STIGMATISATION, HEALTH DISCLOSURE AND SEXUAL FUNCTIONING: PREDICTORS OF PSYCHOLOGICAL WELLBEING OF OBSTETRIC FISTULA PATIENTS

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UNIVERSITY OF NIGERIA, NSUKKA

FEBRUARY, 2019

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DEPARTMENT OF PSYCHOLOGY

FACULTY OF SOCIAL SCIENCES

UNIVERSITY OF NIGERIA, NSUKKA

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TITLE PAGE

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CERTIFICATION

This is to certify that this research is the original work of **ESSIEN, NSIDIBE FRANCIS**, a post-graduate student of the Department of Psychology, Faculty of Social Sciences, Univeristy of Nigeria, Nsukka with registration number **PG/MSC/13/66767** for the award of the Master of Science degree in Clinical Psychology. The work embodied in this project is original and has not been submitted in part or in full for any degree in any other institution nor published anywhere.

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Prof. Lawrence. O. Amazue **Rev Sr (Prof). Mary Basil Nwoke**

Supervisor **Head of Department**

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Dean Faculty of the Social Sciences **External Examiner**

DEDICATION

This thesis is dedicated to my parents Mr/Mrs Francis and Elizabeth Essien. God bless and keep you.

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I thank various individuals who contributed in one way or the other to my study. My gratitude goes first to God Almighty for His protection and guidance, for His love and mercy throughout my graduate study. Abba Father, I thank you. I am grateful and will continue to be indebted to my supervisor, Prof. Lawrence Amazue. I am really very grateful and happy to have worked with you.

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Nsidibe Francis Essien

ABSTRACT

The present study examined stigmatisation, health disclosure, and sexual functioning as predictors of psychological wellbeing among women with obstetric fistula. The study adopted a cross sectional design. A sample of 183 women with obstetric fistula from the National Obstetric Fistula Centre Abakaliki were purposively sampled and administered with a questionnaire comprising the Ryff (1989) Psychological Well-Being Scale (PWBS), the Szivos (1991) Stigma Perception Questionnaire (SPQ), Checkton's (2010) Distress Disclosure Inventory (DDI), and the Female Sexual Quality of life Questionnaire (SQL-f) by Symonds, Boolell, and Quirk (2005). Cross sectional design was used for the study and hierarchical multiple regression was used for data analysis. Results showed that that age was positively related to psychological wellbeing ($r=.29$, $p < .01$). Length of time before corrective surgery was also positively related to psychological wellbeing ($r=.36$, $p < .01$). However, stigmatisation was negatively related to psychological wellbeing ($r=-.35$, $p < .01$). A hierarchical multiple regression analysis showed that stigmatisation significantly predicted psychological wellbeing ($\beta=-.35$, $t=-5.03$, $p<.05$).It also contributed 12% to the explanation of the variance in psychological wellbeing ($\Delta R^2=.12$). Illness disclosure significantly predicted psychological wellbeing ($\beta=-.38$, $t=-5.65$, $p<.05$). Also, 13% of the variance in psychological wellbeing was explained by illness disclosure ($\Delta R^2=.13$). Also, sexual functioning significantly predicted psychological wellbeing ($\beta=.35$, $t=5.45$, $p<.05$) and 11% of the variance in psychological wellbeing was explained on account of sexual functioning. Findings were discussed and suggestions for further studies made.

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CHAPTER ONE

INTRODUCTION

Provision of adequate healthcare to all citizens contributes immensely to the overall development of a nation. In similar fashion, the poor delivery of healthcare impacts negatively on the development of any nation (Ibrahim, 2015). One of the critical areas requiring constant improvement in developing countries is maternal pre- and post- natal care. However, the prevalence of obstetric fistula in developing countries such as Nigeria, especially among young women, has over time become a major health problem which deserves serious attention by the government (Ibrahim, 2015). The World Health Organisation (WHO) noted that obstructed labour contributes significantly to maternal mortality in several countries of the world (WHO, 2014).

An obstetric fistula can be described as an abnormal communication between the vagina and the bladder (or rectum) of a woman that result in a constant leakage of urine and/ or faeces (Aboh, Nwankwo, Obi, & Agu, 2013). Ahmad and Holtz (2007) also state that being the outcome of prolonged obstructed labour, an obstetric fistula is an abnormal communication between the vagina and the genito-urinary system and/or the rectum, and it is characterised by continuous urinary and/or faecal incontinence. Tebeu (2012) further described an obstetric fistula as the existence of a breach in a female's genital tract or in the middle of the genital tract and the intestines.

Tebeu (2012) also noted that it is usually characterised by the leakage of the urine through the vagina. It is worthy of note that the breach between the vagina and the bladder is called the Vesico Vaginal Fistula (VVF) while the breach between the rectum and the vagina is

called the Recto Vaginal Fistula (RVF). The VVF is marked by the leakage of urine through the vagina while the RVF is evident by leakage of the flatus and faeces through the vagina (Tebeu, 2012). The continuous urinary and faecal dribbling excoriates the adjacent genital areas, produces painful rashes, and emits offensive odours (Ahmad & Holtz, 2007).

The incidence of obstetric fistula varies from country to country and continent to continent as do the main causative factors (Aboh et al., 2013). Globally, over two million women are estimated to be living with obstetric fistula and majority is in sub-Saharan Africa and South East Asia (Kelly & Kwast, 1993). Furthermore, the reported incidence rate of obstetric fistula in West Africa ranges between 1-to-4 per 1000 deliveries (Ijaiya, 2004; Margolis & Marcer, 1994). An annual obstetric fistula incidence is estimated at 2.11 per 1000 birth (Tsui, Creanga, & Ahmed, 2007) and between 100,000 -to- 1,000,000 Nigerians live with obstetric fistula (Wall, 1988). It is estimated that the number of untreated obstetric fistula cases in Nigeria lies between 800,000 and 1,000,000, thus, indicating that maternal health in Nigeria is under siege (Villey, 2006). It is however not impossible that some of these incidences are under-reported. The World Health Organisation (WHO, 2006) estimated that in developing countries each year, five million women suffer severe maternal morbidity, with obstetric fistula being on the top of the list and it was further estimated by Nawaz, Khan, Tareen, and Khan (2010) that about 2 million women are awaiting fistula reparation surgery worldwide.

Treatment, correction, and repair of obstetric fistula is possible, however, due to the expensive nature of such, a vast majority of the victims are unable to afford the high cost of treatment, thus, further worsening their physical, social and psychological health. According to Browning and Patel (2004), at the world’s current capacity to repair fistulas, it will take at least 400 years to clear the backlog of patients, provided that there are no more new cases and by this

estimate, the unmet need for surgical treatment could be as high as 99%. The World Health Organisation's Global burden of disease study estimated that 21.9% of the disability adjusted life years lost by women aged 15 through 44 years were attributed to reproductive ill health and that 14.5 years per woman were lost to adverse maternity causes (Murray & Lopez, 1996).

Most of the previous studies focused on investigating obstetric fistulas are conducted from the medical view point. Nevertheless, the psychological, social and physical consequences of this disorder are enormous. As observed by Robertson (1957), the misery of this condition is one of the most frightful afflictions of human kind, hour by hour, night and day; the incontinence wets, excoriates and hurts the victim of this misfortune. Clothes are messed up, the bed becomes a nightmare, sexual intercourse stop; a pariah is made and the individual becomes alienated.

Similarly, Ahmed and Holtz (2007) observed that very few of the studies have examined the women's emotional and psychological status in relation to obstetric fistula. According to Ahmad and Holtz (2007), not only that mourning a dead child is almost inevitable for a woman with a fistula from obstructed labour, but she soon finds herself fighting for her own survival, social position as well as her value in the society. Mentally, she is tormented and devastated. A Nigerian study further held that about 33% of women with obstetric fistulas are psychologically depressed while an additional 51% were indicated to be bitter about life (Kabir, Abubakar, & Umar, 2004). Thus, irrespective of cause, urinary incontinence being a resultant effect of obstetric fistula impacts several aspects of the affected woman's life including physical, psychological, social and economic wellbeing (Hayder & Schnepp, 2010). Furthermore, women with obstetric fistula live a stigmatised life with social, economic, psychological, reproductive, and sexual repercussions, the extent of which varies from setting to another (Barageine, Beyeza-Kashesya, Tumuiesigye, Almroth, & Faxelid, 2015).

Strauss (1975) suggests that aside from the medical difficulties, the psychological impact of living with an illness condition is equally important to take into account. Studies have illustrated that the symptoms of illness (especially long term conditions) can have a serious impact on the individual's ability to participate in daily activities which in turn may have a negative impact on their identity (Charmaz, 1991; Radley, 1989; Bury, 1982, 1991). Indeed, Radley (1989) argued that the unpredictable symptoms of long-term conditions may limit the everyday activities of individuals and so influence psychosocial aspects of their lives. Thus, the unpredictable yet pressing demands of the body dictates the terms in which that day shall be lived and personal relationships engaged in.

Health is defined not only as the absence of infirmity, but also as a state of physical, psychological and social wellbeing (WHO, 1991). This implies that psychological wellbeing is a key component of the overall health of an individual. Thus, Taylor (1989) observed that throughout human history, normative understandings of wellbeing have defined particular human characteristics and qualities as desirable and worthy of pursuit or emulation. Such normative understandings of Taylors' (1989) position are often represented by traditional philosophies and religion that often stress the cultivation of certain virtues (Diener, 1984). This further led Moe (2012) to describe psychological wellbeing as the corner stone of mental health.

According to the World Health Organisation (2011), mental health is a state of wellbeing in which every individual realises his or her own potential, can cope with normal stress of life, can work productively and fruitfully and is able to make a contribution to her or his community. While psychological wellbeing has been traditionally defined by a lack of symptoms distress (that is, lack of anxiety, depression as well as other symptoms of psychopathology), over time, the term has taken on a more positive definition (Keyes & Magyar, 2003). This implies that

psychological wellbeing has become increasingly recognised as more than just an absence of distressful symptoms, but now includes positive qualities individuals possess that can lead to mental health (Moe, 2012).

Historically, mental health research has been dramatically weighted on the side of psychological dysfunction, and health has been equated with the absence of illness, rather than the presence of wellness. Ryff and Singer (1996) suggested that the absence of well-being creates conditions of vulnerability to possible future adversities and that the route to enduring recovery lies not exclusively in alleviating the negative, but also in engendering the positive. Bringing the person out of negative functioning is one form of success, but facilitating progression toward the restoration of positive functioning is quite another.

Psychological wellbeing is among the most central ideas in psychology as it plays a crucial role in theories of personality and development in both pure and applied forms. It provides a baseline from which we assess psychopathology, it serves as a guide for clinical work by aiding the clinician determine the direction clients might move to alleviate distress and find fulfilment, purpose and meaning; and it further informs goals and objectives for counselling related interventions (Christopher, 1999). Psychologists and health professionals have conducted extensive studies on psychological wellbeing (Deci & Ryan, 2008; Campbell, 1981). Thus, while the distinct dimensions of psychological wellbeing have been debated, the general quality wellbeing refers to optimal psychological functioning and experience (Tsegaye, 2013).

Psychological wellbeing involves the combination of feeling good and effective functioning (Huppert, 2009). Sustainable psychological wellbeing does not require the individual to feel good every time as the experience of painful and negative emotions (E.g. grief, failure,

disappointment) is deemed a normal part of life and being able to manage these painful emotions is essential for long term psychological wellbeing. Psychological wellbeing is however compromised when negative emotions tend to be extreme or long lasting and therefore interfere with the individual's ability to function optimally in his or her daily life (Huppert, 2009).

Ryff (1989) conceptualised psychological wellbeing as the optimal functioning and experience of an individual. However, Shek (1992) defined psychological wellbeing as that state of a mentally healthy person who possesses a number of positive mental health qualities such as active adjustment to the environment and unity of personality. Similarly, Dzuka and Dalbert (2000) defined psychological wellbeing as the overall satisfaction and happiness or the subjective report of one's mental state of being healthy, satisfied or prosperous and broadly to reflect quality of life and mood states. However, Deci and Ryan (2008) in their definition observed that psychological wellbeing refers to living life in a full and deeply satisfying manner. This conceptualisation believes that psychological wellbeing is not so much an outcome or end state, rather, it is a process, and it is concerned with actualising one's human potentials.

Psychological wellbeing as a broad construct comprises several components as delineated by Ryff (1989). Ryff (1989) critiqued researches on subjective wellbeing for what Ryff stated as its impoverished theoretical basis and also acknowledged that current approaches to subjective wellbeing have been extensively evaluated and that psychometrically standardised measures have been developed (Christopher, 1999). This led Ryff (1989) to develop an alternative approach to subjective wellbeing which was then referred to as psychological wellbeing. Ryff developed a measure of psychological wellbeing with six subscales denoting the six component of psychological wellbeing which are autonomy, environmental mastery, positive relations with others, purpose in life, personal growth and lastly self-acceptance (Ryff, 1989).

The psychological wellbeing of individuals suffering from obstetric fistulas tends to be affected by their condition since due to the high cost of surgery and treatment associated with this condition and the inability of a vast majority of individuals to afford such cost, their physical, social, and psychological conditions worsen (WHO, 2006). According to Wall (1988), the affected woman suffers from continuous and uncontrollable stream of urine or faeces coming out of her vagina. This is both a psychological and physical catastrophe. No escape is possible from the constant trickling of urine as well as the insistent oozing of stool 24 hours each day. Furthermore, these women become morally and physically offensive to their husbands, their families, their friends, and their neighbours. Indelibly stigmatised by their condition, they are forced to the margins of the society where they live a precarious existence (Wall, 1988).

Thus, the stigmatisation of women with fistula is a powerful phenomenon with far reaching effects (Link & Phelan, 2001). Stigma has been linked to poor mental health, physical illness, academic under-achievement, infant mortality, poverty, and even poor access to education and jobs (Braddock & Mc Partland, 1987). The World Health Organisation (2001) highlights the damage resulting from stigma, observing that those being stigmatised can experience rejection by friends, neighbours, relatives and employers, thus, leading to aggravated feelings of rejection, loneliness and depression. They also highlight that possible denial of equal participation in family life, normal social networks, and productive employment, as well as the reduced chances of recovery, since their ability to find access to services may be hampered, and the type of treatment and level of support received may be affected. Corrigan, Kerr and Kundsen (2005) further states that stigma can have significant adverse repercussion on not only the people with health problems, but also their family members, friends and groups which caters for the individual’s needs. Research has further indicated that stigmatising attitudes may prevent help

seeking and also increase psychological distress (Link, Struening, Rahau, Phelan, & Nutlbroak, 1997).

Falk (2001) states that the term ‘stigma’ was originally adopted by the ancient Greeks who used it to represent the marks that were pricked to slaves to indicate ownership and to further reflect their inferior social status. The ancient Greek word for prick was “Stig” and the resulting mark, “a stigma” (Falk, 2001). Thus, it was subsequently used to denote any bodily sign that signified something bad about the moral character of a particular person (Falk, 2001). However, the first remarkable modern use of the term was by Goffman (1963) in his classic work “Stigma: note on the management of spoiled identity”. Goffman observed that stigma reflects a social attitude towards people with illness that is deeply discrediting and a position of social disgrace. It also reflects a discrepancy between a person’s virtual social identity, which refers to the societal assumption of a particular person and their actual social identity which refers to any attribute that a person could be proved to possess (Goffman, 1963).

Goffman (1963) characterises stigma as a mark of social disgrace, arising within social relations and disqualifying those who bear it from full social acceptance. Marks take various forms: ‘abominations of the body’ such as physical deformities, alleged blemishes of individual character such as mental illness or unemployment and tribal identities, such as religion or ethnicity. People who possess such characteristics acquire a spoiled identity associated with various forms of social devaluation (Campbell and Deacon, 2006).

According to Campbell and Deacon (2006), some scholars often argue that it is important to distinguish between stigma (understood as negative ideologies or attitudes) from discrimination (negative behaviours). Other researchers such as Heatherton, Kleck, Hebb, and Hull (2003) defines stigma as a blend of affective, cognitive and behavioural responses with the

primacy of each factor resulting from variable interactions between the nature of the stigma, the context in which it is encountered and individual differences amongst people interacting.

Faced with multiple layers of social disadvantage, it may be difficult for people to challenge their stigmatised status as seen among women who suffer from obstetric fistula (Campbell & Deacon, 2006). Thus, they engage in self-policing. The self-policing that Crawford (1994) speaks of are deeply psychological, rooted in the complex mechanisms through which the social becomes deposited in the individual psyche. Even when members of stigmatised groups are not exposed to overt and direct acts of discrimination, individuals who carry stigmatised markers may internalise negative representations of their status (Goffman, 1963). This may lead to loss of confidence and self-esteem, undermining the likelihood that they will challenge their devalued status (Campbell & Deacon, 2006).

In discussing stigma, Deacon, Stephney, and Prosalendis (2005) makes a distinction between symbolic stigma and disease stigma. Stigma refers to value-based ideology that imposes moral judgements on others to affirm the in-group's safe and moral identity. Disease stigma constitutes negative social baggage associated with a disease that is not justified by the medical effects of the disease on the human body. While both are interrelated, the later fixes attention on the physical and social consequences of disease: this is crucial for understanding chronic disease experiences and handicap and the place of stigma within these (Deacon et al., 2005).

Another variable of interest in this study is health disclosure. Studies have suggested the influence of disclosure on psychological wellbeing. Despite the relatively high number of people living with a long-term condition such as a fistula and the resulting challenges which they face, there is little understanding of disclosure of illness conditions. The means by which individuals decide to disclose their condition and how they cope with the responses to such disclosure,

particularly for those with conditions which may not be immediately obvious to others, is not evident (Joachim & Acorn, 2000). Typically, a gap has been left in terms of the decision and experience of disclosing one's illness to friends, family or work colleagues (Williams & Healy, 2001). As a consequence, the nature and role of disclosure remain unclear.

Disclosure is defined by the Oxford English dictionary (2001) as to make secret or new information known. However, definitions of disclosure within health care research are less clear. A qualitative study of individuals living with long-term illness entitled, Good days, Bad days (to indicate the variable nature of living with long-term illness) identified two types of disclosure (Charmaz, 1991). Firstly, "protective disclosing" a strategy adopted to manage the disclosure in terms of both the information provided and the selection of to whom it is told. The purpose of this disclosure is to protect the 'disclosee' (the recipient of the information) and to allow others to adjust their expectations of them. Secondly, spontaneous disclosing denotes a form of disclosure, which is not pre-planned or managed. This can occur on receipt of particularly negative news or information such as the perception that there has been a significant downturn in the prognosis of their condition. However, whilst long-term conditions were the focus of the study, disclosure of illness condition was not, but rather emerged as an area of concern (Charmaz, 1991).

Williams and Healy (2001) in their study defined disclosure as the process of revealing one's illness to others. It is one of the few studies conducted within health care research which defines disclosure. Also, there is a lack of clarity as to the dimensions of the term disclosure and its context. Aside from "verbal" disclosure, studies have indicated that a condition may be disclosed through behaviour. One study found that coughing may constitute a form of disclosure

of cystic fibrosis (Lowton, 2004), and others have argued that acting differently may reveal mental conditions (Williams & Healy, 2001).

Psychologically, Jourard (1971) defines disclosure as to describe the act of revealing personal information to others. Jourard's research interest in disclosure stemmed from his work as a psychotherapist working with clients encouraging them to disclose, to clarify what Jourard described as the parameters of secretiveness and openness (Jourard, 1971). However, within the discipline of Psychology, the role of disclosure has a different and broad focus to studies in health care research. For example, common to psychological definitions is a sense of disclosing something personal about oneself to a trained professional which does not necessarily relate to simply one's health status.

Derlerga and Grzelak (1979) have described disclosure as a verbal message about the self. More recently Rosenfield (2000) has defined it as the process that grants access to private things and secrets. This suggests that disclosure is not a decision to be taken lightly because what is being disclosed may be a "secret" and as such only disclosed under specific circumstances. In contrast to studies in the field of health care research, within psychological literature disclosure is clearly defined in terms of what disclosure is, and what it represents for the person disclosing (Williams & Healy, 2001).

The present study focuses specifically on the disclosure process and Greene, Derlega, and Mathews (2006) definition of disclosure as an interaction between at least two individuals where one intends to deliberately divulge something personal to another. Whether they are verbal or nonverbal, disclosures are voluntary acts in which the discloser intentionally shares personal or private information that may be highly sensitive (e.g., I have a fistula) or less immediate (e.g., I have a family history of fistula). Additionally, disclosures are not necessarily restricted to

information about the self as Greene et al. (2006) distinguish between personal disclosure (i.e., disclosure about oneself) and relational disclosure that focuses on one's relationships with another or interactions with others. Further, disclosure (and nondisclosure) can reflect a self-, other-, or relationship-focus (Derlega, Winstead, Greene, Serovich, & Elwood, 2004; Derlega, Winstead, & Folk-Barron, 2000; Greene et al., 2006).

Disclosure is associated with greater psychological wellbeing for marital and cohabiting couples (Finkenauer & Hazam, 2000; Lippert & Prager, 2001). In health contexts, women with breast cancer who shared concerns, feelings, and problems with their husbands enjoyed better psychological adjustment (Lichtman, Taylor, & Wood, 1987) and enhanced social and emotional adjustment, and self-esteem (Zemore & Shepel, 1989). For patients who recently experienced a myocardial infarction (i.e., heart attack), talking with a partner about lifestyle changes can be empowering in terms of taking control of one's life but may also serve as a reminder of loss (Goldsmith, Miller, & Caughlin, 2007). Further, low levels of disclosure for patients with gastrointestinal (GI) cancers predicted lower relationship functioning and psychological distress (Porter, Keefe, Hurwitz & Faber, 2005). Thus, sharing personal information in relationships has its benefits. Yet, there are also risks involved in disclosing.

Individuals weigh the risks and benefits of disclosing private information and regulate their privacy boundaries accordingly (Derlega & Chaiken, 1977). For example, personal or self boundaries surround people's information and allow them to determine how open or closed they want to be with the information. Collective boundaries focus on information that relationship partners reveal to one another. The idea of "shared ownership" of mutually disclosed information suggests that relationship partners weigh multiple goals in managing the dialectic to be open versus closed (Altman, Vinsel, & Brown, 1981). For example, after sharing information with a

recipient, that person "co-owns" the information and the discloser expects that the recipient will observe the negotiated (or stated) privacy boundaries. Although individuals report greater use of explicit rules (e.g., don't tell anyone) rather than implicit or no rules when sharing private information, disclosure recipients do not necessarily abide by the rules. Thus, there are times when individuals opt for nondisclosure of private information ((Derlega & Chaiken, 1977; Altman, 1975; Baxter, 1988; Rodriquez & Ryave, 1992; Petronio, 2002).

Health disclosure is further complicated as some long-term conditions have been referred to as "visible" or "invisible" (Joachim & Acorn, 2000). Those with visible conditions arguably have no control over whether or not to disclose their condition because others can see the existence of the long-term condition (Joachim & Acorn, 2000). This has been described by Goffman (1963) as the special indignity of knowing that they wear their situation on their sleeve. In contrast, conditions which do not have visible symptoms are therefore described as invisible because there are no obvious signs of illness. A study of the rare condition-scleroderma found that those with "invisible" symptoms had a choice as to whether to disclose or not because they appear "normal" to others (Joachim & Acorn, 2003). Decisions to disclose may be problematic because it may result in additional stigma and an alternative strategy would be to try to hide the condition and be perceived as "normal" (Joachim & Acorn, 2000).

Moreover, an important factor also implicated in psychological wellbeing is sexual functioning. Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality and not merely the absence of disease, dysfunction or infirmity (WHO, 2006). Human sexuality is constructed through interactions between the individual and wider society, and its development depends on the expression of basic human needs, including intimacy, emotional expression and love (World Association for Sexual Health, 1999). Thus, the

sexual functioning of women with obstetric fistula is influenced by a complex web of biological and social factors. It requires a positive, responsible approach to sexuality and sexual relationships as well as pleasurable, safe sexual experiences that are free from coercion, discrimination or violence.

Research has demonstrated that disruptions to sexual functioning are prevalent among women with obstetric fistula. Lack of interest in sex and inability to reach orgasm are examples of sexual problems or sexual dysfunctions commonly reported by women with obstetric fistula (Laumann, Paik, & Rosen, 1999). DeLamater and Karraker (2009) defined sexual functioning as the perceived quality of a person's sexual life and relationships. Laumann, Paik, and Glasser, Kang, Wang, Levinson, and Gingell (2006) further defined it as the cognitive and emotional evaluation of an individual's sexuality. Sexual functioning refers to a series of bodily responses and/or behaviours (Rosen, Brown, Heiman, Leiblum, Meston & Shabsigh, 2000).

The sexual functioning of women experiencing fistula and its effects on their psychological wellbeing is not well understood. Nevertheless, in the general population, not only are sexual problems and sexual dysfunctions prevalent, they also have a profound impact on personal and relational aspects of life. Decreased self-esteem, decreased personal well-being and decreased happiness have been identified as consequences of sexual problems (Heiman, 2002). Similarly, sexual problems have been associated with stress, anxiety and depression (Shifren, Monz, Russo, Segreti, & Johannes, 2008). Relational issues such as marital strain and relationship instability have also been identified as correlates of sexual problems (Bartlik & Goldberg, 2000; Heiman, 2002; Pridal & LoPiccolo, 2000).

Due to the prevalence of sexual problems and the damaging effect they can have on personal and relational well-being, much research has focused on examining the sources of these

problems. These investigations have identified physical factors (cardiovascular disease, diabetes) and psychological factors (sexual trauma) (Elliot & O'Donohue, 1997; Wallner, Sarma, & Kim, 2010).

Sexuality literature is rich in information on sexual problems that result from physical illness, likely because the source of the problem can more easily be identified than if the source is psychological (Tiefer, 2010). Although research have identified various psychological factors that impact sexuality, the current state of knowledge presents a limited picture of the range of these factors threatening sexual functioning (Anderson & Cyranowski, 1995). This may be a result of the subtle, hidden or invisible nature of psychological disturbances to sexual functioning. Unlike the physical factors (i.e., obstetric fistula) where consequences are visible in many situations, psychological factors, particularly cognitions and feelings, may only manifest in sexual situations, making them difficult to treat (Binik, Bergeron, & Khalife, 2007). This study will therefore investigate the role of stigmatisation, disclosure, and sexual functioning on the psychological wellbeing of women suffering from obstetric fistula.

Statement of the Problem

The devastating complication of obstetric fistula is the psychological consequences victims have to put up with, the major problems being incontinence, fear of disclosing their illness, stigmatisation, and impaired sexual functioning, childlessness, divorce, and poverty. Often times the victims become a social outcast with suicide sometimes, a terminal event (Moir, 1967). However, while the physical consequences of an obstetric fistula can be treated with surgical repairs, the psychological scar often tends to be overlooked. With successful repairs, it is often taken for granted the impacts of the illness on the psychological wellbeing of the patients. It is often believed that the stigma experienced by the victim would have dissolved and her

distrust leading to poor disclosure may have resolved itself while the sexual functioning of the victim would have taken care of itself. Thus, this research will seek to answer the following questions:

1. Will stigmatisation significantly predict the psychological wellbeing of women suffering from an obstetric fistula?
2. Will health disclosure significantly predict the psychological wellbeing of women suffering from an obstetric fistula?
3. Will sexual functioning significantly predict the psychological wellbeing of women suffering from an obstetric fistula?

Purpose of Study

Most studies discuss the psychological distress experienced with fistula based on what women were said to report, which is far inadequate to elicit an in-depth understanding of their psychological wellbeing. Perhaps, Nigerian researchers have not been able to undertake an extensive study on the psychological wellbeing of women who suffer from an obstetric fistula due to the sparse nature of this population as caused by the unavailability of treatment facilities in all parts of the country, emotional engagement, follow up rigours, the time factor, and travel risks associated with studying this population. Psychological wellbeing is a construct that is likely to be influenced by several factors which includes; stigmatisation, self-disclosure, and sexual functioning. Consequently, the current study intends to investigate the following:

1. Whether stigmatisation will significantly predict psychological wellbeing in women suffering from an obstetric fistula.

2. If health disclosure will significantly predict psychological wellbeing in women suffering from an obstetric fistula
3. Whether sexual functioning will significantly predict psychological wellbeing in women suffering from an obstetric fistula

Operational Definition of Terms

Psychological wellbeing: this is an individual meaningful engagement in life, self-satisfaction, optimal psychological functioning and development at one's true highest potential. It has six dimensions that are autonomy, environmental mastery, personal growth, positive relationship with other, purpose in life and self-acceptance of individuals as measured by the Ryff (1995) Psychological wellbeing Scale.

Stigmatisation: Stigmatisation is the social devaluation associated with an obstetric fistula that is not justified by the medical effects of the disease as measured by the Szivos (1991) Stigma Perception Questionnaire.

Disclosure: This is defined as the process of revealing the distress from the illness to others as measured by Checkton's (2010) Health Disclosure Scale.

Sexual Functioning: This refers to an individual's hunger, desire or interest in sexual activity including desire, arousal, orgasm and resolution as measured by the Female Sexual Quality of Life (SQL-F) Questionnaire developed by Symonds, Boolell, and Quirk (2005).

Obstetric Fistula: This is a medically diagnosed condition in an individual as an abnormal communication between the vagina and the genito-urinary system and/or the rectum, and is characterised by continuous urinary and/or faecal incontinence.

CHAPTER TWO

LITERATURE REVIEW

The review of relevant literature on psychological wellbeing, stigmatisation, disclosure, and sexual functioning were discussed in two parts- theoretical and empirical reviews.

Theoretical Review

The theories reviewed in this study are as follows:

Ryff's (1989) theory of psychological wellbeing, Deci and Ryan's (2000) self-determination theory of psychological wellbeing and Seligman's (2011) PERMA theory of psychological wellbeing. Goffman (1963) social interactionist theory of stigma, Scheff's (1966) labelling theory, Heider's (1958) attribution theory of stigma, Serovich's (2001) consequence theory, Kalichman's (1995) disease progression theory**,** Masters and Johnson's human sexual response cycle (HSRC), Kaplan's triphasic model of sexual functioning, the push-pull model of incentive motivation (Laan, Everaerd, van Bellen, & Hanewald, 1994). These theories were deemed relevant to the study by the researcher as they explain the study's variables.

Theories of Psychological Wellbeing

Ryff's (1989) Theory of Psychological Wellbeing

Ryff (1989) proposed a modern theory of psychological wellbeing. Ryff posits the key components of well-being are self-acceptance (positive attitude toward the self), positive relationships with others (reciprocal and supportive), autonomy (self-determined and independent), environmental mastery (sense of mastery and competence), purpose in life (goals and sense of direction), and personal growth (aspiring to continually develop). Ryff's conceptualisation of the dimensions of psychological well-being came from a compilation of

constructs proposed by previous researchers and Ryff (1989) believes that these encompass an individual's total well-being.

Autonomy: Ryff (1989) ranked autonomy with other attributes such as internal locus of control, independence, self determination, individuation, as well as internal regulation of behaviour. Underlying the various attributes is the belief that one's actions and thoughts are one's own and should not be determined by agencies and causes outside the individual's control. The fully functioning person can be described as having an internal locus of evaluation whereby the individual does not look to others for approval, but evaluates his/ herself by personal standards (Ryff & Singer, 1996). Like it can be observed in women with obstetric fistula, Tsihoanne (2006) states that a perceived lack of control produces a feeling of helplessness and loss of hope, while diminishing an individual's willpower.

Environmental Mastery: According to Ryff (1989), environmental mastery is the ability of the individual to choose or create environments that are suitable to whom they are as a person and the ability to be flexible in different environmental settings. Maturity is viewed as requiring participation in a significant scope of activity outside of oneself. Life-span development can be conceptualised as requiring the ability to manipulate and control complex environments and also one's ability to progress in the world and change it creatively through mental or physical activities. This active participation in, as well as mastery of the environment are key ingredients in an integrated framework of positive psychological functioning (Ryff & Singer, 1998).

Positive Relations with Others: In her definition, Ryff (1989) viewed positive relations with others as warm, trusting interpersonal relations and strong feelings of affection and empathy. At first, this criterion/subscale appears most sympathetic to or compatible with collectivism.

Nevertheless, there is a significant difference between having relations with others and being psychologically constituted by one's location in a social network (Christopher, 1999). Many of the earlier theories in psychology often emphasised the importance of warm, trusting interpersonal relations. The ability to love is viewed as a central component of mental health. Self-actualisers are viewed as having strong feelings of affection and empathy for all humans as well as being capable of greater love, deeper friendship, and more complete identification with others. Warm relation with others can thus be seen as an index of maturity (Ryff & Singer, 1996).

Purpose in Life: Ryff (1989) further suggested that having a clear comprehension of life's purpose, a sense of directedness, and intentionality are critical parts of the feeling that there is purpose and meaning of life. Therefore, an individual who functions positively has goals, intentions, and a sense of direction, all of which contributes to the overall feeling that life is meaningful (Ryff & Singer, 1996).

Personal Growth: Ryff (1989) conceptualised personal growth as the continuing ability to develop one's potentials, to grow and expand as an individual. Openness to experience is therefore a key feature of the fully functioning person. Such a person is continually developing, rather than achieving a fixed state wherein all problems are resolved. Life-span approaches also give explicit emphasis to continued growth and to facing new challenges and tasks at different periods of life (Ryff & Singer, 1996).

Self Acceptance: Ryff (1989) further posit that holding a positive attitude towards oneself emerges as a central feature of psychological wellbeing. This is often defined as a significant property of positive psychological functionality as well as having a positive attitude towards

oneself. Self-acceptance means a positive attitude towards oneself. Also, it is being viewed as a central feature of mental health as well as a characteristic feature of self actualisation, optimal functioning, and maturity. Life-span theories also emphasise acceptance of one's self as well as one's past life. Therefore, holding positive attitudes towards oneself usually emerge as a central feature of positive psychological functioning (Ryff & Singer, 1996).

Ryff and Singer (1998, 2000) have explored the question of well-being in the context of developing a lifespan theory of human flourishing. Also drawing from Aristotle, they describe well-being not simply as the attaining of pleasure, but as the striving for perfection that represents the realisation of one's true potential (Ryff, 1995). Ryff & Keyes (1995) thus spoke of psychological well-being (PWB) as distinct from Subjectve Wellbeing (SWB) and presented a multi-dimensional approach to the measurement of PWB that taps six distinct aspects of human actualisation. These six constructs define PWB both theoretically and operationally and they specify what promotes emotional and physical health (Ryff & Singer 1998).

They have presented evidence, for example, that eudaimonic living, as represented by PWB, can influence specific physiological systems relating to immunological functioning and health promotion. In an engaging and instructive debate, Ryff & Singer (1998) challenged SWB models of well-being as being of limited scope where positive functioning is concerned, and specifically that SWB is often a fallible indicator of healthy living.

In turn, Diener, Sapyta, and Suh (1998) retorted that Ryff & Singer's eudaimonic criteria let experts define well-being, whereas SWB research allows people to tell researchers what makes their life good. What is most clear from this clash of paradigms is that these differing definitions of wellness have led to quite different types of inquiry concerning the causes, consequences, and dynamics of well-being. In addition to sharing similar theoretical

components, Ryff (1989) also agrees lacking components of well-being can create psychological manifestations of depression, anxiety, and addictive behaviours. This suggests that Ryff (1995) believes that the fulfilment of these dimensions is essential for optimal functioning. In addition, Ryff (1989) posits that these dimensions of well-being are universal even though their expression may be culturally dependent.

Ryff's (1989) theory has undergone testing and several studies demonstrate Ryff's conceptualisation of well-being is empirically sound. Research has supported the existence of the six dimensions of well-being in samples of non-institutionalised adults over 25 years of age (Keyes, Shmotkin, & Ryff, 2002; Ryff & Keyes, 1995), women over the age of 55 (Kling, Seltzer, & Ryff, 1997; Kwan, Love, Ryff, & Essex, 2003), and in middle aged adults (Ryff, Schmutte, & Lee, 1996). Although Ryff's (1989) scale of Psychological Well-Being (PWB) was used in all the studies mentioned above, the instrument was modified in every study, providing only tentative support for her operationally defined theory.

In addition to the research that supports the theory, Ryff's theory should be praised for its forward thinking about the components and measurement of well-being, and suggestions about how to treat psychological distress. Ryff (1995) believes in order for treatment to be effective, one has to "identify what is missing in people's lives" rather than pathologising the individual. By identifying the parts that are missing in the lives of victims of obstetric fistula, psychological treatment can focus on filling these voids in appropriate ways rather than focusing solely on symptom management.

Ryff's (1989) theory is based upon arguably the "best" aspects of prior theories and subsequent research has supported both the theory and scale of well-being, there are some questionable aspects of Ryff's conceptualisation of holistic well-being. First, although not

considered to be a psychological variable, physical needs certainly contribute to well-being and therefore should be included in a holistic analysis of any individual. Ryff does not state why the physical component was not included in her model, but perhaps like Deci and Ryan (1985), Ryff is aware of the importance of physical needs but does not focus on its assessment. Also, it was argued that personal growth may not be a unique dimension of well-being because of its likely connection to purpose in life.

Although Ryff (1989) defines these two variables (personal growth and purpose in life) differently, the theory does not explain why they are separated. In addition, there could be many situations where because someone has purpose in life they are experiencing growth (e.g. parenting, teaching). It is also argued that the dimension of self-acceptance is similar to the self-esteem need, and research has not been able to determine whether it is a need or an outcome of having needs met. Without providing evidence of why Ryff (1989) believes self-esteem is a separate need, it is difficult to support Ryff's use of it as one. It is suggested that another limitation of Ryff's (1989) theory in terms of including personal growth and self-acceptance into the well-being dimension is that these constructs are difficult to objectify. While positive relations with others (relatedness), autonomy, environmental mastery (competence), and purpose in life could all be confirmed by collateral data, personal growth and self-acceptance are purely subjective and therefore more difficult to verify.

Deci and Ryan's Self Determination Theory (SDT) of Psychological Wellbeing

The self-determination theory as postulated by Deci and Ryan (2000) posits three innate psychological needs- for competence, autonomy and relatedness and theorises that fulfilment of these needs is essential for psychological growth, integrity and psychological wellbeing (Ryan & Deci, 2001; Deci & Ryan, 2000). They conceive of these constructs as factors that foster

wellbeing by maximising one's potential, rather than as indicative of wellbeing itself. Further, they argue that the thwarting of any of these three needs is psychologically harmful. Deci and Ryan developed the self-determination theory (SDT) to explain both goal content and the processes through which goals are pursued. They posit that process and goal content make distinct contributions toward psychological wellbeing- and stress whether goal fulfilment is made in a way that facilitates the three basic needs, and whether it is intrinsically or extrinsically motivated (with the former associated with better motivation, performance and wellbeing) (Deci & Ryan, 2000).

Evidence suggests that the Self Determination Theory is applicable across cultures. Despite cultural, ideological and location differences, Kenny and Kenny (2007) reports that it appears that status, level of control, and levels of social interaction are universal determinants of psychological wellbeing across cultures. Ryan and Deci (2001) find that SDT does not suggest that the basic needs are equally valued in all families, social groups, or cultures, but it does maintain that thwarting of these needs will result in negative psychological consequences and poor psychological wellbeing in all social or cultural contexts. Ryan and Deci's (2000) Self-determination theory (SDT) is a perspective that has both embraced the concept of eudaimonia, or self-realisation, as a central definitional aspect of psychological well-being and attempted to specify both what it means to actualise the self and how that can be accomplished. Specifically, SDT theorises that fulfillment of these needs is essential for psychological growth (e.g. intrinsic motivation), integrity (e.g. internalisation and assimilation of cultural practices), and psychological well-being, as well as the experiences of vitality (Ryan & Frederick, 1997) and self-congruence (Sheldon & Elliot, 1999). Need fulfillment is thus viewed as a natural aim of

human life that delineates many of the meanings and purposes underlying human actions (Deci & Ryan, 2000).

Specification of basic needs defines not only the minimum requirements of psychological wellbeing but also delineates prescriptively the nutrients that the social environment must supply for people to thrive and grow psychologically (Ryan & Deci 2000). Thus, SDT describes the conditions that facilitate versus undermine well-being within varied developmental periods and specific social contexts such as schools, workplaces, and friendships. SDT does not, however, suggest that the basic needs are equally valued in all families, social groups, or cultures, but it does maintain that thwarting of these needs will result in negative psychological consequences in all social or cultural contexts (Ryan & Deci, 2000). As such, contextual and cultural, as well as developmental factors continually influence the modes of expression, the means of satisfaction, and the ambient supports for these needs, and it is because of their effects on need satisfaction that they, in turn, influence growth, integrity, and psychological well-being at both between-person and within-person levels of analysis (Ryan & Deci, 2000).

SDT has both important similarities and differences with Ryff's approach. Scholars wholly concur that psychological well-being consists in what Rogers (1963) referred to as being fully functioning, rather than as simply attaining desires. Studies also are largely in agreement concerning the content of experiencing wellbeing, e.g. being autonomous, competent, and related. However, some approach theorises that these contents are the principal factors that foster psychological well-being, whereas Ryff's approach uses them to define psychological well-being (Ryan & Deci, 2001).

SDT posits that satisfaction of the basic psychological needs typically fosters subjective wellbeing as well as psychological well-being. This results from the belief that being satisfied

with one's life and feeling both relatively more positive affect and less negative affect (the typical measures of SWB) do frequently point to psychological wellness, for, as Rogers (1963) suggested, emotional states are indicative of organismic valuation processes. That is, the assessment of positive and negative affect is useful insofar as emotions are, in part, appraisals of the relevance and valence of events and conditions of life with respect to the self. Thus, in SDT research, studies have typically used subjective wellbeing (happiness) as one of several indicators of psychological well-being. However, studies have at the same time maintained that there are different types of positive experience and that some conditions that foster Subjective Wellbeing (SWB) do not promote psychological well-being (Ryan & Deci, 2001). A research by Nix, Ryan, Manly, and Deci (1999) showed that succeeding at an activity while feeling pressured to do so resulted in happiness (a positive affect closely linked to SWB), but it did not result in vitality (a positive affect more closely aligned with psychological well-being).

That there ought to be an association between health status as experienced by women with obstetric fistula and psychological well-being seems intuitively clear (Ryan & Deci 2000). Ryan and Deci (2000) observed that sickness is often associated with displeasure or pain, so the presence of illness may directly increase negative affect. Further, illness such as a fistula often presents functional limitations, which can detract from opportunities for positive affect and life satisfaction (Ryan & Deci, 2000).

PERMA Well-Being Model (Seligman, 2011)

The PERMA wellbeing model was developed by Seligman (2011) who identified five essential elements of psychological well-being: Positive emotions, Engagement, Relationships, Meaning, and Accomplishment The first element of the PERMA model is positive emotions. As a cornerstone of the wellbeing model, experiencing positive emotions such as hope, compassion,

contentment, empathy, gratitude, joy, or love is considered the most essential element contributing to well-being conditions (Seligman, 2011; Webster, 2014). The second element of the PERMA model is engagement, which concerns whether a person is deeply engaged with something in life such as work, personal interest, or hobby (Seligman, 2011). Relationships, the third element in the PERMA well-being model, deals with whether a person is able to build and maintain positive relationships with others (Seligman, 2011).

According to Seligman (2011), the fourth and fifth elements of well-being are meaning and purpose. Meaning refers to one's purposeful existence in the world, whilst purpose is related to feeling a sense of accomplishment and success. Noble and McGrath (2008) believes that people have a sense of 'meaning' when what they do has impact on others beyond themselves. They have a sense of 'purpose' when they pursue worthwhile goals. While the individual elements of the model can be seen to function alone to generate wellbeing effects, they often work together, interacting to produce a range of outcomes, which in combination offer well-being impact. Thus, as a model, PERMA offers a range of elements and levels of engagement that may produce well-being. With this in mind, the current paper applies the PERMA well-being model to consider how stigmatisation, health disclosure and sexual functioning can offer a context to examine the psychological well-being of women with obstetric fistula. However, the key criticism of this model is the lack of empirical support and its excessive focus on the individual.

Theories of Stigmatisation

This section explains the existing theories of stigma in the context of an illness such as the obstetric fistula. Research since Goffman's seminal essay from 1963 has been incredibly productive, leading to elaborations and refinements of the concept of stigma.

Goffman (1963) Social Interactionist Theory of Stigma

Goffman's pioneering work provides a conceptual framework based on social interactionist theory. According to Goffman (1963), stigma is an attribute that is deeply discrediting and the person carrying that stigma is different from the rest or of less desirable kind. Goffman states that the stigmatised self arises when there is an undesirable discrepancy between one's virtual social identity (what society expects of him/her in a given situation at a given point of time) and actual identity (what the person actually is). Thus, the stigma makes the person less desirable and different from the ones who are normal, that is, those who do not carry the stigma. According to this theory, stigma arises when there is a feeling of inferiority, which stems from the failings, vis-à-vis social expectations that the person carrying stigma has (Goffman, 1963).

According to Goffman (1963), although a social intercourse between a normal and stigmatised person can happen at various points spread across a time span, Goffman delves largely on 'mixed contacts' i.e., immediate social contact of a normal person with a stigmatised one in same the social situation. In such social intercourses, Goffman (1963) opines that both the normal and the stigmatised adjust their lives to avoid each other; but in most cases the adjustment is more on the part of the later. These adjustments can be in many ways – avoiding social contacts due to fear and anxiety of being rejected by the normal, cowering him/herself or portraying that he/she has bravado. Mixed social contacts produce anxiety among both normal and stigmatised people – anxiety on the part of the normal of how to avoid the stigmatised person and anxiety on the part of the stigmatised on how to deal with rejection, so that he/she can be accepted by the normal. However, most cases of mixed contacts give rise to a categorisation wherein either the stigmatised person is treated like someone better than he/she actually is or someone worse than he/she actually is or the stigmatised person is totally ignored.

In cases where the failing is not obvious, the uncertainty is not about acceptance by the normal but the question is of sharing the information about his/her shortcomings (Goffman, 1963).

For Goffman (1963), stigma is a public mark, something which can be noticed by the rest and which results in a 'spoiled identity'. Thus, stigma is the idea that somehow one is imperfect given the norms that the society has set for him/her. Goffman's expression of spoiled identity makes clear that stigma is comprised of a global attribution about the self as bad. A spoiled identity therefore reflects a whole self spoiled by some condition or behaviour (Lewis, 1998). Stigma thus reflects the spoiled identity which is shame inducing, and this shame and stigma are likely to reflect the spoiled identity, whether the stigma is visible or not (Goffman, 1963).

Goffman's (1963) conceptualisation of the term stigma is not restricted to people with chronic illness alone, rather his understanding arises from diverse groups of people, like ex-convicts, people with different sexual preferences, people with some sort of disability and/or deformity and so on. Therefore, Goffman's conceptualisation of stigma does not encompass the specificities of chronic illness per se, i.e., the conceptualisation is more generic. The core crux of Goffman's theorisation of stigma is comprised of feelings of inferiority, which arise from the failings vis-à-vis social expectations that the person carrying stigma has and realisation of the same. This feeling thus raises a question of acceptance of the stigmatised person by the normal. It's very evident from the following paragraph:

The central feature of the stigmatised individual's situation in life can now be stated. It is a question of what is often, if vaguely, called "acceptance." Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding that some of his own attributes warrant it (Goffman, 1963).

Goffman's theorisation of stigma is more of a social construct; wherein he concentrates on social interaction patterns and the fashion in which stigma operate. Goffman (1963) opines that people with stigma are not quite human. In his words; the standards he/she (the person with stigma) has incorporated from the wider society equips him to be intimately alive to what others see as his failing; inevitably causing him/her to agree that he/she does indeed fall short of what he/she really ought to be. Shame becomes a central possibility, arising from the individual's perception of one of his/her own attributes as a defiling thing to possess, and one he can readily see himself not possessing (Goffman, 1963).

According to Goffman (1963), stigma operates in relation to what others view about the person; although the feelings of being stigmatised may happen in the absence of others, it is more associated with feelings based on social interactions with others (mixed social contacts) or an anticipation of such social interactions, thus stigma is a public mark, significantly marked by social interactions. Goffman's theory has been criticised for failing to realise that individuals do not come to social interaction devoid of affect and motivation and also, all social interactions take place in the context in which the larger cultural structure determines normative expectations (Lewis, 1998).

Scheff's (1966) Labelling Theory

By far the most explicit theory of viewing illness from a labelling perspective as postulated by Scheff (1966). According to Scheff (1966), the society has perceptions about people with chronic illness. Scheff maintains that everyone in society learns the stereotyped imagery of a chronic illness through ordinary social interaction. From childhood, people learn to use certain terms and associate them with illness behaviours. The media also contributes to this bias against ill people by associating them with vulnerable behaviours. Scheff (1966) believes that illness is a label

given to a person who has behaviour which is away from the social norms and so is treated as deviant. The symptoms associated with chronic illness are actually deviations from the social norms rather than just medical pathology. Once a person is given the label of ‘chronic illness’, he/she receives a set of uniform responses from the society, which are generally negative in nature. These responses from the society compel the person to take on the role of ‘chronically ill’ as he/she starts internalising the same. When the individual takes on this role of being chronically ill as his/her central identity, he/she becomes a case of a stable chronically ill person. Chronic illness is thus a social role and the societal reaction is the most important determinant of one’s entry into this role (Scheff, 1966).

According to Scheff (1966) hospitalisation of the ill person further reinforces this social role and forces him/her to take this role as part of his/her self perception. Once the person is institutionalised for an obstetric fistula, she has been publicly labelled ‘sick’ and forced to become a member of a deviant social group. It then becomes difficult for the deviant to return to her former level of functioning as the status of ‘patient’ causes unfavourable evaluations by self and by others. Other labelling theorists like Becker (1963) believe that the status of deviant is a ‘master status’ which overrides all other statuses in determining how others will behave towards one. Once a person is stigmatised by being labelled as deviant, a self-insight develops based on the perceptions of others ‘perceiving and responding as deviant’.

Furthermore, once a person goes through the social process of degradation, which often happens in three phases namely he/she becomes the member of deviant group (Becker, 1963). This process of degradation involves social confrontation between the suspected deviant and representative member of the society, a psychiatric consultation followed by an official announcement of a judgment of deviance like a diagnosis of chronic illness and finally

performing an act of social exclusion like hospitalisation or institutionalisation that puts him/her as a member of deviant group (Becker, 1963).

This social process of degradation is irreversible; the person has not only acquired a status which is inferior but which has a deviant world view wherein people share similar knowledge, skills and deviant self image (Becker, 1963). According to Becker (1963), such groups have one thing in common: their deviance; they share a similar fate, face similar problems, and have the same deviant sub culture. This subculture is comprised of a similar world view. 'Membership in such a group solidifies their deviant identity', (Becker, 1963). According to Labelling theorists, once a person is stigmatised by labelling it is very difficult to break that label. While attempting to explore what makes some people deviant and others not, the Labelling theorists emphasise the following four societal attributes as determining factors for labelling one as deviant (Scheff, 1966).

i. **Power and Resources**; the more the power and resources of the person, the less likely that he/she will be labelled (i.e., the higher the social status, the lesser probability that he/she will be labelled as sick).

ii. **Tolerance Level Towards Deviance**: The lower the tolerance levels of the community towards deviant behaviour, the higher the chances that one will be labelled as deviant. According to the Labelling theorists, communities are usually low tolerant to deviant behaviour of people who belong to marginal sections of the society than those who are well integrated into society.

iii. **Social distance:** The labelling theorists put explicit stress on the fact that if the labellee (the individual being labelled) belongs to the marginal sections of the community and the social distance between the labeller (the person ascribing the label) and the labellee is more, then he/she has more chances of being labelled; rather if the social distance between the two is less then, the

labellee can avoid labelling.

iv. **Visibility of the deviant behaviour**: It is also stressed that if the deviant behaviour is very visible, then there are more chances that the person will be labelled.

Miller's (1967) study among 1045 state mental hospital patients released on leave of absence in California very clearly confirmed these above stated propositions by Scheff. The study established that ex-mentally ill patients differed markedly in their family roles from 'normal' adult population. The findings of the study are very similar to the propositions made by Labelling theorists like Scheff (1966) which states the various reasons of why it becomes difficult for people to get into a non-deviant role after hospitalisation The Labelling theory emphasises that labelling process plays an important role in the causation of severe chronic illness thereby creating the illness. The labelling theory has however been criticised. According to critics (Schneider & Conrad, 1981), a person takes on the role of chronically ill only when he/she recognises him/herself with the societal perception of how society thinks about a person with chronic illness and accepts that role.

Heider's (1958) Attribution Theory of Stigma

According to attribution theory as postulated by Heider (1958), people begin to understand others by making personal or situational attributions about their behaviour. This has become an important framework for explaining the relationship between stigmatising attitudes and discriminatory behaviour (Weiner, 1995). According to Weiner's (1995) attribution theory, behaviour is determined by a cognitive emotional process by which people make attributions about the causes and controllability of a person's behaviour that lead to inferences about responsibility. These inferences lead to emotional reactions such as anger or pity that affect the likelihood of helping or punishing behaviours. If the causes of a person's behaviour are

attributed to factors outside the individual's control, they are less likely to be judged responsible and peoples' emotional reactions and behaviours towards the individual will be less negative. Alternatively, if the causes of a person's behaviour are attributed to factors within the individual's control, the individual is likely to be judged responsible, resulting in negative emotions and behaviours towards them.

Corrigan (2000) adapted Weiner's (1995) theory and applied it specifically to the stigmatisation of chronic illness. Corrigan highlighted the relationship between signalling events (person with chronic illness), mediating knowledge structures (attributions), emotional/affective responses and behavioural reactions. Corrigan further proposed that people who believe that chronic illness is under an individual's control (i.e., they are responsible), are likely to respond in anger towards the individual and act towards them in a punishing manner. In comparison, people who consider that chronic illness is due to factors outside the individual's control (i.e., they are not responsible) are likely to respond in pity towards the individual, resulting in helping behaviour.

According to Corrigan's (2000) model, people who believe that individuals with chronic illness are likely to react with fear leading to increased social distance. Although this model outlines the different components of stigma towards people with chronic illness, and explains how attributions of chronic illness lead to discriminatory or helping behaviour, limited studies have tested the model (Angermeyer, Matschinger, & Corrigan, 2003; Corrigan, Green, Lundin, Kubiak, & Penn, 2001). Additionally, the model implies a linear relationship between the components and does not consider that other factors may influence the relationship between the separate components (e.g., familiarity with chronic illness).

Theories of Health Disclosure

Disease Progression Theory of Health Disclosure (Kalichman, 1995)

According to the disease progression theory, individuals disclose their obstetric fistula diagnosis as they become ill since due to the nature and progression of the illness, they can no longer keep it a secret (Babcock, 1998; Kalichman, 1995). Disease progression often results in hospitalisations and physical deterioration as occasioned by the burden of the disease, which, in some cases, mandates individuals to explain their illness (Kalichman, 1995). Not only would hospitalisation require explanation, but if individuals fear they will need additional assistance to manage their illness, they may disclose as a means of accessing additional needed resources (Holt, Court, Vedhara, Nott, Holmes & Snow, 1998). Delaying disclosure may be a way to normalise their life and protect others from pain (Babcock, 1998).

The relationship between disease progression and disclosure has been substantiated in numerous studies using various indexes of disease progression (Hays, McKusick, Pollack, Hilliard, Hoff, & Coates, 1993; Marks, Bundek, Richardson, Ruiz, Maldonad, & Mason, 1992; Mason, Marks, Simoni, Ruiz, & Richardson, 1995). Marks et al. (1992) documented in a study of HIV positive Hispanic men that as overall symptom severity increased, disclosure to others increased. This trend remained consistent for both overt and less overt symptoms as well as various targets of disclosure such as parents and siblings. Using a sample of symptomatic and asymptomatic men, Hays et al. (1993) found asymptomatic men were less likely to disclose their HIV status to family and friends than symptomatic men. Furthermore, disease severity and time since testing for HIV have both been shown to be positively related to disclosure (Mason et al., 1995). Marks et al. (1992) hypothesised that illness progression heightens anxiety and need for social support, which may motivate disclosure to significant others.

Mansergh, Marks, and Simoni (1995) used both time since diagnosis and symptomology to investigate the relationship between disease progression and disclosure and found significant differences. That is, rates of disclosure were found to be higher among symptomatic than asymptomatic men and disclosure increased with time since diagnosis. These differences were significant for disclosure to mothers, fathers, sisters, brothers, and friends and has provided the most compelling evidence for the disease progression theory. Studies of disease progression and disclosure of HIV status to sexual partners, however, have failed to find this same relationship (Mansergh et al., 1995). Perry, Card, Moffatt, Ashman, Fishman, and Jacobsberg (1994) did not find a relationship between severity of physical symptoms and disclosure to sex partners among 129 HIV-positive adults. Thus, while disclosure to family may be influenced by disease progression, disclosure to sexual partners may not be. Most of the theories on disclosure were developed and validated in studies with persons who were HIV positive. However, they still provide sufficient explanations about obstetric fistula disclosure.

Consequence Theory of Health Disclosure (Serovich, 2001)

The consequence theory of distress disclosure as postulated by Serovich (2001) suggests that the relationship between disease progression and disclosure is moderated by the consequences one anticipates resulting from the disclosure. That is, as the disease progresses, stresses accumulate which result in the need to evaluate the consequences of disclosure. Persons with obstetric fistula are likely to reveal to significant others and sexual partners once the rewards for disclosing outweigh the associated costs.

This theory employs core assumptions of social exchange theory (Thibaut & Kelley, 1959). Social exchange theorists maintain that individuals avoid costly relationships and interactions and seek rewarding ones to maximise the profits in their relationships or behaviours

(Thibaut & Kelley, 1959). More specifically, when individuals are faced with numerous choices they tend to make those which provide the most rewards with the least associated costs. Rewards are pleasures, satisfactions, and gratifications the person enjoys (Thibaut & Kelley, 1959) and include social, physical, psychological, or emotional dividends that satisfy or please. Costs are things of value that are relinquished in preference for an alternative reward that is of equal or greater value or something that would be punishing or distasteful that one would otherwise avoid.

For persons with obstetric fistula, consequences of disclosing are substantial. Sharing a fistula diagnosis can provoke feelings of anxiety and threats to psychological well-being. Negative social consequences external to the individual with obstetric fistula, such as fear expressed by others, ostracism, and degradation may be experienced. Costs in terms of stressors within the individual's family network, such as denial, anger, guilt, and uncertainty are also associated with obstetric fistula (Barageine et al., 2015). Negative emotional consequences of disclosure that have been documented include rejection, abandonment, and isolation (Lovejoy, 1990). This might be especially true if the disclosure also leads to an admission of sexual behaviours that have not otherwise been acknowledged. In addition, these physical, social, and emotional consequences can be confounded by fear of, or actual loss of, employment, insurance, housing, medical services, child custody, and the right to education (Anderson, 1989).

Rewards or positive consequences of disclosing can also be substantial. Disclosing a fistula diagnosis can result in the acquisition of emotional, physical, and social resources. These resources include assistance with home-related chores and errands, health and child care, housing, medical attention, and the provision of medical information. Emotional benefits include the acquisition of social support and acceptance. Furthermore, disclosing one's obstetric fistula

frees the individual from hiding the physical burden of the illness from friends, family, and co-workers. Thus, indirectly, support for adhering to medical regimens is a positive consequence of disclosure. Each of these consequences may be important for the physical, emotional, and social functioning of the person.

Support for this consequence theory has begun to emerge from the work of prominent disclosure theorists. These authors contend that individuals who are distressed contemplate the need for privacy and disclosure in determining whether to disclose a diagnosis (Derlega et al., 1993). Derlega, Lovejoy, and Winstead (1998) tested and found support for this hypothesis in a qualitative study of 42 HIV-positive individuals. They concluded that the process of reducing risks and increasing benefits of disclosure results in selectivity of disclosure. That is, individuals who are ill disclose to those who pose little risk while avoiding disclosing to those who could harm them.

Theories of Sexual Functioning

To understand the concept of Sexual functioning, it is first helpful to consider the Human Sexual Response Cycle. Different dysfunctions interfere with different phases of a woman's sexual response and so it is important for researchers to be able to identify where in the cycle a woman gets blocked. The human sexual response cycle is an organisational tool and roadmap to our different states of arousal.

Masters and Johnson's Human Sexual Response Cycle (HSRC)

Masters and Johnson (1966) developed the Human Sexual Response Cycle (HSRC), in which sexual functioning was conceptualised as a linear process comprised of physiological stages. Excitement, defined by physiological preparedness to engage in sexual activity, was the initial phase in this model. The plateau phase followed and was characterised as the time between

excitement and maximum pleasure. The plateau phase was followed by orgasm which was defined by the experience of extreme pleasure and satisfaction. Finally, the model concluded with a resolution stage in which an individual returned to a pre-aroused state. Over the course of two decades Masters and Johnson (1966) examined almost 700 subjects in their laboratories and were the first to document physical features associated with human sexual arousal. The Masters and Johnson's (1966) model of sexual response cycle comprises the following stages:

1) Excitement: Masters and Johnson (1966) postulated that this phase is the result of sexual stimulation which may be psychological, physiological, or both. It is marked by increased blood flow to the genital region also called vasocongestion, which then leads to vaginal lubrication. The vasocongestion in the walls of the vagina causes moisture to trickle across the vaginal lining. This progression is called transudation. The clitoris becomes erect during this time, as do the nipples. Heart rate increases, blood pressure rises, and the labia majora and minor enlarge and open. (Berman & Berman, 2002; Kelly, 2006; Masters, Johnson, & Kolodny, 1985).

2) **Plateau:** The plateau phase begins to really stimulate the parasympathetic nervous system (Cervanka, 2003). This phase is considered a more progressive state of arousal and potentially heralds orgasm. The uterus becomes entirely elevated and the vaginal tissues swell to their maximum and the opening actually narrows – this is called the orgasmic platform. The breasts increase in size and nipples become erect. Masters et al (1985) note that women, who have not breast fed, may actually experience a 20-25 percent increase in their breast size during this phase. Often, women get what is known as a sex flush across their chest, abdomen, and back. They attribute this flush to changes in the blood flow just below the epidermis (Masters, et al., 1985). Additionally, respiration, heart rate and blood pressure continue to increase (Miracle, et al., 2003; Kelly, 2006).

***3)* Orgasm:** If efficient stimulation to the clitoris or pressure on the walls of the vagina endure throughout the plateau phase, the body experiences a build-up of sexual tension and energy followed by a release known as an orgasm, also sometimes referred to as a climax. This is the shortest phase of the cycle (Masters et al., 1985). Orgasm was originally conceptualised by the Masters and Johnson model of sexual response as a psycho-physiologic experience (Masters & Johnson, 1966).

Psychologically, it is defined as the subjective perception of a sexual peak. Physiologically, it is defined as a release of sexual excitement that has escalated (Masters & Johnson, 1966). During the orgasmic phase, a woman's uterus undergoes wavelike muscular contractions as does the sphincter muscle; The body expels blood flow out of the genital region back into the body for circulation (Berman & Berman, 2002) the rest of the body may also enjoy rhythmic muscle tremors. The first of these contractions are often rapid and close together, gradually decreasing in frequency and intensity. At the point of climax, a woman's sex flush deepens (Miracle et al., 2003; Kelly, 2006) Also, some women release liquid from their Skene's glands out of their urethra, and thus engage in an ejaculatory phenomenon.

4) Resolution: During this phase the body returns to its normal, non-aroused stated of functioning. Muscle tension in the body, also called myotonia, decreases, and tension in the genitals caused by increased blood flow disappear; nipples also lose their erection and the breasts, if enlarged return to their baseline state. The uterus returns to a lower position and the labia return to their normal hue. Blood pressure, heart rate, and respiration return back to normal (Miracle et al., 2003; Kelly, 2006).

Masters and Johnson's four-phase model is still widely regarded as having merit and as a pragmatic examination tool. There was however some dissent to their model. Hite (1976)

critiqued the Masters and Johnson model stating that it erroneously resembled a Rube Goldberg model, whereby orgasm could be reached through penile thrusting in the vagina (too circuitous a route to be regularly successful). This thrusting action was assumed to create traction on the labia minora, which would in turn cause the clitoral hood to move enough over the clitoral glands and create sufficient stimulation to produce orgasm. While Hite affirmed this model's focus on the necessity for clitoral stimulation in female orgasm, she disagreed with the model insofar as it seemed to assert the normalcy of orgasm during intercourse is still to be expected as part of the automatic "normal" course of things.

Of the people who disagreed with the structure of Masters & Johnsons sexual response cycle, Kaplan's (1977) criticism might be the most notable. Kaplan (1977) challenged the purely physiological nature of the HSRC model. Kaplan argued that the model lacked consideration of interest in or desire for sex. As defined by Kaplan, sexual desire referred to an individual's hunger, desire or interest in sexual activity. Kaplan proposed that interest in or desire for sex (sexual desire) initiated the sexual response cycle (Kaplan, 1977). In her model, she retained the HSRC concepts of excitement (renamed arousal), orgasm, and resolution, and situated these following the desire component. Kaplan's strong argument for the inclusion of sexual desire into sexual response has led to a theoretical combination of the two models. Notably, the combined models are currently used as a framework for identifying sexual dysfunctions in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Additionally, Kaplan (1977) went on to state that the four phase model proposed by Masters and Johnson does not take into account enough of the psychology behind sex. Specifically, she stated that you cannot get excited unless you are mentally experiencing desire (Kelly, 2006).

Kaplan’s Triphasic Model of Sexual Functioning

Kaplan (1977) went further to postulate a theory of sexual functioning. Kaplan’s model emphasised the role desire plays in our sexual response cycle. Instead of making the assumption that human desire stems from an internal force or drive, this model proposes that there is a unique interaction between external stimuli, our emotions, our experiences, our social norms, and our interpretations that affect our levels of desire (Miracle et al., 2003). Kaplan emphasised the cognitive aspect of sexual response. The other chief difference between her model and Masters and Johnson’s model was that she stated each of the three phases may exist separately and one does not have to precede the other. For instance, a person may have an orgasm without much desire or may feel desire after being physiologically excited. In summation, this model is not as linear or sequential as the Masters and Johnson one and focuses much more on the psychological role of desire in sexual response. The following is a breakdown of the Kaplan triphasic model.

1. Desire: Kaplan (1977) postulated that sexual desire has been defined variously as an appetitive state, an innate psychological drive which shapes the personality, an instinct, a need, and most generally, as "lust" (Beck, Bozman & Qualtrough, 1991). Sexual desire was further conceptualised as an internal feeling of wanting or needing sexual intimacy that often includes engaging in sexual behaviours that leads to sexual satisfaction. This is the first stage of Kaplans Triphasic Model and basically consists of one who becomes psychologically interested in sex before any physical and bodily changes happen (Beck et al., 1991). During this phase, the brain and its interpretations of stimuli are the driving force. The interactions between the environment and our mind come together to initiate or inhibit desire (Beck et al., 1991).

2. Excitement: This phase mirrors the characteristics as outlined in the Masters and Johnson model. Here the body starts to make a shift from an un-aroused state to an aroused state. Physical

characteristics discussed above are the same. This was initially the first phase of the model developed by Masters and Johnson but is the second stage of Kaplan's model of sexual response. According to Kaplan, this is the stage where arousal begins in response to physical stimulation, psychological stimulation or both. The excitement phase may last for minutes or hours. Signs include increased heart rate, breathing and blood flow mainly to the genital areas. As vasocongestion continues, men may get an erection, and women may experience lubrication (Kaplan, 1977; Beck et al., 1991).

3. Resolution/Orgasm Phase: This stage mirrors the orgasmic stage introduced by Masters and Johnson. The resolution phase encompasses the orgasm stage. An orgasm is a peak of sexual arousal, during which a series of rhythmic, involuntary contractions of the genitals and anus occur along with highly pleasurable feelings. Kaplan and Horwith (1983) stated that an orgasm may result from: manual stimulation, oral sex, intercourse, masturbation, massage, fantasy, sex toys or any number of other activities. On average, orgasm typically lasts for few seconds and is commonly accompanied by ejaculation in men and, less often but for some women, female ejaculation (Good in Bed). This final stage of sexual response proposed by Kaplan is the phase of the cycle where there is a return to the pre-aroused state. However, the model did not emphasise that this stage needed to exist in every sexual interaction (Kaplan & Horwith, 1983).

While this model addresses the phase of sexual responses, it also is used to address sexual dysfunctions as Kaplan believes that sexual dysfunction falls into one of these three categories and that the categories are separate and distinct being that one could properly function in two out of the three phases but might find a problem in the third (Greenberg, Bruess & Conklin, 2010). Critics believes that the Kaplan model isn't an original model but it is an improvement on the Masters and Johnson's model (Greenberg et al., 2010).

The Push-Pull Model of Incentive Motivation (Laan, Everaerd, van Bellen, & Hanewald, 1994)

The sexual response models identify sexual responses and characterise the cognitive and physiological processes associated with each response. Further, the models recognise that sexual functioning is a "psychosomatic" process, comprised of the interaction between physiological and psychological processes (Basson, 2001). Despite this, the models do not make explicit the mechanisms whereby psychological and physiological processes interact to initiate, sustain and link sexual responses. However, these processes are described in the push-pull model of incentive motivation.

The Push-Pull Model of Incentive Motivation suggests that cognitive-affective processing of sexual cues result in sexual responses (both physiological and psychological) (Laan, Everaerd, Van Der Velde, & Geer, 1995; Laan & Janssen, 2007a). The model proposes that cognitive appraisal of a stimulus initiates the response cycle. Considering humans have limited attention capacity, the model posits that an individual must have available attention capacity to appraise the cue (Barlow, 1986). If attention capacity allows for a stimulus to be recognised as such, an emotional response is generated. The valence of the emotional response is largely influenced by previous experience with the sexual cue. For instance, a positive previous experience with a stimulus is likely to result in positive affect whereas a negative previous experience will likely result in negative affect.

The emotional valence of a response to a sexual cue initiates one of two feedback loops (Barlow, 1986; Rosen & Beck, 1988). Positive emotion is believed to initiate the positive feedback loop, facilitating an individual to consciously or unconsciously approach or pursue the sexual cue. Further, the positive affect allows for uninhibited attention focused on the sexual cue

and the possible ensuing sexual encounter. Negative emotion initiates a negative feedback loop which may potentially lead to a conscious or unconscious avoidance of that sexual cue (Janssen, et al., 2000; Koukounas & McCabe, 2001; Laan et al., 1994). The negative affect may not directly facilitate an avoidance of the sexual cue; however, it has the potential to occupy a significant portion of one's attention, thus indirectly disrupting sexual response. In summary, the push-pull model of incentive motivation describes sexual response as the product of an interaction between sexual cues and cognitive-affective processing (Laan et al., 1994).

Using the push-pull model of incentive motivation, sexual dysfunction or sexual problems can be caused by cognitive appraisal that inhibits sexual response (i.e., determination that the cue is not sexual) and/or negative feelings elicited in response to a cue that directly disrupts sexual response (i.e., make a sexual cue unappealing) or indirectly disrupts sexual response by diminishing attention capacity. Important to note that critics of the theory posits that sexual problems can occur as a result of many other factors (e.g., physical illness such as an obstetric fistula, drug treatment side effect), and the push-pull model of incentive motivation's explanation of sexual problems is mainly specific to cognitive appraisal of environmental, psychological and social stimuli (Laan et al., 1994).

Theoretical Framework

While the self-determination theory believes that there ought to be an association between health status as experienced by women with obstetric fistula and psychological well-being seems intuitively clear, Ryan and Deci (2000) observed that sickness is often associated with displeasure or pain, so the presence of illness may directly increase negative affect. Further, illness such as a fistula often presents functional limitations, which can detract from opportunities for positive affect and life satisfaction (Ryan & Deci, 2000). However, the

PERMA offers a range of elements and levels of engagement that may produce well-being. Considering how their positive emotions especially in relation to their sexual functioning, relationships as affected by stigma, and meaning/purpose as shown by their disclosure will predict their psychological wellbeing. With this in mind, the current paper applies the PERMA well-being model to consider how stigmatisation, health disclosure and sexual functioning can offer a context to examine the psychological well-being of women with obstetric fistula.

EMPIRICAL REVIEW

The review of relevant empirical studies is organised under three sub headings: stigma and psychological wellbeing, disclosure and psychological wellbeing as well as sexual functioning and psychological wellbeing.

Stigma and Psychological Wellbeing

In a study designed to assess the extent to which abandonment, social isolation and stigmatisation influences psychological wellbeing as measured by the coping strategies of women affected by Vesico Vaginal fistula (VVF) in Akwa Ibom State, Nigeria, Nsemo (2014) adopted an Ex- post Facto design using mixed method of quantitative and qualitative approach to study a sample of 120 VVF women (inpatients and outpatients), 18 VVF women coming back for follow-up care after repairs and 3 key informants were purposively selected for the study. Instruments for data collection were structured interview guide and in-depth (unstructured) interview. A regression analysis was used to analyse the data and verbatim transcription/coding for qualitative data with result was presented based on themes. The results showed that abandonment, social isolation and stigmatisation were significant predictors of psychological wellbeing as evident in the coping strategies of VVF women in the area of study, with

abandonment and stigmatisation having a high influence though with a negative coefficient while social isolation exerted a weak influence. This implied that the more abandoned and stigmatised the VVF women, the poorer their psychological wellbeing as indicated by a less active coping ability while social isolation exerted less influence on their wellbeing and coping strategies. The study concluded that the more abandoned and stigmatised the VVF women, the less active their psychological wellbeing as respondents during the interview stated that they felt very hopeless and preferred death to such a humiliating and stigmatising experience of a fistula, while social isolation exerted less influence on the coping strategies of the women affected. The study recommended psychoeducation as one of the ways to terminate stigmatisation and also help the victims of VVF have elevated self esteem and sufficient psychosocial benefits.

Further seeking to understand the relationship between stigma and psychological wellbeing among the intellectually disabled, Nartey (2013) investigated the influence of the presence of having a brother or sister with intellectual disability and the positive and negative sibling relationship on the psychological well-being of the siblings. A sample of 69 siblings of a brother or sister with intellectual disability from four special schools in the Greater Accra Region of Ghana participated in this study. A correlational survey research design was used. Tests assessing psychological well-being, perceived stigma and attitude towards intellectual disability, family relationship were administered to participants. Parents or guardians were also asked to rate siblings' relationship with their intellectually disabled sibling. Results of the study reveal that only positive sibling relationship one develops affects their psychological well-being. The type of intellectual disability, siblings' attitude towards intellectual disability and perceived stigma did not predict the siblings' psychological wellbeing. This study implies that developing

of quality positive relationship between helps maintain the psychological well-being in spite of perceived stigma

Munivenkatappa and Raguram (2014) carried out a study on the effects of perceived stigma and psychological well being of the adult children of parents having schizophrenia and to assess the relationship between perceived stigma and psychological well being. The study adopted a two group comparison cross sectional methodology. The study group comprised of 30 adult children of parents with schizophrenia and control group consisted of 30 individuals without the history of any mental illness in the parents. The tools used were sociodemographic data Sheet (SDS), the stigma items of Explanatory Model Interview Catalogue (EMIC) and Psychological Well Being scale (PWB). Results indicated that more than 50% of the participants in study group experienced stigma. Perceived stigma was positively correlated with current psychopathology of the parents. Active psychopathology in parents turned out to be a significant predictor of the stigma. The control group had better psychological well being compared to the study group. The authors concluded that **e**ven in the absence of any diagnosable psychological problem, children of patients with schizophrenia experience stigma and they have poor psychological wellbeing compared to children of parents without psychiatric illness. They recommended the development of planning intervention programs to address stigma and improve support networks.

Most studies investigating stigma and psychological wellbeing have been carried out with people living with HIV. Thus, Sanjuán, Molero, Fuster, and Nouvilas (2013) investigated the relationship among stigma perception, active and avoidant coping strategies, and subjective and psychological well-being in a sample of 133 people with HIV. The results showed that stigma perception and avoidant coping strategies (venting, self-blame, denial, behavioural

disengagement and substance use) were positively associated, whereas, both stigma perception and avoidant coping were negatively associated with different measures of well-being (affect balance, self-acceptance and environmental mastery). These negative relationships between stigma perception and the three well-being measures were mediated by the use of avoidant coping strategies. Results suggest that psychosocial intervention programs for people who report psychological distress arising from prejudice must be aimed at developing appropriate ways to deal with this prejudice. They recommended that intervention programs should also include strategies to directly increase well-being since from a positive psychology viewpoint, certain interventions have been shown to do so, and HIV research has also shown that well-being is associated with lower mortality rates.

Markowitz (1998) examined the relationships between stigma, psychological wellbeing, and life satisfaction among persons with mental illness. The study used longitudinal data from 610 individuals in self-help groups and outpatient treatment. Data was obtained from a two-wave study of persons with mental illness in consumer-run self help groups and outpatient's settings in New York. A questionnaire measuring anticipated stigma and stigma experiences, psychological wellbeing, and interpersonal life satisfaction. Analysis of data was done using cross sectional and lagged regression models. Results from the cross sectional and lagged regression models show adverse effects of stigma on psychological wellbeing and interpersonal satisfaction. However, much of the effects of anticipatory rejection were due to discriminatory experiences. The results also indicated that stigma is related to anxiety-depressive types of symptoms but not psychotic symptoms. Although the findings of the study revealed a negative effect of stigma and psychological wellbeing, it was partly mediated by self concept and further using a reciprocal

effects model, Markowitz (1998) study indicated that the relationship between self concept, psychological wellbeing and life satisfaction.

Hsiung and Savbäck (2011) investigated the psychosocial consequences resulting from obstetric fistula in Tanzania. The study was conducted at *Kilimanjaro Christian Medical Centre* (KCMC), Moshi, Tanzania. Data regarding fistula patients were collected from medical records in purpose to learn about general features of a fistula patient as well as operation outcomes. In order to penetrate the psychosocial consequences, interviews with fistula patients, admitted at KCMC and had their fistula repaired at the center, were made with a questionnaire as a base. The questionnaire was constructed such as to firstly cover basic patient history like age, civil status, and occupation. Following questions were regarding the patient's obstetric history, sexual habits, symptoms, time to treatment, number of repairs, and the woman's overall knowledge about fistula. Finally, the questionnaire had some questions about the condition's impact on the family and social situation. The questionnaire consisted in total of 23 questions with alternative options for the patient to choose. The total number of 63 patients was sampled in the study. The mean age of the patients at the time when fistula developed was 31.0. Eighty-one per cent of the fistulas were caused by obstructed/prolonged labour, whereas 12 per cent were caused iatrogenic, and 7 per cent were either caused by trauma, cancer, or 4th grade tear. The most common type of fistula was Vesico Vaginal Fistula (VVF), and the proportion of Recto Vaginal Fistula (RVF) and VVF+RVF (complex fistula) was 10 per cent respectively. In 59 per cent of the obstructed labour cases the baby could not be saved, the rest survived the labour that caused the fistula. The study found that Eighty-three per cent of the patients were not leaking after the operation. However, contrary to most studies, none of the women in the study reported being stigmatised

and they were very hopeful of the future without signs of psychological distress or diminished psychological wellbeing.

In regards to the stigma of people towards Vesico Vaginal Fistula (VVF), Fasakin (2007) carried out a research on the effect of Vesico Vaginal Fistula on the psychosocial well-being of victims in Nigeria. The study assesses the effect of VVF on the psychosocial-well-being of victims in Nigeria. The research questions were logically coined to address the psychological and emotional impacts of VVF on patients, their family attitude towards victims and public attitude towards them. Six selected VVF Hospitals were used, one from each geographical zone of the country. In all 506 respondents were used. The result shows that VVF has adverse significant effect on the psychosocial well-being of victims as stigma was frequently reported by the respondents.

In a qualitative study targeted at unravelling the experiences of women living with genital fistula in Uganda, Barageine, Beyeza-Kashesya, Byamugisha, Tumwesigye, Almroth, and Faxelid (2015) utilised group interaction to explore the women's own and shared experiences. Data were collected from October 2012 to March 2013 at Mulago National Referral and Teaching Hospital, located in Kampala, the capital city of Uganda. The hospital provides routine female genital fistula care, including prevention, treatment and rehabilitation. Annually, the centre receives over 300 fistula patients. The patients are referred from all over the country and receive free treatment. To ensure maximum variation in the group, participants were purposively selected from both women awaiting surgery and those already operated on. A total of 56 women, aged 14 to 60 years of age, participated in the eight focus group discussions with a group composition of five to ten women. A Focused Group Discussion guide developed by a multidisciplinary research team comprised of a fistula surgeon, gynaecologists, a midwife, a

social scientist and public health specialists was used. The guide had open-ended questions. Altogether, 56 participants between 14 and 60 years old participated in the eight FGDs. The researchers concluded that though it was difficult to have a sharp divide between social and psychological effects of living with a fistula, women with a fistula demonstrated actions that showed they were stigmatised and often depressed by the condition of leaking urine and or stool. Almost all the participants reported having faced some form of stigma. The stigma manifested itself as feelings that others were irritated by the smell and leakage of urine. The women were constantly worried that others would notice their problems. Stigma was also experienced through the behaviours of others, especially close relatives, towards women with a fistula.

Disclosure and Psychological Wellbeing

Disclosure has been investigated among different special populations. Thus, Lam (2015) investigated the role of disclosure on the psychological well-being of adolescents with child sexual abuse experience in a subsample of 74 disclosers among 800 adolescents recruited in a community in Hong Kong. Several measures of psychological wellbeing were adopted for the study. The results of the study showed that child sexual abuse experiences have differential impact on adolescents' psychological well-being. Also, family characteristics of the disclosers accounted for only a small amount of the variance in an array of psychological well-being measures. Child sexual abuse characteristics were robust predictors of disclosers' sexual eroticism and externalising behavioural symptoms. Disclosers' cognitive appraisal of child sexual abuse experiences and quality of parental attachment were strong predictors of their self-esteem and internalising behavioural problems. After controlling for the aforementioned factors, negative disclosure experience still significantly predicted lower self-esteem, higher sexual

anxiety, more internalising behaviour, and more severe post-traumatic stress disorder responses. From the findings of the study, it was concluded that understanding the factors that generate negative disclosure experiences is key to developing effective intervention strategies to mitigate the negative consequences of disclosure.

In a cross-sectional study on the impact of disclosure of HIV positive status to HIV positive adolescents and social support on their psychological well-being, Ngonga (2013) randomly sampled 80 respondents (Forty with disclosed and 40 undisclosed infection status) from a teaching hospital. Respondents were within the age group of 11 to 15 years. The measures used for data collection were; the Strength and Difficulty Questionnaire- Youth version (SDQ-Y) to determine the Psychological well-being of HIV positive adolescents with regard to disclosure. Social Support from Friends (PSS - Fr) was used to measure perceived social support from friends and family with regards to psychological well-being. Comparison between the two status groups was done using the Mann Whitney u–test and correlation analysis to explore the relationship of status disclosure and social support on the psychological wellbeing. Eighty questionnaires were distributed; 70 were completed and returned. Forty two (42) of the 70 participants were female and 28 were male. A Mann Whitney u- test revealed a very strong significant relationship between status disclosure and psychological well-being; indicating that respondents who had their status disclosed to them had a better psychological well-being than the undisclosed groups. The findings of the study further showed that though there was a weak negative correlation between psychological well-being and social support, the relationship was not significant. Based on the findings of the study, it was concluded that there is a significant relationship between HIV status disclosure and psychological well being. But there was no significant relationship between social support and status disclosure on the psychological well

being. It was concluded that disclosure is important as it enhances psychological wellbeing and people should be fully informed and counselled about all aspects of their psychological health.

Park, Bharadwaj and Blank (2011) examined the centrality of cancer, disclosure and well-being. Using a cross-sectional design, 167 participants (cancer survivors aged 18–55, diagnosed 1–3 years prior) completed measures of demographics, centrality of cancer identity, openness/disclosure, and well-being (including health-related quality of life [HRQOL], positive and negative affect, intrusive thoughts, life satisfaction, and post-traumatic growth). The result of the study showed that cancer identity centrality was fairly low while disclosure/openness was fairly high. In regression analyses, centrality was adversely related to most measures of well-being, except unrelated to physical HRQOL and post-traumatic growth. Openness/disclosure about cancer survivorship status was positively related to psychological well-being. Based on the findings of the study, the authors stated that both cancer identity centrality and openness/disclosure are important aspects of the cancer survivorship experience that impacts psychological well-being.

Ward, Doherty, and Moran (2007) investigated the relationship between levels of distress disclosure and psychological wellbeing in the general population. Two measures of psychological wellbeing were used – the 12–item General Health Questionnaire (GHQ12) and a self–reported rating of participants' mental health in the previous 12 months. Distress disclosure was measured using a 12–item Likert scale called the Distress Disclosure Index. A nationally representative sample of 2,711 adults aged 18 years and over living in private households in Ireland was surveyed. Four socio–demographic determinants of levels of distress disclosure were explored including gender, age, marital status and geographic location. The association between

distress disclosure and psychological wellbeing was investigated. The results of the study revealed that those most willing to disclose distressing information to others were females and those in the younger age groups. Furthermore, a greater willingness to disclose distressing information was related to better mental health. Levels of distress disclosure was shown to be positively correlated to individual psychological wellbeing Higher levels of distress disclosure were associated with psychological wellbeing and lower levels of distress disclosure were associated with poorer mental health. Based on the findings of the study, the authors concluded that disclosing distressing information increases psychological wellbeing by providing a means with which to confront the stressor and also by encouraging the use of supports either within a formal or informal setting.

Zea, Reisen, Poppen, Bianchi, and Echeverry (2005) examined the disclosure of HIV-positive sero-status by 301 gay and bisexual men to members of their social networks and the mental health consequences of such disclosure. The sample was recruited from clinics, hospitals, and community agencies in New York City, Washington, DC, and Boston. Proportions disclosing differed depending on the target, with 85% having disclosed to closest friend, 78% to male main partner, 37% to mother, and 23% to father. Although there were differences depending on the target, disclosure was related to greater quality of social support, greater self-esteem, and lower levels of depression. Moreover, findings indicated that social support mediated the relationship between disclosure of sero-status and both self-esteem and depression. Thus, disclosure resulted in greater social support, which in turn had positive effects on psychological well-being. The findings of the study demonstrated that generally gay men are selective in choosing people to whom they disclose their sero-status and that disclosure tends to be associated with positive psychological wellbeing.

Chaudoir and Quinn (2010) examined how people's motivations for disclosing a concealable stigmatised identity for the first time affect the quality of their first disclosure experiences and how these experiences, in turn, affect current psychological well-being. A sample of 235 undergraduates with concealable identities took part in the survey. A structural equation model was used in analysing the data obtained from the study. The study showed that people who disclosed report more positive first disclosure experiences which, in turn, were related to higher current self-esteem. Analyses further suggested that one reason why this first disclosure experience is related to current psychological well-being is because positive first disclosure experiences may serve to lessen chronic fear of disclosure. Overall, the results highlighted the importance of motivational antecedents for disclosure in impacting well-being and suggest that positive first disclosure experiences may have psychological benefits over time because they increase level of trust in others.

Alana (2011) used 90 participants to examine whether written emotional disclosure of stressful experiences was related to overall mental health. The results showed that individuals who wrote about personally distressing stressors three times over approximately three weeks tended to report significantly better psychological wellbeing and physical health, when compared to those who wrote about non-stressful activities. A unique finding was that participants who wrote about their stressful life experiences reported fewer physical and psychological symptoms. They also reported improved hardiness and self-efficacy following written expression of their most stressful life experiences.

Also, Pennebaker (1997) found that disclosing distressing information increases psychological wellbeing by providing a means with which to confront the stressor and also by encouraging the use of supports either within a formal or informal setting.

Sexual Functioning and Psychological Wellbeing

Carrobles, Guadix, and Almendros (2011) investigated the association between sexual functioning, sexual satisfaction and psychological well-being in a sample of Spanish women. The participants were 157 female university students who completed questionnaires regarding their sexuality. Independent variables were various dimensions of sexual functioning, including orgasm likelihood, sexual assertiveness, physical and sexual attractiveness, sexual anxiety, sexual motivation, sexual esteem, and cognitive distraction during sex. The results indicated that sexual assertiveness, sexual anxiety, and sexual motivation were strong predictors of sexual satisfaction. It was also found that the main factors related to psychological well-being were sexual satisfaction and physical and sexual attractiveness. The findings of the study reveals that the variables most strongly associated with sexual satisfaction and highlight the role of sexual satisfaction and sense of attractiveness in psychological wellbeing of women.

Davison, Bell, LaChina, Holden, and Davis (2009) sought to explore the relationship between psychological well-being and self-perceived satisfaction with sexual function in women and to determine if there is an independent effect of menopausal status or age using a community-based cross-sectional study. A total of 421 women, aged 18 to 65 years were recruited from the community who were required to self-identify at study outset as being either satisfied or dissatisfied with their sexual life and be premenopausal or postmenopausal. Scores from the Psychological Well-Being Index (PWB), the Beck Depression Index (BDI) and a daily diary of sexual function were obtained from the respondents. A group of 349 women were included in the analysis. The results of the study indicated that the total PWB and domain scores of positive well-being and vitality were lower in dissatisfied women compared to satisfied women. Also, PWB total and domain scores of depressed mood, positive well-being and vitality

were higher in older women. However, menopause did not have an independent effect on psychological well-being. Women who self-identify as having sexual dissatisfaction have lower psychological general well-being. These findings as reported by the authors reinforce the importance of addressing sexual health and well-being in women as an essential component of their health care.

Islam and Begum (1992) conducted an extensive study on the psychosocial consequences of having a fistula in Bangladesh. A majority of women (61.4%) reported embarrassment in their social lives, 39.4% reported feeling constantly ill, and 33.3% reported difficulty in maintaining a sexual relationship. About 50% reported a significant decrease in libido; 59% a reduction in the frequency of coitus; and 45% a delay in experiencing orgasm. Moreover, 52% of the husbands expressed a loss in sexual pleasure with their wives. Regarding their social lives, 87% reported embarrassment; 67.4% an inability to perform their prayers; and 62% unhappiness in their married life. Dyspareunia was also reported by 37.9% of the women.

Yim, Wang, Jiang, Zakir, Poh, Lopez, and He, (2015) examined health-related quality of life, psychological well-being, and sexual function in patients with benign prostatic hyperplasia after prostatic surgery using a cross-sectional, descriptive, correlational study. A convenience sample of 94 participants was recruited from a urology centre in a tertiary public hospital in Singapore. Results showed that compared to the general population norms and the findings of similar studies conducted in Western countries, this group of patients reported poorer physical health but better psychological wellbeing as assessed by SF-12v2. Despite the prostatic surgery, over a quarter of the patients experienced moderate severe lower urinary tract symptoms, and 13.8% experienced severe erectile dysfunction. Multiple linear regression analysis identified that severe lower urinary tract symptoms and maximum flow rate predicted poor physical health,

accounting for 45.9% of variance, while anxiety and severe lower urinary tract symptoms predicted poor psychological wellbeing, accounting for 57.2% of variance. Thus the relationship between sexual functioning and psychological wellbeing was moderated by poor physical health. From the findings of the study, it was concluded that the physical health of patients with prostatic surgery was poor, with many suffering moderate severe lower urinary tract symptoms and poor sexual functioning.

Duncan, Talbot, Shedrick and Caswell (2009) explored the effects of psychological wellbeing (as measured by anxiety and depression) and self-reported quality of life (QOL) on sexual function of men with epilepsy. Sixty-nine Men with Epilepsy (MWE) taking one antiepileptic drug and 50 controls were recruited. All completed sexual function questionnaires, the Hospital Anxiety and Depression Scale (HADS), and the World Health Organisation Brief Quality of Life Questionnaire (WHOQOL-BREF). Blood was taken to analyse testosterone and dihydroepiandrosterone sulfate levels. The results of the study showed that compared with controls, MWE reported higher levels of anxiety, depression, and poor psychological wellbeing; lower overall quality of life and health; and lower levels of sexual desire and erectile function. Seizure frequency did not affect any of these variables, and testosterone levels did not correlate with sexual desire or erectile function. Simple linear regression showed a significant negative correlation between sexual desire and indices of anxiety, depression, and psychological distress. Multiple linear regression using overall QOL as dependent variable showed that anxiety, depression, psychological distress, and the Psychological Well-Being subscale of the WHOQOL-BREF predicted 48% of its variability. From the findings of the study, it was concluded that MWE reported lower levels of sexual desire and were more likely to report erectile dysfunction

than controls. But the most important determinant of QOL was psychological status, not seizure frequency or sexual function.

Luk and Loke (2015) undertook a systematic review to identify, with supporting evidence, the impact of infertility on the psychological well-being, marital relationships, sexual relationships, and quality of life of couples. MEDLINE, PsycINFO, and CINHAL Plus articles were searched for relevant studies (2000–2014) published in English. Twenty articles were adopted for the review. The results showed that infertility affected couples in the following four aspects of their life: psychological well-being, marital relationships, sexual functioning, and quality of life. The findings of the study showed evidence that infertility has a negative effect on the psychological well-being and sexual functioning of couples.

Voogt, De Vries, Fonteijn, Lohle, and Boekkooi (2009) assessed the effects of uterine artery embolization (UAE) on psychological and sexual well-being 3 months after treatment in a prospective study using a sample of 141 premenopausal women with symptomatic uterine fibroids from a teaching hospital in Tilburg, the Netherlands. Measures of sexual functioning and psychological wellbeing were completed by the respondents. Results showed that the total score for sexual functioning showed a statistically significant increase, 3 months after UAE, indicating that sexual functioning improved. Thirty-four percent and 37% of women reported an increase in sexual activity and desire. The percentage of women reporting sexual problems of lubrication, orgasm, or pain decreased 7%, 36%, and 14%, respectively. The results further showed improved wellbeing scores as measures of psychological distress showed a statistically significant decrease 3 months after UAE, indicating a decrease in emotional and somatic concerns. The authors concluded that sexual functioning and psychological well-being improved significantly 3 months after UAE in women with symptomatic uterine fibroids.

Summary of Literature Review

The different theories reviewed indicated differential roles and relationships among psychological wellbeing, stigma, disclosure and sexual functioning. Ryff's (1989) psychological wellbeing theory postulated the key components of well-being to include self-acceptance (positive attitude toward the self), positive relationships with others (reciprocal and supportive), autonomy (self-determined and independent), environmental mastery (sense of mastery and competence), purpose in life (goals and sense of direction), and personal growth (aspiring to continually develop). Also, Deci and Ryan's (2000) self-determination theory of psychological wellbeing was reviewed. Deci and Ryan theory believed that three innate psychological needs are central to psychological wellbeing. These include the need for competence, autonomy and relatedness and they further theorise that fulfilment of these needs is essential for psychological growth, integrity and psychological wellbeing. Since no single theory could sufficiently explain the variables of the study, an eclectic approach encompassing all the theories was therefore adopted by the study.

The empirical studies investigated the role of various variables on psychological wellbeing of which most indicated a positive relationship whereas some did not. Studies on disclosure and psychological wellbeing especially yielded mixed results. Not many studies have been done on stigmatisation, disclosure, sexual functioning and psychological wellbeing and most importantly no study has been done on the relationship between these variables in the Nigerian setting. But since illness conditions has been known to pose a threat to the psychological wellbeing of individuals, to throw more light on these related constructs andto find out the relationship among these variables among victims of obstetric fistula in Nigeria, the

researcher undertook this study. Thus the issues of interest to the researcher were; Will stigmatisation, distress disclosure, and sexual functioning predict psychological wellbeing?

Hypotheses

The following hypotheses were proposed:

(1) Stigmatisation will significantly predict psychological wellbeing among women with obstetric fistula

(2) Health disclosure will significantly predict psychological wellbeing among women with obstetric fistula

(3) Sexual functioning will significantly predict psychological wellbeing among women with obstetric fistula

CHAPTER THREE

METHOD

Participants

Participants in this study were 183 women who had obstetric fistula and were currently registered at the National Obstetric Fistula Hospital, Abakaliki, Ebonyi State. They were drawn from the outpatient, surgical, and pre-surgical wards. The respondents were purposively drawn from the National Obstetric Fistula Hospital, Abakaliki. A purposive sampling technique was used to select participants for the study. In this study, the age of the participants ranged from 14-to-70 years with a mean age of 22.88years (SD=5.64). Taking a view at the marital status of respondents, 136 (74.3%) were married, 23 (12.6%) were single, 3 (1.6%) were divorced, 18 (9.8%) were in a heterosexual relationship, and 3 (1.6%) were in an informal union (cohabitation).

The composition of the sample based on educational status showed that 79 (43.2%) of the respondents had First School Leaving Certificates (FSLC), 88 (48.1%) had completed their Senior Secondary School Certificate Examination (SSCE), 12 (6.6%) had National Diplomas, and 4 (2.2%) had Higher National Diplomas/First Degree, and this indicates that all respondents have attained a form of formal education. Also, 156 (85.2%) of the respondents were Christians, 26 (14.2%) were Muslims while 1 (0.5%) was an adherent of other religions. In terms of the type of obstetric fistula, 176 (96.2%) of the respondents had vesico vaginal fistula (VVF) while 5 (2.7%) had recto vaginal fistula (RVF) and 2 (1.1%) had a complex fistula. The main inclusion criteria for the study was an obstetric fistula diagnosis and currently on admission in the hospital.

Instruments

Four instruments were used in the study to assess different constructs and domains of the respondents. The instruments administered to the respondents included: Psychological Well-Being Scale (PWBS) (Ryff, 1989), The Stigma Perception Questionnaire (SPQ) (Szivos, 1991; Szivos-Bach, 1993), Illness Disclosure Inventory (DDI) (Checkton, 2010), and the Female Sexual Quality of Life Questionnaire (SQL-f) developed by Symonds, Boolell, and Quirk (2005).

Psychological Well-Being Scale

Psychological Well-Being Scale (Ryff, 1989) is considered to be a widely accepted measurement of psychological well-being. Ryff developed her scale of Psychological Well-Being (PWB) as an operational definition of her multidimensional theory of well-being. The PWB has six subscales of 18 items to measure well-being (self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth), and responses are entered on a 6-point Likert-type scale ranging from 1 (strongly agree) to 6 (strongly disagree). Eight items (Items 1, 4, 5, 8, 15, 16, 17, and 18) are reverse-scored so that higher scores correspond to greater psychological well-being. The normative sample included over 300 healthy, well-educated, and financially stable adults (Ryff).

The internal consistency and test-retest (over a six week period on a sub sample of respondents) coefficients from this sample on the six scales were as follows: self-acceptance: .93, .85, positive relations with others: .91, .83, autonomy: .86, .88, Miller environmental mastery: .90, .81, purpose in life: .90, .82 and personal growth: .87, .81 respectively. A factor analysis yielded a three-factor solution with the first factor (general well-being) accounting for 51% of the variance, however the existence of the two other factors (accounting for 8.5% and

7.3% of the variance respectively) demonstrate the prior indexes of well-being do not address the other aspects of well-being suggested in the theoretical literature (Ryff, 1989).

All subsequent research has made modifications to the original Psychological Well-Being scale (Ryff, 1989). Schmutte and Ryff (1997) conducted a study with middle-aged adults (only using 14 items per scale) and reported internal consistency coefficients ranging from .82 to .90. A similar study was conducted with women over 55 years of age and slightly lower coefficients were reported (ranging from .77 to .85), although this study also reported test-retest reliabilities that ranged from .81 to.90 (Kwan et al., 2003). Another study on two samples of women over 55 years of age reported internal consistency coefficients ranging from .59 to .74 (relocation sample) and .58 to .73 (care giving sample) (Kling et al., 1997). In the present study, a pilot study was conducted using seventy three (73) women suffering from obstetric fistula at the Family Life Center, Mbibit Itam, Akwa Ibom State. An internal consistency reliability estimate (Cronbach's alpha) of .83 was obtained for the scale.

The Stigma Perception Questionnaire (Szivos, 1991; Szivos-Bach,1993)

This measure was developed for use with individuals with illness or disability by Szivos (1991). It contains 10 items which assess participants' perceptions of their own , such as being treated like a child, being made fun of or feeling reluctant to identify with the adult resource centre. Szivos-Bach (1993) indicates that participants should be encouraged to 'talk around' each item before deciding on a score in order to ensure more accurate responses. The participants were asked to rate how often the items occur using five-point visual analogues as well as written and spoken response options. These consisted of drawn blocks of decreasing size with the words 'nearly always', 'often', 'half the time', 'sometimes' and 'never' underneath them. These responses were assigned a score from 1 to 5 so that higher scores represented lower perception of

stigma. Szivos-Bach (1993) reported that the scale had item-total correlations between 0.34 and 0.61 and a scale alpha of 0.81. Dagnan and Waring (2004) repeated this analysis and found a mean item-total correlation for the scale of 0.42 (range = 0.22 - 0.57) and a scale alpha of 0.75.

Szivos-Bach (1993) also reported a factor analysis of the scale that revealed it has three main factors that were labelled as: (i) Feeling Different, (ii) Anxiety and (iii) Poor In-Group Concept. However, Abraham, Gregory, Wolf, and Pemberton (2002) failed to replicate this factor structure and challenged the reliability of the scale. They first identified that 5 of the 10 items could be used to form a reliable scale with an alpha of 0.75, however, they stated that three of the items had poor test-retest reliability. Consequently, they used the remaining items to form an abridged stigma scale and they reported that it had acceptable test-retest reliability.

Despite Abraham *et al.* (2002) questioning the reliability of the stigma scale, the full version is included in this study for the following reasons. Firstly, it is the only scale that has been developed to look at the experience of stigma in people with illness. Rather than design a new questionnaire for the purpose of the current study, it was considered more practical to use a measure that was already in use. Secondly, although the scale was developed in the early 1990s, it has been used again in recent research in 2002 and 2004 (Abraham *et al.,* 2002; Dagnan & Waring, 2004). Only one of these papers questioned the reliability of the scale (Abraham *et al.,* 2002). The scale has a direct scoring format with scores ranging from 1-never, 2- Sometimes, 3- Half the time, 4- Often to 5- Nearly always. The items include; My family is disappointed in me, Other people treat me oddly, I am uncomfortable in the company of strangers. In the present study, a pilot study was conducted using seventy-three (73) women suffering from obstetric fistula at the Family Life Center, Mbibit Itam, Akwa Ibom State. An internal consistency reliability estimate (Cronbach's alpha) of .77 was obtained for the scale.

Health Disclosure Scale (HDS)

The Checkton (2010) Health Disclosure Scale (HDS) was used in measuring illness disclosure in the study. The Health Disclosure Scale (HDS) measures the extent (*depth*) to which individuals share intimate information about their health condition, the range of topics (*breadth*) that individuals share about their health condition, and how often individuals share information about their health condition (*frequency*).

Perceptions of the *depth* or intimacy of disclosure to spouses about a health condition were measured by four 5-point Likert items with responses ranging from 1 (s*trongly disagree*) to 5 (s*trongly agree*). The following four items formed a uni-dimensional measure of the depth of health condition communication with a spouse: “I have heart-to-heart talks with my spouse/friend about my health condition,” “My spouse/friend and I only talk about superficial issues related to my health condition” (reverse scored), “I hold back from sharing intimate issues about my health condition with my spouse” (reverse scored), and “I share my innermost fears about my health condition with my spouse.” The items were summed and averaged to form a composite measure of depth of disclosure about a health condition with a spouse, with higher scores indicating greater depth. An alpha coefficient of .75 was obtained for the subscale.

Perceptions of the *breadth* or range of topics that individuals share with their spouses about their health condition were measured by four 5-point Likert items with responses ranging from a 1 (s*trongly disagree*) to 5 (s*trongly agree*). Items were developed based on prior research on the role of self-disclosure in relationship development and maintenance and topic avoidance in marital relationships. The following four items formed a unidimensional measure of breadth of disclosure with a spouse: “I discuss a wide variety of issues related to my health condition,” “There are some issues about my health condition that I do not talk about” (reverse scored);

"There are some areas related to my health condition that I avoid discussing" (reverse scored), and "I am hesitant to share small health concerns" (reverse scored). The items were summed and averaged to form a composite measure of breadth of disclosure about a health condition with a spouse, with higher scores indicating greater breadth. An alpha coefficient of .82 was obtained for the scale.

Perceptions of the *frequency* with which individuals disclose to a spouse about their health condition were measured by three 5-point Likert items with responses ranging from 1 (*strongly disagree*) to 5 (s*trongly agree*), and one item with responses ranging from 1 (*never*) to 5 (*multiple times a day*). The following four items formed a uni-dimensional measure of frequency of disclosure about one's health condition: "We often talk about my health condition," "I rarely talk about my health condition" (reverse scored), "My spouse and I have frequent conversations about my health condition," and "How often do you talk with your spouse about your health condition?" An alpha coefficient of .84 was derived for this scale. An overall alpha reliability coefficient of .89 was obtained for the Health Disclosure Scale by the authors. In the present study, a pilot study was conducted using seventy three (73) women suffering from obstetric fistula at the Family Life Center, Mbibit Itam, Akwa Ibom State. An internal consistency reliability estimate (Cronbach's alpha) of .72 was obtained for the scale.

The Sexual Quality of Life-Female (SQOL-F) (Symonds, Boolell, & Quirk, 2005)

Developed by Symonds, Boolell, and Quirk (2005), the Sexual Quality of Life-Female (SQOL-F) questionnaire is a short instrument that specifically assesses the relationship between female sexual dysfunction and quality of life. Symonds et al. (2005) developed the questionnaire to assess sexual functioning in women who had sexual dysfunction in relation to their quality of life. The basis for the generation of the SQOL-F questionnaire was Spitzer's Quality of Life

(QOL) model that involved physical, emotional, psychological and social components. As such, the SQOL-F questionnaire was generated from semi-structured interviews studying a sample of 82 women, aged 19–65 years, from 7 countries: UK, US, Australia, France, Denmark, Holland and Italy. The SQOL-F questionnaire is a specific and self-report instrument that focuses on sexual self-esteem, emotional and relationship issues. It consists of 18 items and each item is rated on a six-point response (completely agree to completely disagree). The response categories could be scored either 1 to 6 or 0 to5 giving a total score of 18–108 or 0–90 90 (1 = completely agree, 2 = moderately agree, 3 = slightly agree, 4 = slightly disagree, 5= moderately disagree, 6 = completely disagree). Items 1, 5, 9, 13 and 18 are reversely scored items.

Higher score indicates better female sexual quality of life. Validity of the SQOL-F questionnaire first was assessed in the UK and the USA. In the UK setting studying a sample of 1296 women aged 18–65 years, internal consistency was found to be 0.95 and the questionnaire discriminated well between depressed and not depressed women (Symonds et al., 2005). Also, factor analysis showed that the questionnaire was a unidimensional construct because there was no obviously split of factor loadings (Symonds et al., 2005). In the USA setting studying three groups of women (women with spinal cord injury, women with sexual dysfunction and a sample of healthy women), the SQOL-F was lower among women with sexual dysfunction as expected lending support to its discriminate validity.

In addition, intraclass correlation coefficient was reported to be 0.85, which showed an appropriate stability for the questionnaire (Symonds, Boolell, and Quirk, 2005). Also, in an Iranian study, Maasoumi, Lamyian, Montazeri, Azin, Aguilar-Vafaie and Hajizadeh (2013) reported an internal consistency of .88 and a cronbach alpha of .73 for the scale. However, for the subscales, they reported a crobach alpha of .70 for psychosexual feelings, .71 for sexual and

relationship satisfaction, .70 for self-worthlessness, and .75 for sexual repression. They also reported an internal consistency of .78 for psychosexual feelings, .50 for sexual and relationship satisfaction, .58 for self-worthlessness, and .83 for sexual repression. Considering that women who suffer from obstetric fistula are deemed to have difficulties with their sexual life, a non-intrusive scale such as the SQOL-F questionnaire was deemed most suitable since it is does not measure actual sexual acts. In the present study, a pilot study was conducted to validate the questionnaire using seventy-three (73) women suffering from obstetric fistula at the Family Life Center, Mbibit Itam, Akwa Ibom State. An internal consistency reliability estimate (Cronbach's alpha) of .77 was obtained for the scale.

Procedure

Permission and ethical clearance were sought for and obtained from the Research and Ethics Committee of the National Obstetric Fistula Hospital, Abakailiki. The researcher and three (3) research assistants then proceeded to the wards and met the nurses on duty, explaining to them the purpose of the study. After this, the researcher and the research assistants met with the respondents and first established rapport with them, after which the aim of the study was made known to the participants. Participants were assured that all their responses will be treated confidentially. The researcher was assisted by the research assistants in administering the questionnaires to the women during their stay in the hospital. Each respondent was given the questionnaire containing an introduction page for demographic information and the instruments for the study. The researcher and the research assistants distributed and collected the questionnaires on the spot to ensure high rate of return. Of the two hundred (200) copies of questionnaires administered, one hundred and ninety-four (194) were retrieved, eleven (11) were

not properly completed and were thus discarded. The properly filled questionnaires were scored and used for data analysis.

Design/ Statistics

Being a survey, the study adopted a cross sectional design. Pearson correlation (r) was conducted to test for the relationship between the predictor variables and the dependent variable, while the hierarchical multiple regression analysis was used to test the hypotheses. Multiple regression analysis was used since it allows researcher to study multiple predictors on the dependent variable (Ezeh, 2003).

CHAPTER FOUR

RESULTS

Table 1: Descriptive Statistics of study participants (N = 183)

Variables		M	SD	%
Age (years)	Range = 14-70	22.88	5.64	
Marital Status		1.52	1.04	
	Married			74.3%
	Divorced			1.6%
	In a Relationship			9.8%
	Informal Union			1.6%
	Single			12.6%
Religion		1.15	0.38	
	Christians			85.2%
	Muslims			14.2%
	ATR and Others			0.5%
Educational		2.40	1.44	
Qualification	HND/Degree & above			2.2%
	National Diploma			6.6%
	SSCE			48.1%
	FSLC and below			43.2%
Stigmatisation		27.13	8.47	
Disclosure		35.29	10.42	
Sexual Functioning		45.81	13.54	
Psychological Wellbeing		56.04	21.24	

Note: M= Mean, SD= Standard Deviation, %=percentage

Table 1 showed the means, percentages and standard deviations of participant's scores on the independent and dependent variables. The average scores in the study's variables of interest were as follows: Stigmatisation= 27.13(SD=8.47), Disclosure= 35.29 (SD=10.42), Sexual Functioning= 45.81(SD=13.54), Psychological Wellbeing= 56.04 (SD=21.24).

Table 2: The result of the correlations matrix of the predictor variables: Stigmatisation, distress disclosure, sexual functioning and psychological wellbeing.

	Variables	1	2	3	4	5	6	7	8	9
1	Age									
2	Educational status	-.01								
3	Marital status	-.02	-.04							
4	Religion	-.06	-.12	-.02						
5	Time before surgery	.08	.05	-.02	-.06					
6	Stigmatisation	-.19**	.09	-.00	-.04	.02				
7	Health Disclosure	-.25**	.07	-.08	-.05	-.17*	.34**			
8	Sexual Functioning	.17*	-.031	.08	.15*	.06	-.19**	-.36**		
9	Psychological wellbeing	.29**	-.08	.01	.03	.36**	-.35**	-.46**	.48**	

*p< .05, **p < .01

The results of the correlation matrix as shown in table 2 revealed that age was significantly related to psychological wellbeing (r=.29, $p < .01$), showing that older women with obstetric fistula had higher scores on psychological wellbeing and they fared better psychologically. Similarly, there was also a significant positive relationship between length of time before

corrective surgery and psychological wellbeing (r=.36, p < .01). However, there was a negative significant relationship between stigmatisation and psychological wellbeing (r=-.35, p < .01), thus showing that the more the stigma, the lesser the psychological wellbeing of the respondents. Also, there was a negative relationship between health disclosure and psychological wellbeing (r=-.46, p < .01), thus revealing that disclosing their obstetric fistula status negatively impacted on their psychological wellbeing. Sexual functioning was positively related to psychological wellbeing (r=.48, p < .01), showing that respondents who still functioned sexually had better psychological functioning.

Table 3: Hierarchical multiple regression (stepwise method) of stigmatisation, health disclosure, and sexual functioning predicting psychological wellbeing.

Step	Predictors	B	SE	B	t	R^2	ΔR^2
1	Stigmatisation	-.88	.18	-.35	-5.03*	.12	.12
2	Health disclosure	-.79	.14	-.38	-5.65*	.25	.13
3	Sexual functioning	.55	.10	.35	5.45*	.35	.11

Dependent Variable: Psychological Wellbeing; ΔR^2= Change in R^2;**p<.001; *p<.05

Table 3 showed that in the first step of the hierarchical multiple regression, stigmatisation negatively predicted psychological wellbeing (β=-.35, t=-5.03, p<.05), indicating that obstetric fistula patients who were stigmatised had low levels of psychological wellbeing. About 12% of the variance in psychological wellbeing was explained on account of stigmatisation (ΔR^2=.12) (see step 1 in table 2). Similarly, in step 2, when health disclosure was added to the regression

model, it was found to be a strong negative predictor of psychological wellbeing (β=-.38, t=-5.65, p<.05), thus, showing that women who disclose their health status had lower levels of psychological wellbeing. The ΔR^2 (.13) further showed that health disclosure explained 13% of the variance in psychological wellbeing. In step 3 of the regression model, sexual functioning was added and it positively predicted psychological wellbeing (β=.35, t=5.45, p<.05), which indicated that women suffering from obstetric fistula who had higher levels of sexual functioning had better psychological wellbeing. As shown by the ΔR^2 (.11), 11% of the variance in psychological wellbeing was explained on account of sexual functioning. Of all the predictors, health disclosure was found to be the strongest predictor of psychological wellbeing (β=-.38) and the entire model explained 35% of the variance in psychological wellbeing (R^2=.35).

Summary of Findings

1. Stigmatisation was negatively related to psychological wellbeing and it negatively predicted psychological wellbeing (β=-.35, t=-5.03, p<.05).
2. Health disclosure was negatively related to psychological wellbeing and it negatively predicted psychological wellbeing (β=-.38, t=-5.65, p<.05)
3. Sexual functioning was positively related to psychological wellbeing and it positively predicted psychological wellbeing (β=.35, t=5.45, p<.05).

CHAPTER FIVE

DISCUSSION

The current study investigated the predictive value of stigmatisation, distress disclosure, and sexual functioning on psychological wellbeing of obstetric fistula patients. Three hypotheses were tested in the study and the first hypothesis which stated that stigmatisation will significantly predict psychological wellbeing among women with obstetric fistula was supported as the results showed that stigmatisation negatively predicted psychological wellbeing. Also, the results revealed a negative relationship between stigmatisation and psychological wellbeing. This result supports the view of relevant theories such as Goffman (1963) and the findings of Corrigan, Kerr and Kundsen (2005), Campbell and Deacon (2006) and Link, Struening, Rahau, Phelan, and Nutlbroak (1997). Studies have shown that even when members of stigmatised groups are not exposed to overt and direct acts of discrimination, individuals who carry stigmatised markers may internalise negative representations of their status. This may lead to loss of confidence and self-esteem, undermining the likelihood that they will challenge their devalued status, therefore affecting their psychological wellbeing negatively (Campbell & Deacon, 2006; Goffman, 1963). It is noteworthy that obstetric fistula patients are often stigmatised because of their conditions and beyond being overtly stigmatised, they may also possess elements of self-stigma in which case they judge themselves unworthy of socialising with others and this may be the result of an avoidant coping strategy which further helps them to conceal their condition.

Also, Scheff (1966) held that the society has negative perceptions about people with chronic illness and that everyone in the society learns the stereotyped imagery of a chronic illness through ordinary social interaction. Scheff (1966) believes that illness is a label given to a

person who has behaviour which is away from the social norms and so is treated as deviant. This therefore interferes with their psychological wellbeing as these negative labels will be internalised by the individual suffering from obstetric fistula leading to negative psychological functioning. Markowitz (1998) had earlier found the adverse effects of stigma on psychological wellbeing among mentally ill patients and observed that much of the negative effects on psychological wellbeing were due to anticipatory rejection and discriminatory experiences. The study also indicated that stigma is related to anxiety-depressive types of symptoms but not psychotic symptoms. In another study, Barageine et al. (2015) found that stigma among women suffering from obstetric fistula manifested itself as feelings that others were irritated by the smell and leakage of urine. These forced the women to be constantly worried that others would notice their problems, thus increasing self-monitoring. Nevertheless, stigma was often experienced through the behaviour of others, especially how close relatives acted towards women with a fistula.

Similarly, the results of the study also supported the second hypothesis which stated that distress disclosure will significantly predict psychological wellbeing among women with obstetric fistula. The results showed that health disclosure was a significant negative predictor of psychological wellbeing among women with obstetric fistula. This implies that women who disclose their health status are likely to have lower levels of psychological wellbeing. They may encounter discrimination and stigma when they inform people and this will further hurt them as people may likely avoid them especially because of the odour of urine. This result corroborates the earlier findings of Lam (2015) who found that negative disclosure significantly predicted lower self-esteem, higher sexual anxiety, more internalising behaviour, severe post-traumatic stress disorder responses and poor psychological wellbeing.

Chapple, Ziebland, and McPherson (2004) in a study of disclosure among cancer patients found that others' views of the manner in which they had contracted lung cancer, for example through smoking, caused them to be stigmatised and that such stigma may influence decisions to disclose to others and have far reaching effects that may lead to not seeking appropriate clinical support thus, such negative disclosure experiences diminish psychological wellbeing. Women suffering from obstetric fistula often feel embarrassed disclosing their condition to others as they feel it will likely lead to discrimination from people who do not understand and this people may in turn mock them. Thus, negative disclosure experiences diminish psychological wellbeing. Joachim and Acorn (2000) thus stated that decisions to disclose may be problematic because it may result in additional stigma and an alternative strategy would be to try to hide the condition and be perceived as "normal". The trauma of an obstructed labour as well as the stigma associated with the incontinence and faecal dripping is a factor that can lead many of the women suffering from obstetric fistula not to disclose and this will further affect their psychological wellbeing as disclosure as been shown in some studies to elicit positive effects on wellbeing.

Results showed that sexual functioning significantly predicted psychological wellbeing. Thus, the third hypothesis which stated that sexual functioning will significantly predict psychological wellbeing among women with obstetric fistula was supported. This result further supports the findings of Davison, Bell, LaChina, Holden, and Davis (2009) who found that women who self-identify as having sexual dissatisfaction have lower psychological general well-being. The result further supports the findings of Carrobles, Guadix, and Almendros (2011) who investigated the association between sexual functioning, sexual satisfaction and psychological well-being in a sample of Spanish women and found that the main factors related to psychological well-being were sexual satisfaction and physical and sexual attractiveness. Thus,

the sexual functioning of women with obstetric fistula and the understanding shown by their partners enhances their psychological wellbeing. Given the disruption in sexual functioning which is a key component in marital satisfaction, the space created between the woman and her partner usually affects the woman's self esteem and feelings of worth. Therefore, with the disruption in sexual functioning comes the negative effects where the woman will be viewed as worthless by the husband or partner and in some cases, the husband will likely remarry as a separation from bed as already occurred.

Implications of Findings

The results of this study indicate that stigmatisation, distress disclosure, and sexual functioning significantly predicted psychological wellbeing among women with obstetric fistula. In essence, these have several practical, empirical and theoretical implications. In Nigerian hospital care settings, professional care of women with obstetric fistula is limited to physical treatment and corrective surgeries and this study therefore raises concern for the urgent need to provide psychotherapeutic services to women who are suffering from obstetric fistula as they battle stigma and discrimination even from close family members. Stigmatisation is associated with negative outcomes and this often impacts negatively on the psychological wellbeing of women with obstetric fistula.

Also, negative disclosure experiences often tend to engender stigma and withdrawal among women with obstetric fistula. Thus, leading these women to avoid disclosing their fistula experiences and also further delaying them from seeking help. This is evidenced in the number of years that these women have to wait before undertaking corrective surgeries and thus, the

general public should be sensitised on the implications of these negative disclosure experiences on the psychological wellbeing of these women suffering from obstetric fistula.

The sexual functioning of these women is equally important and the government should commit more resources to training medical personnel to enhance the success rate of corrective surgeries and a half-way home should be provided to delay the return of these women to their communities during the period stipulated for sexual abstinence to avoid coital collapse which will thus necessitate another surgery and further consumes more resources. Equally, surgeries should be free and accessible to women suffering from obstetric fistula.

Empirically, the study will further add to the growing body of quantitative studies in the area of psychological wellbeing of women with obstetric fistula and this will further lend credence to the work of researchers in the future. Theoretically, the findings of the study further supports the theories reviewed in the study which emphasised the importance of psychological wellbeing in individuals and how this can be influenced by stigmatisation, health disclosure and sexual functioning.

Limitations of the Study

A few limitations were encountered during the course of this study including the limited time frame in which the study was conducted. Also, the literacy rate of the respondents was a barrier as the questionnaire items were frequently interpreted to the native language of the respondents. Another limitation of the study was the sample size as the study was only limited to a single facility treating obstetric fistula cases. Also, the financial implication of carrying out this study served as a key limitation as it impeded the reach of a larger population across different facilities in the country.

Suggestions for Further Studies

Since the present study used a sample of 183 respondents, researchers should use a larger sample size in the future to ensure that the findings could be generalised. Studies should also focus on women at the point of entry and assessment of their fistula before being admitted into the hospital for corrective surgeries so as to assess their psychological wellbeing at that point. Meanwhile, future studies should investigate other mental health indicators which may be important in comprehensively assessing the psychological healthcare needs of women with obstetric fistula.

Summary

The psychological impact of obstetric fistula can be pervasive. Thus, the present study examined stigmatisation, distress disclosure, and sexual functioning as predictors of psychological wellbeing among women with obstetric fistula. A sample of 183 women with obstetric fistula from the National Obstetric Fistula Centre Abakaliki participated in the study. The result of the study showed that stigmatisation was negatively related to psychological wellbeing and it negatively predicted psychological wellbeing. Also, health disclosure was negatively related to psychological wellbeing and it negatively predicted psychological wellbeing while sexual functioning was positively related to psychological wellbeing and also positively predicted psychological wellbeing. It was therefore stated that stigmatisation, distress disclosure, and sexual functioning are predictors of psychological wellbeing in women with obstetric fistula.

Conclusion

This study therefore contributes to knowledge by espousing the roles of stigmatisation, distress disclosure and sexual functioning as predictors of psychological wellbeing. Stigma is a negative social baggage that is not justified by the consequences of the illness and women with obstetric fistula often experience stigma due to the odour of the urine or faecal materials which continuously drips from their genitals. Thus, they become socially isolated and obstetric fistulas often limit the everyday activities of these women and so influence the psychosocial aspects of their lives. Also, disclosure becomes negative when these women do not get the help they seek and thus affecting their psychological wellbeing. However, women who have obstetric fistula and could function sexually had a better psychological wellbeing. Therefore, beyond corrective surgeries, psychotherapeutic services should be provided to these women to further enhance their psychological wellbeing and complete their cure.

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APPENDIX A

STUDY'S QUESTIONNAIRE

Department of Psychology

Faculty of Social Science

University of Nigeria

Nsukka

Dear Respondent,

The researcher is a postgraduate student of the above mentioned institution. He is undertaking a research report on factors affecting **Psychological Wellbeing** in people with obstetric fistula, in partial fulfilment of the award of Master of Science (M.Sc.) Degree in Psychology. This is purely an **academic exercise**. Please kindly respond to the questionnaire as **truthfully** and **sincerely** as possible by **ticking the appropriate box** of your choice. There is no right or wrong answer and your response will be treated with utmost confidentiality. Thank you.

SECTION A

Please give the needed information about yourself by filling the blank spaces.

Age.............................

Educational Qualification: SSCE ☐ ND ☐ HND/DEGREE ☐

Religion: CHRISTIAN ☐ MUSLIM ☐ OTHERS...

1. Do you have any other medical conditions except from the fistula?

No ☐ ☐ Yes? Which...

2. What is your civil status?

Married ☐ Single ☐ Divorced ☐ In a Relationship ☐ Informal Union ☐

3. Number of Surgeries: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

4. Length of time before each surgery:..
5. Were you sexually active before the surgery?
   Yes ☐ No ☐
6. How long did you stay after surgery before resuming sexual activities?

Less than a month ☐ one month ☐ two months ☐ three months ☐ four months and above ☐

7. Type of Fistula: VVF ☐ RVF ☐ COMPLEX ☐

8. Symptoms noticed after surgery:

☐ No

☐ Difficulties to let urine

☐ Difficulties to keep urine

☐ Difficulties to pass stool

☐ Difficulties to keep stool

☐ Pain during sexual intercourse

☐ Bleeding from genital tract

☐ Blood in urine or stool

☐ Others. Please specify...

9. Where did you visit for your ante-natal care?

Hospital/Health Centre ☐ Traditional Birth Attendant ☐ None ☐

10. What caused the problem requiring each of the repairs?

☐ Coital breakdown

☐ Obstructed Labour

☐ Ianotropic/ cancer

11. Experienced bladder or muscle spasm during the repair surgery ☐

APPENDIX B2

The Stigma Perception Questionnaire (SPQ)

Instructions: Please read each of the following items carefully. Indicate the extent to which you pass through each of the experiences by ticking the options from 'Never' to 'Nearly Always'

S/N	ITEMS	Never	Sometimes	Half the time	Often	Nearly Always
1	My family is disappointed in me					
2	People treat me like a child					
3	I wish I were someone different					
4	I get teased or made fun of					
5	I am uncomfortable in the company of strangers					
6	In groups I feel the odd one out					
7	I worry about what other people think of me					
8	Other people treat me oddly					
9	I hate telling people I come from/go to this place					
10	I hate going out in a group with people from here					

APPENDIX B3

Health Disclosure Scale (HDS)

Instructions: Please read each of the following items carefully. Indicate the extent to which you agree or disagree with each item according to the rating scale as indicated below ranging from strongly disagree to strongly agree

S/n	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I have heart-to-heart talks with my spouse/friend about my health condition					
	My spouse/friend and I only talk about superficial issues related to my health condition					
	I hold back from sharing intimate issues about my health condition with my spouse					
	I share my innermost fears about my health condition with my spouse					
5	I discuss a wide variety of issues related to my health condition					
6	There are some issues about my health condition that I do not talk about					
7	There are some areas related to my health condition that I avoid discussing					
8	I am hesitant to share small health concerns					
9	We often talk about my health condition					
10	I rarely talk about my health condition					
11	My spouse and I have frequent conversations about my health condition					

12. How often do you talk with your spouse about your health condition?

Never	1-2 Times a month	1-2 Times a week	1-2 Times a day	Multiple times a day
☐	☐	☐	☐	☐

APPENDIX B4

Sexual Quality of Life Questionnaire-Female (SQoL-F)

The questionnaire consists of a set of statements, each asking about thoughts and feelings that you may have about your sex life. The statement may be positive or negative. You are asked to rate each according to how much you agree or disagree with the statement by circling one of the six response choices.

Usually, the first answer that comes into your head is the best one, so please do not spend too long on each question.

S/N	ITEMS	Completely Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Completely Disagree
1	When I think about my sex life, it is an enjoyable part of my overall life						
2	When I think about my sex life, I feel frustrated						
3	When I think about my sex life, I feel depressed						
4	When I think about my sex life, I feel like less of a woman						
5	When I think about my sex life, I feel good about myself						
6	I have lost confidence in myself as a sexual partner						
7	When I think about my sex life, I feel anxious						
8	When I think about my sex life, I feel angry						
9	When I think about my sex life, I feel close to my partner						
10	I worry about the future of my sex life						
11	I have lost pleasure in sexual activity						
12	When I think about my sex life, I feel embarrassed						
13	When I think about my sex life, I feel that I can talk to my partner about sexual matters						
14	I try to avoid sexual activities						
15	When I think about my sex life, I feel guilty						

16	When I think about my sex life, I worry that my partner feels hurt or rejected						
17	When I think about my sex life, I feel like I have lost something						
18	When I think about my sex life, I am satisfied with the frequency of sexual activity						

APPENDIX B5
PSYCHOLOGICAL WELL-BEING INDEX

Please select your extent of agreement with each of the following sentences.

S/N	Items	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1	I tend to be influenced by people with strong opinions						
2	In general, I feel I am in charge of the situation in which I live						
3	I think it is important to have new experiences that challenge how you think about yourself and the world						
4	Maintaining close relationships has been difficult and frustrating for me						
5	I live life one day at a time and don't really think about the future						
6	When I look at the story of my life, I am pleased with how things have turned out						
7	I have confidence in my opinions, even if they are contrary to the general consensus						
8	The demands of everyday life often get me down						
9	For me, life has been a continuous process of learning, changing and growth						
10	People would describe me as a giving person, willing to share my time with others						
11	Some people wander aimlessly through life, but I am not one of them						
12	I like most aspects of my personality						
13	I judge myself by what I think is important, not by the values of what others think is important						
14	I am quite good at managing the many responsibilities of my daily life						
15	I gave up trying to make a big improvements or changes in my life a long time ago						
16	I have not experienced many warm and trusting relationships with others						
17	I sometimes feel as if I've done all there is to do in life						
18	In many ways, I feel disappointed about my achievements in life						

APPENDIX C

Reliability

Scale: Stigma Perception Questionnaire

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.778	.783	10

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.478	-.484	1.040	1.523	-2.149	.089	10

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	21.1370	56.398	.207	.101	.786
VAR00002	22.4932	49.003	.465	.384	.757
VAR00003	22.9315	49.176	.536	.494	.748
VAR00004	22.8767	54.887	.205	.403	.791
VAR00005	22.8219	50.398	.547	.389	.748
VAR00006	22.9315	51.315	.435	.501	.761
VAR00007	22.8219	47.954	.706	.638	.729

VAR00008	22.3014	49.130	.424	.466	.764
VAR00009	22.4932	49.559	.570	.392	.745
VAR00010	22.3151	51.552	.436	.293	.761

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
25.0137	61.375	7.83421	10

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		441.899	72	6.137		
Within People	Between Items	193.567	9	21.507	15.819	.000
	Residual	881.033	648	1.360		
	Total	1074.600	657	1.636		
Total		1516.499	729	2.080		

Grand Mean = 2.5014

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.260[b]	.185	.357	4.514	72	648	.000
Average Measures	.778[c]	.694	.847	4.514	72	648	.000

APPENDIX C2

Reliability

Scale: Health Disclosure Scale

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.728	.732	12

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.356	-.566	1.375	1.940	-2.430	.200	12

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	30.2877	59.930	.373	.459	.709
VAR00002	29.7671	63.820	.248	.473	.724
VAR00003	30.2877	59.069	.537	.479	.691
VAR00004	29.2192	70.618	-.087	.368	.761
VAR00005	30.8630	55.398	.690	.678	.669
VAR00006	31.0685	61.342	.384	.461	.708
VAR00007	30.9178	53.660	.657	.681	.667
VAR00008	29.5753	66.220	.077	.357	.749
VAR00009	30.4795	54.503	.571	.603	.678
VAR00010	30.7123	57.958	.491	.498	.693
VAR00011	30.6849	62.302	.337	.476	.714
VAR00012	30.1918	62.518	.187	.239	.739

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
33.0959	70.393	8.39008	12

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		422.361	72	5.866		
Within People	Between Items	263.653	11	23.968	15.034	.000

Residual	1262.680	792	1.594		
Total	1526.333	803	1.901		
Total	1948.694	875	2.227		

Grand Mean = 2.7580

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.183[b]	.123	.265	3.679	72	792	.000
Average Measures	.728[c]	.626	.812	3.679	72	792	.000

APPENDIX C3

Reliability
Sexual Quality of Health

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.772	.771	18

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	3.128	2.603	3.425	.822	1.316	.055	18

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

Var001	53.21	145.471	.268	.474	.769
Var002	53.01	140.153	.500	.535	.751
Var003	52.92	144.410	.398	.668	.758
Var004	52.90	140.199	.513	.698	.750
Var005	52.97	142.860	.341	.651	.763
Var006	52.88	142.804	.403	.676	.758
Var007	52.99	147.430	.286	.577	.767
Var008	53.14	140.064	.486	.556	.751
Var009	53.16	146.028	.313	.486	.765
Var010	53.03	139.388	.484	.543	.751
Var011	53.07	138.842	.523	.642	.749
Var012	53.26	144.556	.356	.391	.761
Var013	53.44	148.250	.289	.436	.766
Var014	53.70	153.491	.165	.494	.774
Var015	53.47	151.975	.207	.525	.771
Var016	53.51	149.865	.251	.418	.769
Var017	53.32	145.802	.322	.414	.764
Var018	53.16	151.973	.162	.245	.775

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
56.30	160.630	12.674	18

APPENDIX C4

Reliability
Scale: Psychological Wellbeing Scale

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.838	.838	18

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.436	-.583	1.840	2.423	-3.154	.148	18
Inter-Item Correlations	.224	-.295	.711	1.006	-2.405	.034	18

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	58.5753	155.525	.327	.199	.835
VAR00002	58.4384	140.027	.719	.653	.814
VAR00003	58.2466	146.633	.625	.592	.821
VAR00004	58.7123	148.430	.492	.485	.827
VAR00005	59.0000	171.583	-.133	.250	.855
VAR00006	58.3288	135.640	.776	.733	.809
VAR00007	57.6712	157.335	.238	.229	.841
VAR0008	58.2055	156.332	.242	.363	.841
VAR0009	58.3151	148.802	.548	.439	.824

VAR00010	58.6575	143.173	.678	.599	.817
VAR00011	58.6986	157.825	.216	.266	.842
VAR00012	58.8630	154.620	.473	.443	.829
VAR00013	58.8219	153.010	.405	.447	.832
VAR00014	58.7808	153.257	.418	.421	.831
VAR00015	58.8767	150.387	.521	.425	.826
VAR00016	58.5890	154.051	.406	.306	.831
VAR00017	58.5616	151.472	.517	.400	.827
VAR00018	58.6575	156.617	.387	.426	.832

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
62.0000	168.722	12.98931	18

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		674.889	72	9.373		
Within People	Between Items	124.636	17	7.332	4.833	.000
	Residual	1856.919	1224	1.517		
	Total	1981.556	1241	1.597		
Total		2656.444	1313	2.023		

Grand Mean = 3.4444

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.223[b]	.164	.305	6.179	72	1224	.000
Average Measures	.838[c]	.779	.888	6.179	72	1224	.000

APPENDIX G

Raw Data Analysis

Frequencies

Age of the respondent

Statistics

Age of the respondent

N	Valid	183
	Missing	0
Mean		22.88
Std. Deviation		5.642
Kurtosis		27.413
Std. Error of Kurtosis		.357
Range		56
Minimum		14
Maximum		70
Sum		4187

Educational qualification

Statistics

Educational qualification

N	Valid	183
	Missing	0
Mean		2.40
Std. Deviation		1.441
Kurtosis		-1.925
Std. Error of Kurtosis		.357
Range		3
Minimum		1
Maximum		4
Sum		440

Educational qualification

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SSCE	88	48.1	48.1	48.1
	ND	12	6.6	6.6	54.6
	HND/DEGREE	4	2.2	2.2	56.8
	FSLC	79	43.2	43.2	100.0
	Total	183	100.0	100.0	

Religion of the respondent

Statistics

Religion of the respondent

N	Valid	183
	Missing	0
Mean		1.15
Std. Deviation		.376
Kurtosis		4.091
Std. Error of Kurtosis		.357
Range		2
Minimum		1
Maximum		3
Sum		211

Religion of the frespondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christian	156	85.2	85.2	85.2
	Muslim	26	14.2	14.2	99.5
	Others	1	.5	.5	100.0
	Total	183	100.0	100.0	

What is your civil status?

Statistics

What is your civil status?

N	Valid	183
	Missing	0
Mean		1.52
Std. Deviation		1.037
Kurtosis		2.588
Std. Error of Kurtosis		.357
Range		4
Minimum		1
Maximum		5
Sum		278

What is your civil status?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	136	74.3	74.3	74.3
	Single	23	12.6	12.6	86.9

Divorced	3	1.6	1.6	88.5
In a relationship	18	9.8	9.8	98.4
Informal union	3	1.6	1.6	100.0
Total	183	100.0	100.0	

Number of surgeries

Statistics

Number of surgeries

N	Valid	183
	Missing	0
Mean		2.77
Std. Deviation		1.733
Kurtosis		1.622
Std. Error of Kurtosis		.357
Range		7
Minimum		1
Maximum		8
Sum		507

Number of surgeries

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	38	20.8	20.8	20.8
	2	67	36.6	36.6	57.4
	3	38	20.8	20.8	78.1
	4	13	7.1	7.1	85.2
	5	10	5.5	5.5	90.7
	6	6	3.3	3.3	94.0
	7	5	2.7	2.7	96.7
	8	6	3.3	3.3	100.0
	Total	183	100.0	100.0	

Type of fistula

Statistics

Type of fistula

N	Valid	183
	Missing	0
Mean		1.05
Std. Deviation		.263
Kurtosis		36.379

Std. Error of Kurtosis	.357
Range	2
Minimum	1
Maximum	3
Sum	192

Type of fistula

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	VVF	176	96.2	96.2	96.2
	RVF	5	2.7	2.7	98.9
	COMPLEX	2	1.1	1.1	100.0
	Total	183	100.0	100.0	

Where did you visit for your ante-natal care

Statistics

Where did you visit for your ante-natal care

N	Valid	183
	Missing	0
Mean		1.70
Std. Deviation		.671
Kurtosis		-.779
Std. Error of Kurtosis		.357
Range		2
Minimum		1
Maximum		3
Sum		312

Where did you visit for your ante-natal care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital/health centre	76	41.5	41.5	41.5
	Traditional birth attendant	85	46.4	46.4	88.0
	None	22	12.0	12.0	100.0
	Total	183	100.0	100.0	

Stigma perception questionnaire

Statistics

Stigma perception questionnaire

N	Valid	183

	Missing	0
Mean		27.13
Std. Deviation		8.465
Kurtosis		-.127
Std. Error of Kurtosis		.357
Range		39
Minimum		10
Maximum		49
Sum		4965

Health disclosure scale

Statistics

Health disclosure scale

N	Valid	183
	Missing	0
Mean		35.29
Std. Deviation		10.420
Kurtosis		-.873
Std. Error of Kurtosis		.357
Range		41
Minimum		14
Maximum		55
Sum		6458

Sexual quality of life questionnaire-female

Statistics

Sexual quality of life questionnaire-female

N	Valid	183
	Missing	0
Mean		45.81
Std. Deviation		13.541
Kurtosis		.448
Std. Error of Kurtosis		.357
Range		74
Minimum		18
Maximum		92
Sum		8384

Psychological well-being index.

Statistics

Psychological well-being index.

N	Valid	183
	Missing	0
Mean		56.04
Std. Deviation		21.238
Kurtosis		-1.214
Std. Error of Kurtosis		.357
Range		73
Minimum		27
Maximum		100
Sum		10256

Regression

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.350[a]	.123	.118	19.949	.123	25.294	1	181	.000
2	.505[b]	.255	.246	18.437	.132	31.902	1	180	.000
3	.601[c]	.361	.350	17.123	.106	29.685	1	179	.000

a. Predictors: (Constant), Stigma perception questionnaire

b. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale

c. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale, Sexual quality of life questionnaire-female

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	10065.598	1	10065.598	25.294	.000[b]
	Residual	72028.052	181	397.945		
	Total	82093.650	182			
2	Regression	20909.525	2	10454.763	30.757	.000[c]
	Residual	61184.125	180	339.912		
	Total	82093.650	182			
3	Regression	29612.776	3	9870.925	33.667	.000[d]
	Residual	52480.874	179	293.189		
	Total	82093.650	182			

a. Dependent Variable: Psychological well-being index.

b. Predictors: (Constant), Stigma perception questionnaire

c. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale

d. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale, Sexual quality of life questionnaire-female

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	79.880	4.964		16.093	.000	70.086	89.674
	Stigma perception questionnaire	-.879	.175	-.350	-5.029	.000	-1.223	-.534
2	(Constant)	98.716	5.671		17.406	.000	87.525	109.907
	Stigma perception questionnaire	-.548	.172	-.218	-3.190	.002	-.887	-.209
	Health disclosure scale	-.788	.140	-.387	-5.648	.000	-1.063	-.513
3	(Constant)	63.024	8.406		7.498	.000	46.437	79.612
	Stigma perception questionnaire	-.483	.160	-.193	-3.022	.003	-.799	-.168
	Health disclosure scale	-.542	.137	-.266	-3.946	.000	-.812	-.271
	Sexual quality of life questionnaire-female	.551	.101	.351	5.448	.000	.351	.751

a. Dependent Variable: Psychological well-being index.

Excluded Variables[a]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics
						Tolerance
1	Health disclosure scale	-.387[b]	-5.648	.000	-.388	.884
	Sexual quality of life questionnaire-female	.435[b]	6.876	.000	.456	.964
2	Sexual quality of life questionnaire-female	.351[c]	5.448	.000	.377	.859

a. Dependent Variable: Psychological well-being index.

b. Predictors in the Model: (Constant), Stigma perception questionnaire

c. Predictors in the Model: (Constant), Stigma perception questionnaire, Health disclosure scale

Correlations

Correlations

		Stigma perception questionnaire	Health disclosure scale	Sexual quality of life questionnaire-female	Psychological well-being index.	Age of the respondent	Educational qualification	What is your civil status?	Religion of the frespondent	Length of time before each surgery
Stigma perception questionnaire	Pearson Correlation	1	.341**	-.190**	-.350**	-.196**	.099	-.008	-.041	-.020
	Sig. (2-tailed)		.000	.010	.000	.008	.181	.917	.583	.785
	N	183	183	183	183	183	183	183	183	183
Health disclosure scale	Pearson Correlation	.341**	1	-.369**	-.461**	-.257**	.077	-.087	-.059	-.177*
	Sig. (2-tailed)	.000		.000	.000	.000	.300	.243	.427	.016
	N	183	183	183	183	183	183	183	183	183
Sexual quality of life questionnaire-female	Pearson Correlation	-.190**	-.369**	1	.486**	.172*	-.031	.088	.150*	.067
	Sig. (2-tailed)	.010	.000		.000	.020	.677	.239	.042	.365
	N	183	183	183	183	183	183	183	183	183
Psychological well-being index.	Pearson Correlation	-.350**	-.461**	.486**	1	.291**	-.086	.019	.038	.364**
	Sig. (2-tailed)	.000	.000	.000		.000	.246	.802	.606	.000
	N	183	183	183	183	183	183	183	183	183
Age of the respondent	Pearson Correlation	-.196**	-.257**	.172*	.291**	1	-.012	-.029	-.061	.088

	Sig. (2-tailed)	.008	.000	.020	.000		.877	.700	.410	.238
	N	183	183	183	183	183	183	183	183	183
Educational qualification	Pearson Correlation	.099	.077	-.031	-.086	-.012	1	-.035	-.125	.051
	Sig. (2-tailed)	.181	.300	.677	.246	.877		.642	.092	.494
	N	183	183	183	183	183	183	183	183	183
What is your civil status?	Pearson Correlation	-.008	-.087	.088	.019	-.029	-.035	1	-.022	-.027
	Sig. (2-tailed)	.917	.243	.239	.802	.700	.642		.771	.715
	N	183	183	183	183	183	183	183	183	183
Religion of the frespondent	Pearson Correlation	-.041	-.059	.150*	.038	-.061	-.125	-.022	1	-.066
	Sig. (2-tailed)	.583	.427	.042	.606	.410	.092	.771		.374
	N	183	183	183	183	183	183	183	183	183
Lenght of time before each surgery	Pearson Correlation	-.020	-.177*	.067	.364**	.088	.051	-.027	-.066	1
	Sig. (2-tailed)	.785	.016	.365	.000	.238	.494	.715	.374	
	N	183	183	183	183	183	183	183	183	183

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

*. Correlation is significant at the 0.05 level (2-tailed).

APPENDIX B
STUDY'S QUESTIONNAIRE

Department of Psychology

Faculty of Social Science

University of Nigeria

Nsukka

Dear Respondent,

The researcher is a postgraduate student of the above mentioned institution. He is undertaking a research report on factors affecting **Psychological Wellbeing** in people with obstetric fistula, in partial fulfilment of the award of Master of Science (M.Sc.) Degree in Psychology. This is purely an **academic exercise**. Please kindly respond to the questionnaire as **truthfully** and **sincerely** as possible by **ticking the appropriate box** of your choice. There is no right or wrong answer and your response will be treated with utmost confidentiality. Thank you.

SECTION A

Please give the needed information about yourself by filling the blank spaces.

Age.............................

Educational Qualification: SSCE ☐ ND ☐ HND/DEGREE ☐

Religion: CHRISTIAN ☐ MUSLIM ☐ OTHERS...

12. Do you have any other medical conditions except from the fistula?

No ☐ ☐ Yes? Which..

13. What is your civil status?

Married ☐ Single ☐ Divorced ☐ In a Relationship ☐ Informal Union ☐

14. Number of Surgeries: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

15. Length of time before each surgery:...

16. Were you sexually active before the surgery?

Yes No

17. [ ] long did you stay afte[ ]surgery before resuming sexual activities?

Less than a month [ ] one month [ ] two months [ ] three months [ ] four months and above [ ]

18. Type of Fistula: VVF [ ] RVF [ ] COMPLEX [ ]

19. Symptoms noticed after surgery:

- [ ] No
- [ ] Difficulties to let urine
- [ ] Difficulties to keep urine
- [ ] Difficulties to pass stool
- [ ] Difficulties to keep stool
- [ ] Pain during sexual intercourse
- [ ] Bleeding from genital tract
- [ ] Blood in urine or stool
- [ ] Others. Please specify...

20. Where did you visit for your ante-natal care?

Hospital/Health Centre [ ] Traditional Birth Attendant [ ] None [ ]

21. What caused the problem requiring each of the repairs?

- [ ] Coital breakdown
- [ ] Obstructed Labour
- [ ] Ianotropic/ cancer

22. Experienced bladder or muscle spasm during the repair surgery [ ]

The Stigma Perception Questionnaire (SPQ)

Instructions: Please read each of the following items carefully. Indicate the extent to which you pass through each of the experiences by ticking the options from 'Never' to 'Nearly Always'

S/N	ITEMS	Never	Sometimes	Half the time	Often	Nearly Always
1	My family is disappointed in me					
2	People treat me like a child					
3	I wish I were someone different					
4	I get teased or made fun of					
5	I am uncomfortable in the company of strangers					
6	In groups I feel the odd one out					
7	I worry about what other people think of me					
8	Other people treat me oddly					
9	I hate telling people I come from/go to this place					
10	I hate going out in a group with people from here					

Health Disclosure Scale (HDS)

Instructions: Please read each of the following items carefully. Indicate the extent to which you agree or disagree with each item according to the rating scale as indicated below ranging from strongly disagree to strongly agree

S/n	Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I have heart-to-heart talks with my spouse/friend about my health condition					
	My spouse/friend and I only talk about superficial issues related to my health condition					
	I hold back from sharing intimate issues about my health condition with my spouse					
	I share my innermost fears about my health condition with my spouse					
5	I discuss a wide variety of issues related to my health condition					
6	There are some issues about my health condition that I do not talk about					
7	There are some areas related to my health condition that I avoid discussing					
8	I am hesitant to share small health concerns					
9	We often talk about my health condition					
10	I rarely talk about my health condition					
11	My spouse and I have frequent conversations about my health condition					

12. How often do you talk with your spouse about your health condition?

Never	1-2 Times a month	1-2 Times a week	1-2 Times a day	Multiple times a day
☐	☐	☐	☐	☐

Sexual Quality of Life Questionnaire-Female (SQoL-F)

The questionnaire consists of a set of statements, each asking about thoughts and feelings that you may have about your sex life. The statement may be positive or negative. You are asked to rate each according to how much you agree or disagree with the statement by circling one of the six response choices.

Usually, the first answer that comes into your head is the best one, so please do not spend too long on each question.

S/N	ITEMS	Completely Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Completely Disagree
1	When I think about my sex life, it is an enjoyable part of my overall life						
2	When I think about my sex life, I feel frustrated						
3	When I think about my sex life, I feel depressed						
4	When I think about my sex life, I feel like less of a woman						
5	When I think about my sex life, I feel good about myself						
6	I have lost confidence in myself as a sexual partner						
7	When I think about my sex life, I feel anxious						
8	When I think about my sex life, I feel angry						
9	When I think about my sex life, I feel close to my partner						
10	I worry about the future of my sex life						
11	I have lost pleasure in sexual activity						
12	When I think about my sex life, I feel embarrassed						
13	When I think about my sex life, I feel that I can talk to my partner about sexual matters						
14	I try to avoid sexual activities						
15	When I think about my sex life, I feel guilty						
16	When I think about my sex life, I worry that my partner feels hurt or rejected						
17	When I think about my sex life, I feel like I have lost something						
18	When I think about my sex life, I am satisfied with the frequency of sexual activity						

PSYCHOLOGICAL WELL-BEING INDEX

Please select your extent of agreement with each of the following sentences.

S/N	Items	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1	I tend to be influenced by people with strong opinions						
2	In general, I feel I am in charge of the situation in which I live						
3	I think it is important to have new experiences that challenge how you think about yourself and the world						
4	Maintaining close relationships has been difficult and frustrating for me						
5	I live life one day at a time and don’t really think about the future						
6	When I look at the story of my life, I am pleased with how things have turned out						
7	I have confidence in my opinions, even if they are contrary to the general consensus						
8	The demands of everyday life often get me down						
9	For me, life has been a continuous process of learning, changing and growth						
10	People would describe me as a giving person, willing to share my time with others						
11	Some people wander aimlessly through life, but I am not one of them						
12	I like most aspects of my personality						
13	I judge myself by what I think is important, not by the values of what others think is important						
14	I am quite good at managing the many responsibilities of my daily life						
15	I gave up trying to make a big improvements or changes in my life a long time ago						
16	I have not experienced many warm and trusting relationships with others						
17	I sometimes feel as if I’ve done all there is to do in life						
18	In many ways, I feel disappointed about my achievements in life						

APPENDIX C

Reliability
Scale: Stigma Perception Questionnaire

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.778	.783	10

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.478	-.484	1.040	1.523	-2.149	.089	10

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	21.1370	56.398	.207	.101	.786
VAR00002	22.4932	49.003	.465	.384	.757
VAR00003	22.9315	49.176	.536	.494	.748
VAR00004	22.8767	54.887	.205	.403	.791
VAR00005	22.8219	50.398	.547	.389	.748
VAR00006	22.9315	51.315	.435	.501	.761
VAR00007	22.8219	47.954	.706	.638	.729
VAR00008	22.3014	49.130	.424	.466	.764

VAR00009	22.4932	49.559	.570	.392	.745
VAR00010	22.3151	51.552	.436	.293	.761

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
25.0137	61.375	7.83421	10

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		441.899	72	6.137		
Within People	Between Items	193.567	9	21.507	15.819	.000
	Residual	881.033	648	1.360		
	Total	1074.600	657	1.636		
Total		1516.499	729	2.080		

Grand Mean = 2.5014

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.260[b]	.185	.357	4.514	72	648	.000
Average Measures	.778[c]	.694	.847	4.514	72	648	.000

APPENDIX D

Reliability

Scale: Health Disclosure Scale

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.728	.732	12

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.356	-.566	1.375	1.940	-2.430	.200	12

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	30.2877	59.930	.373	.459	.709
VAR00002	29.7671	63.820	.248	.473	.724
VAR00003	30.2877	59.069	.537	.479	.691

VAR00004	29.2192	70.618	-.087	.368	.761
VAR00005	30.8630	55.398	.690	.678	.669
VAR00006	31.0685	61.342	.384	.461	.708
VAR00007	30.9178	53.660	.657	.681	.667
VAR00008	29.5753	66.220	.077	.357	.749
VAR00009	30.4795	54.503	.571	.603	.678
VAR00010	30.7123	57.958	.491	.498	.693
VAR00011	30.6849	62.302	.337	.476	.714
VAR00012	30.1918	62.518	.187	.239	.739

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
33.0959	70.393	8.39008	12

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		422.361	72	5.866		
Within People	Between Items	263.653	11	23.968	15.034	.000
	Residual	1262.680	792	1.594		
	Total	1526.333	803	1.901		
Total		1948.694	875	2.227		

Grand Mean = 2.7580

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.183[b]	.123	.265	3.679	72	792	.000
Average Measures	.728[c]	.626	.812	3.679	72	792	.000

APPENDIX E

Reliability
Sexual Quality of Health

Scale: ALL VARIABLES

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.772	.771	18

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Item Means	3.128	2.603	3.425	.822	1.316	.055	18

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
Var001	53.21	145.471	.268	.474	.769
Var002	53.01	140.153	.500	.535	.751
Var003	52.92	144.410	.398	.668	.758
Var004	52.90	140.199	.513	.698	.750
Var005	52.97	142.860	.341	.651	.763
Var006	52.88	142.804	.403	.676	.758
Var007	52.99	147.430	.286	.577	.767
Var008	53.14	140.064	.486	.556	.751
Var009	53.16	146.028	.313	.486	.765
Var010	53.03	139.388	.484	.543	.751
Var011	53.07	138.842	.523	.642	.749
Var012	53.26	144.556	.356	.391	.761

Var013	53.44	148.250	.289	.436	.766
Var014	53.70	153.491	.165	.494	.774
Var015	53.47	151.975	.207	.525	.771
Var016	53.51	149.865	.251	.418	.769
Var017	53.32	145.802	.322	.414	.764
Var018	53.16	151.973	.162	.245	.775

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
56.30	160.630	12.674	18

APPENDIX F

Reliability
Scale: Psychological Wellbeing Scale

Case Processing Summary

		N	%
Cases	Valid	73	100.0
	Excluded[a]	0	.0
	Total	73	100.0

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.838	.838	18

Summary Item Statistics

	Mean	Minimum	Maximum	Range	Maximum / Minimum	Variance	N of Items
Inter-Item Covariances	.436	-.583	1.840	2.423	-3.154	.148	18
Inter-Item Correlations	.224	-.295	.711	1.006	-2.405	.034	18

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	58.5753	155.525	.327	.199	.835
VAR00002	58.4384	140.027	.719	.653	.814
VAR00003	58.2466	146.633	.625	.592	.821
VAR00004	58.7123	148.430	.492	.485	.827
VAR00005	59.0000	171.583	-.133	.250	.855
VAR00006	58.3288	135.640	.776	.733	.809
VAR00007	57.6712	157.335	.238	.229	.841
VAR0008	58.2055	156.332	.242	.363	.841
VAR0009	58.3151	148.802	.548	.439	.824

VAR00010	58.6575	143.173	.678	.599	.817
VAR00011	58.6986	157.825	.216	.266	.842
VAR00012	58.8630	154.620	.473	.443	.829
VAR00013	58.8219	153.010	.405	.447	.832
VAR00014	58.7808	153.257	.418	.421	.831
VAR00015	58.8767	150.387	.521	.425	.826
VAR00016	58.5890	154.051	.406	.306	.831
VAR00017	58.5616	151.472	.517	.400	.827
VAR00018	58.6575	156.617	.387	.426	.832

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
62.0000	168.722	12.98931	18

ANOVA

		Sum of Squares	df	Mean Square	F	Sig
Between People		674.889	72	9.373		
Within People	Between Items	124.636	17	7.332	4.833	.000
	Residual	1856.919	1224	1.517		
	Total	1981.556	1241	1.597		
Total		2656.444	1313	2.023		

Grand Mean = 3.4444

Intraclass Correlation Coefficient

	Intraclass Correlation[a]	95% Confidence Interval		F Test with True Value 0			
		Lower Bound	Upper Bound	Value	df1	df2	Sig
Single Measures	.223[b]	.164	.305	6.179	72	1224	.000
Average Measures	.838[c]	.779	.888	6.179	72	1224	.000

APPENDIX G

Frequencies

Age of the respondent

Statistics

Age of the respondent

N	Valid	183
	Missing	0
Mean		22.88
Std. Deviation		5.642
Kurtosis		27.413
Std. Error of Kurtosis		.357
Range		56
Minimum		14
Maximum		70
Sum		4187

Educational qualification

Statistics

Educational qualification

N	Valid	183
	Missing	0
Mean		2.40
Std. Deviation		1.441
Kurtosis		-1.925
Std. Error of Kurtosis		.357
Range		3
Minimum		1
Maximum		4
Sum		440

Educational qualification

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SSCE	88	48.1	48.1	48.1
	ND	12	6.6	6.6	54.6
	HND/DEGREE	4	2.2	2.2	56.8
	FSLC	79	43.2	43.2	100.0
	Total	183	100.0	100.0	

Religion of the respondent

Statistics

Religion of the respondent

N	Valid	183
	Missing	0
Mean		1.15
Std. Deviation		.376
Kurtosis		4.091
Std. Error of Kurtosis		.357
Range		2
Minimum		1
Maximum		3
Sum		211

Religion of the frespondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christian	156	85.2	85.2	85.2
	Muslim	26	14.2	14.2	99.5
	Others	1	.5	.5	100.0
	Total	183	100.0	100.0	

What is your civil status?

Statistics

What is your civil status?

N	Valid	183
	Missing	0
Mean		1.52
Std. Deviation		1.037
Kurtosis		2.588
Std. Error of Kurtosis		.357
Range		4
Minimum		1
Maximum		5
Sum		278

What is your civil status?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	136	74.3	74.3	74.3
	Single	23	12.6	12.6	86.9
	Divorced	3	1.6	1.6	88.5

In a relationship	18	9.8	9.8	98.4
Informal union	3	1.6	1.6	100.0
Total	183	100.0	100.0	

Number of surgeries

Statistics

Number of surgeries

N	Valid	183
	Missing	0
Mean		2.77
Std. Deviation		1.733
Kurtosis		1.622
Std. Error of Kurtosis		.357
Range		7
Minimum		1
Maximum		8
Sum		507

Number of surgeries

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	38	20.8	20.8	20.8
	2	67	36.6	36.6	57.4
	3	38	20.8	20.8	78.1
	4	13	7.1	7.1	85.2
	5	10	5.5	5.5	90.7
	6	6	3.3	3.3	94.0
	7	5	2.7	2.7	96.7
	8	6	3.3	3.3	100.0
	Total	183	100.0	100.0	

Type of fistula

Statistics

Type of fistula

N	Valid	183
	Missing	0
Mean		1.05
Std. Deviation		.263
Kurtosis		36.379
Std. Error of Kurtosis		.357
Range		2

Minimum	1
Maximum	3
Sum	192

Type of fistula

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	VVF	176	96.2	96.2	96.2
	RVF	5	2.7	2.7	98.9
	COMPLEX	2	1.1	1.1	100.0
	Total	183	100.0	100.0	

Where did you visit for your ante-natal care

Statistics

Where did you visit for your ante-natal care

N	Valid	183
	Missing	0
Mean		1.70
Std. Deviation		.671
Kurtosis		-.779
Std. Error of Kurtosis		.357
Range		2
Minimum		1
Maximum		3
Sum		312

Where did you visit for your ante-natal care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital/health centre	76	41.5	41.5	41.5
	Traditional birth attendant	85	46.4	46.4	88.0
	None	22	12.0	12.0	100.0
	Total	183	100.0	100.0	

What caused the problem requiring each of the repairs

Statistics

What caused the problem requiring each of the repairs

N	Valid	183
	Missing	0
Mean		1.98
Std. Deviation		.267
Kurtosis		11.332
Std. Error of Kurtosis		.357
Range		2
Minimum		1
Maximum		3
Sum		363

What caused the problem requiring each of the repairs

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Coital breakdown	8	4.4	4.4	4.4
	Obstructed labour	170	92.9	92.9	97.3
	Ianotropic/cancer	5	2.7	2.7	100.0
	Total	183	100.0	100.0	

Stigma perception questionnaire

Statistics

Stigma perception questionnaire

N	Valid	183
	Missing	0
Mean		27.13
Std. Deviation		8.465
Kurtosis		-.127
Std. Error of Kurtosis		.357
Range		39
Minimum		10
Maximum		49
Sum		4965

Health disclosure scale

Statistics

Health disclosure scale

N	Valid	183

	Missing	0
Mean		35.29
Std. Deviation		10.420
Kurtosis		-.873
Std. Error of Kurtosis		.357
Range		41
Minimum		14
Maximum		55
Sum		6458

Sexual quality of life questionnaire-female

Statistics

Sexual quality of life questionnaire-female

N	Valid	183
	Missing	0
Mean		45.81
Std. Deviation		13.541
Kurtosis		.448
Std. Error of Kurtosis		.357
Range		74
Minimum		18
Maximum		92
Sum		8384

Psychological well-being index.

Statistics

Psychological well-being index.

N	Valid	183
	Missing	0
Mean		56.04
Std. Deviation		21.238
Kurtosis		-1.214
Std. Error of Kurtosis		.357
Range		73
Minimum		27
Maximum		100
Sum		10256

Regression

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.350[a]	.123	.118	19.949	.123	25.294	1	181	.000
2	.505[b]	.255	.246	18.437	.132	31.902	1	180	.000
3	.601[c]	.361	.350	17.123	.106	29.685	1	179	.000

a. Predictors: (Constant), Stigma perception questionnaire

b. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale

c. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale, Sexual quality of life questionnaire-female

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	10065.598	1	10065.598	25.294	.000[b]
	Residual	72028.052	181	397.945		
	Total	82093.650	182			
2	Regression	20909.525	2	10454.763	30.757	.000[c]
	Residual	61184.125	180	339.912		
	Total	82093.650	182			
3	Regression	29612.776	3	9870.925	33.667	.000[d]
	Residual	52480.874	179	293.189		
	Total	82093.650	182			

a. Dependent Variable: Psychological well-being index.

b. Predictors: (Constant), Stigma perception questionnaire

c. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale

d. Predictors: (Constant), Stigma perception questionnaire, Health disclosure scale,

Sexual quality of life questionnaire-female

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	79.880	4.964		16.093	.000	70.086	89.674
	Stigma perception questionnaire	-.879	.175	-.350	-5.029	.000	-1.223	-.534
2	(Constant)	98.716	5.671		17.406	.000	87.525	109.907
	Stigma perception questionnaire	-.548	.172	-.218	-3.190	.002	-.887	-.209
	Health disclosure scale	-.788	.140	-.387	-5.648	.000	-1.063	-.513

3	(Constant)	63.024	8.406		7.498	.000	46.437	79.612
	Stigma perception questionnaire	-.483	.160	-.193	-3.022	.003	-.799	-.168
	Health disclosure scale	-.542	.137	-.266	-3.946	.000	-.812	-.271
	Sexual quality of life questionnaire-female	.551	.101	.351	5.448	.000	.351	.751

a. Dependent Variable: Psychological well-being index.

Excluded Variables[a]

Model		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics
						Tolerance
1	Health disclosure scale	-.387[b]	-5.648	.000	-.388	.884
	Sexual quality of life questionnaire-female	.435[b]	6.876	.000	.456	.964
2	Sexual quality of life questionnaire-female	.351[c]	5.448	.000	.377	.859

a. Dependent Variable: Psychological well-being index.

b. Predictors in the Model: (Constant), Stigma perception questionnaire

c. Predictors in the Model: (Constant), Stigma perception questionnaire, Health disclosure scale

Correlations

Correlations

		Stigma perception questionnaire	Health disclosure scale	Sexual quality of life questionnaire-female	Psychological well-being index.	Age of the respondent	Educational qualification	What is your civil status?	Religion of the frespondent	Lenght of time before each surgery
Stigma perception questionnaire	Pearson Correlation	1	.341**	-.190**	-.350**	-.196**	.099	-.008	-.041	-.020
	Sig. (2-tailed)		.000	.010	.000	.008	.181	.917	.583	.785
	N	183	183	183	183	183	183	183	183	183
Health disclosure scale	Pearson Correlation	.341**	1	-.369**	-.461**	-.257**	.077	-.087	-.059	-.177*
	Sig. (2-tailed)	.000		.000	.000	.000	.300	.243	.427	.016
	N	183	183	183	183	183	183	183	183	183

Sexual quality of life questionnaire-female	Pearson Correlation	-.190**	-.369**	1	.486**	.172*	-.031	.088	.150*	.067
	Sig. (2-tailed)	.010	.000		.000	.020	.677	.239	.042	.365
	N	183	183	183	183	183	183	183	183	183
Psychological well-being index.	Pearson Correlation	-.350**	-.461**	.486**	1	.291**	-.086	.019	.038	.364**
	Sig. (2-tailed)	.000	.000	.000		.000	.246	.802	.606	.000
	N	183	183	183	183	183	183	183	183	183
Age of the respondent	Pearson Correlation	-.196**	-.257**	.172*	.291**	1	-.012	-.029	-.061	.088
	Sig. (2-tailed)	.008	.000	.020	.000		.877	.700	.410	.238
	N	183	183	183	183	183	183	183	183	183
Educational qualification	Pearson Correlation	.099	.077	-.031	-.086	-.012	1	-.035	-.125	.051
	Sig. (2-tailed)	.181	.300	.677	.246	.877		.642	.092	.494
	N	183	183	183	183	183	183	183	183	183
What is your civil status?	Pearson Correlation	-.008	-.087	.088	.019	-.029	-.035	1	-.022	-.027
	Sig. (2-tailed)	.917	.243	.239	.802	.700	.642		.771	.715
	N	183	183	183	183	183	183	183	183	183
Religion of the frespondent	Pearson Correlation	-.041	-.059	.150*	.038	-.061	-.125	-.022	1	-.066
	Sig. (2-tailed)	.583	.427	.042	.606	.410	.092	.771		.374
	N	183	183	183	183	183	183	183	183	183
Lenght of time before each surgery	Pearson Correlation	-.020	-.177*	.067	.364**	.088	.051	-.027	-.066	1
	Sig. (2-tailed)	.785	.016	.365	.000	.238	.494	.715	.374	
	N	183	183	183	183	183	183	183	183	183

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

*. Correlation is significant at the 0.05 level (2-tailed).