Emotional Maturity of Institutionalized Children Living With HIV: A Cross-sectional Study

Renny Thomas[1]*, A Shahin Sultana[2]

ABSTRACT

Children with HIV who living in institutions experience stimulus and responses/reactions emotionally towards various life experiences, which influence their emotional development either positively or negatively depending on the nature and the context of the circumstances. This study attempts to understand the Emotional Maturity of the Institutionalized Children living with HIV by Mixed Methods Research Design using Purposive Sampling. The objectives of the study include (i) to assess the level of Emotional Maturity of the institutionalized children living with HIV, (ii) to identify various emotional problems of the children, their reasons and the ways to manage them; and (iii) to find out how the children can be emotionally empowered. The researcher collected data from twenty Children living with HIV in two institutions (from Karnataka and Tamil Nadu) belonging to 10–18 years using the Emotional Maturity Scale developed by Singh & Bhargava. The collected data were coded, tabulated and analyzed using SPSS; Correlation was also used to analyze the data. Qualitative data was collected by semi-structured in-depth interviews from the President, Superintendent, Welfare Officer, Counsellor, and an institution inmate using telephonic interviews. The interviews were transcribed, coded, generated themes, and summarised. This study brings about the children's emotional problems that need to be addressed effectively by employing effective interventions and community support programmes. Love, personal care and attention are essential elements for supporting them. The Institutions can help them live like others with proper medication, nutritious food, exercise, yoga and meditation. Guidance, counselling and motivation emotionally empower the children at the institution. Caregivers and Counsellors are likely to improve the emotional wellbeing of these children. The findings encourage further studies on the Emotional Maturity of Children living with HIV living outside Institutional care and other geographical areas.

Keywords: Emotional maturity, children, HIV, emotional problems

INTRODUCTION

According to Campos et al. (2004), emotion is the person's ability to establish, retain, or change the connection between their adjustment to the situations. So, as human beings, Children living with HIV (CLWH) who live in institutions also experience stimulus and responses/reactions emotionally towards various life experiences, which influences their emotional development either positively or negatively depending on the nature and the context of the circumstances. This study aims to understand the Emotional Maturity among Institutionalized Children living with HIV. The objectives include (i) to assess the level of Emotional Maturity of the Institutionalized Children living with HIV, (ii) to identify various emotional problems of the children, their reasons and the ways to manage them; and (iii) to find out how the children can be emotionally empowered. The issue can be vital for the governmental, non-governmental and community-based organizations concerning the interventions to deal with emotional problems and providing adequate training to caregivers.

[1]PhD. Research Scholar; [2]Professor, Department of Social Work, School of Social Sciences and International Studies, Pondicherry University, Puducherry, India.

*Corresponding Author's Email: shahin.samroh@gmail.com

The findings may encourage further studies on the Emotional Maturity of Children living with HIV outside Institutional care.

REVIEW OF LITERATURE

Highly Active Antiretroviral Therapy (HAART) and its widespread availability in many settings have reduced the mortality rate among People Living with HIV/AIDS (PLHA). Still, there are challenges related to physical, psychological, and socio-cultural problems caused by many different factors, including symptoms of the virus, side effects of HAART, and opportunistic infections (Tesfay et al., 2015).

As the disease progresses, children confront the physical and mental decline associated with AIDS. Family members are overwhelmed at this stage and have difficulty communicating with the child about the issues related to prognosis and death. More than coping with their mortality, the children and adolescents have to cope with the mortality of their loved ones living with HIV. Facing and understanding their possible death are significant challenges faced by Children living with HIV. The child's cognitive and Emotional Maturity often determines their level of awareness about their mortality and their coping skills and defences to deal with this realization (Vranda & Mothi, 2013).

According to Kumar & Kumar (2013), Children living with HIV have more severe adjustment problems, lower self-esteem, and more insufficient emotional competencies than those without HIV. Girls living with HIV have more severe adjustment problems, lower self-esteem and lower emotional competencies than Boys. Rural Children living with HIV have more severe adjustment problems, lower self-esteem, and more inadequate emotional competencies than Urban Children.

A study by Manhas (2014) evaluated the Self-esteem and Quality of life of people living with HIV in the Indian population using a correlational design and established a significant positive correlation between self-esteem and the different dimensions of Quality of life. Interventions designed for people living with HIV could include self-esteem as a moderator of Quality of life.

Mental health concerns are essential for people living with HIV, as evidenced by the high prevalence of depressive symptoms in the home care population and aggressive behaviours in the Institutionalized populations. Isolation and social conflict are essential Quality of life concerns for people living with HIV irrespective of the care setting. In the home care environment, the feeling of isolation may coincide with various health issues, e.g. higher rates of loss of appetite and poor self-rated health (Foebel et al., 2015).

Depression impacts the progression of illness and Quality of life in children living with HIV resulting in outcomes that increase the social burden of disease and the diffusion and mortality of HIV. Findings suggest that perceived social support has a significant and positive effect on depression in children affected by HIV. Children's social desirability and catastrophizing, one dimension of cognitive emotion regulation, negatively impact (Zhou et al., 2019).

Many people living with HIV find it challenging to attend to daily living tasks, participate in moderate to vigorous physical activities, or have sufficient energy or vitality to engage in an active social life while managing HIV. Fatigue or low energy is associated with both physical and psychological morbidity (Breitbart et al., 1998) and low Quality of Life (QOL)in persons living with HIV(Zinkernagel et al., 1999).

Many CLWHs are experiencing severe life events that could affect their psychosocial wellbeing, such as losing caregivers to AIDS-related illnesses, stigma, shock about their

status, and not understanding the importance of adhering to treatment. Hence, it is essential to encourage children to have a positive outlook on life, which can help make full use of support groups (Anouk et al., 2013).

In addition to the disease's biological and physical impacts, many People Living with HIV/AIDS (PLHA) struggle with severe social problems such as stigma, poverty, depression, and substance abuse, which adversely affect their Quality of Life (QOL). These social problems pose numerous barriers to the patients' everyday activities and interests (Legesse Tesemma et al., 2019).

Stigma is also negatively correlated with QOL (Nyamathi et al., 2019). It has been recognized as a barrier to receiving care due to healthcare-seeking delays and denial of providers' proper care (Steward et al., 2011). Stigma fears are associated with impaired healthcare access, adherence, social interaction and social support (Carr & Gramling, 2004). Several studies have linked internalized stigma and depression in HIV populations in Southern India (Chan et al., 2017; Steward et al., 2011). Moreover, in HIV-positive individuals in India, depression and stigma were highly correlated and depression predicted lower QOL (Charles et al., 2012).

A cross-sectional study in Southern India (Nirmal et al., 2008) revealed that PLHA with family support had higher mean Quality of life scores in the environment domain as compared to those without family support ($P < 0.001$). It indicates the need to improve family and friends' help for all patients with poor perceived social support. High social support may reduce discomfort and stabilize an individual's mood and thoughts and, therefore, better perceived Health-Related Quality of Life (HRQOL). PLHAs affiliated with any social organization reported higher Quality of life in the social relationships domain than those not affiliated. It highlights the role of social organizations in providing essential social networks. PLHAs receive various forms of social support through this platform (Peter et al., 2014).

Children living with HIV attended fewer school days (Anabwani et al., 2016; Cohen et al., 1997; Mayes et al., 1996)) and dropped out of school more frequently (Bele et al., 2011; Parchure et al., 2016). They were more likely not to be in the correct class for their age or to have repeated one and had low grades while in school (Bandason et al., 2013; Henning et al., 2017). These results indicate that physical illness is the main barrier to HIV-infected children's schooling.

In a comparative study of children living in foster homes and their own homes (Gopakumar et al., 2018), the mean Total HRQOL of child's self-report was higher for children staying in foster homes. It may be partly due to the caregiver's higher educational qualification, who can understand this vulnerable group of children's needs and 100% adherence to the treatment. The environment and the recreational activities provided by these well-managed foster homes and the feeling of togetherness might have also contributed to the Quality of life.

An overview of the literature revealed that most studies on Children living with HIV are related to physical, psychological, and socio-cultural problems, especially depression, self-esteem, adjustment problems, stigma and educational backwardness, family & social support and Institutionalized care. Studies on Institutionalized Children living with HIV, especially on their Emotional Maturity, are inadequate. Therefore, it becomes imperative to study Emotional Maturity among Institutionalized Children living with HIV.

MATERIALS AND METHODS

The current cross-sectional study was intended to understand Emotional Maturity among the Institutionalized Children living with HIV by Mixed Methods Research Design. The

researcher collected quantitative data from twenty Children living with HIV in institutions belonging to the age group of 10–18 years using Purposive sampling. The researcher approached five institutions for data collection but received it only from two (belonging to Karnataka and Tamil Nadu) due to COVID restrictions.

The researcher used the Emotional Maturity Scale developed by Yashvir Singh & Mahesh Bhargava (1990) to assess the participants' Emotional Maturity. The scale consisted of 48 questions related to five domains: Emotional instability, Emotional regression, Social maladjustment, Personality disintegration and Lack of independence. Items of the scale were in question form seeking information for each of the five options: Always, Mostly, Uncertain, Usually, Never. The items were scored as 5, 4, 3, 2 and 1, respectively. Therefore, the higher the score on the scale leads to the greater the degree of emotional immaturity and vice versa. The test-retest reliability has been estimated at 0.75, and internal consistency for various factors ranged from .42 - .86. The validity against the Adjustment Inventory by Singh and Bhargava (1980) at 0.46, and the interpretation of the scores: 50-80 extremely stable; 81-88 moderately stable; 89-106 unstable; 107- 240 extremely unstable.

Respondents were informed about the purpose and the benefits of carrying out the study. Besides, the confidentiality of the participants' responses and voluntary participation was guaranteed to them before distributing the questionnaires. They were allowed to withdraw at any time without detriment to their studies and were informed that the questionnaire's completion implied consent to participate in the study. After that, the questionnaires were provided to the desired participants using Google forms. It took around 15 minutes on average for the respondents to fill up the questionnaires. After completion of the questionnaires, the participants submitted them through online mode. The collected data were coded, tabulated and analyzed using Statistical Package for Social Sciences (SPSS) Version 22.0through descriptive statistics in frequency, mean and percentage. Statistical test, namely Correlation, was also used to examine the data.

Qualitative data was collected using semi-structured in-depth interviews from the President, Superintendent, Welfare Officer, Counsellor and one inmate of the institution using telephonic interviews. An Interview Guide consisting of five questions about the study's objectives was prepared and sent to respondents who have given their consent. The researcher transcribed, coded, generated themes and summarized them. Qualitative data were analyzed using QDA Miner Lite v1.0, a free qualitative data analysis software.

INTERVIEW GUIDE FOR CARE GIVERS/COUNSELLORS

1. Do the children in your institution experience any kind of emotional disturbances or problems? What are they?
2. What are the interventions employed or services provided by the institution for addressing these problems?
3. Do the children experience any sort of mental tension or fear of their future life? How is it expressed by the children and understood by the caregivers? How do you address/handle this?
4. How can the children be emotionally empowered at your institution?
5. What is the role or support of Governmental/Non-governmental organizations in this regard?

CASE PROFILES

Case1: Inmate

He is one of the inmates of an institution where his mother left him at the age of 4years, two years ago. He is studying 11th standard (Agriculture, Computer Technology, Biology, Tamil

and English) in a Government School. The institution provides free education, food, accommodation and medicines. He is an orphan, hence no family support after Institutional Care. He thinks that his weak health condition may affect his future life. As he is taking medicines, he believes that others may criticize him. He feels that "Who will help me?" He fears death and sickness and becomes very sad when he sees anyone sick; his body temperature shoots up and becomes expected after encouragement or counselling services. He usually needs an environment change, so going to a park, garden, or church for a silent prayer or relaxation time. In future, he is confident of managing himself by prayer and support of family & friends.

Case 2: Counsellor

She is the full-time residential counsellor providing counselling services and necessary guidance for the inmates. Her husband is the Superintendent, who is in charge of the institution's daily activities. According to her, the children's various emotional problems are: anger, fear, sadness, dissatisfaction, disagreement, short-tempered, very stubbornness, sense of discomfort, felt blamed by others, short time lonely situations; don't like to have daily medication and feel wrong about their parents & society. Some of them ask the caregivers why it happened to me?

The children are emotionally empowered employing (a) Daily moral lessons, (b) Yoga classes, (c) Need-based one to interactions, and (d) Need-based Counselling is given. The institution provides different teaching sessions for (a) encouraging others, (b) how to participate in groups events, (c) to have good habits & respecting others, (c) to develop volunteering, serving, apology habits, obedience, listening attitude, (d) to establish friendly nature & thanking habits, and (e) produce the best behaviours.

The role or support of various Governmental/Non-governmental organizations are (i) Child welfare committee provides legal assistance (ii) District child protection unit provides service or inspections to run the HOME with complete rules, regulations & norms, (iii) Local primary health centre conducts need-based health camps/treatment/ awareness, (iv) ART centre provides ART treatment & medicines every month, and (v) Local Police department/ Panchayat / Fire provides need-based protection.

Case 3: Welfare Officer

She is the Child welfare officer responsible for providing Counselling taking care of children's food, health, education and problems. Children are emotionally attached to their parents who passed away, so children sometimes have those missing feelings and feel that they don't have anyone to love and care. They seek more love and affection. Counselling is the primary service they provide to the children and makes them comfortable, showing more respect and love. Mainly, elder boys fear their academic and future life like how they should walk or choose. So, they give them options about their career and help them achieve that even financially too. More advice and counselling emotionally empower the children at their institution. Government authorities used to provide suggestions and ways to handle the issues with the children.

Case 4: Superintendent

He has been working as the Superintendent for three years and staying in the institution and his family. According to him, the children are anxious about society's stigma towards HIV patients, as the fear of being infected keeps others away. Thus, they feel a sense of discrimination and isolation. People don't like them to work, especially in shopping malls, the hotel industry, mechanical works and driving taxis/auto rickshaws.

Individual health issues like opportunistic infection, skin infections, T.B., and tiredness make them depressed. High viral load gives way to fungal skin infections, which don't get cured completely. They feel bad about their odd appearance due to these skin problems. They usually say, "I may die anytime". Fear of death grabs them almost all the time. They wish to get married but decide not to marry because of their HIV status. They don't think that they can marry and have non-infected children.

Love and counselling are essential elements for supporting them. The institution ensures that they can live like others with proper medication, nutritious food, exercise, yoga and meditation.

Case 5: President

He has been the President of the institution for the last five years. He is active in providing various services for Children living with HIV. According to him, the children face fear and lack of love and hope; some have suicidal tendencies; they wonder why so many tablets they have to take at this age. Some face depression, and some do not like to talk, very silent. There is no motivation to study. Some think we will die, why to learn, face psychological distress; some are very hyperactive, emotional, and attached to the caregivers or parents.

The institution has employed counsellors to deal with the above behavioural distress. The children have various sports activities like hockey, football, volleyball, cricket, and indoor games. Hobby classes, courses in magic, music classes, origami, zen tangles, poster making, greeting card making and glass painting are also available to keep their interest high.

The senior boys know something is wrong with their bodies, so constant fear lingers with them. Some have married after leaving home in their early 20s.

Regular counselling and making them focus on studies and English language skills, motivation are the key factors. After eighteen years, when they leave, the institution supports them with an educational grant of fifty thousand rupees for higher studies. They also tell them and support children who are not interested in studies to become small entrepreneurs.

Empathize with children, listen to them patiently, teach them to be confident and face all problems. They allow children to express in action and spirit, making them comfortable even if they make mistakes or mischief. They give them opportunities to have a home committee meeting, and they express their needs. They listen to their needs, ask them if they prefer movies or picnics, send them shopping with pocket money to learn about buying and limitations in purchase power. They teach them problem-solving, teamwork, helping each other, respect for elders and sponsors.

Government deals with emotional wellbeing and advise children to behave and listen to caregivers. They support all for their ART medicines, inform about counselling and child rights, NGOs maintain the child's rights are with due diligence.

RESULTS

QUALITATIVE ANALYSIS

The thematic analysis of case studies of the respondents resulted in generating four themes. Figure 1 depicts the frequency distribution bar diagram of the codes, and Figure 2 shows its Pie chart. The themes are summarized as follows:

(a) Emotional problems

Children living with HIV are prone to various emotional problems. It includes anger, fear, sadness, dissatisfaction, disagreement, temperedness, stubbornness, feeling blamed by others,

short-time lonely situations; don't like to have daily medication, and feel wrong about their parents & society. Sometimes have missing feelings and think that they don't have anyone to love and care. Some face depression, and some do not like to talk, are very silent; some have suicidal tendencies.

Figure 1 Frequency Distribution Bar Diagram of the Codes

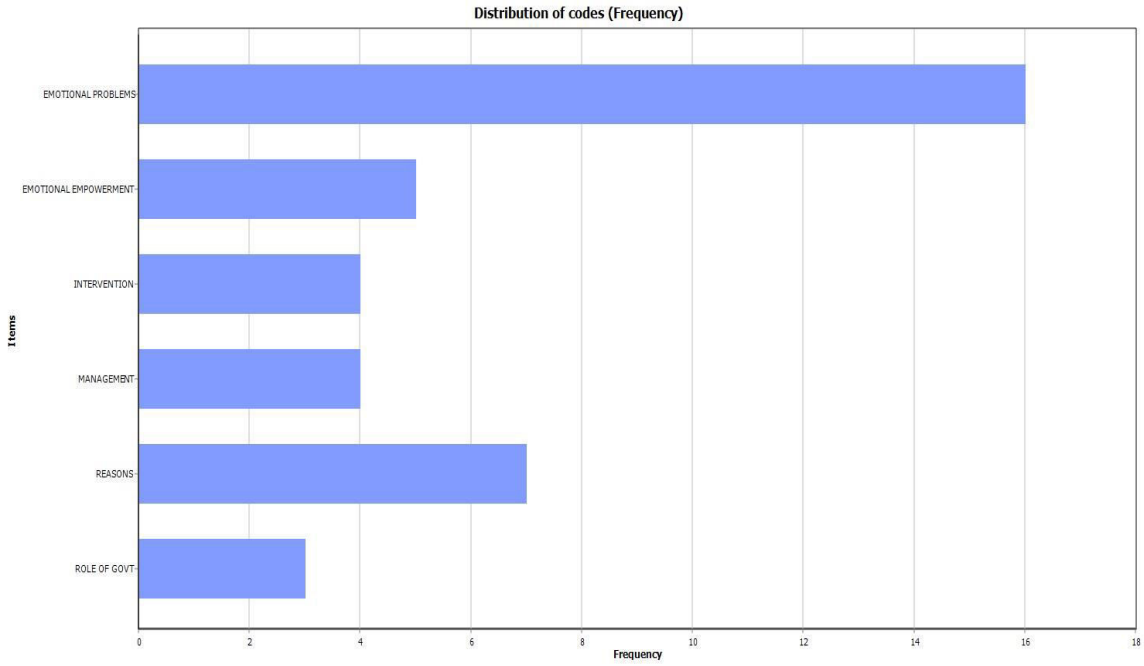
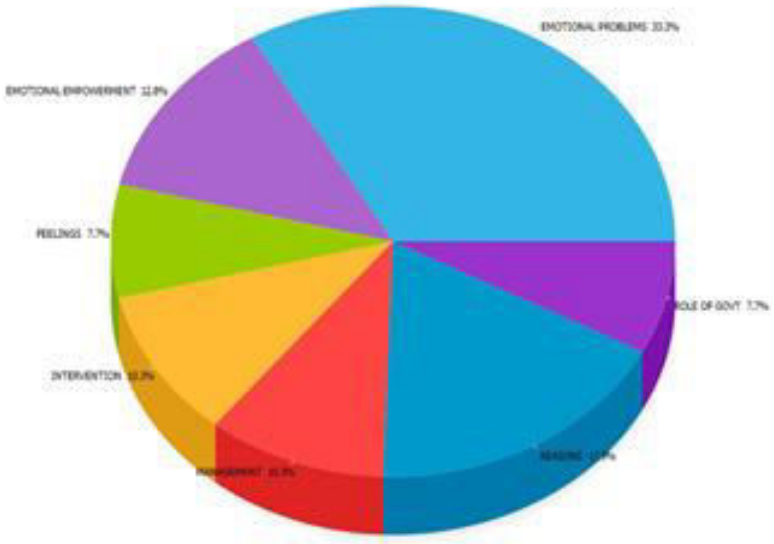


Figure 2 Pie-chart of Frequency Distribution of the Codes



Some of them ask the caregivers why it happened to me?

They wonder why so many tablets they have to take at this age.

The children feel bad about their odd appearance. They wish to get married but decide not to marry because of their HIV status. They feel a sense of discrimination and isolation. The elder boys fear their academic and future life, like how they should walk or choose. One of

the inmates thinks that his weak health condition may affect his future life. As he is taking medicines, he believes that others may criticize him. He fears death and sickness and becomes very sad when he sees anyone sick; his body temperature shoots up and becomes normal after encouragement or counselling services.

He feels that "Who will help me?"

He usually needs an environment change, so going to a park, garden, or church for a silent prayer or relaxation time.

They usually say, "I may die anytime".

Fear of death grabs them almost all the time. Some think we will die, why to learn, face psychological distress; some are very hyperactive, emotional, and attached to the caregivers or parents.

(b) Reasons

The various reasons for emotional disturbances among Children living with HIV include individual health issues like opportunistic infection, skin infections, T.B., and tiredness.

They know something is wrong with their bodies.

They have an emotional attachment towards their departed parents. The stigma of the society towards HIV patients, and the fear of being infected, keep others away.

People don't like them to work, especially in shopping malls, the hotel industry, mechanical works and driving taxis/autorickshaws.

High viral load gives way to fungal skin infections, which don't get cured completely. They don't know that they can marry and have non-infected children.

(c) Emotional Empowerment

The children are emotionally empowered, employing (a) Daily moral lessons, (b) Yoga classes, (c) Need-based one to interactions, and (d) Need-based counselling is given. The institution provides different teaching sessions for (a) encouraging others, (b) how to participate in groups events, (c) to have good habits & respecting others, (c) to develop volunteering, serving, apology habits, obedience, listening attitude, (d) to establish friendly nature & thanking habits, and (e) produce the best behaviour

The institution has employed counsellors to make the children feel comfortable, showing more respect and love. Focusing on studies and English language skills are also vital factors in this regard. One of the inmates responded that he could manage himself by prayer and family & friends support.

Love and counselling are essential elements for supporting them.

More advice, motivation and counselling emotionally empower the children at the institution.

The institution ensures that they can live like others with proper medication, nutritious food, exercise, yoga and meditation. Children have various sports activities like hockey, football, volleyball, cricket, and indoor games. Hobby classes, courses in magic, music classes, origami, zen tangles, poster making, greeting card making and glass painting are also available to keep their interest high.

Empathize with children, listen to them patiently, teach them to be confident and face all problems.

They allow children to express themselves in action and spirit, making them comfortable even if they make mistakes or mischief. They give them opportunities to have a home committee meeting, and they express their needs. They listen to their needs, ask them if they prefer movies or picnics, send them shopping with pocket money to learn about buying and limitations in purchase power. They teach them problem-solving, teamwork, helping each other, respect for elders and sponsors.

They provide career guidance to enable them to choose their future and help them achieve that even financially. After eighteen years, when they leave, the institution supports them with an educational grant of fifty thousand rupees for higher studies. They also tell them and support children who are not interested in studies to become small entrepreneurs.

(d) Role of Government and other organizations

The role or support of various Governmental/Non-governmental organizations are (i) Child welfare committee provides legal assistance (ii) District child protection unit provides service or inspections to run the institution with complete rules, regulations & norms, (iii) Local primary health centre conducts need-based health camps/treatment/ awareness, (iv) ART centre provides ART treatment & medicines every month, and (v) Local Police department/ Panchayat / Fire provides need-based protection.

Government authorities used to give the Institutional caregivers suggestions and ways to handle the issues with the children. They deal with the children's emotional wellbeing and advises them to behave and listen to caregivers. They support all for their ART medicines, advice about counselling and child rights.

QUANTITATIVE DATA ANALYSIS

The statistical analysis of data obtained from the questionnaire provides insights regarding the emotional status of children living with HIV.

Table 1 Socio-demographic Profile of Children Living in the Institution

Variable	Variable Category	**Frequency**	**Percent**
Age	10 – 12 Years	3	15
	12 – 14 Years	3	15
	14 – 16 Years	8	40
	16 – 18 Years	6	30
Religion	Hindu	17	85
	Christian	3	15
	Muslim	0	0
Gender	Male	20	100
	Female	0	0
	Transgender	0	0
Duration of Stay in institution	Below 1 Year	2	10
	1 – 3 Years	9	45
	3 – 6 Years	6	30
	More Than 6 Years	3	15
Emotional Maturity	Extremely Stable	0	0
	Moderately Stable	4	20
	Unstable	3	15
	Extremely Unstable	13	65

Table 1 shows the respondents' descriptive statistics according to their religion, gender, and duration of stay in the institution.

Table 2 Correlation between age & duration of stay in the institution with Emotional Maturity

Emotional Maturity					
Variables	N	Mean	Std. Deviation	Pearson Correlation	Sig
Age of Respondent	20	15.20	2.29	-0.46	.043*
Duration of Stay in Institution	20	3.5625	2.57	-0.53	.016*

Table 2 shows the Correlation between age and duration of stay in the institution with the Emotional Maturity of the Children living with HIV. The Pearson Correlation Coefficient value share -0.46 for the age of the respondents and -0.53 for the duration of stay in the institution, which is significant at <0.05 level. Hence, there is a negative correlation between age and duration of stay in the institution with the Emotional maturity scale value of the Children living with HIV. As the Emotional maturity scale value depicts the degree of emotional immaturity, age and duration of stay are positively related to the children's emotional maturity. As their age and duration of stay in the institution increase, Emotional Maturity also increases and vice-versa.

Table 3 Correlation between the various domains of Emotional Maturity

Variables	1	2	3	4	5	6
1. Emotional Instability		.721**	.642**	.679**	.595**	.888**
2. Emotional Regression	.721**		.662**	.616**	.539*	.873**
3. Social Maladjustment	.642**	.662**		.663**	.284	.784**
4. Personality Disintegration	.679**	.616**	.663**		.452*	.837**
5. Lack of Independence	.595**	.539*	.284	.452*		.704**
6. Emotional Maturity	.888**	.873**	.784**	.837**	.704**	

Table 3 shows the relation between the various domains of Emotional Maturity, i.e., Emotional instability, Emotional regression, Social maladjustment, Personality disintegration and Lack of independence. The Pearson Correlation Coefficient values of the five domains are 0.888,0.873, 0.784, 0.837 and 0.704, respectively, which are significant at <0.05 level, indicating a strong positive correlation with Emotional immaturity of children.

Other Findings

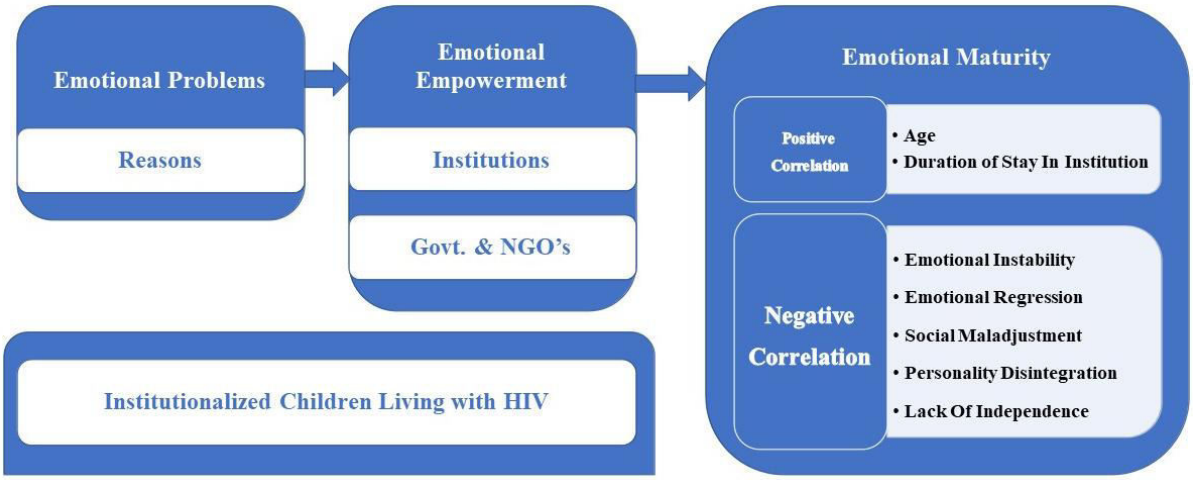
- 65% of respondents are extremely unstable (an emotional maturity score of 107-240)
- The mean score of emotional maturity of the respondents is 119 (extremely unstable)
- No respondent belonged to the category of extremely stable (emotional maturity score of 50 – 80)

- The mean age of the respondents is 15.2 years
- Mean duration of the respondent's stay in the institution is 3.6 years
- All the respondents are male
- 85% of the respondents are Hindus
- 70% of respondents disagree with the opinions of their group
- 65% of respondents are dissatisfied with themselves
- 60% of respondents think that people hesitate to take their help in any work
- 60% of respondents feel that they are self-centred
- 50% of respondents hate others
- 50% of respondents avoid joining in social gatherings
- 50% of respondents like to be alone a lot

CONCEPTUAL FRAMEWORK

The Emotional maturity of children living with HIV can be improved by (a) assessing the various emotional problems they face and their reasons, (b) emotionally empowering them by providing care for those children and other stakeholders. Emotional maturity is greatly influenced by the children's age and duration of stay in the institution. Emotional instability, emotional regression, social maladjustment, personality disintegration and lack of independence may negatively influence their emotional maturity. Figure 3 depicts the conceptual framework of this study.

Figure 3 Conceptual Framework of the Study



DISCUSSION

Children living with HIV feel a sense of discrimination and isolation. The stigma of the society towards HIV patients, and the fear of being infected, keep others away. People don't like them to work, especially in shopping malls, the hotel industry, mechanical works and driving taxis/auto rickshaws. About fifty per cent of the respondents avoid joining in social gatherings and like to be alone a lot. Moreover, sixty per cent of the respondents think that people hesitate to receive their help in any work. According to Legesse Tesemma et al. (2019), several social problems such as stigma, poverty, depression, and substance abuse pose numerous barriers to the normal activities and interests of the people living with HIV/AIDS.

Fear of death grabs them almost all the time. Facing and understanding their possible death are significant challenges faced by Children living with HIV. Vranda & Mothi (2013) opines that the child's cognitive and emotional maturity often determines their level of awareness

about their mortality and coping skills and defences to face this reality. More than coping with their mortality, the children have to cope with the death of their loved ones living with HIV/AIDS. They have an emotional attachment towards their departed parents. Sometimes they may have missing feelings and think that they don't have anyone to love and care.

One reason for emotional disturbances among Children living with HIV includes individual health issues like opportunistic infection. Tesfay et al. (2015) also suggest that many different factors, including symptoms of the virus, side effects of HAART, and opportunistic infections, cause challenges related to physical, psychological, and socio-cultural problems.

Isolation and social conflict are essential Quality of life concerns for people living with HIV irrespective of the care setting (Foebel et al., 2015). Institutionalized children exhibit aggressive behaviour. About forty per cent of the respondents feel that they are short-tempered and stubborn. They become angry towards the other children and caregivers. The Child Welfare Committee members will send those children who quarrel with fellow inmates to other institutions.

Some children face depression, while some have suicidal tendencies. Counsellors can play a vital role in making the children feel comfortable, showing more respect and love. Love, personal care and attention are essential elements for supporting them. Guidance, counselling and motivation emotionally empower the children at the institution. According to Anouk etal. (2013), children living with HIV experience severe life events that affect their psychosocial wellbeing. Hence, it is essential to encourage children to have a positive outlook on life, which can help make full use of their support groups.

About forty per cent of the respondents feel that they are exhausted. They think that their weak health condition may affect their future life. They get tired after engaging in various physical activities, thus requiring some time for relaxation. Many people living with HIV/AIDS find it challenging to attend to daily living tasks, participate in moderate to vigorous physical activities, or have sufficient energy or vitality to engage in an active social life while managing HIV/AIDS. Fatigue or low energy is associated with both physical and psychological morbidity (Breitbart et al., 1998) and low Quality of Life (QOL) in persons with HIV/AIDS (Zinkernagel et al., 1999).

LIMITATIONS

- The researcher conducted the study over a small population, so generalizations may not be possible.
- As the researcher collected data online due to COVID restrictions, Institutional caregivers' help was sought and could not interact with the respondents.
- The researcher did not have access to the children's family members, as the study was conducted in an Institution.

CONCLUSION

The childhood stage of development is the critical period where emotional maturity develops. Family, peer groups, schools, and broader society are the major influences contributing to children's emotional development. In the present circumstances, children face difficulties in life, especially those living with HIV/AIDS. These difficulties give rise to many emotional problems that need to be addressed effectively by employing Governmental, Non – governmental and community support programmes. Effective interventions and emotional empowerment techniques are essential to support them. The institutions can help them live like others through proper medication, nutritious food, exercise, yoga and meditation. Caregivers and Counsellors can enhance the emotional wellbeing of these children.

Funding: None

Conflict Interest: None

Acknowledgements: Sincere thanks to the Institutions and the Respondents for accepting to be part of this study, especially during the pandemic phase.

REFERENCES

Anabwani, G., Karugaba, G., & Gabaitiri, L. (2016). Health, schooling, needs, perspectives and aspirations of HIV infected and affected children in Botswana: A cross-sectional survey. *BMC Pediatrics*, *16*(1), 106. https://doi.org/10.1186/s12887-016-0643-5

Amzel, A., Toska, E., Lovich, R., Widyono, M., Patel, T., Foti, C., ... &Altschuler, J. (2013). Promoting a Combination Approach to Paediatric HIV Psychosocial Support. *AIDS*, *27*(2), 147–157.

Bandason, T., Langhaug, L. F., Makamba, M., Laver, S., Hatzold, K., Mahere, S., Munyati, S., Mungofa, S., Corbett, E. L., & Ferrand, R. A. (2013). Burden of HIV among primary school children and feasibility of primary school-linked HIV testing in Harare, Zimbabwe: A mixed-methods study. *AIDS Care*, *25*(12), 1520–1526. https://doi.org/10.1080/09540121.2013.780120

Bele, S. D., Valsangkar, S., & Bodhare, T. N. (2011). Impairment of nutritional, educational status and Quality of life among children infected with and belonging to families affected by human immunodeficiency virus/acquired immune deficiency syndrome. *Vulnerable Children and Youth Studies*, *6*(4), 284–292. https://doi.org/10.1080/17450128.2011.608439

Breitbart, W., McDonald, M. V., Rosenfeld, B., Monkman, N. D., & Passik, S. (1998). Fatigue in ambulatory AIDS patients. *Journal of Pain and Symptom Management*, *15*(3), 159–167. https://doi.org/10.1016/s0885-3924(97)00260-1

Campos, J. J., Frankel, C. B., & Camras, L. (2004). On the nature of emotion regulation. *Child Development*, *75*(2), 377–394. https://doi.org/10.1111/j.1467-8624.2004.00681.x

Carr, R. L., & Gramling, L. F. (2004). Stigma: A health barrier for women with HIV/AIDS. *The Journal of the Association of Nurses in AIDS Care: JANAC*, *15*(5), 30–39. https://doi.org/10.1177/1055329003261981

Chan, B. T., Pradeep, A., Prasad, L., Murugesan, V., Chandrasekaran, E., Kumarasamy, N., Mayer, K. H., & Tsai, A. C. (2017). Association between internalized stigma and depression among HIV-positive persons entering into care in Southern India. *Journal of Global Health*, *7*(2). https://doi.org/10.7189/jogh.07.020403

Charles, B., Jeyaseelan, L., Pandian, A. K., Sam, A. E., Thenmozhi, M., & Jayaseelan, V. (2012). Association between stigma, depression and Quality of life of people living with HIV/AIDS (PLHA) in South India—A community based cross sectional study. *BMC Public Health*, *12*, 463. https://doi.org/10.1186/1471-2458-12-463

Cohen, J., Reddington, C., Jacobs, D., Meade, R., Picard, D., Singleton, K., Smith, D., Caldwell, M. B., DeMaria, A., Hsu, H.-W., Children, the M. W. G. on S. of H. in, Health, M. D. of P., & Prevention, the C. for D. C. and. (1997). School-related Issues Among HIV-Infected Children. *Pediatrics*, *100*(1), e8–e8. https://doi.org/10.1542/peds.100.1.e8

Foebel, A. D., Hirdes, J. P., Lemick, R., & Tai, J. W.-Y. (2015). Comparing the characteristics of people living with and without HIV in long-term care and home care in Ontario, Canada. *AIDS Care*, *27*(10), 1343–1353. https://doi.org/10.1080/09540121.2015.1058893

Gopakumar, K. G., Bhat, K. G., Baliga, S., Joseph, N., Mohan, N., & Shetty, A. K. (2018). Impact of care at foster homes on the health-related Quality of life of HIV-infected children and adolescents: A cross-sectional study from India. *Quality of Life Research*, *27*(4), 871–877. https://doi.org/10.1007/s11136-017-1726-y

Henning, M., Kirk, C. M., Franchett, E., Wilder, R., Sezibera, V., Ukundineza, C., & Betancourt, T. (2017). Over-age and underserved: A case control study of HIV-affected children and education in Rwanda. *Vulnerable Children and Youth Studies*. https://www.tandfonline.com/doi/abs/10.1080/17450128.2017.1400785

Kumar, R., & Kumar, S. (2013). Psychosocial problems of children with HIV AIDS. *University of Mysore*.http://shodhganga.inflibnet.ac.in:8080/jspui/handle/10603/36408

Legesse Tesemma, A., Girma Abate, M., Hailemariam Abebo, Z., & Estifanos Madebo, W. (2019). Determinants of Poor Quality of Life Among Adults Living with HIV and Enrolled in Highly Active Antiretroviral Therapy at Public Health Facilities of Arba Minch Town Administration in Southern Ethiopia. *HIV/AIDS (Auckland, N.Z.)*, *11*, 387–394. https://doi.org/10.2147/HIV.S227244

Manhas, C. (2014). Self-esteem and Quality of life of people living with HIV/AIDS: *Journal of Health Psychology*, *19*(11). https://doi.org/10.1177/1359105313493812

Mayes, S. d., Handford, H. a., Schaefer, J. h., Scogno, C. a., Neagley, S. r., Michael-Good, L., & Pelco, L. e. (1996). The relationship of HIV status, type of coagulation disorder, and school absenteeism to cognition, educational performance, mood, and behavior of boys with hemophilia. *Journal of Genetic Psychology*, *157*(2), 137–151. https://doi.org/10.1080/00221325.1996.9914852

Nirmal, B., Divya, K. R., Dorairaj, V. S., & Venkateswaran, K. (2008). Quality of life in HIV/AIDS patients: A cross-sectional study in south India. *Indian Journal of Sexually Transmitted Diseases and AIDS*, *29*(1), 15.

Nyamathi, A. M., Garfin, D. R., Shin, S. S., Ekstrand, M. L., Yadav, K., Carpenter, C. L., & Sinha, S. (2019). Depression, social support, and stigma as predictors of Quality of life over time: Results from an Asha-based HIV/AIDS intervention in India. *AIDS Care*, *31*(5), 563–571. https://doi.org/10.1080/09540121.2018.1563281

Parchure, R., Jori, V., Kulkarni, S., & Kulkarni, V. (2016). Educational outcomes of family-based HIV-infected and affected children from Maharashtra, India. *Vulnerable Children and Youth Studies*, *11*(4), 332–338. https://doi.org/10.1080/17450128.2016.1218097

Peter, E., Kamath, R., Andrews, T., & Hegde, B. M. (2014). Psychosocial Determinants of Health-Related Quality of Life of People Living with HIV/AIDS on Antiretroviral Therapy at Udupi District, Southern India. *International Journal of Preventive Medicine*, *5*(2), 203–209.

Singh, Y., & Bhargava, M. (1990). *Manual for Emotional Maturity Scale*. National Psychological Corporation, Agra.

Steward, W. T., S, C., Singh, G., Panicker, S. T., Ta, O., E, H., & Heylen, E. (2011). Depression is not an inevitable outcome of disclosure avoidance: HIV stigma and mental health in a cohort of HIV-infected individuals from Southern India. *Psychology, Health & Medicine*, *16*(1). https://doi.org/10.1080/13548506.2010.521568

Tesfay, A., Gebremariam, A., Gerbaba, M., & Abrha, H. (2015). *Gender Differences in Health Related Quality of Life among People Living with HIV on Highly Active Antiretroviral Therapy in Mekelle Town, Northern Ethiopia*. BioMed Research International; Hindawi. https://doi.org/10.1155/2015/516369

Vranda, M. N., & Mothi, S. N. (2013). Psychosocial Issues of Children Infected with HIV/AIDS. *Indian Journal of Psychological Medicine*, *35*(1), 19–22. https://doi.org/10.4103/0253-7176.112195

Zhou, E., Qiao, Z., Cheng, Y., Zhou, J., Wang, W., Zhao, M., Qiu, X., Wang, L., Song, X., Zhao, E., Wang, R., Zhao, X., Yang, Y., & Yang, X. (2019). Factors associated with depression among HIV/AIDS children in China. *International Journal of Mental Health Systems*, *13*(1), 10. https://doi.org/10.1186/s13033-019-0263-1

Zinkernagel, C., Ledergerber, B., Battegay, M., Cone, R. W., Vernazza, P., Hirschel, B., & Opravil, M. (1999). Quality of life in asymptomatic patients with early HIV infection initiating antiretroviral therapy. Swiss HIV Cohort Study. *AIDS (London, England)*, *13*(12), 1587–1589. https://doi.org/10.1097/00002030-199908200-00024

How to Cite this Article: Thomas, R., & Sultana, A. S. (2021). Emotional Maturity of Institutionalized Children Living With HIV: A Crosssectional Study. *National Journal of Professional Social Work*, 22(2), 96-109. https://doi.org/10.51333/njpsw.2021.v22.i2.269