Journal of Psychology and Behavioural Disciplines, COOU, Vol. 2, No 2, July, 2022.
Published by Psychology Department, Chukwuemeka Odumegwu Ojukwu University (COOU), Anambra State, Nigeria.
ISSN (PRINT): 2814-3183: e-ISSN (ONLINE): 2955-0572

MENTAL-HEALTH AMONG HEALTH-CAREGIVERS IN ANAMBRA STATE, NIGERIA, AND ITS SOCIAL SUPPORT CORRELATE

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ABSTRACT: *The study investigated mental-health among health-caregivers in Anambra State, Nigeria, and its social support correlate. Total of 224 health-caregivers sampled through purposive sampling, with mean-age of 45.41, SD 8.89, 42(18.8%) males, and 182(81.3%) females participated. The instruments were Multidimensional Scale of Perceived Social Support (MSPSS), and Mental Health Continuum-Short Form. The study adopted correlational design, and Pearson Product Moment Co-efficient to examine the relationships between study variables. Findings were that social support significantly (friends, family, and significant others) correlated with mental-health. Recommendation was for social support (empathy) to be shown to health-caregivers for them to work effectively.*

KEYWORDS: Mental-Health, Social Support, and Health Caregivers

INTRODUCTION

Health caregivers are workers that provide care for patients. Health caregivers are also there for the patient to help them cope with their situation. A health caregiver experience might be positive which helps them to cope with the illness or condition of the patients. However, most of the time it is demanding; mind consuming and may have a negative effect on the caregiver (Herbert, Arnold Robert, & Schulz, 2017). The negative effect could be physical and psychological reactions as highlighted by World Health Organization (2018). Because they assume many different roles for instance physical role which includes giving medication, personal assistance like bathing, dressing, monitoring symptoms. Emotional role, these constitutes listening, talking, reading, giving love and companionship and practical role such as handling financial matters (Hudson *et al.,* 2018).

In addition to these responsibilities health caregivers have to deal with, their loved ones are also in much pain, not to mention the impending death of someone they care about. These aspects pose an exclusive challenge no matter how experienced and hardy a caregiver may be. The emotional, social, physical and financial consequences of caring for a loving family member are hefty. These impacts are manifested in health caregiver as exhaustion, fatigue, anxiety, sleeplessness, weight loss, depression and burn out, hence affecting the mental well-being (Hudson et al., 2018). Health caregivers experience more psychological distress, develop anxiety and show signs of depression advancement that is in accordance with the progression of the patient's condition. These stressors not only pose threat to the health caregiver's mental and physical well-being but also endanger the patient; hence the recognition and consideration of caregiving stressors remain essential for not only the health caregiver but also the patient (Ratkowski, Hebert, Arnold, & Schulz, 2017).

Mental health is referred to as a "state of wellbeing" There are many aspects to be considered when speaking of mental healthiness that will encompass a total health. These aspects are satisfaction, accomplishment optimism or positive outlook and so forth, suggesting that physical health alone is not viewed as an individual being healthy. Moreover, mental health is a positive combination of intellectual, emotional physical and spiritual element of an individual. Mental health is usually also seen as an absence of a psychological disorder or having some level of intellectual and emotional well-being, furthermore it is an individual's possession of a positive traits that enables them to enjoy life and to harmonize their daily living and psychological resilience (Basavanthapa., 2017). According to WHO (2018) mental health is defined as a state of well-being in which every individual realizes his or her own potential, can

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cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community. Since, healthy caregiver shows resilience in ability to solve problems through innovation and resourcefulness and in their ability to work together with patients for a common cause.

Hence, social support can be best defined as a complex transactional process in which an active interplay between a person and his or her support network is involved (Vaux, 2018). It includes providing empathy, caring, love and trust, actual aid in time, money and energy, evaluative feedback, and information, advice and suggestions (House, 2017). Social support can be categorized in different ways. In terms of its content, for example, social support can be divided into emotional support (liking, love, empathy); instrumental support (goods and services); informational support (information about the environment); or appraisal support (information relevant to self-evaluation) (House, 2017). In terms of its degree of subjectivity, social support is dichotomized into perceived support and objective or actual support (Caplan, 2019). In terms of the role relationship between the recipient and the donor, social support could be kin-based (e.g., parents, spouses, children, siblings, other relatives) or nonkin-based (e.g., friends, neighbours, co-workers) (Dean & Lin, 2017; Thoits, 2016). In terms of its contexts, social support could be routine support within an ordinary situation or nonroutine support within a crisis situation (Lin, Dean, &Ensel, 2016).

However, study on the mechanisms through which social support influences mental health and well-being is inconclusive (Ganster, Fusilier, & Mayes, 2018; Gore, 2017): However, social support is supposed to have a positive effect on one's mental health and well-being (Kaufmann & Beehr, 2019; Sarason, Sarason, & Pierce, 2018). Social support has been shown to promote mental health and acts as a buffer against stressful life events (Dollete & Phillips, 2018). Social support is derived from a network of people drawn from family, friends and community (Zimet, Dahlem, Zimet, & Farley, 2018). A lack of social support is a determinant of mental health problems including depressive symptoms and has a negative impact on caregivers (Dafaalla, 2016).

Statement of the Problem

There is a growing recognition of the essential role of health caregivers' play. However, there still remain knowledge gaps regarding how to best support caregivers. It is imperative of health caregiver to understand how the home environment and patients might affect their mental health (Morris et al., 2015). Since caregiving is a challenge irrespective or age and no matter how experienced and hardy a caregiver may be. The emotional, social, physical and financial challenges associated with caregiving ere enormous. These fuelled exhaustions, fatigue, anxiety, sleeplessness, weight loss, depression and burn out, hence affecting the mental health of caregiver (Hudson et al., 2018). Unfortunately, health caregivers experience more psychological distress, develop anxiety and show signs of depression advancement that is in consonance with the progression of the patient's condition. These stressors may not only serve as threat to the health caregiver's mental and physical well-being but also affects the patient. Thus, the recognition and consideration of caregiving stressors remain essential for not only the health caregiver but also the patient and scholars (Ratkowski, Hebert, Arnold, & Schulz, 2017). For lack of social support is likely to increase mental health problems including depressive symptoms Dafaalla, 2016). Hence, this study explored if social support will influence mental health among health caregiver in Anambra State in order to fill the knowledge gap in literatures.

Purpose of the Study

1. The purpose of this study is to examine if social support will correlate with mental health among health caregiver in Anambra State, Nigeria.

Research Question

1. To what extent will social support correlate with mental health among health caregiver in Anambra State?

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LITERATURE REVIEW

Theoretical Review

Social Support

Stress Buffering by Cohen and Wills (1985): The theory distinguished between social support's stress buffering and main effects, and this has played a foundational role in shaping research and theory. Stress buffering occurs when social support protects (i.e., buffers) people from the bad effects of stress. Evidence for stress buffering is indicated when the link between life stress and poor mental health is stronger for people with low social support than for people with high social support. A key idea is that in the absence of stress, social support is not linked to mental health (Cohen & Wills, 1985). Main effects occur when people with high social support have better mental health than those with low social support, regardless of stress levels. Stress buffering theory has been thoroughly developed and has dominated social support research. Nearly all research on social support is guided by the assumption that social support's link to mental health reflects stress buffering.

Moreover, even though theory specifically predicts stress buffering, this effect is rarely reported in the coping or appraisal literatures. Finally, coping theory and research have their own empirical and theoretical challenges (Coyne & Gottlieb, 1996; Coyne &Racioppo, 2000) that present additional problems for relying on coping to explain perceived support's link to mental health. Thus, although this literature does not permit definitive conclusions, coping and appraisal do not appear to explain perceived support's link to mental health at present. Thus, stress buffering theory does not provide a complete explanation for main effects between perceived support and mental health. That does not mean that stress buffering does not occur. Rather the well replicated main effects between perceived support and mental health are not completely explained by stress and coping.

Mental Health

Health belief model by Rosenstock (1966): The health belief model (HBM) is perhaps the oldest and most widely used social cognition model in health psychology (Rosenstock 1966; Becker 1974). The HBM has been considered more a loose association of variables that have been found to predict behaviour than a formal model (Conner 1993). The HBM uses two aspects of individuals' representations of health behaviour in response to threat of illness: perceptions of illness threat and evaluation of behaviours to counteract this threat. Threat perceptions are seen to depend upon two beliefs: the perceived susceptibility to the illness and the perceived severity of the consequences of the illness. Together these two variables are believed to determine the likelihood of the individual following a health-related action, although their effect is modified by individual differences in demographic variables, social pressure and personality.

The particular action taken is believed to be determined by the evaluation of the available alternatives, focusing on the benefits or efficacy of the health behaviour and the perceived costs or barriers to performing the behaviour. So, individuals are likely to follow a particular health action if they believe themselves to be susceptible to a particular condition which they also consider to be serious, and believe that the benefits of the action taken to counteract the health threat outweigh the costs.

Empirical Review

Social Support

Shadabi, Saeieh, Qorbani, Babaheidari, and Mahmoodi (2021) determined the relationship of supportive roles with mental health and satisfaction with life in female household heads in Karaj, Iran using a structural equations model. The x descriptive-analytical study was conducted on 286 eligible female household heads in Karaj, Iran, in 2020, who were selected by convenience sampling. Data were collected using Vaux's Social Support, the perceived social support scale, the general health questionnaire (GHQ), and the satisfaction with life questionnaire plus a socio-demographic checklist, and were analyzed in SPSS-16 and Lisrel-8.8. The participants' mean age was 43.1 ± 1.7 years. According to the path analysis results, satisfaction with life had the highest direct positive relationship with perceived social support (B = 0.33) and the highest indirect

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positive relationship with age (B = 0.13) and the highest direct and indirect positive relationship with education and social support (B = 0.13). Also, mental health had a direct negative relationship with satisfaction with life (B = -0.29), an indirect negative relationship with social support, and both a direct and indirect negative relationship with perceived support (B = -0.26).

Bedaso, Adams, Peng, and Sibbritt (2021) examined the relationship between social support and mental problems during pregnancy. The PRISMA checklist was used as a guide to systematically review relevant peer-reviewed literature reporting primary data analyses. PubMed, Psych Info, MIDIRS, SCOPUS, and CINAHL database searches were conducted to retrieve research articles published between the years 2000 to 2019. The Newcastle-Ottawa Scale tool was used for quality appraisal and the meta-analysis was conducted using STATA. The Q and the I^2 statistics were used to evaluate heterogeneity. A random-effects model was used to pool estimates. Publication bias was assessed using a funnel plot and Egger's regression test and adjusted using trim and Fill analysis. From the identified 3760 articles, 67 articles with 64,449 pregnant women were part of the current systematic review and meta-analysis. From the total 67 articles, 22 and 45 articles included in the narrative analysis and meta-analysis, respectively: From the total articles included in the narrative analysis, 20 articles reported a significant relationship between low social support and the risk of developing mental health problems (i.e. depression, anxiety, and self-harm) during pregnancy. After adjusting for publication bias, based on the results of the random-effect model, the pooled odds ratio (POR) of low social support was AOR: 1.18 (95% CI: 1.01, 1.41) for studies examining the relationship between low social support and antenatal depression and AOR: 1.97 (95% CI: 1.34, 2.92).

Mental Health

Tibubos, Otten, Ernst and Beutel (2021) explored the mental health and health behaviour ramifications. They systematically searched the databases PsyArXiv, PubMed, PsycInfo, Psyndex, PubPsych, Cochrane Library, and Web of Science for studies assessing mental health outcomes (main outcomes) as well as potential risk and protective health behavior (additional outcomes) up to July 2, 2020. Findings showed most of the 80 publications fulfilling the selection criteria reflected the static difference perspective treating sex and gender as dichotomous variables. The focus was on internalizing disorders (especially anxiety and depression) burdening women in particular, while externalizing disorders were neglected. Sex- and gender-specific evaluation of mental healthcare use has also been lacking. With respect to unfavorable health behavior in terms of adherence to prescribed protective measures, men constitute a risk group.

Coughlan *et al.*, (2021) investigated online mental health animations for young people. Qualitative data were collected from a sample of 17 youth in Ireland, aged 18-21 years, as part of the longitudinal population-based Adolescent Brain Development study. Interviews explored the life histories and the emotional and mental health of participants. The narrative analysis revealed 5 thematic findings relating to young people's emotional and mental health. Through a collaboration between research, the Arts, and the online sector, the empirical thematic findings were translated into 5 public health animations. The animations were hosted and promoted on 3 social media platforms of the Irish youth health website called SpunOut. Viewing data, collected over a 12-month period, were analyzed to determine the reach of the animations. Results showed that narrative thematic analysis identified anxiety, depression, feeling different, loneliness, and being bullied as common experiences for young people. These thematic findings formed the basis of the animations.

During the 12 months following the launch of the animations, they were viewed 15,848 times. Donisi, Tedeschi, and Gonzalez-Caballero, (2021) examined mental well-being in the oldest old different from that in younger age groups in Europe. Using a resources approach, the study provided empirical evidence about the structure of MWB in the 80 + year age group and to compare this with the structure of MWB in the old (65–79 years) and adult (18–64 years)

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population. Twenty-eight items reflecting a focus on positive aspects of MWB were selected from the European Social Survey data (24 countries). After application of an exploratory approach using Exploratory Structural Equation Modelling, five- and six-factor model solutions were found to be statistically appropriate, and the results are consistent with the most widely studied dimensions of MWB. Despite specific differences in the factor models and item loadings, evaluation of formal invariance showed that dimensions built in the same way are comparable across age groups.

Hypothesis

1. Social support will significantly influence mental-health of health-caregivers in Anambra State, Nigeria.

METHOD

Participants: Two hundred and twenty-four health caregivers participated in the study; they were drawn from Teaching Hospital Nnewi, Psychiatric Hospital Nawfia, and General Hospital Onitsha, all in Anambra State, Nigeria. In the study purposive sampling technique (non-probability) was adopted for the selection of the participants. Because the participants are the ones with knowledge, experience, and clear understanding of the operational functioning of health caregiver activities at all times. The participants' age is from 30 to 58 years with mean age of 45.41 and standard deviation of 8.89. The participants' comprised of 42 (18.8%) males and 182 (81.3%) females. Educational level data showed 34(15.2%) have B. Sc, 38(17.0%) have HND, 86(38.4%) have OND, and 66(29.5%) have SSCE. Marital status data indicated that 162(72.3%) are married, and 62(27.7%) are unmarried. working experience data showed that 55(24.6%) have worked for one to ten years, 77(34.4%) have worked for eleven to twenty years and 92(41.1%) have worked for twenty-one to thirty years.

Instruments: Two instruments were used in the study, namely: Multidimensional Scale of Perceived Social Support (MSPSS) by (Zemet et al, 1988) and The Mental Health Continuum - Short Form byKeyes, Wissing, Potgieter, Temane, Kruger, and van Rooy (2008).

Multidimensional Scale of Perceived Social Support (MSPSS) by (Zemet et al, 1988) had twelve (12) items scale will be used to measure perceived social support. MSPSS measures the three sources of the social support; family support, friends support and significant others support (Zemet et al, 1988). MSPSS was scored on a 6-piont Likert format ranging from 1 "very strongly disagree" to 5 "very strongly agree". Items 3, 4, 8 and 11 measure family supports; items 6, 7, 9 and 12 measures friend support while items 1, 2, 5, and 10 measures significant other support. Sample items on the scale includes, "my family really tries to help me", "I have friends with whom I can share my joys and sorrows", "There is a special person who is around when am in need". Validity of the scale was obtained by Onyishi et al (2010) by reporting that factor loading of the items were relatively high. Reliability of the scale was obtained by Onyishi et al, (2016) by reporting internal consistencies of the subscales (Cronbach's alpha) were: Family, 0.78, friends, 0.76 and significant others, 0.70. Onyishi et al (2016) reported a predictive validity of $p < .01$ by using MSPSS to predict life satisfaction of prison workers.

The Mental Health Continuum Short-Form by Keyes, Wissing, Potgieter, Temane, Kruger, and van Rooy (2008) contained 14 items that are responded to on a six-point Likert scale, which ranges from "never" (1) to "every day" (6). The instrument includes three subscales that assess subjective or emotional well-being (three items), psychological well-being (six items) and social well-being (five items). Keyes (2005b) found reliability values of over 0.94 for all the scales, and for the subscale 0.89 for emotional wellbeing, 0.86 for social wellbeing and 0.93 for psychological wellbeing.

Procedure: The researchers recruited two research assistants that helped them administer the instrument. The research assistants were trained on the modalities of administering the instruments. However, before the researchers embark on the distribution of the questionnaires, the researchers secured the approval of the management of the hospitals used. After securing approval, the researchers and the assistants meet the participants and explained the nature of the

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study to the health caregiver, and the right they have to withdraw from the study if they feel otherwise. Ethically, the researchers secured informed consent of the participants after, the participants were debriefed about the purpose of the study and they were assured of anonymity and privacy of their names as regards to the study. Further, the researchers assured them of the utmost confidentiality of the information they provided.

Design and Statistics: The study adopted correlational design. The statistics adopted for the study was Pearson Product Moment Correlation because the study established relationships between study variables.

RESULT

Descriptive and Pearson Product Moment Coefficient Statistics of Social Support and Mental Health

Sources	Mean	Std. D	1	2	3	4
1. Mental Health	31.80	13.62	1.00			
2. Family Support	7.51	1.70	.67**	1.00		
3. Friend Support	9.60	2.94	.18**	.43**	1.00	
4. Significant Others Support	8.48	2.59	.28**	.41**	.06	1.00

The result showed that family support of social support had significant relationship with mental health at ***r***(224), .67**, p. <.01. Friend support of social support showed significant relationship with mental health at ***r***(224), .18**, p. <.01. Significant others support of social support had significant relationship with mental health at ***r***(224), .28**, p. <.01.

DISCUSSION

The study investigated social support as correlate of mental health among health caregivers in Anambra State. The study confirmed that social support has significant relationship with mental health. This shows that as social support increases mental health of health caregivers increases. This is in line with the idea that mental health and satisfaction with life had the highest direct positive relationship with perceived social support and the highest indirect positive relationship with age and the highest direct and indirect positive relationship with education and social support (Shadabi et al., 2021). Perhaps this happens because low social support usually trigger the risk of developing mental health problems (i.e. depression, anxiety, and self-harm) among health caregivers. If the health caregivers lacked resilience that couldfacilitate social support and thereby promote mental health.Since, the perception of social support affectsmental health. Health caregivers who had a high balance of affections had a greater perception of general social support than the groups of positive evolution of affections and a low balance of affections. In the case of the friends and family support dimensions, the perception in the high-balance group of affections concerning the low-scale group is greater (Cobo-Rendón*et al.,* 2020). Therefore, improving the social support of health caregivers means increasing their mental healthas well as their well-being. So, health caregivers are likely to follow a particular health action if they believe themselves to be susceptible to a particular condition which they also consider to be serious, and believe that the benefits of the action taken to counteract the health threat outweigh the costs (Rosenstock 1966). This action taken is believed to be determined by the evaluation of the available social support, focusing on the benefits or efficacy of the health behaviour and the perceived costs or barriers to mental health.

Implications of the Study

1. This study will help the health caregivers to understand the connection between social support and mental health. With the finding, they will be able to maximize any support received from well-wishers, since it is linked with mental health.
2. Similarly, experts like counselling psychologists will this finding the study very impressive in managing mental health issues.
3. Theoretically, this study will improve theory reviewed in this study.

Conclusion

The study found that social support correlated with mental health. Consequently, the hypothesis which stated Social support will

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significantly influence mental health of health caregivers in Anambra State was accepted and the following recommendations were made.

Recommendations

1. Health caregivers need to be trained on mental health status knowledge. This very necessary in their self-knowledge and insight in health delivery.

Limitations of The Study

The following limitations are observed in the study:

1. The study only considered health caregivers working in government owned health institution in Anambra State. Even though the present study had an overall large population sample, possibly a larger and a more representative sample could give additional answers to the questions posed.

Suggestions for Further Studies

1. The qualitative approach should be applied in future research in this area.
2. Similar study should be replicated in other sub-sectors of the health.

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APPENDIX

Mental Health Continuum Short-Form

S/N	Items	1	2	3	4	5	6
	Emotional Wellbeing						
1	Happiness						
2	Interest						
3	Life Satisfaction						
	Social Wellbeing						
4	Social contribution						
5	Social integration						
6	Social actualization						
7	Social acceptance						
8	Social coherence						
	Psychological Wellbeing						
9	Self-acceptance						
10	Mastery						
11	Positive relations						
12	Personal growth						
13	Autonomy						
14	Purpose in life						

Developed by Keyes, C. L. M., Wissing, M., Potgieter, J. P., Temane, M., Kruger, A., & van Rooy, S. (2008).

Multidimensional Scale of Perceived Social Support (MSPSS)

Very Strongly Disagree=1, Strongly Disagree=2, Mildly Disagree=3, Mildly agree=4, Strongly Agree=5, Very Strongly Agree=6.

S/N	Items	1	2	3	4	5	6
	Family Support						
1	My family really tries to help me.						
2	I can talk about my problems with my family.						
3	My family is willing to help me make decisions.						
4	I get the emotional help and support I need from my family.						
	Friends Support						
5	My friends really try to help me						
6	I can count on my friends when things go wrong.						
7	I have friends with whom I can share my joys and sorrows.						
8	I can talk about my problems with my friends.						
	Significant Others Support						
9	There is a special person who is around when I am in need.						
10	There is a special person with whom I can share my joys and sorrows.						
11	I have a special person who is a real source of comfort to me						
12	There is a special person in my life who cares about my feelings.						

Developed by Zemet et al, (1988).