

**COPING STRATEGIES OF AFRICAN MOTHERS OF
CHILDREN DIAGNOSED WITH BEHAVIOURAL
PROBLEMS**

By

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DEDICATION

This work is dedicated to my family: my dad, my mom, my brothers and in loving memory of my late paternal and maternal grandparents.

DECLARATION

I declare that this thesis hereby submitted to the University of Limpopo for the degree of Master of Science in Clinical Psychology, has not been previously submitted by me for a degree at this or any other university; that it is my own work in design and in execution, and that all material contained herein has been duly acknowledged.

SIGNED AT _____ On the _____

K.K.E. Mashego

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ABSTRACT

This study aims at finding out whether Black Northern Sotho speaking mothers of children diagnosed with behavioural problems cope differently from their English speaking counterparts, and whether the Black mothers have more support than their control group.

Forty-eight Northern Sotho speaking Black African mothers with children diagnosed with behavioural problems were drawn using a convenience sample method. Thirty-two English speaking White mothers who have the same type of children were used as the control group. Participants were drawn from clinical populations in public hospitals in the Limpopo Province (Mankweng, Polokwane, Groethoek, and Lebowakgomo hospitals). All participants were given a questionnaire. The questionnaire had the following sections: bibliographical data of the mother and family; Social Support Scale (Sarason, Levine, Basham, & Sarason, 1983); Ways of Coping Scale (Billings & Moos, 1981) and an in-depth interviewing schedule.

Ten subjects from the forty-eight were interviewed using the in-depth-interviewing schedule. The ten were selected by choosing every fifth numbered participant from the experimental group until the tenth participant. Results show that White mothers (control group) of children with behavioural problems coped better than the Black mothers (experimental group). Age of the mothers and the mothers' perception of the level of health significantly influenced scores

on the Coping Scale. As the mothers' ages decreased, their scores on the Coping increased (they coped better) and as the perceived level of health increased (more positive), the Coping score increased. However, Black mothers have more support than their control group. The perceived level of health was the only factor that significantly influenced the scores on the Social Support scale. As the perceived level of health decreased, the Social Support received increased.

It is also found that the Black mothers' use of external locus of control in their explanations of the causes of their children's problems led to a number of feelings in the mothers. Feelings for example, of not being in control of the situation, feelings of dissatisfaction with family life, decreased motivation together with feelings of guilt and self-blame.

It appears a process of acculturation could be involved in the difficulties the Black mothers experience. This acculturation process and the effect of the problematic child on their system (school, family, and parents) need to be addressed further so they could be incorporated into future intervention programmes.

Due to the limitations of the study, the findings should be used with caution. Further research should be done to shed more light on the coping strategies of mothers of children with behavioural problems.

CHAPTER 1

INTRODUCTION

1.1. Introduction

The main aims of this chapter are to give some background as to what prompted the undertaking of the present study, which comprises to state the aims of the study, describe the methods of the research, and to outline the structure of the dissertation as a whole.

1.2. Background

Most children, who come to psychologists, present with behavioural difficulties, such as, poor peer relationships, sleeping in class, child seeming lonely, child crying a lot, a child not having much fun or not taking part in things, reluctance or refusal to go to school, reluctance to sleep, distress for separation, delayed development, fearfulness, nightmares, and physical complaints (Sadock & Sadock, 2003). The behavioural difficulties are common clinical symptoms of most of the childhood disorders (Culbertson & Silovsky, 1996). For example, it is common for children with learning disorders to present with primarily behavioural symptoms such as refusal to complete assignments, disruptive or oppositional behaviour at school, or extremely withdrawn or anxious behaviour. Certain universal human developmental phenomena exist which are an expected part of development in children; for example separation anxiety during infancy and young children entering school is common. A diagnosis is made when this anxiety is developmentally inappropriate and excessive (Sadock & Sadock, 2003). It is found that in “Western” cultures the conditions diagnosed in children identify not only the children but also the mothers who society regards as unable to fulfill their mothering role (Carpenter, 1999). Society attempts to control the mother after diagnosis and judgement occurs from the very

society that the mother with a diagnosed child has failed in the mothering role. The difference experienced by mothers and the socially constructed meaning of both the disorder and mothering can disable the mother (Carpenter, 1999). In other words the meaning of motherhood and the disorder combine to form the perceived difference that influences the lived experiences of some mothers.

Studies (see point 1.3 below) have been found to focus on White Western mothers and the pathology that develops due their children's behavioural problems, and rarely on coping strategies or Black mothers of children with behavioural problems. In the present study the researcher would like to explore the possible coping strategies of Black Northern Sotho speaking mothers.

1.3. Statement of the problem

For mothers, managing a child with behavioural difficulties can be problematic. Studies have shown that mothers of children with behaviour problems that are often diagnosed as childhood disorders (such as Attention Deficit Hyperactivity Disorder; Conduct Disorder, Oppositional Disorder, Mental Retardation and Learning Disorder) have higher rates of psychological difficulties and seek treatment more often than mothers with "normal" children (Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000).

More specifically, one study on Western mothers of children with behavioural disorders showed higher rates of depression symptoms among the mothers due to decreased sense of competence, feelings of being restricted in mother role, poorer parent –child attachment,

negative spouse relationship, and increased family distress (Johnson & Reader, 2002). Taken together the above studies' findings suggest that having a disruptive child within the home is associated with a range of psychological and or interpersonal difficulties experienced by parents as well as perhaps more general family problems.

Society often creates problems for these Western mothers who are already stressed by the diagnosis of their children. In this regard the relationship between oppression and motherhood were interrelated in one study. This study used a narrative enquiry to examine how mothers of problematic children are affected by their children's diagnosis and further how the mothers are treated by society (Carpenter, 1999). The findings were that these mothers are treated as "people of difference". They experience marginalization, isolation and silence. The children are seen as a reflection of the mother's coping style (if the child is misbehaving it implies the mother's inability to control own child) (Carpenter, 1999; Mehl-Madrona, 2000). Management of the disorders fails to take into account the sociological implications of the condition.

More stress is added by the fact that "Western" mothers are part of the dominant society, which, if they have a disordered child, can exclude them pushing them to occupy the position of "the other" (they are oppressed, marginalized and isolated in their own society) (Carpenter, 1999). Expectations of society, how mothers see themselves, and how society treats the difference, all influence the Western mother's experience.

It is the oppression that is associated with the experience of being a 'different mother' that makes a child's disorder a hidden disability for a Western mother (Carpenter, 1999). The difference occurs when the mother appears to be unsuccessful in the management of socially inappropriate behaviour of her child. Western mothers are seen as unsuccessful because

behavioural problems and the childhood disorders diagnosed are western phenomena to be avoided (Carpenter, 1999; Mehl-Madrona, 2000). The mother might feel rejection from society and if she internalizes it (takes it personally) and believes it, this could lead to depression based on Beck's Cognitive triad. The perceived difference affects the lives of mothers.

The disabling component of a child's problems, can serve to exclude some people from full participation in interpersonal, social, cultural, economic and political affairs. It is this disabling effect on a woman mothering a child with behavioural problems that leads to her identification as being different, which in turn has an additional disabling effect on her as a person (Carpenter, 1999; Mehl-Madrona, 2000). The mother might feel she is incapable of handling situation; she could feel isolated because the family is not supportive; might feel it is her own responsibility; and she might feel stuck as well as denied of freedom (Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000).

Exploitation occurs when women invest in carrying out mothering with negligible returns. Frequently some mothers devote an excessive amount of time and energy in comparison to mothers with regular children. However, mothers are rarely rewarded for their efforts. They receive criticism and are advised to try harder. A considerable amount of time, physical energy and emotion is exerted, in an attempt to be good mothers but often without success (Carpenter, 1999; Mehl-Madrona, 2000). Marginalization is the most dangerous form of oppression because it means the exclusion of people from useful participation in life. It often flows from exploitation. It seems that a woman becomes the "other woman" when she is considered lacking in mothering skills, expertise and knowledge (Carpenter, 1999).

Powerlessness is experienced both as the subject of the public gaze and in the lack of control they often experience in the management of their non-compliant child. They frequently

experience powerlessness because they feel that they are under the control of their child. This situation occurs usually when mothers have to constantly change their behaviour to accommodate the child's behaviour that escalates in its inappropriateness (Carpenter, 1999).

Studies rarely focus on the coping strategies of the Western mothers with even fewer studies available on the way Black African mothers of children with behavioural problems cope (Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000).

It is very clear that most studies take the pathogenic approach, which tends not to be empowering to the mothers in dealing with their environment. The present study will thus focus on a strength-based approach with the hope of using the mothers' often 'unrecognized' strength to recommend intervention coping strategies. Instead of focusing on the pathogenic model of intervention (focusing on the pathology in the mothers) the researcher would focus on resilience factors, resistances and possible positive coping strategies, which would help empower the mothers. In the long run this might even reduce the underlying pathology that might have developed due to maladjusted coping strategies (Boyd-Franklin, 1989).

The Black mothers, based on their traditional communal African way of living, could have more social support which the researcher speculates could be affecting their coping strategies positively. Social support therefore would be a looked into in the present study to see what role it plays. It is hypothesized that social support exerts a direct effect on psychological adjustment so that the more effective the social support individuals have, the better will be their mental and physical health. Secondly, it has been hypothesized that social support moderates the effect of stressful life events. Further it indicates that both direct (health-sustaining) and stress

buffering (stress-reducing) effects of social support has been demonstrated with diverse subject groups. (Pretorius & Diedricks, 1994).

Cultural differences are often found in what is seen as a disorder, as its cause, and the suitable treatment. There is a great need to clarify and understand the strengths of black families, which can serve as a foundation for therapeutic work (Boyd-Franklin, 1989). It is necessary to differentiate between what is functional and dysfunctional in Black families who are treated in order to construct an accurate framework for the process of restructuring in family therapy.

There is a need in the work with Black families in particular to focus on the concept of empowerment as a central part of the treatment plan (Boyd-Franklin, 1989). The researcher hopes that a better understanding of these Black mothers' experiences, feelings, and perceptions will help refine treatment approaches and assessment of the mothers.

1.4. Research Questions

This section introduces the six research questions hoping to be answered by the present study.

1. Do Black Northern Sotho speaking mothers of children with behavioural problems cope differently from their English speaking White counterparts (control group)?
2. Do these Black mothers have more support than their control group?
3. Do the following factors: age of the mothers, age of the children, perceived state of health of the mothers, number of children and people in the household and

marital status significantly influence the Coping Scale score and the Social Support Scale score of the Black Northern Sotho speaking mothers?

4. How do Black Northern Sotho speaking mothers of children with behavioural problems view the problems? What meaning do they attach to the problematic behaviour(s)?
5. Does such a cultural view of the child with behavioural problems and the meaning attached to it help them cope?
6. Does society play a significant role in Black African mothers' ability to cope with the diagnosed children?

1.5. Aims of the study

This study aims at finding out whether Black Northern Sotho speaking mothers of children diagnosed with behavioural problems cope differently from their English speaking counterparts. Furthermore it aims at finding out whether the Black mothers have more support than their control group.

1.6. Objectives of the study

The objectives of this study are as follows:

1. To determine whether Black Northern Sotho speaking mothers of children with behavioural problems cope differently from their English speaking White counterparts (control group).
2. To determine whether these Black mothers have more support than their control group.
3. To find out whether the following factors: age of the mothers, age of the children, perceived state of health of the mothers, number of children and people in the household,

and marital status significantly influence the Coping Scale score and the Social Support Scale score of the Black mothers.

4. To elicit the Black mothers' view of the problems and the attached meanings of the causes of the disorders for the mothers.
5. To find out whether their cultural view of the child with behavioural problems and the meaning attached to it, help them cope.
6. To determine the most difficult concern the Black mothers have about their problematic children. To find out whether society plays a significant role in their coping abilities.

1.7. Background to the problem

Psychological literature supports the notion that children are a major source of stress for their parents. Particularly parents of children with behavioural problems, experience elevated levels of daily child-rearing stresses (Crnic & Aceveco, 1995). Childhood problems have a disabling effect in the person affected and the important people around the person are also affected in one way or another by the behaviour. Because behaviours are chronic, effort for treatment to be successful is required (Wicks-Nelson & Israel, 2000).

Little has been written about the experience from the parent's perspective, but recently some literature has begun to answer questions concerning the experiences of the parents (like what parents experience on a day-to-day basis; what kind of feelings come up for them; what impact the child's behaviour has on their relationships with other parents and their adult relationships; perception of problem and thoughts on it; how parents process their experience of living with a child diagnosed with behavioural problems and how their marital relationship is affected) (Webster-Stratton & Herbert, 1994).

Previous literature (Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000) focused on a deficit-approach especially in Western mothers. Studies mentioned above note the stress exerted on the mothers with children diagnosed with behavioural problems and the pathology that forms, with no focus on possible strengths in the mothers. This study will look at possible strengths in the Black African mothers with children diagnosed of behavioural problems.

The need to help mothers cannot be over-emphasised. For in the absence of proper intervention, the long-term outlook for behaviour-problem disorders is poor. It can be a problem when little is known from parents' point of view of the difficulties they encounter as they try to cope with the child's disorder, and as they try to manage stresses within the family system as well as accompanying stresses in their relationships outside individuals and agencies. Watchel (1994) states that one needs to use resiliency and growth potential of both children and parents and intervene actively to mobilize change that is at times not thought possible.

1.8. Previous studies

This section gives a brief review of the previous studies and the improvement and relevance of the present study in South Africa.

1.8.1. Prevalence of the negative view of Black families

Many of the early studies of Black American people and their families characterize them as 'disadvantaged, disorganized, deprived; some research even saw them as highly unstable and

approaching complete breakdown' (Boyd-Franklin, 1989). The family structure could itself be categorized as fundamentally pathological. This negative view of Black American people has been challenged by many researchers who are now exploring strengths in the well functioning of Black American families (Boyd-Franklin, 1989). This negative view of Black African Americans, which was common for Black South Africans as well, was due to lack of understanding of the Black African family structure.

The Black Africans' unique cultural experiences are shaped by traditional values, history and the current social status. This cultural experience is different from other cultures. The family structure has values and beliefs that are distinct from those of White cultures with the distinct being relationships to the non-immediate family members. Whereas white cultures view family as composed of immediate families, Black family systems utilize extensive kinship based support (Everett, Chipungu & Leashore, 1991). The family system of African Americans has been shaped not only by adaptation to the American historical and contemporary social experiences but also by a rich African heritage (Hale, 1982; Otto & Burns, 1983).

Most studies (Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000) of mothers of children with behavioural problems were done with samples that did not include South African Blacks, while in the present study the sample will be made only of Black South African Northern Sotho speaking mothers. Previous studies (e.g. Carpenter, 1999; Fischer, 1990; Mehl-Madrona, 2000) focused on pathology in mothers of children diagnosed with behavioural problems while forgetting that even though it can be difficult for the mothers, they at times have coping abilities. The present study would rather highlight these coping strategies. Although the study and concomitant findings will be limited and cannot be generalized to all South African

Black mothers, hopefully this will spur on future research that will help in intervention and treatment plans focusing on strengths and not weaknesses.

1.9. Structure of the Dissertation

The remainder of the dissertation is structured as follows:

Chapter 2 provides a background to the theoretical framework and gives the operational definitions and indicators. Chapter 3 is the literature review, while Chapter 4 is the Research methodology. Chapter 5 sets out the research hypotheses, and the results of the statistical tests are given and interpreted. Chapter 6 contains the discussion of the study, review of the study, implications, conclusion, and the chapter further points out the limitations and areas for future research.

CHAPTER 2

THEORETICAL CONCEPTS

2.1. Introduction

The objectives of this chapter are to define the key words used in the study and to give the theoretical basis of the present study.

2.2. Operational definitions and indicators

The key words to be defined are as follows:

Behavioural problems: can be referred to by many labels: behavioural disturbances; problematic behaviour; disruptive behaviour; behavioural dysfunction; psychological problems; abnormal behaviour; maladaptive behaviour; impairments; deficits; and psychopathology. Behavioural problems can be an impairment or dysfunction that causes distress to the person or increased risk of death, pain, disability or loss of freedom. These problematic behaviours are deviant from some standard and can be harmful to the individual. They can create difficulty for the people around the individual with these problems. When trying to help children with such problems parents' participation is often crucial (Wicks-Nelson & Israel, 2000).

Black African mothers: often referred to as Black mothers in the text, refers to mothers of Black nationality from South Africa.

Black African American mothers: mothers of Black nationality within the American culture.

Western White mothers: often referred to as White mothers in the text, refers to mothers without colour.

Coping: According to Folkman and Lazarus (1980) it is the cognitive and behavioural efforts made by an individual to master, tolerate or reduce external and internal demands that are caused by stressful transactions.

2.3. Theoretical Framework

The theoretical basis of the study is as follows:

2.3.1. A strength –based approach

There has been a shift from the commonly held view of a problem-orientated approach to a strengths-based approach (Howard & Dryden, 1999). In the problem-orientated paradigm [deficit approach] emphasis is on risk factors that define what is wrong, missing, or abnormal, while a strengths-based approach is characterized by its emphasis on capacities, competencies, strengths, and resources that exist within and outside the family, the individual or community. The deficit approach lens if used to view the world prohibits seeing strengths, resources or capabilities (Roepers, 2000 in Utesch, 2000).

Risk factors have historically been identified as biological, psychological, cognitive and environmental conditions impeding normal developmental (Roepers, 2000 in Utesch, 2000). This particular view labels individuals, families and groups according to the problems without recognizing strengths or competencies (Kaplan & Girard, 1994). Individuals or families are often seen as being unable to solve their own problems, cope, or achieve their own goals without outside resources. Risk factors have been consistently debunked as predictors of

individual success or failure (Werner & Smith, 1996). Going beyond the usual disease focus by exploring resilience or those factors that not only help sustain people through life's challenges, but help them grow and become stronger as a result makes an important contribution to our understanding of mental health.

Resilience is the human capacity to deal with stress and adversity and it should form a component of intervention. Today the increased bombardment of stressors makes one vulnerable and it becomes important to show how the affected can draw on supports, build inner strengths and acquire interpersonal and problem solving skills to deal with adversity. Resilience plus the strength-based approach delivers hope to individuals or communities faced with overwhelming challenges (Roeper, 2000 in Utesch, 2000).

The theoretical basis of this perspective cannot be attributed to one source or discipline but is a culmination of work in the areas of developmental resilience, healing and wellness, and constructionist narrative through the professions of social work, nursing, marriage and family therapy, clinical psychology, psychiatry, child development and education (Saleebey, 1996). A significant factor in the process of applying a strengths-based model is resilience, a phenomenon that has been studied extensively. Among the populations studied were children born into families with a mental illness (Goldstein, 1990); exposed to divorce; exposed to early parental death; high levels of maternal stress; addiction to drugs or exposure to family violence and rearing in poverty (Garmezy, 1991).

The literature on resilience is divided into two camps with one defining it as a cluster of individuals' skills and competencies, while the other states that resilience is more about the outcome result of an individual's effort to overcome adversity (Kaplan, 1999). Strength-based

approaches are developmental and process oriented. They identify and reveal internal strengths and resources (resiliencies) that exist within the individual, family, or group as they occur in specific problem contexts (Egeland, Carlson & Stroufe, 1993).

2.3.1.1. Strength-based applications

Several applications have been made of the strengths paradigm across many disciplines. Though intervention methods tend to be unique to specific circumstances, all applications have in common the premise of facilitating strengths over quantifying deficits. Psychologists need to move away from documenting failure to enhancing resilience (Utesch, 2000).

2.3.1.2. Limitations when transitioning to a strength-based perspective

Transition can be difficult because there is a tendency to rely upon programmes to create resilience instead of using programmes to facilitate strengths that capitalize on resilience factors that already exist. Building skills in order to enhance the outcome results of individuals labelled 'high risk' without addressing individual or contextual factors can be another obstacle in making the transition from deficits to strengths a successful one (Utesch, 2000).

2.3.1.3. Positives when transitioning to a strength-based perspective

Individuals must be perceived to be resilient and as possessing strengths before a strength-based approach can be successfully implemented. By emphasising strengths, the innate resilience of an individual is enabled to assist them in their attempts to overcome adversity. Members with strengths possess abilities and inner resources that allow them to cope effectively with the challenges of living. Individuals typically seen as hopeless and without

resources are presumed to be able to make significant positive strides when their own strengths and abilities are identified, emphasised, and built upon within the context of adverse conditions. When educators, mental health professionals and other helpers see people differently, they are given the opportunity to see themselves differently (Utesch, 2000).

Research on resilience has shed light on family protective factors and family recovery factors that appear to play a major role in promoting the ability of a family to maintain established patterns of functioning after being challenged by risk factors, and in fostering the family's ability to recover from misfortune or crisis (Utesch, 2000).

2.3.2. Theoretical framework of coping

Although a number of theoretical models exist, this study has adopted the theoretical framework postulated by Folkman and Lazarus (1980). Folkman and Lazarus (1980) stated that it is the cognitive and behavioural efforts made by an individual to master, tolerate or reduce external and internal demands that are caused by stressful transactions. In this case diagnosed behavioural problems in children constitute a stressful event that is demanding to both internal and external resources of the mothers of the children. Therefore it would be interesting to note the coping capacity of mothers with the stressful behaviour of their children, in spite of the other challenges presented by the environment (how they cope with their lives and the children's behavioural problems).

2.3.2.1. Social support

Leavy (1983) in a review of the literature pertaining to social support and psychological adjustment, indicates that both direct (health-sustaining) and stress buffering (stress-reducing) effects of social support have been demonstrated with diverse subject groups. From the standpoint of attachment theory, the empirically demonstrated link between attachment and social support is clear. Yet another approach is to categorize social support into several dimensions, such as the emotional support provided by close friends or family, support derived from "belongingness" to a group with a shared sense of identity, appraisal support offered by others in talking through problems, and tangible support or practical help (Horsten, Ericson, Perski, Wamala, Schenck-Gustafsson & Orth-Gomer, 1999; Orth-Gomer, 1998).

However, dimensional descriptions of social support usually do not distinguish whether social support is a property of the environment or of the individual. This is particularly problematic if the assessment of social support is based on self-report measures, because such methods are obviously tied to subjective perceptions. However, self-report bias is not necessarily a threat to the validity of such measures if one conceptualizes social support as a function of perception rather than an objective reality.

Defining social support in terms of an individual's perception of his/her social network is similar to the "felt security" component of secure attachment theorized by attachment researchers. Viewed in this way, the felt security that leads to the capacity to seek support and depend on others becomes characteristic of both secure attachment and sufficient levels of social support. With the shared foundation of felt security, an individual with high social support thus becomes conceptually identical to a securely attached individual (Bartholomew & Horowitz, 1991; Collins & Read, 1990). Defining social support in this way (i.e., as the

perception of support) seems to be popular among researchers, as indicated by the preponderance of studies using scales like the Social Support Questionnaire (e.g., Priel & Shamai, 1995; Sarason, Levine, Basham & Sarason, 1983), which makes the distinction between the number of people available as supports and the satisfaction derived from their support. It is satisfaction with the support received, rather than number of supports, that has been found to moderate the negative impact of stressors.

Social support can be defined as the existence or availability of people on whom we can rely, and who let us know that they care about, value and love us (Sarason, Levine, Basham & Sarason, 1983). The afore mentioned researchers argue that social support boosts individuals' sense of positive personal identity and self esteem by enabling them, when under stress, to “avoid internalizing diminished views of themselves” (p. S5).

Schumaker and Brownell (1984) hypothesised that social support exerts a direct effect on psychological adjustment so that the more effective the social support individuals have, the better will be their mental and physical health. Secondly, it has been hypothesised that social support moderates the effect of stressful life events (Pretorius & Diedricks, 1994).

2.3.2.2. Maintaining inner control

People differ in their perceptions of how much control they have over their lives. This perception of control is termed locus of control. It develops according to learning and experiences as one grows up. It can be re-evaluated and changed because locus of control is based on life perceptions (Kleinke, 1998).

Those who believe that most of what happens to them is beyond their control have an external locus of control and those who believe that most of what happens to them is their responsibility are called internals; they have an internal locus of control. Literature seems to support the notion that having an internal locus of control is adaptive in certain areas in life. Internals are independent and have a greater tendency to cope with stressful events with a problem-solving approach, especially when the stressful event is one over which they have some control (Parkes, 1984). They view situations as challenges to be solved; they know they have to take care of themselves. Externals are more likely to respond to stressful events that are controllable with fantasy and wishful thinking. External locus of control is commonly found in Black Africans while internal locus of control is found in Western White cultures.

My argument is that having a child with behavioural problems can be a life-event beyond one's control and attempting to cope using internal locus of control might lead to internalization and depression. Having a child with behavioural problems requires good coping skills to maintain feelings of competence and self-efficiency. In my view, a Black with traditional views (external locus of control; specific way of understanding the problems and specific treatments; extended family support; social support) stands a better chance at coping. This is because Blacks would have more social support, less pressures to 'cure' the child, less self blame, less internalization, less individualistic efforts to help the child, less rejection and marginalization. The extended family structure, because it is often characterised by the following, could be helpful to Black mothers with behavioural problematic children (Nzimande, 1996):

1. The structure links a wider circle of people who are related by blood or marriage in a network of relatives who normally identify with and care for one another.

2. It is more durable as a social unit than the nuclear family and continues over a long period of time.
3. Its growth and decline over the years is affected by fertility, marriage, divorce and mortality.
4. In many societies it acts also as an effective social welfare system by providing care and support for a variety of categories of dependent people.

The wide circle of relatives in the Black family structure is still expected to lend a helping hand as a support measure in hardship and distress. Caplan (1976) refers to the family as an extended network of relationships through birth and kin which functions as an important social support structure where helping behaviour can be exercised. Through a set of prescriptions, values and socialization patterns, a sense of social obligations for mutual assistance is created and exercised.

Among Black people the family, however seen, is ranked as the primary source of support. Generally in terms of their culture, Black people relate to one another collaterally i.e. individuals identify more with the family group than with individual values of the family group. The nuclear family in Black society is thus not the same in Western society as it is bound by traditional values and obligations.

Further the support system in the Black family has its basis in the extended family structure (Nzimande, 1996) provides emotional support that is described as “information that one is cared for and loved”; esteem support that refers to the “information that one is valued and esteemed”; network support, that is, “information that one belongs to a network of mutual obligation” and socio-economic support. The Black African family has for a long time

advocated care for their children without the recognition of the larger society. More importantly, intervention programmes (e.g. The child welfare community in the African American community) have never involved, consulted with, or co-operated with the Black African community. Only with open communication, understanding and involvement can the Black African community serve as a resource for intervention programmes and in return can obtain improved services for the larger systems (Everett, Chipungu & Leashore, 1991).

2.4. Conclusion

This chapter has indicated all the theoretical concepts and it further gave the theoretical framework to be applied in the study.

CHAPTER 3

LITERATURE REVIEW

3.1. Introduction

This chapter provides an overview of some of the research into coping strategies and the difficulties of having children diagnosed with behavioural problems. Hopefully this will not only highlight the effect on mothers of children diagnosed with behavioural problems, but will also highlight the importance of continued research into the area.

3.2. Summary of behavioural problems

Substantial evidence supports two general clusters of behaviours or characteristics in children with behavioural problems. The groups are internalizing and externalizing syndromes. The externalizing syndromes are often labelled as under-controlled and the characteristics frequently associated with this pattern include: fighting, temper tantrums, disobedience, and destructiveness. The second grouping often labelled internalizing syndromes (often referred to as over control, or anxiety withdrawal) has descriptions such as anxious, shy, withdrawn, and depressed. A third group of syndromes which is composed of neither internalizing nor externalizing is called mixed syndromes (Wicks-Nelson & Israel, 2000).

According to Culbertson & Silovsky (1996); Sadock & Sadock (2003); and Webster- Stratton & Herbert (1994) disorders that usually present with behavioural difficulties, which can be grouped into the above syndromes, include:

1. Learning disorders (LD) such as reading (dyslexia), mathematics (dyscalculia), written expression (dysgraphia), and social-emotional disorders (social-emotional LD).
2. Mood disorders: Para suicide and depression disorders (cyclothymic, Major depression, and schizoaffective).
3. Phobia and anxiety disorders: Separation anxiety; panic disorder; social phobia; selective mutism; specific phobia and adjustment disorder.
4. Attention deficit and disruptive behaviour disorders: Attention Deficit Hyperactivity Disorder (impulsive, inattention or combined type); and other disorders overlap with ADHD such as oppositional defiant disorder (ODD) and conduct disorder (CD). ODD children are irritable and actively defiant towards parents and teachers whereas children with CD exhibit non-violating behaviour (aggression, stealing and property destruction).
5. Elimination disorders: encopresis and enuresis.
6. Mental retardation (MR): can be mild, moderate, severe, or profound.
7. Sleep disorders: Nacrolepsy, nightmare disorder, night terror disorder and sleep walking disorder.
8. Childhood disorders not otherwise specified.
9. Other conditions requiring clinical attention: relational problems, problems related to abuse or neglect, borderline intellectual functioning, academic problem, antisocial behaviour and identity problem.

3.3. The experience of having a ‘problem’ child

The behaviour of diagnosed children can contrast with expected normal behaviour; and the behaviour can range from inattentiveness and poor concentration to impulsive outbursts of violence and aggression, defiance, argumentativeness and continued disobedience (American Psychiatric Association [APA], 1994). Such a child can be highly tyrannical, destructive, oppositional and defiant; and at other times loving, intelligent, understanding and sensitive. They could disregard parental requests, commands, and rules; fight with siblings; disturb neighbours; and have frequent negative encounters with school teachers. They have problems paying attention, controlling impulses and modulating their activity level. At times their behaviours may be age-inappropriate due to some retardation. These problems can manifest in early childhood and continue through to adolescence and adulthood.

The families can feel out of control, develop negative interactions with their children, and the parents can be disempowered or cope ineffectively with the child. If the severity of the child’s symptoms increase, the mother’s frustrations are likely to worsen. Displayed behaviour can be very difficult, that plus the difficulty in understanding the disorder (causes thereof) can often lead to distress or even pathology for the caretakers, specifically the mothers (Webster-Stratton & Herbert, 1994). Treatment interventions are not simple, they include working with the parents, and they are time, money and effort consuming. It can be difficult to differentiate whether the disorder traits are part of development, since some patterns of behaviour can be common to developmental traits (Webster-Stratton & Herbert, 1994). Characteristics of the behaviour disorders in childhood can be chronic in nature, and not be accounted for by physical, mental, or emotional cause (Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000).

3.4. Difficulties with disorders in children

Misunderstanding of the disorders leads to negativity toward child and at times parents. For good prognosis, early intervention is required as early as pre-school year, which is at times not the case. It can be costly to treat; can create parental guilt which causes parents to feel they have done something to create these problems, also parents can withhold basic, necessary information to help the child (Webster- Stratton & Herbert, 1994). Some problems cannot be treated.

3.5. Consequences of childhood behavioural problems

Complaints of the child as 'useless', 'naughty' or 'difficult' could occur and this sort of labelling of the child can affect the family (the child, the parents or siblings). Blaming from others and at times self-blame by the mother can occur due to colloquialisms used to describe such children (including naughty, useless, vegetable-like, cheeky or hyperactive). When the child is observed, questions like "who/where the mother is," are often asked; implying a lot of unspoken judgment which can be internalized by the mother (Webster- Stratton & Herbert, 1994).

The behavioural problems are usually viewed in the parenting skills-deficit model which when adhered to leads to conscious or unconscious attribute of blame to the parents, ignoring the stressful factors (over which parents have little or no control) in the family's situation that have lead to and therefore explain the breakdown in parenting skills. Though the deficit model has helped develop effective interventions, it short-circuits understanding of behaviour-disordered

children families and does not help us understand what it is like to be a parent of these diagnosed children (Webster-Stratton & Herbert, 1994).

Studies (for e.g. Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000) show that mothers of children with behavioural problems have higher rates of psychological difficulties and seek treatment for personal psychopathology significantly more often than mothers of normal children (Fischer, 1990). Parental adjustment can be maladjusted. This is indicated in that higher rates of depressive symptoms, increased alcohol consumption, strained personal relationships and increased marital discord in comparison to mothers of 'normal' children are also reported.

Other reported complications include higher levels of maternal anxiety, depression, feelings of being restricted in parental role, a decreased sense of parenting competence, poorer parent-child attachment, and negative relationship with spouse, and increased level of family related stress (Fischer, 1990).

3.6. Problems of care giving

Caregiver strain is well documented in studies that deal with helping those that have been traumatized, chronic illness sufferers and sufferers of HIV/AIDS and many other distressing situations. The impact of care giving was found to range from the negative extreme to the positive extreme depending on multiple factors guiding the process of healing for those who are being cared for. Results from a study by Folkman, Chesney, Cooke, Boccellari & Collette (1994) showed that HIV + caregivers reported more burden and, compared with the HIV – caregivers, they were more religious or spiritual, had less income, and coped by using positive reappraisal and cognitive escape-avoidance and by seeking social support.

According to Folkman (1997) a study of the caregiving partners of men with AIDS showed that in addition to intense negative psychological states, these men also experienced positive psychological states in the midst of enduring and profoundly stressful circumstances. This indicates the researches point that there could be both negative and positive psychological states, and this has important implications for our understanding of the coping process.

Similar position of coping following how one feels has been noted by Folkman and Lazarus (1988). They found in their study that people's emotions determine the strategy they'll choose for coping. According to Folkman and Lazarus (1988) some strategies of coping in caregiving are associated with increases in positive emotions and other forms associated with increase in negative emotions. They maintain that the way people in care-giving roles cope with the demands of a stressful event, make a difference in how they feel emotionally.

In Folkman and Lazarus (1988) study on coping as a mediator of emotion, four types of coping that were strongly associated with changes in emotion were identified viz. planful problem-solving, positive reappraisal, confrontive coping and distancing. Planful problem-solving was associated with an improved emotion state that is, it was associated with less negative emotion and more positive emotion. One explanation from the study for this association is that people can begin to feel better when they turn to the problem that is causing distress. Another explanation is that, when effective, it can result in an improved person-environment relationship, which should in turn lead to a more favourable cognitive appraisal and hence a more positive emotion response.

Confrontive coping, unlike planful problem solving is consistently associated with worsened emotions. Findings suggest that expressing anger and hostility may make one feel worse and

leads to unfavourable encounter outcomes. Positive reappraisal and distancing, theoretically, should help reduce distress. Research findings contrary to expectations showed that distancing contributes to a worsened emotion state. One explanation is that the reduction of distress achieved cognitively through distancing and positive reappraisal may be difficult to sustain. Not only might distancing fail to diminish distress it could even divert attention from the needed problem-solving and lead to further distress.

Although it is tempting to argue from the above that planful problem-solving is an inherently adaptive form of coping and confrontive and distancing are inherently maladaptive. It is important not to lose sight of the principles that the adaptive value of a coping process often depends on the context. Thus planful problem-solving can be maladaptive if people use it in circumstances where nothing can be done to alter the outcome and confrontive can be adaptive when the situation calls for another to act. It can be concluded that both coping strategies are associated with changes in the emotions (Folkman & Lazarus, 1988).

Mothers of children in the present study have a caregiver role of children with behavioural problems. The impact of their caregiver role need to be investigated to inform intervention strategies about the route to take to empower mothers with beneficial coping skills when such children are presented for professional help.

3.7. Cultural contextualization

3.7.1. Cultural standards

Culture can influence the way the parents view problematic behaviour and this makes the evaluation of child quite subjective. It is valuable information at times that is given because they can state whether their child's behaviour is 'good, poor, or average' compared to other

parents' children in the neighbourhood and whether their behaviour at home is acceptable (Groth-Manart, 1997).

A study in Wicks-Nelson and Israel (2000) showed that cultures might influence the degree to which childhood problems are considered serious. Culture can also influence how the behaviour problems are explained (internal or external loci of control), how they are treated and how the problems affect the parents (how problems are experienced, how they make the parents feel). Culture imposes a particular framework of interpretation that is sustained not by direct observation but rather by myths. Variance occurs in the degree to which behaviours are experienced as disruptive or place excessive burden on the caretaker.

3.7.2. Situational standards

People are expected to act in certain ways based on gender, situation and changing societal values. These norms or expectations are some of the additional factors that together with cultural standards can affect parents' reactions to children's' behaviour (Wicks-Nelson & Israel, 2000).

3.7.3. Specific African cultural values that differ from traditional Western values

Blacks, like any other culture, have their own values, which prescribe the way they live and socialize with their children (Mashego, 2000). Some values are similar but many differ from other cultures. The following section deals with some of the Black Africans' values, which help contextualize ways of dealing or coping with crisis situations, which can include having a child with behavioural problems. Typical values relevant to the study include: maintenance of close contact with the extended family, group orientation (collectivism and Ubuntu), value of children and extended family units, value of ancestral worship, mysticism and belief in the

strength of traditional healers, external locus of control, and view of witchcraft or supernatural powers as cause for illness (Mashego, 2000).

There is cultural diversity among Black people in South Africa but in spite of the diversity certain cultural similarities are found. Some similarities are even found between South African Blacks and American Blacks and this is due to the shared African heritage. The similarities include: development and utilization of extensive kinship-based support systems as a “natural” coping mechanism and resource for families. These primary group support systems enable the exchange of goods and services, the sharing of emotional life, and the protection of members (Everett, Chipungu & Leashore, 1991).

3.7.4. Collectivism

Hofstede (1991) defined collectivism as a concept applicable to societies wherein people are integrated into cohesive groups, which continue to protect and help each other. This is in contrast with individualism characteristic of Western cultures, which, as seen by Hofstede (1991), is comprised of loose ties between individuals, where everybody is expected to look after oneself and/or immediate family. These definitions show the different foci that the two groups have about families, extended family relations and ties (Mashego, 2000).

Collectivistic cultures have more emphasis on group goals and maintenance of harmony, cohesion and co-operation and less emphasis on personal individual needs, goals and desires (Matsumoto, 1996). This focus on group goals is referred to as ‘Ubuntu’. Values differ between dominant groups (Western specifically white in South Africa) and others (Black Africans). The latter due to their communal way of living and high value they place on own culture may not be affected by perceived rejection from dominant group if support from home is enough.

In this study culture is expected to influence the understanding of the cause of the disorder; what is seen as the problem; what is seen as important; what is seen as the best treatment; the mother's feelings and reactions; the community's reactions and the family's reactions. A collectivistic view of life can provide a necessary support system that provides emotional support (useful when one needs someone to confide in); tangible support (useful when one needs assistance with a job); informational support (useful when one needs information or advice); and belonging support (provides one with a sense of belonging (Kleinke, 1998). Good support can bolster self-worth, trust and life-direction. It can help one become a better 'coper' by inspiring one to do one's best in dealing with life challenges. A third benefit of good support is the companionship it provides in making one's life more enjoyable (Kleinke, 1998).

Extended families are co-operative and enduring units in which affection is not contingent on performance; rather, feeling and morality govern the relationship among its members. Despite a history of oppression, bondage and unfairness, Africans' spiritual beliefs fostered interdependence and collective responsibility for family well-being. Informal adoption is one manifestation of this collective responsibility. Institution of family was never destroyed during the hard times; instead it existed as a mechanism of coping and surviving. As a kinship help system, extended families attend to the expressive and instrumental needs of their members, becoming mechanisms for coping with the exigencies of life (Everett, Chipungu & Leashore, 1991).

The Black African family's major component for survival is this 'kinship help system'. This is a network of relatives, friends, and neighbours providing one another with emotional and economic support and acts as supplements and protection for the family. It acts as a buffer against negative environmental forces and provides a pattern of responses for coping with

external stress by supplementing nuclear family units (McAdoo, 1978), by providing for example, nurturance, material assistance and aid in time of need. The quality of care for children increases when the extended family is involved. The extended-family organization is a coping mechanism activated by the high incidence of poverty, unemployment, extramarital births, and marital dissolution in the Black African community (Everett, Chipungu & Leashore, 1991).

3.7.5. Mothering role in Black families

Many Black women place an extremely high value on motherhood. Boyd-Franklin (1989) found repeatedly in her work with Black women that no matter how problematic their early years may have been or how much they value their careers, they feel strongly about the need to raise children. Motherhood is then a very important part of the role image of many Black women. It is however a 'complex, compounded image' not an isolated activity, i.e. it is shared with others. Mothers grow up in multigenerational models of 'mother' and multimothering is common in the sense that many that raise their children away from extended family create 'substitute mothers, grandmothers and babysitters'. With young motherhood, teenage pregnancy or children born out of wedlock, the children are cared for and raised within the extended family network (in both South Africans and American Blacks) unlike in Western cultures (Boyd-Franklin, 1989).

Generational concerns also play a role in which older Black women (age 60 years and above) have the expectation that they will always mother. They know that even if they are working the well being of their children requires reciprocal help with baby-sitting and childcare. In addition to that the grandmother role is central to Black families and can be a complex and complicated

role. It is also a crucial role in childcare because through informal adoption situations the grandparents at times raise children. The grandparents are then a major source of strength and security for the Black children (Boyd-Franklin, 1989). The way mothering is not individualistic but a communal occurrence especially in the extended family of Black Africans might be a strength that helps them cope with the children with behavioral problems.

Black African families as currently constructed are viewed as models of resistance and survival. Family survival depends on the interchangeability of parental roles and functions among adult family members, particularly grandmothers. Grandmothers provide continuity and consistency (Everett, Chipungu & Leashore, 1991).

3.7.8. Context of the Black African family

Certain traditional traits are typical in the Black African and these are as follows:

1. A familial interaction network and a kinship of help and support characterize the Black African extended family.
2. Values of spirituality and collectivism exist in varying degrees in Black African families. Spirituality refers to the belief that the universe is basically one nonmaterial and interconnected element (McCombs, 1995).
3. Spiritual values are the moral and religious influences on behavior that lead a person to be respectful of life, harmonious of nature, and connected with others.
4. Collectivism refers to the belief that human survival depends on the group as opposed to the individual. The basis of collectivism lies in the notion that the individual owes his or her existence to other members of the family. The individual exists when they are part of the collective unity (Nobles, 1980).

From the above it can be concluded that both spirituality and collectiveness facilitate helping

responses and a sense of responsibility for individuals and communities. When extending help to Black Africans, recognition and integration of the resilient and protective aspects of Black African community life are essential. Giving advice and guidance to adults occurs frequently in African families. Family members often turn to their elders for counsel on job choices, children and decisions concerning their children (Martin & Martin, 1978; McAdoo, 1981). This process is significantly different from the way decisions are made in white families. This type of decision-making occurs easily within Black African families because the style is consistent with the structure of the family and respect for authority.

3.8. The occurrence of similarities and differences between cultures

As much as differences are seen in values between Western and Black it does not mean there is an either-or-position. Similarities could be due to some universal (or commonly shared) psychological or structural factors. There is a need to discover underlying behaviours and strengths that may be shared to some extent. Strengths specific to the Black African cultures may or may not help the Black African mothers cope with their children and these need to be explored (Kagitcibasi, 1996).

Change is occurring, but in groups with rigid boundaries, we may find that intervention with Black African children and their mothers is complex. Nonetheless, Black Africans also need therapeutic intervention; but a therapist should not just assume that because literature says there is pathology in Western mothers with children diagnosed with behavioural disorders that Black African mothers would automatically indicate pathology. This implies that pathology should also not be automatically indicated in all the White Western mothers before proper investigation is done. Further, if there is pathology, one should not make the mistake of

assuming that it develops in Western White and Black Africans for the same reasons (Kayongo-Male & Onyango, 1994).

Even though situations change due to urbanization, certain traditional views appear to be internalized and certain practices are still visible (Kayongo-Male & Onyango, 1994). It was even shown by several researchers that urban transition did not deter family development, specifically the role played by the extended family (Everett, Chipungu & Leashore, 1991). For example the typical Western view that a child belongs to the parent is still not common with some Black African parents. Formally adopting a family member is not common in traditional Black African families.

Certain traits unique to the Black African culture can be beneficial to the Black Africans' psychological state, for example, the influence and increased interaction in Black Africans can elevate a person's mood and their closeness can create an increased number of people to help with the children. External locus of control and collectiveness, seen in most Blacks, can remove the mother from blaming self, and thereby making the child's behaviour her problem, instead she might view the problem as being due to some external cause and for the community to sort out thereby creating a coping mechanism. These aspects need to be looked at to see how they could influence the diagnosed children mother's view of self and psychological functioning (Carpenter 1999; Harrison & Sofroff, 2002).

3.9. Conclusion

Because I am not aware of any studies that have considered coping strategies of Black African mothers of children diagnosed with behavioural problems, specifically in South

Africa, the following hypotheses have emerged from the available literature or rather from the lack of sufficient current literature on the topic:

3.9.1. Hypotheses

Hypothesis one: Black African mothers of children with behavioural problems cope better than their control group.

Hypothesis two: Black African mothers of children with behavioural problems have more Social Support than their control group.

CHAPTER 4

RESEARCH METHODOLOGY

4.1. Introduction: Rationale for the choice of methods used

In choosing a research design, the appropriateness of the chosen methods used to carry out the research must be demonstrated. Furthermore, there should be built-in flexibility in the design to enable the researcher to include elements of the traditional plans, as well as the right to modify the plan during data collection (Marshall & Rossman, 1995). The present study used a quasi-experimental method by combining qualitative and quantitative data. The qualitative method was used to collect data of the mothers' understanding of the children's behavioural problems and to elicit any cultural influence on the results. The quantitative method was used for collective data on the Ways of Coping Scale and the Social Support Scale. Both the quantitative and qualitative methods constituted a triangulation of methods and findings.

4.2. Methods Used

4.2.1. Qualitative methods

The qualitative methodology is an anti-positivistic approach which discards the notion of an external objective reality. It aims at understanding reality by discovering the meanings attached by people to the settings. To qualitative researchers behaviour is intentional, creative and can only be explained and not predicted (De Vos, 1998). It is defined as a "multi-perspective" approach (utilizing different qualitative techniques and data collection methods) to social interaction in terms of the meanings that the subjects attach to it (De Vos, 1998).

In this study the qualitative method was used (the in-depth interviewing guiding schedule) to deal with the issues the mothers of children with behavioural problems might have around the child's behavioural problems and to illustrate any cultural influence on the findings. The aim is commensurate with selecting a method that will deal with a topic in an exploratory nature way. The in-depth interview is described as "conversation with a purpose" (Kahn & Cannell, 1957,

p. 149). The fundamental assumption in this method is to converse with the aim of exploring the general topics in order to uncover the respondents' meaning perspective. By using this method, the researcher respects the respondents' own framing and structuring of responses. The phenomenon studied should unfold in accordance with the participant's way of viewing the phenomenon and not the researcher's view.

4.2.2. Quantitative method

This is a positivist approach to research that aims at objectifying data. The Ways of Coping scale was used in this study as an objective scale aimed at quantifying the coping strategies of the two groups of mothers. The Social Support Scale was used in this study to quantify perceptions of social support.

4.2.3. Triangulation of method

The concept of "methodological triangulation" is used to describe techniques attempting to obtain a rounded picture of a particular phenomenon by studying it from multiple viewpoints, drawing on different data sources, and involving different research methods. The two most common triangulation methods are those of triangulation by different sources and that of different methods (Kopola & Suzuki, 1999).

The rationale for using triangulation was to validate findings. Triangulation is a verification method which is aimed at enhancing the credibility of findings and the interpretations thereof. The use of multiple methods is a form of triangulation in which different types of data provide cross-validity checks (Patton, 1990: 188).

4.3. Sampling

The sample in the present study consists of an experimental group and a control group.

4.3.1. Experimental group

Forty-eight Northern Sotho speaking Black African mothers with children diagnosed with behavioural problems were drawn using the convenience sample method. Participants were drawn from clinical populations in public hospitals in the Limpopo Province (Mankweng, Polokwane, Groethoek, and Lebowakgomo Hospitals). All participants were given the written part of the questionnaire but only ten from the forty-eight were interviewed using the in-depth-interviewing schedule. The ten were selected by choosing every fifth numbered participant from the experimental sample group until the tenth participant.

4.3.2. Control group

Thirty-two English speaking White mothers with children diagnosed with behavioural problems were drawn using the convenience sample method. Participants were drawn from clinical populations in public hospitals in the Limpopo Province (Mankweng, Polokwane, Groethoek, and Lebowakgomo Hospitals). All thirty-two participants were given the written part of the questionnaire, but only ten from the thirty-two were interviewed using the in-depth-interviewing schedule. The ten were selected by choosing every fifth numbered participant from the control sample group until the tenth participant.

The sample consisted of forty-eight Black mothers and thirty-two mothers because of the uneven distribution of the races in the population sample. There are more Black Northern Sotho speaking people than White English speaking people in the study population, which made it difficult to get an equal number of the mothers.

4.4. Instruments

A questionnaire was given with sections on bibliographical data of the mother and family (For more information see Appendix A, Section A); Social Support Scale (Sarason, Levine, Basham, & Sarason, 1983); Ways of Coping Scale (Billings & Moos, 1981) and an in-depth interviewing schedule (For more information see Appendix A, sections B-D).

4.4.1. The Social Support Questionnaire

Questions in Appendix A section B of the questionnaire are based on the Social Support Questionnaire. It has been used in South Africa by various researchers (Edwards & Besseling, 2001; Moller, Fouladi, McCarthy, Hatch, 2003; Pretorius, 1996; 1997). The Social Support Questionnaire (SSQ) was developed to measure the number of social supports as well as satisfaction with social supports (the degree of perceived support from one's family and friends) (Sarason, Levine, Basham, & Sarason, 1983). It consists of 27 items. Sarason et al. (1983) reported good test-retest reliabilities ($r = 0.90$) and high internal consistency ($\alpha = 0.97$). Pretorius and Diedricks (1994) reported good test-retest reliabilities and high internal consistencies (both $r = 0.95$) with a sample of South African students.

4.4.2. Ways of Coping Scale

Ways of Coping Scale is an empirically derived inventory of specific ways in which people might cope with a specific stressful event. This scale measures the thoughts and actions people use to handle stressful encounters and identify the processes people use to cope with stressful situations. It can help counselors work with clients to develop practical coping skills by evaluating their processes, their strengths and weaknesses, and providing models of alternative coping mechanisms. A revised version of Coping Strategies by Billings and Moos (1981) was used to measure the coping strategies of mothers of children in the samples. The scale has 32-item measures of three coping strategies, namely, active behavioural strategies (13 items); active cognitive strategies (11 items); and avoidance strategies (Holahan & Moos, 1987). Each item on the scale will be rated on a three point scale, ranging from “not at all” to “regularly”. Studies (Billings & Moos, 1981; 1985) have been conducted to establish the validity of each set of coping items. Cronbach’s alphas of 0.62 for active cognitive-coping, 0.74 for active behavioural coping, and 0.60 for avoidance coping were established for the scales, a fact that reflects a psychometrically acceptable internal consistency. This scale is valid since it has been used in South African studies (such as Boya, 1990; Brink & dela Rey, 2001; Eagle, 1987; Govendor & Killian, 2001; Moran, 1994). For more information see Appendix A, Section C.

4.4.3. In-depth interviewing schedule

The in-depth interviewing schedule explores general topics in order to discover the mother’s meaning perspective of her child’s behavioural problems and to illustrate any cultural influence on the results. Questions 1 to 13 in Appendix A section D is the in-depth interviewing schedule. Questions are asked to elicit the patient’s explanatory model. These

are based on questions seen in Sadock and Sadock (2003). For more information see Appendix A, Section D.

4.5. Procedure

4.5.1. The questionnaire was translated from English into Northern Sotho by a Northern Sotho-speaking translator and then back-translated into English by another translator. The accuracy of the translation was subsequently checked by a university lecturer in Northern Sotho. Back-translation technique was used to ensure consistency of meaning amongst the English and the Northern Sotho versions of the questionnaire.

4.5.2. When, both the experimental and control groups, brought their children to the hospitals the purpose of the research was explained to them and they were given a choice either to participate or not. If they agreed to participate they signed consent forms. They were then comfortably seated in a room where they were given the questionnaire, by a trained research assistant, to complete. The research assistant was seated in the room in case they had any questions. The experimental group was given a choice of language (English or Northern Sotho) in which to complete the questionnaire.

4.5.3. After completion of the written part of the questionnaire, if the participant from the sample was to be one of the ten to be interviewed, they would then be interviewed using guiding questions (see Appendix A Section D). The interview was recorded.

4.5.4. A time limit of an hour was given for completion of the questionnaire. The short interview was given a time limit of twenty minutes. If some participants did not have the time on the specific day, it was then arranged that they fill in the questionnaire and be interviewed on another day. After completion of the questionnaire the participants were given some refreshments.

4.6. Data analysis

First of all, coding of the scale items and the attached meanings was done. The scores of the two groups on The Ways of Coping Scale and the Social Support Scale were compared with each other quantitatively using the ANOVA-test and the *t*-test. The SPSS (SPSS, 2000) statistical package was used. The recorded interviews were then transcribed and thematic analyses of the interviews were done by the researcher. The tape recording was then given to a second person to listen to and to repeat the above process for the sake of validation. The themes from the in-depth interview were taken together with the scores from the Ways of Coping Scale and Social Support Scale to observe the relationship between the mothers' meaning and understanding of the children's behavioural problems, cultural influence on the findings, the total effect of the children's problems, the mothers' perception of social support system and the coping strategies. Further Multiple Linear Regressions analysis was done using the Stepwise Method (SPSS, 2000) to determine whether the following independent factors or variables in the biographical section for the experiment group (age of the mothers; age of the children; state of health of the mothers; number of children; number of people in the household and marital status) significantly influenced the Coping Scale score and the Social Support Scale score respectively.

4.7. Ethical considerations

The purpose of the study was explained to mothers and it was their choice to participate; consent forms were signed by the mothers. Confidentiality and anonymity were respected. There were no risks or discomfort and provision (referrals to the available psychological and

support services in the various hospitals) was made for mothers who needed counselling or psychotherapy.

4.8. Conclusion

The aim of this chapter was to give the background of the procedure that was to be followed in collecting and analysing the data. Further, it was to give background of the instruments used in the study.

CHAPTER 5

RESULTS

5.1. Introduction

This chapter illustrates the various tables of the research results.

Table 1 represents the sample size of the participants.

Table 1: Sample size of the participants

Race	Frequency	Percent	Valid Percent	Cumulative Percent
Black	48	60.0	60.0	60.0
White	32	40.0	40.0	100.0
Total	80	100.0	100.0	

There are more Black participants than the White participants (mothers) in the study because the area where the sample was collected is predominantly populated by Black people. All mothers were employed and had matric, and some sort of further education.

Table 2 that follows presents the frequencies of number of children in the participants' households

Table 2: Number of children in the participants' households

Race	Number of children	Frequency	Percent	Cumulative Percent
Black mothers	One	6	12.5	12.5
	Two	16	33.3	45.8
	Three	16	33.3	79.2
	Four	3	6.3	85.4
	Five	5	10.4	95.8
	Six	2	4.2	100.0
	Total	48	100.0	
White mothers	One	3	9.4	9.4
	Two	9	28.1	37.5
	Three	14	43.8	81.3
	Four	3	9.4	90.6
	Five	1	3.1	93.8
	Seven	2	6.3	100.0
		Total	32	100.0

Results in Table 2 indicate that most of the participants from both groups tended to have two or three children.

Table 3 that follows presents the mean and standard deviations for the participants' ages

Table 3: Mean and standard deviations for the participants' ages

Race		Age of the mothers
Black	Mean	40.92
	N	48
	Std. Deviation	3.107
White	Mean	42.03
	N	32
	Std. Deviation	3.157

Table 3 indicates that the mean score for the White mothers (mean score= 42.03) was slightly higher than that of the Black mothers (mean score = 40.92).Table 4 that follows presents the mean and standard deviations for the participants’ responses to age of the child with behavioural problems.

Table 4: Mean and standard deviations for the ages of the participants’ children with behavioural problems

Race		Age of children
Black	Mean	5.67
	N	48
	Std. Deviation	2.444
White	Mean	6.13
	N	32
	Std. Deviation	2.498

The above table shows that the mean age of the White mothers’ children (mean score= 6.13) was slightly higher than that of the Black mothers’ children (mean score = 5.67).

Table 5: The behavioural problems as reported by the mothers

The children’s problems were categorized in the following categories based on the mothers’ subjective reports of the children’s behavioral problems.

Behavioural problems reported	Number of children
Traits of Attention deficit and disruptive behaviour disorders: Attention Deficit Hyperactivity Disorder (impulsive, inattention	

or combined type)	19
Other disorder traits that overlap with ADHD such as oppositional defiant disorder (ODD) and conduct disorder (CD). ODD children are irritable and actively defiant towards parents and teachers whereas children with CD exhibit non-violating behaviour (aggression, stealing and property destruction).	14
There were children with traits of social-emotional disorders (social-emotional LD)	10
Phobia and anxiety disorder traits such as: Separation anxiety; panic disorder; social phobia; selective mutism; specific phobia and adjustment disorder.	13
Traits of Childhood disorders not otherwise specified and other conditions requiring clinical attention were found as well and these included: relational problems, borderline intellectual functioning, academic problem and children displaying problems due to their dysfunctional families.	24
Total	80

In general table 5 illustrates that the externalizing syndromes (included: fighting, temper tantrums, disobedience, and destructiveness); the internalizing syndromes (which has descriptions such as being anxious, shy, withdrawn, and depressed); and syndromes which are composed of neither internalizing nor externalizing (called mixed syndromes) were found in the children of mothers from both groups of the sample.

Table 6 that follows presents the frequencies of the participants' perceived level of health.

Table 6: Frequencies of the level of health for the participants' perceived level of health

Race	Level of health	Frequency	Percent	Cumulative Percent
Black mothers	Good	37	77.1	77.1
	Satisfactory	9	18.8	95.8
	Poor	2	4.2	100.0
	Total	48	100.0	

White mothers	Good	23	71.9	71.9
	Satisfactory	8	25.0	96.9
	Poor	1	3.1	100.0
	Total	32	100.0	

Table 6 indicates that most of the participants from both groups rated their health as good. Table 7 that follows presents the frequencies of the number of people in the participants' households.

Table 7: Frequencies of the number of people in the participants' households

Race	Number of people in current household	Frequency	Percent	Cumulative Percent
Black	Three	7	14.6	14.6
	Four	13	27.1	41.7
	Five	11	22.9	64.6
	Six	9	18.8	83.3
	Seven	5	10.4	93.8
	Eight	3	6.3	100.0
	Total	48	100.0	
White	Three	4	12.5	12.5
	Four	8	25.0	37.5
	Five	9	28.1	65.6
	Six	7	21.9	87.5
	Seven	2	6.3	93.8
	Nine	2	6.3	100.0
	Total	32	100.0	

Table 7 shows that mostly the number of people in the sample participants' households generally ranged from four to six.

Table 8 presents the frequencies for the marital status of the participants.

Table 8: Frequencies for the marital status of the participants

Race	Marital status	Frequency	Percent	Cumulative Percent
Black	Married	32	66.7	66.7
	Divorced	4	8.3	75.0
	Cohabiting	9	18.8	100.0
	Widowed	3	6.3	81.3
	Total	48	100.0	
White	Married	28	87.5	87.5

	Separated	1	3.1	90.6
	Cohabiting	3	9.4	100.0
	Total	32	100.0	

Table 8 indicates that most of the participants are married. Table 8 that follows is a presentation of the mean and standard deviation scores for scores on the Coping and the Support Scale.

Table 9: Mean and standard deviation for scores of the Support Scale and the Coping Scale

		Coping Scale	Social Support Scale
Experimental Group (N = 48)	Mean	12.62	11.58
	Standard deviation	2.734	5.794
Control Group (N = 32)	Mean	12.69	8.28
	Standard deviation	4.146	3.665

The above table indicates that the mean score of the experimental group on the Social Support Scale is higher than that of the control group, while the mean score of the control group on the Coping Scale is higher than that of the experimental group. These scores were tested statistically, and will be discussed next.

5.2. Hypotheses Testing

Hypothesis one: Black African mothers of children with behavioural problems cope better than their control group.

Table 9 that follows is the Table for the *t*-test on the Coping Scale.

Table 9: *t*-test Table on the Coping Scale

	Test Value =					
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	0					
	<i>t</i>	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Coping	33.820	79	0.000	12.65	11.91	13.39

Table 9 indicates that there is a significant difference ($t = 33.820$, $df = 79$, $p < 0.05$) between the group's scores on the coping scale. However Hypothesis one is rejected since contrary to expectations, the control group scored higher (mean score = 12.65, standard deviation score = 4.15) than the experimental group (mean score = 12.62, standard deviation score = 2.73). This indicates that the White mothers coped better than the Black mothers.

Further analysis was done to verify whether the mothers of both groups scored significantly differently on the Coping Sub-Scales.

Table 10 that follows is the Table for the Analysis of Variance (ANOVA) test for scores on the Coping Subscales between the two sample groups.

Table 10: Analysis of variance (ANOVA) for the Coping Subscales

		Sum of Squares	df	Mean Square	F	Sig
Active behavioral strategies (ABS)	Between groups	4.219	1	4.219	0.255	0.615
	Within groups	1290.969	78	16.551		
	Total	1295.188	79			
Active cognitive strategies	Between groups	0.602	1	0.602	0.189	0.665
	Within groups	248.385	78	3.184		
	Total	248.987	79			
Avoidance Strategies	Between Groups	0.300	1	0.300	0.475	0.493
	Within groups	49.250	78	0.631		
	Total	49.550	79			

The table above shows that there are no significant differences between the groups' specific coping strategies (subscales). Both groups are using similar coping strategies equally.

Hypothesis 2: The Black African mothers have more Social Support than their control group

Table 11, that follows, is the Table for the *t*-test on the Social Support Scale.

Table 11: *t*-test Table for the Social Support Scale

	Test Value = 0					
	<i>t</i>	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval	

					of the Difference	
					Lower	Upper
Social Support	17.380	79	0.000	10.26	9.09	11.44

Table 11 indicates that there is a significant difference between the scores of the two groups on the Social Support Scale ($t = 17.38$, $df = 79$, $p < 0.05$).

Thus Hypothesis 2, which states that Black African mothers have more social support than their control group, is accepted (mean score for the experimental group = 11.58 and standard deviation = 5.794; mean score for the control group = 8.28 and standard deviation = 3.665).

Multiple Linear Regression Analysis was done using the Stepwise Method to determine whether the following independent variables or factors for the experiment group (age of the mothers; age of the children; state of health of the mothers; number of children; number of people in the household and marital status) would significantly influence their scores on the Coping and Social Support Scales respectively.

Table 12 presents the Multiple Linear Regressions analysis of the independent variables or factors and the scores on the Coping Scale using the Stepwise Method among the experimental group.

Table 12: Multiple Linear Regression analysis for the Coping Scale among the experimental group.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.485	0.235	0.218	2.417
2	0.568	0.323	0.293	2.299

a Predictors: (Constant), age of the mothers

b Predictors: (Constant), age of the mothers, state of health

ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	82.533	1	82.533	14.128	0.000
	Residual	268.717	46	5.842		
	Total	351.250	47			
2	Regression	113.373	2	56.686	10.724	0.000
	Residual	237.877	45	5.286		
	Total	351.250	47			

a Predictors: (Constant), age of the mothers

b Predictors: (Constant), age of the mothers, state of health

c Dependent Variable: coping

Coefficients

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model		B	Std. Error	Beta		
1	(Constant)	30.077	4.656		6.460	0.000
	age of the mothers	-0.427	0.113	-0.485	-3.759	0.000
2	(Constant)	24.673	4.962		4.972	0.000
	age of the mothers	-0.396	0.109	-0.450	-3.644	0.001
	Level of health	1.523	0.631	0.298	2.415	0.020

a Dependent Variable: coping

Excluded Variables

		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics
Model						Tolerance
1	number of children	-0.211	-1.626	0.111	-0.236	0.950
	number of people in current household	-0.154	-1.201	0.236	-0.176	0.998
	state of health	0.298	2.415	0.020	0.339	0.987
	Marital status	0.036	0.278	0.782	0.041	0.998
	income	0.153	1.164	0.251	0.171	0.960
	age of child	-0.036	-0.275	0.784	-0.041	0.999

2	number of children	-0.149	-1.155	0.254	-0.171	0.899
	number of people in current household	-0.046	-0.344	0.732	-0.052	0.848
	Marital status	0.006	0.050	0.960	0.008	0.988
	Income	0.223	1.783	0.081	0.260	0.921
	age of child	-0.038	-0.306	0.761	-0.046	0.999

a Predictors in the Model: (Constant), age of the mothers

b Predictors in the Model: (Constant), age of the mothers, state of health

c Dependent Variable: coping

Table 12 above shows that age of the mothers significantly influenced scores on the Coping Scale (model 2: $B = -0.396$, $Beta = -0.450$, $t = -3.644$, $p < 0.05$). Furthermore, it shows that as the mothers' ages decrease, their scores on the Coping increase (they cope better). Table 12 also indicates that the mothers' perception of their level of health significantly influences the Coping score (model 2: $B = 1.523$, $Beta = 0.298$, $t = 2.415$, $p < 0.05$). From the table, it can be seen that as the perceived level of health increases (more positive), the Coping score increases. On the whole, age of the mothers and perceived level of health of the Black mothers' accounts for 32.3% of the variability on their coping scores ($R^2 = 0.323$). Besides age and perceived level of health, all the other tested factors do not contribute significantly to the coping scores.

Table 13 presents the Multiple Linear Regressions analysis of the independent factors and the Social Support Scale using the Stepwise Method for the experimental group.

Table 13 Multiple Linear Regression analysis for the Social Support Scale among the experimental group.

Model Summary

Model	R	R Square	Adjusted R	Std. Error
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			Square	of the Estimate
1	0.291	0.085	0.065	5.603

a Predictors: (Constant), state of health

ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	133.478	1	133.478	4.252	0.045
	Residual	1444.189	46	31.395		
	Total	1577.667	47			

a Predictors: (Constant), level of health

b Dependent Variable: support total

Coefficients

		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
Model		B	Std. Error	Beta		
1	(Constant)	20.172	4.243		4.754	0.000
	State of health	-3.147	1.526	-0.291	-2.062	0.045

a Dependent Variable: support total

Excluded Variables

		Beta In	t	Sig.	Partial Correlation	Collinearity Statistics
Model						Tolerance
1	number of children	0.066	0.453	0.653	0.067	0.960
	number of people in current household	0.031	0.198	0.844	0.030	0.856
	Marital status	0.270	1.961	0.056	0.281	0.991
	Age of the mothers	-0.100	-0.698	0.489	-.104	.987
	Income	0.048	0.330	0.743	.049	.952
	Age of child	0.225	1.620	0.112	.235	1.000

a Predictors in the Model: (Constant), state of health

b Dependent Variable: support total

Table 13 indicates that only the perceived level of health significantly influences the scores on the Social Support Scale (model 1: $B = -3.147$ Beta = -2.91 , $t = -2.062$, $p < 0.05$). It further illustrates that as the perceived level of health decreases, the social support received increases ($B = -3.147$). However, the table also shows that perceived level of health accounts for only 8.5% of the variability in the Social Support scores ($R^2 = 0.085$).

Qualitative aspects of the results:

Next the responses to the in-depth interviewing schedule of the control and experimental groups will be dealt with. This will illustrate the cultural influence on the results.

1. *Describe your child.*

Both groups described their children positively and negatively. In other words they emphasised the positive side of their children first, and then they would mention the negative side.

For example a Black mother said “My child is caring, strong and helpful but at times he can be so difficult” and a white mother said “My child is sweet, loving, kind but can be very moody”.

2. *Who complains about your child? Did the person show understanding?*

The school teachers were mentioned as the main complainers about the children. Mothers from both groups indicated that the teachers often have negative attitudes towards their children.

3. *How did this complaint make you feel? What sort of feelings do you experience due to your child's problems?*

The White mothers mostly reported that they were rather motivated to help their children. The Black mothers on the other hand reported feelings of being hurt and being motivated at the same time. They also reported feelings of self-blame and guilt. The experimental group

expressed statements like “It hurts me and I blame myself” while the White mothers had statements like “I am motivated to help my child because he needs me”.

4. *Who helps with your child at home?*

From the interviews conducted with the White mothers, it appears most of them have helpers (nannies) at home. Some Black mothers have helpers (nannies) in their homes, while others have a member of the family of origin (for example grandmothers) who comes around often to help out.

5. *What do you think is the cause of your child's problems and how do you feel about it?*

Most White mothers saw the cause of their child's problem(s) as something beyond their control. They said things like “My child's difficulties are due to nature”. The control group further felt their children's problems are a challenge they would have to deal with. A white mother said for example “It is just one of life's challenges I have to accept and to deal with”. There were some Black mothers who saw themselves as the cause for their children's problems, and some did not know what was causing their children's difficulties. The Black mothers said for example: “I do not know what's causing my child's difficulties”.

Based on my clinical impressions, the mothers' not knowing the cause of their children's problems could be an indication of their use of external locus of control. By saying “I do not know what is causing my child's difficulties” should not merely be taken as an indication of their not knowing.

They could be attributing their children's problems to supernatural causes such as witchcraft, “muti” bewitchment, punishment from God, or punishment from their ancestors for something they or their family did. The statements should not be taken at face value.

The Black mothers further said things like: “I feel it’s my fault that my child is like this”. “Maybe I’m expecting too much from my child”. “Maybe I’m not doing enough as a mother to help my child”.

There were two Black mothers who stated that they are having increased conflict with their spouses, which could be causing the child’s behaviours. They said: “There is tension between my husband and myself and maybe my child is picking up on that”. “Because of the tension between my husband and I; I tend not to be there for my child as I should be and that could be causing the problems”.

There were Black mothers like the White mothers who felt it was a challenge for them to face. However, fewer Black mothers than their control group saw it as a challenge. One Black mother said: “It’s a challenge of life that one has to accept”. While another said “It’s a challenge we would have to learn to live with”.

6. *General satisfaction with your life? Name any area(s) in which you would like to see improvement?*

From the interviews, it appeared that many Black mothers have less satisfaction with their lives than control group who expressed more satisfaction and had no area (s) they wished would change.

Most of the Black mothers were dissatisfied with life (especially in the area of their marriages and family lives). One Black mother said: “I am not really satisfied I wish I could change the interactions with my spouse”. The White mothers on the other hand made statements like: “I am generally satisfied with life, no area I want to change”.

7. *Day to day difficulties. What are they? Do you always feel in control and motivated to be there for your child?*

Punishing the child, and the effects of the problematic child on the other children in the family are expressed as difficult for both groups of mothers. The Black mothers reported that though they are motivated to help their children, they are at times physically or emotionally unable. This leads to feelings of lack of control; impatience coupled with self-blame; hurt feeling in the mothers for their impatience; and at times negative interactions with their children.

A black mother said: "The other children in the family at times do feel as if this child is getting more attention. As a mother trying to find balance can be stressful." Another Black mother stated: "I often feel like helping my child, but am physically tired and therefore unable". Furthermore, one said: "I often lose patience with my child, then I feel bad for losing my patience and I never know what to do to correct the situation".

One White mother reported "I find it difficult to punish this child because of his condition".

8. *How is your child's interaction at the school?*

Some mothers reported that the teachers are at times not patient with their children. One Black mother said, "They do not understand my child's condition".

A white mother stated, "The teacher is at times too impatient with my child". A Black mother mentioned that, "The teachers often do not give my child the attention he needs". One white mother said, "The teachers at times have a negative attitude towards my child".

9. *Worries or concerns about your child?*

Both groups are concerned about their children's futures.

A White mother said: "I am worried about my child's future. I am wondering if he will manage." One Black mother went on to say "I wonder where my child will be if I am to pass away?"

10. *Do you feel overworked at home?*

Both groups stated that they have help so they do not really feel overworked.

11. *Do you feel any different to the other mothers? Do you feel any pressure from your society because of your children's difficulties?*

The mothers from both groups stated that they do not really feel different from other mothers and that they did not feel a lot of pressure usually from society and their community.

12. *Are there times when you feel overly stressed about your child?*

Most of the Black mothers agreed with this. The Black mothers' responses, for example, were "Yes I do feel stressed, but what can I say (do)". Another Black mother said: "I do feel stressed, and I feel it is not fair". The White mothers mostly responded that they were, like the Black mothers, often stressed about their children. A White mother said, "I try and sit with my child and talk to him". "My husband at times helps out where he can and gives me time to relax".

Summary of the qualitative results:

This section is to emphasize the cultural influences on the results.

The qualitative results indicate that both groups describe their children both positively and negatively. The experimental and control group seem to see the children's teachers as having negative attitudes towards the children. Both groups seem to have helpers at home and the

Black mothers generally appear to have their extended family's helping hand when needed. The day-to-day problems appear to be similar for the groups (punishing the child, having to balance time for all children) on a certain level, however the Black mothers often seem to feel that they are not controlling the situation and this leads to negative interactions with their children. The Black mothers appear to have a certain degree of self-blame, guilt and less motivation where the majority of White mothers feel their children's problems are a challenge. The Black mothers tended to be more dissatisfied with life in general (especially their family lives) and some were distressed due to their relationships with their spouses. The control group is more motivated to help their children than the experimental group, which appears to have the cause of their children's problems been internalized.

There were Black mothers who stated that they do not know what is causing their children's difficulties. Based on my clinical impressions, their not knowing what the cause of their children's problems is, could be an indication of their use of external locus of control. They could be attributing their children's problems to supernatural causes such as witchcraft, "muti" bewitchment, punishment from God, or punishment from their ancestors for something they or their family did. The external loci of control explanations of the causes of the child's problems could be the reason why the Black mothers have feelings of guilt, decreased motivation, feeling of self-blame, dissatisfaction with family life, and the feeling of not being in control of the situation with the child.

CHAPTER 6

DISCUSSION

6.1. Introduction

The objectives of this chapter are to discuss the results of the research, to review the contribution of the study in terms of the aims set out in chapter 1, to comment briefly on the implications, and the limitations of the study as well as areas for further research.

6.1.1. Summary of the Coping Strategies results

The White mothers (control group) of children with behavioural problems coped better than the Black mothers (experimental group). From the literature it would seem that no research on similar groups' coping strategies with respect to children with behavioural problems has been done. Studies found indicated that Western mothers of children with behavioural problems have higher rates of psychological difficulties more often than mothers of undiagnosed children. This is due to decreased sense of competence, feelings of being restricted in the mothering role, negative society labeling of the mothers, poorer-parent child attachment, negative spouse relationships and increased family distress (Crnic & Aceveco, 1995; Fischer, 1990; Johnson & Reader, 2002; Mehl-Madrona, 2000; Wicks-Nelson & Israel, 2000). The reasons cited were that the Western mothers of children diagnosed with behavioral problems had reduced coping abilities.

Interestingly the above-mentioned (difficulties and) poor coping strategies reported in the earlier research on White mother samples were not identified as is the case with the results of the White mothers in the current study.

In the present study, there was an indication that the two groups, even with the control group coping better, used similar coping strategies, i.e. there was no significant difference between

the two groups' individual three main coping strategies (avoidance strategies, active-cognitive strategies and active-behavioural strategies).

There also appeared to be similarities in the Coping strategies between Black mothers and the White mothers in samples from studies done in other countries. Both groups were found to have used internalization. In my opinion, these similarities should be treated with caution because they could be due to different reasons. The White mothers in earlier studies were found to internalize their children's problems due to a number of reasons, one being negative societal labeling. This negative societal labeling was not found to be significantly different in both groups in the present study. This is not to say that it may not exist, it could have been due to the size of the sample. It was found though that the internalization of feelings among the Black mothers related positively to external locus of control. This has not been reported in any other study.

It appears there are similarities between the White mothers in studies done in other countries and the Black mothers in the present study, but it is a "complex" similarity. It is complex because there could be different reasons for the internalization. With the white mothers in other countries it appears to be due to the societal expectations and pressure. For the Black mothers in the present study it could be due to the external locus of control. This will be discussed in a section to follow.

The results of the current study indicate that the White South African mothers could be experiencing having a child with behavioural problems differently to Western mothers used as samples in other countries (such as the USA).

Age of the mothers and the mothers' perception of the level of health significantly influenced scores on the Coping Scale. It seemed as the mothers' ages decreased, their scores on the Coping increased (they coped better). Also as the perceived level of health increased (more positive), the Coping score increased. This indicates that the younger the mothers, the better they coped and that if the mothers perceived their health positively, they coped better. The researcher found no possible explanations for the fore-mentioned, but the latter could be explained in the sense that if the mothers perceived their health in a more positive light, the more positively they coped.

6.1.2. Summary of the Social Support results

There was an indication that the Black mothers have more support than their control group. The perceived level of health was the only factor that significantly influenced the scores on the Social Support Scale. As the perceived level of health decreased, the Social Support received increased. The researcher found no possible explanations for the fore-mentioned, but felt it could be explained in the sense that the more negatively the mothers perceived their health, the more social support they received. The Black mothers' having more support than the White mothers was expected. This is because the literature shows that the Black culture views family as not only composed of immediate families, but as a system that utilizes extensive kinship based support (Everett, Chipungu & Leashore, 1991). This expected support system, I feel, could be to a certain degree part of a "resilience" factor for the Black mothers, because studies have shown that good support can bolster self-worth, trust and life-direction. It can help one become a better 'coper' by inspiring one to do one's best in dealing with life challenges. Further it provides the companionship that enhances life quality (Kleinke, 1998).

6.1.3 Cultural influence on the results

I expected the support system together with external locus of control explanations (a Black African traditional style of thinking and living) to help the Black mothers cope. But it appears the Black mothers, despite this external locus of control and support system, had more internalization than the White mothers. The literature supports the notion that having an internal locus of control is adaptive in certain areas of life (Parkes, 1984). I argue that viewing a child's behavioural problems as an "internal" problem could be maladaptive because it is perceived as something beyond one's control. I would have thought that by being a Black mother of a child with behavioural problems and with traditional views (specific way of understanding problems: believing external forces cause illness, specific treatments-rituals that should be performed, having extended family support and therefore more social support), one would stand a better chance at coping.

What was found however, was that the Black mothers' use of external locus of control in their explanations of the causes of their children's problems led to negative feelings. For example, mothers had feelings of not being in control of the situation, increased dissatisfaction with family life, and decreased motivation together with feelings of guilt and self-blame. In as much as there was a small "resilience factor" with the Black mothers (they had traits of Black African traditional style of living), their use of these traits led to negative internalized feelings.

It appears that change is occurring especially with the Africans; they are becoming more Westernized with respect to certain values due to urbanization. Nevertheless, certain traditional views appear to be internalized. Values such as maintenance of close contact with the extended

family, group orientation (collectivism and Ubuntu), and value of children and extended family units are some of the values found to be internalized in other studies (Mashego, 2000; Nefale & Van Dyk, 2003). Other internalized values that were found included: value of ancestral worship, mysticism and belief in the strength of traditional healers, external locus of control, and view of witchcraft or supernatural powers as cause for illness (Kayongo-Male & Oyango, 1994; Mashego, 2000; Nefale & Van Dyk, 2003). In the present study the use of extended family as part of support, and external loci of control for explanations of the causes, are examples of the values that were found to be internalized.

It appears though that the Black people, the mothers in this instance, might be in a slight dilemma. Because even though they internalize certain traditional African values and style of living (for example, viewing disorders as caused by external forces: “muti” [native charm], bewitchment), they are being greatly influenced by Western culture as well, in the sense that they tend to internalize and treat their children in a Western manner. They treat them in a Western manner because of the fact that they taking them to Western professionals, such as Clinical Psychologists and Psychiatrists.

There seems to be a process of acculturation occurring, which is defined as a process whereby people move to dominant society traits (Triandis, 1996). Acculturation is an important phenomenon in Western societies whereby culture-mix and certain traits, especially of the dominant societies, are acquired by the minority group.

In this study, the Western style of living may be regarded as being dominant while the African style of living and its values takes the position of the other. This is due to the past apartheid system. The Western style of living in the past apartheid era was advantaged, hence they still take the dominant position. The Africans due to being previously disadvantaged take the minority position. Although the country is currently going through changes, it will, nevertheless, take time before there is a shift from what was previous a way of thinking about certain cultures to a more equal view of the cultures. This process of acculturation can be very stressful and especially so when the traits or values of the cultures are contradictory or very different (Triandis, 1996). This is the case with Western and the African cultures. It is even more stressful for the society that was previously disadvantaged because they could have internalized feelings of inferiority towards or regarding their own culture and mixed feelings of the other more dominant culture due to the past apartheid system.

This is not to rule out that the previously advantaged could be struggling with the acculturation process taking place. It is merely to emphasise that the Black mothers seem to be functioning in between two extremities of values. They have a bit of the African view of viewing disorders (which is a “minority” view), but at the same time they have to deal with the disorders in a more “acceptable” Western manner (which they do not fully understand or accept because they have internalized African values).

6.1.4. Conclusion on the Black mothers based on the findings

The Black mothers are not taking an “either or” position but are rather taking a bit of the values from the different cultures. This leads to a lack of complete acceptance of the cultures.

In other words the mothers are not taking a Western stance and saying that their children are experiencing behavioural problems due to a biological predisposition, for example. They are saying that they do not know what is causing their children's problems. This is an indication that they could be weary because it could be due to bewitchment, "muti" [native charm] or punishment from the ancestors. Their feelings of not being in control imply that the problems their children experience could be due to a force outside of themselves, which is more of an African stance. Their view of their children's problems is further complicated by the steps they take in trying to help their children. Even though they feel it might be due to an external force (an African view), they take their children to the Psychologist and Psychiatrist (Western intervention which focuses on intra-psychic methods of intervention). The Western trained helpers might be able to help the problematic child. But if they are not aware of the culturally attached meanings for the mother (for example, if the questions about the cause and the steps needed to be taken are not answered by the Western helpers which could be answered by the African healers), the mother might develop internalization of negative feelings. For example, she might develop feelings of self blame because she might feel she has not adequately controlled the situation in line with her cultural beliefs.

Culture seems to play a role in influencing the experience of having a child with behavioural problems. Differences are found in between the cultures and within the cultures; further similarities are found in presentation between the Black culture and the Western culture in the previous studies. This indicates that for interpretation of the mother's experiences and for intervention, one should be culture specific. Western and European based intervention methods were previously the norm but given the fact that South Africa is multicultural with its unique history, cultures and experiences, intervening will have its challenges (Nefale & Van Dyk, 2003). My standpoint is that it would be different specifically for the Non-western

cultures. My results have indicated this and further illustrate that even the Western cultures in South Africa could be different from other cultures. To provide effective treatment for children with behavioural problems, one has to bring in the experience and understanding, the coping strategies and the strengths of the mothers. The need to consider/take note of the cultural aspect cannot be overemphasised.

6.2. Limitations of the study

The sample size was a limitation of the study. Also the experimental group was bigger than the control group due to both the uneven distribution of the population in the area and the sensitivity of the research topic. Therefore results of the study cannot be generalized to all South African mothers (Black or White). The methodology could be limiting as well, because the study could have elicited more attached meanings and created a better understanding if it had a bigger qualitative aspect. Further because education could influence coping it should be emphasized more in studies to come. As it is, it is a start to future research that is needed to help develop intervention and treatment plans.

6.3. Conclusion

Contrary to expectations, the Black mothers were found to have less coping strategies than the White mothers, although they had more support. They further seemed to use external locus of control in their explanations for the causes of their children's problems. These explanations, contrary to expectations, contributed to feelings of self-blame, and feelings of not being in control. The current study did not show significant society labeling in either the experimental or the control groups. The Black mothers in the current study have negative feelings due to the

use of external locus of control (e.g. they say they do not know what is causing their children's problems and could be attributing it to witchcraft, "muti" use or punishment for wrong-doing). The Black mothers due to the acculturation process could be functioning between two extremities of values (African versus Western values). This may contribute to more stress while trying to deal with their problematic children.

The study shows the need to look at different cultural aspects and the importance of not throwing a blanket eye over the experience of the similar cultures. Due to the limitations of the study, the findings should be used with caution. Further research should be conducted to shed more light on the coping strategies of mothers of children with behavioural problems.

6.4. Recommendations

Based on the findings the following recommendations are made:

1. Psychologists and other mental health professionals should be made aware of the implications of having a child with behavioural problems and not to treat the problem at face value. The helpers should further be aware of the unique and often common experience for the mothers.
2. The suspected acculturation process and the effect of the problematic child on the system (school, family, and parents) need to be addressed further so they can be incorporated into future intervention programs.
3. Educators should be aware of such children in education settings and cater for their specific needs. The educators should be trained in dealing with both the problematic children in the education settings and their mothers.

Teachers' formal awareness and skill training in identification of children with behaviour problems and how to refer them for professional help should be put into

place. The teachers' competence in these areas can assist children with behaviour problems with the process of intervention. Such intervention should basically start with knowing how to involve parents i.e by informing them, giving them the necessary education about the problems and the impact of the children's behaviour on them and by giving the parents places they could take their children for professional help. This will, above-all be aimed at helping the parents develop a full understanding of their predicament as parents to these children- by being very sensitive to the situations that develop around the children's difficulties.

4. Mothers should be helped to increase their strengths and resiliencies and be helped to develop long-term coping strategies which should be internalized. Psychoeducation of pathological symptoms which are found in the mothers due to the experienced stress should be given to them and their helpers. Information regarding facilities that are available should be communicated to the mothers.
5. Government policy makers should be educated on the need to create policies that would be beneficial to problematic children and their families.
6. Traditional healers should be trained with respect to the importance of recognizing mothers' difficulties (even if the child is the patient), and the need to promote their good psychological functioning.
7. Persons planning preventative and therapeutic strategies should be aware of the effect the child could be having on their entire system.
8. There is a possibility that both groups (White and Black mothers) are experiencing some sort of denial and this needs to be explored further.
9. Further are necessary studies that focus on not only the different experiences between the cultures but also on the actual experiences of the different cultures in South

Africa. Further research in this area of study is required (especially by mental health professionals) to increase expertise in this field.

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Appendix A

PSYCHOLOGY DEPARTMENT

SCHOOL OF SOCIAL SCIENCES

UNIVERSITY OF THE NORTH

Questionnaire for mothers of children with behavioral disorders

Please do fill in the questionnaire in the best way you can. There is no wrong or right answer.

Some questions may be very private, but be assured that your responses shall be handled anonymously and confidentially. Thank you for agreeing to participate. Questions could be asked if an item is not understood.

Section A: biographical data

INSTRUCTIONS: Tick in box or write on line according to the question's structure

Mother's details

1. Name: _____
2. Age: _____
3. Highest level of education: _____
4. Marital Status Single Married Divorced Widowed
 Cohabiting
5. Occupation of self: _____
Occupation of spouse (if applicable): _____
6. Contact details: _____
7. Total monthly income of household
 R1 - R2999
 R3000 - R5999
 R6000 - R8999
 R9000 - R11999
 R12000 and above
8. Number of children: _____
9. Ages of the children: _____
10. Grades or highest qualifications of the children:

11. Number of people in current household: _____
12. The state of my health could be described as good, satisfactory, or poor.

Write down the onset and the cause of ill-health (if applicable)

Section B: Social support

12. The following statements, please rate them on a scale of 1-6.

1=Strongly agree 2=Agree 3=Slightly agree 4=Slightly disagree 5=Disagree
6=Strongly disagree

There is a special person who is around when you are in need. _____

There is a special person with whom you can share joys and sorrows. _____

You get the emotional help and support you need from your family. _____

You can really talk about your problems with your family. _____

Your spouse/partner supports you. _____

Section C: Ways of Coping Scale

Instructions: Tick under the response that best suits your reaction when faced with a difficult situation

ACTIVE – COGNITIVE STRATEGIES			
	Not at all	Sometimes	Regularly
Prayed for guidance and/or strength			
Prepared for the worst			
Tried to see the positive side of the situation			
Considered several alternatives for handling the problem			
Drew on my past experiences			
Took things a day at a time			
Tried to step back from the situation and be more objective			
Went over the situation in my mind to try to understand it			
Told myself things that helped me feel better			
Made a promise to myself that things would be different next time			
Accepted it, nothing could be done			
ACTIVE – BEHAVIOURAL STRATEGIES			
	Not at all	Sometimes	Regularly
Tried to find out more about the situation			
Talked with spouse or other relative about the problem			
Talked with friend about the problem			
Talked with professional person (e.g. doctor, lawyer, clergy)			
Got busy with other things to keep my mind off the problem			
Made a plan of action and followed it			
Tried not to act too hastily or follow my first hunch			
Got away from things for a while			
I knew what had to be done and tried harder to make things work			
Let my feelings out somehow			
Sought help from persons or groups with similar experiences			
Bargained or compromised to get something positive from the situation			
Tried to reduce tension by exercising more			
AVOIDANCE STRATEGIES			
	Not at all	Sometimes	Regularly
Took it out on other people when I felt angry or			

depressed			
Kept my feelings to myself			
Avoided being with people in general			
Refused to believe that it happened			
Tried to reduce tension by drinking more			
Tried to reduce tension by eating more			
Tried to reduce tension by smoking more			
Tried to reduce tension by taking more tranquilizing drugs			

Section D: In depth interviewing guiding schedule

Guiding questions for the mothers

1. Describe your child.
2. Who has complained about your child?
3. How did this make you feel? What sort of feelings do you experience due to your child's problems?
4. Who helps with your child at home?
5. What do you feel is the cause of your child's problems?
6. General satisfaction with your life? Name any area(s) you would like to see improvement?
7. Day to day difficulties. What are they? Do you always feel in control and motivated to be there for your child
8. How is your child's interaction at the school?
9. Worries or concerns about your child?
10. Do you feel overworked at home?
11. Does your work environment interfere with your family life?
12. Do you feel any different to the other mothers?
13. Are there times when you feel overly stressed about your child?

Appendix B: Ethic forms

UNIVERSITY OF THE NORTH ETHICS COMMITTEE

APPLICATION FOR HUMAN EXPERIMENTATION

PROJECT TITLE: Coping styles of Black mothers of children diagnosed with behavioral problems.

PROJECT LEADER: K.K.E. Mashego

DECLARATION

I, the signatory, hereby apply for approval to execute the experiments described in the attached protocol and declare that:

1. I am fully aware of the contents of the Guidelines on Ethics for Medical Research, Revised Edition (1993) and that I will abide by the guidelines as set out in that document (available from the Chairperson of the Ethics Committee); and
2. I undertake to provide every person who participates in any of the stipulated experiments with the information in Part II. Every participant will be requested to sign Part III.

Name of Researcher: K. K.E. Mashego

Signature:

Date: 06/ 04/ 2004

-

For Official use by the Ethics Committee:

Approved/Not approved

Remarks:

Signature of Chairperson:

Date:

PROJECT TITLE: Coping styles of Black mothers of children diagnosed with behavioral problems.

PROJECT LEADER: K.K.E. Mashego

APPLICATION FOR HUMAN EXPERIMENTATION: PART II

Protocol for the execution of experiments involving humans

1. Department: Psychology.
2. Title of project: Coping styles of Black mothers of children diagnosed with behavioral problems.
3. Full name, surname and qualifications of project leader: K.K.E. Mashego, B.Sc Hons. Psychology
4. List the name(s) of all persons (Researchers and Technical Staff) involved with the project and identify their role(s) in the conduct of the experiment:

Name:	Qualifications:	Responsible for:
K. Mashego	Hons. B.Sc Psychology	Project leader and analysis of data

5. Name of supervisor:
Prof S.N. Madu (University Of the North)
6. Procedures to be followed:

Mothers of children with behavioural problems will form the sample. They will be given the choice of participation. If they agree to participate, they will be given consent forms to sign and questionnaires to complete. A number of the participants from the sample will further be interviewed. A report will be written of the final findings. The participants will be kept anonymous.

7. Nature of discomfort:
No discomforts are expected but if there is a sign of psychological distress, psycho education of psychological services will be given. The participants will be given refreshments. If money for transport to place of the interview is a problem, the researcher will help were possible.

8. Description of the advantages that may be expected from the results of the experiment:

If there are any unrecognized strengths that help the mothers of children with behavioural problems cope, they will be emphasised and be used as part of intervention. They will be used to empower the mothers, who if empowered could help their children to the fullest potential.

Signature of Project Leader:

Date:

PROJECT TITLE: Coping strategies of Black mothers of children diagnosed with behavioral problems.

PROJECT LEADER: K.K.E. Mashego

APPLICATION FOR HUMAN EXPERIMENTATION: PART II

INFORMATION FOR PARTICIPANTS

1. You are invited to participate in the following research project:

Coping strategies of mothers of children diagnosed with behavioral problems.
2. Participation in the project is completely voluntary and you are free to withdraw from the project/experiment (without providing any reasons) at any time. You are, however, requested not to withdraw without careful consideration since such action might negatively affect the project/experiment.
3. It is possible that you might not personally experience any advantages during the experiment/project, although the knowledge that may be accumulated through the project/experiment might prove advantageous to others.
4. You are encouraged to ask any questions that you might have in connection with this project/experiment at any stage. The project leader and her/his staff will gladly answer your question. They will also discuss the project/experiment in detail with you.
5. Your involvement in the project will be to assist the researchers by taking the time to be interviewed and to fill in the questionnaire. By taking part in the research you are really assisting the researcher to find the best possible ways to help empower mothers of children with behavioural problems.

APPENDIX C: CONSENT FORM

UNIVERSITY OF THE NORTH ETHICS COMMITTEE

PROJECT TITLE: Coping strategies of Black mothers of children diagnosed with behavioral problems.

PROJECT LEADER: K.K.E. Mashego

CONSENT FORM

I, _____ hereby voluntarily consent to participate in the following project:

Coping styles of African mothers of children diagnosed with behavioral problems.

I realise that:

1. The study deals with coping strategies of mothers of children with behavioural problems and the effect the children's behaviours have on the mothers
2. The Ethics Committee has approved that individuals may be approached to participate in the study.
3. The project protocol; i.e. the extent, aims and methods of the research, has been explained to me.
4. The protocol sets out
 - possible discomfort for persons participating in the research
 - an explanation of the anticipated advantages for myself or others that are reasonably expected from the research
5. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation.
6. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research.
7. Any questions that I may have regarding the research, or related matters, will be answered by the researcher.

8. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact the researcher.
9. Participation in this research is voluntary and I can withdraw my participation at any stage.
10. If any psychological problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person.
11. I indemnify the University of the North and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

SIGNATURE OF RESEARCHED PERSON

SIGNATURE OF PERSON THAT INFORMED
THE RESEARCHED PERSON

Signed at _____ this ____ day of _____ 2004

THANK YOU FOR YOUR CO-OPERATION

