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EMOTIONAL INTELLIGENCE AND PSYCHOSOCIAL SUPPORT AS PREDICTORS OF QUALITY OF LIFE AMONG PERSONS LIVING WITH HIV/AIDS

EMOTIONAL INTELLIGENCE AND PSYCHOSOCIAL SUPPORT AS PREDICTORS OF QUALITY OF LIFE AMONG PERSONS LIVING WITH HIV/AIDS

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Abstract

The study adopted a correlational research design to examine emotional intelligence and social support as predictors of quality of life among persons living with HIV/AIDS (PLHIV) at the Federal Medical Centre, Keffi, Nigeria. Seventy participants were purposively drawn from a population of 100 persons living with HIV/AIDS. Three instruments were used to elicit responses from participants on quality of life, social support, and emotional intelligence. Three hypotheses were tested using inferential statistics, Pearson product-moment correlation, and multiple regression analysis. The result of the first hypothesis indicated that there was a statistically significant relationship between social support and quality of life, $r(68) = 0.433$, $p < .01$. The result of the second hypothesis showed that there was a statistically significant relationship between emotional intelligence and quality of life, $r(68) = 0.271$, $p < .05$. The third hypothesis revealed that emotional intelligence and social support jointly predicted quality of life ($r = .444$; $F = 8.237$, $p < .01$), accounting for about 19.7% of the variance in quality of life among persons living with HIV/AIDS. Independently, social support (beta = .387; $t = 3.219$, $p < .01$) significantly predicted quality of life, whereas emotional intelligence (beta = .110; $t = .914$, $p > .05$) did not significantly predict the quality of life of persons living with HIV/AIDS. By implication, emotional intelligence and social support as predictors of quality of life among PLHIV require adequate social support and emotional intelligence to enable them live fulfilling lives. It is therefore recommended that family, friends, and social organizations should endeavor to support PLHIV, as such support will improve their quality of life and, in essence, encourage productive and fulfilling living.

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HIV/AIDS. Three instruments were used to elicit responses from participants on quality of life, social support, and emotional intelligence. Three hypotheses were tested using inferential statistics, Pearson product-moment correlation, and multiple regression analysis. The result of the first hypothesis indicated that there was a statistically significant relationship between social support and quality of life, $r(68) = 0.433$, $p < .01$*. The result of the second hypothesis showed that there was a statistically significant relationship between emotional intelligence and quality of life,* $r(68) = 0.271$, $p < .05$*. The third hypothesis revealed that emotional intelligence and social support jointly predicted quality of life (*$r = .444$; $F = 8.237$, $p < .01$*), accounting for about 19.7% of the variance in quality of life among persons living with HIV/AIDS. Independently, social support (beta = .387;* $t = 3.219$, $p < .01$*) significantly predicted quality of life, whereas emotional intelligence (beta = .110;* $t = .914$, $p > .05$*) did not significantly predict the quality of life of persons living with HIV/AIDS. By implication, emotional intelligence and social support as predictors of quality of life among PLHIV require adequate social support and emotional intelligence to enable them live fulfilling lives. It is therefore recommended that family, friends, and social organizations should endeavor to support PLHIV, as such support will improve their quality of life and, in essence, encourage productive and fulfilling living.*

Keywords: Emotional Intelligence, Psychosocial Support, Quality of Life, HIV/AIDS, PLHIV

Keywords:

Introduction

The health of individuals has long been a central concern in both medical and behavioral sciences, with increasing attention devoted to understanding overall human well-being across physical, psychological, and social domains. Consequently, numerous studies conducted in both Western countries and Africa have sought to explain the causes, progression, and outcomes of diseases, infections, and their implications for quality of life. Central to these investigations is the concept of health-related quality of life (QOL), which reflects an individual's level of functioning and well-being as influenced by their health status across physical, psychological, and social dimensions.

Globally, several life-threatening diseases and infections continue to pose significant risks to human well-being, often resulting in prolonged illness or death. These include hepatitis, tuberculosis, cancer, and HIV/AIDS, among others. While some of these conditions are curable, others are chronic and require long-term management. Regardless of their nature, such diseases significantly impair individuals' physical, psychological, and social functioning, thereby adversely affecting their overall quality of life (Benito-Leone et al., 2011).

Among these conditions, HIV/AIDS remains particularly significant due to its complex biomedical and psychosocial implications. HIV (Human Immunodeficiency Virus) leads to the development of AIDS (Acquired Immune Deficiency Syndrome), a condition characterized by severe immune system compromise caused by HIV-1 and HIV-2 (Mediciment, 2017). As the immune system weakens, individuals become highly susceptible to opportunistic infections such as tuberculosis, bacterial pneumonia, human herpes virus, toxoplasmosis, and certain cancers including Kaposi sarcoma.

Beyond its physiological effects, HIV/AIDS exerts profound psychological and social consequences on affected individuals. Persons living with HIV/AIDS (PLHIV) often experience challenges in their daily lives across home, workplace, and societal contexts. Disclosure of HIV status is frequently associated with feelings of loneliness, hopelessness, stress, and anxiety, largely due to stigma and discrimination. These experiences may also lead to fear of social isolation, relationship breakdown, and job loss, all of which further diminish psychological well-being and overall quality of life. In this regard, social support emerges as a critical factor in mitigating these negative outcomes.

Social support has been widely recognized as a protective mechanism that enhances psychological well-being and improves quality of life among individuals with chronic illnesses. It encompasses the assistance, care, and protection provided through social relationships and interactions (Greenberger & Don, 2000). Key sources of social support include family, friends, and peers, particularly during periods of crisis and emotional distress (Crystal & Kersting, 1998). Empirical evidence suggests that strong social support systems play a vital role in reducing psychological distress and enhancing quality of life among PLHIV (Rueda, 2011; Shafique et al., 2018). Furthermore, different forms of support, including emotional, tangible, and informational support, contribute to well-being, with emotionally sustaining support often reported as the most impactful (Basavaraj et al., 2010).

In addition to social support, emotional intelligence has been identified as an important psychological resource that influences how individuals cope with health-related challenges. According to Mayer and Salovey (1997), emotional intelligence comprises four key components: emotional perception, emotional facilitation of thinking, emotional understanding, and emotional regulation. These competencies enable individuals to effectively manage their emotions, adapt to stressful situations, and maintain psychological stability. Consequently, emotional intelligence has been increasingly examined in relation to patients with chronic health conditions, including HIV/AIDS, to better understand variations in coping, adjustment, and overall quality of life.

The concept of quality of life itself is multidimensional and has been extensively defined within the health literature. The World Health Organization Quality of Life (WHOQOL) Group conceptualizes QOL as individuals' perceptions of their position in life within the context of their culture, value systems, goals, expectations, and concerns. It encompasses physical health, psychological state, level of independence, social relationships, personal beliefs, and environmental factors. Similarly, quality of life has been associated with health status, functional ability, psychological well-being, life satisfaction, and the fulfillment of personal needs (Fatiregun et al., 2009). In the context of HIV/AIDS, assessment of QOL has become an essential outcome measure, reflecting both the effectiveness of treatment and the overall well-being of affected individuals (Basavaraj et al., 2010).

Statement of Problem

Many persons living with HIV (PLHIV) experience multiple social and psychological challenges, including stigma, poverty, depression, substance abuse, and culturally rooted beliefs, all of which significantly undermine their quality of life (QOL). These challenges affect not only their physical health, but also their mental and social well-being, thereby limiting their ability to engage in meaningful daily activities and sustain productive lives (Armoon et al., 2022). Despite the multidimensional nature of these challenges, the concept of suffering in illness has not received sufficient systematic scholarly attention. This is partly because suffering is often perceived as a matter of common sense, possessing an air of self-evidence that discourages deeper analytical exploration (Aranda-Naranjo, 2004).

Beyond individual suffering, social factors play a critical role in health outcomes. A substantial body of literature suggests that individuals with limited social networks are at a higher risk of adverse health outcomes, including increased mortality. Early sociological work established a connection between social integration and suicide risk (Durkheim, 1951), and subsequent studies have expanded this understanding by demonstrating the significant influence of social support on a wide range of health outcomes over time. This growing body of evidence highlights the importance of social relationships in shaping both psychological well-being and survival.

The relevance of these issues is further underscored by the persistent global burden of HIV. As of 2023, approximately 39 million people were living with HIV worldwide, with 1.3 million new infections and about 630,000 AIDS-related deaths recorded within the same year, particularly in sub-Saharan Africa, which remains the most affected region (UNAIDS, 2024). While biomedical advancements have improved survival rates, the psychosocial dimensions of living with HIV continue to pose significant challenges.

However, empirical understanding of HIV progression and lived experiences within African contexts remains relatively limited. This is partly due to the methodological demands of studying the natural history of HIV infection, which requires large cohorts, repeated biological sampling to determine seroconversion, and long-term follow-up over several years (Jaffar et al., 2004). As a result, more nuanced psychosocial variables that influence adaptation and well-being among PLHIV have not been sufficiently explored.

In response to this gap, recent research has increasingly focused on emotional competencies, particularly emotional intelligence, as critical protective factors. Emotional intelligence has been shown to enhance individuals' ability to cope with stress, anxiety, and depression, while also promoting positive psychological well-being (Salovey & Mayer, 1990). This is particularly relevant in the context of chronic illnesses such as HIV, where individuals often experience persistent negative emotions that can impair adaptation and increase psychological distress (Basi?ska & Wo?niewicz, 2012).

Despite these insights, there is a noticeable scarcity of research within the Nigerian context examining how emotional intelligence and social support interact to influence the well-being of PLHIV. Furthermore, the role of psychological interventions in the management of HIV remains underexplored and underutilized in

Nigeria. This gap limits the development of comprehensive care strategies that address not only the biomedical but also the psychosocial needs of affected individuals.

Therefore, this study is carried out to examine the role of emotional intelligence and social support in shaping the quality of life of persons living with HIV in Nigeria. By doing so, it seeks to contribute to the existing body of knowledge and provide empirical evidence that can inform more holistic and psychologically grounded interventions for improving the well-being of PLHIV.

Research Questions

What will be the relationship between social support and quality of life of persons living with HIV/AIDS at the Federal Medical Centre, Keffi?

What is the relationship between emotional intelligence and quality of life of persons living with HIV/AIDS at the Federal Medical Centre, Keffi?

To what extent will social support and emotional intelligence predict the quality of life of persons living with HIV/AIDS at the Federal Medical Centre, Keffi?

Hypotheses

There will be a significant relationship between social support and quality of life of persons living with HIV/AIDS.

There will be a significant relationship between emotional intelligence and quality of life of persons living with HIV/AIDS.

Emotional intelligence and social support will jointly predict the quality of life of persons living with HIV/AIDS.

Research Methodology

Design

The research design adopted in this study was a correlational research design. This design was adopted because the study aimed to examine the relationship among emotional intelligence, social support, and quality of life among persons living with HIV/AIDS.

Population, Sample and Sampling Techniques

The population from which participants were drawn was the Federal Medical Centre, Keffi, Nasarawa State. One hundred participants were purposively selected based on predetermined criteria for selection.

Table 1 presents the frequency and percentages of the characteristics of 70 PLHIV (male = 35 and female = 35); age ranged between 20 and 64 years with a mean age of 40.19 and SD = 9.324. Age was also categorized as follows: 20-30 years (N = 12, 17.1%), 31-40 years (N = 27, 38.6%), 41-50 years (N = 20, 28.6%), and above 50 years (N = 11, 15.7%). Marital status: single (N = 35, 35.7%), married (N = 39, 55.7%), and widow/widower (N = 6, 8.6%). Educational qualification: SSCE (N = 11, 15.7%), ND/NCE (N = 35, 50.0%), and BSc/HND (N = 24, 34.3%).

Variables	Category	Frequency	Percentages
Gender	Male	35	50.0
Female	35	50.0	
Total	70	100%	
Age	20-30 years	12	17.1
31-40 years	27	38.6	
41-50 years	20	28.6	
Above 50 years	11	15.7	
Total	70	100%	
Marital Status	Single	25	35.7
Married	39	55.7	
Widow/Widower	6	8.6	
Total	70	100%	
Educational Qualification	SSCE	11	15.7
ND/NCE	35	50.0	
BSc/HND	24	34.3	
Total	70	100%	

Out of the 100 participants who received the test instruments, 70 participants correctly filled out and returned their instruments for analysis and so represented the final sample used for the study. Criteria for participation included: (1) participants must be PLHIV who had tested positive for HIV/AIDS; (2) participants must be above 18 years and below 64 years of age; (3) participants must be Nigerian; (4) participants must be able to read, write, and comprehend English; and (5) participants must have lived with HIV/AIDS for 2 to 10 years. The sample for this study constituted 35 males and 35 females. All participants were married or unmarried PLHIV who regularly received treatment from the Anti-Retroviral Treatment Department of the Federal Medical Centre, Keffi.

Methods of Data Collection

The research adopted the use of questionnaires to collect data from participants. Section A contained the demographic information of the respondents, which included gender, age, marital status, and educational qualifications. The questionnaires used are explained as follows:

Schutte Self-Report Emotional Intelligence Test (SSEIT)

Schutte Self-Report Emotional Intelligence Test (SSEIT) was developed by Schutte et al. (1998). The Schutte Self-Report Emotional Intelligence Test (SSEIT) is a method of measuring general emotional intelligence (EI) using four subscales: emotion perception, utilizing emotions, managing self-relevant emotions, and managing others' emotions. The SSEIT is structured on the EI model by Salovey and Mayer (1990). The SSEIT model is closely associated with the EQ-I model of emotional intelligence. The SSEIT includes a 33-item self-report measure using a 1 (strongly agree) to 5 (strongly disagree) scale for responses. Each subtest score is graded and then added together to give the total score for the participant. Schutte and her colleagues reported a reliability rating of 0.90 for their emotional intelligence scale. The present study established a reliability coefficient of 0.887 for the Schutte Self-Report Emotional Intelligence Test (SSEIT). The scale was found useful for the present study.

Multidimensional Scale of Perceived Social Support Scale (MSPSS)

The Multidimensional Scale of Perceived Social Support Scale (MSPSS) was developed by Zimet (2016). The scale adopted a 7-point Likert response format ranging from very strongly disagree to very strongly agree. Examples of the items on the scale include: "There is a special person who is around when I am in need," "There is a special person with whom I can share joys and sorrows," "My family really tries to help me," "I get the emotional help and support I need from my family," and "I have a special person who is a real source of comfort to me." Scoring information: To calculate mean scores-Significant Other Subscale: sum across items 1, 2, 5, and 10, then divide by 4. Family Subscale: sum across items 3, 4, 8, and 11, then divide by 4. Friends Subscale: sum across items 6, 7, 9, and 12, then divide by 4. Total Scale: sum across all 12 items, then divide by 12. The present study yielded a Cronbach reliability coefficient of .618, which was found useful for the study.

World Health Organization Quality of Life (WHOQOL)-BREF

The World Health Organization Quality of Life (WHOQOL)-BREF (2004) was developed by the World Health Organization. WHOQOL is a 26-item questionnaire with a 5-point Likert-type response style. The WHOQOL-BREF is an abbreviated 26-item version of the WHOQOL-100 containing items that were extracted from the WHOQOL-100 field trial data. The WHOQOL-BREF contains one item from each of the 24 facets of QOL included in the WHOQOL-100, plus two benchmark items from the general facet on overall QOL and general health (not included in the scoring). WHOQOL-BREF contains four domains: Domain 1, Physical Health; Domain 2, Psychological; Domain 3, Social Relations; and Domain 4, Environment. Skevington, Lotfy, and O'Connell (2004), in their study, established the discriminant validity and Cronbach reliability for Domains 1, 2, and 4, that is, physical health = 0.82, psychological = 0.81, and environment = 0.80, but marginal for social relationships = 0.68. Across sites, results were consistently high with most of the alphas in Domains 1 and 2 above 0.75, in the range of 0.51-0.77 for Domain 3, and 0.65-0.87 for Domain 4. A pilot study was conducted to establish the reliability coefficient of the Quality of Life Scale. Factor analysis was conducted and the items were reduced to 24 items as against the original 26 items. This was because the two deleted items generated weak responses and were therefore removed. The reliability coefficient generated was .642. This was considered reliable.

Procedure

The researcher obtained an introductory letter from the Department of Psychology, Nasarawa State University, to secure approval from the Ethical Board Committee of the Federal Medical Centre, Keffi, to collect data for the research. After approval was obtained from the Board, the researcher proceeded to the ART Clinic. The participants were informed of the purpose of the study, and all three instruments (WHOQOL-BREF, SSEIT, and MSPSS) were administered by the researcher to willing participants who met all criteria for participation. The approximate time for completion of all three questionnaires was 20 minutes. All responses were treated confidentially and in accordance with other stipulated ethical considerations.

All returned instruments that were correctly filled out were subjected to appropriate statistical analysis and are presented in the next chapter.

Ethical Considerations

Ethical approval was obtained from the FMCK Research Ethics Committee. The researcher adhered to ethical principles in the course of the research. First, the researcher introduced the aims of the study and made a formal request to the participants to take part in the study to enable the research achieve its objectives. The researcher noted that some participants raised pertinent concerns regarding providing information after perusing the scales. Specifically, statements such as "I hope this work will not implicate me?" and "I don't want my name written" were among the issues the researcher had to address. Participants were informed that all information provided would be used strictly for research purposes only, and their liberty to withdraw from the study at any time was assured without penalty. Participants were also assured of confidentiality regarding their involvement in the research.

Results

Demographic Information

This section describes the distinct characteristics of the participants. They are presented in the tables below:

Variables	Category	Frequency	Percentages

Gender	Male	35	50.0
Female	35	50.0	
Total	70	100%	
Age	20-30 years	12	17.1
31-40 years	27	38.6	
41-50 years	20	28.6	
Above 50 years	11	15.7	
Total	70	100%	
Marital Status	Single	25	35.7
Married	39	55.7	
Widow/Widower	6	8.6	
Total	70	100%	
Educational Qualification	SSCE	11	15.7
ND/NCE	35	50.0	
BSc/HND	24	34.3	
Total	70	100%	

Table 1 presents the frequency and percentages of the characteristics of 70 PLHIV (male = 35 and female = 35); age ranged between 20 and 64 years with a mean age of 40.19 and SD = 9.324. Age was also categorized as follows: 20-30 years (N = 12, 17.1%), 31-40 years (N = 27, 38.6%), 41-50 years (N = 20, 28.6%), and above 50 years (N = 11, 15.7%). Marital status: single (N = 25, 35.7%), married (N = 39, 55.7%), and widow/widower (N = 6, 8.6%). Educational qualification: SSCE (N = 11, 15.7%), ND/NCE (N = 35, 50.0%), and BSc/HND (N = 24, 34.3%).

Duration	**Frequency**	**Percentages**
2-5 years	19	27.1
6-10 years	32	45.7
Above 10 years	19	27.1
Total	70	100.0

Table 2 shows the duration of illness among PLHIV in the study. The results revealed that PLHIV between 2 and 5 years (N = 19, 27.1%), 6 and 10 years (N = 32, 45.7%), and above 10 years (N = 19, 27.1%). This implies that the majority of the PLHIV have lived with this illness for the past 9 years on average.

Gender	Statistic	Quality of Life	Emotional Intelligence	Social Support
Male	Mean	47.23	64.94	51.69
N	35	35	35	
Std. Deviation	4.525	12.424	7.824	
Female	Mean	47.29	64.29	47.80
N	35	35	35	
Std. Deviation	7.168	13.575	9.019	
Total	Mean	47.26	64.61	49.74
N	70	70	70	
Std. Deviation	5.951	12.921	8.607	

Table 3 shows the indexes for interpreting quality of life, emotional intelligence, and social support between male and female PLHIV in the study. The results revealed the index for quality of life is 47.26, emotional intelligence is 64.61, and social support is 49.74. However, male mean scores are 47.23, 64.94, and 51.69 respectively; these indicated that males have high emotional intelligence and adequate social support but moderate quality of life, while female mean scores are 47.29, 64.29, and 47.80 respectively. These indicated that the females have moderate quality of life, low emotional intelligence, and inadequate social support.

Educational Qualification	Statistic	Quality of Life	Emotional Intelligence	Social Support
SSCE	Mean	46.55	60.64	50.09
N	11	11	11	
Std. Deviation	4.947	6.932	7.943	
ND/NCE	Mean	48.14	62.51	48.77
N	35	35	35	
Std. Deviation	5.857	13.367	6.440	
BSc/HND	Mean	46.29	69.50	51.00
N	24	24	24	

Std. Deviation	6.517	13.293	11.417	
Total	Mean	47.26	64.61	49.74
N	70	70	70	
Std. Deviation	5.951	12.921	8.607	

Table 4 shows the indexes for interpreting quality of life, emotional intelligence, and social support between educational qualifications of PLHIV in the study. The results revealed the index for quality of life is 47.26, emotional intelligence is 64.61, and social support is 49.74. PLHIV with SSCE have mean scores of 46.55, 60.64, and 50.09 respectively; these indicated that PLHIV with secondary school qualification had adequate perceived social support but experienced low quality of life and emotional intelligence. PLHIV with ND/NCE qualifications have mean scores of 48.14, 62.51, and 48.77 respectively; it indicated that these PLHIV had high quality of life, low emotional intelligence, and inadequate perceived social support, while PLHIV with BSc/HND qualification have mean scores of 46.29, 69.50, and 51.00 respectively; this indicated that PLHIV had high emotional intelligence and adequate social support but were low in quality of life.

Test of Hypotheses

Hypothesis one stated that there will be a significant relationship between social support and quality of life in PLHIV. This hypothesis was tested with Pearson product-moment correlation in Table 5.

Variables	**M**	**SD**	**df**	**r**	**Sig.**
Social Support	49.74	8.607	68	0.433	0.000
Quality of Life	47.26	5.951			

r(68) = 0.433, p < .01

r

p

Table 5 shows the summary results of the Pearson correlation between social support and quality of life of patients with HIV/AIDS. The results revealed that social support (M = 49.74, SD = 8.607) and quality of life (M = 47.26, SD = 5.951). Furthermore, the result revealed a statistically significant relationship, r(68) = 0.433, p < .01, between social support and quality of life, indicating a moderately positive relationship. In other words, the hypothesis was confirmed in the study.

r

p

Hypothesis two stated that there will be a significant relationship between emotional intelligence and quality of life in PLHIV. This hypothesis was tested with Pearson product-moment correlation in Table 6.

Variables	**M**	**SD**	**df**	**r**	**Sig.**
Emotional Intelligence	64.61	12.921	68	0.271	0.023
Quality of Life	47.26	5.951			

$r(68) = 0.271, p < .05$

r

p

Table 6 presents the summary results of the Pearson correlation between emotional intelligence and quality of life of patients with HIV/AIDS. The results revealed that emotional intelligence (M = 64.61, SD = 12.921) and quality of life (M = 47.26, SD = 5.951). Furthermore, the result revealed a statistically significant relationship, $r(68) = 0.271, p < .05$, between emotional intelligence and quality of life, indicating a weak positive relationship. In other words, the hypothesis was confirmed in the study.

r

p

Hypothesis three stated that emotional intelligence and social support will jointly predict quality of life of PLHIV. This hypothesis was tested with multiple regression analysis in Tables 7 and 8.

Variables	**Quality of Life**	**Emotional Intelligence**	**Social Support**
Quality of Life	1		
Emotional Intelligence	.271*	1	
Social Support	.433**	.415**	1

Sig. Level: $*p < .05$ $**p < .01$

p

p

Table 7 shows the inter-correlational analysis to examine the extent to which emotional intelligence, social support, and quality of life were interrelated. The summary of the inter-correlation revealed that quality of life was significantly related with emotional intelligence ($r = .271, p < .05$) and social support ($r = .433, p < .01$). Also, the result indicated a significant relationship between the mediating elements, emotional intelligence and social support ($r = .415, p < .01$). This implies that the model of quality of life is measured by the significant interplay of emotional intelligence and social support strategies.

r

p

r

p

r

p

Furthermore, the analysis in Table 8 revealed that the combination of the predictor variables (emotional intelligence and social support) jointly predicted quality of life (R = .444, F = 8.237, p < .01) and accounted for about 19.7% variance in quality of life among PLHIV. Independently, social support (beta = .387, t = 3.219, p < .01) significantly predicted quality of life, while emotional intelligence (beta = .110, t = .914, p > .05) did not predict quality of life in PLHIV. See Appendix II for the histogram. On the basis of the joint influence, the hypothesis was confirmed in the study.

R

F

p

t

p

t

p

Variables	beta	t	R	R2	F
Emotional Intelligence	.110	.914	.444	.197	8.237**
Social Support	.387	3.219**			

Sig. Level: *p < .05, **p < .01 (df = 2, 67)

p

p

df

Summary of Results

The results in this study were summarized as follows:

The results revealed that the majority of the participants were found to have been living with HIV/AIDS for the past nine years on average.

Both male and female participants had a moderate level of quality of life but differed in their level of emotional intelligence as well as their perceived social support.

The study found that one's level of education influences quality of life. Also, emotional intelligence is high among clients with a higher educational level.

There is a significant positive relationship between social support and quality of life in clients with HIV/AIDS. This hypothesis was confirmed.

There is a significant positive relationship between emotional intelligence and quality of life in persons living with HIV/AIDS. This hypothesis was confirmed.

The study found that emotional intelligence and social support significantly inter-correlated with quality of life of persons living with HIV/AIDS.

The result confirmed the third hypothesis and concluded that emotional intelligence and social support jointly predicted the quality of life of persons living with HIV/AIDS.

Discussion

The present study investigated social support and emotional support as predictors of quality of life of persons living with HIV/AIDS. Three research hypotheses were tested. The first hypothesis, which stated that there will be a significant relationship between social support and quality of life of persons living with HIV/AIDS, was confirmed. The result showed a statistically significant relationship between social support and quality of life, with an indication of a moderately positive relationship. This finding is consistent with previous studies such as Mohammad (2020), Parveen et al. (2019), Shafique et al. (2018), and Ansah (2017), whose research indicated that social support or perceived social support influences quality of life. This explains that the lower the social support or the poorer the perceived social support, the poorer or lower the quality of life.

The second hypothesis stated that there will be a significant relationship between emotional intelligence and quality of life of persons living with HIV/AIDS. This hypothesis was confirmed in this study and further revealed a statistically significant positive relationship between emotional intelligence and quality of life among persons living with HIV/AIDS. The finding was related to the findings of Mirzaei et al. (2018), Al-Huwailah (2017), Anjum and Swathi (2017), Shahnavazi et al. (2016), Kolade (2015), Ugoani (2015), and Ogoemeka (2013), whose reports stated that emotional intelligence has a significant relationship with quality of life among students' academic achievement, patients' health, and adolescents' personality.

The third hypothesis stated that emotional intelligence and social support will jointly predict quality of life of persons living with HIV/AIDS. The result was confirmed using the inter-correlational matrix on quality of life, which showed that emotional intelligence and social support of the PLHIV are positively related to quality of life in the study. This result of the present study was in tune with the findings of Zysberg and

Zisberg (2020), Rakizadeh and Hafezi (2016), Kolade and Dennis (2015), and Gallagher and Vella-Brodrick (2008), which confirmed in their research that social support or perceived social support and emotional intelligence significantly have a joint relationship with worries, quality of life, life satisfaction, and subjective well-being, respectively.

Conclusion

The study concludes that persons living with HIV/AIDS should be provided with consistent emotional and psychosocial support from family members, friends, caregivers, and hospital-based psychological service units. Such comprehensive support systems are essential for enhancing their coping capacity, reducing psychological distress, and ultimately improving their overall quality of life.

Recommendations

Findings from this study indicate that persons living with HIV/AIDS are partly influenced by perceived stigma, and certain coping strategies significantly predict their quality of life. In view of this, it is recommended that maladaptive coping strategies be discouraged, while adaptive coping mechanisms should be strengthened through counselling and psychological interventions.

Intervention programmes should focus on reducing stigma and improving coping capacity among persons living with HIV/AIDS. This can be achieved through targeted health education for both the general public and PLHIV, aimed at promoting acceptance, awareness, and long-term improvement in quality of life.

Given the limited availability of structured psychological care within many Nigerian hospital settings, there is a need for the integration of professional psychological services into HIV/AIDS treatment units. This will ensure that the psychosocial needs of PLHIV are adequately addressed alongside their medical care.

All individuals diagnosed with HIV/AIDS should be routinely provided with psychological support services, including counselling and emotional care, as part of a comprehensive treatment approach to enhance their overall well-being and quality of life.

Limitations of the Study

Like most empirical studies, this research is not without limitations. First, the study was constrained by time, which limited the extent of data collection and depth of engagement with participants. Second, the sample size was relatively limited, which may affect the generalizability of the findings to a broader population of persons living with HIV/AIDS beyond the study setting.

In addition, the study adopted a cross-sectional and correlational design; therefore, the findings are based on associations among variables and do not establish cause-and-effect relationships between emotional intelligence, psychosocial support, and quality of life.

Suggestion for Further Studies

Based on the findings of this study, it is recommended that future researchers employ larger sample sizes in order to enhance the generalizability and external validity of their results, as well as improve the applicability of findings across broader populations.

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