



CHAPTER 5

SELF-ESTEEM

Many psychologists are of the opinion that there is no value-judgement more important to a person - no factor more decisive in his psychological development and motivation - than the estimate the person passes on himself (Kashani, 1986, Gurney, 1988, Mruk, 1995).

The nature of this self-evaluation has profound effects on the individual's thinking processes, emotions, desires, values and goals. It is often considered the single most significant key to a person's behaviour. To gain an understanding of a person psychologically one must understand the nature and degree of his or her self-esteem and the standards by which he/she judges himself/herself.

A person's need of self-esteem can therefore be considered a basic need, a need which is inherent in his nature. However, nobody is born with the knowledge of what will satisfy that need or of the standard by which self-esteem is to be measured.

This knowledge must be discovered through life experiences. Furthermore, this discovery takes on a particular significance during adolescence and especially with adolescents with physical disabilities.

5.1 Definitions of Self-esteem

Self-esteem would appear to be an extremely important phenomenon. It would appear to involve issues of identity and value, but would also reflect how individuals feel and act in a variety of circumstances. It is therefore not surprising to note that self-esteem has generated a great deal of research, and that this research represents a wide range of theoretical orientations.

Despite the popularity of the concept of self-esteem, the definition and measurement of self-esteem remains largely elusive and ambiguous. This has allowed individual definition and measurement in each research design, with researchers using the concept of self-esteem as an independent variable, a dependent variable, an intervening and controlling variable, etc. (Brennan, 1985).

Wells and Marwell (1976) concluded that there were four basic ways of defining self-esteem;

- (a) Definitions which are based on the idea that the self can be treated as an object of attention, i.e. one can have an emotional, cognitive and behavioural response to oneself in the same way as one responds to other objects.
- (b) Definitions which are based on the relation between different sets of attitudes, e.g. the difference between one's attitude towards one's real and ideal selves.
- (c) Definitions which focus on the psychological responses one holds towards oneself, e.g. feelings of acceptance and rejection.
- (d) Definitions which hold self-esteem as being part of the self or self-system.

Cheshire and Thomae (1987) in turn attempt to identify self-esteem in accordance with what they describe as the almost universally accepted components of self-esteem;

- (a) The cognitive element, i.e. characterizing some parts of self-esteem in descriptive terms.

- (b) The affective element, i.e. a degree of positiveness or negativeness attached to those facets identified.
- (c) The evaluative element, i.e. an attribution of some level of worthiness relating to some ideally held standard.

Jackson (1984), contends that what is required is a more naturalistic approach, which can explore self-esteem in a living context. The themes that constitute self-esteem should be examined. The opportunities, the problems, the triumphs and the defeats which an individual encounters in the development of the self should be examined. At the same the investigation should not lose sight of how these themes are woven together into a person's own story.

According to Mruk (1995), a good theory of self-esteem must comply with at least three major criteria;

- (a) It must be founded on a major scientific perspective to have credibility.
- (b) The definition of self-esteem must include either aspects of competence, worthiness or both.
- (c) It must address certain key characteristics and dimensions of self-esteem e.g. the different types of

self-esteem, the developmental nature of self-esteem, the motivational aspects of self-esteem, etc.

In perusing the many definitions Mruk (1995) contends that while each tells us something about this vital phenomena, it fails to define self-esteem definitively, or describes it as it is lived in both every day life as well as structurally. The task, he feels, falls to phenomenology to do this. In his review of the major theories on this phenomena, he concludes;

- (a) We must consider competence and worthiness, as well as the relationship between them, as that which creates self-esteem.
- (b) We must take into account the lived quality of self-esteem i.e. the processes of judgement and self-awareness and emotional reaction, as it is embodied in the situations of real life for any given individual.
- (c) We must capture the dynamics of self-esteem, i.e. its relative stability whilst holding the possibility of change.

The development of a phenomenology of self-esteem thus shows it to be the lived status of one's individual competence and personal worthiness at dealing with the challenges of life over time. Self-esteem is construed to have two interrelated aspects: it entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is competent to live and worthy of living.

5.2 Disability and self-esteem

To fully comprehend the impact of physical disability on the self, it is important to note that body images and self images are not merely mental reflections of the physical self; they are associated with others' appraisal of and reactions to one's appearances and actions. According to van der Velde (1985);

"...body images are fundamental dynamisms in the development of self-concept; they contribute to the characteristics of personality; they are our mental blueprints for the organization of our social behaviour." (p 527).

According to Magill and Hurlbut (1986) very little has been written on the self-esteem of adolescents with cerebral palsy, or any other form of physical disability. In order to examine the full implications of physical disability on self-esteem, it might be important to examine the different dimensions which constitute the self, namely, physical self, personal self, the self within the family and social self.

5.2.1 The Physical self

Since the handicap is constantly present in a cerebral palsied child's life, his realm of life is in that respect always different from that of a non-disabled child. Teplin, et al. (1981) suggested that cerebral palsied children begin to regard themselves as "different" as early as four years old, but the negative effect on self-esteem does not begin until much later. In the case of younger children with cerebral palsy, there is generally a higher expression of self-competence, which Ostring and Nieminen (1982), has interpreted as an attempt on the part of these children to deny their dependence.

Ostring and Nieminen (1982), has further argued that the acceptance of the dependence brought about by the handicap and its integration into the self concept are essential for positive self-concept and self-esteem of the cerebral palsied child. Should this process succeed, a positive attitude towards the handicap is achieved and the handicap is not considered a factor which causes failure. Denial of dependence leads to experiencing the handicap as lowering the human value and self-esteem.

According to Teplin, et al. (1981) the initial positive self - image which is present in the young cerebral palsied children, gradually disappears as the child grows older and he begins to experience the physical restrictions which his body places on him. Adolescence is the period when a young person has to accept the finality of his disability and to abandon the unrealistic fantasies which might have sustained him when he was younger (Freeman, 1970). During this stage the body is experienced as inferior, and influences the adolescent's willingness to participate in social activities (Minde, 1978).

During adolescence the sense of physical body becomes a central concern and influences a person's self-esteem or evaluation of self-worth. Magill and Hurlbut (1986) are of the opinion that while there is very little literature on the self-esteem of adolescents with cerebral palsy, some of the findings on the self-esteem of non-disabled adolescents can be applied to the disabled.

Puberty is a period marked by considerable change in the biological, psychological and sociocultural realms of life. During this period the adolescents struggle to determine their relationship with society, and the roles and lifestyles they will assume. The handicapped adolescent may experience more conflicting answers to the question "Who am I?". The social information his parents or teachers provide may differ radically from that which his non-disabled peers provide, and thus a lack of self-confidence may develop.

5.2.2 The Personal Self

The inability of most cerebral palsied children to perform at an age-appropriate level on the physical, social and cognitive level, has a negative effect on his development of self

competence and self worth (Richardson, 1972). These feelings of inferiority and a lack of self confidence could lead to the child withdrawing from active participation in social activities (Anderson & Clarke, 1982).

In two different studies by Richardson, et al. (1964) and Magill and Hurlbut (1986), it was found that in the former study, that girls would generally provide more negative self descriptions than would boys, and in the latter study, the self concepts of girls were significantly poorer than those of boys.

5.2.3 The Self within the Family

The first inter-personal relationship which a child develops is with his mother and other family members. This relationship to a large degree determines the basis for the child's attitude, feelings and behaviour towards others. It is through the interactions between the cerebral palsied child and his family members that the child also begins to gain some insight and understanding of how others view him. Studies have shown that the child with a disability who is given responsibility and decision making powers within the family, has a greater

chance of developing self-confidence and a positive self-concept (Anderson & Clarke, 1982). The development of independence is severely impaired, and in adolescents regression may occur, if a child is not part of the decision-making process within the family (Freeman, 1970).

5.2.4 The Social Self

The self-image a person develops is largely a result of how others relate and react to him (Dovey & Graffam, 1987). Furthermore, Du Plessis (1991) contends that interpersonal experiences lead to a continual re-creation and re-development of the self-image.

Disability severely restricts the child's ability to socialise and the child is isolated from the reactions of society. Where such contact does take place, the reactions of others are often very negative. The stigmatised views which society holds of disability has a direct impact on the self concept. Of the forms of physical disability, studies have shown that cerebral palsy elicits the most negative responses from society (Magill & Hurlbut, 1986). According to Du Plessis (1991) it is this stigmatising factor which results in cerebral palsied



children, especially in late adolescence, refusing to associate with others with disabilities. The irony is, of course, that these adolescents have equal difficulty in forming associations with non-disabled peers, and hence socialising is even further restricted.

Urbani (1982) is of the opinion that disabled children experience the world very differently from non-disabled children. He further contends that they only experience the reality of their differences when they interact with the non-disabled. This sense of being different can result in serious emotional problems for disabled children. In this regard, Halliday (1989) refers to feelings of powerlessness, anxiety and feelings of low self-worth which can result in withdrawal and fear. According to Richardson (1972), one of the major problems experienced by cerebral palsied young people was the stereotyped and often negative reactions of people who found it difficult to treat the cerebral palsied, and the disabled in general, as human beings. Besides being demoralising, such stereotypes were often so powerful and pervasive that it would have been difficult not to fall into society's conception of how they should behave.

Factors which affect adjustment are as numerous and as unique as the individuals learning to adjust. Each person brings a multitude of factors of physical competence, of social experience and of family background to their life experiences which render ludicrous the expectation to have a standardised formula which can predict or measure levels of adjustment or self-esteem.



CHAPTER 6

PSYCHOTHERAPY WITH DISABLED ADOLESCENTS

Grzesiak and Hicok (1994), suggests that the paucity of literature on psychotherapy, physical disability and rehabilitation, is due to three main reasons :

- (a) Firstly, the psychotherapists who work with the physically disabled are usually identified primarily in the field of clinical psychology and psychiatry and only secondarily do they identify themselves with physical rehabilitation.
- (b) Secondly, rehabilitation psychology has generally placed greater emphasis on the somatopsychological processes and ecologic-environmental approaches to the psychological difficulties of the disabled.
- (c) Thirdly, the majority of the literature on intervention in physical rehabilitation has focused on behavioural approaches, which is primarily action orientated, and not insight orientated.

It is generally felt that the failure of the adolescent with a disability to accomplish the tasks of normal adolescence results in a range of psychosocial symptoms which is characteristic of this population. This includes :

- (a) emotional dependency, mainly on parents.
- (b) difficulties in experiencing and expressing intimacy.
- (c) depression, with features of withdrawal, helplessness, hopelessness, and marked self-depreciation.
- (d) a diffused sense of identity containing a defective body-image.
- (e) episodic aggressive behaviour.
- (f) the persistence of the stage of concrete thinking (Brier & Demb, 1980).

Grzesiak and Hicok (1994) is of the opinion that the principles and practice of psychotherapy with physically disabled persons are no different from those who are non-disabled. There are, however, several important psychodynamic themes which are uniquely prevalent in the psychotherapy with physically disabled people. The first theme is the effect of early physical damage on the developing ego. Some authors have

focused on the destructive aggression that might be expressed as a result of ego defects secondary to physical disability (Castelnuovo-Tedesco, 1981). Others believe that the psychological consequences of disability could be a more positive vitality that would allow unexpected achievement. Yorke (1980), for example, holds the view that physical disability can act as a spur for compensatory achievement or as a convenient focus onto which all difficulties and frustrations can be bitterly projected. Jureidini (1988) further points out that many physically disabled people lack the physical skills necessary to give expression to normal aggression, while physical restrictions combine with the disabled individual's treatment by the environment to make successful individuation a more difficult achievement than it is the case for the non-disabled.

The second theme revolves around the importance of parental acceptance of the disability. The birth of a disabled child is a narcissistic blow to the parents who grieve the loss of their fantasised "normal" baby. Conflict arises between drives to protect the helpless child and revulsion and shame at the abnormality. Thus the mutual mirroring between mother and

child is disrupted (Kohut, 1972). It is thus possible that feelings of inferiority arise in disabled people because of the withdrawal of maternal love rather than because of the disability itself (Poznanski, 1984).

The third theme refers to the relationship of mind and body and how that relationship determines the special role of fantasy in the inner world of disabled people. Winnicott (1954) did not consider the mind as a separate entity, but as those aspects of mental processing with which the infant accommodates the mother's inevitable failure to adapt perfectly to the infant's needs. Thus he saw the function of mind as allowing adaptation to an imperfect and traumatic environment. In the case of the disabled child, should mothering be too erratic, there would be an overdevelopment of this mental processing so that the mind could begin to take over from the mother in organizing the caring functions. As a result the psyche, which should bear an intimate relationship to the whole body, could become falsely localized in the mind and the individual loses the ability to live in his body.

Disabled individuals are vulnerable to this course of events because of the practical and emotional difficulties of mothering a disabled child. Thus there is a tendency to identify the mind as an ally against the body, and for fantasy to become localised in the mind rather than the body (Ogden, 1973).

Ogden (1973) remarked that psychotherapy of a patient with cerebral palsy highlights particular issues focusing on self-representation, body representation, and the handling of aggression. Ogden (1973) further concluded that there was very little hope of addressing issues of aggression while the body was experienced as the executor of aggression and the self was experienced as a separate, powerless observer of the body. Thus integration of self and body representations had to take place, before any progress in any other area could take place.

On reviewing the psychotherapeutic methods which have been found to be effective when working with disabled adolescents, two assumptions emerge. Firstly it is assumed that the developmental stage of the disabled adolescent is fundamentally different to that of the non-disabled adolescent

in that the traditional tasks of "normal" adolescence are often not accomplished by this population (Lewis, 1993).

Secondly, it is assumed that when one treats disabled adolescents, the therapist must take into account a range of cognitive deficits of such individuals (Brier & Demb, 1980).

On the reasons for the appropriateness of group psychotherapy as a form of psychotherapy for disabled adolescents, Rudnitzki (1988), expressed himself as follows;

"...the whole may have a complementary meaning for the part, in particular for the incomplete individual who, in addition, is excluded, rejected and devalued...the whole group can function as an image of the whole body; likewise the potential of others in the group can represent parts of the body and physical completeness. This concept of group experiences inspired us to use group analysis with disabled young people as a kind of psycho-social prosthesis. The many dimensions of group experience make up for the deficient individual experience." (p.173).

Many disabled adolescents tend to be overly self-critical, tend to attach pejorative labels to themselves, anticipate failure, feel different and/or strange and are generally ill-confident. They often refer to themselves or think that others refer to them as "mentally retarded". They are overly concerned with the possibility of failure and tend to interpret the behaviour of others as consensually validating this concern. They often interpret others as being rejecting and/or disapproving even when they are not. The psychological crisis engendered by the existential feeling that they have no identity or definite sense of themselves is, perhaps, the most profound existential crisis a human being can experience. The most exaggerated form of this feeling means that they do not have faith in their existence as a person. This is particularly so when, in their attempt to crystallize their identity, they feel seriously alienated, lonely or confused. The psychotherapist can therefore play a unique role in the healing process itself. Cassell (1992) notes that a therapeutic goal includes maintaining or restoring the integrity of the person. Goldberg (1978) points out that in general, psychotherapy with adolescents demands a conservative



approach in that one sees a self in the midst of restructuring or reorganizing, and only careful consideration of the particulars of intervention will allow this self-development to proceed.



CHAPTER 7

RATIONALE FOR STUDY AND PROBLEM

STATEMENT

A disabled child has to face many unique and complex developmental tasks in addition to the usual ones in adjusting to himself, to his disabling condition and to his immediate environment. It has been pointed out that, despite the commonly held, but erroneous view of a single neat effect of disability, a physical disability, and especially cerebral palsy, may, in fact, impair not only motor functioning, but also one or several other functional capacities, namely sensory, behavioural, cognitive or social. The effects of a physical disability influence all aspects of the child's growth and development, and thus all areas of his life (Dunn, et al. 1988).

Battle (1974) has pointed out that both the mandatory parental relationship in the first year of life and the voluntary social relationships from age three through to the school years, are influenced significantly by the presence of a



physical disability. In reviewing the socialisation process of the very young disabled child, Battle (1974) examined general modes of interacting with the environment, dependency and independence, emergence of a clear body-image, self-concept, self-esteem, relationships with siblings and the peer group, and opportunities for play and for participation in interpersonal relationships and concluded that each of these aspects of early childhood socialization is markedly altered in the disabled young child. In considering the magnitude of the social disruptions and barriers for the young disabled child, Battle (1974) cautions that these barriers are likely to increase as the child grows older.

Adolescence is an appropriate age to examine the relations between mental health and self-understanding because it is an age during which adjustment disorders arising from self-concept and self-esteem problems are relatively common. Damon & Hart (1991) contends that studies have shown that during adolescence, self-criticism is highest and that throughout adulthood people are most likely to identify adolescence as the worst period in their life (Damon & Hart, 1991).

Rosenberg (1985) in fact, has written that adolescence is the



age at which there are most likely to be disturbances and conflicts in self-concept and self-esteem.

In their report on the health needs of the adolescent, the World Health Organization (WHO, 1977) has pointed out that an able-bodied adolescent can worry unduly about being physically or mentally different from others. In the case of the physically disabled adolescent, additional sources of anxiety at the time of sexual maturation are likely to occur, such as the search for an identity compensating for the disability, and the prospect of probable or possible failure in the emotional, social and occupational spheres.

The physical and social changes which occur during adolescence have been found to be associated with changes in self-concept. (Simmonds, et.al, 1987; Ellis & Davis, 1982). As body-image is an important factor in adolescent self-concept development it seems reasonable to assume that impairment of motor functioning could have adverse effects on self-concept and self-esteem (Harvey & Greenway, 1984). Anna Freud (1952) and Greenacre (1958) were pioneers in exploring the effects of physical disability on the developing ego, identity and body



image. Previous studies of children with cerebral palsy have shown adverse effects, including low self-esteem (Richardson, et al. 1964; Minde, 1978).

Although there is considerable literature about the self, it is a complex field which has generated diverse and often contradictory theoretical frameworks. Current theories generally assume that self-concept involves a description an individual uses to identify his or her characteristics. Self-esteem is seen to involve an additional evaluative component and is usually defined in terms of personal judgements of worth (Brennan, 1985), or alternatively in terms of attitude towards the self as object (Rosenberg, 1985).

The natural science orientation of treating self-esteem as if it is an actual phenomenon is limiting. Phenomenologists view self-esteem as a construct, it is a means of conceptualising the unique combination of feelings of competence and worthiness that is lived by individuals through positive and affirmative experiences in their life-world. Therefore, self-esteem cannot be the object of study, but what should be studied is "the actual experiences that enhance or lessen one's competence and worthiness at living" (Mruk, 1983).



Of relevance to this particular study is the fact that within the phenomenological existential tradition, there is only a limited exploration of self-esteem (Mruk, 1983), no comprehensive psychology of adolescence (Fischer & Alapack, 1987), and as far as this researcher is aware, no significant study of disability has been undertaken within this perspective.

Furthermore, very little has been written about psychotherapy with the physically disabled. The majority of the literature on psychological intervention in physical disability has focused on behavioural approaches (Grzesiak & Hick, 1994).

The exceptions to the behavioural approach are few, e.g. the use of psycho-analytic psychotherapy with cerebral palsied patients (Ogden, 1974) and the use of group analysis with a group of physically disabled adolescents (Rudnitzki, 1988).

From a phenomenological viewpoint, before one can assist the physically disabled adolescent with his or her life's journey it is essential to consider one's view of being human.

Although man is more than his body, he inhabits the world with his body, and he makes contact with the world of objects

and people through his body. It is the experiences which people have of their bodies, which provides us with access to all that can be directly known, because all knowledge is ultimately grounded in human experience.

The body comprises one's earliest capacity for relating to, and interacting with and experience of the world of objects and people. Phenomenological psychology emphasises the total structure of our activity and experience. It also discloses the structural inter-dependence of ;

- (a) the individual's lived body and its surroundings.
- (b) the individuals actions and experiences.
- (c) those actions and experiences, and the organization of the individual's personal life-world (Moss, 1989).

Therefore, when we encounter another person in psychotherapy, we make contact with another person whose actions and experiences all occur within a personal life-world. These actions and experiences have meaning for that person only within their personal life-world. Thus we have to understand the personal organization of that person's life-world, if we wish to understand who that person is for himself or herself

and for others. To explore the life-world of an individual, is to confront continually the role of the lived body in organizing that life-world (Moss, 1989).

A disabled body will of necessity exert an influence on how a person relates to himself and to his world. The disabled person is firstly a human being, but he is also, as a result of his disability, a special human being. The special nature of his being human must be understood before he can be helped to deal with the world which often offers little understanding, and frequently even less acceptance.

The purpose of this study is to investigate from a phenomenological perspective, the self-esteem of a group of physically disabled adolescents who have been diagnosed as cerebral palsy. The study will attempt to understand the changing relationship between body, self and the world as experienced by these individuals during this specific stage of their development.

Why a changing relationship ? Essentially because adolescents experience regular fluctuations in their quest for certainty.

They are constantly confronted with the dilemma of choice



between independence and dependence, acceptance and rejection and expectation and performance. For the physically disabled adolescent, these dilemmas are exacerbated because this period also heralds a change in the meaning of their relationship with themselves, their bodies, their families, their social peer group and broader society. The non-disabled adolescent community also start to develop interests which often exclude the disabled adolescent. These changing perceptions and relationships could influence their sense of self-worth and competence.

What is it about the encounter or relationship between non-disabled adolescents and disabled adolescents which can elicit the experience of self-esteem or a change in the experience of self-esteem ? Many studies have shown that differences, whether physical, academic or social are experienced most acutely during adolescence (Schegel & Barry, 1991).

Physically disabled adolescents realise that they are part of a mainstream society, and that they need to establish some form of relationship beyond the restricted environment which they might have become accustomed to and comfortable with, eg.



special schools. On a personal, social and emotional level, their encounter with their non-disabled peers is an indicator of their readiness and ability to integrate effectively.

Mainstream society also realises that it cannot continue to ignore and marginalise the disabled. As we gradually move towards a more inclusive society at all levels, it becomes increasingly more important to understand this encounter between disabled and non-disabled adolescents.



CHAPTER 8

RESEARCH DESIGN

The research design was descriptive, using a phenomenological method of protocol analysis of transcribed, unstructured and open-ended interviews with 8 cerebral palsied adolescents. The researcher attempted to obtain spontaneous descriptions from the participants of their subjective experience of feeling good or bad about themselves in their contact with their non-disabled peers. Polkinghorne (1988) reminds us that the phenomenological interview focuses on the the life-world experience of the interviewee and is thus theme-oriented rather than person-oriented. Rather than seeking general views, the interview focused on specific situations and actions which could be considered as instances of the theme under investigation.

A phenomenological explication bases itself on the data as presented. The data of phenomenological research are the descriptions of the experiences as they present themselves, not the descriptions of objects and actions as they are

assumed to exist outside of the experience. This faithfulness to the phenomenon resulted in the listing of a wide range of expressions and descriptions whether or not believed worthwhile by the researcher.

8.1 Description of the sample

The sample was purposive, based on the potential participants ability to identify and to clearly describe an encounter with a non-disabled peer group which led to them experiencing either positive or negative feelings about themselves and their handicap.

Eight adolescents aged between 15 to 19 years from Std 8 - 10 (Gr.10 - 12) participated in the study. Five of the participants were girls and three were boys. From those pupils approached, it would appear as if the girls were more ready to discuss and explore such a personal experience.

All the participants had a disability known as cerebral palsy. Cerebral palsy is a chronic non-progressive condition caused by damage to a developing brain. This damage normally occurs during pregnancy, at birth or in the first few years of life.

Cerebral palsy is not quite a single condition, but is an umbrella term to describe a variety of conditions which result in movement disorders (Stopford, 1987).

There are three major types of cerebral palsy, namely Spasticity, Ataxia and Athetosis, and the participants were representative of these three groups. These classifications are according to the area of the brain damage, the muscle tone and associated movement characteristics. In addition to these factors, there are other secondary difficulties which characterise these three categories, e.g. learning ability, speech difficulties and hearing difficulties (Stopford, 1987).

Four of the participants were classified Spastic. In Spasticity the motor cortex is damaged. Movement is often stiff and jerky with a loss of control in the affected limbs. Muscle tone is increased and limbs involved tend to be stiff but weak (Stopford, 1987).

Two of the participants were classified Athetoid. Athetosis is a result of damage to the basal ganglia. This area of the brain ensures smooth and organised movements. Injury to this

area is therefore characterised by increased and involuntary, jerky and irregular movements with an apparent lack of control over the whole body. Anxiety can often intensify these jerky movements. People with athetosis may lack facial control, leading to grimacing and dribbling and this was the case with two participants. These facial movements often evoke adverse responses from people who may wrongly make presumptions based upon them. These presumptions are mostly unfounded, since young people with athetosis tend to have unimpaired learning and intelligence (Stopford, 1987).

The third classification is known as Ataxia, and two participants were in this group. Here damage is to the cerebellum, which governs balance and co-ordination. Ataxia is consequently characterised by unsteady movements and difficulty in balance and co-ordination (Stopford, 1987).

Since cerebral palsy is a heterogeneous disorder whose physical parameters are clear and in which associated handicaps are commonly present and diverse in nature, the lack of data with regard to emotional problems, socialization and self-esteem should not be surprising (Freeman, 1970).

What is important to note however, is that the social interaction of children with cerebral palsy may for example at the very onset be hindered by their physical difficulties. Abnormal facial expressions and grimaces, slurred speech and waving arms and clenched fists, can easily disrupt the so-called "infant elicited social behaviour" of adults. People quickly conclude that the child is being difficult when it comes to making contact with others. This often leads to problems of attachment, which in turn is predictive of poor patterns of peer relations (Erwin, 1993).



CHAPTER 9

DATA COLLECTION

After having obtained approval from the Governing Board of the institution, the researcher proceeded to obtain the written consent from the individual participants and their parents to participate and to be recorded. The researcher then made an appointment to conduct the interviews at a time and place convenient to each participant.

Each participant was asked to recall a particular situation in which they were in contact with a non-disabled peer group and to describe what was good or bad about this encounter. They were requested to describe their experience as they remembered it, including their thoughts, feelings and perceptions as they remembered experiencing them. They were further requested to continue to describe this experience until they felt it was fully described. Clarifying questions were asked at appropriate times during the course of the interview. However, suggestive and leading questions were strictly avoided.

The questions were left as open-ended and non-directive as possible. More specifically, the questions were not phrased around aspects of worthiness and competence. The researcher believes that in the participants' descriptions of their encounter with non-disabled peers, those very aspects of self-esteem would be reflected.

These recorded interviews were then transcribed and typed out. The researcher read the transcript and where certain areas were not too clear, the participants were then consulted in order to obtain greater clarity about certain areas.