

TITLE PAGE

THE SELF-CONCEPT OF ADOLESCENT LEARNERS WITH CEREBRAL PALSY IN SPECIAL SCHOOLS IN LIMPOPO PROVINCE

by

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DECLARATION

DECLARATION

I declare that the Self-concept of Adolescent Learners with Cerebral Palsy in Special Schools in Limpopo Province hereby submitted to the University of Limpopo, for the degree of Masters of Education In Educational Psychology, has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Legodi M. M. (Mrs)

Date

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DEDICATION

This work is dedicated to both of my beloved moms, Pheladi, Melida Legodi and Pheladi, Paulina Mabitsela.

To my adorable grandchild, Tshiamo Mmankwana Legodi, this is for you!!

ABSTRACT

Self-concept is a driving force, (Barongo & Nyamwange, 2013: 7) and Harter (1998: 559) pointed out that improved self-concept is an important means to enhance other desirable outcomes like, self-acceptance and academic improvement. The purpose of this study was therefore to explore the self-concept of adolescent learners with cerebral palsy in special schools in Limpopo Province, to check their level of self-concept. The objectives of this study were to determine if cerebral palsy affects the self-concept of these learners, to measure their level of self-concept and to find out if intervention improves their self-concept.

The sample was selected by means of random sampling. The Self Descriptive Questionnaire (SDQ) with nine subscales was administered to a group of participants, 65 adolescent learners with cerebral palsy, (30 males and 35 females) at the three special schools; Helena Franz, Letaba and Tšhilizini. The questionnaire was administered to the respondents twice, before and after intervention. Pre-test and post-test were done at Helena Franz Special School since it was the only high school among the three special schools catering for cerebral palsied learners in Limpopo Province.

The empirical investigation revealed that the self-concept of adolescents with cerebral palsy in special schools in Limpopo Province is not negative but just leaning in the direction of the positive judgments. It further indicated that cerebral palsy affects the self-concept of the adolescent learners and that intervention has a positive impact on the self-concept of adolescent learners with cerebral palsy.

Key terms:

- Cerebral palsy
- Self-concept
- Adolescent

CHAPTER 1

1. Introductory Orientation

1.1 Introduction

During the apartheid era, the education system of South Africa turned a blind eye on Black children with special needs. The Education White Paper 6 (2001: 5) on special needs education states that specialized education and support were reserved for whites. This is also evident in the following data which revealed the extent of the differences in the provision for learners with disabilities (Education White Paper 6, 2001: 7).

1. Gauteng had 17, 4% of the disabled population but had 25-26% of the special schools.
2. The incidence of disabilities in the Eastern Cape constituted 17, 39% of the disabled population, yet the province had only 10, 79% of the total number of special schools.
3. The Western Cape had 5, 47% of the disabled population but had 21, 58% of the schools.
4. Limpopo Province had 11, 17% of the disabled population but had 5, 00% of the total number of special schools. This resulted in illiteracy of many children with special needs, which is contradictory to the principle of equal opportunities for education, including equal standards in education (Education White paper 6, 2001: 7). Mendis (2006: 2) emphasized that Children who have disability and who are deprived of early childhood education are deprived of many rights: the right to play with other children; the right to enjoy their childhood like other children of their age; the right to form friendships, and the right to opportunities and stimulation to promote their maximum development and realize their full potential. Pretorius and le Roux (1998) maintained that a child who is deprived of opportunities is characterized by poor self-concept.

With inclusive education, which is being introduced at the present moment, there is hope for the future generation of children with disabilities because they have many

schools to go to. There is still a lot to be done by reconstructing the existing buildings to accommodate disabled learners, work-shopping of children (both able-bodied and disabled), teachers and parents. It is the belief of the researcher that this will alleviate frustrations and stress from parents of disabled children. It will further minimize not only illiteracy, but also labelling, categorization and stigmatization of disabled children, which have an adverse effect on their self-esteem and self-worth.

1.2 Background of the problem

The researcher focused on the self-concept of cerebral palsied children in this study. Cerebral Palsy (CP) is a condition in which humans become unable to use some of the muscles in their bodies in the normal way due to injury of the brain. This is one of the conditions which, if not well cared for, can cause frustrations and distress to children and parents. According to Yahaya, Ramli, Boon, Ghaffar and Zakariya (2009: 290), a family has a strong influence and effect on the development of a child. According to them, this is because a child spends his/her formative years among family members than he/she does in a school with friends and teachers. Yahaya et al. (2009: 290) emphasized that these years lay the foundation of the whole life of a child, thus parents influence the development of the self-concept and personality of their children way before they start school. Children who do not have acclaimed personality are a result of the family that does not fulfil their responsibility. Parents have a tendency of over-protecting and over sympathizing with their cerebral palsied children. These, in fact, work to the children's disadvantage in the sense that decisions in the family are made without their contribution and they are forbidden to go on outings with their peers. According to Barker (1953: 86-88), this encourages premature superficial development and disturbs the desirable development of the ego. Some children are not allowed to contribute to household chores, for example. As a result, they grow up to be disempowered adults, unable to take decisions, solve problems or take initiatives (Department of Education White Paper 6, 1997: 6).

In developing the self-concept of cerebral palsied children, Rogers saw conditional and unconditional positive regard as key. The children who are raised in an environment of unconditional positive regard have the opportunity to fully actualize themselves. Those raised in an environment of conditional positive regard only feel worthy if they match conditions (what Rogers describes as conditions of worth) that

have been laid down by others (Farber, 1998: 50). The question is: do parents of cerebral palsied children possess this knowledge?

According to Woolfson (2004: 4), the effects of CP are certainly not limited to the person with the illness. Family members, especially parents, can be under huge amounts of stress as they try to accept the fact that their child is cerebral palsied and also try to cope with their child's dilemma. Though it is sometimes hard, the underlying love for one's child and the desire to do everything within one's power to help inspire some parents. The researcher understood that this underlying love does not exist in every parent of a child with cerebral palsy and it results in the children being put into orphanages. This deprives some children with cerebral palsy of the support from parents when it is actually one of the greatest predictors of global self-worth in children with cerebral palsy (Harter, 1999: 125).

According to Woolfson (2004: 9), a cerebral palsied child is a social being; having one friend at least reduces loneliness. It is also a proactive factor against being picked on, unless the friend is a potential victim too, which then is an additional risk for rejection. Children with CP, particularly girls, tend to have a positive perception of other children based on physical similarities, social status and behaviour. This criterion leaves out other children with different physical features and also encourages avoidance among children with cerebral palsy, which is contrary to the development of a positive self-concept (Harter, 1999: 125). The role of parents and teachers in maintaining positive social adjustment is very important. Many adolescents with CP depending on the severity of the disorder have restrictions in daily activities and social activities such as mobility, self-care, community living and leisure activities. According to Lalkhen (2000: 50), these restrictions may contribute to the development of a negative self-concept in adolescents with CP as success in mobility, self-care, leisure activities etc. are vital for the development of a positive self-concept in these children.

Cerebral palsied children need to be encouraged to view their disabilities as one component of themselves but not the only component. CP children should be made to understand that they too have got strengths and weaknesses. Barker (1953: 61) stated that CP children are unique persons with many qualities in common with the

rest of humanity.

It was the feeling of the researcher that discrimination and stereotypes from society might have a negative effect on the self-concept of the cerebral palsied children as Department of Education White paper 6 (1997: 19) stated, that our society puts more emphasis on looks and being same as everyone else. Thus, CP children might put additional pressure on themselves to try to meet society's impossible standards. It should be the aim of the parents of cerebral palsied children, teachers and the society at large to consciously foster a positive self-image and self-worth in children with CP. The sense of self in turn provides the emotional resilience that people need to persevere through defeats, conflicts and many stressors of day-to-day life. According to Baron, Branscombe and Byrne (2009: 165), parents provide a crucial role in shaping the child's self-concept because a child's self-concept is more dependent on what the parents and others declare it to be than on the child's actual feelings and perceptions. Parents of CP children should therefore learn to be supportive in the upbringing of their children. It is the belief of the researcher that if they give their children the necessary support, their self-concept will be positive.

Self-concept is the underlying force that energizes, directs and sustains behaviour across a wide variety of situations. It is therefore the researcher's wish to see the self-concept of cerebral palsied children being positive. It is equally the belief of the researcher that there is a necessity for the cerebral palsied children to get professional help on how best they can cope in their condition. Though professionals for helping cerebral palsied children with coping skills are available, they seem to be accessible to a certain socio-economic group. As Bornman and Allant (2002: 34) stated, the majority of services provided by professionals are in a few large cities, making it inaccessible to the rural population thus, leading to services being provided to less than three percentages of disabled people in need.

1.3 Preliminary literature review

Self-concept has both a descriptive and an evaluative aspect such that individuals may describe themselves as ("I am happy") and evaluate themselves as ("I do well in maths"). It is noted that the distinction between self-evaluation and self-description has not been clarified conceptually or empirically, so the term self-concept and self-esteem are used interchangeably (Baron, Branscombe & Byrne, 2009: 59). Arnold

and Chapman (1992: 102) conducted their research in Britain in which the self-esteem of 15 adolescents with physical disability, six had cerebral palsy, two had spina bifida, two asthmatic, one had a heart ailment and four had other conditions, was compared with 35 able-bodied students. The major finding was that the students with physical disability and the able-bodied did not have significantly different levels of self-esteem.

Different studies were done in America comparing the self-concept of cerebral palsied children including other physical disabilities and able-bodied ones (Magill-Evans & Restall, 1991: 819-825: 406, Rickards, Kelly, Doyle, & Callanan, 2001: 11-18, Anderson, Clarke & Spain, 2002: 141). Magill-Evans & Restall, (1991: 819-825) conducted a longitudinal study of self-esteem in 22 adolescents with cerebral palsy. The subjects were matched with nondisabled adolescents by age, sex, IQ, and school. Seven years later, 39 of the 44 subjects (mean age = 22.8 years) completed the Tennessee Self-Concept Scale, the Social Support Inventory, and a demographic questionnaire with some open-ended questions. The results showed that as adolescents, the girls with cerebral palsy scored significantly lower than the other groups on physical, social, and personal self-esteem; however, as adults, these subjects were no longer significantly different from the other groups. Male subjects with cerebral palsy had self-esteem scores similar to those of the nondisabled groups in both adolescence and adulthood. The factors that the subjects identified as leading to changes in self-esteem were relationships and experiences. According to Magill-Evans and Restall (1991: 819-825), the low self-esteem scores indicated that psychosocial occupational therapy intervention with adolescent girls with cerebral palsy and with some adults with cerebral palsy would be appropriate.

Rickards, Kelly, Doyle and Callanan (2001: 11-18) made a comparison of cognition, academic progress, behaviour and self-concept of children of very low birth weight (VLBW) and children of normal birth weight (NBW), it was found that VLBW children had significantly reduced self-esteem. It was further found that VLBW children had more cognitive, academic and behavioural problems and lower self-esteem at 14 years of age than NBW control subjects. According to Rickards et al. (2001: 11-18), very low birth weight infants are 100 times more likely to develop CP. Anderson,

Clarke & Spain, 2002: 141) compared the self-esteem of disabled children with that of the able-bodied people. The results have shown that some children with physical disabilities had low levels of self-esteem. They also reported that disabled children described themselves in more negative terms than able-bodied controls. In the abovementioned study by Anderson et al. (2002: 141), it was found that in general, the handicapped group presented themselves frequently as lacking in self-confidence, having low self-esteem, and worrying about their handicaps and lack of skills, and in consequence very often showing signs of real misery and depression.

Cooper-smith (1967: 41) carried out an extensive study in San Francisco of cerebral palsied children possessing high self-concept and found that parents of those children were firm in their control of them, but also took time to explain the reason for their actions. Such reasoning confers respect because it assumes that the child is important enough to be entitled to an explanation and intelligent enough to comprehend it.

Laker (2001: 10) investigated the self-concept of a group of adolescent learners with physical disability in Eastern Cape. The short-term aim of her investigation was to examine the relationship between the self-concept and physical disability, while the long-term aim was to develop an understanding for “being different”, especially within an inclusive school environment. The results indicated that physical disability has implications for self-rated popularity, as well as the degree of denial resulting in problematic behaviour during the adolescent phase.

Curtis and Shaver cited in Mwamwenda (1995: 96) in their research conducted in Botswana observed that self-concept can be facilitated in the classroom setting by allowing pupils with negative self-concept to experience success and by challenging the pupils intellectually. Pupils should be given tasks which they are able to complete successfully, since this is likely to contribute to a positive self-concept. Any pupil according to Mwamwenda can experience success if the instruction test is structured in such a way that it matches his mental ability.

Self-concept develops from childhood through adulthood as a result of a person's interaction with their environment which includes parents, siblings, peers, teachers, other members of society as well as the various tasks and responsibilities a person

is assigned and how well they cope with them (Mboya, 1999: 6). Increasing evidence supports the theory that there is a correlation between self-concept and academic achievement (Engelbrecht, Kriegler, & Booysen, 1996: 225). Mboya (1999: 6) further stated that successful students feel more sense of personal worth and somewhat better about themselves. According to them however, the relationship is reciprocal. Those who have high self-esteem have higher academic achievements and those who are academic achievers have higher self-esteem. Students who have confidence in themselves have the courage to try and are motivated to live up to what they believe about themselves. Those who are not confident of themselves impose limitations on their own achievements. They feel they “cannot do it anyhow” or are “not smart enough”.

Mboya (1999: 85-86) made rural-urban and gender comparisons of African adolescents’ self-concept in Pretoria using the Self-Description Inventory questionnaire. The results indicated that rural-urban differences in self-concept did appear in the sample of African adolescents since both students of rural and urban domicile obtained different self-concept scores in most domains of self-concept. Rural students scored higher than their urban counterparts on those aspects of self-concept that are communal and relational in nature (such as relations with family, general school, relations with peers).

A research was conducted in Pretoria where in Lalkhen (2000: 5) attempted to arrive at a phenomenological understanding of self-esteem as experienced by a group of physically disabled adolescents with cerebral palsy in a non-disabled environment. The results showed that the disabled adolescents who are denied opportunities to engage with non-disabled peers, and who are denied choice and the possibility of making independent decisions, are intuitively less likely to develop a sense of self-worth and competence, and consequently less likely to participate in adult society and relationships. From a phenomenological point of view, lowered self-esteem results from the infringement of, or impending threat to the integrity of the disabled adolescent, not simply the body and its functioning.

1.4 Statement of the problem

Self-concept is the underlying force that energizes, directs and sustains behaviour

across a wide variety of situations. Therefore, if a child is to be successful, he/she has to have a positive self-concept. As already mentioned, little information is available on the self-concept of learners with cerebral palsy in Africa and none was found in Limpopo Province therefore, can we sincerely say cerebral palsy affects the self-concept of adolescent learners?

1.5 Aim of the study

1.5.1 General aim

The aim of the study is to explore the self-concept of cerebral palsied adolescent learners in special schools in Limpopo Province.

1.6 Research questions

1. Do the CP children in special schools in Limpopo Province have a positive or negative self-concept?
2. What is the relationship between cerebral palsy and self-concept of learners in special schools in Limpopo Province?
3. What is the effect of intervention on the self-concept of children with cerebral palsy?

1.7 Objectives

1. To find out if cerebral palsy affects the self-concept of adolescent learners with CP in special schools in Limpopo Province.
2. To measure the level of self-concept of cerebral palsied learners in special schools in Limpopo Province.
3. To find out if intervention strategies improve the self-concept of cerebral palsied children.

1.8 Hypotheses

The hypotheses of this study are as follows and more have been added in Chapter Five:

H_1 The self-concept of adolescent learners with CP in special schools in Limpopo Province is positive.

H_0 The self-concept of adolescent learners with C P in special schools in Limpopo

Province is negative.

H₁ Cerebral palsy affects the self-concept of adolescent learners with CP.

H₀ Cerebral palsy does not affect the self-concept of adolescent learners with CP.

H₁ Life Skills Intervention programme has a positive effect on the self-concept of cerebral palsied adolescent learners.

H₀ Life Skills Intervention programme does not have a positive effect on the self-concept of cerebral palsied adolescent learners.

1.9 Rationale for the Study

During adolescence, self-concept becomes increasingly important. This is a time of rapid change, and differences between the genders become more apparent. Sometimes these changes have either a positive or negative effect on the way these youth perceive themselves. The self-concept of these children change based on how they view themselves. According to Carl Rogers (1959: 184), self-concept includes three components:

- Self-image - how one sees oneself, however; this does not always coincide with reality.
- Self-esteem - how much you value yourself. A number of different factors can impact self-esteem, including how we compare ourselves to others and how others respond to us.
- Ideal-self - how one wishes he/she could be. In many cases, the way we see ourselves and how we would like to see ourselves do not quite match up.

How adolescents with cerebral palsy value themselves and view themselves may therefore be key predictors of their future life success (Harter, 1998: 557). Thus, the purpose of this study was to explore the self-concept of cerebral palsied adolescent learners in special schools in Limpopo Province, to take a look at the level of self-concept of these learners. Self-concept is a driving force (Barongo & Nyamwange, 2013: 7), it was therefore the researcher's belief that CP learners like their normative counter parts, need a positive self-concept. Harter (1998: 559) pointed out that improved self-concept is an important means to enhance other desirable outcomes like, self-acceptance and academic improvement.

1.10 Significance of the study

This study intends to find out the self-concept of learners with cerebral palsy. It may help those learners by recommending for the employment of professionals such as, physiotherapists, speech therapists and occupational therapists. These professionals may either be permanently employed at the special schools in Limpopo Province or visit those schools on a regular basis depending on the needs of these learners. Physical therapy, for example is one of the most important aspects of cerebral palsy therapy. It consists of activities and education to improve flexibility, strength, mobility and function. Improvement of flexibility, strength, mobility and function in the cerebral palsied child greatly improves his/her quality of life which in turn boosts the self-concept (Trahan & Malouin, 2002: 236). According to Harter (1998: 559), improved self-concept is an important means to enhance other desirable outcomes like, self-acceptance, academic improvement etc. Though information on the self-concept of learners with cerebral palsy is available in Africa, search of literature did not produce studies which have a similar topic to the recent study in Limpopo Province. The degree to which the disability affects the self-concept of these learners is therefore not fully known. Also, little is known of the social lives and emotional maturation of children with cerebral palsy, hence, this research will assist in that regard.

1.11 Definition of concepts

1.11.1 Cerebral palsy

Cerebral palsy is a condition in which human beings are unable to use some of the muscles in their bodies in a normal way due to an injury to the brain. Cogher, Savage and Smith (1992: 3) defined cerebral palsy as referring to a group of conditions, which share the features of central motor deficit which is non-progressive pathologically, and which is acquired in early life. It is a condition characterized by paralysis, weakness, in co-ordination or any pathology of the motor control centres of the brain. “Medical News Today” (2009) defined cerebral palsy as a term which encompasses a set of neurological conditions that cause physical disability in human development. These neurological conditions affect the brain and nervous system. The word “cerebral” according to “Medical News Today” (2009) refers to the area in the brain that is affected, while “palsy” means complete or partial muscle paralysis. This is frequently accompanied by loss of sensation and uncontrollable body movements or tremors. Kapp, Joubert and Bezuidenhout (2001: 270) defined

cerebral palsy as a physical disability caused by factors which affect the not yet fully grown brain prior to or during birth, or during the early postnatal period. They further stated that the disability comprises one or more of the following characteristics: paralysis, weakness, in co-ordination and functional deviation of the motor system. In this study, cerebral palsy is a condition in which adolescents display a variety of motor defects associated with damage to the brain cells, probably as a result of lack of oxygen during the birth process.

1.11.2 Self-concept

Pastorino and Doyle-Portillo (2013: 14) defined Self-concept as our perception or image of our abilities and our uniqueness. According to them, at first one's self-concept is very general and changeable but as we grow older, these self-perceptions become much more organized, detailed and specific. According to Barongo and Nyamwange (2013: 7), self-concept is a collection of beliefs about one's own nature, unique qualities, and typical behavior. Ones' self-concept is his/her mental picture of himself/herself. It is a collection of self-perceptions and a descriptive component of oneself. For example, a self-concept might include such beliefs and descriptions as 'I am easygoing' or 'I am pretty' or 'I am hardworking.' Delamater (2006: 208) defined self-concept as a totality of the individual's thoughts and feelings having references to himself as an object. It reflects the individual's unique body of information and point of view about himself. In this study self-concept refers to the overall view an adolescent with cerebral palsy has of him/herself which includes appearance, ability, attitudes, health and relationship with others.

1.11.3 Adolescent

In this study adolescent refers to a child between fourteen (14) and twenty one year (21) of age. Atkinson, Atkinson and Hilgard (2009: 92) defined adolescence as a period of transition from childhood to adulthood.

1.12 Structure of the Report

The aim of this study was to explore the self-concept of adolescent learners with cerebral palsy in special schools in Limpopo Province. The field work was conducted in Limpopo Province of South Africa. This chapter served as an orientation for the study and outlined the problems that necessitated this study. The problems were

identified and analysed to develop an understanding of the background of the adolescents with cerebral palsy in general. It also provided the aims, gave some definition of concepts relevant to this study. Chapter two focused on the self-concept, its structure and development and how effectively the parents and teachers can improve the self-concept of children with cerebral palsy. Chapter three gave an insight of what cerebral palsy is, its origin and classification. It also gave a summary of the previous studies done on cerebral palsy and self-concept and intervention of children with cerebral palsy. In chapter four the focus was on the collection of data. A questionnaire was used to collect data on the self-concept of the adolescents with cerebral palsy. Intervention programme on how to improve the self-concept of the adolescents with cerebral palsy was laid out. In chapter five the data were analysed and the research findings communicated. The research findings gave answers to the research questions and hypotheses. Chapter six gave a detailed overview of this study. It put emphasis on major conclusions and recommendations for further research.

1.13 Conclusion

This chapter provided the orientation of the study: the background to the problem and a layout provided of the plan of the study. The significance of the study was stated as well as the research questions, aims, hypotheses and the explanation of the definitions of the most important concepts that were used during the research. The chapter concluded with the structure of this report. In the chapter that follows discussion of theoretical framework on self-concept will be made.

CHAPTER 2

2. Theoretical Framework on Self-Concept

2.1 Introduction

Adolescence is the period of psychological and social transition between childhood and adulthood. This transition involves biological (i.e. pubertal) and psychological changes. It is also a cultural and social phenomenon; therefore, its endpoints are not necessarily tied to physical milestones (Tessie & Rodriguez, 2009: 98). It represents the second decade of life. According to Tessie and Rodriguez, during this stage, world views become important and the individual enters what is called a ‘psychological moratorium’, which refers to a period of exploring different roles, values, and skills. Important decisions about jobs and life have to be made. Every child has dreams and expectations about life. There is also anxiety about success and failure. The level of anxiety varies from individual to individual. This may depend upon how an individual perceives or evaluates himself, that is, a person’s self-concept.

2.2 Definition of self-concept

Delamater (2006: 208) defined self-concept as a totality of individuals’ thoughts and feelings having reference to them as an object. It reflects individuals’ unique body of information and point of view about themselves. Barongo and Nyamwange (2013: 7) noted that self-concept is a collection of self-perceptions and a descriptive component of oneself. Some parts of the self-concept may be regarded as good or bad, but some may be neutral. Self-concept is the organized set of characteristics that individuals perceive as peculiar to themselves which is based largely on the social evaluations they have experienced (Rogers in Ryckman, 1993: 106). Connected to the development of the self-concept are secondary needs: the need for positive regard from others and the need for positive self-regard. These, according to Maddi (1996: 50), lead to the favouring of behaviour that is consistent with the person’s self-concept. When the significant others in the person’s world (usually parents) provide positive regard that is conditional, rather than unconditional, the person interjects the desired values, owning them and thus acquiring ‘conditions of

worth'. The self then becomes based on these values rather than on organismic evaluation. Rogers cited in Baron, Branscombe and Byrne (2009: 165) further stated that a child's self-concept is more dependent on what the parents and others declare it to be, than on the child's actual feelings and perceptions. It is therefore reasonable to assume that the quality of teacher-student relationships, perceived quality of school life, relationship with peers, parents-child relationships and personal views are the contributing factors in the development of the adolescent's self-concept.

Self-concept evolves through constant self-evaluation in different situations. Adolescents are continually asking themselves, "How am I doing?" They gauge the verbal and non-verbal reactions of significant people-parents and other family members in the early years and later friends, schoolmates and teachers to make judgments (Hendrick, 2005: 200, Barker, 2007: 61). Students compare their performances with their own standards and with the performances of peers. Both personal (internal) and social (external) comparisons are important. Self-concept is the concept or image a person has of him/her, and is unique, personal and highly meaningful to the person concerned. It is a core of a person's personality (Gouws & Kruger, 1994: 6). Personality factors, including self-esteem and self-concept, are among the main factors thought associated with psychological problems in adolescents (Anderson, Clarke, & Spain, 2002: 141). Personality is also considered a proactive factor that can reduce the likelihood of adjustment problems (Garmezy, 1983: 50). How adolescents with cerebral palsy value themselves and view themselves may therefore be key predictors of their adjustment and future life success (Harter, 1998: 557).

During adolescence, feelings of self-worth are more closely tied to physical appearance and social acceptance (Woolfolk, 1998: 75). The physical and social changes which occur during this stage have been found to be associated with changes in self-concept (Lalkhen, 2000: 35). As body image is an important factor in adolescent self-concept development, it is reasonable to assume that physical disability would have an effect on self-concept and self-esteem. Mussen et al. (1984: 356-357) differentiated self-concept and self-esteem as follows: Self-concept is a set of ideas about one-self that is descriptive rather than judgmental. Self-esteem, on the other hand, refers to one's evaluation of one's own qualities. It is further

assumed that with cerebral palsied children, the permanence of their disability can truly be felt during this stage as they become increasingly aware of their physical differences and areas of competence. As a sequence of functional limitations and attitudes and reactions of those around them, adolescence with cerebral palsy often feel socially isolated. Success to them is defined as "being happy," while the opposite is frustrating. Adolescents with cerebral palsy often experience their own physicality in such a negative way that it may cause a distorted self-concept (Kaap, 1997: 203, Kusherets, 2000: 5).

2.3 The effects of physical disability on the development of self-concept

Though the physically disabled often experience their own physicality in a negative way one of the Freudians, Meng, in Barker (1953: 87) pointed out that physical disability does not necessarily result in a distorted self-concept. He emphasized that although some factors in the environment of a physically disabled person often tend to produce distortion, other factors operate at the same time to lessen the probability of its occurrence. He described some of those factors as follows:

Narcissistic satisfactions are commonly experienced by people with cerebral palsy. Defect and pain give them a claim to approval and attention, even to admiration. The fact of being different elicits some narcissistic satisfaction. The cerebral palsied, therefore, are usually free from this obstacle to desirable personality development. They are people of some importance by virtue of their peculiar physique. This is particularly applicable to the cerebral palsied adults. In the case of children with cerebral palsy, the actions of adults tend to prevent the development of a normal childish narcissism. Spoiling or over indulgence, on the other hand, and neglect or rejection, on the other, both have this effect. These reactions of adults frequently result either in prolongation or shortening of the period of dependency, both of which are unfortunate for the desirable development of the ego.

Overcompensation frequently occurs in cerebral palsied children. The cause according to Barker (1953: 87) lies much deeper. The child feels inferior only when he/she is not loved or when love is withdrawn. Organic inferiority does not have the etiological significance for the development of neuroses, but because of the frequent tendency to overprotect or to reject cerebral palsied children, inferiority feelings are

common (Barker, 1953: 87).

The physically handicapped person easily becomes hypochondriacal for two reasons. First it is easier for the healthy person to forget his/her body because he/she does not have any deformity or body ailment, than for the sick or physically disabled persons. According to Freud's "Sociological Theory", when a person feels a physical pain in a hurting body organ, he/she puts a cathexis on the psychic representation of that body part, that is, he/she concentrates on it and it seems to have a role and image of its own in the body. Barker (1953: 88) emphasized that a defect in any part of the body emphasizes the libidinal attachment to that part. The more the social environment rejects or indulges the person, the greater the cathexis will become, that is, the deformity will always be blamed for the rejection or indulgence. Second, Baker continued to point that the handicapped person who has other anxieties will tend to transfer them to the bodily handicap for instance, if he/she has to prepare for a difficult test, he/she will start complaining about the deformed body part.

All young children believe that their parents are supreme, that they are the givers and the takers-away. When this belief is carried over to older ages, it gives rise to paranoid ideas. Cerebral palsied children also have this belief. They are likely to blame their parents for their handicap. This gives rise to hostility and frequently to disapproved actions. It is more likely, however, that the hostile impulses will be repressed, laying the basis for anxiety and accompanying guilt feelings (Barker, 1953: 89).

Barker (1953: 89) found no indication that physical disability increases the castration complex. He thinks it probable that cerebral palsied children are not fearful of castration since they have already experienced it. Adaptation for reality is in some ways easier for the cerebral palsied, and in some ways more difficult. It is easier in that less is demanded of them, and more difficult in that more effort and self-control are usually required in order to fulfil the demands that are made. In fact, every person with cerebral palsy has to become a virtuoso in those activities to which he/she is limited. Achievement of this virtuosity according to Downey, Riedel and Kutscher (1982: 56) requires a great deal of time, perseverance, and insight on the part of the person with cerebral palsy. In addition, his/her environment must be

protective, self-sacrificing, strong and secure; whether the goal can be reached depends partly upon the environment. Interference with achieving this virtuosity has all the results it has for the real virtuoso: irritability and sensitivity against disturbance. The cerebral palsied child lives in fear that perfection will not be achieved. Achievements give great satisfaction, failure greatly injures narcissism.

The chief task of the parents and teachers of children with cerebral palsy according to Mwamwenda (1995: 368) is to diminish their anxieties. This can be done by bringing to consciousness the children's blame of their parents, which is the basis of their partly repressed hostility and their guilt. The blame and guilt may, to some extent, be avoided in young children if expression of it is encouraged and reassurance given at any age. The second task is to avoid premature superficial development by providing opportunities for play. Children with cerebral palsy can also be helped to set realistic goals. Self-contentment will come only if they set goals of the maximum difficulty achievable by them. The cerebral palsied must first be taught to accept their defect without jealousy of others (Barker, 2007: 61) and without making extravagant demands upon themselves.

2.4 How self-concept can be facilitated

The quest for personal worth is of central importance not only to children, but also to all human beings throughout their lives. It motivates much of our activity in seeking personal attachments and meaningful work. Religious beliefs and institutions are fashioned to enhance self-worth, and artistic creativity is intimately connected with the need to accomplish something which will give us value. Nothing is more important than the maintenance of well-being. Conversely, no experience is more obviously distressing, or more intimately linked to emotional disturbances of many kinds and in psychiatry, to various types of psychopathology, than is a diminished sense of worth or a low opinion of oneself (Watkins & Akande, 1992: 123). That is why it is vital that adults, i.e., parents and teachers, understand more clearly the importance of helping children to generate good feelings that form the basis for a healthy self-concept and self-esteem. Negative feelings about oneself can affect the child's motivation, work, inter-personal relationships, and future success. Once formed a negative self-concept is difficult to reverse (Watkins & Akande, 1992: 124). Self-concept is not innate, but is acquired through learning, therefore, the secondary

educator, the teacher, can play a vital part in facilitating and enhancing self-concept of adolescents at school.

Along with instructional objectives and methods of teaching, the nature of the learner is a major factor in education. A conceptual and empirical approach requires educators to consider differences among students and teaching methods in order to match individual students with instructional treatments that are most effective for them (Gage & Berliner, 1998: 182). An exceptional student or a student with cerebral palsy is one whose education must be specially designed to fit his or her particular physical characteristics, mental characteristics, social behaviour etc.

2.4.1 Positive methods of enhancing self-concept

2.4.1.1 Unconditional positive regard

The most effective way of helping child build basic feeling of self-esteem is the ability to feel and project what Rogers in Baron, Branscombe and Byrne (2009: 165) termed unconditional positive regard. This kind of fundamental acceptance and approval of each child is not contingent upon his/her meeting the teacher's expectations of what he/she should be, but simply depends on his/her being alive, being a child, and being in the group. A good test of being accepting or not is to become aware of what one is usually thinking about when looking at children. An educator can ask: ``Am I taking time to enjoy the children, or am I looking at each one with a critical eye noting mainly what behaviour should be improved?'' If a teacher catches himself/herself habitually noting only what should be changed, this is a sign one is losing sight of half the pleasure of teaching, which is to appreciate the children and enjoy who they are right now, at this particular moment in time, with no strings attached. This ability to be uncritical implies a kind of faith in the way the child will turn out. This is an attitude that subtly makes the child aware that the teacher has confidence; such a child will grow in sound directions. Acceptance of a child as he/she is also includes accepting his/her right to be different from the teacher and from other children. Teachers can make a significant contribution to developing a positive self-concept of the child by unconditionally valuing him/her by using him/her as a model to influence the attitudes of the other children.

2.4.1.2 Honest recognition and praise

According to Kash and Borich (1978: 75), rewarding a child with praise is usually the first way teachers think of to build self-concept. As a matter of fact, it is only one of several ways to enhance a child's feeling of self-worth. To be an effective esteem raiser and motivator, praise should include information about something specific a child has achieved. Praise should be based on performance. Used in that context it can heighten the inner intrinsic satisfaction of the child. Using encouragement rather than praise is another effective way of building self-concept while recognizing what a child is accomplishing. Comments such as: "I believe you can do it if you try", or "Look how much work you have done", encourage children without passing judgment on what they have done.

2.4.1.3 Respect

One basic way to show respect is to abide by the child's decision when he/she has been given a valid choice. When a teacher does this, he/she is really saying "What you want is important. I have confidence that you know yourself better than I do, and I count on you to choose what will enhance your existence most". Children also feel respected when the teacher asks for their opinion and listens carefully to their replies. Another way to show respect, and thus sustain the child's self-concept is to avoid humiliating him/her in front of other people. Belittling a child's behaviour at any time is, of course, fundamentally disrespectful as well as destructive of self-concept (Kash & Borich, 1978: 75).

2.4.2 Improving self-concept among African children

According to Mwamwenda (1995: 370), among African children self-concept can be improved by acknowledging appropriate response. This can be done by positive comments such as "that's a good question", "Very good", "Good point", etc., or simply by a nod or smile in recognition of desirable behaviour. Pupils should be allowed the freedom to express views which differ from those presented during the lesson, as long as such views are supported by logical reasoning. As far as possible, pupils should be treated equally and be given the opportunity to contribute to the proceedings.

According to Mwamwenda, the teacher should learn each pupil's name and use it as often as possible because every individual feels more comfortable and valued when called by his or her name. When time permits he/she should chat with pupils on a one-to-one basis. A teacher should show his/her pupils that he/she cares about them and regards them as his/her friends. If one of them is sick, he/she should be visited or be sent greetings through one of the other pupils or via a note. When the pupil returns to school his/her presence should be acknowledged by a warm welcome. It should be remembered that positive self-concept grows from success in operating in the world and from being valued by important people in the environment. He emphasized that teachers should set reasonable tests, assignments and examinations, so that every pupil who has studied diligently stands a good chance of doing well. They should communicate with every student and make it a point to interact with every student as often as possible, as this will give them the impression that the teachers recognize their presence and the contribution they are capable of making toward the proceedings of the class.

As far as possible, teachers should avoid the use of corporal punishment in disciplining pupils and instead concentrate on reinforcing positive behaviour. The teachers should be genuine, be real and serious in what they say and do. They should not act as if they are super-human. If there is a need to admit shortcomings they should do so. They should not forget that students are capable of judging whether what teachers say is really true or not. Teachers should also be empathetic. They should look at problems or whatever pupils are engaged in from their perspective. Dornyei (2001: 134) emphasized that pupils should be encouraged to evaluate themselves realistically because one of the reasons for negative self-concept is setting goals that are too high or unattainable. Therefore, students should be encouraged in their self-evaluation and what they are capable of achieving. Teachers should set up support groups or "study buddies" in school and teach students how to encourage each other. Students should also be helped to set clear goals and objectives; to brainstorm about resources they have for reaching their goals.

Students should be encouraged to praise themselves. According to Mwamwenda (1995: 370), they should be told that it is appropriate for them to praise themselves

and where the situation warrants it, this is likely to foster and consolidate one's self-concept. They should also be encouraged to praise others. Praising others brings praise and reinforcement in return, which is a very therapeutic process.

Teachers should value and accept all pupils for their attempts as well as their accomplishments. They should create a climate which is physically and psychologically safe for students and become aware of their personal biases and expectations. They should make sure that their procedures for teaching and grouping students are really necessary, not just a convenient way of handling problem students or avoiding contact with some students. Partin, Robertson, Maggin, Oliver, and Wehby (2009: 174) stated that the strategy for handling problem students and minimizing behavioural disruptions is by praising students and increasing giving those opportunities to respond during lessons. Students should be accepted even when the teacher must reject a particular behaviour or outcome. Students should feel confident, for example, that failing a test or being reprimanded in class does not make them ``bad'' people. Teachers should encourage students to take responsibility for their reactions to events and show them that they have choices in how to respond. In whatever students, teachers should try to find something that is positive as a way of building on their self-concept.

2.4.3 Using the power of families to improve students' self-concept

The following strategies were proved effective in improving students' self-concept in Fantuzzo, Davis and Ginsburg's study (1995: 272). The teacher who is working with families to co-create methods for family involvement offers a range of possible participation methods and makes sure that the plans are realistic and fit the lives of the families. He/she maintains regular home-school contact through telephone calls or notes. If a family has no telephone, he/she identifies a contact person (relative or friend) who can take messages. According to Fantuzzo et al. (1995: 273), if literacy is a problem the teacher should use pictures, symbols, and codes for written communication. All communications are made positive, emphasizing growth, progress, and accomplishments. Together with the families, the teacher designs family-student celebrations of the student's efforts and success (a movie, special meal, trip to the park or library, going out for ice cream or pizza). On a regular basis, he/she sends home a note in words or picture form that describes the student's progress. He/she also asks families to indicate how they celebrated the success and

to return the note. The teacher should make a follow up with a telephone call to discuss progress, answer questions, solicit family suggestions, and express appreciation for the families' contributions. Lastly, he/she should encourage families to visit the classroom.

2.5 School practices that reduce the development of a positive self-concept.

The following school practices should be avoided as they are likely to reduce the development of positive self-concept (Fantuzzo, Davis & Ginsburg, 1995: 276):

2.5.1 Using comparison and competition to motivate good behaviour

The trouble with motivating behaviour by drawing such comparison and setting up competitive situations is that only a few children ``win'' under this system. Even a child who turns out to be ``best'' and whose self-concept has presumably been enhanced pays an unfortunate price, since he/she has obtained his/her self-concept at the expense of the other children's well-being and may have earned their dislike in the process. A more desirable way to use comparison is by invoking it in relation to the child's own past performance.

2.5.2 Judging children in their hearing.

Children often develop ideas of who they are from hearing what other people say about them. Sometimes this happens in direct form as when the teacher says impatiently, ``Come along now, you are always so slow'' or asks, ``How can you be so selfish?'' Other children are also prone to deliver pronouncement such as, ``You pig! You never share anything'', or ``Hazen is a pooh-pooh pants''. Labels such as these tend to stick, enough of them plastered on a child can convince him/her that he/she is neither liked nor worth much, so he/she might as well not try. Verbal attacks are destructive to other people's self-concept. Sometimes negative evaluations are not delivered directly to the child, but are said over his head to someone else instead: ``My, aren't we in a terrible temper today! I see he's having a hard day again!'' Somehow, overheard comments have a special, painful power to compel belief. Teachers should avoid making them not only for his/her reasons, but also because they may hurt a child's feelings and can strengthen a negative self-image. On a more subtle level, talking over children's head implies that they are not important enough to be included directly in the conversation.

2.6 Theoretical orientation

2.6.1 Self-concept theory

The self-concept theory emphasizes the study of an individual as a whole and the active role which each person plays in actualizing his/her own inherent potentials. The theory believes that the environment plays a facilitating or inhibiting role in this process. According to Carl Roger's phenomenological approach, self-concept determines behaviour (Pervin & John, 2001: 140). The purpose of all life, according to him, is to become that self which one truly is. The cerebral palsied child may find it very difficult if not impossible to become that self which he/she truly is because of his/her physique (Miyahara & Piek, 2006: 5). Rogers emphasized that the self is the most important aspect of each person's world (Baron, Branscombe & Byrne, 2009: 165). He believed that in addition to maintaining and enhancing the self, everyone needs to have a positive self-regard. That is, from infancy on, we need love and the parents should be the most sources of the affection. As already mentioned, a child's self-concept is more dependent on what the parents and others declare it to be than on the child's actual feelings and perceptions (Baron, Branscombe & Byrne, 2009: 165). In view of the above and on the studies of Barker (1953: 67) which showed no difference in behaviour and personality between disabled persons and normal persons, the researcher is of the opinion that if parents of cerebral palsied children can show confidence in them, they will incorporate that as part of their self-concept.

According to Cooley in Mercadante (2009: 2), self-concept is formed from the reflected images that emanate from social relations. Cooley's central concept is the 'looking glass self' which is a self-image based on how we think others see us, the idea being that those we interact with are as a mirror, reflecting our self-back to us. According to him, how we believe others see us affects how we view ourselves. He basically asserts that our self is simply how we appear to the world. If we believe we come off as intelligent to others, we will believe we are intelligent, and that becomes part of our 'self'. To him, the self does not develop in any way from biological factors. According to Mercadante (2009: 3), Mead's central concept is the "Self" which is part of the individual's personality and is composed of self-awareness and self-image. Mead divides the self into three different parts. In his explanation, the self develops

only with social experiences. The self is not physical, and therefore does not exist at birth. It develops through interaction with others. Mead does not believe that the self is determined by any biological drives. He claims that the self would not grow without human interaction. He explains that social experience is the exchange of symbols. Only humans attach meanings to their actions. They determine the meanings of others' actions by trying to understand their interactions. He compares humans to dogs. According to him, dogs can respond to, and be trained by what people do, but humans respond to what one has in mind as one does it. According to him, humans can consider alternative solutions and actions when what is desired is unattainable. Mead said that understanding intention requires imagining a situation from the other's point of view. According to him, humans are able to take the role of others and view themselves the way others do. Mead also stated that, by taking the role of others, we become self-aware. He divided the self into two parts: the 'I' and the 'Me'. The 'I' is the part of the self which is subjective and is basically our self-directed towards others. The 'Me' part of self according to him is subjective and is how we view our self. It is basically our self-directed towards our self by taking the role of those it is actually directed towards.

2.6.2 Sigmund Freud: A psychoanalytic theory of personality

The psychoanalytic theory is based on the notion that human beings have a complex energy system. According to this theory, each individual has a limited amount of such energy available for mental activity. The goal of all human behaviour is the reduction of tension created by the unpleasant accumulation of energy over time (Pervin & John, 2001: 145). Among the Freudians, Meng (Barker, 1953: 87) studied the problem of physical disability most extensively. According to him, even the most serious physical disability does not necessarily result in a distorted personality. Although some factors on the environment of disabled persons often tend to produce distortion, other factors such as the following operate at the same time to lessen the probability of its occurrence.

1. According to "Mental Health" (2009), narcissism is a term used to describe a focus on the self-admiration that is taken to an extreme. Hotchkiss and Masterson, (2003: 28) argued that unhealthy narcissism is the behaviour and attitudes that protect an undeveloped Self at the expense of others. Meng (Barker, 1953: 87) said that

narcissistic satisfactions are commonly experienced by disabled persons. The actions of adults i.e. spoiling or overindulgence and neglect or rejection, tend to prevent the development of a normal childish narcissism. Those reactions of adults frequently result either in prolongation or shortening of the period of dependency, both of which are unfortunate for the desirable development of the ego.

2. Barker (1953: 87) argued that for the disabled child, the difficulty of engaging in normal play activities is a serious obstacle to normal development in as much as the natural development from the pleasure principle to the reality principle is impeded. According to him, for the said reason, one frequently finds young disabled children talking and acting like adults but without any understanding of what they do or say. They have come to the verbal stage too early because they spend most of their time at home exposed to the adults' conversations and their (children's) understanding is superficial because they have little contact with reality.
3. The physically handicapped person easily becomes hypochondriacal for two reasons. First it is easier for the healthy person to forget his/her body because he/she does not have any deformity or body ailment, than for the sick or physically disabled persons. A defect in any part of the body emphasizes the libidinal attachment to that part. The more the social environment rejects or indulges the person, the greater the cathexis will become, that is, he/she will always blame his/her deformity for the rejection or indulgence. Second, the handicapped person who has other anxieties will tend to transfer them to the bodily handicap. For instance, if he/she has to prepare for a difficult test, he/she will start complaining about the handicap (Barker, 1953: 87).
4. According to Barker (1953: 87), there is no indication that physical disability increases the castration complex. He thought it probable that the physically handicapped are not fearful of castration since they have already experienced it.
5. Barker (1953: 89) found out that some non-psychotic disabled women denied their disability. In the "obliterative reaction", subjects tended to repress any conscious recognition of their disability and to refuse to admit that they were incapacitated in any way. Landis and Bolles in Barker (1953: 88) asserted to this to be the most

satisfactory type of adjustment exhibited by their subjects. It may be that as long as the discrepancy between the actual disabled body and the desired normal body is not so great that a semblance of normal behaviour is impossible, the obliterative reaction leads to satisfactory adjustment. On the other hand, if the discrepancy is great as to lead to a marked dissociation between reality and desire, maladjustment results and in extreme cases becomes delusional.

2.7 The structure and development of self-concept

According to Pervin and John (2001: 171), self-concept represents an organized and consistent set of perceptions. The patterns of experiences and perceptions known as the self, are in general, available to awareness, that is, they can be made conscious. Although individuals do have experiences of which they are unaware, the self-concept is primarily conscious. One's concept of self is composed of interrelated self-perceptions: the perceived self, the ideal self, one's self-esteem, a set of social identities and elements as reflected in figure 2.1 below:

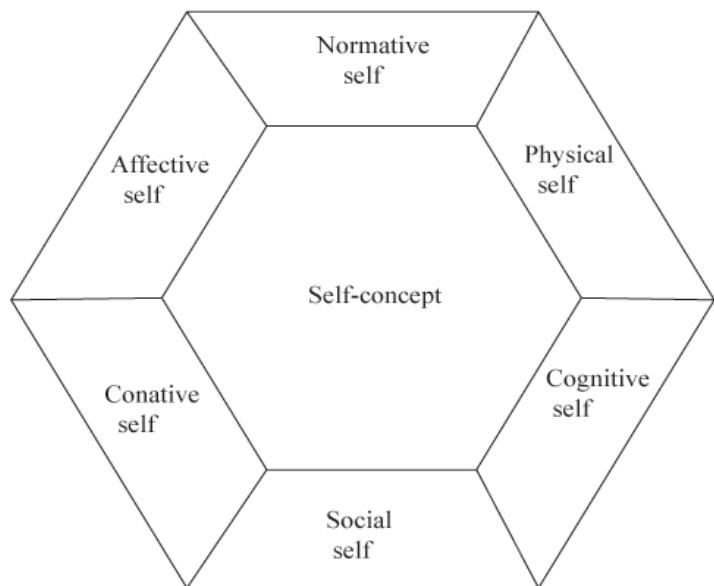


Figure 2.1 Self-concept diagram, adopted from Gouws and Kruger (1995: 7)

The relative importance of these elements may differ from one person to another, but the whole is always affected by the evaluation of specific parts. Fluctuating circumstances and other people's reactions influence the maintenance and change of a person's self-concept. Each of these elements plays a crucial role in understanding how self-concept relates to energizing, directing and sustaining

behaviour (Gouws & Kruger, 1995: 7). The four self-representations, that is, the perceived self, the ideal self, one's self-esteem and social identities will be described and their interrelationships discussed.

2.7.1 The perceived self

One of the earliest theorists writing on the nature of the self was James (1890: 150). He saw the self as consisting of whatever the individual views as belonging to him/her, which includes a material, a social, and a spiritual self. The perception of the material self are those of one's own body, family and possessions. The social self includes the views others have of the individual, and the spiritual includes perceptions of one's emotions and desires. Kihlstrom and Cantor (1984: 147) suggested that individuals hold perceptions of themselves in terms of traits and values, their attributes, experiences, thoughts and actions (Cantor & Kihlstrom, 1985: 16; 1987: 70), and their physical appearance, demographic attributes and dispositions of various sorts (Kihlstrom, Cantor, Albright, Chew, Klein & Niedenthal, 1988: 150). Gecas (1982: 30) asserted that the content of the self-concept consists of perceptions of social and personal identities, traits, attributes, and possessions. The self-concept based model which was proposed utilizes three general categories of self-perceptions (Gecas, 1982: 30). These include traits, competencies and values.

Traits

Traits are labels for broad reaction tendencies and express relatively permanent patterns of behaviour (Cattell, 1965: 25). Fundamental to this definition is the assumption that people make internal attributions to individuals who demonstrate a particular behaviour pattern in different situations or at different times without apparent external reasons. The more cross-situational consistency one observes, and the more external causes of behaviour seem to be lacking, the more likely one would make an internal or dispositional attribution (Harvey, Kelley, & Shapiro, 2006: 300). Individuals hold a set of self-perceptions regarding many different traits.

Competencies

A second element in the perceived self is competencies. Individuals hold perceptions of what skills, abilities, talents and knowledge they possess. These can range from

very specific skills, such as the ability to play piano, to more general competencies, such as the leadership skills to create and manage change.

Values

Values are defined as concept and beliefs about desirable states or behaviours that transcend specific situations, guide selection or evaluation of behaviour and events, and are ordered by relative importance (Schwartz & Bilsky, 1990: 878). Individuals demonstrate certain values through their speech and actions. This element of the perceived self is concerned with the set of values that the individuals believe guide their decisions and actions.

An individual's perception, his or her attributes (i.e., traits, competencies, and values) can be described in terms of two separate dimensions, level and strength. Levels of self-perception refer to the degree to which the individual perceives he/she possesses these attributes. Does the individual see himself/herself as highly introverted (trait), or a very good netball player (competency), or a hard worker (value)? This dimension deals with the issue of where individuals see themselves, relative to their ideal selves, and is directly related to the issue of high and low self-esteem.

When determining the level of an attribute, individuals use two types of evaluative frames of reference. An ordinal standard or frame of reference is used when the individual rates or compares himself/herself to others (i.e., how good he/she is relative to others). To be the first or best is the ultimate criterion when using this type of standard. An individual may also use a fixed standard, whereby he/she rates or evaluates attributes against a goal or predetermined metric or criterion (i.e., to earn a Master's degree). This may take the form of reaching a set of internalized goals or timetables. The second dimension of the perceived self is the strength of the perception, and refers to how strongly the individual holds the perception of attributes level. Individuals with strong perceived selves are relatively firm in their perception of an attribute level. These strong perceptions of self are a result of consistent and clear feedback regarding the attributes. A weak perceived self is reflected in individuals who are relatively unsure of an attribute level, often resulting from conflicting or ambiguous feedback regarding the attributes. How these self-

perceptions develop is explained next.

2.7.1.1 Development of perceived self

Self-perceptions are determined through interaction with one's environment. The process of attitude formation, attitude change, and self-attribution (Jones, 1990: 20) all contribute to the development of a set of self-perceptions. When feedback is unambiguous, plentiful, and consistent, a set of strongly held self-perceptions is formed. Ambiguous, lacking, or inconsistent feedback results in weakly held self-perceptions (Scholl, 2002: 2).

According to Scholl (2002: 2), two primary forms of information one receives about the self from the environment come in the form of task feedback and social feedback. Task feedback comes directly from observation of the results of one's efforts on different task activities. Completion of a project, accomplishment of a goal, and winning a competition are all forms of task feedback. Social feedback is probably the most prevalent type of feedback one receives regarding his or her traits, competencies, and values. It is the feedback one derives from the behaviour and communication, verbal and non-verbal, or others.

The link between social feedback and perceived self is grounded in the process of attribution. As people seek to understand the behaviour of a particular individual, they make certain attributions as to the cause of patterns of behaviour they observe in that individual (Jones & Nisbett, 1971: 15). Under certain conditions, observers make internal or dispositional attributions, mostly in the form of traits, competencies, or values, and these internal attributions become the basis for self-perceptions. These attributions are communicated to the person in a number of ways, both directly and indirectly. Attributions may be communicated directly in the form of written or oral evaluation, praise, reprimand, or recognition. For example, direct feedback may be regarding a trait (you are too aggressive), a competency (you are an excellent teacher), or a value (you are an honest person). In addition, attributions are communicated indirectly in a number of ways. An evaluative statement regarding a project or task for which the individual feels responsible is an example of indirect social feedback. Other types of indirect social feedback come in the form of inclusion or non-inclusion of the individual by group members in their activities, the best owing of positions of status on the individual, and when others accept or fail to accept an

individual's influence by acting or failing to act on his or her advice, recommendations, or orders. It is important to note that the feedback provider does not have to intend to provide feedback for the feedback receiver to interpret an action as social feedback.

2.7.2 The ideal self

While the perceived self describes the set of perceptions individuals hold of their actual traits, competencies and values, the ideal self-represent the set of traits, competencies and values an individual would like to possess (Rogers, 1959: 185). By possess it is meant that the individual desires to believe that he/she actually has a particular trait, competency, or value, or wants others to believe that the individual has the trait, competency, or value. This view of ideal self is similar to Schlenker's (1985: 17) idealized image (i.e., the ultimate person one would like to be).

2.7.2.1 Development of the ideal self

In the early stages of interaction with a reference group, whether the reference group is primary group (i.e., the family for a young child) or a secondary group (i.e., one's peers or co-workers), choices and decisions are channelled through the existing social system. As an individual interacts with the reference group, he/she receives a feedback from reference group members. If the feedback is positive and unconditional, the individual will internalize the traits, competencies and values which are important to that reference group. In this case, the individual becomes inner-directed, using the internalized traits, competencies and values as a measure of his/her own success/failures. Internalized competencies and values have been suggested as the basis of the ideal self (Higgins, Klein & Strauman, 1987: 175) and as an internal standard for behaviour (Bandura, 1986: 17). If the individual receives negative feedback or positive but conditional feedbacks, the individual may not internalize or only partially internalize the traits, competencies and values of the reference group. This type of individual becomes other-directed and will either withdraw from the group or seek constant feedback from group members. Thus, the establishment of the ideal self is determined through a mix of external, or other-directed standards, and internal, or inner-directed standard, depending on one's orientation of the world (Reisman, 1961: 101). The ideal self of the other-directed individual is developed largely through the established norms and role expectations

of reference group members. The audience for one's actions becomes the reference group, in that it is important that reference group members see the individual as possessing accepted attributes. For the inner-directed individual, the ideal self is determined largely through the development on a set of internalized goals and standards, and the individual becomes his/her own audience. Riding and Rayner (2001: 214) perspective on individual and social achievement motivation is similar to this conceptualization. This latter author asserts that in individually oriented achievement motivation, the individual strives to achieve some internalized standard of excellence. In contrast, socially-oriented achievement motivation reflects an individual's perseverance to fulfil the expectations of significant others.

2.7.3 Social identities

According to Mael and Ashforth (1992: 105), social identification is a process by which individuals classify themselves and others into different social categories, such as "woman," "Catholic", and "nurse". This classification process serves the functions of segmenting and ordering the social environment. Thus, social identification provides a partial answer to the question, "Who am I?" Social identities are thus those aspects of an individual's self-concept that derive from the social categories to which he/she perceives him-or herself as belonging (Tajfel & Turner, 1985: 15).

2.7.3.1 Development of social identities

Individuals establish social identities through involvement with reference groups in social situations. Reference groups provide three major functions with respect to social identities: the determination of the profile of traits, competencies, and values for a particular social identity; the establishment and communication of the relative value and status of various social roles or identities, and the basis of social feedback regarding one's level of these traits, competencies, and values. Specifically, social identities link individuals to reference groups. These groups establish a set of role expectations and norms which guide the individual's behaviour within each of the social identities. For example, the identity of an accountant may be associated with reserve and self-control (traits), analytical ability and good memory (competencies), and honesty and free enterprise (values). Individuals who desire to be identified with the reference group will attempt to demonstrate the traits, competencies, and values

associated with that identity. These are aspired-to traits, competencies, and values that serve as the basis for the ideal self. Once established, the attributes then reinforce the identity. The determination of the relevant set of attributes that compromise the identity is not fixed, but rather it is the result of an interaction process between individuals and subgroups and members of the relevant reference group. This definition and redefinition of the identity is a constant process (Bandura, 1986: 45; Markus & Wurf, 1987: 301).

Individuals establish at least two types of social identities: A global identity and role-specific identities. The global identity is the identity one wishes to portray across all situations, across various roles, and to various reference groups. The global identity exists independently of any specific social identity. The reference group for the global identity includes those members of one's primary group, and the traits, competencies and values which are relevant to the individual are those, which are reinforced by the individual's culture. The global identity is formed early in life, and one's family, functioning as a primary reference group, performs the three functions mentioned above.

The global identity provides a starting point for role-specific identities. As the individual matures, the control of primary group lessens and the individual begins to establish certain role-specific social identities. Role-specific social identities are those identities established for a specific reference group or a specific social role. It is this process of selecting and "earning" the identity that act to define one's self to various reference groups. By "earning" the identity, we are describing the process whereby the individual meets basic expectations of the reference group (either formal or informal credentialing) necessary to carry out the role.

As an individual begins to interact with reference group members in a role-specific identity, the global identity provides input to this specific identity. However, as an individual remains in a role-specific identity and receives positive feedback from group members, the role-specific identity begins to provide input to the global identity. The reference groups in these social situations (e.g., friends, etc.) begin to perform the functions which were previously performed by the primary reference group. The individual is now exposed to the traits, competencies, and values which

are valued by each new reference group. The identity-specific reference groups also provide the social feedback important in the development of the perceived self. Thus identities may be thought to exist in a hierarchy, starting with the global identity and working through role-specific identities. As reference groups become more specific, the identity becomes more specific. For example, an individual may identify himself/herself as an academic at one level, a member of the business administration faculty at another and a finance professor at yet another level of specificity (Stryker & Serpe, 1982: 125). Roberts and Donahue (1994: 201) provided empirical evidence that individuals do see themselves differently in each of their roles and, in particular, they rated the trait attributes of some roles more highly than the trait attributes of others. They also found that general self-perceptions (i.e., global identity) are related to the role-specific self-perceptions.

As participation in a social identity continues over time, reference group itself becomes the basis of identification, and the success or failure of the reference group as a whole becomes a source of feedback for the individual. As defined by social identity theory (Mael & Ashforth, 1992: 105; Tajfel & Turner, 1985: 11), social identification is the perception of oneness with or belonging-ness to a reference group. When an individual identifies with a social referenced group, he/she perceives the fate of the group as his/her own (Foote, 1951: 15; Tolman, 1943: 145). The more an individual identifies with a social identity, the more the individual vests his/her self-concept in the identity.

2.7.4 Self-esteem

Self-esteem is the evaluative component of the self-concept (Delamater, 2006: 208). It is a function of the distance between the ideal self and perceived self. When the perceived self matches the ideal self, self-esteem is relatively high. Low self-esteem occurs when the perceived self is significantly lower than the ideal self. Since the distance between the ideal and perceived self constantly varies depending on task and social feedback, self-esteem is a dynamic component of the self-concept and it is always in a state of change and development. Korman (1970: 35) suggested three types of self-esteem: chronic self-esteem, which is defined as a relatively persistent personality trait or dispositional state that occurs consistently across various situations; Task-specific esteem, which is one's self perception of his or her

competence concerning a particular task or job, and socially-influenced self-esteem, which is a function of the expectations of others. Chronic self-esteem is the result of past experience and focuses on one's competencies and directs the individual into situations which will require the use those competencies. Task-specific self-esteem is the results of feedback which comes directly from observation of the results of one's efforts. Lastly, socially-influenced self-esteem results from communication of feedback from reference group member or society as a whole, concerning the value of an identity and the individual's ability to meet the expectations of the reference group and or society as a whole.

2.8 Determinants of the self-concept

According to Biddle, Fox and Boutcher (2000; 90), roles in life domains like, social relationships in the family and the physical self which is indicated by qualities related to our appearance and physical prowess, determine the self-concept. Support from parents and peers, family functioning, personal qualities such as having attractive facial features, academic ability, social competence and having lots of friends are totalled to produce a self-concept score (Harter, 1999: 125, Varni, Rubenfeld, Talbot & Setoguchi, 1989: 13). Harter, (1999: 125) further emphasized that among adolescents, parents and classmates' support are the greatest predictors of global self-worth. Self-concept is the underlying force that energizes, directs and sustains behaviour across a wide variety of situations that is, it serves as a basis for motivating behaviour. For it to serve its purpose well, it has to be positive, well-structured and developed. Apart from the abovementioned determinants of the self-concept, an individual's concept of self is composed of interrelated self-perceptions, each of which playing a crucial role in understanding how it relates to energizing, directing and sustaining behaviour. A child, who is referred to as an adolescent learner with cerebral palsy in this study, is not born with a self-concept. The self-concept develops as he/she interacts with his/her environment, first, home (family) and second, school (teachers and classmates). The home and the school should work together in order to facilitate a well-developed, positive self-concept in a child which will in turn energize, direct and sustain behaviour.

2.9 Conclusion

The components of the self-concept are illustrated in figure 2.1 (see page 26). The

following summarizes the structure and development of the self-concept as proposed in this research: The self-concept is a relatively stable, but changeable, set of self-perceptions that are developed through social interaction, and includes self-perceptions, ideal selves, social identities, and self-esteem. The perceived self is comprised of a set of self-cognitions regarding one's traits, competencies and values. It is developed and reinforced through social and task feedback, which results in two dimensions: level of perception and strength of perception. Level of perceptions refer to the degree to which an individual possesses an attribute relative to their ideal self and is expressed on a continuum from low to high. Strength of perceptions refers to how strongly the individual holds the perception of attribute level and is expressed on a continuum from weak to strong. The frame of reference or standard used to compare perceived and ideal self is either fixed or ordinal. The type of feedback which an individual receives from their primary group (i.e. conditional or unconditional) determines whether they use an inner-or other-directed standard to measure the ideal self. Social identities are those aspects of the self-concept that derive from social categories to which he or she perceives him or herself as belonging. Reference groups establish the role expectations and norms which guide the individual's behaviour within the social identities. Two types of social identities are established: Global identity and Role-specific identities. The global identity is formed early in life and is the identity one wishes to display across all situations, roles and reference groups. The global identity forms the basis for role-specific identities. Role specific identities are those established for a specific reference group or social role. Global and role-specific are inter-active. Self-esteem is the evaluative component of the self-concept, and is a function of the distance between the ideal self and the perceived self. Three types of self-esteem are proposed: chronic, task-based and socially influenced.

CHAPTER 3

3. Literature Review

3.1 Introduction

In this chapter, an attempt will be made to give an insight into cerebral palsy since the participants who took part in this research are adolescents with cerebral palsy. This will be done by reviewing aspects such as aetiology and types of cerebral palsy. The chapter also focuses on previous studies done nationally and internationally on physical disability, with special emphasis on cerebral palsy, and self-concept as well as intervention and self-concept of children with cerebral palsy.

3.2 Cerebral palsy

There has been much discussion among specialists in the field of how to arrive at a definition of cerebral palsy, which encompasses a wide variety of symptoms that the disorder manifests clinically. Nelson and Ellenberg (1986: 83) for example, viewed cerebral palsy as an umbrella-like term used to describe a group of chronic disorders impairing control of movement that appear in the first few years of life and generally do not worsen over time. Denhoff and Robinault (1960: 102) define cerebral palsy as one aspect of an entire syndrome of “brain damage”, while Doll (1951: 50) described it as “neurophrenia” and includes children whose brain injuries cause epilepsies, perceptual and sensory defects, disturbances in conceptualization, mental retardation and impaired personality development. An individual with cerebral palsy may have difficulty with fine motor tasks, such as writing or cutting with scissors, experience trouble with maintaining balance and walking, or be affected by involuntary movements, such as uncontrollable writhing motion of the hands or drooling. The symptoms differ from one person to the next, and may even change overtime in the individual. Some people with cerebral palsy are also affected by other medical disorders, including seizures or mental impairment. According to Cogher et al. (1992: 3), contrary to common belief, however, cerebral palsy does not always cause profound handicap. While a child with severe cerebral palsy might be unable to walk and need extensive, lifelong care, a child with mild cerebral palsy might only be slightly awkward and require no special assistance. Cerebral palsy is not

contagious nor is it usually inherited from one generation to the next (Cogher et al., 1992: 3). According to Nelson and Ellenberg (1986: 85), cerebral palsy refers to the brain's two halves or hemispheres. Palsy describes any disorder that impairs control of body movement. Thus, these disorders are not caused by problems in the muscles or nerves. Instead, faulty development or damage to motor areas in the brain disrupts the brain's ability to adequately control movement and postures. Nelson and Ellenberg (1986: 85) pointed out that for many years, some physicians referred to the disorder as "spastic cerebral-palsy paralysis", but today the term "spastic" is used to designate only one of the symptoms of cerebral palsy. Some practitioners refer to the disorder as the "cerebral palsies" in order to denote the multiplicity of the disability.

From the discussion, it is evident that as more researchers directed their attention to the exploration of cerebral palsy, many difficulties developed among them as to the nature of the disease. It required thorough investigation and great skill to merge the findings of specialists into an overall definition of cerebral palsy, which would be acceptable to all members of the American Academy for cerebral palsy. This was accomplished by Minear (1956: 841) who states that cerebral palsy comprises those motor and other symptom complexes caused by a non- progressive brain lesion or lesions. The characteristics of cerebral palsy are that it is a well-defined entity with a variety of aetiologies and pathologies.

3.3 Aetiology of cerebral palsy

Cerebral palsy is not one disease with a single cause, like chickenpox or measles. It is a group of disorders with similar problems in control of movement, but probably with different causes. According to Rees (1997: 383), when physicians try to uncover the cause of cerebral palsy in an individual child, they look at the form of cerebral palsy, the mother's and child's medical history, and onset of the disorder.

Since cerebral palsy refers to a group of disorders, there is no exact known cause. According to Geralis (1998: 14), some major causes are asphyxia or hypoxia of brain, birth trauma or premature birth, genetic susceptibility, certain drugs or infections in the mother during and before birth, central nervous system infections, trauma, and consecutive hematomas. After birth, the condition may be caused by

toxin, physical brain injury, incidents involving hypoxia to the brain (such as drowning) and encephalitis or meningitis. Despite all of these causes, the cause of individual cases of cerebral palsy is unknown (Cogher et al., 1992: 4). Recent research has demonstrated that asphyxia is not the most important cause as it was once considered to be, though it still plays a role, probably accounting for about 10% of all cases. The research has shown that the infections in the mother, even the infections that are not easily detected, may trigger the development of the disorder. Premature babies have a higher risk because their organs are not yet fully developed. This increases the risk of asphyxia and other injury to the brain, which in turn increases the incidence of cerebral palsy (Han, Bang, Lim, Yoon, & Kim, 2002: 280). In view of the above, it is worthy to say that cerebral palsy can occur during the pre-natal, para-natal and post-natal periods.

3.4 Classification of cerebral palsy

There are four types of cerebral palsy according to Morgenstern (1965: 29) and Morris (2007: 4). They note that the common type of cerebral palsy is called Spastic type. The main sign of spasticity is that the muscles have a tendency to contract when placed under tension and become rigid because they are blocked from achieving the desired motion by what is called the “stretch reflex”. They point out that, in a normal person, when a muscle contracts the opposite muscle relaxes; in cerebral palsy the opposite muscle also contracts leading to a state of temporary inability. According to them, there are five kinds of Spastic cerebral palsy which are categorized according to the limbs that are affected. When either both arms or both legs are involved, the term used is diplegia. Hemiplegia means that the effects of CP are felt by the arm and leg on one side of the body. Quadriplegia denotes that all four limbs are compromised. Monoplegia and triplegia, which are the rarest forms of CP, involve one and three limbs, respectively. Dyskinetic or athetoid type is characterized by involuntary and purposeless movement of muscles which are intrinsically normal but cannot be controlled or directed. Ataxic type is characterized by primary incoordination and disturbances in balance and equilibrium and the patient shows poor body balance, an unsteady walk and difficulties with hand-eye co-ordination and control. Morgenstern (1965: 30) and Morris (2007: 6) continue to state that there is mixed type which is made up of those patients who cannot be conveniently classified into the categories already defined and it is estimated that they comprise 19% of all

cases.

3.5 Cerebral Palsy and Self-Concept

3.5.1. Studies done internationally

Cerebral palsy is often assumed to have a negative impact on the way children feel about themselves. The muscle weakness, spasticity, or in co-ordination that are commonly associated with cerebral palsy can make every day functional activities such as walking and dressing, difficult for children with cerebral palsy and this could negatively affect a child's self-concept. Due to this assumption, Shields (2007: 351) conducted a research in Australia in which she examined whether the self-concept of children with cerebral palsy differed from that of children without impairment. In her study, forty-seven children (24 male and 23 females), with spastic diplegia or hemiplegia were matched with children without impairment. The level of disability of the children with cerebral palsy was classified as Gross Motor Function Classification System Level I (N=24), Level II (N=16), Level III (N=7). The 36 item Self-Perception Profile for Children was used to assess six domains of self-concept. No difference was found between the groups for Global Self-Worth, Physical Appearance, and Behavioural Conduct. Children with cerebral palsy scored lower on Scholastic Competence ($t=2, 75, P=0, 01$), Social Acceptance ($t=1, 96, P= 0.05$), and Athletic Competence ($t= 3.63, P< 0.01$) than children without impairment. Males with cerebral palsy had lower scores for Scholastic Competence ($t= 3, 54, P< 0, 01$) than males without impairment. Females with cerebral palsy had lower scores for Social acceptance ($t= 2, 31, P= 0.03$) than females without impairment. Both males and females with cerebral palsy had lower scores for Athletic Competence than their peers without impairment. These results suggest that children with cerebral palsy do not have a lower Global Self-Worth even though they may feel less competent in certain aspects of their self-concept.

Johnston and Sinclair (2003: 104) also investigated if children with disabilities have lower self-worth than their typically developing peers. Their sample was 246 children aged six to twelve years, drawn from six Sydney Metropolitan schools in Australia with additional children with cerebral palsy identified through the voluntary organization from which they were receiving services (123 learners). The instrument

used was The Self-Description Questionnaire (SDQ) developed by Marsh and Smith (1981: 45) which had 76 items. They asked children to respond to statements about their skills and views of self along a five point Lickert Scale. It was initially predicted that no differences would be found in the levels of General Self-Worth between the children with cerebral palsy and their typically developing peers. The predictions were indeed supported. Lack of differences found among the groups in their estimations of their self-worth provides the support for the view that the presence of a disability does not in itself result in lowered self-worth. Yet, other researchers had different views on the relationship between physical disability and self-concept. Some stated that physical disability has a positive effect on the self-concept of learners while others believed the opposite.

3.5.1.1 Positive Effects of Cerebral Palsy

Fielding (1950: 65) whose research was conducted in New York, found that while 98% of his participants reported that they occasionally perceived their disability to be a disadvantage, 70% also reported it to be a help in some areas of their lives. He also added that some cerebral palsied children perceive their apparent disadvantage as a challenge to be met. Weinberg and Williams (1978: 33) also reported that the most commonly cited advantage of physical disability is that it provides goals and purposes to work for. Another source of positive self-image for the physically disabled is the finding by Mussen and Barker (1944: 354) that able-bodied people rated those with physical disability more favourably than average, describing them as kinder, as well as more intelligent, persistent, creative and unselfish. According to Ray (1946: 55), high school students judged an individual with physical disability to be a better friend and to be conscientious and even tempered.

3.5.1.2 Negative Effects of Cerebral Palsy

Several studies of cerebral palsied individuals have demonstrated adverse social and psychological effects, including poor self-esteem/concept, as a result of the handicaps. In a study done in the United States, Teplin, Howard and O'Connor (1981: 734) made an observation of handicapped children between four to eight years of age. The study's population consisted of 15 handicapped children of the said age and a control group of 15 non-handicapped children, matched for age, sex ethnicity, IQ and socio-economic status. Each group consisted of seven males and

eight females. All the handicapped children had cerebral palsy and were of normal intelligence. The children in the control group were non-handicapped classmates, friends or neighbours of some of the handicapped children. Except for one child in each group, all were from middle to upper-middle socio-economic families. Each child was administered the Purdue Self-concept scale which consisted of a series of 40 pairs of stick-figure pictures of a child, each pair showing the positive and negative aspect of some characteristic or activity. A caption under each picture was read aloud by the examiner and the child was asked to point to the figure in the pictures most like him or herself. Items on the scale relate to such characteristics as gross and fine motor skills, academic skills, social acceptance, social acceptability, independence and emotions. In the test results overall self-concept scores tended to be lower for the handicapped group. This study confirms the findings of Hussain (2006: 43) who investigated the impact of disability on the development of self-concept. In his study conducted in India, 30 normal and 60 physically challenged children ($n=90$) were drawn from three different schools of metropolitan city of Delhi. The age group of sample was 11-16 years and was purposively selected from Grade nine and 10. The normal students were taken from government senior secondary school and physically challenged consisting of blind and orthopedically handicapped were drawn from Jouta Adarsh Andhvidyalaya and Amar Jyoti School respectively. Out of the 30 normal students, 15 were boys and 15 girls. Similarly out of 60 physically challenged adolescents 30 were orthopedically impaired consisting of 15 boys and 15 girls and rest 30 were blind with 15 males and 15 females. A 48 items self-concept inventory by Mohsin as cited in Hussain (2006: 44) was used for assessment of level of self-concept of adolescents. The high score was indicating high level of self-concept and low score indicating low level of self-concept. The results indicated the average score of self-concept for the normal adolescents was higher than the physically challenged subjects. The mean score of self-concept of normal adolescence was found to be 34.5, whereas for the blind the scores were 29.5 and 28.1 respectively. The mean scores of self-concept of physically challenged in total was found 30.81. To test the reliability of the difference between the normal and physically challenged adolescents taken as a whole with regard to their self-concept, critical ratio was computed between the two handicapped groups which found 2.39 and statistically significant. Thus on the basis of results, it can be said that there was significant difference in the level of self-concept of normal and

physically challenged adolescents.

The results of Hussain's (2006: 43) study were also very much similar to the findings of Chapman (1988: 370), Cooley and Ayres (1988: 175) and Grolnick and Ryan (1990: 180). They found in a number of studies conducted in London that individuals with disabilities have lower levels of self-esteem and self-worth. However, the difference between the two groups of physically challenged, namely blind and cerebral palsy was found very little as mean for the said two groups were found 29.5 and 28.1 respectively and the difference between the two means was too small to be significant. Hence they concluded that there were adverse impact of disabilities on the development of concept of self among the adolescents, and adolescents who were physically challenged were found to be inferior to their normal peers irrespective of the types of disability they were having. The study further revealed that self-concept of girls in general was lower than that of boys. On average, the mean score of self-concept for boys was 32.82, whereas for the girls the mean score was found to be 28.64; the difference between the means was also found statistically significant as the value was 2.786. On the whole, it was inferred that disabilities not only restrict functioning of the individual, but also prove to be hurdle in the development of self-image which paves the way for the development of a sense of inferiority and maladjustment.

McMaugh and Bowes (1995: 10) conducted a research on the self-concept of adolescents with physical disability in Australia. The research involved case studies of ten high school students with physical disabilities. The study was based in four comprehensive state high schools in metropolitan regions of Sydney. Students with a disability present since birth and with no intellectual impairment were selected over students whose disability may have resulted from recent traumatic injury such as car accidents and burns. The participants consisted of eight males and two female students with cerebral palsy. Each participant was interviewed for approximately one hour during which Harter's self-perception profile for adolescence was administered. Each student then completed a social-comparison interview and a friendship measure, followed by an interview regarding the determinants of the self-concept. The results showed that the self-concept scores of the students fluctuated around a middle range of self-concepts with most students having some areas of high and

some areas of low-self-concept. The areas of Athletic Competence and Physical Appearance were the lowest areas of self-concept for eight of the ten participants, while Behavioural conduct and Global Self-worth were the highest areas of self-concept for the ten participants. The results indicated that younger students in this sample had a consistently lower self-concept than older students, except in the area of Scholastic Competence. Gender differences were also evident in the areas of Athletic Competence and Physical Appearance. Boys reported higher perceptions of Athletic Competence, while girls reported higher perceptions of their Physical Appearance.

Shields, Murdoch, Loy, Dodd, and Taylor (2006: 151) conducted a research in Australia to find out if the Self-concept of young people with Cerebral Palsy was different from that of young people without a disability. To achieve this, a systematic review of the literature was conducted. To obtain relevant articles, comprehensive searches of electronic databases and web-based reference libraries were conducted to the earliest possible date (from 1966 to March 2005). The results indicated that the global self-concept of children with cerebral palsy was significantly lower than that of matched controls without disability (Shields et al., 2006: 155). The global self-concept scores of adolescent females with CP and younger children with CP tended to be lower than in matched children without disability, with the results approaching significance. These results according to Shields et al. (2006: 156) further indicated that some children with CP may have lower self-concept in some domains, compared with children without disability. There is evidence that adolescent females with CP may have a lower self-concept in the domains of social acceptance, physical appearance, and athletic and scholastic competence compared with adolescent females without disability. However, the researchers in Shields et al. (2006: 151-157) were unable to conclude whether children with CP in general have a lower global self-concept compared with children without disability.

Wiegerink, Roebroeck, Kervoort, Stam and Cohen-Kettenis (2006: 1023) reviewed literature to explore possible factors for successful social and sexual relationships in adolescents and young adults of normal intelligence with cerebral palsy. Their study aimed at providing a comprehensive review of the different aspects of social and sexual relationships as described in the literature. The research was conducted in

United Kingdom and the Netherlands for the period 1990-2003. For comprehensive description of outcome and associated factors the International Classification of Functioning, Disability and Health was used as a framework. Outcome related to the participation dimension addressed three items: Social relationships, intimate relationships and sexuality. Four groups of associated factors were distinguished: personal factors, functional limitations, environmental factors and performing in social activities.

The results were divided into two sections. Section A addressed the outcome concerning social and sexual relationships and section B described the associated factors as follows:

A. Social and Sexual Relationship

According to Stevenson, Pharoah and Stevenson (1997: 338), adolescents and young adults with cerebral palsy were less active, especially in spontaneous social activity and leisure activities and spent less time with their friends. People with congenital physical disabilities have lower level of sexual knowledge (43% accuracy on a questionnaire) and experience than their able-bodied age mates. The lowest scores were consistently seen in the participants with cerebral palsy. Although people with congenital disabilities showed lower levels of sexual knowledge, they considered sexuality to be an important aspect of their lives. However, they experienced difficulties in developing a sexual relationship.

B. Factors related to developing social and sexual relationships

It was demonstrated that Self-efficacy was the only significant predictor of independence in interpersonal style; adolescents with cerebral palsy had a less independent personal style, were less persistent and experienced lower self-efficacy compared to persons with other disabilities and compared to age mates (Powers, Sowers, & Stevens, 1995: 37).

A positive (Sexual) Self-esteem (feelings of self-acceptance and worthiness) was found to be an important determinant for dating. It was shown that women with disabilities who had a more positive sexual self-image and who perceive themselves to be approachable by potential romantic partners had higher levels of sexual activity. Disabled men with CP felt the dilemma of masculine ideals in relationship

with those to whom they were sexually attracted, for these men the social comparison with able-bodied people hampered dating behaviour. It is not known if the same applies to adolescents and young adults with cerebral palsy. It was found that for people with cerebral palsy, functional limitations, bodily responses and speech impairments were perceived barriers to dating, but the severity of the disability appeared to be unrelated to social and sexual activity. Young people with cerebral palsy and other physical disabilities were found to be less socially active than non-disabled young people.

3.5.1.3 Intervention and Self-concept

Intervention is a social action aimed at enhancing or maintaining the functioning of the individual and the well-being of the individual, family, group, community or population (Babbie, Mouton, 2001: 342, De Vos, Strydom, Fouche & Delport, 2005: 394). For this study, intervention refers to a social action aimed at enhancing the functioning and well-being of the adolescents with cerebral palsy.

One of the important tasks during adolescence is the development and maintenance of a strong sense of self. Positive self-evaluations are essential components in the development of one's sense of self (Harter, 1998: 590, Rosenburg, 1985: 240). Adolescents with negative self-evaluations are at greater risk for antisocial behaviour, academic failure, peer rejection, and depression (Bird Canino, Davies, Zhang, Rami-rez, & Lahey, 2001: 470, Donnellan, Trzesniewski, Robins, Moffitt & Caspi, 2005: 330). Families, schools and communities may seek out interventions to address negative self-evaluations and problem behaviours of adolescents. School-based and community-based interventions are often successful in addressing negative self-evaluations and problem behaviours in youth (Farmer, Compton, Burns, & Robertson, 2002: 1270). However, not all adolescents benefit from these interventions and some youth may require more intense intervention outside their communities.

Cook (2008: 751) introduced Therapeutic Wilderness programmes which they thought could provide one alternative context that may be effective in addressing negative self-evaluations and promoting the healthful development of self for at risk youth. The programmes emphasized high levels of social support provided through

activities, emotional expression and social interactions. According to Kagan (1990: 106), interventions that enhance social support contribute to the development of positive self-evaluations. The participants in the residential wilderness programme included 13 male adolescents aged from 12 to 16 years. They voluntarily enrolled in a year-long residential wilderness programme for boys located in Southern United States. Of the participants 23% were African American and 77% were Caucasian. Their characteristics included defiance of authority, behavioural problems, low self-esteem, poor communication skills and low academic achievement. Central to successful completion of the programme is the role of the group in shaping the social and emotional development of participants. For the duration of the programme the group of 8 to 10 adolescents, served as participant's support system and helped individual work through behaviours and problems that brought them to the programme. The support system was fostered through daily rituals and activities that included, problem solving, daily chores, cooking meals at campsite etc. In addition, the boys engaged in experiential activities such as ropes courses, extended hiking trips, canoe trips and day trips. The successful interactions with the group and improvement in problem-solving skills helped improve the adolescents' rate of progress through the programme. As they progressed they were given greater leadership roles which ideally increased their self-esteem and served as a model to new participants.

To assess change in self-evaluations, qualitative interviews were conducted with adolescents upon entry to the programme and four months later. Participants' responses suggested that self-evaluation improved in relation to specific factors in the residential wilderness programme. Specifically, increased level of social support provided through cooperative experiences and opportunities for emotional expression helped participants develop a more positive sense of self.

The fact that intervention programme brings about improved self-concept was also supported by Carin-levy and Jones (2007: 14). In their study in Canada, they investigated the psychosocial benefits of scuba diving for individuals with cerebral Palsy. In their investigation, in-depth, semi-structured interviews were conducted with 3 volunteers recruited from a diving club specializing in training people with disabilities to a dive. In the results, the respondents indicated that diving was a

challenging, enjoyable activity that enhanced their quality of life through enriched social experiences and improved self-concept.

Hutzler, Chacham, Bergman, and Reches' (1998: 177) study done in Israel to study the effect of an experimental movement and swimming programme of six months on motor function in the water, measured by means of the Water Orientation Score and Self Perception measured by means of the Martinek-Zaichkowsky, self-concept scale was investigated. Twenty-three children with different types of cerebral palsy and positive self-concept participated in the programme, completing both tests prior to and after intervention. An age, sex and disability matched control group of 23 children completed only the self-concept scale at pre and post-test. Analysis indicated a significant improvement in Water Orientation Score of children in the trained group, but no effect on scores of the self-concept scale.

Van der Burg, Jongerius, Van Limbeek, Van Hulst and Rotteveel (2006: 37) investigated the impact of salivary flow reduction following the use of scopolamine and botulin neurotoxin, on social interaction and emotional development (Self-esteem). Their research was conducted in Europe. The objective of the study was to evaluate the change that the above-mentioned interventions have produced in the child's social interaction and self-esteem. The participants were 45 children with cerebral palsy who suffered from severe drooling. The children ranged in age from 3 to 16 years, 28 males and 17 females. A list of questions was developed to evaluate the impact of drooling on social interaction and self-esteem, partly based on the section self-esteem of the child Heath Questionnaire. The questionnaire evaluated parental experiences as well as personal reactions of the child. The children were assessed at baseline, during scopolamine treatment, and 8 and 24 weeks following Botulin neurotoxin injections.

The results for baseline investigations indicated that drooling appeared to have a remarkably negative influence on the social interaction. The child's play with peers and his/her social interaction with both children and adults were limited. It was also found that, for six of these drooling children, even their own parents kept their distance. In addition, parents of seven children reported that the unsightly appearance of their child caused outsiders to underestimate the child's mental

ability. The parents of seven children reported their child to be dissatisfied (VAS score 0-32) in one or more domains. Three children were not happy about their social contact with peers, with one indicating drooling to be the main reason (VAS score 67-100). None of the children were dissatisfied with their physical appearance. No significant change across time was found in social interaction as a result of treatment with the exception of "is avoided by other children" (Chi-squared 8, 33, df - 3, P= 0. 043). The valid percentage of this item showed a significant decrease, indicating that gradually participants were less frequently avoided by other children after treatment = 35.1% at baseline, 33.3% at scopolamine, 25.0% at 8 week after BONT and 21.4% after 24 weeks.

Parental report on the child's satisfaction with school abilities, sports and play participation, social contact with peers, physical appearance, relations within the extended family, and life in general did not change significantly as a result of treatment. Nevertheless, parents reported a significant increase of perceived impact of drooling on the level of child's satisfaction on physical appearance, relations within the extended family and life in general. The parents of only seven of these children reported that their child expressed negative feelings about drooling in relation to one or more emotional factors during the study. There was no change for this outcome variable before and after treatment. The negative feelings about drooling could be emanating from the reactions of other people towards the children who are drooling. It is not always the case where people express their negative feelings verbally but their facial expressions say it all. Due to the rejection and negative attitudes of other people towards children who are drooling, it will be hard for the affected children to accept their disability.

Robins, Trzesniewski, Tracy, Gosling and Potter (2002: 425) conducted a research on global self-esteem across the life span in America. The results showed that the transition to adolescence entails a drop in self-esteem presumably because of conflicting role demands, rapid maturational changes, and increasingly complex peer and romantic relationships that characterize this transition. Bearing this knowledge in mind and considering the age differences between 14 and 21 in the present study, individual variability in the way self-esteem changes with age should be expected. With regard to gender, boys and girls whether cerebral palsied or not, fare differently

in some aspects of self-concept for example in McMaugh and Bowes' study (1995: 10), gender differences were evident in the areas of athletic competence and physical appearance. Boys reported higher perceptions of athletic competence while girls reported high perceptions of their physical appearance.

The literature is mixed as to whether short-term interventions can have a positive impact on self-concept of learners with special needs. Thorkildsen and Lowry (1991: 120) reported that a 2 years maths intervention for integrated students with an intellectual disability brought about significant increases in self-concept. Polatjko (1991: 170) found that a 6 month reading intervention improved skills but had little effect on self-concept.

3.5.2 Studies done in Africa

Petajan, Gappmaier, White, Spencer, Mino and Hicks (1996: 432) conducted a research in Congo wherein children and adolescents with cerebral palsy participated in a strength training programme. The results showed significant improvements in strength and ability to walk, run, jump and climb stairs after participating in the strength-training programme.

Steinke's (2009: 2) study in Kenya examined the adequacy of the psychological services and support offered by the Association for the Physically Disabled of Kenya (APDK) to the children in its care and the families who utilize the centre. First and foremost, the study examined the psychological effect CP and other physical disabilities have on children and their families to determine what services are necessary for these individuals. The results revealed that CP and other physical disabilities have a psychological effect both on the CP children and those who live with them. This made it necessary to provide these parties with adequate mental health care. The study also revealed that the children's self-concepts are linked to the perceptions they have of their own abilities and the messages they receive from interactions with others in their environment. It was further revealed that caring for the CP child is extremely stressful for parents. According to Steinke (2009: 4) this stress, results in frustration, anxiety and depression.

Omolayo (2009: 449) conducted a research in Nigeria to compare the self-esteem and self-motivational needs of disabled and non-disabled children. One hundred and eighty-six disabled and non-disabled selected from the South-Western States of Nigeria participated in the study. Two instruments, Index of Self-Esteem (ISE) and Manifest Need Questionnaire (MNQ) were used to generate data for the study, while collected data were analysed with t-test for independent groups and regressions analysis. The results showed that sex status, disability and ability do not significantly affect self-esteem and self-motivational needs of people.

In another study, Mwamwenda (1995: 368) wanted to establish whether in the context of Botswana, a pupil's self-concept could be used as a predictor of his/her academic achievement. He examined the relationship between the two variables on the basis of a pupil's performance overall as well as his/her performance in Mathematics, English, Science and social studies. Two personality tests, the self-appraisal scale and the Canadian self-esteem inventory were administered to each subject. The results indicated that there was a relationship between a pupil's self-concept and his/her performance in the final set of examinations.

3.5.3 Studies done nationally

Laker (2001: 6) investigated the self-concept of a group of adolescent learners with physical disability in the Western Cape province of South Africa. The short-term aim of her investigation was to examine the relationship between self-concept and physical disability in an adolescent group. The relationship between self-concept and physical disability with regard to gender and age was examined. The long-term aim of her investigation was to develop an understanding for "being different", especially within the inclusive school environment.

The results indicated that physical disability has implications for self-rated popularity, as well as the degree of denial of problematic behaviour, during the adolescent phase. Physical disability had no significant effect for the following sub-scales of the self-concept, namely physical appearance, intellectual and school status, anxiety, happiness and contentment, as well as the global self-concept. It was taken into account that the respondents probably compared themselves to members of their own group within specific school settings rather than to members of a non-

stigmatized group. There was no significant gender difference in the subjective experience of physical disability. On three subscales of self-concept, namely the global self-concept, physical appearance as well as popularity, a statistically significant decline in the self-concept of learners with physical disabilities between the ages of 12 and 16 years occurs.

According to Lalkhen (2000: 40) and Llewellyn (2001: 71), a small number of studies have examined the self-esteem and self-concept of individuals with cerebral palsy, or any other form of physical disability and indeed, very few were found nationally and none provincially. Lalkhen's study attempted to arrive at a phenomenological understanding of self-esteem as experienced by a group of physically disabled adolescents with cerebral palsy in a non-disabled environment (Lalkhen, 2000: 5). The research was conducted in Pretoria in South Africa.

The participants were eight adolescents aged between 15 and 19 years from Grades 8 to 10. Five of the participants were girls and three were boys. 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 participants were recorded as they were participating in the study. The 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.

The results showed that the disabled adolescents who are denied opportunities to engage with non-disabled peers, and who are denied choice and the possibility of making independent decisions, are intuitively less likely to develop a sense of self-worth, and competence and consequently less likely to participate in adult society and relationships. From a phenomenological point of view, lowered self-esteem results from the infringement of, or impending threat to the integrity of the disabled

adolescent, not simply the body and its functioning.

3.6 Conclusion

In this chapter, cerebral palsy was shown to be a long term, non-progressive disorder of the central nervous system which can manifest in many different ways and to varying degrees. Cerebral palsy is also found to be not contagious nor inherited from one generation to the next. Cerebral palsy occurs during the pre, para and, post-natal periods. There are four main types of CP: the spastic type, which is characterized by the muscles that have a tendency to contract when placed under tension, the athetoid type characterized by involuntary and purposeless movement of muscles and mixed type which may be present in one or more limbs and may manifest in a mild, moderate or severe form. The chapter focused on national and international studies done on physical disability and self-concept as well as intervention and self-concept of physically disabled children. Some researchers have different views on the relationship between physical disability and self-concept. Physical disability was reported to have advantage of providing goals and purposes to work for. It was further reported in some studies that able-bodied people rated those with physical disability more favourably than average, describing them as kinder, as well as more intelligent, persistent, creative and unselfish. Physically disabled people were judged to be better friends and to be conscientious and even-tempered. Yet, other studies of cerebral palsied individuals have demonstrated adverse social and psychological effects, including poor self-concept, as a result of the handicap. In other studies, it was reported that although some domains of self-concept was comparatively lower in some groups, the results for global self-concept were variable, with some studies reporting a comparatively lower global self-concept in children with cerebral palsy, others reporting that global self-concept tended to be higher than normative ranges. The other studies reported no significant difference in global self-concept between children with cerebral palsy and those without disability. Some researchers looked at intervention and self-concept of children with cerebral palsy. Intervention was defined as a social action aimed at enhancing the functioning and well-being of the adolescents with cerebral palsy. Some studies reported that intervention helped participants develop a more positive sense of self, while others reported the global self-concept not to have changed significantly as a result of intervention. In the next chapter the method and how the data were collected from

the participants will be discussed.

CHAPTER 4

4. Methodology

4.1 Introduction

This chapter gives an overview of the methodology of this study which includes the following: the research questions and hypotheses, the research design and method, population, sample and size, instrument, changes made to the questionnaire, data collection, intervention programme, data analysis, validity and reliability, and ethical consideration.

4.2 Research questions and Hypothesis

4.2.1 Research questions

The following are the problem statements as stated in chapter 1:

1. Do the CP children in special schools in Limpopo Province have a positive or negative self-concept?
2. What is the relationship between cerebral palsy and self-concept of learners in special schools in Limpopo Province?
3. What is the effect of intervention on the self-concept of children with cerebral palsy?

4.2.2 Research Hypotheses

The hypotheses of this study as stated in chapter 1 were:

1. The self-concept of adolescent learners with CP in special schools in Limpopo Province is positive;
2. Cerebral palsy affects the self-concept of adolescent learners with CP, and
3. Life Skill Intervention programme has a positive effect on the self-concept of cerebral palsied adolescent learners.

4.2.2.1 Null Hypotheses

The null hypotheses were stated as follows:

1. The self-concept of adolescent learners with CP in special schools in Limpopo

- Province is negative;
2. There is no relationship between cerebral palsy and self-concept of learners in special schools in Limpopo Province, and
 3. Intervention programme does not have any effect on the self-concept of children with cerebral palsy.

4.3 Research Design and Methods

4.3.1 Research Design

Research design is the structure of any scientific work and gives direction and systematizes the research (“Explorable.com”, 2008). According to Bless, Higson-Smith and Kagee (2006: 80), research design is also the planning of any scientific research from the first to the last step. The researcher has chosen a survey design for this study because it is used in educational research to describe attitudes, beliefs, opinions and other types of information. In such a design, usually information about a large number of people can be inferred from the responses obtained from a smaller group of individuals. Survey design describes the incidence, frequency and distribution of the characteristics of the CP children. According to Nesbary (2000: 10), survey research is the process of collecting representative sample data from a larger population and using the sample to infer attributes of the population. It uses instruments such as questionnaires and interviews to gather information from groups of subjects and permits the researcher to summarize the characteristics of different groups or to measure their attitudes and opinions toward some issue (Ary, Jacobs, & Razavieh, 2002: 373). The main purpose of a survey is to estimate, with significant precision, the percentage of population that has a specific attribute by collecting data from a small portion of the total population and to explain or predict connections between characteristics or variables (Dillman, 2000: 95). According to McNamara (1994: 50), surveys are often used to assist in planning and decision making, as well as to evaluate the effectiveness of an implemented programme. Survey research design attempts to describe and explain conditions of the present by using many subjects and questionnaires to fully describe an occurrence (Carroll, 1994: 1), hence, in this study a questionnaire was used as a tool for collecting data from the 65 cerebral palsied adolescent learners, a sample selected to represent a larger population of learners with cerebral palsy in special schools in Limpopo Province.

The researcher wanted to find out from the members of the population if their self-concept was positive or negative, if disability did affect their self-concept and if Life-Skill intervention had a positive effect on the self-concept of the members of the population. The researcher focused on the exploration of the self-concept and on a cause- and- effect relationship between two variables (Bless, Higson-Smith & Kagee 2006: 81). She explored the self-concept of adolescent learners with cerebral palsy. She focused on the relationship between cerebral palsy and self-concept of adolescent learners with cerebral palsy and also on the relationship between intervention and self-concept of these learners.

Research design focuses on the end product, what kind of study is being planned and what kind of results are aimed at (Babbie & Mouton, 2001: 75). As adopted here, it relates directly to the testing of the hypotheses. Research design is a specification of the most adequate operations to be performed in order to test specific hypotheses under given conditions. When planning research design, it is important to consider the following:

- Unit of analysis which is the person or object from whom the social researcher collects data. In this study, the unit of analysis is not a person but people, a group of adolescent learners with CP.
- Conditions which are studied when the researcher wishes to explore the current state of the subjects of the research (Bless, Higson-Smith & Kagee, 2006: 84). In the present study the researcher measured the self-concept of the adolescent learners with CP to check whether it was positive or negative.

The researcher used survey research design because it is the most frequently used research design in the social sciences. She also used a questionnaire as a tool for collecting data because questionnaires are essential to and most directly associated with survey research. In survey design when designing a questionnaire, the researcher is interested in determining the extent to which respondents hold a particular attitude or perspective (Babbie & Mouton, 2001: 233). In this study the researcher was interested in determining the extent to which the participants viewed their relationships with family, school, peers and how they viewed themselves. This was done to check if the self-concept of the participants was positive or negative.

4.3.2 Research Methods

In this study the researcher used quantitative approach to gather data. Quantitative research is based on a positivist philosophy, which assumes that there is an objective reality out there to be discovered. The researcher used quantitative method because she wanted to find out if the self-concept of adolescent learners with CP is positive or negative. In quantitative research, a proposition is being validated, that is, data are being gathered that would either support or reject the hypothesized condition or relationship. Quantitative research also employs inductive reasoning centring on hypothesis testing. The researcher wanted to test if cerebral palsy does affect the self-concept of adolescent learners with cerebral palsy. She also wanted to test if intervention does have a positive effect on these learners' self-concept. This study is a survey method where a questionnaire was presented to the respondents. This is a two-phase study in which the questionnaire was administered to the respondents twice, before and after intervention. Pre-test and post-test were done at Helena Franz Special School since it was the only high school among the three special schools catering for cerebral palsied learners in Limpopo Province and therefore had more adolescent learners as compared to Letaba and Tshilizini special schools.

4.4 Population

There are three schools with cerebral palsied learners in Limpopo Province, namely Helena Franz, Tshilizini and Letaba special schools. The number of all cerebral palsied learners found in all the three special schools for the physically disabled was 444 which formed the population size for the present study. From the cerebral palsied learners who were found, the researcher selected only adolescents because they were deemed suitable participants for this study.

4.5 Sample and size

A random sampling strategy was used to draw participants from the abovementioned population. Random sampling was used because the researcher wanted to give every adolescent learner who was cerebral palsied an equal chance of being included in the study. The researcher took all adolescent learners (males and females) aged between 14 and 21 years that were found in each of the three special schools and randomly chose a sample for this study. The participants were given

questionnaires to investigate their self-concept.

The number of all adolescent learners selected from the population was 65, (30 males and 35 females) which formed the sample size for this study. Data on self-concept of these learners was gathered and compared. The researcher selected 17 participants from Letaba special school; 10 from Tšhilizini, and 38 from Helena Franz special school. The participants had to be adolescent learners who were educable and afflicted enough to warrant admission at special schools. It did not matter to the researcher whether the participants resided at school as boarders or lived at home with their families. The participants were chosen from Grades 4 to 11. To test the hypotheses in this study, data were collected from 65 participants.

4.6 Instrument

In this research, a questionnaire was used as a tool for collecting data. According to Philliber, Bast and Sloss (1980: 50), questionnaires are the most widely used and valuable technique for collecting data in educational research. As mentioned in 4.3.1 above, survey research design, as used in this study, used questionnaire as one of the instruments for collecting data. The questionnaire comprises biographical data consisting of 19 items and 43 items measuring self-concept. The researcher has adopted a Self-Description Inventory questionnaire (Mboya, 1999: 63) which is designed to use with the adolescents in Africa. The questionnaire comprises eight subscales, namely: relations with family, general school, physical abilities, physical appearance, emotional stability, music ability, relations with peers and health (See Appendix C).

In order to maintain objectivity the researcher used a group self-administered questionnaire in collecting data, that is, the questionnaire was administered to a group of learners by the researcher personally. The researcher read the questions one by one until the last question. The questionnaire was administered twice at Helena Franz, before and after intervention and once at both Letaba and Tšhilizini special schools. As has been mentioned in 4.3.2, the pre-test and post-test were done only at Helena Franz Special School. Helena Franz was the only high school among the three special schools for the physically disabled and therefore had a lot of adolescent learners.

As mentioned above, a standardized instrument, the Self-Descriptive Questionnaire (SDQ) developed by Mboya (1999: 68) was used as a tool for collecting data in this study. Data pertaining to self-concept was obtained from a group of adolescents with cerebral palsy from three special schools, i.e., Tshilizini, Letaba and Helena Franz. The SDQ was chosen to assess the multidimensionality of self-concepts of the students, which is particularly relevant to this study since the study was not interested in measuring one specific domain of self-concept e.g. English or Vocational skill but, general self-concept of the adolescents with cerebral palsy. SDQ has better psychometric properties and is one of the three most commonly used tests for assessing self-concept. It is designed to measure self-concept in adolescents. It was also designed to be used with adolescents in Africa since it was compiled specifically to be used on Black African children (Mboya, 1999: 68). Unlike the SDQ-11 which measures three areas of academic self-concept and eight non-academic areas of general self-concept, it specifically measures only eight non-academic areas of general self-concept namely; Relationship with family, General school, Emotional stability, Health, Physical appearance, Physical ability, Music ability and Relationship with peers.

The instrument was also used by Mboya (1999: 85-86) who made Rural-Urban and gender comparisons of African adolescent self-concept. The SDQ was also used by Johnston and Sinclair (2003: 3) in their study entitled *The impact of disability on children's self-concept*. According to them, the instrument is important because it takes account of the multi-dimensionality of the individual's view of self, allowing comparisons within and between subjects with respect to different facets of development and competence. Kistner, Haskett, White and Robbins (1987: 38) emphasized that such specificity is needed when considering the impact of disability upon the development of self-concept. As mentioned above, the questionnaire comprised of eight subscales and the respondents were required to answer each question on a five point Likert Scale (strongly agree = 1 to strongly disagree = 5). A brief description of the SDI scale and example of items are as follows: Relations with Family: Students' perceptions of their interaction with their family. Examples are: "My family loves me", "I feel my family does not care for me", and "I feel I am an important member of my family".

General School: Students` perceptions of their interest in and enjoyment of school. Examples are: "I find most subjects difficult to learn", "I enjoy doing work in most school subjects", and "At school I get all the support I need from my teachers."

Physical Ability: Students' perceptions of their skills and interest in sports and physical activities. Examples are, "I enjoy sports and games", "I do well at sports and games", "I am good at sports and games".

Physical Appearance: Students` perceptions of their physical appearance. Examples are: "I am satisfied with my appearance", "I like the way I look", and "I would like to change the way I look".

Emotional Stability: Students` perceptions of their emotional stability. Examples are, "I often cry" and "It irritates me when someone shouts at me".

Music Ability: Students' perception of their interest in and enjoyment of music. Examples are: "I enjoy listening to people playing music", "Music makes me feel irritated", and "Music to me does not make any difference".

Relations with Peers: Students' perceptions of their interactions with peers. Examples are: "I am well liked by others of my age", "It is difficult for me to make friends", and "My peers avoid me when they can."

Health: Students' perceptions of their physical well-being. Examples are: "I am in good health," and "I feel guilty because I am not able to look after my body".

4.7 Changes made to the questionnaire

Very few changes were made i.e., items: B3, B11, B39, B18, B12, B43, B15, B14, B2, B28, B31, B26, B27, B23, B24 and B38 have been reversed because strongly agree for them would mean the opposite. One self-scale, (personal view) was added to the SDQ. It comprised two items ("I feel I do have much to be proud of" and "I have a strong personality"). The subscale was added because self-concept is a core of a person's personality and the self-scale is also one of the eight non-academic areas of general self-concept of the SDQ-11.

4.8 Data collection

On arrival at the schools, the researcher went to the principals' offices and asked for the list of learners with cerebral palsy. The researcher met the learners on two consecutive days at the three special schools. Rapport with learners was established on the first day of the meeting after providing clear instructions to the respondents. On the next day the questionnaires were administered. The participants were all assured that their names would not be used and that all information gained would be strictly confidential. The questionnaires were completed in a classroom situation during normal school periods. All participants were gathered in one classroom. The researcher needed assistance for translating the questionnaire into Xitsonga and Tshivenda when administering the questionnaires at Letaba and Tshilizini because she did not know the home languages of the respondents. Participants were first briefed about the purpose of the study with strong emphasis on voluntary participation and anonymity of responses. The questionnaires were presented in English, Xitsonga and Tshivenda respectively. No time limit was given, but on average learners took 1h00 to 1h30 to complete the questionnaires.

4.9 Intervention Programme

The aim of this study was to explore the self-concept of adolescent learners with cerebral palsy in special schools in Limpopo Province and to develop an intervention programme aimed at enhancing those learners' self-concept. For the purposes of this study, the researcher decided to call the intervention programme The Life-Skill because it aimed at giving the adolescent learners with cerebral palsy a life orientation so as to empower them to live meaningful lives which will bring forth a positive self-concept.

The length of the intervention was one month, one hour thirty minutes, from Monday to Friday every week. The programme is basically life-skill and was adopted from what was done with the cerebral palsied learners in a Pretoria school for the cerebral palsied children. The topics treated in the programme include, invited or excluded, hopes and wants and the things that crush them, unfinished business, wheel of faces (past and present relationships), fortifications, the givers and the takers, how one feels in relation to other people, life crossroads, the critic in one's head, good things one says to him/herself, chaos, festival of moments, suitcase of valuables, diploma

ceremony, important relationships, one's personal universe and the role one plays in groups (See Appendix D) (Glouberman, 1992: 55, Glouberman, 1986: 100, Hargreaves, 1975: 90, Smeyers, Smith & Standish, 2007: 105). According to Mrs Viljoen, the chief psychologist at the above-mentioned school, this programme improves some but not all of the learners' self-concept, the explanation being, the uniqueness of individuals, what works for one may not work for the other and vice versa. Each topic was explained to the participants and later given the opportunity to participate in the discussions, sharing their emotional pains and their past and present experiences relating to the topics. In addition, some situations were even role-played. As used in this study, the findings indicated that the programme had contributed towards growth in the participants' self-concept.

4.10 Data analysis

To answer the research questions, the following statistical data analysis were used: Data were collected using a questionnaire and captured onto the computer's Excel spread sheet. Analysis of variance (ANOVA) was used for comparing means of self-concept of learners from the three special schools. ANOVA was chosen because unlike t-test which measures the difference between the means of two groups, an ANOVA tests the differences between the means of two or more groups. In this study, though it was not the major concern for the study, the researcher compared the means of self-concept of all the learners from the three special schools. Descriptive statistics were also used to describe the basic features of the data in this study, i.e. age and gender of the participants. This gave the researcher an insight of the age-groups and the number of males and females who participated in this study. Age is particularly important for this study because although the researcher assessed the level of self-concept of adolescents, the age-group is from 14 to 21 years and it is said that there is a decline in positive self-concept during adolescent stage in both boys and girls (Robins, Trzesniewski, Tracy, Gosling & Potter, 2002: 425, Hadley, Hair & Moore, 2008: 1). According to them, the positive self-concept generally starts recovering in the mid-teen years. Correlation coefficient was used for describing the extent of the relationship between the self- concept subscales. According to Cass and Riddell (1999: 420), correlations have to be either poor if at (0.4 and below), moderate if at (0.5 to 0.6) or strong if at (0.7 to 0.9). The paired sample t-test was computed to compare the means sub-scale scores of the self-

concept of the adolescents with CP before and after the intervention and to see whether a statistically significant difference exists between the two means.

4.11 Validity and Reliability

The instrument which was used in the present study had been subject to validity and reliability analysis. The Self-Description Inventory questionnaire was agreed to by the university research experts, Professor Cherian and Mrs. Olwagen, attached to the departments of Educational Studies and Statistics respectively at the University of Limpopo and was considered as a relevant tool for the present study. The researcher used Cronbach's Alpha coefficient to test the reliability and validity of the Self-Descriptive Inventory questionnaire, and found it to be 0.7 which is above Nunnally and Bernstein's (1994: 224) modest reliability range.

4.12 Ethical Consideration

In conducting research, the researcher has to ensure that the interests of his/her respondents are protected. Notter in Hott and Budin (1999: 40) said in this regard:

In recent years considerable concern has been expressed about the protection of the rights of the individuals used as subjects of research.

McNamara (1994: 42) identified ethical concerns to be considered when conducting research. These guidelines deal with voluntary participation, no harm to respondents, anonymity and confidentiality. In this study, firstly, the University of Limpopo Ethics Committee and the Senior Degrees Committee approved the research proposal (SSDC2005/603-620). Permission was obtained from the office of the Superintendent-General of the Limpopo Provincial Department of Education to conduct research at the special schools: Letaba, Helena Franz and Tshilizini (See appendix; A). A letter of permission was taken to the principals of the said schools. The principal of Helena Franz willingly agreed to assist the researcher in this study and the application letters to parents of adolescent learners with cerebral palsy to allow their children to participate in this study were handed out to them during a parents' meeting. The parents' responses were given to the principal on the same day. The principals of Tshilizini and Letaba special schools were contacted telephonically and the appointments were made to meet the parents during a

parents' meeting. On the day of the meeting, the researcher was introduced to the parents and the reason and purpose of the study was explained to them. They were assured that their children were selected according to objective criteria such as age and disability and not according to any personal attributes of the child such as misbehaviour. They were also assured that all information gained would be held in the strictest confidence and that anonymity would be maintained by not using their children's names on the questionnaires. The application letters for permitting their children to participate in this study were handed out and they responded on the same day (See Appendix B). Once the parents agreed, an appointment was made with the principals for a meeting with the relevant learners.

4.13 Conclusion

This chapter reflected on the research methods and procedure followed in the present study. It includes the research questions and hypotheses, the research design and method, population, sample and size, instrument, changes made to the questionnaire, data collection, data analysis, validity and reliability, and ethical consideration. The intervention programme is also included in this chapter. The topics included in the intervention programme are: invited or excluded, hopes and wants and the things that crush them, unfinished business, wheel of faces (past and present relationships), fortifications, the givers and the takers, how one feels in relation to other people, life crossroads, the critic in one's head, good things one says to him/herself, chaos, festival of moments, suitcase of valuables, diploma ceremony, important relationships, one's personal universe and the role one plays in groups. In the next chapter, the results will be presented and discussed.

CHAPTER 5

5. Results and discussion

5.1 Introduction

This chapter analyses data collected to explore the self-concept of adolescent learners with cerebral palsy in special schools in Limpopo Province of South Africa.

The analysis was made to test the following null hypotheses:

- The self-concept of adolescent learners with CP in special schools in Limpopo Province is negative;
- CP does not affect the self-concept of adolescent learners with CP, and
- Life Skill intervention programme does not have a positive effect on the self-concept of CP adolescent learners.

The chapter also summarizes the research findings which can either accept or reject the null hypotheses. It explains the analysis of data using the means, standard deviations and coefficients of variation, descriptive statistics, correlation coefficient, analysis of variance (ANOVA) and paired sample t-test. The means, standard deviations and coefficients of variation (see Table 5.2 and 5.31) were used to show the self-concept of the participants before and after intervention. Descriptive statistics was used to show the gender and age differences in self-concepts, ANOVA for showing schools' differences in self-concepts, while correlation coefficient was for showing the extent of the relationship between the self-concept subscales. Finally, the paired sample t-test (see Table 5.32) was used to compare the means of the subscale scores before and after intervention.

5.2 Results of the study

The results were presented by first stating the research question and hypotheses, reporting the analyses of the data and then reporting the results using tables.

5.2.1 Exploring the self-concept of CP adolescent learners

The aim of this study was to explore the self-concept of cerebral palsied adolescent learners in special schools in Limpopo Province. Cerebral palsy is a condition in which humans are unable to use some of the muscles in their bodies in the normal

way due to injury of the brain. Research has shown that this condition, if not well attended to in time, can cause frustrations and distress to the affected children and the significant other.

5.2.1.1 Do the CP children in special schools in Limpopo Province have a positive or negative self-concept?

H₁: The self-concept of adolescent learners with CP in special schools in Limpopo Province is positive.

H₀: The self-concept of adolescent learners with CP in special schools in Limpopo Province is negative.

In exploring the self-concept of the cerebral palsied adolescent learners, checking whether it is positive or negative, the determinants of the self-concept were taken into consideration. As mentioned in chapter two, roles in life domains, such as social relationships in the family, family functioning, physical self which is indicated by qualities related to people's appearance and physical prowess, support from parents, peers etc, contribute to the development of a positive self-concept. To check whether the self-concept of the adolescent learners with cerebral palsy in special schools in Limpopo Province was positive or negative, the SDQ with nine subscales was administered to a group of participants, adolescent learners with cerebral palsy at the three special schools.

The results from biographic information showed that many children in special schools for physically disabled got therapy from a physiotherapist (See figure 5.1). Figure 5.1 shows that of the 65 participants in this study, 32% got therapy from the physiotherapist. The researcher strongly felt that there is a need for the provision of a physiotherapist in every school for the physically disabled. Physiotherapists help with physical therapy, which is one of the most important aspects in cerebral palsy. Physiotherapy consists of physical activities and education to improve everyday functional activities such as walking, climbing up the stairs, dressing up and other tasks of personal care, which add to the development of a positive self-concept of the cerebral palsied children (Trahan & Malouin, 2002: 236, Lalkhen, 2000: 50). Figure 5.1 also shows that 23% of the participants did not respond to this item which, in the understanding of the researcher, means that they did not need any therapy.

Where do you get therapy?

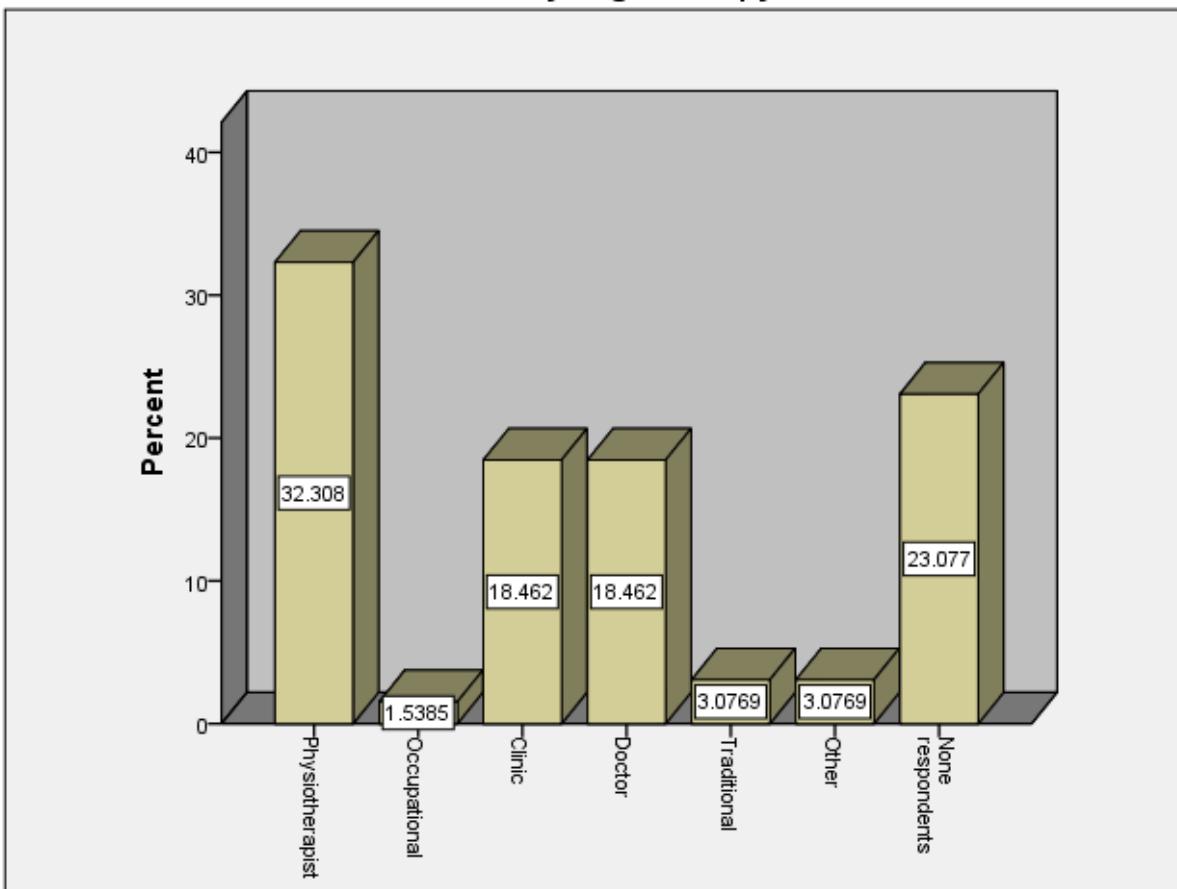


Figure 5.1: Bar chart showing places where the cerebral palsied children got therapy

Support from parents as one of the determinants of the self-concept according to Biddle et al. (2000; 90) was taken into consideration. Figure 5.2 below is a summary of the biographic information showing that 33%+ of the participants' parents/guardians were separated either by divorce or death. This means that some participants in this study were deprived of the support from both parents when they actually needed it for their global self-worth (Harter, 1999: 125).

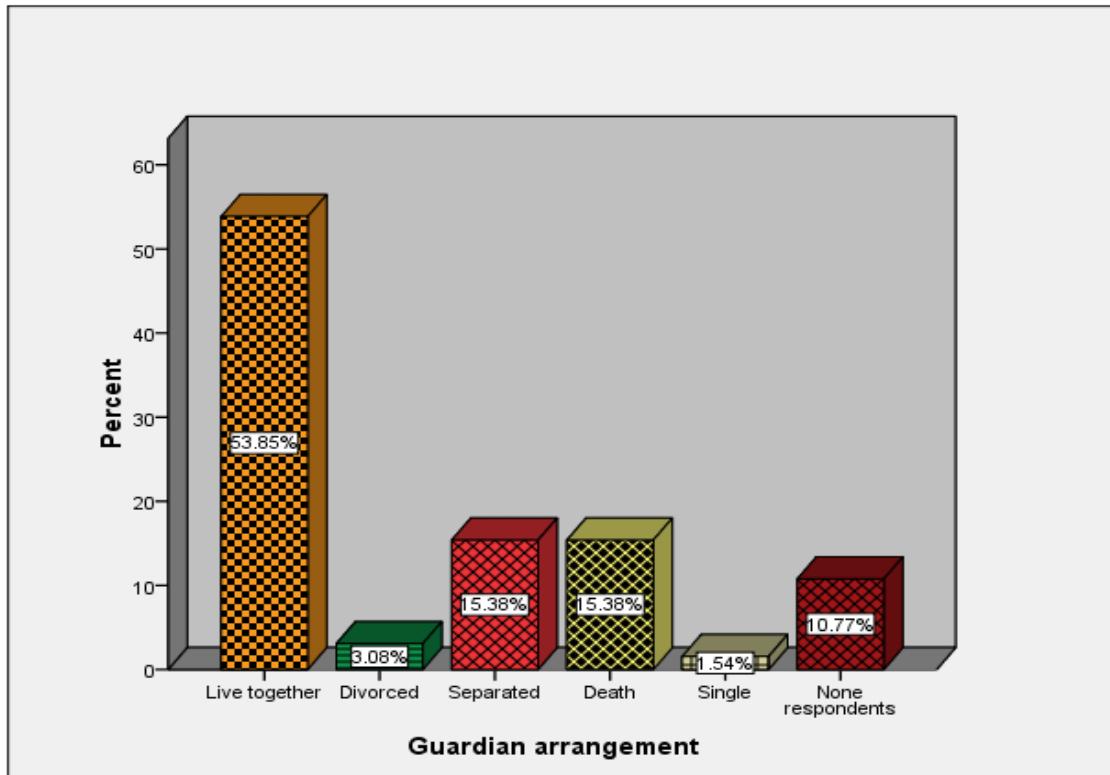


Figure 5.2: Bar chart showing the marital status of the participants' parents/guardians

To check whether the CP learners have a positive or negative self-concept, the interaction with family as the other determinant of the self-concept was considered. Table 5.1 below shows that 96.9% of the participants in this study lived in the school dormitories and only 3.1% were day-scholars. The researcher observed that for these participants, the contact with family, parents/guardians was limited. In her understanding this could have affected their contribution towards their families' decision making, interaction with family members, helping out on household chores etc. which according to Mboya (1999: 6) contribute towards the development of a positive self-concept. Much of these participants' time was spent at school with

teachers and friends than at home with family members.

Table 5.1 Frequency table showing where the participants lived

	Frequency	Percent
Dormitory	63	96.9
Home	2	3.1
Total	65	100.0

To answer the research question, “Do the CP children in special schools in Limpopo Province have a positive or negative self-concept?”, the means and standard deviations of the self-concept were also examined.

Table 5.2 shows the means and standard deviations of the self-concept scores of the participants in this study. It shows that the self-concept was higher for the subscales; general school, emotional stability and physical ability. The mean for general school was 2.468. This means that the participants enjoyed the time they spent at school. For emotional stability the mean was 2.549. This means that the participants were emotionally stable as it is said that if a CP child gets support from different sources early in life, it is beneficial in easing the emotional impact of CP (“lessening the impact”, 2010). The participants in this study were privileged to get support from teachers, house-mothers, school-mates and a bit from parents as they lived in the school dormitory. The mean for physical ability was 2.665. This indicates that the adolescents with CP in this study participated well in sports and also enjoyed it. It further indicates that they understood themselves and were therefore able to choose suitable sporting activities for themselves. For physical appearance the mean was 2.438. This means that the participants were so used to their physical appearance that it did not bother them. No matter the type or severity of CP, the fact remained, they were all deformed. For health, the mean was 2.346. This means that these participants were matured enough to understand that they were healthy in their condition. For personal view, the mean was 2.331 which was the 4th lowest in Table 5.2. This means that there was a bit of inferiority complex in the participants in this sample. The low scores on music ability (2.000) mean that though the participants took part in music, it was not something that they enjoyed. More so that music for the

disabled children is also used for therapy, it means that they did not do it voluntarily but were compelled to do it. This also means that the participants lacked knowledge and understanding of what music could do for and in them. It is said that music therapy helps the CP children in their social skills by making them feel important. This helps to boost up their confidence and self-esteem (Kops, 2008). The mean for the relationship with family was 2.261. This means that the participants' interaction with their families was not that good. It was probably because more than 96% of them lived in the school dormitory (see Table 5.1), which means they only had meaningful interaction with their family members during the holidays. The low score on relationship with peers (2.285) indicates that there was some kind of rejection among the participants in this study probably because of the lack of knowledge on the types and severity of CP.

Table 5.2 The means and standard deviations of the self-concept scores

Self-concept subscales	Number of participants	Means	Standard Deviation
Relationship with family (11 items)	65	2.261	0.505
General School (9 items)	65	2.468	0.355
Emotional Stability (3 items)	65	2.549	0.210
Health (2 items)	65	2.346	0.402
Physical Appearance (4 items)	65	2.435	0.359
Physical Ability (5 items)	65	2.665	0.396
Music Ability (3 items)	65	2.000	0.307
Relationship with Peers (4 items)	65	2.285	0.283
Personal View (2 items)	65	2.331	0.184
Overall		2.371	

Though self-concept scores were low in some domains, the overall self-concept (2.371) was skewed in the direction of the positive judgment as it was greater than 2.346, which is the median in Table 5.2. According to Zady (1999: 56), a negatively skewed curve has a mean which is smaller than the median. In view of these results, the researcher concluded that the self-concept of adolescent learners with CP in special schools in Limpopo Province was not negative, but skewed in the direction of the positive judgment. The null hypothesis (H_0): "The self-concept of adolescent

learners with CP in special schools in Limpopo Province is negative," was therefore rejected.

These findings agree with the literature review, especially the findings of Shields, (2007: 351) who found that the CP children did not have a lower global self-worth even though they might feel less competent in certain aspects of their self-concepts. From these results, the researcher understood that the following contributed towards the self-concept of the participants not being negative or positive but skewed in the direction of the positive judgement:

- The participants' lack of knowledge about music.
- Scarcity of special schools for the physically disabled learners in Limpopo Province, which led to 96.9 of the participants living in the schools' dormitories.
- Separation of the participants' parents/guardians which could have been caused mostly by the participants' diagnosis of CP as mentioned by some of the participants during intervention.
- Lack of permanently employed physiotherapists in special schools for physically disabled.

5.2.1.2 Descriptive Statistics

In exploring the self-concept of the CP adolescent learners the descriptive statistical analysis was also performed. The following descriptive statistical analysis was meant to show the gender and age differences in self-concept subscales of the participants. The p-values for Tables 5.3 to 5.20 combined boys and girls and all ages. An alpha level which is a priori criterion for a probability of rejecting the null hypothesis was set to .05. This is the standard value of significance. Therefore, when the p-value is less than the predetermined significance level which is 0.05, the null hypothesis is rejected. Furthermore, when the p-value is greater than the 0.05 significance level, the null hypothesis is accepted.

Relationship with family

For this subscale, the questionnaire items were: My family does not understand me at all, I contribute a lot towards the family's decision making, my parents allow me to help with household chores, I feel I am an important member of my family etc.

The adolescent learners with CP's relationship with their families.

H₁: The adolescent learners with cerebral palsy have a good relationship with their families.

H₀: The adolescent learners with cerebral palsy do not have a good relationship with their families.

The results are presented in Table 5.3. The Table shows that for this subscale the p-value was greater than 0.05 level of significance ($0.131 > 0.05$). Thus, the null hypothesis was accepted. This means that the participants in this study did not have favourable relationships with their families.

Table 5.3 Descriptive statistics showing how the adolescent learners with CP relate to their families

Subscale	Boys	Girls	P-value
Relationship with family	30	35	0.131

General school

The questionnaire items that dealt with this subscale were: I hate most school subjects, my teacher makes me feel I am not good enough, at school I get all support I need from my teachers, I find most subjects very difficult to learn etc.

The adolescent learners with cerebral palsy's experience of school.

H₁: The adolescent learners with cerebral palsy enjoy schooling.

H₀: The adolescent learners with cerebral palsy do not enjoy schooling.

The results in table 5.4 below show that the p-value was 0.000 which was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the adolescents with cerebral palsy in this study enjoyed the time they spent at school.

Table 5.4 Descriptive statistics showing the participants' experience of school

Subscale	Boys	Girls	P-value
General School	30	35	0.000

Emotional stability

The questionnaire items for this subscale were: It irritates me when someone shouts at me, I often cry and I do not cry easily.

The emotional stability of adolescent learners with CP.

H₁: The adolescent learners with cerebral palsy are emotionally stable.

H₀: The adolescent learners with cerebral palsy are not emotionally stable.

The results in Table 5.5 show that the p-value was 0.000 which was below the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the participants in this study were emotionally stable.

Table 5.5 Descriptive statistics showing the emotional stability of the adolescent learners with CP

Subscale	Boys	Girls	p-value
Emotional Stability	30	35	0.000

Health

The questionnaire items involved under this subscale were: I am in good health and I feel guilty because I cannot look after my body.

The cerebral palsied adolescent learners' health.

H₁: The adolescent learners with cerebral palsy have a good health.

H₀: The adolescent learners with cerebral palsy do not have a good health.

The results in Table 5.6 show that the p-value was 0.000 which was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the participants were matured enough to understand that CP is not a disease but just a condition and therefore were healthy in their condition.

Table 5.6 Descriptive statistics showing the health of the adolescent learners with cerebral palsy

Subscale	Boys	Girls	P-value
Health	30	35	0.000

Physical appearance

The questionnaire items were: I am not happy with my appearance, I would like to change the way I look, I am satisfied with my appearance and I like the way I look.

The adolescent learners with CP's feeling about their physical appearance.

H₁: The adolescent learners with CP are pleased with their physical appearance.

H₀: The adolescent learners with CP are not pleased with their physical appearance.

The results show that the p-value was 0.000 (see Table 5.7). This was less than the 0.05 level of significance and the null hypothesis was therefore rejected. This means that the participants in this study were pleased with their physical appearance. This shows another element of maturity in the participants in this study, that although they were physically disabled, they were pleased with their physical appearance.

Table 5.7 Descriptive statistics showing how the adolescent learners with CP viewed their physical appearance

Subscale	Boys	Girls	P-value
Physical appearance	30	35	0.000

Physical ability

For this subscale, the questionnaire items were: I enjoy sports and games, I do well at sports and games, I am good at sports and games, I am a leader in sports etc.

The cerebral palsied adolescent learners' physical ability.

H₁: The adolescent learners with CP participate in sports.

H₀: The adolescent learners with CP do not participate in sports.

The results in Table 5.8 show that the p-value was less than the 0.05 level of significance ($0.000 < 0.05$). In this case, the null hypothesis was rejected. This means that the participants in this study participated in sports. It further means that there

were sporting activities that the physically disabled children like the normative ones participated in.

Table 5.8 Descriptive statistics showing the participants' participation in sports

Subscale	Boys	Girls	P-value
Physical ability	30	35	0.000

Music ability

For this subscale, the following items were involved: I enjoy listening to people playing music, music to me does not make any difference and music makes me feel irritated.

The adolescent learners with CP and music ability.

H₁: The adolescent learners with CP like music.

H₀: The adolescent learners with CP do not like music.

The results in Table 5.9 show that the p-value was also 0.000, which was less than 0.05 level of significance. The null hypothesis was therefore rejected. This means that the participants in this study enjoyed music. This was to be expected because music, especially for the disabled children, is not only used for entertainment but also for therapeutic purposes.

Table 5.9 Descriptive statistics showing the participants' attitude towards music

Subscale	Boys	Girls	p-value
Music ability	30	35	0.000

Relationship with peers

The questionnaire items for this subscale were: It is difficult for me to make friends, my friends avoid me when they can, I am well liked by others of my age and it is easy for me to make friends.

The cerebral palsied adolescent learners' relationship with peers.

H₁: The adolescent learners with CP have a good relationship with peers.

H₀: The adolescent learners with CP do not have a good relationship with peers.

The results in Table 5.10 show that the p-value was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the adolescent learners with CP related well with peers.

Table 5.10 Descriptive statistics showing how the adolescent learners with CP related to their peers

Subscale	Boys	Girls	P-value
Relationship with peers	30	35	0.000

Personal view

The items in this subscale were: I feel I do have much to be proud of and I have a strong personality.

The cerebral palsied adolescent learners' view of themselves.

H9: The adolescent learners with CP have a positive view of themselves.

H_o: The adolescent learners with CP do not have a positive view of themselves.

The results in Table 5.11 show that the p-value was 0.000, which was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the adolescent learners with CP were self-confident; they viewed themselves positively.

Table 5.11 Descriptive statistics showing how adolescent learners with CP viewed themselves

Subscale	Boys	Girls	P-value
Personal view	30	35	0.000

The above results show that the participants in this study did not have a good relationship with their families. This does not coincide with the literature review, especially the study by Harter (1999: 125) who found in his research that family members, especially parents are the support system for the CP children. According to him, support from parents is one of the greatest predictors of global self-worth in children with CP. The results further show that the participants enjoyed schooling and music, were emotionally stable, had a good health, had a good relationship with

peers and a positive view of themselves. In their condition, they also participated in sports. All these aspects, in the understanding of the researcher, show that the participants had a positive attitude towards life.

As already mentioned in 5.2.1.2 above, the following descriptive statistical analysis was meant to show the age differences in self-concept subscales of the participants. Unfortunately though the p-values indicated that there were age differences in some subscales; they did not specify between which age groups (see Tables 5.12 to 5.20). In this analysis too, the significance level of 0.05 was chosen. When the p-value is less than the predetermined significance level, 0.05, the null hypothesis is rejected. Furthermore, when the p-value is greater than the 0.05 significance level, the null hypothesis is accepted.

Relationship with family

The cerebral palsied adolescent learners' relationship with their families.

H₁₀: Age influences the way the adolescent learners with CP relate to their families.

H_o: Age does not influence the way the adolescent learners with CP relate to their families.

The results in Table 5.12 show that the p-value was 0.821, which was far above the 0.05 level of significance. The null hypothesis was therefore accepted. This means that the participants in this study irrespective of age related the same way to their families.

Table 5.12 Descriptive statistics showing the age differences in the way the CP adolescent learners related to their families

Subscale	Age group	N	P-value
Relationship with family	14 - 21	65	0.821

General school

The adolescent learners with CP and their experience of school.

H₁₁: Age influences the way the adolescent learners with CP experience school.

H_o: Age does not have any influence in the way the adolescent learners with CP experience school.

The results in Table 5.13 show that the p-value was 0,000 and it was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that the participants in this study experienced school differently.

Table 5.13 Descriptive statistics showing how the participants experienced school

Subscales	Age group	N	P-value
General school	14 - 21	65	0.000

Emotional stability

Emotional stability of the adolescent learners with CP

H12: Age influences the emotional stability of adolescent learners with CP.

H_0 : Age does not influence the emotional stability of adolescent learners with CP.

The results in Table 5.14 show that the p-value was 0.000 and was also less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that some but not all of the participants in this study were emotionally stable.

Table 5.14 Descriptive statistic showing the emotional stability of the adolescents with CP

Subscale	Age group	N	P-value
Emotional stability	14 - 21	65	0.000

Health

The cerebral palsied adolescent learners' understanding of health.

H13: Age influences the understanding of health in adolescent learners with CP.

H_0 : Age does not influence the understanding of health in adolescent learners with CP.

The results in Table 5.15 show that the p-value was 0.000, which was less than the 0.05 level of significance. The null hypothesis was therefore rejected. This means that age influenced the understanding of health in the participants in this study.

Table 5.15 Descriptive statistics showing the participants' understanding of health

Subscale	Age group	N	P - value
Health	14 - 21	65	0.000

Physical appearance

The cerebral palsied adolescent learners' view of their physical appearance.

H14: Age influences the way the adolescent learners with CP view their physical appearance.

H_0 : Age does not influence the way the adolescent learners with CP view their physical appearance.

The results show that the p-value was less than the 0.05 significance level ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that the age of the participants influenced the way they viewed their physical appearance.

Table 5.16 Descriptive statistics showing how the participants viewed their physical appearance

Subscale	Age group	N	P-value
Physical appearance	14 - 21	65	0.000

Physical ability

The physical ability of the adolescent learners with CP.

H15: Age influences the participation of adolescent learners with CP in sports.

H_0 : Age does not influence the participation of adolescent learners with CP in sports.

The results in Table 5.17 show that the p-value was less than the 0.05 level of significance ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that age determined the participants' participation in sports.

Table 5.17 Descriptive statistics showing the participants' participation in sports

Subscale	Age group	N	P-value
Physical ability	14 - 21	65	0.000

Music ability

The adolescent learners with CP and music ability.

H16: Age determines music interest in adolescent learners with CP.

H_0 : Age does not determine music interest in adolescent learners with CP.

The results show that the p-value was 0.000 and was less than the 0.05 level of significance (see Table 5.18). The null hypothesis was rejected. This means that as the participants grew up, the music interest and the understanding of what music was meant to do for them also intensified (Robins et al., 2002: 425).

Table 5.18 Descriptive statistics showing music interest of the participants

Subscale	Age group	N	P-value
Music ability	14 - 21	65	0.000

Relationship with peers

The cerebral palsied adolescent learners' relationship with peers.

H17: Age influences the cerebral palsied adolescent learners' relationship with peers

H_0 : Age does not influence the adolescent learners with CP's relationship with peers.

The results in Table 5.19 show that the p-value was less than the 0.05 level of significance ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that as the participants grew up their relationship with peers changed.

Table 5.19 Descriptive statistics showing the participants' relationship with peers

Subscale	Age group	N	P-value
Relationship with peers	14 - 21	65	0.000

Personal view

The cerebral palsied adolescent learners' view of themselves.

H18: Age has an effect in the way the adolescent learners with CP view themselves.

H_0 : Age does not have any effect in the way the adolescent learners with CP view themselves.

The results in Table 5.20 show that the p-value was less than the 0.05 level of significance, ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that the participants' age affected the way they viewed themselves.

Table 5.20 Descriptive statistics showing how the participants viewed themselves

Subscale	Age group	N	P-value
Personal view	14 - 21	65	0.000

The above results show that the participants irrespective of age related the same way to their families. This was actually expected because more than 90% of these participants lived in the schools' dormitories since they started schooling. For these participants, school and home were just swapped around because they spent much of their time at school than at home. The results further indicated that age influenced the participants' experience of school, understanding of health, and their relationship with peers. Age also determined the participants' interest in music, had an effect in the way they viewed themselves and influenced their participation in sports. This concurs with the literature review, especially the findings of Robins et al. (2002: 425) and Hair and Moore (2008: 1). They found in their studies that there is a decline in positive self-concept during the adolescent stage in both boys and girls. According to them, the positive self-concept generally starts recovering in the mid-teen years. This means that as the participants reached mid-teen years, they experienced school positively, understood that they were healthy in their condition and actually viewed life positively.

5.2.1.3 Analysis of variance

As mentioned in chapter one, though it was not the major concern for this study, the researcher used Analysis of Variance (ANOVA) for comparing the self-concept of the participants from the three special schools. ANOVA can tell whether there is a significant difference either between subjects or within subjects simultaneously, but it does not tell where that significance lies. For analysing the schools' difference in self-concept of the participants, the significance level of 0.05 was chosen. When the p-value is less than the predetermined significance level, 0.05, the null hypothesis is rejected. Also, when the p-value is greater than the 0.05 significance level, the null hypothesis is accepted.

Relationship with family

The adolescent learners with CP's relationship with their families.

H19: The adolescent learners with cerebral palsy in Letaba, Tšhilizini and Helena Franz have a different relationship with their families.

H_0 : The adolescent learners with cerebral palsy in Letaba, Tšhilizini and Helena Franz do not have a different relationship with their families.

The results are presented in Table 5.21. The Table shows that for this subscale the p-value was less than 0.05 level of significance ($0.012 < 0.05$). Thus, the null hypothesis was rejected. This means that the participants in the three special schools had different relationships with their families.

Table 5.21 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Relationship with family	Letaba	17	0.012
	Tšhilizini	10	
	Helena Franz	38	

General school

The adolescent learners with CP and their experience of school.

H20: The adolescent learners with cerebral palsy in Letaba, Tšhilizini and Helena Franz experience school differently.

H_0 : The adolescent learners with cerebral palsy in Letaba, Tšhilizini and Helena Franz do not experience school differently.

The results are presented in Table 5.22 below. The Table shows that the p-value was less than the 0.05 level of significance ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that the participants in the three special schools experienced school differently.

Table 5.22 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
General school	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Emotional stability

Emotional stability of the adolescent learners with CP.

H21: The emotional stability of the adolescent learners with CP in Letaba, Tšhilizini and Helena Franz is different.

H_0 : The emotional stability of the adolescent learners with CP in Letaba, Tšhilizini and Helena Franz is not different.

The results in Table 5.23 show that the p-value was less than the 0.05 significance level ($0.000 < 0.05$). The null hypothesis was therefore rejected. This means that the emotional stability of the adolescent learners with CP in the three special schools was different.

Table 5.23 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Emotional stability	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Health

The questionnaire items under this subscale were: I feel guilty because I cannot look after my body and I am in good health.

The cerebral palsied adolescent learners' understanding of health.

H22: The adolescent learners with CP's understanding of health in Letaba, Tšhilizini and Helena Franz is different.

H_0 : The adolescent learners with CP's understanding of health in Letaba, Tšhilizini and Helena Franz is not different.

The results show that the p-value was less than the 0.05 significance level (see Table 5.24). The null hypothesis was therefore rejected. This means that the participants' understanding of health in the three special schools was different.

Table 5.24 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Health	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Physical appearance

The adolescent learners with CP's view of their physical appearance.

H23: The adolescent learners with CP in Letaba, Tšhilizini and Helena Franz view their physical appearance differently.

H_0 : The adolescent learners with CP in Letaba, Tšhilizini and Helena Franz do not view their physical appearance differently.

The results in Table 5.25 show that the p-value was less than the significance level of 0.05 ($0.000 < 0.05$). The null hypothesis was rejected. This means that the adolescent learners with CP in the three special schools viewed their physical appearance differently.

Table 5.25 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Physical Appearance	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Physical ability

The physical ability of adolescent learners with cerebral palsy.

H24: Sporting activities are offered differently in Letaba, Tšhilizini and Helena Franz.

H_0 : Sporting activities are not offered differently in Letaba, Tšhilizini and Helena Franz.

The results in Table 5.26 show that the p-value was less than the significance level ($0.000 < 0.05$). The null hypothesis was rejected. This means that for some of the participants in this study, the choices in sports were limited.

Table 5.26 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Physical Ability	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Music ability

The adolescent learners with CP and Music Ability.

H25: The love of music in adolescent learners with CP in Letaba, Tšhilizini and Helena Franz was different.

H_0 : The love of music in adolescent learners with CP in Letaba, Tšhilizini and Helena Franz was not different.

The results in Table 5.27 show that the p-value was less than the 0.05 level of significance. The null hypothesis was rejected. This means that in some schools, the adolescent learners with CP did not have interest in music, neither did they love it.

Table 5.27 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Music ability	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Relationship with peers

The adolescent learners with CP and their relationship with peers.

H26: The relationship with peers among the adolescent learners with CP in Letaba, Tšhilizini and Helena Franz is different.

H_0 : The relationship with peers among the adolescent learners with CP in Letaba, Tšhilizini and Helena Franz is not different.

The results in Table 5.28 show that the p-value was less than the predetermined significance level, $0.000 < 0.05$. The null hypothesis was rejected. This means that the adolescent learners with CP related differently with peers in the three special schools.

Table 5.28 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Relationship with peers	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Personal view

The cerebral palsied adolescent learners' view of themselves.

H27: The school environment influences the cerebral palsied adolescent learners' view of themselves.

H₀: The school environment does not influence the cerebral palsied adolescent learners' view of themselves.

The p-value was less than the significance level, $0.000 < 0.05$ (see Table 5.29). The null hypothesis was therefore rejected. This means that how the participants in this study viewed themselves was dependent on the environment in which they found themselves.

Table 5.29 ANOVA for showing schools' difference in self-concept of the participants

Subscales	School		P-value
	Name	Count	
Personal view	Letaba	17	0.000
	Tšhilizini	10	
	Helena Franz	38	

Though the results in Table 5.21 to 5.29 show that there were school differences in self-concepts of the participants, one could have expected the opposite because of the following:

During the administration of the questionnaire, the researcher had a conversation with teachers and the principals of the special schools involved in this study. She was told that the services of the professionals like teachers with knowledge of children with special needs and physiotherapists were provided equally in the three special schools. It was mentioned that even extramural activities like music, ballroom dance and other sporting activities that contribute towards the development of a positive self-concept in CP children were offered in the three special schools.

All three special schools had boarding houses. This means that many of these participants started living there from the time they started schooling. Although this means being far from their families for long, it was also beneficial for these children because they had the privilege of learning to ask for emotional support from different sources: teachers, house mothers, school counsellors, peers etc. It was further

revealed that the participants in this study were developed spiritually and academically. Apart from being taught, it was mentioned that on a regular basis, the spiritual leaders were invited from outside the school premises to come and share the Word of God.

All these special schools are situated near hospitals: Tšhilizini Special School near Tšhilizini Hospital, Helena Franz Special School near Helena Franz Hospital and Letaba Special School located close to Letaba Hospital. The researcher believed that this was done purely for therapeutic purposes. None of these schools had a physiotherapist when 32.31% of the participants in this study alone needed the services of one. It was therefore surprising that ANOVA showed schools' differences in self-concept of the adolescent learners with cerebral palsy.

5.2.1.4 Correlation

Correlation coefficient for describing the extent of the relationship between the self-concept subscales was computed and the results are shown in Table 5.30. According to Cass and Riddell (1999: 420), correlations have to be either poor (0.4 and below), moderate (0.5 to 0.6) or Strong (0.7 to 0.9). Table 5.30 shows that Health was strongly correlated with Personal View and moderately correlated with Emotional Stability, Physical Appearance, Music Ability and Relationship with Peers. This means that a healthy person has a positive view of himself/herself and is also emotionally stable. Emotional stability contributes to a sense of well-being and also influences other aspects of health, including physical, mental and social health. Music was strongly correlated with Emotional Stability, Relationship with Peers and Physical Appearance. Music was also moderately correlated with Personal View, Health and Physical Ability. This means that music soothes the mind, elevating the moods of adolescents with cerebral palsy and stabilizing their emotions. An emotionally stable person views him/herself positively, has healthy relationships, is also inspired and motivated and thereby develops a positive self-concept. Table 5.30 also shows a strong correlation between Physical appearance, Relationship with Peers and Music Ability. Physical appearance was also moderately correlated with Physical Ability and Personal View. This means that an adolescent with good physical features has a positive view of himself/herself and the self-perceived level of attractiveness is more strongly related to a positive self-concept. These results show

that there was a close connection between the seven self-concept subscales, namely: Emotional Stability, Health, Physical Appearance, Physical Ability, Music Ability, Relationship with Peers and Personal View. These subscales depended on one-another in the development of a positive self-concept in adolescents with cerebral palsy. It should be noted that General School and Relationship with Family did not have connection with each other and with the rest of the self-concept subscales. This means that each of the two subscales could stand by itself in developing the self-concept in adolescent learners with cerebral palsy.

Table 5.30 Correlation between the self-concept subscales

	Relationship with Family	General School	Emotional Stability	Health	Physical appearance	Physical Ability	Music Ability	Relationship with Peers	Personal View
Relationship with Family	1								
General School	.020	1							
Emotional Stability	-.096	.233	1						
Health	-.072	.175	.633	1					
Physical Appearance	-.074	.219	.631	.555	1				
Physical Ability	-.031	.244	.567	.459	.693	1			
Music Ability	-.096	.243	.824	.654	.712	.603	1		
Relationship with Peers	-.074	.232	.710	.582	.831	.719	.740	1	
Personal View	-.097	.148	.667	.853	.587	.511	.693	.586	1

5.2.1.5 What is the relationship between CP and self-concept of learners in special schools in Limpopo province?

H₁: CP affects the self-concept of adolescent learners with CP.

H₀: CP does not affect the self-concept of adolescent learners with CP.

To find out if cerebral palsy affects the self-concept of adolescent learners in special schools in Limpopo Province and to find out if intervention improves the self-concept of adolescent learners with cerebral palsy, the means, standard deviations and coefficients of variation for both before and after intervention were calculated and compared (see Table 5.31). The results in Table 5.31 show that the subscale means ranged from 2.000 (Music Ability) to 2.665 (Physical Ability) for before intervention and 2.395 (Health) to 2.886 (Music Ability) for after intervention. The visual inspection shows that mean scores for after intervention appeared higher in all domains with the exception of emotional stability (2.549 before intervention and 2.535 after intervention). These results show that intervention was an eye opener to the participants in this study. They started looking at life from a new perspective. They accepted themselves and understood that it is normal to be emotional. The results for Music Ability were a complete turn-around, from the lowest mean before intervention (2.000) to the highest after intervention (2.886). This means that intervention programme made the adolescents with cerebral palsy aware that music is for enjoyment, it soothes the mind, elevating the moods and stabilizing the emotions. These results did not support the null hypothesis: Cerebral palsy does not affect the self-concept of adolescent learners in special schools in Limpopo Province. The null hypothesis was therefore rejected. Looking at the results in Table 5.31, the overall mean scores before intervention was 2.371 and 2.666 after intervention, which means that after intervention the adolescents with cerebral palsy viewed themselves positively, became emotionally stable and physically more able, having better interpersonal skills etc. Also considering the length of the intervention in the present study, 1h30 minutes five days a week for one month, this is a great improvement as compared to Polatjko (1991: 170) who found in his study that a six months' reading intervention had little effect on self-concept.

Table 5.31 Means, standard deviations and coefficients of variation showing the self-concept of the participants before and after intervention

Scale components	Before intervention			After intervention		
	Mean	SD	CV	Mean	SD	CV
Relationship with Family (11 items)	2.261	0.505	0.223	2.773	0.412	0.149
General School (9 items)	2.468	0.355	0.144	2.576	0.320	0.124
Emotional Stability (3 items)	2.549	0.210	0.158	2.535	0.344	0.136
Health (2 items)	2.346	0.402	0.171	2.395	0.670	0.280
Physical Appearance (4 items)	2.435	0.359	0.147	2.691	0.348	0.129
Physical Ability (5 items)	2.665	0.396	0.149	2.768	0.281	0.102
Music Ability (3 items)	2.000	0.307	0.154	2.886	0.691	0.239
Relationship with Peers (4 items)	2.285	0.283	0.124	2.612	0.428	0.164
Personal View (2 items)	2.331	0.184	0.079	2.763	0.110	0.040
Overall	2.371			2.666		

5.2.1.6 What is the effect of intervention on the self-concept of children with cerebral palsy?

H₁: Life Skill intervention programme has a positive effect on the self-concept of the cerebral palsied adolescent learners.

H₀: Life Skill intervention programme does not have a positive effect on the self-concept of cerebral palsied adolescent learners.

The paired sample t-test in comparing the means of the subscale scores for before and after intervention was performed. The results are shown in Table 5.32. Table 5.32 shows that there is evidence of a difference in means before and after intervention, p-value was $0.000 < 0.05$. This means that the Life-Skill intervention programme as used in this study had a positive effect on the self-concept of the adolescent learners with cerebral palsy in special schools in Limpopo Province. The null hypothesis was therefore rejected.

Table 5.32 Paired sample t-test for comparing the means of the subscale scores for before and after intervention

	t	df	Sig. (2-tailed)
Pair Before intervention	-3.961	42	.000
1 After intervention			

5.3 Conclusion

This chapter reflected on data analysis and the findings of the present research study. The findings gave answers to the research questions and hypotheses. The results indicated that the self-concept of adolescents with cerebral palsy is not negative but just leaning in the direction of the positive judgments. It was further indicated that cerebral palsy affects the self-concept of the adolescent learners and that intervention has a positive impact on the self-concept of adolescent learners with cerebral palsy.

The next chapter will deal with summary of this study, conclusions and recommendations pertaining to the findings. It further deals with the issues that could have limited the findings of this research.

CHAPTER 6

6. Conclusions, Recommendations and Limitations

6.1 Introduction

This chapter gives a detailed overview of this study. It puts emphasis on selected major conclusions, summaries and recommendations for further research. The conclusions are based on the interpretation of the gathered data from the adolescent learners in special schools in Limpopo Province. The information obtained was analysed to obtain relevant interpretation in order to arrive at appropriate conclusions. Therefore, conclusions drawn from the study and recommendations are discussed in this chapter.

The following objectives were set for this study:

- To measure the self-concept of adolescent learners in special schools in Limpopo Province;
- To find out if cerebral palsy affects the self-concept of adolescent learners with cerebral palsy, and
- To find out if Intervention improves the self-concept of adolescents with cerebral palsy.

6.2 Findings of the research study

The way the adolescents with cerebral palsy view themselves cannot be regarded as unique. In fact, it is applicable to all children with special needs. The overall findings of this study showed that cerebral palsy affects the self-concept of adolescent learners. These results confirm the findings of Hussain (2006: 44), Chapman (1988: 350) and Cooley and Ayres (1988: 176) who found in a number of studies that individuals with disabilities have low levels of self-concept than those with no disability.

The results further indicated that intervention contributes towards growth in the self-concept of adolescents with cerebral palsy. It was indicated that after intervention, self-concept had improved in all domains except emotional stability (see table 5.2 in

chapter 5). This means that during intervention the participants learnt to accept their disability and to realize that it is normal to cry and to be irritated sometimes. The results in the present study are very much similar to Cook (2008: 751), Carin-levy and Jones (2007: 14) and also Polatjko (1991: 170), who found in their studies that intervention had a positive impact on the self-concept of cerebral palsied children.

The findings from demographic information showed that 33%+ of the participants' parents in this study were either separated by divorce or death and during intervention it was discovered that many children had only one parent, the mother, and after the death of the mother, they became orphans. These learners had mothers only because amongst other reasons, the researcher suspected that after they were diagnosed with cerebral palsy, it might have been very difficult for some fathers to have to deal with the reality of a child with a disability and decided to abandon their families. This has deprived some participants in this study of the support from both parents when it is actually one of the greatest determinants of global self-worth in children with cerebral palsy. This means that if all the participants in this study had both parents that could have given them the support they needed and improved on their self-concept in the relationship with family subscale. The other reason for low score on relationship with family as compared to general school might be that many cerebral palsied children spent much of their childhood years hospitalized (as indicated in chapter 5, figure 5.1 that they needed medical help) because of their condition. This had separated these children and their parents at crucial times when maternal bonding had to take place. When they reached school age, they had to be sent to boarding schools; 96,9% of the participants in this study stayed at the school dormitory which means that much of their time was spent at school than with their families (see Table 5.2). Furthermore, the practicality of many items in this domain could have been more practical if the respondents had direct contact with parents/families on a daily basis (see Appendices A, B1, 3, 8, 10, 21 and 22). The other reason for the high self-concept in general school subscale is because the social environments in special schools are tolerant of the children's disability (some types of cerebral palsy are rather scary) and helpful. The staff is positively engaged with these children, trying to create a stimulating social interaction and to emphasize the relative strengths of each child to foster the child's self-concept. This may also explain why cerebral palsied children express positive

feelings about their physical appearance, physical ability and why they express few negative emotions.

It was also shown in the results that the adolescents with cerebral palsy are overprotected and denied the opportunity to contribute towards the family's decision making. Parental overprotection impacts on the children's psychological well-being and independence. As already mentioned above, most of the participants in this study lived at the schools' dormitories and they therefore spent a very limited time at home; only during the holidays. The short time which they spent with their families limited the possibility of being understood by their parents hence, they overprotected them and could not let them contribute towards the family's decision making as they were unconsciously viewed as visitors. Overprotection and the denial of making decisions at home made the adolescents with cerebral palsy not develop a sense of self-worth, becoming unhappy and having a lower self-esteem. This means that it is not only cerebral palsy which has affected the self-concept of the participants in this study, but the circumstances beyond their control such as overprotection by parents and living in the boarding house because of lack of special schools near their homes. If the adolescents with cerebral palsy can be given the freedom they need and the opportunity for participation in their families' decision-making, their self-concept would have been better, and not just skewed in the direction of the positive judgements as they appear in the present study.

6.3 Recommendations

Based on the findings of the present study, the following recommendations for schools teaching children with cerebral palsy have been made:

- Since a large number of the cerebral palsied children need physiotherapy, it is recommended that the Department of Education should employ physiotherapists at every special school for the physically disabled to help with physical therapy. Physical therapy is one of the most important aspects of cerebral palsy therapy. It improves mobility, dressing and other tasks of personal care that are at the heart of self-concept.
- The Department of Education should build enough special schools to allow many physically disabled children to travel daily to school. This will enable

these children to bond with their families and to get parental support which, as already mentioned, is one of the greatest predictors of global self-worth in children with cerebral palsy.

- Though the self-concept is higher in the subscale of general school compared to the subscale of the relationship with family, the overall self-concept of the participants in this study is just leaning in the direction of the positive judgement. This means that the cerebral palsied children generally need help to develop a positive self-concept. In view of this, basic training should be provided within schools to all the teaching staff. This training should aim to provide information and practical skills, and challenge pre-existing attitudes and beliefs. This training may be provided by external organizations such as the Self-esteem Advisory Service.
- The teaching staff should be made aware that not all children with cerebral palsy can make it academically, therefore, considering individual uniqueness of children and severity of the disability programmes like Building Tomorrow should be introduced to enhance the self-concept of these children and to allow them to have hands-on experience in the working environment. Building Tomorrow is a programme in which CP children, especially those who are not performing well academically, are given the opportunity to be registered as students, but sent out to the surrounding businesses as interns under the supervision of either a teacher or psychologist if the school is privileged to have one. Teachers/Psychologists make follow-up on their progress until they master the work assigned to them. The duration differs from child to child depending on how quick the skill is mastered. Once a child has mastered three or four skills, curriculum vitae is compiled by the school for the child to look for employment opportunities.
- The staff working directly with children with cerebral palsy must be aware of the child's strengths and weaknesses and structure activities to allow the child to excel.
- The schools should be made aware of self-concept and self-esteem issues and explicitly provide appropriate activities designed to enhance self-concept and self-esteem. Self-esteem games show children how wonderful it can be to be themselves emotionally, socially, physically and intellectually. By sharing

thoughtful activities in self-esteem games, teachers can reinforce the adolescent learners' positive feelings and provide a lasting foundation for learning.

- The teaching staff should actively promote supportive, reciprocal friendships between the children and their peers. This may be done by using well-known intervention strategies such as 'circles of friends' or 'mentoring systems'. They should also educate all children about different disabilities as Clark (2010: 3) states:

Children are often scared of the unknown, when they are unfamiliar with children who suffer from different disabilities, they will be more likely to shy away from them, avoid them when they can.

If children are educated about different disabilities, this will promote tolerance and acceptance of the differences between them and discourage avoidance of one another. This acceptance and understanding of one another will pave the way for lasting friendships which promote support among adolescents with CP hence, development of a positive self-concept.

- Parent-teacher discussion groups should be formed to assist the parents or caregivers with taking care of their children with cerebral palsy and also with ways of preventing cerebral palsy. The approach should not allow for authoritarians who operate from positions of power, but instead should be in such a way that both parties (parents and teachers) should learn from each other for the benefit of the children. The characteristic of a meeting as provided by the Department of Education: First steps School Governance Starter Pack (1997: 27) can also be applied to parent-teacher discussion groups.
- Helping the cerebral palsied children to develop a positive self-concept must include identification and intervention with various family members, addressing their emotional responses, grieving of losses, and overall adaptation. Recognition of concomitant feelings of anger, guilt, resentment and conflict is essential. The therapists may promote the greatest impact on the facilitation of the development of a positive self-concept in children with cerebral palsy by addressing the needs of the family unit because ultimately,

the patient will return to this system, be it chaotic or resilient, and because the self-concept of the child (the patient) is more dependent on what the parents and others declare it to be rather than on the child's actual feelings and perceptions.

6.4 Limitations of the study

Intervention was done during the busiest school term of the year and learners were fully engaged with their school activities. Contact time with the participants was in the afternoon when they were already tired of their daily routines, but the researcher tried to solve the problem by letting the participants to dramatize some situations in the Life-Skill intervention programme. The researcher did not include the normative sample in this study to compare them with the cerebral palsied sample. However, she tried to minimize the problem by comparing the means of the self-concept scores of the participants before and after the intervention. Also, the descriptive statistics did not include gender and age differences which the researcher noticed as a flaw in this study.

6.5 Conclusion

In view of the results in this study, the researcher is of the opinion that cerebral palsy does affect the self-concept of the adolescent learners. The researcher concurs with Fantuzzo et al.'s (1995: 87) argument that cerebral palsy is but one category among many that may affect a child's self-concept. According to him, how such disability is managed and whether some relative degree of unnecessary failure results, depend on the environment, especially the family and school environments in which the child grows up. It is also important that the parents or guardians of children with cerebral palsy know the condition thoroughly so that they are in a position to help these children in ways that would improve not only their health, but also their general growth and emotional maturation. This will make these children live meaningful lives to their benefit and the benefit of their families and significant others as well as their communities at large.

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APPENDIX A



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF EDUCATION

Enquiries: Mokoka M B
Telephone: 015 290 7918
Fax 015 297 2690

TO WHOM IT MAY CONCERN

Sir/Madam

The bearer, Legodi MM, has been given permission by Limpopo Department of Education (LDoE) to conduct research at special schools in Limpopo Province. The title of the research is "The self-concept of adolescent learners with cerebral palsy at special schools in Limpopo province." The research will be conducted during the first three quarters of the calendar year.

The Department requests departmental officials, learners, managers and educators to cooperate with the researcher when research activities are conducted.

It is envisaged that the research report will assist LDoE in many ways.

Thank you



HEAD OF DEPARTMENT

10/09/2007

DATE

APPENDIX B

P.O. Box 365
Mashashane
0743
13 July 2008

To: Mrs Mashilo Legodi

With reference to your letter dated 13 July 2008, whereby you were requesting to include my child as a research subject for your project with the University of Limpopo, I am **granting you a permission/not granting you permission.**

I hope that the inclusion and engagement of my child in your research project is not going to affect him/her negatively.

Thank you

Yours sincerely
Shibe Ngcobo

APPENDIX C

SELF-CONCEPT QUESTIONNAIRE FOR CEREBRAL PALSYED LEARNERS OF SPECIAL SCHOOLS IN LIMPOPO PROVINCE

GENERAL INSTRUCTIONS

PLEASE ANSWER ALL THE QUESTIONS. YOUR RESPONSE WILL NOT BE LINKED TO YOU AS YOUR NAME WILL NOT BE WRITTEN ON THE QUESTIONNAIRE.

SECTION A: BIOGRAPHICAL DATA

COMPLETE THE FOLLOWING ITEMS BY MAKING A CROSS (X) IN THE SQUARE NEXT TO THE RESPONSE APPLICABLE TO YOU.

1. Where do you live?

1	Village
2	Township
3	Suburb/City
4	Other (specify)

2. What is your gender?

1	Male
2	Female

2.1. What is your race? _____.

3. How old are you? _____.

4. What is the name of your school?

1	Letaba School for the Handicapped
2	Tšhilizini Special School
3	Helena Franz Special School

4.1. Do you

1	Stay in the school dormitory?
2	travel daily to school?

4.2. If you live in the school dormitory, how often does your family come to visit you?

1	Not at all
2	Once quarterly
3	Once a month
4	Every weekend

4.3. What grade are you in? _____.

5. Who is supporting you financially?

1	Parents
2	Guardian
3	Other (specify)

6. How do you rate your family economically?

1	Well-off
2	Average
3	Poor
4	Very poor

7. What is the occupation of your parents?

Mother	Father	
1	1	Unemployed
2	2	Labourer/domestic worker
3	3	Civil servant (e.g. clerk, magistrate)
4	4	Self-employed (e.g. farmer, business man/woman)
5	5	An academic (e.g. lecturer)
6	6	Pensioner

8. What is your parent's highest academic qualification?

Mother	Father	
1	1	Never been to school
2	2	Primary
3	3	Secondary
4	4	Tertiary

9. What is your parents' marital status?

1	Living together
2	Divorced
3	Separated
4	Separated by death

10. How many members are there in your household? _____.

11. How many members sleep in your household? _____.

12. How many sleeping rooms are there in your household? _____.

13. Do you get any medical help to cope with your condition?

1	Yes
2	No

14. If your answer in 13 is (1), where do you get medical help from?

1	Physiotherapist
2	Occupational therapist
3	Psychologist
4	Clinic
5	Medical doctor
6	Traditional doctor
7	Other (specify)

15. I am unable to care for myself because

1	I am confined to a wheel-chair
2	I cannot use both hands
3	I cannot move
4	I can hardly walk

SECTION B

PLEASE INDICATE YOUR REACTION TO THE FOLLOWING STATEMENTS USING THE ALTERNATIVES LISTED BELOW. MAKE A CROSS (X) IN THE SQUARE NEXT TO THE RESPONSE APPLICABLE TO YOU.

STRONGLY AGREE = SA

AGREE = A

UNDECIDED = U

DISAGREE = D

STRONGLY DISAGREE = SD

SA A U D SD

1	My family does not understand me at all	1	2	3	4	5
2	I feel guilty because I am not able to look after my body	1	2	3	4	5
3	My parents are so overprotective of me	1	2	3	4	5
4	I feel I am an important member of my family	1	2	3	4	5
5	I am in good health	1	2	3	4	5
6	I feel my family does not care much for me	1	2	3	4	5
7	I like my family	1	2	3	4	5
8	I contribute a lot towards the family's decision making	1	2	3	4	5
9	My family loves me	1	2	3	4	5
10	My parents allow me to help with household chores	1	2	3	4	5
11	I hate most school subjects	1	2	3	4	5
12	My teacher makes me feel I am not good enough	1	2	3	4	5
13	It is easy for me to make friends	1	2	3	4	5
14	It irritates me when someone shouts at me	1	2	3	4	5
15	I often cry	1	2	3	4	5
16	I enjoy listening to people playing music	1	2	3	4	5
17	At school I get all support I need from my teachers	1	2	3	4	5
18	I find most subjects very difficult to learn	1	2	3	4	5
19	I like the way I look	1	2	3	4	5
20	I am good at sports and games	1	2	3	4	5
21	My parents give me the freedom I need	1	2	3	4	5

SA A U D SD

22	My parents and I have a lot of fun together	1	2	3	4	5
23	Music makes me feel irritated	1	2	3	4	5
24	It is difficult for me to make friends	1	2	3	4	5
25	I am well liked by others of my age	1	2	3	4	5
26	I avoid sports and games when I can	1	2	3	4	5
27	Music to me does not make any difference	1	2	3	4	5
28	I am not happy with my appearance	1	2	3	4	5
29	I do not cry easily	1	2	3	4	5
30	I have a strong personality	1	2	3	4	5
31	I would like to change the way I look	1	2	3	4	5
32	I do well at sports and games	1	2	3	4	5
33	I enjoy sports and games	1	2	3	4	5
34	I feel I do have much to be proud of	1	2	3	4	5
35	I look forward to going to school each day	1	2	3	4	5
36	I enjoy doing work in most school subjects	1	2	3	4	5
37	I enjoy the time I spend in my class	1	2	3	4	5
38	My peers avoid me as they can	1	2	3	4	5
39	I would not go to school if it was my choice	1	2	3	4	5
40	I am a leader in sports	1	2	3	4	5
41	I am satisfied with my appearance	1	2	3	4	5
42	My parents and I talk on a regular basis	1	2	3	4	5
43	I hate schooling	1	2	3	4	5

MUINGO C

**MBUDZISO DZA VHAGUDISWA VHA RE CEREBRAL PALSIED VHA ZWIKOLO
ZWA SIPESHALA ZWA VUNDU LA LIMPOPO**

KHA VHA TEVHEDZE MILAYO IYI I TEVHELAHO

KHA VHA FHINDULE MBUDZISO DZOTHE. PHINDULO DZE VHA NEA DZI DO
DZULA DZI TSHIDZUMBE NAHONE A DZI NGA NWALWI KHA INO
QUESTIONNAIRE.

SECTION A: NGA HA VHONE VHANE

KHA VHA FHINDULE IZWO ZWI RE AFHO FHASI NGA U ITA (X) KHA
TSHIDANGA TSHO TEAHO.

1. Vha dzula gai?

1	Tshikolobulasi
2	Nyinga dorobo
3	Dorobo
4	Hunwe vho

2. Mbeu?

1	Munna
2	Mufumakadzi

2.1. vha wa lushaka lufhio? _____.

3. Minwaha? _____.

4. Dzina la tshikolo tshavho?

1	Letaba School for the Handicapped
2	Tšhilizini Special School
3	Helena Franz Special School

4.1. Vha?;

1	Dzula hostele ya tshikoloni?
2	Vha da duvha linwe na linwe?

4.2. Arali vha tshi dzula hostele ya tshikoloni ndi lungana lune mashaka a vho a da atshsi vha dalela?

1	Avha di na luthihi
2	Luthihinga kotara
3	Luthihinga nwedzi
4	Mafhelo a vhege inwe na inwe

4.3. Vha kha murole u fhio? _____.

5. Ndi nnyi o no vha thusa nga masheleni?

1	Ahabebi
2	Muundi
3	Vhanwe vho

6. Muta wa havho zwitshi da kha masheleni?

1	Vhaa dikona
2	Vha khwine
3	Vho siwana
4	Vho siwana nga maanda

7. Vhabebi vhavho vha shuma gai?

Mme	khotsi	
1	1	A vha shumi
2	2	Ndi mushumi zwawe
3	3	Vha shuma muvhusoni (e.g. clerk, magistrate)
4	4	Vha tou dishuma (e.g. Farmer, Business man/woman)
5	5	Ndi vho Raakhademi (e.g. Lecturer)
6	6	Vha hola mundende

8. Pfunzo ya vhabebi vhavho ya nthesa?

Mme	khotsi	
1	1	A vho ngo dzhena tshikolo.
2	2	Phuraimari
3	3	Sekondari
4	4	Zwikolo zwa pfunzo ya nntha.

9. Vhabebi vhavho vho?

1	Vha dzula vhothe
2	Vho divosa
3	Vho fhambana
4	Vho fhambanyiswa nga lufu

10. Mirado ya mita ndi mi ngana? _____.

11. Ndi vha ngana vha no edela heneffo? _____.

12. Huna kamara nngana dza u edela? _____.

13. Vha a wana thuso ya dzilafho?

1	Ee
2	Hai

14. Arali phindulo yavho kha 13 i (1),vha i wana gai thuso ya dzilafho?

1	Physiotherapist
2	Occupational therapist
3	Psychologist
4	Clinic
5	Medical doctor
6	Traditional doctor
7	Other (specify)

15. A thi koni u dithogomela ngauri?

1	Ndi shumisa wheel-chair
2	A thi koni u shumisa zwanda zwothe
3	A thi koni u shumisa mirado ya muvhili wanga
4	A thi koni u tshimbila

SECTION B

KHA VHA SUMBEDZE NDILA INE VHA DI PFA NGAYO ZWI TSHI DA KHA
ZWITEVHELAHO, VHA VHEE (X) TSINI NA PHINDULO YE VHA NANGA;

NDI TENDELANA NAZWO NGA MAANDA= SA

NDI A TENDELANA NAZWO = A

A THINA VHUTANZI = U

NDI A HANEDZA = D

NDI HANEDZA NGA MAANDASD

SA A U D SD

1	Muta wa hashu a vha mpesesesi na luthihi	1	2	3	4	5
2	Ndi pfa ndi tshi disola ngauri a thi thogomeli muvhili wanga	1	2	3	4	5
3	Vhabebi vhanga a vha ntsireledzi zwo kalulaho	1	2	3	4	5
4	Ndi pfa ndi wa ndeme u vha murado wa muta hoyu	1	2	3	4	5
5	Ndi na mutakalo wavhudi	1	2	3	4	5
6	Ndi pfa u nga muta wa hashu a vha nthogomeli	1	2	3	4	5
7	Nd funa muta wa hashu	1	2	3	4	5
8	Ndi tshipida tsha u dzhia tsheyo mutani wa hashu	1	2	3	4	5
9	Muta wa hashu u a mpfuna	1	2	3	4	5
10	Vha a tenda ndi tshi thusa nga mishumo ya hayani	1	2	3	4	5
11	A thi takaleli vhunzhi ha therodza tsikoloni	1	2	3	4	5
12	Mudededzi wanga vha ita uri ndi pfe u nga a thi koni	1	2	3	4	5
13	A zwi nkondeli u vha na khonani ntswa	1	2	3	4	5
14	A thi zwitakaleli musi musi muthu a tshi amba na nne nga u tou u zhambelela.	1	2	3	4	5
15	Ndi dzulela u lila	1	2	3	4	5
16	Ndi takalale u pfa musi vhathu vha tshi kou tamba muzika	1	2	3	4	5
17	Ndi wana thuthuwedzo yothe u bva kha vhadededzi vhanga	1	2	3	4	5
18	Vhunzhi ha therodza dzia nkondela	1	2	3	4	5
19	Ndi takalale ndila ine nda vhonala ngayo	1	2	3	4	5
20	Ndi a kona kha zwa zwipotso na mitambo	1	2	3	4	5
21	Vhabebi vha nga vha mpha vhudivhusi vhune nda vhu toda.	1	2	3	4	5

		SA	A	U	D	SD
22	Ndi vha na tshifhinga tshinzhi tsha u diphina na vha muta wanga	1	2	3	4	5
23	Muzika u a mphiliphitha	1	2	3	4	5
24	Zwi a nkondela u vha na khonanai ntwswa	1	2	3	4	5
25	Thanga dzanga dzi a ntakalele.	1	2	3	4	5
26	A thi andani na zwa zwipotso na zwa mitambo	1	2	3	4	5
27	Muzika kha nne a u iti phambano	1	2	3	4	5
28	A thi takaleli ndila ine nda vhonala ngayo	1	2	3	4	5
29	A thi lili zwi song tea	1	2	3	4	5
30	Ndi na mbvumbo ya vhudi	1	2	3	4	5
31	Ndi tama u shandula ndila ine nda vhonala ngayo	1	2	3	4	5
32	Ndi a kona zwa zwipotso na zwa mitambo	1	2	3	4	5
33	Ndi takalele zwa zwipotso na zwa mitambo	1	2	3	4	5
34	Ndi pfa uri ndi zwinzhi zwine nda dihudza ngazwo	1	2	3	4	5
35	Ndi pfa ndi tshi takalale u ya tshikoloni duvha linwe na linwe	1	2	3	4	5
36	Ndi takalela u ita mushumo wa ther o dza tshikolo	1	2	3	4	5
37	Ndi takalale tshifhinga tshine nda tshifhedza ndi kilasini	1	2	3	4	5
38	Mirole yanga a i takalei u vha nne	1	2	3	4	5
39	Ndo vha ndi sa do ya tshikoloni arali lo vha lu lu tamo lwanga	1	2	3	4	5
40	Ndi murangaphanda kha zwa mitambo	1	2	3	4	5
41	Ndi takalela mbonalelo yanga	1	2	3	4	5
42	Ndi dzulela u amba shifhinga tshothe na vhabebi vhanga	1	2	3	4	5
43	Ndi a vhenga u ya tsikoloni	1	2	3	4	5

APPENDIX C

SELF-CONCEPT QUESTIONNAIRE FOR CEREBRAL PALSYED LEARNERS OF SPECIAL SCHOOLS IN LIMPOPO PROVINCE

SWILETELO

HLAMULA SWIVUTISO HINKWASWO. TINHLAMULO TA WENA A TI NGE FAMBISANI NA WENA TANI HI KU VITO RA WENA A RI NGE TSARIWI EKA PAPILA LERI RA SWIVUTISO

XIYENGE XA A: BIOGRAPHICAL DATA

Hetisa swilo leswi landzelaka, hi ku endla xihambano endzeni ka bokisi kutani kutani uhlawula leswi swi faneleke.

1.U tshama kwihi?

1	Kaya
2	Doroba ntsongo
3	Doroba nkulu
4	Swin'wana(boxa)

2. U munhu wa ri mbewu rihi?

1	Wa xinuna
2	Wa xisati

a. 2.1. Xana u wela eka rixaka rihi ra vanhu? _____.

3. Xan u na malembe mangani? _____.

4. Xana l mani vito ra xikolo xa wena?

1	Xikolo xa va tsoniwa xa Letaba
2	Xikolo xo hlawuleka xa Tšhilizini
3	Xikolo xo hlawuleka xa Helena Franz

4.1. Xana u

1	tshama ehositele ya xikolo?
2	ta exikolweni ku suka ekaya masiku hinkwawo?

4.2. Loko unga va u tshama ehositele ya xikolo, vatswari va wena va ku endzela hi ndlela yihi?

1	A va ndzi endzeli
2	Kan'we hi kotare
3	Kan'we hi nhweti
4	Ku hela ka vhiki rin'wana na rinwana

4.3. Xan u endla ntangha mani? _____.

5. I maniaku hlayisaka hi thlelo ra swa timali?

1	Vatswari
2	Muhlaysi
3	Van'wana (boxa)

6. Xana muti wa ka n'wina u wu veka eka tlhelo rihi eka swa ti mali?

1	Swi fumi
2	Xikarhi
3	Pfumala
4	Wu xaniseka swinene

7. Xana vatswari va wena va tirha mintirho yihi?

Manana	Tatana	
1	1	A va tirhi
2	2	Va tirha emakaya/Mutirhi wo pfumala vu swikoti
3	3	Mu tirhela pfumo (xikombiso: matsalana, magisitarata)
4	4	Va titirha (xikombiso: Murimi, N'wa mabhindzu)
5	5	Swi dyondzeki (xikombiso: mudyondzisi eyunivhesiti)
6	6	Va holi va mudende

8. Xana tidyondzo ta le henhla leti va tswari va wena va nga na tona hi tihi?

Manana	Tatana	
1	1	A va nghenangi xikolo
2	2	Phurayimari
3	3	Sekondari
4	4	Ku hundza ntanga khume

9. Xana va tswari va wena va swin'we hi tlhelo ra swa vukati?

1	Va tshama swin'we
2	Va hambanile
3	Va hambanisiwile
4	Va hambanise hi rifu

10. Xana mi va ngani ekaya ka n'wina? _____.

11. Xana mi etlela mi ri vangani ekaya ka n'wina? _____.

12. Xana kuna makamara mangani yo etlela ekaya ka n'wina? _____.

13. Xana wa wu kuma pfuneto hi tlhelo ra swa ri hanyu ku kondelela xi yimo xa wena?

1	Ina
2	Ee

14. Loko nhlamlulo ya wena leyi u yi nyikeke laha henhla ka 13 yi ri (1), u wu kuma kwihi mpfuneto hi tlhelo ra ta rihanyu?

1	Physiotherapist
2	Occupational therapist
3	Psychologist
4	Kliniki
5	Dokodela
6	Dokodela wa xintu
7	Ku n'wana(boxa)

15. Andzi koti ku ti hlayisa hi kuva;

1	ndzi tirhisa xitulu xa mavhilwa
2	a ndzi koti ku tirhisa mavoko ha mambirhi
3	a ndzi koti ku famba
4	ndzi famba hi ku tikeriwa

XIYENGE XA B

Nyika tinhlamulo eka swivulwa leswi swi landzelaka hi endla xihambano eka swibokisana leswi nga laha hansi etlhelo ka nhlamulo ya wena;

NDZI PFUMELELANA NA SWONA HI KU HETISEKA	= SA
NDZA PFUMELA	= A
KU KA DZI NGA SI EHLEKETISISA	= U
A NDZI YIMI NA SWONA	= D
A NDZI YIMI NA SWONA HI KU HETISEKA	= SD

		SA	A	U	D	SD
1	Ndyangu wa mina a wu koti ku ndzi twisia na swintsongo	1	2	3	4	5
2	Ndzi ti twa nandzu hikuva a ndzi koti ku hlayisa miri wa mina	1	2	3	4	5
3	Va tswari va mina va ndzi yimelela swinene	1	2	3	4	5
4	Ndzi ti twa ndzi wa nkoka endyangwini wa ka hina	1	2	3	4	5
5	Ndzi hanyile kahle	1	2	3	4	5
6	Ndzi twa onge ndyangu wa mina a wuna mhaka na mina	1	2	3	4	5
7	Ndzi rhandza ndyangu wa ka hina	1	2	3	4	5
8	Ndzi hoxa xandla eka swi boho leswi endliwaka hi ndyangu wa ka hina	1	2	3	4	5
9	Ndyangu wa ka hina wa ndzi rhandza swinene	1	2	3	4	5
10	Vatswari va mina va ndzi pfumelela ku ndzi pfuneta hi mintirho ya le kaya	1	2	3	4	5
11	Ndzi venga tidyonzto to tala ta xikolo	1	2	3	4	5
12	Mudyondzisi wa mina u endla ndzi ti twa ndzi nga tirhi hi ndlela leyi hetisekeke	1	2	3	4	5
13	Swa ndzi olovela ku endla vunghana	1	2	3	4	5
14	Swa ndzi karhata loko munhu a ndzi huwelela	1	2	3	4	5
15	Ndza rila mi nkarhi yi n'wana	1	2	3	4	5
16	Ndzi rhandza ku yingisela vanhu va tlanga vuyimbeleri	1	2	3	4	5
17	Exikolweni ndzi kuma kuseketeriwa hinkwako lebyi ndzi ku lavala byi humaka ka vadyondzisi va mina	1	2	3	4	5
18	Ndzi kuma tidyondzo to tala ti ndzi tikela ku ti endla	1	2	3	4	5
19	Ndzi rhandza ndlela leyi ndzi langutekaka ha yona	1	2	3	4	5
20	Ndzi na vuswikoti eka swa mitlangu na mitlangu	1	2	3	4	5
21	Vatswari va mina va ndzi nyika ntshuxeko lowu ndzi wu lavaka	1	2	3	4	5

22	Ndzi rhandza ku tlanga na vatswari va mina	1	2	3	4	5
23	Vuyimbeleri bya ndzi nyangatsa	1	2	3	4	5
24	Swa ndzi tikela ku endla vunghana	1	2	3	4	5
25	Ndzi rhandziwa ngopfu hi tintangha ta mina	1	2	3	4	5
26	Ndzi papalata ta mitlangu na mitlangu loko ndzi swi kota	1	2	3	4	5
27	Vuyimbeleri a byi endli ku hambana eka vutomi bya mina	1	2	3	4	5
28	A ndzi tsaki hi xivumbeko xa mina	1	2	3	4	5
29	A ndzi rili hi ku olova	1	2	3	4	5
30	Ndzi na vumunhu byo helela	1	2	3	4	5
31	Ndzi lava ku cinca xivumbeko xa mina	1	2	3	4	5
32	Ndzi tirha kanhle eka swa mitlango na mitlangu	1	2	3	4	5
33	Ndzi rhandza swa mitlangu na mitlangu	1	2	3	4	5
34	Ndzi ti twa ndzi ri na swo tala leswi ndzi tinyungubiyisaka hi swona	1	2	3	4	5
35	Ndzi langutele ku ya exikolweni masiku hinkwawo	1	2	3	4	5
36	Ndzi rhandza ku endla mintirho ya tidyondzo ta mina to tala	1	2	3	4	5
37	Ndzi rhandza nkarhi wa mina lowu ndzi wu tirisaka etlisini	1	2	3	4	5
38	Tinthanga ta mina ta ndzi papalata loko ti swi kota	1	2	3	4	5
39	A ndzi nga ta ya exikolweni loko a ku ri ku rhandza ka mina	1	2	3	4	5
40	Ndzi murhangeri wa swa mitlangu	1	2	3	4	5
41	Ndza eneriseka hi xivumbeko xa mina	1	2	3	4	5
42	Vatswari va mina na mina hi tshama hi vulavurisaneni minkarhi hinkwayo	1	2	3	4	5
43	Ndzi venga ku nghena xikolo	1	2	3	4	5

APPENDIX D

The life-skill intervention programme

The participants were given exercises on the following topics:

Invited or Excluded?

This topic is about adjustment to situations in relationships. People often adjust to situations in relationships which are not good for them. They sometimes begin to view abusive relationships as the norm. The objective of this exercise was to heighten the participants' awareness of the relationships in their lives which are healthy and nurturing and those which are not, to focus on feelings of being loved, wanted and let in by others, or unloved, unwanted and shut out. It was hoped that with that awareness, they may then find the energy to work to improve poor relationships where this is feasible, to give up those relationships which seem past, repair and, most importantly, to appreciate in a new light those warm and accepting people in their lives.

Hopes and Wants and Things that crush them

The topic is about self-doubts, internal critical voices and negative beliefs. The objective was to enable the participants to highlight self-doubts, internal critical voices and negative beliefs they may have about themselves. This was done with the hope that it may also heighten their awareness of actions which are actually a form of self-sabotage that is, actions which prevent the achievement of ambitions, dreams and goals.

Unfinished business

This is about a person's unresolved, unspoken or swallowed feelings. Unresolved, unspoken or swallowed feelings one has for other people (sometimes known as "unfinished business") can weigh heavily. Such feelings do not simply go away. They can prevent a person ever really feeling at peace. They are sometimes the cause of a constant state of anxiety. The objective of this exercise was for the participant to become more aware of the unresolved feelings he/she has with other people. This was done with the hope that the participant would be motivated to think

of ways of expressing those feelings, rather than continuing to carry them around in both body and mind, to the detriment of both.

Wheel of faces, past and present relationships

This is about important relationships. Feelings one has about people can be triggered simply by a picture or resemblance and one often projects the unresolved feelings which he/she has about one person on to another, sometimes even a stranger or someone he/she has met for the first time. The objective was to enable the participants to learn more about their important relationships, both past and present and to consider any unresolved feelings they may have about these relationships.

Fortifications

This topic is about defence mechanisms.

People have a tendency of overprotecting themselves, where for example, a person may be keeping out benevolent, supportive and nurturing people, along with the abusive ones and so ending up feeling emotionally starved and alone. The objective was to focus both on the participants' feelings of invasion and on their unhealthy and outdated or healthy and protective, defence mechanisms.

The givers and the takers

This is about support. If people remain more or less unaware of what support is and what it feels like to be supported, they may jeopardize their chances of seeing it or walking towards it when it is there. The objective was to heighten awareness of the concept of support. Heightening the participants' awareness of the givers and takers in their life may help them to take more responsibility over who they spend time with because, healthy people tend to walk towards people who are good for them and away from people who are bad for them.

How one feels in relation to other people

This is about how people feel about the people they meet. People feel differently with each person they meet, small with some, insignificant with others or even more important with others. The objective was to increase the participants awareness of how they feel in relation to other people with the hope that the participants will then

use this information to improve their relationships.

Life crossroads

This is about difficult decision or dilemma: when people are faced with a difficult decision or dilemma, they may panic, get confused or say, “Oh, I do not know what to do!” and leave it at that, without exploring the various options in a creative, interesting and fun way. The objective was to offer the participant the opportunity for better handling of decision-making processes and encouragement to be proactive rather than becoming passive, confused and frightened around decisions.

The critic in one's head

This is about the daily messages. Owing to the undeveloped sense of self, message (both verbal and nonverbal) given to the young child can be as powerful as hypnosis. Such messages tend to be swallowed whole, believed fully and then played in the mind repeatedly, as if they were the child's own views, whilst he or she forgets who said them or implied them in the first place. The objective was to help participants to become more aware of the negative things they say to themselves in their heads (sub-vocally), the daily messages which can be both energy-draining and confidence-sapping.

Good things one says to him/herself

This is about positive as opposed to negative things. This was meant to follow “The critic in your head”. The objective being, to remind participants that they have options as to what they say to themselves in their heads and that they can say positive as opposed to negative things.

Chaos

This is about chaos in one's life. It is important for people to distinguish between creative and destructive chaos as the former can be an important first stage to new and creative insights or ventures. The objective was to focus on areas of chaos and confusion in the participant's life and to explore how greater clarity might be achieved.

Festival of moments

This is about the good things in one's life. In a fast-moving technological society, time spent in savouring the good things in life or the moment of profound joy, intimacy or ecstasy, are all too rare. The objective was to offer the participants both the time and space to savour the good times they have experienced and to stay in a state of satisfaction.

Suitcase of valuables

This is about nice memories in one's life. When things get tough, it often helps to think of nice memories or wonderful loving people or even funny jokes or funny happenings, or wonderful places that one has or has not been to. The objective here is to enable the participants to realize that they can call on inner resources when they feel bad.

Diploma ceremony

This is about the acknowledgement and appreciation of one's qualities. The objective was to enable the participants to celebrate and savour what they like about themselves because to give 'thought time' to this can be all too infrequent for some people.

Important relationships

This is about relationships. People play different roles in relationships, e.g., they tend to play 'victim' or 'persecutor,' 'leader' or 'follower', with other people, they feel powerful or impotent, insignificant or important. The objective was to make the participants aware of the role they choose to play in their relationship life, which might motivate them to try out healthier roles and different ways of relating.

One's personal universe

This is also about relationships. In life there are people whom we feel very close to or distant from, or we may even want to remove others from our universe altogether, as this can feel very relieving where relationships have been abusive and psychologically damaging. The objective was to help participants to identify feelings about their relationship life as a whole, to consider, for example, who is central and foreground in their life, who they feel close to or distant from emotionally or

geographically and who they imagine feels distant or close to them.

The roles people play in groups

This is about the role people play in groups. The objective was to highlight the common roles participants tend to play when in groups. If these tend to be limiting or unhealthy roles, e.g., if participants are usually the scapegoat or outside of a group, they could be encouraged to discuss ways of identifying and then changing the behaviour which is contributing to their adoption of these positions.