RELATIONSHIP BETWEEN ATTACHMENT AND BEHAVIOURAL PROBLEMS AMONG CHILDREN IN RESIDENTIAL GROUP HOMES/ALTERNATIVE CARE IN POLOKWANE, LIMPOPO PROVINCE

by

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Declaration of Originality

I declare that the **"Relationship between Attachment and Behavioural Problems among Children in Residential Group Homes/Alternative Care in Polokwane, Limpopo Province" (**mini-dissertation) hereby submitted to the University of Limpopo, for the degree of Master of Arts (Clinical Psychology) has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

_____ _____

Ms Nkuna TS Date

Dedication

Dedicated to my family:

From you I derive my inspiration.

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Abstract

The currents study investigated the relationship between attachment and behavioural problems in children in residential group homes (alternative care) in Polokwane, Limpopo.

The sample consisted of children (n = 52) and their caregivers (n= 7) from the Samaritan Children's Home. Both males (n = 30) and females (n = 22) were represented. All caregivers were female. A quantitative, cross-sectional design and simple random sampling were employed. Data was collected using the Relationship in Close Relationships Questionnaire (ECR-RC) and the Child Behaviour Checklist (CBCL). Methods of analysing were correlational (Pearson's r) to establish relationships and t-test and ANOVA to establish between- and within-group differences.

Results revealed that there was a statistically significant positive correlation between poor attachment and behavioural problems. Male children were found to exhibit more internalising behaviour than externalising behaviour when compared to females on the CBCL. Older children, both male and female (aged 12-14 years) were found to exhibit more behavioural problems than their younger counterparts aged 9-11.

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Chapter 1: Overview of the Study

1.1 Background and Motivation

The South African Constitution states that children should be protected against being neglected, maltreated, abused, and degraded (Republic of South Africa, 1996). It further states that the State is responsible for protecting a child whose parents are unable or unwilling to protect him/her. This means that, if there is nobody willing or able to care for a child on a long-term basis, long-term alternative care should be made available for such a child (Department of Social Development, 2005).

Various ways have been implemented in practising alternative care worldwide, with special reference to the specific needs of the child and their culture, as well as the type of alternative care system in place for certain countries (Johnson, 2005). Alternative care has been known to be diverse- ranging from a few days, short-term, or a child's entire childhood (Johnson, 2005). One type of identified alternative care facilities is residential group care which James et al. (2010) described as being characterised by multiple programmes such as those with a therapeutic approach, centres for substance abuse rehabilitation, family-style residence, as well as those on the extreme end of the spectrum such as centres for sexual offenders. Alternative care placement is usually determined by a conjunction of systems responsible for mental wellbeing, juvenile justice, and child welfare (James et al., 2010). Residential group homes are amongst the long-term facilities for long-term alternative care in South Africa. The current research is mainly focused on these residential group homes.

Various reasons have been identified for the placement of children in alternative care. Scholars have also mentioned maternal deprivation, which is the absence of a primary, stable, and care-giving figure, as a main contributing factor of children getting placed in alternative care as well as in attachment disturbances (Elovainio, Raaska, Sinkkonen, Makippa, & Lapinleimu, 2015; Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, & Roisman, 2010). Other reasons include, amongst others, neglect as well as physical, emotional and sexual abuse (Bovenschen et al., 2016). The problem is worsened when there is severe maltreatment and care-giving neglect (Lionetti, Pastore& Barone, 2015). McGrath-Lone, Dearden, Nasim, Harron, and Gilbert (2015) pointed out that this history is often responsible for poor parent/child

relationships and the inability to form attachments to the caretaker adults. These difficulties often lead to alternative care such as foster care, which is considered the most effective and least restrictive type of residence, tofail, thus leading to placement in residential home care (Hawkins-Rodgers, 2017).

It is important to note that Bowlby (as cited in Bovenschen et al., 2016) asserted that children's ability to form attachment bonds with their primary caregivers is a flexible process rather than a fixed state, thus leaving room for change to occur at any stage if the child's care-giving environment changes. This makes it possible to establish a secure attachment relationship if a child is placed in a well-functional and nurturing home (Bovenschen et al., 2016). Children are capable of transitioning through different environments as secure bases for exploration and safe havens for forming secure attachment bonds provided the said environments are emotionally warm and nurturing.

Younger children often display attachment behaviour which reflects their perception of their caregivers (Jonkman, Oosterman, Schuengel, Bolle, Boer, & Lindauer, 2014). These perceptions are regularly associated with social competence and the regulation of emotions and behaviour. According to Fearon et al. (2010), however, negative developmental outcomes are associated with insecure and disorganised attachment. Ultimately, because of past experiences of not having their emotional needs met, children placed in residential group homes are likely to find it difficult to perceive their new caregivers as secure and trusted bases for exploration, irrespective of their age at placement (Jacobsen, Ivarsson, Wentzel-Larsen, Smith, & Moe,2014). Consequently, caregivers are also likely to misunderstand the needs of these children which then lead to the failure of these children to form internal working models of a predictable and secure world, which is often seen as a hallmark of securely attached children in basic families (Jacobs et al., 2014).

The literature has suggested that placing children in alternative care, whether a foster home or residential group home, moreover, may exacerbate attachment problems. Fearon et al. (2010), for example, found that children in residential group homes are likely to have difficulties transitioning and adjusting into a new home environment. Jacobsen et al. (2014), also postulated that, irrespective of age, foster children find it difficult to articulate their needs to new caregivers, and, when their needs are then neglected by their caregivers. The risk of these children forming poor

attachment patterns (insecure, anxious, or disorganised) is often higher (Jacobsen et al., 2014).

Although Lionetti et al.(2015) found that life in residential group homes does not necessarily prevent the formation of an attachment bond, they also found that attachment is notably compromised by regular turnovers of professional caregivers who often lack the experience and knowledge of caring for children in challenging conditions, and mostly work shifts (Barth, 2015). There is also a problem with the ratio of caregiver to children in many residential centres (Zeenah, Smyke, Koga, & Carlson, 2015). This means that the children have to compete for or depend on limited emotional and physical resources such as affection and care. Moreover, it indicates that it might be difficult for the caregivers to be emotionally and sometimes even physically available for these children to establish a secure attachment bond. Perhaps unsurprisingly, children who have been placed in multiple alternative care facilities have been identified as likely to exhibit a greater risk of attachment difficulties (Bruce, Tarullo, & Gunnar, 2009). Moreover, it has been reported that the duration of stay in institutional care can perpetuate symptoms related to poor attachment (Bruce et al., 2009).

A number of studies have shown that attachment insecurity was associated with internalising and externalising behaviour symptoms, and other forms of psychopathology, including Reactive Attachment Disorder (RAD), Attention Deficit Hyperactivity Disorder (ADHD), as well as similar cognitive deficits as those seen in adopted children (Elovainio et al., 2015; Jacobsen et al., 2014; Jonkman et al., 2014). Welcome (2013) defined internalising behaviour as actions that are taken out toward the self; often characterised by a child hurting him/herself instead of lashing out at others. The inhibited subtype of RAD, which is associated with internalising behaviour, is characterised by children who do not prefer a specific caregiver and rarely display positive affection or seek comfort when in distress, and often have difficulties regulating their emotions (Jonkman et al., 2014). Other symptoms of internalising behaviour include withdrawal, anxiety, and substance abuse (Fearon et al., 2010). In contrast to internalising behaviour, externalising behaviouroften results in lashing out at others through aggression, violence, defiant, and criminal behaviour (Welcome, 2013).

The literature has suggested that, although they face many challenges, some children are do develop secure attachment bonds withthe new caregivers they encounter in alternative care (Bovenschen et al., 2016). However, this may not be the case for every child as others experience difficulties in attaching to their new caregivers and adjusting to the new family environment (Fearon et al., 2010).

1.2 Research problem

Gabler et al. (2014) proposed that one generally exhibits attachment orientations which are reflective of attachment styles experienced in previous relationships; however, this orientation is prone to change based on the expectations and experiences of current and new relationships. As mentioned above, the placement of children in nurturing environment provides room for the children to develop attachment bonds with their new caregivers even if their previous experiences were negative. However, it is also likely that, even if children are placed in alternative care for reasons other than the neglect and abuse that is common, their experience of the alternative care may create attachment problems.

Despite evidence that many children placed in alternative care have trouble relating to or forming secure attachment bonds with their caregivers because of the adverse circumstances of their family backgrounds, studies have mostly focused on attachment bonds formed between children and their biological parents rather than the development of attachment bonds in children in alternative care (Gabler et al., 2014). Moreover, most of the studies which have been conducted have been on bonds formed by children outside Africa, and specifically outside South Africa.

This is also the case with studies focusing on attachment in relation to behavioural problems. Like much of the international literature, South African studies have focused more on investigating attachment and behavioural problems with children who are staying with their biological families. For instance, a study by Mashegoane and Ramoloto (2016) investigating the relationship between children and their caregivers in a normal family setting was done in Limpopo, South Africa. Therefore, the current study sought to identify if any relationship existed between attachment and behavioural problems amongst children placed in residential group homes in the South African context. The study specifically focused on residential group

homes in Polokwane, Limpopo and also on the attachment relationship between a child and his/her primary caregiver or the caregiver the child identified with the most within the group home.

1.3 Operational Definition of Terms

1.3.1 Attachment

According to Raaska, Elovainio, Lapinleimu, Matomäki, and Sinkkonen (2015), attachment is defined as the strong tendency a child displays in seeking proximity or contact with a desired primary caregiver when in need of support, nurturance, or comfort. For the purpose of this study, the above definition will be adopted in relation to attachment between a child and his/her caregiver in the residential group homes.

1.3.2 Residential group homes

Residential group homes generally refer to facilities which provide full-time care to children. These facilities are often under the supervision of unrelated adults working shifts (Barth, 2015). Residential group homes differ from foster care which is characterised by children being taken care of by people who are not their biological parents in a family setting (Department of Social Development, 2006).

1.3.3 Behavioural problems

According to Welcome (2013), behaviour is the manner in which one may act or conduct oneself. Behaviour becomes a problem when it interferes with a child's social and academic development. Thus, children may exhibit behavioural problems by showing signs of aggression, violence, defiance, impulsivity, or withdrawal (Welcome, 2013).

1.4 Purpose of the study

1.4.1 Aim of the study

The aim of the study was to investigate the relationship between attachment and behavioural problems among children in residential group homes in Polokwane, Limpopo.

1.4.2 Objectives of study

The objectives of the study were:

- To determine the type of relationship that exists between attachment and behavioural problems experienced by children in residential group homes.
- To investigate the types of behavioural problems that were likely to be reported by the children's caregivers on the Child Behaviour Checklist (CBCL).
- To identify the gender and ages of children who were likely to experience attachment and behavioural problems.

1.4.3 Hypotheses

- There is a positive relationship between attachment and behavioural problems in children in residential group homes.
- Children in residential group homes are likely to exhibit a higher frequency of externalising as opposed to internalising behavioural problems as measured by the Child Behaviour Checklist (CBCL).
- There are no differences between the genders and age in relation to attachment and behaviour exhibited.

1.5 Significance of the Study

The study will help identify any need for psychological interventions which might be developed for residential group homes in order to assist the caregivers in

implementing a holistic approach when caring for these children. Moreover, the study will further serve as a psycho-educational tool to assist the caregivers in their interactions with the children.

1.6 Summary of Subsequent Chapters

Chapter 1 dealt with the overview of the study as a whole. The chapter was comprised of background information to the study, the research problem, objectives, operational definition of terms applied in the study, as well as the significance of the study. It also included hypotheses which were tested through the research findings.

Chapter 2: This chapter focuses on the theoretical framework applicable tothe explanation of the study. It therefore gives a comprehensive description and explanation of the main theories used in the conduct of the study.

Chapter 3: This chapter provides relevant information obtained from perusal of similar studies which have been conducted by other researchers. Special emphasis will be on the results obtained in these previous studies. This literature review will be used to form a basic foundation for the current study.

Chapter 4: This chapter gives a detailed account of the methodology used in this study. It contains a presentation of the type of research design, the population sample chosen to participate in the study, the sampling techniques used, how data collection tools were used and how the data was analysed, as well as the ethical concerns addressed while conducting the current study.

Chapter 5: This chapter reports the results of the study based on the data analysis. These will be presented through the use of graphs and tables for aid in explaining the results.

Chapter 6: The final chapter comprises an overall discussion of the research findings. This will be done through integrating the theoretical framework previously introduced, testing and discussing the hypotheses, discussing the conclusions drawn, and making recommendations based on the research findings. The chapter also speaks to the limitations of the study.

Chapter 2: Theoretical Framework

2.1 Introduction

Every research project draws on certain theories in order to direct the researcher in their journey. The theoretical framework for this study ispresented through the use of attachment theory, focusing on the contributions of John Bowlby and Mary Ainsworth. The theory explores how attachment bonds are formed and ultimately maintained, as well as how different attachment styles result in certain behaviours.

2.2 Bowlby's Attachment Theory

Bowlby argued that a person's mental health throughout their entire life is influenced by intimate relationships with attachment figures who are capable of proving physical protection and emotional support (as cited in Bretherton, 1992). Irrespective of their age, human beings are at their happiest and are able to best showcase their talents and capabilities when they are assured that there are people willing to provide support when the need arises (Bretherton, 2008).

The ability of attachment relationships to provide a secure base primarily depends on how their patterns of interactions form a translation of relationship representations, which Bowlby coined *internal working models*. Bowlby (as cited in Jacobs, Bifulco, & IIan-Clarke, 2012) described internal working models as mechanisms through which children internalise their interactions with their caregivers. These models of the self and others assist members of an attachment bond in predicting, interpreting, and guiding interactions in the attachment relationship. For example, a child's internal working model may be used as a basis for predicting the caregiver's ability to be available and responsive, and also provide room for the children to maintain the attachment bond through affective communication with the caregiver (Dozier et al., 2014). Bretherton (1992) argued that this communication and the ability to openly discuss feeling and emotions, as well as the quality and characteristics of the interactions, in turn influence the development of the internal working models.

Expectancies form the core of internal working models and anticipate how the caregiver will respond in variety of contexts given the individual's changing needs and goals. For instance, a child who experiences consistent responses that are attuned to his or her changing motivational states will develop confident expectations in the caregiver's availability and responsiveness. These expectancies, therefore, conform to a *secure base script* that anticipates how attachment-related events with a particular caregiver typically unfold (Bretherton & Munhollan, 2015).

Because a child's attachment working models are developed through real-life, day-to-day interactions with caregivers, Bowlby (1982) postulated that a child's attachment working models are relationship–specific. Moreover, due to the nature of these relationships being interpersonal, they therefore become reinforced within the self in relation to the attachment figure. Thus, the child may view the parent as loving and caring and themselves as being loved. These internal working models also tend to form a base for how the child perceived him or herself in relation to others (Bowlby as cited in Bretherton & Munhollan, 2015).

Research on attachment has described individuals as having secure attachment, irrespective of their age, when they display confidence in the assurance that other individuals will be available to provide care and comfort when needed (Bretherton & Munhollan, 2015). The family experience of such individuals is characterised both by unfailing parental support, frank communication, and by steady encouragement of increasing autonomy (Bretherton, 1992). Children who grow up with anxiety and being fearful, however, are noted to be generally raised in environments characterised by inconsistent support and subtle pressures from their parents.

According to Bowlby (1982), the type of relationships children have with their caregivers in childhood have an overall long-term impact on their ability to adjust as well as their mental health (Jacobsen et al., 2014). Bowlby emphasised that, although internal working models are often formed in early childhood, the process of the child developing attachment to their primary caregiver is on-going, and may change should the child's care-giving environment change at any stage. This is why placing children with insecure internal working models in a caring and nurturing environment in alternative care may enhance the development of secure attachment bonds (Jacobsen et al., 2014). Indeed, a child in alternative care is just as likely at any age to form secure attachment with a new caregiver as a child staying with biological parents.

2.3 Ainsworth's Theory of Attachment

Like Bowlby, Ainsworth's study of patterns of attachment provided initial evidence for the development of internal working models. Her observations expanded on Bowlby's theory, demonstrating that, by one year of age, infants have begun to internalise expectancies for caregiver availability and responsiveness, and subsequently organising how they communicate and behave toward the caregiver when they were distressed. She further noted that mothers who were unresponsive were likely to produce babies who were anxious, thus leading to insecure attachment (Sadock & Sadock, 2007). Later researchers extended the assessment of internal working models to older children and adults (Dozier et al., 2014). These researchers highlighted the need to consider how ongoing experiences in attachment relationships, as well as an individual's exposure to attachment disruption, may create *lawful discontinuities* in internal working models (Dozier et al., 2014). Bretherton and Munhollan (2015) suggested that, even in adulthood, these models may be amenable to change based on new experiences in relationships with partners.

Ultimately, the internal working models concept is important in predicting how one is likely to cope with attachment disruptions in one's life. Individuals with secure working models (organised by confident expectancies for caregiver availability) are likely to bring more resources to interpreting and coping with the disturbance. Not only does a secure internal working model enable the individual to cope more effectively, but it is also likely to facilitate more direct emotionally attuned communication with caregivers (Bretherton & Munhollan, 2015).

Ainsworth originally identified three types of attachment to the primary caregiver (the mother): secure (Type B), insecure-avoidant (type A), and insecure-ambivalent/resistant (type C). A fourth type (insecure disorganised) was later added to the model (Jacobsen et al., 2014; Sadock & Sadock, 2007). Ainsworth's classification system was based on the s*trange situation* procedure in which a child was placed in a situation that did not include his or her caregiver, and then was reunited with the caregiver (Barnett &Vondra, 2013). Ainsworth postulated that, in that situation, a child who is securely attached reunites with the attachment figure without showing excessive anger, and soon returns to exploring their environment or playing and readily seeks proximity with the caregiver (Ainsworth, 1978; Sadock & Sadock, 2007). In contrast, a child with an insecure-avoidant attachment is likely to fail to greet

the attachment figure, often ignoring her or trivialising her importance, while children with insecure ambivalent attachment styles fluctuate between rejecting interaction with the caregiver and manoeuvring for close proximity with her. Some ambivalent children are noted to be passive while others are likely to display anger.

2.4 Types of Attachment Styles

Attachment styles may be considered organised or disorganised. Dubois-Comtois et al. (2015) indicated that attachment patterns are considered organised when they reflect, with consistency, a style of managing various developing systems (e.g., emotional, behavioural, and physiological) with special reference to prior knowledge acquired regarding the caregiver's typical response style. Attachment styles are further considered organised if they are believed to be a reflection of behavioural strategies in relation to the caregiver's response styles. When a child feels rejected by an attachment figure who is often or always ineffective in their modulation of a child's stress, the child's attachment system is thus programmed/organised and equipped to cope with continuous experiences of frustration due to their need not being met (Godinet, Li, & Berg, 2013).

The manner in which a caregiver anticipates, interprets, and ultimately responds to the child's attachment behaviour often influences the type of attachment bond (secure or insecure) that is formed. For instance, caregivers who are dealing with personal challenges such as domestic violence or mental illness are likely to be less responsive or experience difficulties focusing on and tending to the needs of the child. Their own childhood experiences, as well as the mental images formed of the parental relationships that they bring into their roles as parents are likely to influence how the caregiver reads and respond to child's attachment behaviour and needs. Thus, caregivers who lack secure attachments with others are likely to experience difficulties responding in a manner that would encourage the development of secure attachment in the chid (Jacobs et al., 2016).

Insecure attachments in children are likely to be generated by interactions with caregivers who have been observed to be less available and inconsistent (Blakely & Dziadosz, 2015). These attachments can be: avoidant, where a child's attachment system is stifled resulting in the child learning to be left-reliant and avoids expressing

their feelings and needs; or they can be ambivalent, where the child's system is over-activated and the childis so focused on the attachment relationships and expression of emotional needs that they end up with an impaired sense of exploring the world. Children exposed to instability, neglect, and abuse have been observed to lack the ability to develop any organised form of attachment (Quiroga & Hamilton-Giachritsis, 2016).

Negative internal working models are usually a characteristic of insecure attachment patterns. These negative internal working models are likely to be present in children who display traits such as low self-confidence and esteem, as well as lack of confidence and trust in one's relationships with others, mainly due to the belief that other people are generally not responsive and are void of care (Blakely & Dziadosz, 2015).

The current study used attachment theory as a lens to assess whether children in alternative care (residential group homes in particular) were able to form attachment bonds with their caregivers even after having disruptions in their attachment bonds with their biological family members. Further exploration was made in terms of the form of attachment that existed in the relationships between the children in the residential group home and their caregiver.

In order to further clarify Attachment Theory, the three main types of attachment styles described by Ainsworth are discussed at length below, along with the disorganised pattern which was added to Ainsworth's model later.

2.4.1 The insecure-anxious/avoidant (type A) pattern

Approximately 15% to 25% of North American samples are made up of infants with an insecure-avoidant attachment make up (Bakermans-Kranenburgetal., 2011). Children with the avoidant or insecure-anxious attachment pattern seldom display positive and warm interaction, or show active interest in their attachment figures. Their positive affect, if ever displayed, is often directed towards complete strangers, toys, or the experimenter. During assessment, children with avoidant attachments towards their caregivers have been observed to also display low levels of overt negative emotional reactivity (Quiroga, Hamilton-Giachritsis, & Fanéz, 2017). Dubois-Comtois

et al. (2015) noted that children with the anxious–avoidant attachment style reflect a negative view of others, but often a positive view of the self.

During separation, these children tend to express little to no distress compared to their securely and mostly ambivalently attached counterparts. When reunited with their caregivers, these infants often divert their attention away from them and are less likely to manoeuvre for or maintain proximity with their caregiver following the stress of the separation period. These children tend to display this kind of behaviour to avoid the arousal of frustration and anxiety and out of fear that the caregiver will likely reject them in time of need and emotional distress (Bakermans-Kranenburg et al., 2011). These children also tend to avoids interaction with others or dismiss them instead of internalising the caregiver's critical views of them (Quiroga et al., 2017).

Research has revealed that children who display avoidant attachment are reared by mothers who often exhibit controlling, intrusive, and overly rejecting behaviour, or behaviour that is dismissive of the child and the child's feelings (Quiroga & Hamilton-Giachritsis, 2016; Welcome, 2013) and often are uncomfortable with close physical contact with their children (Quiroga & Hamilton-Giachritsis, 2016). Infants with this attachment style have been known to be object-oriented, less sociable, and less cuddly than infants with the other attachment styles (Quiroga et al., 2017).

Children with an insecure attachment style lack confidence in the caregiver's availability in time of need (Jacobs et al., 2016). Because the children are unable to rely on their caregiver's prompt response to their needs, they may over emphasise their display of emotion by being demanding and fussy when they are ignored.Furthermore, their overt anger towards their caregivers may lead to their refusal to accept their attachment figure's attempt to provide care and comfort. This type of behaviour from the child is likely to provoke confusion from the caregiver resulting in difficulties distinguishing between the child experiencing genuine distress and the child merely being in need of comfort and to simply be held (Dozier et al., 2014).

This confusion serves as a contributing factor to a stain in the relationship. In response to unresponsive and insensitive caregivers, these children tend to avoid provoking anger in their caregivers by downplaying and suppressing their distress.

These children are likely to be distressed and insecure although they often display an independent and self-reliant exterior (Jacobs et al., 2016).

2.4.2 The secure (type B) pattern

A secure attachment style is formed when a primary caregiver is psychologically available, sensitive, and consistent in their positive responsiveness (Quiroga et al., 2017), actively showing care and comfort to the child (Dubois-Comtois et al., 2015). Securely attached children are usually confident that their caregivers will be available and responsive in times of distress (Barnett &Vondra, 2013; Johnson, 2005; Quiroga & Hamilton-Giachritsis, 2016), and are able to be comfortable seeking and maintaining attachment relationships even when they are aware of the caregiver's unavailability at certain points.

Securely attached infants typically use their relationship with their caregivers as a base for exploring and interacting with their environment. When reuniting with their caregivers, these infants tend to initiate interaction with their caregivers, displaying warm affect with them (Bakermans-Kranenburg et al., 2011). Naturally, these children also tend to get distressed by separation from their caregiver, but they are comfortable seeking contact with the caregivers as quickly as possible, thus allowing them to return to independent play shortly after the reunion. These children seldom display any degree of ambivalence, resistance, negative affect, passivity, or avoidance towards their caregiver. When these negative behaviours occur, they tend to be quite brief (Quiroga et al., 2017).

2.4.3 The insecure-ambivalent or resistant (type C) pattern

The insecure-ambivalentstyle usually results from interaction with caregivers who are observed to be inconsistent in their behaviours; they often show praise on one day and display condemnation and condescending behaviour the next day, often leaving a child confused without knowing how to respond (Quiroga & Hamilton- Giachritsis, 2016). In addition, children with this attachmentstyle have been shown to have often been reared by caregivers who display behavioural characteristics such as not actively responding, as well as being passive and ineffective (Barnett & Vondra, 2013; LaMont, 2010). The child's behaviour is often used to elicit a response from their

caregiver (Quiroga & Hamilton-Giachritsis, 2016). It is believed there is a negotiated relationship between the caregiver and the child where dependence on each other is emphasised (Bakermans-Kranenburg et al., 2011).

Children with the Type C attachment style have been noted to be preoccupied with finding out the whereabouts of their caregivers (Bakermans-Kranenburg et al., 2011). Unlike children with the Type A style, they often spend a large amount of time in close proximity or clinging to their caregivers, resulting in a halt in exploration of their environment and engagement in play (Blakely & Dziadosz, 2015). When separation occurs, these children exhibit overt distress and continue to be overly distressed for prolonged periods even after their reunion with their caregiver, often only settling down and becoming soothed after several minutes.

These children tend to display clear indications of anger and ambivalence towards their caregivers, as evidenced by rejecting toys or resisting contact with their caregiver even after motioning for close proximity by use of squirming (Quiroga & Hamilton-Giachritsis, 2016). Ambivalence can also be displayed through behaviours such as crying, distress, or being passive in seeking close proximity to the caregiver in such a way that the child shows behaviour that mimics dismissal of the caregiver and not actively making effort to seek proximity with the caregiver (Barnett &Vondra, 2013) even when their desire to be close is clear. Children with the ambivalent attachment style have been observed during the neonatal period to exhibit irritable temperaments (Barnett &Vondra, 2013). People with this type of attachment style generally view themselves in a negative light while holding other people in high esteem.

2.4.4 The disorganised attachment style

Disorganised/disoriented attachment is usually presents in children who have minimal or lack any connection with their caregivers (Lesch, Deist, Booysen & Edwards, 2013) or when they view their caregiver as either frightening, such as when they sexually or physically abuse the child, or frightened, such as when the caregiver seem helpless and unable to protect and reassure the child (Jacobsen et al., 2014). Factors such drug abuse and mental illness (including maternal depression) have been described as contributing factors to the development of disorganised attachment styles (Jacobsen et al., 2014; Lesch et al., 2013).

Children with the disorganised attachment style are prone to prolonged emotional distress and feeling overwhelmed due to lack of a clear strategy when dealing with their distress and regulating their emotions (LaMont, 2010; Quiroga & Hamilton-Giachritsis, 2016). Children who grow up having a disorganised attachment style tend to shift to a form of attachment that is exhibited through controlling behaviour such as aggression towards the caregiver (Dozier et al., 2014). Children are described as controlling when they attempt to assume a role which would be considered more appropriate for a parent and actively try to actively seek to be in control of the parent-child relationship (Dozier et al., 2014).

Children who display the disorganised attachment style are likely to be considered the most insecure as they tend to hold a negative view of both the self and other, with the caregiver often regarded as an object of fear thus leading the child feeling helpless with regard to how they can best regulate their emotions and explore their functioning in a social environment (Blakely & Dziadosz, 2015). During the strange situation experiment, children with disorganised/disoriented attachment styles tend to display behaviour that is seen as contradictory, conflicted, or odd, such as suddenly showing signs of fearing the caregiver and withdrawing from the caregiver (Barth, 2015).

2.5 Conclusion

The study sought to take a closer look at attachment in children who are being cared for by caregivers other than their biological parents. The idea was to establish whether any attachment bonds could be formed in these types of relationships and ultimately establish the types of behaviour likely to be prominent in the residential group homes. Attachment theory was used as a point of reference for the current study.

Chapter 3: Literature Review

3.1 Introduction

The review of previous studies similar to this one as presented here will be used as a basis for this current study in order to provide a comprehensive context for the purpose of the study. Much of the research conducted globally has revealed that there are multiple challenges which come with being raised in alternative care. Of these challenges, behavioural problems are among the most prominent challenges faced by both children and their caregivers. Moreover, many studies have looked at the relationship between attachment and behavioural outcomes. These studies have revealed that most poorly attached children exhibit several behavioural problems which will be discussed in this chapter. The current study, however, seeks to investigate this phenomenon in relation to residential group homes in the South African context in particular.

3.2 Alternative/Out-of-Home Care

Two million children have been estimated to be raised in alternative care worldwide. However, this number is believed to be an underrepresentation of actual statistics as most countries do not keep systematic records of these children (Dozier et al., 2014).Various family circumstances have resulted in anincrease in the number of children who are in alternative care, such as divorce, financial difficulties, neglect, maltreatment, abuse, parental mental illness (Suzuki & Tomodo, 2015; Ward, 2014). Worldwide, including in South Africa (see the Children's Act no. 38 of 2005), legislation requires that, should they be at risk of or directly experiencing harm, children should be removed from their parents or guardians (Stein-Steele, 2015). Several of these children are placed in alternative care shortly after birth while others are placed at a later stage (McLean, Price-Robertson & Robinson, 2011).

Where the children are placed depends on their circumstances. Some children in alternative care get adopted into families, while others go through various foster care and multiple placements in residential group homes (Suzuki & Tomoda, 2015). Foster care seems to be the preferred placement. A study by Ohara and Matsuura (2016) revealed that the majority (75%) of children placed by Child Protective Services (CPS)in England were placed in foster care in the previous year, while 9% were placed residential homes) in the same year (Ohara, & Matsuura, 2016). A study in the United

States showed that, of the nearly 400,000 children in foster care in 2013, 15% lived in either a group home or an institution compared to 47% living with non-relative foster families (Stein-Steele, 2015).In comparison, in Australia, 6.6% of children and young people were in residential placement including small group homes in 2013–2014 (Ohara, & Matsuura, 2016).

According to UNICEF (2009), in 2008, nearly 40% (18.7 million) of the South African population was comprised of children under 18 years, the majority (over 66%) living in Gauteng, KwaZulu-Natal, Limpopo, and the Eastern Cape.13.6% of these had lost their father, 2.7% of them had lost their mother, and 2.9% had lost both parents. Unsurprisingly, 0.5% of these children lived in child-only households (UNICEF, 2009). Most of these children were subsequently placed in different alternative care facilities for their wellbeing. These facilities are discussed below.

3.3 Out-of-Home Care Facilities

Various terms been used to refer to the facilities/residences used to house and care for children who are in need of out-of-home care. Therefore, taking a closer look at these facilities is of paramount importance to provide adequate context for the study.

According to Ward (2014), alternative care facilities vary according to their design, structure, and ideology. They are also likely to differ in relation to the goals, the restrictiveness of intervention, and the type of support and staff available for each facility (Ward, 2014).

3.3.1Types of out-of-home care facilities in South Africa

The different types of out-of-home care facilities identified in South Africa (McLean et al., 2011) are:

- **Children's Shelter/Receiving Home**: This describes centralised emergency shelters where children are temporarily placed while decisions are being made regarding their permanent placement.
- **Receiving/Transfer Centre**: A temporary environment in which children who have been removed from their homes can be cared for while waiting to be taken to the next already identified placement.

- **Emergency Foster Home**: A foster home that is designed for care for a few children on a short-term basis.
- **Conventional Foster Care**: Commonly used for children who have been victims of abuse and neglect, this is where children are cared for by non-kin adults.
- **Kinship Foster Home**: This is care proved by the child's relatives, with the exception of the biological parents.
- **Specialised or therapeutic foster care**: Provided by trained foster carers, this is a home-based type of therapeutic and trauma-informed care, and is often employed for juvenile offenders or children with special needs.
- **Group/Congregate Care/Children's Residential Centres**: These are facilities which provide full-time care to children supervised by unrelated adults in shifts. A group home generally provides a6 to 8 bed facility for adolescents.
- **Residential Treatment Centre**: An organisation with the primary purpose of providing planned mental health treatment programs in conjunction with residential care for emotionally disturbed youth and children 17 years old and younger.
- **Juvenile Detention Centre**: A facility where young offenders placed in foster care are detained while awaiting a court date or alternative placement after being charged with a crime

3.3.2 A closer look at children's group/ residential homes

According to Ward (2014), alternative care service provision generally offers various service options. These range from those requiring the most amount of support and being the most intrusive, to those being the least intrusive and requiring the least support). Ultimately, residential group care has been treated as a last resort (Barth, 2015), being employed only after other methods of alternative placement have failed (Hawkins-Rodgers, 2017; McLean et al., 2011). Poor parent/child relationships and the inability to form attachment bonds with the caregivers, particularly when it is due to chronic abuse and trauma, have been reported as contributing to the failure of foster

care placement (Hawkins-Rodgers, 2017). Because of this, residential group homes often liaise with child welfare services and mental health care professionals (Ward, 2014).

3.4 Attachment among Children in Alternative Care

John Bowlby described an attachment bond as an intimate, warm, and progressive relationship a child and their primary care giver (usually the mother) or a permanent and preferred substitute for the mother in which both parties find fulfilment and satisfaction (Ward, 2014). According to Bowlby (as cited in Jacobs et al., 2016), an infant who is attached displays attachment behaviours such as smiling, crying, or vocalising in order to communicate their needs to the caregiver in seeking proximity and safety. The notion is that children who form secure attachment bonds are likely to display good emotional and social outcomes in future (Ward, 2014).

According to Fearon et al. (2010), children can form attachment bonds with their primary caregivers in all aspects of developmental functioning. Although the bond between the child and the mother was the main focus of previous studies (Bowlby, 1969), Attachment Theory is considered to be evolving in light of new research, with current recognition of developmental issues in middle childhood or adolescence as well as children's experiences outside the home environment such as at school and with peers (Barth, 2015). As such, later developments have included a focus on multiple attachment relationships, such as those of the child with the father, or day-care providers, (Fearon et al., 2010). Moreover, attachments are increasingly seen as patterns of behaviour which are mutually reinforced between the child and the caregiver, with the children actively engaged in the development and maintenance of the attachment bond, except in times of need when the general response of the caregiver serves as motivation in reinforcing the kind of behaviour likely to be exhibited by the child (Jacobs et al., 2016).

These developments are crucial to note when considering abandoned children or orphans who have been removed from their primary families and situated in some form of alternative care such as foster care or residential group homes (Suzuki & Tomoda, 2015). The type of relationship these children develop with their new caregivers can both positively change or aggravate the attachment patterns which

were formed in previous relationships (Quiroga & Hamilton-Giachritsis, 2016). Barth (2015), for example, pointed out that these children tend to be disruptive in their relationships with their new primary caregivers as a result of having been exposed to unpredictable and severe environments of care giving before placement. Therefore, these children are mostly at risk of developing poor attachment bonds with their new caregivers (Jacobsen et al., 2014).

As mentioned above, although residential care used to be the main placement option for children in the last century, more recently it has become considered only as a last resort (McLean et al., 2011). Group residential facilities are often considered for children who display disruptive and problematic behaviour associated with mental illness such as conduct disorders, or neuro-developmental problems with a view to reducing the risk of or preventing them from harming themselves or others (Bask, 2015). These children's histories, which are marred with experiences of neglect, abuse, or breakdowns in multiple placements, can also hinder them from developing secure bonds and relationships of trust with others. Many of these children show symptoms of complex trauma and sometimes even Post-Traumatic Stress Disorder which also contribute to their inability to appropriately adapt their emotions and behaviours (Van der Kolk, 2005).

A large body of research conducted in Europe with children who were raised in alternative care and then later got adopted or placed in foster care has revealed that being raised in large institutions, which are often seen as impersonal, had a negative impact on the types of attachment likely to be formed by these children, and also impacted on their socio-emotional and behavioural outcomes (Quiroga & Hamilton-Giachritsis, 2016). Thus, growing up in deprived institutions has been considered a risk factor in itself in terms of developing problem behaviour characterised by aggression, inhibited behaviour, or impulsivity, as well as an inability to self-regulate, feelings of anxiety, and a tendency to withdraw along with other socio-emotional difficulties (Bakermans-Kranenburg et al., 2011).

Similarly, research conducted among Chinese children regarding infant-caregiver attachment patterns in children living in alternative care revealed a high level of avoidance (approximately 50% in toddlers) with the majority of children failing to display any behaviour of attempting to seek close proximity with their caregiver (Barnett & Vondra, 2013). Another study conducted in Russia revealed that up 80% of

the children in residential group homes displayed disorganised attachment behaviour. This percentage remained high (60%) even following an intervention which included structural changes and caregiver training (Blakely & Dziadosz, 2015).

Disorganised attachment can be considered a direct reaction to the conditions which are associated with placement in residential group home. Some researchers have indicated that the manner in which attachment bonds are disorganised in the residential group homes may not be reflective of the similar processes within a family setting and emphasised the importance of taking into account other specifics when studying attachment in the alternative care context (Bakermans-Kranenburg et al., 2011; Barnett &Vondra, 2013; Bovenschen et al., 2016). These other factors include limited resources, limited caregiver-child ratio, and the staff change and the shift system, which often hinder the development of organised attachment, leading to more disorganised attachment (Quiroga & Hamilton-Giachritsi, 2016). Some scholars have suggested that the lack of developing attachment bonds in the alternative care context may be misconstrued as a disorganised attachment style as conceived based on family dynamics (Bakermans-Kranenburg et al., 2011).

Some research conducted on attachment within institutions has revealed that infants who are reared in residential group homes often develop attachments with specific/selective caregivers, even when raised in alternative care facilities which are comprised of multiple caregivers (Bakermans-Kranenburg et al., 2011; Quiroga et al., 2017). Gabler et al. (2014) conducted a meta-analysis in 2009 summarising ten studies that focused on attachment in children in alternative care. These results showed that, although some children showed a disorganised attachment style, others developed secure attachment bonds with their caregivers, some showing signs of attachment as early as 14 days after placement, and developing stable attachment patterns within two months of placement (Lindheim & Dozier, 2007).

Some scholars have identified the age of the child at the time of placement as an important influence on the development of attachment bonds (Bovenschen et al., 2016). Placement before a child’s first birthday, for example, has been found to result in the development of stable patterns and the display of secure attachment behaviour within a short period of time in placement (Lindhiem & Dozier, 2007). Ultimately, certain children tend to attach quickly to their new caregivers, whereas some children

take longer or fail to form secure attachments to their caregivers (Jacobsen et al., 2014).

The variations in the attachment styles developed by children in alternative care may be partially explained by the quality of care provided. Quiroga et al. (2017) noted that many studies indicating the prevalence of secure attachment styles were conducted in residential group homes which were considered to be of notably good quality with the ratio of chid-caregiver being balanced, as well as being characterised by low staff turn-over and small sizes. This, therefore, is a reflection that residential group homes are likely to vary widely in terms of the quality of care provided and that these variances impact strongly on the emotional and attachment. Therefore, neither all institutions are the same nor will they have similar outcomes (Quiroga & Hamilton-Giachritsi, 2016).

Because attachment relationships formed with new caregivers are likely to perpetuate or cause a change in the child's previous attachment patterns (Jacobsen et al., 2014), children in alternative care need to be allowed a time to process and deal with their losses and prior traumatic experiences, in order to allow room for them to develop trust in the new caregiver as a secure base while they go through this process (Suzuki & Tomoda, 2015). While this is often allowed in adoptive situations, allowing children to form positive attachment bonds with their adoptive parents if they have had prior experience with secure attachment styles, in alternative care situations, research has shown that children are often discouraged from developing attachment bonds in order to ‘‘protect’’ the children from experiencing additional suffering due to possible future separations. This can hinder the possibility of change in the children's internal working models (Quiroga & Hamilton-Giachritsis, 2016).

3.5 Behavioural Problems among Children in Residential Group Homes

Literature has suggested that the risk of developing problematic attachment styles is higher for children placed in residential care, and the impact of such styles on how they perceive and deal with threats or stressful situations is long-term (Lesch et al., 2013;Maaskant, Van Rooii, & Hermanns, 2014), and thus impair their functionality even as adults (LaMont, 2010).Emotional, brain and neurobiological, as well as behavioural development have been reported to be among the areas which get

negatively impacted. These areas also include social relationships with peers and parents (Maaskant et al., 2014).

Caregivers of young children placed in alternative care have identified behavioural difficulties and mental health factors as a challenge they experience, often leading to failure to successfully transition into foster care, thus increasing instability in placement (Bernedo, Salas, García-Martín, & Fuentes, 2012). Indeed, compared to their community counterparts, children in residential group homes showed a higher incidence of various clinical and behavioural difficulties (Perry & Price, 2018; Tarren-Sweeney, 2008). Previous research has indicated that the percentage of children in alternative care who exhibit behavioural problems may range between20% and 60% (Stein-Steele, 2015).

Various studies, as reviewed by Maaskant et al. (2014), have confirmed a high prevalence of both behavioural problems and mental health issues among children in residential group homes. For instance, the Child Welfare System of the United States conducted a survey with 400 children placed in alternative care with the sample consisting of children from 2-14 years old together with their caregivers (Ohara & Matsuura, 2016). The study was conducted using the Child Behaviour Checklist (CBCL) which measures behavioural problems among 6-18yearolds, and the results revealed that 63.1% of children placed in non-kinship foster care and 39.3% of foster children placed with relatives had elevated scores on the clinical range scales of the CBCL.

Furthermore, two other surveys conducted in Australia revealed that school-aged children who were reared in residential group homes scored higher on all broadband and subscales of the CBCL (Jacobsen et al., 2014). Fernandez (2008) conducted a study using the Teacher Rating Form (TRF) to assess problematic behaviour in children placed in foster care. Although the teachers reported that most children scored within the normal ranges, nearly 25% were found to have scored higher on various scales of problematic behaviour. Another study conducted by Tarren-Sweeney (2008) on 347 (171 girls and 176 boys) children aged from 4-11 years placed in alternative care, revealed that 57% of the boys and 53% of the girls had at least one score on the clinical range of the Child Behaviour Checklist.

Two types of behaviour problems, internalising and externalising are commonly studied in the literature and are explored in more detail below. Several studies have revealed comorbidity between externalising and internalising behavioural problems (Perry & Price, 2018). Furthermore, there may be a complex relationship between the two. Alcohol abuse which is usually identified as an externalising behaviour may be seen as different from other such behaviours because it is so closely related to internalising behaviours such as having feelings of low self-worth (Bask, 2015). However, the distinction can be a helpful one in understand problematic behaviour and so it will be maintained in the discussion below.

3.5.1 Externalising behaviour

According to LaMont (2010), a child whose attachment is insecure is likely to experience difficulties when dealing with distress, leading to dysfunctional ways of stress management which manifest as externalising behaviours. In their study, Jacobsen et al. (2014) found that children with disorganised attachment styles also displayed such behaviour. Externalising behaviour indicates that emotional responses are directed away from the self (Welcome, 2013), and is characterised by, amongst others, aggression, hyperactivity, being impulsive, as well as being defiant and destructive (LaMont, 2010; Tarren-Sweeney, 2008). Other externalising behavioural problems are comprised of delinquent behaviour such as fighting and destroying property; disobedience and running away; as well as lying stealing and substance abuse (Thijssen, 2016).

Although aggression is part of normal development and is usually observed to decline at the children grow older, some children show continuous high levels of aggression which may lead to an elevated risk of developing a chronic pattern of delinquency and physical violence (Fearon et al., 2010). In the Netherlands, for example, 13.6% of the children between 4 and 11 years of age show externalising behavioural problems (Thijssen, 2016). Moreover, children in residential group homes have been found to present with more eternalising behavioural problems such as aggression in comparison with their peers (Fernandez, 2008).

According to Perry and Price (2018), these behavioural patterns are also inclusive of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Sadock and Sadock (2007) described ODD as characterised by display of behaviours such as

active defiance against set rules, anger outbursts, and unpleasant behaviour not usually expected at the child's age; the disorder is thus comprised of consistent and persistent patterns of hostility, negativity, and defiant behaviour without violating the right of other and social norms. CD on the other hand was defined as characterised by behaviours such as threatening to harm other people, aggression, theft and deceit, frequent violation of age-appropriate rules, as well as destruction of their own property and that of others (Sadock & Sadock, 2007).

Research has shown that this behaviour is considered risky and is often associated with high levels of substance abuse and violent criminal activities, as well as bullying and aggressive behaviour (Perry & Price, 2018). Some of the children with externalising behavioural problems display what Thijssen (2016) termed callous-unemotional traits. These traits are said to resemble the emotional detachment component often observed in adult forensic samples linked with psychopathy. Children with the callous-unemotional traits are likely to show behaviour characterised by minimal fear and high frequencies of impulsive behaviour, are not remorseful of their rule-breaking, and display lack of empathy (Thijssen, 2016). Moreover, these children usually start committing criminal acts and have more contact with the police when compared with children with antisocial behaviour without the callous-emotional traits (Thijssen, 2016).

Research has shown that the improvement of positive parental practices often leads to a decrease in children's externalising behaviour (Fearon et al., 2010). However, in children with callous-emotional traits, there was no indication or evidence that negative or ineffective parenting contributed to their frequent and high levels of antisocial behaviour (Thijssen, 2016). These children are regarded as less sensitive to punishment which then results in the being less responsive to any methods of effective parenting (e.g., privilege removal).

Interestingly, in the general population, behavioural problems were found to be aggravated by factors such as negative relationships between siblings characterised by aggression and conflict (Tarren-Sweeney, 2008). A longitudinal study conducted on boys from low-income backgrounds, for example, revealed that children who experienced high levels of conflict with their siblings were more likely to exhibit aggressive behaviour than their counterparts; these children were also found to experience higher levels of delinquency (Perry & Price, 2018). Children whose older

siblings exhibited externalising behavioural difficulties were also more likely to display the same over time (Jacobs et al., 2016). Sibling conflict was found, together with deviant peer association, to contribute to externalising behaviour problems in adolescents (Perry & Price, 2018). This could have relevance in terms of the interactions between children in residential group homes. However, Jacobs et al., (2016) have suggested that it would prove difficult to establish, in a group home, whether behaviour of one “sibling” influences the behaviour of another.

3.5.2 Internalising behaviour

Internalising behaviour speaks of behaviour which the individual directs inward (Welcome, 2013). Tarren-Sweeney (2008) described internalising behavioural problems as behaviour characterised by social withdrawal, demands for attention, feeling inferior and worthless, lack of emotional control, and excessive dependency. Anxiety, low self-worth and depression are also examples of such behavioural problems (Bask, 2015; Thijssen, 2016). Bask (2015) regarded internalised problem behaviour as comprised of low self-esteem, anxiety, and psychosomatic symptoms, some of which are cormobid with Attention Deficit Hyperactivity Disorder (ADHD).

Research has shown that internalising problem behaviour is evident even in early childhood (Thijssen, 2016) and is related to attachment styles. For instance, a study by Bask (2015) conducted on children aged 18- to 59-months old insecure attachment, revealed that that these children were more likely to exhibit internalising behaviour than children with secure attachment styles. Previous research has further shown that emotional difficulties such as depression and anxiety among adolescents may be directly linked to early stressful and negative life events (Thijssen, 2016). Uncontrollable events such as parental divorce and age-specific factors like transitioning through different scholastic levels are also likely to increase the risk of internalising behavioural problems (Bask, 2015).

3.6 Factors Influencing Behavioural Problems

Various researchers have investigated the causes of behavioural problems in children placed in alternative care. Factors that have been mentioned include the attachment styles of caregivers or parents, and the resultant attachment styles developed by the child (Hawkins-Rodgers, 2017; Villegas & Pecora, 2012). These

styles, as suggested above, can serve as a protective factor (in the case of secure attachment), thus leading to more positive outcomes, or, in the case of insecure or disorganised attachment styles, a factor that inhibits the children's ability to adjust to alternative care and form secure attachments to the new care-givers (Bovenschen et al., 2016; Hawkins-Rodgers, 2017; Villegas & Pecora, 2012). Other researchers have found that multiple factors such as reasons for removal, illnesses, gender and age, as well as the duration of children's stay in alternative care were contributing factors in the prediction of internalising and externalising behaviour (Perry & Price, 2018). The most common factors relating to the focus of this study are examined in more detail below.

3.6.1 Child maltreatment

Children who have experienced maltreatment generally have been known to present with difficulties such as symptoms of depression, delinquent behaviours, as well as externalising and internalising behavioural problems (Godinet et al., 2013). According to Ohara and Matsuura (2016), adverse childhood experiences such as maltreatment and abuse have a negative impact on the child's developmental outcome, being proven to predict deficits in social functioning, and cause an increase in health risks and early death (Ohara & Matsuura, 2016). Moreover, child abuse and neglect were found to have a strong correlation with alcohol addiction, depression, and use of illegal drugs (Gabler et al., 2014), as well as an increase in aggressive behaviour, committing continuous violent crimes, and being incarcerated in adulthood (Ohara & Matsuura, 2016).

Given that many children are placed in residential group homes because of prior maltreatment, it is perhaps unsurprising that previous research has also made a connection between these experiences and behavioural problems in such children (Villegas & Pecora, 2012). Leathers, Spielfogel, Gleeson, and Rolock (2012), for example, reported that children who have experienced neglect and abuse have a high prevalence of behaviour problems. According to Elovainio et al. (2015), such symptoms or behavioural patterns include those termed as "excessive need for adult attention", "indiscriminate friendliness", or a failure to seek comfort even when distressed.

3.6.2 Caregiver-child ratio

Research has revealed a relationship between the number of children available in a residential group home and behavioural problems likely to be exhibited by these children. In their study, Perry and Price (2018), for example, found that the prevalence of externalising behavioural problems increased as the number of children in the home increased. Specifically, they found that, for each additional child added, there was a likelihood that each of the other children would exhibit one more behavioural problems (Perry & Price, 2018). Similarly, a study conducted by Quiroga et al. (2017) among children in residential group homes revealed a significant correlation between the security of attachment and the number of children living in the homes; thus, the more children in the home the more the behavioural problems exhibited.

Japan provides a revealing case study. Most research has shown that, out of all the children who are reared in alternative care in Japan, about 70% of them are being raised in residential group homes with only about 9% in foster care placements (Perry & Price, 2018).The caregiver-child ratio in residential group homes in Japan is reported to be 6:1, and thus one staff member has to care for six children. Due to other circumstances, such as the staff members being required by the Labour Law to only work eight hours a day, as well as working shifts, the practical caregiver-child ratio only ends up being about 18:1 (Suzuki & Tomoda, 2015). The children in such a situation are likely to encounter deprivation after getting placement (Perry & Price, 2018), with the staff being able to offer only limited emotional and psychological investments, causing emotional burdens for both them and the children they care for (Jacobsen et al., 2014).

This situation sheds light on the pressure the caregivers in residential group homes are under as well as the noted difficulty children in group residential homes have to develop secure emotional bonds with their caregivers and with one another.

3.6.3 Caregiver sensitivity

Children tend to thrive when they have a caregiver who is available to tend to their needs (Suzuki & Tomoda, 2015). Thus, exposure to a caregiver who consistently provides care, is sensitive to the child’s needs and assists the child in developing emotional intelligence and social competencies is crucial in the ultimate formation of

attachment bonds and thus the child's ability to form healthy expectations of others (Jacobs et al., 2016; Ward, 2014). The caregiver's sensitivity and emotional support lead to the child feeling a sense of love towards the caregiver and a belief that the caregiver loves them in return (Ward, 2014). These children tend to experience little or no fear and anxiety as they believe that their caregivers and other people are readily available when needed (Dozier et al., 2014; Hawkins-Rodgers, 2017). The security such children feel energises and allows them to be curious, explore, and learn about their environment and the world (Suzuki & Tomoda, 2015; Ward, 2014). This sense of security, in turn, helps equip the child to better cope with traumatic experiences later in life (Jacobs et al., 2016).

As an example of the relationship between caregiver sensitivity and attachment, a study using the Maternal Behaviour Q-Sort which was revised by Pederson, Moran, and Bento (1999) conducted with 76 children who were placed in foster care showed that the mother's maternal sensitivity was noted to predict the attachment security the child was likely to experience. More children were found to lean towards and form more secure attachment bonds with the caregivers who were thought to be less detached and more sensitive (Quiroga & Hamilton-Giachritsi, 2016). In contrast, another study reported that negative care-giving qualities, such as detachment, a flat affect and a lack of sensitivity, were associated with the symptoms of Reactive Attachment Disorder (RAD), and particularly the inhibited subtype. The *Diagnostic and statistical manual of mental disorders* (4thed.) (DSM IV) described RAD as a clinical condition that occurs when children exposed to problematic care are unable to seek closeness with or form attachments to a preferred caregiver (Sadock & Sadock, 2007).

Perceived sensitivity may be partly linked to communication skills. Research has shown, for example, that positive and effective communication within a group home was linked to a reduction in the internalising and externalising behavioural problems of early adolescents (aged 13 years) (Dubois-Comtois et al., 2015). Moreover, poor communication within the residential homes resulted in the display of high frequencies of behavioural problems (Dubois-Comtois et al., 2015).

3.6.4 Gender differences in relation to behavioural problems

Although some studies have not observed any gender differences between male and female children (Bernedoet.al., 2012; Ohara & Matsuura, 2016), much of the literature has indicated that there is some difference. According to Fearon et al. (2010), for example, boys usually show externalising behaviour under stress, while girls tend to internalise their behaviour. Godinet et al. (2013) similarly found that, among the adolescents they studied, girls displayed more internalising behaviour, while boys exhibited more behaviour problems related to externalising behaviour.

There is evidence proving that gender differences in terms of externalising behaviour may be declining (Bernedo, Salas, García-Martín, & Fuentes, 2012). For instance, statistics of arrest from 1980 to 2002 revealed a consistent increase in the prevalence of externalising behaviour such as being aggressive (physical and verbal fights), breaking rules, and destroying others' property among female juveniles (Bask, 2015). Accordingly, Berkout, Young, and Gross (2011) opined that more effort should be made to include female participants when studying gender difference with regard to Conduct Disorder (CD) and related aetiological factors.

Gender differences may be the result of several factors. Research has showed, for example, that boys tend to display risk-taking behaviour due to less strict or close supervision from their parents (Jacobsen et al., 2014). On the other hand, girls have been found to develop more attachment bonds with their caregivers in alternative care than boys, which ultimately encourages socially acceptable behaviour and protects them from negative peer influence (Bask, 2015). However, this protection may not always be effective. Rodgers (2017) reported that anger and dissociative behaviour was more prevalent in female adolescents who displayed ambivalent and avoidant attachment styles. Other researchers have found that hormonal changes also attribute to the differences in behaviour displayed by children of both genders, especially in children who have reached puberty (Papas, 2015). Moreover, population studies using self-report measures have revealed that girls report more health problems (somatic complaints) compared to boys. The health problems include stomach-aches, rash, nausea, vomiting, etc (Bask, 2015). This gender difference appears to increase with age (Bask, 2015). Age difference is discussed in more detail below.

3.6.5 Age as a contributing factor to behavioural problems

The age of children in alternative care has also been related to their behaviour problems (Jacobsen et al., 2014), although the results have been mixed. Ohara and Matsuura (2016), for example, found that the severity of behavioural problems increased with age. This might be attributed to the hormonal changes as discussed by Papas (2015). Godinet et al. (2013), however, demonstrated that, as children grow older, internalising behavioural problems tend to decreases in girls, while externalising behavioural problems decrease in both girls and boys. Bask (2015), on the other hand, found that, in alternative care, that behavioural problems were more prevalent during mid-adolescence (12-15 years of age) than they were during early or late adolescence. Contrarily, several studies noted no age difference between younger children and adolescents in terms of behavioural difficulties (Bernedoet.al., 2012).

3.7 Conclusion

According to the literature perused in relation to the study, many factors play a role in the determination of behavioural problems among children reared in residential centres. This particular study takes a closer look at these different factors and tests them against the proposed hypotheses in the first chapter in relation to the residential group homes in Limpopo Province.

Chapter 4: Research Methodology

4.1 Introduction

This chapter outlines in detail the research methodology employed for the current study. Here the population sample and its identification, the research design, the tools used for data collection, the methods by which the data was analysed, the measures taken to ensure reliability and validity, as well as ethical considerations will be discussed.

4.2 Research Design

The study was conducted by making use of a quantitative research design. According to Welman, Kruger, and Mitchell (2005), quantitative research is characterised by utilising methods which put emphasis on the analysis and measurement of contingent relationships between certain variables in a specific context. A cross-sectional design was used, specifically an observational study that analysed data from a sample at a certain point in time. The study employed correlation to establish relationships between the variables under investigation. A correlation study, according to Babbie (2010), is quantitative in nature and is characterised by determining a relationship/co-variance between two or more variables. Futhermore, this study used tests to determine significant difference between the means of two groups (t-test and ANOVA). A t-test is used to determine if there is a significant difference between the means of two groups. The analysis of variance test (ANOVA), is used to divide variations in a set of observations into distinct components (Sirkin, 2015).

4.3 Population and Sampling

The study was conducted using simple random sampling. According to Bless, Higson-Smith, and Kagee (2006), the simple random sampling procedure awards equal opportunity for the population to be selected for participation. The research sample comprised of 52 children (aged 9-14 years) from the Samaritan Children’s

Home in Polokwane, Limpopo. Following the ruling out of any cognitive difficulties, each second child was selected from the remaining children to participate in the study. The sample further included seven of the children's primary caregivers from the Samaritan Children Centre who were expected to rate the children's behaviour as observed during their interactions with them. All of the caregivers were female, in their 30s, and had all obtained a Grade 12 level of education. Four of the caregivers were married with children, and the rest were single mothers.

4.4 Data collection tools

The Child Behaviour Checklist (CBCL) and the Experiences in Close Relationships Scale–Revised Child Version (ECR-RC) were used to collect data. These data collection tools are outlined below:

4.4.1 Child Behaviour Checklist (CBCL)

The Child Behaviour Checklist (CBCL) created by Achenbach (1991), is designed for children aged 6-18 years and provides a checklist of problem behaviours. It was designed for parents and close relatives/guardians to rate their children's behaviour (Goldfinger & Pomerantz, 2014). The CBCL has 118 items, each briefly describing problem behaviour. Participants rate the applicability of each statement to the child by indicating that it (1) not true, (2) somewhat or sometimes true, or (3) very often true (Goldfinger & Pomerantz, 2014). The CBCL contains two major scales, with an externalising scale measuring inattention, delinquent and aggressive behaviours, and an internalising scale measuring behaviours of withdrawal, anxiety, depression and somatic complaints. Additional scales generate scores on other problems such as attention problems (e.g. item 10: "can't sit still, restless, or hyperactive"), thought problems (e.g. item 18: "deliberately harms self or attempts suicide"), and social problems (e.g. item 11: "clings to adults or too dependent") (Goldfinger & Pomerantz, 2014).

4.4.2 Experiences in Close Relationships Scale–Revised Child Version (ECR-RC)

The Experiences in Close Relationships Scale–Revised Child Version (ECR-RC) was initially created by Fraley, Waller, and Brennan (2000) as a measure of assessing adult romantic relationships and attachment styles. However, it has been adapted to assess attachment between a child and their parent/caregiver as a self-report questionnaire (Mashegoane & Ramoloto, 2015). The ECR-RC is characterised by 36 statements which centre around the views of the children in relation to their parents, with 18 of the statements tapping into feelings of anxiety and fear of being abandoned, as well as a desire for close proximity (e.g., “I am afraid my father/mother will stop loving me”), and 18 items regarding avoidance and focusing on discomfort with being emotionally transparent and being uncomfortable with closeness and dependence(e.g., “I prefer not to show my mother/father how I feel deep down”). Items are rated on a 7-point scale ranging from strongly disagree to strongly agree. Seeing that all the children in this study were black and Northern-Sotho first-language speakers, the scale was also translated to a Northern-Sotho version for better understanding of the children. The scale was translated by Ms Molepo Tiisetso Mamitje from the University of Limpopo’s school of Languages and Communication, Department of Translations.

4.5 Reliability and Validity

Validity looks at whether an instrument measures the concepts in question (that is, what it sets out to measure) and whether it does so accurately (De Vos, 1998; Lehase, 2008). In order to ensure the validity of the study, the researcher made use of assessment scales which had been used by previous researchers in South Africa.

Reliability is less concerned with what is being measured, and rather focuses on the consistency with which an instrument assesses what it sets out to assess (De Vos, 1998; Lehase, 2008). In order to measure the reliability of the assessment tools used in the study, previous literature was consulted to determine the internal consistency of similar studies which were conducted using the same assessment tools. One such study was conducted by Mashegoane and Ramoloto (2015) using the Experiences in Close Relationships Scale–Revised Child Version (ECR-RC) and generated a

Cronbach α of .716 and .855 for the avoidance and anxiety subscales respectively. Another study done in Cape Town using the CBCL yielded a Cronbach α of 0.94 (Preston and Lester, 2015). The Cronbach α (a measurement ofinternal consistency) for the present sample was 0.97 for the CBCL and 0.87 for the ECR-RC.

4.6 Procedure

The researcher undertook the research process by first seeking and obtaining ethical clearance from the University of Limpopo's ethics committee (TREC/312/2017: PG-Amended). Permission was then obtained from the Samaritan Children Home's gatekeepers in Polokwane. The researcher then identified (with the assistance of the caregivers) children who had been in the centre for a period of longer than 6-months and had not been diagnosed with any cognitive impairment such as 1) epilepsy, 2) cerebral palsy, 3) Intellectual Developmental Disorder (IDD), and so forth. The final sample was then randomly selected from these children. The caregivers were also requested to complete questionnaires which required them to rate the identified child's behaviour.

4.7 Data Analysis

Data was captured using the computerised Statistical Package for Social Sciences (SPSS) programme (SPSS IBM Version 20) to capture data and Statistica v 10 was used for analysis. Pearson's correlation coefficient (r) was also used in the data analysis. This is a statistical measure of the strength of relationships between variables (Welman et al., 2005) and, accordingly, was used to measure the strength of the correlation between the variable under study. Descriptive analysis was also used to organise data into gender, age groups, and behavioural problem categories. In order to test hypothesis 3, multivariate analysis of analysis (ANOVA) was used in determining whether there were any significant differences between the scores of the variables under consideration.

4.8 Ethical considerations

When conducting research with human participants, it is of utmost importance that the researcher upholds certain ethical guidelines to ensure that participants are neither physically nor mentally harmed (Welman et al., 2005). The *Turnitin* plagiarism prevention service was used to ensure that the researcher's work was original. The ethical principles upheld in this study are discussed below.

4.8.1 Informed consent

The aim and objectives of the study were communicated by the researcher to the participants prior to participation. This was done in order to ensure that participants understood what they were consenting to. The caregivers were asked to sign a written consent form for themselves and on behalf of the child participants. Verbal assent was also requested from the children. The researcher also offered to answer all questions the participants had in relation to the study. Participants were assured that their participation would be solely as a result of their choice and that, should they decide to participate, they would have the right to withdraw that participation at any time they wished to without having to give any explanations for their withdrawal.

4.8.2 Confidentiality

The participants' privacy was prioritised and taken seriously when conducting the research; hence, anonymity was ensured during the conduct of the research. All identifying information about the participants collected during the course of the research was kept confidential.

4.8.3 Protection from harm

In order to protect the participants from harm, the researcher ensured that appropriate methods were used when conducting the study, thus eradicating any possible physical or psychological harm (Alderson & Morrow, 2011). Special care was taken as the research involved child participants. In particular, in order to ensure that no harm was done to the children, the Children's Act 38 of 2005 was considered for guidance on the best way to commence with working with minors. This Act states that a child's interests should take first precedence in any matter that concerns the child

(Department of Social Development, 2006). Therefore, the researcher ensured that the research was conducted in a manner which did not violate the rights and integrity of the children in any way. Ultimately, the children's rights were highly respected and protected throughout the whole process of the study, thus keeping up with both the Children's Act and the South African Constitution's Bill of Rights.

4.9 Conclusion

The current chapter focused on the methodological aspects of the study. It provided an overview of the procedures taken in the completion of the study and the ethical procedures which underpinned it.

The next chapter presents the study results and analysis.

Chapter 5: Data Analysis and Presentation of Results

5.1 Introduction

This chapter outlines and interprets the findings of this study yielded through analysis of the data collected. The current study investigated whether there was a relationship between attachment and behavioural problems in children in residential group homes (alternative care) in Polokwane, Limpopo as a function of gender and age. The final population sample consisted of fifty-two children (30 girls and 22 boys) aged 9-14. The boys consisted of 11 participants (n=11) aged 11-years and 11 participants aged 12-14, while the girls consisted of 19 participants (n=19) aged 9-11 years and 11 participants (n=11) aged 12-14 years (see Table 4 for more details). The study also included and seven of the children's caregivers (see Table 5). All participants were of African ethnic group. The findings were presented according to the sequence of the hypotheses as stated below:

- There is a positive relationship between attachment and behavioural problems in children in residential group homes.
- Children in residential group homes are likely to exhibit a higher frequency of externalising than internalising behavioural problems as measured by the Child Behaviour Checklist (CBCL).
- There are no differences between the gender and ages in relation to attachment and behaviour exhibited.

5.2 Data Analysis

The type of data analysis conducted was descriptive analysis. Inferential analyses methods (the Pearson's r, t-test and ANOVA) were also used in order to establish correlations and differences between variables. The reliability calculations of the two questionnaires done in the current study found that the Experiences in Close Relationships Scale–Revised Child Version (ECR-RC) and the Child Behaviour Checklist (CBCL) yielded a Cronbach's alpha coefficient values of 0.97 and 0.87 respectively.

5.2.1 Correlation between attachment and behavioural problems

The following section of the study focuses on the relationship between attachment and behavioural problems in children in residential group homes. Table 1 below shows a summary of correlations, means and standard deviations for scores on attachment and internalising and externalising behavioural problems among children in residential group homes.

Table 1:Summary of correlations, means and standard deviations for scores for attachment, internalising and externalising behavioural problems among children in residential group homes.

	N	Mean	SD	R	P
Attachment	52	140.71	23.13		
Internalising	52	14.61	10.38	0.2	0.11
Externalising	52	13.69	11.86	0.4	0.0004*

The table above revealed that there was a positive relationship between attachment and externalising behavioural problems in children in residential group homes only. (r = 0.4, p= 0.004). There was no significant relationship between internalising behavioural problems and attachment (r = 0.2, p= *0.11).*

This indicated that children who formed poor attachment bonds with their caregivers were likely to exhibit more externalising behavioural (p= 0.004) problems than internalising behavioural (p=0.11) problems as measured by the Child Behaviour Checklist (CBCL).

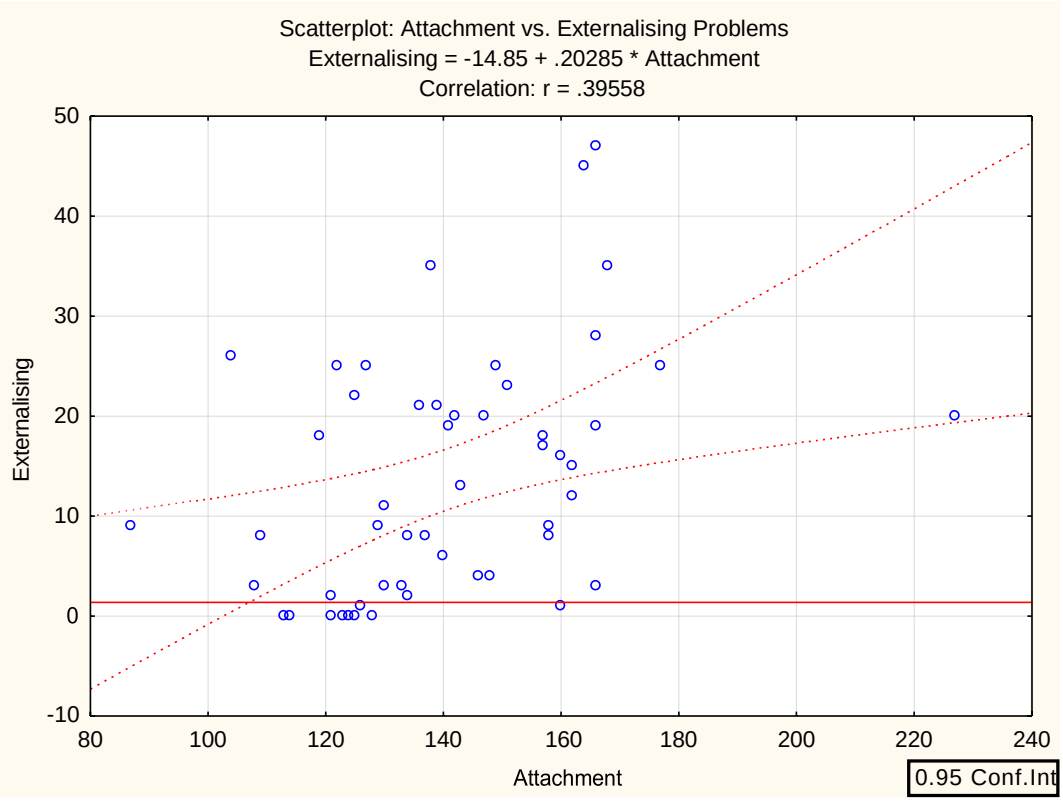

Figure 1.Showing a scatterplot between attachment and externalising behavioural problems in children in residential group homes

The scatterplot above displays the correlation between attachment and externalising behavioural problems in children in residential group homes. The scatterplot confirms that, as mentioned above, attachment was found to have a positive correlation with externalising behaviour with r= 0.4.

5.2.2 Types of behavioural problems as measured by the Child Behaviour Checklist.

This part of the study investigated the type of behaviour which was likely to be exhibited by the children in the Samaritan Children's Home. Specifically, comparison was made between externalising and internalising behavioural problems to highlight behaviours that were prevalent in the above mentioned children. Table 2 below shows a summary of correlations, means and standard deviations for scores (derived through the t-test) on internalising and externalising behavioural problems in children in residential group homes.

Table 2: T-test for dependent samples (internalising and externalising behavioural problems):

	Mean	**SD**	**N**	**Tdf*P***
Internalising	14.67	10.39	0.11	51
Externalising	13.69	11.86	52	0.64 51 0.52

A t-test for dependent samples was used to compare internalising behaviour and externalising behaviour. There was no significant difference in the scores for internalising (M = 14.67, SD = 10.39) and externalising (M =13.69, SD = 11.86) behaviours; t (51) = 0.64, *p* = 0.52. Hypothesis two was therefore rejected as there was no significant difference between results on the internalising and externalising behaviour scales of the CBCL (*p* = 0.52). This implies that children in residential group homes are just as likely to exhibit internalising behavioural problems as they are to exhibit externalising behavioural problems.

5.2.3 Gender and age differences in relation to attachment and behaviour exhibited.

The following section of the study focuses on gender and age in relation to the attachment and behavioural problems exhibited by children in residential group homes. Table 3 below shows an analysis of variance in mean scores between gender, internalising and externalising behavioural problems, and attachment in children in residential group homes.

Table 3: Analysis of Variance: Gender difference for internalising and externalising behaviours and Attachment.

	Male (n = 22)	**Female (n = 30)**	**ANOVA**	
	Mean (SD)	Mean (SD)	F(1.50)	*P*
Internalising	18.05 (13.19)	12.20 (6.99)	4.28	0.04*
Externalising	15.50 (13.71)	12.37 (10.34)	0.88	0.35
Attachment	141.27 (27.04)	140.30 (20.28)	0.02	0.88

* P < 0.05

The table shows that there are no significant differences between the genders in relation to attachment. However, significant difference was noted for internalising behaviour (*P*= 0.04). Males were found to exhibit far more internalising behaviour than

females. Hypothesis 3 can thus only be partially accepted as the only significant difference found was in the gender differences for internalising behaviours (p = 0.04). The males had significantly more internalising behavioural problems than their female counterparts.

This table shows a breakdown of the behaviour in relation to age and gender as derived from the Child Behaviour Checklist (CBCL).

Table 4: Effects of gender and age (MANOVA)

	Male		**Female**		***Group Comparison***			***Post-hoc***	
					DF	***F***	***P***	**Gender**	**Age**
Age	n = 22		n = 30						
Percentage	(42%)		(58%)						
	Mean (SD) 11.45 (1.47)		Mean (SD) 11.10 (1.40)				n/s		
Ethnicity: ***African (Northern Sotho)***	n = 22 (42%)		n = 30 (58%)				n/s		
Age groups	9-11 n=11 (21%)	12-14 n=11 (21%)	9-11 n=19 (37%)	12-14 n=11 (21%)	4, 45	6.64	<0.001		
Anxiety/ Depression	6.00 (4.80)	10.45 (5.92)	5.16 (3.13)	4.82 (2.93)				n/s	0.001
Withdrawal/ Depression	3.55 (2.77)	9.09 (4.87)	4.05 (2.91)	4.55 (2.25)				0.04	0.01
Rule Breaking	3.45 (3.30)	10.73 (6.29)	3.42 (4.78)	8.27 (3.74)				n/s	<0.001
Aggression	3.64 (3.44)	13.18 (7.93)	5.00 (4.93)	10.91 (5.36)				n/s	<0.001

* P < 0.05

n/s= not significant

Table 5: Demographic information of caregivers

Gender	N	%	
Male	0	0	
Female	7	100	
Age			
31	1		
32	0		
33	2		
34	1		
35	0		
36	2		
37	1		
Mean age:			34.29
Ethnicity			
African	7	100	

The above table (Table 4) indicates the differences in age and gender in relation to the types of behavioural problems displayed by children in residential group homes. The results showed that there was a main effect of gender on the anxiety/depression (internalising behaviour) scale of the CBCL as per the ratings from the children's caregivers. The males were noted to have scored significantly higher on this scale than the females *(p = 0.001).*

Moreover, there were main as well as interacting effects for both gender and age on this scale. Post-hoc analysis (Bonferroni) revealed that the older males (12-14) scored significantly higher than the females and the younger males (9-11) on the withdrawal/depression scale *(p = 0.01)*. The older group (12-14), both male and female, scored significantly higher on the rule breaking scale of the CBCL than the younger groups (9-11) of both males and females *(p <0.001).* This indicated that there was no significant difference in gender in relation to externalising behavioural problems. There was a main effect of age. The older group (12-14), both males and females, also scored significantly higher on the aggression scale of the CBCL than the younger groups (9-11), both males and females *(p <0.001).*

Table 5 indicates the demographic information of the caregivers who were involved in the study. The caregivers included seven African women: one of the

women was 31 years old, two were 33, one was 34, two were 36, and one was 37 years old.

5.3 Conclusion

This chapter presented data analysis and results of the study. The results revealed a positive correlation between poor attachment and externalising behavioural problems. Furthermore, there was no significant difference in terms of the types of behavioural problems which were prominent in the residential group homes as both externalising and internalising behavioural problems were likely to be exhibited. Moreover, no gender differences were found in terms of attachment. However, in terms of behavioural problems, males were found to exhibit more internalising behavioural problems than females. Both genders were likely to exhibit externalising behavioural problems, with the older groups (12-14 years) showing more behavioural problems than the younger groups (9-11 years old).

Chapter 6: Discussion of Results, Recommendations and Conclusion

6.1 Introduction

This chapter discusses the results and draws conclusions on the data collected. The study sought to investigate if there was any relationship between attachment and behavioural problems among children in residential group homes (also known as alternative care) in Polokwane, Limpopo. Several studies such as those conducted by Elovainio et al. (2015) and Bruce et al. (2009) have investigated this relationship. The results of the current study will be discussed in detail below. This section discusses the main findings of this study with regard to the following objectives which were proposed in chapter one:

- To determine the type of relationship which exists between attachment and behavioural problems experienced by children in residential group homes.
- To investigate the types of behavioural problems which were likely to be reported by the children's caregivers on the CBCL.
- To identify the gender and ages of children who were likely to experience attachment and behavioural problems.

6.1.1 The relationship between attachment and behavioural problems among children in residential group homes

The study found that there was a positive correlation between attachment and behavioural problems in children in residential group homes in the Polokwane area. This was the case especially in relation to externalising behavioural problems. The results showed that poor attachment resulted in the exhibition of behavioural problems among the children housed at the Samaritan Children's Home in Polokwane, and particular, that poorly attached children in residential group homes tend to express their emotional frustrations through behaviours such as aggression, disobedience, destroying things and rule breaking. This implies that the more poorly adjusted children are in the residential group homes, the more likely they are to exhibit negative behavioural problems.

These findings support much of the literature reviewed in chapter 2 which indicated that children with poor attachment to their caregivers further develop severe problematic behavioural difficulties to an extent that some end up being diagnosed with Reactive Attachment Disorder (RAD) amongst other behavioural problems (Jacobsen et al., 2014; LaMont, 2010; Tarren-Sweeney, 2008; Thijssen, 2016; Vanschoonlandt, Vanderfaeilie, Van Holen, & De Maeyer, 2012). The findings also concur with those from a study by Leloux-Opmeer, Kuiper, Swaab, and Scholte (2016), which reviewed characteristics of children in residential group homes and found that 39 to 57 % of the children in care had poor attachment, as well as emotional problems as measured with the Child Behaviour Checklist (CBCL). Paczkowski (2016) also found a positive correlation between attachment and externalising behaviour in a study done in the Mid Atlantic United States. This implies that poorly attached children have an increased tendency of externalising behavioural frustration.

This can be explained in terms of the Attachment Theory which postulates that maladaptive views of the self and other (internal working models) result in aggressive behaviour (Paczkowski, 2016). Aggressive behaviour has been described in this study as one of the most common externalising behaviours.

6.1.2 Types of behavioural difficulties likely to emerge on the Child Behaviour Checklist (CBCL)

The study found that there was no significant difference in terms of the types of behavioural problems which emerged on the Child Behaviour Checklist (CBCL) questionnaire as portrayed by the children (based on their caregivers' feedback) in the study. Thus, both internalising and externalising behavioural problems were equally exhibited. This is contrary to a study done by Vis, Handegard, Holtan, Fossum, and Thornblad (2014) which revealed a higher prevalence of internalising than externalising problems on the CBCL among children in alternative care.

The children in the study were found to exhibit both internalising and externalising behavioural problems with no specific type being more prevalent than the other. This implies that both internalising and externalising behaviour were prevalent in almost equal measures in the residential group home.

6.1.3 The influence of gender and age on attachment and behavioural difficulties

The results revealed no significant differences between the genders in relation to attachment. This finding can makes sense in terms of Attachment Theory which postulates there is no difference in the ability of males and females in attachment bonds with their caregivers (Paczkowski, 2016).

However, regarding the behaviour exhibited in relation to gender among the children in the Samaritan's Children Centre, internalising behaviours problems were found to be more prevalent than externalising behaviour in male children than in females. This includes behaviours displayed when children avoid externalising their feelings but rather portray their frustration through behaviours such as depression, passive aggressive tendencies, and anxiety. This is in contrast to other studies such as that done by Paczkowski (2016) which have found no gender differences in the type of behaviour exhibited when investigating the relationship between attachment and behaviour in high risk children. It is also in contrast the findings of Vis et al. (2014) that Conduct Disorder symptoms (externalising behaviour) are more common among boys than girls, but that, when they are present in girls, they are more severe.

The internalising behavioural problems among male children can also be explained in terms of the African adage "monna ke nku, ollela teng", which loosely translates to "a man is a sheep, he cries on the inside". This proverb thus encourages male children to internalise their feelings from a very young age. Furthermore, Shelly (2007) found evidence that children of both genders tend to show similar reactions to situations, but that males are encouraged, thought different platforms such as the media, toys, parents, to suppress their emotions (Shelly, 2007). Thus, the suppression of emotions in males is seen as a portrayal of masculinity.

In terms of age, the current study revealed that older male children (12-14 years) scored higher on the internalising scale than the female children. A breakdown of the internalising behaviour scales from the Child Behaviour Checklist (CBCL) revealed that the older males scored higher on the anxiety, withdrawal, and depression scales than both the girls of all ages, as well as the younger males (aged 9-11 years). Furthermore, the results showed that both older male and female children (12-14 years

old) scored higher than the younger children of both genders on externalising behaviour (mainly aggression and rule breaking).

This can be explained in terms of Attachment Theory in that, although attachment bonds between children and their caregivers are likely to form at any point in the child's life, the bond is particularly stronger when the child is still young (Bakermans-Kranenburg et.al., 2011). Also, behavioural problems could be more prevalent in older children as they are entering into puberty where naturally, behavioural difficulties are likely to emerge in this age group due to biological factors such as changes in hormones in both genders.

Previous studies have revealed that externalising behaviour was more prevalent among boys than girls while other studies found it to be prevalent in both boys and girls. Focusing on externalising behaviour (especially aggression), Shields and Pierce (2012) suggest that factors such as family influence and processes often fuels childhood aggressive behaviour in both genders, which then leads to these children being socially rejected and isolated by peers. Therefore, emphasis should be placed on positive social interactions which enhance the development of positive social skills that can help enhance the children's interactions with peers and adults alike. Without these opportunities, aggressive behaviour is likely to perpetuate and be used as a tool to deal with the environment (Shields & Pierce, 2012).

6.1.4 Overall summary of the findings

The current study was conducted on children residing in the Samaritan Children's Home in Polokwane. The children's respective caregivers completed the Child Behaviour Checklist in order to provide an outline of behaviour the children exhibited regularly. The results revealed a significant correlation between attachment and behavioural problems in children in residential group homes. It was noted that externalising behavioural problems had the strongest correlation to poor attachment compared to internalising behavioural problems. Additionally, in terms of behavioural difficulties exhibited on the Child Behaviour Checklist (CBCL) there was no difference in prevalence between externalising and internalising behaviour; both behavioural difficulties were prominent. Lastly, male children were found to exhibit more

internalising behavioural problems than their female counterparts. The older children of both genders were found to exhibit more behavioural difficulties than their younger counterparts.

6.2 Limitations of the Study

6.2.1 Sample size

The sample size in the current study was small and thus could not be considered a holistic representative of all residential group homes in the Polokwane area.

6.2.2 Control group

The researcher realised in hindsight that the study would have been more informative had the population group been compared with a control group of children in a different residential setting.

6.2.3 Cultural consideration

It is imperative for studies on behaviour to take into consideration the cultural context in which they are undertaken. Although many studies have been done with children of different racial groups and cultural backgrounds, most studies on attachment have been done in the Western culture. The current study was conducted on African children who are socialised differently than Western children. Therefore, attachment could be perceived differently and African children may be encouraged to express their needs in different ways than their Western counterparts.

6.3 Recommendations

6.3.1 Focus of future studies

Future studies should also make reference to the age at placement which is also likely to play a significant factor in the prediction of attachment and behavioural difficulties. Other variable such as adverse childhood effects (abuse, neglect, etc.),

genetics, and physiological factors can also be looked at as contributing agents in the formation of secure attachment or lack thereof in children in residential group homes.

6.3.2 Caregiver training and wellness

The type of (in relation to educational background) and experiences of caregivers allocated to take care of the children in alternative care significantly impact the children's transition into the new setting. Caregiver sensitivity has been known to play a significant role in forming attachment bonds. Thus it is crucial for the caregivers to receive professional training and also be sensitised to Attachment Theory in order for them to be aware of and promptly respond to the children's needs. The caregivers also need support in terms of mental health so they are in a better mental/emotional state to allow them to positively respond to these children's needs.

6.4 Conclusion

The study aimed at investigating the relationship between attachment and behavioural problems in children in residential group homes in the Polokwane area in Limpopo Province. Previous studies conducted have also found that a relationship existed between the two concepts and that poor attachment resulted in behavioural problems both in children who were in alternative care and with children who lived with their biological parents. Although there were similarities between the results derived from these studies and the current study, it was interesting to note the difference in the behaviour observed in male children. Most studies have reported that males exhibit more externalising behaviour than females; however, the current study found that males were found to have more internalising behaviour than females. Also interesting was the finding that externalising behaviour was prevalent in both genders. Attachment Theory was used as a framework for this study.

References

Ainsworth, M. D. S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Lawrence Erlbaum.

Alderson, P.& Morrow, V. (2011). The ethics of research with children and young people: A practical handbook. London, UK: Sage.

Babbie, E. (2010). *The practice of social research*. Cape Town, South Africa: Oxford University Press Southern Africa.

Bakermans-Kranenburg, M.J., Dobrova-Krol, N., Van IJzendoorn, M. (2011). Impact of institutional care on attachment disorganization and insecurity of Ukranian preschoolers: Protective effect of the long variant of the serotonin transporter gene (5HTT). *International Journal of Behavioural Development, 17*(6), 87-90.doi:177/0165025411406858

Barnett, D., & Vondra, J.I. (2013). Atypical patterns of early attachment: Theory, research, and current directions. *Journal of Developmental Psychology, 12*(6), 212-310.

Barth, R.P. (2015). *Institutions vs. foster homes: The empirical base for the second century of debate*. Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Bask, M. (2015). Externalising and internalising problem behaviour among Swedish adolescent boys and girls. *International Journal of Social Welfare, 42*(2), 111-121.

Berkout, O.V., Young, J.N., Gross, A.M. (2011). Mean girls and bad boys: Recent research on gender differences in conduct disorder. *Aggression and Violent Behaviour, 16*(6), 503-511.

Bernedo, I.M., Salas, M.D., García-Martín, M.A., Fuentes, M.J. (2012).Teacher assessment of behaviour problems in foster care children.*Children and Youth Services Review, 34*(12), 615–621.

Blakely, T.&Dziadosz, G.M. (2015).Application of attachment theory in clinical social work. *Health and Social Work, 40*(4), 59-67.

Bless, C., Higson-Smith, C., &Kagee, A. (2006).*Fundamentals of Social ResearchMethods*: *An African Perspective*. Cape Town: Juta& Co. Ltd.

Bovenschen, I., Lang, K., Zimmermann, J., Förthner, J., Nowacki, K., Roland, I., &Spangler, G. (2016). Foster children's attachment behaviour and representation: Influence of children's pre-placement experiences and foster caregiver's sensitivity. *Child Abuse & Neglect, 51*(2), 323–335.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment* (2nd ed.). New York, NY: Basic Books.

Bowlby, J. (1969). *Attachment and loss*. New York, NY: Basic Books.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(2), 759-775.

Bretherton, I. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. *Journal of Psychology, 22*(3), 87-93.

Bretherton, I., & Munholland, K.A. (2015). The origins of attachment and a closer look atinternal working models. *Journal of Developmental Psychology,37*(2), 214-223.

Bruce, J., Tarullo, A.R., & Gunnar, M.R. (2009).Disinhibited social behaviour among internally adopted children.*Journal of Developmental Psychopathology, 21*(1), 157-171.

De Vos, A.S. (1998). *Research at grass root: A primer for caring professions*. Pretoria, South Africa: Van Schaik.

Department of Social Development. (2005). *Children's Act No. 38 of 2005*. Cape Town: Government Printers.

Dozier, M., Kaufman, J., Kobak, R., O'Connor, T.G., Sagi-Schwartz, A., Scott, S., Shauffer, C., Smetana, J., & Van Ijzendoorn, M.H., (2014). Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association. *American Journal of Orthopsychiatry, 84*(3), 219–225.

Dubois-Comtois, K., Bernier, A., Tarabulsy, G.M., Cyre, C., St-Laurent, D., Lanctôt-Béliveau, M. (2015). Behaviour problems of children in foster care: Associations

with foster mothers' representations, commitment, and the quality of mother–child interaction. *Child Abuse & Neglect, 48*(2), 119–130.

Elovainio, M., Raaska, H., Sinkkonen, J., Makippa, S., &Lapinleimu, H. (2015). Associations between attachment-related symptoms and later psychological problems among international adoptees: Results from the FinAdo study. *Scandinavian Journal of Psychology, 2*(56), 53-61.doi:10.1111/sjop.12174

Fearon, R. P., Bakermans-Kranenburg, M. J., van Ijzendoorn, M. H., Lapsley, A. M., & Roisman, G.I. (2010). The significance of insecure attachment and disorganization in the development of children's externalising behaviour: A meta-analytic study. *Journal of Child Development, 81*(2), 435–456.

Fernandez, E. (2008). Unravelling emotional, behaviour and educational outcomes in a longitudinal study of children in foster care. *British Journal of Social Work, 38*(3),1283–1301.

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000).An item response theory analysis of self-report measures of adult attachment. *Journal of Personality and Social Psychology, 78*(1), 350–365.

Gabler, S., Bovenschen, I., Lang, K., Zimmermann, J., Nowacki, K., J. Kliewer, J., & Spangler, G. (2014). Foster children's attachment security and behaviour problems in the first six months of placement: associations with foster parents' stress and sensitivity. *Attachment & Human Development, 16*(5), 479–498.

Godinet, M.T., Li, F., & Berg, T. (2013). Early childhood maltreatment and trajectories of behavioural problems: Exploring gender and racial differences. *Child Abuse& Neglect, 1*(38), 544–556.

Goldfinger, K. & Pomerantz, A.M. (2014). Psychological assessment and report writing (2nd ed.). London: Sage.

Hawkins-Rodgers, Y. (2017). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behaviour and building resiliency. *Children and Youth Services Review, 29*(2), 1131–1141.

Jacobs, C., Bifulco, A., &Ilan-Clarke. (2016). Adolescents Attachment Style in Residential Care: The Attachment Style Interview and Vulnerable Attachment Style Questionnaire. The British Journal of Social Work, *17*(1), 1870-1883.

Jacobsen, H., Ivarsson, T., Wentzel-Larsen, T., Smith, L., & Moe, V. (2014). Attachment security in young foster children: continuity from 2 to 3 years of age. *Attachment & Human Development, 16*(1), 42–57.

James, S., Leslie, L.T., Hurlburt, M.S., Slymen, D.J., Landsverk, J., Davis, S.G., Zhang, J. (2010). Children in out-of-home care: Entry into intensive or restrictive mental health and residential care placement. *Journal of Emotional and Behavioural Disorders, 14*(4), 28-39.

Johnson, T.J. (2005).*Literature review of out-of-home care*. Retrieved from www.fostercareeducation.org

Jonkman, C.S., Schuengel, C., Lindeboom, R., Oosterman, M., Boer, F., &Indauer, J.L. (2014). The effectiveness of multidimensional treatment out-of-home care for preschoolers for young children with severe behavioural disturbances: Study protocol for randomized controlled trial. *Journal of Child and Adolescent Psychiatry, 12*(7), 134-146.

LaMont, M. (2010).Mother-child attachment and preschool behaviour problems in children with developmental delays. *Journal of Social Work, 16*(2), 23-27.

Leathers, S.J., Spielfogel, J.E., Gleeson, J.P., &Rolock, N. (2012). Behaviour problems, foster home integration, and evidence-based behavioural interventions: What predicts adoption of foster children? *Children and Youth Services Review, 34*(20) 891–899.

Lehase, K.C. (2008). *Factors influencing output in the four (4) year nurse training programme in the Free State province* (Unpublished master's dissertation). University of South Africa, Pretoria, South Africa

Leloux-Opmeer, H., Kuiper, C., Swaab, H., & Scholt, E. (2016). Characteristics of children in foster care, family-style group care, and residential care: A scoping review. *Journal of Child and Family Studies, 25*(8), 235-241.

Lesch, E., Deist, M., Booysen, L., & Edwards, E. (2013).South African social workers' knowledge of attachment theory and their perceptions of attachment relationships in foster care supervision. *Children and Youth Services Review,1*(35),1101–1109

Lindhiem, O., & Dozier, M. (2007). Caregiver commitment to children in out-of-home care: The role of child behaviour. *Child Abuse & Neglect, 31*(4), 361–374.

Lionetti, F., Pastore, M., & Barone, L. (2015). Attachment in institutionalised children: a review and meta-analysis. *Child Abuse and Neglect, 42*(5), 135-145.

Maaskant, A.M., van Rooij, F.B., & Hermanns, J.M.A. (2014). Mental health and associated risk factors of Dutch school aged foster children placed in long-term foster care. *Children and Youth Services Review, 44*(2), 207–216.

Mashegoane, S., & Ramoloto, N.P. (2016).Attachment dimensions' capacity to predict problem behaviours in an African context. *South African Journal of Psychology, 46*(2), 266–277.doi:10.1177/0081246315603334

McGrath-Lone, L., Dearden, L, Nasim, B., Harron, K., & Gilbert, R., (2016). Changes in first entry to out-of-home care from 1992 to 2012 among children in England. *Child Abuse & Neglect, 51*(2), 163–171.

McLean, S., Price-Robertson, R., & Robinson, E. (2011).Therapeutic residential care in Australia Taking stock and looking forward. *Journal of the National Therapeutic Residential Care, 21*(6), 345-430.

Ohara, R., & Matsuura, T. (2016). The characteristics of delinquent behaviour and predictive factors in Japanese children's homes. *Children and Youth Services Review*, 6(2), 159–164.

Paczkowski, E.A. (2016). The relationship between attachment and externalizing behaviours in normative versus high-risk samples. *Journal of Psychology, 1*(2), 12-17.

Papas, S. (2015). Oxytin: Facts about the "cuddle hormone". *Journal of Science, 2*(1), 16-19.

Pederson, D.R., Moran, G., & Bento, S. (1999). Maternal Behaviour Q-sort Version 3.1. Journal of Psychology, *1*(2), 12-15.

Perry, K.L., & Price, M. (2018). The role of placement history and current family environment in children's aggression in foster care. *Journal of Child And Family Studies, 26*(7),1135–1150, doi:10.1007/s10826-016-0642-z

Preston, N., & Lester, S. (2015). *Do contextual stressors affect parenting behaviours and child aggression in South African Townships?* (Unpublished master's dissertation). University of Cape Town, Cape Town, South Africa

Quiroga, M.G., & Hamilton-Giachritsis, C. (2016). Attachment styles in children living in alternative care: A systematic review of the literature. *Child Youth Care Forum, 16*(45), 625–653, doi:10.1007/s10566-015-9342-x

Quiroga, M.G., & Hamilton-Giachritsis, C., & Fanéz, M.I. (2017). Attachment representations and socio-emotional difficulties in alternative care: A comparison between residential, foster, and family based children in Chile. *Journal of Child Abuse and Neglect, 70*(3), 180-189.

Raaskaa, H., Elovainio, M., Lapinleimud, H., Matomäkid, J., & Sinkkonene.J. (2015). Changes in attachment-related behavioural problems of internationally adopted toddlers in Finland: Results from the FinAdo Study*. Infant and Child Development, 24*(1), 79-93. doi:10.1002/icd.1876

Republic of South Africa. (1996). *Constitution of the Republic of South Africa, Act No. 108 of 1996*. Pretoria: Government Printers.

Sadock, B.J. &Sadock, V.A. (2007).*Synopsis of Psychiatry: Behavioural Science/Clinical Psychiatry* (9th ed.). Philadelphia, PA: Williams &Wilkins.

Shelly, M.T. (2007). Take it like a man: A study of men's emotion culture. *Journal of Philosophy, 1*(1), 19-25.

Shields, N. & Pierce L. (2012). Factors relating to aggressive and violent behaviour among preadolescent African-American boys. *International Journal of Adolescence and Youth, 10*(2), 51-68.

Sirkin, R.M. (2015). Statistics for the Social Sciences*. Journal for Social Psychology, 8*(2), 23-26.

Stein-Steele, E.C. (2015). Perspectives of foster parents on parental roles and involvement in their foster children's academic work.*Journal of Ethnographic & Qualitative Research, 9*(1), 317–332.

Suzuki, H., & Tomoda, A. (2015). Roles of attachment and self-esteem: impact of early life stress on depressive symptoms among Japanese institutionalised children. *Journal of Psychiatry, 15*(8), 119-243.doi:10.1186/s12888-015-0385-1

Tarren-Sweeney, M. (2008). Retrospective and concurrent predictors of the mental health of children in care. *Children and Youth Services Review, 30*(1), 21–25.

Thijssen, J. (2016). Children with externalising behaviour problems: Risk factors and preventive effort. *American Journal of Psychiatry, 17*(3), 125-140.

UNICEF (2009).*Attachment theory into practice*(Paper No. 2).New York, NY: Author.

Van der Kolk, A.B. (2005). Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories. *Journal of Psychiatry, 35*(2), 401-408.

Vanschoonlandt, F., Vanderfaeilie, J., Van Holen, F., & De Maeyer, S. (2012). Development of an intervention for foster parents of young foster children with externalising behaviour: Theoretical basis and program description. *Clinical Child Family Psychology Review, 15*(2), 330-344.

Villegas, S.A., & Pecora, P.J. (2012). Mental health outcomes for adults in family foster care as children: An analysis by ethnicity. *Children and Youth Services Review, 1*(34), 1448–1458.

Vis, S.A., Handegård, B.H., Holtan, A., Fossum, S., & Thørnblad, R. (2014). Social functioning and mental health among children who have been living in kinship and non-kinship foster care: results from an 8-year follow-up with a Norwegian sample. *Child and Family Social Work, 2*(2), 557–567.

Ward, T.K. (2014). Adjustment Differences in Teenage Children: Foster Care versus Group Home. Journal of Social Work, 17(2), 134-140. Retrieved from https://sophia.stkate.edu/msw_papers/406

Welcome, K. (2013). The externalising and internalising behaviour in children: Preventing negative future consequences. *Journal of Child Psychology, 7(*2), 21-29.

Welman, C., Kruger, F., & Mitchell, B. (2005).Research Methodology. Cape Town, South Africa: Oxford University Press, Southern Africa.

Zeenah, C.H., Smyke, A.T., Koga, S.F., & Carlson, E. (2015).Attachment in institutionalised and community children in Romania. *Journal of Child Development, 15*(2), 121-142.

Appendices

Appendix A: Consent form

Consent form to be signed by caregivers

I _____ hereby agree to participate as well as give permission for _____

(Name of child) to participate in a Masters research project that focuses on the relationship between attachment and behavioural problems among children in residential group homes in Polokwane. The purpose of the study has been fully explained to me and the children. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my answers will remain confidential.

Signature: _____

Date: _____

Appendix B1: Experiences in Close Relationships Questionnaire – Revised For Children (ECR-RC)

Your name_____ **Today's date** _____

Age_____ **Gender** _____

The statements below concern how you feel in your relationship with your mother. Using the 1 to 7 scale, after each statement write a number to indicate how much you agree or disagree with the statement.

1	2	3	4	5	6	7
Strongly disagree	**Disagree**	**Somewhat disagree**	**Neutral**	**Somewhat Agree**	**Agree**	**Strongly agree**

	ANXIETY ITEMS	1	2	3	4	5	6	7
1.	I'm afraid my mother will stop loving me							
2.	I'm worried that my mother might want to leave me							
3.	I am worried that my mother doesn't really love me							
4.	I am worried that my mother doesn't love me as much as I love her							
5.	I wish my mother would love me just as much as I love her							
6.	I worry a lot about my relationship with my mother							
7.	When I don't see my mother, I worry she may stop thinking about me							
8.	When I show my mother I love her, I'm afraid she doesn't love me just as much							
9.	I do not often worry that my mother would abandon me							
10.	The things my mother says and does make me unsure about myself							
11.	I feel that my mother does not want to get as close to me as I'd like							
12.	I sometimes think my mother has changed her feelings about me without any reason							
13.	I'm afraid that I want to feel too close to my mother and she does not like it							
14.	I'm afraid my mother wouldn't love me any more if she found out how I really feel and what I really think							
15.	I get angry because my mother doesn't give me enough love and support							

16.	I'm afraid my mother thinks less of me than she does of other children							
17.	I think my mother only pays attention to me when I make a fuss							
	AVOIDANCE ITEMS							
18.	I don't like telling my mother how I feel deep down inside							
19.	I find it easy to tell my mother what I think and how I feel							
20.	I find it difficult to admit I need help from my mother							
21.	I am very comfortable feeling close to my mother							
22.	It's not easy for me to tell my mother a lot about myself							

23.	I prefer not to get too close to my mother							
24.	I don't feel comfortable when my mother cuddles up to me too much							
25.	Feeling close to my mother comes easily me							
26.	It's not difficult for me to feel close to mother							
27.	I usually talk to my mother about my problems and worries							
28.	When I feel bad, it helps to talk to my mother							
29.	I tell my mother nearly everything							
30.	I talk things through with my mother							
31.	I get nervous when my mother wants me to share really close moments							
32.	I find it easy to ask my mother for help							
33.	I find it easy to rely on my mother							
34.	I find it easy to show my mother I love her							
35.	I feel that my mother understands me well							

Appendix B2: Letlakalapotšišo La Maitemogelo Ka Dikamano Tša Kgauswi – E Diretšwe Bana (ECR-RC)

Leina la gago_____ Letšatšikgwedi la lehono _____

Mengwaga_____ Bong _____

Ditatamentetšakafase di amana le ka moo o ikwagokagonakakamanoyagago le mmewagago. Go dirišwapapetšoya 1 go ya go 7, kamoragogasetatamente se sengwe le sesengwengwalapalo go šupaka moo o dumelelanagogoba o gananago le setatamente.

1	2	3	4	5	6	7
Ketlogakes adumele	**Gakedumele**	**Gakedumele egannyane**	**Kekamo le kamo**	**Kedumelag annyane**	**Ke a dumela**	**Kedumela kudu**

	DITATAMENTE TŠA MABAPI LE GO TSHWENYEGA	1	2	3	4	5	6	7
1.	Ketšhoga gore mmewaka o tlotlogela go nthata							
2.	Ketshwenyegile gore mmewaka a ka no nyaka go ntlogela							
3.	Ketshwenyegile gore mmewakaga a nthate e le kannete							
4.	Ketshwenyegile gore mmewakaga a nthate go lekana le ka moo kemoratagokagona							
5.	Ke duma gemmewaka a kanthata go lekana le ka moo kemoratagokagona							
6.	Ketshwenyega kudu kakamanoyaka le mmewaka							
7.	Gekesa bone mmewaka, ketshwenyega gore a katlogela go gopolakanna							
8.	Gekebontšhammewaka gore ke a mo rata, Ketšhoga gore ga a nthate kudu							
9.	Gaketshwenyegegantši gore mmewaka a kantlogela							
10.	Dilotšeommewaka a di bolelago le tšeo a di dirago di dira gore kehlokennetekanna							
11.	Ke bona gore mmewakaga a nyake go amana le nnaka moo nkaratagokagona							
12.	Kadinakotšedingwekenagana gore mmewaka o fetotšemaikutlo a gagwekannantle le lebaka							
13.	Ketšhoga gore kenyaka go iponakeamana le mmewaka kudu gommeyenaga a rate seo							

14.	Ketšhoga gore mmewaka a ka se hlwe a nthatage a katsebaka moo keikwagokagona le seoke se naganago							
15.	Ke a kwataka gore mmewakaga a mphelerato le thekgo yeo e lekanego							
16.	Ketšhoga gore mmewakaga a mponebjaloka ban aba bangwe							
17.	Kenagana gore mmewaka o ba le šedi go nnafelagekebalabalakaseo							
	DITATAMENTE TŠA MABAPI LE GO TLOGELA							
18.	A ke rate go botšammewakaka moo keikwagokapelongyaka							
19.	Ke bona go le bonolo go botšammewakakaseoke se naganago le ka moo keikwago							
20.	Go boima gore keamogele gore kehlokathušo go tšwa go mmewaka							
21.	Keikwakelokologilegeketlwaetšemmewaka							
22.	A go bonolo go nna go botšammewakatšedintšikanna							

23.	Kekgetha go se tlwaelemmewaka kudu							
24.	A keikwekelokollogilegemmewaka a raloka le nna kudu							
25.	Go tlwaelammewaka go bonolo go nna							
26.	A go boima go nna go ikwaketlwaetšemmewaka							
27.	Gantšikebolela le mmewakakamathataaka le matshwenyego a ka							
28.	Gekeikwagampe, go a thuša go bolela le mmewaka							
29.	Kebotšammewakadilokamoka							
30.	Keboleladilo le mmewaka							
31.	Ke a tšhogagemmewaka a nyakagoba le kamanayakgauswi le nna							
32.	Ke bona go le bonolo go kgopelathušo go mmewaka							
33.	Ke bona go le bonolo go beaTshepho go mmewaka							
34.	Ke bona go le bonolo go bontšhammewaka gore kea mo rata							
35.	Kenagana gore mmewaka o nkwešišagabotse							

Appendix B3: The Child Behaviour Checklist (CBCL).

Please print. Be sure to answer all items.

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters)
☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. Performance in academic subjects. ☐ Does not attend school because:

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

Other academic subjects–for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?
☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start?_____
Have these problems ended? ☐ No ☐ Yes–when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.

Be sure you answered all items.

Please print. Be sure to answer all items.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe): _____
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Too shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Inattentive or easily distracted
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up too many things he/she doesn't need (describe): _____
_____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Smokes, chews, or sniffs tobacco
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses drugs for nonmedical purposes (***don't*** include alcohol or tobacco) (describe): _____
_____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

Please be sure you answered all items.

Appendix C: Samaritan children's home permission

60 Gazelle Str
Fauna Park
Polokwane
limpopo Province
South Africa

Samaritan Children's Home
www.samaritanlimpopo.org
REG No 019-569-NPO

Box 284
Fauna Park
0787
Tel/Fax: 015 296 0149

Reg no- 019-569

12/09/2017

SOCIAL@SAMARITANLIMPOPO.ORG

THE UNIVERSITY OF LIMPOPO

To whom it may concern:

RE: Permission to conduct research study.

It is my understanding that Ms Tshepiso Sharon Nkuna will be conducting a research study at a group foster care home on the **"RELATIONSHIP BETWEEN ATTACHMENT AND BEHAVIOURAL PROBLEMS AMONG CHILDREN IN FOSTER CARE IN POLOKWANE, LIMPOPO PROVINCE"**. Ms Nkuna has informed me of the design of the study as well as the targeted population to participate in the study.

Therefore, this letter serves as permission for Ms Nkuna to carry out her research study at the **Samaritan Children's Centre.** I support this effort and will be available to provide any assistance necessary for the successful implementation of the study. Should you have any questions, I can be reached at (0794201335/ 0152960149).

Kind regards

Mokwena K.T (Social worker)

MOKWENA K.T

Appendix D: TREC Ethical Clearance Certificate

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: **27 November 2018**

PROJECT NUMBER: **TREC/312/2017:PG-Amended**

PROJECT:

Title:	Relationship between attachment and behavioural problems among children in Residential Group Homes/Alternative Care in Polokwane, Limpopo Province.
Researcher:	TS Nkuna
Supervisor:	Dr MB Setwaba
Co-Supervisor/s:	Dr S Govender Prof K Nel
School:	Social Sciences
Degree:	MA Clinical Psychology

PROF FAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:
i) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.**
ii) **The budget for the research will be considered separately from the protocol.**
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.