Chapter - II

REVIEW OF LITERATURE

The study examined the role of psychosocial problems such as adjustment problems, self-esteem and emotional competencies among children with HIV/AIDS. In this chapter the aim was to review the existing research literature related to psychosocial problems of children with HIV/AIDS. The review includes published research articles, books, data bases, reports and abstracts. The review attempted to accomplish the objectives of the study and made subchapter accordingly as follows:

1. Studies related to psycho-social problems of children with HIV/AIDS.
2. Studies related to adjustment problems of children with HIV/AIDS.
4. Studies related to emotional competencies of children with HIV/AIDS.
5. Studies related to gender differences of psycho-social problems of children with HIV/AIDS.
6. Studies related to domicile differences of psycho-social problems of children with HIV/AIDS.

Most of the studies were conducted in the last ten years or so, although the review includes studies conducted from 2003 to till date. In recent years, several studies have been undertaken to examine the impact of HIV/AIDS on psychological and sociological variables among adult population. However, no study has been done to document systematically among children with HIV/AIDS. A few important studies were reviewed here.
1. Studies related to psycho-social problems of children with HIV/AIDS

Children 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.

Taha and Taha (2000) said that 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 with HIV-uninfected children. HIV infected children on clinical examination, 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, respectively 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 increased adjustmental problems in children living with HIV/AIDS as compared to those Non-HIV/AIDS.

Gent and Winkelman (2007) study reveal that children with HIV/AIDS show significantly more depression/anxiety, withdrawal and social problems than children without HIV/AIDS. Children with HIV/AIDS have significantly more traumatic experiences than children without HIV/AIDS, but in contrast to the expectations these traumatic experiences as well as the age of the participants have no effect on their social and emotional functioning. These findings indicate that the children with
HIV/AIDS develop more psychological problems in social and emotional functioning compared to children without HIV/AIDS.

Gelder & Kraa (2006) reported that no significant differences were found between the children with HIV/AIDS who entered the ARV-program and children without HIV/AIDS, even after controlling for several possible covariates. These covariates were trauma, age, gender and type of primary caregiver of the child. Significant differences were found in the amount of traumatic experiences between these two groups; the group of children with HIV/AIDS had encountered more traumas. These results indicated that the HIV/AIDS infected children experience approximately the same amount of psychosocial problems as the control group, despite of the large difference in traumatic experiences or environments they live in. But this did not appear to have an effect on the psycho-social problems experienced by these children. Taru et al. (2007) say that the children with HIV/AIDS have more depression/anxiety and withdrawal problems than non-HIV/AIDS children.

According to Benton (2010) the psycho-social impact of HIV/AIDS disease has been recognized since the beginning of the epidemic for affected children. Among HIV infected children high levels of distress, psychiatric symptoms, and their associations with worse health outcomes were recognized early in the epidemic. Subsequently, many studies have focused on understanding the prevalence of psychiatric symptoms among HIV infected child and on identifying effective treatments for these symptoms. Fewer studies have examined these symptoms and their treatments among HIV infected children. This reviews what is known about psychiatric syndromes among HIV infected children, their treatments, and other
psychosocial factors of concern to the psychiatrist when treating children with HIV/AIDS.

Giannattasio et al. (2011) reported that after active antiretroviral therapy, children with HIV are clinically well, where as psycho-social problems issues continue to influence their quality of life. The International Classification of Functioning, Disability and Health (ICF) of the World Health Organization evaluate health status and environmental and social factors associated with health. Four major areas included in the ICF instrument were investigated: impairments of body structures; impairments of body functions; environmental factors; and activity limitations and restrictions to social life. Forty-one families of children with HIV were enrolled. Body structures and functions were marginally impaired, whereas environmental factors and psycho-social problems issues had a relevant impact on quality of life. Most families considered environmental factors to be barriers; these were poverty, unemployment, and single-parent family structure. Activity limitations and social restrictions were also reported in a few cases.

Xu et al. (2009) the findings showed that children with HIV/AIDS relied heavily on caregivers and peers to gain psychological support. Children’s psychosocial problems included fear, anxiety, grief, and low of self-esteem and confidence. Stigma towards children existed, including isolation, ignorance and rejection. This studied illustrates that HIV/AIDS has impacted negatively on the psychosocial well being of children. These findings can be used as preliminary data supporting more researches to profoundly explore the psychosocial impact of HIV/AIDS on children.
Gent & Winkelman (2006) said that the children with HIV/AIDS were more depressed and more anxiety than the children without HIV/AIDS. The psychological problems of the children with HIV/AIDS increased from measurement. The Highly Active Antiretroviral Therapy (HAART) which slows the progression of the HIV infection and allows infected children to live a healthier and longer life. The positive physical effect due to the medicines could have caused a response bias in the caregivers, leading to more positive feedback on the psychosocial problems of the children instead of evaluating the psychosocial functioning of the children at the measurement.

The study conducted by Mellins et al. (2003) reports that HIV infected children are at risk for behavioral problems. Inadequate control groups and sample sizes have limited the ability of investigators to consider multiple influences that place HIV infected children at risk for poor behavioral outcomes. The unique and combined influences of HIV, prenatal drug exposure, and environmental factors on behavior in children who were perinatally exposed to HIV. Multivariate analyses comparing the HIV infected children with perinatally exposed but uninfected children from similar backgrounds failed to find an association between either HIV status or prenatal drug exposure and poor behavioral outcomes. The strongest correlates of increased behavioral symptoms were demographic characteristics. This study suggests that although a high prevalence of behavioral problems does not exist among HIV infected children, HIV infection prenatal drug exposure is the underlying cause. Rather, other biological and environmental factors are likely contributors toward poor behavioral outcomes.
Gaughan et al. (2004) said that psychological manifestations of pediatric HIV infection have been described. HIV infected children, regardless of age, were hospitalized because of psychological illnesses. The majority of children were admitted because of depression or behavioral disorders and multiple psychiatric hospitalizations. Knowledge of HIV seropositivity status and having experienced a significant life event were both significantly associated with an increased risk of psychiatric hospitalization. Children with HIV/AIDS are at increased risk for psychiatric hospitalizations during childhood, compared with the general pediatric population. Knowledge of HIV seropositivity status and recent significant life events were significantly associated with increased risks of admission in this population.

Scharko (2006) reported that HIV infected children, psychological disorders in poor quality of life, HIV disease progression, poor compliance and increased mortality. The same may be true for children challenged with HIV/AIDS. The literature regarding the prevalence of Diagnostic and Statistical Manual of the American Psychological Association (DSM-APA) psychological disorders in children with HIV/AIDS was reviewed. Average prevalence of 28.6% for Attention Deficit Hyperactivity Disorder (ADHD), 24.3% for Anxiety Disorders and 25% for Depression were found with respective risk ratios of 6.0, 3.8 and 7.1 on psychological problems of children with HIV/AIDS.

Rao, Sagar, Kabra, & Lodha (2007) reported that HIV infection in children has been transformed from an acute to a chronic illness. The routes of transmission and clinical manifestation of HIV infection in children are unique and different from those of adults. There are number of biological, psychological and social factors associated with HIV infected child that may predispose him/her to develop
psychological illness. However, there are very few studies on psychological morbidity in HIV infected children. In the existing studies, a number of psychological illnesses including: depression, anxiety, emotional, disruptive disorders, adjustment problems and hyperactive disorders have been observed in HIV infected children.

Leslie et al. (2010) said that compared to HIV infected children at entry in to a multicenter investigation of the prevalence and severity of psychiatric symptoms. A total of 576 children were enrolled from June 2005 to September 2006. Subject self-reports of pain were measured by the Wong-Baker visual analog scale and Short-Form McGill Pain Questionnaire. Symptomatology for anxiety, depression, emotion and dysthymia was assessed through symptom inventory instruments. Logistic regression models were used to evaluate predictors of pain. We found that a higher proportion of HIV infected than uninfected subjects. The odds of reported pain in HIV increased with higher symptom severity for generalized anxiety, major depression, emotion and dysthymia. This study underscores the importance of queries concerning pain and emotional stressors in the care of HIV infected children and uninfected children exposed to HIV infected children’s individuals.

Ric, Timothy and Brian (2007) said that children with HIV/AIDS are more likely to experience parental illness and possible death, social stigmatization, and the prospect of lifelong adherence to complicated medical regimens. Families face difficult decisions regarding disclosure of the illness both to the child and to others within and outside of the family. Similarly, appropriate disclosure outside of the immediate family may confer some benefits to the child in terms of psychological and physical health. However, research into the larger social ecologies of youth with HIV
remains lacking, limiting the conclusions that can be drawn regarding longer term outcomes.

Misrahi et al. (2004) said that, HIV infected children presenting with psychological and psychiatric problems were included. Mental disorders were evaluated according to DSM-IV criteria. Neurological disorders and progressive encephalopathy (presence or absence) diagnosis were evaluated by clinical and radiological examination. The severity of infection was assessed by the percentage of CD4 lymphocytes. The most frequent diagnoses were major depression and Attention Deficit Hyperactivity Disorder (ADHD). Percentage of CD4 lymphocytes were close to 0 for more than 80% of children presenting with psychiatric complications. The very low percentage of CD4 lymphocytes of these children suggest that the appearance of a psychiatric complication should be regarded as a factor indicating severe HIV infection. Depressive disorders may be a clinical form of encephalopathy.

Grover, Pensi & Banerjee (2007) said that to behavioral patterns and factors responsible for psychological disorders among HIV infected and uninfected children. The Child Behaviour Check List was used to assess behaviour patterns. Behaviour and adjustment problems in HIV infected children were reported by 80.7% of primary caregivers compared with 18.3% for controls. Psychological behaviour and adjustment in HIV infected children as a risk factor for HIV was also identified in a significant proportion. By analyzing behaviour, a psycho-medical team can examine the extent to which psychosocial and demographic factors are involved in causing and exacerbating behaviour adjustment problems in HIV infected children.
Li et al. (2009) said that analyze the clinical feature, growth, development and intelligence in HIV infected children, and to explore the impacts of HIV on development and intelligence of children. Physical and psychological examinations, development and intelligence detections were carried out for comparison to control groups. There were suffering with diarrhea, fever, bacterial pneumonia, recurrent upper respiratory tract infection and oral candidacies in HIV infected children. The development indexes in HIV infected children, such as lower than those in normal children at the same age.

Thanyawee et al. (2010) said that aim at assessing cognitive functioning in school-aged HIV infected children and the change after receiving Antiretroviral Therapy (ART). The conducted a prospective cohort study of HIV infected Thai children compared with HIV-affected and normal control groups. HIV infected and HIV-affected children which were statistically lower than that of the control group. School-aged HIV infected children have lower cognitive function than HIV-affected and normal children.
2. Studies related to adjustment problems of children with HIV/AIDS

Xiaoming et al. (2009) pointed out that participants completed self-report measures of exposure to traumatic events, and psychosocial adjustment including behavior problems, emotional, depression, self-esteem, and future orientation. HIV/AIDS and vulnerable children reported experiencing a higher occurrence, density, duration, initial impact and lasting impact of traumatic events compared to comparison children. Scores reflecting adjustment were lower among AIDS children and vulnerable children than among comparison children. HIV/AIDS children status and traumatic events contributed unique variance in the expected direction to the prediction of psychosocial adjustment.

According to Conte, Walco, & Kimura (2003) children living with HIV/AIDS chronic illness has significant impact on family functioning, including less family cohesion, parental reported higher levels of anxiety, depression, low self-confidence and lower overall psychological adjustment compared to their control groups.

Bose et al. (1994) said that investigated the psychosocial adjustment of children with HIV/AIDS and factors associated with level of adjustment. Children completed measures of depression, emotional, anxiety, and self-concept. Parents completed measures of behavior problems, social functioning, personality characteristics, and life events. An index of disease stage was also collected. Children reported experiencing low levels of depressive and anxious affect and felt positively about themselves. By contrast, parents saw their children as more anxious, emotional and less socially active than respective standardization samples. A greater than expected proportion of these children, as reported by their parents, scored in the maladaptive range on measures of social functioning, anxiety, and conduct problems.
Experience of adversive life events and progression of the disease were associated with more behavioral and social problems.

Judy et al. (2012) reported that HIV infected children interviewed and findings of psychological problems of major depression, adjustment problems, social and emotional phobia, Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD). There is a higher psychological morbidity in HIV infected children than normal group, with depression and anxiety disorders being the most common.

Fielden et al. (2006) said that compared to children with HIV/AIDS has worries, anxieties, adjustment problems, emotional problems and other psychosocial problems. HIV infected children do not feel "normal" in HIV determines the child's identity. According to Thorne (1997) children the psychological suffering as a result of the AIDS epidemic may be greater than the suffering for infected adults. Children have to cope with their own infection and their lack of knowledge about the disease.

Kashikar et al. (2007) said that the psychological effects of Human Immunodeficiency Virus (HIV) infection on children range from mild to severely overwhelming. Children living with HIV/AIDS are at risk for psychological disturb studies have documented that children with chronic illnesses are at increased risk for experiencing emotional, behavioral, adjustment problems, and educational difficulties.

Bachanas et al. (2001) assessed for significant differences in psychological functioning between HIV infected children and a demographically matched healthy control group and to examine the utility of applying a stress and coping model to
children with HIV disease. Children completed measures of psychological adjustment, health locus of control, and coping style, and caregivers completed measures of their own and their child’s psychological adjustment. Hierarchical multiple regression analyses revealed that the stress and coping model accounted for 36% of the variance in HIV infected children’s self-reported of psychological adjustment.

Howland et al. (2000) reported that the association of negative stressful life events such as bereavement, hospitalisation of a family member, loss of change in housing with HIV/AIDS cannot be ignored and it can be expected that these children who are facing multiple losses and stressors will experience significant developmental disruptions and ultimately psychological distress and psychiatric disorder. Negative life events have also been shown to increase the incidence of immune suppression.

According to Moss et al. (1998) consisted of a prospective examination of factors associated with psychological adjustment in children with HIV/AIDS. Measures of depression, anxiety, adjustment and self-concept were administered to the children, and measures of behavioral problems, social functioning, and negative life events were administered to the parents. Generally, psychological adjustment seemed stable, though a decrease in positive social self-concept over time was observed. Negative life events were significantly associated with greater adverse psychological and behavioral outcomes at both baseline and follow-up. An additional component to the study investigated factors associated with survival. It was found that psychological resilience to the stress associated living with HIV seemed to be a stabilizing characteristic.
Bose et al. (1994) said that to psycho-social adjustment of HIV infected children and factors associated with level of adjustment. Children completed measures of depression, anxiety, adjustment and self-concept. Children reported experiencing low levels of adjustment, depressive and anxious affect and felt positively about themselves. By contrast, parents saw their children as more anxious and less socially active than respective standardization samples. A greater than expected proportion of these children, as reported by their parents, scored in the maladaptive range on measures of social functioning, anxiety, and conduct problems.


According to Tyler, Kramer & John (1999) the self refers an individual’s personality traits based on personal differences from others such as attitudes, values, goals, beliefs, interpersonal relationships, and styles. Hansford and Hattie (1982) study that reviewed 143 studies and determined 15 different self-terms such as self, self-concept, self-esteem, self-concept of ability, self-acceptance, self-perception, ideal-self, self-assurance, self-sentiment, self-attitude, self-confidence, self-regard, self-actualization, identity development and self-expectation. Among various self-terms, self-esteem has been one of the widely studied one.

According to Huurre and Aro (2002) children and adolescents reporting persistent chronic illness were compared with those without any chronic illness in their life situation, the group of persistent chronic illnesses included allergies, non-allergic skin conditions, migraine, diabetes mellitus, and others. Adults with persistent chronic illness limiting their daily life reported more depression and lower self-esteem than those with non-limiting chronic illness or healthy controls. No significant differences were found between adults with any persistent chronic illness
and healthy controls in psychosocial well-being. More attention in health care should be paid to psychological well-being in persons with limiting chronic illness. The study also raises the question how to improve health habit counselling within health care among females with chronic illness.

Domek (2006) said that chronically ill children are at more risk of mental illnesses. Children with HIV/AIDS have to deal with so much emotional pain and complex feelings of loneliness, low self-esteem, guilt, anger, confusion, depression, fear and psycho-social problems. Clinical anxiety and depression is common in children with HIV/AIDS, as a result of recurrent and cumulative losses. Children with HIV/AIDS also have more traumatic experiences including dealing with the death of family members (from AIDS-related illnesses), living in poverty, violence, sexual abuse, and comprehending their own mortality.

The study conducted by Xu et al. (2010) said that Health-Related Quality Of Life (HRQL) of children living in HIV/AIDS affected families in rural areas in Yunnan, China. Some potential influencing factors were questioned, such as demographic characteristics, the families’ social and economic status, foster models, children’s self-esteem, etc. The HRQL of children’s caregivers may also have been among the influencing factors, as measured by short-form. The findings showed that children from HIV/AIDS-affected families reported lower scores of HRQL than those from unaffected families, especially in domains of psychosocial functioning, emotional functioning, and school functioning. Multiple regression analysis showed that lower levels of children’s self-esteem and caregivers. The findings indicate that the child’s self-esteem, the caregiver’s perceived quality of life, the child’s foster pattern, the average hours of company provided by the caregiver, and whether the
child was informed of the parent’s HIV/AIDS status are important factors influencing HRQL.

Brown and Lourie (2000) study that children living with HIV/AIDS have additional risk factors for mental illness, including poverty, a disrupted home life, family history of mental illness, psychological problems, psychiatric disorders, and/or substance abuse, and inadequate social support. Other possible risk factors that are more specific for HIV-infection include forced disclosure of HIV status to others, fear and anxiety of progression to AIDS, and body image concerns resulting from delayed development, low self-esteem, low self-confidence and chronic dermatologic conditions.

Ireland, Mary, Omega (1998) pointed out the AIDS-diagnosed children did not manifest more death anxiety lower self-esteem than healthy peers. Findings are in contrast to previous studies about fatally ill children which routinely reported them to have high levels of death concern and low levels of self-worth. These results therefore provide a different framework for understanding the emotional needs of children with AIDS.

Guoxiang et al. (2009) findings reveal that the families of the children by AIDS had experienced financial burdens because of treatment costs for sick parents and loss of labor in the household. The majority of the participants reported some level of stigmatization because of their parents’ HIV status. The participants described feelings of sadness, fear, anxiety, anger, loneliness, low self-esteem, social withdrawal, and sleep problems.
4. Studies related to emotional competencies of children with HIV/AIDS

Sophie, Ann, and Margot (2004) said that Poor emotional competence has been identified as a precursor to later social, emotional, and behavioral difficulties in children. Aspects of parenting, including modeling, reactions to and coaching of children’s emotions, have been associated with the development of emotional competence in children. In this paper, a parenting program with this theoretical basis is outlined and a pilot study of the program is presented. The six-session parenting program was delivered in preschool centers to 47 parents with a four or five year old child, and data were collected about parenting and children’s functioning twice prior to program commencement, following program completion, and at three month follow-up. Pre and post program teacher assessments were also collected. Following the program parents reported that they were more encouraging of their children’s emotional expression, used emotion-focused approaches more frequently in interactions with their children, and were less critical and dismissive of their children’s emotional expression. Their children showed less emotional negativity and had significant reductions in difficult behaviors, especially those who had behavior problems prior to their parents’ participation in the program. This program offers a promising approach to fostering the development of children’s emotional competence and consequently enhancing social and behavioral functioning.

According to Mellins, Smith, O’Driscoll et al. (2003) data from the Women and Infants Transmission Study (WITS) indicated high rates of emotional and behavioral problems among HIV infected children. The association ceased to be significant, however, in multivariate analyses comparing the HIV infected children with HIV-exposed, uninfected and control subjects, which led the authors to conclude
that the relationship between these disorders and HIV may be attributable to psychosocial factors, as opposed to the disease itself.

Mellins et al. (2006) reported that to explore rates and types of psychological and substance use disorders, as well as emotional and behavioral functioning in HIV infected children. Forty-seven infected children and their primary caregivers recruited from a pediatric HIV clinic were interviewed using standardized assessments of child psychological disorders and emotional and behavioral functioning, as well as measures of health and caregiver mental health. According to either the caregiver or child report, 55% of child met criteria for a psychological or psychiatric disorder. The most prevalent diagnoses were anxiety disorders, attention deficit hyperactivity disorders, conduct disorders, and oppositional defiant disorders. However, the majority of caregivers and children scored in the normative range on the symptom questionnaires on emotional and behavioral functioning. None of the demographic or child health variables or measures of caregiver mental health was significantly associated with presence of a child psychological disorder.

Amare et al. (2012) studied that children infected with Human Immunodeficiency Virus (HIV) are at particular risk for psychological disturbance. Little is known about the mental health status of children on Highly Active Antiretroviral Therapy (HAART). Behavioral and emotional problem was assessed using the child behavior check list. There is high prevalence of behavioral and emotional problems in children on HAART, because low family monthly income, poverty, lack of awareness, older age, and parental loss were found to be determinants of behavioral and emotional problems.
Bomba et al. (2010) study that to evaluate Health-Related Quality Of Life (HRQL), social competence, and behavioral problems in children with HIV infection receiving Highly Active Antiretroviral Therapy (HAART). The evaluated HRQL, social competence, and behavioral problems in HIV infected children compared with control subjects. Children with HIV/AIDS displayed significantly reduced physical and psychosocial health functioning, particularly at school, compared with healthy subjects, resulting in a significantly reduced total score. Although the introduction of HAART regimens has prolonged the survival of HIV infected children, other factors, including disease morbidity and familial and environmental conditions, negatively affect their social competence and quality of life, thereby contributing to increased risk for behavioral problems.

Maureen (2001) reported that explored the relation between measures of emotional competence, behavioral regulation, and general social competence and African-American preschoolers’ peer acceptance and popularity. These children came from both lower and middle income families. Data were collected in a short-term longitudinal study following children over the course of a school year. Gender, emotion knowledge, emotion regulation, and themes of violence in response to hypothetical situations of interpersonal conflict were strongly related to peer acceptance. The results are consistent with findings from middle-class Caucasian samples. The results also highlight the importance of potential influences of context and setting on children’s peer status as well as the need for greater understanding of within group variability with regard to these constructs. Given the growing evidence that peer relationships are related in important ways to children’s school adjustment, understanding the development of positive peer relationships may help shed light on ways to help children achieve at more optimal levels in the school context.
According to Mendoza et al. (2007) HIV infected children are at risk for anxiety, depression, and behavioral problems, the study detected 39.3% of children living with HIV/AIDS have behavioral and emotional problems.

The study conducted by Brown et al. (2001) says that children from developed countries showed behavioral or emotional abnormalities, including depression, anxiety, attention deficits, social and emotional problems, and general behavior problems to be 12-44% among HIV infected children.

5. Studies related to gender difference of psychosocial problems of children with HIV/AIDS

Marcotte, Fortin, Potvin & Papillion (2002) findings reveal that girls have a lower self-esteem and lower adjustment 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 girls’ 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 and feelings of competency (Corbin, 2002).

FAWE (2000) reported a study conducted in Uganda and observed those lower educational adjustment girls’ knowledge, self-confidence and self-esteem. However, it was also observed that school drop-out rates were higher among girls students compared to boys in Uganda. Most of the reasons for female school dropout were due to family socio-cultural reasons including illness of parents due to HIV/AIDS or orphan hood due to HIV/AIDS or other causes. Other sociocultural reasons included the gender inequality accorded to girls. Boys were generally
provided with the opportunities to continue with their education uninterrupted, while girls were usually requested by their families to stay at home to continue providing household services in the event of illnesses or demise of their parents (Baguma and Muhanguzi, 2000; Uganda Bureau of Statistics, 2006). It should be noted here that, orphanhood due to HIV/AIDS has been one of the greatest effects of HIV/AIDS on school girls' education in Africa leading to school absenteeism during their parents' illnesses and emotional stress manifested in inappropriate behavior (Yun, 2001).

Kling, Hyde, Showers, & Buswell (1999) said that research on gender differences in children self-esteem of boys have a higher self-esteem than girls. Various studies indicate that female children with low self-esteem are less successful at school (Mann, Hosman, Schaalma, & De Vries, 2004). With regard to social functioning, research demonstrated that children with low self-esteem are usually less accepted by their peers (Donders & Verschueren, 2004). Low self-esteem is related to child psychopathology, including anxiety (Beck, Brown, Steer, Kuyken, & Grisham, 2001; Muris, Meesters, & Fijen, 2003) depression (Mann et al., 2004) and eating pathology (Muris, Meesters, Van & Mayer, 2005). There is still much debate about the relation between self-esteem and externalizing problems such as aggression, antisocial behaviour and delinquency.

6. Studies related to domicile difference of psychosocial problems of children with HIV/AIDS

The study conducted by Heckman et al. (1998) said that children with HIV/AIDS disease, particularly those in urban and rural areas face many barriers that prevent them from receiving important life-care services. Both urban and rural respondents indicated that major barriers to life-care services included the lack of
knowledge about HIV/AIDS among citizens in the community, insufficient personal financial resources, the lack of educational and employment opportunities for children with HIV, and the lack of supportive and understanding work and school environments. Rural children living with HIV disease, compared to their urban counterparts, assigned significantly higher problem severity ratings to the following barriers: the need to travel long distances to medical facilities and personnel; a shortage of adequately trained medical and mental health professionals; a lack of personal or public transportation; community resident’s stigma discrimination and psychological adjustment problems toward children living with HIV.

According to Reif, Golin, & Smith (2005) HIV infected individuals face multiple barriers to care and therefore frequently experience unmet medical and support services needs. Rural areas often lack the infrastructure to support the delivery of comprehensive HIV/AIDS services; however, few studies have examined service barriers faced by rural residents with HIV/AIDS, the seven barriers assessed one is long travel for care, HIV-related stigma, a lack of transportation, HIV-trained medical practitioners, housing, mental health services and substance abuse treatment, a substantial proportion of case managers reported it was a major problem. Multivariate analysis revealed that rural case managers and case managers with more female clients reported a greater number of barriers.

Kimani, Manderson, Norris & Kahn (2012) says that to understand critical barriers to seeking HIV-related care for children in rural South Africa. Structural barriers leading to poor access to health care and social and systems barriers, all influenced paediatric HIV treatment seeking of concern was the expressed need to maintain secrecy regarding a child’s HIV status to avoid stigma and discrimination,
and misconceptions regarding the course of HIV disease in children; this led to a delay in seeking appropriate care. These barriers need to be addressed, including through focused awareness campaigns, improved access to health care and interventions to address rural poverty and development at both household and community levels. In addition, training of health care professionals to improve their attitudes and practice may be necessary.

**SUMMARY**

The reviewed previous research reveals that the children with HIV/AIDS must deal with psycho-social problems. The studies related to effects of HIV/AIDS on adjustmental problems, self-esteem and emotional competencies, and the physical and psychological health of the children have been clearly delineated. The review of literature did not reveal any research, investigating the emotional competencies of children with HIV/AIDS. Several studies have been undertaken to examine the impact of HIV/AIDS on psychological and sociological variables among adult population. However, little has been done among children with HIV/AIDS.