Chapter - I

INTRODUCTION

The acquired immuno deficiency syndrome (AIDS) is a fatal illness caused by a retro-virus known as human immunodeficiency virus (HIV). It breaks down the body's immune system, leaving the victim vulnerable to a host of life-threatening opportunistic infections, neurological disorders or unusual malignancies. Acquired means it is obtained or received by a person and is something which does not ordinarily exist within one's body. Immune deficiency means the immune system is weakened. AIDS is a syndrome which means it is not one particular isolated disease but one which has a variety of symptoms leading to various disorders and a set of diseases. HIV/AIDS are one of the most challenging, perplexing and alarming realities of recent times (Larson & Narain, 2001; UNAIDS, 2002). Powell-Cope and Brown (1992) have labeled HIV/AIDS as the most controversial disease in modern history. Correspondingly, Lyell (1995) warns that HIV/AIDS is fast becoming a major epidemic and psychological emergency.

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). More specifically, there are three main ways, in which HIV is transmitted. The Centre for Disease Control and Prevention has (CDC) (1999) identified the following routes:

1. 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.
2. Semen and vaginal and cervical secretions transferred during sexual intercourse.
3. 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, Murray (1999) say that it is important to note that contamination does not occur through day-to-day activities. HIV cannot be contracted through such things as tears, saliva, sweat, vomit, urine, sneezing, coughing, swimming, shaking hands, kissing, sharing clothes, sharing toilet seats, sharing cups and plates.

HIV-infection results in a spectrum of disease, ranging from the absence of symptoms, to mild nonspecific symptoms to severe infections, cancers, and neurological conditions. The earliest symptoms of HIV-infection are known as the primary HIV syndrome. They occur soon after becoming infected and include fever, rash, muscle and joint aches, and swollen lymph glands. Other symptoms such as seizures, hepatitis, and diarrhea can also be present, although they are less frequent. The HIV antibody blood test can be negative during the primary HIV syndrome, but becomes positive within the following three to six months. After these primary symptoms, the HIV infected person usually remains without symptoms for a period of time. This is described as latency period. This latency period is, on average, ten to twelve years. During the latency years, the T-cell count usually declines from its normal value of 750-1500. When the count drops below 500, the person may be at risk for herpes simplex infection, and Kaposi's sarcornia, globally known as opportunistic diseases. When the T-cell count drops below 350, the individual is considered to have advanced HIV or AIDS.
UNAIDS report on the global HIV/AIDS epidemic (November-2011) since the beginning of the Acquired Immuno-Deficiency Syndrome (AIDS) epidemic in the late 1970s, and nearly 30 million deaths worldwide have occurred due to illnesses associated with the virus. There is no denial of the enormity of the problem. 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 toward primary prevention or major developments in treatment take place (Altman, 2002). Despite the large number of people who have already died of AIDS, the epidemic is actually still in its early stages and is now being transmitted to every part of the world.

World Epidemic of HIV/AIDS

UNAIDS report on the global HIV/AIDS epidemic (November-2011) since the first AIDS case was detected in USA in 1981 and estimated that the HIV/AIDS epidemic continues its expansion with approximately a day 7000 new people per day HIV-infections and 6000 people would die due to HIV/AIDS. Further an estimated 34 million people worldwide, including 30.6 million adults and 3.4 million children under the age of 15 were living with HIV/AIDS and nearly 30 million people have died of AIDS-related causes since the beginning of the epidemic. An estimated 6.6 million of adult and 0.4 million of children living with HIV/AIDS are received antiretroviral therapy (ART) at the end of 2010.

UNAIDS report on the global HIV/AIDS epidemic (2012) pointed out Sub-Saharan Africa remains most severely affected, with nearly 1 in every 20 adults (5 %) living with HIV and accounting for 69% of the people living with HIV worldwide. Although the regional prevalence of HIV infection is nearly 25 times higher in
sub-Saharan Africa than in Asia, almost 5 million people are living with HIV in South Africa, South-East and East Asia combined. After sub-Saharan Africa, the regions most heavily affected are the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV at the end of 2011.

According to UNAIDS report on the global HIV/AIDS epidemic (2011) in Asia, an estimated 4.8 million people were living with HIV/AIDS, the estimated 0.36 million people were newly HIV infected and 0.31 million people died from HIV/AIDS related causes by the end of the 2010. India, China, Thailand, Indonesia, Viet Nam, Myanmar and Malaysia (ranked by the number of people living with HIV in each) are more than 90% of people living with HIV/AIDS in these Asian countries, with India alone accounting for 49% of the people living with HIV/AIDS in the entire region. The estimated 0.11 million to 0.18 million of children living with HIV/AIDS increased from 2001 to 2010. The number of children newly infected with HIV declined by 23% in Asia over all between 2001 and 2010, from an estimated 28 000 to 22 000. This probably reflects the slowing rate of HIV incidence in this region over all as well as the expansion of services to Prevention of Parent-To-Child Transmission (PPTCT) of HIV. However, an opposite trend is evident in East Asia, where the incidence of HIV infection among children rose by 31%, from 1600 to 2200 children newly infected in the same period.
Indian Epidemic of HIV/AIDS

UNAIDS report on the global HIV/AIDS epidemic (2011) and NACO (2010) says that, India has the third highest estimated number of individuals infected by HIV in the world after South Africa and Nigeria, an estimated 2.3 million people living with HIV/AIDS. National AIDS Control Organization annual report (2012) indicated that approximately 13, 71, 232 adults and 97, 208 HIV infected children have been registered at 342 ART Centres. There are approximately 7, 61, 488 adults and 42,973 children were put on Antiretroviral Therapy treatment across the country.

Children with HIV/AIDS in Karnataka State

Karnataka State Aids Prevention Society (KSAPS) Consolidated ART report pointed out in Karnataka state, there are 49 ART centers. There total numbers of registered pediatric cases are 16,432, and 2, 10, 469 cases are of adult living with HIV/AIDS as on August 2012. In Karnataka’s B4 districts of Belgaum, Bagalkot, Bijapur, Bellary and Indira Gandhi Institution of Child Health (IGICH) Bangalore were about approximately 1000 above pediatric case were registered at ART centers. Among them 1, 27, 722 adult and 8071 of children with HIV/AIDS have receiving on antiretroviral therapy.

AIDS is the final stage of infection with the retrovirus. HIV gradually impairs the immune system which is crucial for the suppression of infections, viruses and bacteria. As the immune system weakens, HIV infected people become infected with opportunistic infections. HIV/AIDS is a chronic disease and without proper treatment the infected persons will eventually die. Yet an outright cure remains elusive, leaving people with the challenges of living with a chronic medical condition.
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 Antiretroviral Therapy (ART) preserves or restores immune function; provides sustained suppression of the viral load and 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 just living longer with a chronic condition that continuously presents physical, psychological and social challenges. Like all patients with chronic medical disorders, HIV infected children are at increased risk for specific psychiatric and psychosocial problems.

A number of studies have found that chronically ill children are at increased risk of psychosocial problems. Huurre & Aro (2002) says that these children have been reported to have lower self-esteem, poor body-image and more problems in psychological well-being, behavior and social adjustment than those without chronic conditions. Tate et al. (2003) said that HIV-positive people can live a longer life because of medical and social advances like ART, but treatment programs have not been able to eradicate the virus and cure the disease. As a result, people are living longer with a chronic condition that continuously presents physical, social, and psychological challenges. Consequently, HIV infected patients, like all patients with chronic medical disorders, are at increased risk for specific psychological and social problems. Tate et al. (2003); Wachsler-Felder & Golden (2002) have linked HIV/AIDS with a number of psychosocial problems, depression, adjustment problems, and emotional problems being the most common. 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, seeing and hearing everything but never addressed directly.

UNAIDS report on the global HIV/AIDS epidemic (2011) point out that many families don’t want to look after AIDS children because of the stigma associated with AIDS deaths in many communities. AIDS-related stigma and discrimination remain the greatest obstacles to people living with HIV-infection. According to Kang and Rapkin et al. (2005) 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 to their access to education, social services and community and familial support.

Children are infected with the virus as a result of prenatal transmission or through sexual abuse. These children experience almost a complete loss of childhood since they are continuously sick and cannot engage in the normal childhood activities. Other children are also warned by their parents not to play with the infected ones for fear of contracting the disease. For an infected child, the fear of dying is constantly prevalent. This of course impairs normal emotional and psychological functioning. According to Foster & Williams (2000); Richter (2001); USAID (2000) have been conducted a study on the impact of children with HIV/AIDS. According to these studies HIV/AIDS has sever negative impact on children. Richter (2001) study on the impact of HIV/AIDS on children reveals that when a family member has AIDS, the average income falls, expenditure on health care quadruples, savings are depleted and families go into debt to care for the sick and food consumption drops in households of
orphans. According to Richter (2001) loss of income of breadwinners, asset selling to afford care, and debt incurred by funeral costs usually deplete all current and future financial reserves of households. This scenario implies that children either have to find themselves adjusted with problems and dropping out of school to look for some means that will supplement the depleting family income or find other means of generating money.

Lyons (2002) indicates that in the absence of capable adult caretakers, children themselves take on responsibilities for the survival of the family and home. In economically disadvantaged communities, the child's contribution is often necessary for the survival of the household. As a result of this economic hardship, in some instances the affected children look for alternative sources of income such as prostitution. Economic hardships impact negatively on most of the children affected by HIV/AIDS. Evidence from literature shows that children affected by HIV/AIDS, provide a high rate of child labor and early marriages. As soon as one or both parents die, children take responsibilities of adults, including economic responsibilities.
Children living with HIV/AIDS face many psycho-social problems such as fear, grief, hopelessness and helplessness syndrome, guilt, low self-esteem, adjustment problems, low emotional competencies, anxiety and depression, denial, anger, aggression and suicide attempts.

1. Fear and loss

Fear of HIV/AIDS is closely associated with fear of our own death, which belongs to the most basic of fears. It is the fear which most of us are trying to fight with by constantly running away from the idea of self-termination or by inventing a series of comforting ideas. Escape and irrationalization will help only to cultivate the fear of death. Above all, children have to be settled with self-extinction, with own death and thus perhaps would help those who just need help in the process of dying.

In countries with high rate of infection children are found amongst doctors and other healthcare staff. Children living with HIV/AIDS are pushed to the margins of the society, and are isolated. They are forced to leave their education, lose their homes, often their family and friends. They are not given adequate health care, and by the provided health care they are confronted with rejection. All of this happens because of an illness which cannot be transmitted by common contact. This attitude of professionals who are unable to overcome prejudices and refuse to provide health care is a deep misunderstanding of their mission. Frensman et al. (2000) gives the reasons for this kind of handling, is fear of being infected with HIV and, ultimately, fear of death itself.
Another aspect which is associated with HIV/AIDS is many losses in life. Children in the developed stage of AIDS are worried because of the loss of their life, their education, their ambitions, physical performance and potency, loss of their position in the society, financial stability and independence. With the increasing essential need of systematic tendency they lose their sense of privacy and control over their lives. Perhaps the most problematic issue is the loss of confidence. It may affect the future, anxiety originating from a relationship with a loved one or caregiver and negative reactions from the society.

For many children finding out about their HIV/AIDS status, it is the first opportunity, to realize their mortality and psychological vulnerability. They face social isolation due to the inability to perform all daily activities which they used to do. Relationships within the family change more frequently, one loses their relations and the attitude of acquaintances and friends changes frequently as well. Many are afraid of the loss of memory, their concentration and ability to make decisions.

Death of a relative, who dies of a deadly disease, presents an extreme burden for each human being. He tends to surrender the pressure of the situation, which seems to be insolvable. Mental failure is accompanied by significant behaviour, changes in physiological and psychological processes in the body, which have sometimes permanent effects on health. This persistent extreme burden, leads to disruption of relationships with the social environment.
2. Grief, hopelessness and helplessness syndrome

Grief is another strong emotion that is closely linked to the loss. The HIV/AIDS positive children often dive into sadness because of their loss they experienced or the one they expect. Natural sadness results from unfulfilled dreams and plans and from the nearness of an inevitable end. The patient may lose the sense of relationship with parents, children, friends or life partner, as well as with other people. In connection with the impending death of a loved one there is mentioned a so called anticipate grief, which occurs by the closest relatives of people with long-term illness, in terms of expected death. HIV/AIDS is a fatal disease. Some children survive ten years, another few months from diagnosis. As the disease gets hold of their body, they lose control over their life. Children living with HIV/AIDS tend not to care anymore about things which made them happy, they submit to their fate, they do not see any hope and wait for the death to come.

Hopelessness and helplessness syndrome includes elements of giving up and leaving. The survival mechanism includes the following:

- Painful feeling of helplessness and hopelessness to face the situation.
- The subjective feeling of reduced ability to deal with the situation (it is beyond my strength).
- Feeling of danger and decreased satisfaction from relationships with others.
- Loss of continuity of the past and future, a reduced ability to hope and trust.
- Tendency to revive and re-construct former deprivations and failures (Bastecky, 1993).
Small children, since most of them do not know about their diagnosis, experience their state very differently. They still have a bit of life joy. In their ignorance, purity and their nativity they can spend a nice childhood, in the case, if somebody takes care of them and provides them with their basic needs as well as health care.

3. Guilt and self-esteem

Diagnosis of HIV/AIDS infection often brings feelings of guilt from the possibility of infecting the other people or from the previous way of life which led to the infection. There is also a feeling of culpability of what disease brings to people in one’s own family, especially children. Previous events that caused pain or sadness of others remained unresolved; they can reoccur and cause the patient even greater feelings of wrongdoing.

Children living with HIV/AIDS, who have to cope with their complicated destiny, very often lose rapidly their self-esteem. Rejection by friends, relatives and loved ones and often children, can very quickly lead to loss of self-esteem and social identity, which leads to the feeling of one’s own worthlessness. This condition can be enhanced by worsening of symptoms accompanying the disease, e.g. facial disfigurement, deteriorating body, loss of strength as well as loss of control over one’s body.

Self-esteem is an ability to appreciate oneself and treat oneself with dignity and love. Anyone who is loved is willing to change. Human beings can grow and change throughout their life. This behaviour is the result of ‘well management’. Coping is the expression of the level of self-evaluation. In coping, how a person
perceives oneself is reflect and one’s own relationship. The problem is not the problem as such, but how one handles it. It can be deduced from that fact that the increase of one’s self-esteem and self-evaluation can lead to well managing the life’s situation of these children.

4. Anxiety disorder and depression

Feelings of anxiety in children living with HIV/AIDS can be detected very soon which reflects the continuous uncertainty associated with the disease. This state results from:

- Short and long-term prognosis.
- Risk of infection with other diseases.
- Risk of infecting other people.
- Social, professional, family and sexual rejection.
- Separation, isolation and physical pain.
- Fear from degradation.
- Fear of undignified dying and dying in pain.
- Inability to change the circumstances and consequences of HIV infection.
- The inability to ensure optimal health condition.
- Failure of one’s close relatives to deal with the situation.
- Unavailability of appropriate therapeutic procedures.
- Loss of privacy and fear of disclosure of information.
- Fear of future social and sexual rejection.
- Sequential failure of vital functions.
- Loss of physical and financial independence (Satir, 2006).
Anxiety disorders are often accompanied by characteristic somatic, physiological, and autonomic, biochemical, endocrinal and behavioral changes. The fact is that so far there is no possibility to cure HIV infection, leading to the feeling of helplessness, loss of personal control, which may be associated with a resulting depression.

Depression can have many causes. An affected child may get the feeling that the virus takes control over of its body. Just the fact that a close person died of AIDS, together with not existing the possibility of planning one’s own long-term future has a negative impact on one’s psychic condition.

In connection with the depressive syndrome there are several types of depression, i.e. exogenous, endogenous or neurotic depression. Exogenous depression has reported such problems as the experience of a sudden loss caused by the death of a loved one. There is expectation of an internal biological inability, which causes depressive psychopathology regardless of external circumstances by the so-called endogenous depression. By the neurotic depression there is an expected effect of long-term stress and frustration. This form is present in the condition of most HIV/AIDS infected orphans. The symptoms of depression are present in neurotic and anxiety disorders such as mixed anxiety depressive disorder and the disorder of adaptation. Depressive behavioral disorder is often diagnosed especially, in the childhood, within a mixed behavioral and emotional disorder (Koutek & Kocourkova, 2003). The prevalence of depressive disorders rates up to 40 to 55% by orphans with HIV up to the age of 10, up to 50 to 75% of adolescents who were given professional help (Rubinstein, 2001).
Depressive syndrome in these children is associated with an extremely sad mood, slowing of psychomotor speed, sleep disturbance and suicidal thoughts. A typical symptom is presented by increased irritability, behavioral problems with elements of aggression.

5. Denial, anger, aggression and suicide attempts

Some children react to news about their HIV/AIDS status by denying it. For some of them, such refusal may present a constructive way to handle the shock of the diagnosis. However, if this condition persists, the denial can become unproductive, because these children refuse also the social responsibility, associated with HIV positivity. This reaction is typical for children, in the case of the death on a parent.

Anger and aggression are typical aspects which accompany children in situations of bereavement. Some individuals become angry and aggressive. They are often very upset about their fate. They continuously have the feeling, that they are not treated decently and tactfully enough. Anger can sometimes escalate into self-destruction: suicide. Bratska (2001) said that aggression is one of the most frequently reported reactions in frustrating situations. In the frustrating situations, an individual may focus his anger, remorse, indignation, outrage, hostility on other children that are considered as suitable object. There is another possibility, presented by the concept of self-accusation, which the aggressive reaction are aimed at oneself.

There is an increased risk of suicidal attempts for HIV positive people. They may see the suicide as a way out from pain and difficult situation, out of their shame and grief for their loved ones. Suicide may be active (causing a fatal injury) or passive (planning or preparation of such a situation, which could result in fatal
complications of HIV/AIDS). HIV positivity presents a risk factor, particularly amongst adolescents. There are significant complications in the development of personality in adolescence age and it can be perceived as an unacceptable problem. Suicidal behaviour is associated with a wide range of mental disorders, HIV positive children and adolescents suffer primarily from depression.

Children living with HIV/AIDS are at particular risk for psychological disturbance due to both direct and indirect effects. Bose, Moss, Brouwers, Pizzo & Lorion (1994) study the HIV infection on brain structures involved in the regulation of emotion, behavior and cognition, and indirect effects are related to coping with the range of medical, psychological, and social stressors associated with HIV disease. Related studies have shown high rates of adjustmental problems, emotional and behavioral disturbance in children with HIV including other problems like Attention-Deficit Hyperactivity Disorder (ADHD), oppositional defiant disorder, and problems in social functioning relative to their peers (Bose, et al.1994; Havens, Whitaker, Feldman & Ehrhardt, 1994). However, little is known about the factors associated with psychological adjustment in children with HIV/AIDS.

The study conducted by Germann (2002) said that also the psychological effect is the least visible effect because it is not tangibly seen. His study of the impact of psychosocial support to children at Masiye Camp, in Bulawayo, Zimbabwe, found that these children manifest emotional trauma ranging from depression, aggression, drug abuse, insomnia, failure to thrive among others. He also found that they often worry about their future that is, where would they go in case their parents die and who will take care of them later.
The study conducted by Richter (2001) argues HIV infected or affected children have traumatic psychological reactions to parental illness and death, they suffer exhaustion and stress from work and worry, as well as from insecurity and stigmatization, because it is assumed that they too are infected with HIV. Loss of home and dropping out of school, adjustment problems, separation from siblings and friends, increased workloads, social isolation and lower self-esteem may all be associated with adverse mental health. He further states that children show internalizing rather than externalizing symptoms: adjustmental problems, depression, anxiety, emotional and withdrawal in contrast to aggression and other forms of antisocial behavior. All the mentioned psychological consequences jeopardize not only psychological development but also the future relations of the child.

Lewis (1995) pointed out that children have been reported to have experienced psychosocial symptoms such as malaise, loss of appetite and sleep disturbance, emotional behaviour, increased attachment behaviors, adjustmental problems, regression, frightening fantasies, and the reactivation of pre-existing psychiatric symptoms. At least some of these symptoms, in particular adjustmental problems, emotional behaviour, regression and the reactivation of previous symptoms, are likely to be the consequence of children’s feelings of hopelessness, loneliness, anger and confusion that can arise in the context of HIV/AIDS (Wild 2001).

According to Fleishman & Fogel (1994); Kalichman & Sikkema (1994) reported given the nature of the disease and the stigma-discrimination suffered by children with HIV/AIDS, it is not surprising, that many children with infection experience psychological problems, most commonly psychological stress, emotion, anxiety, adjustment problems, and depression. Other frequently occurring
psychological problems include poor self-esteem, hopelessness, low emotional competencies, guilt, increased suicidal risk and anger. Guilt is related to self-blame for having contracted the infection and concerns about the possibility of infecting others. Anger is often directed against the medical establishment for failing to find a cure of effective treatment, and at people whom they believe have discriminated against them because of their infection. Richter, Manegold & Pather (2004) the reported 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.

Domek (2006) points out that HIV infected individuals children deal with much emotional pain and complex feelings of loneliness, guilt, anger, confusion, depression, and fear. HIV-positive children can have clinical anxiety and depression as a result of recurrent and cumulative losses. Another related studied by Olley, Seedat, Nei & Stein (2004) said that low socio-economic variables, lower self-esteem and self-confidence, hopelessness, younger age, and an advanced HIV disease stage, have all been reported to be associated with depression in HIV/AIDS persons. Thus there is evidence that particular variables increase the risk for depression in HIV-positive individuals.

Haihambo (2004) studied that Researchers have observed symptoms associated with trauma, depression and lack of bonding and attachment in very young children. This may lead to children feeling deprived of their childhood, causing misery and sometimes thoughts of suicide. Access to experiences which address
psychosocial needs such as consistency of care appeared to be unmet for many children.

Tate et al. (2003); Wachsler-Felder, & Golden (2002) said that children with HIV/AIDS will have a number of psychosocial problems, depression being the most common. A number of cross-sectional studies have found that chronically ill children are at increased risk of psychosocial problems. Huurre & Aro (2002) said that these children have been reported to have lower self-esteem, poor body-image, and more problems in psychological well-being and adjustment than those without chronic conditions.

The study conducted by Watstein and Chandler (1998) said that the HIV-positive teenager who is stunted and has the tell tale signs of AIDS in form of skin rashes and healing scars, is bound to have a very low self esteem. Poor academic performance and possibly inconsistent tuition as well as constant absenteeism due to ill health, will lay a good back ground for a high school dropout. The teenager’s social, financial and psychological needs become compounded. The psychological or internal challenges a person with HIV/AIDS faces, vary from individual to individual. Not everyone will experience all of the emotional problems or stages of the emotional problems described above. Each HIV/AIDS situation is as unique as the person involved. There are individuals who might face catastrophic changes not only in their personal and job relationships, but also in their physical bodies and in their self-images and self-esteem.

Some of the studies reported that children are likely to be faced with the cumulative presence of a set of material and psychosocial stressors, including self-esteem, isolation, social stigma-discrimination, economic deprivation and disrupted
school (Wild, 2001). Girls in particular may take on the role of care providers, experiencing a shift in parent-child relationship, and assume increasing household responsibility in order to ward off problems regarding shelter, material needs and access to adequate health services (Foster & Williamson, 2000; Wild, 2001). Consequently children become more vulnerable to abuse and exploitation (Foster & Williamson, 2000; UNICEF, 2004), and may experience a loss of educational opportunities and health status, and even increased exposure to HIV infection (Hunter & Williamson 2002).

The study on psychosocial problems conducted by Whetten et al. (2008) said that the individuals with HIV/AIDS often experience psychosocial challenges, such as social isolation, adjustment problems, depression, anxiety, low self-esteem, emotional problems and traumatic life events that can complicate the course of the disease. The psychological and physical demands of coping with medication side effects and co-morbid illnesses can be overwhelming and may influence behaviors that affect health outcomes.

It is clear from the research to date that psychosocial problems exist in many children infected with HIV. In this previous research HIV/AIDS has been linked with a number of psychosocial problems, like lower self-esteem, more problems in psychological well-being and social adjustment problems, and depression (Huurre & Aro, 2002; Tate et al., 2003; Wachsler-Felder & Golden, 2002). In the present research investigation HIV/AIDS has been linked with psychosocial problems, such as adjustment problems, lower self-esteem and lower emotional competencies. Thus adjustment problems, lower self-esteem and lower emotional competencies are considered in the study as major psycho-social problems.
1. Adjustment

Adjustment is the process of establishing satisfactory relationship between individual and his environment. According to Cronbach (1953) a well adjusted person is one who commits oneself to socially desirable goals and uses their energies effectively in working towards them. The individual has a sense of security and feeling of adequacy, which grow out of their feelings of belongingness, being desired and appreciated.

The term adjustment is often used as a synonym for accommodation and adaptation. Strictly speaking, the term denotes the results of equilibrium, which may be affected by either of these processes (Monroe, 1990). It is used to emphasize the individual’s struggle to get along or survive in his or her social and physical environment. Adjustment is a process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfaction of these needs. Adjustment is harmonious relationship with the environment involving the ability to satisfy most of one’s needs and most of the demands, both physical and social those are put upon one.

In adjustment, the two crucial factors are; the individual and the environment. In a study of the individual, the considerations are the heredity and biological factors, the psychological factors, and the quality of socialization given to him or her. Where as the environment includes all the social factors. School adjustment among gender-atypical students, we draw on the literature on school bias against gender-atypical behaviors. This point out that school emphasizes traditional gender expectations and that student’s ability to perform these roles influences their social status at school.
Consequently, students who exhibit gender-atypical behaviors face rejection and harassment by peers and sometimes by teachers, as documented in qualitative studies (Payne, 2007; Risman and Seale, 2009). Several studies have been reported in the area of social, educational, health and emotional adjustment of school students of both genders. Some studies try to relate adjustment with variables like intelligence, achievement, age, gender, socio-economic status, needs, anxiety, and security. Student’s reaction to frustration has also been studied. A few studies focused on the nature, causes, and extent of indiscipline among students. The relation between indiscipline and variables like achievement, participation in co-curricular activities etc., were also examined.

Every individual from the time he or she steps out of the family and goes to school makes to a long series of adjustments between the whole unique personality and the environment. The ardent desire of each boy and girl to become an individual person having a healthy physique, an adequate adjustment, a growing intellectual ability, a greater degree of emotional poise and increased participation in social groups, such characteristics enhance one’s Personality.

Children may also suffer from economic constraints as the household provider becomes sick, can’t work, and loses their job. The responsibility of earning money and providing food is left to the children. They often go hungry, become malnourished, and become unable to concentrate. Other economic impacts include no money for school fees, uniforms, materials, clothing and other necessities. Hunger is a common cause of poor school performance and dropout.
Numerous investigators have documented that children with chronic illness are at increased risk of experiencing emotional, behavioral, and educational difficulties (Wallander & Varni, 1998). Problems vary from increased rates of behavioral problems, depression, anxiety, and school dysfunction to impaired self-images and social withdrawal avoidance. Childhood chronic illness also has a significant impact on family functioning, including high rates of maternal depression and anxiety, marital distress, and sibling adjustment problems. However, although many children with chronic illness and their families experience significant psychological distress, most children and families do not experience significant adjustment problems and many would cope remarkably well, given good circumstances.

Several factors are thought to influence the psychosocial adjustment of children with HIV infection, including (a) the presence of HIV in the central nervous system during fetal development and throughout childhood; (b) co-occurring medical conditions and complications of HIV disease, including body image issues; (c) teratogenic effects of drug and alcohol during the prenatal period; (d) cognitive and neurological deficits; (e) other psychosocial factors (maternal illness, multiple separations, transitions, and losses); (f) whether the child knows his or her HIV status; and (g) environmental factors (Brown et al., 2000; Gaughan et al., 2004; Mellins et al., 2003). Environmental factors affecting families living with HIV include poverty, violence, racism, overcrowding, and single-parent households (Armistead & Forehand, 1995). Such factors would likely increase the risk of psychological problems.
Children affected by HIV/AIDS usually cannot afford to go to school and thus are deprived of a number of educational related benefits. Richter (2001) in his study states that, in households affected by HIV/AIDS, the school attendance of children drops because child labor is required for subsistence and the money earmarked for school expenses is used for medication and other health services. School tends to compete with many other duties that affected children are required to take on. Again, stigmatization may prompt affected children to remain away from school rather than endure exclusion and/or ridicule at school. Basaza and Kaija (2002) in their study conducted in Uganda discovered that the percentage of children dropping out of school due to AIDS increased from 45% to 53% in 1999. Even those who manage to remain at school, face problems of lack of parental guidance, inadequate socialization, financial and material support.

According to Claudia (2002) the HIV/AIDS has negative effects on children's education. These children fail to achieve according to the expected potentials, while others attain their goals. This may obviously lead to psychological problems such as low self-esteem, adjustmental problems, aggression, elective mutism, juvenile delinquency. There are many other problems usually not recognized by teachers in particular. These and other educational problems later manifest as psychological problems and will thus necessitate psychological support. The psychosocial impacts of stress, grief, avoidance, and teasing by other children, social isolation and stigma and discrimination can lead to behavioral disturbances, fatalism, self stigmatization, and increased opportunities for abuse.
2. Self-Esteem

In a study by Kinney and Miller (1988) the classic definition of self-esteem by Stanley Coopersmith is quoted as "the evaluation a person makes and maintains with regard to him or herself." Coopersmith (1967) points out that self-esteem expresses an attitude of approval or disapproval and indicates the extent to which an individual believes him or herself to be capable, significant, successful and worthy.

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) describes self-esteem as an attitude, either positive or negative; a person has about him or herself. Self-esteem has been defined as a socially constructed emotion, which is based on a need for acceptance by and belongingness to a social group. It further includes components of a desire for efficacy and self-actualization (Battle, 1992; Maslow, 1970).

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.

Rosenberg (1981) offers a definition of self-esteem based on the principle of attribution that states that people draw conclusions about what they like by observing their behavior through the behavior of others. This means that individuals' interpretation of their behavior, not just their behavior, is what influences their self-esteem. He says that I believe self-esteem plays a major role in all aspects of a child’s life, having an appreciable impact on learning, school performance, and peer relationships. A lack of self-confidence is often associated with feelings of helplessness and hopelessness that serve to intensify a child’s sense of failure and loss of dignity.

Kerniss & Waschull (1995) says that self-esteem instability has been conceptualized in terms of either long-term or short term fluctuations in one's contextually based global self-esteem which have important implications for psychological functioning. Long-term fluctuations reflect change in one's baseline level of self-esteem that occurs slowly and over an extended period of time. Short-term fluctuations between feelings of worthiness and worthlessness must be dramatic to be considered unstable. Although some people with unstable self-esteem may experience dramatic short-term shifts from feeling very positively to very negatively about themselves, others may fluctuate primarily in the extent to which they feel positive or negative about themselves. The tendency to exhibit fluctuations can be
viewed as a dispositional characteristic that interacts with contextual factors to result in specific patterns of fluctuations.

The humanistic personality theories of Rogers (1959, 1963) and Maslow (1970) emphasize the need to belong, as a strong motivational need which affects people's emotional responses to their social life. Many of the strongest emotions people experience, both positive and negative, are linked to the need to belong (Baumeister & Leary, 1995). The humanistic perspectives of Maslow (1970) and Rogers (1980) emphasize in particular the motivational aspect of self-esteem and positive self-regard. People conform to social expectations in order to receive the approval of others, thereby enhancing self-esteem. They associate with others selectively, choosing those who will provide or confirm a positive self-evaluation. Self-esteem is enhanced when the person is able to make favorable comparisons with other people or with an ideal self, and also when the person acts effectively in his or her physical or social environment (Hewitt, 2002; Owens, 1995; Swann, 1996).

According to Bentall (2004) the negative self-appraisal habitually results in lowered self-esteem which in turn is related to one developing a pessimistic attribution style. This author explains how a lowered self-esteem is very often associated with negative appraisal of the self in present and future. Abramson (as cited in Bentall, 2004) said 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.
Battle’s model of self-esteem

Battle (1992) 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 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 (1992) further emphasizes the affective (subjective feelings), personal (social acceptance) and cognitive aspects (self-evaluation) of self-esteem.

Battle’s (1992) model of self-esteem is relevant to this research as its underlying principles allows psychologist to study the construct self-esteem in a socially embedded context such as the workplace. Battle (1982, 1990, and 1992) supports the multidimensional theoretical approach to defining the construct self-esteem. According to Battle (1992) the construct self-esteem comprises a number of facets or dimensions. He differentiates these self-esteem dimensions as general, social, academic, and parent-related self-esteem for children; and general, social, and personal self-esteem for adults. General self-esteem is the aspect of self-esteem that refers to individuals' overall perceptions of and feelings about their worth; social self-esteem is the aspect of self-esteem that refers to individuals' perceptions of and
feelings about the quality of their relationships with peers; and personal self-esteem is the aspect of self-esteem that refers to individuals' most innate perceptions and feelings of self-worth. When combined, these three sub-components equal overall self-esteem.

Kartell and Chabilall (2005) found that HIV/AIDS has a negative impact on the social and educational development of children with HIV/AIDS. They further identified the taking off the child responsibilities, abandoning school, poverty, lack of parental, educational and social support and social discrimination as inhibiting factors on these children development. The study conducted by Carr (2004) reported that when considering the aforementioned stressors of AIDS children 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, high confidence, positive effect, 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, suicide and such other psychosocial problems.

Gilbert (1992) 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 children 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 in-group and lowered by being a member of the out-group.

Children 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 adjustment problems, depression, anxiety, low self-esteem and anger compared to controls (AVERT, 2007). Rosenberg & Owens (2001) point out that 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.
3. Emotional Competencies

According to Saarni (1999) emotional competence is a complex phenomenon consisting of a number of distinct, yet interrelated component skills including emotion appraisal, emotion expression and emotion understanding. Further, he defines in his book, Development of Emotional Competence, ‘emotional competence as the demonstration of self-efficacy in emotion-eliciting social transactions’. Self-efficacy in this context implies that the individual has the capacity and skills to achieve a desired outcome. The application of the notion of self-efficacy to emotion-eliciting social transactions refers to how people can respond emotionally, yet simultaneously and strategically apply their knowledge about emotions and their emotional expressiveness to relationships with others. In this way they can both negotiate their way through interpersonal exchanges and regulate their emotional experiences. According to him the notion of competence as the capacity or ability to engage in transactions with a variable and challenging social-physical environment, resulting in growth and mastery for the individual. The term emotional competence, then, refers to the identifiable emotion-related capacities and abilities people need to engage with the changing environment such that they emerge more differentiated, better adapted, effective, and confident. The effective functioning of the individual is a changing and dynamic environment and the employment of self-regulatory strategies is implicit in the notion of emotional competence.

Emotional competence refers to person’s ability in expressing or releasing their inner feelings or emotions. Thus emotionally competent people will express emotion appropriate to the situation and their needs. They will not seek to suppress emotions in others. Emotional competence can lead to improved health through
avoiding stress that would otherwise result from suppressing emotions. It can also lead to improved relationships since inappropriate emotions are less likely to be expressed.

According to Saarni (1997) emotional competence consists of three skills such as emotion appraisal, emotion expression and emotion understanding.

i.  *Emotion Appraisal*

Cognitive model of emotion suggests that appraisals of event, in contrast to the event itself, are more important in determining emotion (Lazarus, 1991). Social information processing and work examining appraisal strategies suggest that children with aggressive behaviour, more often make errors in interpreting intent in ambiguous social situations and attend selectively to hostile social cues than do their non-aggressive peers (Crick & Dodge, 1994). A recently modified version of the social information processing model (Lemerise & Arsenio, 2000) highlights both the role of emotion and the integration of affect and cognition to explain individual differences in children's social development.

The functionalist approach to emotion suggests that emotions represent an attempt by an individual to establish, maintain, change, or terminate the relation between the person and the environment on matters of significance to the person (Campos et al., 1994). Children are more likely to report anger when they have appraised both the presence of an aversive outcome and the possibility of goal reinstatement.
ii. *Emotion Expression*

The control, modification and management of emotional reactivity and expressivity are important components of emotional competence. The complex interplay between emotion and behavior suggests that children might be less prone to aggressive outbursts if they are successful at managing their emotions and expressions than if they are unsuccessful at doing so (Eisenberg et al., 1996). Younger children with aggressive symptoms exhibit more negative affect during a series of challenge episodes than do those at low risk for aggressive behaviour (Calkins & Dedmon, 2000). In one of the few studies on school-age children revealed that aggressive symptoms were associated with decreased ability to verbally express negative feelings, exhibit empathy towards others, and display a range of emotion (Shields & Cicchetti, 1998).

iii. *Emotional Understanding*

Saarni (1999) say one of the most basic aspects of emotional competence is the ability of an individual to recognize what he is feeling. Emotion understanding consists of the ability to identify emotional states and the ability to identify causes and correlates of emotional states (Harris, 1983). A common premise with clinical settings is that children with higher level of aggressive behaviour have more difficulty in identifying and understanding their emotions than do children with lower levels of aggressive behaviour. Correspondingly, preschoolers with higher levels of aggressive behaviour exhibited less ability to identify others’ emotions than did those with lower levels of aggressive behaviour (Arsenio et al., 2000).
Another important aspect of emotion understanding includes the particular emotions that children report to describe their feeling states. Kaczynski and Cummings (1989) found that aggressive boys were more likely to report feelings of anger than non-aggressive boys in response to being exposed to an angry adult interaction. However, verbalization of emotion is one way that children can successfully and appropriately regulate their emotions (Cole et al., 1994), and previous research suggests that children rated as exhibiting high levels of aggressive behaviour have difficulty in regulating their emotions (Shields & Cicchetti, 1998). Because of the fact that verbalizing about negative emotions may serve a regulatory function, it was predicted that children rated as having high levels of aggressive behaviour would be less likely than their non-aggressive peers to verbalize feelings of anger. Children who are rated as having more aggressive behaviour may also be less sensitive in recognizing the causes of a particular emotions and consequently less able to reflect upon and learn from their experiences.

Allport (1961) says to achieve and maintain a feeling of adequacy, the individual has to acquire a few workable assumptions about the world, where need for competence emerges as most of the fundamental motives of life, because we survive through competence, grow through competence and actualize ourselves through competence. A sense of humour and the ability to both give and receive love are related to the sphere of emotions that are not provided as gifts but are to be developed by the individuals as their own characteristic pattern of emotional reactivity, which may contribute to or detract from mental and physical health and effectiveness of the individual.
Specific emotional competencies underlie the key domains of emotional intelligence abilities. These emotional competencies can include attitudes and beliefs, as exemplified by achievement drive and self-confidence, as well as skills and abilities. Emotional competencies are socially embedded; they are learned rather than innate. People are not born with a high degree of self-confidence or achievement drive (Cherniss & Adler, 2000). However, emotional competence distinguishes individual differences in workplace performance. Emotional competence addresses emotional intelligence behaviours, individual traits and values, which assist in the improvement of workplace competency (Dulewicz & Higgs, 2000). This perspective is aligned with Boyatzis (1982) concept of a competency as an underlying characteristic of a person in that it may be a motive, trait, skill, aspect of one's self-image or social role, or a body of knowledge which he or she uses or apply to accomplish goals and improve his or her performance achievements.

Emotional competence is the demonstration of self-efficacious behaviour in emotion-eliciting social transactions. It is the capacity and skill to respond emotionally (with feeling), yet simultaneously and strategically apply knowledge about emotions and express emotions in relationships with others. Individuals with well-developed emotional competence can both negotiate their way through interpersonal exchanges and regulate their emotional experiences in a variable and challenging socio-cultural environment. Emotional competence implies a sense of psychological well-being (a positive inner state of being) and an ability to skillfully, creatively and confidently adapt in an uncertain, unstructured, and changing socio-cultural environment (Worline, Wrzesniewski & Rafaeli, 2002; Wolmarans & Martins, 2001). Emotional competence also implies that people use their cognitive and affective intelligence to monitor their socio-cultural environment and engage in
competent behaviour in organizations to make a difference in collective outcomes (Creed & Scully, 2001; Worline et al., 2002). Emotional competence is developable and can be learned to improve workplace performance (Goleman, 1998). The perspectives of humanistic psychology and social psychology, it appears that self-esteem, as a measure of psychological well-being, will influence people’s ability to demonstrate emotionally competent behaviour. Ciarrochi, Chan, and Caputi (2000); Schutte, Malouff, Simunek, Hollander, and McKenley (2002) report correlations between emotional intelligence and self-esteem as a measure of emotional well-being, with higher emotional intelligence being associated with positive mood and higher self-esteem.

Researches studies to date say that psychosocial problems exist in many children infected with HIV. Previous researches have linked children with HIV/AIDS to a number of psychosocial problems, like lower self-esteem, more problems in psychological well-being and social adjustment problems, and depression (Huurre & Aro, 2002; Tate et al., 2003; Wachslr-Felder & Golden, 2002). In the present investigation it is attempted to gain insight and understanding of children with HIV/AIDS, and their adjustment, self-esteem and emotional competencies. It is hoped that possibility of improving their life circumstances in the future. Thus in the present investigation adjustment problems, lower self-esteem and lower emotional competencies are considered as major psycho-social problems of children with HIV/AIDS.
SIGNIFICANCE OF THE STUDY

The Interagency Coalition on AIDS and Development (ICAD, 2002) summarizes the arising problems and needs for children affected by HIV/AIDS, as follows;

1. The threat of psycho-social problems.
2. Increased exposure to discrimination and stigmatization.
3. Increased resulting malnutrition.
4. Increased risk to personal safety.
5. Lack of parental supervision.
6. Increased demands on health care systems, resulting in decreased availability and access to health care.
7. Loss of inheritance resulting in fewer opportunities for school and education.
8. Increased homelessness, vagrancy, starvation, crime and
9. Increased vulnerability and exposure to HIV infection and other STDs (sexually transmitted diseases)

Whetten et al. (2008) reports that the individuals with HIV/AIDS often experience psychosocial challenges, such as social isolation, adjustment problems, depression, anxiety, low self-esteem, emotional problems and traumatic life events that can complicate the course of the disease. The psychological and physical demands of coping with medication side effects and co-morbid illnesses can be overwhelming and may influence behaviors that affect health outcomes. It is clear from the research to date that psychosocial problems exist in children infected with HIV.
The HIV/AIDS epidemic challenges the constitutional and conventional rights of children affected by AIDS; their rights to a home, care, health and education. As Desmond and Gow (2002), Richter et al., (2004) put it: Every child in South Africa will feel the impact of HIV/AIDS, whether first-hand or in the changed nature of the society in which they grow to maturity. So far, research has linked HIV/AIDS with several psychosocial problems (Huurre & Aro, 2002; Lichtenstein et al., 2002; Tate et al., 2003; Wechsler-Felder & Golden, 2002).

The HIV epidemic has increased the necessity to address psychological and social problems of children in equal proportion to other interventions. The long term consequences for children who experience profound loss, grief, hopelessness, adjustment problems, fear and anxiety without assistance can include psychosomatic disorders, chronic depression, low self esteem, low levels of life skills, learning disabilities and disturbed social behavior (Richter et al., 2004). Nonetheless, the existing literature does not focus on the influence of antiretroviral treatment on the children’s psychosocial well-being. Now drugs are available to a great deal for children who is tested HIV-positive, the impact of the disease will inevitably alter. These children can now stay relatively healthy and live longer, which is a great development. But in reality antiretroviral therapy does not prohibit the social, economic and psychological consequences of HIV/AIDS as yet. Moreover, living with a chronic disease brings along its own challenges. For this reason it is of greatest interest to monitor these developments in the treatment of HIV/AIDS and the impact it has on the psychosocial functioning of children. Only by expanding our knowledge of these influences, it is possible to offer children infected and affected by HIV/AIDS the care they need.
Children living with HIV/AIDS are considered as highly deprived class of society. These children are left helpless, abandoned, neglected by the parents/caregivers due to social, psychological, economic and personal reasons like gender, domicile, age, etc. 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 psychosocial development resulting in adjustmental problems, lower self-esteem and lower emotional competencies. So it becomes necessary to know whether positive children who are devoid of family life with the emotional warmth grow up normally. How well they are able to cope with themselves and adjust to the demands of the environment/society around them.

The psychosocial problems faced by children with HIV/AIDS can become overwhelming and often results in serious opportunistic illnesses and even deaths. Most of the causes of the death are psychosocial problems in general and adjustmental problems, low self-esteem and low emotional competencies in particular. This reality makes formulating the problem, so that the appropriate interventions may be developed for the needy group. Therefore, the present study attempts to know the level of adjustment problems, self-esteem and emotional competencies of children living with HIV/AIDS. As a result the study can suggest the need for appropriate guidance and counselling, and care and support to overcome the psychosocial problems. The study also has implications for the public health approach to the care and prevention of disease. It directly targets the population affected by HIV/AIDS to solicit information that can be useful in improving the care of both infected and affected populations.
PURPOSE OF THE STUDY

Previous researches on the impact of HIV/AIDS have focused generally on adults. Richter et al. (2004) argued that, particularly where children are concerned, HIV/AIDS needs to be treated as a broad developmental concern rather than as a narrow health or even public health issue. However, the majority of the studies performed on children have been conducted by researchers working for the medical discipline. The research consists mainly of the immunological, medical, and neurological consequences of the disease and tends to neglect the psychosocial effects (Wachsler-Felder & Golden, 2002).

The Purpose of the present study is to determine the psychosocial problems of children living with HIV/AIDS. The main expectation is that there will be a difference in psychosocial problems of children with HIV/AIDS and non-HIV/AIDS. The study focuses on psychosocial factors rather than medical and neurological.

RESEARCH QUESTIONS

The research questions are based on the three psychosocial factors, respectively adjustment, self esteem and emotional competencies.

1. Is there any difference in the level of adjustment problems between children with HIV/AIDS and children without HIV/AIDS?
2. Is there any difference in the level of self esteem between children with HIV/AIDS and children without HIV/AIDS?
3. Is there any difference in the level of emotional competencies between children with HIV/AIDS and children without HIV/AIDS?
4. Is there any difference in the level of adjustment, self-esteem and emotional competencies between girls’ and boys’ with HIV/AIDS?

5. Is there any difference in the level of adjustment, self-esteem and emotional competencies between rural and urban children with HIV/AIDS?

**SUMMARY**

The psychosocial problems faced by children with HIV/AIDS can become overwhelming and often results in serious opportunistic illnesses and even deaths. Most of the causes of the death are psychosocial problems in general and adjustmental problems, low self-esteem and low emotional competencies in particular. This reality makes formulating the problem, so that the appropriate interventions may be developed for the needy group.