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Original Article

The Mediating Effect of Spiritual Well-Being on the Relationship between Social Support and Depression among Family Caregivers of Patients with Cancer Undergoing Chemotherapy

Muhamad Zulfatul A'la[1], Rondhianto[1], Akhmad Zainur Ridla[1], Maria Putri Sari Utami[2], Wiwi Kustio Priliana[2], Yuwadee Wittayapun[3]

[1]Department of Medical Surgical and Critical Care Nursing, Faculty of Nursing, University of Jember, Jember, Indonesia, [2]Department of Nursing, Notokusumo Yogyakarta School of Health Sciences, Yogyakarta, Indonesia, [3]Department of Physical Therapy, School of Allied Health Sciences, Walailak University, Nakhon Si Thammarat, Thailand.

ABSTRACT

Objectives: This study aimed to examine the mediating effect of spiritual well-being on the relationship between social support and depression among family caregivers of cancer patients (FCPC) undergoing chemotherapy.

Materials and Methods: A total of 180 families of cancer patients participated in this study, meeting the following inclusion criteria: Individuals aged 18–65 years, providing care for a patient with cancer in 4 months, residing with the patient and demonstrating no communication difficulties. Convenience sampling was conducted in two hospitals located in Yogyakarta and Jember, Indonesia, from May to August 2024. A valid and reliable self-reported structured questionnaire was used to collect data on depression, spiritual well-being and social support. The characteristic respondent questionnaire was also used. The unpaired t-test, analysis of variance and Pearson correlation were used to examine the relationships between depression and respondent characteristics, as well as the correlations among depression, spiritual well-being and social support. In addition, the Statistical Package for the Social Sciences (SPSS) PROCESS macro version 4.2 was used to examine the mediating factor model hypothesis confirmation.

Results: The results showed that, based on the correlational test, spiritual well-being and social support were interconnected. The occupational status of the respondents correlated with depression. Social support positively affected spiritual well-being ($B = 0.245$; $P < 0.001$), and spiritual well-being was negatively affected by depression ($B = -0.248$; $P < 0.001$). In addition, social support was directly affected by depression ($B = -0.236$; $P < 0.001$). Bootstrap analysis supported the relationship between social support and depression with spiritual well-being as a mediating factor ($B = -0.061$; $P < 0.05$).

Conclusion: This study indicated that social support was a significant predictor of depression in FCPC undergoing chemotherapy, with spiritual well-being acting as a mediating factor. Therefore, nurses should integrate spiritual nursing care and incorporate significant others to mitigate depression. Future studies are needed to explore further mediators and develop specific interventions for reducing depression.

Keywords: Caregiver, Depression, Social support, Spirituality

INTRODUCTION

Cancer is a primary global concern, with data from global cancer statistics (GLOBOCAN) in 2022 reporting approximately 20 million new cancer cases and over 9.7 million cancer-related deaths worldwide. According to the GLOBOCAN projection, the number of cases will continue to rise, reaching 35 million worldwide by 2050.[1] In Indonesia, the cancer incidence increased to 1 million from 2018 to 2021.[2] A prevalent approach in cancer therapy is cytotoxic treatment, specifically chemotherapy.

Although chemotherapy can enhance life expectancy, it poses significant physical, psychological and social challenges for patients and their families.[3-5] Family caregivers of cancer patients (FCPC) frequently experience psychological distress

***Corresponding author:** Muhamad Zulfatul A'la, Department of Medical Surgical and Critical Care Nursing, Faculty of Nursing, University of Jember, Jember, Indonesia. m.zulfatul@unej.ac.id

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due to these challenges, regardless of the treatment phase.[6,7] Depression – characterised by emotional exhaustion and sadness[8] – affects approximately 42% of FCPC,[9] significantly impacting both caregiver quality of life and patient care quality,[10] with chemotherapy's prolonged duration and complex symptom burden potentially amplifying this risk.[5]

Nurses must investigate the factors influencing depression in FCPC and the underlying mechanisms to ensure that interventions are appropriate, especially in chemotherapy. Social support is a primary factor influencing depression. Increased social support is associated with decreased depressive symptoms within FCPC.[11,12] The relationship between these two concepts remains dynamic and multifaceted, necessitating a need to be further explored. Spirituality or spiritual well-being might act as a mediating factor in the relationship between these two concepts.[10,13]

Spirituality and spiritual well-being are interrelated. Spiritual well-being is a component of spirituality which is subjective and dynamic.[14] In addition, spiritual well-being serves as a predictor of depression and is associated with the quality of life.[12,15] In Indonesia, spiritual well-being plays a significant role in alleviating psychological problems within families of patients with chronic diseases.[16,17] Spirituality also plays a crucial role in shaping FCPC coping mechanisms.[18] However, the correlation and mechanism of spirituality in affecting depression are not clearly understood.

Although numerous reports have identified a correlation between social support, depression and spiritual well-being, there is a lack of studies demonstrating the mediating role of spiritual well-being in the relationship between social support and depression among FCPC. Therefore, this study aimed to examine the mediating role of spiritual well-being in the relationship between social support and depression among FCPC undergoing chemotherapy.

MATERIALS AND METHODS

Study design and respondents

This study used a cross-sectional design in two hospitals (Jember and Yogyakarta) with chemotherapy centres in Indonesia. The respondents consisted of FCPC who met the following inclusion criteria: aged 18–65 years, providing care for the patient diagnosed with cancer undergoing chemotherapy for a minimum of 4 months, residing with the patient during treatment and possessing no communication difficulties. Sampling was carried out using the convenience method.

The minimum number of samples was estimated using the G*power 3.1 programme, setting the significance level at 0.05, a medium effect size of 0.15, a statistical power of 80% and accounting for 12 predictive factors, which included nine respondent characteristics and three variables in development models. A total of 127 samples were used in the G*power calculation. This study required a minimum of 200 samples, as determined by the maximum likelihood method.[19] A total of 200 questionnaires were distributed, allocating 100 to each of the hospitals in Jember and Yogyakarta.

Measures

This study used a questionnaire for data collection. The respondents completed questionnaires assessing characteristics, social support, spiritual well-being and levels of depression. The characteristics of respondents were analysed concerning gender, age, education level, marital status, relationship with patients, occupation, income, place of residence and duration of care. The assessment was completed based on the patient's condition.

The multidimensional scale of perceived social support (MSPSS), which has been translated into the Indonesian context, was used to measure social support.[20] This questionnaire comprises 12 questions across three domains, namely support from family, friends and other significant persons, each containing four questions. Options are available on strongly agree, agree, neutral, disagree and strongly disagree. The scoring range for this questionnaire is from 1 to 7, and the outcome is the MSPSS score, ranging from 12 to 84, with a higher score describing more excellent social support received by respondents. The reliability of the Indonesian version of the MSPSS was categorised as high (Cronbach's alpha = 0.7).[20]

The spiritual well-being scale (SWBS) was used to assess spiritual well-being. SWBS comprises two sub-scales, namely religious well-being (RWB) and existential well-being (EWB). The total number of items in the statement is 20. A total of 10 items characterise the RWB subscale, while 10 items delineate the EWB subscale. Each statement item is assigned a value ranging from 1 to 6. The outcome is a spiritual well-being score ranging from 20 to 120, with higher scores indicating a greater level of spiritual well-being among respondents. The literature search yielded an accurate value of 0.86 for the SWBS in the Indonesian version.[21]

Depression was evaluated using the BDI-Second Edition (BDI-II) questionnaire. The BDI-II is a 21-item instrument designed to assess depression, incorporating cognitive symptoms.[22] This self-report questionnaire comprises 21 items designed to assess the severity of depression in adolescents and adults, though it is not intended for diagnostic purposes. Respondents may evaluate answers using a scale from 0 to 3, resulting in a total score that spans from 0 to 63. The BDI-II experienced cross-cultural adaptation in the adult Indonesian population, yielding Cronbach's alpha = 0.89.[22]

Data collection

Self-reported questionnaires were used in the data collection process, with the support of trained assistants. The study was conducted in the chemotherapy outpatient department at hospitals in Jember and Yogyakarta from May to August

2024. A total of 180 questionnaires were administered, resulting in a response rate of 90%. About 20 questionnaires cannot be included in the analysis due to eight respondents refusing to complete the questionnaire and 12 incomplete questionnaires.

Data analysis

The Statistical Package for the Social Sciences (SPSS) version 27 was used for data analysis, with *t*-test, analysis of variance and Pearson correlation being applied to analyse the differences and relationships between respondent characteristics and depression among FCPC undergoing chemotherapy. Given that the data on depression, spiritual well-being and social support showed a normal distribution, the Pearson correlation was used to examine the correlation and strength among these variables. Furthermore, to examine the mediating effect of spiritual well-being on the relationship between social support and depression, a bootstrap programme was performed using the plugin in SPSS process macro Version 4.2, with an alpha value of 0.05.[23] Figure 1 shows the comprehensive study framework in the mediating model, which includes four hypotheses. Specifically, (1) the independent variable (social support) had a significant effect on the mediation variable (spiritual well-being) [Figure 1, Path a], (2) the mediation variable (spiritual well-being) significantly influenced the dependent variable (depression) [Figure 1, Path b] and (3) the independent variable (social support) significantly impacted the dependent variable (depression) [Figure 1, Path c]. The c pathway showed the impact of independent variables on the dependent through mediating variables [Figure 1, Path c'].

Ethical consideration

This study obtained ethical approval and complied with the standards set forward in the Helsinki Declaration. The respondents received explanations on the right to withdraw from the study and the information collected. Informed consent was also requested to participate in the study. Access to comprehensive patient data was exclusively granted to healthcare professionals. After communication of the consent process, the respondents received a study code that facilitated the appropriate analysis by associating the data with the study. The data and results will remain unpublished, ensuring the maintenance of confidentiality.

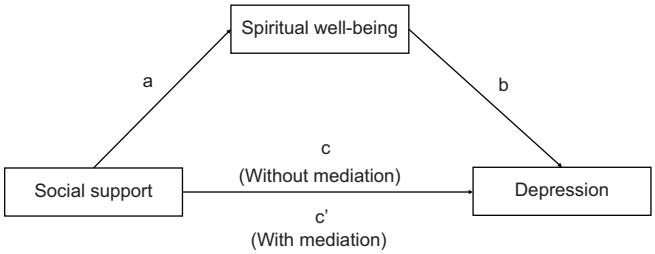

Figure 1: The hypothesised mediation model.

RESULTS

Respondent characteristics and the correlation with depression

Table 1 shows that the FCPC undergoing chemotherapy comprised predominantly females (66.7%), with a mean age of 39.69 ± 12.56 years. The dominant education level was high school, accounting for <77.2% of individuals, with couples comprising 73.9% of the population. The predominant relationship status with patients was that of children, accounting for 57.8%, while the majority of respondents reported not having an occupation, also at 57.8%. The income of the majority was above or equal to the regional minimum wage (58.9%), and a significant portion resided in urban areas (52.8%). The average duration of patient care was 1.73 ± 2.02 years.

There were no significant differences in gender, age, education level, marital status, relationship to patients, income per month, residence area and length of care concerning depression among FCPC undergoing chemotherapy (P = 0.742, P = 0.176, P = 0.905, P = 0.257, P = 0.867, P = 0.624, P = 0.555, P = 0.353, respectively). There was a statistically significant difference between respondents with an occupation and those without (P = 0.048; 19.25 ± 8.98 vs. 16.53 ± 9.05).

Correlations among social support, spiritual well-being and depression

Table 2 shows the mean and standard deviation for the independent, mediation and dependent variables. The mean and standard deviation of social support, spiritual well-being and depression in FCPC undergoing chemotherapy were 17.68 ± 9.094, 54.81 ± 9.53 and 90.05 ± 13.72, respectively. Table 1 shows a positive correlation between social support and spiritual well-being (P < 0.05; r = 0.17) as well as a negative correlation with depression (P < 0.001; r = −0.31). There was a negative correlation between spiritual well-being and depression (P < 0.001; r = −0.42).

Mediating effect of spiritual well-being on the relationship between social support and depression

The mediating effect of spiritual well-being was evident from the four hypotheses derived from the established framework. As illustrated in Figure 2, social support was found to be a significant positive predictor of spiritual well-being (B = 0.245, P < 0.001), which, in turn, significantly and negatively predicted depression (B = −0.248, P < 0.001). Furthermore, the direct effect of social support on depression (B = −0.236, P < 0.001) was partially mediated by spiritual well-being (B = −0.061, P < 0.05).

DISCUSSION

This study is the first to examine spiritual well-being as a mediating factor in a specific population, namely FCPC

Table 1: Characteristics and correlation with depression among FCPC (*n*=180).

Variables	Category	*n*(%) or mean SD	Depression	
			Mean SD	*P*-value
Gender	Women	120 (66.7)	17.84±9.16	0.742[a]
	Men	60 (33.3)	17.37±9.03	
Age (year)		39.69±12.56	17.68±9.094	0.176[b]
Education level	High school or less	139 (77.2)	17.73±8.54	0.905[a]
	Undergraduate or above	41 (22.8)	17.51±10.88	
Marital status	Couple	133 (73.9)	17.22±8.52	0.257[a]
	Single	47 (26.1)	18.97±10.55	
Relationship to patients	Spouse	44 (24.4)	16.84±10.08	0.867[c]
	Parents	6 (3.3)	18.33±6.25	
	Children	104 (57.8)	17.75±8.52	
	Other	26 (14.4)	18.69±10.38	
Occupation	Yes	76 (42.2)	19.25±8.98	0.048[a]
	No	104 (57.8)	16.53±9.05	
Income per month (based on the regional minimum wage	Above or equal	106 (58.9)	17.96±9.31	0.624[a]
	Below	74 (41.1)	17.28±8.82	
Residence area	Rural	85 (47.2)	17.25±9.23	0.555[a]
	Urban	95 (52.8)	18.06±9.00	
Length of care (year)		1.73±2.02	17.68±9.094	0.353[b]

[a]Calculated using unpaired t-test. [b]Calculated using Pearson correlation. [c]Calculated using analysis of variance. Statistical significance of *P*-value: $P < 0.05$. SD: Standard deviation, FCPC: Family caregivers of cancer patients

Table 2: Correlations of depression with social support and spiritual well-being among FCPC (*n*=180).

Variable	Mean±SD	Depression	Spiritual well-being	Social support
		r (*P*-value)	r (*P*-value)	r (*P*-value)
Depression	17.68±9.094	1	−0.42 (<0.001)[a]	−0.31 (<0.001)[a]
Spiritual well-being	90.05±13.72		1	0.17 (<0.05)[a]
Social support	54.81±9.53			1

[a]Calculated using Pearson correlation. Statistical significance of *P*-value: $P < 0.05$. SD: Standard deviation, FCPC: Familiy caregivers of cancer patients

undergoing chemotherapy, and demonstrated a significant effect on the relationship between social support and depression. Descriptive analysis indicated that the average family depression score among patients was at a moderate level. The sample predominantly comprised female caregivers (66.7%) with a mean age of 39.69 years, most of whom had completed high school (77.2%) and were unemployed (57.8%). Occupational status was significantly associated with depression ($P = 0.048$), suggesting that economic stability may help buffer psychological distress.[15]

These sociodemographic findings provide important context for understanding depression in this population and highlight the relevance of examining spiritual well-being as a mediating factor. Building on this context, the first hypothesis was supported by the positive correlation between social support and spiritual well-being. Studies among adult COVID-19 survivors in Iran,[24] Christian clergy,[25] and individuals in collectivist contexts[26] confirmed this relationship. Social support influences worldview beliefs, a precursor to spirituality[27] and is particularly significant for FCPC undergoing chemotherapy.[18]

The second hypothesis, indicating a negative correlation between spiritual well-being and depression, was also supported. Research involving Latino,[28] South Korean,[12] and American[29] families facing terminal illness demonstrated spirituality's role in mitigating depression. Spirituality functions as a protective factor against psychological distress.[27] The third hypothesis, which posited a negative correlation between social support and depression, was confirmed by studies among family caregivers in Türkiye[11] and South Korea.[12]

Furthermore, the fourth hypothesis was supported by the mediating role of spiritual well-being in the relationship

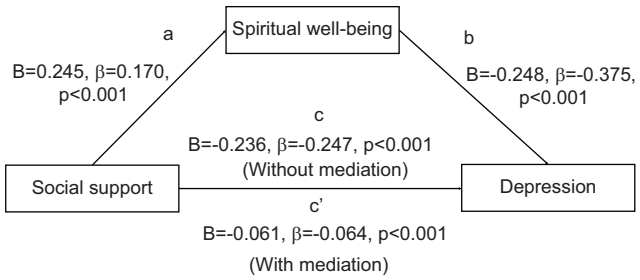

Figure 2: The mediated effect of spiritual well-being on the relationship between social support and depression among family caregivers of patients with cancer undergoing chemotherapy.

between social support and depression. Spiritual well-being served as a mediator in the correlation between social support and depression. According to the framework of Kristanti *et al.*[18] and Effendy and Kristanti[30] belief or spirituality among FCPC is believed to be a core phenomenon that can influence psychological impact and is shaped by contextual elements such as the quality of care, financial difficulties and caring conditions. Social support might act as a mediating factor in the association between contextual elements and core phenomena. This theoretical framework demonstrates the relationship between psychological effects (such as depression) and social support in FCPC, whose mechanisms are impacted by spiritual well-being.

In this study, spiritual well-being was assessed using SWBS, which includes two subscales: RWB and EWB. By employing the composite score in the analysis, the religious dimension was inherently incorporated into the overall measure of spiritual well-being, thereby partially controlling for its influence when testing the mediation model. This methodological choice allows the mediating effect to capture both existential meaning and religious aspects, which is particularly relevant in the Indonesian context, where religiosity is strongly intertwined with social relationships, coping strategies and family caregiving practices.[18,31]

These findings should be understood within an expanded Indonesian cultural framework, marked by strong familial collectivism, entrenched religious customs and community-oriented support systems. Cultural values can enhance perceived social support and spiritual well-being, as caregiving duties are frequently distributed among extended family members, while religious practices offer emotional satisfaction and a sense of purpose. This study did not quantitatively evaluate cultural orientation; rather, the context intrinsically exemplifies a high-context collectivism where interpersonal ties, societal solidarity and shared spiritual beliefs are essential for managing caring challenges. Previous studies in Southeast Asia indicate that these cultural traits bolster resilience, augment caring abilities and promote favourable psychological outcomes among family caregivers of individuals with chronic illnesses.[18,32]

Nurses, as healthcare providers, play a crucial role in minimising depression in FCPC. In the context of palliative services, nurses have a holistic responsibility, caring not only for cancer patients but also giving support to families as a component of the patient care system.[33] The prolonged and demanding process of chemotherapy may elevate the possibility of depression among the family members.[34] This study provides nurses with information about the factors influencing depression and the underlying mechanisms. Considering social support affects depression and spiritual well-being, nurses can implement interventions for families that combine social support strategies and spiritual well-being to minimise depression.

This study had several limitations. First, data were collected from only two chemotherapy centres in Indonesia. More central chemotherapy for data collection and a larger sample size are expected to produce generalisable outcomes. Second, other mediating factors may influence the association between social support and depression, requiring the exploration of possible additional concepts as mediators. This study can serve as a reference for the advancement of future investigations.

CONCLUSION

This study showed that social support was a predictor of depression among FCPC undergoing chemotherapy. The mechanism of this effect was mediated by spiritual well-being as a variable factor. Depression among FCPC may result from inadequate coping mechanisms linked to decreased spiritual well-being due to insufficient support from significant others. Nurses have to integrate elements of spiritual nursing care as well as engage significant others to reduce depression. Future studies should investigate additional mediating elements and develop social support interventions focused on spiritual well-being.

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Ethical approval: The research/study was approved by the Institutional Review Board at the Faculty of Nursing, University of Jember, approval number 94/UN25.1.14/KEPK/2024, dated 8th May 2024.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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