

Academic and Social Self-esteem among Children Living with HIV/AIDS

Sampathkumar and M. B. Ravikumar

*Department of Studies in Psychology, University of Mysore,
Mysore 570 006, Karnataka, India
E-mail: askmys@rediffmail.com*

KEYWORDS Self-esteem. HIV/AIDS Boys. HIV/AIDS Girls. Rural HIV/AIDS. Urban HIV/AIDS

ABSTRACT The major objective of the paper is to study the academic and social self-esteem of boys and girls from rural and urban areas, living with HIV/AIDS. Further, the paper also attempted to study the level of academic and social self-esteem of children living with HIV/AIDS and those without HIV/AIDS. The participants were 300 children living with HIV/AIDS and 300 were non-HIV/AIDS children. Selected children were measured on the Self-Esteem Inventory. The findings indicated that children living with HIV/AIDS have lower academic and social self-esteem compared to non-HIV/AIDS children. The girls living with HIV/AIDS have a lower academic and social self-esteem compared to boys. The rural children living with HIV/AIDS have lower academic and social self-esteem compared to urban children.

INTRODUCTION

Despite the large number of people who have died of AIDS, the epidemic is still in its early stage and is now being transmitted to every part of the world. According to UNAIDS global report (2009), it is estimated that there are 33.3 million people worldwide and 4.9 million people on the Asian continent infected with HIV/AIDS. According to National Aids Control Organization (NACO) report 2009-2010, India has 2.27 million HIV-infected persons, the third highest in the world after South Africa and Nigeria. According to Karnataka State Aids Prevention Society (KSAPS) Consolidated ART report from June 2011, in the state of Karnataka, 0.165 million adults and 0.013 million children have registered for the Anti Retroviral Therapy (ART). HIV/AIDS researchers are projecting an estimated 65 million deaths from AIDS by the year 2020, more than triple the number who died in the first 20 years of the epidemic, unless major efforts are put toward primary prevention, or major developments in treatment take place (Altman 2002).

Yet an outright cure remains elusive, leaving patients with the challenges of living with a chronic medical condition. HIV positive children can live a longer life because of medical and social advances like ART. But treatment programs have been unable to eradicate the virus and cure the disease. Antiretroviral therapy (ART) in children preserves or restores immune functions, provides sustained suppression of

the viral load, promotes or restores normal growth and development, improves the quality of life, prevents complicating infections and cancers, and prolongs the child's life. As a result, they are living longer with a chronic condition that continuously presents physical, psychological and social challenges.

According to Tate et al. (2003), the new advances for treatment of HIV using Highly Active Antiretroviral Therapy (HAART) have dramatically improved disease prognosis. In children, the Antiretroviral Therapy (ART) preserves or restores immune function, provides sustained suppression of the viral load, promotes or restores normal growth and development, improves the quality of life, prevents complicating infections and cancers, and prolongs the child's life. Therefore, HIV-positive children can live a longer life because of medical and social advances, but treatment programs have not been able to eradicate the virus and cure the disease. As a result, they are living longer with a chronic condition that continuously presents physical, psychological and social challenges. Like all patients with chronic medical disorders, HIV-infected children also are at increased risk for specific psychiatric and psychosocial problems.

Children are affected in different ways by the HIV/AIDS pandemic. Many children are infected with HIV, and all children in regions with high HIV prevalence are likely to be affected by the ensuing deterioration of services, the weakening of social institutes and high levels of

stress. Other categories of children affected by HIV/AIDS are children who lose a parent or parent-substitute, children who live in a household in which one or more people are ill, dying or deceased, children whose caregivers are too ill to continue to look after them, and children living with very old and frail caregivers (Richter et al. 2004). So in addition to dealing with HIV/AIDS, due to the severity of the epidemic, many children face recurrent losses among family members and guardians, as well as the loss of familiar surroundings and schooling. Thus, the psychological impact may also be recurrent (Atwine et al. 2005).

Children suffer tremendously when their parents are tested HIV positive, and the needs of children with infected parents are often neglected. According to Wood et al. (2006), AIDS-related bereavement is likely to be particularly complicated and difficult to accommodate. Grief may precede the actual death in the form of anticipatory loss and AIDS-related death may be more stigmatized. Children often witness debilitating illness and may experience compromised parenting. In many societies there is no tradition of talking to children as equals and on an intimate basis, and caregivers often report seeing the suffering of children, who are seeing and hearing everything but never addressed directly. Many families don't want to look after AIDS children because of the stigma associated with AIDS deaths in many communities (UNAIDS 2004). AIDS-related stigma and discrimination remains the greatest obstacles to people living with the HIV infection. Stigma and discrimination increase people's vulnerability, social isolation, deprive them of their basic human rights, care and support, and worsen the impact of infection. Stigma and discrimination also intensify violations of the rights of AIDS children in particular, their access to education, social services and community and familial support (Kang et al. 2005).

Like all patients with chronic medical disorders, HIV-infected persons also are at increased risk for specific psychiatric and psychosocial problems. Various studies have linked HIV/AIDS with a number of psychosocial problems, depression being the most common (Tate et al. 2003; Wechsler-Felder and Golden 2002). Huurre and Aro, (2002) say that infected children have been reported to have lower self-esteem, poor body image and more problems in psychologi-

cal wellbeing, behavior and social adjustment than those without the chronic conditions.

Self-Esteem

The construct self-esteem is one that is frequently referred to in both, popular culture and social science. 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-behavioral perspective conceptualized self-esteem in terms of coping strategies and problem solving skills, while the humanistic approach highlights the experiential elements of self-esteem (Mruk 1999). Maslow (1970) 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) 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.

Battle's Model of Self-esteem

Battle (1981) identifies four dimensions, namely general, social, academic and parent-related self-esteem, as comprising the global construct of self-esteem for children. For adults, this changes to include general, social and personal self-esteem. Within this conceptualization, 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) further emphasizes the affective (subjective feelings), personal (social acceptance) and cognitive aspects (self-evaluation) of self-esteem.

Children living with 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). 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 behavior (Rosenberg and Owens 2001).

Children living with HIV/AIDS are considered to be a highly deprived class of society. These children are left helpless, abandoned, neglected by the parents or caregivers due to social, economic and personal reasons like gender, domicile, or age. They are deprived of one or more necessities of life. Early separation from parents, deprivation of parental care, love, affection, warmth, security, acceptance and discipline during childhood, disrupts their normal socio-academic development resulting in low self-esteem. In this context it becomes very important to understand how well they are able to cope with lower self-esteem and adjust to the demands of the environment and society around them. Therefore, the present study attempts to know the level of academic and social self-esteem of children living with HIV/AIDS. As a result, the study can suggest the need for appropriate counseling and guidance, and care and support to overcome their academic and social self-esteem issues. Thus the following objective and hypotheses were formulated.

Objectives

1. To study the level of academic and social self-esteem in children living with HIV/AIDS and those without HIV/AIDS.
2. To study the academic and social self-esteem in boys and girls living with HIV/AIDS.
3. To study the academic and social self-esteem in rural and urban children living with HIV/AIDS.

Hypotheses

- H_1 : Children with HIV/AIDS have lower academic, social and over all self-esteem than those without HIV/AIDS.
- H_2 : Girls with HIV/AIDS have lower academic, social and overall self-esteem than boys.
- H_3 : Rural children with HIV/AIDS have lower academic, social and over all self-esteem than urban children.

METHODOLOGY

Participants

The participant group consists of total 600 children, wherein 300 children were infected with HIV/AIDS and 300 children were not. For sample selection, the purposive sampling method was used (Table 1). The age ranges from 9 to 14 years and the mean age was 11.5 years.

Table 1: Samples for the present study

Variables	Children with HIV/AIDS		Non-HIV/AIDS children	
	Boys	Girls	Boys	Girls
Rural	75	75	75	75
Urban	75	75	75	75
Total	150	150	150	150
	300	300		

Measures

1. Personal information schedule
2. Self-Esteem Inventory (SEI): Cooper Smith developed SEI in 1987. It consists of 58 items, used to measure five different areas: General, Social, Home, Lie scale and School self-esteem. The reliability and validity of the inventory were satisfactory. A higher score indicates a higher level of self-esteem. A Personal Informational Data sheet was also used with the Inventory.

Procedure

The participants were given appropriate instructions and administered the Self-Esteem Inventory in groups of 10. They were also asked to give their socio-demographic details in the prescribed profarma. They indicated their responses in the answer sheets given to them.

Whenever they had doubt in understanding items, the test administrator clarified their doubts in their local language. Data collection was done in one session, which lasted for about 45 to 60 minutes. Then the data was scored and statistically analyzed by using descriptive and ANOVA techniques.

RESULTS AND DISCUSSION

Table 2 shows mean, SD and F values for academic and social self-esteem domains of children with and without HIV/AIDS. The academic self-esteem of children with HIV/AIDS (Mean=2.45; SD= 1.329) and Non-HIV/AIDS children (Mean=6.10; SD=1.363) (F=1464.301; $p < .000$) indicate a highly significant difference. Children with HIV/AIDS were statistically lower than those without, in academic self-esteem. Therefore, formulated $H_{1,1}$, that is, children with HIV/AIDS have a lower academic self-esteem than those without, was accepted.

Social self-esteem of children with HIV/AIDS (Mean=3.40; SD= 1.095) and Non-HIV/AIDS (Mean=4.94; SD=1.149) (F=354.202; $p < .000$) indicate a highly significant difference. Children with HIV/AIDS were statistically lower than those without in academic self-esteem. Therefore, formulated $H_{1,2}$, that is, children with HIV/AIDS have a lower social self-esteem than those without, was accepted.

Total self-esteem of children with HIV/AIDS (Mean=5.86; SD= 1.889) and Non-HIV/AIDS (Mean=11.04; SD=2.030) (F=1387.449; $p < .000$) indicate a highly significant difference. Children with HIV/AIDS were statistically lower than those without, in overall self-esteem. Therefore, formulated $H_{1,3}$, that is, children with HIV/AIDS have a lower total self-esteem than non-HIV/AIDS children, was accepted.

Table 3 shows the mean, SD and F values of academic self-esteem of boys and girls, and rural and urban children, living with HIV/AIDS. Academic self-esteem of boys (Mean=2.20; SD=1.395) and girls (Mean=2.71; SD=1.213) (F=15.229; $p < .000$) indicate a highly significant difference. Girls were statistically lower than boys in academic self-esteem. Therefore, formulated $H_{2,1}$, that is, girls living with HIV/AIDS have significantly lower academic self-esteem than boys, was accepted.

Academic self-esteem of rural (Mean=1.81; SD= 1.149) and urban children (Mean=3.09; SD=1.183) (F=97.197; $p < .000$) indicate a highly significant difference. Rural children were statistically lower than urban children living with HIV/AIDS in academic self-esteem. Therefore, formulated $H_{3,1}$, that is, rural children living with HIV/AIDS having significantly lower academic self-esteem than urban children, was accepted. When we see the interaction effects between gender-domicile on academic self-esteem,

Table 2: Mean, SD and F values for academic and social self-esteem domain of children with HIV/AIDS and Non-HIV/AIDS

Domains	Source of variations	N	Mean	SD	F	p
Academic	HIV/AID	300	2.45	1.329	1464.301	.000
	Non-HIV/AIDS	300	6.10	1.363		
Social	HIV/AID	300	3.40	1.095	354.202	.000
	Non-HIV/AIDS	300	4.94	1.149		
Total	HIV/AID	300	5.86	1.889	1387.449	.000
	Non-HIV/AIDS	300	11.04	2.030		

df=1

Table 3: Mean, SD and F values of academic self-esteem of boys/girls and rural/urban children living with HIV/AIDS

Variables	Source of variations	N	Mean	SD	F	p
Academic	HIV/AID	300	2.45	1.329	1464.301	.000
	Gender	Boys	150	2.20		
Domicile	Girls	150	2.71	1.213	97.197	.000
	Rural	150	1.81	1.149		
Interaction	Urban	150	3.09	1.183	9.492	.002
	Gender*Domicile	300	2.45	1.329		

df =1

($F=9.492$; $p<.002$) they were found to be significantly influenced.

Table 4 indicates the mean, SD and F values of social self-esteem between boys and girls and rural and urban children living with HIV/AIDS. Social self-esteem of boys (Mean=3.85; SD=1.066) and girls (Mean=2.96; SD=.933) ($F=61.518$; $p<.000$) indicate a highly significant difference. Girls were statistically lower than boys in social self-esteem. Therefore, formulated $H_{2,2}$ that is, girls living with HIV/AIDS having significantly lower social self-esteem than boys, was accepted.

Social self-esteem of rural (Mean=3.18; SD=1.093) and urban children (Mean=3.63; SD=1.053) ($F=15.612$; $p<.000$) indicate a highly significant difference. Rural children were statistically lower than urban children in social self-esteem. Therefore, formulated $H_{3,2}$, that is, rural children living with HIV/AIDS have a significantly lower social self-esteem than urban children, was accepted. The interaction effects between gender-domicile on social self-esteem ($F=.588$; $p<.444$) were not significantly influenced.

Table 5 reveals the mean, SD and F values of total self-esteem between boys and girls and rural and urban children living with HIV/AIDS. Overall, self-esteem of boys (Mean=6.05; SD=1.991) and girls (Mean=5.67; SD=1.767) ($F=3.885$; $p<.050$) indicate a significant difference. Girls were statistically lower than boys in total self-esteem. Therefore, formulated $H_{2,3}$ that

is, girls living with HIV/AIDS having significantly lower total self-esteem than boys, was accepted.

Total self-esteem of rural (Mean=4.99; SD=1.539) and urban children (Mean=6.72; SD=1.814) ($F=80.222$; $p<.000$) indicate a highly significant difference. Rural children were statistically lower than urban children in total self-esteem. Therefore, formulated $H_{3,3}$, that is, rural children living with HIV/AIDS have a significantly lower total self-esteem than urban children, was accepted. The interaction effects between gender-domicile on overall self-esteem ($F=2.642$; $p<.105$) were not significantly influenced.

The overall results indicate that children living with HIV/AIDS have lower academic and social self-esteem than without. Girls and rural children living with HIV/AIDS have lower academic and social self-esteem than boys and urban children living with HIV/AIDS.

Taha (2000) also reported similar findings. According to that study, HIV-related adjusted recurrent problems of fever, chronic diarrhea, vomiting, ear infections, skin conditions, oral thrush, and cough were significantly higher among HIV-infected children compared to HIV-uninfected children. HIV infected children on clinical examination showed otitis media, dermatitis, oral candidiasis, signs of active chest problems, lymphadenopathy, and developmental delay, and cough (could be attributed to malaria), malnutrition, and respiratory tract infections,

Table 4: Mean, SD and F values of social self-esteem of boys/girls and rural/urban children living with HIV/AIDS

Variables	Source of variations	N	Mean	SD	F	p
Gender	Boys	150	3.85	1.066	61.518	.000
	Girls	150	2.96	.933		
Domicile	Rural	150	3.18	1.093	15.612	.000
	Urban	150	3.63	1.053		
Interaction	Gender*Domicile	300	3.40	1.095	.588	.444

df=1

Table 5: Shows mean, SD and F values of total self-esteem of boys/girls and rural/urban children living with HIV/AIDS

Variables	Source of variations	N	Mean	SD	F	p
Gender	Boys	150	6.05	1.991	3.885	.050
	Girls	150	5.67	1.767		
Domicile	Rural	150	4.99	1.539	80.222	.000
	Urban	150	6.72	1.814		
Interaction	Gender*Domicile	300	5.86	1.889	2.642	.105

df=1

respectively. These were significantly more frequent in them compared to HIV-uninfected children. All these frequent physical sufferings along with the suffering of the family members, and their HIV status will have adverse influence on the psychosocial well-being of a child and will translate into decreased self-esteem in children living with HIV/AIDS as compared to those without HIV/AIDS.

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

A study conducted by Marcotte et al. (2002) also reported similar findings that girls have a lower self-esteem than boys. Given this finding, much attention can be directed at determining why it is that girls have lower self-esteem than boys. It could be said that factors that affect a girl's self-esteem include, but are not limited to, the following: adjusting to the onset of puberty (Marcotte et al. 2002), methods of coping (Byrne 2000), less attention in the classroom, feelings of inadequacy at math and science, physical appearance (Corbin 2002), overall support system (Marcotte et al. 2002), and feelings of competency (Corbin 2002).

Findings of the present study also, indicate that rural children living with HIV/AIDS have lower academic, social and total self-esteem than their urban counterparts. It may be because rural families have lower access to modern health facilities and awareness of HIV/AIDS. Consequently children may develop fear, anxiety, and depression, resulting in lower self-esteem.

Under the circumstances wherein the family atmosphere is unhealthy, institutional care is the best available alternative for children living with HIV/AIDS. However, a stable, reliable and understanding relationship does not depend pri-

marily on words but on consistent response to a child's feelings, which gradually develops foundations of trust, confidence, and a sense of security. This provides a strong base from which they develop self-identity, self-esteem, self-confidence, self-respect, a sense of confidence and work. The government and non-government institutions, and social scientists should focus their attention on these children and families as they struggle to cope with this devastating disease. The present study suggests that there is a need for intervention targeting HIV/AIDS children to restore their optimum level of functioning and preventing them from lower self-esteem.

CONCLUSION

1. Children with HIV/AIDS have lower academic and social self-esteem than those without HIV/AIDS.
2. Girls living with HIV/AIDS have lower academic and social self-esteem compared to boys.
3. Rural children living with HIV/AIDS have lower academic and social self-esteem compared to urban children.

REFERENCES

- Altman LK 2002. UN Forecasts Big Increase in AIDS Death Toll. The New York Times, pp. A1, A6. In: Shelly E Taylor (Ed.): *Health Psychology*. 6th Edition. New Delhi: Tata McGraw-Hill. P. 389.
- Atwine B, Cantor-Graae E, Bajunirweb F 2005. Psychological distress among AIDS orphans in rural Uganda. *Social Science and Medicine*, 61: 555-564.
- AVERT 2007. AIDS Orphans. From <<http://www.avert.org/aidsorphans.htm>> (Retrieved on 25 June 2007).
- Battle J 1981. *Culture-free SEI: Self-esteem Inventories for Children and Adults*. Washington: Special Child Publications.
- Byrne Bruce 2000. Relationships between anxiety, fear, self-esteem, and coping strategies in adolescence. *Adolescence*, 35(137): 201-216.
- Coopersmith S 1967. *The Antecedents of Self-esteem*. San Francisco: Freeman.
- Corbin Charles 2002. Physical activity for everyone: What every educator should know about promoting lifelong physical activity. *Journal of Teaching in Physical Education*, 21(2): 128-145.
- Gilbert P 1992. *Depression: The Evolution of Powerlessness*. UK: LEA.
- Huurre TM, Aro HM 2002. Long-term psychosocial effects of persistent chronic illness, *European Child and Adolescent Psychiatry*, 11(2): 85-91.
- Kang E, Rapkin BD, Remien RH, Mellins CA, Oh A 2005. Multiple dimensions of HIV stigma and psychological distress among Asians and Pacific Island-

- ers living with HIV illness. *AIDS and Behavior*, 9(2):145-154.
- KSAPS 2010. *Consolidated On ART Report-June-2011*. Bangalore: Karnataka State Aids Prevention Society.
- Marcotte D, Fortin L, Potvin P, Myra Papillion 2002. Gender differences in depressive symptoms during adolescence: Role of gender-typed characteristics, self-esteem, body image, stressful life events, and pubertal status. *Journal of Emotional and Behavioral Disorders*, 10(1): 29-43.
- Maslow AH 1970. *Motivation and Personality*. New York: Springer.
- Mruk CJ 1999. *Self-esteem: Research, Theory and Practice*. USA: Springer.
- NACO 2009-10. *Annual Report 2009-10*. New Delhi: National AIDS Control Organization, Ministry of Health and Family Welfare, Govt. of India.
- Richter L, Manegold J, Pather R 2004. *Family and Community Interventions for Children Affected by AIDS*. Cape Town: HSRC Publishers.
- Rosenberg M, Owens T J 2001. Low self-esteem people: A collective portrait. In: TJ Owens, S Stryker, N Goodman (Eds.): *Extending Self-esteem Theory and Research*. New York: Cambridge University Press, pp. 400-436.
- Taha E 2000. Morbidity among HIV infected and uninfected African children. *Journal of the American Academy of Pediatrics*, 10: 677.
- Tate D, Paul RH, Flanigan TP, Tashima K, Nash J, Adair C, Boland R, Cohen RA 2003. The impact of apathy and depression on quality of life in patients infected with HIV/ AIDS. *Patient Care and STDs*: 17(3): 115-120.
- UNAIDS 2004. *Children on the Brink 2004: A Joint Report of New Orphans Estimates and a Framework for Action*. New York: Author. UNAIDS: Geneva.
- UNAIDS 2010. *Report on the Global HIV/AIDS Epidemic*. Geneva: The Joint United Nations Programme on HIV/AIDS.
- Wechsler-Felder JL, Golden CJ 2002. Neuropsychological consequences of HIV in children: A review of current literature. *Clinical Psychology Review*, 22: 441-462.