

SELF-ESTEEM OF AIDS ORPHANS –  
A DESCRIPTIVE STUDY

by

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## DECLARATION

I, the undersigned, hereby declare that this dissertation of limited scope is my own original work and that it has not been submitted previously in its entirety or in part to any other university for a degree. I also declare that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signed

Date

.....

.....

## **ACKNOWLEDGEMENTS**

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## **SUMMARY**

### **SELF-ESTEEM OF AIDS ORPHANS –**

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In the light of the child's self-esteem that is affected by traumatic events, the goal of the research was to explore and describe the self-esteem of children orphaned by HIV/AIDS. The researcher made use of a quantitative research method. 30 (N=30) respondents, both male (n=16) and female (n=14), between the ages of 11 to 15, were randomly sampled for inclusion in the study. Each participant completed a self-report measure of self-esteem, The Culture-free Self-esteem Inventory for Children, which yielded a score of Global Self-esteem, as well as in four sub-domains including: General, Social, Academic and Parent-related Self-esteem.

The results of this study demonstrated that the participants experienced a lowered self-esteem. These findings were explored in light of a literature review, after which conclusions and recommendations were provided.

#### **Key Terms;**

HIV/AIDS, Self-esteem, AIDS orphans, Quantitative research, Cross-Sectional Survey Design, Emotional trauma.

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# CHAPTER ONE

## AN OVERVIEW OF THE RESEARCH

### 1.1 INTRODUCTION

The first reported case of AIDS was in the United States in 1981, following the diagnosis of *Pneumocystis carinii* pneumonia and Kaposi's sarcoma in young gay men. It was not, however, until 1983 that a virus was identified. Its existence was made public the following year (Chase & Aggleton, 1994, in Aggleton, Rivers, Warwick & Whitty, 1994: 9). Two decades on, HIV has had a worldwide impact. In 2001 an estimated 40 million people were living with HIV/AIDS, including 2.7 million children (Kennedy, 2003: 17). The worst affected continent is Africa, with South Africa reportedly having the largest number of people living with HIV/AIDS in the world (UNAIDS, 2004: 12).

AIDS orphans, children who have lost both parents to AIDS, have been greatly affected by this epidemic. In Africa, AIDS has already orphaned a staggering 11 million children, half of whom are between the ages of 10 and 14. Some of the problems encountered by children affected by HIV/AIDS include taking on adult responsibilities, child labor, psychological stress, loss of parents, societal discrimination, growing up in impoverished conditions, poor nutrition and health care, a negative impact on education, loss of inheritance and physical and sexual abuse. As a result of the many burdens carried by these children, depression and alienation are common (Berger, 2003: 1).

A study by Baguma, Kyomugisha and Kimeze (2005: 369), exploring the psychosocial needs of AIDS orphans in Uganda, showed that the prevalence and seriousness of psychosocial problems was higher among orphans than

among the control group. Furthermore, qualitative results identified the presence of physical, sexual and emotional abuse, as well as behavioural problems among this population group.

Kartell and Chabilall (2005: 214) assessed the socio-educational development of adolescents orphaned by AIDS in child-headed households. These researchers found that HIV/AIDS has a negative impact on the social and educational development on this population. They further identified the taking on of adult responsibilities, abandoning school, poverty, lack of parental, educational and social support and social discrimination as inhibiting factors on these adolescents' development.

When considering the aforementioned stressors of AIDS orphans the possibility of developing a low self-esteem is possible. Self-esteem is a construct that significantly influences the quality of life of a child. It is concerned with an individual's global evaluation of their self-worth and self-efficacy. Correlates of high self-esteem are: good personal adjustment, positive affect, managing stress well, coping well with criticism, internal locus of control and personal autonomy. Low self-esteem, however, has been associated with poor psychological adjustment, mental health problems such as anxiety and depression, drug abuse and eating disorders and suicide (Carr, 2004: 207).

Gilbert (1992: 199) argues that self-esteem was developed from a capacity for self-awareness, motivated by social comparison. This author explains that self-esteem is the collective experience of social comparative information and the position of oneself in a network. What this then translates into for the AIDS orphan is that through the mechanism of social comparison this child's self-esteem greatly impacts and facilitates his relative standing in society. Furthermore, introjected social comparative data, through imposed comparative sources such as societal attitude towards HIV/AIDS, allows the child to match their self in an ingroup-outgroup way. Self-esteem may therefore be raised by being a member of the ingroup and lowered by being a member of the outgroup.

According to Bentall (2004: 247), negative self-appraisal habitually results in lowered self-esteem which in turn is related to one developing a pessimistic attributional style. This author explains how a lowered self-esteem is very often associated with negative appraisal of the self, world and future. Abramson (as cited in Bentall, 2004: 247) argues that, “*excessively stable and global attributions for negative events lead to a sense of hopelessness – a pervasive conviction that life cannot get better which in turns saps the individual’s motivation to cope with adversity*”.

The interplay of self-esteem and the appraisal of the self, world and future may be understood from a Gestalt perspective. According to Zinker (1978: 198), a person with a healthy self-concept is aware of and accepts the opposing forces within himself. Since he is able to say, ‘*I am kind, but sometimes cruel*’, despite society’s disapproval of the negative polarity, he is able to incorporate this notion of himself and continue to view the world as a positive place. However, according to Zinker (1978: 199), a person who sees himself in a unilateral stereotypic manner is rigid in his view of self and is unable to accept his negative polarities. Therefore, when confronted with a negative thought, instead of incorporating this into the self, it is projected onto the world, thus viewing the world and others as bad, and the future as bleak.

## **1.2 MOTIVATION**

Having worked as a volunteer within the South African HIV/AIDS population at Jerusalem Ministries, the researcher became increasingly aware of the despair felt by many of the orphaned children. Further work in the field of psychology has brought to light the interaction between emotional wellness and future success and the role of self-esteem. Bednar and Peterson (1996: 1) give reference to the acclaim that self-esteem historically received in literature on mental health and personality development, portraying self-esteem as “*one of the premier elements in the highest levels of human functioning*”. These researchers also highlight the distressing consequences resulting from the absence of a healthy self-esteem. According to Bednar and Peterson (1996:

1), *“the absence of a healthy sense of self-appreciation seems to be one of the basic warning signs of a dysfunctional personality, and it is an assumed condition in virtually all contemporary models of disordered behaviour”*.

In the presence of the current literature on self-esteem as well as the plight of the HIV/AIDS orphan, the researcher is compelled by both a personal interest as well as a professional curiosity of the presence of self-esteem in the HIV/AIDS orphan. According to the role of self-esteem, outlined by Bednar and Peterson (1996: 1-17), the absence of a healthy self-esteem could have far reaching implications for this population, conversely, the presence of a healthy self-esteem could function as a protective factor against the assaulting variables imposed on this population. The researcher is thus motivated by a personal investment in the country, as well as by an interest in exploring the construct of self-esteem within the South African HIV/AIDS population.

### **1.3 PROBLEM FORMULATION**

The trauma experienced by the AIDS orphan is very often exacerbated by stigma, discrimination and victimization. To function effectively in such an environment demands a degree of resilience on the part of the child. Despite the overwhelming agreement in the literature that these children do indeed suffer emotionally, research and intervention in the area of self-esteem in this population is limited. Yet, according to Carr (2004: 207) the impact of this construct on a child's adjustment has far reaching effects, and research in this area will provide a deeper understanding of the population and open directions for intervention.

In considering the position of the AIDS orphan (Baguma *et al.*, 2005: 369), and drawing on the work of Zinker (1978: 199), the researcher suggests that the societal stigma of AIDS could become introjected into the life the AIDS orphan. He is discriminated against, rejected and abandoned, impoverished and abused (Baguma *et al.*, 2005: 369) and the presence of a lowered self-esteem deems the child vulnerable, resulting in translating of these introjections into bad aspects of the self. These bad parts become

overwhelming, resulting in the continued projection of these onto the world, saying '*the world is bad, everyone hates me and I have no future*' (Bentall, 2004: 247).

When considering the vast impact of self-esteem on the individual, it is clear that this construct may have a significant impact on the AIDS orphan. Geldard and Geldard (2005: 139) have found that a child's self-esteem is inevitably adversely affected in the face of traumatic events. Self-esteem may play a vital role in the AIDS orphan's ability to adjust to their life circumstances and impact their quality of life and future.

Research shows that AIDS orphans are experiencing exceeding psychosocial pressure, yet little is known about the type and magnitude of these problems and the interventions that could address them (Baguma, *et al.*, 2005: 366). According to the researcher there is a lack of research into the area of self-esteem within this population group. The implications of an unhealthy self-esteem, experienced in conjunction with such adverse environmental factors of poverty, stigmatization, social isolation and inconsistent nurturance (Brazdziunas, Roizen, Kohrman & Smith, 1994: 145) are potentially grave. This combination of an unhealthy self-esteem and negative environmental factors may result in such things as dangerous alcohol use, drug use and suicidal ideation or behaviour (Wild, Flisher, Bhana & Lombard, 2004: 1). Engaging in such negative behaviour may further influence such things as school attendance, engagement in violent behaviour, and risky sexual relationships (Kruger & Richter, 2003: 1).

Play therapy is reportedly beneficial for children who have issues with self-esteem, and have experienced loss in their lives. According to Scott (2007: ¶6) lay therapy provides an environment of support, which creatively enhances self-esteem. Children orphaned by HIV/AIDS may greatly benefit from such intervention.

## 1.4 AIMS AND OBJECTIVES

According to Fouché (2002: 107) aims and objectives of research are the “*end towards which effort or ambition is directed*”. Mouton (1996: 101) provides a further description in saying that research aims and objectives provide an overview of what the researcher intends to achieve in their study.

The aim of the research study was to explore and describe the self-esteem of AIDS orphans in middle childhood by means of the following objectives:

- A review of the literature on the subjects of HIV/AIDS and the construct self-esteem, including prior research and theory, is important for the present study. According to Cooper (1984: 9) “the value of any single study is derived as much from how it fits and expands on previous work as from the study’s intrinsic properties”. A literature description, providing an investigation of the historical background of HIV/AIDS and the impact of the disease on South Africa and the proposed population, has therefore been undertaken. Secondly, a literature investigation on self-esteem is provided, giving attention to the area of middle childhood.
- Thirty respondents were sampled by means of a probability sampling technique, making use of randomization (Compare Strydom & Venter, 2002: 203.). The Culture-Free Self-esteem Questionnaire for children, which is a 30-item self report measure of explanatory style and is well used in assessing the self-esteem in young children aged 11 to 15, was employed (Compare Kaslow, Tannebaum & Seligman, 1978.). A review of the literature provided the researcher with information regarding HIV/AIDS, children orphaned by HIV/AIDS and the construct self-esteem. Further information was obtained from the findings of the questionnaire. This information was used together with the information obtained from the literature review in order to arrive at certain conclusions and recommendations at the end of the study.

- Conclusions and recommendations were made to professionals in the field with regards to intervention. The researcher aimed to help those at Jerusalem Ministries working with this population to approach the area of self-esteem, so as to optimize the potential of each child.

## 1.5 HYPOTHESES

According to Davis and Rose (2001: 44) “*hypotheses are formal statements of predictions derived from evidence from earlier research and theory, or simply the result of a hunch*”.

A review of the literature on the construct self-esteem demonstrated that self-esteem can be understood as a socially constructed emotion, which is based on a need for acceptance and belonging to a social group. It further includes components of a desire for efficacy, and self-actualization (Battle, 1992; Maslow, 1970). It was further noted that levels of self-esteem typically fluctuate; mirroring environmental, social and maturational changes (Robins & Trzesniewski, 2005: 158). Self-esteem was therefore considered by the researcher to be a construct that was fairly vulnerable to external influences as well as lifespan and developmental changes. Some of the extraneous factors identified in the literature, experienced by HIV/AIDS orphans, include stressors such as poverty, racism and limited access to resources (Pequegnat & Bray, 1997: 5). These factors were further identified by the researcher as having a negative impact on the development of a positive sense of self in this population. Gerwitz and Gossart-Walker (2000: 315) identify depression, hopelessness and a feeling of loss, as well as confusion, loneliness, fear and suicidal ideation as typically experienced by those associated with HIV.

In considering the nature of self-esteem in light of the challenges faced by HIV/AIDS orphans, hypothesis 1 was constructed.

H1: If a child is orphaned by AIDS, he will have a lowered self-esteem.

H0: If a child is orphaned by AIDS, his self-esteem will not be lowered.

The HIV/AIDS epidemic has been shown in the literature review to affect a large range of people, regardless of age, race, religion or socio-economic status. Despite the range of people affected by this epidemic, and the ongoing awareness campaigns, there remains a largely negative stigma attached to those associated with HIV/AIDS. Children orphaned by HIV/AIDS are largely impacted by this stigmatization, often feeling isolated by society, peers and often by other family members (AVERT, 2007: 11). When considering these factors in light of Battle's (1981: 9) definition of social self-esteem, which refers to the individual's perceptions of the quality of his or her relationship with his or her peers and the associated feelings, the assumption in hypothesis 2 was made.

H2 = If a child is orphaned by HIV/AIDS, the area of social self-esteem will be the lowest.

H0 = If a child is orphaned by HIV/AIDS, the area of social self-esteem will not be the lowest.

## **1.6 RESEARCH APPROACH**

According to Fouché (2002: 104), a research approach refers to whether the research study is qualitative, quantitative or combined qualitative-quantitative. For the purpose of this study, a quantitative research approach was employed. According to Fouché and Delpont (2002: 97), quantitative research is 'concerned with explanations; controlled measurement and obtaining an outsider's perspective of a given phenomenon.

Self-esteem was explored by means of a culture-free psychometric questionnaire. The researcher opted for the quantitative approach as it aims to test hypotheses predicted about an individual's social reality. (Compare Fouché & Delpont, 2002: 81; Durrheim, 2002: 39.)

The focus of this study was therefore to explore and describe by means of a controlled measure the hypothesis mentioned before.

## **1.7 RESEARCH TYPE**

The researcher is motivated by the lack of research in the area of self-esteem and the HIV/AIDS orphan, as such; this research was constructed from an applied strategy, thereby contributing to the literature in this field. According to Mouton (1996: 105), applied research aims at solving a social problem or making a contribution to real-life concerns.

This research can be further described as being exploratory in nature. According to Fouché (2002: 109), exploratory research aims to give an in-depth understanding of a given situation, phenomenon, community or individual. As a descriptive study, this study aims to describe the phenomena explored. This study aimed at exploring and describing the self-esteem of children orphaned by HIV/AIDS.

## **1.8 DESIGN**

For the purpose of this study, a Cross-sectional Survey Design was used. According to Fife-Schaw (2000: 89), the sample in this design is regarded as a cross-section of the population, thereby making it possible to explore the relationship between related variables, such as age and gender. The advantage to this design is that it is both cost and time effective. Also, the response rate when employing this design is generally higher than for other designs. The main disadvantage to this design is that the data obtained may be susceptible to time of measure. Respondents may be influenced by an immediate historic event, such as media coverage.

## **1.9 RESEARCH PROCESS AND METHODOLOGY**

The research process is the way in which the researcher goes about achieving the aims of the study (Haslam & McGarty, 2003: 86). Fouché (2002: 271) makes use of the term 'research strategy', which refers to the plan, made by

the researcher, for conducting the study. The following provides an overview of the research process.

### **1.9.1 Paradigm**

For the purpose of this research study, the researcher will be working from a phenomenological paradigm. When adopting a phenomenological paradigm, the researcher works towards an understanding of an individual's perceptions, perspectives and understanding of a given situation (Fouché & Delpont, 2002: 268). Each individual has a unique position in life, and by joining the environment and reality of the individual, the researcher has the opportunity to experience the actual phenomena and report on it from the individual's perspective. The researcher aimed to work towards a global comprehension of the AIDS orphan's unique experience, position and awareness of his self, thereby working towards a richer understanding of the self-esteem of this population and providing insight into future intervention.

### **1.9.2 Literature Review**

According to Fouché and Delpont (2002: 127) the literature review serves to provide a more comprehensive understanding of nature and meaning of the research problem. Barrett (2000: 27) explains that the literature contains information to aid in the generation of ideas, as well as findings from previous research that can be built upon or questioned. Therefore, according to this author, a review of the literature is essential when planning a research study. For this research, a literature review of HIV/AIDS and self-esteem was undertaken. The researcher made use of books, articles, journals and the internet. Most of the resources were no older than 10 years, yet, in some instances more historic references were referred to where applicable to this study, such as understanding the foundations of the construct self-esteem, such as the contributions made by Maslow (1990) to this field of inquiry.

### **1.9.3 Feasibility of the study**

The researcher had contact with Jerusalem Ministries, a non-profit organization working with children orphaned by HIV/AIDS, which allowed for easy access to a sample for this study. The literature surrounding HIV/AIDS and the construct self-esteem separately is vast, making for easy access to literature.

### **1.9.4 Description of the Universe, Sample and Sampling Technique**

Strydom and Venter (2002: 197) highlight the importance of defining the terms universe, population and sample before undertaking a study. According to these authors the universum includes all subjects possessing the characteristics outlined for the study. The population refers to subjects within the universum who possess specific characteristics, such as being of a specific age. Finally, the sample is a smaller, representative group of the universum and population.

For the purpose of this study, the universum included all children orphaned by HIV/AIDS, between the ages of 11 and 15 years, living in the area of Port Elizabeth in South Africa. The population included children orphaned by HIV/AIDS, between the ages of 11 and 15 years, cared for by Jerusalem Ministries. Finally, the sample for this study included 30 (N=30) children orphaned by HIV/AIDS, between the ages of 11 and 15 years, cared for by Jerusalem Ministries. Of the 30 participants, 16 were boys (n=16) and 14 were girls (n=14). Furthermore, of the 30 participants included, none of these are known to have HIV/AIDS.

Sampling was done by means of probability sampling, making use of randomization. All children orphaned by HIV/AIDS, between the ages of 11 and 15 years, within Jerusalem Ministries, were randomly assigned a number. Thirty of these were then randomly selected to make up a sample.

### **1.9.5 Data Collection and Analysis**

Once the sample was identified, the researcher met with each participant individually. This meeting was held in a private room identified by staff at Jerusalem Ministries, so as to ensure confidentiality. At this time, the researcher explained the research to the participants and explained the process of informed consent and confidentiality. Once consent was obtained, each participant then completed the Culture-free, Self-esteem Questionnaire for children. This is a 30-item self-report measure of self-esteem. The measures was then hand-scored by the researcher, which yielded a score of overall self-esteem, as well as four sub-scales of self-esteem, namely general, social, academic and parental self-esteem. The data was analysed against the literature.

## **1.10 ETHICAL CONSIDERATIONS**

The researcher considers the subject of ethical practice to be of utmost importance and the fundamental principle that underlies the profession of Play Therapy. It was the researcher's sincere intent to ensure that no harm came to any participant of this study. The researcher took measured steps to ensure the following ethical considerations.

### **1.10.1 Ensuring Informed Consent**

When obtaining consent, the researcher is required to ensure that this is voluntary and informed and that participants receive full, non-technical and clear explanation of what is expected of them (compare Durrheim & Wassenaar, 2002: 66; Kazdin, 1998: 436). The researcher provided each participant with a clear outline of research goals, procedure, publishing of results, as well as the possible advantages and disadvantages of this study. Participants were informed that they were free to withdraw from the study at any point without need of an explanation. Guardians were included in this process and also gave their consent.

### **1.10.2 Ensure Confidentiality**

Each participant is entitled to his or her privacy; including the right to decide who receives access to their responses and identity. The researcher is aware of and grateful for the trust each participant placed in her and ensured that there was no breach of confidentiality. The researcher was therefore the only person who had access to the information shared by each participant. No names were revealed at any point in this study.

### **1.10.3 Data Protection**

In order to further ensure confidentiality, all data had been recorded, stored and processed for release under secure conditions, protecting the identity of participants. Furthermore, only relevant information pertaining to the present research study was collected, avoiding unnecessary invasion of privacy.

### **1.10.4 Dissemination of Results**

A publication of research findings will be made available in the UNISA and Huguenot College libraries. A copy of the findings will also be presented to Jerusalem Ministries.

## **1.11 DEFINITION OF KEY TERMS**

For the purpose of this study, the following terms are defined.

### **1.11.1 HIV**

HIV is an acronym for the term 'Human Immunodeficiency Virus' and can be explained as a virus which enters into the cells of the body and weakens the body's ability to fight other disease and infection (Murray, 1999: 5).

It is further described by the Centre of Disease Control and Prevention as the virus which causes, or results in the onset of AIDS (2006).

For the purpose of this study, both definitions will be applied when referring to HIV.

### **1.11.2 AIDS**

Murray (1999: 5) describes AIDS as the disease a person with HIV gets. AIDS is an acronym for 'Acquired Immune Deficiency Syndrome' (Mbuya, 2000: 11). Acquired means that it is not genetically inherited but is a result of an environmental factor. Immune Deficiency describes the resulting weakening of the infected person's immune system, and Syndrome refers to the characteristic of this disease in that it does not present with one specific disease but rather a collection of symptoms.

The researcher agrees with both given definitions and will be adopting both for the present study.

### **1.11.3 Orphan**

An orphan, according to the Wordnet definition, is a child who has lost both parents (2007). The legal term for orphan refers to a child who has, through either death, abandonment or separation, lost both parents (UNAIDS, 2004: 11). This definition has been applied to the study.

### **1.11.4 Self-esteem**

James (1890) provides a definition of self-esteem, describing it as a relationship between ones achievements and ones aspirations, or as the discrepancy between one's ideal and perceived self.

Rosenberg (1965, as cited in Emler, 2001: 11) describes self-esteem as an attitude, either positive or negative, a person has about him or herself.

For the purpose of this study, self-esteem has been defined as a socially constructed emotion, which is based on a need for acceptance and belonging to a social group. It further includes components of a desire for efficacy and self-actualization (Battle, 1992; Maslow, 1970).

## **1.12 RESEARCH REPORT OUTLINE**

This study is made up of five chapters.

Chapter one provides a general introduction to and an overview of the study.

Chapter two consists of a literature review. An overview of the literature on the HIV/AIDS epidemic is provided. Special attention is given to the literature surrounding the HIV/AIDS orphans.

Chapter three also consists of a literature review. Information regarding Self-esteem is discussed in this chapter and includes a discussion on how self-esteem may impact the life of the HIV/AIDS orphans.

Chapter four provides an in-depth presentation on the empirical research. Results are presented in tables and graphs, accompanied by a discussion of findings.

Chapter five consists of a summary of findings, a conclusion and recommendations for future research in this area.

## **1.13 SUMMARY**

Chapter one provided a brief introduction to the study that was undertaken, including an introduction to the topics of both HIV/AIDS and self-esteem. The following two chapters will focus more comprehensively on these subject areas, providing a platform for analysis data collected.

## CHAPTER 2

### LITERATURE REVIEW

#### AN OVERVIEW OF THE IMPACT OF HIV/AIDS ON A NATION

##### 2.1 INTRODUCTION

This chapter focuses on reviewing the literature on HIV/AIDS. HIV/AIDS is a formidable disease that knows no race, age, colour, religious affiliation or sexual orientation. As such, an exploration of the literature covering this subject is immense. The literature review will therefore focus on the impact of this epidemic on the family system in the South African context and more specifically, South African children orphaned by HIV/AIDS.

##### 2.2 THE NATURE OF HIV/AIDS

HIV, Human Immunodeficiency Virus, is the virus that causes AIDS, Acquired Immune Deficiency Syndrome. AIDS is a constellation of symptoms, which manifests as a depletion of a person's immune functioning. The term AIDS was coined in 1982 to replace GRID, Gay-related Immune Deficiency, and at the time the nature and origin of the virus eluded scientists and laypersons alike (Winiarski, 1991: 11).

It is now, according to Rogers (in Lyon & D'Angelo, 2006: 4), widely accepted that some 50 years ago in an African forest, someone got infected with a virus, popularly thought to have come from a monkey, which jumped a species, being transferred from one species to another. Unlike many other viruses that jump species, this one presented as a thief in the night, a slow killer, lying dormant. Rogers (in Lyon & D'Angelo, 2006: 4) explains how this virus emerged at a time of "*economic expansion*" and "*trans-continental mobility*". Many men, typically the family providers, were required to leave

their home and families in search of work. As such, this virus rapidly moved, undetected, across oceans and borders, from Africa to the rest of the world. Now, in 2007, HIV/AIDS has a hold on every nation, sparing none.

### 2.2.1 The Transmission and Prevention of HIV

HIV is transmitted from one person to the next, when a person receives into his body the HIV-infected fluids from another person (Winiarski, 1991: 14). More specifically, there are three main ways in which HIV is transmitted, and Kinghorn and Steinberg (1999: 5) and the Centre for Disease Control and Prevention (CDC) (1999: 1) identify the following routes:

- Transmission through the reception of blood or blood products, which includes blood contained in needles and other supplies shared by intravenous drug users, or via blood transfusion with HIV-contaminated blood.
- Semen and vaginal and cervical secretions transferred during sexual intercourse.
- In utero transmission from an HIV-positive mother to the fetus, through breastfeeding and childbirth.

In the presence of an enduring stigma relating to those infected with HIV, it is important to note that contamination does not occur through day-to-day activities. HIV cannot be contracted through such things as shaking hands, sharing clothes, kissing, sharing toilet seats, sneezing or sharing cups and plates (Murray, 1999: 10).

In a recent study by Rutenberg, Kehus-Alons, Brown, Macintyre, Dallimore and Kaufman (2001: 35) these researchers measured to what extent respondents held fearful and stigmatising attitudes towards those infected with HIV. Over two-thirds of the respondents reported being comfortable engaging in casual contact, but felt uneasy sharing toilet seats, utensils, food and beds. Furthermore, one-quarter of the youths interviewed indicated that HIV-positive students should not be permitted in school (Rutenberg *et al.*,

2001: 36). The impact of such a stigma on those affected and infected with HIV is social isolation, seeing the entire family ostracised (Rankin, Brennan, Schell, Laviwa & Rankin, 2005: 2). Rankin *et al.* (2005: 2) identify the experience of internalised stigma. Here the person infected or affected by HIV, “*ceases to be who they were, instead becoming a unitary ‘person with an illness’ or – more damning – an ‘ill person’, a thing in which personhood and illness have become completely fused*”. The far-reaching impact of stigma on the HIV/AIDS orphan will be explored in greater depth further on in the chapter.

According to Winiarski (1991: 15), the predominant epidemiological pattern of HIV transmission in central Africa and the Caribbean is through heterosexual intercourse, whereas in Northern America and Western Europe, homosexual transmission and transmission via intravenous drug use are the predominant patterns of infection. This is important to note, as irrespective of the cause of transmission, many children orphaned by HIV/AIDS very often end up in either child-headed homes or on the street. According to Kruger and Richter (2003: 8), children living on the street are typically exposed to rape, survival sex and male, homosexual relationships. These researchers further noted that a street child’s sense of invulnerability and low sense of self-worth contribute to them taking greater risks and thus being exposed to HIV.

In light of these patterns of transmission, prevention programmes have been developed aiming at reducing high-risk sexual behaviour. One such programme identified by Tevendale and Lightfoot (in Lyon & D’Angelo, 2006: 167-169) is called Choosing Life: Empowerment, Action, Results (CLEAR). This programme targets “(1) *reducing unsafe sexual behaviour, needle use, and alcohol/drug use to protect others from HIV; (2) improving physical health and adherence to medical regimens; and (3) improving quality of life*” (Tevendale & Lightfoot, in Lyon & D’Angelo, 2006: 167). The effectiveness of this programme is based on the premise that protective behaviours are influenced by self-regulatory skills, social support and the impact of affect and arousal states on self-regulation.

The researcher recognises the significance of nurturing self-regulation as viewed from a Gestalt perspective. Through a process of increasing awareness, new patterns of behaviour are identified and integrated, while old, introjected ideas and behaviours are challenged and dislodged. The new, more effective way of being is set in motion and interruptions in the sensation, awareness and mobility cycle are undone, resulting in increasing insight and improving problem-solving abilities. According to Yontef (1993: 67):

Aware contact creates new, meaningful wholes and thus is in itself an integration of a problem ... Awareness is cognitive, sensory and affective. The person who verbally acknowledges his situation but does not really see it, know it, react to it and feel in response to it is not fully aware and is not in full contact. The person who is aware knows what he does, how he does it, that he has alternatives and that he chooses to be as he is.

In 1996, a complex treatment plan called HAART, Highly Active Antiretroviral Therapy, became available to those infected with HIV, allowing them to live relatively normal lives. However, advances in medical science in the area of HIV are still ongoing and according to Koenig and Bachanas (in Lyon & D'Angelo, 2006: 47) research has shown that people are less likely to adhere to medication without educational input. People living in poor conditions, those without health insurance and substance abusers are also less likely to comply with the taking of medication. For these reasons, programmes such as CLEAR, referred to earlier, are crucial in the fight against HIV/AIDS.

### 2.3 HIV/AIDS: A GLOBAL EPIDEMIC AND THE SOUTH AFRICAN CONTEXT

HIV/AIDS is a global epidemic. It has altered the face of the world and despite increasing awareness the threat of this disease has lost little momentum. Levine, Foster and Williamson (2004: 1) give reference to the fact that the last children born before the emergence of HIV are now in their mid-twenties, and that in all probability, children born in the foreseeable future

will be living in a world, “*where the epidemic persists, albeit with variable consequences for each of them*”.

In 1991, 15 000 people were infected with HIV and approximately 800 known to have AIDS. Two decades later, in 2001 an estimated 40 million people were living with HIV/AIDS, including 2.7 million children (Kennedy, 2003: 17). The continent worst affected by this epidemic is Africa, with South Africa reportedly having the largest number of people living with HIV/AIDS in the world (UNAIDS, 2004: 12). UNICEF (as cited in Freeman & Nkomo, 2006: 302) estimates that by 2010, 20 million children under the age of 15 will be orphaned by AIDS, with the majority of these being in South Africa.

Table 2.1 provides a representation of the number of HIV/AIDS orphans living in some of the Sub-Saharan African countries (AVERT, 2007: 2).

**Table 2.1** Number of Orphans due to AIDS, 2005

South Africa	1,200,000
Tanzania	1,100,000
Zimbabwe	1,100,000
Kenya	1,100,000
Uganda	1,000,000
Nigeria	9,300,000
Zambia	710,000
DR Congo	680,000
Malawi	550,000

Each country has a percentage of orphans due to circumstances other than HIV/AIDS. However, in many countries, the number of orphans is dominated by those who have lost their parents to HIV/AIDS (AVERT, 2007: 3). Table 2.2 shows the proportion of children that are orphaned by HIV/AIDS from the total national numbers of orphans.

**Table 2.2** AIDS Orphans as a Percentage of all Orphans, 2005

Zimbabwe	77%
Botswana	76%
Swaziland	66%
Lesotho	64%
Malawi	57%
Zambia	57%
South Africa	49%
Kenya	46%
Uganda	45%

Nghonyama (2005: 35) identifies the following factors that make South Africa more vulnerable to this epidemic:

- High levels of poverty;
- Disrupted families and communities;
- Cultural shunning of condom use;
- The cultural acceptance and encouragement of men to have more than one sexual partner;
- Women's inferior status in society and in relationships, economic dependence and the threat of physical abuse make them more vulnerable to infection;
- Developed transport routes and increased mobility allow for a rapid movement of the epidemic to new communities and
- A cultural resistance to the open discussion of sexual matters with children.

From this it can be concluded that despite medical advances in the area of HIV/AIDS, for the containment of this epidemic in the South African, and possible worldwide context, attitudinal changes are paramount.

## 2.4 HIV/AIDS'S IMPACT ON CHILDREN

The HIV/AIDS epidemic in South Africa places a significant strain on societal resources. One of the most devastating social consequences of HIV is the extensive number of children orphaned by the AIDS illnesses. Typically, an epidemic places the greatest threat to the elderly of a population. However, the HIV epidemic is most likely to attack the productive and caregivers (Christiansen, 2005: 173). As a result of the increase in orphaned children and escalating mortality rates among people in the reproductive years, an increasing demand is placed on the community for adequate childcare. Snipstad, Lie and Winje (2005: 183) identify the importance of social support and collective efficacy in meeting the demands that result from this increasing loss of a generation. However, these researchers state that the responses required by the community to meet this growing need are unfortunately contaminated by stigma and social isolation. Snipstad *et al* (2005: 183) goes on to say that the “*statistics on the number and plight of affected children are overwhelming, yet the numbers cannot justly describe their multidimensional experience of adversity and poverty*”.

### 2.4.1 The Impact on Families and Children

The Interagency Coalition on AIDS and Development (ICAD, 2002: 1), defines children affected by HIV/AIDS as those who:

- Are infected with HIV;
- Have AIDS;
- Have parents who are sick or have died of AIDS;
- Have siblings, friends or relatives who are sick or have died from AIDS;
- Have other children orphaned by AIDS living with their family or

- Are at high risk of infection.

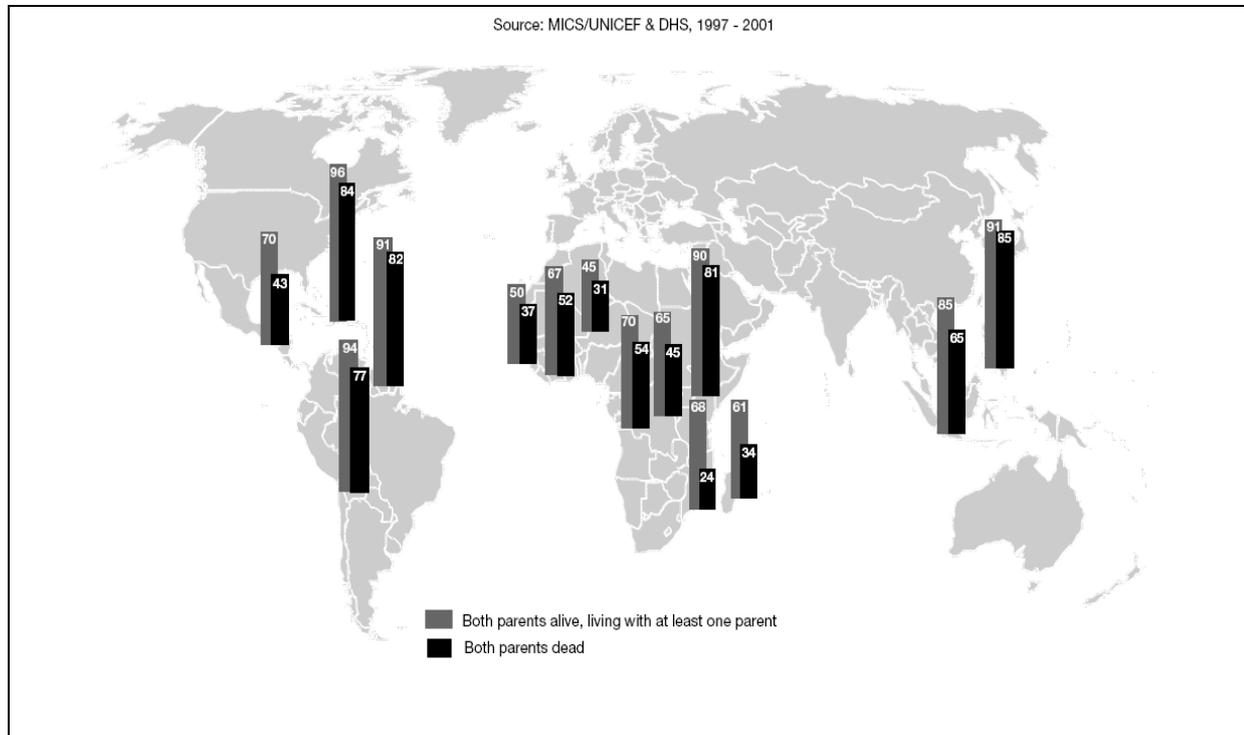
In Africa, UNICEF (2003: 22) identifies the extended family as the traditional social security system where the members are responsible for the protection of the vulnerable and care of the poor and sick. However, hopes that the extended family would be sufficient to absorb the full social, economic and psychological impacts arising from the AIDS epidemic, have been found by UNICEF (2003: 22) to be unrealistic.

The needs of children are wide and varied, extending from such things as food, shelter, education and physical health care, to vital emotional and psychological needs. These may also vary in relation to the developmental stage and other social factors that the child may present. Moreover, children orphaned by AIDS are more likely to require added emotional support from caregivers (Freeman & Nkomo, 2006: 303).

The added stresses placed on a household as a result of HIV/AIDS are far reaching. Many families suffer a loss of income from having to stay home and care for the infected family member. The household income endures added loss of wages and income to a rise in spending, particularly spending related to increased medical care and funeral costs. The cycle of poverty and unemployment is reinforced and maintained as a result of lack of finance for schooling and education (UNICEF, 2003: 22).

Other influences that hinder school attendance include children having to stay home to care for other siblings, having to seek employment to help support the family and being exploited by others (AVERT, 2007:8). Furthermore, AIDS orphans do not receive the valuable life-skill knowledge that a parent would typically pass on. AVERT (2007:8) says that without this knowledge and skills gained through school education and parental guidance, “*children may be more likely to face social, economic and health problems as they grow up*”.

Figure 2.1 provides a visual representation of the proportion of children between the ages of 10 and 14 years, who are still in school according to whether their parents are alive or dead (USAID, 2002:12).



**Figure 2.1:** Proportion of children still in school

A case documented by CNN (1999: 1) tells the overwhelming story of KwaZulu-Natal resident's life, caring for 17 orphans. She is a mother to seven children, and has adopted six grandchildren from two of her own children who died from AIDS, as well as several more from other relatives who have succumbed to AIDS. The financial strain alone is such that she does not manage to school or clothe the children.

In a study by Bledsoe (as cited in Freeman & Nkomo, 2006: 303), this researcher found that orphaned children absorbed into a fostering family were treated inferior to the biological children of the family. Further problems arise in that many caregivers were found to be too young or too old to provide adequate care for the orphaned child. Due to the overwhelming demands of caring for an orphaned child, many families are only able to take in one child, resulting in the separation of siblings. This separation places added emotional

and psychological stress on the children, and Bledsoe (as cited in Freeman & Nkomo, 2006: 303) found that many children opted for child-headed households as a way of avoiding this separation.

The ICAD (2002: 2) summarises the arising problems and needs for children affected by HIV and AIDS:

- The threat of psycho-social distress;
- Increased exposure to discrimination and stigmatisation;
- Increased resulting malnutrition;
- Increased risk to personal safety;
- Lack of parental supervision;
- Increased demands on health care systems, resulting in decreased availability and access to health care;
- Loss of inheritance results in fewer opportunities for school and education;
- Increased homelessness, vagrancy, starvation, crime and
- Increased vulnerability and exposure to HIV infection and other STDs (sexually transmitted diseases).

#### 2.4.2 Living with the Stigma

The word *stigma* is derived from Greek, meaning a tattoo or brand used in identifying a criminal or slave (Brookes & Gilmour, 2000: 541). *Stigma*, according to Brookes and Gilmore (2000: 541) is synonymous with disgrace and being reproached, dishonoured and shamed. The psychological impact of stigmatisation, as noted by Krauss, Godfrey, O'Day, Freidin and Kaplan (in Lyon & D'Angelo, 2006: 86) is that a person's identity formation depends greatly on how people react to him/her. These researchers clarify how stigmatisation often results in self-blame and shame, and give reference to scientific writings on how stigma "*spoils the identity*", leaving it incomplete, likening it to a "*formerly perfect fruit with bruises*" (Krauss *et al*, in Lyon & D'Angelo, 2006: 86).

The researcher, drawing on her own experience in working with institutionalised children orphaned by AIDS, realised the shame and inferiority that these children often present with. The shame response of many of these children, in the researcher's experience, is that of belonging to a certain 'out-group', punished for the way they are. According to an international AIDS charity, AVERT (2007: 11), children orphaned by HIV/AIDS often have to deal with the associated stigmatisation by society due to their association with AIDS. This is further exacerbated by the trauma of grieving for the loss of their parents. AVERT notes that the distress and social isolation felt by these orphans is compounded by shame, fear and rejection.

The researcher identifies two factors contributing to stigmatisation towards those having or those associated with HIV/AIDS. The first is that of fear. Krauss *et al.* (in Lyon & D'Angelo, 2006: 89) draw attention to research supporting the idea that stigma materializes from misconceptions about transmission. Furthermore, these researchers suggest that for fear and avoidance to occur, fear needs to be shared with a feeling of have little control over that which is feared. Therefore, due to insufficient or incorrect knowledge on HIV and its transmission, people fear that they might be infected and that they have no control over this. This fear results in avoidant behaviour and rejecting that which they fear, in this case, those infected and affected by HIV.

The second contributing factor is derived from considering the routes of transmission and people's 'beliefs' regarding these. Despite society becoming less rigid in their attitude towards drug use and sexually transmitted diseases (STDs), drug users and people carrying STDs or engaging in risky sexual behaviour still feel judged and shamed. According to Wild (2001: 12) the terms 'junkie' (describing drug users), 'gay' and 'promiscuous' are still strongly associated with the transmission of HIV. This stereotyping, according to the researcher, results in the grouping and negative labelling of those infected and affected by HIV, reinforcing the stigma.

Krauss *et al.* (in Lyon & D'Angelo, 2006: 88) identify the impact of stigma on those infected and affected by HIV, in that “*shame and the experience, or even expectation, of reproach lead people to stay away from others and to become socially isolated*”. The researcher is aware of the tendency of people to avoid hurtful situations, or situations where someone is made to feel embarrassed, as if something is wrong with him/her. Stigma is therefore closely linked to isolation (Krauss *et al.*, in Lyon & D'Angelo, 2006: 88).

The researcher identifies a ‘vicious cycle’ in that the more the HIV infected or affected individual feels stigmatised, the more they are likely to avoid situations encouraging this. However, the more they present with avoidant behaviour, the more likely it is that HIV remains a threatening, misunderstood illness, thus reinforcing the stigma. Rankin *et al.* (2005: 2) identify the fear of stigma as limiting the “*efficacy of HIV-testing programs*”. Pregnant women avoid HIV testing for fear of stigmatisation. These researchers further identify how stigmatisation reinforces social oppression and social isolation (Rankin *et al.*, 2005: 4).

Secrecy, like avoidance of social situations, is a common defence used by those infected or affected by HIV to avoid discrimination. Children, who are aware of their parent’s HIV status, tend to hide the diagnosis from their families and communities. The result, however, is that these children become isolated and miss out on the opportunity to receive support. Secrecy leaves the child without anyone outside of the family with whom to share their fears and hurt (Rankin *et al.*, 2005: 2). According to Zayas and Romano (in O’Dane & Levine, 1994: 64), children often choose not to disclose the HIV status of their parents in an attempt to protect them. Furthermore, these researchers identify that in keeping the HIV status of their parents a secret, children are deprived of the opportunity to discuss their fears of the future, and the possibility for dealing with the pending loss and stigma increases (Zayas & Romano, in O’Dane & Levine, 1994: 64).

It is clear that a stigma impacts not only on the person stigmatised, but also on the entire community. Since stigma encourages isolation and secrecy, this inhibits the open discussion of HIV.

### 2.4.3 The Psychological Impact

Families affected by HIV very often have to face challenges above and beyond that of those associated with the disease. Regardless of whether the infected person is the parent, sibling, child or relative, the entire family is subject to psychological distress. Pequegnat and Bray (1997: 5) identify stressors such as poverty, racism and limited access to resources, as contributing to the psychological distress of those affected by HIV as well as aggravating commonly associated psychiatric disorders. Depression, hopelessness and a feeling of loss, as well as confusion, loneliness, fear and suicidal ideation are all typically experienced by those associated with HIV (Gerwitz & Gossart-Walker, 2000: 315).

Research carried out by Bauman, Camacho, Silver, Hudis and Draimin (2002: 39) explored the behavioural problems of school-aged children with mothers infected with HIV. These researchers found that children of mothers with HIV were more likely to experience both behavioural and emotional problems, presenting with such things as anxious or aggressive behaviour and a depressed mood. These researchers further observed more behavioural and emotional problems in children, when the mother experienced greater psychological distress. It is hypothesised that the experience of loss on the child will be greater in a family that is cohesive and enmeshed, where the loss of a mother will be strongly felt (Bauman *et al.*, 2002: 50).

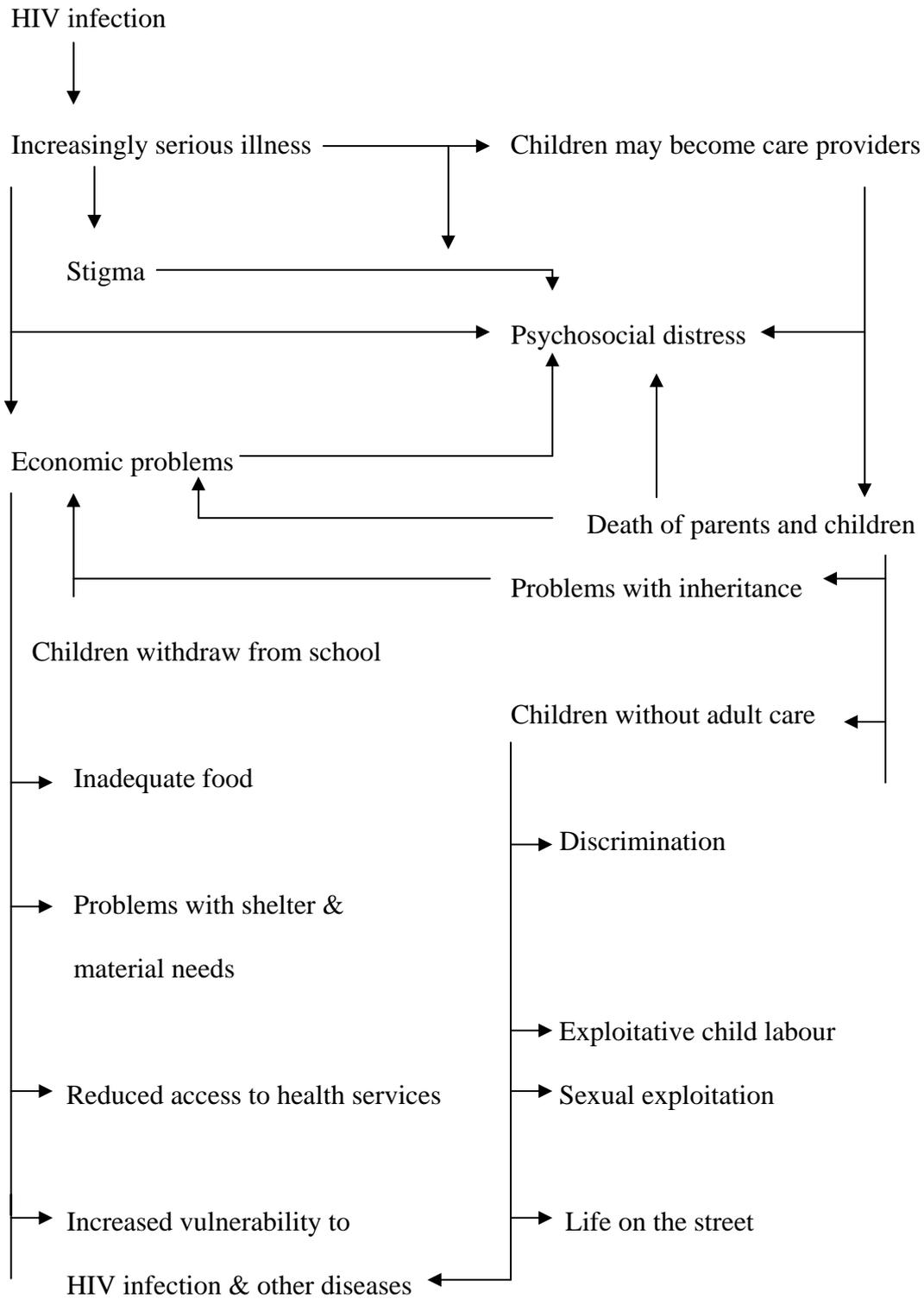
Further research in the area of mental health issues observed that HIV infected mothers are often overwhelmed by their HIV status or engaging in drug use and having further physical and mental health problems, that they are unable to provide emotionally for their children (Ellenbogen & Hodgins, 2004: 113;

Szapocznik, Feaster, Mitrani, Prado, Smith, Robinson-Batista, Schwartz, Mauer & Robbins, 2004: 298; Sander & McCarty, 2005: 203).

According to the researchers Fonagy, Gergely, Jurist and Target (2004: 57), developmental delays and psychological vulnerabilities in later life are strongly associated with maternal neglect in the early years. Children of HIV infected parents often meet the overwhelming task of taking on inappropriate roles, negotiating problems without support or parental guidance and having to cope with unstable living arrangements. Pequegnat (in Lyon & D'Angelo, 2006: 130) identifies the consequences of these as threatening the ability of the child to develop age-appropriate activities that nurture psychosocial developmental and the acquisition of cognitive skills. Furthermore, research into maternal absence and neglect, carried out by Newcomb, Locke and Goodyear, (2003: 219), revealed an association between a disrupted mother-child relationship due to HIV and risky sexual behaviour, psychological distress, drug use and negative self-efficacy.

Lastly, children of HIV parents have to come to terms with the pending loss of a parent. The loss of a parent has a distinctive effect on a child. Rotheram-Borus, Weiss, Alber and Lester (2005: 221) explored the impact of HIV-related parental death on 414 adolescents over the age of six. These researchers found that bereaved children had significantly more emotional distress, negative life events and contact with the criminal system than non-bereaved children. Furthermore, depressive symptoms, passive problem solving, and risky sexual behaviour were found by these researchers to increase following the passing of a parent.

Figure 2.2 (Levine *et al.*, 2004: 7) provides a visual summary of the far-reaching impact of HIV/AIDS on the individual and society.



**Figure 2.2** The Impacts of HIV/AIDS on children – A Vicious Cycle

From this figure it can be shown how children, whose parents are infected by HIV/AIDS, can become caught up in a vicious cycle of poverty, lack of schooling, discrimination and more.

## 2.5 SUMMARY

A review of the literature presents a devastating picture of the nature and impact of HIV/AIDS. Many people feel the impact of this disease, yet children deserve special attention. Children experience a multitude of related problems associated with HIV, and are very often not properly equipped to deal with the challenges they face. Concerns regarding the progression of the illness in their family members, difficulties in maintaining routine life, and in handling the stigma associated with HIV, isolation and guilt are just some of the identified problems facing these children.

HIV/AIDS can thus be seen as having far-reaching effects. AIDS presents as a constellation of illnesses, as well as a constellation of psychological, political, social and economic issues. In considering the literature on HIV/AIDS and the impact it has on children orphaned by the disease, the researcher is of the impression that a large body of focus needs to be placed on the children. Confronting this menacing disease through nurturing the children affected by HIV, the researcher believes that the 'vicious cycle' will be disrupted. It is felt that the age-old saying of 'prevention is better than cure' is truly applicable to this condition.

Chapter two provided a literature review of HIV/AIDS, with a focus on South African children orphaned by HIV/AIDS. The researcher thus met the first aim of the research, namely to explore the literature on HIV/AIDS. The following chapter will focus on the construct self-esteem and the protective factors of this construct on a child faced with the problems associated with HIV/AIDS.

## CHAPTER 3

### LITERATURE REVIEW

#### AN OVERVIEW OF THE CONSTRUCT SELF-ESTEEM

##### 3.1 INTRODUCTION

What can't you hear, see or touch, but it is there every time you look in the mirror, it is in your voice whenever you talk about yourself and it affects the way you feel? *Self-esteem*. The construct self-esteem is one that is frequently referred to in both popular culture and social science, with its origins going back to at least 1890, making it one of psychology's oldest themes. Still, over a century later, this construct is still considered fundamental in the social sciences (Mruk, 1999: 2). The following chapter will provide an overview of the construct self-esteem, considering a variety of available definitions of self-esteem and the nature of this construct. The development of self-esteem, the factors influencing the development of self-esteem and the function of self-esteem will also be discussed. Finally, the chapter will conclude with a review of the literature on self-esteem enhancement.

Children orphaned by HIV/AIDS very often experience a large number of negative experiences including stigmatization, rejection, exploitation and emotional neglect. Studies indicate that these children often suffer higher rates of depression, anxiety and anger compared to controls (AVERT, 2007: 9). A healthy self-esteem in the face of all these difficulties is an important variable in protecting these children against such secondary problems as depression, lack of motivation, dropping out of school and engaging in risky behaviour (Rosenberg & Owens, 2001: 408,409).

## 3.2 TOWARDS A DEFINITION OF SELF-ESTEEM

Self-esteem has received contributions from almost every leading theoretical perspective. The psychodynamic approach constructed self-esteem as being a developmental process; the social psychologists concentrate on the formation of attitudes. The cognitive-behavioural perspective conceptualised self-esteem in terms of coping strategies and problem solving skills, while the humanistic approach highlights the experiential elements of self-esteem (Mruk, 1999: 2). Maslow (1970: 45) described self-esteem in terms of a person's feelings of worth and confidence, which is based on actual competence and not on the opinions of others. Clemens and Bean (1981: 35) however, describe self-esteem as arising from a feeling of satisfaction which results from having one's needs met. A problem arising from having so many varying perspectives on self-esteem is the resulting difficulty in arriving at a definition. Further compounding this problem is that self-esteem is a human phenomenon, and as such, most people would be able to describe their experience of this phenomenon and provide a definition for this construct. Research (Smelser, 1989, in Mruk, 1999: 10) exploring the definitions of self-esteem found that there are, in essence, "*as many ways to define self-esteem as there are people trying to do so*" (Mruk, 1999: 8). From a phenomenological perspective, this problem of arriving at a definition can be understood in terms of *perception* (Scott, 2002: 11) in that each time a new position is taken, only a part of the field is in view, while the rest remains hidden. In order to achieve a global, comprehensive understanding of self-esteem, one is required to consider a variety of definitions.

James (1890), widely considered the father of this field of study (Emler, 2001: 10), described self-esteem as a relationship between one's achievements and one's aspirations, or as the discrepancy between one's ideal and perceived self, providing the following definition:

So our self-feeling in this world depends entirely on what we back ourselves to be and do. It is determined by the ratio of our actualities to

our supposed potentialities; a fraction of which our pretensions are the denominator and the numerator our success: thus,

$$\text{Self-esteem} = \frac{\text{Successes}}{\text{Pretensions}}$$

Such a fraction may be increased as well by diminishing the denominator as by increasing the numerator (James, 1983: 296).

According to this formula, achieving success and avoiding failure maintain self-esteem. Furthermore, this formula identifies the importance of pretensions or aspirations, in that success cannot be measured objectively, but is relevant to the person's individual aspirations (Emler, 2001: 10).

Mruk (2006: 12) identifies both advantages and disadvantages to this approach. Since competence is mostly observable, it is measurable. Also, competence is part of a developmental process, such as achieving age appropriate skills, making it easier to research the connection between self-esteem and actions. Mruk (2006: 12) also identifies two major disadvantages to this approach. Firstly, people may achieve success in areas that are undesirable, for example a con artist, and such behaviour is in direct opposition to the abilities typically associated with healthy self-esteem. Also, many people with low self-esteem can also be very able in a variety of areas such as a career or sport.

Rosenberg (1965, as cited in Emler, 2001: 11) offers a definition of self-esteem in which it is understood as an attitude, either positive or negative, a person has about him- or herself. Rosenberg (1979, as cited in Bednar & Peterson, 1996: 40) identified three distinct selves: "*the extant self (as one privately views oneself), the desired self (as one would like to be), and the presenting self (the self one attempts to disclose to others)*". Problems in self-esteem arise when there is marked disparity between these selves. For

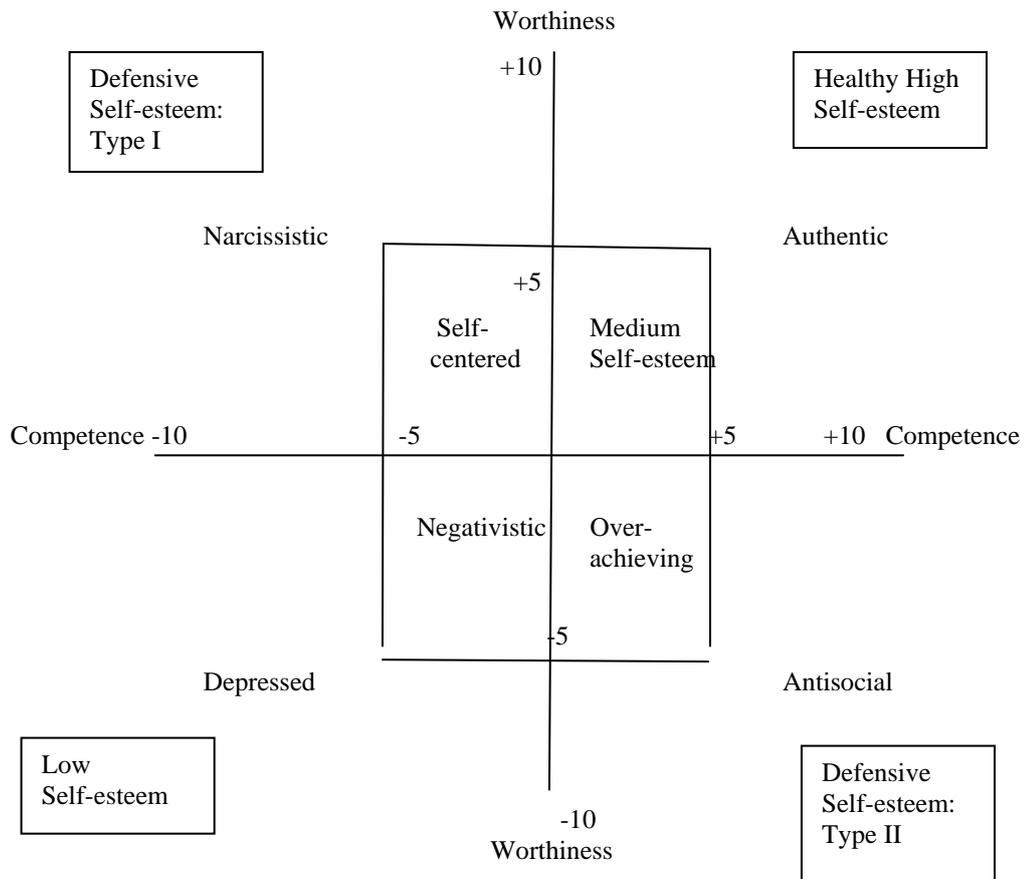
example, an individual may privately view himself as being inadequate, yet having a desire to be confident, and therefore projecting an impression of confidence to others in an attempt to gain verification for the desired self. However, the disparity between the presenting self and the extant self results instead in feelings of apprehension and insecurity. Therefore, what influences self-esteem is not just the behaviour, but rather the individual's interpretation of their behaviour.

The advantage to this definition of self-esteem is that it is easy to measure an individual's global feeling about him- or herself (Mruk, 2006: 11). However, the disadvantage to viewing self-esteem in terms of feelings of worth alone, as noted by Mruk (2006: 12) arises in that *'to feel good about oneself without earning it risks all kinds of problems, such as tolerating undesirable academic performance in school, facilitating the development of narcissism, or even risking an increase in the likelihood of violence'*. The difference between high self-esteem and narcissism, according to Mruk's criticism of this definition, becomes marginal, and self-esteem enhancing programmes based on this definition aim simply at making a person feel good about him- or herself, instead of matching feelings of worth to actual behaviour.

Branden (1969: 110) explains self-esteem as the integration of two components, namely self-efficacy and self-respect (competence and worthiness).

Self-esteem has two interrelated aspects: it entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is competent to live and worthy of living.

This definition considers both competence and worthiness, and the relationship between these two constructs. Mruk (2006: 13) provides a visual presentation of this definition in the form of a self-esteem matrix.



**Figure 3.1** Self-esteem Matrix

From this diagram, four types of self-esteem can be identified. The top right quadrant represents healthy, high self-esteem, which is comprised of high self-worth and competence. This is contrasted in the lower left quadrant by low self-esteem, which includes a low sense of self-worth and low competence. A further two defensive self-esteem types are identified in this diagram. The first defensive self-esteem is comprised of a high sense of self-worth and low competence with associated problem behaviours of self-centeredness and narcissism. The second defensive self-esteem includes high competence but a low sense of self-worth with resulting defensive problem behaviours such as overachieving and antisocial behaviour (Mruk, 2006: 13).

Finally, Battle (1992: 3) offers a definition of self-esteem which gives reference to the cognitive self-evaluations or perceptions, and subjective feelings an individual has about his or her own worth. Where the 'self' is a composite of the person's feelings, fears, hopes, thoughts and views of who he or she is, has been or might become, in terms of the self and his or her relationship with others. Therefore, the cognitive evaluations and feelings of acceptance by others are an important aspect of the construct self-esteem.

Against the background of the foregone literature review, self-esteem can be considered a construct that has received interest and contributions from a vast array of fields and perspectives. As such, a number of definitions have been put forth, with a great deal of debate in the scientific community in arriving at a consensus. However, the researcher is able to identify common themes of cognitive, affective and social aspects of self-esteem. The cognitive aspect of self-esteem takes into account the cognitive evaluations an individual makes about his or her worth, including perceptions, beliefs and attitudes (Battle, 1992; Branden, 1969). Feelings of positive or negative self-regard as well as having one's emotional needs met make up the affective aspect of self-esteem (Battle, 1992; Branden, 1969; Clemens & Bean, 1981). Finally, the social aspect of self-esteem is represented by self-appraisal and social comparison and a sense of belonging and being accepted as a member of a group (Battle, 1992; Maslow, 1970).

In considering the foregone literature review and the emerging themes of self-esteem, the following definition is adopted for the present research as it takes into account the principles of the phenomenological, humanistic approach to the human experience, making it applicable to the context of the HIV/AIDS orphan: self-esteem is a socially constructed emotion, which is based on a need for acceptance and belonging to a social group; it further includes components of a desire for efficacy and self-actualization (Battle, 1992; Maslow, 1970).

### 3.3 THE NATURE OF SELF-ESTEEM

Self-esteem can be examined from either a unidimensional or multidimensional theoretical perspective (Marsh, Craven & Martin, 2006: 16). The unidimensional perspective of self-esteem conceptualises this construct in singular, global terms, whereas the multidimensional perspective puts forward that self-esteem is both hierarchical and based on multiple, distinct qualities (Marsh, 2006: 16).

The unidimensional perspective of self-esteem has received much criticism in the literature, in that it has been found to ignore the specific as well as global aspects of the self-concept, as well as the idea that global self-concept is somewhat differentiated from other, more specific features of self-concept (Marsh, Craven & Martin, 2006: 191). According to these researchers,

If the role of self-concept research is to better understand the complexity of self in different contexts, to predict a wide variety of behaviours, to provide outcome measures for diverse interventions, and to relate self-concept to other constructs, then specific domains of self-concept are more useful than a general domain.

The multidimensional perspective of self-esteem has received increasing recognition as to its value, in that it remains with the idea that there are different types of self-esteem within each person (Marsh *et al.*, 2006: 16). Battle (1981: 9) adheres to this view of self-esteem and differentiates the following components as general, social, academic and parent-related self-esteem for children. A global self-esteem is equal to the sum of these individual components.

The multidimensional approach will be used for the purpose of the present research. As such, the researcher will be able to consider both global self-esteem as well as other interpersonal and intrapersonal aspects of self-esteem.

### 3.3.1 Battle's Model of Self-esteem

Battle (1981: 9) identifies four dimensions, namely general, social, academic and parent-related self-esteem, as comprising the global construct self-esteem for children. For adults, this changes to include general, social and personal self-esteem. Within this conceptualisation, general self-esteem refers to the overall perceptions and feelings of worth an individual has about him- or herself; social self-esteem refers to the individual's perceptions of the quality of his or her relationship with his or her peers and the associated feelings; academic self-esteem is that aspect of self-esteem that involves the individual's beliefs and feelings regarding his or her self-efficacy and ability to cope with challenges; finally, parent-related self-esteem refers to the individual's perception of the feelings and beliefs their parents hold towards them. When combined, these four dimensions of self-esteem make up global self-esteem. Battle (1981: 10) further emphasises the affective (subjective feelings), personal (social acceptance) and cognitive aspects (self-evaluation) of self-esteem.

## 3.4 LIFE-SPAN DEVELOPMENT OF SELF-ESTEEM

Through life, self-esteem has been found to show fairly predictable patterns of increase and decrease. According to these researchers, these changes in self-esteem mirror an individual's social, environmental and maturational changes such as puberty and age-related cognitive decline. Since research has demonstrated that most people experience these fluctuations in self-esteem at about the same age and in a similar manner, a consensus has emerged about the life-span development of self-esteem (Robins & Trzesniewski, 2005: 158).

### 3.4.1 Early Childhood

In considering the emergence and development of self-esteem, Harter (2006: 144, 145) highlights important developmental questions: 1) at what age does a child's sense of worth, as a person, first emerge? 2) When are children first

able to verbalise their worth as a person, their global self-esteem? 3) ‘*What determines whether such an evaluation is positive or negative?*’ According to Harter (2006: 145) research findings indicate that the ability for a child to reflect on who they are as a person and self-evaluate, does not emerge until the age of 8. This can be further explained by Piaget’s stages of development (as cited in Atkinson, Atkinson, Smith, Bem & Nolen-Hoeksema, 2000: 77). Prior to this age, that is between the ages of 2 and 7 years, children are in what Piaget referred to as the pre-operational stage. This stage is characterised by *egocentrism*, where children are not aware of the perspectives of others, and cannot appreciate that other people have their own point of view. As such, children at this stage cannot accurately evaluate what others (parents and peers) think of them. Similarly, they do not yet have the cognitive ability to reflect on their environment and engage in social comparison. Children in the pre-operational stage are able to evaluate singular domains of competence and adequacy such as physical abilities and appearance, but lack the cognitive ability to combine these domains and arrive at an overall self-esteem (Harter, 2006: 145).

### 3.4.2 Middle Childhood

Piaget (Atkinson *et al*, 2000: 80) refers to the stage between the ages of 8 and 12 years as the concrete operational stage. During this stage cognitive abilities develop and egocentric thinking begins to wane; children start paying attention to the views of others, and learn that other people have beliefs and opinions that are different to their own. As such, children begin to evaluate themselves based on social comparisons and external feedback. According to Robins and Trzensniewski (2005: 159) children at this stage begin to form more accurate appraisals of their ‘*academic competence, social skills, attractiveness, and other personal characteristics*’; receiving negative feedback would result in ‘*their self-evaluations correspondingly becoming more negative*’.

### 3.4.3 Adolescence

Adolescence, according to Piaget's model of cognitive development (as cited in Atkinson *et al*, 2000: 80) is marked by the development of formal operational thought. This stage is characterised by an evident progression in cognitive abilities. As such, adolescents increasingly imagine for themselves what others think of them, and tend to perceive these evaluations as critical and negative. This results in increased concerns about body image, academic efficacy and acceptance. The opinions of their parents become less central to the self-evaluation, and focus shifts to the judgment of their peers. Robins and Trzesniewski (2005: 159) attribute these changes to the normative decline in self-esteem over this period.

### 3.4.4 Adulthood

According to Robins and Trzesniewski (2005: 159), the normative trajectory across the life span shows a gradual increase in self-esteem throughout adulthood, peaking at the age of 60. According to Erikson's stages of psychosocial development (as cited by Van Wagner, 2007: 4) adulthood marks the stage of generativity vs. stagnation. Development here is typically marked by increased mastery and self-actualizing, with a focus on promoting feelings of self-worth and increased control over the environment (Van Wagner, 2007: 4). Furthermore, personality changes signify '*increased levels of maturity and adjustment, as indicated by higher levels of conscientiousness and emotional stability*' (Robins & Trzesniewski, 2005: 159).

### 3.4.5 Old Age

From the age of 70, research indicates a steady decline in self-esteem. This decline has been attributed to the many losses associated with aging, including the loss of loved ones, changes in status, decline in physical functioning and cognitive declines (Robins & Trzesniewski, 2005:160). A further explanation is offered by Erikson's psychosocial stage of integrity vs. despair (Van

Wagner, 2007:5). Successful negotiation of one's life results in positive reflection and a feeling of integrity. This is further associated with a humble and more balanced view of oneself, and openness to admit to weaknesses (Robins & Trzesniewski, 2005:160).

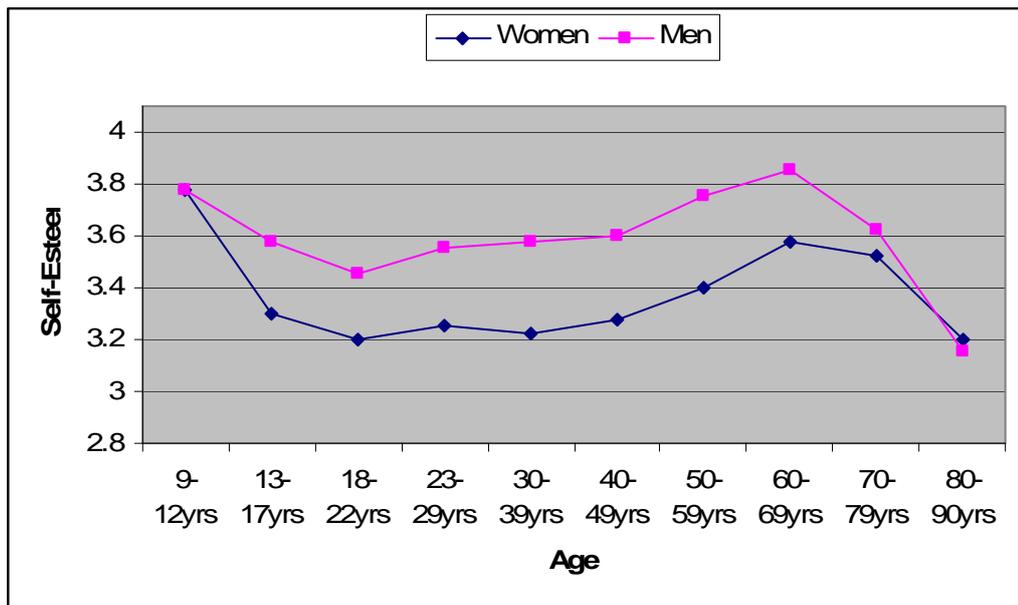
### 3.4.6 Gender Differences

Research similarly reveals a trajectory of self-esteem for both females and males, with some divergence occurring during adolescence, where males attain slightly higher levels of self-esteem which persists until old age, where the gap narrows (Robins & Trzesniewski, 2005: 160). Some explanations for these differences are offered by Demo (2001: 148):

- In childhood, girls evaluate their athletic abilities as being inferior to that of boys;
- In adolescence, girls have a poorer appraisal of their body image and general appearance and
- In adolescence, girls view themselves as being academically superior, more responsible and being stronger in personal character than boys.

These explanations provide some insight into the gender differences in self-esteem, however there is a lack of empirical evidence and theoretical models explaining this process.

Figure 3.2 offers a presentation of the normative trajectory of self-esteem across the life span, as outlined by Robins and Trzesniewski (2005: 159).



**Figure 3.2** Mean Levels of Self-esteem for Males and Females across the Life-span

From this figure it can be seen how self-esteem begins fairly high during early childhood and gradually decrease, reaching a low at the age of 18 years. It gradually increases again, reaching a peak at the age of 60 years, which is followed by a rapid decline in later life. Figure 3.2 also shows how, on a whole, men experience higher levels of self-esteem throughout the life span, except in early childhood (9-12 years) and later life (80-90 years).

### 3.5 FACTORS INFLUENCING THE DEVELOPMENT OF SELF-ESTEEM IN CHILDHOOD AND ADOLESCENCE

Self-esteem appears to be a universally experienced human phenomenon, some cultural differences may exist, but mostly people are influenced by how others evaluate them, have their feelings about themselves altered by their own actions, and would choose rather to have good than bad feelings about themselves (Leary, 2006: 197). The researcher considers some of the factors influencing the development of self-esteem. These factors (family, peer

relations and school and social inequality) have been highlighted as they relate directly to the areas of disruption identified in the life of the HIV/AIDS orphan (Levine *et al* 2004: 7).

### 3.5.1 Family Relations and Self-esteem

Parents, or the primary significant other, are considered to be the centre players in the development of a child's self-esteem. Most children and adolescents hold their parents in high regard and with great affection, and as such the child's perception of the parent's evaluation of them, greatly impacts on the formation of their self-esteem (Demo, 2001: 143). Parents both encourage and criticize their children's attempts to grow and define who they are; these are gradually introjected or internalized, and become the voice within, the same voice they use to judge their own self-worth (Bednar & Peterson, 1996: 48).

According to Coopersmith (as cited in Bednar & Peterson, 1996: 49), there are three main characteristics of parents of high self-esteem children. Firstly, the ability of the parents to communicate their acceptance of their child, giving the child a sense of belonging and value. Secondly, parents who create an environment which encourages a healthy balance between demands and limits communication to the child that they are confident in their abilities to meet the expected behaviour. Thirdly, parental respect nurtures individuality and uniqueness within healthy boundaries. According to Coopersmith, these qualities encourage the child to be self-motivated and confident in their own judgments of themselves, and thereby not relying on the reinforcement from others (Bednar & Peterson, 1996: 49).

Similarly, Demo (2001: 144) makes note of the positive influence of parental control, in the form of supervision and monitoring, on the development of a healthy self-esteem. In contrast, authoritarian parenting, which makes use of threats and physical punishment as a means of maintaining control, has been shown to result in the child having a devalued sense of self.

Demo (2001: 143) gives reference to the compelling evidence for the importance of reflective appraisal and parental approval in the healthy development of a positive self-esteem. This researcher identifies the significance of a parent's *'approval, encouragement, responsiveness, warmth, nurturance, support, and affection'* in the development of their child's self-esteem, and general emotional, social and academic regulation. Barber, Ball and Armistead (2003: 362) also found that emotional closeness and healthy attachment between the parent and child results in positive psychological adjustment, whereas insecure attachment and less emotional closeness is associated with negative psychological outcomes.

Modeling also plays a significant role in the development of a positive self-concept. How parents appraise themselves is mirrored to their child. When the child observes a parent approaching tasks and coping with disappointment with confidence and strength, he or she learns how to evaluate events not as threatening but rather as challenging (Bednar & Peterson, 1996: 49).

The quality of the marital relationship has also been found to have significant implications in the development of a healthy self-esteem. Research indicates that being from broken families, single parent homes or families where the relationship between the parents is unstable, was found to be harmful to how children view themselves (Demo, 2001: 145,146). This researcher notes that children who live in an environment of parental conflict often tend to blame themselves, receive less affection and attention from their parents and very often receive indirect or direct acts of aggression from their parents. As such, they tend to evaluate both their family and themselves negatively.

Finally, research (Ho, Lempers, & Clark-Lempers, 1995, in Demo, 2001: 46) indicates that economic hardship and financial stress negatively influence the parents' ability to attend to their children with warmth and affection. Parents experiencing economic stress tend to be *'inconsistent, harsh, and rejecting in their discipline ... toward their children'* (Demo, 2001: 146).

Overall, studies show that parental support has long-term effects on a child's sense of self-worth (Demo, 2001; Bednar & Peterson, 1996; Barber, Ball & Armistead, 2003). Conversely, parental neglect, abuse and rejection result in children thinking less of themselves. According to Demo (2001: 142-148), the positive influence of parental support in the form of acceptance, warmth and affection cannot be overstated.

### 3.5.2 Peer Relations, School and Self-esteem

As children mature, the structure and size of their social networks change and develop. Also, the nature of friendships evolves from playmates in childhood to more intimate friendships in adolescence. As previously established, children and adolescents rely strongly on the appraisals of others for self-evaluation. In adolescence the importance of peer support and evaluation comes to the foreground as those of their parents' begins to wane (Robins & Trzesniewski, 2005: 159). A study by Harter, Stocker and Robinson (1996, as cited in Demo, 2001: 147,148) examined the relationship between peer approval and self-worth in adolescents. These researchers were able to identify three ways in which adolescents categorised this relationship. The first group reportedly based their evaluations of the own sense of worth on the appraisals of their peers. The second group considered self-worth as preceding approval from peers; an individual with a positive sense of self-worth would receive positive appraisal from their peers. The third group did not identify a connection between self-worth and peer approval and saw these constructs as being independent of each other. These researchers further observed that those in the first group were more inclined to be preoccupied with the approval of their peers and tended to focus more on the negative judgements of their peers, whereas those in the second group were more focused on the positive appraisals (Demo, 2001: 148).

A further study examining the relative importance of peer attachment in adolescents' psychological well-being found that parental attachment was more important than peer attachment. Also, peer attachment did not

compensate for poor parental attachment (Wilkinson, 2004: 481). In contrast, a study by Laible, Carlo and Raffaellie (2000, cited in Wilkinson, 2004: 481) found peer attachment to be more important than parental attachment in predicting psychological well-being. A further study examining the importance of maternal, paternal and peer attachments in self-esteem found that maternal and paternal attachments were strongly correlated with self-esteem, with peer attachments showing no correlation (Noom, Dekovic & Meeus, 1999, as cited in Wilkinson, 2004: 481). Although a consensus has not been reached, Wilkinson (2004: 481) suggests that peer attachment has a role in psychological well-being; however peer attachment cannot replace parental attachment, which has been found to be more important in predicting positive self-esteem and psychological well-being.

### 3.5.3 Social Inequality and Self-esteem

In western, democratic societies, the issue relating to the relationship between social inequality and self-esteem is one of great concern (Wells, 2001: 301). Democratic societies advocate for the right of all to happiness and personal well-being. If social inequality, such as that experienced by ethnic minorities, women and those of a lower social status, significantly influence the development of self-esteem, particularly if this is in a derogatory way, then the values upheld by democracy become void. Tajfel (1981: 255) said that *'social identity is that part of an individual's self-concept which derives from his knowledge of his membership in a social group together with the value and emotional significance attached to that group membership'*.

The foregone literature review on self-esteem has focused mainly on personal identity; however, Tajfel (1981: 255) identifies a second form of identity, collective identity. Most people see themselves as belonging to one or more social groups, based on such things as age, social class, gender, race, sexual orientation, marital status and occupation, and membership to these groups make up the individual's collective identity (Katz, Joiner & Kwon, 2002: 419).

Katz *et al.* (2002: 420) identify three ways in which membership to a devalued social group may impact the development of personal identity and emotional adjustment. Firstly, membership to a devalued social group (such as those infected and affected by HIV/AIDS) may result in negative self-appraisal, as the person begins to internalise the negative introjections associated with membership to that group. Secondly, being devalued simply on the basis of membership to a group, despite personal qualities, may influence emotional well-being. Thirdly, members of a devalued group may become socialised to view themselves in a negative light, which may impact their behaviour and motivation.

Wells (2001: 318) makes note of a study conducted by Rosenberg and Simmons, which explored how black children evaluate and perceive themselves. Findings from this study reveal no correlation between skin colour and self-esteem. These researchers found that black children rated lighter skin as more attractive, but were satisfied with their own appearances. Also, despite coming from poorer economic backgrounds, the black children in the study were as inclined as white children to regard their family status as 'good'. The children sampled for this study came from schools and areas which were predominantly black. This, according to Wells (2001: 318), was likely to have impacted on the research findings. According to this researcher, racially homogeneous environments are likely to serve as a buffer against racial prejudice. Similar studies which included black children from racially integrated schools found that black children from racially integrated schools had lower self-esteem than black children from schools that were predominantly black (Crocker & Major, 1989, as cited in Wells, 2001: 320).

These research findings, together with the three factors identified by Katz *et al.* (2002: 420) suggest that it is not belonging to a particular group that necessarily influences the development of self-esteem, but rather the prejudice that is directed towards that group. A child that grows up in a homogeneous environment may then be protected from developing negative self-appraisal.

The researcher has, thus far, considered the complexities surrounding the definition of self-esteem, and identified the multidimensional nature of self-esteem as well as the development of self-esteem and the variables influencing the development of self-esteem. It is from this theoretical platform that the researcher will now explore the functions of self-esteem, including low self-esteem people, deviant behaviour and self-esteem as well as mental health and emotional well-being and self-esteem.

### 3.6 FUNCTIONS OF SELF-ESTEEM

High self-esteem has been found to be positively correlated with a number of desirable outcomes, as well as with positive emotional experience and positive self-appraisal. Crocker (2006: 274) asserts that high self-esteem people have been found to experience *'more positive affect, more life satisfaction, less anxiety, less hopelessness, and fewer depressive symptoms than those with lower self-esteem'*. Overall, high self-esteem people are happier and more satisfied with life than low self-esteem people (Solomon, 2006: 256). High self-esteem therefore serves as a buffer against negative outcomes. Some of these will now be considered in greater depth.

#### 3.6.1 People with Low Self-esteem and People with High Self-esteem

Everyone, at various times in their lives, are vulnerable to attacks on their self-esteem. However, there is a marked difference in how people with high self-esteem and people with low self-esteem react to these threats. According to Rosenberg and Owens (2001: 403), low self-esteem people tend to be more sensitive to criticism, and tend to interpret these events as signs of inadequacy and rejection. These researchers also found that when faced with life stressors, such as financial stress, people with low self-esteem are more inclined, than people with high self-esteem, to turn to alcohol as a means of coping with stress. These are also large disparities between people with low self-esteem and people with high self-esteem in terms of self-confidence and

self-actualisation. According to Rosenberg and Owens (2001: 408,409), people with low self-esteem tend to view themselves as being less confident than people with high self-esteem. This negative self-appraisal results in a self-fulfilling prophecy: because they have low self-confidence, they are less inclined to explore new relationships and experiences, reducing the chance of positive feedback, and reinforcing the negative self-appraisal.

Crocker (2006: 277) identifies how people with high self-esteem, although viewing themselves in a positive light, are more likely than people with low self-esteem to continually strive to better themselves. People with high self-esteem are motivated to challenge themselves and to see how much they can achieve and to continually work on their deficiencies, as opposed to people with low self-esteem who act to protect their self-esteem through avoidance (Rosenberg & Owens, 2001: 409).

As a result of their protective behaviour and fear of rejection, people with low self-esteem approach life in a reactive way, unlike people with high self-esteem who are more proactive in their approach to life.

### 3.6.2 Self-esteem and Deviant Behaviour

According to Kaplan (2001: 380), a deviant disposition can be conceptualised as *'the loss of motivation to conform to conventional patterns, and the acquisition of motivation to deviate from these patterns'*. Kaplan further explains how deviant behaviour is a result of rejection. Children who grow up in a society where they do not 'fit'; constantly strive for a sense of belonging, so as to avoid rejection. However, constant attempts to 'fit in', which are met with continued rejection, result in the onset of protective behaviour, so as to minimise the pain of rejection. The child abandons previous attempts to conform, and motivation shifts from conforming to deviating. According to Kaplan (2001: 382),

Youngsters with low self-esteem have frequently undergone unsatisfactory experiences in the conventional society – experiences that

have created painful feelings about their self-worth. Seeking to alleviate these feelings, many turn to the delinquent reference group to enhance their self-esteem. The delinquent group provides more favourable reflected appraisals, social comparison, and self-attributions.

There is a large body of empirical support for the position that low self-esteem is a strong predictor of later deviant behaviour (Kaplan, 2001: 375-397), however, studies illustrate that in terms of aggression and hostility, it is not low self-esteem, but rather high, unstable self-esteem that is related to this negative, deviant behaviour. Narcissists, people with a high sense of self-worth and a low level of competence, are viewed as having an unstable self-esteem. When their self-esteem is threatened, they typically act out with hostility (Kaplan, 2001: 375-397).

It is evident to the researcher that, since it is unstable self-esteem that is of the greatest threat to society, it would appear that low self-esteem children who join deviant groups in an attempt to raise their self-esteem are at great risk of developing an unhealthy, unstable self-esteem. In their attempts to protect and maintain their desired self-concept, the child may become caught in a deviant group that serves to boost their self-worth. However, because this is not genuine high self-esteem, based on competence and self-worth, the child instead develops an insecure view of the self and an unstable self-esteem (Kaplan, 2001; Mruk, 2006).

### 3.6.3 Self-esteem and Mental Health

Fennel (1999: 6-14) identifies self-esteem as having an impact on our day-to-day functioning. This researcher makes note of how low self-esteem is negatively reflected in the thoughts we have and statements we make about ourselves, our behavioural responses, emotions and body states, as well as in our school and work achievements, relationships and self-care. According to this researcher, low self-esteem can either be a consequence of or a vulnerability factor for a number of negative outcomes. Low self-esteem can, for example, be the result of a depressed mood, or may have been a

vulnerability factor for the onset of depression (Rosenberg & Owens, 2001: 410).

Low self-esteem has also been associated with a number of other psychopathologies including mood disorders, personality disorders, anxiety disorders, schizophrenia, eating disorders, learning disorders, substance abuse and conduct disorders (O'Brien, Bartoletti & Leitzel, 2006: 306-309).

The negative content of cognitions is also associated with low self-esteem. Pessimism, cynicism, uncertainty and weakness of conviction are all characteristics of low self-esteem (Rosenberg & Owens, 2001: 414). People with low self-esteem view the future in a negative, fatalistic light, always expecting the worst and as a result never strive for better. They view daily stressors as being rooted in their identity, and as such, they do not see a possibility to overcome and change the outcome. These negative cognitions result in psychological distress and emotional vulnerability (Fennel, 1999: 12).

In summary, low self-esteem does not appear to be the root of delinquent behaviour, but it is associated with people being less happy in life, and experiencing greater psychological distress. In a study by De Witt and Lessing (2005: 13), which explored the needs and support required by HIV/AIDS orphans in their psychosocial development, these researchers found that depression, sadness and stigmatisation were the primary influences on their psychosocial behaviour. Low self-esteem has also been shown to be a vulnerability factor to a number of psychological dysfunctions (O'Brien, Bartoletti & Leitzel, 2006; Fennel, 1999; Rosenberg & Owens, 2001). In light of the negative impact that low self-esteem has on an individual's motivation for life, optimism for the future and overall emotional and psychological well-being, the researcher will now consider the processes and implications for changing self-esteem.

### 3.7 CHANGING SELF-ESTEEM

After considering the structure and nature of self-esteem, as well as the factors that influence the development of self-esteem and the functions of self-esteem, the question remains: can self-esteem be changed and if so, what are the implications?

From a humanistic perspective, everyone is entitled to a positive self-regard, it is '*the natural birthright of all humans – a gift*' and it is from this standpoint that the view is held that respect, nurturance and trust are seen as the key to self-esteem enhancement (Covington, 2006: 245). However, there is a second, opposing opinion that views the pursuit of high self-esteem as both stressful and anxiety provoking. From this perspective, enhancing self-esteem requires more than increasing self-regard, but it also greatly depends on achieving goals and developing a sense of competence (Covington, 2006: 247).

According to Rhodewalt (2006: 285), there are a number of self-esteem enhancement programmes, aiming at increasing the individual's sense of value and self-worth. However, this researcher warns against an unhealthy pursuit for high self-esteem. Healthy self-esteem is derived from a combination of worth and competence, and as such, genuine, healthy self-esteem is not something that needs to be pursued. The danger then in raising self-worth, which is not based on genuine outcomes, results in an insecure and uncertain view of the self. Rhodewalt (2006: 285) explains how the consequence of this is that the individual is constantly striving for validation, becoming completely self-absorbed.

Self-esteem enhancement in children and adolescents, as it pertains to the present study, should therefore include giving praise where praise is due, encouraging the creation of meaningful activities and setting challenges for learning and growth. Children should be encouraged to set goals and to take responsibility for attaining them. Enhancement programmes should aim at

guiding children through failures and helping them accept their failures and to persevere despite these setbacks. Self-esteem enhancement that is based on these outlines will help establish healthy, stable self-esteem, which is built on both competence and positive self-regard.

### 3.8 SUMMARY

Chapter three explored the construct self-esteem and the diversity in theoretical contributions to the construct. The nature and development of self-esteem, as well as the factors influencing the development of self-esteem and the functions thereof were also examined. This chapter concluded with a discussion on self-esteem enhancement. The following chapter provides an overview of the research methodology employed for the present research.

## CHAPTER 4

### PRESENTATION AND INTERPRETATION OF EMPIRICAL DATA ON THE SELF-ESTEEM OF CHILDREN ORPHANED BY HIV/AIDS

#### 4.1 INTRODUCTION

Chapters two and three provided a detailed literature outline of HIV/AIDS and the construct Self-esteem. In this chapter, the researcher will provide a presentation and interpretation of the empirical data, which was obtained by the employment of The Culture-free Self-esteem Questionnaire for children (Battle, 1981). This Questionnaire will be discussed later on in the chapter.

#### 4.2 RESEARCH APPROACH AND METHOD

In order to understand the presented empirical data it is important to return to the main goals and objectives set out in the beginning of the research. The main goal of this study was to explore and describe the self-esteem of children orphaned by HIV/AIDS. In order to achieve this goal, a number of objectives were outlined. These objectives are summarised below, with a more detailed description presented in Chapter one:

- A review of literature on the subjects of HIV/AIDS and the construct self-esteem, including prior research and theory, was undertaken prior to the empirical study;
- Thirty respondents completed the Culture-Free Self-esteem Questionnaire for children, which is a well used measure for assessing self-esteem in young children, aged 11 to 16. (Compare Kaslow, Tannebaum & Seligman, 1978.)

- Conclusions and recommendations were made to professionals in the field with regards to intervention.

For the purpose of this study, the universe included all children orphaned by HIV/AIDS, between the ages of 11 and 15 years, living in the area of Port Elizabeth in South Africa. The population included children orphaned by HIV/AIDS, between the ages of 11 and 15 years, cared for by Jerusalem Ministries. All participants were English speaking and of Black ethnicity. Finally, the sample for this study included 30 children (N=30) orphaned by HIV/AIDS, between the ages of 11 and 16 years, cared for by Jerusalem Ministries (boys (n=16) and girls (n=14)).

The researcher contacted Jerusalem Ministries regarding a proposed study to explore and describe the self-esteem of children orphaned by HIV/AIDS. On making contact, Jerusalem Ministries provided a list of HIV/AIDS orphans between the ages of 10 and 16 years, in their care. The total list provided, included a total of 46 children. From this list, 30 children were randomly sampled to participate in the study. The researcher then met with each participant individually to discuss the study and issues of confidentiality. Each participant gave their consent, together with Jerusalem Ministries, to participate in the study by signing their name on a consent form (See appendix 6).

#### 4.2.1 Formulas Used for Analysis of Data

The following formulas were used for analysis of the data obtained:

##### 4.2.1.1 Raw Data

Raw data is the data that has been collected before it is summarized or transformed into t-scores for interpretation and comparison (Haslam & McGarty, 2003: 140). The researcher made use of raw scores for description

of domains (global self-esteem, general self-esteem, social self-esteem, academic self-esteem and parent-related self-esteem) and t-scores for an overall comparison of domains.

#### 4.2.1.2 T-Scores

A t-score is a standard score, with a mean (see 4.2.1.4) of 50 and a standard deviation (see 4.2.1.5) of 10 (Battle, 1981: 21). By converting raw scores to t-scores, the researcher is able to make comparisons between the domains, since domains have been normalised.

#### 4.2.1.3 Rounding Up

Rounding up involves reducing the number of digits reported after a decimal point (Haslam & McGarty, 2003: 140). The researcher rounded all data up to two decimal points.

#### 4.2.1.4 Mean

The mean refers to the average of a set of scores and is calculated by taking the sum of all scores and dividing it by the number of scores (Haslam & McGarty, 2003: 140). The researcher made use of the mean to describe the average scores obtained on each domain and to compare scores between the domains.

#### 4.2.1.5 Standard Deviation

The standard deviation is the square root of variance (Haslam & McGarty, 2003: 152). The researcher made use of standard deviation to determine the spread of data about the mean as it is the most common measure of statistical distribution. By looking at the standard deviation the researcher was able to determine how widely spread the values were.

#### 4.2.1.6 Frequency Graph

A frequency graph shows how many times a variable has been observed (Haslam & McGarty, 2003: 152). For the purpose of this study the researcher made use of histograms and frequency tables to report on the number of participants who obtained a given score on the variables of the study, namely: global, general, social, academic and parent-related self-esteem. Frequency tables and histograms were constructed by means of the SPSS, which is a statistical package for social sciences.

### 4.3 THE CULTURE-FREE SELF-ESTEEM QUESTIONNAIRE FOR CHILDREN

The Culture-free Self-esteem Questionnaire (SEI) for children was developed by James Battle, a school psychologist, who identified in his professional work the impact that a child's self perception has on his ability to develop and achieve. Furthermore, Battle (1981: 7) identified the need for a reliable and valid measure of self-esteem, and therefore set about developing this measure which, according to Battle, has been described by psychologists, educators and researchers as both reliable and valid.

#### 4.3.1 Description of the Culture-free SEI for Children

Form B of the Culture-free SEI for Children was used for this study. This form contains 30 items, five of which comprise the lie scale. A lie scale provides the researcher with an indication of whether the respondents were truthful in their response to questions. The remaining 25 items make up 4 scales that include the general, social, academic and parent-related scales (Battle, 1981: 9).

#### 4.3.2 Standardisation of the Culture-free SEI for Children

The Culture-free SEI for Children was standardised on boys and girls, grades three to nine, but has also been successfully used with older children (Battle, 1981:9).

#### 4.3.3 Reliability and Validity of the Culture-free SEI for Children

The initial test-retest reliability study for Form B (the version used for this study), included 110 participants, both boys and girls. The findings of this study showed that the correlations for the 110 participants ranged from .79 to .92, with subscale correlations ranging from .49 to .80 (Battle, 1981: 12). These results show the measure to be reliable.

The content validity for the Culture-free SEI for children was built into this measure by developing a construct definition for self-esteem, and constructing items so as to cover all the areas of the construct (Battle, 1981: 14). The construct definition for this measure is:

Self-esteem, as measured by the Culture-free SEI for Children and Adults, refers to the perception the individual possesses of his own worth. An individual's perception of self develops gradually and becomes more differentiated as he matures and interacts with significant others. Perception of self-worth, once established, tends to be fairly stable and resistant to change (Battle, 1981: 14).

In a recent study, carried out by Coetzee (2004: 1), this researcher sought to investigate the construct validity of the Culture-free SEI for black and white South Africans. The results of this study provided support for the construct validity of the Culture-free SEI. The confirmatory factor analysis confirmed that the proposed model underlying the self-esteem construct fits the data. The Cronbach Alpha coefficients of the item analyses on the total and subscales showed a relatively high internal consistency (0.85). In addition

test-retest reliability showed that all the correlations, on each subscale, are higher than 0.74, and 0.91 on the total scale. The sample population consisted of 52.6% Whites and 47.4% Blacks, thus confirming the culture free properties of the instrument.

#### 4.3.4 Administration and Scoring of the Culture-free SEI for Children

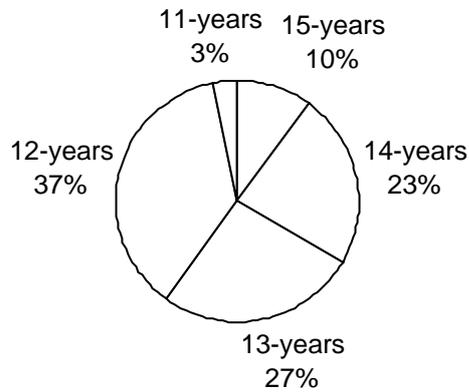
The Culture-free SEI for Children can be administered to either groups or individuals. Participants are asked to read and follow the directions printed on the form, and then asked if they are uncertain of anything they have read. Participants then indicate their agreement or disagreement with the statements given by making a mark in either the yes or no blocks (Battle, 1981: 19). Administration of Form B takes approximately 15 minutes.

### 4.4 PRESENTATION OF BIOGRAPHICAL DATA – DESCRIPTIVE STATISTICS

#### 4.4.1 Age of the Participants

The ages of the respondents ranged from 11 to 15, with a mean age of 13. According to the estimates presented by UNAIDS (2004: 7), which were jointly developed by UNAIDS, UNICEF, USAID, and the U.S. Bureau of Census, the larger percentage of children orphaned by HIV/AIDS in South Africa are between the ages of 10 and 15 years. The age range for this sample therefore falls within the age category containing the largest percentage of HIV/AIDS orphans.

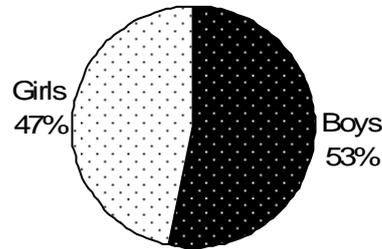
Chart 1: A presentation of the age distribution of the sample



#### 4.4.2 Gender of the Participants

According to UNAIDS (2004: 6) HIV/AIDS is an indiscriminate disease that attacks all people regardless of race, class and gender. All children orphaned by HIV/AIDS, regardless of gender, are vulnerable to the same hardships including “*exclusion, abuse, discrimination and stigma*”. For the purpose of this study there was a fairly equal distribution of male (n=16) and female (n=14) participants included in the sample group, where N=30.

Chart 2: A presentation of the gender distribution of the sample



#### 4.4.3 HIV status of participants

Of the participants (N=30) included in the sample for this study none were known to have been tested positive for HIV. This is important to note as the added stress and complications of being infected with the HIV virus may have influenced the results.

### 4.5 PRESENTATION OF RESULTS FROM PSYCHOMETRIC MEASURE – INFERENCE STATISTICS

#### 4.5.1 Testing Hypothesis 1

H1 = If a child is orphaned by AIDS, he will have a lowered self-esteem.

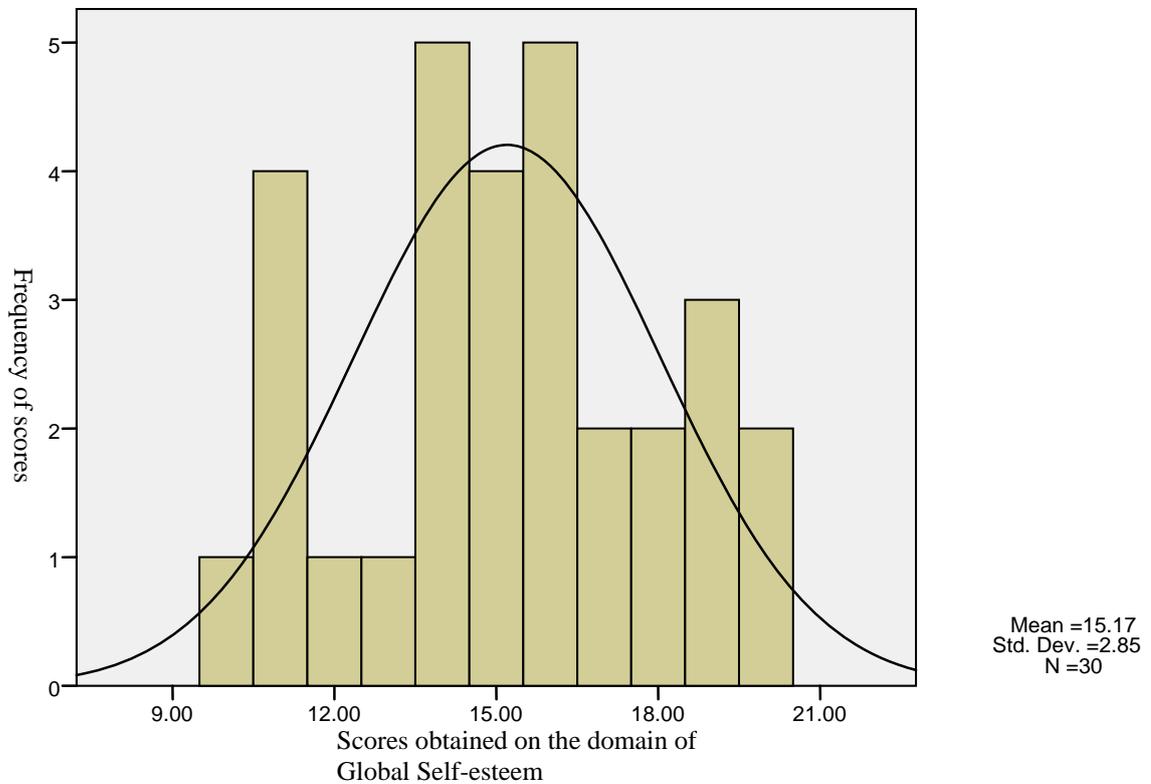
H0 = If a child is orphaned by AIDS, his self-esteem will not be lowered.

The Culture-free SEI for Children was employed to test this hypothesis. The results are presented below, beginning with global self-esteem, followed by a presentation of each individual sub-scale (general, social, academic and parent-related self-esteem). Histograms were created for all variables, prior to analysis and a normal curve was applied to each of these to test which variables were appropriate for use in analysis of results. A histogram is used

to summarise and display the frequency distribution of the data graphically. By applying a normal curve to the histogram it is possible for the researcher to determine the validity of the data. Where the data is seen to fit sufficiently below the curve, this data is considered to have a ‘good fit’ and can therefore be used for analysis (Haslam & McGarty, 2003: 140). From the histograms created it was evident that there was a good fit for all variables namely: global, general, social, academic and parent-related self-esteem, thus making them suitable for use in analysis. These are presented under each domain.

#### 4.5.1.1 Global Self-esteem

Histogram 1 provides a presentation of distribution of the scores and the nature of the fit for the domain of global self-esteem. Table 4.1 provides a presentation of the frequency distribution of the results for global self-esteem (see Appendix 1 for full table and histogram). From this table it can be seen, for example, that 4 participants obtained a total score of 11 on the domain of global self-esteem.



**Histogram 1:** Global Self-esteem

From this histogram it can be seen that the scores obtained for the domain of global self-esteem fit well beneath the curve. The following table shows how the scores obtained are distributed. From this table and the histogram it can be seen that five participants obtained scores of 14 and 16 respectively. Four participants obtained scores of 11 and 15 respectively. A score of 19 was obtained by three participants, while two participants obtained scores of 17, 18 and 20 respectively. Only one participant obtained scores of 10, 12 and 13 respectively.

**Table 4.1** Presentation of the frequency distribution of results for Global Self-esteem

<b>Valid Scores</b>	<b>Frequency (N)</b>
10	1
11	4
12	1
13	1
14	5
15	4
16	5
17	2
18	2
19	3
20	2
<b>Total Score</b>	<b>30</b>

The following Table 4.2 provides a presentation of the mean results for global self-esteem, taken from the Culture-free SEI for children.

**Table 4.2** Presentation of the mean results for Global Self-esteem

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std. Deviation</b>
Global Self-esteem	30	10.00	20.00	15.17	2.85

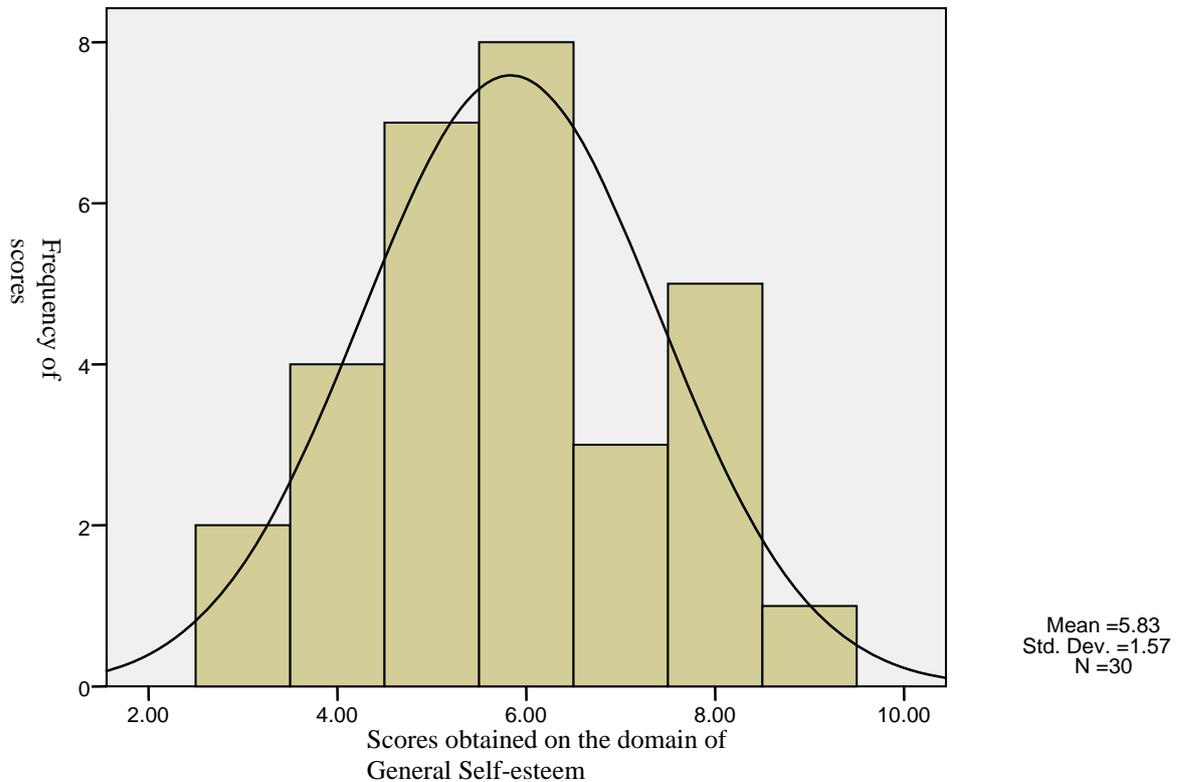
The highest possible score for global self-esteem is 24, and the lowest possible score for global self-esteem is 1. From this table it can be seen that the lowest score from the sample was 10 (labelled minimum in Table 4.2), which falls within the 7<sup>th</sup> percentile, indicating that this participant has scored lower than

93% of those subjects who participated in standardising the scale. This score is considered to be very low. The highest score (labelled maximum in Table 4.2), as indicated in Table 4.2, was 20, which falls within the 54<sup>th</sup> percentile, indicating that this participant has earned a score which is higher than 54% of the subjects who participated in the standardising of the scale. This score is considered to be moderate to high. The mean score, as indicated in Table 4.2, for the sample was 15.17 (SD=2.85), which falls within the 17<sup>th</sup> percentile, indicating that on average this sample has earned a score that is lower than 83% of the subjects who participated in standardising the scale. This score is considered to be moderate to low.

On returning to the statement made for Hypothesis 1, that if a child is orphaned by HIV/AIDS he will have a lowered self-esteem, it can be seen from the results presented for global self-esteem that this hypothesis is true. In the light of these results the null hypothesis is rejected. Hypothesis 1 is not rejected. From the sample for this study, the mean score for global self-esteem is 15.17 (SD=2.87), demonstrating a moderate to low self-esteem.

#### 4.5.1.2 General Self-esteem

The results for general self-esteem will be presented below. Histogram 2 provides a presentation of distribution of the scores and the nature of the fit for the domain of general self-esteem. Table 4.3 provides presentation of the frequency distribution of results for general self-esteem (see Appendix 2 for full table and histogram).



**Histogram 2: General Self-esteem**

From this histogram it can be seen that the scores obtained for the domain of general self-esteem fit well beneath the curve. The following table shows how the scores obtained are distributed. From this table and the histogram it can be seen that two participants obtained scores of 3. Four participants obtained scores of 4. A score of 5 was obtained by 7 participants, while eight participants obtained scores of 6. Three participants obtained a score of 7, and five participants obtained a score of 8. Only one participant obtained a score of 9.

**Table 4.3** Presentation of the frequency distribution of results for General Self-esteem

<b>Valid Scores</b>	<b>Frequency</b>
3	2
4	4
5	7
6	8
7	3
8	5
9	1
Total Score	30

Table 4.4 provides a presentation of the mean results for general self-esteem, taken from the Culture-free SEI for children.

**Table 4.4** Presentation of the mean results for General Self-esteem

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std. Deviation</b>
General Self-esteem	30	3.00	9.00	5.83	1.57

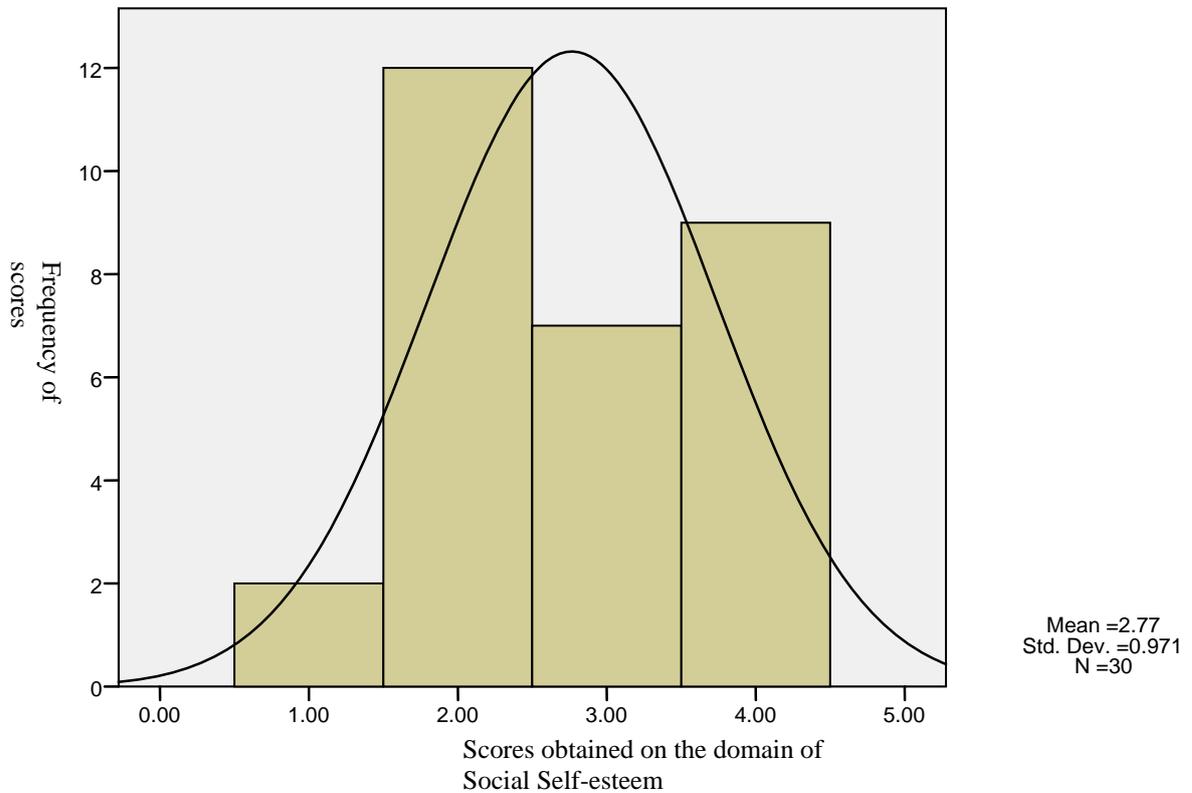
The highest possible score for general self-esteem is 9, and the lowest possible score for general self-esteem is 1. From this table it can be seen that the lowest score from the sample was 3, which falls within the 6<sup>th</sup> percentile, indicating that this participant has scored lower than 94% of those subjects who participated in standardising the scale. This score is considered to be low. The highest score, as indicated in Table 4.4, was 9, which falls within the 88<sup>th</sup> percentile, indicating that this participant has earned a score which is higher than 88% of the subjects who participated in the standardising of the

scale. This score is considered to be high. The mean score for the sample, as indicated in Table 4.4, was 5.83 (SD=1.57), which falls within the 18<sup>th</sup> percentile, indicating that on average this sample has earned a score that is lower than 82% of the subjects who participated in standardising the scale. This score is considered to be moderate-low.

According to Battle's (1981: 9) definition of general self-esteem, as being the overall perception an individual has about his self-worth, it could be said that, from the results presented in Table 4.4, the participants in this sample demonstrate a moderate-low sense of self-worth.

#### 4.5.1.3 Social Self-esteem

The results for social self-esteem will be presented below. Histogram 3 provides a presentation of distribution of the scores and the nature of the fit for the domain of social self-esteem. Table 4.5 provides presentation of the frequency distribution of results for social self-esteem (see Appendix 3 for full table and histogram).



### **Histogram 3: Social Self-esteem**

From this histogram it can be seen that the scores obtained for the domain of social self-esteem fit well beneath the curve. The following table shows how the scores obtained are distributed. From this table and the histogram it can be seen that two participants obtained a score of 1. Twelve participants obtained a score of 2. A score of 3 was obtained by seven participants, while nine participants obtained a score of 4.

**Table 4.5** Presentation of the frequency distribution of results for Social Self-esteem

<b>Valid Scores</b>	<b>Frequency</b>
1	2
2	12
3	7
4	9
Total Score	30

Table 4.6 provides a presentation of the mean results for social self-esteem, taken from the Culture-free SEI for children.

**Table 4.6** Presentation of the mean results for Social Self-esteem

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std. Deviation</b>
Social Self-esteem	30	1.00	4.00	2.76	.97

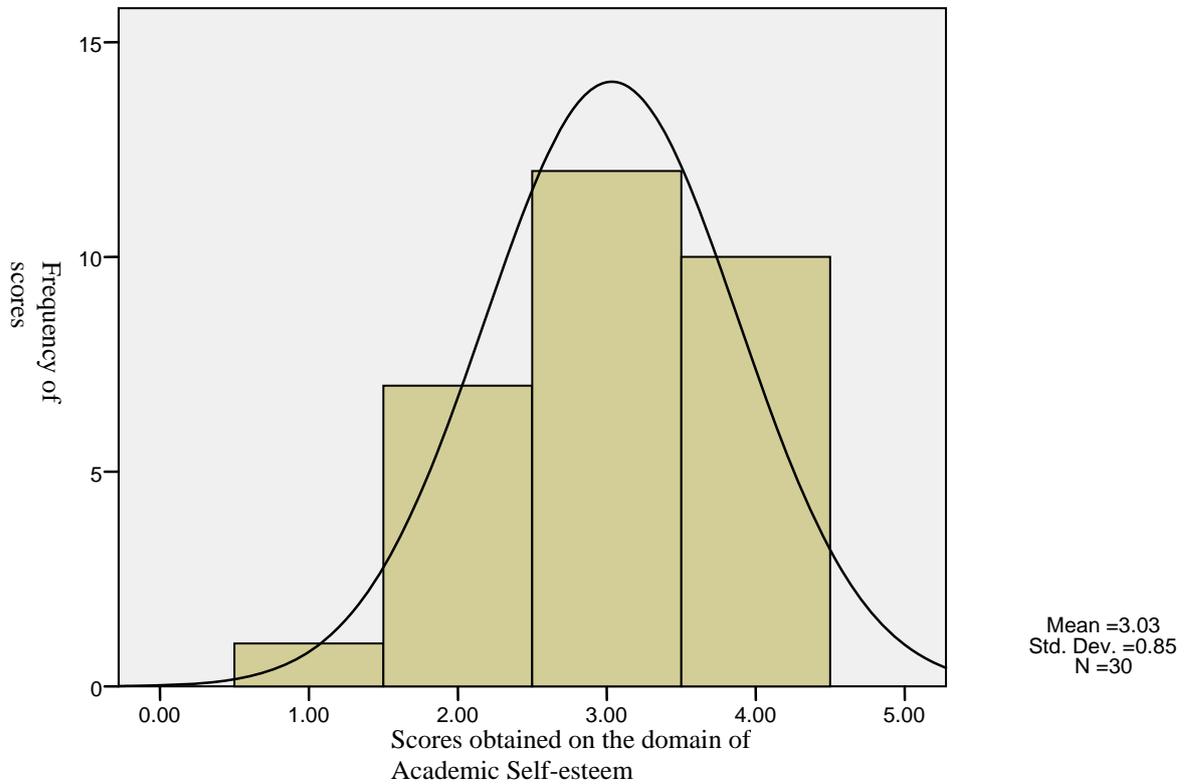
The highest possible score for social self-esteem is 4, and the lowest possible score for social self-esteem is 1. From this table it can be seen that the lowest score from the sample was 1, which falls within the 10<sup>th</sup> percentile, indicating that this participant has scored lower than 90% of those subjects who participated in standardising the scale. This score is considered to be very low. The highest score, as indicated in Table 4.6, was 4, which falls within the 85<sup>th</sup> percentile, indicating that this participant has earned a score which is higher than 85% of the subjects who participated in the standardising of the scale. This score is considered to be high. The mean score for the sample, as indicated in Table 4.6, was 2.76 (SD=.97), which falls within the 25<sup>th</sup> percentile, indicating that on average this sample has earned a score that is

lower than that of 75% of the subjects who participated in standardising the scale. This score is considered to be low.

According to Battle's (1981:9) definition of social self-esteem as being the overall perception an individual has about the quality of relationships he has with his peers, as well as the associated feelings, it could be said that from the results presented in Table 4.6, the participants in this sample demonstrate having a low perception and feeling about his relationship with his peers.

#### 4.5.1.4 Academic Self-esteem

The results for academic self-esteem will be presented below. Histogram 4 provides a presentation of distribution of the scores and the nature of the fit for the domain of academic self-esteem. Table 4.7 provides presentation of the frequency distribution of results for academic self-esteem (see Appendix 4 for full table and histogram).



**Histogram 4:** Academic Self-esteem

From this histogram it can be seen that the scores obtained for the domain of academic self-esteem fit well beneath the curve. The following table shows how the scores obtained are distributed. From this table and the histogram it can be seen that one participant obtained a score of 1. Seven participants obtained scores of 2. A score of 3 was obtained by twelve participants, while ten participants obtained scores of four.

**Table 4.7** Presentation of the frequency distribution of results for Academic Self-esteem

<b>Valid Scores</b>	<b>Frequency</b>
1	1
2	7
3	12
4	10
Total Score	30

The following Table 4.8 provides a presentation of the mean results for academic self-esteem, taken from the Culture-free SEI for children.

**Table 4.8** Presentation of the mean results for Academic Self-esteem

	<b>N</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std. Deviation</b>
Academic Self-esteem	30	1.00	4.00	3.03	.85

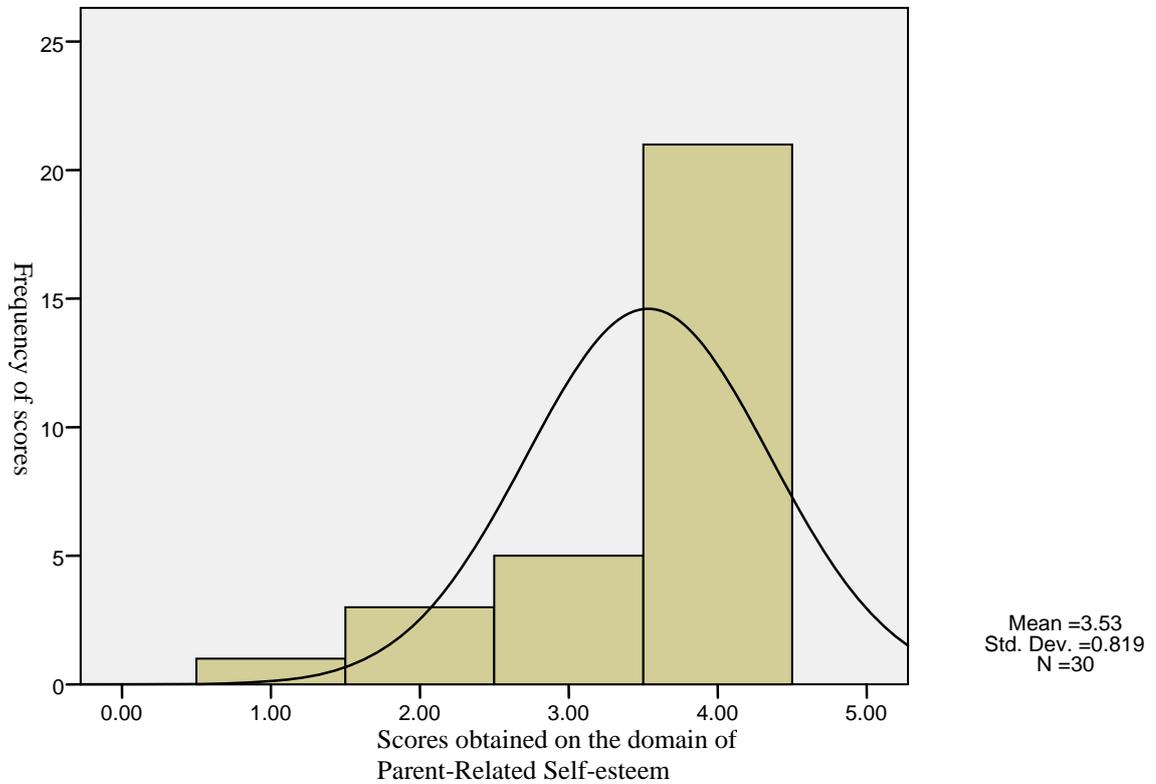
The highest possible score for academic self-esteem is 4, and the lowest possible score for academic self-esteem is 1. From this table it can be seen that the lowest score from the sample was 1, which falls within the 10<sup>th</sup> percentile, indicating that this participant has scored lower than 90% of those subjects who participated in standardising the scale. This score is considered to be very low. The highest score, as indicated in Table 4.8, was 4, which falls within the 77<sup>th</sup> percentile, indicating that this participant has earned a score which is higher than 77% of the subjects who participated in the standardising of the scale. This score is considered to be high. The mean score for the sample, as indicated in Table 4.8, was 3.03 (SD=.85), which falls

within the 42<sup>th</sup> percentile, indicating that on average this sample has earned a score that is lower than 58% of the subjects who participated in standardising the scale. This score is considered to be moderate-low.

According to Battle's (1981: 9) definition of academic self-esteem as being the overall perception an individual has about his self-efficacy and ability to cope with challenges, it could be said that from the results presented in Table 4.8, the participants in this sample demonstrate having a moderate-low perception about their self-efficacy and ability to cope.

#### 4.5.1.5 Parent-Related Self-esteem

According to Battle (1981: 9) parent-related self-esteem refers to the individual's perception of the feelings and beliefs their parents hold towards them. For the purpose of this study, all statements relating to 'parents' was replaced with 'carers', as the children in this study are orphaned. The results for parent-related self-esteem will be presented below. Histogram 5 provides a presentation of distribution of the scores and the nature of the fit for the domain of parent-related self-esteem. Table 4.9 provides presentation of the frequency distribution of results for parent-related self-esteem (see Appendix 5 for full table and histogram).



**Histogram 5:** Parent-Related Self-esteem

From this histogram it can be seen that the scores obtained for the domain of parent-related self-esteem fit well beneath the curve. The following table shows how the scores obtained are distributed. From this table and the histogram it can be seen that one participant obtained a score of 1. Three participants obtained scores of two. A score of 3 was obtained by five participants, while twenty-one participants obtained scores of 4.

**Table 4.9** Presentation of the frequency distribution of results for Parent-related Self-esteem

Valid Scores	Frequency
1	1
2	3
3	5
4	21
Total Score	30

Table 4.10 provides a presentation of the mean results for parent-related self-esteem, taken from the Culture-free SEI for children.

**Table 4.10** Presentation of the mean results for Parent-related Self-esteem

	N	Minimum	Maximum	Mean	Std. Deviation
Parent-Related Self-esteem	30	1.00	4.00	3.53	.82

The highest possible score for parent-related self-esteem is 4, and the lowest possible score for parent-related self-esteem is 1. From this table it can be seen that the lowest score from the sample was 1, which falls within the 9<sup>th</sup> percentile, indicating that this participant has scored lower than 91% of those subjects who participated in standardising the scale. This score is considered to be very low. The highest score, as indicated in Table 4.8, was 4, which falls within the 76<sup>th</sup> percentile, indicating that this participant has earned a score which is higher than 76% of the subjects who participated in the standardising of the scale. This score is considered to be high. The mean score for the sample, as indicated in Table 4.8, was 3.53 (SD=.82), which falls

within the 38<sup>th</sup> percentile, indicating that on average this sample has earned a score that is lower than 62% of the subjects than participated in standardising the scale. This score is considered to be moderate-low.

According to Battle’s (1981: 9) definition of parent-related self-esteem, as being the overall perception an individual has about the feelings and beliefs his parents have about him , it could be said that from the results presented in Table 4.8, the participants in this sample view their carers as having moderate-low feelings and beliefs about them.

Table 4.11 provides a summary of the mean results earned on all scales. This is followed by a brief discussion.

**Table 4.11** A presentation of the summary of mean results earned on the Culture-free SEI for Children

	N	*Possible Score	Mean Score	Percentile Rank %	Class
Global Self-esteem	30	24	15.17	17	Moderate-Low
General Self-esteem	30	9	5.83	18	Moderate – Low
Social Self-esteem	30	4	2.76	25	Low
Academic Self-esteem	30	4	3.03	42	Moderate – Low
Parent-Related Self-esteem	30	4	3.53	38	Moderate – Low

\* Possible score refers to the highest possible score to achieve on the given domain.

From this table it can be seen that on the domain of global self-esteem, the average score obtained by the participants in this sample (N=30) was 15.17. The highest possible score for this domain is 24. This score falls within the 17<sup>th</sup> percentile, and is considered moderate to low. On the domain of general self-esteem it can be seen that, on average, participants achieved a score of 5.83, of a possible score of 9. This score falls within the 18<sup>th</sup> percentile, and

is considered to be a moderate to low score. The average score on the domain of social self-esteem was 2.76, of a possible 4. This score falls within the 25<sup>th</sup> percentile and demonstrates low social self-esteem. Finally, the average score achieved on the domain of parent-related self-esteem was 3.53, of a possible 4. This score falls within the 38<sup>th</sup> percentile and is considered to be an indication of moderate to low parent-related self-esteem.

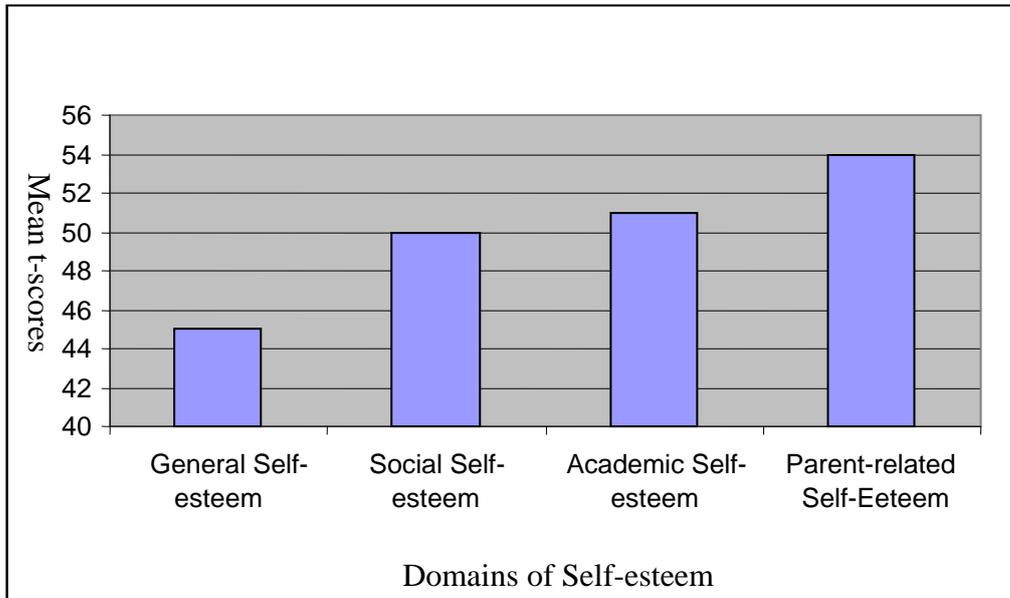
Overall, children orphaned by HIV/AIDS, participating in this study, have demonstrated a moderate to low self-esteem, proving the first assumption made in hypothesis 1 to be true, namely that children who are orphaned by HIV/AIDS will have a lowered self-esteem. H1 is therefore accepted and the null hypothesis is rejected. These findings will be discussed according to literature in Chapter 5.

#### 4.5.2 Testing Hypothesis 2

H2 = If a child is orphaned by HIV/AIDS, the area of social self-esteem will be the lowest.

H0 = If a child is orphaned by HIV/AIDS, the area of social self-esteem will not be the lowest.

Hypothesis 2 was tested by examining the mean t-scores earned on each domain (general self-esteem, social self-esteem, academic self-esteem and parent-related self-esteem). The results from this comparison are shown in Figure 4.1.



**Figure 4.1** Comparison between mean t-scores on the domains of general, social, academic and parent-related self-esteem

From Figure 4.1 it can be clearly seen that the lowest domain of self-esteem was earned in the area of general self-esteem. Social self-esteem was the second lowest scoring domain, followed by academic self-esteem. Parent-related self-esteem was the highest scoring domain. These results disprove the assumption made in Hypothesis 2, that social self-esteem would be the lowest scoring domain. H1 was therefore accepted, and the null hypothesis was rejected.

#### 4.6 SUMMARY

Chapter four provided a presentation of the empirical data, as well as a brief discussion of findings. From the data collected in this study, it is apparent that children orphaned by HIV/AIDS who participated in this study, did experience a lowered self-esteem, particularly in the domains of social and general self-esteem.

Chapter five will provide a summary of conclusions based on the findings of this study. Chapter five will conclude with a number of recommendations being made to those in the field as well as for future research.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

In this chapter, conclusions are made based on the findings of the study. Chapter 5 also provides recommendations to those in the field and for future research.

#### 5.2 SUMMARY OF THE RESEARCH

The researcher, having worked as a volunteer within the South African HIV/AIDS population, as well as being at Jerusalem Ministries, has become increasingly aware of the despair felt by many of the orphaned children. Further work in the field of psychology has brought to light the interaction between emotional wellness and future success and the role of self-esteem. This motivation led the researcher to undertake this study, exploring and describing the self-esteem of children orphaned by HIV/AIDS. Thirty HIV/AIDS orphans were randomly sampled from Jerusalem Ministries in Port Elizabeth to participate in this study. Each of these participants was introduced to the research and completed a consent form, indicating that they understand the nature of the study. Following this, each participant completed the Culture-free Self-esteem Questionnaire for children, which gave an overall score of global self-esteem, as well as four subscales of self-esteem, namely, general, social, academic and parent-related self-esteem.

The results from this study showed that these children experience a lowered global self-esteem, as well as lowered scores on all of the subscales of self-esteem.

### 5.2.1 Aim and Objectives of the Study

The main aim of this study was to explore and describe the self-esteem of HIV/AIDS orphans. In order to achieve this aim, a number of objectives were outlined, as described in Chapter one. A description of how the objectives were achieved:

- To review the literature on the subjects of HIV/AIDS and the construct self-esteem, including prior research and theory.

The researcher was able to reach this objective by thoroughly studying a large body of material, from a number of sources, including books, journal articles and the internet, on these subjects.

A review of the literature (Crocker, 2006; Kaplan, 2001; Mruk, 2006; Rosenberg & Owens, 2001) on self-esteem and HIV/AIDS demonstrates that a positive self-esteem may serve as a protective factor in the face of external stressors, as identified in the context of the HIV/AIDS orphans. However, a lowered self-esteem may have the opposite effect, and act instead as a vulnerability factor when the environment exerts stressors on the individual. The results from this study, presented in Chapter 4, demonstrate that the children orphaned by HIV/AIDS, who participated in this study, presented with a lowered self-esteem.

Battle (1981:10) explains that global self-esteem is made up of general, social, academic, and, in children, parent-related self-esteem. The development and nature of these sub-categories are largely unique. One sub-category may present as being very low, while another may present as high. As such the global score may, for example, appear high but it is important to consider each sub-category so as to achieve an in-depth understanding of the nature of the self-esteem of the individual under consideration.

On average, the participants who formed part of the sample for this study demonstrated a lowered self-esteem across the domains of general, social, academic and parent-related self-esteem.

- Participants in this study achieved a lowered score on the scale of general self-esteem. The participants can therefore be described as experiencing a self-aversion, which equates with feelings of inferiority, timidity, self-hatred, lack of personal acceptance and submissiveness. These feelings of poor self-regard impact on a child's ability to assert themselves and their belief that they can, and deserve to, achieve more in life.
  - The participants in this study demonstrated a low social self-esteem, demonstrating that the participants may feel that the quality of their relationship with others is low.
  - Results show that the participants in this study have a low belief in their ability to achieve and to cope with challenges. This was demonstrated by the low score obtained on the scale of academic self-esteem.
  - The results of this study show that the participants scored highest on the domain of parent-related self-esteem. It can be seen from the results that from all the domains of self-esteem (general, social, academic and parent-related), the participants are most confident and secure in themselves, in relation to their carers. This domain of self-esteem has positively impacted their global self-esteem.
- Thirty respondents completed the Culture-free Self-esteem Questionnaire for children, which is a well-used measure for assessing the self-esteem in young children aged 11 to 16.(compare Kaslow, Tannebaum & Seligman, 1978).

The researcher reached this objective by randomly sampling thirty participants from Jerusalem Ministries to participate in this study. Each participant was

briefed on the nature of the study and completed a consent form, indicating that they understand the study. Following this, each participant then completed the Culture-free Self-esteem Questionnaire for children.

- Conclusions and recommendations were made to professionals in the field with regards to intervention.

The researcher was able to reach this objective by providing a description of the research findings, and exploring the limitations of this study.

### 5.3 CONCLUSIONS

From this study the following conclusions have been reached.

- The participants in this study experience a lowered global self-esteem, as well as lowered self-esteem in the domains of general, social, academic and parent-related self-esteem.
- The lowest areas of self-esteem were achieved in the domains of social and general self-esteem. The highest scoring domain of self-esteem was in the area of parent-related self-esteem.
- These results demonstrate that there is a need for intervention in this area, in terms of self-esteem enhancement programmes and educating those working with this population as to the nature and influence of self-esteem.
- A review of the literature on this population shows that this research was, as far as the researcher was able to ascertain, the first of its kind. The results of this research suggest that this population do experience difficulties with regards to their self-esteem. The researcher is therefore able to conclude that further research in this area is necessary.

## 5.4 RECOMMENDATIONS

The following recommendations are made based on the conclusions reached.

### 5.4.1 Professionals Working with HIV/AIDS Orphans

Self-esteem has a significant influence on a child's level of achievement, his ability to overcome and adjust to environmental stressors, and his overall well-being. It is recommended that those in the field working with children orphaned by HIV/AIDS be mindful of this influence and work to enhance their feelings regarding their self-worth.

Self-esteem has been shown to be multifaceted, and as such enhancement strategies should be designed to enhance the specific domains of self-esteem, namely general, social, academic and parent-related self-esteem.

### 5.4.2 Future Research

For the purpose of future studies it is recommended that a study be carried out, implementing, and assessing an intervention strategy. Such a study would be an important step in addressing the self-esteem of children orphaned by HIV. It is further recommended to include educators and carers in the intervention, so as to address all the facets of self-esteem.

Making use of play therapy as an intervention for addressing self-esteem may be of particular use with this population, and more so with children of this age group. Play therapy offers an opportunity for self-healing, and a medium of safe communication. Furthermore, since the influence of peers on a child's identity has a significant impact, group play therapy offers children the opportunity to share their experience with others, which anchors their experience in reality (McMahon, 2000: 23).

It is also recommended that similar research be conducted, sampling from a broader community, so as to access a deeper understanding of the experience of all children orphaned by AIDS.

This study did not explore any correlations between how long the child had been orphaned and their level of self-esteem. Further research in this area would add value to this area of enquiry.

Lastly, a study including a larger population from a more diverse background may provide a clearer understanding of the HIV/AIDS orphan population.

## 5.5 LIMITATION OF THE STUDY

The sample for this study included participants sampled from Jerusalem Ministries, and as such does not represent children orphaned by HIV/AIDS, living with relatives or in child-headed homes.

As this study included only 30 participants, living within a specific area, the results of this study can therefore not be generalized to the larger HIV/AIDS orphan population.

## 5.6 SUMMARY

This research was motivated by both a personal investment in the South African community at large, and more specifically the HIV/AIDS orphan population, and an interest in the area of self-esteem and the impact this construct has on an individual's functioning and future.

As is indicated throughout this chapter, it is evident that this population of HIV/AIDS orphans experiences a lowered self-esteem. Self-esteem is an important construct for everyday living, and for children who are already facing so many life challenges, this construct is essential for achieving a better future.

The HIV/AIDS epidemic is hitting our nation, and world, with such a rapid range, and it is the responsibility of each individual to act, whether it is by educating one's children or supporting organizations working with these individuals, to contain and eliminate its threat.

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## Appendix 1

Frequency Distribution Table and Histogram for scores earned on Global Self-esteem

### Statistics

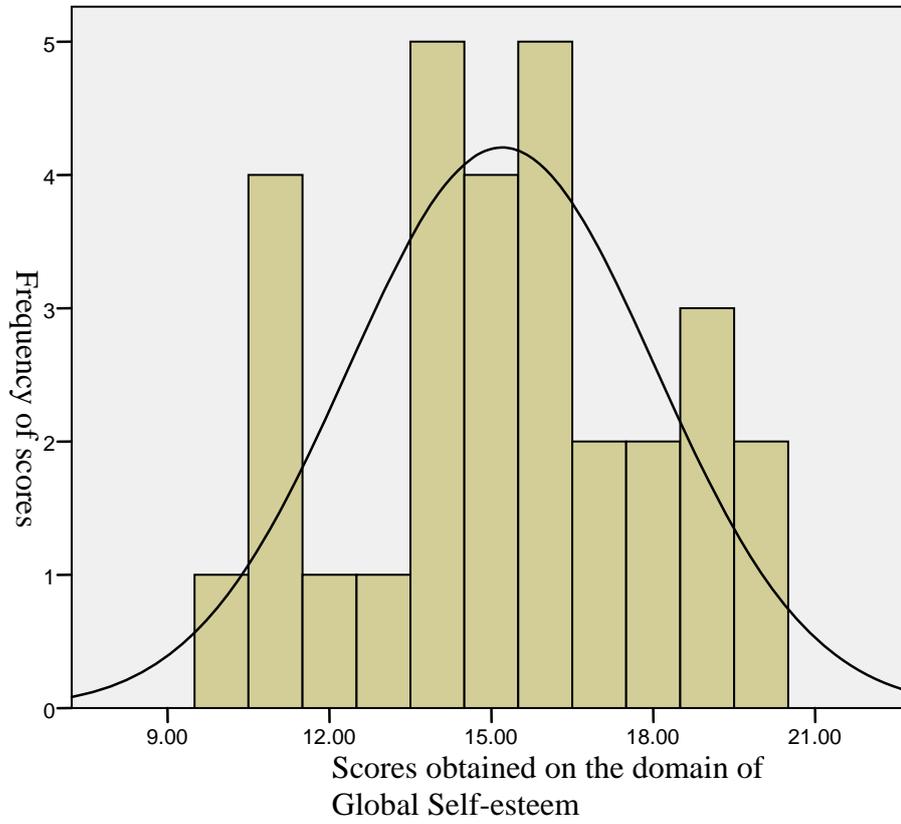
Global Self-esteem

N	Valid	30
	Missing	0
Mean		15.17
Std. Deviation		2.85
Skewness		-.072
Std. Error of Skewness		.427

### Global Self-esteem

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 10.00	1	3.3	3.3	3.3
11.00	4	13.3	13.3	16.7
12.00	1	3.3	3.3	20.0
13.00	1	3.3	3.3	23.3
14.00	5	16.7	16.7	40.0
15.00	4	13.3	13.3	53.3
16.00	5	16.7	16.7	70.0
17.00	2	6.7	6.7	76.7
18.00	2	6.7	6.7	83.3
19.00	3	10.0	10.0	93.3
20.00	2	6.7	6.7	100.0
Total	30	100.0	100.0	

**Histogram: Global Self-Esteem**



Mean =15.17  
Std. Dev. =2.85  
N =30

## Appendix 2

Frequency Distribution Table and Histogram for scores earned on General Self-esteem

### Statistics

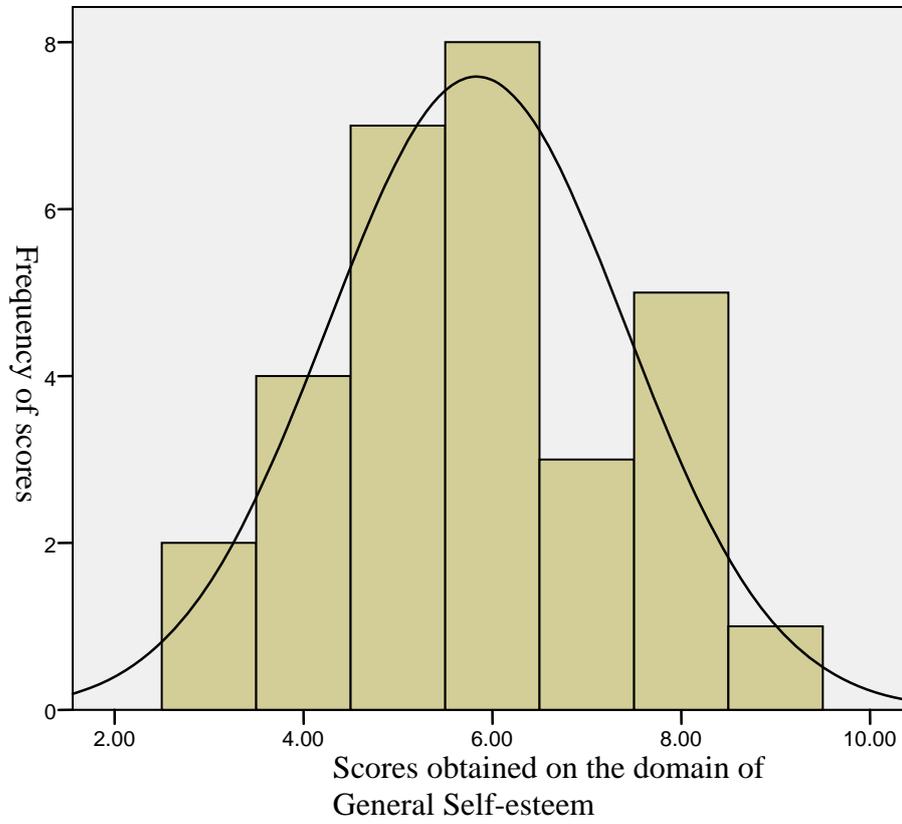
General Self-esteem

N	Valid	30
	Missing	0
Mean		5.83
Std. Deviation		1.57
Skewness		.12
Std. Error of Skewness		.42

### General Self-esteem

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 3.00	2	6.7	6.7	6.7
4.00	4	13.3	13.3	20.0
5.00	7	23.3	23.3	43.3
6.00	8	26.7	26.7	70.0
7.00	3	10.0	10.0	80.0
8.00	5	16.7	16.7	96.7
9.00	1	3.3	3.3	100.0
Total	30	100.0	100.0	

**Histogram: General Self-esteem**



### Appendix 3

Frequency Distribution Table and Histogram for scores earned on Social Self-esteem

#### Statistics

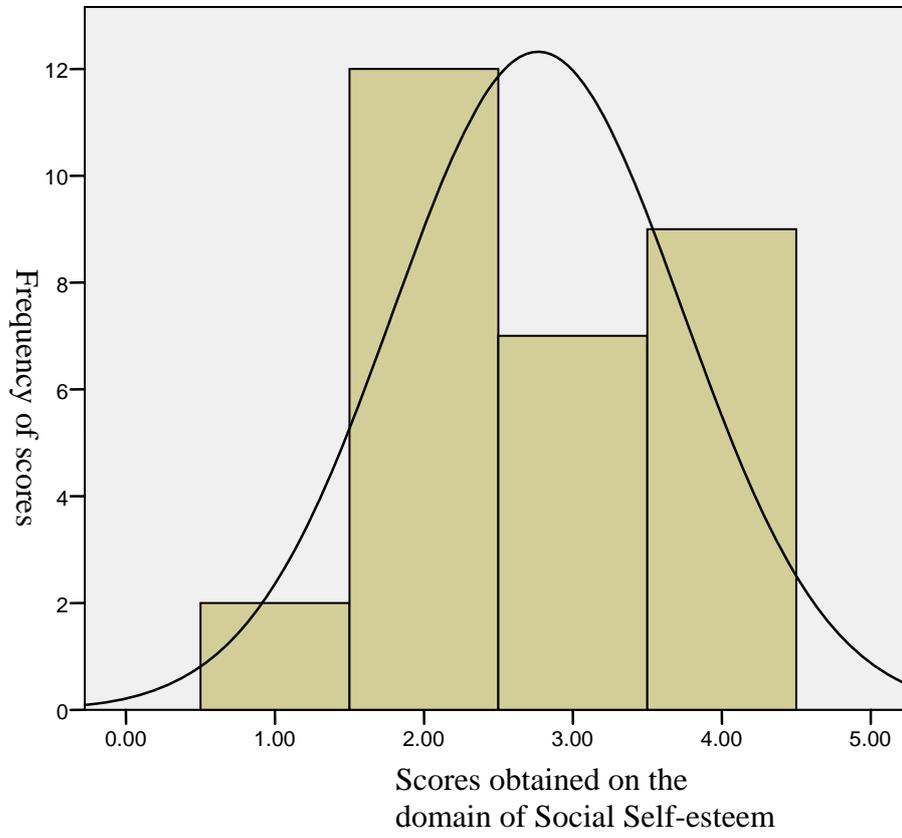
Social Self-esteem

N	Valid	30
	Missing	0
Mean		2.76
Std. Deviation		.97
Skewness		.02
Std. Error of Skewness		.42

#### Social Self-esteem

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1.00	2	6.7	6.7	6.7
2.00	12	40.0	40.0	46.7
3.00	7	23.3	23.3	70.0
4.00	9	30.0	30.0	100.0
Total	30	100.0	100.0	

**Histogram: Social Self-esteem**



## Appendix 4

Frequency Distribution Table and Histogram for scores earned on Academic Self-esteem

### Statistics

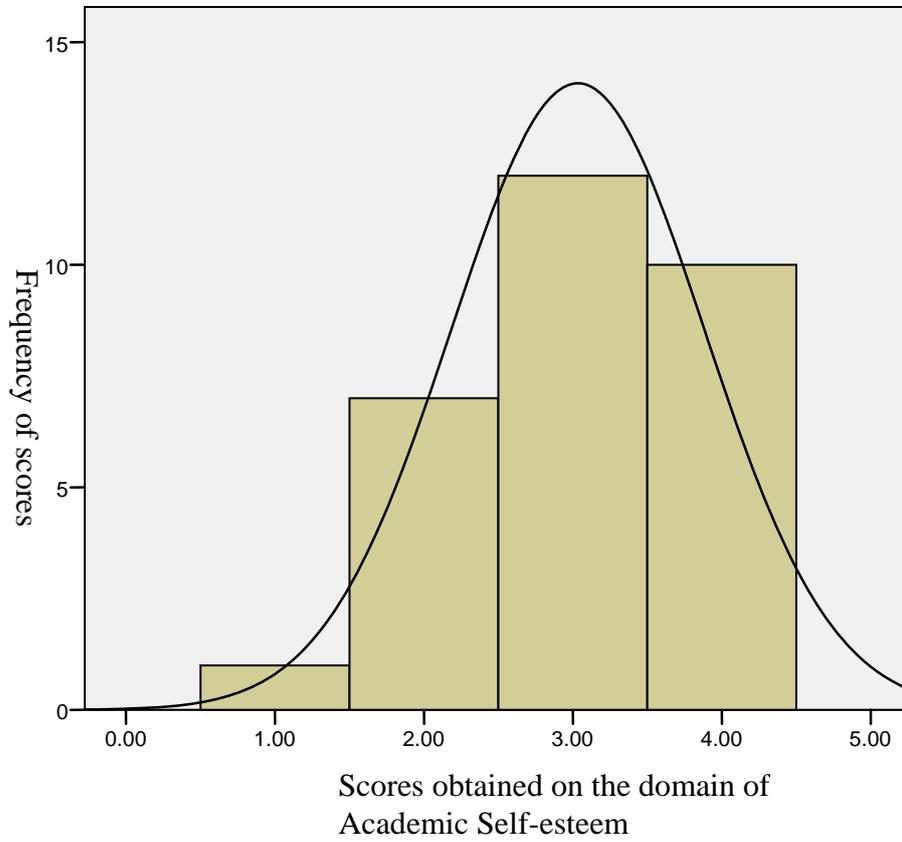
Academic Self-esteem

N	Valid	30
	Missing	0
Mean		3.03
Std. Deviation		.85
Skewness		-.42
Std. Error of Skewness		.42

### Academic Self-esteem

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 1.00	1	3.3	3.3	3.3
2.00	7	23.3	23.3	26.7
3.00	12	40.0	40.0	66.7
4.00	10	33.3	33.3	100.0
Total	30	100.0	100.0	

**Histogram: Academic Self-esteem**



Mean =3.03  
Std. Dev. =0.85  
N =30

## Appendix 5

Frequency Distribution Table and Histogram for scores earned on Parent-Related Self-esteem

### Statistics

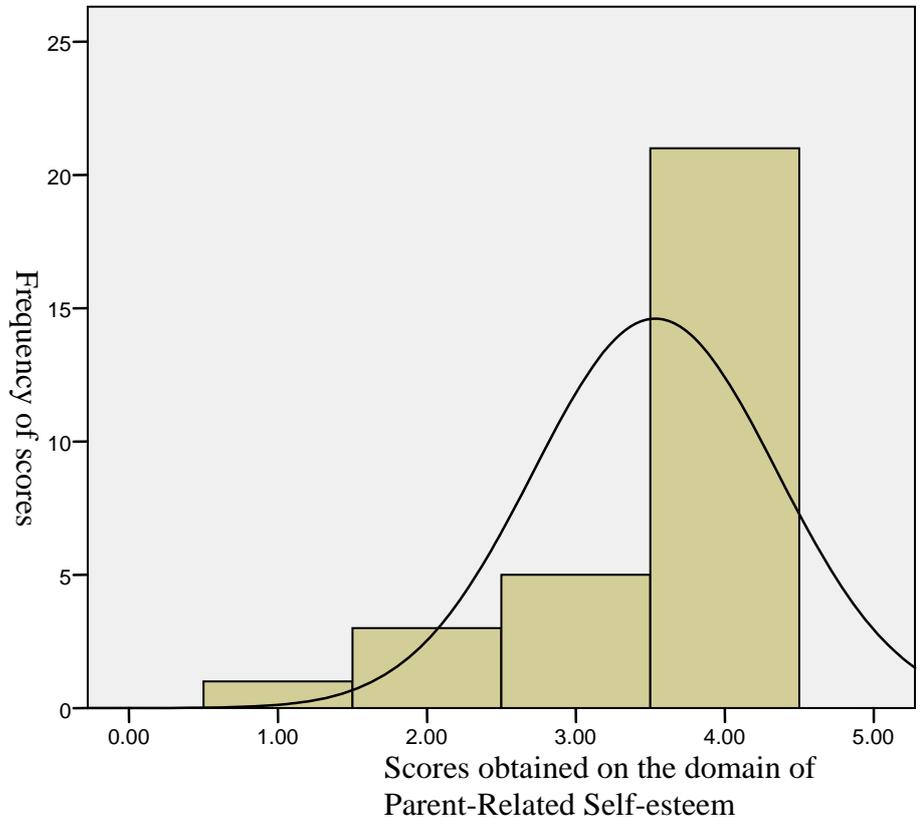
Parent-Related Self-esteem

N	Valid	30
	Missing	0
Mean		3.53
Std. Deviation		.82
Skewness		-1.72
Std. Error of Skewness		.42

### Parent-Related Self-esteem

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	1	3.3	3.3	3.3
	2.00	3	10.0	10.0	13.3
	3.00	5	16.7	16.7	30.0
	4.00	21	70.0	70.0	100.0
	Total	30	100.0	100.0	

### Histogram: Parent-Related Self-esteem



Mean =3.53  
Std. Dev. =0.819  
N =30

## Appendix 6

### Letter of Consent

I, the undersigned, hereby confirm that the nature of the study entitled 'Self-Esteem of AIDS Orphans – A Descriptive Study' has been fully explained to me, as has my participation in this study. I understand that my identity will remain confidential. I further understand that my participation is completely on a voluntary basis and I am free to withdraw my participation at any point in this study. I thereby give my consent for the researcher to make use of my biographical information, including my age, race and gender, as well as my results from the Culture-Free Self-Esteem Inventory for Children.

.....  
Participant

.....  
Guardian

Date.....

Place.....