SELF-ESTEEM, PERSONALITY-TYPE AND GENDER AS FACTORS IN SELF-DISCLOSURE OF PERSONS LIVING WITH HIV/AIDS

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CERTIFICATION

This is to certify that Peter, Solomon Akpan, a Postgraduate student of Department of Psychology, University of Nigeria, Nsukka with registration number PG/M.sc/10/57757 has satisfactorily completed the requirements for the course and research work for the award of Master of Science (M.Sc) Degree in Clinical Psychology. The work embodied in this thesis is original and has not been submitted in part or full for any other diploma or degree of this or any other University.

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EXTERNAL EXAMINER

DEDICATION

This work is dedicated to the Almighty God, whose supernatural support, sustenance and supplies made this work a reality; and to my dear wife, Rose and my wonderful children; ThankGod, Treasure and Godsgift for their prayers, partnership and practical love during the period of this work.

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I wish to acknowledge the unique contribution of significant figures that made this work a reality.

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ABSTRACT

This study investigated self-esteem, personality-type and gender as factors in self-disclosure of persons living with HIV/AIDS. Three hundred (300) persons living with HIV/AIDS (120 males and 180 females) aged 18-60 years with a mean age of 39 participated in the study. Three instruments were used for data collection: Index of self-esteem (ISE), Eysenckôs Personality Questionnaire (EPQ)-Adult, and Self-Disclosure Index (SDI). The result indicated that self-esteem - $F(1,292) = 16.12$, $p < .001$, and personality-type - $F(1,292) = 27.72$, $p < .001$ were statistically significant factors in self-disclosure, where participants with high self-esteem, and those who are extraverted scored higher than their counterparts in self-disclosure. A very significant interaction was found between self-esteem and personality type. It was concluded that Psychological tools and therapy should be fully exploited in facilitating the self-esteem of persons living with HIV/AIDS to enable them reach out to other persons in openness for necessary psychosocial support.

CHAPTER ONE
INTRODUCTION

Many are the challenges of life, including ill-health such as Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), which mankind has to cope with. However, the ability to self-disclose ones HIV status to gain information or to seek emotional and practical support from inside or outside oneôs social network remains an essential ingredient in creating and maintaining hope and quality of life for the persons living with HIV/AIDS and for public health. Self-disclosure to significant others (spouse/partners, father or mother, children, friends, colleagues, etc) is a life-long process for persons living with HIV/AIDS, as disclosure is something that every person living with HIV/AIDS experiences and struggles with. The process is complex and fraught with mixed emotions, as the outcome can be unpredictable and difficult to handle, though, with proper preparation, timing and strategy, positive outcomes that outweigh the negative ones are guaranteed. Given the personal and societal importance of self-disclosure in HIV/AIDS (better medical adherence, better level and quality of social support, lower level of emotional distress/anxiety, prevention of the spread of HIV, improved family cohesion and improved relationship, etc), it is expedient to explore the possible factors in self-disclosure of persons living with HIV/AIDS, with particular reference to psycho-social variables such as self-esteem, personality-type and gender.

HIV/AIDS which began as a handful of recognized cases among homosexual men in the United States in 1983, is still without a cure, and has become a global pandemic of such proportion that it clearly ranks as one of the most destructive microbial scourges in history (Mohan & Bedi, 2010). Emerging statistics reported by Sacanews (2012) reveals that the virus has claimed over 20 million lives globally, with an estimated 33 million people living with it. Out of which, sub-Saharan Africa accounts for 25million, and Nigeria has about 3,150,000 persons infected with the virus. Nigeria bears the second highest burden of HIV/AIDS, next to South Africa and third in the world after South Africa and India. On the national HIV/AIDS prevalence table, Benue State is ranked first with 12%, followed by Akwa Ibom State with a

prevalence rate of 10.9%, and this incurable disease is associated with a very high degree of stigmatization and social rejection. AIDS Brief (2004) also reported that of the 15 million young people living with HIV/AIDS worldwide, 8 million live in sub-Saharan Africa; 75% of these are young women (aged 15-24).

Mohan and Bedi (2010), advocate a probe into the psyche of people living with HIV/AIDS by behavioural scientists in order to relate certain personality variables and their psychological impacts on their risky behaviours. According to Walter, Vaughen and Cohall (1995), living with HIV/AIDS can damage more than the immune systems; it can also have a devastating impact on the sense of self-worth, as the stigma and discrimination that often accompany HIV/AIDS can make one to feel self-conscious, afraid, less worthy or even depressed. However, a strong sense of self-esteem enhances self-disclosure of HIV status in order to gain information, to seek emotional and practical support from within and outside oneôs social network, to gain identity and to gain better relationship (Caughlin, Bute, Donovan ï Kicken, Kosenko, Ramey & Brashers, 2009).

Research reports on disclosure and HIV/AIDS have attributed disclosure or non-disclosure to various factors, as well as their outcomes. Non-disclosure is viewed as a mechanism to maintain a positive identity by poorly informed HIV positive persons to avoid stigma and discrimination. However, non-disclosure exacerbates fear, anxiety and stigma due to constricted social networks, thus compounding the difficulties faced by those with limited social support (Letteney, 2006; and Rodkjaer, Sodemann, Ostergaard & Lomborg, 2011). Perceived stigma is reported to be associated with an individualôs self acceptance of their disease status and overall perception of self-if they have not come to terms with their disease, and feel shameful and guilty, then would be unlikely to talk about it with others (Chaudor, 2010). In other words, self-disclosure of persons living with HIV/AIDS is associated with their level of self-acceptance, self-worth and self-regard (self-esteem).

Literature also shows that HIV positive persons tend to disclose more frequently to family and relatives, than to friends, and also to steady/long termed/monogamous partners more often than casual partners, perhaps because of the

perceived probability of gaining support and the inherent level of trust (Sowell & Philips, 2010). Again, HIV positive persons may also disclose in order to find relief from the stress of harbouring a secret (Obermeyer, Baijal & Pergum, 2011), or to share knowledge about the disease with others (Ortiz, 2005). On the other hand, persons living with HIV/AIDS might choose to disclose in order to avoid second-hand disclosure (someone finding out from someone or somewhere else) which has a higher likelihood of affecting their identity and create regret (Kennedy, Cowgil, Bogart, Corona, Ryan & Murphy, 2010). It is with this background that the researcher intends to study self-disclosure of persons living with HIV/AIDS in Akwa Ibom State and the influence of self-esteem, personality-type and gender.

Self-disclosure is an index of interpersonal relationship which encompasses ñwillful disclosuresò, where the aim is to let another person know with no shadow of doubt what you have done, what you feel, etc (Jourad, 1971). Consistent with the notion of willful disclosure, Derlega, Metts, Petronio & Margulis (1993), define self-disclosure as an interaction between at least two individuals where one intends to deliberately divulge something personal to another.

Rosenfield (2000) defines self-disclosure as the communication process that grants access to private things and to secrets. The mode of disclosure (also termed message channel) can be face-to-face, non-face-to-face (letter writing or an e-mail message), or third party (where one has another person to disclose oneôs personal information to others either face-to-face or non-face-to-face). Two alternative disclosure message strategies have been identified namely: verbal form and symbolic/non ï verbal means of enacting self ï disclosure in personal relationship (Greene, Derlega, Yep & Petronio 2003). If verbal disclosure might be burdensome, symbolic disclosure may be an effective and efficient way of communicating information about the self to intimates. For instance, a person with HIV/AIDS described how he had the virus tattooed on his biceps to forewarn potential sexual partners (Greene et al, 2003)

Self disclosure as a transactional process is important for achieving important goals (such as developing relationship closeness, gaining emotional support), but it is

often just one component in an ongoing interaction involving disclosure input reactions of the disclosure recipients, initial disclosers and recipientôs perceptions of what happened, and so on (Derlega et al, 1993). In this transactional process, the phenomenon of reciprocity may occur in the disclosure of other potentially stigmatizing information. For example, Greene et al (2003) found that people with HIV/AIDS are more likely to disclose their HIV sero ïpositive status to another person if the other first discloses about being HIV positive. Thus, the social benefits of self ï disclosure depend, in part, on the reactions of the disclosure target and others (third parties) who find out about the private information (Greene et al, 2003). For instance, disclosure targets might be able to provide useful information or material assistance to the discloser to cope with health challenges. The understanding and acceptance that others provide as listeners might also promote or mar feelings of self ï worth in the discloser. Thus, disclosure in HIV/AIDS may be greatly influenced by oneôs level of self ï acceptance, self ï regard and self ï pride (Chaudor, 2010).

The research on the link between disclosure and health often focuses on the possible health benefits of self ï disclosure in coping with negative life events and negative thoughts and feelings; but there may be psychological benefits from disclosure about pleasant events and positive emotions both to the discloser and the disclosure target and others (Gable, Reis, Impett & Asher, 2004). Concealing personal thoughts, feelings and even actions could be a stressor on the body, ultimately increasing susceptibility to illness, while disclosing on the other hand, may reduce the negative effects of concealment, including improving health (Pennebaker, 1995). Suppressing thoughts and feelings via non ï disclosure may have negative cognitive consequences. According to the preoccupation model of secrecy (Wegner & Lane, 1995), ñsecrecy sets into motion certain cognitive processes that create an obsessive preoccupation with the secret thoughtsò. Attempting not to think about a particular thought or feeling paradoxically increases intrusive thoughts about the information. The intrusive thoughts lead to further attempts at thought suppression, causing a ñself ï sustainingò cycle of obsessive preoccupation with the secret. However, from a cognitive processing perspective, talking about stressful thoughts and feelings to a

confidant enables someone to make sense of their experiences as well as desensitize them to upsetting or stress ï related events.

Despite the difficulty disclosure in HIV might pose, non-disclosure has detrimental impacts on the person living with HIV/AIDS and is associated with personal distress, loneliness, social isolation and medical non-adherence as a way to conceal the disease from others (Stutherheim, Bos, Pryor, Brands, Lebregts & Schaalma, 2011). Furthermore, non-disclosure of oneôs HIV positive status prior to a sexual act can lead to criminal prosecutions in Canada and other developed countries (Rapid Response Service, 2013). It is also important to note that the outcomes of HIV disclosure can be stressful but also rewarding as overall evidence suggests that positive reactions to disclosure outweigh negative ones (Arnold, Rice, Flannery & Rotheram- Bonus, 2008 and Smith, Rosseto & Peterson, 2008). Negative outcomes have been associated with lack of preparation, poor timing, wrong context or setting, unsatisfactory disclosure content and second-hand disclosure (Murphy, Roberts & Hoffman, 2003). Again, the most difficult disclosure with the highest risk is that of mother to child in cases of mother-to child infection (Murphy, et al, 2003).

According to Rodkjaer et al (2011), approaches to HIV disclosure fall under three categories, namely: disclosure to everyone, disclose to no one; and selective and strategic disclosure. Those who choose to disclose to everyone face the highest risk of stigma and discrimination, but when they tend to be more prepared to deal with those negative outcomes, they have a high sense of self-esteem and have a ñtake me as I am attitudeò. Contrastingly, those who disclose to no one have lower self-acceptance, less access to social support networks, greater fears and concerns of stigma, and face the highest risk of social isolation and loss of close personal relationships due to disease-related stress (Obermeyer et al, 2011). The selective approach to disclosure is most common among persons living with HIV/AIDS, as they often weigh the benefits and harms of disclosure for each disclosure event, (Arnold et al, 2008). Even though these approach categories are helpful in summarizing disclosure experiences, they are not static; as individualsô decisions around disclosure change constantly over time depending on their circumstances, as disclosing or not disclosing is a way of coping.

Disclosure as a coping strategy in HIV/AIDS has been associated with oneôs level of self-acceptance, self confidence and self regard. Self esteem reported by Obermeyer et al (2011) and Arnold et al (2008) as a factor in HIV disclosure, is a term used in psychology to reflect a personôs overall emotional evaluation of his/her own worth, judgment of oneself as well as an attitude toward the self. And it encompasses beliefs (for example, ñI am competentò, ñI am worthyò) and emotions such as triumph, despair, pride and shame (Crocker & Park, 2004). Self-esteem is also known as the evaluative dimension of the self that includes feelings of worthiness, pride and encouragement; and is closely associated with self-consciousness (Mruk, 2006).

Self esteem is defined as a personôs subjective appraisal of himself or herself as intrinsically positive or negative to some degree (Sedikides & Greg, 2003). Branden (2001) defines self-esteem as the experience of being competent to cope with the basic challenges of life and being worthy of happiness. According to Branden (2001), self esteem is the sum of self-confidence (a feeling of personal capacity) and self-respect (a feeling of personal worth), that exists as a consequence of the implicit judgment that every person has the ability to face lifeôs challenges, to understand and solve problems and their right to achieve happiness, and be given respect.

Generally, self-esteem is described as a personal evaluation that an individual makes on himself/herself, their sense of their own worth, value, importance or capabilities (Rosenberg & Rosenberg, 1978). From the descriptions of self-esteem, it could be regarded as a filter mechanism that plays a significant part in how we generally perceive the world and hence how we behave, such as to self-disclose HIV status or not to disclose.

Robinson and Cervone (2006) construed self-esteem as a permanent characteristic (trait self-esteem), as well as a temporary psychological condition (state self-esteem). Traits are often conceptualized as dispositional forces that create consistency in individualôs experiences and actions; as such they carry the past into the present and across the diverse circumstances. Psychologists usually regard self-

esteem as an enduring personality characteristic (trait self-esteem) though normal, short term variations also exist (state self-esteem) (Rodewalt & Tragakis, 2003).

Peopleôs self-evaluations, whether explicit or implicit are presumably formed through interactions with significant others. According to theories in the tradition of symbolic interactionism, people develop a sense of self-worth on the basis of how other people treat them (Dehart, Pelham & Tennen, 2006). Individuals with low self-esteem have been reported to have repeatedly experienced perceived interpersonal rejection. Conversely, people with high self-esteem have experienced many subjectively successful or non-rejecting interpersonal relationships that favour self-disclosure especially of highly sensitive private matters with risk of stigmatization like oneôs HIV status (Walter et al; 1995).

The unique adjustment of persons living with HIV/AIDS (be it healthy or unhealthy; with high or low level of self-esteem as evidenced by disclosure or non-disclosure of status may be associated with the personality trait of the person such as being an extrovert or introvert. Eysenek (1947), perceived personality as the more or less stable and enduring organization of a personôs character, temperament, intellect and physique which determine his/her unique adjustment to the environment. Endler (1981) reports that human behaviour is in fact determined by the complex interaction of traits and situations. The interaction between peopleôs traits and situations are more important in accounting for anxiety than either traits or situations alone. Thus, the unique adjustment of a sero-positive individual is a product of the complex interaction of his/her personality type and the health situation (HIV status). Such unique adjustments and interpretations influenced by oneôs personality traits and the environmental cues are often internalized to form a self-schema, from where an individual appraises his/her self-worth and eventually the resultant behaviour of disclosure or non-disclosure.

The word personality is derived from the Latin word ñpersonaò, meaning an actorôs mask. In ancient Greece and Rome, actorôs marks symbolized the kind of characters they portrayed. Over the years, persona came to mean not only the roles that actors play, but also the consistent traits and characteristics that people display

(Burnham, 1968). The term personality, then traditionally referred to the consistent, stable and distinctive traits and behaviours that characterize individuals (Burnham, 1968). Again, Brooker (2003) defines personality as the sum total or aggregate of the mental attitudes, traits and characteristics which distinguish a person.

Eysenck (1947) define personality as ñthe sum total of the actual or potential behaviour patterns of the organism, as determined by heredity and environmentò. He also perceived personality as the more or less stable and enduring organization of a personôs character, temperament, intellect and physique, which determine his/her adjustment to the environment. Eysenckôs definition of personality included four main sectors of behaviour patterns: the cognitive sector (intelligence), the conative sector (character), the affective sector (temperament) and somatic sector (constitution). Eysenck and Eysenck (1968), therefore proposed the classification of personality based on a psychological test that provides scores on various personality dispositions. They identified three dimensions of personality or personality types, namely: Extraversion-introversion, psychoticism and neuroticism.

- Extraversion-introversion explains the extent of an individualôs interaction with others. An introvert according to Eysenikôs personality test is associated with controlled behaviorus, seriousness, pessimism and reliability. He does not act on impulse, nor does he like excitement. An extrovert, on the other hand, is associated with sociable tendencies (which favour self-disclosure), optimism, aggressiveness and impulsive behaviours (Wilson, 1977).
- Psychoticism refers to the extent of an individualôs tough mindedness.
- Neuroticism refers to the extent of an individualôs emotionality.

As the unique personality characteristic of a sero-positive individual may influence his/her disposition to self-disclosure, the gender of the individual may also contribute to the unique adjustment to the health status, as well as self-evaluation as a sero-positive individual, leading to the behavioural aspect of either disclosure or non-disclosure. Gender as defined by Santrock (2003) is a socio-cultural dimension of being male or female. Myers (2002) defines gender as the characteristic whether biologically or socially influenced, by which people define male or female. Brooker (2003) defines gender as a term more than just biological sex, but encompasses the

socially constructed views of feminine and masculine behaviour within individual cultural groups.

Gender and gender roles can dramatically affect social relationships and social interaction, as gender roles may influence the development and expression or consequences of psychopathology (Oaltmanns & Emery, 1995). Some theorists have suggested for example, that womenôs traditional roles foster the considerably higher rate of depression among women. Others have suggested that gender roles are not responsible for the etiology of abnormal behaviour, but they do influence how psychopathology is expressed (Oaltmanns & Emery, 1995). According to this view, each gender may experience helplessness, but women are allowed to be depressed, whereas men gender roles dictate that they ñcarry onò as if nothing were wrong. Instead of becoming depressed with low self-esteem, men may express their inner turmoil (vial verbal or non-verbal disclosure) as a psychosomatic disorder (Oaltmanns & Emery, 1995).

Gender identity which refers to the individualôs self-perception as a male or female is an important aspect of self-concept and the way one evaluates oneôs self-worth generally (self-esteem). According to Franzoi (2002), gender identity and gender schemas are important aspects of self-concept. The identification of oneself as male or female, when internalized into oneôs self-concept results in self-labeling. Thus, the product of the match or mismatch of oneôs actual gender and oneôs ideal gender is the individualôs level of self esteem that may affect disclosure of HIV status.

Whether or not one sex shares more readily is a heated debate in social psychology, but sex-role identities plays a large part in the amount of information one chooses to reveal to another. Androgynous people disclose more intimately across contexts than do notably masculine and feminine people (Ignatius, & Kokkonen, 2007).

Research findings on gender differences in self-disclosure are mixed. Women self-disclose to enhance a relationship, while men self-disclose relative to their control and vulnerabilities. Men initially disclose more in heterosexual relationships, while women tend to put more emphasis on intimate communication with same sex friends than men do (Barry, 2006). Also, girls are noted for usually disclosing their problems to their mothers, while boys reveal more about bad grades, behaviorual conflicts and

other issues to both parents. Women more than men tend to disclose overall, though may be affected by the situation (Dindia & Allen, 1992). From the submission above, this research work is focused on investigating self-esteem, personality-type and gender as factors in self-disclosure of persons living with HIV/AIDS in Akwa Ibom State.

Statement of the Problem

Self-disclosure of persons living with HIV/AIDS is a complex process fraught with mixed emotions and unpredictable outcomes, especially disclosure of mother to child infection by an infected mother. Due to the importance of disclosure to the HIV-positive persons and the people around them for personal and public health, disclosure becomes an indispensable issue/variable in the management of HIV/AIDS despite the difficulty disclosure may pose.

Differences in the decision to disclose or not to disclose and the content of disclosure message have been associated with oneôs level of self-esteem (Arnold et al., 2011; Chaudor, 2011; Obermeyer et al., 2011), with oneôs personality-type such as extroversion and introversion and gender (Barry, 2006; Ignatius & Kokkonen, 2007). From the foregoing, the problem of this study is:

- Is self-esteem a factor in self-disclosure of persons living with HIV/AIDS
- Is personality-type a factor in self-disclosure of persons living with HIV/AIDS?
- Is gender a factor in self-disclosure of persons living with HIV/AIDS?

Purpose of the Study

The purpose of this study is to investigate whether:

- Self-esteem is a factor in self-disclosure of persons living with HIV/AIDS.
- Personality-type is a factor in self-disclosure of persons living with HIV/AIDS
- Gender is a factor in self-disclosure of persons living with HIV/AIDS.

Operational Definition of Terms

In this study on self-esteem, personality-type and gender as factors in self-disclosure of persons living with HIV/AIDS, the following operational definitions apply:

- **Self-Esteem:** This refers to the subjective appraisal by the respondents of their own self-wroth, value, importance and capabilities as measured by the Index of Self-esteem (ISE) (Hudson, 1982).
- **Personality-Type:** This is the consistent, stable and distinctive traits and behaviours that characterize respondents as measured by the extraversion-introversion scale of Eysenckôs Personality Questionnaire (EPQ-Adult) (Eysenck & Eysenck, 1991).
- **Gender:** This refers to the categorization of being male or female as indicated by the respondent on the sexual status column of the scale.
- **Self Disclosure:** This is the level of sharing personally private thoughts, feelings and actions with others as measured by the Self-Disclosure Inventory (SDI) (Miller, Berg & Archer, 1983).

CHAPTER TWO

LITERATURE REVIEW

The review of literature for this study has been organized under the following sub-themes:

- Theoretical review
- Empirical review
- Summary

Theoretical Review:

The theories of self disclosure converge on reciprocity and intimacy as factors in self-disclosure as well as reduction of uncertainty in relationship.

Thus the following theories of self-disclosure are reviewed in this study:

- Social penetration theory
- Social exchange theory
- Social comparison theory
- Uncertainty reduction theory

Social Penetration Theory: Social penetration theory states that the development of a relationship is closely linked to systematic changes in communication; as relationships generally begin with the exchange of superficial information and gradually move on to more meaningful conversations. Altman & Taylor (1973), the early theorists of relationship development identified two dimensions to self-disclosure: breadth and depth; and emphasized that self-disclosure progress in depth (sensitivity of material disclosed) and breadth (variety of topics disclosed). According to social penetration theory, both depth and breadth are crucial in developing a fully

intimate relationship. The range of topics discussed by two individuals is the breadth of disclosure. The degree to which the information revealed is private or personal is the depth of that disclosure. It is easier for breadth to be expanded first in a relationship because of its more accessible features; it consists of outer layers of personality and everyday lives, such as occupation and preferences. Depth is more difficult to reach, given its inner location; it includes painful memories and more unusual traits that we might try to hide from most people. This is why we reveal ourselves most thoroughly and discuss the widest range of topics with our spouses and loved ones (Forgas, 2011).

Social penetration maintains that interpersonal relationships evolve in some gradual and predictable fashion. Penetration theorists believe that self-disclosure is the primary way that superficial relationships progress to intimate relationship. Intimacy in close relationships can only develop if both partners reciprocate disclosures in terms of the breadth and depth of disclosure. According to this theory, this process of reciprocity needs to be gradual and partners need to match the intimacy of the disclosures. Saying something too personal too soon creates an imbalance in the relationship which can make the other partner very uncomfortable. However, this gradual process varies from relationship to relationship and can depend on the specific partner one is communicating with (Altman &Taylor, 1973).

Social Exchange Theory: Social exchange theory explains that people attempt to maintain equality in self-disclosure because an imbalance in this makes them uncomfortable. According to Levinger & Snoek (1972) in their incremental exchange, theory, reciprocity in self-disclosure is well described by the social exchange theory

as a positive response from the disclosure target; whereby he/she discloses in return to the discloser.

The theoretical position of social exchange theory argues that the major force in interpersonal relationships is the satisfaction of both peopleôs interest. Theorists in social exchange posit that self-interest is not necessarily a bad thing, and that it actually enhances relationships. The social exchange approach views interpersonal exchanges as analogous to economic exchanges where people are satisfied when they receive a fair return on their expenditures. Two types of reciprocity have been identified in self-disclosure; turn-taking reciprocity and extended reciprocity. Turn-taking is when partners immediately self-disclose with one another; and extended is when disclosure happens over a period of time, in which one partner may be the only one disclosing while the other just listens. Those who engage in turn-taking reciprocity are shown to like their interaction partners more than those who engage in extended reciprocity. Turn-taking partners are also shown to feel closer and similar to each other and to enjoy the otherôs company more than extended pairs. (Sprecher & Hendrick (2004).

Partner responsiveness has been identified as a key component for reciprocity and intimacy. This is important because emotional disclosures must be reciprocated with emotional disclosures and not factual. Emotional disclosures are also shown to foster intimacy more than factual disclosures. Factual disclosures reveal facts and information about the self (e.g. ñ I am divorced from my husbandò); while emotional disclosures reveal a personôs feelings, thoughts and judgment (e.g. ñmy divorce was so painful, it has made it difficult for me to trust a romantic partner againò). Emotional disclosures can increase intimacy because they allow the listener to

confirm and support the disclosersôs view (Laurenceau, Barrett & Pietromonaco (1998).

Social Comparison Theory:

Social comparison theory as theorized by Festinger (1954), states that we evaluate ourselves based on how we compare with others. This theory centres on the belief that there is a drive within individuals to gain accurate self-evaluations. The theory explains how individuals evaluate their own opinions and abilities by comparing themselves to others in order to reduce uncertainty in these domains, and learn how to define the self. Thus, we may disclose information about our intellectual aptitude or athletic abilities to see how we relate to others. According to Aarigu (2011), this type of comparison helps to decide whether we are superior or inferior to others in a particular area.

Since the inception of social comparison theory, its critical framework has undergone several advances. Key among these are:

- Development in understanding the motivations that underlie social comparisons.
- The particular types of social comparisons that are made.

The motives that are relevant to social comparison include:

- Self-enhancement (Gruder, 1971).
- Maintenance of positive self-evaluation (Tesser & Campbell, 1982)
- Components of attributions and validation (Goethals & Darley, 1977)
- The avoidance of closure (Suls, Martin & Wheeler, 2002).

Two types of social comparison have been identified: Downward social comparison and Upward social comparison (Wills, 1981). Downward social comparison is a defensive tendency that is used as a means of self-evaluation when

people compare themselves to someone worse off. When a person looks to another individual or group that they consider to be worse off than themselves in order to feel better about their self or personal situation, they are making a downward social comparison. Research has suggested that downward social comparisons can elevate self-regard or self-esteem (Gibbons, 1986). Thus, downward comparison theorists emphasize the positive effects of comparisons in increasing oneôs subjective wellbeing. For example, it has been found that breast cancer and HIV patients made the majority comparisons with patients less fortunate than themselves (Wood, Taylor & Lichtman, 1985).

Upward social comparison on the other hand occurs when people compare themselves to someone better off or superior. Research has suggested that social comparisons with others who are better off or superior, or upward comparisons, can lower self regard or self-esteem (Tesser, Millar & Moore (1988). Individuals make upward comparisons, whether consciously or subconsciously, when they compare themselves with an individual or comparison group that they perceive as superior or better than themselves in order to improve their views of self or to create a more positive perception of their personal reality. In simple terms, downward social comparisons are more likely to make us feel better about ourselves, while upward social comparisons are more likely to motivate us to achieve more or reach higher heights in life.

Uncertainty Reduction Theory:

Uncertainty reduction theory presumes that the beginning of personal relationships are fraught with uncertainties, thus people are motivated to use communication (self-disclosure) to reduce their uncertainties through understanding

and knowledge. The uncertainty reduction theory, developed in 1975 by Charles Berger and Richard Calabrese, is a communication theory from the post-positive tradition. The theory asserts the notion that, when interacting, people need information about the other party in order to reduce their uncertainty. In gaining this information, people are able to predict the others behaviour and resulting actions, all of which are according to the theory crucial in the development of any relationship.

Berger and Calabrese (1975) identified two types of uncertainty when strangers meet (cognitive and behavio;ural uncertainties); three interactive strategies which people may use to seek information about someone (passive, active and interactive); and three stages of relational development when strangers meet (the entry stage, the second stage and the final stage).

According to the uncertainty reduction theory, in initial interactions, there are two types of uncertainty; cognitive and behaviorual. Cognitive uncertainty pertains to the level of uncertainty associated wit the cognition (beliefs and attitudes) of each other in the situation (Berger, & Bradac (1982). Uncertainty is high in initial interactions because individuals are not aware of the beliefs and attitudes of the other party. Behaviorual uncertainty pertains to the extent to which behaviour is predictable in a given situation. That is, the strangers meeting for the first time may be unsure of how to behave (or how the other person would behave). However, in most societies, there are behaviour norms, that we all tend to abide by, and if in initial conversations one chooses to ignore those norms, there are risks of increasing behavioural uncertainty and reduction of the likelihood of having future interactions. A great example of ignoring societal norms is engaging in inappropriate self-disclosure.

In addressing these uncertainties, Berger and Calabrese (1975), proposed two processes: proactive uncertainty reduction and retroactive uncertainty reduction. Proactive uncertainty reduction involves strategic communication planning prior to interaction. While retroactive uncertainty reduction is the process of analyzing the situation post interaction.

Three interactive strategies which people use to seek information about others in order to reduce uncertainty according to Berger (1995) are: passive, active and interactive strategies.

- Passive strategy involves shrued and unobtrusive observation of the natural environment, intentionally unnoticeable, to gain information on another for reducing uncertainties. For example, watching someone in class, cafeteria, or any common area without attracting attention.
- Active strategy involves tactics of gaining information about someone to reduce uncertainty without any personal direct contact. For example, if one were to ask a friend about a particular person, one would ask the particular personôs friend for some information without actually confronting the person directly. In other words, active strategy involves the use of a third party in self-disclosure.
- Interactive strategy involves directly confronting the individual to engage in some forms of dialogue to reduce uncertainties between the two.

According to Berger and Calabrese (1975), three separate stages of relational development exist at the initial interaction of strangers; the entry stage, the personal or second stage and the final or exit stage. Each stage includes interactional behaviours that serve as indicators of liking and disliking.

- **The Entry Stage:** The entry stage of relational development is characterized by the use of behavioural norms, where interactions begin and are guided by implicit and explicit rules and norms, such as greeting someone or laughing at ones innocent jokes. The contents of the exchanges are often demographic and transactional. The level of involvement will increase as the strangers move into the second stage.
- **The Personal Stage:** This phase occurs when strangers begin to explore one anotherôs attitude and beliefs. Individuals typically enter this stage after they have had several interactions with a stranger and emotional involvement tends to increase as disclosure increases.
- **The Final Stage or Exit Phase:** Here, the former strangers decide whether they want to continue to develop a relationship. If there is no mutual liking, either can choose not to pursue a relationship. Understanding the cycle of relational development is key to studying how people seek to reduce uncertainty about others.

Empirical Review

Empirical literatures on self-disclosure of people living with HIV/AIDS have been scarce, but some are reviewed below in relation to the problem of this study as follows:

Armistead, Morse, Forehand, Morse and Clark (1999) in their study on African-American Women and Self Disclosure of HIV Infection: rates, predictors and relationship to depressive symptomatology; examined patterns of disclosure to significant others, predictors of disclosure and the relationship between disclosures and psychological functioning. Analyses indicated that women disclose at varying rates to different categories of others: disclosure to mothers (66%), disclosure to partners (56%), disclosure to children (28%), disclosure to fathers (23%). Womenôs illness status predicted disclosures to fathers and friends. Only disclosures to partners was significantly related to womenôs psychological functioning. Fewer symptoms of depression were evident in women who had disclosed their HIV status to their partners compared to those who had not disclosed.

Simoni, Mason, Marks, Ruiz, Reed and Richardson (1995) in their study on womenôs self-disclosure of HIV infections; rates, reasons and reactions; sampled an ethically-diverse group of women (13% of whom were African-American), and reported that the rate of disclosure to categories of significant others vary. Disclosure to partners was most common (87%), followed by disclosure to mothers (59%), and fathers (31%). This pattern of variations in disclosure rate to different categories of significant others was reported by Hays, Mckusick, Pollack, Hilliard, Hoff and Coates (1993), in their study on self-disclosure among gay men. The discrepancy in disclosure rates was explained by the researchers as a factor of ñdouble disclosuresò.

They explained that disclosures of sero-status often carries the risk of double disclosure, in that disclosers may be revealing along with their diagnosis, a history of high-risk behaviour (sexual activity). The revelation of such clandestine information may be perceived by a potential discloser as particularly distressing to parents, as compared to partners who may already be aware of the high-risk behaviour.

Sachperoglou and Bor (2001) in their study on disclosure of HIV sero-positivity and social support: general pattern in Greece, reported that HIV-positive individuals disclosure experiences that provided the most support were from friends, lovers and partners, whereas fathers and children provided the least support. Their result agreed with the variation in the rate of disclosure to different categories of significant others, where partners and mothers received highest rate of disclosure and the least to children. This follows the principle of reciprocity in self-disclosure.

Stirrat, Remien, Smith, Copeland, Dolezal and Kreger (2006) studied on the role of HIVsero-status disclosure in antiretroviral medication adherence, and reported a direct link between HIV-disclosure and better medical adherence; however, this relationship is mediated by the amount and quality of social support. A systematic review by this study also revealed that social support was consistently associated with better medical adherence, thus by association, disclosure should lead to better adherence as well.

Beals (2003) studied the association between self-disclosure and self-esteem as an index of mental health, using 45 gay men and 40 lesbians. The subjects participated in a diary study and indicated whether they disclosed or concealed information about their sexual orientation when ñdisclosure opportunitiesò occurred during a two week time period. At the end of the day, each participant completed

measures of social support, self-esteem and satisfaction with life. The result indicated that self-disclosure was associated with greater social support and high level of self-esteem (psychological wellbeing).

Laurenceau, Barrett and Pietromonaco (1998), studied the importance of self-disclosure, partner disclosure and perceived partnersô responsiveness in interpersonal exchanges. Two studies were conducted, illustrating how recipient responsiveness to disclosure input contributes to the experience of intimacy. The 120 participants kept a daily diary record for 1 or 2 weeks (studies 1 and 2 respectively), and recorded how much they (and their partners) disclosed. The research results revealed that self-disclosure and partner disclosure were both significant predictors of intimacy, but partner responsiveness also mediated the relationship between self-disclosure and intimacy. Greater disclosure by self and partners disclosure was associated with a perception of greater responsiveness by the partner that, in turn, was associated with a perception of higher intimacy of the interaction.

Lippert and Prager (2001) conducted a diary study focusing on predictors of daily experiences of intimacy between cohabiting couples. Consistent with the findings of Laurenceau et al (1998); Lippert & Prager found that the perception of being understood by oneôs partner (together with interaction pleasantness, disclosure of private feelings, and the disclosure of emotion) were predictors of perceived intimacy of daily interactions.

Walter, Vaughan and Cohall (1995) in their research on psychosocial influences on risk behaviours among HIV positive persons; sampled 360 high school students living with HIV/AIDS (170 males and 190) females). The participants reported HIV risk behaviours- unsafe sex and substance abuse. The researchers used

Rosenberg self-esteem scale (Rosenberg, 1965) to measure their participantsô self-esteem; and reported a low level of self-esteem which they linked with their risk behaviours. In their submission; ñliving with HIV/AIDS can damage more than our immune system, it can also have devastating impact on our self-esteem, and the low self-esteem can prevent people from doing everything possible to stay healthy and create the conditions for healingò.

Sterk, Klein and Elifson (2000) studied the relationship between low self-esteem and HIV-related risk behaviour of ñat-riskò women, and reported a low level of self-esteem from their 220 participants, using Coopersmith Self-esteem Inventory (Coppersmith, 1967) to assess self-esteem. They reported that their participants fell prey easily to peer pressure and faulty life styles as implication of low self-esteem. They also submitted the following in their report as factors that predict self-esteem of persons living with HIV/AIDS: stigmatization, guilt, loss of positive body image, loss of roles, loss of work and loss of social network.

Castringhini, Girl, Neves, Reis, Galvao and Hayashido (2010), researched on depression and self-esteem of patients positive for HIV/AIDS, using 75 participants aged 21-39 years, of whom 50.7% were males. Data were collected through interviews with individuals living with HIV/AIDS using as instruments Beck Depression Inventory and Rosenberg self-esteem scale, as well as a questionnaire for economic, demographic, clinical and epidemiological data. They reported low self-esteem and moderate-severe depression to submit that depression associated with anxiety are serious psychological consequences of HIV/AIDS.

Madu, Jali, Ramoroko, Kropiunigg and Summer (2009), in a study investigating the effect of HIV/AIDS related knowledge and self-esteem on the

disposition of pregnant women to go for voluntary HIV-testing; sampled 457 pregnant women in South-Africa. Using HIV/AIDS Knowledge Test (Carey & Schroder, 2002) and Rosenberg Self-esteem Scale (Rosenberg, 1965) to measure HIV/AIDS related knowledge and self esteem respectively, they found that self-esteem was a significant factor that positively contributed to pregnant women disposition to go for HIV testing, as the more the self-esteem increased, the more the pregnant women disposition for HIV/AIDS testing increased. HIV/AIDS related knowledge did not emerge as a significant factor that influences the disposition of pregnant women to go for voluntary HIV testing.

Ifeagwazi and Ezema (2010) in their study on influence of house help status and self-esteem on the psychological health of Igbo (Nigerian) adolescents, using a sample of 205 adolescents (91 house helps and 114 non-house helps), who completed index of self-esteem (ISE) (Hudson, 1982) and the general health questionnaire (GHQ-12) (Goldberg, 1972); reported low self-esteem scores for the house helps with a corresponding higher score on GHQ-12; an evidence of poor psychological health. The study showed that house help status and self-esteem are important factors that could impact on psychological health.

Penedo, Gonzalez, Dahn, Antoni, Malow, Costa and Schneiderman (2003) evaluated the relationship between personality traits and quality of life among 116 men and women living with HIV/AIDS. The personality traits of study were neuroticism and extroversion and they used Eysenck Personality Questionnaire (EPQ Adult) (Eysenck & Eysenck, 1991). The result showed a high, positive correlation between personality traits and quality of life, viz; Neuroticism was significantly associated with poorer quality of life, while extroversion was significantly associated

with better quality of life. The missing link in this study is the failure of the study to account for the reason behind the extrovertôs better adjustment and better quality of life even with HIV/AIDS. Is it their sociability and disposition to self-disclosure, or is it their impulsive temperament?

Mohan and Bedi (2010) in their study on some personality correlates of HIV positive individuals (namely, extraversion, neuroticism anger and self-esteem), used a sample size of 250 HIV positive persons (aged 15-25 years) comprising of 190 males and 60 females as the experimental group, and a control group of 125 males and 125 females selected from colleges who were HIV negative. They used Eysenckôs Personality Inventory (Eysenck & Eysenck, 1968), State-Trait Anger Expression Inventory (Speilberger, 1988) and Rosenberg Self-esteem Scale (Rosenberg, 1965) to measure the relevant personality traits in the study. The result indicated that on the traits of extraversion and neuroticism, HIV positive males scored higher than HIV positive females, while overall, the HIV positive subjects scored higher than HIV-free subjects. The HIV positive subjects also scored higher on self-esteem than the HIV free subjects, but with no gender difference on the level of self-esteem for both the HIV subjects and the control group. On extraversion-introversion, no significant gender difference was reported. Hence the scores on self-esteem of both sexes could be pooled for further analysis (Mohan & Bedi, 2010).

Burnett, Anderson and Heppner (1995) researched on gender roles and self-esteem using 286 undergraduate students (90 males and 146 females). Personal Attributes Questionnaire (PAQ) (Spence, Helmreich & Stapp, 1974) was used to assess participantsô individual sex role orientation; and Coppersmith Self-esteem Inventory (CSI) (Coppersmith, 1967) was used to measure participantsô self-esteem.

The result indicated that individual masculinity was significantly correlated with self-esteem for both men and women, as individuals who posses a larger amount of masculine characteristics such as decisiveness, independence and competitiveness reported; higher level of self-esteem than those with less of those traits. The present study intends to explore the association between the biological gender and self-esteem of HIV positive persons, bearing in mind, the vulnerability of the female gender to HIV/AIDS due to their biological structures as well as other psycho-social factors.

Watkins, Akande, Cheng and Regmi (1996) studied culture and gender differences in self-esteem of college students. They compared Hong Kong undergraduate college students with Nigerian, American and Nepalese male and female students using index of self-esteem (ISE) (Hudson, 1982). American males reported the highest self-esteem regarding physical ability, American and Nigerian participants tended to report higher self-esteem than both Asian samples. The American participants had the lowest self-esteem compared to other countries when dealing with shyness.

Crocker, Lahtamen and Cooper (2003) in a similar study on culture and gender differences in self-esteem reported that black Americans self-esteem were more strongly correlated with religiosity than white Americans, and their self-esteem is based less on approval, regard from others and academic performance than the white Americans. Crocker et al (2003) further reported an overall higher self-esteem for females than males in college. In a related study, Frost and Mckelvie (2004) in a longitudinal study found that self-esteem is higher in girls than boys under 13, but is higher in boys during adolescence and young adulthood, and this is positively correlated with body satisfaction. Thus, Frost and Mckelvie (2004) concluded that as

one grows older, there are diminishing concerns about appearance and independence and this leads to an increase in self-esteem. Therefore self-esteem tends to be higher in young adulthood.

Summary of Literature Review

Four theories of self-disclosure reviewed in this work include; social penetration theory, social exchange theory, social comparison theory and uncertainty reduction theory.

Social penetration theory maintains that interpersonal relationships evolve in some gradual and predictable fashion from superficial to intimate, where relational closeness develops through self-disclosure.

Social exchange theory posits that reciprocity in self-disclosure is a key component for intimacy; as interpersonal exchanges in relationship are analogous to economic exchanges where people are satisfied when they receive a fair return on their expenditure.

Social comparison theory explains that individuals evaluate their own opinions and abilities by comparing themselves to others in order to reduce uncertainty in these domains, and learn how to define the self.

Uncertainty reduction theory presumes that the beginning of interpersonal relationships is fraught with uncertainties, thus people want to reduce uncertainty in relationship through knowledge and understanding as they are motivated to use communication (self-disclosure) to achieve this.

This study is anchored on the social comparison theory, an upsurge from the tradition of symbolic interactionism which states that peopleôs self-evaluations

whether explicit or implicit are presumably formed through interaction with significant others. With the high level of stigmatization and discrimination associated with HIV/AIDS, persons living with the virus find it an heculine task to disclose their seropositive status due to perceived negative reaction from the significant others, as well as their negative self-worth. Moreover, the social interaction which favours self-disclosure may be influenced by the personality characteristics and gender of HIV-positive persons, as they relate with their significant others.

From the literature reviewed above, persons living with HIV/AIDS generally struggle with the issue of self-disclosure of status to significant others. Thus the present study seeks to find the missing link (the psychological variables that account for this) as it seeks to explore the role of self-esteem, personality-type and gender as factors in self-disclosure of persons living with HIV/AIDS.

Again, from the literature reviewed above on self-disclosure of persons living with HIV/AIDS, the data are mostly from the West, except only two, are from Africa, and one of them is from South Africa, which has a culture close to that of the West. Thus the present study seeks to contribute a truly African (Nigerian) empirical data to the literature on self-disclosure of persons living with HIV/AIDS.

Finally, from the literature reviewed, the research population have been mostly people negative for HIV/AIDS, thus the present research seeks to contribute to the literature of self-disclosure of persons actually living with HIV/AIDS.

Hypotheses

The study is guided by the following hypotheses:

- Self-esteem will not be a statistically significant factor in self-disclosure of persons living with HIV/AIDS.
- Personality-type will not be a statistically significant factor in self-disclosure of persons living with HIV/AIDS.
- Gender will not be a statistically significant factor in self-disclosure of persons living with HIV/AIDS.

CHAPTER THREE
METHOD

Participants

The participants for this study were 300 persons (made up of men and women) living with HIV/AIDS in Akwa Ibom State (100 from each of the three Senatorial Districts), who are on treatment at the HIV treatment centres in the state. Their age range were from 18 years to 60years. The sampling technique used was the incidental sampling method; where the patients who were available at the clinic and who volunteered to participate in the study were involved in the study, to maintain confidentiality and avoid perceived rejection and stigmatization among patients in the clinic not allowed to participate in the study.

Instruments

The following instruments were used to collect data for the study:

- **Index of Self-Esteem (ISE):** This is a standardized psychological assessment tool developed by Hudson (1982) and validated for use with Nigerian samples by Onighaiye (1996). The 25-item questionnaire measures self-perceived and self-evaluative components of self-concept which is the sum total of the self-perceived and other perceived views of the self held by a person. It is scored on a 5-point scale ranging from 1 (none of the time) to 5 (most or all of the time). 12 items according to ISE manual are scored in a reverse direction (3,4,5,6,7,14,15,18,21,22,23 and 25), while the other 13 items are directly scored. The total score is then compared with the norm for interpretation.

Hudson (1982) obtained a co-efficient alpha of .93 and a two-hour test re-test co-efficient alpha of .92. Onighaiye (1996) obtained a co-efficient alpha of .93 and two-hour tests re-test co-efficient of .92. Onighaiye further validated the instrument for Nigerian samples with the norm as follows: Males-30.09, Females-32.04. The norm serves as the basis for separating clients/participants into high self-esteem and low self-esteem groups. Scores higher than the norm indicates low self-esteem, and the lower a score is below the norm, the higher the self-esteem (Onighaiye, 1996).

Pilot study was conducted to determine the validity and reliability of the instrument for the present study. Fifty (50) HIV/AIDS patients from three (3) hospitals in Akwa Ibom State participated in the study. A Cronbachôs Alpha of .74 was obtained for the instrument. A two-hour test-retest reliability co-efficient of .99 was also obtained for the instrument.

- **Eysenck Personality Questionnaire (EPQ-Adult):** This is a standardized personality instrument developed by Eysenck and Eysenck (1991). The extraversion-introversion subscale of EPQ which measures extraversion-introversion dimension of personality is used for this study. The 21-item true-false questionnaire for assessing extraversion-introversion (19 positively scored and 2 negatively scored items), are taken from the 90-item original Eysenck Personality Questionnaire. Eysenck and Eysenck (1991) reported a test-retest reliability coefficient (in a monthôs time) of .80 on extraversion-introversion and a Cronbachôs Alpha of .79 as well as a norm for Nigerian subjects (Males 13.32; Females 14.48).

Pilot study was conducted to determine the validity and reliability of the instrument for the present study. Fifty (50) HIV/AIDS patients from three (3) hospitals in Akwa Ibom State participated in the study. A Cronbachôs Alpha of .74 was obtained for the instrument. A two-hour test-retest reliability co-efficient of .99 was also obtained for the instrument.

- **Self-Disclosure Index (SDI):** This 10 item self-report measure developed by Miller, Berg and Archer (1983), is designed to measure a participantsô willingness to disclose personal information that is not necessarily distressing. It contains items describing a range of personal issues that could be disclosed such as emotions and relationships. Participants are expected to rate the extent of their disclosure on each situation on a five-point scale ranging from 1 (discuss not at all) to 5 (discuss fully and completely). Scores can range from 10-50, and a higher score reflect higher tendencies to self-disclose and a score of 30 as the dividing point. Miller, et al (1983) report internal consistency ranges from .86 to .93; and Cronbachôs Alpha of .86.

  Pilot study was conducted to determine the validity and reliability of the instrument for the present study. Fifty (50) HIV/AIDS patients from three (3) hospitals in Akwa Ibom State participated in the study. A Cronbachôs Alpha of .69 was obtained for the instrument. A two-hour test-retest reliability co-efficient of .99 was also obtained for the instrument.

Procedure

A letter for permission was collected from the Department of Psychology, University of Nigeria, Nsukka; to the hospitals for opportunity to conduct a study on patients in the HIV/AIDS unit of the hospitals. The researcher administered about 350

copies of each of the three questionnaires to the participants during a scheduled visit to the hospitals after proper explanation of the procedure to the participants and informed consent was obtained. The researcher involved some clinical psychologist interns for assistance in administering and collecting the questionnaires, especially in giving sufficient guidance on how to respond effectively to the items on the instruments. No monetary reward was given for participating in the study, but participants were adequately appreciated at the end of the assessment.

The instrument was later scored and the data analyzed using SPSS.

Design/Statistics

The study adopted a cross-sectional design and a survey method. ANOVA was used for data analysis to test the hypotheses.

CHAPTER FOUR

RESULT

Table 1: Univariate ANOVA Table for Self-esteem, Personality-type and Gender as factors in Self-disclosure of Persons Living with HIV/AIDS.

SOURCE	df	Mean square	F	Sig.
Self-esteem	1	460.60	16.12	.000
Personality-type	1	791.90	27.72	.000
Gender	1	8.67	.30	.582
Self-esteem/ personality-type	1	618.31	21.64	.000
Self-esteem/gender	1	6.36	.27	.637
Self esteem/personality-type/gender	1	19.81	.69	.406
Error	292	28.57		
Total	300			

A total of 300 persons living with HIV/AIDS participated in the study (males – 120, females – 180, low self-esteem – 169, high self-esteem- 131, introverts – 145 and extroverts – 155)

The univariate ANOVA table above shows that self-esteem and personality-type are significant factors in self-disclosure of persons living with HIV/AIDS, as individual factors as well as factors of interaction.

The result of the analysis indicated that self-esteem was a statistically significant factor in self-disclosure $F(1,292) = 16.12$, $p < .001$. Therefore the null hypothesis is rejected. As table 2 shows, Persons Living with HIV/AIDS who have high self-esteem scored higher ($M=29.70$, $SD=6.13$) in self-disclosure than their counterparts who have low self-esteem.

Table 2: Mean and Standard Deviation for Self-esteem.

Self-esteem	Mean	Standard Deviation	N
High	29.70	6.13	169
Low	26.08	5.50	131
Total			300

It was also found that personality-type was a very statistically significant factor in self-disclosure $F(1,292) = 27.72$, $p < .001$. This led to the rejection of the null hypothesis. As table 3 shows, Persons Living with HIV/AIDS who were extroverts scored higher (M=30.37; SD=6.63) in self-disclosure than the introverts (M=25.70; SD=4.40).

Table 3: Mean and Standard Deviation for Personality-type.

Personality-type	Mean	Standard Deviation	N
Introvert	25.70	4.40	145
Extrovert	30.37	6.63	155
Total			300

Gender was not a significant factor in self-disclosure in this study $F(1,292) = .30$, $p > .05$. Thus, the null hypothesis was not rejected. Among persons living with HIV/AIDS, being male/man or female/woman was not a factor in their self-disclosure.

Further, a statistically significant interaction effect between self-esteem and personality-type in self-disclosure was found $F(1,292) = 21.64$, $p < .001$. Introverts with low self-esteem scored lower (M=25.34; 3.82) than extroverts with low self-esteem (M=32.14;

SD=5.83). Equally for those with high self-esteem, extraverted personality participants scored higher (M=26.32; SD=6.64) in self-disclosure than those of introverted personality (M=25.95; SD=4.78).

Table 4: Mean and Standard deviation for Interaction between Self-esteem and personality-type.

Self-esteem	Personality-type	Mean	Standard Deviation	N	₣N
Low	Introvert	25.34	3.82	61	169
	Extrovert	32.14	5.83	108	
High	Introvert	25.95	4.78	84	131
	Extrovert	26.32	6.64	47	
Total				300	300

The interaction between self-esteem and personality is graphically illustrated in figure 1.

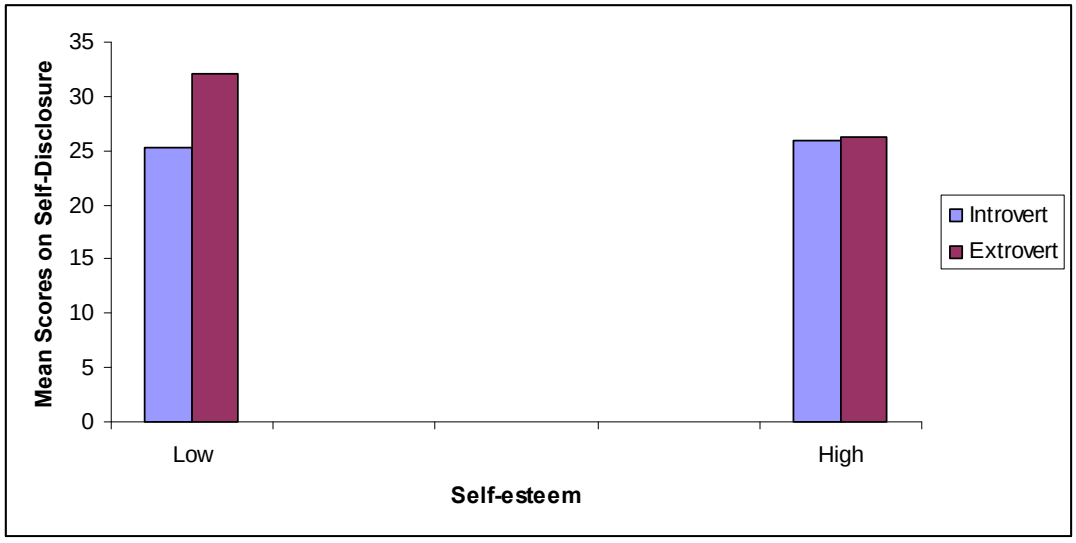

Figure 1: Graph showing the interaction between Self-Esteem and Personality in Self-Disclosure

CHAPTER FIVE
DISCUSSION

The result of this study on self-esteem, personality-type and gender as factors in self-disclosure of persons living with HIV/AIDS shows that self-esteem and personality-type are significant factors in self-disclosure. The result of the study rejected the first hypothesis which states that ñself-esteem will not be a statistically significant factor in self- disclosure of persons living with HIV/AIDSò. This indicates that self-esteem is a significant factor in self-disclosure of persons living with HIV/AIDS, with those who have high self-esteem scoring higher in self-disclosure than those with low self-esteem. This finding is consistent with Beals (2003), who reported a positive association among self-disclosure, greater social support and high self-esteem. The result of this study which shows that persons living with HIV/AIDS have high self-esteem agrees with previous study by Mohan and Bedi (2010), who found that HIV positive subjects scored higher on self-esteem than HIV free subjects and no gender difference on extraversion-introversion scores. This result also is consistent with the findings of Madu, Jali, Kropiunigg and Summer (2009), who found that self-esteem was a significant factor that positively contributed to pregnant womenôs disposition to go for HIV testing; as the more the self-esteem increased, the more the pregnant womenôs disposition for HIV/AIDS testing increased. People with high self-esteem tend to disclose more than those with low self-esteem as they feel competent to cope with their basic challenges of life and feel that they are worthy of happiness. Again, high self-esteem enhances successful interpersonal relationships that favour disclosure especially of highly sensitive, private matters with risk of stigmatization like oneôs HIV status.

However, the result of this study disagrees with findings of Walter, Vaughen and cohall (1995);, Sterk, Klein and Elifson (2000) and Castrighini, Girl, Nerves Reis, Galvao

and Hayaashido (2010), that persons living with HIV/AIDS generally have low self-esteem. In their submission ñliving with HIV/AIDS can damage more than oneôs immune system; it can have devastating impact on oneôs self-esteem, and the low self-esteem can prevent people from doing everything possible to stay healthy and create conditions for healingò.

The result of this study also rejected the second hypothesis which states that ñpersonality-type will not be a statistically significant factor in self-disclosure of persons living with HIV/AIDSò. This shows that personality-type is a significant factor in self-disclosure, with the extrovert personality favoring self-disclosure of HIVï status. This finding is consistent with Mohan and Bedi (2010) who reported that extroverts have higher self-esteem than introverts, and are more disposed to self-disclosure than introverts. This finding is consistent with Penedo et al (2003), who reported a positive correlation between personality traits (extraversion) and quality of life. In their submission, extraversion was significantly associated with better quality of life including the ability to self-disclose, while introversion was associated with poor quality of life.

The result of this study however supports the third hypothesis which states that ñgender will not be a statistically significant factor in self-disclosure of persons living with HIV/AIDS. This indicates that being male or female is not a factor in self-disclosure among persons living with HIV/AIDS. This finding agrees with Armistead, Morse, Forehand, Morse and Clark (1999) who found no gender difference in self-disclosure. However, this finding disagrees with Barry (2006) who found that men initially disclose more than women in heterosexual relationship; and Dindia and Allen (1992) who found that women more than men tend to disclose overall, though may be affected by the situation.

No gender difference in self-disclosure has reported in this study agrees with Ignatius and Kokkonen (2007) that it is sex role identity that plays a large part in the amount of

information one chooses to reveal to another. This is because androgenous people disclose more intimately across contexts than do notably masculine and feminine people. This then explains why there is no gender difference in self-disclosure.

The result also shows an interaction effect between personality-type and self-esteem as significant factors in self-disclosure. It can be observed from the result that a trait-characteristic (extroversion) interacts with a state-characteristic (high self esteem) among the respondents to enhance self-disclosure. This interaction effect agrees with the assertion by Endler (1981) that human behavior is in fact determined by the complex interaction of traits and situations. Interaction between self-esteem and personality-type in this study reveal that the unique adjustment of persons living with HIV/AIDS is a product of the complex interaction of nature and nurture (resulting in the behavior of disclosure or non-disclosure).

Implication of the Result

The result of this study indicates that self-esteem and personality-type are significant factors in self-disclosure of persons living with HIV/AIDS. This implies that oneôs level of self-esteem can enhance or mar self-disclosure among persons living with HIV/AIDS. In essence, a high self-esteem favors self-disclosure, as people with high self-esteem have a feeling of personal capacity and self-worth to face the challenges of life and solve problems to achieve happiness and be given respect. This calls for greater provision of emotional and social support to persons living with HIV/AIDS to enhance their well being and minimize stigmatization and discrimination which are great impediments to their sense of self-worth. Another implication here is that psychological treatment is central in the management of HIV/AIDS especially in boosting self-esteem of persons living with HIV/AIDS to enhance self-disclosure for treatment and preventive purposes.

Again, the implication of personality-type (extroversion) as a factor in self-disclosure of persons living with HIV/AIDS is that individuals who are sociable can share their feelings, fears, emotions and life-challenges with others in order to receive the needed help and support to cope. Thus, the primary agent of socialization-the family and the secondary agents of socialization such as the school, church, age-groups, etc must play their roles effectively in order to raise up open-minded people in the society.

Again, the findings of this study on personality type as a factor in self-disclosure implies that human beings are unique in their perceptions, interpretations and reaction to life issues, thus each client must be treated as a unique individual, with respect to ones personality-trait, while using strictly professional and scientifically proven tools / techniques to modify dysfunctional personally-traits.

Finally, the implication of the result of this study is that psychology has a great role to play in the treatment and prevention of HIV/AIDS. This is because a psychological variable such as self-disclosure, which is a major factor in anti-retroviral medication adherence, lowering of emotional distress, prevention of the spread of HIV/AIDS, improved family cohesion and improved relationship, can be enhanced through psychological principles/ techniques, such as self-esteem management and personality therapy. It must be added that, unless persons living with HIV/AIDS can confide/disclose to health professionals who are ready to assist them to live a more fulfilling life; they may not benefit from such medical/psychological intervention.

Limitation of the Study

The cross-sectional design adopted for this study limited the respondents to a single time of evaluation of their self-esteem and self disclosure disposition, during illness, without any reference to their pre-morbid self-esteem level and self-disclosure disposition. Without such reference figure, one may blindly accept the state self-esteem that may occur during the illness or at the period of test to mean the respondentsô global self-esteem level.

Another limitation of this study is its concentration on only persons living with HIV/AIDS, thereby limiting the generalization of the result of the study to the general society including sero-negative persons.

Finally, this study focused only on adults aged 18-60 years, whereas children from birth are living with HIV/AIDS, as well as aged people beyond the age of 60, thus limiting the generalization of the findings of the study to all the age groups of persons living with HIV/AIDS.

Recommendation for Further Studies

The following recommendations are made for further studies:

⟶ Further studies in this area should adopt a longitudinal method of research to enhance the comparison of pre-morbid self-esteem and self-disclosure data with the morbid data for better explanation.

⟶ Again, further studies in this area should sample from both the sero-positive and sero-negative persons in order to enhance the generalization and applicability of the findings to the general population.

⟶ Finally, further studies in this area should consider the use of both children and adult versions of the respective instruments in order to sample all the age-groups in the study, to enhance generalization of the result to all age groups.

Summary and Conclusion

This study examined self-esteem, personality type and gender as factors in self-disclosure of persons living with HIV/AIDS. Three hypotheses were tested using a cross-sectional design and unvariate analysis of variance. The result rejected the first two null hypotheses, indicating that self-esteem and personality-type are factors in self-disclosure of persons living with HIV/AIDS. The result also indicated a significant interaction effect between self-esteem and personality-type. The result of the analysis supported the third hypothesis that gender would not be a significant factor in self- disclosure of persons living with HIV/AIDS.

In conclusion, the result of the study is a wake up call on the central role of psychology in the therapy and prophylaxis of HIV/AIDS in particular and global health in general.

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APPENDIX A

ISE

NAME:..... SEX..... AGE..... DATE.....
OCCUPATION:..... TRIBE.....

INSTRUCTIONS: The following are a number of statements which indicate how people see or feel about themselves. It is not a test, so there are no right or wrong answers. Please read each statement carefully and shade the appropriate number to the right of each statement to indicate how the statement.

❖ The numbers stand for:

1. = Rarely or none of the time
2. = A little of the time
3. = Some of the time
4. = A good part of the time
5. = Most of all the time

1	I feel that people would not like me if they really knew me well	1	2	3	4	5
2	I feel that others get along much better than I do.....	1	2	3	4	5
3	I feel that I am a beautiful person.....	1	2	3	4	5
4	When I am with other people I feel they are glad I am with them	1	2	3	4	5
5	I feel that people really like to talk to me.....	1	2	3	4	5
6	I feel that I am a very competent person.....	1	2	3	4	5
7	I think I make a good impression on others.....	1	2	3	4	5
8	I feel that I need more self-confidence.....	1	2	3	4	5
9	When I am with strangers I am very nervous.....	1	2	3	4	5
10	I think that I am a dull person.....	1	2	3	4	5
11	I feel ugly.....	1	2	3	4	5
12	I feel that others have more fun that I do.....	1	2	3	4	5
13	I feel that I bore people.....	1	2	3	4	5
14	I think my friends find me interesting.....	1	2	3	4	5
15	I think I have a good sense of humour.....	1	2	3	4	5
16	I feel very self-conscious when I am with strangers.....	1	2	3	4	5
17	I feel that if I could be more like other people, I would have it made.....	1	2	3	4	5
18	I feel that people have a good time when they are with me.....	1	2	3	4	5
19	I feel like a wall-flower when I go out.....	1	2	3	4	5
20	I feel I get pushed around more than others.....	1	2	3	4	5
21	I think I am a rather nice person.....	1	2	3	4	5
22	I feel that people really like me very much.....	1	2	3	4	5
23	I feel that I am a likeable person.....	1	2	3	4	5
24	I am afraid I will appear foolish to others.....	1	2	3	4	5
25	My friends think very highly of me.....	1	2	3	4	5

APPENDIX B

EPQ (E -I)

Name:.....Age:.....Sex:.....
Educational Level Attained.....Date:.....
Occupation:.....Tribe:.....

Instructions

Please answer each question by making an (x) beside the "Yes" or the "No" following the question. There are no right or wrong answers, and no trick questions. Work quickly and do not think too long about the exact meaning of the question.

PLEASE REMEMBER TO ANSWER ALL QUESTIONS.
IN EVERY QUESTION, MARK JUST ONE BOX

1. Do you have many different hobbies?.....Yes ( ) No ( )
2. Are you a talkative person?.....Yes ( ) No ( )
3. Are you rather lively?..... Yes ( ) No ( )
4. Can you usually let yourself go and enjoy something you knew was really party?.. Yes ( ) No ( )
5. Do you enjoy meeting new people?..... Yes ( ) No ( )
6. Do you like going out a lot?..... Yes ( ) No ( )
7. Do you tend to keep in the background on social occasion?..... Yes ( ) No ( )
8. Do you prefer reading to meeting people?..... Yes ( ) No ( )
9. Do you have many friends?..... Yes ( ) No ( )
10. Would you call yourself happy –go –lucky?..... Yes ( ) No ( )
11. Do you usually take the initiative in making new friends?..... Yes ( ) No ( )
12. Are you mostly quiet when you are with other people?..... Yes ( ) No ( )
13. Can you easily get some life into a rather dull party?..... Yes ( ) No ( )
14. Do you like telling jokes and funny stories to your friends?..... Yes ( ) No ( )
15. Do you like mixing with people?..... Yes ( ) No ( )
16. Do you nearly always have a "ready answer" when people talk to you?..... Yes ( ) No ( )
17. Do you like doing things in which you have to act quickly?..... Yes ( ) No ( )
18. Do you often take on more activities than you have time for?..... Yes ( ) No ( )
19. Can you get a party going?..... Yes ( ) No ( )
20. Do you like plenty of hustle and excitement around you?..... Yes ( ) No ( )
21. Do other people think of you as being very lively?..... Yes ( ) No ( )

PLEASE CHECK TO SEE THAT YOU HAVE ANSWERED ALL THE QUESTIONS

APPENDIX C

SDI

Name: ---------- Age: ---------- Sex: ----------
Educational Level ---------- Date ----------
Occupation: ---------- Tribe:----------

Instructions

Please indicate the degree to which you would be willing to disclose the following types of information (to a stranger). Rate your willingness to discuss this information on the following scale: 1= discuss not at all, 2= discuss partially, 3= discuss to some extent, 4 = discuss almost in full 5= discuss fully and completely.

S/N	ITEMS	1	2	3	4	5
1	My personal habits					
2	Things I have done which I feel guilty about					
3	Things I wouldn't do in public					
4	My deepest feelings					
5	What I like and dislike about myself					
6	What is important to me in life					
7	What makes me the person I am					
8	My worst fears					
9	Things I have done which I am proud of					
10	My close relationships with other people					

APPENDIX D
UNIVARIATE ANALYSIS OF VARIANCE

Univariate Analysis of Variance

Between-Subjects Factors

		Value Label	N
Selfesteem	1	High	169
	2	Low	131
Personality	1	Introvert	145
	2	Extrovert	155
Sex	1	Male	120
	2	Female	180

Descriptive Statistics

Dependent Variable: Self-disclosure

Selfesteem	Personality	Sex	Mean	Std. Deviation	N
High	introvert	male	26.1200	3.96148	25
		female	24.8056	3.67866	36
		Total	25.3443	3.82049	61
	extrovert	male	31.3111	5.96513	45
		female	32.7302	5.70288	63
		Total	32.1389	5.82848	108
	Total	male	29.4571	5.86734	70
		female	29.8485	6.33159	99
		Total	29.6864	6.12877	169
Low	introvert	male	25.6786	5.34064	28
		female	26.0893	4.51372	56
		Total	25.9524	4.77671	84
	extrovert	male	25.8182	6.19244	22
		female	26.7600	7.11384	25
		Total	26.3191	6.64342	47
	Total	male	25.7400	5.67058	50
		female	26.2963	5.41166	81
		Total	26.0840	5.49691	131
Total	introvert	male	25.8868	4.70131	53
		female	25.5870	4.23266	92
		Total	25.6966	4.39590	145
	extrovert	male	29.5075	6.53284	67
		female	31.0341	6.66859	88
		Total	30.3742	6.63242	155
	Total	male	27.9083	6.04882	120
		female	28.2500	6.17878	180
		Total	28.1133	6.11926	300

Tests of Between-Subjects Effects

Dependent Variable:Selfdisclose

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	2853.317[a]	7	407.617	14.267	.000
Intercept	196399.881	1	196399.881	6.874E3	.000
Selfesteem	460.603	1	460.603	16.121	.000
Personality	791.896	1	791.896	27.716	.000
Sex	8.670	1	8.670	.303	.582
Selfesteem * Personality	618.306	1	618.306	21.641	.000
Selfesteem * Sex	6.359	1	6.359	.223	.637
Personality * Sex	43.518	1	43.518	1.523	.218
Selfesteem * Personality * Sex	19.806	1	19.806	.693	.406
Error	8342.829	292	28.571		
Total	248304.000	300			
Corrected Total	11196.147	299			

a. R Squared = .255 (Adjusted R Squared = .237)

APPENDIX E

RELIABILITY STATISTICS FOR THE SELF DISCLOSURE INVENTORY

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.691	.697	10

Item Statistics

	Mean	Std. Deviation	N
VAR00001	2.5600	1.03332	50
VAR00002	2.4200	1.44406	50
VAR00003	2.4400	1.63083	50
VAR00004	2.3400	.96065	50
VAR00005	2.8800	1.25584	50
VAR00006	3.0800	1.27520	50
VAR00007	3.5200	1.28158	50
VAR00008	2.4800	1.41767	50
VAR00009	4.1400	1.27791	50
VAR00010	2.8800	1.30368	50

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
VAR00001	26.1800	35.253	.513	.362	.619
VAR00002	26.3200	29.406	.298	.658	.557
VAR00003	26.3000	29.480	.627	.343	.581
VAR00004	26.4000	29.633	.535	.494	.518
VAR00005	25.8600	29.143	.401	.272	.533
VAR00006	25.6600	31.045	.645	.537	.571
VAR00007	25.2200	27.767	.499	.650	.506
VAR00008	26.2600	28.645	.362	.462	.539
VAR00009	24.6000	36.245	-.112	.626	.650
VAR00010	25.8600	29.551	.346	.392	.545

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
28.7400	36.156	6.01295	10

TEST RE-TEST FOR THE SELF DISCLOSURE INVENTORY

Correlations

		Test1	Test2
Test1	Pearson Correlation	1	.996**
	Sig. (2-tailed)		.000
	N	50	50
Test2	Pearson Correlation	.996**	1
	Sig. (2-tailed)	.000	
	N	50	50

**. Correlation is significant at the 0.01 level (2-tailed).

RELIABILITY STATISTICS FOR THE EYNSECK PERSONLITY QUESTIONNAIRE (EPQ)

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.788	.610	21

Item Statistics

	Mean	Std. Deviation	N
VAR00001	.6200	.49031	50
VAR00002	.0600	.23990	50
VAR00003	.9600	.19795	50
VAR00004	.6600	1.57286	50
VAR00005	.9800	.14142	50
VAR00006	.1600	.37033	50
VAR00007	.6200	.49031	50
VAR00008	.6400	.48487	50
VAR00009	.3400	.47852	50
VAR00010	.6400	.48487	50
VAR00011	.6200	.49031	50
VAR00012	.5200	.50467	50
VAR00013	.5400	.50346	50
VAR00014	.6600	.47852	50
VAR00015	.8600	.35051	50
VAR00016	.6400	.48487	50
VAR00017	.6200	.49031	50
VAR00018	.3200	.47121	50
VAR00019	.6600	.47852	50
VAR00020	.5800	.49857	50
VAR00021	.8800	.32826	50

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
VAR00001	11.9600	10.896	.392	.	.468
VAR00002	12.5200	11.275	.264	.	.471
VAR00003	11.6200	11.506	.359	.	.481
VAR00004	11.9200	9.177	.511	.	.615
VAR00005	11.6000	11.837	-.101	.	.495
VAR00006	12.4200	10.698	.381	.	.447
VAR00007	11.9600	11.141	.115	.	.481
VAR00008	11.9400	12.384	.252	.	.538
VAR00009	12.2400	10.758	.246	.	.459
VAR00010	11.9400	10.507	.324	.	.446
VAR00011	11.9600	11.060	.541	.	.477
VAR00012	12.0600	11.160	.102	.	.483
VAR00013	12.0400	10.774	.221	.	.463
VAR00014	11.9200	10.361	.379	.	.437
VAR00015	11.7200	11.185	.192	.	.472
VAR00016	11.9400	10.507	.324	.	.446
VAR00017	11.9600	10.774	.231	.	.461
VAR00018	12.2600	11.258	.388	.	.485
VAR00019	11.9200	10.769	.242	.	.460
VAR00020	12.0000	10.735	.237	.	.460
VAR00021	11.7000	10.949	.323	.	.458

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
12.5800	11.759	3.42911	21

TEST RE-TEST FOR THE EYNSECK PERSONLITY QUESTIONNAIRE (EPQ)

Correlations

		Test1	Test2
Test1	Pearson Correlation	1	.987**
	Sig. (2-tailed)		.000
	N	50	50
Test2	Pearson Correlation	.987**	1
	Sig. (2-tailed)	.000	
	N	50	50

**. Correlation is significant at the 0.01 level (2-tailed).

RELIABILITY STATISTICS FOR THE INDEX OF SELF-ESTEEM

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.741	.756	25

Item Statistics

	Mean	Std. Deviation	N
VAR00001	2.4400	1.26427	50
VAR00002	2.5400	1.12866	50
VAR00003	1.9200	1.10361	50
VAR00004	1.9000	.93131	50
VAR00005	2.4000	1.29363	50
VAR00006	2.0600	.95640	50
VAR00007	2.0800	.87691	50
VAR00008	3.6200	1.22708	50
VAR00009	1.8200	1.00387	50
VAR00010	1.4400	.83690	50
VAR00011	1.3200	.76772	50
VAR00012	2.8000	1.17803	50
VAR00013	2.1400	1.16075	50
VAR00014	2.0000	1.06904	50
VAR00015	2.1000	1.19949	50
VAR00016	3.9000	1.21638	50
VAR00017	2.7200	1.40029	50
VAR00018	2.0400	1.04900	50
VAR00019	2.9800	1.18649	50
VAR00020	2.0800	1.19249	50
VAR00021	2.2600	1.30634	50
VAR00022	2.3200	1.15069	50
VAR00023	2.4600	1.23239	50
VAR00024	1.7200	1.10730	50
VAR00025	1.9800	.93656	50

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
VAR00001	54.6000	100.694	.262	.488	.734
VAR00002	54.5000	101.194	.385	.696	.732
VAR00003	55.1200	102.557	.231	.537	.736
VAR00004	55.1400	100.898	.383	.682	.727
VAR00005	54.6400	95.541	.464	.694	.718
VAR00006	54.9800	103.367	.239	.645	.735
VAR00007	54.9600	100.896	.413	.676	.726
VAR00008	53.4200	106.616	.032	.359	.750
VAR00009	55.2200	100.828	.352	.511	.728
VAR00010	55.6000	99.592	.518	.852	.721
VAR00011	55.7200	101.185	.464	.750	.725
VAR00012	54.2400	99.043	.363	.543	.727
VAR00013	54.9000	100.786	.292	.717	.732
VAR00014	55.0400	101.386	.298	.559	.731
VAR00015	54.9400	100.670	.284	.566	.732
VAR00016	53.1400	105.960	.060	.459	.748
VAR00017	54.3200	98.957	.288	.552	.732
VAR00018	55.0000	97.755	.486	.656	.719
VAR00019	54.0600	106.874	.027	.651	.750
VAR00020	54.9600	98.692	.372	.562	.726
VAR00021	54.7800	101.196	.230	.602	.737
VAR00022	54.7200	108.777	-.048	.572	.754
VAR00023	54.5800	98.820	.351	.634	.727
VAR00024	55.3200	99.773	.359	.653	.727
VAR00025	55.0600	104.956	.162	.320	.739

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
57.0400	108.937	10.43730	25

TEST RE-TEST FOR THE INDEX OF SELF ESTEEM

Correlations

		Test1	Test2
Test1	Pearson Correlation	1	.999**
	Sig. (2-tailed)		.000
	N	50	50
Test2	Pearson Correlation	.999**	1
	Sig. (2-tailed)	.000	
	N	50	50

**. Correlation is significant at the 0.01 level (2-tailed).