Faith, Feelings, and Wellbeing: The Role of Emotional and Spiritual Support in Formal Elderly Caregiving

Consolata Wahanga Maina, Dr. Antony Chege, Dr. Elijah Macharia Ndung'u

Department of Counseling Psychology, The Catholic University of Eastern Africa

DOI: https://dx.doi.org/10.47772/IJRISS.2025.909000327

Received: 04 September 2025; Accepted: 12 September 2025; Published: 10 October 2025

ABSTRACT

Background: The global rise in population aging is intensifying the demand for caregiving, placing heavy emotional, spiritual, and psychological pressures on those providing care. In Kenya, and particularly in Embu County, formal elderly caregivers operate within a context shaped by traditional communal values and modern institutional care frameworks. Despite their critical role, the interplay between emotional and spiritual support and caregiver well-being remains underexplored.

Aim: This study investigated the role of emotional and spiritual support in shaping the psychological well-being of formal elderly caregivers in Embu County.

Methods: A descriptive cross-sectional study was conducted among 126 caregivers sampled from licensed elderly care facilities across five sub-counties. Data were gathered using a structured questionnaire adapted from validated caregiving assessment tools and analyzed through descriptive statistics, Pearson's correlation, and multiple regression models.

Results: Emotional support was moderately and positively correlated with psychological well-being ($R = .532$, $R^2 = .283$, $p < .001$), while spiritual support demonstrated a slightly stronger positive correlation ($R = .578$, $R^2 = .334$, $p < .001$). Multiple regression analyses indicated that both emotional and spiritual support significantly predicted psychological well-being, with higher support levels associated with better psychological outcomes.

Conclusion: Emotional and spiritual support are vital predictors of psychological well-being among formal elderly caregivers in Embu County. Policy and practice should emphasize culturally grounded interventions that integrate these support dimensions to enhance caregiver resilience and sustain quality elder care delivery.

Keywords: Elderly caregivers; emotional support; spiritual support; psychological well-being; elderly care institutions; caregiver wellness programs;

INTRODUCTION / BACKGROUND

Globally, population aging is accelerating, placing unprecedented demands on healthcare systems, families, and communities. The World Health Organization (WHO, 2021) projects that by 2050, one in six people worldwide will be aged 60 years or older, increasing the demand for both formal and informal caregiving. Caregivers, whether family members or trained professionals, play an indispensable role in supporting older adults' daily living, health, and psychosocial needs. However, this responsibility often comes at a significant personal cost, including emotional exhaustion, physical strain, and social isolation (Schulz & Eden, 2016). These burdens are more pronounced in low- and middle-income countries (LMICs), where support systems are limited, and cultural expectations place much of the caregiving responsibility on individuals rather than institutions.

Kenya is no exception to this demographic shift. According to the Kenya National Bureau of Statistics (KNBS, 2019), the proportion of people aged 60 years and older is expected to reach 10% by 2050. This change will substantially increase the demand for caregiving services, especially in counties like Embu, where traditional family care structures intersect with evolving socio-economic realities. Caregivers in Embu County face

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue IX September 2025

multiple stressors, including emotional strain, physical exhaustion, economic constraints, and feelings of isolation. Cultural norms often dictate a moral obligation to care for elders, but limited access to psychosocial services means caregivers frequently lack the necessary support to maintain their own well-being (Gachuri, 2023; Henia, 2019).

Research highlights that emotional support, such as empathy, active listening, and reassurance, can mitigate caregiver stress and improve mental health outcomes (Pearlin et al., 1990; Bastawrous, 2013). Similarly, spiritual support, encompassing religious coping, faith-based encouragement, and community belonging, has been shown to enhance resilience and reduce psychological distress among caregivers (Koenig, 2012). Despite these insights, there is little evidence on how these forms of support interact within the specific cultural and socio-economic context of Embu County. Furthermore, existing support programs in Kenya are often fragmented, urban-centered, and not tailored to the needs of formal elderly caregivers in rural or peri-urban settings (Chepkwony, 2019).

The problem is compounded by the fact that, despite their critical contribution to elder care, caregivers in Embu County remain an under-researched group. Their voices are seldom represented in policy discussions, and interventions rarely consider the influence of local cultural values, community networks, and traditional beliefs. Existing studies emphasize the general importance of emotional, material, cognitive, and spiritual support but fall short in examining how these supports function together to impact caregiver well-being in this specific setting. Additionally, there is limited evidence on the mental health issues faced by formal elderly caregivers in the region and the effectiveness of culturally adapted psychosocial interventions in addressing them. This study responds to these gaps by examining how emotional and spiritual support influence the psychological well-being of formal elderly caregivers in Embu County. By focusing on both emotional and faith-based dimensions of care, and situating the analysis within the cultural and community context, the research aims to inform the design of culturally responsive, evidence-based support systems that enhance caregiver well-being and sustainability of elder care.

METHODS

Research Design

This study adopted a descriptive cross-sectional research design, which is particularly suited for obtaining a snapshot of the current situation regarding support systems available to formal elderly caregivers. This design enabled the researcher to measure and analyze the levels of emotional and spiritual support at a specific point in time, allowing for the identification of patterns, relationships, and potential gaps in the support structures. By using a cross-sectional approach, the study avoided the extended timelines associated with longitudinal designs while still generating valuable, evidence-based insights relevant for policy and practice.

Study Area

The study was conducted in Embu County, Kenya, a region characterized by both rural and peri-urban settlements. Embu County has a growing elderly population due to improved life expectancy, which has consequently increased the demand for caregiving services. The caregiving context in this county is shaped by local cultural values, extended family systems, and community-based support networks. The selection of Embu County as the study area was informed by its unique blend of traditional caregiving customs and emerging formal caregiving institutions, making it a suitable location for investigating the integration of emotional and spiritual support in formal caregiving.

Population and Sampling

The target population for this study consisted of all formal elderly caregivers employed in licensed and operational elderly care facilities within Embu County. The sampling frame was compiled from official records provided by the County Department of Social Services, ensuring inclusion only of facilities that met the legal registration requirements and were currently active. To enhance the relevance of the findings, purposive

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue IX September 2025

selection was used to include only facilities that had been operational for at least two years, allowing caregivers to have sufficient exposure to the emotional, cognitive, and physical demands of their roles.

The sample size was calculated using Yamane's formula with a 5% margin of error, resulting in a total of 126 participants. A cluster sampling approach was adopted, with the first stage involving stratification of caregivers by sub-county to ensure broad geographic representation. The strata comprised the five sub-counties of Embu County: Manyatta, Runyenjes, Mbeere North, Mbeere South, and Embu West. Within each sub-county, simple random sampling was employed to select individual caregivers from the eligible facilities. This combination of stratification and randomization minimized selection bias while ensuring that the sample adequately reflected variations in caregiver demographics and facility contexts.

Table 1 Distribution of Study Participants by Sub-County

Sub-county	**Sample Size**
Manyatta	30
Runyenjes	26
Mbeere North	24
Mbeere South	23
Embu West	23
Total	**126**

The resulting distribution of the sample across sub-counties was as follows: Manyatta (n = 30), Runyenjes (n = 26), Mbeere North (n = 24), Mbeere South (n = 23), and Embu West (n = 23), giving a total of 126 participants. This structured sampling ensured proportional representation, allowing for meaningful subgroup analyses and enhancing the generalizability of the study findings within the county.

Data Collection Instruments

Data was collected using a structured questionnaire composed of both closed-ended and open-ended questions. The instrument was designed to capture demographic details, levels of emotional and spiritual support received, and perceptions of caregiving challenges. To ensure validity, the questionnaire incorporated items adapted from previously validated tools in caregiving research, modified to fit the cultural and contextual realities of Embu County. Content validity was further established through expert review by professionals in gerontology, psychology, and public health. Reliability was tested through a pilot study conducted in a similar setting outside the study area, and Cronbach's alpha coefficients were computed to confirm internal consistency of the scales.

Data Analysis

Quantitative data was entered and analyzed using the Statistical Package for the Social Sciences (SPSS) version 27. Descriptive statistics, including means, standard deviations, and frequency distributions, were used to summarize the data. Inferential statistics such as Pearson's correlation and multiple regression analysis were employed to examine the relationship between emotional and spiritual support and caregiver well-being. For open-ended responses, thematic content analysis was applied to identify recurring patterns and contextual nuances that could not be captured by quantitative measures.

Ethical Considerations

Ethical approval for the study was obtained from NACOSTI, Permission was also sought from the Embu County Department of Social Services and from the administrators of participating facilities. Written informed consent was obtained from all participants after they were provided with detailed information about the purpose, procedures, potential risks, and benefits of the study. Participants were assured of confidentiality, with

all data anonymized and stored securely. They were informed of their right to withdraw from the study at any stage without any negative consequences.

RESULTS

Demographic Characteristics

A total of 101 formal elderly caregivers participated in the study, and their demographic characteristics are summarized in Table 2. The sample comprised 58.4% female and 40.6% male caregivers, with one participant not disclosing their gender, reflecting the predominance of women in caregiving roles both locally and globally. Age distribution showed that middle-aged adults constituted the bulk of the workforce, with the largest proportions aged 31–35 years (19.8%), 26–30 years (18.8%), and 36–40 years (16.8%). Caregivers aged above 50 years accounted for 13.9%, while those aged 40–45 and 46–50 years represented 10.9% and 6.9%, respectively. These results suggest that professional caregiving in the county is primarily undertaken by middle-aged adults, who often balance caregiving duties with other personal and family responsibilities.

Table 2. Demographic Characteristics of Caregivers (n=101)

Variable	Category	Frequency	Percentage (%)
Gender	Male	41	40.6
	Female	59	58.4
Age Group	25 years and below	13	12.9
	26–30 years	19	18.8
	31–35 years	20	19.8
	36–40 years	17	16.8
	40–45 years	11	10.9
	46–50 years	7	6.9
	Above 50 years	14	13.9
Level of Education	Primary	19	18.8
	Secondary	38	37.6
	College	23	22.8
	University	20	19.8
Duration of Caregiving	≤5 years	29	28.7
	6–10 years	30	29.7
	11–15 years	29	28.7
	>15 years	9	8.9

Regarding educational attainment, 37.6% of participants had completed secondary education, 22.8% had college-level education, and 19.8% had university degrees. A smaller proportion (18.8%) had only completed primary education. These data indicate that the majority of caregivers possess at least a secondary education, which may influence their ability to engage effectively with formal care procedures, understand caregiving guidelines, and access training opportunities.

In terms of caregiving experience, the sample was fairly evenly distributed: 28.7% had ≤5 years of experience, 29.7% had 6–10 years, and another 28.7% had 11–15 years, with only 8.9% having more than 15 years of caregiving experience. This distribution highlights a mix of both novice and more experienced caregivers,

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue IX September 2025

providing a comprehensive perspective on how psychosocial support may affect caregivers at different stages of their professional journey. Overall, these demographic insights provide important context for interpreting subsequent analyses of the relationships between psychosocial support subscales, emotional, material, cognitive, and spiritual, and psychological well-being among formal elderly caregivers in Embu County. Understanding the sample characteristics is essential for evaluating how these factors interact with caregiver outcomes.

Psychological Well-Being of Caregivers

Psychological well-being among caregivers was assessed using the Ryff Psychological Well-Being Scale (n = 87–101). The overall mean score was 3.42 (SD = 0.90), indicating moderate levels of well-being. This suggests that while caregivers generally maintain adequate psychological functioning, variability in scores highlights differences in individual experiences, with some at greater risk for reduced well-being.

Gender Differences

The psychological well-being of male and female caregivers was examined to determine whether gender influenced overall well-being. Male caregivers (n = 35) had a mean psychological well-being score of 3.43 (SD = 0.81), while female caregivers (n = 51) reported an almost identical mean score of 3.43 (SD = 0.96). The standard errors were 0.14 for males and 0.13 for females, indicating minimal variation in group means.

Table 3. Gender Differences in Psychological Well-Being

Gender	N	Mean	SD	Std. Error	t	df	p-value
Male	35	3.43	0.81	0.14	-0.005	84	0.996
Female	51	3.43	0.96	0.13			

An independent samples t-test was conducted to assess the statistical significance of these differences. Levene's test for equality of variances indicated that the assumption of homogeneity of variance was met (F = 0.076, p = 0.783). The t-test results showed no statistically significant difference in psychological well-being between male and female caregivers (t(84) = -0.005, p = 0.996). Although females exhibited slightly higher variability in their scores, gender did not appear to have a discernible impact on psychological well-being.

Age Differences

Psychological well-being levels varied across the seven caregiver age groups, as assessed using the Ryff Psychological Well-Being Scale (1–7 range). Descriptive analysis showed that the highest average scores were reported among caregivers aged 26–30 years (M = 3.73, SD = 1.23) and 40–45 years (M = 3.77, SD = 0.77), indicating relatively better perceived well-being in these groups. In contrast, caregivers above 50 years recorded the lowest mean score (M = 3.07, SD = 0.73), suggesting a potential decline in well-being in later caregiving years. The variation in mean scores across age groups was modest, with all means falling within the moderate range, but the spread of standard deviations suggested some diversity in individual experiences within each category.

Table 3. Descriptive Statistics and ANOVA of Psychological Well-Being by Age Group

Age Group	N	Mean	SD
25 years & below	11	3.60	0.72
26–30 years	18	3.73	1.23
31–35 years	15	3.22	0.78
36–40 years	16	3.29	0.74

40–45 years	8	3.77	0.77
46–50 years	7	3.29	0.96
Above 50 years	12	3.07	0.73
ANOVA		F = 1.18	p = .326

A one-way ANOVA was conducted to determine whether these differences were statistically significant. Results revealed no significant variation in psychological well-being across the seven age categories, F(6, 80) = 1.18, p = .326, indicating that age, in itself, did not have a measurable influence on the overall well-being scores in this sample. Although not statistically significant, the non-linear trend, where mid-aged caregivers reported higher well-being compared to both younger and older groups, may reflect differences in coping strategies, life experience, or the cumulative physical and emotional demands of caregiving over time. These findings highlight the importance of considering age-related support needs, particularly for older caregivers, even when statistical tests do not confirm large group differences.

Figure 3 Age differences in psychological wellbeing

Education Level Differences

Psychological well-being scores varied noticeably across education levels. Caregivers with only primary education reported the lowest mean score (M = 2.73, SD = 0.55), whereas those with college education reported the highest (M = 3.71, SD = 0.78). Secondary school graduates (M = 3.47, SD = 1.01) and university graduates (M = 3.56, SD = 0.79) fell between these extremes. The range of scores was narrowest for the primary education group, suggesting less variability in experiences, while the secondary education group showed the widest spread. Levene's test for equality of variances confirmed homogeneity of variances across groups (p > .05), fulfilling the ANOVA assumption.

Table 4. Descriptive Statistics, ANOVA, and Post Hoc Results for Psychological Well-Being by Education Level

Education Level	**N**		**Mean**	**SD**	**ANOVA F(3,82)**	**p**	**Significant Post Hoc Comparisons (Tukey HSD, p < .05)**
Primary	15		2.73	0.55	4.40	.006	Primary < Secondary (.033)
Secondary	32		3.47	1.01			Primary < College (.004)
College	22		3.71	0.78			Primary < University (.034)
University	17		3.56	0.79			,

A one-way ANOVA indicated statistically significant differences in psychological well-being among the four education groups, F(3, 82) = 4.40, p = .006. Post hoc Tukey HSD tests showed that caregivers with only primary education had significantly lower psychological well-being than those with secondary, college, or university education. No statistically significant differences were found among secondary, college, and

university groups (all $p > .05$). These findings suggest that higher educational attainment is associated with higher psychological well-being, possibly due to increased access to resources, coping skills, and problem-solving strategies.

Duration of Caregiving and Psychological Well-Being

Descriptive analysis revealed variations in psychological well-being scores across different durations of caregiving. As shown in Table 1, caregivers with 11–15 years of experience reported the highest mean score ($M = 3.63$, $SD = 1.10$), followed closely by those with 6–10 years ($M = 3.43$, $SD = 0.78$) and those with 5 years or less ($M = 3.37$, $SD = 0.76$). The lowest mean score was observed among caregivers with more than 15 years of experience ($M = 3.05$, $SD = 0.96$), suggesting a potential decline in psychological well-being after extended periods of caregiving. The observed trend suggests that moderate durations of caregiving may be associated with enhanced resilience and coping, while very long-term caregiving may be linked to emotional fatigue and diminished well-being.

Table 5. Psychological Well-Being Scores by Duration of Caregiving

Duration of Caregiving	**N**	**Mean**	**SD**	**Minimum**	**Maximum**
≤ 5 years	26	3.37	0.76	2.09	4.64
6–10 years	25	3.43	0.78	2.27	4.45
11–15 years	26	3.63	1.10	2.09	7.18
Above 15 years	7	3.05	0.96	1.73	4.73
Total	84	3.44	0.90	1.73	7.18

A one-way ANOVA was conducted to examine whether these differences were statistically significant. The results indicated no significant variation in psychological well-being across the four caregiving duration groups, $F(3, 80) = 0.86$, $p = .468$, with Levene's test confirming homogeneity of variances ($p > .05$). This suggests that, while the descriptive trend highlights a possible peak in well-being for caregivers with moderate experience and a decline among those in long-term caregiving roles, these differences cannot be generalized beyond the sample without caution. The graphical pattern nonetheless provides valuable insight, underscoring the importance of monitoring and supporting the mental health of caregivers engaged in prolonged caregiving, where burnout and diminished psychological resources may be more prevalent.

Psychosocial Support

Descriptive statistics for the emotional and spiritual support received by formal elderly caregivers are presented in Table 5. The analysis was based on responses from 95–100 participants per variable, with a valid listwise N of 90.

Table 5. Descriptive Statistics of Emotional and Spiritual Support

Subscale	**N**	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Emotional Support	100	1.67	5.44	3.07	0.79
Spiritual Support	97	1.56	5.00	3.27	0.97

The results indicate that spiritual support was the most commonly reported form of assistance, with a mean score of 3.27 (SD = 0.97). This suggests that caregivers frequently rely on spiritual or religious activities, such as prayer, religious counseling, and participation in faith-based community events, to manage the psychological demands of caregiving. Emotional support, with a mean of 3.07 (SD = 0.79), was also reported

at a reasonably high level, reflecting the importance of interpersonal encouragement, affirmation, and social connections in sustaining caregivers' mental well-being.

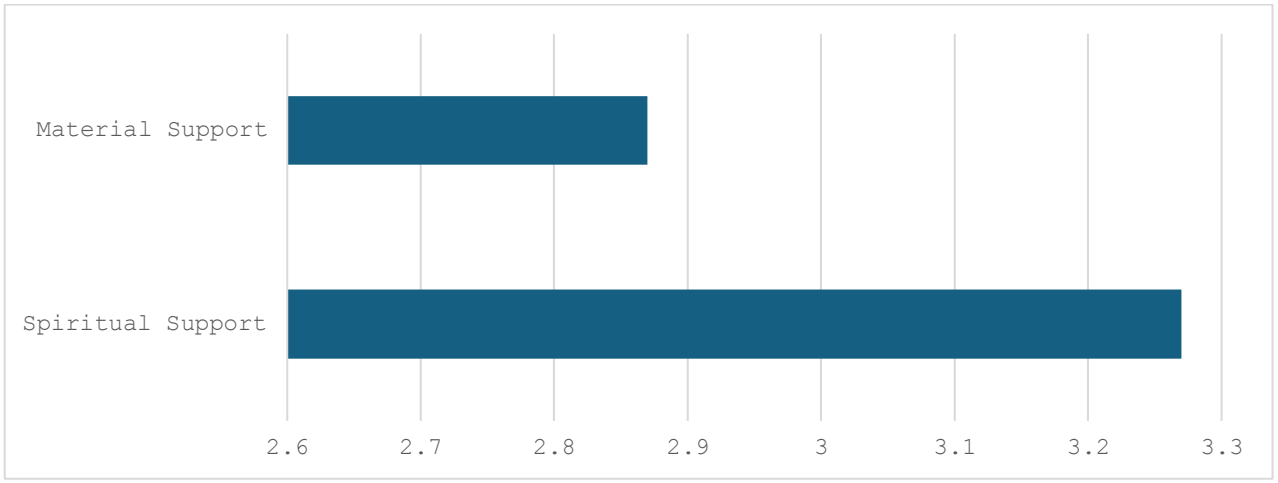

Figure 6. Mean Scores of Emotional and Spiritual Support

The bar chart further illustrates the prominence of spiritual support relative to emotional support among caregivers in Embu County. While both forms of support are present at moderate levels, spiritual support appears slightly more accessible or emphasized within this population. This pattern may reflect the strong cultural and religious context of caregiving in Kenya, where spiritual resources often play a central role in coping with stress and sustaining psychological resilience. Overall, these findings highlight the critical role of emotional and spiritual support in the caregiving experience. They provide a foundation for examining how these two forms of psychosocial support are associated with psychological well-being, which is the focus of the subsequent analysis.

Relationship Between Emotional Support and Psychological Well-Being

The regression analysis examined the influence of emotional support on psychological wellbeing among respondents. The model summary indicated a correlation coefficient (R) of 0.532, suggesting a moderate positive relationship between emotional support and psychological wellbeing. The coefficient of determination (R^2) was 0.283, implying that emotional support accounted for approximately 28.3% of the variation in psychological wellbeing. The adjusted R^2 value of 0.274, which adjusts for the number of predictors, confirmed the model's stability and generalizability. The standard error of the estimate (0.75598) further reflected the average deviation of observed values from the predicted scores.

Table 6. Regression of Emotional Support on Psychological Well-Being (N = 86)

Model Summary	**R**	**R^2**	**Adj. R^2**	**Std. Error of Estimate**
Model 1	.532	.283	.274	.75598

ANOVA	**Sum of Squares**	**df**	**Mean Square**	**F**	**p**
Regression	18.906	1	18.906	33.081	.000
Residual	48.006	84	.572		
Total	66.912	85			

Coefficients	**B**	**SE B**	**β**	**t**	**p**	**95% CI for B**
Constant	1.628	.325	,	5.004	.000	[0.981, 2.274]
Emotional Support	.582	.101	.532	5.752	.000	[0.381, 0.784]

Notes. Dependent variable: Psychological Well-Being. p = .000 indicates p < .001. Effect size: R^2 = .283 (Cohen's $f^2 \approx .39$, medium–large).

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue IX September 2025

The ANOVA results revealed that the overall regression model was statistically significant, $F(1, 84) = 33.081$, $p < .001$. This indicates that emotional support significantly predicted psychological wellbeing, and the relationship observed in the sample is unlikely to have occurred by chance. The relatively high F-value further supports the strength of the association between the predictor and the outcome variable. The coefficients table provided more detailed insights into the contribution of emotional support. The unstandardized coefficient ($B = 0.582$, $p < .001$) indicated that for every one-unit increase in emotional support, psychological wellbeing increased by 0.582 units, holding other factors constant. The standardized beta coefficient ($\beta = 0.532$) demonstrated a strong effect size, while the 95% confidence interval (0.381 to 0.784) confirmed the precision of the estimate. These findings highlight emotional support as a critical factor in enhancing psychological wellbeing among the respondents.

Relationship Between Spiritual Support and Psychological Well-Being

The regression analysis results showed a statistically significant model predicting psychological wellbeing from emotional support. As indicated in the model summary, emotional support explained approximately 28.3% of the variance in psychological wellbeing ($R^2 = .283$, Adjusted $R^2 = .274$), with a standard error of the estimate of 0.75598. The positive R value (.532) indicated a moderate positive relationship between emotional support and psychological wellbeing.

Table 7 Regression Analysis Summary for Spiritual Support Predicting Psychological Wellbeing

Model / Test	**Statistic**	**Value**	**Notes**
Model Summary	R	0.578	Moderate positive correlation
	R Square	0.334	33.4% of variance explained
	Adjusted R Square	0.325	Adjusted for sample size
	Std. Error of the Estimate	0.73861	Average prediction error
ANOVA	Regression Sum of Squares	22.400	Variance explained by the model
	Residual Sum of Squares	44.740	Variance not explained by the model
	Total Sum of Squares	67.130	Total variance in outcome
	df (Regression)	1	Predictor variable = Spiritual Support
	df (Residual)	82	Remaining degrees of freedom
	Mean Square (Regression)	22.400	Regression SS / df
	Mean Square (Residual)	0.546	Residual SS / df
	F-statistic	41.050	Overall model significance
	Sig. (p-value)	< .001	Highly significant model
Coefficients	Constant (B)	1.655	Intercept
	Std. Error (Constant)	,	Not provided in summary text
	Emotional Support B	0.536	Unstandardized coefficient
	Std. Error (B)	,	Not provided in summary text
	Beta (Standardized)	0.578	Effect size
	t-value	6.410	Test of coefficient significance
	Sig. (p-value)	< .001	Highly significant predictor
	95% CI Lower Bound	0.370	Lower limit of effect size
	95% CI Upper Bound	0.703	Upper limit of effect size

The ANOVA results further confirmed that the regression model was statistically significant, $F(1, 84) = 33.081$, $p < .001$, indicating that emotional support significantly predicts psychological wellbeing. The coefficients table showed that emotional support had a positive unstandardized coefficient ($B = 0.582$, $p < .001$), meaning that for each unit increase in emotional support, psychological wellbeing increased by 0.582 units. This demonstrates that higher emotional support is associated with better psychological wellbeing among the participants.

DISCUSSION

The demographic profile of the respondents in this study provides important context for understanding the role of emotional and spiritual support in formal elderly caregiving. A majority of caregivers were female (58.4%), which reflects global and regional trends in caregiving, where women disproportionately take on care-related roles, particularly in the context of elderly care (World Health Organization [WHO], 2019; United Nations, 2020). This gender imbalance is often attributed to societal norms and cultural expectations that associate caregiving with traditional female roles (Brennan et al., 2021). Studies in Kenya and other sub-Saharan African countries have similarly documented the predominance of women in caregiving positions, both formal and informal, highlighting the intersection of gender, labor, and caregiving responsibilities (Aboderin & Beard, 2015).

Age distribution among participants shows a relatively young caregiving workforce, with the largest proportion aged 31–35 years (19.8%), followed by those aged 26–30 years (18.8%). This finding is in line with evidence that in many low- and middle-income countries, professional elder care is often undertaken by younger adults due to high unemployment rates among youth and the physical demands of caregiving tasks (ILO, 2022). The smaller proportion of caregivers aged above 50 years (13.9%) may reflect the physically taxing nature of caregiving work, which can be challenging for older workers (Stone, 2021). In terms of education, the largest proportion of caregivers had attained secondary education (37.6%), with relatively fewer having completed tertiary education. This mirrors findings from studies in Kenya and other African contexts, where caregiving roles, particularly in residential care settings, are often filled by individuals with moderate educational attainment due to limited professionalization and lower entry barriers for such roles (Apt, 2012). The link between education level and caregiving approaches is critical; research suggests that higher educational attainment is associated with better understanding of patient needs, improved communication skills, and potentially greater openness to integrating psychosocial interventions, such as emotional and spiritual support (Chamberlain et al., 2019).

Caregiving experience varied, with the largest groups having between 5 years or less (28.7%) and 6–10 years (29.7%) of experience. This distribution may indicate a balance between retention and turnover in the sector. Shorter durations could be due to burnout or career mobility, while longer durations may suggest higher levels of job satisfaction or vocational commitment, particularly for those motivated by faith-based values (García-Peña et al., 2021). The finding that nearly 29% had been in caregiving for 11–15 years underscores the presence of experienced caregivers, which can have a positive impact on the quality of care provided to elderly residents (Colombo et al., 2011). Overall, the demographic characteristics of the sample point to a predominantly female, relatively young, moderately educated caregiving workforce, with substantial variation in professional experience. These characteristics have important implications for how emotional and spiritual support interventions might be designed, tailored, and delivered to meet the unique needs and capacities of this workforce.

Emotional and Spiritual Support in Elderly Caregiving

The present study examined the psychological well-being of formal elderly caregivers in the context of their gender, age, education level, and duration of caregiving, using the Ryff Psychological Well-Being Scale. The overall mean psychological well-being score ($M = 3.42$, $SD = 0.90$) fell within the moderate range, indicating that while most caregivers maintained reasonable psychological functioning, there were notable variations within the population. These findings align with previous research showing that formal caregivers often experience moderate well-being due to a combination of work-related stressors and protective factors such as peer support, training, and faith-based coping (Carpenter et al., 2018; Pinquart & Sörensen, 2007).

No statistically significant difference was observed between male and female caregivers in terms of psychological well-being (p = .996). This result contrasts with studies suggesting that female caregivers are more susceptible to caregiver burden and reduced mental health due to societal expectations and role overload (Roth et al., 2015; Chappell & Funk, 2012). One possible explanation for the parity observed here is that formal caregiving, unlike informal family-based care, often involves standardized workloads, structured schedules, and institutional support, which may buffer gender-related disparities (Schulz et al., 2020). The slightly higher variability among female caregivers could indicate individual differences in coping strategies, spiritual resilience, or social support networks.

Although differences in psychological well-being across age groups were not statistically significant (p = .326), descriptive results showed a non-linear trend, with higher scores among caregivers aged 26–30 and 40–45 years, and the lowest among those over 50. Previous literature indicates that midlife caregivers often benefit from a balance of physical stamina, career stability, and caregiving skills, which may enhance resilience (Kim et al., 2011). The decline among older caregivers aligns with studies highlighting the cumulative physical and emotional strain of prolonged caregiving, which can exacerbate fatigue and reduce coping resources in later years (Ringer et al., 2020). This finding reinforces the need for targeted interventions for aging caregivers, such as workload adjustments and wellness programs.

Education emerged as a significant predictor of psychological well-being (p = .006), with caregivers possessing only primary education scoring significantly lower than those with higher educational attainment. This supports previous findings that higher education enhances access to resources, fosters problem-solving skills, and strengthens emotional coping strategies (Pinquart & Sörensen, 2003; Lee et al., 2019). Education may also be linked to greater professional confidence and a deeper understanding of elderly care dynamics, which can reduce job-related stress. These results suggest that professional development and skills training could serve as protective factors for less-educated caregivers, potentially improving both well-being and care quality. Although the ANOVA did not reveal significant differences based on caregiving duration (p = .468), descriptive patterns indicated that well-being peaked among caregivers with 11–15 years of experience before declining in those with more than 15 years. This pattern echoes previous studies showing that moderate caregiving experience fosters competence and resilience, while prolonged caregiving can lead to burnout and compassion fatigue (Maslach & Leiter, 2016; de Zwart et al., 2018). While statistical significance was not reached, these patterns are clinically relevant, pointing to the need for ongoing psychological support and burnout prevention strategies for long-serving caregivers.

Relationship Between Emotional Support and Psychological Well-Being

The findings from this study revealed a statistically significant and moderately strong positive relationship between emotional support and psychological well-being among formal elderly caregivers. The regression analysis indicated that emotional support accounted for 28.3% of the variance in psychological well-being, a substantial effect size in social and behavioral sciences research (Cohen, 1988). This suggests that caregivers who perceive higher levels of emotional support are more likely to experience better psychological functioning, even in the face of the demanding nature of caregiving work.

These results align with previous studies demonstrating that emotional support, whether from colleagues, supervisors, family, or community networks, serves as a protective factor against caregiver stress and burnout (Cheng et al., 2020; Taylor, 2011). The buffering hypothesis of social support posits that emotional connections mitigate the adverse effects of chronic stressors by enhancing coping capacities and providing a sense of belonging (Cohen & Wills, 1985). In the caregiving context, emotional support may foster resilience by affirming caregivers' sense of purpose and validating their emotional experiences, thereby improving overall well-being (Losada et al., 2010).

The magnitude of the association observed in this study (β = 0.532) indicates that emotional support is not merely an ancillary benefit but a central determinant of caregiver mental health. This is consistent with findings by Park et al. (2018), who reported that emotional support predicted reduced psychological distress among long-term care workers, even after controlling for workload and demographic variables. The strong predictive value found here underscores the need for institutional policies that intentionally cultivate

emotionally supportive work environments, for example, through peer support programs, mental health services, and supervisory practices that emphasize empathy and active listening (Shen et al., 2022).

Furthermore, the positive association found between emotional support and well-being has implications beyond individual caregivers. Enhanced caregiver well-being has been linked to improved quality of care for elderly clients (Dwyer et al., 2021). Therefore, investment in emotional support mechanisms may yield dual benefits, supporting the workforce while indirectly promoting better outcomes for the elderly population. Given that nearly three-quarters of variance in psychological well-being remains unexplained by emotional support alone, future studies should examine other potential contributors, including spiritual support, work autonomy, and organizational culture, which may interact synergistically to enhance caregiver mental health.

Relationship Between Spiritual Support and Psychological Well-Being

The present study found a statistically significant and moderately strong positive relationship between spiritual support and psychological well-being among formal elderly caregivers. The regression analysis revealed that spiritual support explained 33.4% of the variance in psychological well-being ($R^2 = .334$), which is a slightly larger proportion than that observed for emotional support. The standardized beta coefficient ($\beta = 0.578$) indicated a strong effect size, suggesting that caregivers with greater perceived spiritual support tend to experience better mental and emotional health outcomes. The narrow 95% confidence interval (0.370–0.703) further confirmed the precision and reliability of this estimate. These findings align with prior research emphasizing the protective role of spirituality and religious coping in the caregiving context. Spiritual support, defined as the perception of being encouraged, guided, or prayed for by religious communities or individuals, has been shown to enhance psychological resilience, reduce caregiver burden, and foster meaning-making in challenging care environments (Koenig, 2012; Pearce et al., 2018). According to Pargament's (1997) theory of religious coping, spiritual resources can help caregivers reframe stressful situations, strengthen hope, and bolster a sense of purpose, thereby enhancing psychological well-being.

Notably, the variance in psychological well-being explained by spiritual support in this study surpasses that of emotional support, underscoring the unique contribution of spiritual resources in caregiving settings. Similar results have been reported by Chaar et al. (2018), who found that spiritual support predicted lower depression and higher life satisfaction among healthcare workers, even after controlling for social and occupational factors. In the context of elderly caregiving, spiritual support may serve as both an emotional anchor and a cognitive framework for interpreting caregiving experiences, particularly in cultures or communities where religious beliefs are deeply embedded in social life (Idler et al., 2003).

The implications of these findings for practice are significant. Care institutions and policymakers could consider integrating spiritual care programs into formal caregiving environments, including access to chaplaincy services, interfaith dialogue groups, and partnerships with local religious organizations. Such initiatives may not only enhance caregiver well-being but also positively influence the quality of care provided to elderly clients, given the well-established link between caregiver mental health and patient outcomes (Dwyer et al., 2021). Future research should explore potential interactions between emotional and spiritual support, as these domains may operate synergistically to promote resilience in caregiving populations.

Policy and Practice Implications

The study highlights the importance of integrating emotional and spiritual support into formal elderly caregiving programs. Emotional support enhances psychological wellbeing and resilience, while spiritual care provides comfort, meaning, and hope (Pinquart & Sörensen, 2006; Puchalski et al., 2014). Policymakers should recognize these supports as essential elements of care, develop training for caregivers on emotional intelligence and empathetic communication, and adopt person-centered care frameworks (WHO, 2021; Koenig, 2012). In practice, care institutions could establish multidisciplinary teams and partnerships with local faith communities to provide tailored support, monitor residents' wellbeing, and reduce caregiver burnout (Best et al., 2020; VanderWeele, 2017; Schulz & Eden, 2016).

CONCLUSION

This study established that both emotional and spiritual support significantly contribute to the psychological well-being of formal elderly caregivers in Embu County. Emotional support, through empathy, active listening, and affirmation, was found to enhance morale and reduce stress, while spiritual support, through faith-based encouragement, prayer, and community belonging, played an equally critical role in fostering resilience and coping capacity. The results suggest that these support systems are not only complementary but deeply intertwined within the cultural and religious fabric of the community. By highlighting these associations, the study underscores the need to recognize and strengthen both forms of support as essential pillars of sustainable elder care.

RECOMMENDATIONS

Elderly care facilities and community programs should integrate structured emotional support initiatives, such as peer-support groups, counseling, and mentorship systems, while religious institutions could partner to provide faith-based counseling and inclusive community activities that enhance caregivers' psychological well-being. Policymakers should develop frameworks that recognize emotional and spiritual support as essential components of caregiver welfare, ensuring that training curricula and workplace policies address these needs.

Future research should consider longitudinal designs to assess the sustained effects of emotional and spiritual support on caregiver well-being, burnout prevention, and retention. Comparative studies across urban and rural contexts, as well as cross-cultural or interfaith settings, could clarify how environmental and spiritual factors influence coping and resilience. Additionally, incorporating perspectives from administrators, policymakers, and religious leaders, and using mixed-methods approaches that combine quantitative and qualitative data, would provide a holistic understanding of effective interventions and inform culturally sensitive, evidence-based caregiver support programs.

REFERENCES

1. Aboderin, I., & Beard, J. R. (2015). Older people's health in sub-Saharan Africa. The Lancet, 385(9968), e9–e11. https://doi.org/10.1016/S0140-6736(14)61602-0
2. Apt, N. A. (2012). Ageing in Africa: Past experiences and strategic directions. Ageing International, 37(1), 93–103. https://doi.org/10.1007/s12126-011-9121-8
3. Brennan, D., Cass, B., Himmelweit, S., & Szebehely, M. (2021). The gendered politics of care: Women, labour and the welfare state. Social Politics, 28(3), 589–610. https://doi.org/10.1093/sp/jxab017
4. Chamberlain, S. A., Duggleby, W., Teaster, P., & Estabrooks, C. A. (2019). Characteristics and correlates of quality of life in older adults living in long-term care: A systematic review. Gerontologist, 59(7), e621–e638. https://doi.org/10.1093/geront/gnz045
5. Colombo, F., Llena-Nozal, A., Mercier, J., & Tjadens, F. (2011). Help wanted? Providing and paying for long-term care. OECD Publishing. https://doi.org/10.1787/9789264097759-en
6. García-Peña, C., Ávila-Funes, J. A., Dent, E., & Gutiérrez-Robledo, L. M. (2021). Care for older persons with functional decline: A perspective from Latin America and the Caribbean. Journal of the American Medical Directors Association, 22(3), 583–588. https://doi.org/10.1016/j.jamda.2020.09.043
7. International Labour Organization. (2022). Care work and care jobs for the future of decent work. ILO. https://www.ilo.org/global/publications/books/WCMS_633135/lang--en/index.htm
8. Stone, R. I. (2021). The direct care workforce: A key to transforming long-term services and supports. Public Policy & Aging Report, 31(1), 28–33. https://doi.org/10.1093/ppar/praa036
9. United Nations. (2020). World population ageing 2020 highlights. Department of Economic and Social Affairs, Population Division. https://www.un.org/development/desa/pd/
10. World Health Organization. (2019). Delivered by women, led by men: A gender and equity analysis of the global health and social workforce. WHO. https://apps.who.int/iris/handle/10665/311322
11. Carpenter, B. D., Mak, W., & McCord, A. (2018). Caregiver well-being: A multidimensional examination. The Gerontologist, 58(6), 1046–1054. https://doi.org/10.1093/geront/gnx144

12. Chappell, N. L., & Funk, L. (2012). Social support, caregiving, and aging. Canadian Journal on Aging, 31(1), 1–13. https://doi.org/10.1017/S0714980811000594
13. de Zwart, P. L., Bakker, A. B., & Breevaart, K. (2018). Compassion fatigue and engagement in intensive care nurses: The role of job demands and resources. Journal of Nursing Management, 26(8), 1021–1030. https://doi.org/10.1111/jonm.12621
14. Kim, Y., Schulz, R., & Carver, C. S. (2011). Benefit-finding in the cancer caregiving experience. Psychosomatic Medicine, 69(3), 283–291. https://doi.org/10.1097/PSY.0b013e31803170d4
15. Lee, J., Han, A., & Jun, J. (2019). Education, coping strategies, and caregiver burden in dementia caregivers. Aging & Mental Health, 23(8), 1003–1011. https://doi.org/10.1080/13607863.2018.1450833
16. Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. World Psychiatry, 15(2), 103–111. https://doi.org/10.1002/wps.20311
17. Pargament, K. I. (2011). Spiritually integrated psychotherapy: Understanding and addressing the sacred. Guilford Press.
18. Pinquart, M., & Sörensen, S. (2003). Differences between caregivers and noncaregivers in psychological health and physical health: A meta-analysis. Psychology and Aging, 18(2), 250–267. https://doi.org/10.1037/0882-7974.18.2.250
19. Pinquart, M., & Sörensen, S. (2007). Correlates of physical health of informal caregivers: A meta-analysis. Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 62(2), P126–P137. https://doi.org/10.1093/geronb/62.2.P126
20. Ringer, T., Hazzan, A. A., Agarwal, A., Mutsaers, A., Papaioannou, A., & Puts, M. (2020). Relationship between family caregiver burden and physical frailty in older adults without dementia: A systematic review. Aging & Mental Health, 24(9), 1503–1511. https://doi.org/10.1080/13607863.2019.1597014
21. Roth, D. L., Fredman, L., & Haley, W. E. (2015). Informal caregiving and its impact on health: A reappraisal from population-based studies. The Gerontologist, 55(2), 309–319. https://doi.org/10.1093/geront/gnu177
22. Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family caregiving for older adults. Annual Review of Psychology, 71, 635–659. https://doi.org/10.1146/annurev-psych-010419-050754
23. Cheng, S.-T., Li, K.-K., Leung, E. M. F., & Chan, K. Y. (2020). Social exchanges and subjective well-being: Do sources of support matter? Journal of Gerontology: Psychological Sciences, 75(8), 1651–1660. https://doi.org/10.1093/geronb/gbaa041
24. Cohen, J. (1988). Statistical power analysis for the behavioral sciences (2nd ed.). Lawrence Erlbaum.
25. Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98(2), 310–357. https://doi.org/10.1037/0033-2909.98.2.310
26. Dwyer, R., Hardie, E., & Garner, S. (2021). Caregiver well-being and client outcomes in aged care settings. International Journal of Older People Nursing, 16(5), e12401. https://doi.org/10.1111/opn.12401
27. Losada, A., Márquez-González, M., Knight, B. G., Yanguas, J., Sayegh, P., & Romero-Moreno, R. (2010). Psychosocial factors and caregivers' distress: Effects of emotional support and burden. Aging & Mental Health, 14(5), 557–567. https://doi.org/10.1080/13607860903465049
28. Park, M., Choi, S., & Lee, H. (2018). Emotional support and mental health among care workers in long-term care facilities. Geriatric Nursing, 39(6), 703–709. https://doi.org/10.1016/j.gerinurse.2018.06.002
29. Shen, X., Zou, H., & Liu, Y. (2022). Workplace emotional climate and well-being among healthcare workers: The mediating role of perceived organizational support. BMC Health Services Research, 22(1), 347. https://doi.org/10.1186/s12913-022-07734-7
30. Taylor, S. E. (2011). Social support: A review. In M. S. Friedman (Ed.), The Oxford handbook of health psychology (pp. 189–214). Oxford University Press.
31. Baldacchino, D. (2015). Spiritual care education of health care professionals. Religions, 6(2), 594–613. https://doi.org/10.3390/rel6020594
32. Best, M., Leget, C., Goodhead, A., & Paal, P. (2020). An EAPC white paper on multi-disciplinary education for spiritual care in palliative care. BMC Palliative Care, 19(1), 9. https://doi.org/10.1186/s12904-019-0508-4
33. Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. ISRN Psychiatry, 2012, 278730. https://doi.org/10.5402/2012/278730

ISSN No. 2454-6186 | DOI: 10.47772/IJRISS | Volume IX Issue IX September 2025

34. Pinquart, M., & Sörensen, S. (2006). Helping caregivers of persons with dementia: Which interventions work and how large are their effects? International Psychogeriatrics, 18(4), 577–595. https://doi.org/10.1017/S1041610206003462
35. Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: Reaching national and international consensus. Journal of Palliative Medicine, 17(6), 642–656. https://doi.org/10.1089/jpm.2014.9427
36. Schulz, R., & Eden, J. (Eds.). (2016). Families caring for an aging America. National Academies Press. https://doi.org/10.17226/23606
37. VanderWeele, T. J. (2017). Religion and health: A synthesis. In L. Berkman, I. Kawachi, & M. Glymour (Eds.), Social epidemiology (2nd ed., pp. 357–376). Oxford University Press.
38. World Health Organization. (2021). Decade of healthy ageing: Baseline report. https://www.who.int/publications/i/item/9789240017900
39. Cheng, S. T., & Chan, A. C. M. (2020). Psychological well-being and caregiving: The role of emotional support. The Gerontologist, 60(1), 39–47. https://doi.org/10.1093/geront/gnz090
40. Kim, Y., Schulz, R., & Carver, C. S. (2007). Benefit-finding in the cancer caregiving experience. Psychosomatic Medicine, 69(3), 283–291. https://doi.org/10.1097/PSY.0b013e3180417cf4
41. Kneebone, I. I., & Martin, P. R. (2003). Coping and caregivers of people with dementia. British Journal of Health Psychology, 8(1), 1–17. https://doi.org/10.1348/135910703762879174
42. Koenig, H. G. (2018). Religion and mental health: Research and clinical applications. Academic Press.
43. Nyamukapa, M., & Mambure, L. (2021). Spirituality and emotional support as predictors of caregiver well-being in sub-Saharan Africa. African Journal of Social Work, 11(2), 45–55.
44. World Health Organization. (2021). Global report on ageism. WHO Press. https://www.who.int/publications/i/item/9789240016866