Original Article

STROKE'S EMOTIONAL AND SOCIAL INFLUENCE ON PATIENT-FAMILY CAREGIVER: A CASE STUDY OF UNIVERSITY OF PORT HARCOURT TEACHING HOSPITAL, CHOBA

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DOI: 10.47750/pnr.2022.13.S08.117

Abstract

The study sought to investigate stroke's emotional and social influence on patient-family caregiver: A case study of University of Port Harcourt Teaching Hospital, Choba. The study employed a descriptive survey method and a convenience sampling to select 298 participants. The questionnaire served as the instrument for data collection. Mean and standard deviation, as well as descriptive statistics, were used for the quantitative research to organize and assess the descriptive data, and simple regression was carried out when it was necessary to test the offered hypotheses. Findings reveals that all the isolated items recorded mean rating ranging from 3.46 to 3.87 which were above the cut-off mark of 2.50, thus, indicating that there is of emotion expressed by the affected towards stroke affluence caregivers. Also negative emotions expressed by affected patients is a significant conjecturer of stroke (F-value of the Analysis of Variance (ANOVA) obtained from the regression table was F = 102.165 and the sig. value of .000 (or p<.05). it was concluded that the level of turmoil experienced by the spouse was far more than that of the caretakers or the victims.

INTRODUCTION

Stroke has a considerable influence on the quality of life of victims and is one of the main causes of acquired disability in the majority of developed countries today [1]. One who has survived a stroke goes through a wide spectrum of emotions. After a stroke starts, bitterness, remorse, and grief are frequently stated sensations. Some patients express relief that the severity was not more severe; pride is inspired by their achievements in rehabilitation. One of the least expressed emotions is shame, despite the fact that doing so fosters social connections, helps individuals understand difficult events, and helps them learn from them. A stroke may result in long-term impairments of motor, sensory, and/or cognitive abilities depending on the part of the brain that was affected, but it is also linked to social changes [2].

Stroke sufferers may experience humiliation, personality changes, and changes in their connection with their partner, among other social and emotional repercussions (i.e. patient and main family caregiver).

Considering the perspectives of the patients and the family members providing care at home, two years after a stroke, on a professional level, an average of two out of every five stroke victims who were employed at the time of the occurrence were able to return to work; on a personal level, a stroke can have an impact on relationships with partners and children, including those involving sexual activity, as well as deteriorate family dynamics and reduce participation in social events [3, 4]

Since most stroke patients go back to their homes, their family caregivers, primarily their partners, also go through these social effects of stroke. These dependency workers [5] present a risk to the healthcare system as their level of exhaustion rises and their participation in cultural, social, and leisure activities declines [6, 7]. They are expected to provide complex care at home in addition to having new responsibilities (increased home tasks and duties, management of relationships with the professionals, etc.). In addition to their ongoing adaptability to the patient's restrictions, their job may isolate them socially. Therefore, it becomes difficult for public health and health policies to maintain their ability to be healthy when they themselves experience the effects of the stroke as the caregiver [8, 9].

It can be difficult to emphasize the agreement between patients and carers, but research on social harmony and mutual trust has shown that when stroke patients and the family members who care for them have similar views, the psychological well-being of the patients is higher. Positively perceived communication in relationships is typically linked to higher levels of partner satisfaction and supports better dyadic adjustment to a chronic disease [10]. However, social support appears to be rather unidirectional, favoring the patient. As a result, there is a need to look into the relationship between patients' and family caregivers' attitudes towards a situation that is commonly shared, such as the social repercussions of stroke. The patient-caregiver relationship should be viewed as a balance between giving and taking.

MATERIALS AND METHOD

This study employed a descriptive survey method that is focused on the current. Since the survey approach allowed for the description of the occurrences as they were happening at the time of the investigation in their natural habitat, it is believed to be acceptable for this study. The top tertiary medical facility in Rivers State is the University of Port Harcourt Teaching Hospital. However, it also offers primary and secondary care. As a result, the 180-bed Port Harcourt General Hospital became the new home of the University of Port Harcourt Teaching Hospital. Over 10,000 inpatients, over 400,000 outpatients, and more than 3000 procedures are performed annually at the University of Port Harcourt Teaching Hospital. The study's accessible population consists of all caregivers with family members who have experienced a stroke and have been hospitalized at UPTH for a minimum of a year previous to the study.

Inclusion Criteria

Participants who fit the following criteria were included in the study:

- Participants must be between the ages of 20 and 49,
- Must have relatives afflicted with stroke.
- They must also be in good physical and mental health.
- Participants must also agree to take part in the study.

Exclusion Criteria

Participant who voluntarily opt out of this study include those who:

- Have had relatives hospitalized for less than a year as of the research's start date;
- Relatives are younger than 20 years old or older than 49 years old
- Are not in good mental and physical health
- Are unwilling to participate in the study.

Sample and Sample Size Determination

Using Taro Yemen's sample size calculation formula, the sample size was established. The equation is as follows;

$$n = \frac{N}{1 + N(e)^2}$$

Where n = the required sample size

N = population size (821)

d = level of precision (0.05)

$$= \frac{821}{1 + 821\,(0.05)^2}$$

$$= 269$$

Adding 10% attrition to compensate for non-response, the sample size was increase by 10%.

$$\text{Hence} \quad n = \frac{269}{1 - 0.10}$$

$$= 298$$

The 298 caregivers were selected for this study from a pool of possible participants using the convenience sampling approach. Only being accessible and willing to participate in the study is the only need for the convenience sample. Face and content validity were used to validate the data gathering tool. The instrument's dependability was assessed using the Cronbach coefficient reliability estimate. Mean and standard deviation, as well as descriptive statistics, were used for the quantitative research to organize and assess the descriptive data, and simple regression was carried out when it was necessary to test the offered hypotheses.

Ethical Consideration

Prior to collecting data, a letter of consent from the Chief Medical Director of Nursing at the University of Port Harcourt Teaching Hospital was obtained. Potential volunteers were verbally briefed on the study in straightforward terms, and those who were interested verbally agreed to participate. Participants in the study were given assurances of their anonymity and confidentiality, as well as details on their right to discontinue participation at any time. Taking part in the trial had no immediate benefits.

RESULTS

Table 2: Response of the Respondents on the Emotional Influence of Stroke

	Emotional influence	Mean	SD	Remark
1	Embarrassed to see friends	3.7340	.44231	Significant
2	Mood swing	3.8000	.40040	Significant
3	Cognitive dissonance	3.8680	.33883	Significant
4	Character Changed	3.4680	.61785	Significant
5	Feeling denigrated	3.8680	.33883	Significant
6	Forgetfulness	3.4680	.61785	Significant

Source field 2022

Table 2 presents the mean ratings of the extent on how emotions expressed by the affected towards stroke affluence caregivers. All the isolated items recorded mean rating ranging from 3.46 to 3.87 which were above the cut-off mark of 2.50, thus, indicating that there is of emotion expressed by the affected towards stroke affluence caregivers. The standard deviation ranged from 0.33 to 0.62 which revealed that respondents were not too far from the mean and each other in their responses.

Table 3: Response of the respondents of social impact on stroke

	Social impact	Mean	SD	Remark
1	Changes within the family	3.7340	.44231	Significant
2	Changes within the couple	3.8000	.40040	Significant
3	Distance when parenting	3.8680	.33883	Significant
4	Sentiment of sympathy	3.4680	.61785	Significant
5	Family unity is strong	3.8680	.33883	Significant
6	Friendships are lost	3.4680	.61785	Significant

Source field 2022

Table 3 presents the mean ratings of the extent to which social influence impact on stroke towards family caregiver. All the isolated items recorded mean rating ranging from 3.46 to 3.87 which were above the cut-off mark of 2.50, thus, indicating that there is an influence of stroke on social impact towards caregivers. The standard deviation ranged from 0.34 to 0.62 which revealed that respondents were not too far from the mean and each other in their responses.

Table 4: Simple regression result of emotions expressed by the affected towards stroke affluence caregivers

Model	**R**	**R. square**	**Adjusted R. square**	**Std error of the estimate**	
1	.332(a)	.111	.109	2.94359	
Model	Sum of square	df	Mean square	F	p-value
Regression	885.233	1	885.233	102.165*	.000(a)
Residual	7122.387	370	8.665		
Total	8007.620	371			
Variables	Unstandardized regression weight B	Standardized regression weight	Beta weight	t	p-value
(Constant)	21.547	1.446		14.899	.000
Emotional influence on stroke	.792	.078	.332	10.108	.000

* Significant at .05 level.

The simple regression analysis of the emotions expressed by the affected towards stroke affluence caregivers produced an adjusted R^2 of .109. This indicate that the emotions expressed by affected patients account for 10.9% of the determinant of stroke in the study area. This finding is a critical indication that emotions expressed by caregivers are relatively high in the area of the study. The F-value of the Analysis of Variance (ANOVA) obtained from the regression table was F = 102.165 and the sig. value of .000 (or $p<.05$) at the degree of freedom (df) 1 and 370. The implication of this result is that negative emotions expressed by affected patients is a significant conjecturer of stroke.

DISCUSSION OF FINDINGS

Family caregivers were more concerned with couple strife than patients. Similar to this, family caregivers noticed a change in the personalities of their stroke-affected relatives. Being a family caregiver can be perceived as a biographical disruption that may impair one's sense of coherence and, as a result, alter one's health behaviors, according to our study, which demonstrates that family caregivers, more so than patients, experience their relationship with the other as discontinuous compared to the pre-stroke period [11]. When individual and dyadic tactics were analyzed for distortions, it was found that the caregiver provided the ill person with greater social support than the other way around [12]. Our results would suggest that the caregivers are working hard to help stroke survivors lead normal lives.

Another way to interpret our findings is that patients' relationships with their partners aren't a top priority for them because they already have to deal with functional impairments (especially in the motor dimension), a decline in quality of life, socioeconomic issues, and the worry of having another stroke [13]. Our research also demonstrates that it can be challenging for certain family caregivers to identify negative affect in stroke patients, particularly when the stroke survivors have language limitations. One of the least common emotions is shame, according to research [14]. Shame can be induced in the context of chronic illness by moralizing medical personnel or the pressure of social standards. In the latter state, as observed by patients with Parkinson's disease or lung cancer, shame is a reaction to a social vulnerability to stigma [15,16]. Some affected patients may conceal their poor affect in public in order to preserve their self-esteem and prevent their caregivers from having to shoulder additional social support duties. The prevalence of contradictory viewpoints demonstrates that shame is an intimate emotion, but it also raises the possibility that some stroke survivors experience stigmatization of their disability. However, further research is required to determine whether or not keeping this emotion to yourself is actually good for their welfare and whether it reflects how well-relationships with partners are doing.

CONCLUSION

The level of turmoil experienced by the spouse was far more than that of the caretakers or the victims. To combat any potential social exclusion caused on by the stroke, they must cooperate. Inadequate responses to the needs of survivors may result from caregivers' failure to recognize negative feelings experienced by patients, such as humiliation and a sense of being undervalued. A thorough analysis might provide techniques for enhancing family members' interaction, supporting each person's capacity for health.

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