

Perceptions of Children with HIV/AIDS from the USA and Kenya: Self-Concept and Emotional Indicators

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Perceptions of children's self-concept and associated emotional indicators were assessed in two populations, United States and Kenya, in children living with HIV/AIDS. Assessment of the self-concept mode of the Roy Adaptation Model used both verbal and nonverbal strategies. The sample of children ($N = 48$), ages 7 to 12 years who were HIV-positive, was recruited from a family clinic that cares for children with chronic illness in the United States ($n = 6$) and an orphanage that provides for HIV-positive children in Kenya ($n = 42$). Self-concept was measured using a modification of Piers-Harris Self-Concept Scale. Emotional indicators were measured from Human Figure Drawings (HFD) described by Koppitz (1968). All U.S. children were found to have an average self-concept and one-third demonstrated significant emotional indicators. In Kenya, 93% of the participants had an average self-concept and half were found to have significant emotional indicators. HFD can be used with other screening tools to perform a psychosocial assessment and screening for referral. This study contributes to nursing science by introducing a model-based assessment with cross-cultural applicability.

By the end of 2007, the Joint United Nations Programme on HIV/AIDS (2007) reported that there were 2.5 million children below the age of 15 living with HIV/AIDS. However, with the advancement in antiretroviral therapies and their subsequent availability, these children are living longer lives. Indeed, the World Health Organization (WHO, 2005) now considers HIV/AIDS to be a chronic illness that can be controlled by strict adherence to the medication regimen. WHO defines chronic illness as a health problem of long duration and generally slow progression, often requiring management for years or decades. Children with other chronic illnesses often experience alteration in their social, emotional, and behavioral functioning. Many studies have evaluated these changes in school-age children with diabetes (Dixon, 2003), hemophilia (Trzepacz, Vannata, Davis, Stehens, & Noll, 2003), and other chronic illnesses. The results of these studies have revealed recurrent depictions of anxiety, depression, and low self-esteem.

Objectives and the CNE Posttest can be found on pages 139-140.

Nursing has the potential to provide for these needs through assessment of adaptation in health and illness. The holistic approach in nursing relates to the treatment of whole or complete systems rather than the analysis or treatment of parts. The needs of the patient in all areas, such as physical, emotional, social, spiritu-

al, and economic, are considered and addressed (Venes, 2001). As such, the child infected with HIV should not only be treated for his/her disease but for any social, emotional, or behavioral problem that arises during the course of care. Children with HIV are often predisposed to highly stressful conditions like death of a family mem-

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ber, drug use by a parent, and the overall stigma attached to their condition. Adherence to antiretroviral therapy (ART) also is one of the major problems in HIV-positive children between the ages of 7 to 12 (Trip, 2001). Assessments of children's perceptions are therefore of great importance and can be used to evaluate the need for other health referrals and formulate new ways of improving adherence in a child-friendly manner.

Drawing is a developmentally appropriate way for children to communicate these perceptions. Art is an unspoken, visual language and form of communication (Malchiodi, 1999). It is present not only in children, but remains in that part of the mind not accessible to rational thought. Art's value lies in its ability to convey symbols and feelings that would otherwise remain unknown. During the early 20th century, the forefathers of psychology, Freud and Jung, both had interests in the interconnections of art, symbols, and personality (Malchiodi, 1998). Because of the universality of art, most healing rituals and ceremonies past and present incorporate music, dance, and drama, along with the power of many visual elements.

Art expression is believed to bring order and containment to feelings that may be contradictory, confusing, or difficult to convey verbally. Art therapy encourages children to say something about their drawing (Malchiodi, 1998). Externalizing the concern through drawing is a springboard for communication (Campbell, Liebmann, Brooks, Jones, & Ward, 1999). DiLeo (1983, p. 207) has stated, "A symbol may be universal, but its meaning is individual." Visual empathy can be communicated as the nurse reflects on the child's symbols or metaphors in the drawing.

Drawing and art making come naturally to children, especially during times of stress. A number of distinctive psychological implications may be present in children living with HIV/AIDS that need additional support. HIV/AIDS is surrounded by a code of silence and secrecy. Even when it is not named, many children recognize signs of illness, so there may be a sense of awareness. Children tend to think problems are their fault and therefore have shame and guilt. The experience of being able to take charge — even in a small sphere of a piece of drawing paper — is vital when a child is unable to control either the medical condition, its life-altering consequences, or the interventions of others. Art is one of

the few expressive modalities used with children that leave a tangible product, a visual legacy, and proof of a child's existence. This is even more apparent during a life-threatening illness. Providing opportunities for art expression is both economical and rich in potential (Malchiodi, 1999).

Review of Literature

Most studies have only examined caregivers' perceptions of caring for an HIV-infected child (Hamra, Ross, Karuri, Orrs, & D'Agostino, 2005; Mawn, 1999) and those with other chronic illnesses (Dixon, 2003; Trzepacz et al., 2003). Few have actually studied children's perceptions on their illness (Instone, 2000).

In a study on the effects of negative life events on immune suppression in children and youth infected with HIV type I (Howland, 2000), disease progression occurred with an increase in stressful events. Disease progression was indicated by a decrease in CD4 cells. These cells are also known as T helper cells and are usually targeted by the HIV virus because they have the most CD4 receptors on their surface than any other cells. Stressful events noted in the study included hospitalization of a family member; death of a parent, sibling, or family member; parent losing a job; loss or change of housing; a family member being very sick; and a family member leaving. Deaths of family members were individually identified as separate life events because previous research has indicated differences in a child's reaction to death of different family members. Helping children living with HIV/AIDS manage stressors in their lives is important to improve the effectiveness of their medication regimen.

Instone (2000) evaluated the perceptions of 6 to 12-year-old children with HIV infection who were not told their diagnosis. Interviews and children's drawings were used to evaluate their adjustment to illness; separate interviews were conducted with parents or guardians. Children whose parents had kept their diagnosis secret for 2 to 8 years exhibited severe emotional distress, disturbed self-image, and social isolation from conversations and drawings. Parents and guardians were often unaware of their children's concerns. There could be a possible association between the length of time before disclosure and the child's understanding of his/her illness and subsequent feelings of low self-esteem and emotional distress. Findings from this assessment can be

used in evaluating the risks and benefits involved in disclosure for children between the ages of 7 and 12 years.

Prochownik (2002) discusses the special needs of the chronically ill child during middle childhood. She states that chronic illness is a determining factor in developmental outcomes and quality of life. Children between the ages of 9-12 years are challenged by additional stressors of maturational changes that occur during the onset of puberty. Chronic illness can therefore interfere with the achievement of normal developmental milestones. The negative life effects of chronic illness on quality of life are mediated by the individual's perception of stress and challenges and are moderated by persons' coping resources. Coping resources include individual characteristics of resiliency, coping skills, knowledge of illness, self-esteem and health beliefs, and social networks like family functioning and social support. Quality of life can be assessed by general well-being (e.g., health perception, happiness/satisfaction), physical functioning (e.g., normal growth and development, no acute or chronic illness-related complications), psychological functioning (e.g., absence of psychopathology), and social functioning (e.g., participating in school, social, and daily living activities). By studying children's perceptions of themselves, general well-being, psychological functioning, and social functioning can all be assessed to determine a child's quality of life.

Purpose and Objectives

The purpose of this study was to assess the perceptions of self-concept and associated emotional indicators of children living with HIV/AIDS in the United States (a developed nation) and Kenya (a developing nation). Due to advances and availability of medical therapies, HIV has become a chronic illness in the United States and with fewer children being born positive. However, the epidemic is more rampant in Kenya, and access to ART is limited, although children in both groups studied are on ART. Effects of chronic illnesses on self-concept can increase as life with a chronic illness is prolonged. Therefore, it is important to increase knowledge of the effect that living with HIV has on a child's self-concept because treatment outcomes and overall quality of life are affected by how children feel about themselves. This can result in finding ways of assessing these effects early and intervening promptly. In an effort

to provide holistic care to the HIV-infected child, there's a need for research on their perceptions in relation to self-concept.

Study objectives were to: (a) observe similarities and differences in the self-concept and emotional indicators of HIV-positive children between the ages of 7 to 12 years receiving care at a family clinic in the United States and in a children's home in Kenya; (b) assess variations that reflect differing cultures and modes of care; (c) determine the usefulness of the Human Figure Drawing (HFD) as a screening tool by nurses working with children with HIV/AIDS; (d) explore the relationship between knowledge of diagnosis and self-concept; and (e) evaluate implications for nursing interventions from the findings, especially nursing in international settings.

Theoretical Framework

Perception is defined as the ability to see, hear, or understand; the quality of understanding; or the way of seeing something (Hornby, 1994). Self-concept refers to the organization of qualities that the individual attributes to himself or herself (Kinch, 1963). To understand self-concept, its three dimensions, body image, cognitive self, social self, and self-esteem need to be investigated (Samuels, 1977). The self-concept adaptive mode is defined in the Roy Adaptation Model as the composite of beliefs and feelings that is held about oneself at a given time, formed from the internal perception and perceptions of others' reactions (Roy, 2007).

The Roy Adaptation Model was used in this study to conceptualize the adaptation of children living with HIV/AIDS in the self-concept mode. The self-concept mode is one of four adaptive modes in the Roy Adaptation Model, encompassing both physical self and personal self (Roy & Andrews, 1999). Children's self-perceptions are affected by AIDS stigma. Stigma is defined as a social condition of attitudinal devaluing or demeaning of persons who are viewed as not capable of fulfilling social roles (Venes, 2001). AIDS stigma is expressed around the world in a variety of ways, including ostracism and discrimination. The President of the International Council of Nurses (ICN), Christine Hancock (2003), declared that stigma fuels the HIV/AIDS epidemic by creating a culture of secrecy, silence, ignorance, blame, shame, and victimization. She went on to state that stigma prevented societies from

addressing HIV/AIDS with the appropriate health care services or legal and educational strategies. A recent study developed a conceptual model of stigma in AIDS from focus group discussions in five African countries (Holzemer et al., 2007) where negative self-perception was found to be a significant internal contributor to stigma.

Within the Roy framework, nursing interventions are holistic, therefore increasing the model's applicability in the care of children living with HIV/AIDS. By using the Roy model, various stimuli affecting adaptation in the self-concept mode were identified. For children in this study, the focal stimulus was coping with HIV/AIDS. The contextual stimulus was the environment of care, either an orphanage or a family clinic with associated differences in cultures and protocols. The developmental level of the school-aged child common to both groups was the residual stimulus. Nursing interventions to facilitate adaptation holistically are needed and can be based on assessments congruent with the model. Research studies in the self-concept mode and with stimuli have been critically reviewed by the Boston Based Adaptation Research Nursing Society, 1999).

A current development in the application of the Roy Adaptation Model (RAM) to nursing practice and research has been the identification of its cultural assumptions (Roy Adaptation Association [RAA], 2007, p. 2). These assumptions are:

1. Experiences within a specific culture will influence how each element of the RAM model is expressed.
2. Within a culture, there may be a concept that is central to the culture and will influence some or all of the elements of the RAM to a greater or lesser extent.
3. Cultural expressions of the elements of the RAM may lead to changes in practice activities, such as nursing assessment.
4. As RAM elements evolve within a cultural perspective, implications for education and research may differ from experience in the original culture.

In the current study, the experiences of stigma within the culture, the child's culture of daily living, and culture-specific setting of care may influence expression of the self-concept mode. In the Kenyan culture, the central concept of emotional restraint among certain groups may affect the self-concept mode assessment to a greater or lesser extent, another rea-

son for using multiple measures. If RAM is emphasized to nurses practicing in the children's home, it may be more likely that self-concept mode assessment will be practiced, providing a basis for more effective care. If self-concept mode assessment is taught in nursing school curricula as a standard practice in nursing care, then in future research we may find evidence of more holistic outcomes.

Methods

A collaborative approach between nursing and art therapy was used in assessing the child's function in the self-concept mode. The study was reviewed and approved by the University of Alabama at Birmingham Institutional Review Board and the Kenyatta National Hospital Ethics and Research Committee. The desired sample was to include children between the ages 7 and 12 years living in Kenya and the United States. The children were to be HIV-positive and with no apparent exacerbation of illness. For purposes of feasibility, the study was divided into two phases to facilitate progress in data collection for Phase I (United States) and Phase II (Kenya).

Sample. The sample was comprised of 48 children with 6 receiving care at a family clinic while living with either a family member or foster parent in the southeastern United States and 42 children living in a Kenyan orphanage. All children in the United States and Kenya were HIV positive and on antiretroviral therapy. The children in the United States were recruited during a scheduled clinic visit and informed consent was given by the children's parents or guardians. Informed consent for the Kenyan children was given by the general manager of the orphanage because she was one of the children's legal guardians. Children in both settings were approached for assent before participation. Those who did not want to give assent were excluded from participation. One child from the United States population opted not to participate and one child in Kenya chose not to continue after giving assent. Measures not to disclose the HIV status of children were implemented by omitting their diagnosis in the study's title. This prevented making any inferences to those who did not know their serostatus. The orphanage maintained a policy that encouraged HIV status disclosure to all children. However due to the developmental stage of each child, varying degrees of awareness existed. A 7-year-old child may not under-

stand the full length and breadth of HIV/AIDS compared to a developmentally appropriate 13-year-old teenager. All Kenyan participants were aware of their HIV status. Demographic data collected during the study revealed that children in both populations had either lost a parent, been abandoned and were unaware of their parents whereabouts, or were in foster care.

Instruments. The Pier-Harris Self-Concept Scale (Piers, 1984) was used to assess self-concept. The scale is comprised of 80 items and 6 subscales. Subscales include physical appearance and attributes, anxiety, intellectual and school status, behavior, happiness and satisfaction, and popularity. The questions are written at a third-grade reading level and require the children to assign a "yes" or "no" response. A high score on a cluster scale indicates a high level of assessed self-concept within that particular subscale. Percentile and stanine scores are then used to give an overall score of self-concept. This tool has been standardized for use in children between the ages of seven and 18.

In this study, four subscales of the Piers-Harris scale — physical appearance and attributes, anxiety, popularity, happiness, and satisfaction — were used. Body image is one of the dimensions of self-concept and thus the need for including questions in the subscale of physical appearance and attributes. The level of happiness and satisfaction affect the overall quality of life in a person. An understanding of a child's cognitive self can be gained by how aware they are of their feelings of happiness and satisfaction. Children's perceptions are influenced by how they think others view them and thus the need to include popularity. The social self-dimension of self-concept could be assessed using the questions included in the popularity subscale. A low self-concept can be a stressor that causes anxiety in children and thus the reason for including the anxiety subscale. Two individual items, one from the Piers Harris scale, "I hate school," and one from the interviewer, "I'm sick a lot," were included in the questionnaire to assess how the children perceive their health and their attitude toward school.

This tool can be individually or group administered and is easily hand-scored and interpreted. Several studies have determined internal consistency of this instrument. Cronbach's alphas ranging from 0.73 to 0.92 have been reported (Piers, 1984). Construct

validity for this tool has been assessed using item analysis, correlations among scales and items, comparison of responses of various criterion groups, and comparison to other scales designed to measure similar constructs. Test-retest reliability coefficients range from 0.42 to 0.96 and internal consistency estimates for the total score range from 0.88 to 0.93. The reliability figures compare favorably with other measures used to assess personality traits in children and adolescents. According to Piers (1984), although not standardized on African American children and other minority groups, the Piers-Harris scale appears to be quite appropriate for use with these populations.

Questions on the scale were read aloud in both English and Swahili for the Kenyan population and the answers were filled out by the children. Due to limitations of time, questionnaires were filled out in groups of five in Kenya. In the United States, the investigator read the questions aloud and filled out the children's responses. The four subscale (38 items) scores from all participants were hand-scored by awarding a point for each favorable response or no point for each negative response. Total scores and subscale scores were converted to percentages for analysis of self-concept. Cronbach's alpha for the modified scale was computed for the study sample as 0.68.

According to Piers (1984), one limitation of the scale arises from children's tendency to respond in socially favorable ways. This could lead to high scores that indicate self-confidence or a lack of critical self-evaluation. In such a case, integration of scores with ancillary data or another tool could help highlight certain discrepancies.

The Human Figure Drawing (HFD) projective drawing test was used to increase the Pier-Harris scale's validity. Drawings of the human figure are among the oldest assessment techniques used with children and adults. The psychological evaluation of HFD has been used extensively in psychology and education, and has recently been introduced as a screening tool for nurses in primary care (Tielsch & Allen, 2005). Throughout the world, children begin drawing in much the same manner, and a child's reaction to the universe is in many ways universal. However, children's capacities to perceive the world are linked to maturation, intellect, and social-cultural views. Koppitz demonstrated how drawing is no longer a pursuit of

older children and the details in their HFD do not increase systematically after age 11 years (Malchiodi, 1998).

The basis of projective drawing tests is that children's drawings reflect their personality, perceptions, and attitudes (Tielsch & Allen, 2005). To use these drawings, the child must developmentally achieve motor functions of grasping, positioning, controlling the writing instrument, and transferring thoughts into intentional hand movements. A child's ability to draw a human figure is usually observed at 3 years of age, and the child assigns definite ideas about how an object should look at age 6. By 12 years, children gain cognitive skills to create more self-consciously and critically as they aim to capture reality in their drawings. School-aged children have difficulty identifying and explaining their feelings of anxiety, depression, fear, or anger due to their concrete operational stage. HFD can be invaluable to nurses when screening children for any emotional problem.

Koppitz (1968) developed one method of evaluating HFD. The child sits in a quiet room, is given a number two pencil, and is asked to draw a self-portrait. Koppitz found that HFD can be analyzed by two different sets of signs or indicators: the first set relating to children's age and level of maturation and the second set relating to children's attitudes and concerns, called emotional indicators. Koppitz lists emotional indicators in three categories: quality signs (poor integration of parts or shading of body parts and size of figure), omissions (eyes, nose, mouth, body, arms, and legs), and special features (teeth, length of arms, positions of legs, genitals, grotesque figure). Emotional indicators are scored as either present or absent. More indicators are expected in depressed, anxious, or emotionally distressed children than in children with no evidence of anxiety or distress. A single emotional indicator on a HFD is not necessarily a sign of psychopathology and may occur in drawings of well-adjusted children. Two or more emotional indicators are highly suggestive of an alteration in emotional wellbeing and thus the need for additional mental health assessments by the provider. According to Koppitz, the diagnostic significance of her 30 Emotional Indicators appears to be greatly enhanced when the total number of such signs on a given HFD is considered instead of each item individually.

Drawing is a universal technique for communicating with children and

Figure 1
HFD with no emotional indicators (USA)

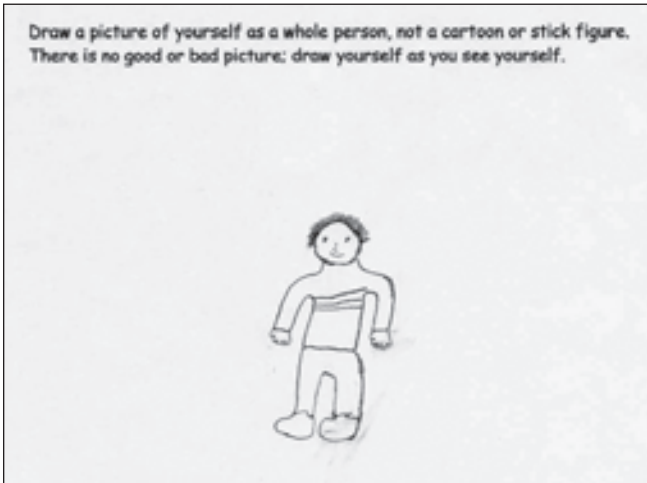


Figure 2
HFD with several emotional indicators (USA)

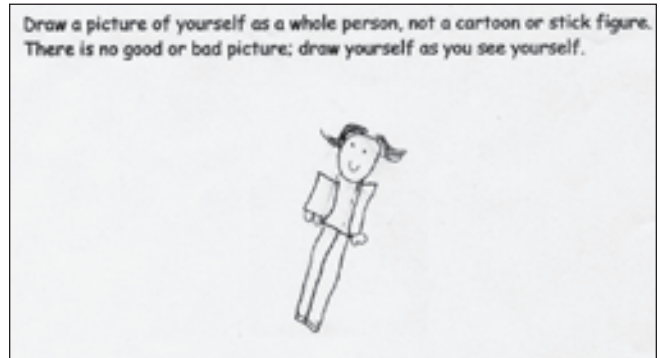


Figure 3
HFD with emotional indicators (Kenya)

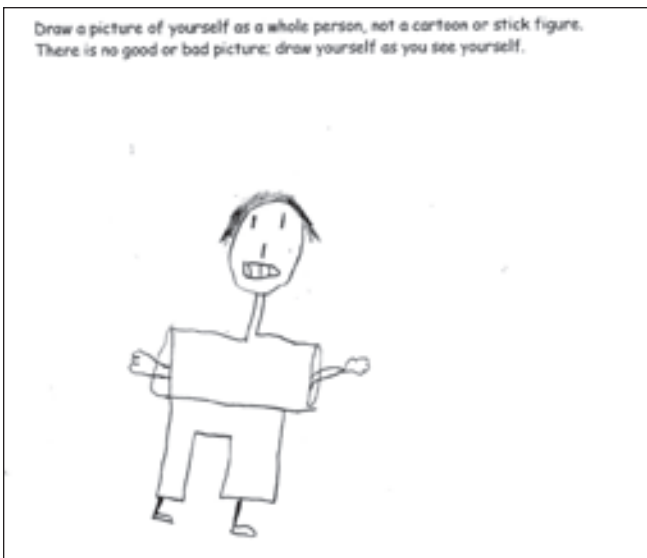
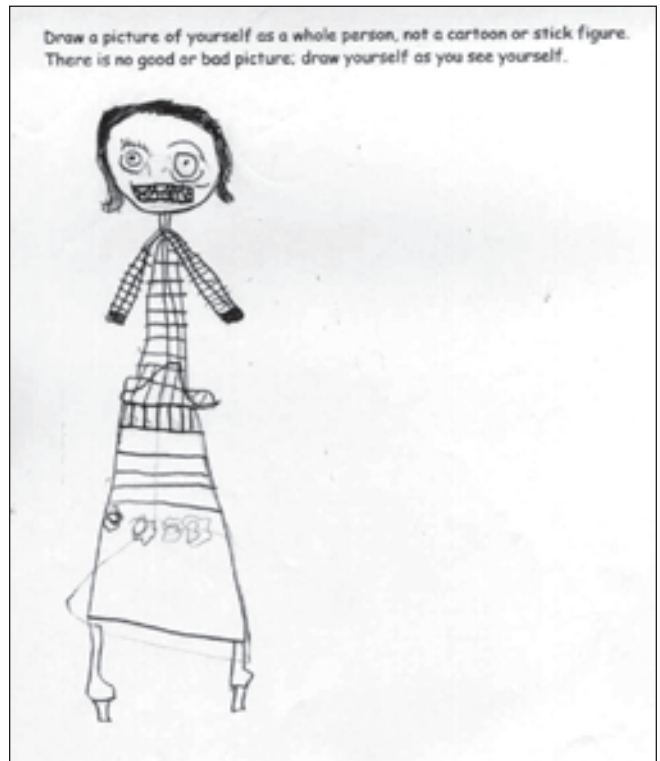


Figure 4
HFD with emotional indicators (Kenya)



can be used with children from any culture. It is particularly useful in cultures where emotional restraint is encouraged. The children in the Kenyan population are representative of all ethnicities in Kenya, some of which discourage the verbal expression of feelings. Use of art as a tool to assess emotional health was therefore considered central to the study's accuracy. The children's drawings in this study were analyzed using the Koppitz scoring manual for 30 emotional indicators. Children were asked to draw a picture of themselves. Instructions were also given to ensure

that the picture was not a stick figure or a cartoon. Scoring of the HFD was verified by a board-certified art therapist on a sample of drawings supporting the accuracy of the investigator's rating.

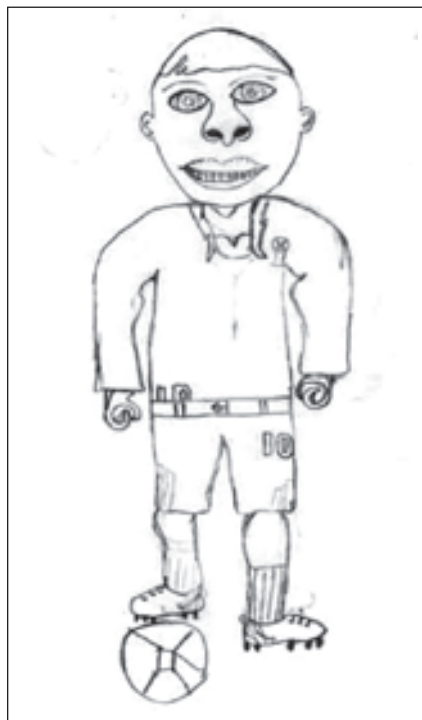
Two open-ended questions were included that asked children (a) who in their lives (including parents, guardians, nurses, and others) made them feel good about themselves, and (b) what they did to make them feel that way. This was to provide insight into the children's social support and to possibly infer recommendations for nurses. Responses to open-ended

questions were analyzed using content analysis (Colorado State University Writing Center, 2007).

Results

Self-concept score averages for both United States and Kenyan populations were computed to assess the existence of any similarities or differences. All six children in the United States population were found to have an average to above average self-concept. Clinically significant emotional indicators, that is, more than two, were found in two (33%) of this population. In analyzing the Kenyan data,

Figure 5
HFD with universal elements
(soccer, glasses, facial features)



39 (93%) of the 42 participants had an average to much above average self-concept and 22 (52%) were found to have more than two emotional indicators. Of the 3 (7.1%) that had a slightly below average self-concept, only one had more than two emotional indicators.

Figures 1–5 show examples of HFD by participants. Figure 1 shows a drawing with no emotional indicators. The figure is well proportioned, has all body parts, and no additional signs. Figure 2 has several emotional indicators, including a tiny figure (defined as less than two-inches tall), the slanting position, arms clinging to body, legs pressed together, and omission of nose. Figure 3 also shows some emotional indicators in lack of proportion of arms and presence of teeth. Figure 4 showed the most indicators of the study sample with a transparent “skeleton-like” backbone, grotesque figure, presence of teeth, no nose, and others. Figure 5 shows many universal features — soccer player, glasses, facial features. The individuality of the art is evident throughout the sample.

Individual subscale averages were calculated to assess areas of self-concept that were similar or different in

the two populations. Due to the small sample size ($n = 6$) of the United States population, there were only very slight differences in the subscales, none of which were statistically significant. In the subscales of anxiety, popularity, and the two individual items, the children from the orphanage population felt slightly more anxious, less popular, reported hating school more, and felt they were sick more times than the family clinic population. However, in the subscales of physical appearance, happiness, and satisfaction, the children from the family clinic population felt less pleased with their physical appearance and were less happy and satisfied (see Table 1).

Content analysis of responses to interview questions revealed three recurrent themes — caring, healing, and companionship (see Table 2). Under the caring theme, both populations felt good about themselves when their parents (in the family clinic population) and house mothers and uncles (in the orphanage population) taught them a skill, such as caring for the younger children or assisting with homework. The healing theme was evident from responses to the question of what nurses did to make the children feel good about themselves. Giving medicine was a common response in both groups. However, there was a nurturing component to what nurses at the family clinic in the United States did. Participants’ responses indicated the presence of a stronger relationship that went beyond just giving medicine. Other people in the lives of these children that made them feel good about themselves did so by offering companionship. Both groups had a huge social network of friends, relatives, volunteers, and staff at the institutions of care.

Table 1
Subscales Averages for Kenyan and U.S. Children

Subscales	Orphanage (%)	Family Clinic (%)
Physical appearance	85.6	81.9
Anxiety	64.3	80.8
Popularity	64.9	70.8
Happiness & Satisfaction	87.6	65
Hates School	28.6	16.7
Sick a lot	19	0

Table 2
Themes from Interviews for Kenyan and U.S. Children

Themes	Examples and Quotes (Kenya)	Examples and Quotes (USA)
Caring	House Mother and Uncle cleaned the house, taught them how to care for the babies, and allowed them to play games	Family cooks, buys clothes and supplies, takes me somewhere special on my birthday, and helps me with homework and extra things I want to learn
Healing	Nurses made them feel better by giving them medicine	Nurses “are nice and friendly and I’ve known them for a long time. They joke with me, cheering me up when I’m sad, give me toys ...” Nurses also were encouraging by saying they are good and smart children and giving them hugs.
Companionship	Friends, the staff, volunteers and founder of the home, were identified as playing with them, sharing things, cheering them up when they cry, buying them supplies and helping them with their homework	Relatives and friends played with them, cheered them on, visited them at their house and laughed at their jokes

Discussion

As described in results, most of the children in this study had a self-concept that ranged from average to above average. This data indicates a similarity in the way these children feel about themselves. Although no direct association between self-concept and the number of emotional indicators exists, this should cue health care professionals on the need to use various tools when assessing emotional health in children. Participants with a high or low self-concept score and more than two emotional indicators should have further assessments performed because that might be a possible sign for an alteration in emotional well-being. Provisions were made in both settings to have a follow-up on those children identified as having low or high self-concept scores and more than two emotional indicators.

These findings are consistent with the results of Instone's study (2000), which showed children whose parents had kept their diagnosis secret for 2 to 8 years elicited severe emotional distress, disturbed self-image, and social isolation from conversations and drawings. Although the children receiving care at the family clinic in the United States have not had their status disclosed to them, two (33%) of them had more than two emotional indicators on their HFD, a possible sign for an alteration in emotional well-being. The majority of the children receiving care at the orphanage seems to have an average self-concept. However, the 22 (52%) of children with more than two emotional indicators suggests some alteration in emotional well-being. Guest (2003) mentions how institutional life can be quite grim and that children rarely thrive in such settings. Emotional health is a sign of thriving, and the data suggests that over half of the children in the orphanage may need further assessments to determine and treat any emotional problems.

From responses to the interview questions, the children indicated that they had other people in their lives that made them feel good about themselves. Prochownik (2002) found that the negative life effects of chronic illness on quality of life are mediated by the individual's perception of stress and challenges and are moderated by a person's coping resources. The children receiving care at the family clinic seemed to have several coping resources, including social support from family members and staff at the clinic, an average self-esteem, and a

living parent. On the other hand, children at the orphanage had no living parent and the majority rarely received a visit from their relatives. However, they had friends with whom they shared a lot in common, as well as volunteers, the founder, and staff members whom they considered a part of their family.

How children perceive their illness can greatly influence their coping. Children in this study seem to be coping because they have an above-average self-concept, which is an indicator of emotional health. They also do not report feeling sick as shown by the 0 (0%) family clinic and the 8 (19%) children in the orphanage who indicated feeling like they were "sick a lot." Those children with a significant number of emotional indicators may not be coping as well as those without. Social support in an orphanage setting is present, but may not be as strong as the social support received from family.

The significance of art therapy as a way of assessing emotional health in children from other cultures is evident in 22 (52%) of the 42 orphanage participants that had more than one emotional indicator. If self-concept was assessed using the Piers-Harris scale alone, 93% of children would have been assumed as being emotionally healthy. The 52% that had more than two emotional indicators would have been overlooked. The tendency to want to give favorable responses to one's feelings could be cultural. Young children can often reveal feelings on a HFD that they cannot put into words. Because HFD reflect both conscious and unconscious attitudes and concerns, the process of making HFD can be quite therapeutic (Koppitz, 1968).

Limitations. A small sample size ($n = 6$) in the U.S. family clinic population was a barrier in making a direct comparison of the two groups. Although this sample was small, it was also an indicator of the changing trends of maternal-to-child transmissions in the United States. The problem was not in recruiting participants, but rather in the number of available participants that met the selection criteria. Recruiting from other similar clinics would likely have yielded a more substantial sample size and should be considered in future studies. Use of part of the Piers-Harris scale was a limitation in that validity could only be inferred from previous studies done to evaluate the whole tool.

Garnering informed consent proved challenging for two participants that were approached for participation;

they expressed confidentiality concerns. A waiver of written consent should be considered in future studies to aid in the recruitment of participants. No other problems were evident in the process of consent/assent or implementation.

According to the Piers-Harris scale (Piers, 1984), children's tendency to respond in socially favorable ways could lead to high scores that indicate self-confidence or lack of a critical self-evaluation. This problem can be prevented with the use of another tool to highlight discrepancies. In this study, HFD were used to increase validity. In art therapy, there are several ways of scoring, such that what is regarded as an indicator in one tool may not be in another. Over- or under-scoring is a possibility. Due to the various limitations in this study, the results are tentative and a replication study is encouraged.

Implications for Nursing

Nurses are concerned about the emotional well-being of their patients and seek to provide holistic care. Findings from responses made by the children on positive things healthcare professionals say should cue nurses on the need to use therapeutic language, positive reinforcements, and a nurturing stance when communicating with children. Children with more social support tend to thrive, so considerations should be made when determining whether to institutionalize orphaned children or to keep them in foster care. Children in orphanages can do just as well emotionally if there are systems in place to ensure frequent assessments, availability of counseling, and staff training.

Although the sample size was limited, the technique of HFD was found to be highly useful in encouraging self-expression in the children. HFD can be used as a feasible and effective way to perform a psychosocial assessment and indicate a need for referral. In international settings, HFD is of greater importance due to various cultural values that could interfere with a person's verbal expressiveness. A system to encourage the use of HFD regularly in the clinical setting should be explored. This study and others have shown the screening potential of HFD and the low cost and universality of HFD as an assessment tool. Expanded use of this technique for nursing assessment in multiple types of settings and in geographically widespread or culturally disparate settings is warranted.

Art can be helpful in establishing

rapport and promoting trust with the child. Creative activities such as art can help children adjust to illness and hospitalization. The nurse can ask, "tell me about your drawing" and respond with "thank you." A child's capacity to use art to tap inner resources, reduce and channel stress, understand their inner and outer world, and communicate demonstrates why art therapy is a powerful tool in sustaining children's health (Malchiodi, 1999).

For nurses and teachers, the use of art as a screening tool can give an added dimension to practice, even if therapy requires skills beyond those of nursing. Even the most sensitive artist, teacher, or nurse is not a therapist. To offer art as therapy, it is important to be able to integrate knowledge about art and therapy, which requires clinical training in the field. Nurses can partner with art therapists to initiate interventions to strengthen self-concept development in children.

Implications from this study relate to the recently developed cultural assumptions of the Roy Adaptation Model. Children expressed generally positive self-concept when measured through verbal measures; however, a larger number of emotional indicators were observed through art. These findings may relate to experiences of stigma and social expectations underlying in the culture. The positive environments of both the family clinic and the children's home (or orphanage) create opportunities for self-expression and growth. In both settings there are mechanisms for follow-up of at-risk individuals and this was incorporated into the project. It is not known what other factors may affect self-expression and self-concept mode assessment, another reason for using multiple measures.

This initial examination into the application of screening tools may open possibilities to more deliberate use of such screening in these and similar settings. New practice approaches promote development of nursing assessment to support adaptation. With increased evidence-based practice opportunities, nursing practice can evolve in many settings such as these, making it more likely that self-concept mode assessment will be

practiced. Nurses can provide holistic care applicable to many cultures. Self-concept mode assessment using multiple measures can be taught in nursing school curricula as a standard practice, potentially leading to more holistic outcomes.

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The purpose of this continuing education series is to increase the pediatric nurse's understanding of selected international issues.

With the remarkable technology that exists today, we are living in a global world. It is critical to identify strategies to promote collaboration and communication between nurses around the world. Through such efforts, nurses can share knowledge and improve professional nursing practice. Keeping updated on international issues in pediatric care also broadens pediatric nurses' understanding of nursing and the issues nurses face worldwide.

This continuing education series consists of four articles that address international issues. The first article describes the Network for Nursing in Child Health, one of more than 10 specialty nursing networks being developed with support from the Pan American Health Organization (PAHO). The second article presents findings from a study of an educational program that supports mothers who are breastfeeding their preterm infants in Cairo, Egypt. The third article offers research results of a study on self-care behaviors of school-age children with heart diseases in China. The fourth article presents findings of a study on perceptions of children's self-concept and associated emotional indicators in two populations, the United States and Kenya, in children living with HIV/AIDS.

ASSIGNMENT

Harrison, L., Montenegro, G., Malvares, S., Astudillo, M., Behn, V. Bertolozzi, M., et al. (2008). The network for nursing in child health. *Pediatric Nursing, 34*(2), 113-116, 138.

Waweru, S., Reynolds, A., & Buckner, E. (2008). Perceptions of children with HIV/AIDS from USA and Kenya: Self-concept and emotional indicators. *Pediatric Nursing, 34*(2), 117-124.

Ahmed, A. (2008). Breastfeeding preterm infants: An educational program to support mothers of preterm infants in Cairo, Egypt. *Pediatric Nursing, 34*(2), 125-130, 138.

Fan, L. (2008). Self-care behaviors of school-aged children with heart disease. *Pediatric Nursing, 34*(2), 132-138.

OBJECTIVES

1. Discuss the importance of promoting collaboration and communication between nurses around the world.
2. Describe the objectives and composition of a network for nursing in child health.
3. List four phases of an educational program that supports mothers who are breastfeeding their preterm infants.
4. List four possible explanations for school-age children with heart disease having a moderate level of self-care behaviors.
5. Discuss the use of a model-based assessment with cross-cultural applicability.
6. Identify opportunities for pediatric nurses to keep current on international nursing issues.

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This test was reviewed and edited by Judy A. Rollins, PhD, RN, *Pediatric Nursing* associate editor, and Veronica D. Feeg, PhD, RN, FAAN, *Pediatric Nursing* editor.

Earn 1.8 Contact Hours

QUESTIONS

1. **The Integrated Management of Childhood Illness (IMCI) program was initiated in**
 - a. 1992.
 - b. 2000.
 - c. 2002.
 - d. 2005.
 - e. 2006.
2. **What percentage of the deaths of children under age 5 in low-resource countries each year are due to preventable causes such as pneumonia, diarrhea, malaria, measles, and malnutrition, or a combination of these problems?**
 - a. 35%
 - b. 40%
 - c. 50%
 - d. 70%
 - e. 90%
3. **How many countries have integrated IMCI guidelines into their health systems?**
 - a. 50
 - b. 60
 - c. 80
 - d. 100
 - e. 120
4. **Which of the following statements are true?**
 - a. Health workers using the IMCI guidelines are taught to diagnose specific medical problems that are primary causes of morbidity and mortality.
 - b. Health workers using the IMCI guidelines are taught to assess, classify, and treat health problems without identifying specific medical diagnoses.
 - c. IMCI guidelines are used to promote health of children from birth to age 15 years.
 - d. IMCI principles are currently taught in all nursing schools in Latin America.
 - e. The manual with guidelines for integrating IMCI principles in nursing curricula has been translated into Spanish, Portuguese, French, and English.
5. **Which of the following are the objectives of the Network for Nursing in Child Health?**
 - (1) To share knowledge and experience related to child health nursing
 - (2) To promote use of the IMCI manual by nursing schools throughout Latin America
 - (3) To evaluate the effectiveness of the dissemination of the manual in promoting inclusion of IMCI content in nursing curricula in Latin America
 - (4) To promote the translation of the IMCI manual to English
 - a. 1 and 4
 - b. 1, 2, and 3
 - c. 1 and 3
 - d. 1, 2, and 4
 - e. 1, 2, 3, and 4
6. **Social Cognitive Theory provided the framework for Ahmed's experimental study because**
 - a. it explains the process of developing self-efficacy.
 - b. this study is intended to measure mother's self-efficacy.
 - c. it provides effective educational strategies for the program.
 - d. it promotes expected outcome.
 - e. All of the above.
7. **The result of this study indicated that**
 - a. it is possible to breastfeed preterm infants successfully.
 - b. breastfeeding preterm infants is a learned behavior.
 - c. breastfeeding preterm infants need continuous support and follow up.
 - d. a preterm infant can tolerate both breast and bottle feeding at the same time.
 - e. mothers of preterm infants are less likely to have problems in establishing breastfeeding.
8. **The most common preterm infant's breastfeeding problems include all of the following EXCEPT**
 - a. poor sucking-swallowing coordination.
 - b. easily fatigued.
 - c. state disorganization.
 - d. sore nipple.
 - e. weak arrhythmical sucking.
9. **Both groups encountered breastfeeding difficulties in this study. Which problem persists with the control group until the end of the third month?**
 - a. Easily fatigued.
 - b. State disorganization and sleepy infant.
 - c. Perceived inadequate milk supply.
 - d. Poor lip closure.
 - e. Nipple confusion.
10. **Group teaching is the most effective method to teach breastfeeding for mothers of preterm infants.**
 - a. True
 - b. False
11. **According to the New York Heart Association (NYHA), heart function can be classified into how many classes?**
 - a. 2
 - b. 3
 - c. 4
 - d. 5
 - e. 6
12. **Parents of children with congenital heart diseases tend to report lower quality of life than parents of healthy children.**
 - a. True
 - b. False

13. According to Orem's theory, when an individual engages in self-care practices, which of the following self-care requisites should be met?
 a. Universal d. a and b
 b. Developmental e. a, b, and c
 c. Health-deviation
14. The results of Fan's study indicate that the total self-care behaviors of school-age children with heart disease in two hospitals in China were at which of the following levels?
 a. Low c. High
 b. Moderate
15. An explanation for Fan's findings include
 a. health impact on growth and development.
 b. health education.
 c. parent education.
 d. family support.
 e. all of the above.
16. The World Health Organization considers HIV/AIDS to be
 a. a chronic illness that can be controlled by medication.
- b. a terminal illness with life expectancy of 6-12 months.
 c. a disease caused by lifestyle and behavior.
 d. a progressive neurological illness with increasing cognitive disability.
17. Measures to protect human participants in research in international studies include:
 a. approval by appropriate agencies and/or ethics committees in the country.
 b. translation of documents into language of participants.
 c. assurance that the study is acceptable in the local context.
 d. provision for informed consent and assent.
 e. all of the above.
18. According to the findings of this study, Human Figure Drawings can be used by nurses as a screening tool for psychosocial responses in children with HIV/AIDS
 a. to identify children who need further assessment.
 b. to predict stigma.
 c. to measure response to institutional life.
 d. to measure effects of disclosure on adaptation.
19. Human Figure Drawing (HFD) have high feasibility for assessing children's adaptation in self-concept mode because these
 a. are an easily accessible way to perform assessment for screening and referral.
 b. are suitable in international settings due to universality of expression of emotions.
 c. are developmentally appropriate for children ages 7-12.
 d. all of the above.
20. Implications of the findings of this international study include
 a. children from both cultures expressed generally negative self-concept on verbal scale items.
 b. nonverbal measures are important in screening for self-concept needs.
 c. orphanages lack opportunities for growth and self-expression.
 d. mechanisms for follow-up of at-risk individuals are not available universally.

Answer Form: International Issues

*PED J0803

Check the box next to the correct answer.

1. A B C D E 2. A B C D E 3. A B C D E 4. A B C D E 5. A B C D E 6. A B C D E 7. A B C D E 8. A B C D E 9. A B C D E 10. A B C D E 11. A B C D E 12. A B C D E 13. A B C D E 14. A B C D E 15. A B C D E 16. A B C D E 17. A B C D E 18. A B C D E 19. A B C D E 20. A B C D E

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Evaluation	Strongly disagree				Strongly agree
1. The objectives relate to the overall purpose/goals of the education activity.	1	2	3	4	5
2. The activity met the stated objectives.					
a. Discuss the importance of promoting collaboration and communication between nurses around the world.	1	2	3	4	5
b. Describe the objectives and composition of a network for nursing in child health.	1	2	3	4	5
c. List four phases of an educational program that supports mothers who are breastfeeding their preterm infants.	1	2	3	4	5
d. List four possible explanations for school-age children with heart disease having a moderate level of self-care behaviors.	1	2	3	4	5
e. Discuss the use of a model-based assessment with cross-cultural applicability.	1	2	3	4	5
f. Identify opportunities for pediatric nurses to keep current on international nursing issues.	1	2	3	4	5
3. Home study format was appropriate.	1	2	3	4	5
4. The content was relevant to my practice.	1	2	3	4	5
5. The content met my needs.	1	2	3	4	5
6. How much time was used to complete reading assignment and posttest:					
a. Less than 1 hour _____					
b. 1-2 hours _____					
c. 2-3 hours _____					
d. 3 hours or more _____					

Comments _____
 Signature _____