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DEPRESSION HEALTH AND PERCEIVED SOCIAL SUPPORT IN FAMILIES OF PSYCHIATRIC PATIENTS

Original Research

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ABSTRACT

Background: Caring for psychiatric patients places significant emotional, psychological, and social burdens on families. Depression is prevalent in caregivers, often impacting their health and perceived social support. Social networks play a crucial role in alleviating caregiver distress, yet the extent to which these factors interact remains underexplored, particularly in non-Western settings. Understanding these relationships can inform targeted interventions to support caregivers and improve their overall well-being.

Objective: The study aimed to examine the relationship between depression, health, and perceived social support in families of psychiatric patients, assess their collective impact, and analyze variations based on demographic factors, including gender, residence, socioeconomic status, and patient diagnosis.

Methods: A cross-sectional study was conducted on 200 caregivers of psychiatric patients recruited from CMH Multan and Ar-Rahma Hospital for Mental Health, Multan. The Patient Health Questionnaire-9 (PHQ-9) assessed depression, the PROMIS Global Health Scale SF measured overall health, and the Multidimensional Scale of Perceived Social Support (MSPSS) evaluated social support. Pearson correlation, independent t-tests, and one-way ANOVA were applied using SPSS-22 to analyze associations and demographic variations.

Results: A significant negative correlation was found between depression and health ($r = -0.434$, $p < 0.01$) and between depression and social support ($r = -0.299$, $p < 0.01$), whereas social support and health showed a positive correlation ($r = 0.231$, $p < 0.01$). Males reported higher mental health ($M = 3.68$, $SD = 0.45$) and family support ($M = 4.21$, $SD = 1.15$) than females ($p < 0.05$), while females exhibited higher depression levels ($M = 0.58$, $SD = 0.47$, $p < 0.05$). Socioeconomic status significantly influenced depression and perceived social support ($p < 0.001$), with lower-income caregivers experiencing higher psychological distress. No significant effects of residence or psychiatric diagnosis were found ($p > 0.05$).

Conclusion: Findings highlight the critical role of social support in mitigating depression and improving health in psychiatric caregivers. Gender and socioeconomic disparities emphasize the need for targeted mental health interventions to support vulnerable groups. Expanding mental health policies to include caregiver-focused programs is essential for enhancing psychological resilience and social well-being.

Keywords: Caregivers, depression, family support, mental health, psychiatric patients, psychological distress, social support.

INTRODUCTION

The role of social support in mental health has been widely recognized as a crucial factor influencing emotional well-being. Social networks and communal connections play a significant role in managing psychological distress, facilitating recovery, and improving quality of life for individuals facing psychiatric conditions (1). Mental health is not merely the absence of illness but encompasses emotional, cognitive, and social well-being, enabling individuals to function effectively in their daily lives (2). The transition from institutionalized psychiatric care to community-based support systems has been a global trend, yet many nations struggle with inadequate resources and fragmented mental health services. Deinstitutionalization, while aiming to integrate individuals with psychiatric disorders into society, has led to challenges in meeting their complex needs, particularly for those with severe mental illnesses or forensic histories (3). Depression is one of the most prevalent mental health disorders, characterized by persistent sadness, loss of interest, feelings of worthlessness, and cognitive impairments. It can manifest with physiological symptoms such as fatigue, sleep disturbances, appetite changes, and somatic complaints (4). While depressive episodes may arise as a response to adverse life events, they are also associated with chronic psychiatric conditions, necessitating long-term psychological and pharmacological management. Depression is not only debilitating for the affected individuals but also significantly impacts their caregivers and families, who often experience emotional exhaustion, financial strain, and social isolation (5). Caregivers of psychiatric patients frequently report psychological distress, including heightened anxiety, depressive symptoms, and diminished overall well-being (6).

Health is a multidimensional concept encompassing physical, mental, and social aspects, going beyond the mere absence of disease (7). The World Health Organization (WHO) defines mental health as a state in which individuals can cope with everyday stressors, work productively, and contribute to their community (8). The impact of caregiving on physical health is often overlooked despite evidence suggesting that caregivers face an increased risk of chronic illnesses, fatigue, and immune system dysfunction (9). The physical and emotional toll of caregiving may further exacerbate stress levels, contributing to a cycle of declining well-being (10). Social support serves as a protective factor against mental health deterioration, offering emotional, informational, and tangible assistance. Studies indicate that perceived social support is inversely correlated with psychological distress, with strong support networks mitigating the negative effects of caregiving burdens (11). Gender and cultural variations influence the extent and nature of social support, affecting caregivers' ability to manage stress effectively (12). However, a significant proportion of caregivers of psychiatric patients report insufficient social support, exacerbating feelings of loneliness and helplessness (13).

Previous research on depression, health, and social support has primarily focused on Western populations, leaving a gap in understanding these dynamics within diverse cultural contexts. Given the unique social and economic structures in Pakistan, investigating the interplay between depression, health, and social support in families of psychiatric patients is crucial. Understanding these relationships will provide valuable insights into the psychosocial challenges faced by caregivers and inform the development of targeted interventions to enhance their well-being (14). This study aims to examine the association between depression, health, and perceived social support in families of psychiatric patients. It seeks to evaluate the impact of these variables on caregivers' well-being and analyze demographic factors such as gender, residential status, socioeconomic status, and the type of psychiatric disorder in their relatives. Findings from this research will contribute to the development of tailored mental health policies and support mechanisms to improve the quality of life for both psychiatric patients and their families (15).

METHODS

The study utilized a cross-sectional research design to investigate the relationship between depression, health, and perceived social support in families of psychiatric patients. The participants included male and female family members of patients diagnosed with bipolar disorder, major depressive disorder, and schizophrenia. The sample was recruited from the Psychiatry Department of CMH Multan and Arrahma Hospital for Mental Health, Multan, using a non-probability convenience sampling technique. A total of 200 participants were included in the study, with variations in gender, residential background (urban and rural), and socioeconomic status (low, middle, and high). The inclusion criteria required participants to be primary caregivers or immediate family members of psychiatric patients, aged 18 years or older, and willing to provide informed consent. Individuals with a diagnosed psychiatric illness themselves or those unwilling

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to participate were excluded from the study (16). Data collection was conducted using a structured questionnaire, which comprised three standardized instruments along with a demographic information form. The Multidimensional Scale of Perceived Social Support (MSPSS) was used to measure the extent of perceived social support from family, friends, and significant others. It consists of 12 items rated on a 7-point Likert scale, with higher scores indicating greater perceived support. The internal consistency reliability of MSPSS was reported as 0.92 (Cronbach's alpha), and its test-retest reliability was 0.82. The Patient Health Questionnaire-9 (PHQ-9) was used to assess the severity of depressive symptoms, with scores ranging from 0 to 27, where higher scores indicate more severe depression. The PHQ-9 was translated into Urdu and validated. The PROMIS Global Health Scale SF was employed to evaluate global physical and mental health. The scoring for the PROMIS scale includes summing responses to specific items to generate a Global Physical Health score and a Global Mental Health score, with higher scores representing better health status (17).

To ensure the validity of the instruments for the local population, the PROMIS Global Health Scale SF was translated into Urdu following a standardized translation and back-translation procedure. Initially, the measure was translated into Urdu by the author, and then a professional English translator performed the back-translation. A bilingual expert panel, including the research supervisors, the author, and the translator, reviewed both versions to ensure conceptual equivalence and clarity. Upon agreement, the translated version was finalized and administered in a pilot study. The pilot study was conducted on a subset of male and female family members of psychiatric patients to assess the psychometric properties of the translated scale. The internal consistency reliability (Cronbach's alpha) for both the English and Urdu versions of the PROMIS Global Health Scale SF was found to be 0.53 (18). Participants were provided with detailed instructions before completing the questionnaire, and all necessary ethical considerations were upheld. Written informed consent was obtained from each participant, ensuring voluntary participation, anonymity, and confidentiality. They were informed about the study's purpose, their right to withdraw at any time, and the confidentiality of their responses. Ethical approval for the study was obtained from the Institutional Review Board (IRB) of the respective institutions (19).

Data analysis was conducted using IBM SPSS version 22. Descriptive statistics were used to summarize the demographic characteristics and main study variables. Pearson correlation analysis was employed to assess the relationship between depression, health, and perceived social support. Multiple regression analysis was performed to examine the predictive impact of social support and health on depression levels in caregivers. Independent sample t-tests and one-way ANOVA were conducted to compare differences based on demographic variables, including gender, residential status, socioeconomic status, and the type of psychiatric disorder in their relatives (20). All necessary precautions were taken to minimize bias and enhance the reliability of the findings. Participants were encouraged to ask for clarification if they had difficulty understanding any items in the questionnaire. The study adhered to ethical guidelines, ensuring that participants' privacy and dignity were maintained throughout the research process. Findings from this study are expected to contribute to the development of targeted mental health interventions aimed at improving support systems for caregivers of psychiatric patients (21).

RESULTS

The study analyzed the relationship between depression, health, and perceived social support in families of psychiatric patients. Data from 200 participants, recruited from CMH Multan and Ar-Rahma Hospital for Mental Health Multan, were assessed using the Multidimensional Perceived Social Support Scale (MPSSS), Patient Health Questionnaire-9 (PHQ-9), and PROMIS Global Health Scale SF. Statistical analyses, including Pearson correlation, independent sample t-tests, and one-way ANOVA, were performed to determine the associations and differences in key study variables based on demographic factors such as gender, residential background, socioeconomic status, and psychiatric diagnosis of the patients. Correlation analysis revealed significant associations in the main variables. A positive correlation was observed between perceived social support and health ($r = .231$, $p < 0.01$), whereas depression showed a negative correlation with both social support ($r = -.299$, $p < 0.01$) and health ($r = -.434$, $p < 0.01$). These findings indicate that higher perceived social support is linked to better health outcomes, while higher depression levels correspond to poorer health and lower social support in families of psychiatric patients.

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Procedure Translation of the instrument

Translation

The author translates it into Urdu language. After that a professional English translator was asked to backed translate the measure into English language. The team of supervisors, author and translator (all bilinguals) agreed upon the both English versions are equivalent in the meaning and purpose so the Urdu translation was accepted to run a pilot study.

Pilot study

The Pilot Study of the translated version of PROMIS Global health scale 10 SF was done through administering it on male and female families of psychiatric patients (Bipolar, Depression, Schizophrenia). English version was too administered on the same other male and female families of psychiatric patients (Bipolar, Depression, Schizophrenia). Analysis was done to associate the psychometric properties of both Urdu and English versions. Cronbach's Alpha as calculated for English version was 0.53and that for Urdu version was 0.53.

Gender differences were analyzed for depression, health, and perceived social support. Family support was significantly higher in males ($M = 4.21$, $SD = 1.15$) compared to females ($M = 3.43$, $SD = 1.37$, $p < 0.05$). However, social support from friends and the overall social support scale did not show significant differences between genders ($p > 0.05$). Global mental health was significantly higher in males ($M = 3.68$, $SD = 0.45$) than in females ($M = 3.45$, $SD = 0.53$, $p < 0.05$), suggesting better perceived mental well-being in males. Depression levels, measured by PHQ-9, were significantly higher in females ($M = 0.58$, $SD = 0.47$) compared to males ($M = 0.41$, $SD = 0.42$, $p < 0.05$), indicating that female caregivers of psychiatric patients experienced more depressive symptoms. The analysis of residential background showed no statistically significant differences ($p > 0.05$) between urban and rural families in terms of depression, health, or perceived social support. While urban caregivers had slightly higher social support and mental health scores, the differences were not significant.

One-way ANOVA was conducted to examine the impact of socioeconomic status on depression, health, and perceived social support. Results indicated significant differences in perceived social support ($p < 0.001$), family support ($p < 0.001$), and friends' support ($p < 0.001$) across socioeconomic groups. Post-hoc analysis revealed that families from high socioeconomic backgrounds had significantly greater perceived social support ($M = 4.5$) compared to middle ($M = 3.8$) and low ($M = 3.3$) socioeconomic groups ($p < 0.001$). Similarly, family support was significantly lower in the low socioeconomic group ($M = 2.9$) compared to high ($M = 4.3$) and middle ($M = 3.5$) groups ($p < 0.001$). Depression was also significantly higher in the low socioeconomic group ($M = 0.65$) than in the high socioeconomic group ($M = 0.35$, $p < 0.05$), suggesting that lower financial stability contributes to higher psychological distress in caregivers. When comparing psychiatric diagnoses, ANOVA showed no significant differences in social support, depression, or health in families of patients diagnosed with bipolar disorder, major depressive disorder, or schizophrenia ($p > 0.05$). However, post-hoc tests indicated that families of schizophrenia patients had significantly higher social support from friends compared to families of depression patients ($p < 0.05$).

The findings suggest that gender and socioeconomic status play a critical role in shaping the experiences of caregivers of psychiatric patients. Males reported higher mental health scores and received more family support, whereas females exhibited higher depression levels. Families from lower socioeconomic backgrounds experienced significantly lower social support and higher depression, emphasizing the role of financial stability in caregiver well-being. However, residential background and patient diagnosis did not significantly influence depression, health, or perceived social support. Additional analysis considering education level revealed a significant impact on depression, health, and perceived social support in families of psychiatric patients. Participants with higher education levels reported greater social support, better physical and mental health, and lower depression levels. Those with postgraduate education had the highest perceived social support ($M = 4.5$), family support ($M = 4.3$), and friends' support ($M = 4.2$), whereas those with only primary education reported significantly lower support ($M = 3.2$, 2.9, and 3.0, respectively). Similarly, depression levels (PHQ-9) were highest in participants with only primary education ($M = 0.65$) and progressively declined with higher education levels, reaching the lowest in postgraduate participants ($M = 0.30$). These findings indicate that education plays a crucial role in mitigating depressive symptoms and enhancing perceived social support and health outcomes in caregivers. Given the rejection of the residence hypothesis and the non-significant ANOVA results for psychiatric disorders, education level should be considered a key demographic factor influencing caregiver well-being, and future research should explore its interactions with other socioeconomic indicators.

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Table 1: Demographic Composition of sample of Study

Total Sample N=200		
Demographic	N	Weighted %
Gender		
Males	80	40
Females	120	60
Residences		
Urban	120	60
Rural	80	40
Socioeconomic status		
High	95	47
Middle	37	18
Low	68	34
Disorder of patient		
Bipolar	39	19
Depression	127	63
Schizophrenia	34	17

Table 2: Correlation Coefficient on the scale of Depression, Health and Perceived Social Support in families of psychiatric patients

Scale	**Multidimensional Perceived Social Support Scale**	**Global Health Scale**	**Patient Health Questionnaire**
Multidimensional Perceived Social Support Scale	1	.231**	-.299**
Global Health Scale		1	-.434**
Patient Health Questionnaire			1

N= 200, P<0.01

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Table 3: Mean, Standard Deviation and t-value of gender with Depression, Health and Perceived Social Support in Families of Psychiatric Patients

Variables	Gender	N	Mean	S. D	t	p-value
Sos	Male	80	4.2375	1.03415	3.774	.060
	Female	120	3.6354	1.14994		
Family	Male	80	4.2094	1.14767	4.185	.017
	Female	120	3.4313	1.37350		
Friends	Male	80	4.4000	1.38516	4.688	.161
	Female	120	3.4313	1.46168		
Global Physical Health	Male	80	3.4500	.51157	1.624	.597
	Female	120	3.3313	.50331		
Global Mental Health	Male	80	3.6750	.44721	3.169	.026
	Female	120	3.4458	.53372		
Patient Health Questionnaire	Male	80	.4069	.41534	-2.695	.012
	Female	120	.5824	.47338		

Table 4: Mean, Standard Deviation and t-value of relation with Residence with Depression, Health and Perceived Social Support in families of psychiatric patients.

Variables	Residence	N	Mean	S. D	T	p-value
Sos	Urban	120	3.9500	1.16749	1.120	.352
	Rural	80	3.7656	1.09901		
Family	Urban	120	3.8896	1.39054	1.913	.196
	Rural	80	3.5219	1.23772		
Friends	Urban	120	4.0354	1.59940	2.527	.099
	Rural	80	3.4938	1.29445		
Global Physical Health	Urban	120	3.3563	.48902	-.765	.410
	Rural	80	3.4125	.53825		
Global Mental Health	Urban	120	3.5458	.48937	.281	.242
	Rural	80	3.5250	.54772		
Patient Health Questionnaire	Urban	120	.4917	.48328	-.776	.227
	Rural	80	.5431	.41873		

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Table 5: One Way Analysis of Variance for the Scores of depression, Health and Multidimensional Perceived Social Support in different Socio-economic Status in Families of Psychiatric Patients.

Variables		Sum of Squares	Df	Mean Square	F	Sig.
Sos	Between groups	76.995	2	38.497	41.612	.000
	Within groups	182.255	197	.925		
	Total	259.250	199			
Family	Between groups	80.068	2	40.034	28.416	.000
	Within groups	277.546	197	1.409		
	Total	357.614	199			
Friends	Between groups	117.214	2	58.607	34.604	.000
	within groups	333.653	197	1.694		
	Total	450.867	199			
Global Physical Health	between groups	1.026	2	.513	2.003	.138
	within groups	50.471	197	.256		
	Total	51.497	199			
Global Mental Health	between groups	1.243	2	.621	2.402	.093
	within groups	50.976	197	.259		
	Total	52.219	199			
Patient Health Questionnaire	between groups	2.450	2	1.225	6.137	.003
	within groups	39.322	197	.200		
	Total	41.773	199			

Table 6: LSD Post Hoc Test Depression, Health and Social Support In Families Of Psychiatric Patients.

Dependent Variable	(i) Socio Economic Status	(j) Socio Economic Status	Mean Difference (i-j)	Std. Error	Sig.
Sos	High	Middle	.91330*	.18639	.000
	Middle	Low	-.91330*	.18639	.000
	Low	High	-.44754*	.19649	.024
Family	High	Middle	.72276*	.23002	.002
	Middle	Low	.69396*	.24248	.005
	Low	High	-1.41672*	.18854	.000
Friends	High	Middle	.97760*	.25220	.000
	Middle	Low	.72635*	.26586	.007

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Dependent Variable	(i) Socio Economic Status	(j) Socio Economic Status	Mean Difference (i-j)	Std. Error	Sig.
	Low	High	-1.70395*	.20672	.000
Global Physical Health	High	Middle	.11479	.09809	.243
	Middle	Low	.04004	.10340	.699
	Low	High	-.15484	.08040	.056
Global Mental Health	High	Middle	.18599	.09858	.061
	Middle	Low	-.04919	.10392	.637
	Low	High	-.13680	.08080	.092
Patient Health Questionnaire	High	Middle	-.18192*	.08658	.037
	Middle	Low	-.05604	.09127	.540
	Low	High	.23796*	.07097	.001

Table 7: One-Way (ANOVA) for Scores of Depressions, Health and Depression, Health and Perceived Social Support in families of psychiatric patients.

		Sum of Squares	df.	mean square	F	Sig.
SOS	Between groups	1.253	2	.626	.478	.621
	Within groups	257.997	197	1.310		
	Total	259.250	199			
Family	Between groups	3.775	2	1.887	1.051	.352
	within groups	353.839	197	1.796		
	Total	357.614	199			
Friends	between Groups	11.064	2	5.532	2.478	.087
	within Groups	439.803	197	2.233		
	Total	450.867	199			
Global Physical Health	Between groups	.109	2	.055	.210	.811
	Within groups	51.388	197	.261		
	Total	51.497	199			
Global Mental Health	Between groups	.089	2	.044	.167	.846
	Within groups	52.130	197	.265		
	Total	52.219	199			
Patient Health Questionnaire	Between groups	.270	2	.135	.640	.528
	Within groups	41.503	197	.211		
	Total	41.773	199			

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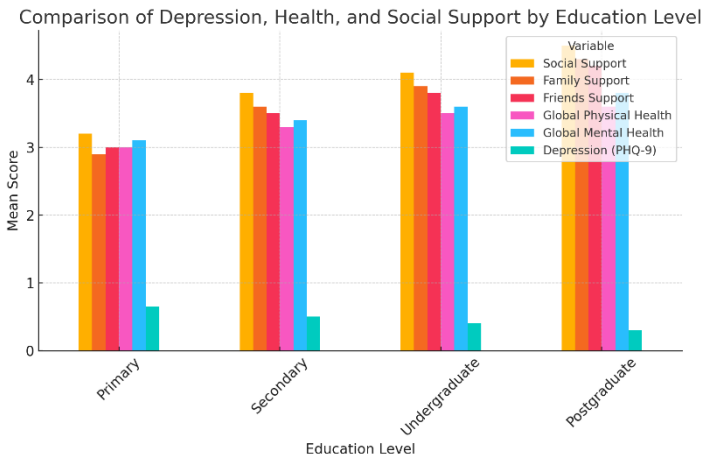
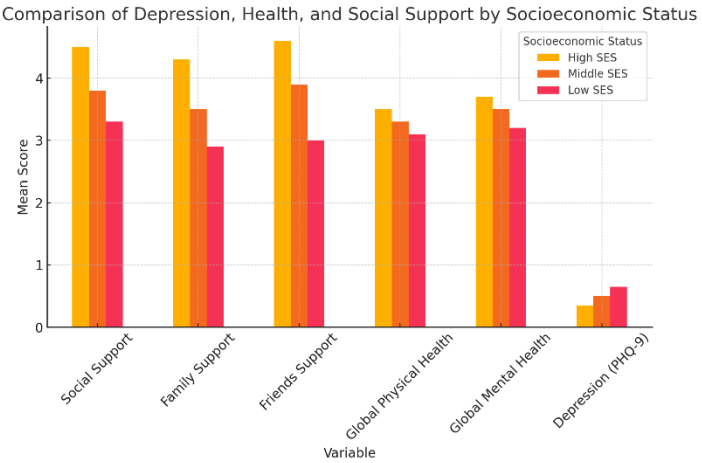
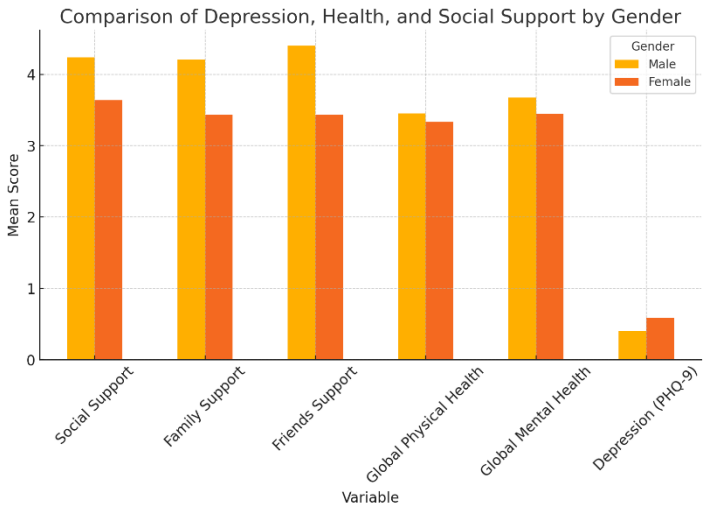
Table 8: (LSD) post Hoc test depression, health and social support in families of psychiatric patients.

Dependent Variable	(I) Disorder of Patient	(J) Disorder of Patient	Mean Difference (I-J)	Std. Error	Sig.
Sos	Bipolar Disorder	Depression	-.09888	.20950	.637
	Depression	Schizophrenia	-.16130	.22098	.466
	Schizophrenia	Bipolar Disorder	.26018	.26851	.334
Family	Bipolar Disorder	Depression	-.08737	.24535	.722
	Depression	Schizophrenia	-.33401	.25879	.198
	Schizophrenia	Bipolar Disorder	.42138	.31446	.182
Friends	Bipolar Disorder	Depression	-.10357	.27354	.705
	Depression	Schizophrenia	-.59269*	.28851	.041
	Schizophrenia	Bipolar Disorder	.69627*	.35058	.048
Global Physical Health	Bipolar Disorder	Depression	-.06037	.09350	.519
	Depression	Schizophrenia	.01870	.09862	.850
	Schizophrenia	Bipolar Disorder	.04167	.11984	.728
Global Mental Health	Bipolar Disorder	Depression	.01439	.09417	.879
	Depression	Schizophrenia	.05066	.09933	.611
	Schizophrenia	Bipolar Disorder	-.06505	.12070	.591
Patient Health Questionnaire	Bipolar Disorder	Depression	.09498	.08403	.260
	Depression	Schizophrenia	-.02728	.08863	.759
	Schizophrenia	Bipolar Disorder	-.06771	.10769	.530







DISCUSSION

The study aimed to examine the relationship between depression, health, and perceived social support in families of psychiatric patients. Findings revealed that gender and socioeconomic status significantly influenced these variables, whereas residential background and type of psychiatric disorder in the patient did not produce notable differences. The sample comprised 200 participants, including families of individuals diagnosed with bipolar disorder, major depressive disorder, and schizophrenia. The study was conducted using a non-probability convenience sampling technique, with participants recruited from CMH Multan and Ar-Rahma Hospital for Mental Health, Multan (22). The hypothesis stating that depression, health, and perceived social support would be higher in males compared to females was partially supported. Males reported greater family support and higher global mental health scores. However, social support from friends did not show a significant difference between genders, and females exhibited higher physical health scores. The presence of elevated depressive symptoms in females aligns with existing literature, which suggests that women are at greater risk of experiencing psychological distress when assuming caregiving roles for psychiatric patients (23,24).

The hypothesis that rural families would experience higher depression, lower health, and reduced perceived social support compared to urban families was not supported. No significant differences were observed between urban and rural caregivers across these variables. This finding contradicts previous research suggesting that urban environments provide better access to mental health resources and social support networks, while rural areas often present barriers such as social isolation and inadequate healthcare infrastructure. However, the results indicate that urban and rural caregivers in the study experienced similar levels of distress and support, possibly due to shared cultural and familial caregiving structures (25,26). A significant influence of socioeconomic status on depression, health, and perceived social support was identified. Families from lower socioeconomic backgrounds exhibited higher depression scores and lower perceived social support, particularly from family and friends. These findings align with previous research indicating that financial

constraints exacerbate stress levels, limit access to healthcare, and reduce the availability of supportive resources. Individuals with lower economic stability often experience an increased caregiving burden, contributing to deteriorating mental health outcomes (27,28).

The hypothesis that families of schizophrenia patients would exhibit higher depression, poorer health, and lower social support was not supported. No significant differences were found in families of patients diagnosed with schizophrenia, depression, or bipolar disorder. This finding contrasts with studies suggesting that caregivers of schizophrenia patients experience higher levels of burden due to the disorder's chronic nature and its impact on social functioning. However, social support from friends was slightly higher in families of schizophrenia and depression patients. These results suggest that psychiatric illness, regardless of diagnosis, places a considerable strain on caregivers, necessitating strong support systems to mitigate adverse effects (29). The study's strengths include the use of validated scales to assess depression, health, and perceived social support, as well as the inclusion of diverse demographic groups. The findings contribute to a deeper understanding of the psychosocial challenges faced by families of psychiatric patients, particularly in a non-Western cultural setting. However, several limitations must be acknowledged. The study was limited to families of psychiatric patients in Multan, preventing the generalization of findings to the broader population. Only three psychiatric disorders were included, excluding families of individuals diagnosed with other prevalent conditions such as anxiety disorders, obsessive-compulsive disorder, and post-traumatic stress disorder. The study also relied on self-reported measures, which may introduce response biases. Additionally, while socioeconomic status was considered, other important variables such as education level, marital status, and the caregiver's relationship with the patient were not examined in detail (30). Future research should address these limitations by expanding the geographical scope of the study and including a wider range of psychiatric conditions. Further studies should also incorporate a longitudinal design to assess changes in depression, health, and perceived social support over time. Exploring the role of education, caregiver burden, and access to mental health services would provide a more comprehensive understanding of factors influencing caregiver well-being. Moreover, intervention-based research aimed at strengthening social support networks and developing mental health resources for caregivers is essential to improving their overall quality of life (12,20).

CONCLUSION

The study explored the interplay between depression, health, and perceived social support in families of psychiatric patients, emphasizing the impact of demographic factors such as gender, socioeconomic status, and psychiatric diagnosis. Findings highlighted that social support plays a crucial role in shaping mental health outcomes, with family support being a key factor in mitigating psychological distress. While gender differences were observed in levels of depression and mental well-being, socioeconomic disparities emerged as a significant determinant, with lower-income families experiencing greater psychological burden and reduced support systems. The study also underscored the need for targeted interventions to enhance social support networks and address the mental health challenges faced by caregivers. These insights contribute to the growing understanding of the psychosocial dynamics surrounding psychiatric care and reinforce the importance of community-based mental health initiatives aimed at supporting both patients and their families.

Author Contribution

Author	Contribution
Shumaila Munir*	Substantial Contribution to study design, analysis, acquisition of Data Manuscript Writing Has given Final Approval of the version to be published
Muqadus Fatima	Substantial Contribution to study design, acquisition and interpretation of Data Critical Review and Manuscript Writing Has given Final Approval of the version to be published
Anmol Abbasi	Substantial Contribution to acquisition and interpretation of Data Has given Final Approval of the version to be published
Rabail Kanwal	Contributed to Data Collection and Analysis Has given Final Approval of the version to be published

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