

Self Management Techniques and Disclosure of Sero Status.

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Abstract

This study looked at using Self Management Technique (SMT) to promote self-disclosure of Sero status in Kwara State, Nigeria. A pre-test, post-test and control group quasi experimental design using a 2x2x2 factorial matrix was adopted. Sixty participants were sampled by balloting from two HIV/AIDS screening centres. Four instruments were used such as Demographic data of the participants, Multidimensional AIDS Anxiety Questionnaire (MAAQ), Self-disclosure Subscale (SDSC) and Eysenck Personality Questionnaire (EPQ). The data were analyzed using ANCOVA and t-test at 0.05 level of significance. The results showed that SMT was effective in enhancing self-disclosure of HIV positive individuals and extroverted personality individuals benefited more in the psychotherapy than introverted persons while male participants benefited more than their female counterparts. Based on the results, it's then recommended that psychotherapists should be freely disposed to the use of this therapy to enhance social relationship/interaction between their clients/patients.

Keywords: Acquired Immunodeficiency virus, Human immuno-deficiency virus, Self-management, Self-disclosure, Sero-status

1. Introduction

Acquired immuno deficiency syndrome is a significant problem in many developing countries especially in Africa facing enormous stress on national health systems. The disease however, is not just a public health concern. The epidemic poses serious social, economic and other development challenges. The consequences of the social impact of HIV/AIDS include falls in life expectancy, loss of skilled labour, weaker agricultural sectors and the sickness and death of family income earners.

Fact Sheet (2001) declared that over 13 million children and youths in Africa who have lost one or both parents in the HIV/AIDS have a higher risk of malnutrition, illness, discontinued education, abuse and sexual exploitation than children orphaned by other causes. They are often condemned if they are sexually active, which hinder them from seeking help and support. Young girls are exposed to greater risk as they often lack the power to make decisions about their own sexuality and means to negotiate about safe sex. Children and young are also forced to cope with the stigma associated with HIV/AIDS.

The creation of effective prevention, treatment and care is a world-wide challenge. Prevention and treatment/care are inextricably linked. Treatment and prevention are mutually dependent and equally necessary elements of any effective strategy to address HIV/AIDS. The social, political, economical, religious and cultural context of the target group must be taken into consideration. Experience shows that empowerment of the individual is a decisive factor for disadvantaged groups. Health infrastructure needs to be developed to ensure quality in the delivery of services and people empowered and equipped with the means to make full use of treatment. Disclosure of HIV status to sexual partners is an important prevention goal emphasized by the World Health Organization (WHO). Disclosure offers a number of important benefits to the infected individual and to the general public. Disclosure of HIV test result to sexual partners is associated with less anxiety and increased social support. HIV status disclosure may also lead to improved access to HIV prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future.

Serovich (2000) observed series of steps that practitioners can take when helping HIV positive individuals disclosed their status to others in their social support network i.e. who should be considered for disclosure. This should include family and friends, acquaintances, associates and anyone the person interacts with on a regular basis. This will allow women to assess the size of their support network and reflect on the depth of the pre-existing support. Secondly, it is important to encourage the individual to evaluate the nature of the relationship with each individual identified on the list. In doing so, patients can determine the potential costs and benefits involved in telling each person prior to disclosing. The third step is determining any special circumstance that might affect disclosure, such as the recipient's mental or physical health, age or personal crises, for example, if the patients fears that a certain individual cannot be trusted with keeping the disclosure confidential, he or she

may decide not to disclose. The fourth step is to think about each individual's knowledge and attitudes regarding HIV, this step will help HIV+ patients anticipate the potential reaction of others while the fifth step is to assess the reasons why it is important to disclose to potential recipients. Reasons may include needing instrumental (childcare, transportation) and expressive (ability to talk to others about concerns) support, or a sense of obligation to warn others. Regardless of the reasons, it is important to identify and evaluate why one may want to disclose. Finally the sixth step in helping an individual disclose HIV status is to place each individual in one of the three categories; (a) to be told now (b) to be told later (c) to wait and see. Thus, the decision whether or not to disclose and to whom to disclose has been made taking into consideration all of the important factors. Ultimately, these steps will help the patients maximize the positive aspects of disclosure such as social support and minimize the negative consequences, such as rejection.

Antelman, Smith, Kaaya, Mbwambo, Msamaya, Hunter and Tawzi (2001) argued that AIDS remains a highly stigmatized illness throughout the world. AIDS stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS as well as the individuals, groups and communities with which they are associated. The stigma attached to AIDS and to the social groups perceived to be associated with it has inflicted additional suffering on sick individuals and their loved ones, hampered treatment and prevention, hindered society's response to the epidemic.

The study was designed using Self-management therapy to enhance self disclosure of the individuals (males and females without age limit) of their HIV+ status. Self-management therapy (SMT) to Kanfer and Goldstein (1991) was based on the participant model which emphasizes the importance of the client's responsibilities instead of offering a protective treatment environment; it encourages rehabilitative experiences in which the client accepts increasing responsibilities for his or her own behaviour for dealing with the environment and for planning the future. Kanfer and Grum (1986) asserted that the traditional concepts underlying the activities of health workers imply an administrative model of treatment. The model presumes that clients seek assistance in an earnest effort to change their current problem situations. The therapist administers a treatment to which the client submits and which eventuates in improvement in the client's life conditions. The model assigns a caretaking function to the therapist and relatively passive, accepting and trusting role to the client. SMTs are prescriptive methods that take place much of the burden of engaging in the change process on the client. Nevertheless, they regard the therapist's role as crucial in providing the most favourable conditions for change.

The SMT framework is based on the following rationale: (1) Many behaviours are not easily accessible for observation by anyone but the client. (2) Changing behaviour is difficult and often unpleasant. Many clients seek assistance but often they are motivated not so much to change as to alternate current discomforts or threats preferably without altering their behaviours or lifestyles. (3) The utility of a change programme has not just in removing situation, specific problems or symptoms. What is learnt in therapy should include a set of generalizable coping strategies and an ability to assess situations and anticipate behavioural outcomes, to aid the client in avoiding or handling future problems more effectively than on the past.

Kanfer and Grum (1980) said the acceptance of responsibility in treatment requires that the client develop a strong motivation to change, therefore, the early phase of SMT is designed to help the client accept the necessity for change and to develop clear objectives for treatment. Theoretical framework of SMT viewed behaviour as the product of three sources of control; the immediate environment, the person's biological system and the cues originating from the person's repertoire of cognitive and self-directive variables. These three spheres of influence interact and it is their joint effect at a particular point in time that ultimately shapes behaviour. Kanfer (1987) was of the opinion that social-learning theory assumes that much everyday behaviour consist of chains of responses that have been previously built up so that a response is automatically cued by completion of the immediately preceding response. For most people, the presence of other persons is a strong determinant of behaviour by selecting the appropriate person or social environment; clients can relieve themselves of much of the burden of generating their own controlling responses.

1.1 Hypotheses

1. It is expected that there will be no significant difference between SMT experimental group and control group in their measure of self-disclosure of HIV+ status.
2. It is expected that there will be no significant difference between SMT introverted and extroverted personality groups in their measure of self-disclosure of HIV+ status.

2. Methods

This section describes how the research was carried out.

2.1 Research design

The study adopted the pre and post-tests and control groups quasi experimental design. It used the 2x2x2 factorial matrix. The design has two groups i.e. experimental group exposed to SMT and control group which received no treatment at all. All the two groups were given pre-test and post-test administration of the research instruments.

2.2 Population of the study

The population of the study was all the clients that attended all the VCT centres in Ilorin metropolis. 60 participants were drawn from these clients that attended Civil Service Hospital and Maternity, Ilorin (n=30) for SMT and Specialist hospital, Ilorin (n=30) for control group.

2.3 Sample of study

The participants were allocated according to their sex and personality using Eysenk's personality inventory and demographic information. The participants in the SMT group were active participants in all the treatment sessions allotted while the control group only participated on the first and last sessions being the pre and post-test sessions. The experimental group consisted of 30 participants who volunteered for the study. They were 13 males (3 introverts and 10 extroverts) and 17 females (7 introverts and 10 extroverts) participants, while the control group also had 30 participants who volunteered for the study; they were 10 males (7 introverts and 3 extroverts) and 20 females (12 introverts and 8 extroverts) participants respectively.

2.4 Ethical consideration

The researchers formally applied to the authorities of the hospitals for permission, the letter was directed to the ethical committees of the hospitals who gave approval for their hospital to be used for the study and they chose a member to assist in the conducts of the study. The ethical committees further arranged for the researchers to meet the clients in their screening centres at most convenient times for them, the involvement of a member from each research centre assisted the study greatly. The participants were met by the researchers and members of ethical committees which made it easier for the informed consent of the participants to be freely given as they volunteered themselves for the study so the volunteered clients became the participants for the study.

2.5 Instruments for data collection

The researchers use the following instruments for the study:

- (a) Demographic data of the participants.
- (b) Multidimensional AIDS Anxiety Questionnaire (MAAQ)
- (c) Self-Disclosure Subscale (SDSC).
- (d) Eysenck's Personality questionnaire (EPQ).

- (a) Demographic data of the participants.

This is a self-reporting instrument designed by the researchers to elicit bio-data information on the participants. This had only eight (8) items.

- (b) Multidimensional AIDS Anxiety Questionnaire (MAAQ)

The MAAQ consists of 50 items where the individuals were asked to indicate how characteristic each statement is of them. A 5-point Likert Scale was used to collect data in their responses with each item scored from 1-5. Test-retest reliability coefficient was 0.92 (Shell&Finney, 1996)

- (c) Self-Disclosure Subscale (SDSC)

It is another self-reporting inventory designed by Shell and Belk (1987) adapted by the researchers that the individual reports his or her experience on self-disclosure of AIDS. It contains 29 items which were responded to by either of the five options of 1-5. test-retest reliability coefficient was 0.90.

- (d) Eysenck's Personality Questionnaire (EPQ)

Eysenck and Eysenck (1975) said the questionnaire was designed to assess the personality of the participants and for this purpose, the extraversion/introversion sub-scale was used. The entire EPQ contains 91 items but 21 of these items were designed to assess the level of extroversion or introversion of an individual's personality. The test-retest reliability coefficient was 0.89 α .

2.6 Statistical analysis of data

Analysis of Covariance (ANCOVA) and t-test were the two statistical methods used for the study at significance level of 0.05. The mean summarized the pre and post-test scores of the participants in the groups. The standard deviation as measure of variability determined the pattern of spread of scores. T-test was used to show which of

the factors of the variables have contributed more to the differences that occurred between the groups. The pre and post-test scores were collated and analyzed then compared to see if there was an improvement in their self-disclosure due to exposure to therapy. The results of the experimental and control groups were compared if there's a significant difference between the two as a result of the therapy applied and measured (ANCOVA).

2.7 Procedure of research

The researchers had 10 sessional contacts with the participants for 10 weeks for the experimental group (SMT) and two contacts with the control group for both pre and post-tests administration. The researchers took the participants through task oriented interactions; it was a teaching-learning process with brief description of the following:

Session I:	General introduction/pre-treatment contact/ pre-test administration
Session II:	The concept of SMT.
Session III:	The rationale for SMT.
Session IV:	Basic skills needed for effective SMT.
Session V:	Environment as an agent of change
Session VI:	Methods for therapeutic change I.
Session VII:	Methods for therapeutic change II.
Session IX:	Self-regulation process.
Session X:	Reviews of the treatment programmes, post-test administration and termination of therapy session and voluntary testing for HIV.

The control group: The researchers with the ethical committee members met with the control group at their screening centre, had social interaction with these volunteered participants. They were told of the research work in order to contribute to the existing knowledge sought for their maximum cooperation for the success of the interaction. The four instruments for the study were administered to the control group as pre and post-tests on the first Friday and last Friday of the programmes respectively. The participants were not given any treatment. The results of the tests were conveyed to them, it was after the post-test that the researchers discussed fully with them about the importance of their self-disclosure of HIV status so that they can be favourably disposed to self-disclosure of their Sero-status.

3. Conceptual model for the study

Figure 1 showed the study model designed by the researchers for the study. Conceptual model designed by the researchers for the study. Conceptual model is the framework on which the study was based derived from the therapeutic technique (SMT) used in the study. The model showed the independent, intervening and dependent variables. The independent variable is the therapeutic technique used in the study i.e. SMT while the intervening variables were sex and personality which intervened with the effect of the independent variable refers to the Self-disclosure of the HIV+ status.

4. Discussion

4.1 Hypothesis One

It is expected that there will be no significant difference between SMT experimental group and control group in their measure of self-disclosure of HIV+ status.

Table II showed the summary of ANCOVA of SMT and control groups; $F(1/56)=1379.92$ $P<0.001$. It also showed main significant difference; $F(1/56)=0.79$ $P<0.05$ on self-disclosure of HIV+ status. Table III showed the adjusted X,Y, Mean scores and adjusted Y-means of self-disclosure of HIV+ status based on SMT and control which indicated that Y-mean scores (163.818, 174.632) were higher than X-mean scores (59.273, 61.263) in the SMT group. However, X,Y,-mean scores of SMT group was observed to be superior to those in the control group while the rows and columns of adjusted Y-means showed that adjusted Y-means of SMT group (162.839, 172.859) were significantly superior to the Y-means of the control group (48.301, 52.702)

Table IV showed pair comparison of the Y-means using t-test on self-disclosure of SMT and control groups showed variations of significant differences of the cells on pair comparison of the Y-means using t-test on self-

disclosure of SMT showed a significant difference of 2.660 at 0.01 significant levels in their personality comparisons.

Table II-IV indicated that there existed a significant difference between the treated SMT and the control groups. The result further confirmed the study of sparks (1976) and Owen, Klapow, Roth and Tucker (2004) in separate studies looked into relationship of self-disclosure and self-concept with SMT, the study showed that participants exposed to SMT disclosed significantly more to their significant others as that will ease their problem for in discussing freely lies the solution because of the greater awareness of the interactive effects that self-disclosure, self-concept and self-management have on each other and O'Brien (1980) in the study looked into a comparison of dimensions of self-disclosure in high and low mentally adjusted couples using SMT focusing on planning something together, discussing what each spouse does that pleases the other and what the other spouse does which irritates the other person, the study concluded that the more the couple discloses their strengths and weaknesses to each other in the course of their interactions, the better adjusted they become and then living peacefully with themselves for better marital developments as transactions and interactions will enhance better disclosure.

4.2 Hypothesis Two

It is expected that there will be no significant difference between SMT introverted and extroverted personality groups in their measure of self-disclosure of HIV+ status.

Table V showed no significance difference existed between SMT introverted and extroverted personality groups; $t(28)=1.690$ $P>0.05$ although the table further revealed that extroverted SMT personality group showed higher mean scores (174.63) on self-disclosure of HIV+ status than their counterparts (163.82), but the mean difference was not significant. But in Table VI looking at Scheffe Pairwise Comparison there was significant difference between SMT (41.000) and control groups (128.467) while in Table VIII showed multiple classification analysis Post Hoc test, it was observed that there was a difference in the mean scores of SMT group as compared with the control group, $P<0.001$. USAIDS (2003) viewed personality difference as a major factor in disclosure of serostatus and that extroverted individuals can easily and freely disclose their serostatus to another person unlike the introverted ones. To Atelman, Smith, Kaaya, Mbwanbo, Msamanga, hunter and Fawzi (2001) disclosure is easier within the same group of personality either as introverted group or extroverted group.

5. Conclusion

Disclosure of HIV+ status along with its attendant issues is fundamental to both preventing the spread of the disease and enabling persons to access treatment, care and support. Disclosure will lead the individuals to receive kindness, understanding and acceptance.

6. Recommendations

Based on the findings of this study, the following are hereby recommended:

- Social workers are advised to encourage their clients to disclose only when the clients feel like it is safe to disclose only when the clients feel it is safe to disclose in order to avoid counter productivity of self-disclosure.
- Providers are to assist their clients to strengthen their interpersonal communication skills and also encourage couple voluntary counselling and testing as a way to facilitate increased communication and disclosure among the couples.
- Clinical psychologists are encouraged to use SMT in group counselling of their clients/patients.
- Service providers are to promote therapeutic group interactions so that each member can be freely disposed to self-disclosure.
- The service providers should create a healthy environment for the clients that will enhance social growth and development.

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Table I
Factorial Design for Study

ROWS	COLUMNS				TOTAL
Groups	Self-disclosure				
A	B1		B2		
	Male		Female		
	Personality		Personality		
	Introvert	Extrovert	Introvert	Extrovert	
	a	b	A	b	
Self-management	4	5	11	10	30
Technique (A1)	9		21		
Control (A2)	7	3	12	8	30
	10		20		
Total	11	8	23	18	60

KEY

Rows: The two groups (SMT and Control groups)

Columns: Sex (Male/Female) and Personality (Introvert/Extrovert)

Table II
Summary of ANCOVA of SMT and the control group

Source of Variation	Sum of Squares	DF	Mean Squares	F	P
Rows	13770.578	1	13770.578	1379.92	S***
Columns	51.989	1	51.989	5.21	S*
Interaction	7.895	1	7.895	0.79	NS
Within	7786.465	56	9.979		

KEY

S*** = Significant at 0.001

S* = Significant at 0.05

NS= Not significant.

Table III
Unadjusted X,Y, Mean scores and adjusted Y-means of Self-disclosure of HIV+ status based on SMT and Control.

ROWS	NO	SEX		PERSONALITY	
		Male	Female	Introvert	Extrovert
		X- \bar{X}	Y- \bar{X}	X- \bar{X}	Y- \bar{X}
SMT	30	59.273	163.818	61.263	174.632
Control	30	53.684	47.053	52.091	50.818

Table IV
Pair comparison of the Y-means using t-test on Self-disclosure of SMT and Control groups

S/N	Source of Variation	N	DF	LMS	S.E	+0D	t.cnt	P
1	a vs b	30	58	9.98	12.29	-0.82	2.000	NS
2	a vs c	30	58	9.98	12.29	9.32	2.000	S**
3	a vs d	30	58	9.98	12.29	8.96	2.600	S**
4	b vs c	30	58	9.98	12.29	10.13	2.600	S**
5	b vs d	30	58	9.98	12.29	9.78	2.600	S**
6	c vs d	30	58	9.98	12.29	-0.36	2.000	NS

KEY

NS= Not significant

S**= Significant at 0.01

- a= Male Introvert (SMT)
- b= Male Extrovert (SMT)
- c= Male Introvert (Control)
- d= Male Extrovert (Control)

Table V

T-test summary table showing significant difference between SMT introverted and extroverted personality groups on Self-disclosure of HIV+ status.

Source of Variation	Personality of participants (SMT)	N	Mean	SD	T	df	P
Self-disclosure of HIV+ status	Introvert	11	163.82	18.03	1.690	28	NS
	Extrovert	19	174.63	16.22			

KEY

NS: Not Significant.

Table VI

Scheffe Pairwise Comparison

Treatment	Mean	1	2
SMT	41.000		
Control	128.467	*	*

Table VII

Multiple Classification Analysis Post Hoc Test

Treatment	N	Unadjusted Dev'n Eta	Adjusted Independent Significant +Covanates
SMT	30	40.08	39.03 0.000
Control	30	32.16	79.78 0.000

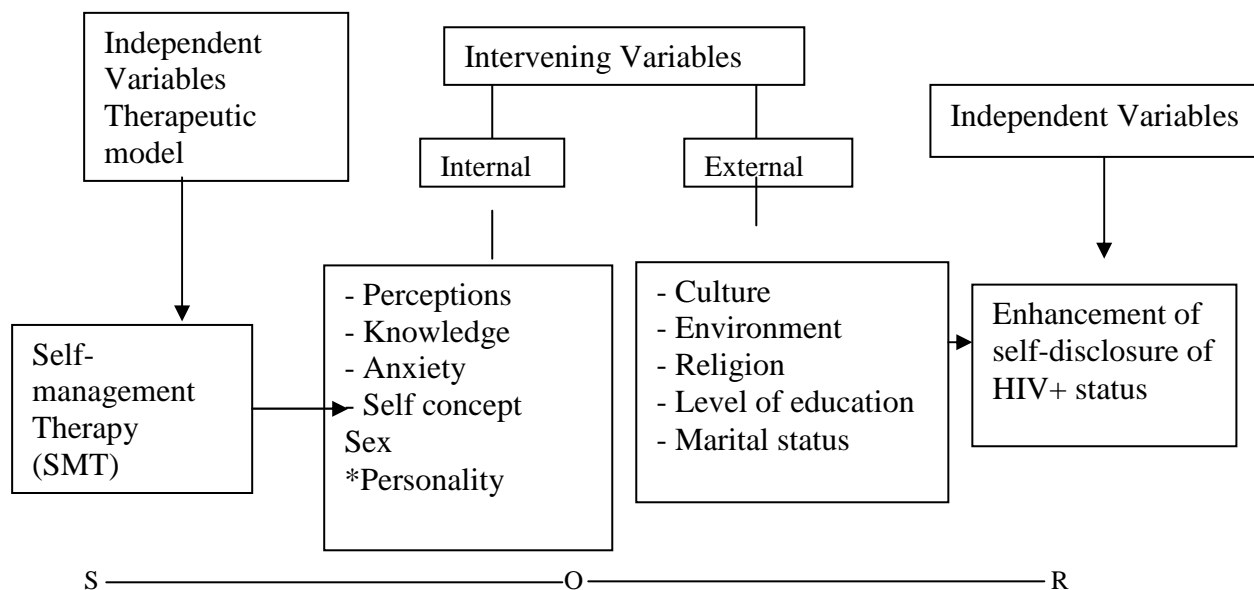


Figure I: Conceptual Model for the Study.

The behavioural equation S-O-R represents the total interpretation of the various variables in the study.

KEY

S= Stimulus (Independent Variable).

O= Organisation (Factors inherent in the organism which are intervening variables).

R= Responses (Dependent Variables i.e. the resultant effect of independent variables)

* Personality } Moderating Variable in the study

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