



Use of Self-management Techniques and Transactional Analysis to Enhance Self Disclosure of HIV Positive Status in Kwara State, Nigeria

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ABSTRACT Acquired immuno-deficiency disease is a life threatening but preventable disease affecting millions of people and a serious threat facing the developing world, especially Africa with consequences that reach far beyond the health sector. Most human immune deficiency virus positive individuals are unwilling to self disclose their serostatus due to fear of stigmatization and discrimination from community members which inhibited proper health delivery to the victims leading to more spread of the disease in Nigeria. Therefore, this study examined how Self-Management Techniques and Transactional Analysis could enhance self disclosure of human immune deficiency virus positive individuals in Kwara State, Nigeria. Pre test, post test control group quasi experimental design was used with random sampling technique in three screening centres to select 90 participants. The findings showed that participants exposed to the two experimental conditions scored significantly higher in their measures of self disclosure of status than those in control group. This means that Self-management Techniques and Transactional Analysis were effective in enhancing self disclosure of human immune deficiency virus positive participants. Scheffe post hoc analysis revealed significant difference between the self disclosure mean scores of participants exposed to Self-management Techniques. It is therefore recommended that the two techniques be adopted by psychologists and social workers to enhance self-disclosure of serostatus.

INTRODUCTION

Acquired immune deficiency disease is a significant problem in many developing countries, especially in Africa, placing enormous stress on national health systems. Serpell (2000) affirmed that the disease however, is not just a public health concern, the epidemic poses serious social, economic, educational and other development challenges. The consequences of the social impact of human immune deficiency virus/acquired immuno deficiency syndrome include, fall in life expectancy, loss of skilled labour, weaker agricultural sectors and the sickness and death of family income earners (Kanabus and Allen 2005). Over 13 million children and youth in Africa have lost one or both parents in the pandemic. The illness and death of one or both parents trigger a host of sociological, economical and psychological effects on the orphaned child or youth. Orphans whose parents died of the killer disease have a higher risk of malnutrition, illness, discontinued education, abuse and sexual exploitation than children orphaned by other causes.

Disclosure of serostatus to sexual partners is an important prevention goal emphasized by the World Health Organization (2002). Hinshaw and Crechetti

(2000) stated that disclosure offers a number of important benefits to the infected individual and to the general public. Disclosure of human immune deficiency virus test results to sexual partners is associated with less anxiety and increased social support. Serostatus disclosure may also lead to improved access to human immune deficiency virus prevention and treatment programmes, increased opportunities for risk reduction and increased opportunities to plan for the future. Disclosure of serostatus also expands the awareness of HIV risk to interested partners which can lead to greater uptake of voluntary human immune deficiency virus testing, counseling and changes in the human immune deficiency virus risk behaviours (Basset 2002).

Serovich (2000) observed series of steps that practitioners can take when helping human immuno deficiency virus positive individuals disclose their status to others in their social support network and that this procedure could be utilized by a range of professionals, including doctors, nurses, support group leaders, volunteer workers and others working with individuals struggling with the psychological impact of an human immune deficiency virus

positive diagnosis. The first step in helping people decide if they want to disclose their disease status to others is to encourage the person to take inventory of 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 access the size of their support network and reflect on the depth of the pre-existing support (Kanfer and Goldstein 1991).

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. As with many other significant stressors, disclosing human immune deficiency virus positive diagnosis, can make a stable relationship stronger and a weak relationship fall apart. Individuals will be better prepared at that point to determine if the relationship quality is strong enough for disclosure to occur. The third step is determining any special circumstances that might affect disclosure, such as the recipient's mental or physical health, age or personal crisis. For instance, if the patient fears that a certain individual cannot be trusted with keeping the disclosure confidential, he or she may decide not to disclose. When a person's characteristics are called into question, that individual can be placed in a "wait and see" category, or it can be determined not to disclose to that person (Takyi 2000).

Sparks (1976) opined that another important consideration is the knowledge and understanding that individuals in the support network have of human immune deficiency virus. Thus, Serovich stated that the fourth step in determining whether or not to disclose is to think about each individual's knowledge and attitudes regarding human immune deficiency virus. This step will help human immune deficiency virus positive patients anticipate the potential reaction of others to whom they may choose to disclose. The fifth step is to assess the reasons why it is important to disclose to potential recipients. Reasons may include needing instrumental (e.g. child care, transportation) and expressive (e.g. 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 human immune deficiency virus status is to place each individual in one of three categories: (1) to be told now (2) to be told later and (3) 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 patient maximize the positive aspects of disclosure, such as social support, and minimize the negative consequences, such as rejection.

Acquired immune deficiency syndrome is eroding hard- worn progress in child survival in many African countries, not on single intervention will adequately address these issues. Anthelman et al. (2001) argued that acquired immune deficiency syndrome remains a highly stigmatized illness throughout the world. Acquired immune deficiency syndrome stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have acquired immune deficiency syndrome, as well as individuals, groups and communities with which they are associated. Fear and hostility toward people living with acquired immune deficiency syndrome appears to be greatest among heterosexuals who express negative attitudes toward gay people. The decision to disclose a human immune deficiency virus diagnosis is a complex issue for those infected. It can also be a stressful and difficult process for women afflicted with the virus. However, because of disclosure's positive impact on social support, it is an important step to decreasing the psychological impact of the disease itself. Acquired immune deficiency syndrome is not merely a medical problem, the manner in which virus is impacting upon society reveals the intricate way in which social, economic, cultural, political and legal factors act together to make certain sections of society more vulnerable.

Disclosure can be more frightening than the fear of acquired immune deficiency syndrome itself. Many people choose to keep their diagnosis secret, a secret that inevitably gnaws away inside them. Some people do not want to disclose their serostatus for fear of being labelled "untouchable", a leper of society, or afraid of being rejected or bringing shame to self or to their family. Self- stigma is a significant barrier preventing others from disclosing the serostatus. Where human immune deficiency virus is transmitted predominantly through heterosexual intercourse, prevailing attitudes may see HIV as

implying morally blameful behaviour while some do not disclose because they do not want to upset those close to them or afraid of any negative impact that they are telling.

World Health Organization (2004) also stated that there are barriers to human immune deficiency virus status disclosure such as fear of abandonment, fear of rejection/ discrimination, fear of violence, fear of upsetting family members, severity of illness and motivators for disclosure. There are also potential risks of sero status disclosure to sexual partners which include loss of economic support, blame, abandonment, physical and emotional abuse, discrimination, disruption of family relationships and the possibility that children may face violence or abandonment as a result of their parents' disclosure of their positive status, whether or not the children are also sero positive. Despite all these identified risks of disclosure of human immune virus positive status, disclosure has its advantages, especially disclosure to partners such as increased opportunities for instrumental and expressive social support, improved access to necessary medical treatment and care, increased opportunities to discuss and implement human immune deficiency virus risk reduction with partners and increased opportunities to plan for the future carefully and thoughtfully.

The study aimed at investigating the use of self-management technique and transactional analysis to enhance self disclosure of sero status in Kwara State, Nigeria and to further determine the most effective therapy out of these two, thereby enhancing a better use of the most effective one in counseling procedure.

METHOD

The study adopted the pre-test, post-test and control group quasi experimental design. It used the 3×2×2 factorial matrix with two experimental groups [Transactional Analysis (TA) and Self-Management Technique (SMT)] and Control group.

All the three groups were given pre-test and post-test administration of the research instrument. The experimental groups were exposed to treatment while the control group was not.

The Population of the Study

The population of the study were all the clients who attended all the Voluntary Counseling

and Testing centres in Ilorin metropolis. Ninety participants were drawn from those clients that attended the Voluntary Counseling and Testing Clinics of the University of Ilorin Teaching Hospital, Civil Service Hospital and Maternity and Specialist Hospital, Centre Igboro, Ilorin, Kwara State, i.e. 30 participants each.

The Sample of the Study

The participants were allocated according to their sex and personality using Eysenck's Personality Inventory and their Biodata information. The participants in the treatment groups were active participants in all the treatment sessions while the control group did not continuously participate in the therapies except the first and the last sessions being the pre and post test sessions.

Experimental group I consisted of 30 participants who were selected by volunteerism from the university of Ilorin Teaching Hospital Voluntary Counseling and Testing Unit. There were nine male (four introverts and five extroverts) and 21 female (11 introverts and 10 extroverts) participants.

Experimental group II also consisted of 30 participants who volunteered for the study from Civil Service Hospital and Maternity Voluntary Counseling and Testing Unit. There were 13 male (3 introverts and 10 extroverts) and 17 female (7 introverts and 10 extroverts) participants.

Control group III had 30 participants who volunteered for the study from Specialist Hospital and Maternity Centre Igboro Voluntary Counseling and Testing Unit. There were 10 male (7 introverts and 3 extroverts) and 20 female (12 introverts and 8 extroverts) participants.

Data Collection Method

The researchers used the following instruments for the study:

- Biodata of the participants
- Multidimensional AIDS Anxiety Questionnaire (MAAQ)
- Self-Disclosure Subscale (SDSC)
- Eysenck's Personality Inventory Questionnaire (EPIQ)

(a) Biodata of the Participants

This is a self-reporting instrument designed

by the researcher to obtain information on the participants' socio-demographic characteristics. The questionnaire had only eight items.

(b) Multi-dimensional AIDS Anxiety Questionnaire (MAAQ)

Snell and Finney (1996) having known that acquired immune deficiency syndrome creates a lot of anxiety which could cause psychological arousal, fear, cognitive worry, sexual inhibition or discussion inhibition. It measured the general anxiety trait level of the participants. The instrument consists of 50 items. In responding to these items, individuals were asked to indicate how characteristic each statement is of them. A 5-point Likert Scale was used to collect data on the participants' responses with each item scored from 1 to 5 such as:

1. Not at all characteristic of me
2. Slightly characteristic of me
3. Some what characteristic of me
4. Very characteristic of me

Test-retest reliability co-efficient of the instrument was found to be 0.92 (Snell and Finney 1996)

(c) Self Disclosure Subscale (SDSC)

This is also a self-report inventory designed by Snell and Belk (1987), adapted by the researcher, that the individual was able to report his or her experience on self-disclosure of serostatus. The scale consists of 29 items. The items were responded to by any of the five options (1 – 5)

1. I have freely discussed this topic with an intimate partner
 2. I have mostly discussed this topic with an intimate partner
 3. I have moderately discussed this topic with an intimate partner
 4. I have slightly discussed this topic with an intimate partner
 5. I have not discussed this topic with an intimate partner
- Test-retest reliability coefficient of the instrument was found to be 0.90.

(d) Eysenck's Personality Inventory Questionnaire (EPIQ)

This questionnaire was designed to assess the personality of the participants. For this purpose, the extraversion subscale of the Eysenck's Per-

sonality Inventory Questionnaire was used. The questionnaire was developed by Eysenck and Eysenck (1975). The entire instrument contains a total of 91 items. By its original design, 21 of these items were designed to assess the level of extraversion or introversion of an individual's personality while the remaining 70 items were designed into three different subscales measuring psychotism, neurotism and lie. This instrument has "Yes" or "No" responses.

Data Analysis

The Analysis of Covariance (ANCOVA) and t-test were the two statistical tools used to analyze the data at .05 level of significance. 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.

RESULTS

Hypothesis One

There will be no significant difference between the experimental groups (exposed to transactional analysis and self management techniques) and the control group in their measure of self – disclosure of serostatus.

Table 1 revealed significant difference in the treatment of the post test scores $F(2 / 77) = 467.443, P < .01$. The result indicated that there was significant difference between the experimental groups and the control group in their measure of self disclosure of serostatus. Hypothesis one was therefore rejected, i.e. the participants in transactional analysis and self management techniques experimental groups responded positively to the treatment when compared with the control. This result is due to the exposure and awareness created in the experimental groups.

Hypothesis Two

There will be no significant difference between transactional analysis experimental group and self management techniques experimental in their measure of self – disclosure of serostatus.

Table 1: Summary of ANCOVA of Post test scores of participants according to treatment sex and personality.

Source of variation	Sum of squares	DF	Mean square	F	P
Covariates SD HIV	74025.681	1	74025.681	321.251	S **
Main effects	231585.192	4	57896.298	244.215	S **
Sex	3691.208	1	3691.208	15.570	S **
Personality	6259.573	1	6259.573	26.404	S **
Treatment	221634.411	2	110817.205	467.443	S **
2 – way interactions	1577.616	5	315.523	1.331	NS
Sex X personality	36.675	1	36.675	155.000	NS
Sex X treatment	1298.774	2	649.387	2.739	S *
Personality X treatment	394.237	2	197.118	831.000	NS
3 – way interactions	138.831	2	69.415	293.000	NS
Sex X Personality X X treatment	138.831	2	69.415	293.000	NS
Explained	307327.319	12	25610.610	108.029	S **
Residual	18254.470	77	237.071		
Total	325581.789	89	3658.222		

Key: *: significant at 0.05 **; -- 0.01 ***; — 0.001 NS: Not significant

table 2 showed significant difference between transactional analysis and self management techniques on measure of self - disclosure of serostatus of the respondents; $F(1/56) = 5.93$, $P < .05$.

The table also showed significant difference in the columns (main effect), $F(1/56) = 4.10$, $P < .05$ and no interaction effect on measure of self – disclosure of positive status. $F(1/56) = 2.88$, $P > .05$.

The results of the data computed revealed that there was a significant difference between transactional analysis experimental group and self management techniques experimental group in their measure of self disclosure of positive serostatus.

Table 2: ANCONA summary of the participants exposed to TA and SMT groups on self – disclosure of HIV + status.

Source of variations	Sum of squares	DF	Mean squares	F	P
Rows	95.267	1	195.267	5.93	S *
Columns	135.021	1	135.021	4.10	S *
Interactions	62.027	1	62.027	2.88	NS
Within	26659.565	56	32.952		

Key: *significant at .05 NS: Not significant Rows: Experimental and control groups. Columns: Main effects.

Table 3: Summary of independent samples t – test showing significant difference between male TA and male SMT groups on self disclosure of HIV + status.

Source of variation	Male group	N	Mean	Standard deviation	t	df	P
Self disclosure of HIV + statusTA		13	177.85	19.50	865	20	NS
SMT	9	184.67	16.52				

Key: NS: Not significant

Hypothesis Three

There will be no significant difference between transactional analysis male group and self management techniques male group in their measure of self – disclosure of serostatus.

Table 3 reveals no significant difference between transactional analysis and self management techniques male groups in their measure of self disclosure of serostatus $t(20) = 856$, $P > .05$.

However, the result showed higher mean score in self management techniques male group (184.67) than their counterparts in transactional analysis male group (177.85) but the mean difference was not significant at .05 level of significance. Hence the hypothesis five was accepted as a t – test revealed that there was no significant difference.

Hypothesis Four

There will be no significant difference between transactional analysis female group and self management techniques female group in their measure of self – disclosure of serostatus.

Table 4 revealed no significant difference

Table 4: t-test summary table of significant difference between TA female and SMT female groups on self disclosure of HIV + Status

Source of variation	Female group	N	Mean	Standard deviation	t	df	P
Self disclosure of HIV + status	TA	17	176.59	17.91	.663	36	NS
SMT	21	172.2g	21.37				

Key: NS: Not significant

between the transactional analysis and self management techniques female groups in their measure of self disclosure of positive serostatus; $t(36) = .663, P > .05$. The table however revealed higher mean scores in the transactional analysis female group (176.59) than their counterparts in the self management techniques female group (172.29) but the mean difference was not significant at .05 level of confidence so hypothesis six was therefore accepted. s.

Hypothesis Five

There will be no significant difference between transactional analysis introverted personality group and extroverted personality group in their measure of self disclosure of serostatus.

Table 5 revealed no significant difference between introvert (Transactional Analysis) and extrovert (Transactional Analysis) personality group in their self disclosure of serostatus; $t(28) = .521, P > .05$. The table further showed a higher mean score in the extroverted personality group (174.67) than their counterparts introverted personality group (170.67) in their measure of self – confidence so hypothesis seven was therefore accepted.

Hypothesis Six

There will be no significant difference between self-management techniques introverted

and extroverted personality groups in their measure of self – disclosure of serostatus.

Table 6 revealed no significant difference between self management techniques introverted and extroverted personality groups in their measure of self disclosure of positive serostatus, $t(28) = 1.690, P > .05$. The table further revealed that extroverted self management techniques personality group showed higher mean score (174.63) on self – disclosure than their counterparts (163.82) but the mean difference was not significant hence the hypothesis was therefore accepted.

DISCUSSION

As the human immune deficiency virus / acquired immune deficiency syndrome continues into the fourth decade, there is a need to focus not only on prevention, treatment and education but also on maintenance of the lives of people living with human immune deficiency virus. People with human immune deficiency virus live like most individuals, in a complex network of social and personal relationships. Olley et al. (2004) were of the view that self disclosure of serostatus is crucial to prevention of human immune deficiency syndrome and that failure of people living with human immune deficiency virus to disclose their serostatus can place their sexual partners at risk. The findings in this study further confirmed

Table 5: t-test summary table showing significant difference between TA introverted and extroverted personality groups on self disclosure of HIV + status.

Source of variation	Personality the respondents (TA)	N	Mean	Standard deviation	t	Df	p
Self disclosure of HIV + status	Introvert (TA)	15	170.67	20.00	521	28	NS
Extrovert (TA)	15	174.67	22.01				

Key: NS: Not significant

Table 6: t-test summary table showing significant difference between SMT introverted and extroverted personality groups on self disclosure of HIV + status.

Source of variation	Personality the respondents (SMT)	N	Mean	Standard deviation	t	df	p
Self disclosure of HIV + status	Introvert (SMT)	11	163.82	18.03	1.690	28	NS
Extrovert (SMT)	19	174.63	16.22				

Key: NS: Not significant

the earlier studies of Omidéyi (1988) and Letteney (2004) reported that when people are treated to therapies, they are likely to relate well with people and then disclose freely to significant others as the treated groups in their studies were more superior to the control group as there were significant differences between treated (disclosure) groups in the use of secrecy as a stigma; management tool and in perceived devaluation - discrimination associated with an acquired immune deficiency syndrome diagnosis as disclosure of parental serostatus to children is an important aspect of continuous care and custody planning. Secrecy and perceptions of devaluation and discrimination related to serostatus diagnosis should be seen as barriers to disclosure of serostatus to children.

Exposure to various therapies encourage disclosure because disclosure has a number of important public health benefits such as increasing social supports for people who are sero-positives, increasing interested partners' awareness of the risk of human immune deficiency viral infection and increasing the opportunities for risk reduction. Furthermore, the service providers are to explore their clients' comfort level with disclosure of their serostatus to significant persons as this will assist them to strengthen their interpersonal communication skills and encourage voluntary counseling and testing as a way to facilitate increased communication and disclosure between them. Sullivan (2009) also asserted that nurses must routinely assess for clients with human immune deficiency virus transmission risk behaviors, and encourage disclosure of serostatus to sexual partners. It is also essential to offer clients behavioural strategies that can enhance their intentions to use condoms.

Saragossi (1996) who investigated on "You are human immune deficiency virus positive whom do you tell?" and that acquired immune deficiency syndrome is not only a medical problem but also a social problem because the diagnosis carries a stigma that has profound psychological, social and emotional ramifications and that is why when a person is human immune deficiency infected, the diagnosis is often a closely guarded secret, even within the family, but concluded that the victims freely self - disclosed after personal interaction with others as trust must have been built within and with each other. Kalichman (2005) also was of the view that if there is a healthy relationship, this will enhance decision-mak-

ing skills for disclosing their human immune deficiency virus status to sexual partners and facilitate the development and maintenance of safer sexual practices and no wonder the participants benefited immensely from the therapies as they transacted and interacted with each other which enhanced their interpersonal relationship. To Baile (1981), disclosure is related to healthy-ongoing interaction or/and relationship and especially when the relationship is relatively long term in nature. And Gielen, Armstead and Simoni (2000) were of the view that women often disclose to multiple categories of people, some disclose to partners and family members, others disclose to female confidants and others disclose in their social network. A higher proportion of women said they intend to disclose than the much smaller proportion of women at follow up who said they have actually disclosed their serostatus. While Antelman et al. (2001) in their study concluded that having the same gender positively enhances self disclosure as they discovered that males freely disclose to themselves while females are favorably disposed to disclosing to themselves better than opposite sexes

Hogan (1998) asserted that for the introverted individual to self disclosure his/her serostatus will depend on a number of factors like establishing of a trusting relationship, as confidentiality is central to establishing trust which allows the client to keep control over sensitive information like acquired immune deficiency syndrome status, client's fear of and experiences of stigma impaired disclosure of serostatus to family/social network. Considering the nature of the typical introvert, quiet, retiring sort of person, introspective, reserved and distant to people except to intimate friends, keeps his feelings under close control and all these characteristics will not make him freely disclose his serostatus to anyone but the extroverted person, who has many friends is sociable, who freely associates and this nature will enhance his free disposition to self disclosure.

While Agne et al. (2000) were of the view that disclosure is predicated on three factors such as perceived necessity of disclosure, subjective feelings of comfort about the disclosure and perceptions of stigmatization and if adequate exposure is given to the clients, they can be favourable disposed to self disclosure and will be done with ease. And Sparks (1976) in his study of self

disclosure and its relationship to self concept and self management among the students in a selected high school in Michigan, also was in conformity with the finding of this study, especially that the extroverted self management techniques group showing a higher mean scores than introverted self management techniques group because extrovert is significantly more likely to disclose to their friends but the introverts will be more likely to disclose to their closest friends whom they have built long term relationship/friendship with. Finally, Kalichman and Nachimson (1999) said that human immune deficiency virus positive persons face significant challenges to disclosing their serostatus, and failure to disclose can place their sex partners at risk so people living with human immune deficiency virus are encouraged to disclose their serostatus, hence interventions are needed to facilitate disclosure decision making.

CONCLUSION

With regard to the deficiency virus positive status, while extroverted personality individuals benefitted more in the psychotherapies than introverted personality individuals and male participants benefitted more in self management techniques but females participants were more advantaged in transactional analysis in enhancement of self-disclosure of positive serostatus.

RECOMMENDATIONS

The following recommendations are made by the researchers from the findings of the study:

Access to information as a fundamental human right should be made available to every client/patient and relatives. Information should be designed to raise awareness about the epidemic should avoid dramatizing acquired immune deficiency syndrome in ways that can lead to further stigmatization for those affected by the epidemic, urgent attention should be given to ways in which gender based discrimination places women at higher risk in relation to acquired immune deficiency syndrome. Acquired immune deficiency syndrome care should be redefined broadly and inclusively to cover not only the provision of medical treatment but also of psychological attention and social reintegration as well as protection and support including of a legal nature, the government should establish a multi – sectoral

consultative body on acquired immune deficiency syndrome to provide advice and dissemination of information to health care workers, the government should ensure that the body is maintained and allowed to function and the prevention / control of human immuno deficiency virus depends on the success of strategies to prevent new infections and to treat currently infected individuals with voluntary human immuno deficiency virus testing and counseling hence the government should show more pragmatic concern/steps in order to stem the scourge of human immuno deficiency syndrome.

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