



## **Role of Religious Commitment, Coping Strategies and Social Support in Learned Helplessness among HIV/Aids Patients in General Hospital Ogoja, Cross River State, Southern Nigeria.**

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### **ABSTRACT**

This study investigated the role of religious commitment, coping strategies and social support in learned helplessness among HIV/AIDS patients in General Hospital Ogoja Cross River State, Southern Nigeria. One hundred and eighty seven (187) patients, (93 males and 94 female) between the ages of 19-64 ( $M=37.7$ ,  $SD=11.55$ ) receiving antiretroviral treatment (ART) at General Hospital Ogoja participated in the study. A convenient sampling method was employed for the study. Participants completed four instruments: Religious Commitment Inventory-10 (RCI-10), Brief Cope, Multidimensional Scale of Perceived Social Support (MSPSS) and the Learned Helplessness Scale (LHS). Hierarchical Multiple Regression results showed that religious commitment statistically predicted learned helplessness in HIV/AIDS patients ( $B=36$ ,  $t=4.20$ ,  $p < 0.001$ ). A closer examination revealed that interpersonal ( $B=28$ ,  $t=2.75$ ,  $p < 0.01$ ) but not intrapersonal religious commitment predicted learned helplessness. The positive relationship between the religious commitment and learned helplessness was rather striking; raising the fact that the more religious commitment people were more likely not to seek out solutions to life problems. The result also showed that emotion focused coping ( $B=30$ ,  $t=3.60$ ,  $p < 0.001$ ) but not problem focused coping significantly predicted learned helplessness. This hints to the idea that among these patients adopting emotion coping will urge them towards not seeking out solutions to presenting life challenges. Social Support, though consistently negatively related to learned helplessness, did not significantly predict learned helplessness in HIV/AIDS patients. The relationship was similar even when the subscale of social support were put into consideration. The implications and the limitations of the study were discussed and suggestions were made for further study.

### **Introduction**

Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), is one of the most serious health and development challenges (Joint United Nation Programme on HIV/AIDS, UNAIDS, 2015). According to World Health Organization (WHO 2014), the population of people that have died as a result of HIV and AIDS related causes since its discovery in 1981 is estimated at more than 39 million lives. The global estimate of adults and children by UNAIDS in 2014 revealed a total of 36.9 million people living with HIV, with women numbering 17.4 million while children (<15 years) was 2.6 million. The population of people newly infected with HIV in 2014 was 2.0 million while deaths from HIV related causes globally was 1.2 million (UNAIDS, 2015).

In the United States, more than 1.2 million people are living with HIV, infection and almost 1 in 8 (12.8%) are unaware of their infection. The black African Americans are the worst hit with the burden of HIV (Centre for Disease Control -CDC, 2013). UNAIDS (2015) report on the prevalence of people living with HIV revealed that Latin America and the Caribbean have an estimated population of 2.0 million. The Caribbean is the second hardest hit region in the world after sub-Saharan Africa. Eastern Europe and central Asia have an estimated population of 1.5 million, while Asia and Pacific is estimated at 5.0 million people.

In Africa, South Africa with the total population of about 54.96 million people (Lehohla, 2015) have the highest profile of HIV epidemic in the world with an estimated 6.1 million people living with HIV and 240,000 dying from AIDS related illnesses. While Sub-Saharan Africa that comprises of 48 countries with a total population of about 973.4 million people (World Bank, 2014) have the largest population of people living with HIV which is estimated at 25.8 million, accounting for a prevalence of 70 percent (UNAIDS 2012). In Nigeria, the prevalence rate of HIV is 3.7%, and worldwide, Nigeria has the second highest number of new infection reported each year (UNAIDS, 2012; FRN, 2012). However, advances in highly active antiretroviral therapy (HAART) options for people living with HIV/AIDS have resulted in decreased morbidity and mortality thus giving it a chronic status (Burgoyne & Tan, 2008; Burgoyne, 2008).

People living with HIV/AIDS (PLWHA) are known to have great emotional needs and require enormous support for coming to terms with dire affliction status (Gerbi, Habtemariam, Robnett, Nganwa & Tameru, 2012). Some of the feelings that PLWHA experience include shock and anger at being diagnosed with HIV, fear over how the disease will progress, fear of isolation by family and friends and worries about infecting others (American

Psychiatric Association 2008). In addition to being a disease that is associated with a number of physical malfunctions and progressive discomfort like pain, shortness of breath, altered sexual functioning and disfigurement, HIV/AIDS is also a highly stigmatized disease. Preventive programmes help to reduce the prevalence rate, and the number of PLWHA that are receiving treatment in resource poor countries has dramatically increased in the past decades. At the end of 2013, 12.9 million people living with HIV were receiving antiretroviral therapy (ART) globally of which 11.7 million were from low and middle income countries (UNAIDS, 2015). There have also been success in the prevention of mother to child transmission of HIV and keeping mothers alive (UNAIDS, 2013). However, advances in the treatment with highly active antiretroviral therapy (HAART) have changed the status of HIV to a chronic illness because PLWHA will live longer while on the treatment. As pointed out by Walker and Avant (2011) learned helplessness occurs when people experience uncontrollable events such as chronic illness and they feel like nothing they do will change the prognosis.

Learned helplessness refers to the passive resignation produced by repeated exposure to negative events that are perceived to be unavoidable (Franzino, 2000). According to Franzino (2000) when an unpleasant situation is perceived as inescapable, human and other animals develop a belief that they are helpless to alter their circumstances by means of any voluntary behaviour. Thus, the failure to respond, acts as coping strategy, to alter, master or reduce the demands of a stressful situation.

Rickenbach, Furrer, & Vernazza, 2004). There is a growing consensus that increased general social support is often a protective factor in coping with challenges imposed by HIV particularly due to its positive effect on diminishing depression-related illness (Aderson, Elam, Solarin, Gerver, Fenton, & Easterbrook 2009; Johnson, Alloy, Panzarella, Metalsky, Rabkin, Williams, & Abramson 2001). Social support is associated with lower levels of negative effect and higher levels of positive effect among PLWHA (Lackner, Joseph, Ostrow, & Eshleman, 1993; Remien, Exner, Kertzner, Ehrhardt, Rotheram-Borus, & Johnson, 2006; Simoni, Frick, Huang, 2006; Turner-Cobb, Gore-Felton, Marouf, Koopman, Kim, & Israelski, 2002). Good social support levels contribute to a better quality of life, help provide an adequate understanding of the illness, and offer mental and physical health benefits (Olapegba, 2005), including adherence to treatment (Aderson, Elam, Solarin, Gerver, Fenton, & Easterbrook, 2009; DiMatteo, 2004; Uchino, 2006, 2009; Wrubel, Stumbo & Johnson, 2010).

Among HIV discordant couple (HDC) social support from partners has been associated with less progression to AIDS in the infected partner (National Collaborating Centre for Infectious Disease, 2010). Studies with HDC have evidenced that social support can facilitate the maintenance of adherence to highly active antiretroviral therapy (HAART) (Power, Koopma, Volk, Israelski, Stone, Chesney & Spiegel, 2003; Remien, Halkitis, O'Leary, Wolitski, & Gómez, 2005). While some reports link social support with increased sexual risk behaviors (Miller & Cole, 1998), others show decreased risk (Darbes, Chakravarty, Beougher, Neilands, & Hoff, 2011). It seems that social support might be a reliable predictor of psychological rather than behavioral outcomes (Darbes, et al 2011).

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## Statement of the Problem

The prevalence of HIV/AIDS in the sub-Saharan African countries is the highest in the world (UNAID 2012). In 2014, about 25.8 million people were living with HIV, accounting for nearly 70 percent of the global total (UNAIDS, 2014). In Nigeria, HIV prevalence is relatively low (3.7 percent). However, because of its large population (being the most populated country in the sub-Saharan Africa) this percentage represent about 3.4 million people living with HIV (UNAIDS, 2013).

As at the moment HIV has no known cure and people living with HIV/AIDS (PLWHA) have to be on antiretroviral treatment (ART) for life, and this requires behavioural modification to live positively healthy while awaiting the invention of curative medication by scientists. People living with HIV/AIDS are faced with different social and health challenges ranging from discrimination, stigmatization, (Shorter & Onyancha, 1995); fear of the loss of their life ambition, financial stability and independence, loss of sense of privacy and control of their lives (Frensmann, 2005); anxiety disorder and depression, social, professional, familial and sexual rejection (Satir, 2006, cited in Fabianova, 2011); grief, hopelessness and helplessness syndrome (Bastecky, 1993 cited in Fabianova, 2011); denial, anger, aggression and suicidal attempts (Bratska, 2001; Yelding, 1990). PLWHA are Prone to develop chronic medical co-morbidities, including diabetes, cardiovascular diseases, kidney diseases, cognitive impairment, osteoporosis and cancer in aging (Chu et al., 2011; Sigel et al., 2012). Other PLWHA are co-infected with Hepatitis C and Hepatitis B virus (Iyer, 2015). The researcher has discovered that many studies have not been conducted on learned helplessness with PLWHA. In addition, healthcare professionals and patients themselves may be unaware of the significant impact of learned helplessness on the health outcomes. Findings from this study will be of clinical significance to the management of people living with HIV/AIDS (PLWHA), and other patients with chronic health conditions.

The study addresses the following research questions:

1. Would religious commitment predict learned helplessness?
2. Would coping strategies predict learned helplessness?
3. Would social support predict learned helplessness?

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## Purpose of the Study

The purpose of this study is to investigate whether religious commitment, coping strategies and social support will significantly predict learned helplessness among HIV/AIDS patients. Several studies on diverse topics have been conducted on people living with HIV/AIDS, but to this researcher's

knowledge, not much has been done on the roles of religious commitment, coping strategies and social support and learned helplessness as a complete research using Nigerian samples. Therefore, this study will lead to more knowledge on the learned helplessness phenomenon among PLWHA.

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### Operational Definition of Terms:

**Learned helplessness:** This refers to a reaction to loss of control that induces cognitive, motivational and emotional deficits following the expectation that response and outcome are independent of each other as measured by Learned Helplessness Scale (Quinless & Nelson, 1988).

**Religious Commitment:** This refers to how much an individual adheres to his or her religious values, beliefs and practices and uses them on daily living as measured by Religious Commitment Inventory-10 (RCI-10) (Worthington, et al., 2003).

**Coping Strategy:** This refers to both problem-focused and emotion-focused styles that people employ to master, tolerate, reduce or minimize stressful events as measured by Brief COPE (Carver, 1997).

**Social Support:** This refers to social resources that persons perceive to be available or that are available to them as measured by Multidimensional Scale of Perceived Social Support (MSPSS), (Zimet, Dahlem, Zimet & Farley, 1988).

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### Research Method

A survey research method was adopted in this study. Participants were one hundred and eighty-seven (187) patients living with HIV/AIDS who were receiving antiretroviral treatment (ART) at the ART Unit of the General Hospital Ogoja Cross River State, were selected in this study using a **Convenience Sampling Technique**. They comprised 93 males and 94 females and their age ranged from 19-64 (mean=37.7, SD= 11.55). The demographic characteristics of the participant are, gender- male 93 (47.73%), female 94 (50.27%). Marital status- married 75 (40.11%), single- 70 (37.43%), separated- 27 (13.90%) and widow 16 (8.56%). Religion- Christianity 162 (86.17%), Islam 26 (13.87%). Employment status- employed 63 (35.51%), unemployed 92 (48.93%) and students 33 (17.55%) This hospital was chosen because it is the oldest government healthcare institution in the Northern Senatorial zone of the state and the first facility to commence the free antiretroviral treatment for HIV/AIDS patients. This Unit caters for the highest population of people living with HIV/AIDS (PLWHA) in the Northern senatorial zone.

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### Instruments

Four instruments were used in data collection in this study. They include:

Religious Commitment Inventory-10 (RCI-10), Learned Helplessness Scale, Multidimensional scale of perceived Social support and Brief COPE.

#### *Religious Commitment Inventory-10 (RCI-10)*

Religious commitment inventory developed by Worthington, Wade, Hight, Ripley, McCullough, Berry, Schmitt, Berry and O'Connor (2003) was used in the study. Religious commitment inventory consists of 10 items. It is designed to assess one's level of religious adherence in daily life and the extent to which an individual interprets life events based on his or her religious views. The 10 items of the inventory are arranged on a five - point Likert type format: with not at all true of me (1), somewhat true of me (2), moderately true of me (3), mostly true of me (4) and totally true of me (5). The RCI-10 has two subscales, namely, intrapersonal religious commitment (6 items) and interpersonal religious commitment (4 items). Examples of items on the scale include: my religious beliefs lie behind my whole approach to life (intrapersonal) and I enjoy working in the activities of my religious organization (interpersonal). Worthington, et al (2003) had an estimated internal consistency with Cronbach's alpha ranging from .93 - .96. Cronbach's alpha of the subscales was .92 (intrapersonal religious commitment) and .87 (interpersonal religious commitment). A study of Nigerian sample by Ifeagwazi and Chukwuorji (2012) obtained Cronbach's alpha of .83 (full scale), .78 (intrapersonal religious commitment) and .71 (interpersonal religious commitment).

#### *Learned Helplessness Scale (LHS)*

The learned helplessness scale developed by Quinless and Nelson (1988). This scale was used to measure learned helplessness in patients living with HIV/AIDS. The scale was first developed by Abramson, Seligman and Teasdale in an effort to examine why organisms exposed to aversive events in one situation often fail to escape that event in a different situation (Quinless & Nelson, 1988). It is a 20-item Likert-Scale measure that assesses learned helplessness such as ideations. The item of the scale has four Likert-type response format, ranging from strongly agree (1), agree (2), disagree (3) and strongly disagree (4). The learned helplessness scale was administered to a normative adult sample by the authors and was shown to have internal consistency coefficient of .85. The test-retest reliability was calculated as r- 0.83. The authors established a content validity through analysis by experts who confirmed that scale items measured three causal attributional dimensions (i.e. locus of control, stability and controllability with a validity of 96.1).

#### *Multidimensional scale of Social support*

The third instrument used was the multidimensional scale of perceived social support (MSPSS) by Zimet, Dahlem, Zimet and Farley (1988). It is a 12-item scale that measures perceived support from three domains: family, friends and significant others. The items are on a 7-point Likert-type scale, ranging from very strongly disagree to very strongly agree. Examples of items on the MSPSS are: there is a special person who is around when I am in

need; there is a special person with whom I can share my joys and sorrows. Cauty-Mitchell & Zimet (2000) found internal reliability estimate of .93 for the total score and .91, .89 and .91 for the family, friends and significant others subscales. Participants completing the MSPSS would indicate their agreement or disagreement with the 7-point Likert scale of very strongly disagree (1) to very strongly agree (7) with the higher scores indicating greater levels of perceived social support. Zimet, et al (1988) reported that the MSPSS has good internal consistency reliability Cronbach's alpha of .85. Previous study in Nigeria also showed that MSPSS has high sensitivity and specificity (Salami, 2010). Also a study by Ifeagwazi, Obi, Udensi and Chukwuorji (2014) obtained a Cronbach's alpha of .67.

### **Brief COPE**

The Brief COPE (Carver, 1997) was used to assess coping strategies of patients living with HIV/AIDS. The Brief COPE is 28-item self-report questionnaire used to assess a number of

different coping behaviors and thoughts a person may have in response to a specific situation. It is made up of 14 subscales: self-distraction, active coping, denial, substance use, use of emotional support, use of instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. After reading a situational-specific scenario, 28 coping behaviors and thoughts (2 items for each subscale) are rated on frequency of use by the participant with a scale of 1 (-I haven't been doing this at all) to 4 (I've been doing this a lot). Internal reliabilities for the 14 subscales range from Cronbach's alpha of 0.57-0.90 (Carver, 1997), and similar results have been found with a population of parents of children with autism spectrum disorders (ASDs) Cronbach's alpha 0.54-0.93 (Benson, 2009). A study by Onyedibe, Onyekwelu and Ugwu (2015) obtained a Cronbach's alpha coefficient of .73 for the entire scale, while the reliability coefficient for the two factors were .65 for both problem focused coping and emotion focused coping. Based on the definitions of problem-based and emotion-based coping, items 2,7,10, 14, 23, and 25 were classified as problem-based coping and the rest of the items fell into emotion-based coping.

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### **Validation Study**

In order to validate the measures to be used in the present study, a pilot study was conducted by the researcher. Participants were 87 persons living with HIV/AIDS (PLWHA) in Yala Local Government Area of Cross River State. They were persons who came for anti-retroviral therapy (ART) in Lutheran Hospital Yahe, Yala. They consisted of 35 males (40.2%) and 52 females, (59.8%). Various age ranges were represented in the pilot study sample as follows: 15-24(8.0%), 25-34(28.7%), 35-44(33.3%), 45-54(19.5%) and 55 years and above (10.3%). The results of pilot study are shown in Appendix F.

The Religious Commitment Inventory (RCI-10) yielded a Cronbach's alpha coefficient of .85. Since the two factor structure of the measure had been confirmed in a previous study (Ifeagwazi & Chukwuorji, 2012), the researcher attempted to obtain separate reliability values for the two dimensions as follows: intrapersonal religious commitment ( $\alpha = .74$ ) and interpersonal religious commitment ( $\alpha = .76$ ).

Multidimensional Scale of Perceived Social Support (MSPSS) yielded a very high Cronbach's alpha reliability coefficient of .90. Cronbach's alpha for the dimensions were as follows: friends support = .77, family support = .81 and special person = .83.

The Brief Cope has two dimensions with acceptable reliability coefficients: problem focused coping = .75, and emotion focused coping = .84.

Learned Helplessness Scale had a very high reliability coefficient ( $\alpha = .91$ ). The Kaiser-Meyer - Olkin measure of sampling, adequacy was .84. Bartlett's test of sphericity was 772.98 ( $P < .001$ ), indicating the adequacy of the data for factor analysis. A one factor structure of the scale was extracted, explaining 36.47% of the variance in the measure. All the items, loaded .35 and above in the component matrix.

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### **Procedure**

This study was conducted at the Antiretroviral Therapy (ART) Unit of General Hospital Ogoja. Having obtained ethical approval from the ethical committee of General Hospital Ogoja, the researcher recruited and trained 4 research assistants who administered the questionnaires to participants. Three of the research assistants were Nursing Officers working at the ART unit, while the fourth was a Nursing officer working at the male surgical ward of the hospital. On arrival at the clinic the research assistants introduced themselves and explained the purpose of the study and obtained informed consent to participate in the study.

Participants were told to read each statement very carefully before they pick the best options that applies to them. There is no right or wrong answers to any statement but objectivity is required as much as possible. You are free to ask questions on any area that you do not understand. Section A of the questionnaire is the demographic data where you will fill in your personal information. Your name is not required; this is to maintain confidentiality of the information you give. Section B is about how important your religious beliefs are to you. You are to choose only one option that best describes religious beliefs. Section C is on how you are coping with your health challenges. There are many ways in which people cope with different problems. You are to indicate how you cope with your present situation by ticking only one option in each of the statement. Section D is information on how much social support you have been getting from your family, friends and other significant persons. You are required to tick only 1 option out of the 7 that best express the type of support. Lastly Section E consists of statements that indicate how you feel about yourself. You are required to tick only one option that best express how you agree or disagree with each statement. Participants were informed that anyone who wishes to withdraw from the study can freely do so.

While the patients were waiting for their hospital folder be retrieved, have their blood pressure, pulse rate, temperature and body weight checked, get their CD4 Count estimation at the laboratory and consultation with the doctor, participants who agreed to participate were administered the questionnaires which they completed and returned at the clinic before they left home. The research assistants examined and encouraged participants to ensure that all the items on the questionnaires are completed. A convenient sampling method was adopted. This is a non- probability sampling technique that makes use of all available and eligible subjects as the study population. The procedure for inclusion in the study was all literate patients who were receiving antiretroviral treatment in the ART unit and who were fit enough to fill in the questionnaire. While the conditions for exclusion are those who were not physically strong and those who are illiterate. A sample of 93 male and 94 female patients living with HIV/AIDS who were receiving antiretroviral treatment (ART) at the ART unit of the hospital were selected. The questionnaires were distributed to every literate patient on daily basis till the stipulated figure was obtained.

**Design/Statistics**

This is a survey research. A hierarchical multiple regressions were employed as statistical package for data analysis.

**RESULT**

**Table 1: Table of correlation among variables of interest**

	Learned helplessness	Gender	Marital status	Age	Region	Employ status	Religious comm.	Rel. comm. Intra	Rel. comm. Inter	Problem focus	Emotion focus	Social Support family	Social Support friends	Social support others
Learned helplessness	-													
Gender	.03	-												
Marital status	-.08	.17*	-											
Age	-.02	-.19*	.19*	-										
Religion	.05	-.06	-.11	-.01	-									
Employment Status	-.12	.04	.11	-.3***	-.02	-								
Religious commitment	.35***	.23**	-.03	-.10	-.01	.07	-							
Rel. commitment intrapersonal	-.31***	.20**	-.04	-.10	-.05	.07	.96	-						
Religious Commitment interpersonal	-.35***	.23**	-.01	-.08	.06	.06	.90	.74	-					
Problem-focus coping	.20**	.14*	-.01	.03	-.16*	-.08	.52	.49***	.48***	-				
Emotion-focus coping	.34***	.17*	.13*	.01	-.08	-.10	.37***	.33***	.38***	.57	-			
Social support family	.14*	.09	.07	.05	-.06	-.02	.25***	.22**	.25***	.28***	.37***	-		
Social support friends	.14*	.07	.04	.01	-.02	-.08	.23**	.21**	.22**	.24***	.47***	.43***	-	
Social support sign. Others	.07	.03	-.04	.05	-.05	-.12	.32***	.30***	.30***	.16*	.21**	.59	.33***	-

\* p<.05, \*\* p<.01, \*\*\* p<.001

The correlation table shows learned helplessness was significantly related to religious commitment (r = .35, p < .001); interpersonal religious commitment (r = .36, p < .001). Problem-focused coping (r = .20, p < .001) and emotion-focused coping (r = .34, p < .001) were equally significantly related to learned helplessness. The family subscale of social support (r = .14, p < .05) and friends (r = .14, p < .05) were significantly related to learned helplessness. Gender was significantly related to marital status (r = .17, p < .05), age (r = .19, p < .05), religious commitment (r = .23, p < .01) religious commitment-intrapersonal (r = .20, p < .01), religious commitment- interpersonal (r = .23, p < .01), problem focused coping (r = .14, p < .05), emotion focused coping (r = .17, p < .05). Marital status was significantly related to age (r = .19, p < .05), emotion focused coping (r = .13, p < .05). Age was significantly related to employment status (r = -.43, p < .001). Religion was significantly related to problem focused coping (r = -.16, p < .06). Religious commitment was significantly related to emotion-focused coping (r = .37, p < .001), it was also significantly related to social support-family (r = .25, p < .001), friends (r = .23, p < .01) and significant others (r = .32, p < .001). Intrapersonal religious commitment was significantly related to problem-focused coping (r = .49, p < .001), emotion-focused coping (r = .33, p < .001), social support-family (r = .22, p < .01), friends (r = .21, p < .01) and significant others (r = .30, p < .001). Interpersonal religious commitment was significantly related to problem-focused coping (r = .49, p < .001), emotion-focused coping (r = .33, p < .001), social support-family (r = .22, p < .01) friends (r = .21, p < .01) and significant others (r = .30, p < .001). Problem-focused coping was significantly related to social support-family (r = .28, p < .001), friends (r = .24, p < .001) and significant others (r = .16, p < .01). Emotion-focused coping was significantly related to social support – family (r = .37, p < .001), friends (r = .47, p < .001) and significant others (r = .21, p < .01) social support (family) was significantly related to support from friends (r = .43, p < .001). Lastly the subscale of social support-friends and significant others were significant related (r = .33, p < .001).

**Table 2: Model summary of coefficient table predicting learned helplessness from the independent variables**

Variables	R	R <sup>2</sup>	B	Beta (β)	T
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Model a.	Gender			.72	.03	.44
	Marital status	.16	.03	-.56	-.05	-.63
	Age			-.06	-.07	-.80
	Employment status			-.2.18	-.14	-.1.71
b.	Religious commitment	.40	.14			
	intrapersonal			.22	.12	1.18
	interpersonal			.82	.28	2.75**
c.	Problem-focused	.47	.06	-.45	-.14	-1.52
	Emotion-focused			.34	.30	3.60***
d.	Social Support family	.48	.02	.17	.10	1.07
	friends			-.09	-.05	-.64
	Significant Others			-.28	-.15	-1.68

\*\* P < .01, \*\*\* P<.001

Table 2 Predicting learned helplessness from the independent variables.

Interpersonal religious commitment ( $\beta = .28$ ,  $t = 2.75$ ,  $p < .01$ ) significantly predicted learned helplessness. Thus, the more the individual religious involvement with his fellow members, the greater their learned helplessness. Emotion-focused coping also significantly predicted learned helplessness ( $\beta = .30$ ,  $t = 3.60$ ,  $p < .001$ ) while problem-focused coping did not significantly predict learned helplessness ( $\beta = -.14$ ,  $t = 1.52$ ,  $p = .13$ ). Intra-personal religious commitment did not predict learned helplessness ( $\beta = .12$ ,  $t = 1.18$ ,  $p = .24$ ). Social support sub-scales did not significantly predict learned helplessness, family ( $\beta = .10$ ,  $t = 1.07$ ), friends ( $\beta = -.05$ ,  $t = -.64$ ) and significant others ( $\beta = -.15$ ,  $t = -1.68$ ). This indicates that social support can mitigate the outcome of learned helplessness. The combined scores (interpersonal and intrapersonal religious commitment) significantly predicted learned helplessness ( $\beta = .44$ ,  $\beta = .36$ ,  $t = 4.20$ ,  $p < .001$ ). However, the combined scores on the social support scales did not significantly predict learned helplessness ( $\beta = -.08$ ,  $\beta = -.10$ ,  $t = -1.20$ ).

## Summary

The analysis above showed that religious commitment significantly predicted learned helplessness in HIV/AIDS patient ( $\beta = .28$ ,  $t = 2.75$ ,  $p < .01$ ). This result is contrary to the hypothesis which states that religious commitment will negatively predict learned helplessness. The analysis also indicated that coping strategies significantly predicted learned helplessness (emotion focused coping ( $\beta = .30$ ,  $t = 3.60$ ,  $p < .001$ )). This result is also contrary to the hypothesis which states that coping strategies will negatively predict learned helplessness in HIV/AIDS patient. The analysis also revealed that social support; combining the three subscales did not significantly predict learned helplessness. Family ( $\beta = .10$ ,  $t = 1.07$ ), friends ( $\beta = -.05$ ,  $t = -.64$ ) and significant others ( $\beta = -.15$ ,  $t = 1.68$ ). This result is in agreement with the hypothesis which states that social support will negatively predict learned helplessness in HIV/AIDS patients.

## Implication of the study

Several implications can be drawn from this study. The study has been able to prove that people living with HIV/AIDS (PLWHA) experience learned helplessness. Hence, treatment modalities should include psychological principles to modify their behaviours towards living positively healthy with the virus.

Another implication is the inability of religious commitment to mitigate learned helplessness in PLWHA. The result of the study predicted positively significant relationship between religious commitment and learned helplessness on the interpersonal religious commitment subscale. By implication it means that despite their engagement and interactions with their fellow religious associates, no consolation could be able to counter their feeling of helplessness. Intra-religious commitment did not predict learned helplessness in this study population. This is in line with previous studies on the role of religion on learned helplessness which revealed negative association with other stressful and chronic conditions. It is therefore necessary to state that these patients be taught to refocus their minds onto God than on fellow man. Learned helplessness persists in this group of persons probably because knowing well that the infection has no known remedy they resigned to fate to allow God to intervene in their plight. This is indeed a state of helplessness. These people require the services of counseling and clinical psychologists as well as priests and pastors to help them overcome the negative outcome of learned helplessness.

Furthermore, the study found that PLWHA adopted emotion-focused coping as a way of handling their stressful situation. By implication this approach to issues has its attendant negative consequences which can culminate into learned helplessness. In this regards PLWHA will need the assistance of clinical psychologists to evaluate and give them psychotherapy on appropriate coping techniques that will enhance their effective physical and mental well-being. Some of the disadvantages of emotion-focused coping is that, it may become a dysfunctional method of coping quiet quickly, can lead to drug abuse and dependence, denial of a problem can have a negative consequences such as not receiving the right treatment, and lowered mental involvement.

More so, social support is an important factor that should be adequately addressed in the care for PLWHA. The provision of sufficient, relevant and timely social support will act as a buffer to enable them cope better with their stressful life tragedy. The result of this study showed that social support inhibited feeling of learned helplessness i.e. the more social support, the less likelihood of developing learned helplessness; and this is logical since man is a social animal.

Lastly, learned helplessness may have not been widely studied among the health practitioners and on PLWHA. This construct may have several negative interactions with treatment regimen on the part of the patients and the medical practitioners. Learned helplessness has been implicated in several psychological disorders such as depression, Barder et al, 1994; Conwill, 1993; Abramson et al., 1989), low self-esteem and increased feeling of hopelessness (Metalsky, et al., (1994). These factors impinge on health maintenance behaviour of patients on highly active antiretroviral treatment which requires about 95% compliance to be positively healthy. Therefore, a better understanding of learned helplessness and its attendant behaviours should be communicated to both patients and medical practitioners. Thus, a better quality of life and well-being would be achieved by those living positively with HIV.

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### **Limitation of the study**

This study has several limitations that should be addressed in subsequent studies. The present study did not adopt a cross-sectional approach because participants were drawn a single health facility. Future studies should use both cross-sectional and longitudinal designs to investigate the role of religious commitment, coping strategies and social support in learned helplessness among PLWHA.

Another limitation is the generalizability of the study which may be limited to Ogoja because they formed the sample population used for this study. In addition, because the researcher used only literate participants in the study, no comparison was made between participants as the illiterate population was excluded from the study.

Furthermore, the researcher had difficulty in getting participants who were willing to participate in the study because majority of people living with HIV/AIDS were never comfortable to disclose their HIV status for fear of stigmatization, even when demographic data was structured in an anonymous pattern.

Lastly the researcher used a non probability sampling technique which may have distorted the characteristics of the participants

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### **Recommendation**

The limitations of this study stated above forms the basis for the recommendations for future research. This study was conducted using participants from a single location. Therefore future researchers on learned helplessness and other variables in this study should consider using participants from different health facilities across the country. With this approach it will enhance generalizability of findings,

Other studies may equally consider the moderating role of religious commitment on learned helplessness. Also qualitative studies may be needed to understand how medical practitioners and other care givers understand the concept of learned helplessness. This is important because the knowledge of learned helplessness will enable the health practitioner to recognize the behaviours associated with helplessness and how it can be addressed.

Finally, studies may be carried out on the role of religious commitment, coping, gender and learned helplessness in treatment adherence among PLWHA.

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### **Summary/Conclusion**

This study investigated the role of religious commitment, coping strategies and Social support in learned helplessness among HIV/AIDS victims. Learned helplessness refers to a reaction to loss of control that induces cognitive, motivational and emotional deficit following the expectation that responses and outcomes are independent of each other (Raps, Peterson, Jonas & Seligman, 1982). The Following theories were reviewed: Reformulated theory of learned helplessness, hopelessness theory of learned helplessness, transactional theory of stress, appraisal theory, the buffering hypothesis and the rational choice theory. Three hypotheses were proposed for this study thus: religious commitment will negatively predict learned helplessness in HIV/AIDS patients, coping strategies will negatively predict learned helplessness in HIV/AIDS patients and social support will negatively predict learned helplessness in HIV/AIDS patients. Four instruments used in data collection included Religious Commitment Inventory 10 (RCI-10), Learned Helplessness Scale, Multidimensional Scale of Perceived Social support and the Brief COPE. One hundred and eighty seven participants (187) (93 males and 94 females) selected through convenient sampling participated in the study. The study was a survey research and hierarchical multiple regression method was used for data analysis.

The result of this study revealed that religious commitment positively and significantly predicted learned helplessness in patients with HIV/AIDS ( $\beta=.36, t=4.20, p<.001$ ). A closer examination reveals that interpersonal ( $\beta=.28, t=2.75, p<.01$ ) and not intrapersonal commitment predicted learned helplessness. Emotion-focused coping strategies, a subscale of coping strategies significantly predicted learned helplessness in patients with HIV/AIDS ( $\beta=.30, t=3.60, p<=.001$ ). In addition, social support negatively predicted learned helplessness in patients with HIV/AIDS. Social support-family ( $\beta=.10, t=1.07$ ), friends ( $-.05, t=-.64$ ), significant others ( $\beta=-.15, t=-1.68$ ).

The researcher discovered that much researches have not been conducted using these concepts on people living with HIV/AIDS therefore, the findings from this study is quite unique when compared with other studies. The uniqueness could be attributed that the fact that participants were people who are endangered spiced by HIV/AIDS. This study result showed that learned helplessness abounds among PLWHA in Ogoja. The consequences of learned helplessness among this group of persons hold greater risks to their quality of life. These range from diminished motivation to initiate problem solving activities, vulnerability to depression and low-self esteem, others are psychological and physical disorders with attendant poor adjustment to disease (e.g. treatment adherence).

Religious commitment and coping strategies were significantly related to learned helplessness among these study population, therefore their significance cannot be over emphasized in view of the health implications. Religious beliefs offer a sense of meaning and acceptance of stressful life adversities and faith in the Supernatural Being offer relief and change. Coping strategies is another grey area that when poorly adopted as in the present study will predispose individual to maladaptive behaviours. Hence, clinical psychologist will be of great assistance to these patients to guide them towards making good choices (coping styles). These individuals will benefit enormously from psychotherapy which will help them to plan and set realistic and achievable goals and objectives. This will modify their expectations that are unrealistic.

In conclusion, PLWHA are confronted with several significant challenges as they battle with stressors associated with their health status. Hence, they require adequate social support from the family, friends, and members of the society, including the three tiers of government to cushion the effect of stressors to live positively healthy.

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