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Hope and psychological resilience in primary caregivers of patients with a chronic mental illness followed in a community mental health center☆

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ABSTRACT

Purpose: The aim of this study is to examine hope and psychological resilience in primary caregivers of patients with a chronic mental illness.
Design and methods: The descriptive study was conducted on 297 caregivers in community mental health centers in Turkey. Data were collected using the Introductory Information Form, Dispositional Hope Scale and the Resilience Scale for Adults.
Findings: Hope and psychological resilience of primary caregivers of patients with a chronic mental illness were moderate. To sociodemographic and caregiver characteristics; caregivers who are over 40 years old, lost his/her spouse, low education level, housewife or retired, unemployed, who evaluated their incomes low, mother, living in the same house with the patient, caring for ten years or more, caring for another patient and not getting help in care had lower hope and resilience levels. Compared to patients with a diagnosis of bipolar disorder, caregivers of patients with schizophrenia had lower hope and psychological resilience levels.
Conclusions: Primary caregivers of patients with a chronic mental illness should be supported in terms of hope and psychological resilience.

Introduction

Chronic mental illnesses (CMI) are severe mental disorders that cause impairment and disability in the individual's areas of emotion, thought, behavior, perception, work life, human relations and self-care; they tend to continue throughout life and require continuous care (Prasad, 2017). Although schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression, chronic obsessive-compulsive disorder, other psychotic disorders, and substance abuse are included in this category, schizophrenia and bipolar disorder constitute the most chronic mental illnesses (Çam & Engin, 2021; Yazıcı et al., 2010).

Chronic mental illnesses are of great importance because they cause disability, are long-term or permanent and are common in society (Turan, 2019). The Global Burden of Disease, Injuries and Risk Factors Study states that 45 million people are affected by bipolar disorder, and 20 million are affected by schizophrenia (GBD, 2017). According to a study examining the prevalence of psychotic disorders, the lifetime prevalence of schizophrenia was found to be 8.9 ‰ (Binbay et al., 2011). In another study examining the prevalence of mental disorders, 37.1 % of the participants were found to have at least one mood disorder (Keskin et al., 2013).

Patients with a chronic mental illness mostly need care, and caregivers are usually family members with whom the patients live (Çam & Engin, 2021). Caregivers have to deal with the difficulties they encounter in many areas, such as emotional, social, economic, and physical problems (Arguvanlı, 2018; Bademli & Duman, 2013). Studies show that caregivers often experience feelings such as guilt, hopelessness, depression, grief, anxiety, stress, fear, anger, and helplessness during the caregiving process (Bademli & Duman, 2013; Duggleby et al., 2021; Yıldırım et al., 2017). A systematic review concluded that the families of patients with a chronic mental illness are at risk from a psychological point of view due to the difficulties they experience in this process (Duman & Bademli, 2013). In order to prevent mental illnesses in caregivers, it is necessary to determine the protective factors and to plan and implement prevention strategies (Gültekin, 2010).

Hope and resilience are extremely important concepts that positively affect mental health (Duggal et al., 2016). Hope is defined as the

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individual setting a goal, taking action to achieve the determined goal, and looking for different ways to achieve the goal when faced with difficulties (Tarhan & Bacanlı, 2015). Psychological resilience is the ability of an individual to remain strong in the face of life's difficulties and to cope with difficulties successfully (Çam & Büyükbayram, 2017). In a study conducted with caregivers of patients with schizophrenia, it was determined that resilience had a more significant effect on distress, and hope had a greater effect on the positive aspects of caregiving (Wang et al., 2020).

It was determined that when the hope of the caregivers increased, well-being, quality of life, life satisfaction, positive mental health, self-esteem, family harmony, self-efficacy, and the hope of the caregiver increased. In addition, it was found that depression, distress, anxiety and stress symptoms, feelings of grief and guilt, maladaptive coping strategies, and caregiving burden were reduced (Duggleby et al., 2021). In a study conducted with caregivers of patients with schizophrenia, hope was positively associated with mental well-being and quality of life (Francisquini et al., 2020). The study determined that the level of hope of those who care for individuals with schizophrenia is lower than those who care for individuals with mild physical illnesses, and as the duration of care increases, the level of hope decreases (Stanley, Balakrishnan, 2021a).

It was found that caregivers with high psychological resilience had higher quality of life and adjustment, and it has been reported that caregiver burden, distress, fatigue, and stress are lower and psychological resilience improves caregiving (Palacio et al., 2019). In a study conducted with caregivers of patients with schizophrenia, it was determined that understanding the characteristics of the disease, the sense of protecting the patient, flexibility, using humor and hope as coping skills, having a positive perspective, and having a social support network increased psychological resilience. It has been determined that caregivers' psychological resilience prevents patients' relapses and contributes to their recovery (Amagai et al., 2016). A study conducted with caregivers of patients with schizophrenia and bipolar disorder found a positive relationship between caregivers' quality of life and psychological resilience (Jain & Singh, 2014).

The families of patients with a chronic mental illness are psychologically risky due to the difficulties caused by the disease (Bademli & Duman, 2013; Duman & Bademli, 2013). Hope and psychological resilience play an important role as protective factors in protecting caregivers' mental health and preventing mental illness development (Abd El et al., 2018; Duggleby et al., 2021; Fan et al., 2014; Hernandez et al., 2019). A limited number of studies have been found in the national and international literature examining hope and psychological resilience in primary caregivers of patients with a CMI. In a study conducted with caregivers of patients with schizophrenia, it was reported that there was a significant and positive relationship between caregivers' hope and psychological resilience levels (Wang et al., 2020). Especially in the international literature, little is known about hope in caregivers of patients with bipolar disorder, whereas in Turkey, very little is known about hope in primary caregivers of schizophrenia and patients with bipolar disorder. Therefore, this research will contribute to the literature by filling the gap in this field. In addition, the results obtained from this study will guide the planning and implementation of multidisciplinary and nursing interventions to increase hope and psychological resilience in primary caregivers.

The aim of this study is to examine hope and psychological resilience in primary caregivers of patients with a CMI in community mental health centers.

The research questions determined for this purpose are as follows:

1) What are the hope and psychological resilience levels of primary caregivers of patients with a CMI?
2) Do the levels of hope and resilience of primary caregivers of patients with a CMI differ according to the characteristics of the caregivers?
3) Do the levels of hope and resilience of primary caregivers of patients with a CMI differ according to the patient's diagnosis?

Methods

Type, place, and time of the study

This descriptive research was conducted between January 2021 and June 2021 in two community mental health centers affiliated with a state hospital in Bursa city center, located northwest of Turkey. In the community mental health centers where the study was conducted, outpatient psychosocial treatment and rehabilitation of patients with severe mental disorders such as schizophrenia, schizoaffective disorder and bipolar disorder are carried out. Individual counseling, group psychotherapies, psychoeducation programs for patients and their families, and psychosocial skills training are organized in the centers. In addition, patients are followed up on drug treatments, and home visits are made.

Population and sample of the study

The universe consists of 1100 primary caregivers with registered patients in the community mental health centers where the research was conducted. The formula for calculating the sample with the known universe was used to calculate the sample size (Krejcie & Morgan, 1970). As a result of the calculation, it was determined that at least 285 caregivers should be reached at a 5 % error and 95 % confidence interval. The study was conducted with a total of 297 caregivers who met the inclusion criteria and gave written or verbal consent to participate in the study.

Inclusion Criteria: Being the caregiver of a patient with a diagnosis of chronic mental illness, being the caregiver of the patient who was diagnosed at least 6 months ago, being the caregiver primarily responsible for the patient's care, not being a paid caregiver of the patient, caregivers who have no obstacle to communication, ability to have the cognitive competence to understand and respond to the statements in the data collection tools, over the age of 18 and volunteering to participate in the research.

Data collection method

Data were collected through face-to-face interviews and telephone interviews. In the face-to-face interview method, written consent was obtained from the participants with an "Informed Consent Form". Caregivers who could not come to the community mental health center were contacted by phone. The questions were asked orally to the participants, and the answers were marked on the forms by the researcher. Face-to-face interviews were completed in an average of 20 min, and telephone interviews were completed in an average of 30 min.

Data collection tools

Introductory information form

The Introductory Information Form consists of a total of 21 questions. The form includes questions about the sociodemographic and caregiving characteristics of the caregiver and the diagnosis of the patient they care for. All questions were answered by caregivers.

Dispositional Hope Scale (DHS)

The Dispositional Hope Scale (DHS) was developed by Snyder et al. (1991) to determine the hope levels of individuals aged fifteen and over, and its Turkish validity and reliability study was conducted by Tarhan and Bacanlı (2015). The scale consists of twelve items and two subdimensions. Sub-dimensions called "Agency thinking" (12, 10, 9, 2) and "Pathways thinking" (8, 6, 4, 1) are measured with four items each. The other four items (11, 7, 5, 3) consist of filler items. Pathways thinking means the ability to design different ways and take action, even

if difficulties are encountered on the way to reach the goal. Agency thinking is a motivating element expressing the will and power to reach the goal. The Cronbach's Alpha coefficient of the scale was found to be 0.83 (Tarhan & Bacanlı, 2015). In this research sample, it was determined that the reliability values of the scale and its subscales ranged between 0.85 and 0.99. DHS is an 8-point Likert scale. The lowest 8 and the highest 64 points are obtained from the scale. Higher scores on the scale mean an increase in hope (Tarhan & Bacanlı, 2015).

Resilience Scale for Adults (RSA)

The Resilience Scale for Adults (RSA) was developed by Friborg et al. (2005) to determine the resilience levels of adults, and its validity and reliability study was conducted in Turkey by Basım and Çetin (2011). The scale consists of thirty-three items and six subscales (planned future, structured style, social competence, family cohesion, perception of the self, and social resources). The Cronbach's Alpha coefficient of the scale was found to be 0.86 in the sample of employees and students (Basım & Çetin, 2011). This study determined that the scale and its subscales had reliability values between 0.80 and 0.99. RSA is a 5-point Likert scale. The lowest score that can be obtained from the scale is 33, and the highest score is 165. Increasing scores on the scale are considered an increase in psychological resilience (Basım & Çetin, 2011).

Data analysis

The data of the study were analyzed using the SPSS 25.0 program. Descriptive statistics and parametric and nonparametric tests suitable for the data distribution were used in the data analysis.

Ethical considerations

Ethics committee approval was obtained from Clinical Research Ethics Committee with the decision no. 2020-12. Institutional permission was obtained with the decision no. 72873149-806.02.02 from the Public Health Services Presidency and E-67508481-799 from the Public Hospitals Services Presidency.

Written or verbal consent was obtained from the caregivers who participated in the study. Participants answered the questions completely. The research was completed with 297 caregivers.

Results

Of the caregivers, 56.9 % are female, 56.9 % are in the 51 and over age group, 72.7 % are married, 44.4 % had a primary school and preschool education, 38 % are housewives, 63.6 % of them were not working, 48.1 % of them have balanced income and expenses. Of the caregivers, %28.3 have given care for 6–10 years, 27.6 % are mothers, 79.1 % live in the same house with the patient, 24.9 % care for another patient, and %48.8 of them received help in meeting the patient's care needs.

It was determined that 23.6 % of the caregivers were diagnosed with a disease during the caregiving process, 69.6 % of those with physical illness had a circulatory system disease, and 58.3 % of those with mental illness had an anxiety disorder. Of the caregivers, %16.2 stated that they had psychological problems during the time they gave care to the patient. Of those with psychological problems, %52.1 stated that their problem was a depressive mood.

It was determined that 64 % of the care receivers were diagnosed with schizophrenia and 36 % with bipolar disorder.

According to the results of the analysis, it was seen that the mean score of pathways thinking of the caregivers was 18.66 ± 9.52, the mean score of agency thinking was 21.88 ± 6.78, and the mean total score of DHS was 40.54 ± 16.23. Structured style mean score was found to be 11.88 ± 5.03, planned future mean score 11.46 ± 7.11, family cohesion mean score 19.08 ± 9.52, perception of the self mean score 18.55 ± 9.79, social competence mean score 19.51 ± 9.43, social resources mean score 24.94 ± 9.09, and RSA mean total score 105.42 ± 48.99 (Table 1).

As seen in Table 2, it was determined that hope and psychological resilience levels were higher in caregivers aged 30 and below, never married, university graduates, civil servants, those working in a job, and with income higher than expenses ($p < 0.05$).

When Table 3 is examined, it has been determined that the hope and psychological resilience levels are higher in the caregivers who care for their children, do not live in the same house with the patient, have <5 years of care, do not have another patient for whom they are responsible and receive help in meeting the care needs of the patient ($p < 0.05$).

The mean score of pathways thinking from DHS subscales and the mean score of planned future from RSA subscales was significantly higher in caregivers of patients with bipolar disorder ($p < 0.05$, Table 4).

Discussion

Hope and resilience levels of primary caregivers

The results of this study show that the hopes of caregivers of patients with a CMI are moderate (Table 1). Considering other studies conducted with caregivers of patients with schizophrenia, it was reported that caregivers had higher hopes (Hernandez et al., 2013; Stanley, Balakrishnan, 2021a; Wang et al., 2020). The reason for the lower hope levels of caregivers in this study may be the differences in cultural and socioeconomic characteristics between countries. In addition, the inadequacy of programs supporting caregivers in the units providing community mental health services in Turkey (Bademli et al., 2016; Bekiroğlu & Attepe Özden, 2021; Karaağaç & Çalık Var, 2019) may have influenced the caregivers' lower hope levels.

Another significant result obtained from the study is that the psychological resilience levels of the caregivers of patients with a CMI are also at a moderate level (Table 1). Similarly, in studies conducted with caregivers of patients only with schizophrenia, caregivers' psychological resilience was moderate (Abd El et al., 2018; Stanley, Balakrishnan, 2021b; Wang et al., 2020). In another study conducted with caregivers of patients with both schizophrenia and bipolar disorder, it was reported that caregivers had a high level of psychological resilience (Jain & Singh, 2014). According to these results, the diagnosis of the patient they care for affects caregivers' psychological resilience. It is noteworthy that higher levels of resilience were found in studies examining the resilience levels of caregivers of patients with schizophrenia and bipolar disorder. In this study, the level of resilience was found to be lower in caregivers of patients with schizophrenia compared to caregivers of patients with bipolar disorder (Table 4). Based on these results, it can be said that caregivers of patients with schizophrenia constitute a more risky group in terms of psychological resilience compared to patients with bipolar disorder.

Hope and resilience levels of caregivers according to caregiver characteristics

In this study, it was determined that the levels of hope and

Table 1
Mean values of caregivers for DHS and RSA and their sub-dimensions ($n = 297$).

Scale and subscales	Min-max	$\overline{X} \pm SS$
DHS Total	15,00-64,00	40,54 ± 16,23
Pathways thinking	4,00-32,00	18,66 ± 9,52
Agency thinking	11,00-32,00	21,88 ± 6,78
RSA Total	37,00-165,00	105,42 ± 48,99
Structured style	4,00-20,00	11,88 ± 5,03
Planned future	4,00-20,00	11,46 ± 7,11
Family cohesion	6,00-30,00	19,08 ± 9,52
Perception of the self	6,00-30,00	18,55 ± 9,79
Social competence	6,00-30,00	19,51 ± 9,43
Social resources	9,00-35,00	24,94 ± 9,09

Table 2
DHS and RSA scores according to sociodemographic characteristics of caregivers (n = 297).

Characteristics	DHS *Mean ± SD*	RSA *Mean ± SD*
Gender		
Female	39.44 ± 16.09	102.88 ± 49.66
Male	41.98 ± 16.37	108.77 ± 48.08
t	−1.334	−1.028
p-value	0.183	0.305
Age		
30 and below (1)	51.76 ± 11.73	141.79 ± 29.71
31–40 (2)	44.74 ± 16.25	116.69 ± 48.00
41–50 (3)	39.66 ± 16.10	102.70 ± 49.94
51 and above (4)	37.57 ± 15.97	96.37 ± 48.47
F	8.766	9.543
p-value	**0.000***	**0.000***
Bonferroni	3 < 1; 4 < 1	3 < 1; 4 < 1
Marital status		
Never married (1)	178.83	174.76
Marries (2)	152.98	154.47
Lost his/her spouse (3)	83.24	84.98
Divorced/Separated (4)	126.68	114.50
KW	21.030	21.040
p-value	**0.000***	**0.000***
Bonferroni	3 < 1; 3 < 2	3 < 1; 3 < 2
Education status		
Primary school and pre-school (1)	33.55 ± 15.10	84.17 ± 44.87
Middle School (2)	39.54 ± 13.87	102.38 ± 45.46
High School (3)	46.83 ± 14.53	123.97 ± 46.75
University (4)	49.31 ± 14.91	132.71 ± 40.75
F	21.145	21.633
p-value	**0.000***	**0.000***
Bonferroni	1 < 3; 1 < 4; 2 < 4	1 < 3; 1 < 4; 2 < 4
Occupation		
Housewife (1)	121.59	123.73
Retired (2)	146.05	149.01
Worker (3)	152.13	151.64
Officer (4)	207.66	199.60
Other (5)	194.11	187.68
KW	33.892	26.234
p-value	**0.000***	**0.000***
Bonferroni	1 < 4; 1 < 5; 2 < 4; 2 < 5	1 < 4; 1 < 5
Working status		
Full day	45.29 ± 15.38	118.73 ± 45.95
Not working	37.82 ± 16.11	97.81 ± 49.16
t	3.905	3.679
p-value	**0.000***	**0.000***
Perceived income level		
Low (1)	96.13	95.58
Middle (2)	196.92	195.72
High (3)	208.58	224.46
KW	103.489	106.617
p-value	**0.000***	**0.000***
Bonferroni	1 < 2; 1 < 3	1 < 2; 1 < 3

* $p < 0.05$.

Table 3
DHS and RSA scores according to caregiving characteristics of caregivers (n = 297).

Characteristics	DHS *Mean ± SD*	RSA *Mean ± SD*
Relationship status with the patient		
Mother (1)	120.69	118.59
Father (2)	135.30	138.47
Sibling (3)	160.29	160.03
Spouse (4)	159.11	155.13
Child (5)	185.06	192.60
Other (6)	132.21	129.14
KW	20.072	24.189
p-value	**0.001***	**0.000***
Bonferroni	1 < 5	1 < 5
Living in the same house with the patient		
Yes	38.46 ± 16.11	98.79 ± 48.84
No	48.42 ± 14.23	130.55 ± 41.00
t	−4.766	−5.203
p-value	**0.000***	**0.000***
Duration of caregiving (year)		
1–5 (1)	51.44 ± 10.78	140.56 ± 32.69
6–10 (2)	46.56 ± 13.88	122.71 ± 44.06
11–15 (3)	36.91 ± 17.09	95.45 ± 48.21
16–20 (4)	33.08 ± 15.66	80.31 ± 45.35
Over 20 (5)	30.02 ± 13.05	74.24 ± 40.20
F	22.874	24.518
p-value	**0.000***	**0.000***
Bonferroni	3 < 1; 4 < 1; 5 < 1; 3 < 2; 4 < 2; 5 < 2	3 < 1; 4 < 1; 5 < 1; 3 < 2; 4 < 2; 5 < 2
The presence of another patient cared		
Yes	26.82 ± 11.76	62.96 ± 30.17
No	45.09 ± 14.91	119.51 ± 45.83
t	−9.590	−12.133
p-value	**0.000***	**0.000***
Getting help in meeting the patient's care needs		
Yes	51.49 ± 11.49	141.94 ± 29.15
No	30.09 ± 12.84	70.57 ± 37.29
t	15.105	18.424
p-value	**0.000***	**0.000***

* $p < 0.05$.

Table 4
DHS and RSA scores of caregivers according to the diagnoses of patients (n = 297).

Scale and subscales	Schizophrenia *Mean ± SD*	Bipolar disorder *Mean ± SD*	t	p-value
DHS Total	39.19 ± 16.37	42.93 ± 15.77	−1.913	0.057
Pathways thinking	17.83 ± 9.63	20.12 ± 9.18	−2.001	**0.046***
Agency thinking	21.36 ± 6.80	22.80 ± 6.68	−1.770	0.078
RSA Total	101.80 ± 49.50	111.84 ± 47.62	−1.701	0.090
Structured style	11.60 ± 5.16	12.36 ± 4.78	−1.258	0.209
Planned future	10.82 ± 7.06	12.59 ± 7.11	−2.067	**0.040***
Family cohesion	18.50 ± 9.61	20.12 ± 9.30	−1.412	0.159
Perception of the self	17.78 ± 9.88	19.90 ± 9.52	−1.793	0.074
Social competence	18.75 ± 9.59	20.86 ± 9.03	−1.888	0.060
Social resources	24.34 ± 9.19	26.01 ± 8.84	−1.522	0.129

* $p < 0.05$.

psychological resilience did not differ significantly according to the gender of the caregivers (Table 2). Similarly, in studies conducted with caregivers of patients with schizophrenia, it was reported that there was no significant difference in the hope levels of caregivers according to their gender (Wang et al., 2020; Yakoobian et al., 2009). Consistent with the results of this study, studies reveal that the level of resilience of caregivers of patients with a CMI does not differ significantly according to gender (Stanley, Balakrishnan, 2021b; Uğurtay, 2019; Wang et al., 2020).

In this study, it was determined that caregivers' hope and psychological resilience levels differed significantly according to age, and the level of hope and psychological resilience of caregivers aged 30 and under was higher (Table 2). According to the results of this research, especially caregivers over the age of 40 are at risk in terms of hope and psychological resilience. In a study conducted with caregivers of patients with schizophrenia, it was reported that the level of hope decreases as the age of caregivers increases (Stanley, Balakrishnan, 2021a). Another study conducted with caregivers of patients with schizophrenia determined that caregivers under the age of 46 had a higher level of hope (Francisquini et al., 2020). These results support the results of the research. It is thought that the hopes of caregivers may decrease due to personal reasons such as decreasing goals, increasing diseases, and feeling closer to death as they get older. At the same time,

the physical problems brought about by aging may have negatively affected the level of hope by making it difficult to care for the patient. Unlike the results of this study, it was reported in a study conducted with caregivers of patients with schizophrenia that age did not affect caregivers' psychological resilience (Stanley, Balakrishnan, 2021b). The reason for these differences between the results may be that the caregivers have different individual, cultural and experiential characteristics.

This study determined that caregivers' hope and psychological resilience levels differed significantly according to their education status. It was determined that university graduates had higher hope and psychological resilience levels (Table 2). According to the research results, caregivers at primary and preschool education levels are more disadvantaged in terms of hope and psychological resilience. Similar to the results of this study, in a study conducted with caregivers of patients with schizophrenia, it was reported that as the education level of the caregivers increased, their hope levels increased (Francisquini et al., 2020). It has been determined that the level of psychological resilience of caregivers with a university or higher education level is higher (Wang et al., 2020). Similarly, in another study conducted with caregivers of patients with schizophrenia, it was determined that as the education level of the caregivers increased, their psychological resilience increased (Nihayati et al., 2020). In a study conducted with caregivers of patients with bipolar disorder, it was reported that being a university graduate increased psychological resilience in caregivers (Uğurtay, 2019). It has been determined that caregivers with high education levels have higher levels of psychological resilience than those with low education levels (Yağmur & Türkmen, 2017). These results are similar to the results of the research. Higher education may positively affect caregivers' hope levels by increasing job opportunities and incomes. In addition, the increase in education level may lead to higher awareness in caregivers about being more open to learning about the disease, establishing healthier relationships with the patient, and seeing the positive aspects of caregiving. It is thought that the positive characteristics gained with the increase in education level improve the psychological resilience of caregivers.

This study determined that caregivers' hope and psychological resilience levels differed significantly according to their income. It was determined that those with high incomes had higher levels of hope and psychological resilience (Table 2). According to the research results, low-income caregivers are at risk regarding low hope and psychological resilience levels. In a study conducted with caregivers of patients with schizophrenia, it was reported that there was no significant difference in the level of hope of caregivers according to their income. However, it has been determined that having a high-income level increases psychological resilience in caregivers (Wang et al., 2020). A study conducted with caregivers of patients with bipolar disorder determined that caregivers with a high-income level had higher levels of psychological resilience (Uğurtay, 2019). Similarly, a study reported that caregivers with higher income levels had higher psychological resilience than those with lower income levels (Yağmur & Türkmen, 2017). The high level of income may have positively affected the psychological resilience levels of caregivers by making it easier for them to cope with difficulties that require financial support and by reducing the economic burden of caregiving.

This study determined that caregivers' levels of hope and psychological resilience differed significantly according to the duration of caregiving. It was determined that the levels of hope and psychological resilience were higher in caregivers whose caregiving duration was <5 years (Table 3). According to the research results, caregivers with >10 years of caregiving are at higher risk of hopelessness and psychological vulnerability. Similar to the results of this study, in a study conducted with caregivers of patients with schizophrenia, it was reported that as the caregiving duration of the caregivers increased, the level of hope decreased (Stanley, Balakrishnan, 2021a). Caregiving is a complex process that imposes severe burdens on the caregiver. Therefore, an increase in the duration of caregiving means that the caregiver is exposed to difficulties for a more extended time. As the duration increases, negative emotions such as stress, sadness, and helplessness may increase. For this reason, it is thought that hope levels may have decreased.

Hope and resilience levels of caregivers according to patient diagnosis

In this study, although the level of continuous hope was lower in caregivers of patients with schizophrenia than in those who care for patients with bipolar disorder, there was no significant difference between the two groups (Table 4). In a study conducted with caregivers of patients with schizophrenia, the level of continuous hope of caregivers was reported as 57.39 ± 3.93 (Stanley, Balakrishnan, 2021a). Compared with the results of other studies, it can be said that the hope levels of primary caregivers of patients with schizophrenia who participated in this study were lower.

In this study, the level of psychological resilience was found to be lower in caregivers of patients with schizophrenia than in caregivers of patients with bipolar disorder (Table 4). In a study conducted with the caregivers of patients with schizophrenia, the mean total score of the RSA was 88.15 ± 11.62 (Lök & Bademli, 2021). In a study conducted with caregivers of patients with bipolar disorder, the mean total score of the RSA was found to be 119.38 ± 24.26 (Uğurtay, 2019). Considering these results, it can be said that the psychological resilience levels of those who care for patients with schizophrenia are lower than those who care for patients with bipolar disorder. An important result of this study is that the level of planned future in caregivers of patients with schizophrenia was lower than in those who care for patients with bipolar disorder (Table 4). Another remarkable result of this study is that caregivers of patients with schizophrenia had significantly lower hopes in pathways thinking than those who care for patients with bipolar disorder (Table 4).

This study found that the levels of pathways thinking and planned future subscales of caregivers of patients with bipolar disorder were higher than those who care for patients with schizophrenia (Table 4). These results show that caregivers of patients with schizophrenia are more at risk regarding pathways thinking and planned future. However, unlike the results of this study, in a study conducted with caregivers of patients with schizophrenia and bipolar disorder, it was reported that there was no significant difference in terms of psychological resilience in caregivers (Jain & Singh, 2014). While mood swings with manic and depressive episodes are prominent in bipolar disorder, hallucinations and delusions are prominent in schizophrenia. This situation can make schizophrenia a more incomprehensible, more challenging to control, and more complex disease. Therefore, while hopelessness increases in caregivers, psychological resilience may decrease. It can be said that since the caregivers of patients with bipolar disorder perceive the symptoms of the disease as less severe and controllable, they continue to struggle by finding alternative ways when they encounter difficulties, and they can look at the future more positively.

Limitations of the study

The results cannot be generalized to primary caregivers of all patients with a CMI. Since the scales used in the study are self-report scales based on self-report, the inability to consistently get correct answers from people is another limitation of the study.

Conclusions

The results of this study show that the caregivers' hope and psychological resilience levels of patients with a CMI are affected by the sociodemographic and caregiving characteristics of the caregivers.

To sociodemographic and caregiver characteristics; caregivers who are over 40 years old, lost his/her spouse, low education level, housewife or retired, unemployed, who evaluated their incomes low, mother,

living in the same house with the patient, caring for ten years or more, caring for another patient and not getting help in care had lower hope levels.

To sociodemographic and caregiver characteristics; caregivers who are over 40 years old, lost his/her spouse, low education level, housewife or retired, unemployed, who evaluated their incomes low, mother, living in the same house with the patient, caring for ten years or more, caring for another patient and not getting help in care also had lower resilience levels.

Caregivers of patients with schizophrenia had lower hope levels in the dimension of pathways thinking and lower levels of psychological resilience in the dimension of planned future compared to caregivers of patients with a bipolar diagnosis.

Implications for nursing practice

Mental health and psychiatric nurses working in community mental health centers should develop and implement psychosocial support programs focusing on increasing hope and psychological resilience for primary caregivers of patients with a CMI.

Nurses should encourage caregivers to participate in self-help groups to provide social support. In family-centered psychosocial approaches, the importance of sharing the caregiving role among family members should be emphasized.

Caregivers of patients with schizophrenia should be supported more psychosocially, as they are a group at higher risk in terms of hopelessness and psychological vulnerability. Caregivers' needs regarding their patients and the challenges posed by the disease should be identified. Psychoeducational programs should be organized for caregivers in line with their needs such as diagnosis, prognosis, factors that trigger exacerbations, and treatment methods.

In order to obtain in-depth data on hope and psychological resilience in primary caregivers of patients with a CMI in the future, it is recommended to conduct experimental studies and demonstrate the effectiveness of intervention programs that increase hope and psychological resilience.

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CRediT authorship contribution statement

Substantial contributions to conception and design: ABG, ŞE; acquisition of data: ŞE; analysis and interpretation of data: ŞE, ABG; drafting the article or revising it critically for important intellectual content: ŞE, ABG and final approval of the version to be published: ABG, ŞE.

Declaration of competing interest

The authors declare that there is no conflict of interest.

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