

Socio-Demographic Predictors of Perceived Burden of Care among Care Givers of Non-Mentally and Mentally Retarded Students in Ibadan, Nigeria

Olaseni Abayomi Oladele *Ph.D*

Department of Pure and Applied Psychology
Adekunle Ajasin University, Akungba, Nigeria
Tel: +234(0)8033539662
E-mail: contactolaseni@gmail.com

Okhakhume Aide Sylvester *Ph.D*

Department of Psychology
University of Ibadan, Ibadan, Nigeria
Tel: 234(0)8023708826
E-mail: okhasly2004@yahoo.com

Abstract

The care of mentally retarded children is often stressful experiences for family members, as the child grows up and disability becomes quite noticeable by others, parents face a very distressing predicament of social embarrassment and stigma, they require more attention and time while at the same time the need for special equipment, and medical care increases; implicating financial income and capability of the care providers. The aftermath effect on the care provider(s) most often is restrictive and disruptive to economic, social or emotional deficiency. The study examines the influence of socio-demographic variables on care burden of care providers of non-mentally and mentally retarded students in Ibadan metropolis. The study adopted cross sectional research design across types of job, social support, religion, ethnicity and age. A total number of 100 care providers participated in the study (50 care providers of non-mentally retarded students & 50 care providers of the mentally retarded students). The instruments that were used was Care Givers Burden Scale developed by Zarit et al (1980). The result of the study revealed that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) do not jointly predict burden of care among care providers of mentally retarded students in Ibadan metropolis. [$F(7,43)=1.722; p>.05$], but revealed that demographic variables jointly predict burden of care among care providers of non-mentally retarded students in Ibadan metropolis. [$F(7,43)=2.39; p<.05$], and finally revealed that social support had significant influence on burden of care among care providers of mentally retarded students in Ibadan metropolis [$t(98)= 11.13; P<.05$]. The study therefore concludes that demographic variables jointly predict burden of care among care providers of non-mentally retarded students not mentally retarded students. While social support was found to significantly influence burden of care among care providers of mentally retarded students in Ibadan metropolis.

Keywords: Demographic factors, Social support, Burden of care, Mentally retarded

I. Background

The birth and continuing care by parents of children with mental retardation experience high level of emotional, financial and physical stress (Byrne & Cunningham, 1985). There are multiple problems of having a mentally retarded child in the family. The problems are mainly related to the social ridicule and social stigma. As the child grows up and disability becomes quite noticeable by others, parents face a very distressing predicament of social embarrassment and stigma. This may lead to isolation of the child even within the family the child may be restricted from coming out when relatives and friends visit the house or may be left back at home when parent go out. Cernic and Greenberg (1985) found that the cumulative impact of daily parenting hassles and difficulty in dealing with children represent significant stressors that may subsequently affect parents and family conditioning. Consequently, parents of the retarded children have been viewed as being at risk for a variety of family life problems and emotional difficulties.



In addition, families often face increased financial burdens while children require special equipment, medical care, and programming and at the same time; family income may be reduced because caregiving responsibilities make it difficult for two parents to work outside the home. An added area of concern for some families is difficulty managing family relations (Featherstone, 1980). Roles within the family may need to be restructured and the resulting strain may manifest itself in family problems, including high rates of dissolution, divorce, family quarrelling and marital breakdown; establishing and maintain satisfying social networks (Kazak & Marvin, 1984). Relationships with professionals also may be source of added stress (Turnbull, 1986); establishing and maintain satisfying social networks (Kazak & Marvin, 1984). Relationships with professionals also may be a source of added stress (Turnbull, 1986) as parents face difficulties in their efforts to secure adequate services for their child or obtain information about their child's disability. Parents undergo chronic sorrow which is periodic in nature, precipitated by child's deviants from normal performance. The intensity of reaction was related to the particular developmental stage and the individual coping strengths of the family (Wilker et al; 1981). Feelings of depression are common, particularly when realization of the child's retardation is recent. Some mothers react to the retarded child as if he had died and manifest the typical grief reaction associated with the loss of a loved one.

Socio-demographic factors are found associated with the burden of caregiving across studies. The factors that tend to be consistently associated with higher levels of burden across studies include lower educational attainment in the caregivers (Zahid et al, 2010; Caqueo-Urizar et al, 2006), and poor social support (Ohaeri et al, 2001).

Care providers of children with developmental disabilities expressed a high level of overall burden, particularly in financial domains, greater subjective caregiver burden, increased disability – related costs; maternal factors such as being younger and having higher educational attainment; and less social support. Extra cost related to disabilities was the strongest predictor of increased caregiver burden and the social support can reduce the burden (Heykyung et al., 2009). As the child grows the families are trying to accept the child and one study also found that older caregivers mobilize their families to acquire and accept the child and experienced significantly less personal burden than others. It also concluded that younger caregivers are more predisposed toward seeking outside help and have higher expectations of the service system. Care providers of children with mental retardation adopt different types of coping strategies to overcome their problems. Denial, Rehearsal of outcome, finding a purpose and seeking emotional support were the commonly utilized coping styles by the mothers of mentally handicapped children.

Social support is broad term encompassing a variety of constructs, including support perceptions (perceived support) and receipt of supportive behaviours (received support). The recent studies report no difference between mothers and fathers in terms of their social isolation. Evidence exists that in some instances families of children without disabilities may have larger and less dense social networks than families of children who are disabled (Fredrich & Fredrich, 1981) both attributes indicative of less adequate support. Some studies found that the presence of social support significantly predicts the individual's ability to cope with stress and it was knowing that they are valued by others is an important psychological factor in helping them to forget the negative aspects of their lives, and thinking more positively about their environment. It also found that social support not only helps improve a person's well-being, it affects the immune system as well. Thus, it also a major factor in preventing negative symptoms such as depression and anxiety from developing (Corey, 2005). Studies found that both hardiness and social support were predictive of successful adaptation.

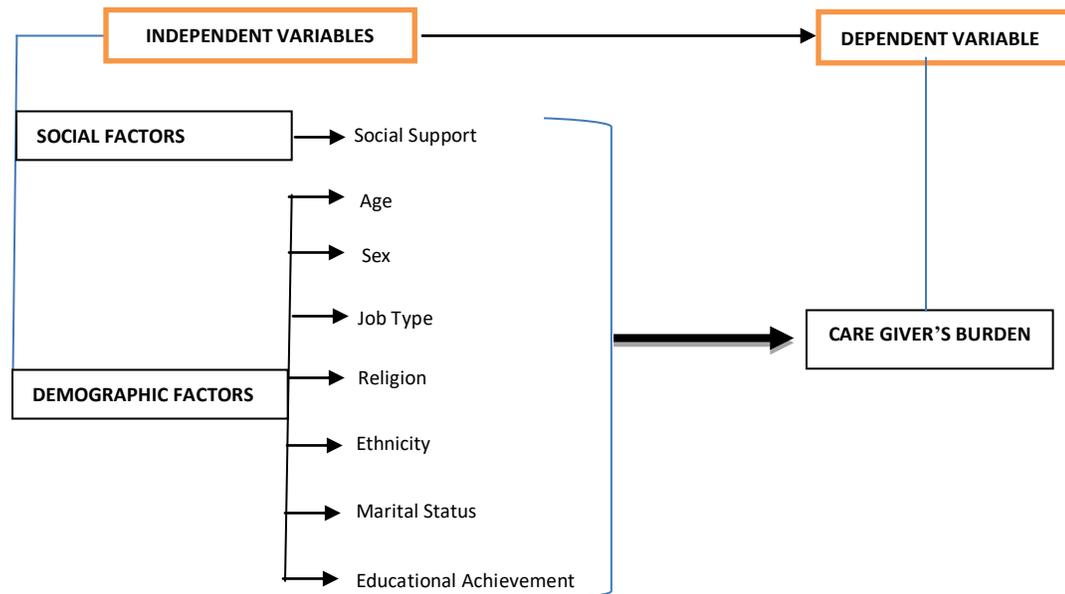
Reduction in the quality of care by the care givers can set in conditions of overdependence on the care providers by the mental retards can result into frustration and over-burdens which in turn will lead to transfer of aggression and confrontation. These conditions can affect the survival and existence of the mental retards. Another problem is the affections of the care providers on the mental retarded individuals. The way the care providers feels about their jobs and the mentally retarded goes a long way in either functioning well or be frustrated and transferring aggression on the mental retard who do not know or are aware of their dependence on the care givers. If the care givers are frustrated, the frustration can result to irrational thinking or behaviours which will determine the action and reaction of the care giver on the mental retards.

The quality of care enjoyed by the mentally retarded can be increase or decrease depending on the efficiency of social support the care givers enjoy.

2. Study Objectives

- To determine if age, sex, marital status, educational achievement, job type, religion, and ethnicity independently and jointly determine burden of care among care givers of non-mentally retarded students.
- To determine if age, sex, marital status, educational achievement, job type, religion, and ethnicity independently and jointly determine burden of care among care givers of mentally retarded students.
- To examine the influence of social support on burden of care among care givers of mentally retarded students.

3. Conceptual framework



4. Research Hypotheses

- To determine if age, sex, marital status, educational achievement, job type, religion, and ethnicity independently and jointly determine burden of care among care givers of non-mentally retarded students.
- To determine if age, sex, marital status, educational achievement, job type, religion, and ethnicity independently and jointly determine burden of care among care givers of mentally retarded students.
- To examine the influence of social support on burden of care among care givers of mentally retarded students.

5. Method

5.1 Design

The study adopted cross sectional research design. In essence to assess and integrates various areas and scopes to the research concepts; such as care providers of non-mentally retarded students and care providers of mentally retarded students, across types of job, religion, ethnicity and age. Data collection involves both quantitative methods in collection of information.

5.2 Sample and Sampling Size

A total number of 100 care providers participated in the study (50 care providers of non-mentally retarded students & 50 care providers of the mentally retarded students). The caregivers are drawn from three (3) schools for special students (Cheshire Home, Eleyele, United School, Ijokodo and Ijokodo School of the disabled) and three (3) schools for non-mentally retarded schools in Ibadan (Richmab International School, ring road, Sunshine Kiddies College, Okebola, and Mercy International School, Joyceb road ring road).

5.3 Instruments

The instruments that were used was Berlin Social Support Scale developed by Ralf Schwarzer & Ute Schulz and Care givers burden scale developed by Zarit et al (1980). The questionnaire comprised of the following sections;

The measurement of socio-demographic information of the participants involves; age, marital status, educational level, job type, religion and ethnicity. Sex was reported as male (A) and female (B); the age range of the participants were 25yrs to 50yrs, the marital status includes married, single, divorced, separated, and others to be specified; the educational level includes primary school certificate, SSCE, ND/NCE, BSC/HND, M.SC/MBA, and others to be specified; the job type includes nurse, doctor, teachers and others to be specified; the religion includes Christianity, Islam and others to be specified; the ethnicity included Yoruba, Igbo, Hausa, and others to be specified.

The caregivers burden scale is a likert format scale of 22 items of which the caregivers were made to respond to how they felt in general towards what they are going through because of their ward. The response format ranges from nearly always (4) to never (0).

The social support scale contained seventeen (17) items cutting across the aspects of the perceived emotional support of the caregivers, perceived instrumental support, need for support, and support seeking. The caregivers were made to think of persons close to them and to rate how the person has treated them in the past few week. It is based on a (4) Point likert scale. The responses ranges from (1) strongly agree (2) somewhat disagree (3) somewhat agree (4) strongly agree.

5.4 Procedure

Proposal was submitted to ethical committee of the schools for ethical approval to conduct the study with the target population. An introductory letter was drafted and distributed to the Heads of the respected schools and care providers of both mentally retarded students and non-mentally retarded students to introduce the researcher and research purpose. The questionnaire and informed consent was translated to Yoruba; for the sake of the participants in target schools who are illiterates therefore cannot read in English language. The questionnaires were then administered among the consenting participants only. Questionnaire was self-administered to over 100 care givers of both care givers of mentally retarded persons and normal persons. In addition, data collected will be analyzed using SPSS package version 17 for statistical sophistication.

5.5 Statistical Analysis

Hypotheses 1 and 2 were analyzed using standard Multiple regression analysis to examine how the demographic variables independently and dependently predict burden of care providers while, hypothesis 3 was analyzed using t-test of independent to compare differences between two groups on the dependent variable.

6. Results

The results of the analyses are presented in Tables 1, 2 and 3.

Hypothesis 1

Age, sex, marital status, educational achievement, job type, religion, and ethnicity will significantly and jointly determine burden of care among care givers of non-mentally retarded students in Ibadan.

Table I: Multiple Regression Analyses showing demographic variables as predictors of Burden of Care among care providers of Mentally Retarded Students in Ibadan.

Predictors	β	T	Sig.	R2	$\Delta R2$	F	P
Age	-.45	-.91	-.03*				
Sex	.02	.60	.56				
Marital status	.16	1.90	.17				
Education Achievement	.08	1.42	.17	.22	.09	1.72	> .05
Job Type	.04	-.03	.54				
Religion	-.02	-.13	.40				
Ethnicity	-.09	-.61	.50				

*Denotes significance at $p < 0.05$

The result in table 1 revealed that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) do not jointly predict burden of care among care providers of mentally retarded students in Ibadan metropolis. [$F(7,43) = 1.722; p > .05$]. However, the result of the independent prediction indicate that age independently predicts burden of care among care providers of mentally retarded students in Ibadan metropolis ($\beta = 0.45, t = -0.91, p < .05$), this implies that age independently accounted for about 45% variance in burden of care experienced by care providers of mentally retarded students in Ibadan metropolis. However, sex ($\beta = 0.03; p.ns$), marital status ($\beta = 0.16; p.ns$) education level ($\beta = 0.08; p.ns$), job type ($\beta = -0.04; p.ns$), religion ($\beta = -0.02; p.ns$) and ethnicity ($\beta = -0.09; p.ns$) did not significant and independent predict burden of care. Hypothesis one is therefore rejected.

Hypothesis 2

Age, sex, marital status, educational achievement, job type, religion, and ethnicity will significantly and jointly determine burden of care among care givers of mentally retarded students in Ibadan.

Table 2: Multiple Regression Analyses showing demographic variables as predictors of Burden of Care among care Providers of Non-mentally Retarded Students in Ibadan

Predictors	β	T	Sig.	R2	Δ R2	F	P
Age	-.01	-.05	.33				
Sex	-.14	-.99	.53				
Marital status	.45	2.91	.01				
Education Achievement	-.03	-.21	.14	.30*	.18*	2.39*	< .05
Job Type	.06	.41	.42				
Religion	-.18	-1.27	.43				
Ethnicity	-.04	-.30	.12				

*Denotes significance at $p < 0.05$

The result in table 2 revealed that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) jointly predict burden of care among care providers of non-mentally retarded students in Ibadan metropolis. [$F(7,43) = 2.39; p < .05$]. This implies that demographic variables of care providers of non-mentally retarded students jointly accounted for 30% variance observed by care providers of non-mentally retarded students in Ibadan metropolis. However, the results of the independent prediction indicate that marital status independently predicts burden of care among care providers of non-mentally retarded students in Ibadan metropolis. Marital status ($\beta = 0.45, t = 2.91, p < .05$), this implies that marital status independently accounted for about 45% variance observed in burden of care among care providers of non-mentally retarded students in Ibadan metropolis. However, age ($\beta = -0.01; p.ns$), sex ($\beta = -0.14; p.ns$), education level ($\beta = -0.03; p.ns$), job type ($\beta = 0.06; p.ns$), religion ($\beta = -0.18; p.ns$) and ethnicity ($\beta = -0.04; p.ns$) do not significant independent predict burden of care among care providers of non-mentally retarded students in Ibadan metropolis. Hypothesis two is therefore accepted

Hypothesis 3

Social support will have significant influence on burden of care among care providers of mentally retarded students in Ibadan.

Table 3: t-test of Independent showing the influence of Social Support on Burden of care among care providers of Mentally Retarded Students in Ibadan.

	Social Support	N	M	SD	df	T	p
Burden of care	Low	52	41.54	12.27	98	11.13	< .05
	High	45	16.09	09.89			

The results of the test as shown in table 3 indicated that social support had significant influence on burden of care among care providers of mentally retarded students in Ibadan metropolis [$t(98) = 11.13; P < .05$]. The result implies that there is significant difference in the social support of participants on the burden of care experienced by care providers of mentally retarded students in Ibadan metropolis sampled. However, care providers of mentally retarded students with low social support experienced more burden of care ($M = 41.54; SD = 12.27$) than care providers of mentally retarded students with high social support ($M = 16.09; SD = 09.89$). Hypothesis three is therefore accepted.

7. Discussion

The outcome of the study revealed that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) do not jointly predict burden of care among care providers of mentally retarded students in Ibadan metropolis. However, the result of the independent prediction indicate that age plays a significant roles in enabling burden of care among care providers of mentally retarded students in Ibadan metropolis, this implies that age independently accounted for about 45% variance in burden of care experienced by care providers of mentally retarded students in Ibadan metropolis, However, sex, marital status, education level, job type, religion and ethnicity did not play significant role predicting burden of care. The study was not in support with the findings of Zahid et al, (2010) that revealed that socio-demographic factors are strongly related the burden of caregiving.

The study further revealed that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) jointly predict burden of care among care providers of non-mentally retarded students in Ibadan metropolis. This implies that demographic variables of care providers of non-mentally retarded students jointly accounted for 30% variance



observed by care providers of non-mentally retarded students in Ibadan metropolis. However, the results of the independent prediction indicate that marital status independently plays significant role in the burden of care among care providers of non-mentally retarded students in Ibadan metropolis. However, age, sex, education level, job type, religion and ethnicity do not play significant role on burden of care experienced by care providers of non-mentally retarded students in Ibadan metropolis. The study was in support with the findings of Caqueo-Urizar et al. (2006) that revealed that socio-demographic factors are strongly related the burden of caregiving.

It shows that the social support programme has significant influence on the burden of care among care providers of retarded persons. This result is related to the study of Kennet, Burgio, & Schulz, (2000) that shows there is also a significant influence of social support on burden of care. The similar findings by Heykyung et al., (2009) conducted a study on Caregiver Burden and Social Support among Mothers Raising Children with Developmental Disabilities in South Korea. They found that respondents expressed a high level of overall burden, particularly in financial domains.

8. Conclusion

The study purpose was to examine the influence of socio-demographic variables on burden of care among non-mentally and mentally retarded students' care providers in Ibadan metropolis. The study therefore concludes that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) do not jointly predict burden of care among care providers of mentally retarded students in Ibadan metropolis, while it was also concluded that demographic variables (age, sex, marital status, education level, job type, religion and ethnicity) jointly predict burden of care among care providers of non-mentally retarded students in Ibadan metropolis. and finally, the study concluded that social support plays significant roles in either in alleviating or strengthening of burden of care among care providers. This implies that, care providers with high social support feel less burden of care than care providers with low social support.

9. Recommendation

The members of the family of the mentally retarded students and the community at large should take conscious steps and act to acknowledge that the quality and quantity of their social support does not only produce direct positive impact to the retarded but alleviate the burden of care of the care givers.

Schools and government are also call on to encourage the provision of social support package by funding provision of social facilities that can enhance the programme in order to boost the reduction of stress and burden of care givers and retarded individual and also enact policy that will lighten the workload of employees whom are car givers to mentally retarded children and adult.

10. Conflict of Interest

Authors declare no conflict of interest.

References

- Beckman, P. (1991). Comparison of mothers' and fathers' perceptions of the effect of young children with and without disabilities. *American Journal on Mental Retardation*, 95, 585-595.
- Byrne, E., & Cunningham, C. (1985). The effects of mentally handicapped children on families-a conceptual review. *Journal of Child Psychology and Psychiatry*, 26, 847-864.
- Caqueo-Urizar & J. Gutiérrez-Maldonado. (2006). Burden of care in families of patients with schizophrenia, *Quality of Life Research*, 15(4),719-724
- Corey M. Clark. (2005) "Relation between Social support and physical health". - Rochester Institute of Technology.
- Featherstone, H. (1980). A difference in the family: living with disabled child. New York, Basic Books.
- Friedrich, W., & Friedrich, N. (1981). Psychological assets of parents of handicapped and nonhandicapped children. *American Journal of Mental Deficiency*, 85, 551-553.
- Heykyung oh, et,al, (2009) care giver burden and social support among mother rising children with developmental disability in South Korea. *International Journal of disability, Development and Education*, 56, 149-167.
- Kazak, A.E., & Wilcox, B.L. (1984). The structure and function of social support networks in families with handicapped children. *American Journal of Community Psychology*, 12, 645-661.
- Mary E Hayden and Tamar Heller (1997) Support, Problem-Solving/Coping Ability, and Personal Burden of Younger and Older Caregivers of Adults with Mental Retardation. *Mental Retardation*,35(5),364-372.
- Mc Andrew, I. (1976). Children with a handicap and their families. *Child: Care, Health and Development*, 2, 213-237.
- Ohaeri, J.U.(2001). Caregiver burden and psychotic patients' perception of social support in a Nigerian setting," *Social Psychiatry and Psychiatric Epidemiology*, 36(2),86-93.



- Turnbull, A., Summers, J., & Brotherson, M. (1986). Family life cycle: Theoretical and empirical implications and future directions for families with mentally retarded members. In J. J. Gallagher & P. M. Vietze (Eds.), Families of handicapped persons: Research, programs, and policy issues. Baltimore: Paul H. Brookes
- Wikler L, Wason M and Halfied E. (1981) .Chronic Sorrow revisited. Parent vs Professional Deception of the adjustment of parents of mentally retarded children, *Americian Journal of orthopsychiatry*, 51-63.
- Zahid M.A., & J. U. (2010) .Ohaeri.Relationship of family caregiver burden with quality of care and psychopathology in a sample of Arab subjects with schizophrenia, *BMC Psychiatry*,10(71).

Copyrights

Copyright for this article is retained by the author(s), with first publication rights granted to the journal. This is an open-access article distributed under the terms and conditions of the Creative Commons Attribution license (<http://creativecommons.org/licenses/by/4.0/>).

