The Relationship between Social Support, Self-Efficacy and PTSD Symptoms among Trauma Survivors in Nigeria's Niger Delta region

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Abstract: *It is widely acknowledged that trauma exposure is associated with posttraumatic stress disorder (PTSD), but not much is understood about the role of social support and self-efficacy in influencing survivors' experience of PTSD symptoms. Thus, the aim of this study was to examine the association between social support, self- efficacy, and PTSD symptoms among trauma survivors. Two hundred and eighty-one (281) adults comprising 131(46.6%) males and 150 (53.4%) females within the age of 18 to 64 years (M=29.62, SD=7.05), all inhabitants of communities in the Niger Delta Region of Nigeria volunteered to participate. A cross-sectional design was adopted and measures used include the Social Support Scale (SPS), Self-Efficacy Scale (SES), and Post-Traumatic Stress Disorder Checklist-Civilian Version (PCL-C).Multiple regression analysis of data indicated a positive relationship between social support and PTSD symptoms, and a negative association of self-efficacy with PTSD symptoms. High level of social support was shown to increase PTSD symptom severity, whereas high self-efficacy reduced PTSD symptoms in trauma survivors. Clinical implication of the findings for mental health professionals in the Nigerian context in particular, and other relevant contexts globally was discussed.*

Keywords: social support, self-efficacy, posttraumatic stress disorder, trauma survivors, Niger Delta

1. Introduction

The high rate of crime, violence, disaster (natural and human-made) and the myriads of adversities currently prevalent in Nigeria potentially expose significant proportion of the population to high level of psychological distress including posttraumatic stress disorder (see Duckers, Alisic, & Brewin, 2016). Although every part of Nigeria has experienced traumatic events such as armed conflicts and violent crimes with potential negative psychological consequences on residents, the Niger Delta Region seems to have experienced more long-standing conflicts and violence beginning from the pre-colonial era, and reaching its climax in the 1990s (Beiser, Wiwa, & Adebajo, 2010; Busari, 2014; Civil Liberty Organization [CLO], 2006). Consequently, as suggested by Busari (2014), the population living in and around the Niger Delta Region may have experienced higher rate of trauma exposure compared to other parts of the country (see also Jimoh, 2010). Majority of inhabitants of the area have had to deal with a wide range of potentially traumatic stressors including sights of mutilated dead bodies, killings and arson, oil tank explosions, experiences of rape, torture, homelessness, and other traumatic conditions perpetrated by both military forces and militants holding sway (HRW, 1995;1999;2002; Asuni, 2009; Idemudia, 2014; Ifeagwazi, Chukwuorji & Zaccheus, 2015; Amaize, Onoyume, Agande, & Yafugborhi, 2012).

Apart from man-made catastrophes, the Niger Delta region also experienced perennial flooding and occasional surges from the Atlantic Ocean by virtue of its coastal location leading to massive destruction of property and sometimes deaths (United Nations Office for the Coordination of Human Affairs [UNOCHA], 2013; Ajani, 2012). The evidence overwhelmingly show that posttraumatic stress disorder tend to occur more in populations that are exposed to severe psychological trauma (eg., Ahmed, 2007; Ayala &

Ochotorena, 2005; Jimoh, 2010; Salami, 2010; Zahrandnik, Stewart, O'Connor, Stevens, Ungar & Wekerle, 2010; Frans, Rimmö, Åberg, & Fredrikson, 2005;Richa, Herdane, Dwaf, Bou Khalil, Haddad, El Khoury, Zarzour, Kassab, Dagher, Brunet, & El-Hage, 2020). Therefore, it can be postulated that significant population of the Niger Delta Region comprising Delta, Rivers, Cross River, Akwa-Ibom, Edo and Bayelsa States of Nigeria may be struggling with high level of emotional distress and psychopathologies (including PTSD) in view of the over 5 decades of oil-related crises, militancy and military operations in the region.

Posttraumatic stress disorder is an anxiety disorder characterized by intense anxiety-related experiences, behaviour and physiological responses that develop after direct or indirect exposure to a psychologically traumatic event (American Psychiatric Association [APA}, 2013). The International Classification of Diseases (ICD-10; WHO, 1992) also identified exceptionally threatening or catastrophic events with likely pervasive psychological distress as the main triggers of post-traumatic stress disorder (PTSD). Symptoms of this disorder as spelt out in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; APA, 2013) include presence of intrusive memories, distressing dreams, and dissociative reactions (e.g., flashbacks or re-experiencing) associated with the traumatic event, persistent avoidance of the stimuli associated with the event, negative alteration in cognitive and mood associated with the trauma event, and marked alterations in arousal and reactivity about the traumatic event. Furthermore, for a diagnosis of PTSD to be made, reported symptoms (not attributable to the effect of substances or medical conditions) must be confirmed to have persisted for more than one month post-trauma, and produced marked impairment of major domains of the individual's life (APA, 2000;2013). According to the DSM-V (APA, 2013), though the onset of symptoms of PTSD is

usually within the first three months after exposure to traumatic event, it may be delayed for more months and even years.

Research has found high prevalent of PTSD among general (non-veteran) populations across the globe including non-western (African) contexts. For instance, Seedat, Nyamai, Vythilingum, and Stein (2004) reported 14.8% prevalence rate of PTSD in the general population for South Africa and Kenya. Though significantly higher, Onyeizugbo (2009) reported similar findings in the South-South and South-Eastern parts of Nigeria (spanning across the Niger Delta Region) where she reported a 41.8% PTSD prevalence rate. Consistent with these findings, Duckers and colleagues (2016) in a cross-national PTSD prevalence study involving 24 countries indicated that Nigeria has the highest level of vulnerability to PTSD globally.

However, despite the well documented association between trauma exposure and PTSD, many individuals who encounter highly traumatic circumstances have been found to be able to maintain optimal psychological functioning and remain mentally healthy in the aftermath of the event (Kessler Sonnega, Bromet, Hughes, & Nelson, 1995). Studies show that most people will encounter at least one traumatic event in their life time but majority of these people do not develop PTSD (Breslau, 2002; Kessler et al., 1995). More often than not, people who experience extremely traumatic events manage to survive the accompanying temporary upheaval and appear to move on well without obvious disruption in their ability to function psychologically (Bonano ,2004). Many psychological variables such as resilience (Salami, 2010; Zahradnik et al., 2010; Taylor, 2007), social support (Wu, Chen, Weng & Wu, 2009), self-esteem (Salami, 2010; Bradley, Schwartz, & Kaslow, 2005) and locus of control (North, Spitznagel, & Smith , 2001) have been extensively examined to explain why some people remain psychologically stable despite being exposed to extremely traumatic situations. Notably, however, greater majority of these studies have been conducted in developed western contexts.

The construct of social support is complex and has been defined differently by various scholars' and researchers. For example, Shumaker and Brownell (1984, p.13) defined social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the wellbeing of the recipient" However, the present research adopts Cohen's (2004) definition of social support as, "........a social network's provision of psychological and material resources intended to benefit an individual's capacity to cope with stress" (p.676), in view of its relevance.

Social support can be described as the material and intangible resources that are made available to help individuals cope with difficult circumstances. Different forms of social support have been identified, namely; structural support, functional support, emotional support, instrumental or material support, and informational/ cognitive social support which are provided by family members, friends, community, national and sub-national governments, and the international community in times of adversity (Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015). According to Sippel and colleagues, structural support relates to the scope of one's social network and frequency of interactions within the network, while functional support is the perception that the social interactions experienced among individuals in the network have really been psychologically beneficial. Emotional support refers to behaviours that convey empathy which promotes feelings of comfort, love, respect, and care in the recipient, whereas material support includes goods and services provided to help an individual faced with adversity meet his/her material needs. Informational or cognitive social support, on the other hand, is the provision of relevant advice and suggestions that may guide people encountering stressful life events or challenges to find solution to their problems, and consequently adjust positively. Shumaker and Brownell (1984) opined that individuals and their levels of social support operate through beliefs, ideas, and values prevalent in cultural contexts, which in turn influences the extent to which social support may be provided and received. This is because cultural contexts largely influence the way people evaluate events as stressful, their view of social support (ie., whether it is indeed supportive) as well as the tendency that social support would be given, gotten, accepted or rejected (see Shumaker & Brownell, 1984).

Social support has been suggested to have direct "buffering" effect on stress, and its absence akin to stressor itself (Cohen & Wills, 1985). The relationship of social support with mental and physical health has been empirically demonstrated and well documented. For example, studies have found that even in our day-to-day living, people who have spouses, family members and friends, and receive psychological and material support from them have better mental and physical health (Barth, Schneider, & von Kanel, 2010; Pinquart, & Duberstein, 2010). Furthermore, it has been shown that people who have better social support networks peri-trauma reported better outcomes (Ren, Skinner, Lee, & Kazis, 1999) as social support tend to moderate the relationship between trauma exposure and posttraumatic stress disorder (PTSD; Wu et al., 2009; Bradley, Schartz, & Kaslow, 2005). When faced with extreme adversity, social support (for instance in form of advice or religious counseling) seems to help people appraise the threats posed by the situation as being less potent, thus minimizing their psychological response to the trauma (Roy, Steptoe, & Kirschbaum, 1998).

Social support also helps people to give positive interpretation to extremely traumatic events as worthwhile (Uchino, 2006), and consequently enhance their coping ability (Gottlieb, & Bergen, 2010). Acknowledging the protective psychological and social functions role of social support for survivors of disaster and their communities,(Kaniasty,2020) characterized social support as a critical coping resource. Various studies using diverse trauma populations and different research methodologies have shown evidence of significant relationship between social support and PTSD (Ozer, Best, Lipsey, & Weiss, 2003; Kimberling & Calhoun, 1994; Jankowski Schnurr, Adams, Green, Ford, & Friedman, 2004; 2005; Barrett & Mizes, 1988; Beiser, Turner, & Ganesan, 1989).

However, contrary to the above proposition that the presence of social support buffers against negative consequences including PTSD (eg.,Cohen & Wills, 1985; Ren, Skinner, Lee, & Kazis, 1999; Wu et al., 2009; Bradley, Schartz et al., 2005) and facilitates the process of recovery (Burgess & Holmstrom, 1979), research has also indicated that the presence of negative social support following trauma may indeed be a stronger predictor of PTSD than the absence of social support (Tarrier, Sommerfield, & Pilgrim, 1999; Ullman, 1996; Zoeliner, Foa & Brigidi, 1999). Furthermore, Kaniasty and Norris (2008) suggests that directionality of the relationship between social support and PTSD may vary over time trauma exposure. In the early stages of coping with trauma (eg., 6-12 months post-trauma) poor social support may act as a risk factor for greater PTSD symptom severity. The PTSD symptoms, if allowed to persist for longer time (eg., 18-24 months) after a traumatic event may lead to the erosion of social support resources (Kaniasty & Norris, 2008; King, Taft, King, Harmond, & Stone, 2006; Laffaye, Cavella, Drescher, & Rosen, 2008). This is understandable as PTSD symptoms such as social withdrawal, numbing, irritability, poor anger management and other forms of "anti-social" behaviour may negatively impact on the quality and quantity of social support available to the trauma survivor (Clapp & Beck, 2009). King and colleagues (2006) in the earlier cited study measured PTSD severity and social support in a sample of Gulf War Veterans 18 – 24 months post-deployment and repeated same measurement 5 years after, and found subsequent decrease in social support. A meta-analysis of studies examining risk factors associated with the development of PTSD also indicated that social support strongly predict PTSD (Brewin, Andrews, & Valentine, 2000).

Self-efficacy is defined as the belief of a person in his or her ability to organize and execute certain behaviors that are necessary in order to attain set goals and complete tasks (Bandura, 1997; Omrod, 2006). It refers to a person's belief that he or she is capable of the specific behavior required to produce a desired outcome in a given situation (Brehm, Kassin, & Fein, 2002), or the perceived capability to manage one's personal functioning and the various environmental demands of the aftermaths of stress arising from a traumatic event. The construct can be categorized into two dimensions;- generalized self-efficacy and the specific self-efficacy. Whereas generalized self-efficacy refers to the belief in one's competence to cope with a broad range of stressful situations or challenging demands (Schwarzer, 1994; Schwarzer & Jerusalem, 1995), specific self-efficacy is considered as the belief in one's ability to handle specific tasks (Caprara, 2001). One's efficacy beliefs influence the type of activity he/she is likely to engage in, the levels of effort to be put in, and his/her level of perseverance in the face of adversities. Therefore, arguably, the subjective appraisals and beliefs associated with self-efficacy can facilitate the regulation of human functioning through cognitive, motivational, affective and decisional processes which in turn influence one's resilience to adversity and vulnerability to stressful situations. It is likely that an individual with high level of self-efficacy who believes in his/her ability to control what happens to him/her may hold the view that he/she can effectively cope with stressful life events (Ifeagwazi & Oguizu, 2006). This view corresponds with previous empirical findings that self-efficacy play a key role in the attainment of goals (Luszczynska, & Schwarzer, 2005), and helps people to cope effectively with adversity (Bandura, 1977).

Research support the link between self-efficacy appraisals and traumatic stress response following exposure to traumatic events (eg., Benight, Swift, Sanger, & Zeppelin, 1999; Murphy, 1987). While Murphey (1987) reported negative relationship between global self-efficacy and psychological distress among Mount St. Helens volcano disaster survivors, Benight and colleagues (1999) demonstrated how self-efficacy directly connects to the specific coping demands of the trauma situation and reported that higher self-efficacy beliefs were related to lower psychological distress . Both studies showed that self-efficacy is a critical variable that can influence psychological reaction to trauma. In addition, Bandura, Taylor, and Williams (1985) proposed that people with high self efficacy show less psychological and physiological symptoms than those with low self-efficacy, when exposed to stressful experiences. Self-efficacy has also been found to confer on an individual a strong belief in his/her personal ability to manage the environment and difficult life circumstances (Bandura, 1997), and mediate the course of PTSD (Diehl, & Prout, 2002). Johansen, Wahl, Eilertsen, and Wiesaeth (2007) studied self-efficacy and PTSD longitudinally and reported that low perceived self efficacy was a predictor of PTSD symptoms among physically injured victims of non-domestic violence. A systematic review of 27 research studies of adult and adolescent survivors of collective trauma also corroborated the view that self efficacy may be a powerful factor in the psychological trajectory and positive adjustment after trauma exposure (Luszcznska, Benight & Cieslack, 2009).

Arguably, the psychological trajectory of a trauma survivor leading to either positive or negative outcomes cannot be well explained without considering the unique socio-cultural context in which the individual lives. This study assumes that the psychological trajectories following traumatic stress or stressful life event among Nigerians can better be understood by exploring psychosocial factors such as social support and self-efficacy. This assumption is premised on empirical works showing that Africans (including Nigerians) have a unique social support structure and socially construed dispositions (Rusenblatt & Wallace, 2005; Barrett, 1998), which (albeit anecdotal) makes them "invincible" to the deleterious impact of trauma. Furthermore, in the view of Solomon and Davidson (1997), an individual's reaction to a traumatic event can be influenced by psychosocial and contextual factors operating within the individual and his/her environment. However, much of what is known about the influence of social support and self-efficacy in PTSD is derived from studies conducted in the western contexts. Thus, the present study is justified by the poor understanding of how Africans (including Nigerians) uniquely cope with adversity and the role of social support and self-efficacy in their posttraumatic adaptation. Apart from enriching the traumatic stress literature, this study will guide mental health professionals working with trauma survivors in the development of effective intervention strategies.

Two hypotheses are tested in this study. First, high social support will be associated with less PTSD symptoms among trauma survivors. Second, high self-efficacy will be associated with less PTSD symptoms among trauma survivors.

2. Methods

Participants

Participants for this study consisted of 281 adults comprising 131 males (46.6%) and 150 females (53.4%) drawn from three communities in the Niger Delta region, namely; Odi, Biseni, and Okobe using cluster sampling method. The age range of the participants was 18 to 64 years (M=29.62, SD=7.05). A list of the quarters making up each of the communities were obtained by the researcher from the Paramount Rulers (or village heads), out of which two quarters each were selected through random picking to represent the communities. The participants were, then recruited by volunteering from the selected quarters. Of the 281 participants, 197 (70.1%) were from the Ijaw ethnicity, while 84 (29.9%) were from other ethnic groups. In terms of religious background, 272 (96.8%) were Christians, while 9 (3.2%) constituted other religions. Also, regarding marital status 184 (65.5%) of the participants were single, 96 (34.2%) married, while one participant was separated. The participants had different levels of educational qualification including university degrees and Higher National Diploma (52.0%), National Certificate of Education (12.4%) as well as Senior secondary School Certificate of Education (SSCE), and First School Leaving Certificate (FSLC) holders (35.6%) and Senior School Certificate (SSC). Among the participants, 33.8% were gainfully employed as public servants, 37.7% were either employed in the private sector or self employees, while 23.5% were students, and 5.0% were retirees.

The three Niger Delta communities were chosen for this study based on their trauma history. Odi community located in Bayelsa State of Nigeria was invaded by military forces of the Federal Government of Nigeria on November 20, 1999 in response to oil-related youth agitation. This attack infamously known as "Odi massacre" led to the death of over 2,500 inhabitants (civilians), burning of every building in the community, and internal displacement of thousands persons (Human Rights Watch [HRW], 1999; Ninmo, 2006). Biseni Community also in Bayelsa State of Nigeria is located on the fringes of the Atlantic and prone to perennial flooding and surges. This community experiences seasonal flooding during which the entire community including farmlands are submerged forcing inhabitants to flee their homes. Consequently, inhabitants of Biseni community suffer huge property losses, internal displacement, and severe psychological trauma on a yearly basis (Ajani, 2012). Okobe Community in Rivers State of Nigeria experienced fuel tanker explosion on July 12, 2012 in which over 100 community members including pregnant women, youths and children were burnt alive and properties destroyed in the blazing inferno (Amaize, Onoyume, Agande, & Yafugborhi, 2012). This incident left the families and friends of the dead ones as well as the entire community in grief and extreme trauma.

Measures

The Social Provision Scale (SPS): The Social Provision Scale (SPS) developed by Cutrona and Russel (1987) contains 24 items (6 sub-scales) that measure perceived social support. Examples of items in this scale include, "There are people I can depend on to help me if I really need it", "I feel part of a group who share my attitudes and beliefs", "If something went wrong o none would come to my assistance", "I feel a strong emotional bond with least one other person". The items of the SPS are developed on 4-point Likert scale response format (4= Strongly Agree, 3=Agree, 2=Disagree and 1=Strongly Disagree). According to Cutrona and Russel (1987), the SPS has a test-retest reliability coefficient of .93, Cronbach alpha coefficient range from .59 to .78. A study in Nigeria by Kpenu (2009) reported significant internal consistency of .92 for total scale and .65 to .76 for subscales. Kpenu (2009) also reported construct validity coefficient of .38 to .79 and Cronbach alpha of .82 for the SPS.

The Self-Efficacy Scale (SES): The Self-Efficacy Scale (SES) is a 30-item inventory developed by Sherrer, Maddox, Mercandante, Prentice-Dunn, Jacobs, and Rogers (1982) to measure the social component of self –efficacy from both the intra-personal and interpersonal perspectives. Examples of items of the SES include, "When I make plans, I am certain I can make them work", "If I can't do a job the first time, I keep trying until I can", "When I have something unpleasant to do, I stick to it until I finish it", "Failure just make me try harder", "I am a self reliant person". The items are developed on 5-point Likert scale response format (1=Disagree Strongly, 2=disagree Moderately, 3=Neither Agree, Nor Disagree, 4=Agree Moderately, 5=Agree Strongly). Sherrer and colleagues (1982) reported Cronbach's alpha internal consistency reliability coefficient of .86 for American population, while Ayodele (1998) reported a divergent validity coefficient of .23 by correlating SES with Mathematical Anxiety Rating Scale-Revised developed by Plake and Parker (1982) using a Nigerian population. In present study, the researcher obtained a Cronbach's alpha reliability coefficient of .72 and Split-half reliability coefficient of .71 as well as significant convergent validity between SES and the 10-item General Self Efficacy Scale (r = .75, p < .01, 2-tailed).

Post-traumatic Stress Disorder Checklist – Civilian Version (PCL-C)
This 17-item Post-traumatic Stress Disorder assessment inventory was developed by Weathers, Litz, Herman, Huska, & Keane (1993) based on the DSM-IV criteria for PTSD symptoms. The PCL-C (civilian) assesses symptoms in relation to "stressful experiences." This inventory is useful because it can be used with any population. In responding to the items, participants indicate the extent to which they have been bothered by each symptom in the past one month based on a five-point Likert Scale ranging from, "not at all (1)" to "extremely (5)". Examples of items of the PCL-C (civilian) include, "Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?", "Repeated, disturbing dreams of a stressful experience from the past, Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?", " Avoid thinking about or talking about a stressful experience from

the past or avoid having feelings related to it?", "Being "super alert" or watchful on guard?". Weathers and colleagues (1993) obtained a Cronbach's alpha reliability coefficient of .97. Blanchard, Jones-Alexander, Buckley, and Forneris (1996) reported a Cronbach's alpha of .94. Test-retest reliability has also been reported as .96 and .88 at 2 to 3 days and 1 week intervals, respectively (Ruggiero, Del Ben, Scotti, & Rabalais, 2003).

The PCL correlates positively with the Mississippi PTSD Scale with convergent validity of between r = .85 and .93 (Weathers et al., 1993). Strong correlations have also been reported with MMPI-2 Keane PTSD Scale (.77), Impact of Event Scale (.77 - .90) and Clinician Administered PTSD Symptoms Scale (.92) (Blanchard et al., 1996). The PCL has further demonstrated strong psychometric properties in some other studies (Norris, & Hamblen, 2004; Harrington & Newman, 2007). Onyedire, Ekoh, Chukwuorji, & Ifeagwazi (2017) obtained an *α* coefficient of .82 in a Nigerian study.

Procedure
Six research assistants were engaged and given proper orientation on the instruments and assigned to the three communities (ie., Odi, Biseni and Okobe). They were properly taught on how to administer the instruments and the need to encourage participants to complete the forms correctly. A total number of 300 booklets comprising the three psychological instruments were administered to the participants directly under the supervision of the research assistants after due consultation and permission by the Paramount rulers (ie., traditional heads) of the communities involved. Out of the 300 booklets, 19 were discarded due to improper completion, leaving 281 which were properly completed giving a response rate of 93.67%. The participants were adequately assured of anonymity and confidentiality.

Statistical analysis
The SPSS for Windows (Version 20.0) was used with Multiple Regression for data analysis and hypotheses testing in this study.

3. Results

Table 1 show the contributions of Social support and Self - Efficacy in PTSD symptom measures of trauma survivors.

Table 1: Summary of multiple regression analysis result showing the relationship between social support, self-efficacy, and PTSD Symptoms

Variables	B	Std. Error	Beta	t	sig
Social Support	.291	.110	.192	2.64	.009
Self-Efficacy	271	.096	-.190	-2.831	.005

*p < .01

The results of the multiple regression revealed that social support (beta =.19, t= 2.64, p<.01) , and self-efficacy (beta = -.19, t= -2.83, p<.01) were significant predictors of PTSD symptoms. The regression equation indicated that social support was positively related to PTSD symptoms, whereas self-efficacy was shown to be negatively related to PTSD symptoms. Individuals who reported higher social support were found to have higher PTSD symptoms, while those

with high self-efficacy were shown to have lower PTSD symptoms.

4. Discussion

This study examined social support and self-efficacy as predictors of Post-traumatic Stress Disorder (PTSD) symptoms among adult trauma survivors.

The results revealed that social support was positively related to post-traumatic stress disorder (PTSD) symptoms as trauma survivors with higher social support obtained significantly higher scores on the PCL-C measure indicating high PTSD symptoms. This finding failed to support the first hypothesis which states that high social support will be associated with less PTSD symptoms among trauma survivors This is contrary to previous findings of many well known studies which indicated that social support was negatively related to PTSD symptoms (eg., Wu et al., 2009; Bradley et al., 2005; Brewin et al., 2000; Burgess & Holmstrom, 1979; Salami (2010). Notably, Vanderwerker and Prigerson (2004) studied 293 elderly bereaved people and found perceived social support to be protective against PTSD.

Nevertheless, the present finding seems to align with some previous empirical works which suggests that social support may predict high PTSD symptoms among trauma survivors. An important aspect in which social support may be detrimental to a trauma survivor is when the interaction with potential supporters are perceived by the traumatized person as undesirable, unhelpful, and negative. For example, Tarrier and colleagues (1999), and Ullman (1996) found that the presence of negative social support may be a stronger predictor of PTSD than the absence of social support. Although family members may feel more morally bound to offer supports and help (eg., care-giving, materials, financial, and advice) to their own than non-family members (eg. colleagues and friends), research has shown that they are the worst supporters and can cause greater distress(Coyne, Wortman, & Lehman, 1986). Williams and Joseph (1999) supported this view in their suggestions that social support in form of negative appraisal or criticism of a trauma survivor's reactions during the trauma as being inappropriate by family members can have deleterious impact on his/her emotion leading to feelings of guilt, shame and panic, and weaken coping strategies (Wegner, 1994; Joseph, Williams, & Yule, 1997). The view that negative social reactions such as blame, sympathy, stigmatisation or "destructive advice" received from family members, friends and others in the social network may significantly predict higher PTSD symptoms in trauma survivors (Ullman & Filipas, 2001) also support the present findings.

Furthermore, the positive correlation established in the present study between social support and PTSD is underpinned by Uehara's (1995) Equity Theory of social support which states that individuals experience psychological distress when they receive more support than they deem equitable. If a trauma survivor who received social support from others fails to reciprocate the gesture, he/she may as a result, feel undeserving of the support and become emotionally distressed (Thompson, Medvene, &

Freedman, 1995). Similarly, Cohen and Wills (1985) in their "matching hypothesis" of social support have argued that effectiveness of social support is a function of how well support received matches the beneficiary's perceived need for support. Consistent with previous studies, Stroebe, Zech, Stroebe, and Abakoumkin (2005) in a meta-analysis of both cross-sectional and longitudinal studies on the influence of social support as a buffer against traumatic stress concluded that social support does not positively influence the path of recovery from bereavement.

In relation to the second hypothesis, results showed that adult trauma victims with higher self-efficacy had lower scores on the PCL-C scale, implying less PTSD symptoms. This study demonstrated that self-efficacy is negatively associated with PTSD symptoms, thus supporting the second hypothesis of this study in consonance with previous findings. In one study, Stock (2006) explored the relationship of self-efficacy of victims of traumatic injury arising from accidents and found that self-efficacy was negatively associated with PTSD symptomatology. Similarly, Hirschel and Schulenberg (2008) in a study of Hurricane Katrina victims concluded that general self – efficacy was negatively correlated with PTSD symptom severity. The literature is replete with similar findings (e.g., Farmer & Lorie, 2008; Luszcznska, Benight, & Cieslack, 2009; Johansen, Wahl, Eilertsen, & Wiesaeth, 2007).

Efficacy beliefs influence one's choice of activities, level of effort put in to attain goals and one's degree of resilience or perseverance in the face of adversity. Thus, as this study seems to suggest, the more individuals perceive themselves as being efficient, the more they tend to adopt various coping strategies and appraisals in dealing with stressful situations. Individuals who perceive themselves as highly efficient and competent are able to cope effectively with trauma in adaptive ways that minimize negative psychological consequences including PTSD symptoms.

5. Implication of the findings

The insights provided by this study regarding the association between social support, self-efficacy, and Post-Traumatic Stress Disorder (PTSD) symptoms among people who have experienced significant trauma has immense clinical implications. This study findings can guide mental health professionals including clinical psychologists, psychiatrists, and social workers who are involved in assisting traumatised populations, particularly in the North-Eastern and North-Central regions of Nigeria currently under the siege of Boko-Harram terrorism and herdsmen attacks, respectively. In addition, it may form the basis for the development of interventions aimed at enhancing the psychological resources of people to cope successfully with extreme adversity and stressful life events, and promote positive adjustment after exposure to trauma. Finally, apart from filling previous knowledge gaps in the area of traumatic stress research and enriching the existing literature, the current findings may stimulate further research.

Limitations of the Study and suggestions for future research

Like any other research endeavours, this study has limitations which should be taken into account while interpreting its findings.

First, caution should be exercised in generalizing the findings of this study as the study was carried out only in three communities in the Niger Delta region of Nigeria. Future study should consider coverage of all the regions of the country for better generalization.

Second, the study adopted a cross-sectional approach, thus its findings are correlational, and do not imply causality. Future research should consider longitudinal approach in order to be able to establish cause-effect relationships between variables, and make more definite findings.

Third, the present sample size seems too small which may affect generalization, therefore, future research should consider larger sample size.

6. Conclusion

This study investigated the influence of social support and self-efficacy on Posttraumatic Stress Disorder (PTSD) symptoms severity among adult trauma survivors. It was found that social support was positively associated with PTSD symptoms, while self-efficacy was negatively associated with PTSD symptoms. To the best of the researcher's knowledge, no published study has explored the relationship between social support, self-efficacy, and PTSD symptoms in the Nigerian context.

Undoubtedly, individuals have the capacity to adapt positively in the face of severe stress, but this requires optimal interaction of both individual, psychological and contextual factors. Considering the evidence regarding the association between social support, self-efficacy, and PTSD symptoms shown in this study, researchers and mental health professionals should look to evolving intervention strategies that integrate elements of social support and self-efficacy to help trauma survivors in Nigeria, and other relent contexts across the globe.

7. Funding

8. Competing interest

The author has declared that there is no existing competing interest.

9. Acknowledgments

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