The Journal of Neurological and Neurosurgical Nursing
Pielęgniarstwo Neurologiczne i Neurochirurgiczne

Wydawnictwo Państwowej Akademii
Nauk Stosowanych we Włocławku
ul. Mechaników 3, pok. 20
87-800 Włocławek

eISSN 2299-0321 ISSN 2084-8021
https://apcz.umk.pl/PNIN

DOI: 10.15225/PNN.2024.13.4.2 JNNN 2024;13(4):139–146 **Original**

Social Support of Informal Caregivers of People with Multiple Sclerosis

Wsparcie społeczne nieformalnych opiekunów osób chorych na stwardnienie rozsiane

Edyta Szydło[1], **Katarzyna Wojtas**[2], **Paweł Jagielski**[3], **Anna Szczypta**[4], **Agnieszka Gniadek**[5]

[1] National Academy of Applied Sciences, Krosno, Poland
[2] Department of Clinical Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Collegium Medicum, Kraków, Poland
[3] Department of Nutrition and Drug Research, Faculty of Health Sciences, Jagiellonian University Collegium Medicum, Kraków, Poland
[4] Department of Nursing, Faculty of Medicine and Health Sciences, A. Frycz Modrzewski Krakow Academy, Kraków, Poland
[5] Department of Nursing Management and Epidemiological Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Collegium Medicum, Kraków, Poland

Abstract

Introduction. Support is defined as an action addressed to an individual or a group, which fosters overcoming difficult situations. It is a form of assistance consisting in mobilizing the strengths of the supported person for action, building self-confidence and triggering predispositions to overcome difficulties. With respect to the experience of caring for a chronically ill patient, social support can make a significant difference.

Aim. The aim of the study was to determine the social support of caregivers of people with multiple sclerosis.

Material and Methods. The study group consisted of 107 caregivers. The study was conducted at the Department of Neurology with Cerebral Stroke Subdivision of the John Paul II Subcarpathian Regional Hospital in Krosno, the Department of Neurology and Cerebral Stroke and the Department of Neurological Rehabilitation with General Rehabilitation Subdivision of the L. Rydygier Specialist Hospital in Krakow and the Helpful Hand Foundation in Kraków. A diagnostic survey method using the Berlin Social Support Scale (BSSS) and the Author's Survey Questionnaire was used. Approval for the study was obtained from the Bioethics Committee No. 176/KBL/OIL/2018.

Results. According to the Berlin Social Support Scale, there was a statistically significant difference p=0.0256 between the age of the respondents and the support currently provided. The results showed a statistically significant difference p=0.0067 between respondents' marital status and support-seeking. Gender, place of residence education and income did not statistically significantly differentiate the social support of caregivers. Statistically significant differences were found between the duration of MS and the caregiver support currently provided and currently received, and between mental illness in the course of MS in patients and the buffering and protective support of caregivers.

Conclusions. Social support is one of the resources for coping with difficult, stressful situations related to the course of the disease, which can be conditioned by various factors, including sociodemographic variables or the duration of the disease. **(JNNN 2024;13(4):139–146)**

Key Words: caregiver, multiple sclerosis, social support

Streszczenie

Wstęp. Wsparcie określa się jako działanie zaadresowane do jednostki lub grupy sprzyjające przezwyciężaniu trudnych sytuacji; jest formą pomagania polegającą na mobilizowaniu sił człowieka wspieranego do działań, budowaniu wiary we własne siły i siebie oraz wyzwoleniu predyspozycji w pokonywaniu trudności. W przypadku doświadczenia sprawowania opieki nad chorym przewlekle wsparcie społeczne może mieć istotne znaczenie.

Cel. Celem badania było określenie wsparcia społecznego opiekunów osób chorych na stwardnienie rozsiane.
Materiał i metody. Grupę badaną stanowiło 107 opiekunów. Badania zostały przeprowadzone w Oddziale Neurologii z Pododdziałem Udarów Mózgowych Wojewódzkiego Szpitala Podkarpackiego im. Jana Pawła II w Krośnie, Oddziale Neurologii i Udarów Mózgu oraz Oddziale Rehabilitacji Neurologicznej z Pododdziałem Rehabilitacji Ogólnoustrojowej Szpitala Specjalistycznego im. L. Rydygiera w Krakowie i Fundacji Helpful Hand w Krakowie. Zastosowano metodę sondażu diagnostycznego z wykorzystaniem Berlińskich Skal Wsparcia Społecznego (BSSS) i Autorskiego Kwestionariusza Ankiety. Na przeprowadzenie badania uzyskano zgodę Komisji Bioetycznej nr 176/KBL/OIL/2018.
Wyniki. Według Berlińskich Skal Wsparcia Społecznego wykazano istotną statystycznie różnicę p=0,0256 między wiekiem badanych a aktualnie udzielanym wsparciem. Wyniki wykazały istotną statystycznie różnicę p=0,0067 między stanem cywilnym respondentów a poszukiwaniem wsparcia. Płeć, miejsce zamieszkania wykształcenie i dochody nie różnicowały istotnie statystycznie wsparcia społecznego opiekunów. Wykazano istotne statystycznie różnice między czasem trwania SM a aktualnie udzielanym i aktualnie otrzymywanym wsparciem opiekunów oraz między chorobami psychicznymi w przebiegu SM u chorych a wsparciem buforująco-ochronnym opiekunów.
Wnioski. Wsparcie społeczne jest jednym z zasobów pozwalających na radzenie sobie w sytuacjach trudnych, stresowych związanych z przebiegiem choroby, które może być warunkowane różnymi czynnikami, w tym zmiennymi socjodemograficznymi czy czasem trwania choroby. **(PNN 2024;13(4):139–146)**
Słowa kluczowe: opiekun, stwardnienie rozsiane, wsparcie społeczne

Introduction

Multiple sclerosis (MS) is classified as a chronic, inflammatory-demyelinating disease of the central nervous system with an autoimmune basis. Despite many studies and research, the cause of MS still remains unknown. The initial symptoms of multiple sclerosis usually occur between the ages of 20 and 40 [1]. The disease affects both the female and male sexes with a predominance of incidence in women. Typical symptoms of MS include visual disturbances, sensory disturbances, impaired sphincter control, impaired coordination and chronic fatigue [1]. Multiple sclerosis is characterized by irreversible, progressive changes in the human body. As MS progresses, the patient's neurological symptoms and disability increase, which means that the disease itself goes beyond the clinical aspect. The diagnosis of a chronic disease affects the daily functioning of the family becoming a traumatic experience for the patient and his caregiver. Multiple sclerosis can take many forms and shapes. In the early stages of the disease, the most common form (in 80% of patients) is the relapsing-remitting form [2]. After 10 years of the disease (in 50% of patients), and after 25 years (in 90% of patients), the relapsing-remitting form turns into a secondary progressive form. Continuous progression of neurological symptoms (without relapses) is observed at various times during this phase [2]. The course of the disease also makes it possible to distinguish a transient, relapsing-remitting phase of the disease, which can be observed at the borderline between the relapsing-remitting and secondary-progressive forms, and thus a gradual progression of symptoms between infrequent relapses. The relapsing-remitting form is found in about 10% of people early in the disease [2]. The primary progressive form of the disease without relapses and remissions is the least common (in 15% of patients). A gradual progression of symptoms is observed from the first clinical symptom of the disease [2].

It is widely believed that social support is a factor that can show preventive properties against the disease [3,4]. Support is defined as an action addressed to an individual or a group, which fosters overcoming conflicts, difficult situations, and problems. It is a form of assistance which involves triggering predispositions to overcome difficulties, mobilizing the strength and activity of the supported person to act for their own development, building self-confidence [5,6]. Social support in structural terms directs attention to existing and available social networks, which, through the fact of social contact, perform a supportive function for people in distress [7]. When considering available support networks, social support resources are taken into account, which usually include friendship, family, neighborhood, social, religious, professional, individuals and helping institutions [8]. For people experiencing unexpected hardship, illness, social support [9] protects important for life, satisfying relationships with others and a sense of security [10,11]. Social support operating through the interactions taking place focuses on overcoming the crisis, solving problems. Depending on the type of content of the social exchange, a distinction is made between instrumental, emotional, informational, material and spiritual support. Instrumental support, is a type, a form of instruction, based on providing understandable information on how to behave. Emotional support involves giving emotions that reflect concern, reassurance, support and a positive attitude to the person being supported. The purpose of emotional support is to raise self-esteem, create care and a sense of belonging. The appropriate and thoughtful action of the supporting person also helps to inspire a sense of hope in the other person. Informational support involves the exchange of information that facilitates a better understanding of the problem, life position and situation, and the provision of feedback on the benefits of the supported person's undertaking remedial practices and actions. Informational support also allows one to understand the causes, the meaning of critical, stressful events, allows to share own experiences of people experiencing similar or the same problems or difficulties. In-kind support is financial, material and in-kind assistance, as well as physical, direct action on behalf of people in need. Spiritual support refers to assistance in the face of experienced spiritual pain and suffering related to death and the meaning of life [7,12, 13]. A distinction is made between primary and secondary sources of support. The leading and fundamental source of support (the so-called primary source of support) for a person is his family and significant others, e.g. friends, neighbors, who maintain a close emotional bond with him. The secondary sources of support can be volunteers, nursing homes, foundations, associations of patients with the disease and their caregivers, foundations, assistance programs dedicated to caregivers and care recipients [4]. The functional parameters of social support have given rise to another division between perceived and received support. Perceived support stems from a person's beliefs and knowledge about who to expect help from in a stressful, critical situation and where to seek it. Perceived support also assesses the belief in the accessibility of the support network. Support received is subjectively or objectively evaluated by the recipient as the type and amount of support actually received. Both perceived and received support depends on the needs of the individual experiencing stress, the crisis situation and the characteristics of the social networks used and available in such a situation [7,14,15].

Long-term care of a chronically ill person, taking on responsible tasks and activities towards them, causes caregivers to need support. The support received very often serves as a buffer and protects against severe stress or mental disorders [8]. It is widely believed that social support has a positive effect on health, well-being, and the ability to overcome difficulties. For caregivers of the chronically ill, social support is proximity and help from other people. Researchers of the concept of social support compare social support to attachment, the phenomenon of social integration, social ties in terms of human needs relating to the need for acceptance, security and belonging [16].

The aim of the study was to determine the social support of caregivers of people with multiple sclerosis.

Material and Methods

The subjects of the study were caregivers of multiple sclerosis patients visiting patients at the following medical care facilities in southern Poland: The Ludwik Rydygier Specialist Hospital in Krakow, the John Paul II Subcarpathian Regional Hospital in Krosno, the Helpful Hand Foundation in Krakow. The study group consisted of 107 multiple sclerosis caregivers. The multiple sclerosis patients accompanied the respondents when the survey was conducted (one caregiver — one patient). The selection of the group was intentional, and one caregiver of an ill person was studied.

A diagnostic survey method was used to determine the social support of caregivers of people with multiple sclerosis, using a standardized survey instrument — the Berlin Social Support Scales (BSSS) and the Author's Questionnaire Survey. The BSSS questionnaire is used to measure behavioral and cognitive dimensions of social support. The tool consists of 6 scales that examine different aspects of support. 6 scales were used for the purposes of the study.

Answers in all scales are given on a 4-point estimation scale, where 1 — means the statement is completely false, 2 — slightly true, 3 — moderately true, 4 — completely true. A higher score indicates greater social support [3,17].

Prior to the study, written approval was obtained from the Bioethics Committee at the Regional Medical Chamber of Krakow No. 176/KBL/OIL/2018.

Results

A survey using the author's survey questionnaire and standardized tests was conducted among 107 caregivers of people with multiple sclerosis. 51.4% (N=55) of women and 48.6% (N=52) of men participated in the survey. Caregivers of multiple sclerosis patients aged 60 and older accounted for 44.9% (N=48) of the total respondents, and those in the 40–49 age range accounted for 22.4% (N=24) of the respondents, while those aged 50–59 accounted for 17.8% (N=19). The smallest group included respondents under the age of 40 — 14.9% (N=16). The majority of those who took part in the survey were urban residents — 60.7% (N=65), while 39.3% (N=42) of those surveyed were rural residents. In the study group, married people or the ones in a civil partnership accounted for 66.4% (N=71) of the respondents, 33.6% (N=36) of the people declared single status: spinster/bachelor, divorced woman/divorced man, widow/widower. Nearly half of the respondents declared secondary education — 47.7% (N=51), and higher education — 30.8% (N=33) of people. Respondents with primary or vocational education accounted for 21.5% (N=23) of the total respondents. More than half of the caregivers — 63.6% (N=68) participating in the survey — were not working, and only 36.4% (N=39) of the caregivers were economically active. Insufficient income was declared by 78.5% (N=84) of respondents, and sufficient income by 21.5% (N=23) of caregivers. The secondary progressive form of multiple sclerosis was diagnosed in 56.1% (N=60), while the primary progressive form was diagnosed in 29.9% (N=32) of those under the care of the study subjects. The relapsing-remitting form of multiple sclerosis was confirmed in 14.0% (N=15). 78.5% (N=84) of caregivers reported that most people had other comorbidities in addition to multiple sclerosis. Nervous system diseases were diagnosed in 26.2% (N=28) of patients, cardiovascular diseases in 25.2% (N=27), gastrointestinal diseases in 7.5% (N=8), and depressive disorders in 18.7% (N=20). The distribution of the duration of multiple sclerosis was: more than 20 years — 62.6% (N=67) of the subjects, 11 to 20 years — 26.2% (N=28) of the patients, no more than 10 years — 11.2% (N=12) of the care recipients. The average duration of the disease was 23.86 years. The duration of the respondents' care ranged from 5 to 45 years. Caregiving lasting more than 15 years was confirmed by 66.4% (N=71) of respondents, while caregiving lasting less than 15 years was declared by 33.6% (N=36) of people. The average duration of care for multiple sclerosis patients by the caregivers surveyed was 18.28 years. The need for support due to the multiple sclerosis care situation was declared by 86.9% (N=93) of caregivers. The majority of survey participants indicated that they needed support in care from a medical caregiver or a disability assistant 69.2% (N=74). Clergy and volunteers are the people from whom 46.7% (N=50) of caregivers needed support. In addition, 39.3% (N=42) of respondents indicated the need for psychological assistance. The majority of respondents, 86.9% (N=93), felt that qualified medical personnel were helpful in caring for the patient: nurses, physicians or physical therapists. Friends and neighbors were helpful — 69.2% (N=74), and family was appreciated by 18.7% (N=20) of respondents. Caregivers reported a demand for improved access to rehabilitation for MS patients — 88.8% (N=95). Respondents also highlighted the need for nursing and care services guaranteed under Primary Health Care — 37.4% (N=40) and improving access to treatment — 19.6% (N=21). In the case of support from local government institutions, expectations were for instrumental support — 96.3% (N=103), informational support — 90.7% (N=97) and material support — 75.7% (N=81).

Based on the results from the Berlin Social Support Scales, the mean of the perceived available support subscale was 20.04 points, need for support was 12.35 points, seeking support was 16.93 points, support currently provided was 46.84 points, support currently received was 52.01 points, and the mean of the buffering and protective support subscale was 18.44 points (Table 1).

According to the Berlin Social Support Scale, there was a statistically significant difference p=0.0256 (p<0.05) between the age of the respondents and the support currently provided. There was no correlation between respondents' age and perceived available support, need for support, support seeking, support currently received and buffer-protective support (Table 2).

Statistically significant differences were not found between gender and social support of caregivers. Men, compared to women, scored higher averages in the subscales of perceived available support 20.54 points

Table 1. Social support as perceived by caregivers (N=107)

Social support	BSSS Scale results				
	$\bar{x}$	SD	Me	Min	Max
Perceived available support	20.04	6.08	19.00	9.00	32.00
Demand for support	12.35	1.91	13.00	7.00	16.00
Seeking support	16.93	2.98	18.00	5.00	20.00
Current support provided	46.84	5.68	47.00	23.00	56.00
Current support received	52.01	5.71	53.00	32.00	60.00
Buffer and protection support	18.44	4.00	19.00	8.00	24.00

BSSS — Berlin Social Support Scale; $\bar{x}$ — mean; SD — standard deviation; Me — median; Min — minimum value; Max — maximum value

Table 2. Age of caregivers and social support according to the BSSS Scale

Age	BSSS Scale	N	$\bar{x}$	SD	Me	Min	Max	p
Under 40 years old	Current support provided	16	46.06	3.79	46.00	36.00	54.00	0.0256
40–49 years		24	48.13	3.84	48.00	40.00	56.00	
50–59 years		19	43.84	7.70	45.00	23.00	55.00	
60 years and more		48	47.65	5.73	49.00	23.00	56.00	

BSSS — Berlin Social Support Scale; N — number of observations; $\bar{x}$ — mean; SD — standard deviation; Me — median; Min — minimum value; Max — maximum value; p — statistical significance vs. 19.56 points, need for support 12.65 points vs. 12.05 points, seeking support 17.25 points vs. 16.64 points, support currently provided 47.00 points vs. 46.69 points, support currently received 52.04 points vs. 51.98 points, and buffer-protective support 18.69 points vs. 18.20 points. There were also no statistically significant differences between place of residence and social support of caregivers. The variation in mean scores indicates that caregivers living in urban versus rural areas in the aspects of perceived available support (20.29 vs. 19.64), need for support (12.49 vs. 12.12), seeking support (17.28 vs. 16.4), support currently provided (47.46 vs. 45.88), support currently received (52.6 vs. 51.1), and buffer-protective support (18.6 vs. 18.1), had greater social support.

The results showed a statistically significant difference p=0.0067 between respondents' marital status and support-seeking. Unmarried caregivers (spinster/bachelor, divorced woman/divorced man, widow/widower) were more likely to seek support than respondents who were married or in a civil partnership. There were no differences between the marital status of caregivers and the other social support scales (Table 3).

There were no statistically significant differences between education and social support of caregivers (p>0.05). Respondents with higher education indicated a greater need for support, seeking support, current support provided, current support received and buffer support compared to other respondents. In contrast, caregivers with a high school education rated the perceived available support higher. No statistically significant differences were found between the income of MS caregivers and social support (p>0.05). More social support was declared by caregivers with sufficient income relative to caregivers with insufficient income in the areas of need for support 12.61 points vs. 12.27 points, seeking support 17.09 points vs. 16.89 points, support currently provided 48.26 points vs. 46.45 points, support currently received 53.00 points vs. 51.74 points, and buffer and protective support 18.96 points vs. 18.30 points. There were no statistically significant differences between the forms of multiple sclerosis of the care recipients and the social support of the subjects (p>0.05). Caregivers of multiple sclerosis patients with the primary progressive form obtained higher mean values in relation to those caring for MS patients with the relapsing-remitting and secondary progressive forms in terms of perceived available support, currently provided support, currently received support and buffer-protective support. On the other hand, in the subscale of need for support, those caring for people with the relapsing-remitting form of MS showed a higher average score to the others. Caregivers of MS patients with the relapsing-remitting and secondary progressive forms received greater social support in the scope of seeking the support compared to caregivers of patients with the primary progressive form.

Sub-analyzing the relationship between the duration of multiple sclerosis in patients and the social support of caregivers showed statistically significant differences in support currently provided (R=0.24; p=0.012) and support currently received (R=0.19; p=0.046). The current support provided and the current support received by caregivers increased as the duration of multiple sclerosis in the care recipients increased. Duration of illness did not correlate statistically significantly with perceived available support, need for support, support-seeking and buffer-protective support (Table 4).

Table 3. Marital status of caregivers versus social support according to the BSSS scale

Marital status	BSSS Scale	N	$\overline{x}$	SD	Me	Min	Max	p
Marriage/civil partnership	Seeking support	71	16.41	3.11	17.00	5.00	20.00	0.0067
Spinster/bachelor/divorced woman/divorced man/ widow/widower		36	17.97	2.41	18.50	10.00	20.00	

BSSS — Berlin Social Support Scale; N — number of observations; $\overline{x}$ — mean; SD — standard deviation; Me — median; Min — minimum value; Max — maximum value; p — statistical significance

Table 4. Duration of multiple sclerosis in patients versus social support of caregivers according to the BSSS (N=107)

	BSSS Scale	R	t(N–2)	p
Duration of the illness of the care recipient	Perceived available support	0.15	1.520	0.131
	Demand for support	0.10	1.016	0.312
	Seeking support	0.07	0.698	0.487
	Current support provided	0.24	2.543	0.012
	Current support received	0.19	2.017	0.046
	Buffer and protection support	–0.02	–0.199	0.842

BSSS — Berlin Social Support Scale; R — Pearson's correlation coefficient; t(N–2) — significance test; p — statistical significance

Table 5. Multiple sclerosis patients' comorbidities and caregivers' social support according to the BSSS

Comorbidities / No comorbidities	BSSS Scale	N	$\bar{x}$	SD	Me	Min	Max	p
Mental	Buffer and protection support	20	20.65	2.52	21.00	15.00	24.00	0.0059
Lack		87	17.93	4.11	18.00	8.00	24.00	
Cardiovascular system		27	17.41	3.96	18.00	8.00	23.00	0.0820
Lack		80	18.79	3.98	20.00	8.00	24.00	
Nervous system		28	18.54	4.58	20.00	8.00	24.00	0.5731
Lack		79	18.41	3.80	19.00	8.00	24.00	

BSSS — Berlin Social Support Scale; N — number of observations; $\bar{x}$ — mean; SD — standard deviation; Me — median; Min — minimum value; Max — maximum value; p — statistical significance

There was a statistically significant difference $p=0.0059$ ($p<0.05$) between mental illness in MS patients and caregivers' buffering and protective support. The patients' cardiovascular and nervous system comorbidities did not correlate statistically significantly ($p>0.05$) with the subscales of the Berlin Social Support Scales (Table 5).

Discussion

There is a widespread perception that social support has a positive impact on health and well-being, on the ability to cope with difficult situations. It leads to an increase in self-efficacy, and has a buffering effect, reducing exposure to the experience of failure. For caregivers of the chronically ill, social support represents proximity and help from other people, and provides a sense of security [18,19]. Ongoing studies by Cummings et al. and Sullivan et al. consistently pointed to the protective function of social support, on mental and somatic health [20,21], and emphasized that the responsibilities of caring for a loved one contributed to caregivers reaching for new resources, including social support [22]. The results of a study conducted in Europe by Kobelt et al. showed that it is crucial to diagnose the social support desired by caregivers [23].

Caregivers of the chronically ill in a study by Stenberg et al. declared a need for social support, primarily in the form of verbal interpersonal contacts with people outside the family and medical staff [24]. The research of Sillence et al. confirmed that the use of information technology provided caregivers of people with multiple sclerosis with social support [25].

The results of our study confirmed the need for support in the vast majority of caregivers (86.9%). Expectations included instrumental, informational and material support, as well as assistance from the health care system in the form of improved access to rehabilitation for the care recipients. Respondents pointed to the need for support from volunteers, a medical caregiver, a clergyman, a disability assistant and a psychologist, which Domaradzki also points out. The results of his survey of caregivers affected by Huntington's disease emphasize the role of social workers and assistants to people with disabilities who, by monitoring ongoing needs, would provide informational support to caregivers, including on therapy options and funding opportunities. The cited studies confirmed that it is crucial to provide caregivers with emotional support, primarily in the form of access to psychological care [26], accompanying them in making important decisions regarding the care of their sick relative and helping them adapt to the new, often dynamic situation caused by their loved one's illness. Hence, Rachel et al. reasonably claim that providing psychological support and understanding the needs of caregivers is essential to providing proper care for the chronically ill [27]. At the same time, Sęk et al. pointed out that too much help from other people or institutions may be a predictor of caregivers' decreased sense of competence to manage the care of the chronically ill on their own [7].

Kosińska et al. showed that in a crisis situation caregivers asked for and received support from friends and neighbors in addition to qualified medical personnel: nurses, nurse practitioners, doctors, and physical therapists [28]. The results of our study also confirm that professionals: nurses, doctors and physical therapists are helpful in caring for the ill. Respondents also declared support from friends and neighbors. On the other hand, the cited results of a study by Mazurkiewicz et al. showed that support from friends is indeed most desirable and important, but nevertheless insufficient and unsatisfactory for those providing care for the patient [29].

Grabowska-Fudala et al. on the basis of a study conducted using the Berlin Social Support Scales among 30 post-stroke caregivers confirmed that social support is among the external factors that should influence the hardship resulting from caregiving. The individual subscales of the BSSS had social support levels ranging from 2.6 points to 3.6 points. The lowest score was recorded on the subscale of the need for support, while the highest score was obtained for the support currently received and perceived available support [30]. The company's own research showed that the lowest score, 12.35 points, concerned the need for support. In contrast, caregivers of people with MS gave the highest score of 52.01 points to the currently received support. A study conducted by Kurowska and Żurek using the Kmiecik-Baran social support scale among mothers of hospitalized children showed that the lowest scores were obtained for emotional and evaluative support — 9 points and 10 points, and the highest scores were obtained for informational and instrumental support — 29 points and 25 points [31]. In comparison, findings from a study of social support in caregivers of Alzheimer's patients completed using the Social Support Questionnaire by Fydrich and his team, presented by Basińska et al. indicated that higher levels of social support resulted in lower levels of caregiver fatigue. The perceived and received social support allowed caregivers to optimistically perceive the experience of the hardship of caring for a chronically ill person and offset the primarily emotional costs of caring for a loved one [32]. The results of a study by Golińska et al. confirmed that caregivers of people with Parkinson's disease needed support related to the organization of health services, especially access to a specialist doctor, speech therapist and physiotherapist [33]. Similarly, the results of our study showed that caregivers of people with multiple sclerosis highlighted the need for support from the health care system regarding improved access to rehabilitation, nursing and care services, treatment programs and professional, specialized care under contract with the National Health Fund.

Conclusions

1. Caregivers of people with multiple sclerosis expect multidimensional support from qualified medical personnel, medical caregivers, disability assistants, clergy, volunteers, and psychologists.
2. The age of caregivers of people with multiple sclerosis statistically significantly determined the support currently provided (the highest levels of support were received by caregivers aged 40–49).
3. The marital status of caregivers influenced the search for support, as single individuals were more likely to seek support.
4. The support currently provided and received by caregivers of people with multiple sclerosis increased with the longer duration of the illness in their care recipients. In contrast, mental illnesses associated with MS in patients had a buffering and protective effect on the support received by caregivers.

Implications for Nursing Practice

It is reasonable to create support groups for caregivers of the chronically ill, to ensure the flow of information on the provision of assistance by health and social care institutions, and to raise public awareness of the role of family caregivers in the health care system. It seems important to help caregivers set up online support groups. The use of information technology would provide caregivers of people with multiple sclerosis with social support. Support using social media can be especially helpful for caregivers who are physically isolated for various reasons.

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Corresponding Author:
Edyta Szydło
National Academy of Applied Sciences
Rynek 1 street, 38-400 Krosno, Poland
e-mail: edyta.szydlo@pans.krosno.pl

Conflict of Interest: None
Funding: None
Author Contributions: Edyta Szydło$^{A, B, E, F, H}$, Katarzyna Wojtas$^{C, E–G}$, Paweł Jagielski$^{B–D}$, Anna Szczypta$^{E, F}$, Agnieszka Gniadek$^{C, E–G}$

A — Concept and design of research, B — Collection and/or compilation of data, C — Analysis and interpretation of data, D — Statistical analysis, E — Writing an article, F — Search of the literature, G — Critical article analysis, H — Approval of the final version of the article

Received: 6.06.2024
Accepted: 14.08.2024