

Caregivers' perceptions of the inter-relationship between Attachment and Attention Deficit
Hyperactivity Disorder (ADHD) in children.

KIM LYNN HARRIS

Student No: 561536

A research report submitted in partial fulfilment of the requirements for the degree of

Master of Arts in Community-Based Counselling Psychology (MACC)

DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF THE WITWATERSRAND

Supervisor: **Dr. Daleen Alexander**

2014

DECLARATION

Except for references specifically indicated in the text, and such help as has been acknowledged, this research report is wholly my own work. This research report is submitted for the degree of Master of Arts in Community-Based Counselling Psychology (MACC) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other Tertiary Institution.

KIM LYNN HARRIS

ABSTRACT

The primary focus of the research is to explore the caregivers' perceptions of the possible inter-relationship between attachment difficulties and ADHD as displayed by these children within a South African context. The researcher specifically attempted to explore the relationship between attachment and ADHD to identify whether the attachment or lack thereof may contribute to the development of ADHD. The theoretical framework encompasses a discussion of the major styles of attachment using John Bowlby (1982), Mary Ainsworth (1978), Margaret Mahler's (1974) and Peter Fonagy (1995) theories.

This study is exploratory and qualitative, focusing on the caregivers' subjective experiences which were gathered through individual, face to face interviews. Participants were selected by the mean of convenience sampling and all ethical considerations such as confidentiality and informed consent were taken into account.

The findings of the research suggested many participants had similar experiences with their children in which many found that the emotional turmoil was more intense than expected, as they realised that raising a child with ADHD had impacts not only on the child as an individual, but on the whole family. Many participants' also experienced difficulties connecting with and understanding the emotional and behavioural development of their child which in turn resulted in various parenting styles and the ultimate relationship they had with their child. The findings of the research therefore suggested that an inter-relationship between attachment and ADHD does exist, however due to the small sample generalisability is limited.

Keywords: Attention Deficit Hyperactivity Disorder (ADHD), Attachment, Primary Caregiver.

ACKNOWLEDGEMENTS

“Our lives begin to end the day we become silent about things that matter”

Martin Luther King, Jr.

First and foremost, praise to the Lord Jesus Christ for giving me the strength, knowledge and wisdom to complete this research report.

My sincere gratitude goes to my supervisor, Dr. Daleen Alexander and mentor, Epimaque Niyibizi. Thank you for your continued assistance and support. It was a privilege and honour to have worked with you and to have received your invaluable tutelage.

My deepest gratitude goes to my parents, Ewan and Olga Harris. I thank you for all that you are in life. Mostly, thank you for your unconditional acceptance as well as your support over the span of my academic career.

To my sister, Tamryn Harris thank you for your constant advice and encouragement to keep pushing and never give up, no matter how hard it seemed to be.

To my partner, Randall Starkey, I thank you for all your support, commitment and sacrifices made during this journey of completing my Masters studies.

To the rest of my family and friends, thank you for your love and unfailing support. It is truly appreciated. Each and every one of you mentioned and not mentioned has allowed me to realise this dream.

Last and certainly not least, to all the participants whose dedication and commitment to looking after their children despite the daily challenges they may face, you are all truly remarkable and inspiring. Without your time and valuable input, this study would not have been possible.

I dedicate this research to my parents, Ewan and Olga Harris. May the Lord Jesus Christ bestow upon you many blessings as you have done for me.

**CAREGIVERS' PERCEPTIONS OF THE INTER-RELATIONSHIP BETWEEN
ATTACHMENT AND ATTENTION DEFICIT HYPERACTIVITY DISORDER
(ADHD) IN CHILDREN.**

TABLE OF CONTENTS

Declaration.....	ii
Abstract.....	iii
Acknowledgements.....	iv
Table of Contents.....	v

**CHAPTER 1:
INTRODUCTION**

1.1	Background and Context for Research.....	1
1.2	Objectives of the Research.....	3
1.3	Statement of the Problem.....	3
1.4	Rationale.....	3
1.5	Theoretical Framework.....	4
1.6	Structure of the Study.....	4

**CHAPTER 2:
SURVEY OF EMPIRICAL LITERATURE**

2.1	Introduction.....	5
2.2	Conceptual Definitions.....	5
2.2.1	Attention Deficit Hyperactivity Disorder (ADHD).....	5
2.2.2	Attachment.....	5
2.2.3	Primary caregiver.....	5
2.2.4	Inter-relationship.....	6
2.2.5	Intra-relational findings.....	6
2.2.6	Inter-relational findings.....	6

2.3	Empirical Research.....	6
2.3.1	Understanding an ADHD diagnosis.....	6
2.3.2	ADHD in South Africa.....	8
2.3.3	Understanding attachment in young children.....	9
2.3.4	Possible link between ADHD and Attachment.....	11
2.4	Conclusion.....	12

CHAPTER 3: THEORETICAL FRAMEWORK

3.1	Introduction.....	14
3.2	Theories of attachment.....	14
3.2.1	Defining the Construct of Attachment.....	14
3.2.2	The Origins of Attachment Theory: John Bowlby & Mary Ainsworth.....	17
3.2.3	Contribution to Theory Building and Consolidation: Margaret Mahler & Peter Fonagy.....	20
3.2.4	Childhood Attachment.....	23
3.2.5	Adult Attachment.....	23
3.3	Conclusion.....	24

CHAPTER 4: METHODOLOGY AND ANALYTICAL FRAMEWORK

4.1	Introduction.....	25
4.2	Research Design.....	25
4.3	Sample.....	26
4.4	Data Collection Procedure.....	27
4.5	Data Analysis.....	28
4.6	Ethical Consideration.....	31
4.7	Conclusion.....	32

CHAPTER 5: PRESENTATION OF FINDINGS

5.1	Introduction.....	33
5.2	Presentation of intra-relational findings.....	33
5.2.1	Participant 1.....	34
5.2.2	Participant 2.....	36
5.2.3	Participant 3.....	39
5.2.4	Participant 4 & 5.....	41
5.2.5	Participant 6.....	44
5.2.6	Participant 7.....	46
5.2.7	Participant 8.....	48
5.3	Summary of inter-relational findings.....	50
5.4	Conclusion.....	50

CHAPTER 6: DISCUSSION OF FINDINGS

6.1	Introduction.....	51
6.2	Biographical information of participants.....	51
6.3	Findings based on interviews.....	52
6.3.1	Theme 1: Difficulties experienced by the caregivers as the primary caregiver of an ADHD child.....	55
6.3.2	Theme 2: The caregiver's perception of the emotional regulation of the child with ADHD and any behavioural changes experienced by the child.....	65
6.4	Summary of findings.....	71
6.5	Conclusion.....	71

CHAPTER 7: STRENGTHS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

7.1	Introduction.....	73
7.2	Strengths of the study.....	73

7.3	Limitations of the Study	74
7.4	Recommendations and areas for further research	74
7.5	Conclusion	75

REFERENCES AND APPENDICES

References	76
Appendices	85
Appendix 1: Participant Information Letter.....	85
Appendix 2: Consent Form – Participant.....	87
Appendix 3: Consent Form – Audio Taped.....	88
Appendix 4: Interview Schedule.....	89
Appendix 5: Diagnostic Criteria for ADHD: DSM-IV-TR.....	92
Appendix 6: Disturbances of Attachment Interview (DAI).....	93
Appendix 7: Researcher’s Personal Reflection.....	100

LIST OF FIGURES

Figure 1: Diagrammatic Representation of Themes.....	54
Figure 2: Steps of ADHD.....	57

LIST OF TABLES

Table 1: Types of Attachment & Antecedents.....	10
Table 2: Phases of Thematic Analysis.....	29
Table 3: Biographical Details of participants.....	52

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND AND CONTEXT FOR RESEARCH

In South Africa, as in many parts of the world, children and families are affected by Attention Deficit Hyperactivity Disorder (ADHD) (DSM-IV-TR, 2000). ADHD is known to affect 3% to 7% of school-going children worldwide in which statistics regarding the severity and prevalence of ADHD indicate that it is the most common psycho-social disorder in children, affecting almost 4.5 million children (Snyman & Truter, 2009). Additionally, ADHD is recognized as the most prevalent child psychiatric disorder in South Africa and according to studies conducted in Africa, the prevalence of ADHD among school-going children ranges between 5.4% and 8.7% (Bakare, 2012). When regarding South African statistics of ADHD, approximately 3% - 6% of the general child population meets the criteria for some form of ADHD (Venter, 2006). Meyer, Eilertsen, Sundet, Tshifulro & Sagvolden (2004) confirms and documents the prevalence to be about 5% for South Africa specifically.

Despite this prevalence, the diagnosis of ADHD still remains a controversial topic, as it is difficult to establish a diagnosis especially in children younger than 4 or 5 years (Sadock & Sadock, 2003). A possible hypothesis for this controversy is due to the fact that children under 5 years generally display age-appropriate behavioural characteristics that may include features quite analogous to the symptoms of ADHD, such as inattentiveness and restlessness (Sadock & Sadock, 2003), but these children might not necessarily be suffering from ADHD. The controversy surrounding the notion of ADHD also relates to the lack of definitive and unified explanations regarding its aetiology and intervention strategies thereby questioning the ontological validity of the disorder (Visser & Jehan, 2009).

Psychostimulant medications are frequently prescribed as the first line of treatment due to it being deemed the most effective (Travell & Visser 2006). ADHD may also be treated by psychological, educational and social measures and is suggested that it should not be treated by medication alone (Snyman & Truter, 2009). It is therefore apparent that the controversies related to the diagnosis and treatment of ADHD can be linked to uncertainty pertaining to aetiology and variations in its treatment.

The terms 'attention deficit', 'attention-deficit hyperactivity disorder', 'hyperkinetic disorder' and 'hyperactivity' are used by professionals to describe the problems of children who are overactive and have difficulty concentrating (Crittenden & Kulbotten, 2007). ADHD

causes impaired executive functions of the brain, and creates difficulty in children to control their attention and behaviour. The symptoms commonly associated with ADHD are impulsivity, hyperactivity and inattention (Grosswald, 2009). Unfortunately there is no clinical test for ADHD, which goes back to the controversy related to the diagnosis. However, many professionals use the Conners Rating Scales-Revised (CRS-R) developed by C. Keith Conners (1997) as an instrument which uses observer ratings and self-report ratings to help assess ADHD and to evaluate problem behaviour in children and adolescents (Conners, 1997). As previously indicated, due to the similarity in behavioural characteristics of children that are 5 years old and younger, such as inattentiveness and restlessness (Sadock & Sadock, 2003), many children under the age of five years are misdiagnosed with ADHD.

Although there are many postulated reasons for the development of ADHD, such as impaired brain functioning (Teeter, 1998) and heredity causes (Biederman, Faraone, Keenan & Knee, 1990), this research hypothesises that the relationship between the caregiver and the child may be a contributory factor to the formation of ADHD. While no empirical research has specifically investigated the association between attachment and ADHD, “a significant body of literature converges in support of the existence of such an association” (Clarke, Ungerer, Chahoud, Johnson & Stiefel, 2002, p. 5).

Specifically, the researcher hypothesises that the attachment (which can signify a secure or insecure attachment) between caregiver and child, may be a contributory factor to the development of ADHD in children. However, due regard must be given to the fact that the findings from this study may either confirm or alternatively disprove this hypothesis.

Attachment is one aspect of the relationship between a caregiver and child that involves making the child feel safe, secure and protected (Bowlby, 1982). The caregiver is seen as a secure base in which the child is able to explore when necessary, while ensuring the safety of the child and presenting as a source of comfort (Waters & Cummings, 2000). Its most important tenet is that an infant needs to develop a relationship with at least one primary caregiver for social and emotional development to occur normally (Joy, 2012).

Attachment theories suggest that the early parent-child relationship serves as the foundation for the emergence of self-regulation skills and that the infant is initially dependent on their caregiver's ability to provide containment and regulation of their psychophysiological states (Clarke, Ungerer, Chahoud, Johnson & Stiefel, 2002). Research indicates that insecurely attached individuals are indeed more vulnerable to problems with

affective and behavioural regulation, which is indicated as core elements of the presentation of ADHD in children (Cassidy, 1994).

In order to explore the caregivers' perceptions of the inter-relationship between attachment and the development of ADHD, the researcher first explores the emotional development of children living with ADHD within a South African context generally and then determines whether there are attachment difficulties displayed by these children living with ADHD, through the eyes of their caregivers.

1.2 OBJECTIVES OF THE RESEARCH

The broad objective of this study is to explore the caregivers' perception of the inter-relationship between attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children. To achieve this, the following sub-objectives were pursued:

1. The exploration of the development of ADHD within a South African context.
2. An exploration of the caregivers' perception of the emotional development of children living with ADHD.
3. An exploration focused on whether there are attachment difficulties displayed by these children through the eyes of their caregivers.
4. An exploration of whether these attachment difficulties could have contributed to the development of ADHD in children.

1.3 STATEMENT OF THE PROBLEM

The high rate of children diagnosed with ADHD in South Africa is a concern as it is the most commonly diagnosed behavioural childhood disorder (Schellack & Meyer, 2012). It is therefore essential to study other avenues such as the inter-relationship between attachment and ADHD, so that if there is a significant relationship, one may intervene to improve the quality of life for the affected individuals.

1.4 RATIONALE

Attention Deficit Hyperactivity Disorder (ADHD) is the most commonly diagnosed childhood behavioural disorder (Rowland, Umbach, Stallone, Naftel, Bohlig & Sandler, 2002) and has become a controversial umbrella term applied to a large number of diverse children. The controversy of ADHD is around the diagnosis and treatment as there is a lack

of certainty pertaining to aetiology and there seems to be a wide variation in its treatment (Crittenden & Kulbotten, 2007). Due to the high prevalence of ADHD in South Africa, as in many other parts of the world and the significant impact it has on children and families, it is important to explore the development of ADHD within South Africa and the emotional development of children living with ADHD. It is even more pertinent to explore this contentious issue through the eyes of the caregivers themselves in order to determine their perception of the inter-relationship between attachment and the development of ADHD in children. The next section reviews the conceptual and empirical literature concerning ADHD and attachment followed by a theoretical framework. This is done by looking at the various theories of attachment and the concept of ADHD within the South African context while focusing on the possible link between ADHD and attachment.

1.5 THEORETICAL FRAMEWORK

The theoretical framework encompasses a discussion of the major styles of attachment using John Bowlby (1969), Mary Ainsworth (1978), Margaret Mahler (1974) and Peter Fonagy's (1995) theories.

1.6 STRUCTURE OF THE STUDY

This study is organised into seven chapters as follows: Chapter 2 provides a conceptual understanding and a review of the existing empirical literature concerning the inter-relationship between attachment and ADHD. Chapter 3 provides the theoretical framework to understanding attachment and how it may relate to ADHD. Chapter 4 provides the methodology used in this study, specifically an exploratory, qualitative approach with the specific use of individual face-to-face interviews. Chapter 5 presents the findings of the study followed by the discussion and interpretation of the findings with supporting literature in Chapter 6. Lastly Chapter 7 explores the strengths, limitations, recommendations and the final conclusion of the study.

CHAPTER 2: A SURVEY OF EMPIRICAL LITERATURE

2.1 INTRODUCTION

This chapter reviews the conceptual and empirical literature about the inter-relationship between attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children. Therefore, this chapter is broadly organised into four main sections. Section 2.2 discusses important concepts which are central to the understanding of the research. Section 2.3 examines the body of existing empirical literature which investigate linkages between attachment and ADHD. Finally, Section 2.4 provides a conclusion to the chapter.

2.2 CONCEPTUAL DEFINITIONS

2.2.1 Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit and hyperactivity disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (DSM-IV-TR, 2000, p.85).

The definition of attention-deficit/hyperactivity disorder (ADHD) has been updated in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) to more accurately characterize the experience of affected adults (DSM-5, 2013).

2.2.2 Attachment

Attachment is one specific and circumscribed aspect of the relationship between a child and caregiver that is involved with making the child safe, secure and protected (Bowlby, 1982).

2.2.3 Primary caregiver

The caregiver or primary caregiver refers to the individual who may be the natural mother or another individual (or a select few individuals) who are responsible for the primary and everyday care of the child (Theilheimer, 2006).

For the purposes of this study, the term “primary caregivers” will be used to refer to the mothers/fathers/grandparents/guardians of children with ADHD who serve as parental

figures for these children and who are responsible for the day-to-day care and maintenance of these children.

2.2.4 Inter-relationship

An inter-relationship may be described as the way in which two or more different variables affect each other because they are related in some way (Kavale & Brinkmann, 2009).

This study explores whether the two variables; namely attachment and attention-deficit hyperactivity disorder (ADHD) are related in some way.

2.2.5 Intra-relational findings

The Intra-relational findings presented in this research, which are found in Chapter 5, are the findings presented on behalf of the participants' subjective views (Kavale & Brinkmann, 2009) pertaining to the various questions asked during their individual face-to-face interviews with the researcher.

These intra-relational findings are presented using the participants' direct quotes. These intra-relational findings are interpreted and discussed in Chapter 6 using the raw data of the participants and integrating it with existing literature to present prevalent themes that arose within the research findings.

2.2.6 Inter-relational findings

The Inter-relational findings presented in this research, which are found in Chapter 5, are the findings presented on behalf of the researcher's objective views of the results obtained from the participants within this particular research.

These inter-relational findings are presented as a summary of the most salient themes in Section 5.3 followed by an interpretation and discussion in Chapter 6.

2.3 EMPIRICAL RESEARCH

2.3.1 Understanding an ADHD diagnosis

Attention deficit-hyperactivity disorder (ADHD) is the most recent diagnostic label for children presenting with significant problems of attention, impulsiveness and over-activity (Barkley, 1998). ADHD is also viewed as a mental neurobehavioral disorder

characterized by either significant difficulties of inattention or hyperactivity and impulsiveness or a combination of the two (Santrock, 2002). When hyperactivity was first identified, it was defined principally as a problem of motor activity and it was therefore used to describe children that could not sit still and who were consistently ‘on the go’ (Sigelman & Rider, 2003). Currently hyperactivity is viewed first and foremost as a problem of attention (Cosser, 2005).

According to the DSM-IV criteria, a child may be diagnosed with attention-deficit hyperactivity disorder (ADHD) if the child presents with one or more of the following characteristics for a period of at least 6 months, which are to a degree which is maladaptive and inconsistent with the child’s development: namely Inattention, Hyperactivity and Impulsivity (DSM-IV-TR, 2000).

Children who are inattentive often fail to listen and have a difficulty in focusing and completing tasks. Those who are hyperactive show high levels of physical activity and are often in motion. Children who are impulsive often have difficulty in curbing their reactions and are often unable to inhibit urges (Santrock, 2002). Furthermore, ADHD is characterized by a pattern of behaviours present in various settings (e.g., school and home), that may result in concerns in social, educational or work settings (DSM-IV-TR, 2000).

Usually, the condition presents in childhood before the age of seven, but is also seen in adolescence and often extends to the adult years (DSM-IV-TR, 2000). Children with ADHD find it difficult to control their behaviour within their social and school environment. Normally, this interferes with their ability to live normal lives and often results in them not being able to achieve their full potential academically (DSM-IV-TR, 2000).

Depending on the specific criteria in which a child may present with, the child may be diagnosed as follows:

- 1) ADHD with predominantly inattention,
- 2) ADHD with predominantly hyperactivity/impulsivity, or
- 3) ADHD with both inattention and hyperactivity/impulsivity (Whalen, 2000).

Children with attention-deficit hyperactivity disorder, who are mainly inattentive, but not hyperactive or impulsive, do not often present as disruptive, but often experience difficulties at school (Weyandt, 2001). Children, who present as predominantly hyperactive and impulsive as well as inattentive, are often found to present with conduct disorder or other externalising problems (Cosser, 2005). Children who present with conduct disorders often find themselves in power struggles with their caregivers and because their behaviour is often

so disruptive, they are often rejected by their peers which may have damaging effects on their future developments (Cosser, 2005).

Not only do children present with conduct disorder, but others may present with a diagnosable learning disorder, depression or an anxiety disorder (Cosser, 2005).

2.3.2 ADHD in South Africa

Attention difficulties and heightened motor activity as an affliction of children has been perceived from various aspects since the 1900's. More recently within the 20th century, what is now termed ADHD (Attention Deficit and Hyperactivity Disorder) was used to describe a number of behaviours in children (Davison & Ford, 2001, p. 265). Attention Deficit Hyperactivity Disorder (ADHD) is the most commonly diagnosed behavioural disorder of childhood (Rowland *et al.*, 2002). It is a condition that becomes apparent in some children in the preschool and early school years. ADHD makes it difficult for children to control their behaviour and/or pay attention (Sadock & Sadock, 2003).

Attention Deficit Hyperactivity Disorder is a lifelong disorder in which the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000), states that the essential feature of ADHD is “a persistent pattern of inattention and /or hyperactivity or impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development” (DSM-IV-TR, 2000, p. 85).

ADHD is reported to affect 3% to 5% of school-going children worldwide, of which the majority are boys (Shellack & Meyer, 2012). Research by Meyer *et al* (2004), suggests that ADHD is the most prevalent child psychiatric disorder in South Africa in which it affects approximately 5% of the school-going population. The Hyperactivity/Attention Deficit Support Group of South Africa estimated in 2004 that 10% of all South African children may have characteristics associated with ADHD (Meyer *et al*, 2004). No official statistics on the prevalence of ADHD in South Africa are available. However, many studies over the past 100 years have shown that ADHD is a chronic disorder which has a negative impact on the child suffering from ADHD, as well as their caregivers. ADHD has been seen to affect every aspect of daily social, emotional, academic and work functioning of the child suffering from ADHD (Barkley, 1998).

According to Mattox and Harder (2007), it was found that children with ADHD are at a greater risk for interpersonal problems such as peer rejection, parent-child conflict as well as educational difficulties such as learning disabilities, grade retention, low graduation rates

and low grade point average. ADHD children are also at a greater risk for comorbidity with other psychiatric illnesses. “Common comorbid conditions include learning disabilities, Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Tourette syndrome, depression, anxiety disorders, and Bipolar Disorder” (Mattox & Harder, 2007, p. 96). Due to a vast amount of children affected by ADHD and the importance of attachment for the development of a child, the researcher will ascertain whether there are any possible links between ADHD and attachment by exploring both the existing literature and the objectives of the study.

2.3.3 Understanding attachment in young children

Attachment is known as a deep and enduring emotional bond that connects one individual to another (Bowlby, 1969). Attachment does not always have to be reciprocal as one person may have an attachment with an individual which is not shared (Ainsworth, 1973). With regards to this study, a child may have an attachment towards his/her primary caregiver, who may not reciprocate the attachment. Attachment is often characterized by behaviours displayed by children such as seeking proximity with their attachment figure, like when they feel threatened. This attachment is usually reciprocated by the attachment figure (usually the primary caregiver) by responding sensitively and appropriately to the child’s needs (Ainsworth, 1973). Attachment therefore provides an explanation of how a parent/primary caregiver-child relationship emerges and how this relationship may affect the child’s later development.

Attachment theory is a well known and empirically grounded theory regarding parenting (Benoit, 2004). Attachment is one aspect within the parent-child relationship, in which the parent ensures the safety and security of the child at all times during their early development. The parent ensures that the child feels safe, secure and protected (Bowlby, 1982). Parents or care-givers are known to play multiple roles within a child’s life. Such roles may include: playmate (play with or entertain the child), teacher (teach the child new skills), disciplinarian (set limits and boundaries for the child), caregiver (feed and provide for the child financially) and an attachment figure (Waters & Cummings, 2000).

With these various roles that a parent/primary caregiver may play, the role of an attachment figure may be one of the most important aspects of a child’s life for their social and emotional development, as the child uses the primary caregiver as a secure base from

which to explore and, when necessary, as a haven of safety and a source of comfort (Ainsworth, 1973).

The quality of the relationship between primary caregiver and child is one of the most powerful factors in a child's growth and development (Brotherson, 2005). This relationship or rather what we call 'attachment', develops between the primary caregiver and child within the first two to three years of the infant's life and it is dependent on how the primary caregiver responds to the child's needs (Brotherson, 2005).

Parents of infants and young children are known to face multiple challenges when dealing with their infant/child's negative emotions such as crying, distress, fear and anger (Miller & Commons, 2010). Miller and Commons (2010) stated that evidence suggests that should a child experience such negative emotions chronically without mitigation from a primary caregiver, then the stress the child experiences may result in brain damage which may increase the likelihood of serious problems in the child's development. It is therefore believed that attachment parenting practices can greatly reduce an infant/child's stress which may produce both physical and psychological benefits.

There are four known types of infant-parent attachment, three 'organized' types namely secure, avoidant and resistant and one 'disorganized' type (Benoit, 2004). These four types of infant-parent attachment are displayed in Table 1. As previously mentioned, the quality of attachment is known to be vital with regards to the child's development. At approximately 6 months of age, an infant is able to distinguish between their primary caregiver and others and therefore anticipate specific caregivers' responses to their distress and shape their own behaviours accordingly, based on daily interactions with their specific caregivers (Sroufe, 1988).

TABLE 1: Types of Attachment and Antecedents

Quality of Caregiving		Strategy to Deal with Distress		Type of attachment
Sensitive	Loving	→	Organized	→ Secure
Insensitive	Rejecting	→	Organized	→ Insecure-avoidant
Insensitive	Inconsistent	→	Organized	→ Insecure-resistant
Atypical	Atypical	→	Disorganized	→ Insecure-disorganized

Table extracted from Benoit (2004).

2.3.4 Possible link between ADHD and attachment

The possible link between ADHD and attachment is hypothesized to be related to emotion regulation. This in turn is intimated to be highly related to attachment insecurity in young children which could play a part in the development of early attention processes (Franc, Maury & Purper-Ouakil, 2009). In addition, a preponderance of the scientific evidence demonstrates that ADHD is indeed associated with poor parenting, difficult family environments and inhumane and oppressive school and community environments (Armstrong, 1997). There has also been evidence from Franc, Maury and Purper-Ouakil (2009) which suggests that an association exists between the behavioural characteristics of ADHD and characteristics of parenting and family environments. Furthermore, in dated texts which are still relevant, Lambert (1982) and Lambert and Harsough (1984) state that parenting and family characteristics may consist of various instabilities within the family system which could result in negative effects on a child's development.

These instabilities range from putting pressure on the children for achievement and conflicting interest in the child's schooling and contradicting disciplinary practices administered at school and home by caregivers and teachers. Negative and pessimistic perceptions by parents of the child's academic and intellectual competencies accompanied by decreased expectation levels and decreased desire to participate with the child in learning activities, also have negative effects on a child's development (Lambert & Harsough, 1984).

Other factors include parents feeling inadequate or threatened in which they unconsciously reject their child and blame the child for the extra problems they are presented with, such as financial difficulties (Lambert, 1982).

Parents who experience any marital discord or where there is any greater familial anger during family conflicts, parents who use aggressive behaviour, indiscriminate aversiveness and submissiveness or acquiescence toward their children during management encounters, may also find that their children exhibit behavioural characteristics of ADHD (Lambert & Harsough, 1984).

Children may also exhibit behavioural characteristics of ADHD if they experience disharmony within the early mother-child relationships and when the mother experiences high levels of stress due to parenting, which leads the child to experience lower levels of self-esteem (Franc, Maury & Purper-Ouakil, 2009). Mothers who are very critical towards their difficult babies during infancy or those who showed a lack of attention and affection towards

their children, often continue to be disapproving of their child during school years as they assess their children's intelligence as low (Armstrong, 1997).

Moreover, a child with a difficult temperament is associated with higher risk for ADHD on the one hand, and can disturb the process of attachment on the other. Parental care-giving, which includes maternal sensitivity and positive parenting practices, is a main factor involved in the development of attachment and has shown to be associated with better outcomes in ADHD children, especially ending in a reduction of oppositional/conduct disorders (Franc, Maury & Purper-Ouakil, 2009).

Other researchers such as Goldberg, Muir and Kerr (1995) indicate that there exists a significant relationship between the quality of parent-child relationships in the first few months of life, the quality of attachment at one year of age and the school performance, sociability, levels of anxiety and general health of children in primary and secondary school.

Further support regarding the link between attachment difficulties and ADHD was led by Crittenden and Kulbotten (2007) who conducted a study identifying the attachment patterns of a child diagnosed with ADHD and of his mother. It was concluded that attachment theory was able to suggest new meanings for the symptoms of ADHD and therefore lead to more effective forms of treatment (Crittenden & Kulbotten, 2007).

John Bowlby (1969) devised a model of human development with his theory of attachment which he based on psychoanalysis and ethology with a systems theory orientation. Bowlby suggested that all babies are phylogenetically determined to attach to their main caregiver within their immediate environment and if the child experiences stress, separation or danger, its attachment system is activated (Kissgen, Krischer, Kummetat, Spiess, Schleiffer & Sevecke, 2009). The child then sends out signals to activate the caregivers' nursing system in which the caregiver will then usually employ suitable measures to provide relief. Holmes (1995) states that a child's sense of security is greatly influenced by the consistency, responsiveness and attunement he or she experienced with his or her parents in infancy.

2.4 CONCLUSION

The above empirical literature of attachment and ADHD has been surveyed in the anticipation to prove or disprove the objectives stated in Chapter 1. It is seen that there is a possible link between ADHD and attachment from previous literature, but there has not been extensive research regarding this topic and therefore the following chapters of this research

hopes to broaden any existing literature. Chapter 3 will briefly look at the predominant theoretical framework that guides this research.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The current study investigates caregivers' perceptions of the inter-relationship between attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children. It is therefore imperative to explore the construct of attachment as well as the predominant theoretical frameworks which formed the origins and then became central to attachment theory. This chapter is broadly organized into four main sections.

Firstly this chapter explores the construct of attachment, followed by the various theorists' views on attachment. A focus is placed on the joint work of John Bowlby (1982) and Mary Ainsworth (1974) who were known as the originators of attachment theory and then a brief exploration of more modern theorists such as Margaret Mahler (1974) and Peter Fonagy (1995) and their contributions to theory building and consolidation. These theories are explored in order to gain a better understanding of attachment and how it may affect the parent/caregiver-child inter-relationship. Once the theories of the above-mentioned theorists have been discussed, a brief description of the childhood and adulthood attachment will be explored. Finally the chapter is concluded with a brief summary of the chapter.

3.2 THEORIES OF ATTACHMENT

3.2.1 Defining the construct of attachment

While literature on attachment is prolific, a true definition still remains indistinct due to the various ways in which the term is used (Zeanah, Mammen & Libermann, 2003). Disagreements have arisen as to whether attachments refer to the "feelings or behaviours of infants, of caregivers, or both" (Zeanah *et al.*, 1993, p. 333). Literature does however agree that attachment is a relational construct found in a relationship between child and caregiver (Belsky, 2005; Bowlby, 1969).

Bowlby (1952, 1969, 1979) used the term attachment to refer to the affectional bonds that developed between babies and their mother. Attachment theory is therefore derived from the empirical research, observational studies and from clinical studies that involved inter-relationships between babies and their mothers (Bretherton, 1992). Bowlby (1979) emphasized that attachment is relational in nature and that attachment theory is therefore a

framework for understanding the nature of the enduring family bonds that develop between children and their parents – their attachment figures). Bowlby (1952, 1969, 1979) also stated that attachment is not located within child or caregiver, but in the dyadic interaction between the two.

Attachment is a characteristic of the relationship and not of either the child or the parent. Congruent with this notion, Zeanah *et al.* (1993) states that the term “attachment” is largely used in literature to refer to the “attachment relationship”. This “attachment relationship” may refer to the series of ‘attachment behaviours’ that take place between child and caregiver (Zeanah *et al.*, 1993). Most children develop relationships with their parents that make them feel loved and safe with a sense of security and confidence (Malekpour, 2007). This results in a subconscious psychological model being formed as the child forms a positive expectation of the parent, while the child has a complimentary model of themselves as being worthy of their parent’s love and support (Zimberoff & Hartman, 2002). This positive expectation of relationships between parent and child is part of a secure attachment which is advantageous and acts as a protective factor. Relationships with less positive attachments result in an insecure attachment, which acts as a risk factor and may contribute to future mental health problems (Malekpour, 2007).

Attachment theory therefore focuses mainly on the relationship between the attachment figure and child during early childhood (Zimberoff & Hartman, 2002). It focuses on the impact of the relationship on both the emotional development and mental health of the child as they grow up. A child’s primary attachment figure is usually the biological mother, but this is not essential (Zimberoff & Hartman, 2002) as a child’s caregiver for example a guardian/aunt/grandparent may also present as the attachment figure.

Attachment theory is highly important as it assists researchers to understand the causal links between people’s childhood experiences of adverse attachment relationship and their subsequent social, emotional and mental health problems (Egeland, 2009).

Bowlby (1969) elucidates that children have a strong disposition to seek proximity with a specific attachment figure. Children have a powerful survival reaction to sense danger. If a child finds themselves in an unfamiliar place, in which they may feel threatened or in danger (Weiss, 1991) the child will seek their primary attachment figure as their attachment seeking response is triggered (Bowlby, 1969; Weiss, 1991; Zeanah *et al.*, 1993). Attachment seeking is a specific response requiring a specific termination and this attachment seeking

will be terminated once the child comes within a certain proximity to their attachment figure which makes them feel safe once again (Howe, Brandon, Hinings & Schofield, 1999).

The attachment response starts at about 6 months and once a child is 36 months old the intensity reduces, which then results in a child becoming comfortable spending time away from their attachment figure without distress (Ainsworth & Bowlby, 1991).

A child may form a secure attachment with one parent and an insecure attachment with the other. The development of either a secure or insecure attachment is a determinant of the parent's sensitivity towards the child's needs. A parent's ability to provide a secure attachment is heavily influenced by their quality of care that they had received in their first two to three years of their own life (Ainsworth & Bowlby, 1991). This is known as an inter-generational transmission of attachment styles. If a parent was raised with the advantage of a secure attachment or the disadvantage of an insecure attachment, the parent is most likely to provide similar parenting to their own children because of its familiarity.

A reverse reaction may also occur as a parent may want to raise their children in an opposite way to which they were raised. Should this take place, an insecure attachment may be a result of a parent's over-protective nature or lack thereof and may provide an equally unbalanced and insensitive care. This may then result in an insecure attachment between parent and child (Ainsworth & Bowlby, 1991).

It takes several months for a baby to form a bond with a parent. From birth, a baby learns to recognise different people as their mental capacity to form attachment develops. At 6 months, a baby shows preference for one person and at about 9 months their primary attachment bond is well advanced (Holmes, 1995). This attachment bond is usually with the biological mother, but it is not necessary (as it may be with the father or primary caregiver such as a nanny or an alternative family member) (Bretherton, 1992). Between the ages of 12 to 14 months, the primary attachment is well established and the baby is able to differentiate between familiar and unfamiliar persons.

Some parents may start to develop a bond with their child during pregnancy, while most form a bond during the first few weeks (Bretherton, 1992). Other parents may struggle to form a bond with their baby which may prevent a secure attachment from developing. It is known that 35-40% of babies develop an insecure attachment to their mothers resulting in the babies feeling anxious in their mother's ability to comfort them emotionally (Ainsworth & Bowlby, 1991). Establishing and maintaining a secure attachment in childhood promotes stable and intimate relationships in adulthood (Holmes, 1995). Understanding the construct of

attachment and its origins is therefore imperative to this current study in order to pursue the objectives found in Section 1.2.

3.2.2 The origins of attachment theory: John Bowlby and Mary Ainsworth

Attachment theory is the joint work of John Bowlby and Mary Ainsworth (Ainsworth & Bowlby, 1991). Although Bowlby and Ainsworth worked independently in their earlier careers, both were influenced by Freud and other psychoanalytic thinkers (Bretherton, 1992). John Bowlby formulated the basic tenets of the theory, thereby revolutionizing our way of thinking about the inter-relationship of mother and child. Mary Ainsworth's innovative methodology not only allowed us to test some of Bowlby's ideas empirically, but also helped expand the theory itself and is responsible for some new direction it is now taking (Bretherton, 1992).

John Bowlby (1982) postulated that normal attachment in infancy is crucial to a person's healthy environment (Sadock & Sadock, 2003). He used the term "attachment" to describe the affective bond that develops between an infant and a primary caregiver (Sadock & Sadock, 2003). Bowlby (1982) believed that the attachment behavioural system is innate and that it is essential to ensure the survival of the species (Sonkin, 2005). Bowlby (1982) formulated basic tenets for his theory on attachment, to reform our thinking of the relationship between mother and child looking at disruption through separation, deprivation, and bereavement (Bretherton, 1992). Attachment is defined as "a special emotional relationship that involves an exchange of comfort, care, and pleasure and is known as a lasting psychological connectedness between human beings" (Bowlby, 1969, p. 194).

Earliest bonds formed by children with their caregivers have a tremendous impact that continues throughout life as mothers who are available and responsive to their infant's needs establish a sense of security in their children (Bretherton, 1992). Bowlby stated that attachment will occur when there is a "warm, intimate and continuous relationship with the mother in which both mother and child find satisfaction and enjoyment" (Sadock & Sadock, 2003, p. 140). The quality of attachment evolves over time as the infant interacts with his/her caregivers (Egeland, 2009).

The type of attachment or attachment status of the infant toward the caregiver is partly determined by the interaction between the caregiver and the child and partly by the caregivers' own attachment figures (Sonkin, 2005). Bowlby (1969) considered that this attachment influences the processing of thoughts, feelings and expectations concerning

particular relationships throughout the individual's life. A parent's ability to provide a secure attachment is heavily influenced by their quality of care that they had received in their first two to three years of their own life. This is known as an inter-generational transmission of attachment styles. Attachment theory embraces concepts of the interpersonal relationships through an integration of psychoanalytic theory, ethological principles and cognitive control theory, exploring both behavioural and experiential perspectives (Bretherton, 1992). The infant uses his/her innate process of what is termed, "proximity seeking" (Bowlby, 1982) to obtain certain reactions from his/her caregiver, and the child uses the innate process to adapt their own behaviours so that they most likely can facilitate the caregiver to respond in an appropriate and effective manner (Bowlby, 1982). If the infant knows that the caregiver is dependable, it creates a secure base for the child to then explore the world. Bowlby describes four key components of attachment, namely; safe haven, secure base, proximity maintenance, and separation distress (Bowlby, 1982). Safe haven is known to be the component when the child feels threatened or afraid, and he or she can return to the caregiver for comfort and soothing. Secure base is when the caregiver provides a secure and dependable base for the child to explore the world (Bretherton, 1992). Proximity maintenance is when the child strives to stay near the caregiver, to ensure safety and separation distress is known by the child becoming upset and distressed when separated from the caregiver (Bretherton, 1992).

Mary Ainsworth (1978) expanded on Bowlby's observations and found that the interaction between mother and child during the attachment period significantly influences the child's current and future behaviour. Ainsworth's innovative methodology not only made it possible to test some of Bowlby's ideas empirically, but also helped expand the theory itself and is responsible for some of the new directions it is now taking, such as Ainsworth's study on the 'strange situation' (Bretherton, 1992, p. 759).

Ainsworth's (1978) study on the 'strange situation' was developed to assess an infant's attachment. This experiment first separated infants from their parent, then exposed them to the presence of a stranger, and finally reunited them with their parent (Ainsworth, Blehar, Waters & Wall, 1978). It was found that during separation, the infant expressed proximity seeking behaviour such as crying or crawling towards the door to look for their attachment figure. The responses and behaviours of the displayed desire or lack of desire were then classified into patterns. Two dimensions were used to determine the infant's attachment behaviour classifications, anxiety and avoidance. These are the degree of anxiety

experienced from abandonment and the avoidance of closeness to the stranger which contributed to the classification (Ainsworth *et al.*, 1978).

The patterns observed during this experiment were divided into three main categories: secure, insecure and unclassifiable. Insecure attachment is further divided into avoidant and anxious-ambivalent attachment (McVay, 2009). Secure infants, who are low in avoidance and anxiety, showed signs of missing their parents upon leaving the room. On return of their parents they greeted them and used their parents as a secure base to explore the room (Ainsworth *et al.*, 1978). Avoidant infants, who are high in avoidance and low in anxiety, showed little sign of missing their parents as they explored the room on their own and showed little to no distress upon their parents leaving. Once their parents returned, the infant was found to continue playing with the toys, without much discern of their return (Ainsworth *et al.*, 1978). Anxious-ambivalent infants, who are low in avoidance and high in anxiety, did not explore the room, were distressed when their parents left the room, and were unable to be soothed upon their parents' return to the room (Ainsworth *et al.*, 1978). The last category which was labelled 'unclassifiable' was classified as disorganized/disorientated in 1990 by Main and Solomon (McVay, 2009). These infants, found to be high in avoidance and high in anxiety, behaved with no intentional attachment strategy or intention, and it was hypothesized that these infants experienced the most interpersonal problems, such as childhood trauma, with their attachment figures (McVay, 2009).

Ainsworth (1978) confirmed that attachment serves the purpose of reducing anxiety and describes the attachment figure as a secure base from which an infant can explore the world. Ainsworth states that maternal sensitivity to the infant's signals plays an important role in the development of infant-mother attachment patterns. Ainsworth's major styles of attachment are known as secure attachment, ambivalent-insecure attachment, avoidant-insecure attachment and disorganized-insecure attachment (Ainsworth, 1978). Secure attachment is exhibited by children when they depend on the caregiver and therefore become distressed when separated from the caregiver. These children depend on their caregivers and may be upset while the parent is away, but they feel assured that the parent or caregiver will return (Sadock & Sadock, 2003). Ambivalent-insecure attachment suggests that children become very distressed when their caregiver leaves. Bretherton (1992) stated that Bowlby and Ainsworth suggested that ambivalent-insecure attachment is a result of poor maternal availability, as the children are unable to depend on their mother (or caregiver) to be there when the child is in need (Bretherton, 1992). Avoidant attachment involves children who are

unable to show preference between caregiver and a complete stranger and therefore tend to avoid parents or caregivers (Bretherton, 1992). It also suggests that attachment style might be a result of abusive or neglectful caregivers. Children who are punished for relying on a caregiver, will learn to avoid seeking help in the future (Bretherton, 1992).

3.2.3 Contribution to theory building and consolidation: Margaret Mahler and Peter Fonagy.

Margaret Mahler's theories of child development focus largely on the relationship between mother and child. Her theory of separation-individuation and rapprochement can be considered a theory of ego development and object relations as well as that of attachment. It is considered her most valued work. Mahler (1974) stresses the importance of consistent attentiveness especially from the mother during a child's first three years of life as vital to the ultimate goal of raising children who grow to be successful, adaptable adults. The child's development depends on the continued attachment from a responsive and responsible caregiver (Coates, 2004). Severely insecure attached individuals are at greater risks for serious disorders, therefore continued attachment is known as being intrinsic to the process of separation-individuation (Blum, 2004).

Mahler (1974) believed that psychological birth did not occur alongside biological birth, but rather it is a slowly unfolding process. She therefore described the process of psychological birth through a series of stages; namely autistic phase, symbiosis and separation-individuation (Coates, 2004). Progression through these phases impacts heavily on the ego development, object relations and personality of the infant. The inability of the mother to meet the needs of her infant may be the root of psychopathology (Mahler, 1974). The autistic phase occurs within the infant's first few weeks of life. At this stage, the infant is blissfully unaware of anything but its own needs, therefore the mother needs to be available to lovingly meet the baby's needs and introduce tender, caring interaction (Coates, 2004). The infant is slowly brought out of this phase through the process of mothering (Mahler, 1974). The symbiotic phase is when the infant develops the capacity for memory and learning in which the child moves from an intrapsychic phase to symbiosis (Mahler, 1974). During this phase, the child develops their very first bond which is usually with their mothers. Positive stimuli such as cuddling and relief of discomfort such as feeding the infant promptly all help the infant to develop a trust that their needs will be met, building a basis for security and confidence (Blum, 2004). The separation-individuation phase is considered the true

psychological birth of the individual, with the separation and individuation being central to the intrapsychic functioning (Mahler, 1974). Separation involves achieving an intrapsychic sense of separateness from the need-satisfying object and the world (Mahler, 1974). Individuation also involves the sense of achievement based on one's own characteristics and potential (Mahler, 1974). This phase consists of four sub-phases namely; hatching, practicing, rapprochement and consolidation of individuality and emotional object constancy. Good development through each stage better facilitates optimal development for the next stage.

Peter Fonagy on the other hand believed that attachment relationships play a key role in the trans-generational transmission of deprivation (Fonagy, 1995) and that standard measures of caregiver sensitivity do not appear to explain trans-generational consistencies in attachment classification (Fonagy, 1995). Therefore, continued attachment is known to be fundamental to the development of a child, as severely insecure attached individuals are at greater risks for serious disorders (Blum, 2004). This trans-generational transmission may also be evident in the importance of the caregivers' own attachment figures (Sonkin, 2005).

Fonagy therefore terms the concept of the 'theory of mind'. A major aspect of human social understanding is the concept of 'theory of mind'. This theory explains how an individual responds to others as well as how one may respond to an individual's mental state and how one relates to an individual's beliefs, desires, intentions, feelings and attitudes (Baron-Cohen, 1995). The concept of 'theory of mind' focuses on the cognitive and developmental psychology and researchers believe that children, even when they are very young, are able to attribute their internal states as causes of their actions (Baron-Cohen, 1995). This notion explores the parent-child interaction linked to the child's mentalization capacity and focuses on the social development (Fonagy & Target, 1997). Theory of mind is a theory insofar as the mind is not directly observable. The presumption that others have a mind is termed a theory of mind because each human can only intuit the existence of his or her own mind through introspection, and no one has direct access to the mind of another (Fonagy & Target, 1997).

There is an ongoing debate on the development of children's acquisition of theory of mind. Baron-Cohen (1995) asserts that there is an innate learning mechanism devoted to social understanding, but many authors focus on the evolutionary and biological origins rather than the social influences (Baron-Cohen, 1995). It is stated that at the age of three years, children are able to understand the intentions behind the actions of others.

Other social learning approaches such as the simulation theory (Harris, 1992) suggest that children simulate or imagine themselves to be the other person, and consider how they would feel, think and act in that person's circumstances. Simulation theorists hypothesize that mental representations arise from introspection, or in other words, mind reading. However, this theory does not account for how children come to think of their selves, which is an important point that this theory falls short of (Harris, 1992). This may link to attachment in that if the child feels insecurely attached, then he/she may use this simulation theory to simulate or imagine the affection and attention that he/she needs; this may then result in the child suffering from a disorder (Blum, 2004). In this regard, Blum (2004) stated that severely insecure attached individuals are at greater risks for serious disorders (Blum, 2004). From a developmental psychopathological approach, none of the above theories explain the full picture as these theories do not take into consideration the child's own capacity to construct a mental theory, but rather emphasize only what the biology or the environment provides him with (Fonagy & Target, 1997). The child's affective interactions, specifically with the primary caregiver, plays a major role in determining their later functioning and a more comprehensive account should explain the mothers' contributions to the development of the child's theory of mind (Fonagy & Target, 1997).

Fonagy and Target (1997), therefore, proposed the concept of reflective functioning, which explained the child's ability to respond not only to others' behaviour, but also their conceptions of their own beliefs, feelings, pretence and plans. This concept refers to the cognitive and affective processes that are hypothesized to be the precursors of theory of mind. According to this view, the caregiver is a means for the child to discover the world and incorporate the new information into the child's mental system (Fonagy & Target, 1997). Where there is a lack of attachment between the caregiver and child, the child is unable to discover the world and incorporate new information into their mental system. The child will also struggle with responding to others' behaviour and to conceptualise their own beliefs, feelings, pretence and plans. The child's learning ability and development process is influenced by the dynamics of the dyadic interaction. Thus, interactions with the primary caregiver provide a strong base for the child's developing representational mind from which the child's social cognitive abilities evolve and assist the child to think and understand the self and the other in terms of mental states (Slade, 1987).

At around 7-9 months of age, children develop major skills that are considered important for later metacognitive development. At this stage, they gain an increased

awareness of the physical constraints of the external world and realize that others' actions are dependent upon these constraints (Gergely & Csibra, 1998). Such an understanding helps a child to differentiate between rational and irrational actions. When a child is insecurely attached, he/she does not sufficiently develop these major skills that are important for later metacognitive development.

3.2.4 Childhood Attachment

Sociability with unfamiliar people, positive representations of self, others, and relationships and personality/behaviour problems all stem from early developed attachment patterns (Thompson, 1999).

Studies have shown that children with securely developed attachment bonds report fewer symptoms of depression and anxiety as they often exhibit more adaptive qualities such as higher empathy, self-efficacy, and ego resilience (Arend, Gove, & Sroufe, 1979). In contrast to this, children with an insecure attachment demonstrate more immaturity than their peers, are more aggressive and maintain a more negative affect (Pierrehumbert, Miljkovitch, Plancherel, Halfon & Ansermet, 2000). Children who are securely attached are found to present with fewer psychological problems in both childhood and adulthood and are often known to present with a positive affect (Muris, Mayer, & Meesters, 2000).

It is therefore clear that children who present with low anxiety often have a secure attachment with their attachment figure, which in turn results in a greater feeling of protection and satisfaction within the child's life. This then leads to healthier infant development, whereas insecure parent-infant attachments are associated with increased negative psychological impairments (Thompson, 1999). Contrary to this, an insecure parent-infant relationship has been found to impact the quality of the later parent-child relationship along with the entrance of the child into all other intimate relationships (McVay, 2009). These children are also found to develop either social, emotional or mental health problems.

3.2.5 Adult Attachment

As with childhood attachment, there has been much investigation into adult attachment. This was due to Bowlby (1982) believing that attachment occurs throughout one's life. In 1985, Mary Main and colleagues were interested in how childhood attachment experiences affect parental behaviours. This then led to the development of the Adult Attachment Interview (AAI), an instrument used to assess an adult's attachment patterns.

These studies lead to identifying three attachment patterns: secure, preoccupied, and dismissing (Main *et al.*, 1985).

Hazan and Shaver (1987), explored attachment by looking at romantic love; focusing on the self-perceptions of the actions and responsiveness of partners within a romantic relationship. Hazan and Shaver (1987), also identified three attachment patterns amongst such adults, namely; secure, ambivalent, and avoidant (Hazan & Shaver, 1987).

More recently in 1991, Bartholomew and Horowitz developed a model to assess an individual's representation of self and others. Four categories of adult attachment were identified, which included secure, preoccupied, fearful, and dismissing (Bartholomew & Horowitz, 1991).

More research on adult attachment materialized independently, exploring the adults' state of mind regarding their experiences with their parents in childhood by means of a standardized interview measure. It also explores adults' attachment patterns in romantic relationships through a self-reporting measure. This research came alongside the parent-infant attachment field to expand on Main's (1985) research. It was discovered that an infant's behaviours towards the parent were correlated with the attachment style and state of mind of the parent, which were identified through parents disclosing their own attachment incidents as a child (Hesse, 1999). This is seen in the inter-generational transmission of attachment styles. Riggs, Paulson, Turnell, Sahl, Atkison & Ross (2007), showed that parents' early attachment experiences might predict their care-giving behaviours later in life as it was discovered that an adult with a secure state of mind is likely to have an infant with secure attachment, whereas an adult with a preoccupied state of mind is likely to have an infant with anxious-ambivalent attachment (Riggs, *et al.*, 2007).

3.3 Conclusion

As seen previously, attachment is a vital process for the development of any child whether they have ADHD or not. However, as the broad objective of this research is to explore the caregivers' perception of the inter-relationship between attachment and the development of Attention Deficit Hyperactivity Disorder (ADHD) in children, it is therefore important to explore the methodology and analytical framework employed within this study, in the following chapter.

CHAPTER 4:

METHODOLOGY AND ANALYTICAL FRAMEWORK

4.1 INTRODUCTION

This chapter builds on the preceding review of literature concerning the inter-relationship between Attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children in an attempt to explore the caregivers' perception. In doing so, this chapter discusses the methodology and analytical framework employed within this study in order to explore the broad objective of the study as well as the sub-objectives discussed in Chapter 1 Section 1.2.

This chapter is divided into seven main sections so as to describe the methodological and analytical framework. Accordingly, Section 4.2 specifies and discusses the research design employed to determine if there is a link between attachment and ADHD. Section 4.3 describes the research sample by looking at the participants who will partake in the study and the sampling techniques utilised. Section 4.4 and 4.5 discuss the data collection procedure and the data analysis, respectively, while Section 4.6 discusses the ethics. Lastly, Section 4.7 concludes the chapter.

4.2 RESEARCH DESIGN

The focus of this research study is on the caregivers' perception of the link or inter-relationship between attachment and children living with Attention Deficit Hyperactivity Disorder (ADHD). For this reason, the research was approached from an exploratory, qualitative approach. The main reason for using a qualitative approach is that qualitative research is concerned with exploring everyday perceptions of the world and uncovering the experiential, subjective dimensions of people's worlds (Mouton & Marais, 1996). The goals in qualitative research are set out as describing and understanding, rather than explaining and predicting human behaviour, as it is the case in quantitative research (Babbie & Mouton, 2001). Qualitative research is therefore known as a "form of systematic empirical inquiry into meaning" (Shank, 2002, p.5).

Exploratory research is also very useful in social research as it yields new insights into a topic of research and it provides comprehensive information about the particular study (Babbie & Mouton, 2010). For example it may provide new comprehensive information about the inter-relationship between attachment and ADHD from the caregivers' perspective

by yielding intra-relational¹ findings as well as inter-relational² findings from the researchers' results and then by integrating them within the existing literature.

A qualitative approach was deemed the most suitable for this particular study as it enables the researcher to use direct elicitation methods to obtain data directly from the informants, in this case – the caregivers' of children living with ADHD. Terre-Blanche and Kelly (1999) postulate that qualitative design allows for a thick description and deep understanding from the perspective of the participants.

The qualitative research design used for this study in turn informed the methods of sampling, data collection and data analysis employed. It also informed the overall process followed in conducting the research and the format in which the data was written up and presented, entailing a deductive approach (Terre-Blanche and Kelly, 1999).

4.3 SAMPLE

With regard to the sample size, Patton (2002, p. 244) explains that there are no rules as to the sample size in qualitative research. In this study, eight primary caregivers' of children living with ADHD were selected to participate in this study, as the focus was on the caregivers' perceptions of the inter-relationship between attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children. All potential participants had to be the primary caregivers of the children who had been clinically diagnosed with ADHD. Participants were required to speak English and all participants had to be 18 years of age and above in order to provide self informed consent for participating in the study.

These participants were selected by means of convenience sampling, which is a type of non-probability sampling in which people are sampled simply because they are 'convenient' sources of data for the researcher (Terre Blanche, Durrheim & Painter, 2006). This method of sampling for participants was selected on the basis of their willingness and availability to take part in the study (Terre Blanche, Durrheim & Painter, 2006).

Convenience sampling may present both strengths and weaknesses. Its advantage is that it is extremely fast, easy, readily available and cost effective (Black, 1999). However, the

¹ The intra-relational findings presented in this research pertain to the participant's subjective views of the questions asked during their individual interviews with the researcher.

² The inter-relational findings presented in this research pertain to the researcher's objective views of the results obtained from the participants within this particular research.

concern that arises with convenience sampling is that it is not possible to prove that the sample is representative of the population (Black, 1999) and therefore not generalisable.

4.4 DATA COLLECTION PROCEDURE

All participants were requested to sign consent forms before participating. A date, time and a place of convenience were arranged between the researcher and the participant for the individual interview. All eight participants were interviewed once and therefore a total of eight interviews took place. The participants were encouraged to describe their perceptions of the inter-relationship between attachment and ADHD focusing on their child living with ADHD. Specific communication techniques were employed such as listening, reflecting, clarifying and summarising. All interviews were audio- recorded with the permission of the participants.

The primary source of data collection was in the form of individual face-to-face, in-depth, semi-structured interviews. The researcher's questions were based on the various aspects of attachment and the emotional development of the child living with ADHD, as outlined in a semi- structured interview schedule³.

The initial questions of the interview schedule consist of biographical questions and the rest of the themes for the questions were guided by an adaptation of the "Disturbances of Attachment Interview (DAI)"⁴ developed by Smyke and Zeanah (1999). DAI is a semi-structured interview designed to be administered to the child's primary caregivers who know the child and the child's behaviour well. The interview schedule was simply used as a guideline allowing open-ended responses from the participants. The interviews conducted with each participant took approximately 50 minutes in which it was designed to elicit more information from the primary caregiver.

Once the interview had been completed, the participants were debriefed about the interview session to ensure that each participant did not leave feeling vulnerable. Afterwards, a reflection session took place between the researcher and the supervisor. The researcher also kept a trustworthiness journal throughout the research procedure, to ensure the researcher was objective at all times by ensuring no counter-transference when analysing the data.

All audio-taped interviews were transcribed verbatim. Thereafter the data were analysed through the process of thematic content analysis-which will be explored in detail in

³ Researcher's semi- structured interview schedule may be found in Appendix 4.

⁴ The Disturbances of Attachment Interview (DAI) questionnaire may be found in Appendix 6.

Section 4.5. Pseudo names were used when necessary to protect the identity of the participants. Participants who resided in the Johannesburg district were referred to the Emthonjeni Centre at Wits University, if counselling was required. The details for Emthonjeni Centre were provided to all participants via an information sheet⁵. These services were available free of charge. Alternatively, for the participants who resided in the Eastern Cape and the Western Cape, appropriate information was provided regarding various options should counselling be required.

4.5 DATA ANALYSIS

For the purpose of this study, all the responses from the individual interviews were audio-recorded and transcribed verbatim. The data that resulted from the transcribed interviews was analyzed using content analysis, which is a technique used to study human communication of various forms (Babbie, 2004). More specifically, thematic content analysis (TCA) was used. This form of analysis is a descriptive presentation of qualitative data which examines the presence or repetition of particular words or phrases in texts in order to make inferences about the author's or speaker's message (Babbie & Mouton, 2001).

Thematic content analysis (TCA) is systematic and allows for large amounts of text (such as the text that resulted from the transcribed interviews) to be placed into categories or themes based on pre-determined rules of coding (Stemler, 2001). This systematic process of coding and theme identification also allows for the "subjective interpretation of the content of text data" (Zhang, 2006, p.1).

It is important to note that when analyzing data using content analysis, more specifically the guidelines from that of thematic content analysis (TCA), active and subjective input is used by the researcher (Braun & Clarke, 2006). Selecting themes using thematic content analysis (TCA) is not believed to simply emerge from data, but are in fact selected by the researcher with the aid of the research questions that directed the study. To emphasise the point, Braun & Clarke (2006, p.80) present the following quote from Ely, Vinz & Downing (1997), *"If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them"*.

Braun & Clarke's (2006) guidelines on how to conduct thematic content analysis (TCA) were followed in analysing the data in Chapter 5; as well as in discussing the findings

⁵ Participant Information Sheet – Appendix 1

in Chapter 6. It is important to note that this process is not a linear process where you simply move from one phase to the next, but rather a recursive process where you go back and forth where necessary, throughout the various phases proposed in Braun & Clarke's (2006) guidelines.

An outline of Braun & Clarke's (2006) guidelines on how to conduct thematic content analysis is presented in Table 1 below with the summary of phases, as extracted from Braun & Clarke (2006, p.35).

Table 2: Phases of Thematic Analysis

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table extracted from Braun & Clarke (2006).

The first phase in thematic content analysis is to familiarise oneself with the data. This phase involves transcribing all data verbatim, and reading through the resultant transcripts at least twice so as to gain an understanding of the breadth and depth of the material. In doing so, it is important to note initial ideas as well as recurring ideas (Braun & Clarke, 2006). During this phase, the researcher transcribed the interviews by herself to ensure confidentiality of all the participants. The researcher then familiarized herself with the transcribed data by reading each transcript multiple times and noting any interesting information that the participant provided.

The second phase started once the researcher has familiarized him/herself with the data and has noted all ideas. This phase involved the generation of initial codes as thematic

content analysis allows the researcher to interpret the social reality of the participants in a subjective manner, and the validity of the inferences made is only ensured when a systematic coding process is adhered to (Zhang, 2006). Codes identify a feature of the data that appear interesting to the researcher and allows the researcher to assess information in a meaningful way by organising them into groups. When coding manually, the researcher uses highlighters, colour pens and makes notes in order to indicate various segments of data (Braun & Clarke, 2006). Phase two saw the researcher allocate each interesting and noted idea from each participant with a different colour highlighter or pen to allow for each idea to be presented in a meaningful way and later to be organised into common groups. These common groups mostly consist of similar or recurring ideas that emerge across the participants. A group was also allocated to any interesting or outstanding information presented by a participant that may not have surfaced across all participants.

Phase three involves searching for themes, and “a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p.82). The codes obtained from phase two are re-examined to form overarching themes. These themes emerge with the use of the researcher’s judgement of what constitutes a theme as there are no hard facts as to what proportion of the data set has to display evidence of a theme (Braun & Clarke, 2006). All themes will be discussed in Chapter 6. The groups that were formed from phase two, each coded with a different colour and title were re-examined to form overarching themes and sub-themes.

The fourth phase entailed the reviewing of the themes obtained in phase three. This involved rereading the codes from phase two whilst noting any consistencies or contradictions with the themes obtained in phase three. It was important to ensure that there were no overlapping themes (Braun & Clarke, 2006).

Phase five entailed defining and naming all themes that pertain to the study with the guide of the research questions. It is important to not simply paraphrase the data, but rather identify what is interesting and important and how such themes link to relevant literature and to the research questions (Braun & Clarke, 2006). The themes which were extrapolated from the data are discussed and interpreted in Section 6.3 as well as diagrammatically presented in Diagram 1 in order to show their inter-relationships.

The final phase includes the writing up of the themes in the results and discussion section of the research report. This phase is detailed in Chapter 5 and Chapter 6 respectively,

in which all themes are discussed in line with literature to cement arguments and illustrate various points made.

4.6 ETHICAL CONSIDERATIONS

The researcher enforced a number of measures in order to ensure that the participants were not harmed in any way as a result of their participation in this study. Firstly, all participants were required to be 18 years of age and older and each participant was required to sign an informed consent form before the commencement of the interview. The process was voluntary and participants were allowed to withdraw from the study at any time without any consequences. Participants had the right not to answer questions they felt uncomfortable answering. Anonymity was not ensured as the interviews took place face to face, however confidentiality was ensured as pseudo names were used and nobody had access to the data except the researcher and the supervisor. All data was stored on a password-protected laptop and the audio tapes were locked up in a safe place where only the researcher and supervisor had access. Direct quotes were only used with the participant's consent and once again pseudo names were used when necessary, resulting in sanitized information, so that it won't be traceable back to any of the participants. All this information was documented in the Participant information letter⁶ and the various consent forms⁷.

The participants were neither advantaged nor disadvantaged in any way for choosing to participate or not to participate in the study. The results were written up in a research report and may possibly be written up for a possible journal publication. All interview materials (tapes and transcripts) will be destroyed after five years. All participants were offered feedback on the study's findings and a summary of findings will be provided on request. Containment took priority. Had any participant felt distressed at any given time, the interview was stopped or terminated and participants were debriefed and referred for counselling. The information regarding a counselling session was given to the participants and these arrangements for counselling were arranged with the clinic beforehand upon request from the participant. Counselling services were available at the Emthonjeni Centre at Wits University, free of charge. Contact details were provided to each participant. For the participants who resided in the Eastern Cape and the Western Cape, appropriate information was provided regarding various options should counselling be required.

⁶ Appendix 1

⁷ Appendix 2 and 3

4.7 CONCLUSION.

This chapter focused on the methodology and analytical framework, which were taken up within this study to explore the inter-relationship between Attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children in an attempt to explore the caregivers' perception. In doing so, a focus was placed on describing methodological aspects including the design, sample, and data collection procedure and data analysis. These results are presented and discussed in the following chapters. Chapter 5 presents the results from each of the participants, while chapter 6 highlights all the themes that emerged from the data and discusses them in relation to the literature to cement arguments and to illustrate various points with examples.

CHAPTER 5:

PRESENTATION OF FINDINGS

5.1 INTRODUCTION

This research study investigated the perceptions that primary caregivers have regarding the inter-relationship between attachment and ADHD in children. In order to answer the research topic, the results from this chapter are used to address sub-objectives one, two, three and four, as set out in Chapter 1. The specific objectives entailed the exploration of the development of ADHD in South Africa and the caregivers' perception of the emotional development of children living with ADHD, whether any attachment difficulties were displayed between mother and child and lastly whether these, if any, attachment difficulties could have contributed to the development of ADHD.

This chapter is divided into four main sections. In section 5.2, the intra-relational findings are presented with each participant's biographic information and a description of their interview with their prominent themes extracted, using questions from the interview schedule as a guideline. Section 5.3 presents the inter-relational findings which constitute a summary of the findings and the common themes extrapolated from all eight participants in preparation for the discussion in the next chapter. Finally, section 5.4 provides the conclusion to the chapter.

5.2 PRESENTATION OF INTRA-RELATIONAL FINDINGS

The intra-relational findings presented below are those of the participants' responses. These findings are presented on the basis of individual face-to-face interview that took place with each participant. It must be noted that Participant 4 and 5 are a married couple and by the request of both participants, they were interviewed together as a couple. These findings are set out by the guidance of the interview schedule and the information presented below are the findings deemed interesting and relevant from the process of using thematic content analysis (TCA) as outlined in Chapter 4, Section 4.5.

Each sub-section presented below starts with a table presenting the participants' biographical information. Thereafter, the discussion focused on the participants' background history, experiences related to their pregnancy from the time they became aware of the pregnancy, to the birth of their child, their experience after the birth of their child and during

their development as an infant and finally their perceptions about their relationship with their child.

The amount of information presented was based on the relevance as well as the openness of the participant regarding the specific topic. Some participants were open and candid with their responses while others were anxious and guarded.

5.2.1 Participant 1

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 1	Coloured	40-50	Female	Married	Eastern Cape	4	1

- *Caregiver's background history*

Participant 1 stated that she grew up living with her grandparents, parents and siblings. She described having a “pretty normal childhood” where kids always played outside as they never grew up with a TV. She further illustrates her relationship with her parents as “pretty good”, despite not being very open with them about things that may have bothered her as she states ‘she...always tried to handle things on her own’. Participant 1’s parents have both died and she often appears to miss the guidance she received from her mother, especially regarding parenting. Participant 1 often recalled what her mother would say when she spoke about her marriage, parenting styles and her feelings regarding her relationships with her children. It appeared that Participant 1 had a closer relationship with her mother than her father.

- *Experiences related to the caregiver's pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 1 was 40 years old when she found out she was pregnant with her fourth child. She stated that she was “shocked” when she found out; as she had thought that the doctor may tell her that the symptoms she was experiencing was due to her going through menopause and that she was “going through a change of life”. As the doctor had told her the

news of the pregnancy, both Participant 1 and her husband had “burst out laughing”. Participant 1 and her husband were in shock as they had just recently had a third child who was a mere 7/8 months at the time they had found out about the pregnancy of their fourth child. Participant 1 explained the worry they had about having another child, due to the financial implications that they may face with a fourth child. However, Participant 1 expressed that she “worked through a couple of emotions in a few seconds, and decided at the very end (they) were blessed”.

Participant 1’s first two children were already grown up, as her eldest had moved out of the house and her second eldest was completing her secondary schooling. Participant 1 and her husband were facing financial constraints as Participant 1 was the breadwinner at the time; where as her husband had brought a minimal or no income at times. Despite this, both Participant 1 and her husband had embraced the news of a fourth child as Participant 1 was glad that both her third and fourth child were able to grow up together.

Participant 1 describes her pregnancy as “pretty eventful” as she had suffered from high blood pressure, hypertension and the risk of an early birth.

- *Caregiver’s experience after the birth of their child and during their development as an infant.*

Participant 1 gave birth at 35 weeks and her child had to spend the initial days in an incubator. She stated that as an infant he “cried quite a bit” and described that it was “very traumatic at one stage”. She recalls not knowing what to do or how to get to grips with the situation and that she felt out of control at one stage. Her child was diagnosed with colic at the time in which she stated that the medication only worked for short periods of time. When Participant 1 compared her fourth child with her other three children, she stated that holding and handling her infant would not help so much. Participant 1 described her child as a difficult baby and often needed additional support from her husband, children and extended family members.

- *The caregiver’s perceptions about their relationship with their child.*

Participant 1 believes that she has a very close relationship with her child as she realised that as an infant her son needed more of her time and she found that she spent the majority of her time with him compared to her other children, whom she thought needed less of her time. She described this time as “very challenging because every mother wants what is

best for her child”, but often found that she became “very impatient”. When Participant 1 had received the diagnosis of ADHD for her child and told that he needed to be put on medication she recalls seeing a “different child”. She stated that “I can’t say that the child I saw is a child I can totally embrace” – when referring to him being on medication. She found that he often became aggressive, would lash out with very little provocation and would often overact at home and at school.

Participant 1 was the breadwinner at the time and so her husband was the individual at home during the day when the children had returned home from school and so believes that her younger children may be closer to their father. She does however attempt to spend quality time with them by assisting them with homework. However, Participant 1 stated that “I just feel sometimes it can be made easier for me, if he actually does his homework at school during aftercare and save me that hour, I won’t mind going over it again to check if he understood... ”.

Participant 1 thought that she was handling “things on my own” and found that the diagnosis of ADHD was the “biggest challenge”. Her third child became very sick at the age of two and for four years had to sleep in the main bedroom, while her youngest, the one diagnosed with ADHD, had to sleep in his own room. This caused a major adjustment as “my attention now shifted over to (my other child)”. Participant 1 recalls no longer being able to spend all her time and supervision with her child who was diagnosed with ADHD.

5.2.2 Participant 2

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 2	Coloured	40-50	Female	Married	Eastern Cape	1	1

- *Caregiver’s background history.*

Participant 2 grew up in a very conservative home. She lived with both her parents and four siblings. Participant 2 came from a previously disadvantaged background in which both her parents worked; however “income was very little”. Participant 2 recalled her parents

always ensuring that as kids they were provided for; “they would ensure you have got clothes on your back... all the necessities...” however she cannot recall them being affectionate. Participant recalls “only at the age of 24 did I pick up a relationship with my mother” and when her father became ill, when he was admitted to hospital, was the first time she recalls giving him a hug, at the age of 33 years. Participant 2 described her upbringing as “lacking warmth” as it “lacked intimacy between family members”.

- *Experiences related to the caregiver’s pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 2 fell pregnant at the age of 26 years. It was an unplanned pregnancy and Participant 2 was not married to the father of her child at that time. She fell ill and the doctors had discovered that she had a cancerous growth in the womb which resulted in subsequent surgery. The doctors had also recommended that should they want children, as a couple, they should try as “quick as possible”. Participant 2 fell pregnant a few months later, however not planned, as she stated that “the pregnancy was not planned, because I did not plan to get married yet”. Participant 2 recalls never feeling connected to the pregnancy and describes the experience as a “fairy-tale”. She stated: “I was never connected to this pregnancy at all, it was like... I could just see the changes to my body... all those kind of things. So when she was born, everything happened so hastily”.

- *Caregiver’s experience after the birth of their child and during their development as an infant.*

Once Participant 2 gave birth, she still did not feel much connection to the baby she held. She recalled everything felt unreal and stated “there was no connection, so... uh... two... three days, I’m feeding her, but I really struggled to, I don’t know why that was... I really don’t know... and then my mother said to me, ‘I’m feeling really bad, it looks like you love your dog more than you love your child’ so then I said... no, it’s true, thank you for your observation, thank you.. But, I can’t help it”. “Still up to now, I’m struggling to give her a hug or kiss... so it’s difficult, but I am trying, I really am trying”.

Participant 2 experienced her child to be very “interruptive with a major lack of concentration”. Once her child began school, she realised that her child was “extremely stubborn and very very irresponsible and impulsive”. She found that her child was also very aggressive and emotional.

- *The caregiver's perceptions about their relationship with their child.*

Participant 2 described her relationship with her child as a “rollercoaster pattern”. Participant 2 expressed how difficult it was for her as a mother to connect to her child from the time she found out she was pregnant. Participant 2 also had a fulltime job throughout her pregnancy and did not take much maternity leave. She continued working for the early years of her child’s life and her job was very demanding, which entailed her having to travel often for business. Due to Participant 2’s highly demanding work schedule, which only allowed her to be home on weekends, she decided it was best that her child lived with her aunt. Participant 2’s child lived with her aunt for 2 years. One day before leaving again for work, Participant 2 recalled her child sitting outside, when she approached her child, she recalled her child stating “oh, here comes my Auntie [Participant 2]!” Participant 2 stated that having her biological daughter refer to her as an aunty, was the moment she realised that she needed to “change things”. Participant 2 requested time off from work and decided together with the father of her child that they would buy a house together that would enable for her child to move back home. Participant 2 felt the needed to improve her relationship with her child.

Participant 2 described her daughter as “very manipulative and aggressive” and stated that her daughter, on three occasions had become “physically abusive” towards her. She recalled the first incident was when her daughter was just over a year old. Participant 2 decided she needed to rest for a short period of time, so she locked her bedroom door to create a safe environment while she lied down on the bed and her daughter played on the floor next to her bed. Participant 2 recalled her daughter asking for a bottle. She stated that she was so tired that all she could say was “Oh man, I will do it now”. Her daughter started to nag and because she did not respond immediately, her daughter reached for the coffee mug on her bedside table and hit her over the head with it. The second incident she recalls was when her daughter was 3 to 4 years old. Participant 2 could not recall exactly what her daughter had done, but remembered as she wanted to “spank” her daughter, her daughter ran outside the house through the front door and back inside through the kitchen door. As Participant 2 ran after her daughter, her daughter managed to get into the house before her and she locked the door, leaving Participant 2 outside. Participant 2 recalled asking her daughter “kindly open the door for mommy”, while she tried her best to stay calm. Her daughter refused to unlock the door, and shouted “first say sorry”. Participant 2 resorted to apologising simply to allow her daughter to open the door, but once she was back in the house and wanting to discipline her daughter, the daughter grabbed the broom stick and

swung it, hitting her on the right ear. The third incident that Participant 2 recalled was when her daughter was 8 years old, in which her daughter tried to stab her with a kitchen knife. They were arguing about her daughter not wanting to take her ADHD medication and as Participant 2 took a wooden spoon and smacked her daughter on the bottom, her daughter grabbed a kitchen knife and tried to stab Participant 2, while screaming “I hate you! I wish my father could buy another wife... I don’t care if I go to jail; at least I know I’m doing something good...”

Participant 2, whose daughter is now 10 years old, stated that it has only been for the last 2 years in which their relationship has become “much better”. Participant 2 has become more involved in her child’s life, both personally and academically. Participant 2 also take her daughter for regular sessions with a psychiatrist and a psychologist which has assisted in the improvement in their relationship. Participant 2 appeared very hopeful and optimistic about the future of her relationship with her daughter, but stated the desire for support groups for parents with children with ADHD in her area.

5.2.3 Participant 3

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 3	Indian	40-50	Female	Separated	Gauteng	3	2

- *Caregiver’s background history.*

Participant 3 has three siblings and they grew up in Johannesburg in the Gauteng region where they were all raised by both their parents. Her relationships with her siblings appear to be good and she stated being closer to her mother than her father. Participant 3 is currently going through a divorce and her husband has moved out of the house which has left her raising her three children on her own. Participant 3 has three children with two of them having been diagnosed with ADHD, her eldest (13) and youngest (8).

- *Experiences related to the caregiver's pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 3's first pregnancy was planned and she stated that she was very excited and had experienced no complications during the pregnancy. However, her third child was not planned and she felt uncertain about having another child so soon after the second. She however embraced her child once he was born.

- *Caregiver's experience after the birth of their child and during their development as an infant.*

When Participant 3 gave birth to her first child, she was very excited and loved every moment she spent with her child, stating "oh I loved it, and I loved the experience...every minute of it". Participant 3 was working at the time and had the assistance of her mother-in-law, but when she had her second child, she had taken time off work to spend with her first two children.

- *The caregiver's perceptions about their relationship with their child.*

Participant 3 was the primary caregiver for all three children, and believes that she has a close relationship with all three of her children. She does however believe that her youngest demands more of her attention than the older two and her middle child is the most independent and demands the least amount of her time, attention and supervision. She has noticed that with the separation from her husband all three children have become more dependent on her as she described that they often "hang on me".

Before the separation, Participant 3 struggled in her relationship with her eldest son as he wrote on her wooden floors at home that he "hates me". She described how he would often write her hate letters stating that he would kill himself. Participant 3 experienced a lot of violence with her eldest child as he once tried to strangle her, not realising how strong he was. He would often scream at her or push her around, but would never display such violent behaviour towards his father.

Her youngest was more passive with no violent outbursts as yet. He appeared to be quiet, shy and reserved. Her middle child who has no diagnosis of ADHD, is often the one who acts "macho man", often checking if she is ok and reminding her to give her other two children their medication.

5.2.4 Participant 4 & 5

- *Biographical information*

	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 4	Coloured	40-50	Female	Married	Gauteng	2	1
Participant 5	Coloured	40-50	Male				

- *Caregiver's background history*

Participant 4 grew up in the Gauteng region. She was one of eight children. She recalled growing up in a very strict home describing her father as “Hitler’s nightmare”. She also comes from a very conservative home, in which they were raised within the Christian faith. Most of her siblings attended boarding school where there were strict rules and regulations and they were not exposed to the environment of the community in which they grew up in. They were not allowed to attend clubs, or have clothing accounts. They were not expected to “pray on fashion”, but rather had to be active within youth groups from the church. As youngsters they were not allowed to move out of the house before they were 21 years old and they would only be allowed to move out, if they were getting married. It was frowned upon should they have children at a young age or out of wedlock.

Participant 4 had to play a parental role to her siblings from a very young age as her mother became very ill and she states that because she had to grow up so fast, she did not know what it meant “to play outside”. She then realised that if you “get married you can get out, and if you don’t get married, you don’t get out”.

Participant 5 grew up in the Western Cape region and have been living in Gauteng for the past 15-16 years. Participant 5 was one of four children who were raised primarily by their mother as their father had passed away. Participant 5 described his childhood as a loving time in which he was “free growing up”. He was closer to his mother while growing up as his father did not “talk much”. Participant 5 left home at a young age in search for work.

- *Experiences related to the caregivers' pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 4 & 5 had planned pregnancies with both their children. They had struggled to fall pregnant, as they had tried for two years. Participant 4 was 32 years old when she fell pregnant with her first child. Participant 4 described her pregnancy as a very difficult time, because of her age, she had suffered from hypertension and she had a “pinched nerve”. She described her pregnancy as the “best thing ever... despite my feet looking like balloons and me being in pain, it was all worth it.” Participant 5 expressed how they had “...just given up hope and came to accept the fact they we were not going to have children”, but when both him and his wife thought they were pregnant, Participant 5 recalls going to the shop to buy five pregnancy tests to ensure the results were correct. Participant 4 had used all 5 tests, and all came out positive. A few days later their doctor also confirmed the pregnancy. Participant 4 and 5 were both elated at the news and ensured that Participant 4 had received the necessary medical care and emotional support that she needed.

During the pregnancy Participant 4 read all the baby books that were available and did a lot of research on the internet about what to expect. Participant 5 described her as a “typical mom-to-be”. They both felt they were prepared both emotionally and financially for their first baby and they had received a lot of social support from family and friends.

- *Caregiver's experience after the birth of their child and during their development as an infant*

Participant 4 had a difficult pregnancy due to her health and after the birth of her child she was hospitalised for a short period of time. Due to having been separated from her child at that time, Participant 4 had promised herself that she would spend as much time as possible with her child once she was discharged from the hospital. Participant 5 described Participant 4 as “very over-protective” because if the baby had made a simply sound, Participant 4 was there to “soothe her”. Participant 4 and 5 had differed on this and Participant 5 believed that one should not be so protective. Participant 4 and 5 described and compared the different ways in which they were raised; Participant 4 was raised in a very conservative home, with very “little affection between parents and child”, while Participant 5 grew up in a very “open and loving relationship”. Due to this, Participant 4 finds it difficult to be as open with her children as compared to her husband. Participant 5 always stated that Participant 4 is working on it and improving each day.

Both Participant 4 and 5 are very involved in their children's lives, especially when it relates to their development and wellbeing. Both Participant 4 and 5 had noticed differences with their child when they compared her to other peers of the same age. They had noticed she was not developing as well academically and noticed that she was often restless with little patience. Despite reaching the required milestones at the appropriate ages, they noticed that their child's development appeared to "decline or not improve as the other children, when she reached a certain age". At this point, Participant 4 and 5 sought advice from various medical practitioners such as general practitioners, psychologists and psychiatrists. Their daughter was diagnosed with ADHD at the age of 6 years. They decided against medication, but rather place her in a special needs school where she received the necessary assistance and they sought psychotherapy.

Participant 4 and 5 are pleased with their daughter's improvement and are optimistic about their daughter's future.

- *The caregiver's perceptions about their relationship with their child*

Participant 4 and 5 appear to have a very close relationship with both their children. They stated that their "relationship improves everyday". Participant 4 noted that their relationship has improved a great deal since her daughter has been attending psychotherapy as she has become "more confident and independent". Participant 4 stated that she is still over-protective over her children and finds it hard to "let-go", but believes that it is necessary. Participant 4 states that she does not want her children to be raised the way she was, where she felt a "lack of affection".

5.2.5 Participant 6

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 6	Coloured	20-30	Female	Single	Western Cape	1	1

- *Caregiver's background history.*

Participant 6 resided in the Western Cape Region throughout her entire life. Both she and her older brother were raised by their parents. Participant 6 was seven years of age when her parents got divorced. This resulted in her father moving out of the house and her and her brother being raised by a single mother. Participant 6 described her family as an “American family”, before the divorce. They had a nuclear family which consisted of a loving mother, father and two children. They had “pets and everything else”. Participant 6 explained that she had always thought that there “was love inside the house”, but described that “obviously we took what was given to us, so we did not see what was happening behind the scenes with my mom and dad...until...my mom and dad told us they were getting a divorce”. Participant 6’s relationships with her father became “non-existent” after the divorce, which lead to Participant 6 and her mother becoming very close. She describes her mom as her “best friend”. They had a very open relationship with each other. When Participant 6 had her first child, she attempted to restore her relationship with her father for the sake of her child, as she stated that “he is in fact (my child’s) grandfather”.

- *Experiences related to the caregiver's pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 6 fell pregnant when she was 18 years of age. She was dating her boyfriend at the time for approximately 2 years. Participant 6 described how at the time she had suspected she was pregnant, despite her aunt and family members thinking she was sick and so took her to the doctor for some tests. At the time she fell pregnant, Participant 6’s mother was abroad and Participant 6 had therefore felt sad that her mother was not around to support her. She however felt “blessed with a baby”.

She recalled calling her mother immediately when she found out the news and stated that despite being so far away, her mother had provided emotional support and gave her the freedom to decide whether she wanted to keep the baby or not. Stating that her mother “would stand by (her), no matter what (she) decides”. This emotional support proved to have made accepting the news “easier and lighter” for Participant 6.

- *Caregiver’s experience after the birth of their child and during their development as an infant.*

Participant 6 worked until she was 8 and half months pregnant in the attempt to support herself. Once she had given birth, she became the primary caregiver of her child as the father of the child was not working at the time and was not always around as he “was into drugs and that... I think drugs took over his life, so he was not there much”. Participant 6 relied on her mother to support her financially. Participant 6 and her partner were living together at the time, but she stated that he “was not always around and so (my son) was my responsibility”. Participant 6’s mother had returned to stay in South Africa when the child was three years old and so Participant 6 and her child had moved in with her mother for extra support.

Participant 6 appeared to have taken full responsibility for the caring of her child with additional support from her mother. She stated that “I didn’t want anyone else to say that they had to take care of him”. For this reason she spent the majority of her time raising her son during his development as an infant and therefore the relationship between the two of them were very close. Today, they are still very close.

She described her child as an “easy and mellow” child who did not cry often. She recalled him meeting all his milestones on time and did not notice anything wrong until he started Grade 1. That was when she noticed something was wrong.

- *The caregiver’s perceptions about their relationship with their child.*

Participant 6 believed that being a single parent, she had to basically raise her child on her own and for this reason she believes that her relationship with her son is very good. Participant 6 furthered her studies to an Honours level and therefore had to spend much of her time at University, but believes she had given all her available time to him. She often assisted him with his homework and took time in the evenings to sit and talk to him about his day.

Participant 6 found it very difficult raising her child on her own and found that with the diagnosis of ADHD, it became very difficult for her as he had required more of her time and supervision. She found that she had to be stronger for both herself and child as there was “no focus on the parent or help for the parent... so it impacts the parent”. Participant 6 wished that there were support groups for parents with children with ADHD, as to “having support groups would help a lot so you have the support and guidance from others who are going through the same things... as it impacts....more so the parents, especially if you a single parent”.

Despite the diagnosis of ADHD, Participant 6 still believes that her child can achieve anything that he wants to and will support him through everything.

5.2.6 Participant 7

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 7	Coloured	30-40	Female	Married	Western Cape	2	1

- *Caregiver's background history.*

Participant 7 grew up in a previously disadvantaged community in Cape Town. She was “born to a single young mother, who still lived at home with her parents and siblings”. Participant 7 was raised in a house with eight aunts and uncles (Mother's siblings) and both her grandparents. She was therefore seen as a child and not a grandchild, which resulted in Participant 7 being raised primarily by her grandmother. Only once Participant 7 began school, did she and her mother move out into their own apartment. At this time, her parents got married and had another child. Like her mother, Participant 7 also had her first child unexpected at a very young age. Despite being married at the time of the pregnancy, both Participant 7 and her husband “were not fully ready for a child”. Participant 7 currently has two children aged 14 and seven respectively.

- *Experiences related to the caregiver's pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 7 was still young and newly married when she found out she was pregnant with her first child. She described the moment as a “bitter-sweet moment”. Participant 7 described that both her and her husband “were not totally ready” as they had many plans and goals to achieve before having children. “We planned to settle in our own little house as it was our first, our first time living together. We never had the opportunity to study after school or ever travel outside of Cape Town and we always wished to go away to another place, we needed to save money first you know, before we could go, but then... the doctor told us we were expecting”.

Participant 7 disclosed feeling worried and concerned at the time as she was unsure if they would be able to afford a child so soon, and so it became difficult to accept and be happy about the pregnancy. “When we told our families about the baby, they said they would help us and they seemed happy so then I felt better...”. Their families proved to be very supportive as many of them had provided various baby necessities such as food, nappies, clothes and other items. Toward the end of the pregnancy, Participant 7 became more accepting to the point where she described herself as excited. However, when the baby came, she “struggled to cope”. It was a “new adventure for me as I was a new wife and now I had to be a MOTHER!” she expressed.

- *Caregiver's experience after the birth of their child and during their development as an infant.*

Participant 7 appeared to struggle significantly with the demands of motherhood, and when probed about how she handled the situation, she stated that she “would call (her) mother to assist with the baby”. Participant 7 experienced no complications during her pregnancy and therefore believes that “physically, the birth was ok”, but emotionally she may have struggled.

Participant 7 recalled feeling disconnected at the beginning and often felt that like she was primarily raised by her grandmother, so the same was happening with her child. She discovered that as her child grew older, he confided in his grandmother, rather than her.

She also stated that it “was my mother who noticed his behaviour changing and stuff... also that he may have not met *all* his milestones at the appropriate ages... but, I just

thought he was being naughty and would not want to listen to me as I did not really raise him”.

- *The caregiver’s perceptions about their relationship with their child.*

According to Participant 7, in the recent years “in his teens, we have become closer...almost like friends”. Participant 7 also believes that now that she has become more involved in both her children’s lives, whether it is at home or school, her relationship has improved significantly. “Now he even comes to me for advice, he does not necessarily always go to my mother”. “It is much better now, I am learning to understand him, and we are really good... I am much happier”.

5.2.7 Participant 8

- *Biographical information*

Interviewee	Race	Age	Gender	Marital Status	Province	Number of children	Number of children diagnosed with ADHD
Participant 8	White	40-50	Female	Married	Gauteng	2	1

- *Caregiver’s background history.*

Participant 8 is originally from Cape Town and comes from a family of five. Her family constituted of both her parents and two siblings. She described her upbringing as a wonderful memory in which she recalls many happy moments with both her parents. She found herself closer to her mother as she was the eldest daughter and would often assist her mom in raising her two younger siblings. She described her father as the “bread-winner who always made time to spend with each of his kids individually as well as a family unit”.

Participant 8 described her life as “just the way I planned it....until...”. Participant 8 was happily married, with a career she always wanted and with a supportive family. Participant 8 was a newlywed when her sister and mother had passed away in a car accident. “The two women in my life that meant the world to me....” (Participant 8 started crying. We took breaks to allow the participant to be contained). Participant 8 then found herself grieving the deaths of her mother and sister for a period of almost two months. In these two months, she found out she was pregnant.

- *Experiences related to the caregiver's pregnancy from the time they became aware of the pregnancy to the birth of their child.*

Participant 8 struggled to recall how she felt when she found out she was pregnant as she stated that all she could recall was how she felt after the deaths of her sister and mother. She stated that she was 5 weeks pregnant when she found out she was expecting and all she remembers was wanting to “share the news with my mom”. During her pregnancy, Participant 8 attended therapy for the grief process as she stated that her “husband was worried about both me and the baby”. “I was 5 months when I think I came to terms with the deaths, or rather started to come to terms with the deaths”. “I then started to go to all those pre-natal classes to start socialising with other mom-to-be's. I was excited about the baby, it was a girl”. The last three months of the pregnancy went off smoothly and “both my husband and I were ecstatic”.

- *Caregiver's experience after the birth of their child and during their development as an infant.*

After the birth, Participant 8 described it “being hard to raise a child without your mom's help”, but Participant 8 had continued therapy to ensure she was the best mom that she could be. She did however feel at times when she was feeling low and felt she was unable to care for her daughter, that her husband was fully capable. Participant 8 found herself going through “ups and downs”, but she recalled always telling herself to “pull yourself together for the sake of the baby”. Participant 8 stated now she perceives her first daughter as a blessing after a tragic event and now believes that it was her baby that did not allow her to fall into a “deep depression”

With regards to ADHD, she simply found that her daughter struggled to complete tasks and to concentrate for long periods of time. She then decided to send her daughter for various assessments, in which she later received the diagnosis. She described it as challenging, but often portrays a positive attitude. She believes the latter brought them closer together as she found herself spending more time with her daughter.

- *The caregiver's perceptions about their relationship with their child.*

Participant 8 described her relationship with her daughter as a loving and caring relationship. She believes that despite having her “ups and downs” that they have a good relationship.

5.3 SUMMARY OF INTER-RELATIONAL FINDINGS

On the exploration of the inter-relational findings, it was found that amongst the majority of the participants, many had found it difficult to accept or come to terms with their pregnancy in the initial phases. This may be due to either not being prepared for a baby as the participant may have had financial difficulties, or that the participants may have found themselves feeling too young or too old to raise a child. This unexpectedness or lack of acceptance of the child may have resulted in a formation of an insecure attachment. Others may have struggled with the diagnosis of ADHD for their child and due to their lack of understanding what it meant to have a child with ADHD may have resulted in a strained relationship. These themes that emerged will be discussed further in Chapter 6 with the aid of existing literature in the attempt to address the research objectives stated in Chapter 1 and to explore the inter-relationship between attachment and ADHD from a caregiver's perspective.

5.4 CONCLUSION

This chapter primarily looked at the intra-relational findings and the inter-relational findings. The intra-relational findings were based on the participants' responses. These findings are presented based on the individual face-to-face interviews that took place with each participant as well as set out by the guidance of the interview schedule and the process of using thematic content analysis (TCA) as outlined in Chapter 4, Section 4.5. It was noted that the participants had reacted differently to the questions presented to them as some were open and candid with their responses, while others were anxious and guarded.

With regards to the inter-relational findings and extrapolating recurring themes from the data, it was found that many participants had similar experiences, and this resulted in a range of themes that are presented and discussed in the next chapter. Chapter 6 therefore focuses on the description and interpretation of the various themes that emerged from the data, through thematic content analysis. These extracted themes are supported by quotes from the raw data to qualify and validate them and are integrated within the existing literature.

CHAPTER 6:

DISCUSSION AND INTERPRETATION OF FINDINGS

6.1 INTRODUCTION

This chapter focuses on the discussion and interpretation of the various themes which emerged from interviews with eight caregivers. All the responses from the individual interview transcripts were analysed through the process of thematic content analysis (TCA). This form of analysis is a descriptive presentation of qualitative data. Thematic content analysis portrays the thematic content from the interview transcripts, by identifying common themes. Thematic content analysis was used as it is the most foundational of qualitative analytic procedures and in some way informs all qualitative methods. In conducting a thematic content analysis, the researcher's epistemological stance is objective (Anderson, 2007).

The discussion and interpretation of findings are explained in terms of various themes, integrated with existing literature. This chapter is broadly divided into four sections. Section 6.2 briefly looks at the biographical information which provides a brief description of the participants of this study and section 6.3 explores the various themes that emerged from the content analysis, using questions from the interview schedule as a guideline. These extracted themes are supported by quotes from the raw data to qualify and validate them and to integrate with existing literature. Lastly section 6.4 concludes the chapter by providing a summary of the findings.

6.2 BIOGRAPHICAL INFORMATION OF PARTICIPANTS

Eight individuals, who were known as the primary caregivers of children living with ADHD, volunteered to be interviewed for the purpose of this study. These individuals, aged between 20-50 years of age, were selected from three provinces in South Africa; namely Gauteng, Eastern Cape and the Western Cape, as the study explored the development of ADHD within the South African context. In total, seven females and one male primary caregiver partook in the study. Four participants resided in Gauteng, while two participants resided in the Western and Eastern Cape respectively. The majority of participants were aged between 40-50 years and having at least two children. Participants were from various socio-economic, ethnic and religious backgrounds. The biographical details of the various participants are tabulated below.

Table 3: Biographical Details of participants

Interviewee	Race	Age	Gender	Province	Number of children	Number of children diagnosed with ADHD
Participant 1	Coloured	40-50	Female	Eastern Cape	4	1
Participant 2	Coloured	40-50	Female	Eastern Cape	1	1
Participant 3	Indian	40-50	Female	Gauteng	3	2
Participant 4	Coloured	40-50	Female	Gauteng	2	1
Participant 5	Coloured	40-50	Male	Gauteng	2	1
Participant 6	Coloured	20-30	Female	Western Cape	1	1
Participant 7	Coloured	30-40	Female	Western Cape	2	1
Participant 8	White	40-50	Female	Gauteng	2	1

6.3 FINDINGS BASED ON INTERVIEWS

The researcher intentionally tried to extrapolate themes from the data obtained through interviews. Themes that were extrapolated from the data were assessed and reassessed by both the researcher and the researcher's supervisor to ensure congruence throughout to establish reliability and validity of the findings presented below.

Various themes about the caregivers' perception of the inter-relationship between Attachment and Attention Deficit Hyperactivity Disorder (ADHD) in children were identified and analysed. Some themes were preconceived themes or categories which were extrapolated with the aid of the interview schedule. Other themes or categories were emergent. An emergent approach allows the categories to emerge from the data (Glaser, 1998). Categories or themes are defined after recurring ideas are pertinent in the research findings.

The themes are divided into superordinate and subthemes, all of which are grouped around:

1. The themes which emerged from the questions asked about the caregiver's perception of what it means it to have a child with ADHD;
2. The themes which emerged from the questions asked about their various experiences with the child from the start of their pregnancy to the present day;
3. The themes which emerged with regards to their various parenting styles
4. The themes which emerged from the questions about their expectations and hopes for their children.

The predominant and overarching theme which emerged throughout the research was the difficulties experienced by the caregivers with regards to the emotional and behavioural development of the child. The various subthemes highlighted the difficulties experienced by the caregivers in relation to their roles as the primary caregiver of the child.

The predominant themes and their respective subthemes are the following:

1. OVERARCHING THEME 1: Difficulties experienced by the caregivers as the primary caregiver of an ADHD child.
 - a. Understanding of ADHD and what it entails for the family and the child.
 - i. Emotional difficulties experienced by the caregiver and family members
 - ii. Interpersonal and social difficulties experienced by both primary caregiver and child
 - iii. Economic difficulties for the family
 - b. Experiences during pregnancy until the present day (day of the interview)
 - c. Beliefs about themselves as caregivers
2. OVERARCHING THEME 2: The caregivers' perception of the emotional regulation of the child with ADHD and any behavioural changes experienced by the child.
 - a. Expectations and hope of/for their child
 - b. Difficulties relating to attachment
 - c. Aggression, bullying or problems at home or school
 - d. Various parenting styles

The above themes and sub themes are firstly presented in a diagram below and then discussed according to relevant literature or supporting narratives, followed by verbatim quotes from the research interviews.

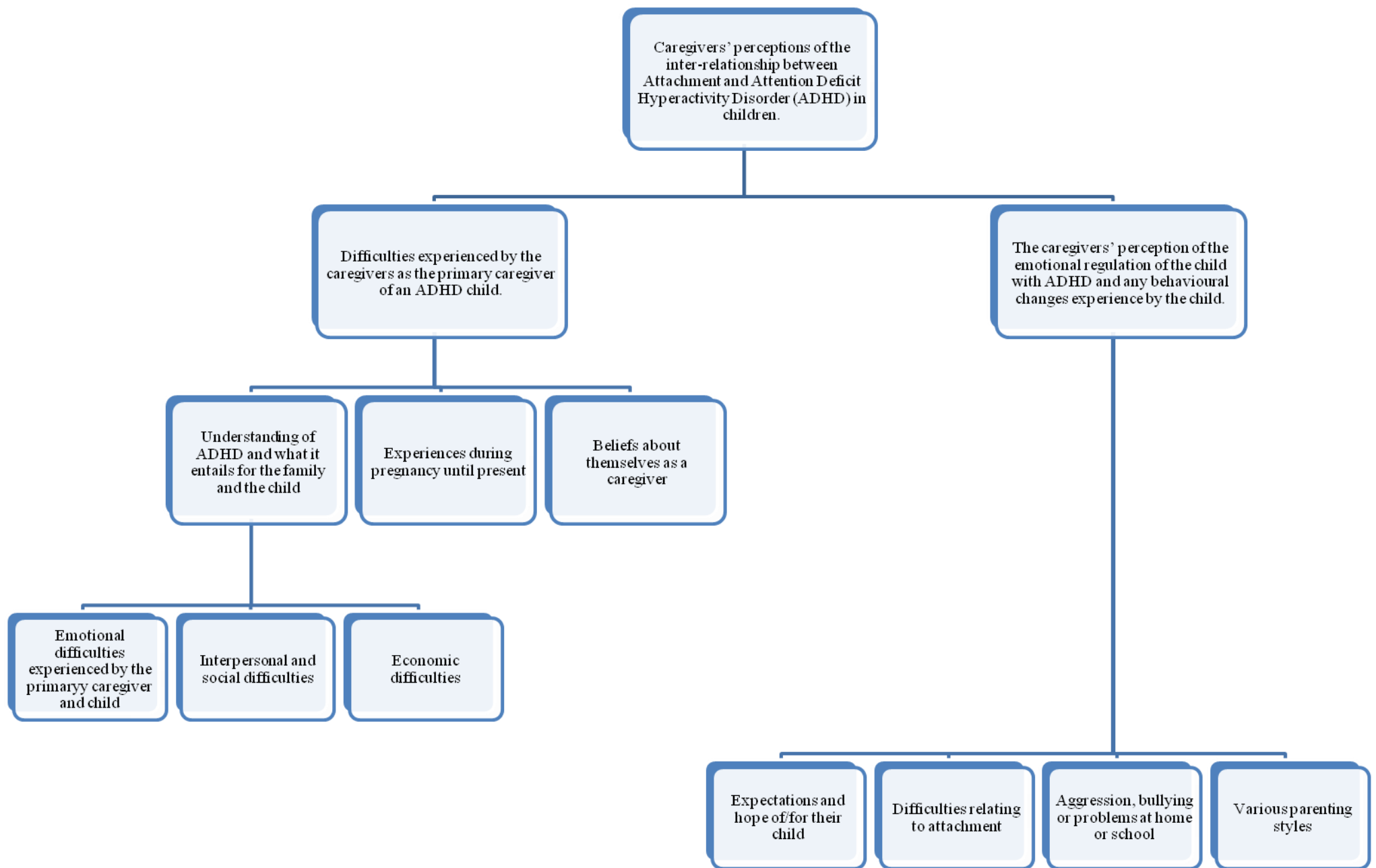


Figure 1: Diagrammatic representation of themes

6.3.1 THEME 1: Difficulties experienced by the caregivers as the primary caregiver of an ADHD child.

Attention deficit/hyperactivity disorder (ADHD) may affect all aspects of a child's life. Adverse affects of ADHD upon children and their families change throughout their years, with varying aspects of the disorder prominent at different stages (Harpin, 2005). ADHD not only impacts the individual child, but imposes difficulties on the parents/caregivers and siblings which may result in disturbances within the family and marital functioning. ADHD has also been associated with increased healthcare costs for families with a child affected by ADHD (Harpin, 2005).

It was evident throughout the various interviews that many participants experienced various difficulties with regards to the caring of an ADHD child. The sub-themes below will explore the various difficulties experienced by the primary caregivers and what it entailed for the family and the child. Many of these difficulties perceived by the caregivers were centred on emotional, interpersonal, social and economic factors. Such difficulties included the lack of understanding of ADHD from a social perspective, being unaware of various behaviours displayed by the child as a result of the ADHD and the emotional turmoil that may present for various interpersonal interactions. Interpersonal interactions such as sibling rivalry, parent-child conflicts and difficulties amongst various familial relationships as well as the disappointment of not achieving certain expectations or the lack of hope were all experienced and observed by the primary caregivers. Economic factors also played a significant role with regards to the difficulties experienced by the caregivers. These difficulties are explored further in the sub-themes below, which were extrapolated from the data.

a. Understanding of ADHD and what it entails for the family and the child.

Attention deficit hyperactivity disorder (ADHD) is a chronic and pervasive condition characterized by developmental deficiencies in sustained attention, impulse control, and the regulation of motor activity, in response to situational demands (American Psychiatric Association, 1987). This diagnosis leads to many problems within the family. In this regard, Edwards, Schulz, and Long (1995) mentioned that families of children with ADHD have been reported to have difficulties in various aspects of functioning. Supporting this, Fischer (1990), purported that studies examining broad areas of functioning have found that parents of children with ADHD report experiencing significantly more stress, feelings of

incompetence, and marital discord than parents of children without ADHD. This is exemplified by the participants' experience below:

Participant 2: *"Due to the initial lack of understanding of ADHD, both my husband and I did not understand this child. I did a lot of research, he was not very interested. I would say he was in denial, so this caused major problems in our marriage, particular regarding the discipline of the child, he always spoilt her".*

Participant 4: *"I kept questioning whether I had did something wrong. Was it because I had my first child at such a later stage in my life?"*

Participant 6: *"I had my child at such a young age, I was also going through my own emotional stuff, I don't believe I was emotionally ready myself... maybe a little incompetent, could that be it?"*

In interviewing the primary caregivers that partook in this study, it was evident that many of them had a clear understanding of ADHD in terms of the signs and symptoms. It was noted that many knew of this childhood disorder, but many were unaware of the emotional difficulties that came with raising a child with ADHD. Many participants had similar experiences on various levels of intensity. Some caregivers experienced their children to be over-active and very inquisitive, while others experienced their children to be more introverted and shy. Many of the participants expressed their concerns with regards to the amount of time and attention their child needed as this had adverse effects on many aspects of the family system. For example Participant 1 said:

"...he just would not sit still, the teachers always complained; I didn't know who to give more attention to, my child who was disruptive or my child who had health issues" (Participant 1).

The difficulties expressed in the extract above are in line with Wehmeier *et al.*'s (2010) statement that children with ADHD may affect parental outcomes for many reasons, as often the arrival of a child with a disorder may be seen as an unanticipated shock to the relationship. Thus may result in conflicts that challenge the caregivers as it imposes higher

psychic costs on the parents than in families without a child affected by ADHD (Wehmeier, Schacht & Barkley, 2010).

It is also in line with Green, McGinnity & Meltzer's (2005) description that a child with ADHD may also affect the parents' time allocation by requiring enhanced time investment due to more need for guidance in daily activities compared to a child without ADHD. To cope with the increased care-giving burden and the higher time-demand, both parents may cut back on working hours. Or, they may rely on a household specialization strategy where one parent, most likely the mother, reduces the time spent on the labour market to engage more in child-caring activities and the father specializes in market related work. In some cases, the mother may even withdraw from the labour market to devote all her time to child-caring and other home-oriented activities (Green *et al.*, 2005). This is what Participant 2 experienced when she said:

"...because I was working all the time, my daughter had to live with my aunt for two years, but then I noticed we didn't have much of a relationship so I had to adjust my work schedule so that she could move in with me and I had to get a nanny that could look after her during the day" (Participant 2).

Many participants noticed that their child had experienced poor concentration, high levels of activity and impulsivity which often resulted in them needing higher levels of supervision in comparison to that of other children. Participants had noticed a significant change in the amount of time and attention they gave to their child who was diagnosed with ADHD, when compared to their other children. They often found that their child with ADHD needed more of their attention, especially when it came to activities such as doing household chores or homework. For example Participant 3 stated:

"I eventually realised that he needed me to spend more one-on-one time with him and I also found out that he often struggled to concentrate when other people were around as they would often distract him... so I believe being in a small classroom environment has been beneficial" (Participant 3).

Many participants also expressed their concerns with regards to their child's delayed development such as walking and talking. A special mention was made to their poor social

skills, while attending preschool and primary school levels of education. This was firmly expressed by Participant 5 as seen in the extract below.

“She is very shy, does not socialize much. She is the quiet one. This was difficult to accept at first as I am a loud mouth, very out-going, but since she has been attending psychotherapy, her social skills have improved. She is more self confident” (Participant 5).

Harpin (2005) stated that the impact of ADHD upon the child as well as the family changes as the child gets older as the “core difficulties in executive function seen in ADHD result in a different picture in later life, depending upon the demands made on the individual by their environment” (Harpin, 2009. p.89). The various stages of ADHD and what the child or parent may experience over various years are represented in Figure 2 below.

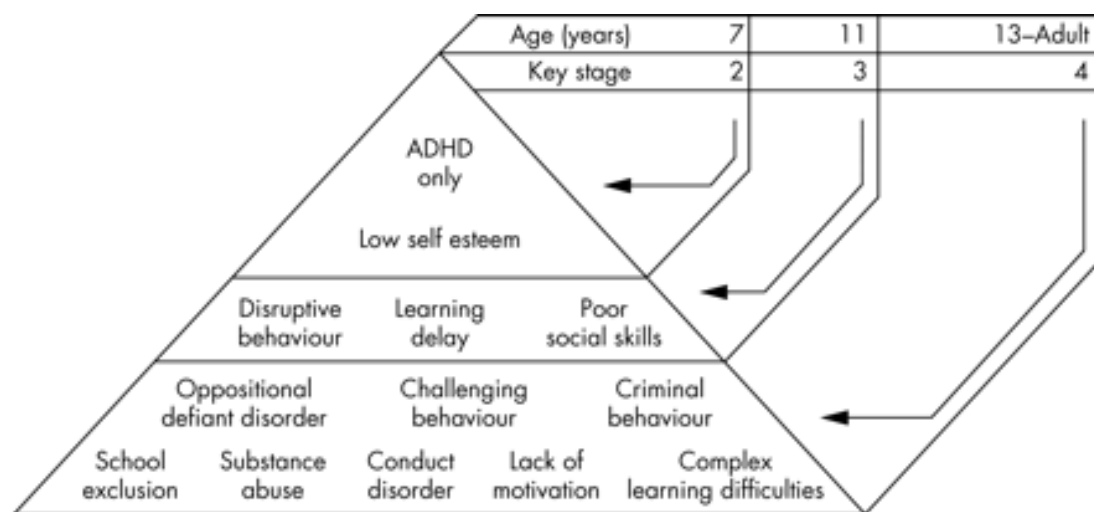


Figure 2: Stages of ADHD (Adapted from Kewley (1999)).

The adverse effects of ADHD on both the child and family varies within the family and school resources, as well as with age, cognitive ability, and insight of the child or young person (Harpin, 2005). Harpin (2005) also states that an environment which is sensitive towards a child’s needs and the implications of ADHD, is vital in order for the child to reach

their full potential. It is also important to source out the optimal medical and behavioural support for the child so to minimize the adverse effects of ADHD (Harpin, 2005).

All participants appeared to have sourced multitudes of avenues when exploring their various support structures. Many participants had consulted general practitioners, psychologists, psychiatrist, teachers and religious leaders. Many participants explored various treatments such as behavioural interventions and pharmacotherapy. This is seen with a few extracts below:

Participant 1: *“His teachers initially suggested he get assessed or tested for ADHD and I myself have taken him to an Educational Psychologist... My faith is very strong... I always pray for him, he is my special baby”.*

Participant 2: *“I was told about behavioural modification by the psychologist in which we have like reward charts so that she can see her progress...like if she completed her chores for the day she would get a star and after collecting a certain amount of stars she would get a reward...like ice-cream...this really helps and she enjoys it”.*

Participant 6: *“He attends extra classes to assist him with his academics; I also took him to a psychiatrist to be assessed for whether he needed medication”.*

Many participants explored pharmacotherapy as a form of treatment as it was often recommended by a psychiatrist as the preferred or necessary course of action. Participant 1 initially struggled to accept her child’s diagnosis of ADHD. She had firstly been called in by the school as it had appeared that her child was lacking in social skills and was not performing academically. Her child was also found to be disruptive and lacked concentration. When participant 1 was called in by her child’s teacher and advised that it may be beneficial for her child to be seen by a psychologist, she recalled:

“...I was looking at them like they were crazy”. In the long run she then thought “okay fine, let us do that”. Her child was then diagnosed with ADHD and was told that “medication was necessary” (Participant 1).

While many participants found that medication had helped their child, many of them had also found that using behavioural interventions in conjunction with the medication was vital. Participants 3 and 8 emphasized that structure was very important when dealing with an ADHD child. Both participants expressed the seriousness of having certain routines such as structured eating and sleeping patterns, homework timetables and household chores:

Participant 3: *“I have 3 children and now that I am separated from my husband, I find that having a routine and structure is very important. It helps with the ADHD as well as I think with my son’s emotional development, especially regarding his father having moved out”*.

Participant 8: *“I am very strict when it comes to bath, dinner and bedtime. I do not allow my child to simply do what she wants when she wants to. This structure also helped me, especially at the time when I was dealing with the death of my mom and sister”*.

It was clear that structure and routine was very important to many of the caregivers and many had also referred to using reward systems or a behavioural modification chart to encourage their children to stick to their routines, as well as to track their behaviour/progress in the process of working towards a goal or reward.

i. Emotional difficulties experienced by the primary caregiver.

Families of children with ADHD have been reported to have difficulties in various aspects of functioning (Edwards, Schulz, & Long, 1995). For instance, Barkley, Fischer, Edelbrock, and Smallfish (1990) found that biological parents of children with ADHD were three times more likely to separate or divorce than parents of children without ADHD. According to Anastopoulos, Guevremont, Shelton, and DuPaul (1992), when parents have to give more time and energy to psychological distress and medical problems, less time and energy will be provided to the children.

Participant 2: *“My husband and I often fought about the child, he always used to say she was simply being naughty...we could never agree on how to discipline...he*

often spoilt her, but now we starting to understanding each other...he is starting to understand her and her diagnosis”.

Participant 3: *“My husband and I are going through a separation at the moment; this has put a lot of strain on me. It is hard to raise children on your own”.*

Thus, if parents continue with neglectful behaviour, it may unintentionally reinforce the child’s negative behaviours. This kind of parenting would ultimately yield an increase in the parents’ stress. The lived experience of a parent with an ADHD-diagnosed child can be very emotional with many challenges (Taylor 1999). This is reemphasized by Participant 2’s experience:

“There was this crossfire between me and my husband when it came to reprimanding or disciplining... he would spoil her rotten and would not admit that she had a problem....so for the past nine years I have been struggling like crazy” (Participant 2).

Harpin (2005), stated that parents with children with ADHD who are in their primary school years, often experience having difficulties when at home or going on outings. Children may then often become disruptive, impulsive or present with poor social skills. During this time many participants found it hard to get friends or family who were willing to assist in looking after their child or found that their child was often excluded from social groups, as their peers struggled to understand them. This then caused conflict amongst the peers. An extract below, by Participant 8 describes her experience:

“I had to raise my child with little social support; it was difficult many people did not understand his behaviour” (Participant 8).

Harpin (2005) also found that many children with ADHD have poor sleeping patterns, which often affect their behaviour in the daytime. This then results in the parents having to constantly keep a close eye on their child leaving them with very little time to themselves.

Johnston and Mash (2001) reviewed the evidence of the effect of having a child with ADHD on family functioning. They concluded that the presence of a child with ADHD results in increased likelihood of disturbances to family and marital functioning, disrupted

parent-child relationships, reduced parenting efficacy, and increased levels of parental stress, particularly when ADHD is comorbid with conduct problems. Such effects on the family system may be seen by Participant 4 and 5 below:

Participant 4: *“She would never sleep out of the house without us; even if it was simply going to my sister’s house... she would wait up for us...”*

Participant 5: *“Once her mother was in hospital, shame, my child struggled without her mother. It is hard spending time alone with my wife, without the children...I also found that she competes with her sister for our attention and affection...they always asking who we love more or whose picture is the best, such things”.*

ii. Interpersonal and Social Difficulties

Having a child being diagnosed with a childhood disorder like ADHD had noticeably put strain on the families, whether it is amongst siblings, strain on the marital relationship or whether it is due to financial and social support. Having multiple children, with at least one child being diagnosed with ADHD, was difficult for the sibling, as many of them lacked the understanding of why their brother or sister was different or why they needed so much more attention. This had caused sibling rivalry in the household, often leading them to compete for the affection of their parents. It was found that many caregivers had to adapt too many new ways and many of them found that a lot of focus had to be moved to the child. This is in line with what Participant 6 meant when she said:

“...you have to be stronger for your child and have order in your life so having a child with ADHD I feel that the parent, there is no focus on the parent or help for the parent so it impacts the parents...” (Participant 6).

iii. Economic difficulties

It was not only emotional support that was needed amongst caregivers and their children, but many had found themselves in financial predicaments, as many did not realise what was expected of a caregiver with regards to financial support. Many participants expressed that the expenses that were required for the child were more than they bargained

for, as it was not simply about taking them to a general practitioner and putting them on medication. This was noted by Participant 8:

“...I then took him to a clinical psychologist who diagnosed him; I took him to an OT who diagnosed him, a remedial therapist last year and an educational psychologist as well...” (Participant 8).

The cost of having a child had now increased tremendously compared to the average child and this had put extra emotional strain on the family systems. Such financial concerns were also expressed by Participant 1:

“We were definitely not in the position to afford another baby, and at the time my husband was not working permanently which meant the income had to come from my side. Luckily we were still able to use our medical aid” (Participant 1).

b. Experiences during pregnancy until present

Many participants found that their pregnancies with their child diagnosed with ADHD, were different to their pregnancies with their other children. They often found that their pregnancy with their child that was diagnosed with ADHD was different. They found that their baby was more active in the womb or they either had some complications with their pregnancy whether it is struggling to fall pregnant or whether it was having their child at an age older than 30 years of age. Many pregnancies were also found to be unexpected or unplanned and therefore resulting in the lack of conceptualising and coming to terms with the unexpected pregnancy. This is in line with Participants' 1 and 2's experiences:

“I was shocked because I went to the doctor, I was sure I was going to hear something about the lack of menstruating at this time is the fact you going through a change of life... so my pregnancy... was pretty eventful I must say because I had things like the norm when you have a late pregnancy like you have high blood pressure, threatening of perhaps an early birth, things like that and eventually I think he was born at 35 weeks, a little bit premature but didn't have to stay too long in the incubator and in hospital, just a day longer and then he was fine to come home. Quite small at birth and he cried a lot....” (Participant 1).

“He confirmed now that I am pregnant but then I don’t know how, I was never connected. I was never connected to this pregnancy at all. It was just like...I could just see the changes in my body and all of those kinds of things” (Participant 2).

In the case where the pregnancies were unplanned, it was found that due to the initial shock, it took participants some time to come to term with their pregnancies.

Participant 1: *“I was 40 years old! And I had just given birth to my third child about 8 months ago...”*

Participant 2: *“We were not married at the time, I was only 26 years old and a doctor had discovered a cancerous growth in my womb in which I had an operation for. The doctor suggested that should we ever have children we should try sooner than later, so I fell pregnant. It was not planned, because I didn’t plan to get married yet... So I was never connected, I don’t know...”*

Participant 8: *“I still couldn’t come to terms with the pregnancy, I was still grieving...”*

It is clear that many participants had different experiences when comparing their children diagnosed with ADHD to their other children with no diagnosis.

c. Beliefs about themselves as a caregiver

All participants had shown the utmost effort and support for their child once the child had been diagnosed. Many participants questioned whether they were to blame for their child’s diagnosis and whether there was anything they could have done differently to prevent the diagnosis. They all tried to be the best that they could be for their children, but often found it difficult to cope. Many had wished for local support groups in their area, as they would be able to share advice and experiences with other caregivers that were going through the same thing. Many of them simply wanted to hear that it wasn’t their fault and that having a child with ADHD was acceptable. A sense of despair was also amongst many of the participants as noted by Participant 2 below:

Participant 2: *“raising a child with ADHD is very difficult as many people are not as educated about this disorder and then simply believe your child is just naughty. I wish there were facilities such as support groups for parents or play groups for the children. It would really help to have that support.*

It is evident from the above theme that many participants experienced a multitude of difficulties regarding their child or children diagnosed with ADHD. It had not simply affected the child as an individual, but it had an effect on the family system as a whole. Such participants' had experienced financial, social, psychological and spiritual distress. These challenges that the participants faced inevitably had an effect on their attachment relationship with their child.

6.3.2 THEME 2: The caregiver's perception of the emotional regulation of the child with ADHD and any behavioural changes experienced by the child.

a. Expectations and hope of/for their child

Before hearing that the child was being diagnosed with ADHD, many participants stated that as a primary caregiver of a child, a person always has certain expectations, hopes or dreams for their child and when they realise that something may be wrong, they often start to worry. This was especially evident in the participants who did not have much social support from family and friends as often; people did not understand their child and yet rather judged the child or classified the child as being rude or disobedient. Despite initially feeling overwhelmed with the news and the thought of what the future will hold for them, many of the participants held on to the hope that their children will live normal lives and that ADHD is in fact not a disability. Such expectations were noted by Participant 7 below:

“...because he has a disorder that won't hold him back if anything it should make him shine even more and when he says he is a failure I have to lift his spirits up and so he knows he can carry on so he can be the scientist he wants to be so a disability shouldn't be something to hold him back” (Participant 7).

b. Difficulties relating to attachment

As noted by Ainsworth & Bowlby (1991), a child may form a secure attachment with one parent and an insecure attachment with the other. The development of either a secure or insecure attachment is determined by the parent's sensitivity towards the child's needs. A parent's ability to provide a secure attachment is heavily influenced by their quality of care that they had received in their first two to three years of their own life. This is known as inter-generational transmission of attachment. So with many participants it was found that many of them may have had an insecure attachment with their parents. This was exemplified by Participant 2 below:

"I don't recall my parents giving us hugs and kisses when we were small, and so I still find it strange... I try my best though... I try to spend more time with my daughter, we have tea parties now and I take her out for shopping and girly days" (Participant 2).

A reverse reaction may also occur as a parent may want to raise their children in an opposite way to which they were raised. Should this take place, an insecure attachment may be a result of the parent's over-protective nature or lack thereof may present as equally unbalanced and insensitive care. This resulting in an insecure attachment between parent and child (Ainsworth & Bowlby, 1991).

Participant 4: *"Because I was in hospital for a short period after the birth and I was not able to spend all my time with my baby, I am a very over-protective mother"*.

Participant 5: *"My wife, Participant 4, does not allow the children to sleep out the house, even to go to her sister's house. She does not like being away from the kids, when she went away in the year and the child is now 9 years old, when she came back it seemed she needed therapy!"*

Participant 6: *"...because my father was not around much, and now my son's father is not in the picture, I try my best to be both parents. It is difficult being a single mom, having to play both father and mother. I know what it means not to have a father around, so I try to compensate for this"*.

It is clear from the above extracts that an over-protective nature may also result in an insecure attachment, which affect not only their current behaviour, but also their future behaviour (Mahler, 1978).

Margaret Mahler stated that the child's development depends on the continued attachment from a responsive and responsible caregiver (Coates, 2004). Participant 1 found herself in a difficult situation when she found out she was pregnant once again after recently giving birth to her third child. The two youngest children were so close in age and she found it difficult to raise two infants at the same time. The older of the two infants had much health related issues and so Participant 1 believed that her youngest, the child diagnosed with ADHD did not need as much attention as her third born. So despite not noticing any immediate problematic signs, Participant 1 found herself spending more quality time with the older of the two infants.

With regards to the difficulties experienced by the various participants, there were mixed experiences. It was noticed that the participants who had unplanned pregnancies had struggle more to form a connection with their child in the beginning, as Participant 2 stated:

"...there was no connection. I'm feeding her but really I struggled to...I don't know why that was...I really don't know. And then my mother said to me," I'm feeling really bad. It looks like you love your dog more than you actually love your child". I said "No its true...but I cannot help it, I don't know as much as I want to...still up till now I'm struggling to give her a hug or a kiss..... So it's difficult, but I'm trying I'm really trying" (Participant 2).

Mary Ainsworth (1978) found that the interaction between mother and child, during the attachment period significantly influences the child's current and future behaviour (Mahler, 1978). All participants were determined to connect or reconnect with their children so to allow them to develop fully, despite it being difficult to understand the needs of an ADHD child and balancing it with the needs of others.

c. Aggression, bullying or problems at home or school

Studies have shown that children with securely developed attachment bonds report fewer symptoms of depression and anxiety as they often exhibit more adaptive qualities such as higher empathy, self-efficacy, and ego resiliency (Arend, Gove, & Sroufe, 1979). In

contrast to this, children with an insecure attachment demonstrate more immaturity than their peers, are more aggressive, and maintain a more negative affect (Pierrehumbert *et al.*, 2000).

Children who are securely attached are found to present with fewer psychological problems in both childhood and adulthood and are often known to present with a positive affect (Muris, Mayer, & Meesters, 2000).

The primary school child with ADHD frequently begins to be seen as being different, as classmates start to develop the skills and maturity that enable them to learn successfully in school, whereas they lag behind. Participant 3 and 4 had noticed that their children were not on par in comparison to their peers so decided to put them in special need schools.

Although a sensitive teacher may be able to adapt the classroom to allow and enable a child with ADHD to succeed, more frequently the child experiences academic failure, rejection by peers, and low self esteem (Fig 2). Comorbid problems, such as specific learning difficulties, may also start to impact on the child, further complicating diagnosis and management (Harpin, 2009). An environment that is sensitive in nature proves to be positives as experienced by Participant 3 and 4:

Participant 3: *“He is in a very small class, so the teacher is able to give him enough attention, all the children read on the same level and so he doesn’t get left behind”.*

Participant 4: *“she has improved tremendously; I have not put her on medication so being in an environment with children similar to her with regards to her social and academically development has made her more confident in her abilities”.*

Many of these children experience bullying at school as they are teased for not being able to complete their work in time, or for being the ‘loud mouth’ in class and many a times this bullying has lead to the child being very frustrated. It was often evident from the caregiver’s perception that many of these children suffer from *“major tantrum or anger outburst”* as noted by Participant 7. Participant 2 and 3 had a similar experience as seen by the extract below:

Participant 2: *“As I am turning this child pulled a knife out of the draw and she wanted to stab me with the knife”.*

Participant 3: *“...major tantrums, he would just scream and go on and I would think that there was something wrong with him. He’d hate me, he actually wrote on the wooden floors in my house how he hates me...At one stage he grabbed me and was going to choke me and he’s much bigger than me and he’s quite strong but he didn’t realize what he did”*.

With regards to these children’s temperament, the intensity had varied amongst participants as some children were found to be aggressive and others were found to be very emotional and soft (Muris, Mayer, & Meesters, 2000) this was noted by Participant 4 and 6 below:

Participant 4: *“Some of the other related concerns I’m having, she is very aggressive and also sometimes very very emotional. She seems to be a very nervous child more especially when it comes to safety around the house or safety with her parents”*.

Participant 6: *“...He will throw a tantrum, he will drop everything and go to his room, he cries very easily so he will put the waterworks on and he will cry”*

d. Various parenting styles

A parent’s ability to provide a secure attachment is heavily influenced by their quality of care that they had received in their own first two to three years of their own life (Ainsworth & Bowlby, 1991). This is known as an inter-generational transmission of attachment styles (Ainsworth & Bowlby, 1991). The ways in which these caregivers raised their children appeared to have been influenced by their own upbringing.

Participant 1: *“my mother and I became very close in my adulthood, in which she provided me with much love and guidance. I try to give this same love to all my children, it’s hard at times, but I do my best to follow in my mother’s footsteps”*.

Participant 7: *“I was raised in a very strict home, as I initially grew up with my mother in her family home, so with her parents (my grandparents) and her siblings. The house was full so we all had a strict schedule; certain things had to be done at certain times, so I try to be less structured when it comes to certain things. I allow my*

child to have some fun. It's like being friends, something I never really had with my mother."

Most caregivers' did not believe in hitting their children as a form of discipline. Many of them used various discipline techniques such as time out, reward/behavioural charts and others believed in taking their privileges away such as TV or computer time or spending time out with friends. Many parents had tried to spank their children, but soon realised that it was not working and therefore resorted to alternative methods as mentioned above. Participant 3, 5 and 8 expressed their experiences in the extracts below.

Participant 3: *"I could understand much better how to cope or how to control myself and try to help her. And then...it's then that I realized how much this child is suffering. I never realized that. So in the beginning there were lots of fights and lots of crying"*.

Participant 5: *"No! We do not hit our children. We take away privileges, they know. If they good we will reward good behaviour, but if they disobey they will get time-out or their favourite things will be taken away"*.

Participant 8: *"He is not allowed to watch TV during the week so if he is naughty or doesn't do his homework I will take away his TV time over the weekend. I will start on a Friday, so I will discipline him by his TV time and computer time ...I try not to hit cause I know I'll hurt him, so I will just threaten him and say I'll hit you, but I never do cause that won't solve the problem or situation"*.

Theme 2, which focused on the caregiver's perception of the emotional regulation of the child with ADHD, found that many of the participants perceived their child who had been diagnosed with ADHD to be either an introvert who was shy and quiet or who were very aggressive. These children, when comparing them to other children of the same age, were seen as different from their classmates and did not have the maturity levels of their counterparts. Many participants struggled with relating to their children as some were unable to understand their behaviours such as the aggression while others were concerned about their expectations of their child and therefore any had tried different parenting styles. Some were

distant and unattached while others presented as over-protective. These various parenting styles may have resulted in an unbalanced relationship which in turn may result in an insecure attachment.

6.4 SUMMARY OF THE FINDINGS

The themes of caregivers' difficulties and understanding of the inter-relationship between ADHD and attachment were overlapping significantly as many participants had similar experiences with their children. The participants that partook in the study had different backgrounds, some experiencing positive attachments with their parents while others had negative attachments. Many participants found that the emotional turmoil was more intense than expected as they realised that raising an ADHD child had impacts not only on the child but on the whole family.

Many participants also experienced difficulties connecting with and understanding the emotional and behavioural development of their child which in turn resulted in various parenting styles and the ultimate relationship they had with their child. Despite the challenges each participant faced, each and every participant strived to do their best to ensure a good quality of life for their children. The findings of the research therefore suggests that an inter-relationship between attachment and ADHD may exist, however due to the small sample generalisability is limited.

6.5 CONCLUSION

This chapter focused on the discussion and interpretation of the findings presented in Chapter 5, by presenting various themes that became prevalent within this study. The themes of the caregivers' perceptions of the inter-relationship between attachment and ADHD such as the caregivers' difficulties relating to their roles as the primary caregiver for a child living with ADHD appear to be nonetheless consistent with existing literature on attachment and ADHD. The themes also confirm that caregivers who experienced negative attachments with their parents often displayed similar behaviours with their own children. Caregivers who also struggled to come to terms with their child's diagnosis and had difficulty understanding their emotional and behavioural difficulties also found it difficult to form a positive attachment, which in turn may prove that an inter-relationship between attachment and ADHD does in fact exist. These findings can be interpreted to indicate that possibly a lack of attachment

between a caregiver and child may predispose the child to the development of ADHD, but it is just hypothetical.

CHAPTER 7:

STRENGTHS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

7.1 INTRODUCTION

This chapter serves as a concluding chapter and includes a brief discussion on the study's strengths, limitations and recommendations for future studies. This chapter is divided into four broad sections. Section 7.2 and 7.3 explores the strengths and limitations of the study. A list of recommendations that resulted from the findings of this study is presented in section 7.4, while section 7.5 presents a final conclusion of this research report in.

7.2 STRENGTHS OF THE STUDY

- The fact that the current study focused on ADHD within a South African context, suggest that this study is highly relevant due to the high prevalence of children diagnosed with ADHD in South Africa.
- The findings of this study provide insights on the caregivers' contributions to ADHD, from an attachment perspective.
- This study primarily focuses on the caregivers' perspective with regards to attachment in which Bowlby's (1952, 1969) theory of attachment focused on the child's perspective.
- This study also adds to a growing body of literature on attachment and ADHD and provides unique perspectives of the caregivers as opposed to the children, who are most commonly focused on in existing literature.
- The results which indicated that an insecure attachment may have a link to ADHD can be seen as providing valuable insight into the perceptions of caregivers raising children with ADHD.
- Such insight is useful in identifying the role of the caregiver in supporting and caring for such children.
- These insights also highlight a significant impact of trans-generational attachment.
- Furthermore, this study, along with the resultant recommendations, may be used to advocate for further research and resources with regards to the inter-relationship of ADHD and attachment.

- The current study also identified a gap in literature with regards to the inter-relationship between attachment and ADHD in general and especially within a South African context.
- The research findings can also be beneficial in motivating for further research in the field of attachment and ADHD, especially against the backdrop of many socio-economic problems facing many South African families.

7.3 LIMITATIONS OF THE STUDY

- Thematic content analysis is subjective in nature (Braun & Clarke, 2006), and thus it is possible that the researcher's biases may have appeared during data analysis. However, steps were taken by the researcher to avoid this pitfall. These steps entailed regular supervision sessions with a mentor and a research supervisor. A self-reflective journal was also used during the research process.
- It is important to note that although the researcher made use of handwritten notes and audio recordings, valuable data might have been lost due to limited time allocated for interviews and due to the fact that tape recorders do not capture non-verbal language of participants.
- Due to time and resource constraints, the findings of the study were not triangulated. For example the study may have been improved by presenting the findings to the participants of the study in order to gain feedback on the degree to which these findings resonated with them.

7.4 RECOMMENDATIONS

- It is recommended that all caregivers' be given some theoretical understanding of the importance for the need to form positive attachment relationships with their children to ensure a positive development.
- Due to the limited research on ADHD in South Africa, it may be beneficial to extend such research especially due to the high prevalence amongst school-going children.
- It is recommended to offer increased support to caregivers' with children suffering from ADHD.
- Due to the small size which limits generalisability of this research, it is therefore recommended that a larger sample size be interviewed.

- It is also suggested that future research could focus on the various cultures in South Africa and how each of these cultures perceive attachment.

7.5 CONCLUSION

This study aimed to explore the inter-relationship between attachment and ADHD and to identify whether attachment or lack thereof may contribute to the development of ADHD. Further aims that were explored was the development of ADHD within a South African context, the emotional development of children living with ADHD and whether these children displayed attachment difficulties and if so, have they contributed to the development of ADHD.

It was discovered that research regarding ADHD within a South African context was limited and due to the high prevalence of ADHD amongst school-going children, this study proves to be relevant for the South African context, especially to all primary caregivers.

The overall findings indicated the importance of an emotional development for all children. It therefore suggested that the type of attachment formed between a parent and child is trans-generational and therefore these initial relationships are fundamental for a child's overall development. The importance of a positive attachment between parent and child was evident as it was seen that caregivers who struggled to accept their child's diagnosis, often found that their children presented with elevated emotional and behavioural difficulties.

This study therefore hypothesizes suggests that the lack of attachment between a caregiver and child may contribute to a certain extent, to the development of ADHD.

REFERENCES

- Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist*, 44, 709-716.
- Ainsworth, M. D. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, 46, 331-341.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders: DSM-III (3rd ed. Rev.)*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text rev.)*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. Washington, D.C.: American Psychiatric Association
- Anastopoulos, A.D., Guevremont, D.C., Shelton, T.L., & DuPaul, G.J. (1992). Parenting stress among families of children with Attention Deficit Hyperactivity Disorder. *Journal of Abnormal Child Psychology*, 20, 503-520.
- Anderson, R. (2007) Thematic Content Analysis (TCA: Descriptive Presentation of Qualitative Data.[online] Available from:
<http://www.wellknowingconsulting.org/publications/pdfs/ThematicContentAnalysis.pdf> [Accessed 10 October 2013].
- Arend, R., Gove, F. L., & Sroufe, L.A. (1979). Continuity of individual adaptation from infancy to kindergarten: A predictive study of ego-resiliency and curiosity in preschools. *Child Development*, 50, 950-959.
- Armstrong, T. (1997). *The myth of the ADHD child*. New York: Plume Books.
- Babbie, E. (2004). *The practice of social research (10th ed.)*. Belmont: Wadsworth/Thomson Learning.
- Babbie, M., & Mouton, J. (2010). *The Practice of social research*. Southern Africa: Oxford University Press.

- Bakare, M.O. (2012). Attention deficit hyperactivity symptoms and disorder (ADHD) among African children: a review of epidemiology and co-morbidities. *African Journal of Psychiatry*, 15, 358-361.
- Barkley, R. A. (1998). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment*. New York: Guildford Press.
- Barkley, R.A., Fischer, M., Edelbrock, C.S., Smallish, L. (1990). The adolescent outcome of hyperactive children diagnosed by research criteria: An 8-year prospective follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29, 546-557.
- Baron-Cohen, S. (1995). *Mindblindness: An essay on autism and theory of mind*. Cambridge, MA: MIT Press/Bradford Books.
- Bartholomew, K. & Horowitz, L.M. (1991). Attachment style among young adults: A Test of a four-category model. *Journal of Personality and Social Psychology*, 61,226-244.
- Benoit, D. (2004). Infant-parent attachment: definitions, types, antecedents, measurements and outcome. *Paediatric Child Health Journal*, 9(8): 541-545.
- Biederman, J., Faraone, S. V., Keenan, K., Knee, E., *et al.* (1990). Family-genetic and psychosocial risk factors in DSM-III attention deficit disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, vol 29, 526-533.
- Belsky, J. (2005). Attachment theory and research in ecological perspective. In K.E. Grossman, K.Grossman, & E. Waters (Eds.), *Attachment from infancy to adulthood: The major longitudinal studies* (pp. 71-97). New York: Guildford Press.
- Black, T. R. (1999). *Doing quantitative research in the social sciences: An integrated approach to research design, measurement, and statistics*. Thousand Oaks, CA: SAGE Publications, Inc.
- Blum, H.P. (1999). *Separation-Individuation Theory and Attachment Theory*. New York.
- Bowlby, J. (1952). *Maternal care and mental health* (2nd ed.). Geneva: World Health Organization.
- Bowlby, J. (1969). *Attachment and loss*. London: Random House Limited.
- Bowlby, J. (1969/1982). *Attachment and loss*. New York: Basic

- Bowlby, J. (1982) *Attachment and Loss. Volume 1: Attachment.* (2nd ed.) New York: Basic Books.
- Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28, 759-775. [online] Available from: http://www.psychology.sunysb.edu/attachment/online/inge_origins.pdf [Accessed 08 March 2013].
- Brotherson (2005). *Understanding attachment in young children.* NDSU Extension service. North Dakota State University: Fargo
- Cassidy, J. (1994). Emotion regulation: Influences of attachment relationships. In N. A. Fox (Ed.), *The development of attachment regulation. Monograph of the Society for Research in Child Development.*
- Clarke, L., Ungerer, J., Chahoud, K., Johnson, S & Stiefel, I., (2002). Attention Deficit Hyperactivity Disorder is Associated with Attachment Insecurity. *Clinical Child Psychology and Psychiatry*, 7,179.
- Coates, S.W. (2004). John Bowlby and Margaret S. Mahler: Their lives and theories. *Journal of the American Psychoanalytic Association*, 52, 571-601.
- Conners, C.K. (1997). *Conners' Rating Scales – Revised.* North Tonawanda: Multi-Health Systems, Inc.
- Crittenden, P.M., & Kulbotten. G.R. (2007). Familial Contributions to ADHD: An Attachment Perspective. *Tydskrift for Norsk Psykologforening. Vol 44 (10).* 1220-1229.
- Davison, J.C., & Ford, D.Y. (2001). Perceptions of attention deficit hyperactivity disorder in one African American community. *The Journal of Negro Education* 70:4, 2001, 264-273.
- Denzin N., & Lincoln Y. (2000). *Handbook of Qualitative Research.* London: Sage
- Edwards, M. C., Schulz, E. G., & Long, N. (1995). The role of the family in the assessment of attention deficit hyperactivity disorder. *Clinical Psychology Review*, 15, 375-394.

- Egeland B. (2009). Attachment-based intervention and prevention programs for young children. Retrieved from http://www.child-encyclopedia.com/documents/EgelandANGxp_rev.pdf
- Ely, M., Vinz., Downing, M. (1997). *On writing qualitative research: Living by words*. London: Routledge/Falmer.
- Fischer, M. (1990). Parenting stress and the child with attention deficit hyperactivity disorder. *Journal of Clinical Child Psychology*, 19, 337-346.
- Franc, N, Maury, M & Purper-Ouakil, D. (2009). ADHD and attachment processes: are they related? France. Vol. 35(3), 256-61.
- Fonagy, P. (1995). Mental representation from an inter-generational cognitive science perspective. *Infant Mental Health Journal*, 15, 57-68.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: their role in self. *Organization development and psychopathology*, 9, 679–700. United States of America: Cambridge University Press.
- Fonagy, P., Steele, H. & Steele, M. (1991). Maternal representations of attachment during infancy predict the organisation of infant-mother attachment at one year of age. *Child Development*, 62, 891-905.
- Gergely, G. & Csibra, G. (1998). The teleological origins of mentalistic action explanations: A developmental approach. *Developmental Science*, 1, 255-259.
- Glaser, B. G. (1998). *Doing grounded theory*. Mill Valley, CA: Sociology Press.
- Goldberg, S., Muir, R., & Kerr, J. (1995). *Attachment theory: Social, developmental, and clinical perspectives*. Jillsdale, NJ: Analytic Press.
- Green, H., McGinnity, A., Meltzer, H., et al. (2005), *Mental Health of Children and Young People in Great Britain, 2004. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive*. Basingstoke: Palgrave Macmillan.
- Grosswald, S.J., Stixrud, W, R., Travis, F., & Mark, A. (2009). Use of the Transcendental Meditation Technique to Reduce Symptoms of Attention Deficit Hyperactivity Disorder (ADHD) by Reducing Stress and Anxiety: An Exploratory Study. A non-drug approach to ADHD.

- Harpin, V.A. (2005). The effect of ADHD on the life of an individual, their family, and community from preschool to adult life. *Arch Dis Child*, 90(Suppl 1), i2-i7.
- Harris, P. L. (1992). From simulation to folk psychology: The case for development. *Mind and Language*, 7, 120–144.
- Hazan, C., & Shaver, P.R. (1987) Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52 (3), 511-524.
- Hesse, E. (1996). Discourse, memory, and the Adult Attachment Interview: A note with emphasis on the emerging cannot classify category. *Infant Mental Health Journal*, 27, 4-11.
- Holmes, J. (1995). “Something there is that doesn’t love a wall:” John Bowlby, attachment theory and psychoanalysis. In S. Goldberg, R. Muir & J. Kerr. Hillsdale, *Attachment Theory: Social, Developmental and Clinical Perspectives*. NY: The Analytic Press.
- Howe, D., Brandon, M., Hinnings, D., & Schofield, G. (1999). *Attachment theory, child maltreatment and family support: A practice and assessment model*. New York: Palgrave.
- Johnston C, Mash EJ. Families of children with attention-deficit/hyperactivity disorder: review and recommendations for future research. *Clinical Child Family Psychology Rev*. 2001 Sep;4(3):183–207.
- Joy, E. (2012). What Attachment is” or “Where I kill a few sacred cows”. *The Natural Parent. New Zealand's Attachment Parenting Magazine*. Retrieved at: <http://www.thenaturalparent.co.nz/blog/?p=503>
- Kavale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oaks, CA, US: Sage Publications.
- Kissgen, R., Krischer, M., Kummert, V., Spiess, R., Schleiffer, R., & Sevecke, K. (2009). Attachment Representation in Mothers of Children with Attention Deficit Hyperactivity Disorder. *Psychopathology*, 42, 201–208.
- Lambert, N.M. & Harsough, C.S. (1984) Contribution of predispositional factors to the diagnosis of hyperactivity. *American Journal of Orthopsychiatry*, Vol 54, 97-109.
- Lambert, N.M. (1982). Temperament profiles of hyperactive children. *American Journal of Orthopsychiatry*, Vol 52, 458-467.

- Mahler, M.S. (1974). Symbiosis and individuation – the psychological birth of the human infant. *Psychoanalytic study of the child*, Vol 29, 89-106.
- Main M, Goldwyn R (1985). Adult attachment scoring and classification system. Berkeley, California: Department of Psychology, University of California at Berkeley, Unpublished manuscript.
- Malekpour, M. (2007). Effects of attachment on early and later development. *The British Journal of Developmental Disabilities*, 105(53), 81-95.
- Mattox, R., & Harder, J. (2007). Attention Deficit Hyperactivity Disorder (ADHD) and Diverse Populations. *Child and Adolescent Social Work Journal*, Vol. 24, No. 2
- Mouton, J. & Marais, H.C. 1996. *Basic concepts in methodology of the social sciences*. Pretoria: HSRC Publishers
- McVay, K.D., (2012). Using attachment to understand intergenerational transmission of intimate partner violence and implications for use in treatment and policy reform. Master's Thesis, University of Pittsburgh.
- Meyer, A., Eilertsen, D. E., Sundet J.M., Tshifularo J.G., & Sagvolden T. (2004). Crosscultural similarities in ADHD-like behaviour amongst South African primary school children. *SAJP*, 34(1), 123–139.
- Miller, P.M. & Commons, M.L. (2010). The benefits of attachment parenting for infants and children: A behavioural development view. *Behavioural Development Bulletin*, Vol. 10.
- Muris, P., Mayer, B., & Meesters, C. (2000). Self-reported attachment style, anxiety, and depression in children. *Social Behavior and Personality*, 28, 157-162.
- Ospina, S. (2004). *Qualitative Research*. London: Sage Publications.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.) Newbury Park, CA: Sage Publications, Inc.
- Pierrehumbert, B., Miljkovitch, R., Plancherel, B., Halfon, O., & Ansermet, F. (2000). Attachment and temperament in early childhood: Implication for later behaviour problems. *Infant and Child Development*, 9, 17-32.

- Riggs, S.A., Paulson, A., Turnell, E., Sahl, G., Atkison, H., & Ross, C. (2007). Attachment, personality, and psychopathology among adult inpatients: Self-reported romantic attachment style versus Adult Attachment Interview states of mind. *Development and Psychopathology*, 19, 263-291.
- Rowland, A., Umbach, D., Stallone, L., Naftel, A., Bohlig, E., & Sandler, D. (2002). Prevalence of medication treatment for attention deficit-hyperactivity disorder among elementary school children in Johnson County, North Carolina. *American Journal of Public Health*, 92, 231-234.
- Sadock, B.J., & Sadock, V.A. (2003). *Kaplan and Sadock's synopsis of psychiatry (9th Ed.)*. Philadelphia: Lippincott Williams & Wilkins.
- Sandtrock, J.W. (2002). *Life-span development*. New York: McGraw-Hill Companies.
- Schellack, N. & Meyer, H. (2012). The management of attention deficit-hyperactivity disorder in children. *S Afr Pharm J*; 79(10), 12-20.
- Shank, G. (2002). *Qualitative Research. A Personal Skills Approach*. New Jersey: Merrill Prentice Hall.
- Sigelman, C.K., & Rider, E.A. (2003). *Life-span human development*. Belmont, CA: Wadsworth.
- Slade, A. (1987). Quality of attachment and early symbolic play. *Developmental Psychology*, 17, 326–335.
- Smyke, A.T., & Zeanah, C.H. (1999). *Disturbances of Attachment Interview*. New Orleans, LA: Department of Psychiatry and Neurology, Tulane University.
- Snyman, S., & Truter, I. (2009). Complementary and alternative medicine for attention deficit/hyperactivity disorder: An Eastern Cape study, 52(2), 161-162.
- Sonkin, D.J., (2005). *Attachment theory and psychotherapy*. California: Professional Exchange.
- Sroufe LA. (1988). The role of infant-caregiver attachments in development. In: Belsky J, Nezworski T, editors. *Clinical Implications of Attachment*. Hillsdale: Erlbaum; 1988. pp. 18–38.

- Stemler, S. (2001). An overview of content analysis. *Practical assessment, research & evaluation*, 79170. Retrieved from <http://PAREonline.net/getvn.asp?v=7&n=17>.
- Taylor E. Clinical foundations of hyperactivity research. *Behavior Brain Res.* 1991 Jul;94(1):11–24.
- Teeter, P. A. (1998). *Interventions for ADHD: Treatment in developmental context*. New York: Guilford Press.
- Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in Practice: Applied Methods for Social Research*. South Africa: University Press.
- Terre Blanche, M. and Kelly, K. 1999: Chapter 7 in Terre Blanche and Durrheim (eds.) *Research in Practice*. Applied methods for social sciences. Cape Town: University of Cape Town Press.
- Theilheimer, R. (2006). *Molding to the children: Primary caregiving and continuity of care*. *Zero to Three*, 26, 3
- Thompson, R.A. (1999). Early attachment and later development. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 265-286). New York: Guilford Press.
- Travell, C., and J. Visser. (2006). ADHD does bad stuff to you: Young people's and parents' experiences and perceptions of Attention Deficit Hyperactivity Disorder (ADHD). *Emotional and Behavioural Difficulties* 11, no. 3: 205-16.
- Visser, J. & Jehan, Z. (2009). ADHD: a scientific fact or factual opinion? A critique of the veracity of attention deficit hyperactivity disorder. *Emotional and behavioural difficulties* 14(2), 127-140.
- Venter, A. (2006). The medical management of Attention-Deficit/Hyperactivity Disorder: spoilt for choice? *South African Psychiatry Review*, 9, 143-151.
- Waters, E & Cummings, E.M.,. (2000). A secure base from which to explore close relationships. *Child Development*, 71, 164–72.
- Weiss, R.S. (1991). The attachment bond in childhood and adulthood. In C.M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 66-67). London: Routledge.

- Wehmeier, P. M., Schacht, A., and Barkley, R. A. (2010), Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life, *Journal of Adolescent Health*, 46(3), 209-217.
- Weyandt, L.L. (2001). *An ADHD primer*. Boston: Allyn & Bacon.
- Whalen, C. (2000). Attention deficit hyperactivity disorder. In A/ Kazdin (Ed.) *Encyclopedia of psychology*. Washington, DC, & New York American Psychological Association and Oxford University Press.
- Zeanah. C.H., Mammen, O.K., & Liberman, A.F. (1993). Disorders of attachment. In C.H. Zeanah (Ed.). *Handbook of infant mental health* (pp. 332-349). New York: The Guild Press.
- Zimberoff, D. & Hartman, D. (2002). Attachment, Detachment, Nonattachment: Achieving Synthesis. *Journal of Heart-Centered Therapies*, 1(5), 3-9.
- Zhang, Y. (2006). Content analysis. Retrieved from, <http://.ils.uncedu/~yanz/content%20analysis.pdf>

APPENDIX 1: Participant Information Letter



March 2012

Dear Caregiver

My name is Kim Lynn Harris and I am conducting research for the purpose of obtaining a Masters degree in Community Based Counselling Psychology at the University of the Witwatersrand. This research aims to explore how caregivers experience and understand the emotional development of children living with ADHD, with specific focus on caregiver's perception of the inter- relationship between attachment and ADHD in children. The focus will primarily be on the caregiver's perceptions; therefore no intervention will be done with the children directly.

I would like to invite you to participate in this study. Participation in this research will entail being individually interviewed by me, at a time and place that is convenient for you. The interview will approximately take 50 minutes. With your permission the interview will be audio taped to ensure accuracy. Participation is voluntary and the process will not be harmful in any way. You will neither be advantaged nor disadvantaged in any way for choosing to participate or not to participate in the study.

All interview material (tapes and transcripts) will be confidential and your identity will be protected. Direct quotes may be used with your permission. However, the quotations will be sanitized so it won't be traced back to you. Pseudo names will also be used to ensure confidentiality. You may choose to withdraw from the study at any time and may refuse to answer any questions that you may feel uncomfortable with. All interview material will be kept safe and a password protected laptop and all audio tapes will be kept safe in a locked up cupboard. The data will only be seen by the researcher and her supervisor. All interview

material (tapes and transcripts) will be destroyed after five years. As a prospective participant you will be required to sign consent forms.

If counselling is needed, you may seek therapy at the Emthonjeni Centre at Wits University, free of charge. Contact details are provided at the end of this letter.

If you require further information, please do not hesitate to contact me.

Kind Regards,

Kim Harris.
Researcher/Student Psychologist
kimharris2605@gmail.com

Dr. Daleen Alexander
Research Supervisor
Dinah.alexander@wits.ac.za

Counselling Centre: Emthonjeni Centre (EC)

Tel: (011) 717 4513

Fax: (011) 717 8324

APPENDIX 2: Consent Form 1

Informed consent to be interviewed

I hereby consent to be individually interviewed by Kim Lynn Harris for approximately 50 minutes.

I understand the following:

- My participation in the study is completely voluntarily.
- I will in no way be advantaged or disadvantaged by agreeing to be interviewed.
- The interview will be confidential.
- My direct quotes may be used, but no information will be made available that could identify me.
- I have the right to withdraw from the interview process at any time.
- I may refuse to answer any questions during the interview which I would rather not answer.
- The interview will be audio-taped
- The study is not harmful.
- All the data will be kept in a safe and will be destroyed once the study has been completed.

.....

Signature

.....

Date

APPENDIX 3: Consent Form 2

Consent to be audio-recorded

I hereby give consent for my individual interview with Kim Lynn Harris to be audio-recorded.

I understand the following conditions:

- The tapes and full transcripts will only ever be in the researcher's or her supervisor's possession.
- All audio-tapes will be destroyed after 5 years.
- My direct quotes may be used however; no information that may identify me will be included in the transcripts or the research report.

.....
Signature

.....
Date

Interview schedule

1. CAREGIVERS HISTORY AND BACKGROUND

a. Tell me a bit about your family history and your childhood

- i. Where did you grow up?
- ii. With whom did you live?
- iii. How would you describe your relationship with your parents?
- iv. Which parent were you closest to?

2. QUESTIONS DIRECTED TO BIOLOGICAL PARENTS.

a. Tell me about your experiences related to your pregnancy from the time you became aware of the pregnancy until the birth of your child of your pregnancy.

- i. Tell me about the first time you found out you were pregnant with your baby (ADHD child).
- ii. How did you feel about the pregnancy? Did you have the necessary support? (Financial/social resources).
- iii. What do you think is different from your (ADHD) child and you other children?

b. Tell me about the experiences after the birth.

- i. How would you describe the interaction between you and the baby when he/she was an infant?
- ii. How would you describe your child's development?
 - 1. When did they reach their specific milestones?
- iii. Tell me about how you would respond to your child when he/she started crying?

3. Questions directed to the guardian.

a. TELL ME ABOUT HOW YOU FELT ABOUT BECOMING THE GUARDIAN OF YOUR CHILD.

- i. How long have you been the guardian of the child?

- ii. How would you describe the interaction between you and the baby when he/she was an infant?
 - iii. Tell me about how you would respond to your child when he/she started crying?
- b. Tell me about the relationship between you and your child in the beginning and how your relationship is now.
- c. How would you describe your child's behaviour?
- d. How would you describe your child's development?
 - i. When did they reach their specific milestones?

4. Understanding of ADHD

- a. **WHAT IS YOUR UNDERSTANDING OF ADHD?**
 - i. How do you think it manifests?
 - ii. What do you believe the impacts of having a child with ADHD are?
- b. Describe your child in relation to other children.
 - i. Would you say there are significant differences and which differences are there, if yes?
 - ii. What do you think of these differences?
 - iii. When did you first notice them?
- c. What do you understand about ADHD? (signs/symptoms).
- d. Have you heard the term ADHD before discovering that your child suffers from ADHD?
- e. Does he/she place close attention to detail?
- f. Are they often easily distracted?
- g. How do they participate in class/sport activity?
- h. Does he/she have trouble waiting for one's turn?

5. Emotional regulation

- a. Describe your child's temperament
 - i. Are they outspoken/very shy?
 - ii. Are they comfortable with strangers?
- b. Describe to me how your child responds when he/she does not get their way
- c. How does your child relate to you emotionally as the parent?

- i. Do they often talk to you? Tell you their secrets?

6. Perceptions of Attachment

a. TELL ME ABOUT YOUR RELATIONSHIP WITH YOUR CHILD.

- i. Tell me about the time you spend with your child while he/she was an infant.
 - ii. Does s/he have one special adult that s/he prefers (dad/mom)?
 - iii. Describe to me how you responded to your child when he/she cried or called for your attention?
 - iv. Who else spent a lot of time with the child?
- b. Describe how your child responds to other adults or strangers.
 - c. What does your child do when you are in an unfamiliar place?
 - d. Tell me about the time your child had to go to school (has to separate from you) and the time when he/she has to do homework.
 - i. Who helps your child with homework?
 - ii. Describe how he/she reacts to doing homework?

APPENDIX 5: DIAGNOSTIC CRITERIA FOR ADHD: DSM-IV-TR

A. Either (1) or (2):

(1) inattention: six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

(2) hyperactivity-impulsivity: six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often "on the go" or often acts as if "driven by a motor"
- (f) often talks excessively

Impulsivity

- (g) often blurts out answers before questions have been completed
- (h) often has difficulty awaiting turn
- (i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorders, or a Personality Disorder).

Code based on type:

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type: if both Criteria A1 and A2 are met for the past 6 months

314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Type: if Criterion A1 is met but Criterion A2 is not met for the past 6 months

314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type: if Criterion A2 is met but Criterion A1 is not met for the past 6 months

Disturbances of Attachment Interview

Anna T. Smyke, M.S.

Charles H. Zeanah, Jr., M.D.

Section of Child and Adolescent Psychiatry
Tulane University School of Medicine

Correspondence:

Charles H. Zeanah, Jr., M.D.
Department of Psychiatry and Neurology
Tulane University School of Medicine
Tidewater Building TB 52
1440 Canal Street
New Orleans, LA 70112
Phone: (504) 588-5402
Fax: (504) 587-4264
Email: czeanah@tulane.edu

Note: Training should be obtained before utilizing this measure.

This is a semi-structured interview designed to be administered by clinicians to caregivers who know the child and the child's behavior well. If possible, it should be administered to the child's primary caregiver. Specific probes are designed to elicit more information; they are not intended to be exhaustive. Clinicians should feel free to probe further. The scoring is completed at the close of the interview based upon responses provided.

We're talking with parents/caregivers about their children and some of the things they do, so we can understand children better. This interview takes about 20 minutes, sometimes a little more, sometimes a little less. Can you tell me how old [child] is?

- 1) Does s/he have one special adult that s/he prefers? Who is it? How does s/he show that he prefers that person? Could you give me a specific example? Are there any other adults that are special, like this? Who does he prefer most of all?

- 0 Clearly differentiates among adults
- 1 Sometimes or somewhat differentiates among adults
- 2 Rarely or minimally differentiates among adults

- 2) When s/he falls down and hurts himself/herself what does s/he do? Is s/he one to sit where s/he is and wait for you or other caregivers to come or does s/he come over and tell you when s/he is hurt? Does she ever go to people that she doesn't know well for comfort? Does she ever go to someone unfamiliar for comfort even when someone familiar is available?

- 0 Clearly seeks comfort preferentially from a preferred caregiver
- 1 Sometimes or somewhat seeks comfort preferentially from a preferred caregiver
- 2 Rarely or minimally seeks comfort preferentially from a preferred caregiver

[The following item is rated but does not count in scoring]

- 0 Actively seeks comfort from an available caregiver when hurt or upset.
- 1 Sometimes or somewhat seeks comfort from an available adult caregiver when hurt or upset.
- 2 Rarely or minimally seeks comfort from an available caregiver when hurt or distressed; sits and cries or does not cry at all when hurt or distressed.

- 3) When s/he does come to you/or the preferred caregiver (or when you go to him/her) does s/he accept being comforted or is s/he one to take a while to calm down?

- 0 Clearly responds to comfort from caregivers when hurt, frightened, or distressed
- 1 Sometimes or somewhat responds to comfort from caregivers when hurt, frightened, or distressed

- 2 Rarely or minimally responds to comfort from caregivers when hurt, frightened, or distressed
- 4) Does s/he share things back and forth with you, let's say, talk with you or show you that s/he's excited about something or is s/he one to not really share back and forth? Does s/he take turns talking or gesturing with you?
- 0 Clearly responds reciprocally with familiar caregivers
- 1 Sometimes or somewhat responds reciprocally with familiar caregivers
- 2 Rarely or minimally responds reciprocally with familiar caregivers
- 5) How are his/her moods? Is s/he generally happy or is s/he one to be more irritable or sad or serious? Would you say s/he is like that most of the time or some of the time? How much of the time is s/he sad, serious, or irritable.
- 0 Clearly regulates emotions well with ample positive affect and developmentally expectable levels of irritability and/or sadness.
- 1 Sometimes or somewhat has difficulty regulating emotions with less positive affect and more irritability and/or sadness than is expected developmentally
- 2 Rarely or minimally regulates emotions well; instead, has little positive affect and definitely elevated levels of irritability and/or sadness.
- 6) When you are in a place that is not familiar for [child], what does s/he do? Does s/he check back with you or s/he one to just go off without checking back? Does s/he tend to wander off without any particular purpose? If s/he finds him/herself separated from you does s/he get upset or does it seem to not really bother him/her?
- 0 Clearly checks back with caregiver after venturing away, especially in unfamiliar settings.
- 1 Sometimes or somewhat checks back with caregiver after venturing away, especially in unfamiliar settings.
- 2 Rarely or minimally checks back with caregiver after venturing away, especially in unfamiliar settings.
- 7) How does s/he behave around adults that s/he doesn't know? Does s/he tend to be friendly or is s/he one to stand back and observe or to approach? Does s/he tend to be sort of shy around strangers or is s/he one to go right up to people s/he doesn't know? (If yes, why do you think s/he does this?) Does s/he cry or cling to you or does she just seem wary/cautious? Does s/he do this all the time or some of the time? Is his/her reaction sort of mixed so that at some times s/he is friendly but other times she might cry or s/he is friendly with some unfamiliar adults but not with others? Could you give me a specific example of a time when s/he was around an adult that s/he didn't know?

If shy, does s/he seem to be shy at first and then tend to warm up or does s/he stay shy? Has she been consistently shy over time or has that been variable? For example, was she at one time more shy or less shy than she is now? (For **Adopted/Foster children**: Has s/he been the same in terms of shyness since you have known him/her or has her/his level of shyness changed at all?)

- 0 Clearly exhibits reticence with unfamiliar adults
 - 1 Sometimes or somewhat exhibits reticence with unfamiliar adults
 - 2 Rarely or minimally exhibits reticence with unfamiliar adults
- 8) Do you think s/he would be willing to go off with a stranger? Why do you think so? Could you give me a specific example? Do you think s/he would do this some of the time or most of the time? Has this way of interacting with strangers changed? Was s/he more/less willing at an earlier age to go off with someone s/he didn't know?
- 0 Clearly is not willing to go off readily with relative strangers.
 - 1 Sometimes or somewhat is willing to go off readily with relative strangers.
 - 2 Willing to go off readily with relative strangers.
- 9) Is s/he one to get him/herself in risky situations? Could you give me a specific example? Is s/he one to run out into traffic or maybe pull stuff off of the stove? Does s/he seem to try to provoke you with his/her dangerous behavior? Does s/he do this with everyone or does s/he do this mostly around one particular person? Why do you think s/he does it?
- 0 Clearly does not engage in a pattern of self-endangering behavior that is more pronounced in the presence of one particular caregiver.
 - 1 Sometimes or somewhat engages in a pattern of self-endangering behavior that is more pronounced with one particular caregiver.
 - 2 Definitely engages in a pattern of self-endangering behavior that is more pronounced with one particular caregiver.
- 10) Does s/he tend to cling to you or stay right up under you? When does this seem to happen? Does it seem to happen if there is an adult around who she doesn't know? Or does it tend to happen at other times, too? Could you give me a specific example?
- 0 Clearly does not engage in a pattern of excessive clinging to a particular caregiver in unfamiliar settings or with unfamiliar people.
 - 1 Sometimes or somewhat engages in a pattern of excessive clinging to a particular caregiver in unfamiliar settings or with unfamiliar people.
 - 2 Definitely engages in a pattern of excessive clinging to a particular caregiver in unfamiliar settings or with unfamiliar people.

- 11) Does s/he tend to watch you or other caregivers a lot of the time, like watching to see what your or their moods are? Does she ever seem to be a bit afraid of any caregivers, or to do exactly what they want, in a sort of automatic way?
- 0 Clearly does not engage in a pattern of fearful, inhibited, and hypervigilant behavior with any particular caregiver.
 - 1 Sometimes or somewhat engages in a pattern of fearful, inhibited, and hypervigilant behavior with any particular caregiver.
 - 2 Definitely engages in a pattern of fearful, inhibited, and hypervigilant behavior with any particular caregiver.
- 12) Does s/he seem to know when you or other caregivers are sad or mad or upset? What will s/he do? Could you give me a specific example? Does s/he ever seem worried about you (or other caregivers) or worried for you (or other caregivers)? Could you give me an example? Does s/he seem almost preoccupied by how you (or other caregivers) are doing? Why do you think s/he does this? Do you ever think that it may be a bit too much for a child his/her age?
- 0 Clearly does not engage in a pattern of controlling or role inappropriate behavior suggesting excessive preoccupation with caregiver's emotional well-being.
 - 1 Sometimes or somewhat engages in a pattern of controlling or role inappropriate behavior suggesting excessive preoccupation with caregiver's emotional well-being.
 - 2 Definitely engages in a pattern of controlling or role inappropriate behavior suggesting excessive preoccupation with caregiver's emotional well-being.

DISTURBANCES OF ATTACHMENT INTERVIEW (DAI)	
Disturbances of Non-attachment 0 = behavior clearly present; 1 = behavior somewhat or sometimes present; 2 = behavior rarely or minimally present	SCORE
1. Differentiates among adults	
2a. Seeks comfort preferentially	
2b. Actively seeks comfort when hurt/upset	
3. Responds to comfort when hurt/frightened	
4. Responds reciprocally with familiar caregivers	
5. Regulates emotions well	
6. Checks back with caregiver in unfamiliar setting	
7. Exhibits reticence with unfamiliar adults	
8. Unwilling to go off with a relative stranger	
Secure Base Distortions 0 = pattern not present; 1 = pattern sometimes present; 2 = pattern definitely present	SCORE
9. Self-endangering	
10. Excessive clinging	
11. Fearful, inhibited, hypervigilant w/caregiver	
12. Pattern of controlling, role inappropriate behaviour	
DAI Sum Score	SCORE
Non-attachment/Inhibited (Items 1-5)	
Non-attachment/Disinhibited (Items 1, 6-8)	
Indiscriminate Behavior (Items 6-8)	
Secure Base Distortions (Items 9-12)	

Add items 1, 2a, 3, 4, 5. The sum is the score for Non-attachment/Inhibited.

Add items 1, 6, 7, 8. The sum is the score for Non-attachment/Disinhibited.

Add items 6, 7, 8. The sum is the score for Indiscriminate Behavior.

Items 9, 10, 11, 12 are separate types of Secure Base Distortions.

APPENDIX 7: Researcher's Personal Reflection

The journey of completing this research report has been a true roller-coaster ride. There were both up's and down's and at the start I was unsure as to which direction I was going. This journey presented itself as both steady and easy going as well as really challenging at times. During these challenging times I was able to reach out to family, friends and respective mentors as mentioned in my acknowledgements (p. iv). They acted as my safety bar which ensured I was strapped in tight during this rollercoaster ride, known as Masters.

It has been a long journey, but every up and every down as well as all the turns that I took I ensured that I choose the most front seat of the roller coaster committing myself to complete the ride. At times it felt that the rollercoaster was about to derail, but it was during this time that I realised that there was no time to stop and break and that the journey must continue. This inspiration was drawn from each and every participant's dedication and commitment to their children which were shown through their devoted love and care. They have shown me how to pursue this research, despite the challenges and it turned out to be a JOY ride! One which I have enjoyed, but mostly learnt from.

I have now completed my ride. What a journey! Filled with smiles, tears, laughs and gasps!! I sincerely thank everybody that played a role in supporting me during this time, both personally and professionally. I thank you! This was a ride of a lifetime.