THE STUDY OF SELF-ESTEEM AMONG PATIENTS DIAGNOSED WITH SCHIZOPHRENIA ATTENDING THE OUT-PATIENT DEPARTMENT OF CECILIA MAKIWANI HOSPITAL IN THE EAST LONDON AREA

By

Ricarda Janet Durrheim

IN LUMINE TUO VIDEBIMUS LUMEN

A mini dissertation submitted in fulfilment of the requirements for the degree of Masters of Curationis

University of Fort Hare
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Department of Nursing Science

Fort Hare University

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Supervisor: NIN Magadla

DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work.

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Signature: ....

Date: 23/04/2010

Reflections

To laugh is to risk appearing the fool.

To weep is to risk appearing sentimental.

To reach out for another is to risk involvement.

To expose feelings is to risk exposing your true self.

To place your ideas, your dreams before the crowd is to risk their loss.

To love is to risk not being loved in return.

To live is to risk dying.

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To hope is to risk despair.

To try is to risk failure.

But risks must be taken, because the greatest hazard in life is to risk nothing.

He may avoid suffering and sorrow, but he simply cannot learn, feel, change, grow,

love, live.

Chained by his certitude, he is a slave, he has forfeited freedom.

Only a person who risks is free.

Author unknown

Abstract

Background

The objective of the current study was to determine the self-esteem of people who suffer from schizophrenia.

The study was aimed at gaining information about the self-esteem of the schizophrenic person living in the East-London area and seen by the psychiatrist at Cecilia Makiwane hospital during the year 2008.

The Method

The sample for this study consists of 32 participants, both male and female, the ages ranged between 37 – 80. They have all been diagnosed with schizophrenia for more than 10 years.

The method used in this study is a quantitative, non-experimental descriptive approach. The data collected was obtained using the Rosenberg Self-esteem Score. The data was analysed using a statistical programme called the statistical package for social scientists (SPSS).

Results

The results indicate that a healthy self-esteem does exist in the schizophrenic person. The distribution of the Rosenberg score, broken down by gender indicates that almost all the participants scored an average score on the Rosenberg scale.

This research concludes that self-esteem does not depend on gender. The score is not

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affected by the fact that one is male or female.

Likewise self-esteem does not depend on age; whether they are young or old.

Conclusion

Based on the results from the current study, the researcher proposes that more research is done on self-esteem and the schizophrenic, as the results went against what the literature said (Silverstone and Salsali 2003) stated that there is a vicious cycle between low self-esteem and the onset of psychiatric disorders, and the presence of a psychiatric disorder lowers the self-esteem. In this research 75% of the respondents had a healthy self-esteem.

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Chapter One: Orientation to the study

1.1 Introduction

The question this research asks: What are the levels of self-esteem in the schizophrenic patients in the East London area, those treated and seen by a psychiatrist at the Cecilia Makiwani hospital?

How is self-esteem affected by the age and gender of the schizophrenic person?

The hypothesis for this research is that the schizophrenic person has a lowered self-esteem. Age and gender will have an impact on their self-esteem.

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Self-esteem is an aspect of the self-concept and refers to the global evaluation of one's own characteristics and attributes (Sorgaard, 2002). Global self-esteem is typically defined as one's overall sense of worthiness as a person (Rosenberg, 1979).

Self-esteem is an important component of psychological health. Previous research suggests that most psychiatric patients suffer some degree of lowered self-esteem (Silverstone and Salsali, 2003). Low levels of self-esteem are not only a central cause of various psychological problems, but are also an important contributing factor to a multitude of social problems (Ward, 1996).

Reliable research on self esteem has been complicated due to the diversity of definitions and the many self-esteem measures being used, and the various factors

which influence it. The preponderance of evidence underscores the significance of self-esteem and its relationship to so many of the problems facing mentally ill people today. Previous research indicates that lowered self-esteem frequently accompanies psychiatric disorders. A low self-esteem is an etiological factor in many psychiatric conditions as well as in suicidal individuals (Overholser, Adams, Lehnert, Brinkman,1995).

Self-esteem has motivational qualities: people try to gain self-respect and avoid self-contempt (Rosenberg, 1979). In this study, the Rosenberg self-esteem score will be used to determine the self-esteem of the participants. The self report version of the Rosenberg Self-Esteem Scale remains the most widely used measure (Byrne, 1996). Self-esteem means having confidence in one's ability to think and cope with the basic challenges of life. It is a confidence in one's right to be successful and happy. The feelings of being worthy, deserving, entitled to assert one's needs and wants, achieve one's values and enjoy the fruits of one's efforts. Self-esteem affects one from the time one is born to the time one dies (Branden, 1994).

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The research design will be a quantitative, non-experimental descriptive approach. Descriptive research is used to obtain information concerning the current status of the phenomena being described; what exists with respect to variables or conditions in a situation. The variables in this research will be age and gender.

1.2 Background to this study

The background to this self esteem study is that persons suffering from mental disorders have been consistently found to have a lowered self-esteem, this occurs in several psychiatric illnesses, mainly anxiety disorders and depression. Silverstone and Salsali (2002) proposed in their study that there is a vicious cycle between low self-esteem and the onset of psychiatric disorders.

Therefore, one prediction that can be derived from this perspective is that an increase in symptoms results in a decrease in life satisfaction.
In schizophrenia, the lack of psychosocial functioning is related to a low self-esteem. Self-esteem is one of the most important factors in preventing recurrence and in ensuring long-term success in rehabilitation among patients with chronic schizophrenia (Seo, Ahn, Byun and Kim, 2006).

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According to Silverstone et al (2003) there is a limited number of research studies regarding self-esteem of psychotic patients, although a study by Krabbendam, Jansen, Beck, Bijl, deGraad and Van Os, (2002) revealed that low self-esteem may be a risk factor for developing psychosis.
In a study by Smith, Fowler, Freeman, Bebbington, Bashforth, Garety, Dunn, Kuipers (2006), it is confirmed that low mood, low self-esteem, and negative schematic beliefs can contribute to the development of symptoms of psychosis.

Exhibiting signs of a mental disorder may be interpreted as personal failure or inadequacy, leading persons to adjust their view of self accordingly (Rosenberg, Schooler and Schoenbach, 1989).

A recent study provides some support for the reciprocal effects between life satisfaction and self-concept among persons with mental illness (Markowitz, 1998). Consequent to the above research, two additional relationships are predicted: as symptoms increase, self-esteem and efficacy decrease, and as life satisfaction increases, self-esteem and efficacy increase.

1.3 Research questions

Research questions may be stated as follows:

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What are the levels of self esteem among schizophrenic patients undergoing treatment at Cecilia Makiwane Hospital?

What is the ratio of males to females with a low self-esteem compared to a healthy self-esteem and a high self-esteem?

Do more males or females have a healthy self-esteem?

Will age play a role in self-esteem?

1.4 Purpose/Aim of this research study

The purpose of this study is to describe the levels of self-esteem among schizophrenic patients treated at Cecelia Makiwane Hospital outpatient psychiatric clinic.

1.5 Key Concepts

Key concepts used in this research: Self-esteem, schizophrenia, and out patient.

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Self-esteem is a term used in psychology to reflect a person's overall evaluation or appraisal of his or her own worth.
Self-esteem encompasses beliefs (for example, "I am competent-incompetent") and emotions (for example, triumph-despair, pride-shame). Behavior may reflect self-esteem (for example, assertiveness-shyness, confidence-caution).

Psychologists usually regard self-esteem as an enduring personality characteristic (trait self-esteem), though normal, short-term variations (state self-esteem) occur. Self-esteem can apply specifically to a particular dimension (for example, "I believe I am a good writer, and feel proud of that in particular") or have global extent (for example, "I believe I am a good person, and feel proud of myself in general"). Synonyms or near-synonyms of self-esteem include: self-worth, self-regard, self-respect, self-love (which can express overtones of self-promotion), and self-integrity. Self-esteem is distinct from self-confidence and self-efficacy, which involve beliefs about ability and future performance. (Wikipedia)

Schizophrenia is a psychiatric diagnosis that describes a neuropsychiatric and mental disorder characterized by abnormalities in the perception or expression of reality. It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking with significant social or occupational dysfunction. Onset of symptoms typically occurs in young adulthood, with around 0.4–0.6% of the population affected. Diagnosis is based on the patient's self-reported experiences and observed behavior. No laboratory test for schizophrenia currently exists. (Wikipedia)

Outpatient: A patient who is not an inpatient (not hospitalized) but instead is cared for elsewhere - as in a doctor's office, clinic, or day surgery centre. (Webster's New World Medical Dictionary, 3rd Edition)

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1.6 Significance of this research study

The significance of this study is to document the levels of self-esteem among schizophrenic patients as most research focuses on other mental disorders and not schizophrenia, for example in a study by Silverstone and Salsali (2002) psychotic disorders were grouped together in a very broad category as other psychiatric disorders, and patients who were manic were also grouped in this category which elevated the results as the manic patients were found to have high levels of self-esteem. The researcher is interested particularly in the schizophrenic patient and to assess if it would be a possibility to implement self–esteem training into future treatment programs.

1.7 Summary

Chapter one introduces the topic of self-esteem and the schizophrenic person. It will highlight the importance of conducting this research and introduces the participants of the study.

Chapter two reviews previous studies done on self-esteem and the schizophrenic person.

In chapter three, the population that participated in the study, as well as the measurement instrument used in the study are discussed. Information about the coding of answers and finally the ethical considerations will be discussed.

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Chapter four provides an analysis of the data obtained. A discussion of the results in relation to the literature provided as well as the conclusion are discussed.

Chapter five is the conclusion of this research study

CHAPTER TWO: Literature Review

2.1 Introduction

The literature will be reviewed in order to understand the subject of self-esteem and the schizophrenic person and to explore the definitions and concepts.

2.2 Overview of Previous Research

Although deinstitutionalisation has enabled many people with serious mental illnesses to spend a lot of their time outside of the institutions, there has not been much research on the individual life of the psychiatric patient. In a study by Soraard, Heikkila, Vinding, Bjarnason, Bengtson-Tops, Merinder, Nilsson, Sandlund and Middelboe (2002) the experts set out to analyse the results of self esteem in a group of non-institutionalised people with schizophrenia. In their finding they identified anxiety, depression and affect balance as the strongest predictors of positive, negative and gross self-esteem, and having at least one close friend was associated with positive and gross self-esteem. According to this study variations in self-esteem were mainly explained by differences in anxiety, depression, affect balance, as well as the extent of satisfaction with the relations to one's family.

Deinstitutionalization is increasing the importance of community mental health services, resulting in increasing numbers of clients living in communities and more community-based psychosocial rehabilitation service agencies. This enhances self-esteem.

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A positive coping style can be critical to successful rehabilitation of psychiatric clients. Using structural equation modelling Kahng, Sang K, Mowbray, T Carol (2005) examined the relationships among clients psychological characteristics, self-esteem, and behaviours, and the role of self-esteem in mediating the relationships between psychological characteristics and behavioural coping. The sample consisted of 290 psychiatric clients recruited from 25 psychosocial rehabilitation service agencies. Conceptualizing self-esteem as an attitude toward the self and allowing one to use the paradigm of attitude theory in examining the mechanisms affecting and factors determinant of client's behaviours, healthy behavioural coping can be critical to success. According to attitude theory, behavioural coping is frequently determined by self-attitudes and psychological characteristics such as affective and cognitive traits. Individuals' psychological characteristics are critical to the attitude formation process, and affective and cognitive traits influence self-evaluations. Although it has not been applied exactly from the perspective of attitude theory, the modified labelling theory developed by Link (1989), accounts for the importance of cognitive traits, that is, beliefs in devaluation-discrimination as predictors of self-esteem.

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Earlier studies endorsing this model found that cognitive traits matter in the formation of self-esteem and coping behaviours. For example, consumers who highly endorse societal beliefs in devaluation-discrimination are more likely to evaluate themselves negatively. Thus, they can develop withdrawal social behaviours and lose motivation for rehabilitation. Emotional disturbance plays a critical role in self-labelling processes which frequently lead to lowered self-esteem (Thoits, 1985). Self-esteem defines self-attitudes because it reflects how individuals evaluate themselves. Attitudes can mediate the relationship between psychological traits and behaviours,

given that they are not only influenced by affective or cognitive traits, but involve behavioural and psychological reactions (Fiske, 1998).

Literature suggests that self-esteem can play a mediating role in that it is influenced by psychosocial factors. It is related to behavioural outcomes and psychological well-being, as well as relationship between global self-esteem and specific self-esteem (M Rosenberg, Schooler, Schoenbach, F Rosenberg, 1995).

A study by Lysaker, Tsai, Yanos and Roe (2007) suggests that global self-esteem among persons with schizophrenia may be negatively affected by stigma or stereotyped beliefs about persons with severe mental illness. The results revealed that the experience of greater levels of stigma was generally related to poorer self-esteem. Participants who accepted stereotyped beliefs tended to view themselves as less competent and tended to have less moral self-approval.

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In a study by Clarke and Kissane (2002) demoralisation is experienced as a persistent inability to cope, together with associated feelings of helplessness, hopelessness, meaninglessness, subjective incompetence and diminished self-esteem. It is arguably the main reason people seek psychiatric treatment, yet is a concept largely ignored in psychiatry. The aim in this study is to review and summarize the literature pertaining to demoralization in order to examine the validity of the construct. Demoralization is a clearly defined syndrome of existential distress occurring in patients suffering from mental and physical illness, specifically ones that threaten life or integrity of being.

A narrative review of demoralization and the related concepts of hope, hopelessness, and meaning were presented, drawing on a range of empirical and observational studies in the medical and psychiatric literature.

Demoralization has been commonly observed in the medically and psychiatrically ill and is experienced as existential despair, hopelessness, helplessness, and loss of meaning and purpose in life. Although sharing symptoms of distress, demoralization is distinguished from depression by subjective incompetence in the former and anhedonia in the latter. Demoralization can occur in people who are depressed as well as cancer patients who are not depressed and those with schizophrenia. Hopelessness, the hallmark of demoralization, is associated with poor outcomes in physical and psychiatric illness, and importantly, with suicidal ideation and the wish to die.

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According to Frank (1973) demoralization results from persistent failure to cope with internally or externally induced stresses that the person and those close to him expect him to handle. Its characteristic features, not all of which need to be present in any one person, are feelings of helplessness, isolation, and despair.

The person's self-esteem is damaged, and he feels rejected by others because of his failure to meet their expectations. Insofar as the meaning and significance of life derives from the individual's ties with persons whose values he shares, alienation may contribute to a sense of the meaninglessness of life. The most frequent symptoms of patients in psychotherapy are anxiety and depression; they are direct expressions of demoralization. At the heart of demoralization is a breakdown in coping. Lazarus and Folkman's model of stress and coping entails two key concepts – appraisal and

coping. Coping refers to mechanisms that regulate distress and is commonly considered in two categories, 'problem-focused' (e.g. information seeking, problem solving and direct action) and 'emotion-focused' (escape, seeking social support and cognitive reframing).

Helping a demoralized person is the role of every health professional and is achieved most importantly through a relationship characterized by empathic resonance, combined with good physical care and symptomatic relief. However, even in the absence of a cure or full relief of symptoms, suffering can be substantially relieved by a restoration of self-esteem and self efficacy that comes through increased competence and human connectedness. Demoralization is an important construct with established descriptive and predictive validity. A place needs to be found for demoralization in psychiatric categorization.

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The California legislature passed a bill creating the California Task Force to Promote self-esteem and personal and social responsibility. They set out to determine whether self-esteem, personal and social responsibility are the keys to unlocking the secrets of healthy human development so that they can get to the roots of the problem, and develop effective solutions for major social problems and to develop and provide for every Californian the latest knowledge and practices regarding the significance of self-esteem, personal and social responsibility. The Task Force believed that esteeming oneself and growing in self-esteem would reduce the epidemic levels of social problems which they currently face (Mecca et al 1989). Seven of the professors researched the above areas and the eighth professor summarized the results. The results were then published in a book titled "The Social Importance of

Self-Esteem" (Mecca et al 1983).

Even though the experts searched for a connection between low self-esteem and problematic behavior, they could not find a cause and effect link. However, more recent studies indicate a definite relationship between violent behavior and high self-esteem.

For persons with severe mental illness, controlling symptoms, regaining a positive sense of self, dealing with stigma and discrimination, and trying to lead a productive and satisfying life is increasingly referred to as the ongoing process of recovery. Drawing on psychiatric-medical and stress-social support models, and theories of self-concept and stigma, this study examine social-psychological processes in recovery from mental illness. Using longitudinal questionnaire data from 610 persons in self-help groups and outpatient treatment, Markowitz estimated a series of models of the relationships between key elements identified as part of the recovery process: symptoms, self-concept, and life satisfaction. The results show that these elements affect each other in a reciprocal manner. Moreover, findings indicate a key role for self-esteem, which mediates the effect of life satisfaction on symptoms.

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This study suggests general framework for examining processes involved in recovery from mental illness. The findings from this study also help confirm that self-concept, as both social product and social force is an important part of the recovery process. Consistent with self-esteem theory, Markowitz found that self-esteem has a positive effect on life satisfaction and a negative effect on symptoms (Fred Markowitz 2001).

2.3 Summary

This chapter provides an overview on the research done in the area of the self-esteem on the schizophrenic person. This overview indicated that

no published research on the topic of the self-esteem of schizophrenic within the South African context could be found.

In order to meet the objectives of this study, a well planned method needs to be implemented.

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Chapter three: Methodology

3.1 Introduction

This study describes the levels of self-esteem amongst schizophrenic patients who are treated at Cecilia Makiwane hospital by a psychiatrist. All the patients are undergoing treatment and appear to comply with medication compliance, as well as return dates to the clinics, all the participants are chronic schizophrenic persons, who have been on medication for longer than 10 years.

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Researchers Silverstone and Salsali (2003) suggest that psychiatric patients suffer some degree of lowered self-esteem. The researchers in this study did not cover the self-esteem specifically for the schizophrenic persons; the researchers looked at anxiety disorders and depression and grouped psychiatric conditions together into a broad category.

This research has investigated what the levels of self-esteem are amongst the schizophrenic population in the East London area of the Eastern Cape. It would be possible to expect the schizophrenic person to have a low self-esteem. The hypothesis for this research is that the schizophrenic person will suffer from a low self-esteem.

If it is found that the schizophrenic person has a low self-esteem, then practical skills could be incorporated into their treatment program to address these issues in order for the schizophrenic person to have confidence in their right to be successful and happy,

and to have confidence in their ability to think and cope with the basic challenges in life.

The Rosenberg scale was translated from English into Xhosa according to the parallel back-translation procedure (Brislin, 1986), in which a bilingual person translates the scale from its original language to the language under study. Another bilingual individual, who is unfamiliar with the original scale, re-translates this version back to the original language. To ensure a correct translation and avoid possible biases, the sequence just described should be repeated twice, four bilingual
people should carry out the parallel back-translation procedure, thus obtaining two pilot versions of the Rosenberg self-esteem score in Xhosa. Secondly,.the items thus obtained were assessed by a professor of languages who ensured that it had maintained the original meaning, and prepared the scale format and the instructions identically to the original version. In this translation, one person whose mother tongue is Xhosa translated it into Xhosa and then a person whose mother tongue was English translated it back. Thus, the Xhosa version of the consent form, letter and the Rosenberg self-esteem scale.

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3.2 Objectives of this research

The objectives of this research study are to:

Measure the level of self esteem on schizophrenic patients using the Rosenberg self-esteem scale:

Document the levels of self-esteem among schizophrenic patients.

Describe the levels of self-esteem amongst the schizophrenic patients who are treated at Cecilia Makiwane Hospital in the East London area of the Eastern Cape.

Having looked at the objectives for this research study, it is necessary to talk about the methodology.

3.3 Research Design

The research design has been a quantitative, non-experimental descriptive approach. Descriptive research is used to obtain information concerning the current status of the phenomena being described; what exists with respect to variables or conditions in a situation. The variables in this research are age and gender.

The question this research answers is; What is the levels of self-esteem of the Schizophrenic persons treated at Cecilia Makiwane hospital in East London area?

The research surveys have been conducted at the clinic where the patients get their treatment. The interview took the form of a structured interview and the set of interview questions were according to the Rosenberg self-esteem scale (Rosenberg, 1965).

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Participants were instructed to answer the questions according to how they typically or generally feel about themselves at the time of the interview. The questions or statements were read out aloud to the participants by the researcher, they had a board with the ratings in front of them, and they responded according to how they felt about themselves.

If the participant is Xhosa speaking then the questionnaire was asked in Xhosa, this was done by a Xhosa speaking person who the researcher had identified with the necessary skills and training to score a person on the Rosenberg self-esteem scale. The researcher then recorded the answers on the Rosenberg scale sheet. The researcher then totalled up the individual score and got a total out of 30.

The researcher then documented the participants age and gender. All questionnaires were coded as this will ensure confidentiality for the participants.

The researcher believed that the Rosenberg scale was a trustworthy instrument as it was used to assess depressed persons, all had a low score and the narsistic personality scored high on a trial of the tool. This is how it was found to be in the literature (Silverstone and Salsali, 2003). This tool was created to investigate the level of self-esteem. This tool has been in use since 1965. It has been found by other researchers namely Knut et al (2002), to be reliable and validity is good.

3.4 The Population

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The population was all the schizophrenic persons treated by the psychiatrist at Cecelia Makiwane hospital and treated in the psychiatric clinics.

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3.5 The Sample

The participants of the study were selected on the grounds that they are suffering from schizophrenia and treated by a psychiatrist in East London at Cecilia Makiwane hospital. They ranged between the ages of 37 to 80 years old. They were both male and female. They were selected conveniently.

The researcher spent a number of days attending the outpatient clinic, and every schizophrenic person who came into the clinic on that day was asked if he/she wanted to participate in the research study. The study was explained to them and consent signed (see annexure). The researcher then interviewed each person, in a one on one interview. Ten statements were read to the participant and they responded how best they felt it describes them. Privacy was ensured. The person was guaranteed that their

data will remain confidential as a coding system was used. This process shall continue until 32 participants were interviewed. This sampling strategy is known as a convenient sample.

The size of 32 participants was selected on the grounds that is study is a mini dissertation and for this purpose the amount of 32 will be sufficient for this study purpose.

3.6 Data Collection

The data was collected by conducting interviews with the participants. The questions the researcher asked was according to the Rosenberg self-esteem scale and these questions steered the interview to obtain the kind of data that answered the research question. The interview agenda for the structured interview consisted of ten questions, which require a response of either: Strongly agree, agree, disagree or strongly disagree. The data was captured by the researcher. If the participant was a Xhosa speaking person, the researcher utilized a person with the expertise of conducting an interview in Xhosa.

The setting was in an office at the clinic where confidentiality was maintained. The questions were read out to the participants and they then choose the response most appropriate to them.

The data was numeric data which is easy to capture and which was well structured (Mouton, 2005).

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3.7 Measurement

The research instrument used was the Rosenberg scale of self-esteem, which consisted of 10 statements to which participants provided ratings of agreement on scales ranging from strongly agree, agree, disagree and strongly disagree. The five questions/statements that are positive to a healthy self-esteem are:

1. I feel that I am a person of worth, at least on an equal plane with others.
2. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
6. I take a positive attitude towards myself.
7. On the whole, I am satisfied with myself.

The other five are negative to a healthy self-esteem. The questions/statements are:

3. All in all, I am inclined to feel that I am a failure.
5. I feel I do not have much to be proud of.
8. I wish I could have more respect for myself.
9. I certainly feel useless at times.
10. At times I think I am no good at all.

The Rosenberg self-esteem scale was found to be the most reliable tool in the assessment of self-esteem according to (Bagley and Mallick).

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3.8 Coding

The scoring structure for the Rosenberg self-esteem scale is as follows.

For statements 1,2,4,6 and 7

Strongly agree = 3

Agree =2

Disagree = 1

Strongly disagree = 0

For statements 3,5,8,9 and 10

Strongly agree = 0

Agree = 1

Disagree = 2

Strongly disagree = 3

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The scale ranges from 0 -30. Scores between 15 and 25 are within normal range, scores below 15 suggest low self-esteem.

Scores between 25 – 30 suggest a high self-esteem

See appendix one for the Rosenberg self-esteem scale.

The participants were coded from 1 -32 as they were interviewed.

3.9 Ethical Considerations

It shall was ensured that no harm came to the participants in this research study either physically, mentally or socially.

The participants were informed of the nature of the work and were requested to give their written consent.

It was important for anonymity and privacy to be guaranteed and honoured. A coding system was used to ensure anonymity and privacy.

It was ensured that nothing will be done to bring the institution into disrepute.

It was ensured that no data was falsified; the findings were presented exactly as they were found.

It was also ensured that no plagiarism occurred and that credit was given to other researchers work.

The researcher adhered to all the departmental guidelines at all times, so as not to bring the University into disrepute.

The researchers kept all information strictly confidential and used all measures necessary to ensure that the subjects' rights and the rights of others in the setting were protected.

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The research study proposal was presented to, and approved by, the Fort Hare institutional Review Board as well as, the department of health.

All of the interviews were coded to ensure confidentiality. The potential benefits of this study outweighed any potential risks to the subjects.

Chapter Four: Analysis of Data

4.1 Introduction

The data was analysed by the researcher and the results were put into tables and graphs to display results.

The statistician used a statistical program called statistical package for social scientists (SPSS). He did hypotheses tests, based on the sample data to find out the cause and effect of gender and age on self-esteem. He did a chi-square test for gender and age.

In order to come to a conclusion about the self-esteem of schizophrenics the data needed to be analysed and interpreted. At the outset, after all the data had been collected the researcher read and scored all the Rosenberg self-esteem scales according to the criteria set out by Rosenberg (1965).

The response rate was good as no one objected to being interviewed. The 32 respondents all willingly participated in this research study. The response rate was 100%.

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4.2 Characteristics of the respondents

Gender

There were 19 males (59% of all) and 13 females (41%).

Age

The age range was 37-80 years old, the mean and mode were 50 years and the median was 58. Only one patient was over 65 years of age. He was 80 years old.

The graphs and tables to follow:

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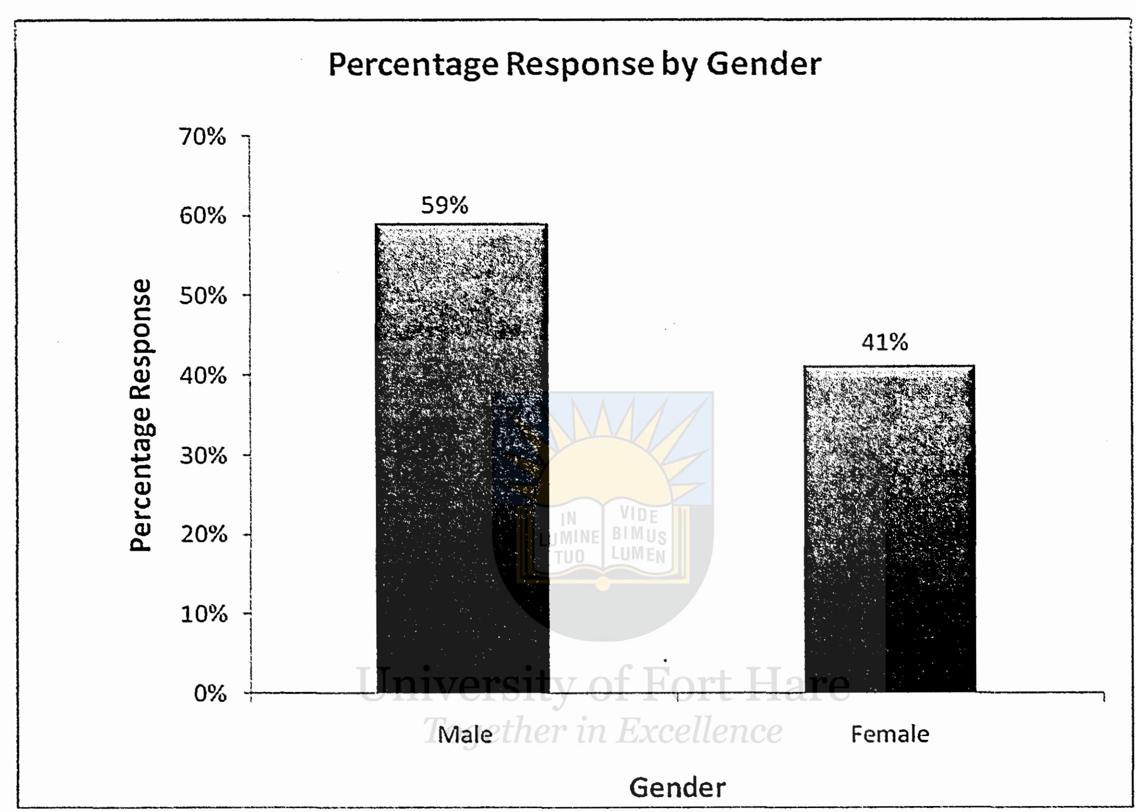
Graph 1: Percentage response by Gender



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As depicted by the bar graph, 59% of the participants were males as compared to their female counterparts, who constituted 41% of the sample.

Table 1: The distribution of sample according to gender

Male	19	59%
Female	13	41%

Table 2: The distribution of participants in age categories

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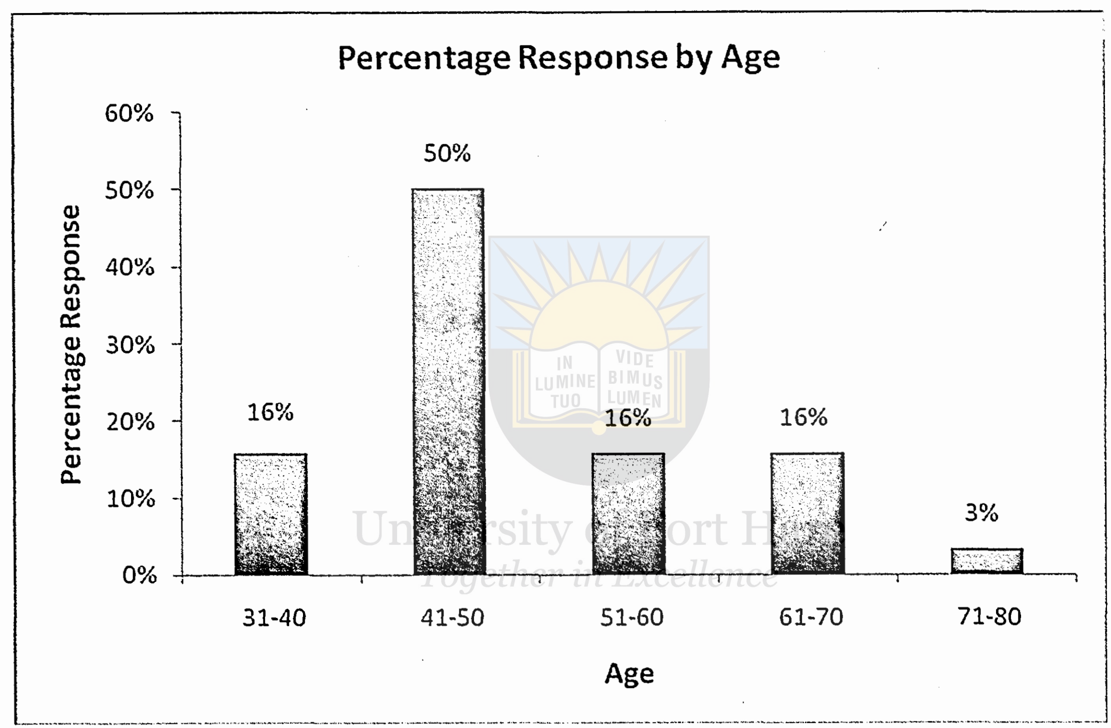
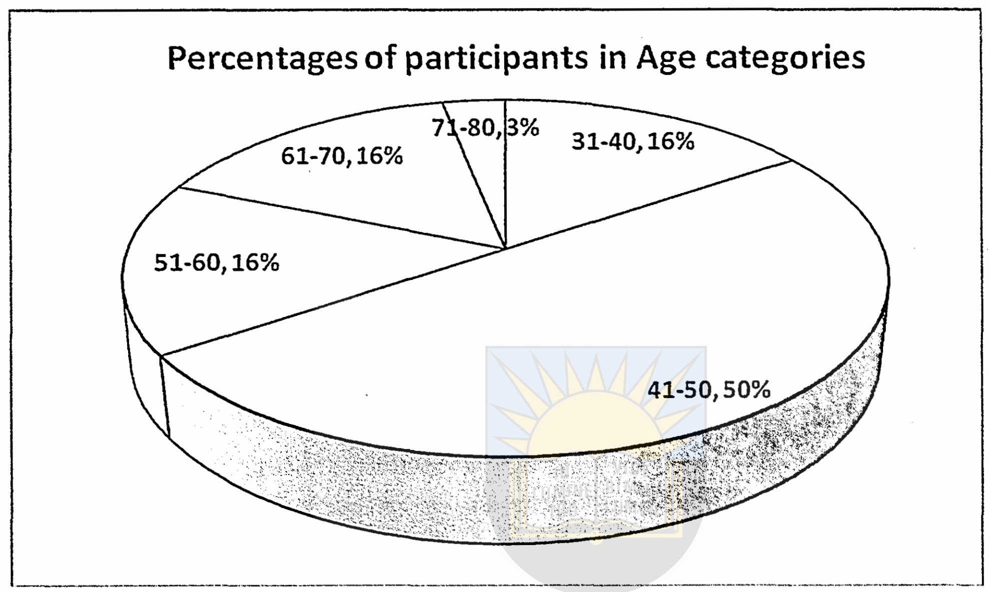
Age categories in years	Number of participants	% percentage
31-40	5	16%
41-50	16	50%
51-60	5	16%
61-70	5	16%
71-80	1	2%
Total	32	100%

Graph 2: Percentage response rate by age categories



Graph 3: Percentages of participants in age categories



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As shown by both the bar graph and the pie chart above, half of the sampled subjects belonged to the 41-50 age group with equal representation from the age groups 31-40, 51-60 and 61-70, each having 16% response. However, the least represented age group was the 71-80, with only 3% response.

Scores and Gender

Table 3: Score categories according to Gender

Score categories	Male No (n) (%)	Female No (n) (%)	Total No (n) (%)
0-15	4 (21%)	4 (31%)	8 (25%)
16-25	15 (79%)	9 (69%)	24 (75%)
Total	19 (100%)	13 (100%)	32 (100%)

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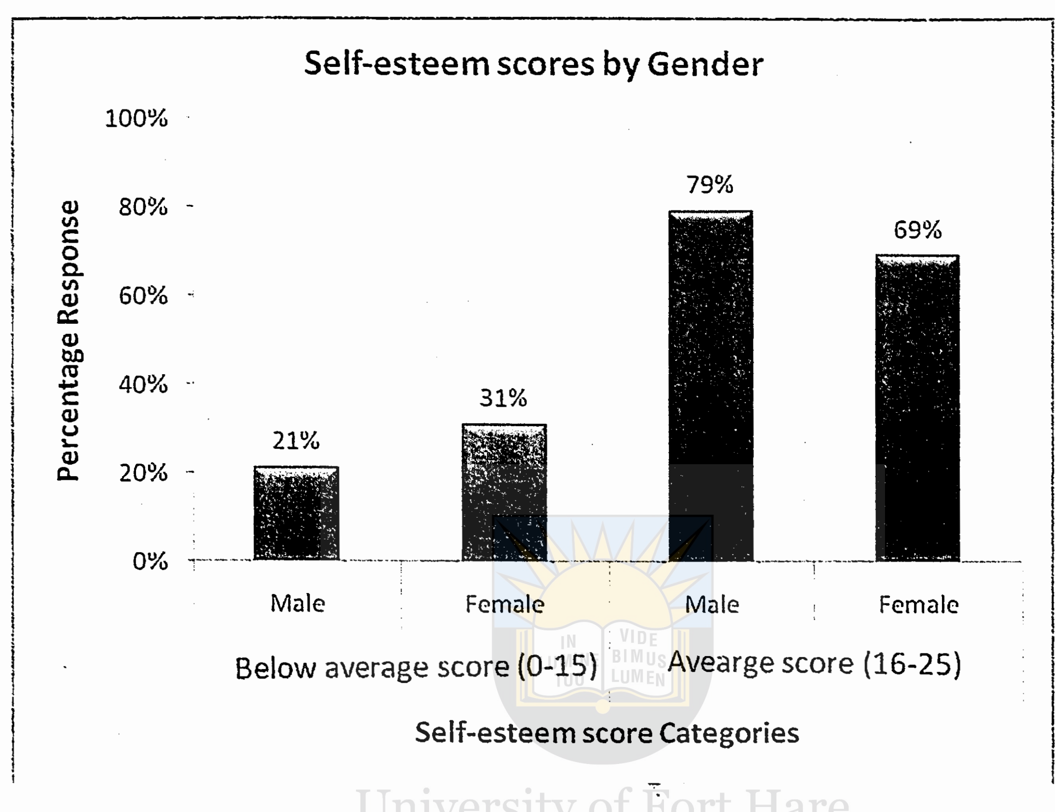
Graph 4: The self-esteem scores by gender



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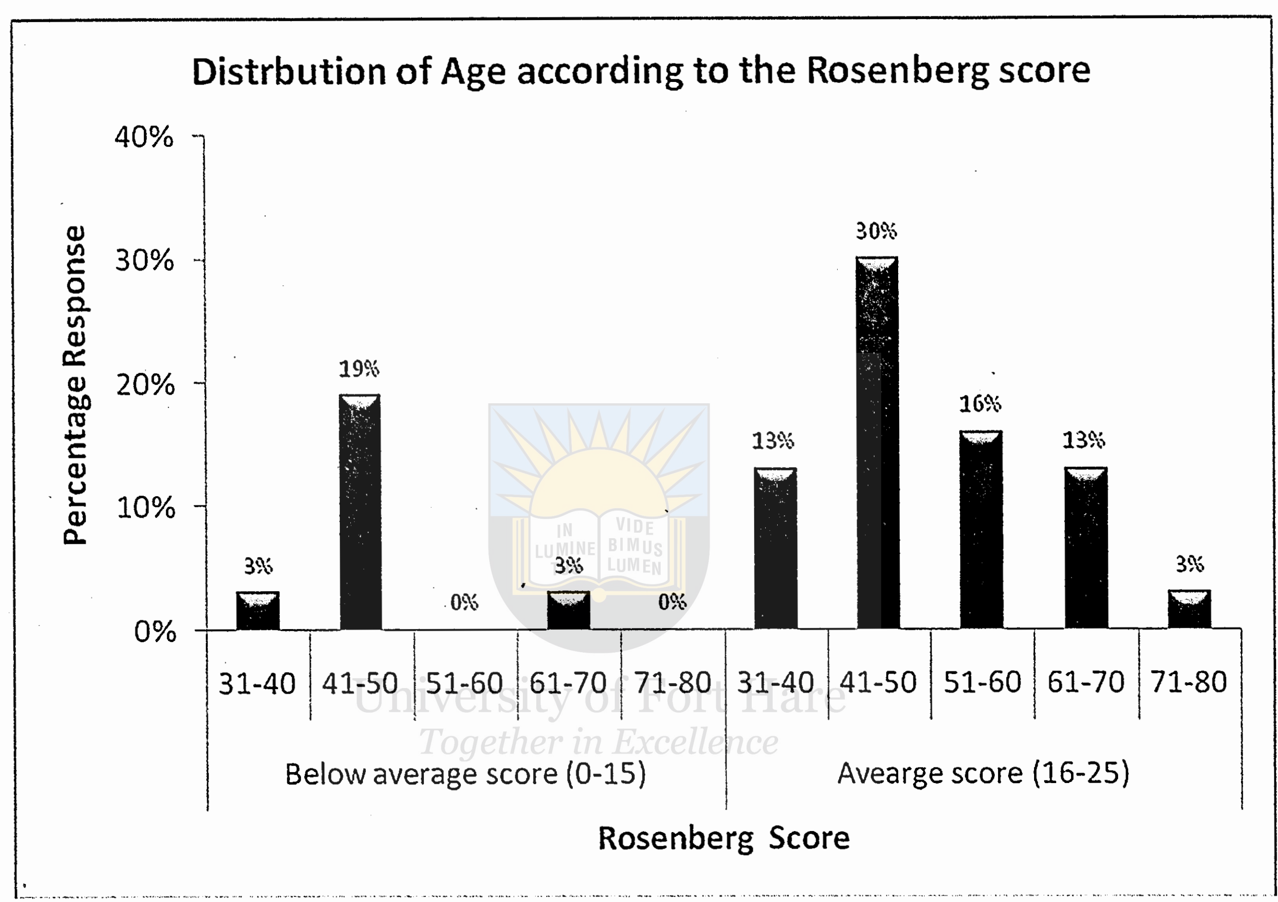
Looking at the distribution of the self-esteem according to gender, it can be seen from the graph above that most of the participants had an average self esteem. However, more males had an average self esteem (79%) as compared to the females (69%) who had an average self-esteem score. In the low self-esteem category, more females had a low self-esteem (31%) as compared to their male counterparts (21%).

Graph 5: The distribution of age according to the Rosenberg score



The distribution of the Rosenberg score, broken down by gender indicates that almost all the participants scored an average score on the Rosenberg scale, to some extent, while in some age groups, for instance the 51-60 and the 71-80, no one scored below average.

Among those who scored average Rosenberg score, the 41-50 age groups had the highest response (30%), followed by the 51-60, 31-40 age groups and the 71-80 being at the bottom of the list with only 3%.

On the other hand, of those who scored below average scores, the 41-50 age group had the highest response (30%) followed by the 31-40 and 61-70 age groups, each having 3%.

Table 5: Distribution of Age according to gender

Age Categories in years	Male		Female		Total	
31-40	5	(16%)	0	(0%)	5	(16%)
41-50	11	(34%)	5	(16%)	16	(50%)
51-60	2	(6%)	3	(9%)	5	(16%)
61-70	0	(0%)	5	(16%)	5	(16%)
71-80	1	(3%)	0	(0%)	1	(3%)
Total	19	(59%)	13	(41%)	32	(100%)

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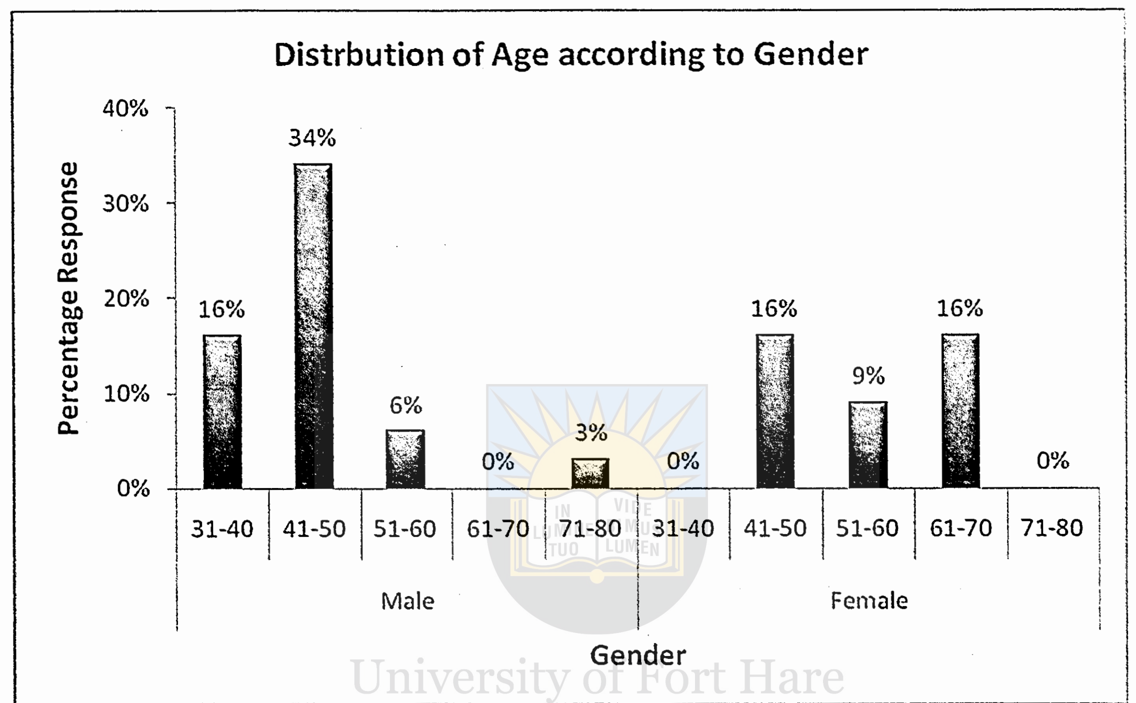
Graph 6: Distribution of age according to gender



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The graph above shows that most of the participants involved in the study were between 31 and 60 years for males and between 41 and 70 years for females. However, there were a few elderly males who were between 71 and 80 years.

It can also be deduced from the foregoing graph that the majority of the males (34%) were of the age group 41-50, while for the females, there were equal representation from the age groups 41-50 and 61-70, each having 16% response.

Table 6: Score categories and number in each and the percentages

Score	Number (n)	(%) Of all
0-15 Below average	8	25%
16-25 Average	24	75%
26 plus Above average	0	O%
Total	32	100%

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The scores of the participants on the Rosenberg Self-esteem Scale 25% were below average, while 75% were Average and no one fell into the above average score.

Table 7: Percentage scores for Males and Female according to statements Positive and negative

Type of statements	Males No (%)	Females No (%)	Total No (%)
Positive			
Strongly agree	22 (12%)	9 (7%)	31 (10%)
Agree	57 (30%)	37 (28%)	94 (29%)
Disagree	16 (8%)	4 (3%)	20 (6%)
Strongly disagree	0/ (0%)	2 (2%)	2 (1%)
Negative			
Strongly Agree	11 (6%)	4 (3%)	15 (5%)
Agree	38 (20%)	41 (32%)	79 (24%)
Disagree	45 (23%)	25 (19%)	70 (22%)
Strongly Disagree	1 (1%)	8 (6%)	9 (3%)
Total	190(100%)	130 (100%)	320 (100%)

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Summary statement: In the males 42% strongly agreed and agreed with the positive statements, while only 8% disagreed or strongly disagreed with positive statements, 26% strongly agreed or agreed with the negative statements and 24% disagreed or strongly disagreed with the negative statements.

In the females 35% strongly agreed and agreed with the positive statements, while only 5% disagreed or strongly disagreed with positive statements.

While 35% strongly agreed or agreed with the negative statements and 25% disagreed or strongly disagreed with the negative statements.

Hypothesis Testing

In order to succinctly address the research problem, hypotheses tests, based on the Sample data were carried out to find out the effect of gender and age on self esteem. This was achieved by carrying out a chi-square test, at 5% significance level, based on the p-value approach. The chi-square tests were performed using statistical software called Statistical Package for Social Scientists (SPSS).

The chi-square test is used to test for association between any two categorical variables. For each test, we set the null hypothesis (H_0) versus the alternative hypothesis (H_1). We reject H_0 if the p-value is less than $0.05\left(p-value \le 0.05\right)$ and do not reject H_0 if the p-value is greater than 0.05 $\left(p-value > 0.05\right)$.

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In this particular case we considered the following hypotheses:

Association between gender and self-esteem

H_0: gender and self-esteem are not associated (they are independent) Vs

H_1: gender and self-esteem are associated

Table: 8

Chi-Square Tests

	Value	df	P-Value
Pearson Chi-Square	9.820[a]	11	.547
Likelihood Ratio	12.087	11	.357
N of Valid Cases	32		

From the above results, since the p-value = 0.547 > 0.05 we fail to reject H_0 and conclude that self-esteem does not depend on gender (they are not associated). In other words, whether one is male or female does not affect one's self esteem.

Association between age and self-esteem

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H_0: Age and self-esteem are not associated (they are independent) Vs

H_1: Age and self-esteem are associated

Table 9

Chi-Square Tests

	Value	df	P-Value
Pearson Chi-Square	189.867[a]	165	.090
Likelihood Ratio	89.921	165	1.000
Linear-by-Linear Association	.115	1	.734
N of Valid Cases	32		

From the above results, since the p-value = 0.09 > 0.05 we fail to reject H_0 and conclude that self-esteem does not depend on age (they are not associated). In other words, one's self esteem does not depend on whether they are young or old.

Chapter five: Discussion

5.1 Overview

This study was aimed to examine what the level of self-esteem was amongst schizophrenics, in the East London area. To see what effect self-esteem has on gender and age. Self-esteem is defined as confidence in one's abilities and judgment and serves as a measure of self praise that individuals attribute to themselves. This includes a general attitude regarding one's worth that influences mood and behaviour, such as " How I feel about my self worth?".

When individuals do not feel as though there is much value in who they are, or what they are able to contribute to others, they are said to have low self-esteem. Self-esteem influences how one relates to others (Klose 1992).

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In this study the researcher determined that the schizophrenic person in the East London area has an average self-esteem.

Many people with mental illness experience low self-esteem. They tend to minimize their own positive attributes, strengths, and abilities, making it difficult to accept positive feedback (Klose 1992).

In this study, it was found that a significant proportion 59% of the sample were males while 41% were females. In a study by (Karatzias et al 2007) they also had a higher male to female ratio, 71.7% were male while 28.3% were female.

When looking at the participants in age categories, 50% belonged to the age category of 41-50, with equal representation from the age groups 31-40,51-60 and 61-70 each having 16% response. However the least represented age group was the 71 – 80%

with only a 3% response rate.

What was evident was that a large amount of people were in the 41-50 age group. Looking at the distribution of the self-esteem according to age, most of the participants had an average self-esteem. However, more males had an average self-esteem (79%) as compared to the females (69%). In the low self-esteem category, more females had a low self-esteem (31%) as compared to their male counterparts (2%).

Participants, on average, presented relatively higher self worth than negative self-depreciation, respectively. This finding was not consistent with the literature as a number of previous studies have reported lower self-esteem in psychiatric patients compared to normal controls. In a study by (Silverstone and Salsali 2003) they confirmed that psychiatric patients have a low self-esteem, especially if there is a diagnosis of a major depressive disorder or anxiety disorder. This research did not look at the schizophrenic person and whether they had any co morbid diagnosis. This research looked at the question of what the actual self-esteem of the schizophrenic person is. The researcher needed to ask why this group had an overall healthy self-esteem. No participants had an above average score. This was good as compared to a study by the (California Task Force to Promote Self-esteem, Personal and Social Responsibility 1987).

Californian task force sought to determine whether self-esteem is the key to unlocking the secrets of healthy human development so that the experts can get to the roots of and develop effective solutions for major social problems and to develop and provide for every Californian the latest knowledge and practices regarding the significance of self-esteem.

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The Task Force believed that esteeming oneself and growing in self-esteem would reduce the epidemic levels of social problems we currently face (Mecca et al 1989).

Even though they searched for a connection between low self-esteem and problematic behavior, they could not find a cause and effect link. However, more recent studies indicate a definite relationship between violent behavior and high self-esteem.

In this study the distribution of the Rosenberg score, broken down by gender indicates that almost all the participants scored an average score on the Rosenberg scale, to some extent, while in some age groups, for instance the 51-60 and the 71-80, no one scored below average.

Among those who scored average Rosenberg score, the 41-50 age group had the highest response (30%), followed by the 51-60, 31-40 age groups and the 71-80 being at the bottom of the list with only (3%).

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On the other hand, of those who scored below average scores, the 41-50 age group had the highest response (30%) followed by the 31-40 and 61-70 age groups each having (3%).

In order to briefly address the research problem, hypotheses tests, based on the sample data were carried out to find out the effect of gender and age on self-esteem. This was achieved by carrying out a chi-square test, at 5% significance level, based on the p-value approach. The chi-square tests were performed using statistical software called Statistical Package for Social Scientists (SPSS).

The chi-square test is used to test for association between any two categorical variables. For each test, we set the null hypothesis (H_0) versus the alternative hypothesis ($H1$). We reject H_0 if the p-value is less than

0.05($p - \text{value} \leq 0.05$) and do not reject H_0 if the p- value is greater than 0.05 ($p - \text{value} > 0.05$).

In this particular case we considered the following hypotheses: Association between gender and self-esteem.

H_0: gender and self-esteem are not associated (they are independent) Vs

H_1: gender and self-esteem are associated

From these results, since the p-value = 0.547 > 0.05 we fail to reject H_0 and conclude that self-esteem does not depend on gender (they are not associated). In other words, whether one is male or female does not affect one's self-esteem.

The association between age and self-esteem.

H_0: age and self-esteem are not associated (they are independent) Vs

H_1: age and self-esteem are associated

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From these results, since the p-value = 0.09 > 0.05 we fail to reject H_0 and conclude that self-esteem does not depend on age (they are not associated). In other words, one's self-esteem does not depend on whether they are young or old.

In the literature the researches looking at self-esteem have not looked specifically at gender and age as it relates to self-esteem.

5.2 Conclusion

Based on the previous studies the researcher has seen that most psychiatric patients do suffer from a low self-esteem due to various factors. This study has identified that the self-esteem of the schizophrenic person are mostly average; only 25% had a poor self-esteem while 75% had an average self-esteem. This was determined by using the Rosenberg self-esteem scale.

This result went against the views of other literature. As seen in a study by (Silverstone and Salsali, 2003). Further research would be needed to determine why this would be and what contributing factors are present to have caused this healthy self-esteem.

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Now that the researcher has examined the self-esteem of the schizophrenic person, the researcher will be able to determine if it would be viable to include self-esteem enhancing programmes into the treatment program of the schizophrenic patient.

The conclusion being that one will need to always be aware of the important role self-esteem plays in the schizophrenic's life and to assess if there are other co morbid conditions which may cause a low self-esteem.

5.3 Recommendations

The question remains: Is self-esteem an important issue in psychiatry, particularly when it comes to the schizophrenic person? This research proves that schizophrenic persons without any other conditions do have healthy self-esteems. With this study being relatively small it was difficult to come out with decisive deductions.

The researcher realised that this study was limited as it would have been advisable to include more participant characteristics, for example, do they comply with medication, do they have support systems in place, and do they suffer from any co morbid conditions. For example, if a person suffers from depression and/or anxiety.

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In future, it would be worthwhile to investigate what could enhance relationships with other people and the schizophrenic person, as despite the healthy self-esteem the schizophrenic person tends to isolate themselves; further research is needed into this whole area of relationships and self-esteem.

Now that this research has been completed it will be appropriate for the information to be dispersed. The ideal would be to have it published in a psychiatric journal. The researcher would like to be invited to present a paper on the research findings at a conference for psychiatry in South Africa and abroad.

The researcher will present the findings at in -service programme at Cecilia Makiwane hospital where this study was conducted.

It would be advisable to make the results available to the health department of the Eastern Cape. Society has a responsibility to keep everybody in a healthy state. If we

can look at various institutions, a great job can be done to keep the self-esteem of schizophrenic sufferers high. Like all other people, they can be given roles. In the community, leaders can give them tasks like preparing for the meeting and arranging chairs. Belonging to support groups is another therapeutic function that can boost self-esteem in society.

According to Roy (1984), low self-esteem is a maladaptive response in the self-concept mode which requires nursing intervention. The nurse needs to identify behaviours which indicate low self-esteem and then identify the focal, contextual, and residual stimuli which affect those behaviours. The nurse may then work in collaboration with the patient to develop a care plan in which goals for optimal adaptation are established. The focus should be on manipulation of the various stimuli to promote an adaptive response by the patient (Catalano, 2003; Fitzpatrick, & Wallace, 2006; Roy, as cited in Lavender, 1988)

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Appendix 1.1: The Rosenberg Scale of Self-esteem Scale

Code: ___________

Gender: ___________

Age: _____________

	Statement	Strongly agree	Agree	Disagree	Strongly Disagree
1.	I feel that I am a person of worth, at least on an equal plane with others.				
2.	I feel that I have a number of good qualities.				
3.	All in all, I am inclined to feel that I am a failure.				
4.	I am able to do things as well as other people.				
5.	I feel I do not have much to be proud of.				
6.	I take a positive attitude towards myself.				
7.	On the whole, I am satisfied with myself.				
8.	I wish I could have more respect for myself.				
9.	I certainly feel useless at times.				
10.	At times I think I am no good at all.				

- For items 1,2,4,6 and 7
  Strongly agree = 3
  Agree =2
  Disagree = 1
  Strongly disagree = 0

- For items 3,5,8,9 and 10
  Strongly agree = 0
  Agree = 1
  Disagree = 2
  Strongly disagree = 3

The scale ranges from 0 -30. Scores between 15 and 25 are within normal range, scores below 15 suggest low self-esteem. Score Results: __________

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Appendix 1.2 Indlela kaRosenberg yokujonga iqondo lokuzithemba

ıgxelo	Ndiyavuma kakhulu	Ndiyavuma	Andivumi	Andivumi konke
. Ndiziva ndixabisekile ndilingana abanye abantu.				
. Ndizibona ndineempawu ezintle ziliqela.				
. Ekugqibeleni ndizibona jengomntu ongenampumelelo.				
·. Ndiykwazi ukwenza iznto :akuhle njengabanye abantu.				
·. Ndiziva ndingenanto ıdinokuzidla ngayo.				
ı. Ndiyazidla ngesiqu sam				
'. Ngokupheleleyo, ndanelisekile ıgumntu endinguye.				
;. Ndinqwenela ukuba kuthi kanti ıendinokuzihlonika nangaphezulu.				
). Ngamanye amaxesha ndiziva ndiyinto engento.				
.0. Ngamaxesha athile ndicinga ukuba andiyomfuneko kwaphela.				

Iziphumo zibalwa ngolu hlobo:

- Kwinqaku 1,2,4,6 no-7
  Ndiyavuma kakhulu = 3
  Ndiyavuma = 2
  Andivumi = 1
  Andivumi konke = 0

- Kwinqaku 3,5,8,9 no-10
  Ndiyavuma = 0
  Ndiyavuma kakhulu = 1
  Andivumi = 2
  Andivumi konke = 3

Isikali sisuka ku-0 – 30. Amanqaku aphakathi ko-15 no-25 athathwa njengamkelekileyo, angaphantsi ko-15 abonakalisa ukuba ukuzithemba kuphantsi.
Iziphumo
Ikhowudi
Isini
Iminyaka

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Appendix 2.1

LETTER OF CONSENT

THE STUDY OF SELF- ESTEEM AMONGST PATIENTS DIAGNOSED WITH SCHIZOPHRENIA AND TREATED AT THE CECILIA MAKIWANE PSYCHIATRIC HOSPITAL IN EAST LONDON IN THE EASTERN CAPE PROVINCE, SOUTH AFRICA.

RE: CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Dear Participant

I am a M Cur student presently enrolled with the university of Fort Hare. I am currently working on the study of self-esteem amongst schizophrenic patients at Cecelia Makiwane hospital at the psychiatric outpatient clinic.

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The purpose of the study is to assess the level of self-esteem among schizophrenic patients according to the Rosenberg scale of self-esteem, treated at Cecelia Makiwane Hospital outpatient psychiatric clinic.

To do this research the researcher needs to conduct interviews with the participants, the questions asked will be according to the Rosenberg scale of self-esteem. It will take 20 minutes to complete. No electronic recording will be made, only a questionnaire will be completed.

You will not experience any discomfort and this research study has no risks to your health or image.

Although the study will not benefit you directly, I am asking you for your time to enable this research to take place. It is hoped that this information which you are giving to the research project will be used to improve the care of the schizophrenic person. No payment will be paid to the subject for his/her time.

The questionnaires will be coded according to the subject with numerical order e.g. 1 – 32. The list of coding will only be with the researcher. Your participation will be confidential and you are not required to identify yourself anywhere on the questionnaire.

You participation is voluntary, it is your choice to participate in this study, and you may withdraw from the study at any time without any consequences. You will not be forced to answer any questions you are not comfortable with.

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If you have any questions relating to this study, I Mrs R.J. Durrheim will be available to be contacted at 0726351115 or 043 7351204. The Fort Hare Review Board will also be available to answer any questions you have about concerns regarding your rights in this research project.

Dr Yako may be contacted on 043 704 7588.

CONSENT FORM

I have read the contents of the letter of consent; I understand and agree to participate in this research study.

I understand that I am free to refuse to answer any of the questions and I can end my participation at any time without this affecting my care now or in the future. This form is signed in duplicate and I will retain a copy for my information.

Participant signature: ______________________________ DATE: ____________

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I have explained this study to the above participant and have sought his/her understanding for informed consent.

Researcher's signature: ______________________________DATE:____________

Appendix 2.2 INCWADI YESIVUMELWANO

UPHANDO NGOKUZITHEMBA KWIZIGULANE EZIFUNYANISWE ZIGULA NGENGQONDO (SCHIZOPHRENIA) EZITHE ZAFUMANA UNYANGO KWIKLINIKI LABAGULA NGENGQONDO LESIBHEDLELE I-CICILIA MAKIWANE EMONTI KWIPHONDO LWEMPUMA KOLONI, EMZANTSI AFRIKA..

ISIVUMELWANO NGOKUTHATHA INXAXHEBA KOLU PHANDO

Mthathi-nxaxheba

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Ndingumfundi weM Cur kwiYunivesithi yaseFort Hare. Ngoku ndisebenza ngophando olumayelana nokuzithemba kwizigulane ezigula ngengqondo (schizophrenic patients) kwisibhedlele iCicilia Makhiwane kwiKliniki yabagula ngengqondo.

Injongo yolu phando kukujonga nzulu iqondo lokuzithemba, nokuchaza la maqondo okuzithemba kwaba bagula ngengqondo ngokuthi kusetyenziswe indlela kaRosenberg yokujonga
Ukuzithemba. Kuya kwenziwa oku kwabagula ngegqondo abafumana unyango eCicilia Makhiwane
kwiKliniki yabagula ngengqondo.

Ukwenza olu phando umphandi kufuneka enze udliwanondlebe nabathathi-nxaxheba. Imibuzo eya kuthi ibuzwe yileyo isetyenziswa kwindlela kaRosenberg yokujonga iqondo lokuzithemba.
Iya kugqitywa kwimizuzu eyi-20. Azizi kurekhodishwa iimpendulo zakho, kuya kusetyenziswa imibuzo ebhaliweyo kuphela.

Akusayi kuzifumana ungakhululekanga kwaye olu phando alusayi kubeka impilo ne idima sakho
emngciphekweni. Noxa nje ungasayi kuzuza nto ngolu phando, ndicela ixesha lakho ukuze olu phando luqhubekeke. Kulithemba ukuba le nkcazelo uyinikezelayo kolu phando iya kuncedisa ekuphuculeni unakelelo lwabo bagula ngengqondo.Akukho bani uya kuthi abhatalwe ngexesha lakhe.

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Amaphepha emibuzo aya kuthi aphawulwe ngokulandelana kwabathathi-nxaxheba, umz. 1 ukuy aku-32. Uluhlu lokungqamanisa la manani luya kuba kumphandi. Ukuthatha kwakho inxaxheba kuya kuba yimfihlo kwaye akukho apho kuya kufuneka ukuba uzichaze ukuthi ungubani na.

Uyazikhethela ukuthatha inxaxheba kolu phando, kwaye ungarhoxa nanini na ngaphandle kwemibuzo. Akusayi kunyanzelwa ukuba uphendule nawuphi na umbuzo ongawuthandiyo.

Ukuba unombuzo ngolu phando, mna Nkosk. R.J. Durhein ndiyafumaneka. Ungaqhagamshelana nam kwezi nombolo: 0726351115 okanye 043 7351204. I *Fort*

Hare Review Board nayo ikho ukuphendula imibuzo malunga namalungelo akho kolu phando. UGqr. Yako ufumaneka ku 043 704 7388.

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IFOMU YESIVUMELWANO

Ndikufundile okuqulethwe yincwadi yesivumelwano, ndiyakuqonda ndikuvuma ukuthatha inxaxheba kolu phando.

Ndiyaqonda ukuba ndinakho ukwala ukuphendula nawuphi na umbuzo kwaye ndingayeka ukuthatha inxaxheba nanini na ngaphandle kokuchaphazela imphatho yam ngoku

nakwixa elizayo. Le fomu isayinwe kabini (*duplicate*), kwaye ndiya kuthi ndigcine eyam ikopi ndisenzela olwam ulwazi.

Umthathi-nxaxheba______________________________ Umhla

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Ndilucacisile olu phando kulo mthathi-nxaxheba ungentla ndenza ukuba athathe inxaxheba

kulo enolwazi oluphangaleleyo ngalo.

Umphandi________________________________ Umhla

Appendix 3: Coding, gender, age and the score

Coding	Gender	Age	Score
1	female	42	18
2	male	50	11
3	male	40	17
4	male	37	17
5	female	63	17
6	male	47	19
7	female	50	14
8	male	55	17
9	male	50	19
10	female	66	17
11	male	47	18
12	male	37	18
13	female	63	16
14	female	42	14
15	male	40	15
16	male	50	14
17	female	55	17
18	male	50	18
19	female	44	17
20	male	58	17
21	female	43	15
22	male	44	20

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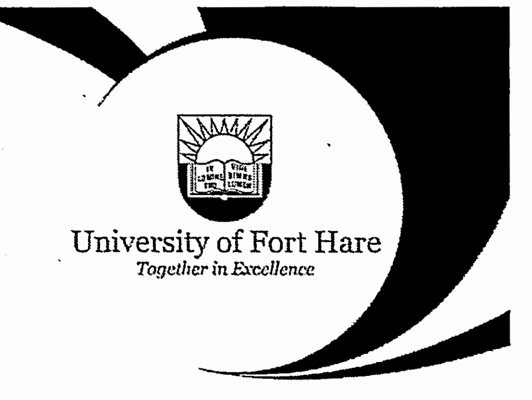
Appendix 4



OFFICE OF THE DEPUTY VICE-CHANCELLOR:
ACADEMIC AFFAIRS AND RESEARCH
Private Bag X1314, Alice 5700
Tel: 04060 22403
Fax: 0866282944
tsnyders@ufh.ac.za

Application for clearance from the University of Fort Hare's Ethics Committee

Project Title: The study of Self-Esteem among Patients Diagnosed with Schizophrenia attending the out -patient Department of Cecilia Makiwane Hospital in the East London Area

Chief Researcher: Ricarda Janet Durrheim

Supervisor/co-supervisor: Mrs. NIN Magadla

Date of application: 29 May 2009

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Having consulted the Dean of Research, I hereby grant permission to conduct the research.

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

6 April 2010

Appendix 5

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	083 378 1202
Date:	05th January 2009	Fax No:	040 608 1177
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Ms R Durrheim

Re: The study of self-esteem among patients diagnosed with schizophrenia

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure you observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants. You will not impose or force individuals or possible research participants to participate in your study. Research participants have a right to withdraw anytime they want to.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

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Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

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