

UNREALISTIC OPTIMISM TOWARD AIDS AND MEDIA
DEPENDENCY: AN EMPIRICAL STUDY BETWEEN
KOREAN AND KENYAN UNIVERSITY
STUDENTS

By

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A

THESIS

Submitted to

Chosun University

In partial fulfillment of the requirements

For the degree of

MASTER OF ARTS

Journalism and Communications Department

College of Humanities and Social Sciences

December 2005

UNREALISTIC OPTIMISM TOWARD AIDS AND MEDIA
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이 논문을 신문방송학 석사 학위신청 논문으로
제출함

2005년 10월 일

조선대학교대학원

신문방송학과
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석사학위논문을 인준함

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위 원 조선대학교 교수 _____

2005년 11월 일

조선대학교대학원

ABSTRACT

UNREALISTIC OPTIMISM TOWARD AIDS AND MEDIA DEPENDENCY: AN EMPIRICAL STUDY BETWEEN KOREAN AND KENYAN UNIVERSITY STUDENTS

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Unrealistic Optimism (Optimistic Bias) is the belief that one is more prepared or at a lesser risk than another person. We are naturally inclined to think that we don't deserve to face the worst even when it is eminent that we will suffer unless we move away from the impending danger. AIDS is a catastrophic disease that sends shrieks of fear to many due to its incurable nature. Various studies have been done on the relationship between AIDS and optimistic bias.

In this paper, the focus is on the comparison of optimistic bias towards AIDS and to evaluate how media influences the level of unrealistic optimism. The analysis is based on Kenyan university students (N=253) and Korean university students (N=353). The uniqueness of the spread of AIDS in these two countries and the information gap were considered as good factors for analytical research.

In this study, social-psychological factors are measured to evaluate the perception of an individual and his place in the society. Variables self respect, personal involvement and social involvement are

used to measure the degree of social-psychological placement in the society. The result is compared with the level of optimistic bias among the two samples.

This study approaches the effect of media in formation of unrealistic optimism through two variables namely, media usage and media dependency. Results showed that there is a correlation between pattern of media usage and the level of optimistic bias in the two samples.

The findings of this study reveal a correlation between media dependency for information about HIV and the level of optimistic bias. The results depict that Kenyan university students have more optimistic bias than Korean students. This study further finds out that there is a relationship between high dependency, low dependency and optimistic bias.

ACKNOWLEDGEMENTS

My sincere gratitude goes to my senior advisor Professor Yang-ho, Choi for his guidance not only in this research but throughout my graduate studies in Chosun University. I could not have completed this research without the immense input in form core ideas and advice on statistical analysis facilitated by my associate advisor Professor Bong-chul, Kim. From these two honorable professors, I have learned to love academic areas I previously dreaded especially statistics.

I am greatly indebted to the other member of my thesis committee, Professor Seong-jae, Kim. Thanks to Professors Dong-geun, Lee and Sun-hee, Park for their guidance and worthy instructions. I could not have made it if the officers at the graduate school administration office were not patient enough especially when I came across language barrier.

I extend my heart-felt acknowledgement to all members of Chosun University family who have had direct or indirect influence in my academic endeavor here. Special thanks to the reporters of the Chosun World for being very close friends. Last but not the least; I extend my special appreciation to God and my family. Mom, I could not have made it without your daily prayers.

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CHAPTER 1

INTRODUCTION

One of the major risks that worry people a lot is the possibility of getting a deadly disease. Due to this, almost everyone tries to be at least prepared to handle the consequences that come with the risk. However, human tendency leads one to lean towards the belief that he/she is less vulnerable than another person. Weinstein (1980) states that people expect others to be victims of misfortunes, not themselves. Such ideas imply not merely a hopeful outlook on life, but an error in judgment that can be labeled unrealistic optimism. While susceptibility to negative events is considered less possible, people believe that positive events are much likely to happen to them.

The higher the risk, the higher the level of unrealistic optimism. Another factor that plays a very important role is the cultural orientation. The location of an individual and his cultural disposition are vital the way risks are perceived. A person's cognition, emotion, and motivation are developed in accordance with one's cultural setting (Markus, & Kitayama, 1991; Markus, & Warf, 1987).

Taylor and Brown (1988) argue that unrealistic optimism is a type positive illusion that is associated with mental well-being. They argue that positively

biased view of one's future carries a variety of benefits such as self-reports of happiness and contentment, increased motivation and persistence, and ultimately better performance and greater success.

This illusory 'shield' is particularly strong if the perceived risk is expected to bring adverse effects in the long run (Kirch, Haefner, Kegeles, & Rosenstock, 1966; Perloff, 1983; Perloff and Fetzer, 1986; Weinstein, 1982, 1984). In a further study, Weinstein (1987) found out that this illusion is consistent across age and social economic class.

In their study on self-enhancing tendencies, Taylor and Brown (1988) listed three distinct domains of self-enhancing biases namely: overly positive views of the self, illusions of control, and unrealistic optimism. In cross-cultural studies, these can be used to determine the degree of risk perception across the examined cultures.

Though on a different perspective, Miller & Ross (1975) called these biases 'information-processing errors'. Other scholars, (Kunda, 1987, 1990; Taylor & Brown, 1988) observed that they are self-protective tactics that serve to bolster the individual's subjective well-being.

Cultural psychology maintains that the self is born of the interaction

between the person and a set of culturally derived beliefs, values, institutions, customs, and practices (Fiske, Kitayama, Markus, & Nisbett, 1997; Greenfield, 1997; Shweder, 1990). The self and attendant psychological structures and processes are thus supported by a web of cultural meanings, and likewise, the interaction of individual selves creates and sustains the cultural environment. In this way, culture and self are seen to make each other up (Shweder, 1990).

Hofstede (1980, 1983, 1991) argued that there were four major dimensions that could be used to classify societies according to their cultural attributes: collectivism-individualism, power-distance, masculinity-femininity, and uncertainty-avoidance. The most important of these was the first, and it has generated a plethora of research studies. Hofstede (1980) claimed that collectivism and individualism were two poles of the one dimension, and western countries such as those in Western Europe, North America, Australia and New Zealand can be categorized as individualistic societies whereas societies from Africa, Middle East (excluding Israel), East Asia and South America can be categorized as collectivist societies (Hofstede 1980, 1991). Hofstede (1980) also found positive correlations between the level of Individualism (at country level) and the gross national product (GNP), population size, and population density.

In this study the comparison is based on two different cultures with very diverse views on many aspects. However, basic tenets that form Asian (Korean) and African (Kenyan) culture fall in the 'collective' form. In this type of cultural composition, acts of an individual are principally tied to his bond to the society to where he/she belongs. Vital decisions even at a very personal level reflect the mainstream traditions that govern the society.

A comparative study on the East and the West's effect of culture on self-discrepancies and self satisfaction (Heine and Lehman, 1999) found that the Western culture places relatively greater value on individuals being adequate, competent, and self-sufficient (Markus & Kitayama, 1991b; Sampson, 1977) suggests that viewing oneself in unrealistically positive terms (i.e., as especially competent, in control, etc.) can thus be seen to bridge the gap between the individual's actual standing and the cultural ideals, thereby authenticating the individual as a meaningful member of the culture (Heine & Lehman, 1995a). Self enhancing biases serve to bring Westerners closer to their cultural ideals of selfhood.

For Asians, the relation between self-enhancing biases and the Japanese cultural ideals of selfhood appears to be quite different. Relatively more important

cultural tasks for Japanese are to fit in harmoniously with others and to gain a sense of belongingness and inter-dependence with others (e.g., Bachnik, 1992; De Vos, 1985; Markus & Kitayama, 1991b).

Though on a very different dimension when it comes to the basics, the unrealistic optimism of Africans (Kenyans in this study) towards susceptibility to health risk at the cultural level can be partially compared with that of Asians (Japanese in the above mentioned study, Koreans in this particular study).

Unrealistic optimism makes people feel better, it appears to be associated with positive social relationships, it predicts high motivation to engage in productive work, and, as a dispositional construct, it is associated with the ability to cope more successfully and recover faster from certain health-related stressors (e.g., Scheier & Carver, 1985 ; Scheier et al., 1989 ; Scheier, Weintraub, & Carver, 1986).

A study by Taylor et al. (1992) reviewed that men who had tested seropositive for human immunodeficiency virus (HIV) were significantly more optimistic about not acquiring AIDS than men who knew they were seronegative for HIV; this surprising finding was construed as suggestive evidence that AIDS-specific optimism among seropositive men is illusory. Moreover, (Shelley and

Jonathan, 1994) this AIDS-specific optimism was associated with reduced fatalistic vulnerability regarding AIDS, with the use of positive attitudes as a coping technique, with the use of personal growth/helping others as a coping technique, with less use of avoidant coping strategies, and with greater practice of health-promoting behaviors.

CHAPTER 2

LITERATURE REVIEW

This chapter starts with the definition of unrealistic optimism and then explores related theories. Various past studies are reviewed with special focus on the evolving of the theories. The relationship between psychological behavioral change and acquired information towards a particular health risk is also discussed in scanty details.

Definition of Unrealistic Optimism

Weinstein (1980) described unrealistic optimism as an error in judgment that crops from the popular belief that makes people tend to think that they are invulnerable. Hence, they expect others to be the victims of the misfortunes they dread. Human judgment under uncertainty has been shown to involve consistent departures from normative rationality. In particular, people show ‘motivational biases’ in judgments of probability, over-estimating the probability of events with a positive return to the self and under-estimating the probability of events with a negative return (Miller & Ross, 1975; Zuckerman, 1979).

This personal fable (Elkind, 1967) also involves the tendency to overestimate one’s probability of experiencing positive life events. For example, in

the area of health, research has shown that more than half of surveyed individuals perceive that they are less likely than others to be afflicted with such health outcomes as drug addiction, cancer, tooth decay, and auto injury. Harris and Guten (1979) found that only a small proportion of the subjects in their study reported to be at a higher risk for a given disease while a much larger proportion assessed their risk as being lower.

Another factor contributing to the optimistic bias is the nature of the comparison other. Studies have shown that when subjects are asked to compare their futures to the future of the "typical other person" (e.g. Perloff, 1987), "the average other" (Perloff, 1987), "(most) people they know" (e.g. Drake, 1984), or "other students at the same university and same sex" (e.g. Weinstein, 1980) the optimistic bias is prevalent. However, when comparing themselves with a good friend instead of "the average other," subjects do not display unrealistic optimism (Perloff & Fetzner, 1986). Perhaps the reason for this is that comparing oneself to good friends implies a comparison of individual to individual instead of a group as is the case with "the typical other person," for example. This can be explained by the "person positivity bias," which says that people value the individuals of a group more positively over the group as a whole (Sears, 1983). Hoorens and Bruunk

(1993) tested both of these factors and found that subjects unrealistic optimism was high when compared to a random other or average other but diminished when comparing themselves to their best friends.

The terms “unrealistic optimism” and “illusions of unique invulnerability” are additionally problematic in that they imply a comparison between personal judgments and an objective criterion such as actual outcomes. There certainly are many instances where people display optimism relative to some objective criterion. Much of the research on the planning fallacy seems an illustration of this form of unrealistic optimism (Buehler, Griffin & Ross, 1994). Dispositional optimism refers to a dispositional belief that one's outcomes will be positive rather than negative (Scheier & Carver, 1985).

People scoring high in dispositional optimism are more likely than people scoring low to believe that good outcomes are attainable and bad outcomes are avoidable. Comparative optimism does not refer to general beliefs regarding whether positive outcomes are more attainable, or more likely to occur than are negative outcomes, but rather to specific beliefs about whether positive and negative outcomes are more likely to occur for oneself than for other people.

(Shepperd, Carroll, Grace, & Terry, 2002)

The bias of unrealistic optimism has been shown to have both merits and demerits. The bias is important as it can affect people's intentions to engage in preventative behaviors (Mulkana & Hailey, 2001). Also it affects the manner in which they process information to update their beliefs (Radcliffe & Kline, 2002). Unrealistic optimism has also been associated with positive mental health (Taylor & Brown, 1988), 1996a, 1996b).

Raats and Sparks (1995) observed that unrealistic optimism refers to a group tendency; not every person is unrealistically optimistic but the tendency is for more people to say that they are at below-average risk than to say that they are at above-average risk. Within a group, we do not know who is being unrealistic but we deduce that some are since we presume that risk is approximately 'normally distributed' with roughly equal numbers of people at above- and below-average risk. The claim of unrealistic optimism also presumes that the sample under investigation is representative of the relevant 'population' of people.

Theoretical Explanation of Unrealistic Optimism

As described above, optimism is the belief that future life event will have

positive outcomes. Unrealistic optimism is the belief that nothing bad will happen because the person feels invincible to things such as accidents, diseases, etc. Although it appears a bit foolish to believe this way, research has found unrealistic optimism and optimism to be highly related in improving psychological and physical well-being. In their study of the relationship between optimism and unrealistic optimism, Davidson & Prkachin (1997) conducted two studies in which participants completed both the Life Orientation Test (LOT) and the Unrealistic Optimism Measure (UOM) and a lifestyle questionnaire with the main focus on exercise behaviors. Participants were assessed at the beginning of the semester and again at six weeks. At six weeks, they were only given the exercise questions.

Results showed that both optimism and unrealistic optimism were positively correlated. Also, those who were high in optimism but low in unrealistic optimism showed the greatest level of exercise over the six-week period. The overall finding for those high in unrealistic optimism was that they reported a lower risk of experiencing future health problems. The general criticism of unrealistic optimism is that these individuals may be negating or not actively participating in healthy behavior or activities.

Current research has described unrealistic optimism in ways that may

allow for it to be more easily distinguished from optimism (Schneider, 2001). The general distinction in this literature attempts to determine if it is better to be optimistic or realistic. The concern is that people will tend to be in denial of their problems and therefore develop optimistic biases about the future. The goal for people is to have a balance between realistic and optimistic thinking or realistic optimism. The research described on optimism and realistic thinking is a bit philosophical. On the one hand reality is being described as the way we move about the environment that increases our chances of success based on what we know. However, this knowledge is not foolproof and many other factors influence the decisions and outcomes we experience.

Unrealistic Optimism and Health Risks

Perceived vulnerability to disease and injury is assumed to be a motivating factor for behavior change in a number of theoretical models (Weinstein, 1989). Health education campaigns have focused on influencing people's risk perceptions by exposure to relevant risk information. However, there is a notion that people do not draw personal implications from risk information. This, in turn, has been related to self-enhancing processes of social comparisons or unrealistic optimism, the tendency to perceive negative events as less likely and positive

events as more likely to self than to others (Klein and Weinstein, 1997). From a practical point of view this phenomenon could hinder the adoption of preventive behavior and thereby undermine the effectiveness of health educational efforts. If health and oral health hazards primarily concern other people and not oneself – there might be no reason to adapt ones behavior.

People might not, however, be optimistic about all health problems and the amount of optimism varies substantially from hazard to hazard. According to social comparison theory, people would be more likely to underestimate their comparative health risk particularly if the illness /injuries are perceived to be under control or are something that they have not yet experienced (Weinstein, 1989).

Risk Perceptions and Personal Actions.

Studies by Baric (1969) and Weinstein (1983) indicate that little is known about the perceptions of susceptibility are formed or how people can be encouraged to recognize when they are at risk. Risk factors that involve personal actions constitute a category that appears to be viewed in a consistently one-sided manner.

Research on causal attributions found that people tend to deny that their

own actions are responsible for undesirable outcomes (Snyder, Stephan, & Rosenfield, 1978; Weary, 1979, 1980; Zuckerman, 1979) .s cited in the introduction part, threats rated high in controllability are more likely to evoke unrealistic optimism in comparative risk judgment (Weinstein (1982). On the other hand, no relationship was observed between perceived importance of heredity or environment and optimistic biases in comparative judgments suggesting that these types of risk factors are viewed in a more balanced fashion.

Weinstein (1984) grouped reasons people give to explain their perceptions into five categories based on the specific predictions about the types that would and would not show systematic bias. The following were the used categories: actions, heredity, physical/psychological, environmental, and psychological.

Risk perception is one of the major components in many health psychology theories based on social cognitive theories. The health belief model (Becker, 1974), protection motivation theory (Rogers, 1983), subjective utility theory (Ronis, 1992), and the theory of reasoned action (Ajzen & Fishbein, 1980) are probably the most frequently used theories for explaining an individual's behavior including the risk component.

The Health Action Process Approach (Schwarzer, 1992) integrates some

of the main components of these theories into a two-stage model with separate processes for pre- and post-intentional phases. In the pre-intentional phase, risk perception is a key component.

Factors that Affect Intensity of Perceived Risk

Even when engaging in a behavior that is undeniably risky, people manage to make self-favoring interpretations for example by creating "risk stereotypes" that depend on their own risk behavior in a self-protective way (Hahn & Renner, 1997).

Hahn and Renner (1997) found that individuals who smoke avoid labeling their own behavior as high risk by consistently setting the limit for "high risk cigarette consumption" over their own level of consumption. Thus the more a person smokes the higher s/he judges the level of high risk consumption to be.

Hoorens and Buunk (1993) discovered that the healthier the behavioral pattern reported by subjects, the lower their own estimated risks, and also the larger the difference between their personal risk estimations and their risk estimations for other people.

Weinstein (1984) gives two basic assumptions that make people aware of their susceptibility to health and safety risks as: (1) that people often

underestimate their susceptibility; and (2) that perceptions of susceptibility lead to preventive action. In a later study, (1987) he claimed that the degree of comparative optimism is associated with the following four factors: a belief that if the disease has not yet appeared, it will not in the future; a perception that personal action can prevent the disease; a perception that the disease is infrequent; and finally, a lack of personal experience with the disease.

A recent study by Sherman and Cohen (2002) argued that addressing the ego-protective motivations underlying defensive biases in response on health-risk information provides a more promising approach to removing defensive biases than the use of informational strategies.

Unrealistic Optimism and AIDS

A sound behavioral science principles and established models of health behavior is one of the principally working prevention and intervention method in the combat of human immunodeficiency virus (HIV). This has been affirmed as a firm and grounding method (Fishbein, 1996; Holtgrave et al., 1995; Kelly, Murphy, Sikkema, & Kalichman, 1993).

An individual's belief in his or her personal susceptibility to illness or disease is an important element in nearly all models of preventive health behavior,

both general (Fishbein & Middlestadt, 1989; Rosenstock, 1974; Weinstein, 1989) and HIV/AIDS specific (Catania, Kegeles, & Coates, 1990; Fisher & Fisher, 1992; Pinkerton & Abramson, 1992, 1995; Rosenstock, Strecher, & Becker, 1994).

Weinstein and Nicolich (1993) have suggested that the reciprocal and constantly changing nature of the relationship between risk perceptions and risk behavior can some-times mask the influence of perceived risk on behavior. For example, the perception that one is at risk may lead to a reduction in risky behaviors, which subsequently leads to an altered view of one's risk.

Researchers have developed several methods of measuring study participants' perceptions of their own HIV risk (Cohen & Bruce, 1997; Poppen & Reisen, 1997). One of the most widely used methods involves asking participants to compare their own risk of contracting HIV with that of people who are more or less similar to themselves. Another method first classifies participants as either "high risk" or "low risk" for HIV infection, according to self-reported risk behaviors, and then compares this classification with the participants' own perceptions of their level of risk. The high and low risk classifications are typically based on qualitative assumptions about risk, such as the presence or absence of particular risk factors (e.g., engaging in unprotected intercourse or

having multiple sex partners in the recent past are usually considered high-risk activities).

Cohen and Bruce (1997) used a mathematical model of HIV transmission to compare college students' estimates with the actual probability of contracting HIV from one or more acts of unprotected vaginal intercourse within three types of relationship strategies (casual encounters, serial monogamy, and extended relationship). Like Linville et al. (1988), they found that participants greatly overestimated the risk of contracting HIV for all types of relationship strategies. However, they did not examine respondents' perceptions of their own vulnerability to HIV infection.

Unrealistic Optimism and AIDS Related Information Processing

When threatened, people often process information in ways that are either qualitatively (e.g., Kunda, 1987) or quantitatively (e.g., Ditto, Scepansky, Munro, Apanovitch, & Lockhart, 1998) different, with the result that those most at risk are typically the least persuaded. This constitutes an important barrier to behavior change, as people remain unpersuaded of the need to change (Sherman, Nelson, & Steele, 2000)

Despite the fact that AIDS related information has been available for many years, many people still engage in acts that put them at a greater risk of being infected with this disease. Saturation of information can sometimes lead to a 'self glorification' otherwise called self-affirmation (Steele, 1988). It involves thinking, affirming and trying to sustain ones self-image at all cost.

Human tendency has protection of individual's worth as one of the central principles that govern social-interactive behavior and even influences life-time decisions. Steel continues to say that when it comes to self-defense, people are concerned primarily with their global sense of self-worth and integrity.

A prediction from Steele's (1988) theory, of both theoretical and applied importance, is that self-affirmation can offset health threats. Health problems can comprise threats to one's very existence, and there is considerable evidence that people are often highly defensive when given personally relevant health-related information (Jemmot, Ditto, & Croyle, 1986; Kunda, 1987; Liberman & Chaiken, 1992).

Theoretically, health therefore provides a compelling domain in which to test mechanisms proposed to reduce defensive or biased processing. In the case of self-affirmation, this involves testing the additional assumption that, for self-

affirmation to work, people must construe threats to health also as threats to self (Correll et al., 2004; Sherman et al., 2000). On the applied front, attempts to encourage those at risk of disease to change their lifestyle and behavior often fall foul of the fact that those who most need persuading are most threatened and least persuaded. Any method that can promote less biased, more open, and accurate assessment of threatening information is thus of great potential value.

In one study (Sherman et al., 2000), sexually active undergraduates watched an educational video suggesting that their sexual behavior could put them at risk for HIV. Half received a self-affirmation prior to watching the video; the others did not. Although nonaffirmed participants tended to resist the presented information, affirmed participants responded by acknowledging their potential risk for contracting AIDS. The effects of affirmation also went beyond perceived personal risk and were seen in actual health behaviors. Whereas 25% of nonaffirmed individuals purchased condoms after viewing the video, 50% of affirmed participants did so. Defensiveness in response to health-risk messages may thus arise because such messages, by contradicting individuals' beliefs about their freedom from risk, inadvertently threaten self-worth. However, a small intervention can buffer people against this threat and thus promote desirable

health behavior. These findings challenge assumptions in social and health psychology concerning the intractability of defensive biases. Past approaches (e.g., Weinstein & Klein, 1995) have attempted to reduce perceived invulnerability to health risk by using informational strategies—for example, by presenting facts about risk factors. However, such strategies are generally ineffective (Weinstein & Klein, 1995). One reason, it appears, is that informational approaches fail to address the ego-protective motivations underlying defensive biases in response to health-risk information.

Treating with Information

Because of the influence that perceptions of personal risk are thought to have on people's health practices (Weinstein, 1993), the communication of health risk information has become a prominent part of health prevention efforts. People are frequently provided with numerical information about the probability that a specific pattern of behavior (e.g., smoking) will lead to a particular health problem (e.g., lung cancer). Although the dissemination of this information has increased public awareness of potential health problems, its effect on perceptions of personal risk for these problems has been less dramatic (Weinstein, 1998).

Information-based behavior change has been slow despite the availability

of huge figures of factual data of victims and prospects of more victims of specific health risks (e.g. smoking). People usually welcome favorable information about their health but often engage in strategies that minimize or discount unfavorable health information—strategies that, in turn, blunt any influence this information might have on decision making and behavior.

Evidence that people are aware of the risks posed by a particular pattern of behavior may indicate the successful communication of health risk information, but it cannot tell us whether people recognize the risk as personally relevant.

Direct measures of personal risk are needed to answer this question. However, it is not clear whether the criterion for an effective intervention should be based on changing absolute levels of personal risk or in modifying comparative risk.

Numerous studies have revealed that people report their own risk of experiencing a health problem to be less than that of the average person and that this occurs even when they are given information about the average person's risk or behavior (Kunda, 1993; Rothman, Klein & Weinstein, 1996).

This optimistic bias has been taken to indicate that people systematically underestimate important personal health risks and, thus, considered a barrier to the adoption of precautionary behaviors (Klein & Weinstein, 1997). However, the

absence of any empirical evidence that people's behavioral decisions are related differentially to perceptions of absolute and comparative risk limits any conclusion that can be drawn as to which measure offers the most informative assessment of people's beliefs.

Despite the fact that investigators have assessed the merits of a range of risk communication strategies, our limited understanding of how different aspects of a health risk message affect people's beliefs and behaviors constrains any recommendations that can be formulated. The observation that information regarding both the antecedents and consequences of a health problem can reliably affect people's risk beliefs may offer a base on which a conceptual model of risk communication can be built (Rothman & Kiviniemi).

Inherent Cultural Factor

Many people who have traveled or lived outside of their home country have a sense that people in other cultures possess different values from their own. In some way, these values could be taken as defining culture itself and systematic differences in values – especially in a small collection of “core” values—could be seen as providing some structure for thinking about cultural differences. This, broadly, is the approach advocated by a large number of cultural psychologists

(e.g., Smith & Bond, 1999, p. 69).

A pioneering figure from these ranks is Hofstede who, some twenty years ago, compiled an almost unparalleled set: he administered a survey of values to nearly 120,000 International Business Machines (IBM) employees in 40 countries. Hofstede factor analyzed the data at the 4 country level (as a proxy for culture) and found four dimensions, which he labeled power distance (willingness to tolerate differences in power and authority), individualism (versus collectivism; orientation toward individual or group), masculinity (versus femininity; the former stressing achievement and material success, the latter, harmony and caring), and uncertainty avoidance (willingness to tolerate ambiguity). Hofstede's approach has been pursued by a number of other scholars, including Schwartz (Schwartz, 1991; Schwartz and Sagiv, 1995) who argues that ten important values (such as tradition, security, power, and stimulation) form a universal structure across two dimensions: openness to change/conservation and selftranscendence/ self-enhancement. According to Schwartz, any given culture has an identifiable position in this value space which allows it to be compared with other cultures.

A number of scholars have examined cross-cultural differences in inference and judgment by focusing on particular value dimensions. Shweder

(1995), for instance, has explored the value of spiritual purity among Hindu Indians. Meanwhile, Leung (1997) has examined how East Asian harmony values affect justice perceptions and decisions, such as reward allocation.

However, the most widespread research program in the value tradition has focused on one of the dimensions identified by Hofstede: individualism–collectivism. This dimension reflects an orientation towards one’s own needs and impulses (individualism) or towards the needs and dictates of one’s social groups such as families and communities (collectivism). Individualism–collectivism has drawn a great deal of attention from cross-cultural researchers and some observers see it as the most overarching theory of cultural psychology (Triandis, 1995).

Scholars have operationalized this dimension at both the country level (assigning “individualism scores” to countries) and at the individual level (with studies gauging individual participants’ values). Most often, East Asians are seen as more collectivist while North Americans and Europeans are viewed as individualist. How does the value tradition prepare us to think about cultural differences in inference?

Three main points emerge. First, in frequently highlighting individualism–

collectivism as central dimension, the value approach draws our attention to inferences that concern judgments about groups and about how individuals relate to groups. If a main source of cultural differences occurs in their members' attitudes about groups and group relations, we would expect to find considerable accompanying cultural variance in inferences related to groups and membership.

Second, and more broadly, the value tradition underscores the importance of prescriptive stances in construal and judgment. Scholars in this tradition don't simply make causal claims about values affecting others values and choices (such as claims about a general stance of individualism affecting a narrow attitude toward wanting to take credit for some good outcomes).

Rather, claims are made connecting values to inferences and resulting beliefs (e.g., between individualism and the belief that a single person is the cause for a good performance). What is the connection between these prescriptive and descriptive stances? How do norms shape inferences from evidence? The value tradition draws attention to such questions. A third, and related, consideration prompted by the values approach is a pragmatic or functionalist one: what are the consequences of certain inferences in, for example, a collectivist culture? If collectivism describes a system of norms, those norms comprise an important part

of the environment in which inferences must be “lived out.” Thus, the value approach prompts consideration of how inferences are shaped by the consequences they might entail in particular cultural contexts.

The Self Tradition

Beginning a century ago with William James (1890), the construct of “self” has been widely regarded by scholars as playing a key role in much psychological functioning. Although James and many of his Western intellectual heirs have voiced the caveat that the self may be experienced differently in various cultural systems, there has been little psychological research on this issue until recently. Is self a cultural concept? A chorus of researchers answers “yes”—and suggests it is perhaps the most important cultural concept.

Markus and Kitayama (1991) have been at the forefront of contemporary thinking about culture and self, suggesting not only that the psychology of self varies across cultures but that self conceptions may be at the very heart of what culture is. Markus, Kitayama and others have described culturally-driven ways of “being” a self, focusing specifically on two types: independent and interdependent selves. An independent construal of self, prevalent in the West, is characterized by a sense of autonomy, of being relatively distinct from others. In contrast, the

interdependent construal of self, prevalent in Asia, is characterized by an emphasis on the interrelatedness of the individual to others; self identity is more socially-diffused across important others rather than strictly bounded with the individual. There is an obvious similarity between these self concepts and individualism-collectivism. However, it's worth noting the descriptive, as well as than prescriptive, nature of these positions. We might crudely characterize the slogan of collectivism as "my in-group is important" while an interdependent self might be described as "my in-group is who I am."

A host of research by Markus and Kitayama (e.g., Markus & Kitayama, 1991), Heine and Lehman (e.g., Heine & Lehman, 1995; 1997), Singelis (e.g., Singelis, 1994), and others have explored this cultural dimension of selfhood. Other culture and self scholarship has emerged as well, including Shweder's (1995) description of divinity in selfhood among Hindu Indians. In this case, self is not so much distributed socially across other persons (as with an interdependent self) but distributed spiritually across reincarnations and all living things.

What guidance does the self tradition provide regarding cultural differences in human inference? Two major considerations emerge. First, understanding the social network that could potentially be implicated in a

perceiver's self concept becomes critical. A perceiver's attention to others in this network may be driven by his or her self concept; the self concept would likely also affect how others in this network are treated in judgments. Second, highlighting the self concept encourages us to expand our view of the domains of inference in which self construal matters. In other words, the impact of self concept can be found in domains beyond self judgment. Cognitive dissonance, for instance, might seem unrelated to the self, but Heine and Lehman (1997) argue that Japanese experience less dissonance than Canadians because of how they understand social contexts and the self.

Communication and African AIDS Realities

Local networks, which play a role in translating and interpreting the risk of HIV/AIDS, appear to be important in sub-Saharan Africa. Such translation and interpretation accompany the arrival of HIV/AIDS, as well as the discussion about modern family planning (Rutenberg & Watkins, 1997; Watkins, 2000).

Local interpretation may be particularly important for AIDS prevention messages in sub-Saharan Africa due to the discrepancy between program messages and well-established attitudes and behaviors (Tawfik & Watkins, 2001). In particular, program messages that urge abstinence, fidelity, or condom use

conflict with local understandings of sexuality: AIDS/HIV prevention programs promote postponement of first sexual intercourse but premarital sex still appears to be common (Harwood-Lejeune, 2000).

In a household survey, which was conducted in Malawi in 2001 among ever-married women and their husbands by Watkins and collaborators, almost all of the respondents reported having engaged in premarital sex, either with the person they subsequently married or with someone else (Watkins, personal communication).

Moreover, it appears that sex is not a taboo topic for discussion among adolescents and young adults (Basompwa, 2001; Nnko & Pool, 1997). In focus groups conducted by Helitzer-Allen (1994), girls between the ages of 9 and 12 said that their friends who were having sex talked about it among themselves; they also evaluated male sexuality, “‘especially’, said one, ‘when girls are in their multitudes at the river, or when going or coming from school.’” Slightly older girls (ages 13–15) reported even more open discussions about sex and male sexuality. One said “‘I found three girls at the open well telling each other how they feel when doing sex. One was telling her friends that her first time to do sex she felt very painful but now she feels OK and she does enjoy it.’” Semi-structured

interviews in Kenya and Malawi with married men and women, as well as the literature, show that there is typically an acknowledgment that strict fidelity is an especially appropriate ideal behavior in the age of AIDS, despite the fact that it was not considered as such in the past (Watkins & Schatz, 2001).

In their networks, both married women and married men discuss strategies of prevention. Women talk with each other about how best to persuade a spouse to be faithful, men talk with each other about how to maintain variety in sexual partnerships without the risk of AIDS (Zulu, Chepngo & Watkins, 2002).

In particular, it is well-known to males that a woman's physical appearance not sufficient to evaluate whether she is HIV infected or not. Thus, men talk with friends to gain information about a woman's past sexual behavior and whether she stayed in urban areas –places perceived to offer a greater risk of HIV exposure.

There is uncertainty about whether younger women or older ones are more likely to be infected. Although some men say that younger women are preferable, others disagree. Much the same suspicion of younger unmarried women was noted in Zambia, where "There is a preference for having married women or men as girlfriends or boyfriends because they are more likely to have fewer sexual partners and, it is believed, less likely to have an STD." (Bond & Dover,

1997:386.)

Condoms – in the context of premarital, extramarital and especially sex within the marriage – are perceived as an unattractive option. It has been widely reported that men tell each other that sex with condoms is “like eating sweets in a wrapper”, that condoms have little holes, that they are deliberately laced with the HIV virus, that women dislike them and that they are “useless” because they “burst” (e.g. Temin, Okonofua, Omorodin & Coplan, 1999 for Nigeria; Bond & Dover, 1997 for Zambia; Varga for South Africa, 1997; Watkins for Kenya and Malawi, personal communication).

There is also “empirical”, almost scientific, analysis of condoms. Respondents in Watkins’ Malawi survey often claimed that either they themselves, or a cousin, or a friend, had subjected condoms to empirical tests: filling them with water and finding that they leaked, or finding little “animal-like things swimming around”.

The kinds of conversations described above suggest that local networks may play a significant role in responses to HIV/AIDS. But is there anything about the characteristics of these networks that might indicate whether some types of networks are more effective in promoting – or hindering – change than others? An

actor is influenced by her network partners if these individuals are visible and important to her. Visible means that the network partners are recognized and known by the respondent, either by a direct relationship, or indirectly. Both conditions arise from two different network properties: social cohesion and structural equivalence (Friedkin, 1993; Marsden & Friedkin, 1993; Marsden, 1998). Within cohesive structures, network members are visible and influential because they are connected with one another, either directly or indirectly by paths of short length members of a cohesive group are more likely to be aware of each other's views on an emergent issue than are actors who are not members of the group. Moreover, visible opinions are likely to be salient in cohesive groups because members are embedded in a field of interpersonal cross-pressures that encourages reciprocity and compromise" (Friedkin 1993: 862). Structural equivalence locates sets of actors who have identical profiles of relationships to actors in the system" (Marsden 1998: 8). Identical profiles lead to identical positions and roles. Therefore, structurally similar individuals are important to one another because they are in comparable social situations.

Network structures of varying degrees of cohesiveness would be expected to have different processes of interpersonal influence based on learning and/or on

social norms. For example, it has been suggested that people rely more on information from network partners they know well and trust than on information from acquaintances. But if a network is primarily composed of confidants, new and heterogeneous information is less likely to enter the network (Granovetter, 1973). Furthermore, it is likely that if an individual knows the several people in her network quite well, they will also know each other well. This creates dense network structures that may have especially powerful influence on the creation, or upholding of norms (Coleman, 1990).

In contrast, open network structures facilitate processes of “social learning” (Montgomery & Casterline, 1996; Kohler et al., 2001). Less connected networks tend to be considerably composed of weak ties and therefore their members may be in contact with more heterogeneous and distant network partners than the members of more cohesive networks. Furthermore, they tend to be characterized by a smaller number of close relationships, so that their members may maintain a larger number of interpersonal relationships. Thus, they receive more information that is heterogeneous and new and normative pressures are less intense. This provides opportunities for the development of new attitudes as well as for the emergence of new behaviors.

Why Does Unrealistic Optimism Occur?

Slovic (1987), Tversky & Kahneman, (1974, 1971) and Weinstein (1989)

give the following as reasons why Unrealistic optimism occur¹: People compare themselves to an incorrect norm. People tend to have stereotypes in mind when they think about who is usually at risk from something. If they do not fit this stereotype, then they will downplay the likelihood of the event happening to them.

People interpret risk information in a self-serving manner. People employ “ego-defensive” mechanisms to downplay their risks. For example...People who are engaging in risky behavior or are exposed to risks will downplay their risks and give reasons to justify their behaviors, which are often ineffective precautions.

People believe they have more control over a situation than they really do. – For example, people who are driving perceive their risks of being in a car accident as much less likely as people who are in the passenger’s seat.

When we compare our chances of being exposed to a risk to someone else’s chances, the more like us that someone else is, the less we have unrealistic optimism. When people perceive a lack of control over their exposure to risk, or they view their exposure as less voluntary, unrealistic optimism decreases. Amount of information

¹ Summarized by Katherine A. McComas, Ph.D. University of Maryland

people are exposed to about a risk, and how salient or meaningful that information is to them personally can influence optimistic biases. Personal exposure to a risk can reduce unrealistic optimism.

J. Sherman, Skov, Hertz, & Stock (1981) argue that if people are asked to generate reasons why a particular outcome might happen to them, or to think through a series of events that could lead to this outcome, their perceptions of the likelihood of this outcome increase.

Because people consider their own chances of experiencing an event but neglect the fact that the average person probably faces the same likelihood (Chambers, Windschitl, & Suls, 2003), they tend to think that they are both more likely to experience common events and less likely to experience rare events than their peers are. Susan Miles and Lynn J Frewer (2003) give the following as the simple basic reasons why unrealistic optimism occurs:

i. Egocentrism: People are naturally bent to favor self. Hence, when facing a risk, people may think about the things they do to prevent harm from a hazard, but they don't ask if others are doing the same.

ii. Previous experience: If one experiences an event before, it is easier to imagine a situation in which the event could occur again. If we've had no prior

experience it is hard imagining that event ever happening to us.

iii. Stereotypes: An individual may incorrectly conclude that the risk from an event is less by comparing self to a higher risk group, rather than to people like that particular individual. Some people may have a stereotypical idea of the type of people that will be affected by different problems.

iv. Denial: Alternatively, it may be that optimistic bias is due to 'defensive denial', where people deny that they are at any risk in an attempt to avoid the anxiety one would feel from admitting a threat to well-being.

v. Self-esteem: Finally, optimistic bias may be due to people claiming that they are less at risk than their peers in order to enhance or maintain their self esteem. Admitting that other people are less susceptible to harm can threaten our feelings of competence and self worth.

Media Dependency

Media dependency theory as developed by DeFleur and Ball-Rokeach (1975) holds that the ultimate basis of media influence lies in the nature of the relationship between the social system, the role of media in that system, and the relationship of the audience and the media.

Their three points of the triangle are audience, society and mass media. They said that people have various levels of dependence on mass media based on the amount of disorder, conflict and change in society among these three poles. They essentially used Weaver's (1977) concept of need for orientation, where the effect of mass communication depends on message relevancy and uncertainty of an individual about a particular subject. The key seems to be peoples' need to reduce ambiguity. Mass communication is very powerful if it reduces ambiguity through defining and structuring reality.

The greater the need society has for the information provided by the media and the more functions the media serve, the greater dependence individuals in that society will have on the media and the greater the media's influence will be on that society.

The ultimate basis of media influence lies in the nature of the interdependencies between the media and other social systems and how these interdependencies shape audience relationships with the media (Melvin and Sandra, 1996).

Black and Bryant (1995) describe this theory, as a holistic and integrated theory. This is because it incorporates multiple perspectives, including psychological,

sociological, uses and gratifications research, and the media effects tradition.

Individuals who are dependent on a medium selectively expose themselves to its content and attend more to its messages to meet their goals, increasing the likelihood that messages are cognitively processed and consequently have effects (Ball-Rokeach & DeFleur, 1976). Although media dependency and exposure are likely to be correlated, ongoing dependencies, and dependency coupled with exposure may provide a more appropriate basis for predicting media impact than exposure per se (Ball-Rokeach, 1985; Grant, Guthrie, & Ball-Rokeach, 1991).

CHAPTER 3

METHOD

Research Design

Sampling and Respondents

This study was conducted on three Kenyan universities (N=254) and on online students taking online courses from two Korean universities (N=353). 50% of Kenyan sample were males and 50% females respectively. Gender distribution for Korean sample was males 39.1% and 60.9% females.

Respondents over 25 years old were the most in both samples. For Kenyan university students (N=254), above 25 years were about a fifth of the total respondents (21.7%). Less than 19 years old constituted the lowest representation in the data (7.1%).

Korean students (N=353) had over 25 years old respondents constituting the highest representation (28.9%). As was the case with Kenyan students, less than 19 years old constituted an extremely low representation of a mere 0.3%.

Kenyan respondents (N=254) were almost evenly distributed in the academic year category. The highest representation was sophomores (27.2%) and the lowest was seniors (19.3%). Korean students were unevenly distributed in the academic year category. Seniors constituted the highest representation (39.7%)

and freshmen had the lowest (13%). Table 3-1 summarizes all categories of the demography of the sample.

1. Table 3-1 Demographic Distribution

		Nationality	
		Kenyan (N=245)	Korean (N=353)
Gender	Male	126(50)	138(39.1)
	Female	126(50)	215(60.9)
Age	Under 19	18(7.1)	1(0.3)
	20	37(14.6)	54(15.3)
	21	43(16.9)	48(13.6)
	22	36(14.2)	43(12.2)
	23	38(15)	59(16.7)
	24	27(10.6)	46(13)
	Over 25	55(21.7)	102(28.9)
Academic Year	1 st	68(26.8)	46(13)
	2 nd	69(27.2)	75(21.2)
	3 rd	65(25.6)	92(26.1)
	4 th	49(19.3)	140(39.7)

Procedure

Kenyan university students (N=254) were given the questionnaire on the campuses of the three studied universities on voluntary basis between November

7th and 11th 2005 in Kenya. The subjects were approached after various lectures and the willing respondents volunteered to remain behind and participate in the survey. After a brief overview of the questionnaires the subjects filled the questionnaire and were debriefed as soon as they finished. Respondents were instructed to fill the most appropriate choice in correspondence to their self evaluation for respective statements in the questionnaire.

Respondents for Korean sample were contacted online. The questionnaire was made available through the online class lecture period. Willing students filled the questionnaire and submitted it online. Survey was conducted for a period of one week from November 20th to 26th, 2005. Instructions on how to fill the questionnaire were similar to those of Kenyan sampled respondents as described above.

Research Questions

Research Question 1

Research question 1 sought to find out whether there is any significant difference in optimistic bias between Korean and Kenyan university students.

Research Question 2

Research Question 2 was about the relationship between social-

psychological factors and AIDS among the subjects of the two samples. This question was poised in a three-pronged perspective anchored on self respect, personal involvement and social involvement. This query further sought to discover what underlying factor social-psychological orientation plays in influencing the level of optimistic bias.

Research Question 3

Research Question 3 was based on the relationship between media dependency for information relative to AIDS and effects of this to the level of optimistic bias. The media commonly used by Korean and Kenyan university students were the foundation of this question. At this stage, this study focused on finding out what the contents of media does to the perception of the dangers associated with contracting AIDS.

Hypotheses

The following hypotheses were developed in pursuit for viable conclusions on the relationship between the level of optimistic bias toward AIDS between Kenyan and Korean university students and to check what role media dependency plays in determining the level of unrealistic optimism.

Hypothesis 1

Hypothesis 1 proposed that there is a significant difference in Optimistic

Bias (OB) towards AIDS between Korean and Kenyan university students.

Hypothesis 2

H2 predicted that there is a significant variation in social-psychological perception of AIDS between Korean and Kenyan university students.

Hypothesis 3

H3 proposed that there is a significant correlation between media dependency for information related to AIDS and the actual level of optimistic bias.

Hypothesis 4

Hypothesis 4 insinuated that the higher the dependency on a particular media for information about AIDS, the higher the resultant level of optimistic bias.

Measures

Unrealistic Optimism (Optimistic Bias)

The optimistic bias is the tendency to view oneself as invulnerable to experiencing negative life events. Weinstein (1980) described unrealistic optimism as an error in judgment that crops from the popular belief that makes people tend to think that they are invulnerable. Hence, they expect others to be the victims of the misfortunes they dread. Human judgment under uncertainty has been shown to involve consistent departures from normative rationality. In particular, people

show ‘motivational biases’ in judgments of probability, over-estimating the probability of events with a positive return to the self and under-estimating the probability of events with a negative return (Miller & Ross, 1975; Zuckerman, 1979). Unrealistic optimism makes people feel better. It appears to be associated with positive social relationships, it predicts high motivation to engage in productive work and, as a dispositional construct, it is associated with the ability to cope more successfully and recover faster from certain health-related stressors. Measurement for Optimistic Bias (OB) were based on 7-point scale anchored on the descriptive statements ranging from very strongly disagree to very strongly agree with the statement ‘Compared to other students, I am more likely to have personal experience with AIDS’.

Self Respect

Self Respect (SR) was compiled from aggregated means of three statements: ‘compared to my fellow students, I am a rational person,’ ‘compared to other students, I am a responsible person,’ and ‘compared to other students, I am a moral person.’ SR was measured on 7-point scale represented by the descriptive statements ranging from very strongly disagree to very strongly agree. Since each of the above mentioned statements were framed as independent

statements in the questionnaire, there was a need to aggregate totals to arrive at a concrete and multi-faceted conclusion on the degree of SR. A combination of rationality, responsibility and morality forms a good basis for a genuine disposition for a social-psychological approach. SR. Cronbach's standardized alpha was .69 for the SR index, suggesting a moderately high internal consistency.

The three statements gave the respondents a repeated stimulated introspection that enhanced correct gauging of self. Inclusion of 'compared to' as the core of the statements was framed to relate to and point the respondents to optimistic bias. Studies have shown that when subjects are asked to compare themselves with "typical other person" (e.g. Perloff, 1987), "the average other" (Perloff, 1987), "most people they know" (e.g. Drake, 1984), or "other students at the same university and same sex" (e.g. Weinstein, 1980) the optimistic bias is prevalent.

Perloff & Fetzer (1986) observed, 'when comparing themselves with a good friend instead of "the average other," subjects do not display unrealistic optimism'. Owing to this crucial fact, phrases like 'friends', 'best friends' and 'partners' were avoided.

Personal Involvement

Personal Involvement (PI) in matters pertaining AIDS and its risks were measured by summing up the means of two statements: 'Aids issue is a serious matter to me' and 'Aids is a serious matter which could have influence on my future'. Both statements' reactions were measured on the 7-point scale anchored on representative statements ranging from very strongly disagree to very strongly agree.

To subtract 'self' from the generalizations associated with AIDS risk, there was a necessity to rephrase the same statement with an added stimulus of relating 'self' to 'a serious matter which could have influence on my future'. A prospect of a bright future triggers wise moves where certain impending barriers are involved. Taylor and Brown (1988) found that unrealistic optimism is a type positive illusion that is associated with mental well-being. They argue that positively biased view of one's future carries a variety of benefits such as self-reports of happiness and contentment, increased motivation and persistence, and ultimately better performance and greater success. Thus, the aggregated means of these two statements provided a solid measure of the genuine level of PI. The Cronbach's standardized alpha of PI was .83 for the PI index, suggesting high internal

consistency.

Social Involvement

Social Involvement (SI) was measured with a combination of two statements; 'AIDS is a serious social problem' and 'Aids is a social issue which could have influence on our future society. Unrealistic optimism is definitely formed based on the surrounding social environment.

Therefore, this study had a quest for understanding the relationship between an individual, the society he/she lives in, and the perceived AIDS risk in order to fully deduce the proper implications of optimistic bias. Measurements for this query were gauged using the scale of 1 to 7 ranging from very strongly disagree to very strongly agree. On Cronbach's standardized alpha, SI had .74 for the SR index, suggesting a fairly high internal consistency.

Media Dependency

Media Dependency (MD) theory states that the more dependent an individual is on a particular media for having his or her needs fulfilled, the more important that media will be to that person. It forecasts a relation between media dependency and importance and influence of the media. In this study, MD was calculated for the following media: television, radio, newspaper, magazine and the

internet. The test of actual MD was presented in form of the following statement, 'on a scale of 1-7 with 7 being very high reliance, and 1 being very low reliance, how much would you say you rely on each of the following media as a source of news and information about AIDS.'

Correlation between Low Media Dependency, High Media Dependency and the Level of Optimistic Bias.

To fully arrive at a conclusive effect of media dependency, there was a need to dissect media dependency to analyze how distributed was the dependency on each particular media, and how the varying level of dependency reflected on the level of optimistic bias. This was tailored to comprehensively study the impact of each media's dependency on the overall level of optimistic bias.

To check this correlation, low and high variables were taken based on the mean of the t-test of media dependency (see table 4-7). Optimistic bias was checked on comparative basis between the 'highs' and 'lows' of Kenyan students and Korean students. The number of students falling below the mean of each media was grouped as 'low dependency' while those who were above the mean were called 'high dependency'

CHAPTER 4

RESULTS

AIDS and Its Perceived Effects

Majority of the respondents had knowledge of AIDS and its consequences. For each of the measured categories, there was significant difference between Korean and Kenyan Samples hence emphasizing the fact that hypotheses speculated in this study are conclusively validated.

The underlying factors like the cultural setup and the magnitude of the risk also seem to have played a major role. There was a steady and almost uniform variation on almost all the measured aspects.

Optimistic Bias Difference between Korean and Kenyan Sample

H1 predicted that there is a significant difference in Optimistic Bias (OB) towards AIDS between Korean and Kenyan university students. Significant mean difference between the two samples was found as shown in Table 4-1.

2. Table 4-1 Two-Sample t-test for Optimistic Bias towards AIDS

Nationality	N	Mean	SD	t	df	Sig.
Kenyan	253	3.37	1.93	12.56	604	.00
Korean	353	1.69	1.04			

Social Psychological Difference between Korean and Kenyan Sample

H2 predicted that there is a significant variation in social-psychological perception of AIDS between Korean and Kenyan university students. This hypothesis was approached through measurements of three variables namely:

- i. Self Respect
- ii. Personal Involvement
- iii. Social Involvement.

Self Respect

Table 4-2 indicates that significant the mean difference in the degree of self respect among the subjects of the two samples. Kenyan students of (N=254) perceived that they have (M = 5.45; SD = 1.18) more self respect in regards to AIDS than Korean students (N=353) (M = 4.95; SD = 0.80).

3. Table 4-2 Two-Sample t-test for Self-Respect

Nationali	N	Mean	SD	t	df	Sig.
Kenyan	254	5.45	1.18	5.87	604	.00
Korean	353	4.95	0.80			

Personal Involvement

This variance had an over average mean for Kenyan university students (M=6.65, SD=1.42) and a below average mean for Korean university students (M=6.60, SD=2.02). This shows clear variation that envisages the intensity of personal involvement into the matters pertaining to AIDS and its risks. Low mean for Korean students can probably be accounted for on the facts there is higher risk perception by Kenyan students than Korean students.

4. Table 4-3 Two-sample t-test for Personal Involvement Pertaining to AIDS

National	N	Mean	SD	t	df	Sig.
Kenyan	254	5.65	1.42	14.72	605	.00
Korean	353	3.60	2.02			

Social Involvement

Social trends play a major role in decision making whether at personal level or at the societal level. The findings of this study have very viable means for Kenyan students (\underline{M} =6.27, \underline{SD} =1.07) and Korean students (\underline{M} =5.60, \underline{SD} =1.09). The subjects in each category clearly indicated their social involvement in matters attached to AIDS as testified by the variation and above average means in both samples.

It is important to note that the results of each of the variances tested to check H2 are very closely related. The results of social involvement test show the same trend as the other two tests above. The results of this variance are summarized in the table below:

5. Table 4-4 Two-sample t-test of Social Involvement in matters pertaining to AIDS

Nationality	N	Mean	SD	t	df	Sig.
Kenyan	254	6.27	1.07	7.56	605	.00
Korean	353	5.60	1.09			

Media Dependency for Information about AIDS

H3 proposed that there is a significant correlation between media dependency and OB. The five commonly used media by Korean and Kenyan university students were studied.

Television

Subjects of sample 1 (N=254) reported higher media dependency with a mean higher than the average (\underline{M} =4.62, \underline{SD} =2.25). Subjects of sample 2 were also slightly above average (\underline{M} =3.98, \underline{SD} =1.89). This shows the validity of H4 especially when compared with the mean of the media usage of TV. It can thus be deduced that media dependency has some effect on the level of optimistic bias.

Radio

Kenyan students depend on radio most to derive information regarding

AIDS and its risk. This particular media scored the highest mean ($\underline{M}=4.80$, $\underline{SD}=2.10$) for this measure. Korean students reported lesser dependency on radio ($\underline{M}=2.10$, $\underline{SD}=1.49$).

Newspaper

Newspaper is the third most used media for Kenyan students. Dependency on newspaper for information related to AIDS scored above average ($\underline{M}=4.49$, $\underline{SD}=2.05$). For Korean students, newspapers rank third too, behind the Internet and TV ($\underline{M}=3.25$, $\underline{SD}=1.73$).

Magazine

For sample 1, magazine is at the middle with mean ($\underline{M}=3.75$, $\underline{SD}=2.20$) and for sample 2, dependency on magazines for information on AIDS rank fourth ($\underline{M}=2.54$, $\underline{SD}=1.59$).

The Internet

Subjects of sample 1 depend on the Internet less than subjects of sample 2. Korean students use the Internet most to get information related to AIDS than other media. Internet got the highest mean ($\underline{M}=4.39$, $\underline{SD}=1.84$) for Korean students and third least for Kenyan students ($\underline{M}=2.64$, $\underline{SD}=2.07$).

6. Table 4-5 Two-sample t-test of Media Dependency

Media	Kenya		Korea		t	df	Sig. (2-tailed)
	Mean	SD	Mean	SD			
TV	4.62	2.25	3.98	1.89	3.77	605	.000
Radio	4.80	2.10	2.10	1.49	18.48	605	.000
Newspaper	4.49	2.05	3.25	1.73	8.06	605	.000
Magazine	3.75	2.20	2.54	1.59	7.86	605	.000
Internet	2.64	2.07	4.39	1.84	-10.94	605	.000

Correlation between High and Low Media Dependency and the Level of Optimistic Bias.

To measure correlation between high dependency, low dependency and the level of optimistic bias, the result of media dependency t-test was used. The number of students falling above the average (M) in the test was categorized as 'high dependency' while those below the average were categorized under 'low dependency'.

Then each of the five studied media was tested for correlation between high and low dependency and the level of optimistic bias. The results of these individual tests are discussed below.

TV Dependency

Kenyan university students' high dependency category had higher optimistic bias ($\underline{M}=6.15$, $\underline{SD}=.85$) than Korean university students ($\underline{M}=5.22$, $\underline{SD}=1.12$). The percentage of students was 62.2% (N=159) and 62.3% (N=220) for Kenyan and Korean university students respectively.

Low dependency category had Kenyan students again leading in level of optimistic bias ($\underline{M}=2.11$, $\underline{SD}=1.38$) and Korean students trailing ($\underline{M}=1.26$, $\underline{SD}=.44$). Korean students in this group were slightly less 37.7% (N=133) than their Kenyan counterparts' 37.8% (N=97).

7. Table 4-6 Two-sample t-test for high and low TV dependency

Nationality	Media Dependency	Number (N)	Mean (M)	SD	t	df	Sig. (2-tailed)
Kenyan	High	159	6.16	.85	-29.08	252	.000
	Low	97	2.11	1.38			
Korean	High	220	5.22	1.12	-29.48	351	.000
	Low	133	1.93	.82			

Radio Dependency

Kenyan university students' high dependency in this category had higher optimistic bias (M=6.15, SD=.83) than Korean university students (M=4.15, SD=1.09). The percentage of Kenyan students with high dependency on radio was 64.2% (N= 163), over two times more than Korean students' 29.2% (N=103).

On the low radio dependency margin, 70.8% (N=250) of Korean students had a low level of optimistic bias (M=1.26, SD=.44). 35.8% (N=91) of Kenyan students were on the lower end with higher optimistic bias (M=2.36, SD=1.36) than

Korean students with low radio dependency.

8. Table 4-7 Two-sample t-test for high and low radio dependency

Nationality	Media Dependency	Number (N)	Mean (M)	SD	t	df	Sig. (2-tailed)
Kenyan	High	163	6.16	.83	-27.58	252	.000
	Low	91	2.36	1.36			
Korean	High	103	4.15	1.09	-35.67	351	.000
	Low	250	1.26	.44			

Newspaper Dependency

54.7% (N=139) of Kenyan university students had a high dependency on TV for information relative to AIDS. This group had a high level of optimistic bias (\underline{M} =6.09, \underline{SD} =.79) in contrast to that of Korean students in the same category (\underline{M} =4.93, \underline{SD} =.98). High dependency on newspaper for Korean students was observed on 43.6% (N=154) of the respondents.

On low dependency scale, 56.4 % (N=199) of Korean university students had a low level of optimistic bias (\underline{M} =1.94, \underline{SD} =81) while on the same scale, 45.3%

(N=115) of Kenyan university students had almost twice as much level of OB ($\bar{M}=2.56$, $SD=1.31$).

9. Table 4– 8 Two-sample t-test for optimistic bias between low and high newspaper dependency

Nationality	Media Dependency	Number	Mean	SD	t	df	Sig. (2-tailed)
Kenyan	High	139	6.09	.79	-26.50	252	.000
	Low	115	2.56	1.31			
Korean	High	154	4.93	.98	-31.32	351	.000
	Low	199	1.94	.81			

Magazine Dependency

Kenyan university students' high dependency on magazines for information related to AIDS had higher optimistic bias ($\bar{M}=5.40$, $SD=1.22$) than Korean university students ($\bar{M}=4.11$, $SD=1.129$). The percentage of Kenyan students with high dependency on magazines was 56.7% (N=144). High dependency on magazines was found on 42.8% (N=151) of Korean university students.

For low dependency on magazines, 57.2% (N=202) of Korean students had

a low level of optimistic bias ($M=1.37$, $SD=.48$). 43.3% ($N=110$) of Kenyan students were on the lower end with a slightly higher optimistic bias ($\underline{M}=1.58$, $\underline{SD}=.94$).

10. Table 4- 9 Two-sample t-test for optimistic bias between low and high magazine dependency

Nationality	Media Dependency	Number (N)	Mean (M)	SD	t	df	Sig. (2-tailed)
Kenyan	High	144	5.40	1.22	-27.14	252	.000
	Low	110	1.58	.94			
Korean	High	151	4.11	1.12	-31.27	351	.000
	Low	202	1.37	.48			

Internet Dependency

51.6% ($N=182$) of Korean university students topped in this category with a higher level of optimistic bias ($\underline{M}=5.92$, $\underline{SD}=.81$). High dependency on the Internet was found on 41.7% ($N=106$) of Kenyan students. Their optimistic bias ($\underline{M}=4.79$, $\underline{SD}=1.41$) was the lowest compared with other media discussed above.

On the low Internet dependency, 48.4% (N=171) of Korean students had a high level of optimistic bias (\underline{M} =2.77, \underline{SD} =1.09) compared with the lows of the other media surveyed. 59.3% (N=148) of Kenyan students had the lowest level of optimistic bias (\underline{M} =1.10, \underline{SD} =.49) in comparison with the lows of all other media discussed above.

11. Table 4-10 Two-sample t-test for High and Low Internet dependency

Nationality	Media Dependency	Number	Mean	SD	t	df	Sig. (2- tailed
Kenyan	High	106	4.79	1.41	-29.42	252	.000
	Low	148	1.10	.49			
Korean	High	182	5.92	.81	-30.97	351	.000
	Low	171	2.77	1.09			

CHAPTER 5

DISCUSSION

Optimistic Bias (Unrealistic Optimism)

As predicted in H1, the results confirmed that there is a significant optimistic bias towards AIDS between Korean and Kenyan university students. Kenyan students indicated that they are more 'defensive' (optimistically biased). According to Weinstein's (1980) observation, people expect others to be victims of misfortunes, not themselves. Kenyan students indicated higher index of optimistic bias hence confirming the authenticity of H1.

Higher variation in OB can be accounted for because of the fact that Kenyans are more exposed to risks of AIDS than Korean student. Many proponents of unrealistic optimism argue that the higher the risk, the higher the level of unrealistic optimism. The higher level of variation can be linked to the factual surroundings that relate to AIDS in the two studied samples.

H1 is closely related to the results of the other predictions because they all produced findings with the same pattern. This confirms that the cultural setting and the prevailing circumstances do greatly influence the level of Optimistic Bias. Even though the consequences are the same once an individual acquires AIDS,

potential victims tend to behave in a way that relate to their locale when reacting to the perceived risk. This explains why though Kenyan and Korean university students have almost the same exposure to information related to HIV, Kenyan students had higher level of OB.

Social-psychological orientation also greatly influences the level of OB. H2 predicted that there is a significant variation in social-psychological perception of AIDS between Korean and Kenyan university students. Self respect, personal involvement and social involvement directly influence perception of 'self safety'. Tests on the above three variables produced results that proved directly effectual or related to the level of OB.

When a health risk is involved, an individual's behavior both at personal level and at the society's principles is influenced in a way that closely relates to the norms of that particular locality. This can be deduced from the pattern of the results of three variables of H2. It can be concluded that formation of OB takes a bottom-top process starting from self-respect which leads to personal involvement in preventive measures and finally ends in merging with others in the society to share and collectively find defensive measures to curb the risk. This agrees with Shweder's (1990) argument that culture and self are seen to make

each other up. From these findings we can conclude that Kenyan students are more involved in AIDS preventive methods than Korean students.

Optimistic Bias makes people feel cushioned from the menace of the perceived risk. This can explain why Kenyan university students had higher level of OB than their Korean counterparts. Scheier & Carver, (1985) argued that OB is ‘associated with positive social relationships, it predicts high motivation to engage in productive work, and, as a dispositional construct, it is associated with the ability to cope more successfully and recover faster from certain health-related stressors.’

The Media Effect

Kenyan university students’ dependency on TV, radio, newspaper and magazines was more than that of Korean students. These media channels are the most available locally for Kenyan students and AIDS campaigners saturate them with information because of the high risk involved. Though Korean students use the same media too, their dependency for AIDS related information is less because the concentration of such information is not as high as it is for in Kenyan media.

The Internet had low dependency found among Kenyan student. Actually,

Korean students had almost twice as high ($M=4.39$, $SD=1.84$) dependency as their Kenyan colleagues ($M=2.64$, $SD=2.07$). This can be logically deduced from the fact that Korea has higher Internet usage than Kenya. While Korean students use Internet for almost every aspect of their studies and daily lives, Kenyan students barely use it and when they do, they just write a mail or chat online with a friend or a relative.

Kenyan students depend on radio for information about AIDS more than other media. On comparative basis, media dependency showed similar pattern in relation to optimistic bias. It however should not be assumed media dependency always has same impact on the level of OB because when tallied, it will be found that though same media is used by two samples the saturation of information related to the health risk is different.

Thus the correlation proposed in H3 does exist but can be more pronounced in a study involving a single sample analysis. In this study, H3 will be more meaningful if viewed together with the implication of H4.

H4 proposed that there is a significant correlation between media dependency and OB. Media dependency for information about a certain risk does influence habit formation and general awareness about the involved risk. Due to

the intensity of AIDS threat and the distribution of media channels, it is imperative that radio is the most used to disperse AIDS related information to Kenyan university students. Availability of the Internet in almost every house in Korea makes it easier for university students to derive AIDS information from the Internet than other media.

A point to note on H4 is that though media dependency influences the level of unrealistic optimism, the intensity of the risk plays a larger role too. This explains why though Radio scored the highest mean ($M=4.80$, $SD=2.10$) and the Internet ($M=4.39$, $SD=1.84$) for Kenyan and Korean students respectively, there was wider variation in actual level of OB ($M=3.37$, $SD=1.93$ & $M=1.69$, $SD=1.04$).

Implications

This study tried to add optimistic bias towards AIDS literature by focusing on a comparative dimension of two different cultures. Though previous studies have classified Asians and Africans in the same group termed as ‘collective form’ culture, there emerged a huge variation that paves way for subsequent studies in this area.

This study also touched on the viability of media as a vital way of

combating the spread of AIDS. Results of this study reveal striking relationship between media usage, media dependency for AIDS related information and the prospects of habits change. This leaves a chance for a follow-up study to investigate for instance how saturation of information related to a certain risk influence the level of optimistic bias.

Also the identified media that have many users hooked on them can be studied further to invent ways that can be used better to bolster positive effect that can alter transmission of AIDS. Since this study focused on university students, the backbone of the society, its findings can be used to address other members of the society who face the same risk.

Limitations and Suggestions for Further Research

This study had a couple of limitations. First, it assumed that there is a comparative homogeneity between Kenyan and Korean university students. It is a fact that Korean culture is very uniform because it is formed by people who speak the same language, and have similar characteristics in many aspects. On the other hand, Kenyan culture is an amalgamation of different tribes and a myriad of sub-cultures. A future study can possibly focus on the comparative effect of optimistic bias in single-culture and multi-culture societies.

Second, this study measured dependency on media for information related to AIDS without paying attention to the concentration of such information. There is a vast difference in content, approach, target and even language of broadcast between the two sampled subjects. These factors were not considered in the framing of this study. A future study can focus on the disparity of media contents and its effects on optimistic bias toward AIDS.

Third, this study assumed that subjects of both samples had prior and same level of knowledge about AIDS and its consequences. Though generally assumed it is not true that all university students involved in this study perceived AIDS risks the same way. Differences in social-psychological orientation were not taken into account. Though spread through different countries and cultures, there are other linking ties like religious affiliations, financial status and other social-economic factors that can be common in two very diverse cultures. This study assumed homogeneity of all subjects of each particular sample.

A further study can further dissect through the divisions and groupings in a cross-cultural setup to further investigate the effect and the level of optimistic bias towards AIDS and other related health risks.

In summary, while this study reveals a close relationship in optimistic bias

towards AIDS and the effect of media, it at the same time leaves many questions unanswered which can be used for further research efforts in this area.

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KOREAN ABSTRACT

국문초록

에이즈(AIDS)와 미디어 의존에 관한 낙관적 편향: 한국과 케냐의 대학생을 대상으로 한 비교 연구

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낙관적 편향(Optimistic Bias)은 자신이 다른 사람보다 위기를 경험할 가능성이 적다고 믿는 것을 말한다. 우리는 어떤 위기가 자신에게 닥쳐오기 전까지는 그 위기가 자신의 일이 아닌 남의 일인 것처럼 편향되게 지각하는 경향이 있다. 에이즈는 많은 사람들이 두려워하는 불치의 병이다. 그동안 많은 연구자들은 에이즈와 낙관적 편향에 관한 관련성에 대해 연구해 왔다. 대부분의 연구결과들을 보면 사람들은 에이즈에 대해 낙관적 편향을 갖고 있는 것으로 나타났다. 즉, 자신은 자신과 비슷한 조건을 가진 다른 사람들보다 에이즈에 걸린 가능성이 적은 것으로 인식한다는 것이다.

이 연구는 두 가지 측면에서 선행 연구들과는 차별화된다. 첫째 에이즈에 대한 낙관적 편향에 있어 미디어 의존도를 새로운 변인으로 추가하고, 둘째 에이즈에 대한 낙관적 편향을 국가 간 비교문화를 통해 고찰했다는 것이다. 이를 위해 본 연구에서는 한국의 대학생(N=353)과 케냐의 대학생(N=253)을 대상으로 설문조사를 실시했다. 한국과 케냐는 에이즈의 발병 빈도나 미디어를 통한 정보량의 차이에 있어 본 연구를 수행하는데 있어 아주 좋은 표본으로 판단된다. 또한 이 연구는 자아 존중감과 에이즈에 대한 관여도 등 사회 심리적 변인들을 추가했다.

본 연구에는 선행연구 및 이론적 검토를 통해 다음과 같이 4 개의 연구가설을 설정했다.

가설 1: 한국과 케냐의 대학생 사이에는 에이즈에 대한 낙관적 편향에 차이가 있을 것이다.

가설 2: 한국과 케냐 대학생 사이에는 에이즈에 대한 자아 존중감 및 관여도에 차이가 있을 것이다.

가설 3: 에이즈와 낙관적 편향과의 관계에 있어 미디어 의존도는 유의적인 관련성이 있을 것이다.

가설 4: 미디어 의존도가 높을수록 낙관적 편향도 더 크게 나타날 것이다.

가설 검증결과를 살펴보면 다음과 같다.

한국과 케냐의 대학생을 대상으로 에이즈에 대한 낙관적 편향을 검증한 결과 케냐의 대학생($M=3.37$)보다는 한국의 대학생($M=1.69$)들의 낙관적 편향이 더 큰 것으로 나타났으며, 이는 통계적으로 유의미한 차이가 있는 것으로 나타났다($t=12.56$, $df=604$, $p<.001$). 따라서 가설 1은 검증되었다.

에이즈에 대한 자아 존중감을 살펴본 결과 한국의 대학생($M=4.95$)보다 케냐의 대학생($M=5.45$)의 자아존중감이 높은 것으로 나타났고 이는 통계적으로 유의미한 차이가 있는 것으로 나타났다($t=5.87$, $df=604$, $p<.001$). 또한 에이즈에 관한 개인적 관여도를 살펴본 결과 한국의 대학생($M=3.60$)보다는 케냐의 대학생($M=5.65$)들이 더 높은 것으로 나타났으며 이것도 통계적으로 유의미한 차이가 있는 것으로 나타났다($t=14.72$, $df=605$, $p<.001$). 에이즈에 대한 사회적 관여도를 살펴본 결과 한국의 대학생($M=5.60$)보다는 케냐의 대학생($M=6.27$)들의 관여도가 높은 것으로 나타났으며, 이는 통계적으로 유의미한 차이가 있는 것으로 나타났다($t=7.56$, $df=605$, $p<.001$). 따라서 가설 2는 지지되었다.

다음은 에이즈에 대한 미디어 의존도이다. 먼저 TV의 경우 한국의 대학생($M=3.98$)보다 케냐의 대학생($M=4.62$)이 더 높은 의존도를 보였으며 이는 통계적으로 유의미한 차이를 나타냈다($t=3.77$, $df=605$, $p<.001$). 라디오의 경우도 한국의 대학생($M=2.10$)보다 케냐의 대학생($M=4.80$)이 더 높은 의존도를 보였으며 이는 통계적으로 유의미한 차이를 나타냈다($t=18.48$, $df=605$, $p<.001$). 신문의 경우

한국의 대학생($M=3.25$)보다 케냐의 대학생($M=4.49$)이 더 높은 의존도를 보였으며 이는 통계적으로 유의미한 차이를 나타냈다($t=8.06$, $df=605$, $p<.001$). 잡지의 경우 한국의 대학생($M=2.54$)보다 케냐의 대학생($M=3.75$)이 더 높은 의존도를 보였으며 이는 통계적으로 유의미한 차이를 나타냈다($t=7.86$, $df=605$, $p<.001$). 인터넷의 경우는 한국의 대학생($M=4.39$)이 케냐의 대학생($M=2.64$)보다 더 높은 의존도를 보였으며 이는 통계적으로 유의미한 차이를 나타냈다($t=-10.94$, $df=605$, $p<.001$). 따라서 가설 3은 지지되었다.

다음은 미디어 의존도가 높은 집단과 낮은 집단으로 나누어 비교 분석해 보았다. 먼저 TV의 경우 케냐 대학생들은 TV 의존도가 높은 집단($M=6.16$)과 낮은 집단($M=2.11$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-29.08$, $df=252$, $p<.001$), 한국 대학생들의 경우도 TV 의존도가 높은 집단($M=5.22$)과 낮은 집단($M=1.93$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-29.48$, $df=351$, $p<.001$). 라디오의 경우 케냐 대학생들은 라디오 의존도가 높은 집단($M=6.16$)과 낮은 집단($M=2.36$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-27.58$, $df=252$, $p<.001$), 한국 대학생들의 경우도 라디오 의존도가 높은 집단($M=4.15$)과 낮은 집단($M=1.26$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-35.67$, $df=351$, $p<.001$). 신문의 경우 케냐 대학생들은 신문 의존도가 높은 집단($M=6.09$)과 낮은 집단($M=2.56$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-26.50$, $df=252$, $p<.001$), 한국 대학생들의 경우도 신문 의존도가 높은 집단($M=4.93$)과 낮은 집단($M=1.94$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-31.32$, $df=351$, $p<.001$). 잡지의 경우 케냐 대학생들은 잡지 의존도가 높은 집단($M=5.40$)과 낮은 집단($M=1.58$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-27.14$, $df=252$, $p<.001$), 한국 대학생들의 경우도 잡지 의존도가 높은 집단($M=4.11$)과 낮은 집단($M=1.37$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-31.27$, $df=351$, $p<.001$). 인터넷의 경우도 케냐 대학생들은 인터넷 의존도가 높은 집단($M=4.79$)과 낮은 집단($M=1.10$) 사이에 통계적으로 유의미한 차이가 나타났으며($t=-29.42$, $df=252$, $p<.001$), 한국 대학생들의 경우도 인터넷 의존도가 높은 집단($M=5.92$)과

낮은 집단($M=2.77$) 사이에 통계적으로 유의미한 차이가 나타났다($t=-30.97$, $df=351$, $p<.001$).

결론적으로 이 연구는 에이즈가 많은 국가(케냐)와 에이즈가 적은 국가(한국)사이에 에이즈에 대한 낙관적 편향에 차이가 있음을 밝혀냈다. 이 연구결과의 시사점은 낙관적 편향에 있어 국가 간의 사회 문화적 환경도 중요한 변수가 된다는 것을 암시하는 것이라고 할 수 있다.

APPENDIX

Questionnaire

Hello,

My name is Mullah James. I am a student at Chosun University, Gwangju, South Korea. We are conducting opinion survey on University students' perceptions of AIDS. I would like you to fill out this questionnaire. Your response will be confidential and anonymous.

If there is any question, do not hesitate to contact me via the following address:

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Instruction: Below are a number of statements concerning your perception of AIDS. Read each item carefully and decide whether you agree or disagree and to what degree. If you very strongly agree, kindly circle 7; if you very strongly disagree, circle 1; if you feel somewhere in between, circle any one of 2, 3, 4, or 5 based on the scale below:

Very Strongly Disagree	1
Strongly Disagree	2
Disagree	3
Neither Agree nor Disagree	4
Agree	5
Strongly Agree	6
Very Strongly Agree	7

1. Compared to my fellow students, I am a rational person.

1	2	3	4	5	6	7
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2. Compared to the other students, I am a responsible person.

1	2	3	4	5	6	7
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3. Compared to my fellow students, I am a moral person.

1	2	3	4	5	6	7
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4. AIDS issue is serious personal matter to me.

1	2	3	4	5	6	7
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5. AIDS issue is a personal issue which could have influence on my future.

1	2	3	4	5	6	7
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6. AIDS issue is a serious social problem.

1	2	3	4	5	6	7
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7. AIDS issue is a social issue which could have influence on our future society.

1	2	3	4	5	6	7
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8. Compared to other students, I am more likely to have personal experience with AIDS.

1	2	3	4	5	6	7
----------	----------	----------	----------	----------	----------	----------

9. Compared to my fellow students, I am more likely to have a healthy sex life.

1	2	3	4	5	6	7
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10. In case of sexual encounter, I am more likely to use an AIDS prevention strategy beforehand.

1	2	3	4	5	6	7
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11. During a typical week day (Monday through Friday), how many hours do you spend using the following media?

- a. Television: _____ hours, _____ minutes.
- b. Radio: _____ hours, _____ minutes.
- c. Newspaper: _____ hours, _____ minutes.
- d. Magazine: _____ hours, _____ minutes.
- e. Internet: _____ hours, _____ minutes.
- f. Satellite TV: _____ hours, _____ minutes.
- g. Mobile Phone: _____ hours, _____ minutes.

12. During a typical Saturday, how many hours do you spend using the following media?

- a. Television: _____ hours, _____ minutes.
- b. Radio: _____ hours, _____ minutes.
- c. Newspaper: _____ hours, _____ minutes.
- d. Magazine: _____ hours, _____ minutes.
- e. Internet: _____ hours, _____ minutes.
- f. Satellite TV: _____ hours, _____ minutes.
- g. Mobile Phone: _____ hours, _____ minutes.

13. During a typical Sunday, how many hours do you spend using the following media?

- a. Television: _____ hours, _____ minutes.

b. Radio: _____ hours, _____ minutes.

c. Newspaper: _____ hours, _____ minutes.

d. Magazine: _____ hours, _____ minutes.

e. Internet: _____ hours, _____ minutes.

f. Satellite TV: _____ hours, _____ minutes.

g. Mobile Phone: _____ hours, _____ minutes.

14. On a scale of 1-7 with 7 being very high reliance, and 1 being very low reliance, how much would you say you rely on each of the following media as a source of news and information about AIDS?

	1	2	3	4	5	6	7
a. Television							
b. Radio							
c. Newspaper							
d. Magazine							
e. Internet							
f. Satellite TV							
g. Mobile Phone							

I would like to get some general background information.

15. Gender: Male _____ Female _____

16. Age: _____

17. Academic Year:

1st year _____ 2nd year _____ 3rd year _____ 4th year _____

18. I have had a sexual encounter: Yes _____ No _____

19. If you answer Yes to Question 18, how many sexual encounters?

_____ times.