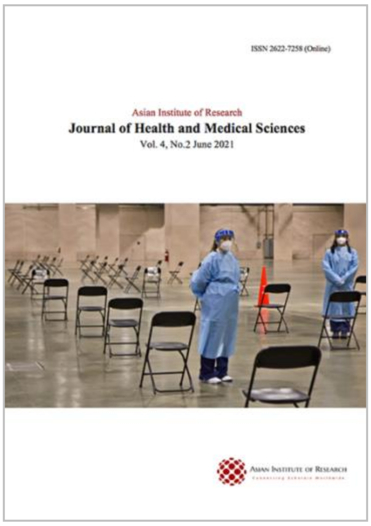

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The Role of Personal, Social and Religious Resources in Caregiving Stress

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Abstract
This study puts personal, social, and religious resources as a stress buffer for caregivers. The limitation of personal, social, religious resources have a detrimental effect on the mental health of caregivers of a family member with schizophrenia (hereinafter referred to as People with Schizophrenia, or PwS). Following the caregiving stress process theory, this study aims to clarify not only the role of personal and social resources but also the religious ones. For this purpose, in-depth interviews with a life history method were done to twenty (20) caregivers of PwS. The result shows that personal resources like coping mechanism management (for example, by doing a positive comparison with others and reducing the expectations on the PwS) would help to perceive the role of a caregiver more positively. Meanwhile, social resources like social support were received by the caregivers from their significant others (family members) and similar others (support group). Social support was received in the form of emotional support, caregiving help, and instrumental aid. Religious resources in the form of religious coping were also used as a buffer for the stress that came from caregiving. This was done by positive religious coping, such as asking for help from God during difficult times, involving God in everything they do, and surrendering themselves to God to get the strength to face life problems. These three resources (personal, social, religious) were needed by the caregivers so they can preserve their mental health.

Keywords: Caregiver Stress, Personal Resources, Social Resources, Religious Resources

1. Introduction

In Indonesia, the services available for mental health still have many issues. According to *Rencana Aksi Kegiatan* (Action Plan) of 2015-2019 of the Ministry of Health of Indonesia, only 33% of the general hospitals in Indonesia provide mental health services and eight provinces don't have any psychiatric hospitals. Only 21.47% of the primary health care provide mental health services. Also, the gap of mental health treatment reaches up to 90%, which means only 10% of the people with severe mental health disorders can be treated in Indonesia.

The scarcity of accessible mental health services for the general public gives rise to numbers of informal caregivers that are forced to take care of PwS (Keith, 1995). This positions informal caregivers as main caregivers who have to take on required new duties and roles regarding the caregiving of PwS, and it is often this leads to unexpected caregiving careers (Aneshensel, et al, 1995). In doing this purpose, there are spectacles and burden that these caregivers have to face, be it objective burden (which includes negative impact faced by the family, such as the expensive caregiving expense, or the fulfillment of the PwS' daily needs) and subjective one (which includes being depressed, lost, or anxious). This might lead to a stressful condition that would influence the caregiver's mental health (shown by the symptoms of depression and anxiety) (Jusuf, 2006).

This imbalanced mental health condition is created socially and is defined by social forces (Thoits, 2006). According to the framework presented by Pearlin et al. (1990), the condition of the imbalanced distribution of mental health issues can be understood via the exposure of stress, the absence of social and personal resources, and its social context (in this case, it is related to the social and economical characteristic, past experience in caregiving, and the composition of the family and its social network, and the availability of the program).

All the studies about the stress process can be divided into three categories. The first one focuses on the stressor and a certain structural context that produces the stress process (Wheaton, 2013; Aneshensel et al. 1991, Aneshensel et al., 1995; Aneshensel, 1996). Second, it focuses on how coping mechanisms and social resources can buffer for the stressors so they give a different impact on mental health (Lin & Ensel, 1989; Wheaton, 1985, Thoits, 2006). The third group focuses on the impact of social structure and stress on different mental health outcomes (Aneshensel et al., 1991). This study belongs to the second group that talks more about coping mechanisms and social resources as a stress buffer due to caregiving. However, in the Indonesian context, the coping mechanism and social support that is used as a stress management resource based on the stress process theory presented by Pearlin et al. (1990) are not enough to explain its effect on the outcome of a caregiver's mental health. The use of a religious coping mechanism which, in this case, comes from religious activities and beliefs will also be taken as a coping mechanism that is influential to the outcome of a caregiver's mental health (Schieman, et al., 2013).

Therefore, this study aims to investigate how caregivers manage the stress due to caregiving using their personal, social, and religious resources.

1.1. Caregiving Stress and Coping Resources

According to the caregiver stress process presented by Pearlin et al. (1990), coping strategy resources consist of personal resources (in the form of individual coping) and social resources (in the form of social support). Solomon and Draine (1995) did a study on 225 family members that joined a psychoeducation program. This study found that 39% of the subjective burden that a caregiver got could be explained by looking at the stressor severity, which was related to the illness of the family member and the available social support, and the caregiver's coping capabilities. According to Lazarus and Folkman (1984), an individual coping mechanism is defined as *"... the process through which the individual manages the demands of the person-environment relationship that are appraised as stressful and the emotions they generate"*. Streid et al. (2014) analyze the caregivers' burden in African Sub-Sahara. This study identified the primary stressor that caregivers experience regarding the daily caregiving treatment of the patient and their emotional support. Secondary stressors that are identified in this study are financial hardship, familial responsibility, and social isolation. This study shows that the social, relational, spiritual, and psychological resources that the caregivers have will reduce the impact that the stressor gives. This study shows that empowerment of a resource will empower other resources, but failing to utilize one of the resources will suppress other resources and eventually make the caregiver's burden worse.

The explanation that focuses on the stressor and the resources used in stress analysis and their relationship with health shows that stress and its resource component from a psychological background directly govern the symptom of physical diseases (Lin & Ensel, 1989). However, the social resources, in this care social support, have a bigger influence because they can support social stress (negative live events) and psychological stress (depression, anxiety, etc.). Meanwhile, psychological resources are limited to being a buffer for psychological stress. An important note from this study is how social resources buffer social and psychological stress and its impact on physical well-being. This aligns with a study of Thoits (2011) that analyzed social support as a stress buffer resource. Thoits (2011) also explained that the social support that the caregivers get may also come in the form of instrumental support, especially if it comes from people who are significant to the caregivers and people with similar situations. Meanwhile, Wheaton (1985) explains the interaction between stress and social support that stress effect will decrease significantly at higher amounts of social support.

Besides social resources that manifested in the form of social support, another missing part in the stress process that Pearlin et al. (1990) presented is the role of religious resources that comes in the form of religious coping. Pargament et al. (2011) mentioned that the studies that employed religious coping in the context of the United States showed that those who weren't white have a better score in the term of positive religious coping against stress. There are only a few studies that employ religious coping in a non-Western context. In the Indonesian context, this concept becomes important because Indonesia has a different character from western countries in terms of religiosity. Koenig (2005) explained in his book a result of a study that connected religion or belief with mental health. Religion is taken as a resource to manage mental health.

1.2. Personal Resources

According to the caregiving stress process by Pearlin et al. (1990), personal resources are visible in the form of individual coping mechanisms -- for example, situation and meaning management. Managing the situation includes things that caregivers need to do to ease their caregiving duty, like being firm in directing the behavior of PwS, doing all the required stuff and being more relaxed on other things, trying to find ways to keep PwS busy, and trying to learn more about schizophrenia (for example, by reading books, asking a medical doctor, or going to a public talk that discusses it). Meanwhile, managing the meaning is about the caregivers' opinion about caregiving -- for example, reducing their expectations, making a positive comparison, constructing a more positive understanding about schizophrenia.

1.3. Social Resources

In the framework presented by Pearlin et al. (1990), there are two forms of social support that he described, namely instrumental support and expressive support. Instrumental support is visible from the presence of another person who helps the caregiver in taking care of the PwS and doing the daily house chores. Meanwhile, expressive support is seen by how much the people around the caregivers care about them, or if the caregivers have people that they can trust (at least a friend or a relative that they can talk to when they get sad or hopeless, etc.). Even though, in this study, monetary support in the form of caregiving cost support is also an important aspect.

1.4. Religious Resources

According to Pargament et al. (2011), religious coping, which comes in the form of positive religious coping, shows how caregivers look for a strong relationship with God to face difficult situations. The forms of religious coping, which includes: (a) collaborative coping by involving God to fix life problems, (b) reframing negative life condition with religious lens -- for example, by seeing life problems as God's plan; (c) looking for spiritual and comfort from God, (d) trying to solve manageable problems on their own, and asking help from God for harder problems. Religious coping also can buffer the effect of stress on caregiver's mental health (Ellison and Henderson, 2011).

2. Method

2.1 Qualitative Method

The qualitative method was used in this study to contextualize stress process theory for PwS' caregivers in Indonesia. This theory was developed by Pearlin et al. (1990), created and constructed in the context of Western communities in the United States. Similar studies that used this theory were more commonly undertaken in Western countries. This study complemented those studies by including religious resources as coping resources.

The qualitative method used in this study was life history. Life history was used to deliver a deeper picture of the stress process happening to caregivers of PwS. Schizophrenia was one of the mental health disorders that required long-term care. We could get a complete picture of how the stressor emerged and how the caregivers coped with it -- from the illness's emergence to the start of the caregiving process to today. The caregivers' social contexts influenced the kind of stressor turned up and the resources that could be used to reduce the stressor's influence on the caregivers' mental health. Through this method, the interviews explored the caregivers' life events chronologically (Neuman, 2014). The retrospective method was used; the informants were asked to recall the events and experiences related to their status and role as caregivers, starting from the emergence of PwS' illness until the time the interviews were done. Information regarding the personal, social, and religious resources that the caregivers had were also explored, as they helped the caregivers to overcome the stress due to caregiving.

2.2 Participants Characteristics

The characteristics of the selected informants included that they were main caregivers and they were already eighteen years old and they had been taking care of a PwS for at least six months. Eighteen was chosen as the minimum age because at this age people had acquired more sophisticated roles in their social lives. The selection also considered these aspects: if the informant was a member of *Komunitas Peduli Skizofrenia Indonesia* (KPSI/Indonesian Care Group for People with Schizophrenia), their caregiving history, their caregiving type (if they were the parent, the child, or sibling, or the partner of the patient), gender, marital status, religion, and working status.

Table 1: Participants Characteristics (N=20)

Characteristics	N	%
Caregiver Type		
Parents	10	50
Child	2	10
Siblings	5	25
Spouse	3	15
Religion		
Islamic	14	70
Christian	3	15
Chatolic	3	15
Sex		
Male	5	25
Female	15	75
Caregiving History		
<1 year	1	5
1-2 year	2	10
3-5 year	1	5
>5 year	16	80
Educational Level		
None/Not Completed in Primary	2	10
School	1	5
Middle School	6	30
High School	10	50
Diploma/Bachelor Degree	1	5
Postgraduate		
Working Status		
Not working	8	40

Characteristics	**N**	**%**
Working part time	6	30
Working full time	6	30
Status Perkawinan		
Single	1	5
Widowed	4	20
Divorced	1	5
Married	14	70

2.3 Data Collection

In-depth interviews and observations of the caregivers were done from 30 August to 24 October 2018. The researcher used gatekeepers that could connect the researcher with the caregiver of PwS. The gatekeepers were the founders and volunteers in KPSI. In the beginning, the caregiver type was not considered as one of the selection criteria, but in the data collection process, the caregiver type showed a distinctive pattern in the stress process of this study. Therefore, four caregiver types were selected based on the status and role the caregiver had in a family, such as a parent, child, sibling, and spouse. Finding a child and spouse caregiver was quite hard because a parent PwS was harder to find in this community, when we can find an older member with this condition they remain unmarried. Meanwhile, the spouse caregiver was also harder to find because many people quit the relationship when their partner suffered schizophrenia. Most of these spouse gave the caregiving roles to the PwS' family.

The data collection process in the form of an in-depth interview was done one to two times for every informant -- with the duration of each interview one to three hours. The interviewing process started with an introduction and after that, the researcher tried building rapport with the caregivers. After things became conducive, the researcher asked the caregiver's consent to be interviewed and explained about the informed consent for the involvement in this study. The informed consent contained an explanation about the study, the purpose of the study, the procedure (including the use of an audio recorder), the risk of participation, the benefit of participation, and the souvenir that would be given as compensation for the time spent for the interview. It also informed about the resignation process if the caregiver ended up refusing to participate, data confidentiality, and the researcher's phone number. At the end of the informed consent, there was a statement letter that the informants and the researcher had to read and sign together. The in-depth interviews used the semi-structured interview guideline because this study followed the stress process framework presented by Pearlin et al. (1990). The interviews were done mostly in the informants' homes. Some informants asked the interviews to be done in public spaces, like restaurants, KPSI's headquarter, or the caregivers' workplace.

2.4. Data Analysis

The qualitative data was processed by the software NVivo 12. The qualitative data processing and analysis in this study can be divided into five phases: *First*, the recording of the interviews had to be transcribed, verbatim; *second*, the transcription was converted into code based on the indicators developed from the stress process framework by Pearlin et al. (1990) and other codes found during the interviews; *third*, the transcription that had been converted to codes were processed by the NVivo program based on the caregiver type; *fourth*, the result of the coding process was issued in the form of (1) quotes of the answers of the informants based on the caregivers' stress process indicators by Pearlin et al. (1990) and the caregiver type, (2) creating a classification sheet that showed caregivers' profile based on their characteristics and social contexts; *fifth*, analyzing the result of the coding process, which would show the pattern of coding resources in each caregiver type.

3. Results

3.1 The Role of Personal Resources

In the stress process theory presented by Pearlin et al. (1990), the coping mechanism that parents do to overcome the problems faced by PwS has several functions, such as managing the situations that might lead to stress, managing the meaning in every problem faced by PwS so the risk of stress would be reduced. The parents' individual coping mechanism was often done with managing the meaning, for example by making positive comparisons with other people about their caregiving experience. This showed that the caregiver is doing a self-reflection about the condition that they have and comparing it with others. Meanwhile, lowering the expectations held against PwS would also help the caregiver to overcome the effect of caregiving. Society set life goals that someone had to achieve and demanded everyone to pursue them. PwS' conditions, which often had structural barriers, should give the caregivers the idea to refuse to fulfill the demand from the society that there should be more roles for PwS in the society, namely working and getting married. This gives a new meaning for the caregivers regarding the demand of the society towards PwS. As stated by one of the caregivers:

> "Yup, grateful.. Take me as an example, beside me, many sold their houses, many got divorced, fight.. We are among the lucky ones. My children still visit us.. So not so many problems." (Interview with Bapak N, Father, 77 years old, October 5th 2018)

Child caregivers carry out a coping mechanism by getting married to expand their role identities. Additional roles provide additional energy and commitment in caregiving because the burden can be shared with new family members (Thoits, 2003). Another treatment carried out by the child caregiver is by making positive comparisons and seeing the good things in PwS (caregivers had to see PwS's past as a reference for current actions). The new meaning given to the role of caregivers, be it in relation to the caregiver's evaluation of their external environment or to PwS, would reduce the effect of caregiving. As explained by one of the following child caregivers:

> "So I think, it's better for me to get married, let's say I will get more help, my partner, so it won't be just me to bear all these burdens. I can share it with my wife, well, at least, even when I am deserted, I will have a friend, my wife. Life must go on. I have to think of my own life too. Not that I am disobedient, but this needs to be shared." (Interview with A, Son, 31 years old, October 3rd 2018)

Meanwhile, the sibling caregivers take care by being firm in directing PwS behavior and learning a lot about how to deal with PwS from the beginning of the care until now. They overcome the life difficulties resulting from caregiving by joining in community activities (Thoits, 2006). Coping is also done by redefining the caregiving actions by focusing on things that the caregivers admire from PwS, focusing on the positive things, and choosing not to see negative things about PwS. In addition, a more positive understanding of the desease generated a new meaning of the illness, which provides strength for the caregivers to continue their role. This is as stated by one of the sibling caregivers:

> "So I have come to the "what can I say, this is my life" phase. All people have their own problems, so this might be my family's problems. About how to cope, this and that, just follow the flow. Being told to take care, I took care; so I have come to the phase that I never think "what would happen to him if.."; no. Just see what happens tomorrow. So, for anything that happens, there will be solutions, just like that." (Interview with N, Sister, 48 years old, September 10th 2018)

Spouse caregivers have a higher sense of agency because before they got married with PwS, they used all their personal resources to study PwS' illness and eventually accepted the role of caregiving when they finally got married. Life difficulties that came from the caregiving activities are compensated by carrying out other activities, especially in their work and involvement in the social activities. Transformative coping was also carried out by involving themselves in education and advocacy on mental health in numerous institutions. Meaning management was shown from the cultural scheme of caregiving, the meaning of marriage for them, and their consistency of life choices. Caregiving wasn't seen as a burden but a struggle that the caregiver and PwS must face together. The life choices the caregiver took showed the caregiver's ability to do care (Hitlin and Elder, 2007) and the caregiver's ability to solve problems (Thoits, 2006).

> “... But when he was like that (showing a behavior of self-withdrawing), I looked through books again, oh it’s part of his illness. Isn’t it like that. So I started to understand him, to understand his illness.” (Interview with U, Wife, 50 years old, September 7th 2018)

3.2 The Role of Social Resources

Social support gives an explanation of how the caregivers would try to use their support network to help them deal with the difficult situations during caregiving. Expressive social action can be seen in the type of support that the caregiver got, which was in the form of emotional assistance for the caregiver. Meanwhile, instrumental social action is reflected in the type of support the caregivers got, which was in the form of caregiving help for the caregiver and instrumental assistance. Parent caregivers get more sources of support from their closest people -- not only family members (children, siblings, spouses), but also work friends, neighbors, college friends, and doctors. Emotional support was given in the form of attention, care, sympathy, love, and mutual sharing. Meanwhile, caregiving help was provided in the form of helping with medical expenses, caregiving costs, providing food when PwS experienced a relapse, lending a vehicle, and helping solve problems (for example, suggesting alternative treatments). In addition to support from significant others, parent caregivers also get support from similar others in the form of participating in community activities, namely the Indonesian Schizophrenia Care Group Community (KPSI). KPSI supported caregivers by providing psychoeducation/information, advice, and direction on how to deal with PwS. Fellow community members provide emotional support to each other by empathizing and validating their feelings and concerns about the caregiving experience.

> “There are friends from the office, friends from college, incidentally they also have nephews who got sick because of drugs. And then we shared. Well, in the end, just got closer to Allah. Thank God that I have my college friends with me until now, almost like relatives. So when I lack financially, they will help.. Did it that far.” (Interview with Ibu S, Mother, October 13rd 2018)

Social support for child caregivers comes from family support networks (uncles and siblings), school friends (when the caregiver was yet to marry), and their partner (after the caregiver was married). The type of support given is emotional support -- for example, being there when the caregiver is experiencing difficulties in life and accompanying them. In addition to emotional support, child caregivers also received from their support sources assistance on how to treat PwS when they are showcasing problematic behavior (significant others are family members with educational or work backgrounds in public health). Another form is instrumental assistance -- for example, financial assistance and helping to look after PwS when they are sick.

> “Thank God, one of my uncle, the one who is from my father’s older sister, he has a degree in health, a nurse. He, thank God, often told my families, and the other families, to her children or wives of my father’s families, that if they relapse again, recur again, don’t treat them differently, or exclude them… So, thank god, not only from my internal family, but also extended family, they are supportive. I am very grateful, I can say that. Can’t imagine if I never get support from here and there.” (Interview with A, Son, 31 years old, October 3rd 2018)

Sibling caregivers have a source of support from both significant others and similar others. Sources of significant others include family members (husbands, uncles, siblings), while similar others are from the chairman and members of KPSI and professionals (doctors and psychiatric nurses). The closest people provide emotional support in the form of a willingness to share, listen, accompany and be there when there are difficulties. Meanwhile, KPSI members give their support in the form of providing information, psychoeducation, direction, and advice that can strengthen caregivers in carrying out their roles.

> “So at least I visit my mother in law once every two weeks. I could be there from day to night. And there, I talk… for my character. Even though they can’t give any advice, I can feel relieved. If I don’t talk to them, or if I don’t talk openly, it will be messed up at home. So, after I talked with my family, my husband’s family, my husband, with KPSI, or even reading things on facebook, or talking on KPSI’s facebook. I can feel relieved again.” (Interview with A, Sister, 45 years old, September 1st 2018)

In spouse caregivers, sources of support from the closest people include family members (siblings, cousins, brother-in-law) and school friends. Meanwhile, the source of support from similar others came through KPSI. The closest people provide emotional support by being there when needed and providing treatment assistance in the form of providing instrumental assistance -- for example, paying for living expenses and medical expenses, assisting PwS when they are experiencing a relapse, and giving support to apply for a state-paid health insurance card so they can get support from the government.

> “... 500 thousand a month. At that time I also paid an installment of 500 thousand a month. I got out of my job because I didn’t have anyone to babysit my kids at home. We used to have the dad to babysit, while I worked. Thank God, my older brother, the oldest, asked me monthly, “Have you paid for your house this month?” That. If I don’t have enough money, he often gives me. For treatment expenses, thank God 100% of it comes from PwS’ cousin.” (Interview with YT, Wife, 50 years old, September 22nd 2018).

Support from KPSI is provided both in the form of emotional support and coping assistance. The meetings held by KPSI can provide emotional support because each caregiver is allowed to tell the difficulties and problems faced in their caregiving process. This hopefully leads to not only an understanding and empathy between fellow caregivers but also mutual having their feelings and concerns mutually validated. Meanwhile, the coping assistance also comes in the form of psychoeducation, advice, and direction can strengthen the caregiver in carrying out their role. However, another interesting thing is spouse caregivers are usually seen as role models in doing a successful caregiving role that inspires other caregivers to achieve similar things.

3.3 The Role of Religious Resources

In the stress process theory by Pearlin et al. (1990), religious coping is not one of the aspects that can be considered as a coping mechanism to reduce the impact of stress. Religious coping becomes important to be included in the caregiver stress process in the Indonesian context because religion is an important factor related to one's identity. The values that come from religious beliefs are often the standard of individual behavior. In the Indonesian context, the role of caregiving is closely related to religious values.

For the parent caregivers, religious coping is shown as the effort in taking medication and submitting the results to God, accepting life difficulties as a fate that one needs to be grateful for and still believing that there will be a way out of all life's problems and overcoming life's difficulties by praying. The parental caregiver's religious coping shows a positive religious coping which interprets adversity as something that can be overcome by relying on the belief in the power of God. This shows a form of collaborative coping, namely by involving God in problem solving (~~Ellison & Henderson~~ Pargament et al. 2011). Meanwhile, for child caregivers, religious handling is shown from the meaning assigned to life difficulties -- they are taken as something that must be accepted as it is the will of God, and this hopefully leads to more tranquility in living their life. As stated by caregivers:

> “... we are ordinary humans, Allah took care of us. I just try my best. Until this second, I never feel proud that I can take care of PwS. I just try to take care of a child. Try. Later, whether recovered or not, it is Allah’s doing. Let it flow..” Interview with Bapak N, Father, 77 years old, October 5th 2018).
>
> “It’s more relieving with religion if we already understand the fundamental, carry through the foundation. We will be calmer to face all of these tests. Now, if we have no religion, what can we do, we receive Allah’s will. We have to be certain that this won’t go in vain.” (Interview with A, Son, 31 years old, October 3rd 2018).

For sibling caregivers, religious coping is shown by the interpretation that the caregiving of a PwS is a test from God and the belief that they can go through this test with help from God. In addition, religious coping is also carried out by interpreting that illness and recovery both come from God and that the existence of PwS as a blessing for the family. Meanwhile, for partner caregivers, religious coping is done by using prayer to get strength from God in order to live life, always involving God in everything they do, and surrendering to God in order to gain strength in facing life's problems.

> “Seeing it as a test, and Allah will not give a test that exceeds our tenacity and I believe that. And Allah will not lessen our fortune by giving us that test. And with positive thinking, it will become real, not a financial burden, not lessening my fortune in the slightest bit. And, it turns out that Allah gives the solution and it makes us stronger.” (Interview with D, Sister, 44 years old, October 24th 2018).

4. Discussion

Thoits (2006) indicates the role of personal agency within the caregiver, which can explain how the caregiver's mental health can be maintained and improved and not damaged when stressors occur or when this stress accumulates due to long-term care for PwS. According to Sewell (1992), agency emerges from the actor's knowledge of rules, which means that actors have the ability to apply these rules in a new context -- in this case the role of caregiving. In addition, the agency also emerges from the control of actor resources, which means that actors have the capacity to reinterpret or mobilize resources with respect to their own rules. Meanwhile, according to Thoits (2003), agency emerges as personal resources increase. This increase expands the role identity that a person has throughout his life so that it is easy for him to enter and leave that identity. Agency is not only seen from a person's ability to solve problems due to structural obstacles, but they deliberately transform meaning or compensate for life's difficulties by exploring into other roles or activities (Thoits, 2006). When associated with the stress process theory by Pearlin et al. (1990), the coping mechanism carried out by the PwS caregiver consists of individual coping mechanisms in the form of situation management and meaning management. The ability of the caregiver in mobilizing individual coping resources (by reinterpreting and giving more positive meaning to the role of care) would help them in overcoming stress due to caregiving.

Social resources in the form of social support represent resources that are attached to individual support networks. Instrumental social action broadly divides social resources through weak ties, but expressive social action maintains personal resources through strong ties (Lin and Dean, 1984). This is in line with what Thoits said (1995) that social support is a function performed for individuals by their significant others (family members, friends, coworkers). This social support cannot be separated from the support network, which shows the level of social isolation/integration and their social embeddedness. The support structure depends on the number of relationships or social roles a person has in a particular social bond, or the frequency of contact with various network members, or the depth of relationships among network members. Furthermore, Thoits (2011) stated that social support as a stress buffer depends on the source and type of support available. Sources of support consist of significant others (namely members of the primary group who have no experience related to the stressors faced by the caregiver). Meanwhile, other sources of support are people who have similar experiences (namely members of the secondary group who have previous experiences with PwS care). Both significant others and similar others provide types of support in the form of emotional assistance and active coping assistance. Emotional support from the significant others comes in the form of love, care, attention, giving sympathy, and being there in difficult times. Meanwhile, the coping assistance comes in the form of instrumental assistance such as helping with medical expenses and other material support. Emotional and social support from similar others is provided in the form of understanding and empathy for the caregiver's difficulties and validating the caregiver's feelings and concerns. On the other hand, coping assistance provided by similar others comes in the form of providing feedback, guidance, information, and encouraging suggestions. Besides that, they also work as role models for caregivers so that it fosters hope for them to keep fighting. This study shows that the sources and forms of support received by PwS caregivers help them in overcoming stressors due to caregiving -- both come from significant others and similar others with a variety of both emotional and instrumental support.

Religion plays a role in reducing stress after experiencing adverse life events, which in this study is stress due to caregiving (Koenig, 2005). In addition, religion can also act as a coping mechanism in increasing spirituality and reducing psychosomatic symptoms due to exposure to stress (Pargament et al., 2011). Positive religious coping method is used by caregivers to get a sense of comfort and closeness to God, as a search for meaning, to involve God in problem solving and to achieve life transformation. The interpretation of disease and the role of caregiving undertaken by the caregiver is now connected to their religious beliefs and values. This strengthens them in their caregiving roles. Caregivers rely on God to help them during difficult times, seek strength from God through prayer, belief in God's promises, taking PwS’ illness as a gift from God, and accept the fate that

God has set on them. Religious coping by caregivers is a religious resource that may help caregivers overcome stressors due to caregiving.

5. Conclusion

This study shows the importance of the role of personal resources, social resources, and religious resources together in overcoming stressors due to caregiving for family members suffering from schizophrenia. This study extent the stress process theory proposed by Pearlin et al. (1990) by introduce the importance of the role of religious resources. Further research is expected to explore specifically the role of these three resources in the context of caregivers who care for family members with other illnesses and in different cultural or religious groups.

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