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Social support, self-efficacy and gender as predictors of reported stress among inpatient caregivers

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ABSTRACT

The study examined the predictive role of social support, self-efficacy and gender on self-reported stress among inpatients' caregivers. One hundred and sixty eight (36 males and 132 females) inpatients' caregivers were sampled from University of Nigeria Teaching Hospital (97) and Niger Foundation Hospital (71) all in Enugu, Nigeria. Three instruments were used for the data collection, namely, Multidimensional Scale of Perceived Social Support (MSPSS), New General Self Efficacy Scale (NGSES), and the Perceived Stress Scale (PSS). The study adopted a cross sectional design and Multiple Regression was used for data analysis. Results showed that social support negatively predicted inpatient caregivers' reported stress ($\beta = -.28, p < .001$). Gender significantly predicted stress among the inpatients' caregivers ($\beta = .35, p < .001$). Findings were discussed and implications of the study highlighted.

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What is known about the topic?

- The dominant conceptual model for caregiving assumes that the onset and progression of chronic illness and functional decline is stressful for both patients and caregivers, and as such can be studied within the framework of traditional stress/health models.
- A number of studies have examined the role of social support on caregiving stress. Studies indicate that social support significantly correlate with caregivers stress.
- Studies have also examined the role of self-efficacy in caregiving stress. Self-efficacy have been reported to significantly predict caregiver stress.

What the paper adds

- The paper extends the literature on the dominant stress models.
- Since existing studies on the topic of the study have been conducted on western populations, with little research in the African setting, this paper contributes to literature by filling this gap.
- Based on the finding of this study, it is possible that self-efficacy mechanism can be domain specific and may be moderated by social support influences.

1. Introduction

Human beings are social beings who take care of one another, especially the sick ones, the disabled and the aged members of one's family. Caregiving involves a significant time expenditure, energy and money over long periods. It involves tasks that may be unpleasant, uncomfortable, and irritable, create psychological discomfort and physical health problems (Norenberg, 2002; Zunz, 1998). Caregiving is not a new phenomenon, it is the family members who care for their sick ones, disabled or the aged ones.

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The family is the primary source of social support. What has changed in the last century is the number of people involved in the care giving tasks (Edwards & Higgins, 2009; Schulz, 2000). There is an increase in life expectancy and the ageing of the population, there is a shift from acute to chronic disease and their associated disabilities. There are changes in healthcare reimbursement, advances in medical technology and this has made caregiving a commonplace (Biegel et al., 1991). The dominant conceptual model for caregiving assumes that the onset and progression of chronic illness and functional decline is stressful for both patients and caregivers, and as such can be studied within the frame work of traditional stress/health models.

Providing care to someone who is sick whether full time, part time, formal or informal or long distance takes a huge toil, both in physical and emotional states. Few people are prepared for the responsibilities and the tasks involved in caring for the sick because of the stress involved. Caregivers provide many kinds of help to the care receivers ranging from assistance with shopping to help with daily tasks such as bathing, dressing, feeding, lifting, turning him/her in bed, cooking, paying bills, running errands, giving medicine, keeping him/her company, providing emotional support and many other things (Lecorich, 2008; Vitaliano et al., 2003). Studies (e.g. Macneil et al., 2010) indicate that caregivers are at more health risk than the receivers because when the caregivers devote themselves to the needs of someone else, they tend to neglect their own needs. Apart from health concern brought about by stress, it is common for caregivers to feel guilty about the things they are unable to do for the sick or aged.

1.1. Review of related literature

Some researchers (e.g., Son et al., 2007) have likened caregiving to being exposed to a severe long term chronic stressor. Within this framework, objective stressors includes: measures of patient's physical disability, cognitive impairment, problem behaviours and intensity of caregiving provided. Caregivers perform important services for humanity and their relatives at considerable cost to their well-being. Studies observe that caring for an aged individual with disability is burdensome and stressful to family members and contributes to psychiatric morbidity and anxiety disorders.

Research emphasize that caregivers' stress is an issue that has given great concern to many scholars (Baronet, 1999). Studies (e.g., Schulz et al., 1997) indicate that the combination of prolonged distress and physical demands of caregivers may compromise their physiological functioning and increase their physical health problems. Evidence supporting this assertion shows that caregivers are less likely to engage in preventive health behaviours. In some other studies, caregivers are found to exhibit greater cardiovascular reactivity and slowing of wound healing.

Identity theory (Montgomery & Kosloski, 2000) maintain that caregivers' role emerge out of an existing role relationship, a familial role such as daughter, wife or husband. As the needs of the care recipient increase in quality and intensity over time, caregivers' stress develops as he/she places the needs of care recipients before his or

her own needs. Exchange theory (Homans, 1961) observe that caregivers' stress emerge when the caregiver believes that he or she does not receive reward that is commensurate to his or her care activities from the care recipient. The theory maintain that exchange relations that get too far out of balance may lead to unstable relationships that could have negative impact for both the caregiver and care recipient, such as stress, role strain, feelings of guilt, and feelings of dependency. In another quarter, Baronet (1999) observe that caregiving stress can be mediated by physical, psychological and environmental resources of caregivers. A number of studies have examined the role of social support on caregiving stress (e.g., Chang, Brecht, & Carter, 2001; Kaufman, Kosberg, Leeper, & Tang, 2010) and reveal that social support emerged as the greatest moderating factor in caregiver stress. Studies (e.g., Logsdon & Robinson, 2000) show that social support serves as a buffer against the negative effect that is associated with inpatient caregiving.

Caregiver's self-efficacy is another variable that has been studied in caregiving research as a potential moderator in the relationship between stressors and distress. Self-efficacy has a link with reduction in health risk behaviours, involvement in stress management and relaxation activities (Marquez-Gonzalez, Losada, Lopez, & Penacoba, 2009; Savundrana-yagam & Brintnall-Peterson, 2010).

Gender differences feature in reported stress among inpatient caregivers. Studies (e.g. Loscalzo, 2010) state that results from caregiving duties indicate that females report more stress than their male counterparts. The probable reason could be that men and women think differently and their expectations seem to be different. Men do not take caregiver's role the way women do so their coping strategies are different. Men seem to consider it more as a task, whereas women may take it more as a duty (Stommel, Collins, Given, & Given, 1999). Some other studies report no gender differences in caregiving stress (Baker, Robertson, & Connelly, 2010).

1.2. The present study

The purpose of this study is to investigate whether social support, self-efficacy and gender will significantly predict reported stress among inpatient caregivers. Research has been conducted in western cultures. There is paucity of literature on social support, self-efficacy and gender differences in caregiver stress. Given the inconsistent findings on gender differences reported stress among inpatient caregivers and based on the fact that most of the reviewed literatures are studies carried outside Africa/Nigerian context. We feel the need to contribute to African/Nigerian perspective in the existing literature of reported stress among inpatient caregivers using Nigerian samples. It is hypothesized that:

1. Social support will not significantly predict inpatient caregivers' stress.
2. Self- efficacy will not significantly predict inpatient caregivers' stress.

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