

DEVELOPMENT OF SELF-ESTEEM AMONG HIV-POSITIVE PREGNANT THAI WOMEN: ACTION RESEARCH

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Received February 2005; accepted June 2005.

ABSTRACT

This action research applied Human Caring Theory and mutual collaboration to come up with a model for developing self-esteem among ten HIV-positive pregnant women in Thailand. Four stages of self-esteem development process were identified beginning with the participants' recognition of their HIV-positive result: a) Stage I: from "Shock/unexpected" or "As expected" to "Acceptance and stop thinking about abortion"; b) Stage II: from "Concealing" to "Disclosure"; c) Stage III: from "Fear of spreading HIV virus to baby/hoping that baby will be free from HIV" to "Gaining of willpower due to anti-HIV medication and the research project participation"; and d) Stage IV: "Self-reliance" and "High self-esteem." Interventions appropriate for each stage were described. The research revealed a salient independent role for nursing professionals in promoting the development of self-esteem among HIV-positive pregnant women.

Keywords : Development of self-esteem, HIV-positive pregnant Thai women.

INTRODUCTION

As of the end of 2003, at least 40 million people have suffered from HIV infection worldwide (US Department of Health and Human Services, 2004). In Thailand, pregnant women make up the most rapidly growing group among individuals who are HIV positive (Thailand Ministry of Public Health, 2002). The rates of HIV infection among pregnant women more than

doubled from 1989 to 1998, especially for those with low income (Thailand Ministry of Public Health, 2002). People with HIV often feel stigmatized and insecure, particularly because, so far, there has been no curative treatment for the HIV virus. Combined with this knowledge, the virus can lead them to feel hopeless, vulnerable, and depressed with low self-esteem.

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Self-esteem, or a sense of self-worth, is a learned phenomenon and part of a lifelong growth process (Rosenberg, 1989). As an attitude about oneself, it can be either negative or positive as a product of the interactions of a person's health, culture, society, family, and interpersonal relationships. When a person has high self-esteem, she or he has a sense of self-confidence, self-respect, and self-satisfaction (Pryor, 2001).

In the past, scholars believed that self-esteem was a stable construct. More recently, longitudinal studies have revealed that self-esteem is actually dynamic across the life span (Roberts and Capsi, 2001; Robins et al., 2002). It can be influenced by life circumstances, relationship experiences, life situations, health problems, shifting social circumstances, social status/roles, life review, and self-reflection (Erlen et al., 2001; Trzemieski et al., 2004). For example, studies have found that work satisfaction and a higher position from a promotion at work are associated with increased self-esteem (Elliott, 1996; Mortimer et al., 1982). Feeling loved and accepted by others can yield a sense of self-worth, thus increasing a person's self-esteem (Harter, 1999; Leary and Downs, 1995; Trzemieski et al., 2004). Life review can boost self-esteem among adults living with AIDS and its effect has been found to last over 12 months (Erlen et al., 2001).

Self-esteem is highly sensitive and can be developed through the recognition of one's strengths as well as learning from one's mistakes (Solomon, 1992). This means that self-esteem as a developmental process utilizes metacognition. Metacognition, or thinking about thinking, is an essential skill that helps a person to learn by thinking about her/his own thought processes and identifying what might work best for her or him in different situations (Feldman, 2003). In our research study, self-reflection was encouraged under the concept of metacognition as a way to facilitate HIV-positive pregnant women's self-esteem development.

Caring and emotional support from others also were applied throughout the whole project since there is evidence that they can bolster a person's self-esteem (Harter, 1999; Leary and Downs, 1995). This is particularly important for pregnant women due to the increased physical and psychological demands of childbearing (Barnett and Slade, 1991).

Development of self-esteem is particularly important for HIV-positive pregnant women in Thailand for three main reasons: First, to be able to competently care for herself and her expected baby, a pregnant woman needs to have a positive attitude about herself. An HIV-positive woman tends to have low self-esteem and is likely to feel less confident, less competent, and more dependent on others in her maternal roles (Sawatphanit et al., 1999). Secondly, self-esteem is strongly related to depression (Chen, 1996; Fontaine and Jones, 1997). There is evidence that people who live with HIV and are depressed tend to have a faster progression of the disease due to low CD4 counts than those who are not depressed (Evans et al., 1997). Thirdly, HIV infection is now considered a chronic illness in developed countries because anti-HIV drugs are available there. In developing countries, however, the infection is still perceived as a death sentence due to the unaffordability of anti-HIV drugs (UNAIDS/WHO, 2003).

Thailand is a developing country situated in Southeast Asia with a limited financial budget. A relatively small quantity of anti-HIV drugs (as compared to the number of HIV patients in Thailand) has been donated mainly by the US Centers for Disease Control (CDC) with the main purpose of experimentation. HIV-positive pregnant women in Thailand begin to receive anti-HIV drugs at 28 weeks gestation, or much later than women in developed countries. The participants in our research project received a drug cocktail of Zidovudine and Nevirapine through a study supported by the American CDC to examine

whether or not receiving the drug cocktail later in their pregnancy would work as effectively as receiving the drug cocktail early in pregnancy (Thailand Ministry of Public Health, 2002).

Because of the limited and experimental nature of drug treatment in Thailand, the potential benefits of developing self-esteem among HIV-positive Thai women can be seen in their importance. This action research study aimed to increase self-esteem of HIV-positive pregnant women in Thailand. We hoped that increasing self-esteem would decrease the participants' depression levels. Higher self-esteem and lower depression levels might not only direct the women away from any suicidal ideas or attempts, but also help them maintain a satisfactory level of CD4 to slow down the disease progression.

This study used action research as an attempt to bridge the gap between theory, practice, and research. According to Holter and Schwartz-Barcott (1993), regardless of any differing epistemological stances, action research should include four central characteristics: a) mutual collaboration between the researcher and participant; b) solution of practical problem; c) change in practice; and d) development/refinement of theory. Action research includes three main approaches: a) *technical collaboration*; b) *mutual collaboration*; and c) *enhancement* (Holter and Schwartz-Barcott, 1993).

METHODOLOGY

The Human Caring Theory as proposed by Jean Watson (1988) was used as the theoretical guideline. The *mutual collaboration* approach, an action research method, was applied as our methodological framework (Holter and Swartz-Barcott, 1993). As stated in the Watson's Caring Model (1988), "*Nursing is an art and a human science that focuses on the meaning of the health-illness experiences of human beings. As person, the nurse and patient are composed of mind, body,*

and spirit. It is the spirit or soul that is the essence of person and is the base of the inner strength and power necessary for transcendent, evolutionary experiences" (Morris, 1996, p. 292).

Mutual collaboration involves mutual and ongoing relationships between the researchers and participants in identifying possible problems, factors affecting such problems, and ways or interventions to address the problems in a specific setting. Changes from this approach tend to last longer than the technical collaboration approach, yet "the changes tend to be connected to the [other] individuals directly involved in the change process and, therefore, the interventions tend to be short lived when these individuals leave or when many new people enter the system" (Holter and Schwartz-Barcott, 1993, p. 304). This study applied this approach where mutual understanding was the focus of collaboration. Descriptive new knowledge, the development of a new theory, or the refinement of an existing theory was expected.

The participants consisted of ten pregnant women, who were recruited in the study by purposive sampling. They visited the antenatal clinic at a provincial hospital in Thailand. The inclusion criteria at the time of admission of participants to the research project were: a) being pregnant with HIV-positive; b) asymptomatic HIV; c) no present signs and symptoms of severe emotional and psychological disturbance (such as, clinical depression, manic-depressive disorder, schizophrenia).

Procedures: This action research was conducted from February 2001 to February 2002.

The research procedures were approved by two appropriate Internal Review Boards. HIV-positive pregnant women were informed about their blood results (Western Blot method) at the hospital, accompanied by hospital counseling. After the counseling, the counselor informed them about this research project and that, if they were inter-

ested, the research team would inform them of its objectives, methods, and the human rights protocol. An informed consent clearly stating the option to withdraw from the study at any time point was signed by all women. The research team consisted of a registered nurse (RN) who had worked at the prenatal clinic for over seven years and the authors of this article, each of whom had at least five years experience in maternity nursing, were trained to provide appropriate counseling, and had at least a master's degree in nursing.

In order to apply Watson's Caring Model (1988) and to be caring, one needs to respect others and be kind with a tender loving attitude. To do this, one needs to understand oneself before understanding others. Therefore, the researchers imagined that they were told that they were HIV-positive then they closed their eyes for 15 minutes and thought about their feelings and what they would do from there. The research team shared their feelings and all agreed that it was extremely painful, especially when thinking about the unborn child. The imagination practices and discussion took place two days before the project began. These helped the researchers to at least partly understand how the participants would feel.

The research team interviewed each woman on the first day she agreed to participate in the study, using a structured-questionnaire to collect demographic data. In-depth interviews were applied to all prenatal visits. A grand-tour question, "How do you feel today?" was asked as the opening question every time. Following questions flowed from the immediate context. The research team asked the woman to take her time. She could ask questions about her pregnancy, HIV infection, or any concerns she had during any interview or prenatal visit.

All interviews were tape-recorded and the tapes were destroyed after the transcription. No real names of the participants appeared on the

transcriptions. The average time of interviews ranged from 45-90 minutes. The team also used field notes.

The research team provided the ten women with consecutive clinical services of 5-12 times within 3-7 months. The RN and the principal investigator (PI) were the main persons to be with the women almost every time. The co-investigators alternatively accompanied the RN to provide services to the women. The initiatives of forming trusting relationships between the research team and the participants went well from the first day for each participant. This might be explained by noting that the research team applied human care and transpersonal caring, the crux of Watson's Theory of Care (Watson, 1988), to our participants.

The researchers' preconceptions were bracketed during the interactions. For example, the participants were not judged by their appearance, life story, or mannerisms. This is crucial, especially for the first-time interaction, so that a trusting relationship in the project can begin without biases from the researchers' side and with trust from the participant's side.

Data analysis:

1. The sample demographic data were analyzed by descriptive statistics.

The ages of the ten pregnant women ranged from 18 to 29 years old. All of them were Buddhists. None had a college degree. Six were from a nuclear family and four were from an extended family. All but one had a monthly income of less than US\$200. Eight were married and two were divorced.

2. Qualitative data were analyzed by using constant interpretive analysis (Glaser and Strauss, 1967), including five steps: a) the tape-recorded interviews were transcribed verbatim; b) initial coding of data; c) similar codes were grouped into categories; d) categories were compared and

clustered; e) themes were generated by linking meaningful categories. Again, the researchers' preconceptions were bracketed during the analysis.

RESULTS

The research process was based on *mutual collaboration* among the HIV positive women and the researchers and consisted of four steps: a) assessment of self-esteem, physical and psychological problems, and knowledge, attitudes, and practices of the women; b) problem identification; c) intervention identification; and d) evaluation.

All participants identified their psychological problems as their first priority. They stated that they felt worthless and depressed. One participant said, "My biggest problem now is not about my body, but my *soul*. I want to feel confident like I used to be. I don't want to be obsessed with the disease like I can't do anything. I keep thinking about it all day long. I want to be free from my crazy mind." The researchers came up with the term "Low self-esteem" and the participants agreed that the term hit the nail on the head. All but two wanted to keep the baby and five stated that they would not want to live any more, if it were not for their babies. The participants voiced their desire to: a) get to know other HIV-positive pregnant women; b) learn how to cope with the confusion in their mind; c) learn more about the disease, its treatment, and the prevention of spreading the virus to the baby and other people; and d) participate in religious activities or read religious stories. Details for each intervention will be explained further.

Stages after the HIV recognition

Four stages were emerged from the data.

Stage I: from "Shock/unexpected" or "As expected" to "Acceptance and stop thinking about abortion"

Most women felt shocked, ashamed, and afraid that their family and friends would reject

them. They were confused and could not believe their ears. One woman cried very hard and said, "I am totally confused! I never thought that I would get the HIV virus from my husband. I am completely shocked."

Two participants were thinking about aborting the fetus. They said that they did not want a baby, as they believed that their baby would certainly get infected. Five out of ten had suicidal thoughts. This result is similar to that of another qualitative study in Thailand in that about half of the 39 Thai mothers in Jiraphet's (2001) study thought about or attempted suicide upon being identified as HIV positive.

Interventions in Stage I

Four interventions were identified by the participants and research team during this stage.

1. Health education. All of the women were aware of the three transmission modes of the HIV virus, and that the disease can be fatal. Other than that, they did not know more about the disease. They stated that they wanted to learn more about HIV/AIDS. The research team provided them with knowledge about the symptoms and stages of HIV/AIDS, as well as vertical transmission rates both with and without taking anti-HIV medicine. The two women who wanted to have an abortion decided to think again and talk with their husbands after learning that not all babies born to HIV-positive mothers will be infected. Later, both participants decided to keep the baby and enrolled in the antiretroviral project. All of the ten participants agreed to join the antiretroviral project. However, one was excluded because of her anemic conditions. A brochure of facts about HIV/AIDS created by the research team was given to all women to keep and review at home. Questions regarding HIV infection were answered by the research team, either at the clinic or through telephone conversations. Knowledge of HIV

prevention transmission was discussed. Condom use during sexual activities and tubal ligation after delivery were identified by the women.

2. **Counseling.** At the study hospital, an obstetrician acts as a counselor to confirm that a patient is HIV positive based on the Western blot result. The obstetrician spends approximately 10-15 minutes with the patient for post-test counseling. Such a short time cannot fulfill a woman's psychological and emotional needs for such a critical time of her life. In most provincial hospitals in Thailand, physicians usually have a high caseload and cannot afford spending more than 15 minutes with a patient. High caseloads for Thai health professionals in general prevent people with HIV from receiving adequate long-term counseling and emotional support. The RNs in this particular prenatal clinic also had a high caseload. There were only two RNs and two nurse aids who worked with around 1,200 patients per month. The office hours were 8 am to 12 noon (Monday to Friday). This means that each woman received prenatal services from an RN for only six minutes per visit. In general, the nursing services included physical examination (including vital signs, fundal height measurement, and fetal heart sound check-ups), albumin-sugar urine test, and weight measurement. Obviously, extra help from the researchers functioning as RNs and counselors helped to improve care for the study participants.

Proactive interventions toward preventing suicide attempt were applied in this study. First, the research team followed the World Health Organization guidelines on HIV counseling (WHO, 2001). Along with knowledge and experiences in guidance and counseling of the researchers, a quiet and private atmosphere was provided so that the women (and sometimes with their families) could reflect on issues and concerns they had. The researchers listened to them attentively, with caring and respect for them as a whole person who

processed their own body, mind, and spirit. Caring, listening, respect, and empathy were paramount throughout the whole study.

Secondly, a problem of the unavailability of telephone services regarding HIV information from government hospitals was brought up by one participant and was confirmed by others. To address this problem, the researchers' cellular phone numbers were given to all of the women. They were encouraged to call the research team anytime, 24 hours a day and seven days a week, especially during the first six weeks after the acknowledgement of their HIV status. This time frame was decided on based on previous research which showed that the most critical time for suicidal ideas among seropositive individuals was the first 4-6 weeks (Chandra et al., 1998). The participants could also make an appointment to talk with one of the researchers before their prenatal visit if they wanted to. All participants highly appreciated this offer. Two participants stated that they had heard about a new hotline initiative of the Thai government available to anyone when they felt prone to suicide. By knowing that the research team was always there for them helped them to feel better and more secure. They stated that they would feel more comfortable calling someone they knew, rather than someone on a hotline in general.

Concerning disclosure of the HIV result, all participants were encouraged to think about whether or not they would like to disclose their status to someone. Previous research findings about disclosure were shown to them. For example, Bennetts and co-workers' (1999) reported that HIV positive women who had not disclosed their HIV status to others were three times more likely to get depressed than those who had disclosed their status. Information about rejections from others as a consequence of disclosure was also given to the participants. At first, three participants thought that they could not find someone to turn to, but

at the end of the research project, only one participant did not reveal her status to anyone, being afraid that she would be rejected. Living with her half-sister and being divorced made it hard for this participant to find someone to talk to. She was not close enough to her half-sister to reveal her status and stated that having the research team to talk with was emotionally saving for her, being unable to talk with anyone else.

Promoting factors of self-esteem

There were two promoting factors that facilitated self-esteem in the first stage:

1. The knowledge of infection risks. The two women who had realized that they were at risk of getting infected were not completely shocked from their HIV result. They could accept it as fact much more easily than the others who were not aware of their risks.

2. Hardiness personality, the characteristic of looking at a difficulty as challenging, finding ways to control the situation if possible, and committing oneself to reaching set goals (Kobasa et al., 1982), was a major asset that helped two women in the study to move on with their pregnancy stages and life circumstances more easily than the other participants. Their self-esteem development process also moved much quickly in a positive direction than the others. One of these two had felt ahead of time that she might become infected. Thus, as noted above, this awareness played an important role in helping her to accept her status. But, hardiness personality doubled her strength. The other woman never thought before that she would receive the virus from her husband, who had just left her. She told the research team that, *"I am a hard worker and always love to work. I also like my co-workers and know that they really like me. I am a happy person who loves my life. Therefore, I will move on even with HIV. I want to keep my baby and know that she or he will be my inspiration."*

These women with knowledge of their infection risks and a hardiness personality were relatively calm and could absorb a lot of information concerning the disease and stated that they were ready to face any future negative circumstances. When giving counseling to these two women, the research team praised them for their emotional strength and reassured them that they had a good asset in themselves. This was helpful for them to fight with the disease and remain happy.

Counteracting factors of self-esteem

The fact that HIV infection is fatal and that there is no cure for the disease caused two women to think about aborting their fetus and committing suicide. Working with these two women, the research team let them vent their feelings, coached them to engage in self-reflection, encouraged them to find psychological resources, and motivated family participation.

One intervention should be mentioned again here is the telephone communications/hotline available for the participants from the research team. For instance, the team received a phone call from one participant who felt bad and wanted to hurt herself. The principal investigator (PI) talked with her and found out that she had been arguing with her husband about their life with HIV. After listening to her over half an hour, the participant began to calm down and was asked if she wanted to meet with the PI at that time. However, the participant stated that she felt much better, and that there was no need to meet. She thanked the PI for being a good listener, and helping her. A week later, the team met with the participant and found that she was not having any suicidal ideas. A month later, both participants who had suicidal thoughts stated that they wanted to move on with their life.

Stage II: from "Concealing" to "Disclosure"

After the first stage, most of the participants

were still keeping their HIV infection a secret and struggling with their thoughts about whether or not they should tell anyone about it. They said they were so afraid that they would be rejected and stigmatized from the disclosure. They believed that with disclosure: a) their family would not love them anymore and they could be expelled from the family; b) their friends would drift apart from them; c) their community would not accept them or their baby; d) and they would be fired from work. In the Thai culture, family bonding and interactions are considered extremely important. It is shameful to be rejected by the family. Therefore, the most significant reason for the participants to keep their secret from others concerned their families.

Some women eventually chose to disclose their HIV result to family and friends. Most told their husband. Some revealed their status to either their own parents or of their husband's parents. One woman who had lost her parents a long time ago told everyone else in the family, including her husband, aunts, nieces, and nephews. This woman was happy with the support from everyone except her husband. Another woman did not receive support from her husband. All other women who disclosed their status to others received satisfying emotional support from their families.

Interventions in Stage II

1. Counseling and Self-help Group. In this stage, counseling was of great importance, particularly for those who felt uncertain and afraid of revealing their HIV status to others. They wanted to keep the secret to themselves. Self-reflection was encouraged. One couple was motivated to analyze their own situation. They reflected upon the pros and cons of telling the truth about their HIV status and they finally revealed the truth to the husband's mother. As expected, they received much help from her. The mother showed them

her abundant and unconditional love and support, which made the couple, feel relieved and much happier.

Another woman who had broken up with her husband several months earlier told us that she did not have anybody except her half-sister. She could not decide whether or not she should disclose her HIV status to her half-sister after weighing the pros and cons, and she felt so smothered by not being able to talk to other people about her situation. Since some participants stated that they wanted to get to know other HIV-positive pregnant women, the investigators asked her whether or not she wanted to get to know seropositive pregnant friends. Right away, she said that she wanted to join a group. As in other studies including self-help groups (Chung and Magraw, 1992; Erik et al., 1992), most of the present study participants were satisfied with the interactions among themselves. They were glad that they could share their feelings and experiences with others.

2. Coping techniques. Some women voiced their interest in learning about coping techniques. The research team motivated each participant to search for suitable coping techniques for herself. Techniques they came up with included praying to supreme spiritual-beings, going to the temple, meditating, reading, shopping, exercising, and doing errand work. The team also offered books regarding Buddhism to those who were interested in reading religious stories. Most participants found the books helpful. Each woman used a few different techniques in combination. They affirmed the usefulness of the techniques they applied in releasing their worries.

Promoting factor of self-esteem

In this stage, family support was found to be very important. One woman told us that both her husband and her mother were her great supporters. As soon as she revealed her HIV

status, her mother stated, *"That's ok, honey. Whatever you are, I always love you and will help you take care of your baby. Don't worry about anything."*

Counteracting factor of self-esteem

The beliefs of some women in the study about being infected hindered their self-esteem. They felt that people in general hated HIV-infected patients and thought that most patients receive the virus through promiscuous or homosexual behavior and drug use. They felt that they themselves were classified as part of "bad people" by society. At the time of the study, all participants stated that they had no other sexual partner, except for their husband. The research team reminded nine participants who had received the virus through their husband and asked them to reflect on whether or not they themselves were "bad people" by their own definition. They all answered, "No." Because of the worries they had sometimes it was hard for the women to think reasonably. However, when they were guided toward the importance of thinking critically and reasonably, they could better understand their reality and circumstances. Self-reflection was found to be a useful technique to help participants raise their self-esteem.

Stage III: from "Fear of spreading HIV virus to baby/hoping that baby will be free from HIV" to "Gaining of willpower due to anti-HIV medication and the research project participation"

In this stage, most women were obsessed with their concerns about vertical transmission. They were so worried that their babies would get infected through the pregnancy. One woman stated, *"Last night I tossed and turned all night long worrying about my baby getting the virus from me. I am so worried!"* The women asked us a lot of questions and vented their fears.

Interventions in stage III

1. Health Education. All participants stated that they wanted to learn about the antiviral medication used at the hospital. Information was given to them about the effectiveness of antiviral medication from previous studies, which was found to reduce perinatal transmission from 1:4 without any prophylactic treatment to 1:12 with antiviral remedies (Centers for Disease Control, 1995; Fiscus et al., 1996; Frank et al., 1998; Sperling et al., 1996). The researchers suggested that they adhere to the treatment to receive the full potential of the medication.

2. Emotional support and self-help group. Emotional support was given to all women in this stage. The support was provided by the family, other women in the self-help group, and the research team. Some received support from more than one source. One lady who did not reveal her HIV status only received support from the research team.

Concerning the self-help group, at one point three participants and the PI visited one participant who had given birth to a baby a couple days before. She was very happy when they arrived. The three group members were glad to see that the baby looked healthy and stated that they had a good feeling that their babies would look healthy too. They were not aware before the visit that babies born to HIV-positive mothers could look this healthy.

Promoting factor of self-esteem

1. Hope. Most women felt that they got hope from taking antiviral medications. They indicated that their baby was an inspiration in their life. Knowing that their baby had a good chance of not being infected by the disease uplifted them spiritually. Most women said that their unborn baby was a reminder that life goes on and the baby became their focus. This result

was found to be congruent with another study among non-pregnant HIV-infected women with older children. Bunting and Seaton (1999) revealed that non-pregnant women who had participated in an antiviral drug project stated that their children were a way for them to focus on the positive aspects of their lives. They were a reason for the women to move on and were a hindrance to committing suicide.

2. Family relationship. Family relationships in this study could have either a negative or positive effect on a participant. Most participants had a good relationship with their family and perceived family support as being helpful and helped them move on. However, one woman had a problem in her relationship with her husband. Most of the times that she saw the research team, she seemed unhappy with her life. She thought about abortion often. She cried almost every time with us, saying that she did not have anybody who understood her, except for the research team. Her husband met with the research team a few times when we met with the participant. The researchers encourage the couple to discuss and reflect on some facts together and attempted to decrease their crossed communication. The couple seemed to understand each other a little more each time.

Counteracting factor of self-esteem

Another counteracting factor besides family problems is economic hardship. Most women in this study were of low socioeconomic status. As part of the self-care instructions, all women was informed that milk is a good resource for calcium and protein. One woman voiced her concern about not having enough money to get it. She told us that her husband was looking for a job and that she could not afford to buy milk, although she wanted to eat and drink well for her baby. The research team gave her 100 baht (Thai currency),

which is approximately US\$2.50 so that she could buy some milk. Three US dollar would buy six 8-ounce bottles of whole milk in Thailand. It is quite acceptable in Thailand for health professionals to give personal money to a patient once in a while so that the patient can get on with their life. Thailand does not have a system that helps its people like welfare, Food Stamps, or WIC in the United States. A month later, the participant's husband got a job and they did better financially. This woman said that she felt so grateful to us and that we helped her to feel better about herself. She felt that the team did not see her as being worthless, although she was HIV-positive.

Stage IV: "Self-reliance" and "High self-esteem"

At this stage most of the women had come to feel that they had more control over their life. They stated that because of the process of journeying along with the support of their HIV-positive friends, and research team, they felt that they started to have a stronger sense of self-worth and self-respect. Eight women stated that, at this point, they felt positive that they would be able to stand on their own without the research team. They stated that they had learned from the researchers how to think critically and use reason to deal with their life circumstances and that there are people who care for HIV-positive women like them. They now knew that not all people hate HIV patients. Caring from the research team, their peers, and their loved ones made them feel happy and wanted.

Interventions in Stage IV

One observation is worth noting. Some women shifted back and forth between Stages III and IV in their thoughts regarding the disease and their own circumstances. It is not unusual among HIV-positive patients to phase back and forth between feeling discouraged and encouraged

(Hall, 2001). Therefore, useful techniques to help them gear toward the positive side of the mind were stressed by the research team. First, they were assured that this back-and-forth transformation was a normal process for most HIV-positive individuals. Secondly, the team reminded them to keep using self-reflection as a tool to think critically and reasonably. Finally, they were guided on how to look for useful resources when they needed help in the future to get through difficult times.

Promoting and counteracting factors of self-esteem development

At this stage, promoting and counteracting factors were similar to those in Stage III. Hope and family relationship were identified as in Stage III.

SUMMARY

Most participants maintained that the research team had helped them to become more self-reliant and to feel better about themselves. A model for developing self-esteem was created based on the study (See Table 1).

Table 1. Model of self-esteem development.

Stage	Promoting factors of self-esteem	Counteracting factors of self-esteem	Interventions to promote self-esteem
I "Shock/unexpected" or "As expected" to "Accepting and stop thinking about abortion"	- Knowledge of infection risks - Hardiness personality	- Awareness of the fact that HIV infection can be fatal.	- Health education - Post-test counseling
II "Concealing" to "Disclosure"	- Family support	- A belief that people in general hate HIV-positive patients.	- Counseling and self-help group - Coping techniques
III "Fear of spreading HIV virus to baby/hoping that baby will be free from HIV" to "Gaining of willpower due to antiretroviral medication and the research project participation"	- Hope - Family relationship	- Economic hardship - Family relationship	- Health education - Emotional support and self-help group
IV "Self reliance and high self-esteem"	- Hope - Family relationship	- Family relationship	- Reassuring - Self-reflection - Looking for useful resources

DISCUSSION AND IMPLICATIONS FOR PRACTICE

This action research confirms new trends of thought on self-esteem which hold that self-esteem does not remain set like plaster (Trzsniewski et al., 2004). Rather, as revealed in this study, self-esteem can be enhanced through self-reflection and caring from others. Almost all participants in the study stated that they started to have an increased sense of self-worth, self-confidence, and self-reliance through self-reflection. Above all, they stated that they felt better about themselves knowing that other people care. In the Thai culture, such caring does not need to come from the family. Caring from health professionals, friends, or neighbors can really make a difference.

This present study is congruent with previous studies among HIV-positive women in terms of the self-help group. For example, a study of 12 HIV-positive American women revealed that ten of the women found a self-help group helpful for personal development (Health and Rodway, 1999). The women who participated in our self-help group stated that it helped them to feel better about their feelings and self-esteem in general.

The study goal to enhance the participants' self-esteem was met. A year after the project was over, the research team tried to follow up with all of the participants. Five had moved out of the area. The rest could be contacted via telephone. Three out of five stated that they were happy and were still applying what they learned from the team to deal with their life circumstances. All of their babies were doing well and the babies' HIV status was negative. The other two were not doing well psychologically at the time. The husband of one lady had just passed away from AIDS. However, she was getting help from her family emotionally and in taking care of the baby. The last woman's baby had some rashes, which worried her very much. The researchers advised her to take her daughter to see a pediatrician. She followed this advice and later told the team

that the rashes were caused by heat, not the virus. That knowledge gave her some peace of mind.

The team contacted these last two women a few more times. It sounded like they were still having their ups and downs, yet not so they felt like giving up hope. They said that, although they could not be peaceful all of the time, joining the research project had taught them about reality. They acknowledged that some people around them were supportive, but some were not. However, learning about the stories of their HIV-positive friends from the support group had motivated them to keep trying. They are not alone. A few women from the project were still keeping in touch and supporting each other well. One lady who had pondered suicide at the beginning of the research project revealed that if she had not joined the research project, she could have killed herself already. Now she was able to move on because she had her daughter as her hope and inspiration. Self-reflection was useful for her as a way to deal with difficult situations.

Although it might sound like the study was successful, this *mutual collaboration* approach does not of course guarantee lasting results. Holter and Schwartz-Barcott (1993) stated that "changes tend to be connected to the individuals directly involved in the change process and, therefore, the interventions tend to be short lived when these individuals leave, or when many new people enter the system" (p. 301). Likewise, now that our project has ended and our team cannot be with the women any longer, we cannot warrant that the effects of the interventions will be sustainable.

As life circumstances change, and especially if such changes can significantly influence a person in a negative way, people might need immediate support and their coping skills boosted. For this reason, it is strongly recommended that a special service similar to the present study be set up to provide continuing help for HIV-positive pregnant women. Such a service should be run by

at least four qualified RNs who can work on shifts and be available 24 hours a day, seven days a week, for emergency needs through telephone calls. Our project hotline probably saved two women's lives after their HIV status acknowledgement.

One drawback of this study is that it did not include family participation as much as the researchers wanted to. Often families of the participants did not have time to join the project because they did not earn much and had to work hard to support each other. For future research, it would be beneficial to get the family more involved. Strong family support is crucial to help HIV-positive people to move on in their lives.

In summary, special services for HIV-positive pregnant women should include counseling, self-help groups, self-reflection training, health education, family participation, and a hotline available after regular hours for emergency needs. A model for supporting self-esteem was created from this research project. It is not the perfect model, but it is an example. Interested nurses may apply it where helpful to their own practice. As with any model, it should be expanded so that new knowledge and new practices can emerge.

ACKNOWLEDGEMENT

This research was funded by The Faculty of Nursing, Burapha University, Thailand.

We would like to acknowledge: our research consultant, Assoc. Prof. Dr. Arphorn Chuaprapaisilp, Prince of Songkla University, Thailand, for her guidance and support, and Jeffrey Ross for editing the manuscript, and thanks to all mothers for their kind participation.

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