physical exhaustion thus higher levels of caregiver distress increase susceptibility to experiencing depressive symptoms. The finding is consistent with that of Peyrovi et al. (2012) who said that positive perceptions of life changes associated with caregiving were related to lower depression scores.

The finding is in line with that of Beach and Schulz (1999). They found out that caregiving is associated with positive outcomes for caregivers. Because they feel positive influencing others by developing a closer relationship with the individual requiring care, experiencing personal growth, developing a sense of mastery over caregiving skills, and feeling useful and like they could give back to other caregivers (Cheng, Mak, Lau, Ng, & Lam, 2016). The result is inconsistent with Chan et al., (2013) who although agree that caregiving has positive benefits for caregivers by influencing others, but he reiterated that caregivers are at a higher risk of negative, physical, and mental health outcomes than non-caregivers. The researcher thinks that although the caregivers will be happy in influencing others life, there is the need to also equally ensure that they are in good health. Therefore Czaja et al., (2009) indicated that depression affects a caregiver's health, which in turn affects his or her ability to provide care. Caregivers' depression impacts the care and quality of life of the individual requiring assistance, increasing the risk of institutionalization for the care-recipient.

This finding can be explained by Stress Process Model which indicates that the development of negative outcomes from primary subjective and objective stressors plus secondary stressors. The objective and subjective measures specifically address the physical and emotional stressors that accompany caregiving. Mediators, including support and the caregiving context, can impact this process and resultant outcomes (Gaugler, Anderson, Zarit, & Pearlin, 2004).

5.5 Gender, social support, emotional distress and physical exhaustion

The data collected and analyzed on the fourth hypothesis states gender influences social support, emotional distress, and physical exhaustion. The result from the analysis indicates that there is a relationship between independent variable gender and the dependents variable: social support, emotional distress, and physical exhaustion. This implies that gender influence social support, emotional distress, and physical exhaustion. The finding is consistent with that of Arai et al., (2014). The researcher indicated that certain demographic predictors cause depression. The researchers gave an example of lower income that can lead to higher rates of depressive symptoms and as such income influences an individual's ability to access resources. When linked to gender, it can lead to social support, emotional distress, and physical exhaustion.

The findings are consistent with that of Williams, Barclay and Schmied (2004). They stipulated that social support is complex in relation to the context and interactions necessary to request, accept and receive support. This is not quite surprising that is why Finfgeld-Connett (2005) reported that emotional support includes those activities or behaviors viewed as comforting, aimed to decrease levels of uncertainty, anxiety, hopelessness, and depression. This means that social support relief or decreases the level of exhaustion, anxiety, uncertainty, and distress. The view of Finfgeld-Connett (2005), has been supported by Chappell and Funk (2011) that social support result in the reduction of distress, stress, loneliness, depression, cognitive decline, biological risk, life satisfaction, psychological health, physical health, functional ability, survival, cognition ability, and adjustment to institutionalization.

This finding can be explained by Stress Process Model which proposes that the background and context of the stress for caregivers included individual caregiver characteristics such as age, gender, ethnicity, educational, occupational, and economic characteristics (Pearlin et al., 1990). Additional components important to the caregiver context include caregiving history, family and network composition, and access to and use of resources.

5.6 Duration of years, physical exhaustion and emotional distress

The data collected and analyzed on the fifth hypothesis which states that “duration of years has a positive relationship with physical exhaustion and emotional distress.” The result indicates that physical exhaustion and emotional distress significantly predicts duration of years. This implies that the duration of years influences physical exhaustion and emotional distress. The finding is consistent with Barker (2002) who highlighted that the quality of emotional connectedness, associations with informal caregivers, and assistance with tasks performed influence the naturally occurring care relationships in community-living older adults.

Based on the usefulness accorded to the aged, Cheng et al. (2016); Li and Loke (2013) posited that caregivers spend an increased amount of time with the aged requiring care, enabling the caregiver to know their family member in a new way and to gain a deeper appreciation for their relationship. This notion helps the caregivers to treat the aged with care since the caregivers have established rapport with the family. There is the need for us to know that those who take care of the aged, majority are relatives, meaning they already know the aged in one way or the other. Peacock et al., (2010) supported Cheng et al. (2016); Li and Loke (2013) by arguing that caregiving skills mastered enable caregivers to feel more competent while providing care. The result is inconsistent with Smith and colleagues (2011). They reported that caregivers who were more depressed provided less respectful care and reported more potentially harmful behavior and therefore they do not treat the aged to feel useful in the family. Czaja et al. (2009), when the aged are not felt as useful in the family, it affects the care and quality of life of the individual requiring assistance, increasing the risk of institutionalization for the care- recipient.

5.7 Findings

The study tested five hypotheses. Linear regression was used to test all the five hypotheses. The first hypothesis indicated that social support predicts emotional distress. The second hypothesis established that social support has a negative correlation with physical exhaustion was rejected. The third hypothesis which states that emotional distress predicts physical exhaustion was supported and established that emotional distress influences physical exhaustion. The fourth hypothesis established that social support, emotional distress and physical exhaustion predicts gender was supported. The fifth hypothesis was accepted and it established that physical exhaustion and emotional distress influences duration of years.

5.8 Conclusion

Generally, the study examined the influence of Social Support on Physical Exhaustion and Emotional Distress: A Case Study of Family Caregivers of the aged 70-100 years in the Methodist Church of the Accra Diocese. Its objectives assessed how social support relief physical exhaustion and emotional distress in family caregivers, the burden of family caregivers, whether background context factors (age, gender, ethnicity, employment status, caregiver education, caregiver relationship and income) contribute to differences in social support on physical exhaustion and emotional distress scores. It also examined caregiving demands, length of time caregiving and if caregiver burden contribute to the prediction of social support on physical exhaustion and emotional distress in family caregivers. It also assessed caregiving demands, length of time caregiving and if caregiver burden contribute to social support in family caregivers. The most influential social support relief physical exhaustion is that in the past 4 weeks, the majority feel that everything was an effort, and the burden of family caregivers is that they feel they are positively influencing other people's lives through their work. Also, the study found out that the most influential social support duke inventory is feeling useful to the family.

All the hypotheses that were tested using the linear regression were significant and therefore social support has influence on physical exhaustion and emotional distress.

5.9 Recommendations

Based on the findings of the study, the following recommendations have been made for consideration:

Family Commitment

Family members should remain committed and play active part of the care of their elderly relatives, instead of leaving everything in the care of a single individual. The study discovered that when other family members shoulder some of the caregiving duties, however little, the significant caregiver does not suffer much consequence. The significant caregiver will require social support, encouragement, and incentives to keep on providing the hands-on care. Family heads should ensure that other family members remain committed to the care of the elderly relative. Where it becomes difficult to ensure the commitment of family members, the church leaders can call such relative(s) to order. Similarly, family members must endeavor to completely shoulder the financial responsibilities of caregiving of their elderly relatives. The study found out that the informal caregiver cannot easily meet the financial needs of the care recipient whiles providing hands-on care. Since the informal caregiver who provides the hands- on care cannot easily engage in any income generating activity, it becomes necessary for other members within the family who are capable to assume the financial obligation throughout the caregiving period.

Education

A sustainable church education should be spearheaded by the Methodist Church and the various Circuits in the Accra Diocese to provide practical knowledge for the caregivers on the care of the elderly, age-related changes, behavioral and attitudinal changes in elderly people. From the study, some caregivers indicated that though knowledge in age-related changes was important for effective caregiving, very few informal caregivers had this knowledge. With this education, the informal caregivers will understand the life course of their care recipients, accept, and expect these changes and be more prepared to care for the elderly without experiencing emotional distress and the surprises that come with behavioral changes in the elderly.

Counselling

The emotional consequences suffered by informal caregivers affect the totality of their life. In view of that, Counsellors/Pastoral Caregivers in the various churches should consider providing counselling services in gerontology for both informal caregivers and their elderly care recipients. Providing counselling will enable the informal caregivers to endure the challenges and pressures that caregiving presents. This area of counselling can be a fertile ground for professional counsellors and social workers in the Methodist Church to explore.

Insulating Caregivers from Social Isolation

Church Leaders, organizations and societies must recognize the need to develop programs and services to help informal caregivers deal with social isolation. This should include regular visits and occasionally helping informal caregivers with their caregiving duties. It will be helpful for societies to organize mini services and programs at the homes of some of the elderly. This will benefit both the caregivers and the care recipients. The church should take up this role and strengthen their social relationship with members who have become immobile because of sickness, frailty, disability, or caregiving burden. The recommendations are useful to help alleviate the consequences; physical exhaustion and emotional distress that informal caregivers suffer and help maximize the satisfaction they obtain especially through social support. Though, the recommendations are geared primarily toward the informal caregivers, the elderly care recipients will benefit from the outcomes as well.

In-depth Research

Further studies by researchers in gerontology should delve into then correlation between the consequences of informal caregiving on the overall health of the caregivers. This will highlight more on how informal caregivers address or deal with elderly care recipients with physical health conditions. It will also reveal whether or not caregivers are affected by any of these terminal illnesses suffered by the care recipients. Again, further studies should focus on comparative analysis of the satisfaction and consequences of informal care. Research should be able to identify clearly whether informal caregivers obtain more satisfaction or fulfilments than the consequences they suffer or vice versa. With this, stakeholder analysis of the experiences of informal care will be easier whiles interventions will be based on objective rather than subjective indicators.

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APPENDIX

QUESTIONNAIRE

METHODIST UNIVERSITY COLLEGE

This questionnaire has been designed to solicit information for purely academic purposes. This is to enable the researcher Deborah O. Benjamin-Addy a final year students of **METHODIST UNIVERSITY COLLEGE**, complete her project work on the topic; **THE INFLUENCE OF SOCIAL SUPPORT ON PHYSICAL EXHAUSTION AND EMOTIONAL DISTRESS: A CASE STUDY OF FAMILY CAREGIVERS OF THE AGED 70-100YEARS IN THE METHODIST CHURCH- ACCRA DIOCESE.**

NB: All information given would be treated with utmost confidentiality. Thank you.

Section A: Personal Information

Please, tick or provide information where necessary.

1. Type of caregiver
   a. Formal [ ] b. Informal [ ] c. Nurse [ ]
2. Duration of caregiving ………………….
3. Relationship with the aged
   a. Relative [ ] b. Parent [ ] c. Friend [ ] d. Other ……………
4. Age …………….
5. Gender
   a. Male [ ] b. Female [ ]
6. Marital status
   a. Single [ ] b. Married [ ] c. Divorced [ ] d. Widowed [ ]
7. Highest level of education
   a. None [ ] b. Primary [ ] c. JSS/Middle [ ] d. SSS/O'level [ ] e. Tertiary [ ]

Section B

Kessler Psychological Distress Scale (K10). Please tick the answer under the number below by using the following five-Likert point:

All of the time = 5, Most of the time =4, Some of the time = 3, A little of the time = 2, None of the time = 1.

STATEMENT	**5**	**4**	**3**	**2**	**1**
1. In the past 4 weeks, about how often did you feel tired out for no good reason?					
2. In the past 4 weeks, about how often did you feel nervous?					
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?					
4. In the past 4 weeks, about how often did you feel hopeless?					
5. In the past 4 weeks, about how often did you feel restless or fidgety?					
6. In the past 4 weeks, about how often did you feel so restless you could not sit still?					
7. In the past 4 weeks, about how often did you feel depressed?					
8. In the past 4 weeks, about how often did you feel that everything was an effort?					
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?					

In the past 4 weeks, about how often did you feel worthless?					

SECTION C

MASLACH BURNOUT INVENTORY – HUMAN SERVICES SURVEY

Please, read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, then tick inside the “0” (zero) box after the statement. If you have had this feeling, indicate how often you feel it by ticking inside the appropriate box (from 1 to 6) that best describes how frequently you feel that way.

Never = 0, A few times a year or less = 1, Once a month or less = 2, A few times a month or less = 3, Once a week = 4, A few times a week = 5, Every day = 6

STATEMENT		0	1	2	3	4	5	6
1.	I feel emotionally drained from my work.							
2.	I feel used up at the end of the workday.							
3.	I feel fatigued when I get up in the morning and have to face another day on the job.							
4.	I can easily understand how my patients feel about things.							
5.	I feel I treat some patients as if they were impersonal objects.							
6.	Working with people all day is really a strain on me.							
7.	I deal very effectively with the problems of							

	my patients.							
8.	I feel burned out from my work.							
9.	I feel I’m positively influencing other people’s lives through my work.							
10.	I’ve become more callous toward people since I took this job.							
11.	I worry that this job is hardening me emotionally.							
12.	I feel very energetic.							
13.	I feel very frustrated by my job.							
14.	I feel I’m working too hard on my job.							
15.	I don’t really care what happens to some patients.							
16.	Working with people directly puts too much stress on me.							
17.	I can easily create a relaxed atmosphere with my patients.							
18.	I feel exhilarated after working closely with my patients.							
19.	I have accomplished many worthwhile things in this job.							
20.	I feel like I’m at the end of my rope.							
21.	In my work, I deal with emotional problems calmly.							

22.	I feel patients blame me for some of their problems.							

SECTION D

SOCIAL SUPPORT DUKE INVENTORY (MODIFIED FOR STUDY).

Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling tick inside the "0" (zero) box after the statement. If you have had this feeling, indicate how often you feel it by ticking inside the appropriate box (from 1 to 3) that best describes how frequently you feel that way. Hardly ever =1, Some of the time=2, Most of the time=3

STATEMENT		1	2	3
1.	In times of trouble, can you count on at least some of your friends?			
2.	When you are with your friends, how often do you feel lonely?			
3.	Does it seem that your friends understand you?			
4.	Do you feel useful to your friends?			
5.	Do you know what is going on with your friends?			
6.	When you are talking with your friends, do you feel you feel you are being listened to?			
7.	Do you feel you have definite role among your friends?			
8.	Can you talk about your deepest problems with at least some of your family and friends?			

9.	Do you feel that you have a definite role in your family?			
10.	Can you talk about your deepest problems with at least some of your family?			
11.	Do you feel useful to your family?			
12.	Do you know what is going on with your family?			
13.	When you are talking with your family, do you feel you are being listened to?			
14.	Do you feel you have a definite role in your family?			
15.	Can you talk about your deepest problems with at least some of your family?			