



SELF-ESTEEM, OPTIMISM AND BURDEN OF CARE AMONG RELATIVES OF CARDIOVASCULAR DISEASE PATIENTS IN SELECTED TERTIARY HOSPITALS IN SOUTHWEST, NIGERIA

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ABSTRACT

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Providing informal care, particularly for a person needing assistance for daily activities as a result of chronic illness such as cardiovascular disease (CVD), is a demanding task which requires time, dedication and preservation. In spite of burdens that caregivers of CDV patients are faced with, there are dearth of studies that have explored the level of the burden of care among relatives of CVD in Nigeria. This study addresses this gap by raising the question: to what extent does care for CVD patients affect caregiver's psychological, behavioral and physiological daily lives. The study was a cross-sectional survey and it adopted the purposive sampling technique. Primary data were sourced from 200 caregivers/relatives from three tertiary hospital: Federal Teaching Hospital Ido-Ekiti, Federal Medical Centre Owo and Obafemi Awolowo Teaching Hospital Complex Ile-Ife. The outcome variable is caregiver's burden, and the key explanatory variables are self-esteem and optimism. The Zarit (ZBIS), Rosenberg Self Esteem and Revised Life Orientation Test (LOT-R) standardised psychological scales were employed to measure caregiver's burden, self-esteem and optimism. Pearson r was applied using Stata version 13. Results showed that a significant proportion of the caregivers experienced moderate to severe levels of burden. Also, results showed that caregivers' burden was not significantly associated with Self-esteem ($r_{200} = 0.04, p >.025$) and optimism ($r_{200} = 0.07, p >.025$). It was imperative to provide professional help and supportive counselling to caregivers of CVD patients, in order to reduce their burden, strengthen the coping skill and thus improve their quality of life.

Contribution/Originality: The paper's primary contribution is that it documents empirical findings that are useful for research, clinical practice and counselling; as such document provides insights on the experience of these informal caregivers are strategies for valuable intervention programmes to reduce the burden among relatives of cardiovascular disease patients.

1. INTRODUCTION

Burden of care are the experiences of caregivers of people who cannot for one reason or the other care for themselves. These experiences are traumatic in nature and subsist inform of shame, resentment, irritation, culpability, loneliness, stress, unhappiness in marriage, anxiety, depression, a retarded social life, repeated loss of self-esteem and dissatisfaction with life. In essence, caring becomes a burden and weigh down on caregivers because it poses multidimensional exertion ranging from social, physical emotional, financial and other health problems

emanating from caring for others. It entails a momentous investment of energy and obnoxious tasks that are very hectic. Caregivers' burden can be defined as emotional, social, financial or physical investment as well as psychological experiences in relation to the changes and demands that emanate from rendering help and support to another person who is incapable of caring for him or herself by virtue of frailty or disability [1]. Caregivers' burden refers to the negative feelings and consequent sprain experienced as an outcome of caring for a chronically ill person [2-4].

Therefore, burden of care can be simply seen as a product of a series of stressors. Caregivers are at a greater health risk than the care receivers because when the caregivers dedicate themselves to the desires of someone else, they tend to overlook their own needs [5]. They may not know or may overlook the signs of ill health, fatigue or despair that they are experiencing. Pressure may negatively impact on the physical health of the caregiver or cause the caregiver to be physically or verbally hostile towards the care receiver [5]. Caregiving has been observed to excite emotional suffering and to have undesirable cost on the quality of life of the caregivers [6]. Mutilation in physical health status, interference in social and leisure activities, interruption in family and connubial relationships and a decline in socio-economic status have been reported [6].

It is also important to note that self-esteem is also a factor to be considered when considering motivation of care givers. People with low self-esteem may tend to be wavy and most times are pessimistic about the recuperation of their patients; therefore, they lose motivation with time and are worn out, especially when the burden is very demanding. On the other hand, a care giver with high self-esteem may stay on with their patients no matter how great the burden is since there is no self-actualization or accomplishment to them if they never stayed.

1.1. Literature Review

Providing care to someone especially a cardiovascular patient whether full time, part time, formal, informal or long distance takes a huge toll, both physically and emotionally. Few people are ready for the responsibilities and tasks involved in caring for this patient because of the stress involved in it [5]. Caregivers provide many kinds of help to the care receivers ranging from assistance with shopping to helping with daily tasks such as bathing, dressing, feeding, lifting, turning him or her in bed, cooking, paying of bills, running errands, giving medicine, keeping him or her company, providing emotional support and so many other things. All these help rendered by caregivers can be time consuming and emotionally, physically and psychologically strenuous [7]. This then contributes a lot of stress on the caregivers. The literature suggests that caregiving produces great amounts of caregiver burden and stress [7]. When stress builds up it can result in poor health and dejection of the caregiver [8].

Burden is all encompassing and usually described as objective or subjective [9]. The objective burden is viewed as tangible factors that are seen to bring the family life into commotion. It includes an economic constraint on caregivers, loss of time and potential for earning, family disagreement, disruption of daily routine and social life abnormal behaviour and interruption of the well-being of the other family members [9]. Subjective burden refers to psychological and emotional impacts as well as the extent to which caregivers see their task as demanding [10]. In particular, actions that may create a risk to caregivers safety increases subjective burden such as hostility or aggression, demolition of possessions and substance abuse [11]. It is subjective burden that describes the psychological reactions such as unhappiness, nervousness, the stress of coping with disturbing behaviours and the frustration caused by changing relationships [12, 13]. Certainly, caring on its own comes with a whole lot of challenges and occasionally distress which affects caregiving and also negatively impacts the overall physical health of caregivers.

Caregivers begin to feel at fault about all things they are not able to do for patients and responding to this, they start again giving more than they should just to know if they could cause change [5]. Guilt, therefore, may be a fundamental attribute of the caregiving experience. Scholars have found that guilt was positively allied with the

burden of stress and that it accounted for a momentous amount of the difference in caregiver's sense of burden even after contextual and stressor variables were controlled [14]. Frustration, though a usual and valid emotional reaction, is one of the feelings that could arise as a result of being a caregiver to cardiovascular patients [14]. This arises out of trying to change an unmanageable condition in taking care of this patient, especially those with stroke or other kinds of a cerebrovascular impediment. It has been reported that caregivers who are home bound tend to be secluded from usual daily contacts. Loneliness may lead to dejection and worry, which in turn increase emanating stress [5, 14].

Cardiovascular disease (CVD) is the umbrella name for a group of diseases of the heart and blood vessels. It's a prevalent disease that cut across all ages. It is a chronic and terminal disease that kills fast when not taken care of properly and promptly [15]. It is the main root of disability and untimely demise all over the world and contributes significantly to the increase in health care cost [15]. Globally, cardiovascular disease burden accounts for 17 million deaths of which 12.75 million is from developing countries [16]. The causal pathology is atherosclerosis, which develops over many years and is usually advanced by the time symptoms occur, generally in middle age. Of a projected 58 million deaths globally from all causes in 2005, cardiovascular disease (CVD) accounted for 30%. This ratio is equivalent to that due to communicable diseases, dietary deficiencies, and maternal and prenatal conditions combined [17]. It is important to know that a significant amount of these deaths (46%) were of people under 70 years of age, in the more productive period of life; in addition, 79% of the disease burden attributed to cardiovascular disease is in this age group [17]. In developing countries, including Nigerian almost half the disease burden is already due to non-communicable diseases of which cardiovascular disease is leading killer with shorter life expectancy [17].

It is, however, saddening that the resources to care for this ill health conditions are derisory in countries like Nigeria. In such situation, caregivers such as family member are often propelled to provide care for the cardiovascular disease patients [7]. Caregivers could be informal (family members) and formal caregivers (professionals). Informal caregivers are viewed as any relative, friend or partner who has a major bond with and provide assistance (emotional and physical) to the patients with a life threatening, incurable illness [7, 14]. A relative can be someone's cousin, nephew, niece, brother, sister, step-father, step-mother and so on and so forth. They are members of the nuclear and extended families who are responsible also for the wellbeing of their various family members. A relative is a person connected by blood or marriage, which is a person or a species, as the case may be, related to another person by common origin. While formal caregivers are doctors, nurses and medical personnel trained to care for ill or sick persons [8, 18].

In the context of the study, self-esteem is viewed as caregivers evaluation of their own self-worth [19]. This general definition can be called one's global self-esteem, considering all internal and external factors. Internal factors refer to emotions, heritable makeup and personality traits, while external factors refer to specific events, family, career and so on. However, that definition covers a few different types of self-esteem. Trait self-esteem is a number of regard individuals have for themselves through time [19]. This type of self-esteem tends to be dominant over a life span [19] which is why some refer to this trait self-esteem as part of one's personality. Another type of self-esteem is state self-esteem. This has to do with how one is feeling about himself or herself at a certain point in time. There also exist more specific types of self-esteem such as academic self-esteem, where one's feeling of self-worth is somewhat contingent upon how well one does academically Driscoll [19]. Emil [20] states that generally self-esteem is formed and altered through a person's beliefs and awareness of their thoughts, feelings, and behaviours.

Optimism refers to caregiver personal, social, intellectual, emotional and physical growth, development and the way in which these dimensions relate to each other and express themselves in everyday life. Optimism is the study of oneself in respect to others and to society. Optimism is an aspect of personality, which can be viewed in two perspectives: dispositional optimism and pessimism. Carver and Scheier [21] illustrated dispositional optimism and

pessimism as generalized outcome expectancies of good against bad outcomes in one's life. However, people identified as optimists have a propensity to imagine good or acceptable outcomes in the future, while those at the other end of the spectrum, pessimists expect bad or unacceptable outcomes or experiences [21, 22]. The optimist does not shy away from the realities of life [troubles, sickness, death, and so on], but views them in the best possible light. Optimism is considered a measure of people's attitude and approach toward life and the way they perceive their life after a cardiac diagnosis of a relative. Cowan [23] describes it as the way individuals 'perceive and attend to obstacles within the context of their lives'.

These definitions arise from a more general model of self-regulation of behaviour that presume peoples' actions are greatly influenced by their beliefs about the possibility of those actions. Expectancies are seen as a major factor affecting the two classes of behaviour: continued striving versus giving up. Accordingly, individuals with positive expectations for the future had the mindset that good thing will occur in their lives and tend to see desired outcomes as attainable and to persist in their goal-directed efforts. In disparity, individuals with negative outcome expectations are assumed to expect bad things to happen and tend to withdraw effort more easily, become passive and in the end may give up in achieving their set goals Carver and Scheier [21]. Carver and Scheier [21] also suggests that outcome expectancies ordinarily are the best indicators of behaviour, rather than the basis from which the expectancies are derived. In a nutshell, it is not imperative why people anticipate good things to ensue in their lives [for example being favoured by God, having good luck]; what is significant is the universal optimistic or pessimistic orientation itself [8, 18]. It is to be anticipated that the optimistic caregivers would persist to believe that care giving to their cardiovascular patient relatives will result in improvements in their state regardless of current challenges and frustrations.

1.2. Statement of Problem

This study was inspired by the experiences of a relative whose father was a heart failure patient stuck to the hospital bed for several months. Caring for this man became a lot of burden for this cousin to the extent that this researcher had to leave his work most of the time to assist and give support. It was an ugly and unpleasant experience because it affected the totality of his wellbeing.

Moreover, the upsurge in cardiovascular disease has made caregiving for victims a big and huge burden. In the attempt to manage people and patients living with this disease, relatives (caregivers) experience physical, emotional, financial and psychological burdens. Those experiences are correlated with psychosocial factors which include self-esteem and optimism

Furthermore, caregivers burden as a multidimensional concept and reaction remain understudied and to date, there are few recorded studies on the psychological correlates of the burden of care experienced by relatives of cardiovascular patients. This study, therefore, addresses the gap in knowledge and intended at exploring factors relating to the level of caregivers burden among relatives of cardiovascular disease patients in Southwestern Nigeria.

Although there have been studies on caregivers' burden of such conditions as dementia, cancer patients, alzheimer, diabetes, stroke survivors and schizophrenia patients in Nigeria [2, 4, 5, 7, 11, 14, 24, 25] few have been carried out on the burden of caring for cardiovascular patients. Also, not much attention had been focused on caregivers' burden of relatives of cardiovascular disease patients. The few studies [1, 8, 10, 13] were conducted in other countries with little or none from Nigeria, hence; this study.

This study addressed the level of burden of care among relatives of cardiovascular patients in southwest Nigeria, also is there any relationship between self-esteem and the burden of care among relatives of cardiovascular patients and finally is there any relationship between optimism and the burden of care among relative's cardiovascular patients?

1.3. Objectives of the Study

The broad objective of study is to assess the burden of care among relatives of cardiovascular patients in South West Nigeria.

The specific objectives of the research are to:

- i. Ascertain the level of burden of care among relatives of cardiovascular patients ;
- ii. Assesse the relationship between self-esteem and caregiver's burden; and
- iii. Determine the relationship between optimism and caregivers' burden.

2. METHOD

2.1. Research Design, Sample Size and Data Collection

This study adopted cross-sectional descriptive survey design. This was because the study used questionnaire in collecting data on all variables under investigation from different age groups at the same time. The study population consisted of relatives of cardiovascular patients who came to stay and help cardiovascular patients at the hospitals/wards of the selected hospitals during the data collection phase of the study. The study adopted the purposive sampling technique in the eliciting of primarily sourced data from 200 caregivers/relatives who had come to the three selected tertiary hospitals - Federal Teaching Hospital (FTH) Ido-Ekiti, Ekiti State, Federal Medical Center (FMC) Owo, Ondo State and Obafemi Awolowo University Teaching Hospital Complex (OAUTHC) Ile-Ife, Osun State through the administering of questionnaire. The unit of analysis in this study was a relative of the cardiovascular patient at the selected health facility who freely consented to be included in the study while a non-consenting relative was excluded from the study. Data was collected from November 2018 through February 2019. A total number of 105 respondents were selected for the study in OAUTHC, Ile-Ife, Osun State, 55 respondents were all selected for inclusion in the study in FMC, Owo, Ondo State and 51 respondents was selected in FTH Ido-Ekiti, Ekiti State for the study. Altogether the total respondents equal 211 which was used as the sample for the study. However, despite all effort made, there was still cases of loss of data due to defacing, incomplete filling of the questionnaires and refusal to return the questionnaire on time; this led to the loss of 11 out of the initial sample slated for analysis making it 200 questionnaires available for analysis.

2.2. Research Variables

The outcome variable in the study was caregiver's burden. The explanatory variables in the study were self-esteem and optimism. Optimism was measured with the revised version of Life Orientation Test (LOT-R) which consists of 10 variables. The LOT-R was developed by [Scheier and Carver \[22\]](#). The items were framed in the form of short sentences and the respondents were to indicate their responses on a 5-point Likert-type scale. Items 1, 3, 4, 7, 9 and 10 measured personal disposition, while the remaining four (4) items (2, 5, 6, and 8) were filler items. Each of these variables carries the 5-point Likert-type that will be scored from one [0] = strongly agree to five [4] = strongly disagree to obtain a total optimism score. This total score could range from zero (0) to 40. The higher the score, the more optimistic the respondent. Items 1, 4 and 10 measured more specifically optimism while variables 3, 7 and 9 measured pessimism. The LOT-R measure has been widely used in health research. Self-esteem scale was measured by the [Rosenberg \[26\]](#) Self-Esteem Scale [RSES]. The RSES consisted of 10 items. The items were framed in the sentence format and respondents were asked to indicate their answer on a 4-point Likert - type scale. The response was scored from the most positive item-strongly agree=1 to the most negative item-strongly disagree=4. Items scored were added together across all the 10 items to obtain a global self-esteem score. This global self-esteem score could range from 13 to 33. The lower this total score is, the higher the self-esteem of the respondent. The RSES is a widely used self-report instrument for evaluating individual self-esteem.

2.3. Data Analysis

The collected data were sorted, cleaned using the SPSS version 20. Two levels of analysis were carried. The first level was carried out using the appropriate descriptive statistics (percentage frequency distribution and derivation of mean and standard deviation scores for count variables). The second level of analysis involved the test for the relationship between the dependent variables and key independent variables of the study using the Pearson Product Moment Correlation. The confidence level for this study was fixed at 95%. Therefore, the results of the study if found to be < 0.05 was considered to be significantly associated.

3. RESULTS

3.1. Socio-Demographic Information of the Respondents

Socio-demographic data was collected using a questionnaire consisting of four (4) Socio-demographic information was collected using a questionnaire consisting sex, the degree of relatedness, age and level of education. Responses to these items were used to describe the participants in the study.

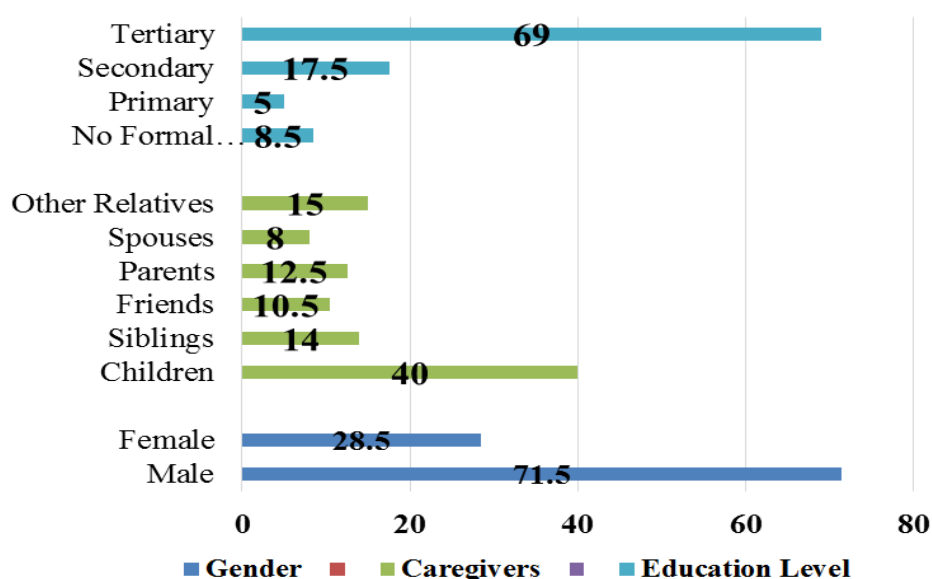


Figure-1. Percentage distribution of respondents by socio-demographic characteristics.
Source: Author's field survey report, 2019

The final sample consisted of (71.5%) male and (28.5%) female relatives of cardiovascular. The age of this sample range between 16 to 67 years with a mean of 34.27 years and a standard deviation of 11.48 years. The caregivers were majorly children (40%), other relatives (15%) and siblings (14%) of the patients. Others were parents (12.5%), concerned other, mostly friends (10.5%) and spouses (8 %) of the patients. The majority of the relatives were highly educated as 69% had attained tertiary education as at the time of the study. 17.5% had secondary education, 8.5% had no formal education and 5% had primary education [Figure 1](#).

3.1.1. Analysis of Objective One

The objective was to ascertain the level of burden of care among relatives of cardiovascular patients in southwest, Nigeria. To achieve this, the mean and standard deviations of scores of respondents on the burden of care were calculated. The mean was approximately a score of 37.50 and the standard deviation was approximately 15.89. The statistics one standard deviation above and below the mean (the mean $\times \pm 1$ SD) was then used to determine the upper and lower cut-off points. These were found to be $37.05 + 15.89 = 52.94$ (approximated to a score of 53) and $37.05 - 15.89 = 21.16$ (approximated to a score of 21). These cut-off points were used to categorize

the respondents into groups based on the severity of burden experienced. The results of this analysis are presented in Table 1 together with the original categorization by authors of the ZBIS.

Table-1. Categories of Respondents by Levels of the Severity of Burden.

Category	Own Score Range	Authors' Score Range	Frequency	Percent
No or Minimal Burden	4 - 21	0 - 20	29	14.50
Mild to Moderate Burden	22 - 40	21 - 40	98	49.00
Moderate to Severe Burden	41 - 60	41 - 60	54	27.00
Severe Burden	61- 87	61 - 88	19	9.50
Total			200	100.00

Source: Author's field survey report, 2019.

The results presented in the Table 1 above show that the categories found in this study were very similar to the original. This in part validates the findings reported below. Table 1 also shows that the frequencies and percentages of respondents in the categories of caregivers' burden. The results revealed that the majority (98 or 49%) of relatives were experiencing mild to moderate levels of burden of care, 54(27%) were experiencing moderate to severe burden, 29(14.5%) were experiencing no or minimal levels of burden and 19(9.5%) were experiencing severe burden. Overall, the results show that 73(36.5%) of the caregivers in this study were experiencing moderate to the severe burden.

3.1.2. Hypothesis Testing

The two hypotheses proposed to guide this study were directional and in the form of relationships. These were all therefore tested with one-tailed Pearson Product Moment Correlation [Pearson r]. The results of this analysis were presented in Table 2:

Table-2. Correlation between Self-esteem, Optimism and Burden of care.

Variables	Self-Esteem	Optimism	Burden of care
Self-Esteem			
Optimism	-0.24**		
Social Support	0.12*	0.19**	
Burden Of Care	-0.04	0.07	

** Correlation is significant at the .01 level (1-tailed).

*Correlation is significant at the .01 level (1-tailed).

3.1.3. Hypothesis One (Objective Two)

This hypothesis stated that there will be a significant positive relationship between self-esteem and the burden of care. The hypothesis was tested with the results of the correlation presented in Table 1. The results of the analysis of data revealed that there was no statistically significant correlation between Self-esteem and the burden of care ($r_{200} = 0.04$, $p > .025$). This finding suggests that the relationship between self-esteem and burden of care, though insignificant may be a negative one. The hypothesis is therefore rejected. The alternative hypothesis that there is no significant positive relationship between self-esteem and the burden of care is accepted.

3.1.4. Hypothesis Two (Objective Three)

This hypothesis stated that there will be a significant positive relationship between optimism and the burden of care. The hypothesis was also tested with the results of the correlation presented in Table 2. The results of data analysis revealed that there is no statistically significant correlation between optimism and the burden of care ($r_{200} = 0.07$, $p > .025$). This finding suggest that through the relationship between optimism and the burden of care is in the positive direction, it is so low as to fail to reach conventional levels of significance. The hypothesis is therefore rejected. The alternative hypothesis that there is no significant positive relationship between optimism and the burden of care is accepted.

4. DISCUSSION

The first finding showed that majority of the caregivers in this study experienced moderate to severe levels of burden as revealed in the study. Findings show that the various choices need the services of the clinical/health psychologist. Invariably, this means that the severe burden with a frequency of 19% adding up to a cumulative percentage of 9.5 is at the chronic and pathology cases/level while the other at 27.0% level seriously needs the attention clinical psychologist and psychotherapist to moderate the situation. The findings corroborate the assertion made in the literature that caregiving stimulate emotional pain and have undesirable consequence on the worth of life of caregivers. It's also results to frustration in physical health status, interruption in social and relaxation activities, intrusion in family and connubial relationships and a downturn in socio-economic class as reported [6]. It then supports the report of Okoye and Asa [5] that indicated that caregivers who are home bound tend to be discouraged and lonely from usual daily friends. Isolation which may lead to depression and anxiety, which in turn increase emanating stress and make caregiving more severe as found in the current study.

Severe level of burden as revealed in the study can lead to stress, frustration, fatigue, economic restriction on caregivers, loss of time and good standard living, family conflict, interruption of daily practice and social life abnormal behaviour, interference of the wellness of other family members and can also cause caregivers to physically or aggressively respond toward care receivers in cases of persistent caregiving [18]. The literature suggests that caregiving produces huge amounts of caregiver burden and pressure. When stress builds up it can result in poor health and depression of the caregiver [5].

The findings also assessed the relationship between self-esteem and burden of care among relatives of cardiovascular patients in selected tertiary hospitals in south western Nigeria. The finding shows that there was no significant relationship between self-esteem and caregiver' burden among relatives of cardiovascular patients included in the study. This result did not line up with the previous finding that self-esteem is seen as an important factor for helping persons deal with life stressor. It fails to support self-esteem as a subjective and enduring sense of realistic self-approval that reflects individuals view and values of the self at the most fundamental levels of psychological experiences [20, 25].

The findings also failed to agree with the findings that showed that self-esteem has a direct influence on the sense of personal value and the height of contentment towards one's self as a factor for caregiving [20]. He identified self-esteem as a function of identity development that results from successfully addressing the tasks associated with each of the developmental stages of life. Thus one's sense of developing, growing, and confronting lives tasks leads to feelings of worth. To him, one with healthy personality actively masters his/her environments showing a certain unity of personality and can perceive the world and himself/herself in a correct way. Self-esteem has been used to identify the almost universally accepted components of self-value. They are a cognitive element, or the characterizing of self in descriptive terms [for example, power and confidence]; an effective element or a degree of positiveness or negativeness [as in high or low self-esteem]; an evaluative element related to some ideal standard [that is, what a high school graduate should be able to do] [20].

The finding also contradicts the finding of Driscoll [19] that considered self-esteem to be closely associated with one's sense of self-worth with inexhaustible relation to burden of care and also disagree with the general definition that can be called one's global self-esteem, considering all internal and external factors. Internal factors refer to emotions, genetic makeup and personality traits, while external factors refer to specific events, family, career and so on Driscoll [19]. Valizadeh, et al. [27] for example also found that self-esteem is the affective or emotional experience of the evaluations one makes in the frame of one's personal worth in caring for cardiovascular patients. He asserted that self-esteem is an important factor for helping persons deal with life stressors and proffers life changing results that will affect caregiving which is an outcome of caregivers' burden.

This finding, however, supported the finding of Baumeister, et al. [18] that self-esteem did not have a significant influence on the stressful life events of caregivers' experience among relatives of cardiovascular patients

which disagreed with other related findings. This may be due to the fact these experiences are traumatic in nature and subsists inform of shame, resentment, irritation, culpability, loneliness, strain, discontentment in marriage, anxiety, dejection, a decreased social life, incessant loss of self-value constantly and displeasure with life and also may lead to a diminished state of their self-worth which is actually important and germane in life as a whole.

Finally, the findings determined the relationship between optimism and burden of care among relatives of cardiovascular patients in selected tertiary hospitals in southwestern, Nigeria. The results however showed that there was no statistically significant correlation between optimism and burden of care among relatives of cardiovascular patients included in the study. Further findings showed that though the relationship between optimism and burden of care was in the positive direction, it could not meet up with the conventional level of significance; therefore the hypothesis was invariably rejected. This findings contradicts with previous findings that see optimism as caregiver personal, social, intellectual, emotional and physical growth, development and the way in which these dimensions relates to each other and express themselves in everyday life. This is not in line with assertions from literatures that optimism in the study is the study of oneself in relation to others and to society, that is it's an aspects of personality, which can be viewed in two perspectives: dispositional optimism and pessimism which Carver and Scheier [21] confirms as universal outcomes expectancies of good versus bad outcomes in one's life. Gillham, et al. [9] in their study, determine that there is a mutual interaction among optimism, pessimism and life difficulties and the pessimistic people psychosocial adaption problems, however, the present study fail to support the aforementioned assertions stated by the authors above.

5. CONCLUSION

This is a recent attempt to discourse the caregivers' burden among relatives of cardiovascular disease patients in selected tertiary hospitals in Southwest, Nigeria. However, the present study adds to existing body of knowledge on self-esteem, optimism and its relationships either positively or negatively to the burden of care. There are psychological, behavioral, physiological daily lives and health issues to burden of care among relatives of cardiovascular patients within the study area. Furthermore, the determination of these correlates (self-esteem and optimism) on the caregivers would also help to identify specifics measures on how to improve caregiving process on cardiovascular patients and also to enhance the wellbeing of these patients.

Finally, from the analysis of the data collected and interpretation of the results, the study concluded that majority of the caregivers in this study experienced moderate to severe levels of burden. This means that Caregiving has been observed to induce affecting pain and to have unwanted punishment on the worth of life of the caregivers.

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