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The need for social support among informal caregivers of geriatric patients

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Abstract

In Poland, population ageing has increased reliance on informal caregivers providing home-based care for geriatric patients. Long-term caregiving for functionally dependent older adults is associated with substantial burden and a need for social support. This study assessed the level and structure of social support among informal caregivers and identified associated factors.

A cross-sectional quantitative study included 102 informal caregivers providing home care to older adults. Data were collected using a questionnaire and the Berlin Social Support Scales (BSSS). Non-parametric statistical analyses were employed.

Caregivers provided intensive, long-term care mainly to functionally dependent patients. The highest BSSS scores were observed for perceived available support, whereas the lowest were noted for actually received support. Institutional support was rated very low, while

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support from family and friends was evaluated more positively. Caregivers who were in a relationship reported significantly higher overall BSSS scores than single participants. A greater number of tasks in which the care recipient was non-independent was significantly associated with lower overall BSSS scores.

Informal caregivers of geriatric patients in Poland experience considerable support-related burden, with institutional support remaining insufficient. Relationship status and the scope of patient dependence were associated with overall BSSS scores. Strengthening community-based, educational, and respite services may improve the support available to informal caregivers.

Introduction

Population ageing constitutes one of the greatest public health challenges of the twenty-first century (Dziechciaż, Filip 2014). Demographic projections indicate a systematic increase in the number of people aged 60 years and over, with particularly dynamic growth in the population aged 80+ (Mollica et al. 2020). According to data published by the World Health Organization (2002) by 2050 the number of older adults will at least double, while the population of the very old will increase severalfold. This process is directly associated with a rising prevalence of multimorbidity, functional dependence, geriatric syndromes and cognitive disorders (*Miasta przyjazne starzeniu…* 2014; World Health Organization 2002). Consequently, a dynamic increase in demand for long-term care is observed, both within institutional structures and in the home environment (Masłyk 2020).

In European countries, including Poland (Minister do spraw Polityki Senioralnej 2024; Wyszkowska et al. 2024), the primary burden of care for older people rests on informal caregivers (Herudzińska 2022; Wyszkowska et al. 2024), most often family members such as adult children, spouses and more distant relatives (Dziechciaż, Filip 2014). Informal care encompasses a wide spectrum of activities, ranging from assistance with mobility, personal hygiene, meal preparation and medication administration to tasks requiring more advanced competencies, such as wound care, operation of medical equipment and supervision of the patient's mental state (Gomes et al. 2024). In many cases, such care is provided for many hours a day or on a round-the-clock basis and continues for months or even years (Szlązak 2023; Wyszkowska et al. 2024).

Long-term caregiving is associated with a substantial burden on caregivers in physical, psychological, social and economic dimensions (Sousa Alves et al. 2019). Numerous studies have demonstrated that informal caregivers constitute a group at increased risk of depressive disorders, chronic fatigue, musculoskeletal pain, sleep disturbances and reduced quality of life (Yuan et al. 2025). This phenomenon is referred to in the literature as 'caregiver burden' and represents one of the key issues in contemporary geriatrics and long-term care (Del-Pino-Casado et al. 2018).

The situation is particularly challenging for caregivers of individuals with a high level of functional dependence, neurodegenerative diseases and dementia syndromes (Yuan et al. 2025). Caring for this group of patients requires not only assistance with activities of daily living but also constant supervision, management of behavioural disturbances, communication difficulties, and emotional strain resulting from disease progression (Daniłowska, Gawska 2024). In this group, the risk of caregiver burnout, depression, and chronic psychological overload is particularly high (Antelo Ameijeiras & Espinosa 2022).

An important issue also concerns the manner in which individuals assume the caregiver role (Minister do spraw Polityki Senioralnej 2024). In many cases, care for an older person begins suddenly, following a stroke, fracture, exacerbation of a chronic illness or deterioration in general health. A lack of prior preparation, insufficient health education and limited access to professional support mean that caregivers often learn caregiving and nursing tasks through trial and error, which further increases their sense of uncertainty and stress (Sousa Alves et al. 2019).

Social support plays a particularly important role in mitigating the negative consequences of caregiving and includes emotional, informational, instrumental and material components (Gomes et al. 2024). Research has shown that higher levels of support are associated with better psychological functioning of caregivers, lower levels of subjective burden and a greater capacity to adapt to the long-term caregiving role. The importance of perceived support is also emphasized, as its presence may have a protective effect even in situations of limited actual assistance (Aman et al. 2020).

Despite the growing importance of informal care for the functioning of healthcare systems, institutional support for caregivers remains insufficient in many countries (Del-Pino-Casado et al. 2021). European analyses point to deficits in the availability of respite care, specialist counselling, psychological support and solutions enabling the combination of caregiving with paid employment. In Poland, an additional problem is the limited access to community-based services and an insufficient level of financial support (Del-Pino-Casado et al. 2018).

The importance of informal caregivers for the stability of the healthcare system is indisputable; however, demographic projections indicate a gradual decline in family resources capable of providing long-term care. This may in the future lead to further overburdening of the institutional system. In this context, the reliable identification of caregivers' actual needs and their demand for social support is of crucial importance (Herudzińska 2022; Daniłowska, Gawska 2024; Masłyk 2020; Szlązak 2023).

For this reason, increasing emphasis is being placed on empirical research aimed at assessing the level of perceived, received and sought social support among informal caregivers (Del-Pino-Casado et al. 2019). Data obtained in this way provide a basis for designing effective clinical interventions, educational programmes and system-wide measures in the field of long-term care (Szlązak 2023).

Materials and Methods

Research assumptions and methods

The study was designed as a cross-sectional quantitative study aimed at assessing the need for social support among informal caregivers of geriatric patients. The study design enabled a one-time assessment of the caregiving situation among the participants at a specific point in time.

To achieve the study objective, the diagnostic survey method was employed, allowing for the collection of both subjective data relating to perceived support and caregiving difficulties, as well as more objective data concerning the scope of care provided and the level of functional dependence of care recipients. A questionnaire was used to collect the data.

Individuals meeting the following inclusion criteria were qualified for participation in the study: age of 18 years or older, performance of the role of an informal caregiver for an older person, provision of care in the home environment and provision of informed consent to participate in the study. The exclusion criteria were defined as the opposite of the inclusion criteria and included: age under 18 years, not performing the role of an informal caregiver, providing care outside the home environment, caring for a person who was not of geriatric age, refusal to participate in the study, or incomplete data preventing statistical analysis.

The research instrument was a questionnaire consisting of section designed by the author and a standardized psychometric tool. The author-designed section included sociodemographic questions, information regarding the scope and duration of care provided, difficulties encountered by caregivers and the sources of the support received. This section also incorporated elements of proxy reporting, involving caregivers' descriptions of the care recipients' dependence on third parties in performing basic activities of daily living.

The second part of the research instrument comprised the Polish version of the Berlin Social Support Scales (BSSS), originally developed by Ralf Schwarzer and Ute Schulz to assess different cognitive and behavioural dimensions of social support in the context of coping with illness. The Polish adaptation was prepared by Aleksandra Łuszczyńska, Monika Kowalska, Magda Mazurkiewicz, Schwarzer, and Schulz, and its preliminary psychometric evaluation confirmed satisfactory internal consistency and usefulness for assessing social support dimensions (Łuszczyńska et al. 2006). In the present study, four BSSS subscales were used: perceived available support, need for support, support seeking, and actually received support. These subscales allow the emotional, informational, instrumental and material aspects of social support to be assessed. Responses are given on a four-point Likert-type scale, with higher scores indicating a higher level of the support dimension being assessed. In the analysis, the results were converted into percentage scores to facilitate interpretation and comparison between subscales.

Having been collected, the data were analyzed using Statistica 13.3 (TIBCO Software Inc.). Descriptive statistics were computed to summarize the participants' characteristics and BSSS results. Owing to the ordinal or non-normally distributed nature of the variables, non-parametric methods were used throughout. Group differences in overall BSSS scores between two-category variables, including sex and marital status, were examined using the Mann-Whitney U test. Associations between overall BSSS scores and ordinal or continuous variables, including age, education, place of residence and the number of tasks in which the care recipient required assistance, were assessed using Spearman's rank-order correlation coefficient. The relationship between the number of tasks requiring assistance and the number of hours devoted to care was also analyzed using Spearman's rank-order correlation. All tests were two-tailed, and statistical significance was set at $p < 0.05$.

Study organization and conduct

The study was non-interventional in nature and consisted of the anonymous completion of a questionnaire by informal caregivers of older people. During the implementation of the project, no data enabling the identification of participants were collected, and participation in the study was not associated with any health risk or burden for the respondents. Participation in the study was entirely voluntary.

The study was conducted on the Geriatric and Internal Medicine Ward with a Rheumatology Subunit at the E. Szczeklik Specialist Hospital in Tarnów (Specjalistyczny Szpital im. E. Szczeklika w Tarnowie). Informal caregivers accompanying patients or remaining in contact with the ward staff during the patient's hospitalization were invited to participate in the study. Data were collected between February and April 2023. Depending on participants' preferences, questionnaires were distributed in either paper or electronic form, with a QR code provided linking to the survey prepared using Google Forms.

During the recruitment process, participants were informed about the aim of the study, its anonymity, the voluntary nature of participation, and the possibility of withdrawal at any stage without providing a reason. In the case of the electronic questionnaire, the provision of informed consent and the selection of the relevant option were additionally required in order to proceed to the first question of the survey. In the absence of consent, the form was automatically closed without access to the content of the questions. Respondents were able to discontinue completion of the questionnaire at any stage. The data were analyzed exclusively in aggregated form.

Owing to the anonymous, non-interventional, and observational nature of the study, in accordance with the legal regulations in force in Poland, the project did not require approval from a bioethics committee. Written consent for the conduct of the study was obtained from the management of the medical facility.

Study participants

A total of 110 informal caregivers of older people were invited to participate in the study, of whom eight did not confirm consent to participate. Ultimately, data from 102 respondents were included in the statistical analysis.

The vast majority of the participants were women (92.16%). The most numerous age groups comprised caregivers aged 50–59 years (30.39%) and those aged 60 years and over (25.49%). A smaller proportion consisted of respondents aged under 40 years (table 1).

Table 1. Sociodemographic characteristics of the participants

Variable	Number of participants	% of participants
Sex		
Female	94	92.16
Male	8	7.84
Age		
Up to 40 years	22	21.57
41–49 years	23	22.55
50–59 years	31	30.39
60 years and over	26	25.49
Place of residence		
City	35	34.31
Village	67	65.69
Marital status		
In a relationship	35	34.31
Single	67	65.69
Education		
Primary	5	4.91
Vocational	9	8.82
Secondary	36	35.29
Higher	52	50.98
Source of income		
Disability pension	2	1.96
Allowance or other benefits	16	15.69
Retirement pension	23	22.55
Employment	61	59.80

Source: own study.

Most respondents lived in rural areas (65.69%) and were not married (65.69%). More than half of the participants reported having higher education (50.98%).

The caregiving role was most commonly performed by patients' children (57%), less frequently by unrelated individuals (19%), more distant relatives (14%), and spouses (10%).

Half of the respondents lived together with the care recipient, while 38.24% declared living a short distance from the care recipient's place of residence; nearly 12% reported that the distance was considerable.

Results

The analysis focused on assessing the need for social support among informal caregivers who provided care to recipients of geriatric age and with varying levels of functional dependence. The results indicate a high level of support needs, alongside differentiation in the availability of support, forms of support seeking and the resources actually received. Most relationships between the level of support and caregivers' sociodemographic characteristics or care-related variables were not statistically significant, which underscores the complexity of support needs in geriatric care.

The surveyed caregivers provided care for older people with markedly limited functional independence. The scope of assistance included basic activities of daily living, in particular maintenance of personal hygiene, bathing, dressing and undressing, mobility, use of the toilet, preparation and consumption of meals, and control of physiological functions. Care recipients most frequently required assistance with personal hygiene (88.24%), full-body bathing (80.39%), dressing and undressing (79.41%), and mobility (78.43%). A high proportion also concerned daily washing (74.51%) and use of the toilet (69.61%). Detailed data on the characteristics of the care provided are presented in table 2.

Table 2. Activities of daily living in which the care recipient requires partial or full assistance from the caregiver (multiple responses allowed)

Activity	Number	%
Bowel control	55	53.92
Walking on flat surfaces	58	56.86
Ascending and descending stairs	59	57.84
Urine control	60	58.82
Eating meals	67	65.69
Using the toilet	71	69.61
Daily washing	76	74.51
Mobility	80	78.43
Dressing and undressing	81	79.41
Full-body bathing	82	80.39
Maintaining personal hygiene	90	88.24

Source: own study.

The duration of caregiving and the number of hours devoted daily to its provision varied. The largest proportion of caregivers reported providing care for approximately 8 hours per day (43.14%), followed by those providing care for 2–4 hours (25.49%) and 5–7 hours (21.57%). Care lasting less than 2 hours per day was reported by 9.80% of respondents.

The largest group of care recipients comprised individuals who were functionally dependent (57.86%), requiring constant assistance with most basic activities of daily living. Partial independence was observed in 28.38% of individuals, while full independence was retained by only 13.76% of the surveyed older adults. This distribution indicates a high level of functional dependence among care recipients.

The largest proportion of respondents (33.33%) assessed the level of support received from institutions at the lowest possible level (1 point on a scale from 1 to 10). Only a small proportion of respondents (4.90%) declared the highest possible level of support (10 points). These results indicate a very low assessment of the availability of institutional support among the participants (figure 1).

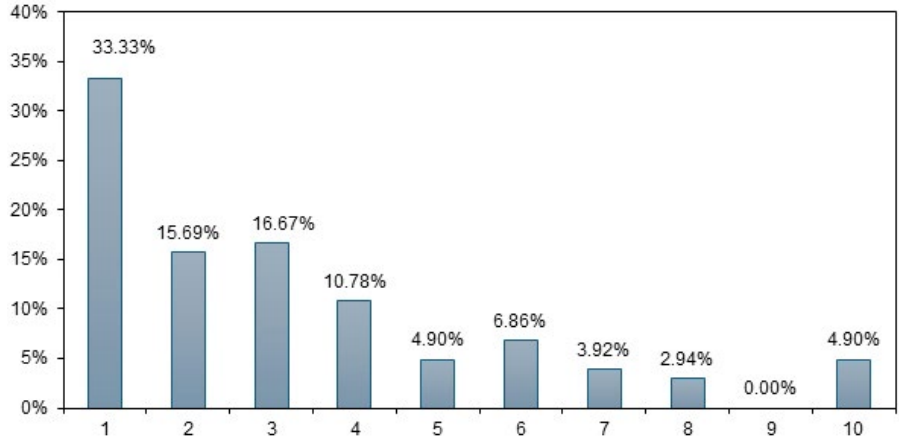

Figure 1. Support received by caregivers from institutions

Source: own study.

The majority of caregivers (63.55%) assessed the level of support received from family and friends at 5 points or higher on a 10-point scale. At the same time, 16.67% of respondents rated this support at the lowest level (1 point), indicating substantial variation in the availability of informal support (figure 2).

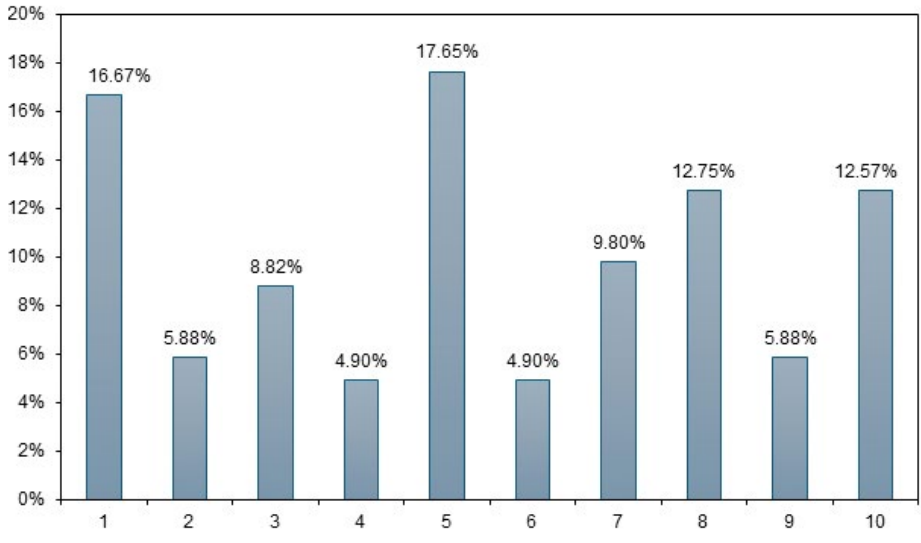

Figure 2. Support received by caregivers from family and friends

Source: own study.

The assessment of support received from institutions indicates a very low level of systemic assistance among the caregivers who participated in this study, whereas support from family and friends was evaluated as clearly higher, although responses also showed considerable variability.

The analysis of results obtained using the BSSS revealed a differentiated level of social support among the participants. The mean level of perceived available support was 66.22% (*SD* = 23.58), the mean level of need for support was 63.56% (*SD* = 18.74), the mean level of currently received support was 59.37% (*SD* = 18.78), and the mean level of support seeking was 60.54% (*SD* = 25.64). The highest values were observed in the perceived available support subscale, whereas the lowest values were noted in the currently received support subscale. Table 3 presents detailed results for the individual subscales.

Table 3. Caregivers' support needs according to the BSSS

Type of support	Mean	Standard deviation	Min	Max	Median
Perceived available support	66.22%	23.58%	4.17%	100%	70.83%
Need for support	63.56%	18.74%	16.67%	100%	66.67%
Currently received support	59.37%	18.78%	6.67%	88.89%	62.22%
Support seeking	60.54%	25.64%	0%	100%	66.67%

Source: own study.

Spearman's rank-order correlation analyses showed no significant associations between overall BSSS scores and education (Spearman's ρ = −0.114, $p = 0.254$), place of residence (Spearman's ρ = −0.040, $p = 0.690$), or age (Spearman's ρ = −0.03, $p = 0.76$). The number of tasks in which the care recipient was non-independent was not significantly correlated with the number of hours devoted to care (Spearman's ρ = 0.189, $p = 0.065$). No significant differences in overall BSSS scores were observed between female and male caregivers, as indicated by the Mann-Whitney U test ($Z = -0.26$, $p = 0.79$).

In contrast, marital status significantly differentiated overall BSSS scores ($Z = -2.30$, $p = 0.021$). Participants who were in a relationship reported higher overall BSSS scores (median = 69.83, Q1–Q3 = 58.23–80.35) than single participants (median = 64.03, Q1–Q3 = 44.86–71.74). Moreover, the number of tasks in which the care recipient was non-independent showed a statistically significant negative correlation with the overall BSSS score (Spearman's ρ = −0.24, $p = 0.015$), indicating that a greater scope of functional dependence was associated with lower overall social support scores (figure 3).

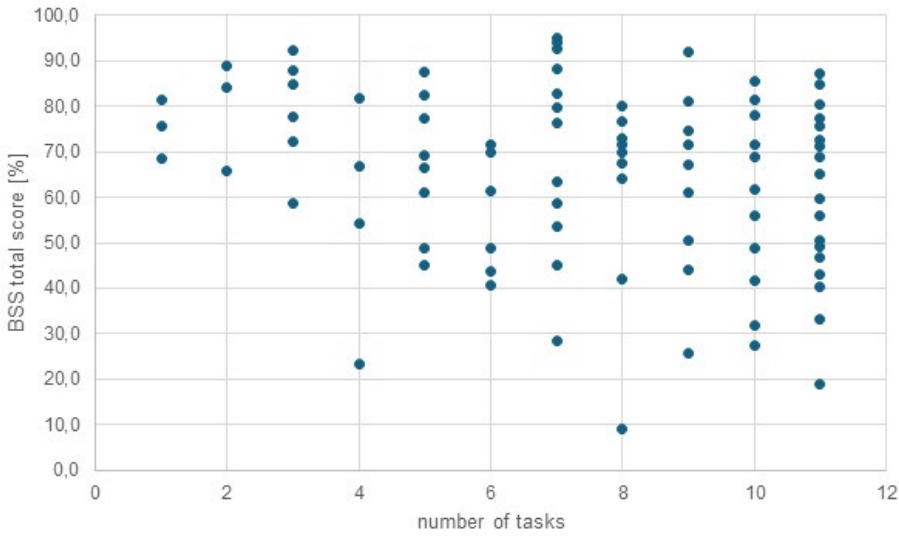

Figure 3. Scatterplot for the association between overall BSSS scores and the number of tasks Spearman's $\rho = -0.24$, $p = 0.015$)

Source: own study.

Discussion

The results allow for an in-depth assessment of the need for social support among informal caregivers providing care to geriatric patients with a high level of functional dependence. The participants were engaged in intensive caregiving covering a broad range of activities of daily living, which directly translates into a high level of social support needs. These findings confirm that the need for support in this group is persistent rather than incidental, consistent with observations from other countries (Gomes et al. 2024; Szczupak 2021).

The majority of care recipients in the study were functionally dependent, requiring assistance with basic activities such as personal hygiene, mobility, use of the toilet and meal consumption. This functional profile aligns with reports from other authors, who indicate that the degree of patient dependence is one of the strongest predictors of caregiver burden and the growing need for social support (Gomes et al. 2024). Studies conducted in populations of caregivers of individuals with neurodegenerative diseases and frailty syndrome have shown that as patient functional capacity decreases, the risk of sleep disturbances, depressive symptoms and burnout in the caregiver increases (Del-Pino-Casado et al. 2018, 2019).

Another significant factor differentiating the situation of caregivers was the amount of time devoted to caregiving. The high proportion of individuals providing care for many hours per day indicates considerable, chronic burden, which contributes to the accumulation of fatigue, reduced recovery, and deterioration of caregivers' psychophysical functioning. This relationship has also been observed in studies conducted in Scandinavian countries and North America, where prolonged, intensive care is associated with a substantially higher risk of overload, anxiety disorders, and withdrawal from professional activity (Aman et al. 2020).

Analysis of the BSSS results revealed a differentiated profile of social support. The highest-rated dimension was perceived available support, while the lowest-rated one was currently received support. This pattern may reflect a discrepancy between the perception of potential availability of assistance and the actual experience of receiving support in daily caregiving situations. Similar findings have been reported in meta-analyses, which demonstrate that perceived support shows a stronger association with caregiver burden than support actually received (Del-Pino-Casado et al. 2018).

A particularly pronounced disparity was observed between informal and institutional support. Support received from family and friends was rated moderately high by most respondents, whereas institutional support was frequently assessed at the lowest possible level. These results indicate that despite the formal existence of long-term care structures and social benefits, their actual availability for caregivers remains limited. This situation confirms the predominance of the family-based care model for older people alongside insufficient systemic support,

a pattern also observed in other Central and Eastern European countries (Aman et al. 2020).

This study also showed that basic sociodemographic characteristics were not consistently associated with overall BSSS scores. No significant associations were found for age, education, place of residence, or sex. This suggests that support-related experiences in this group may depend less on demographic characteristics and more on the caregiving context itself. Similar observations have been reported in studies indicating that caregiver burden and support are shaped primarily by care demands and available support resources rather than by sociodemographic variables alone (Aman et al. 2020; Del-Pino-Casado et al. 2021).

By contrast, marital status significantly differentiated overall BSSS scores. Caregivers who were in a relationship reported higher overall social support than single participants. This may reflect the protective role of a closer personal support network and the presence of a partner as a source of emotional, organizational and instrumental assistance. In the context of long-term caregiving, the availability of such close support may facilitate adaptation to daily demands and reduce the sense of being left alone with caregiving responsibilities (Aman et al. 2020; Del-Pino-Casado et al. 2018).

An important finding was also the significant negative association between the number of tasks in which the care recipient was non-independent and the overall BSSS score. This indicates that caregivers supporting more functionally dependent older adults reported a less favourable overall support profile. This observation is consistent with previous reports showing that greater patient dependence increases caregiving burden and may exceed the support resources available to informal caregivers (Del-Pino-Casado et al. 2018, 2019; Gomes et al. 2024).

Although many respondents provided care for several hours a day, the correlation between the number of tasks requiring assistance and the number of hours devoted to care did not reach statistical significance. Accordingly, this result should be interpreted with caution and should not be treated as evidence of a linear relationship between the extent of dependence and caregiving time in this sample.

The predominant difficulties among the participants, related to physical and psychological overload and a lack of time for rest, indicate a substantial risk of long-term health consequences for caregivers. Prolonged functioning under high burden promotes exhaustion, sleep disturbances, reduced emotional functioning, and increased risk of somatic illnesses. These consequences may indirectly affect the quality of care provided and the safety of geriatric patients, which is particularly significant in the context of long-term care (Aman et al. 2020; Del-Pino-Casado et al. 2019).

Limitations and strengths of the study

The study has certain limitations. Its cross-sectional design does not allow for causal inferences, and the non-random sample selection limits the generalizability of the findings. Data regarding patients' functional status and the scope of care provided were based on caregiver self-report, which carries the risk of subjective assessment. The study was conducted within the context of the Polish healthcare and social care system, which should be considered when interpreting the results in an international context. Strengths of the study include the use of a standardized tool for assessing social support and the inclusion of caregivers providing intensive care to patients with a high degree of functional dependence, enhancing the clinical value of the data obtained.

Recommendations

The results indicate the need to intensify systemic forms of support directed at informal caregivers of geriatric patients in Poland. Key priorities include improving access to reliable information, health education and specialist counselling. Expanding the availability of respite care as a means of temporarily relieving caregivers also plays a crucial role.

It is advisable to more widely involve primary healthcare nurses, long-term care services and community care teams in interventions aimed not only at the patient but also at the caregiver, including systematic assessment of the caregiving situation, education and psychosocial support.

For future research, longitudinal studies appear appropriate, allowing for the assessment of changes in support needs over time and the identification of factors conducive to maintaining caregiver well-being.

Conclusions

Informal caregivers of geriatric patients in Poland experience substantial support-related burden and function within a support system dominated by family resources, with limited institutional involvement. The overall BSSS profile indicated the highest scores for perceived available support and the lowest for actually received support, suggesting a gap between potentially available and actually obtained assistance. Caregivers who were in a relationship reported higher overall BSSS scores, whereas a greater number of tasks requiring assistance by the care recipient was associated with lower overall BSSS scores. These findings support the need for systemic interventions aimed at strengthening accessible community-based, educational and respite services for caregivers of functionally dependent older adults.

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Supplementary Materials

None. The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

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Ethics Approval Statement

The study was conducted in accordance with the principles of the Declaration of Helsinki. For this non-interventional study, approval from a Bioethics Committee was not required in accordance with applicable national regulations and institutional guidelines. Participation in the study was entirely voluntary. All participants provided informed consent prior to taking part, and confidentiality of the data as well as compliance with the General Data Protection Regulation (GDPR) were fully ensured.

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Data Availability Statement

Data can be obtained by contacting the corresponding author.

Declaration of Generative AI Use

The authors used ChatGPT (OpenAI) exclusively for language editing and improving the clarity of the manuscript. All scientific content, analyses, interpretations, and conclusions were developed independently by the authors, who take full responsibility for the final manuscript.

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Conflict of Interest Statement

The authors declare no conflicts of interest.