

**THE ASSOCIATION BETWEEN
SELF-CONCEPT AWARENESS AND
EMOTION- FOCUSED COPING OF
CHILDREN WITH ATTENTION
DEFICIT- HYPERACTIVITY
DISORDER**

Jacqueline Caseiro Gomes Da Silva

2008

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AWARENESS AND EMOTION- FOCUSED COPING
OF CHILDREN WITH ATTENTION DEFICIT-
HYPERACTIVITY DISORDER**

by

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Supervisor:

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In loving memory of my grandfather, Adelino Caseiro.

DECLARATION

I, Jacqueline Caseiro Gomes Da Silva (26220963) hereby declare that all the resources that were consulted are included in the reference list and that this study is my original work.

J. Caseiro Gomes Da Silva

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SUMMARY

THE ASSOCIATION BETWEEN SELF-CONCEPT AWARENESS AND EMOTION-FOCUSED COPING OF CHILDREN WITH ATTENTION DEFICIT-HYPERACTIVITY DISORDER

by
Jacqueline Gomes Da Silva

Supervisor: Prof. Liesel Ebersöhn
Department: Educational Psychology
Degree: M Ed (Educational Psychology)

The purpose of this exploratory and descriptive study was to determine the association (if any) between the self-concept awareness and emotion- focused coping of children with ADHD. Theories informing this study were Barkley's conceptualisation of ADHD, Bandura's social cognitive theory as a means of understanding self-concept awareness and Gonzales and Seller's theory of emotion- focused coping. The study was conducted by means of *an intervention research design*. I purposively selected two children with ADHD and their respective parents, educators and therapists to participate in the study. Ebersöhn's intrapersonal regulation intervention was implemented with the child participants at different intervals. Both child participant's self-concept awareness and emotion- focused coping strategies were assessed pre- and post intervention, through the use of formal interviews and observations. The data was analysed and interpreted through thematic analysis. The following themes emerged; self-concept awareness, adaptive emotion-focused- coping strategies and maladaptive emotion-focused coping strategies. Findings of the study confirmed that prior to the intervention, the two child participants were predisposed towards emotion- focused coping, especially maladaptive emotion- focused coping strategies. Post- intervention findings suggested that increased self-concept awareness resulted in the use of two adaptive emotion- focused coping strategies (namely relaxation methods and re-appraisal) with maladaptive emotion- focused coping (namely direct- active physical aggression and direct-passive aggression) remaining. Thus, an association exists between self-concept awareness and emotion- focused coping in children with ADHD.

Die doel van hierdie ondersoekende en beskrywende studie was om die assosiasie (indien enige) vas te stel tussen self-konsepbewustheid en emosie-gefokusde hantering van kinders met AAHV. Teorie wat hierdie studie ondersteun was Barkley se konseptualisering van AAHV, Bandura se sosiale kognitiewe teorie as 'n middel om self-konsep bewustheid te verstaan en Gonzales en Sellers se teorie van emosie-gefokusde hantering. Die studie was gerig deur middel van 'n intervensie-navorsingsontwerp. Ek het doelbewus twee seuns met AAHV en hulle onderskeie ouers, opvoeders en terapeute eeselekteer om deel te neem in die studie. Ebersöhn se intra-persoonlike regulasie intervensie was geïmplementeer met die kinder-deelnemers op



verskeie tye. Beide kinder-deelnemers se self-konsepbewustheid en emosie-gefokusde hanteringstrategieë was voor- en na intervensie ge-assesseer, deur middel van formele onderhoude en observasies. Die data was toe ge-analiseer en geïnterpreteer deur tematiese analise. Die volgende temas het te voorskyn gekom; self-konsepbewustheid, funksionele emosie-gefokusde hanteringstrategieë en nie-funksionele emosie-gefokusde hanteringstrategieë. Bevindinge van die studie het bevestig dat voor die intervensie, die twee kinder- deelnemers geneig was tot emosie-gefokusde strategieë, veral nie-funksionele emosie-gefokusde hanteringstrategieë. Na-intervensie bevindinge stel voor dat verhoogde self-konsepbewustheid gelei het tot die gebruik van twee funksionele emosie-gefokusde hanteringstrategieë (naamlik ontspanningsmetodes en her-evalueering) terwyl nie-funksionele emosie-gefokusde hantering (naamlik direkte-aktiewe fisieke aggressie en direkte-passiewe aggressie) nog teenwoordig was. Dus, 'n assosiasie bestaan tussen self-konsepbewustheid en emosie-gefokusde hantering in kinders met AAHV.

Key Words:

Attention Deficit- Hyperactivity Disorder

Self-Concept Awareness

Emotion- Focused Coping

Intervention

Interpretivism

Interventionist Research Design

TABLE OF CONTENTS

	Page
Chapter 1: Contextualising my Research Study	
1.1 Introduction and Rationale	1
1.1.1 Why ADHD?	3
1.1.2 Why Emotion- Focused Coping?	4
1.2 Purpose of the study	5
1.3 Research Question	6
1.4 Clarification of Key Concepts	6
1.4.1 Introduction	6
1.4.2 Children diagnosed with Attention-Deficit Hyperactivity Disorder	6
1.4.3 Self-Concept Awareness	7
1.4.4 Emotion-focused coping strategies	7
1.4.5 Intervention	8
1.5 Paradigmatic Assumptions	9
1.5.1 Metatheoretical Paradigm	9
1.5.2 Methodological Paradigm	10
1.6 Research Methodology and Data Collection Strategies	10
1.6.1 Research Design: Intervention Research	10
1.6.2 Selection of Participants	10
1.6.3 Data Collection Strategies	11
1.6.4 Data Analysis and Interpretation	11
1.7 Ethical Considerations	11
1.8 Quality Criteria	12



1.9	Role of Researcher	12
1.10	Outline of Chapters	12
1.11	Conclusion	12

CHAPTER 2: Conceptual Parameters

Page

2.1	Introduction	14
2.2	Fundamental underpinnings of Attention Deficit Hyperactivity Disorder	14
2.2.1	An Introduction to Attention Deficit Hyperactivity Disorder	14
2.2.2	What are the challenges experienced by children with ADHD	15
2.2.3	Challenges associated with ADHD and their impact on the self-concept awareness of the child with ADHD	18
2.3	Fundamental Underpinnings of Coping	22
2.3.1	Introduction to Coping	22
2.3.1.1	Problem-Solving Coping Strategies	23
2.3.1.2	Emotion- Focused Coping Strategies	23
2.3.1.3	Conceptualization of Coping in this study	24
2.3.2	Coping strategies and the child with ADHD (hyperactive-impulsive type)	27
2.3.3	How do these challenges associated with ADHD impacts on the child with ADHD's chosen coping strategies?	28
2.4	What interventions exist to impact on self-concept awareness and emotion-focused coping	30
2.5	Conclusion	34



	Page
Chapter 3: Paradigmatic Assumptions	
3.1 Introduction	35
3.2 Purpose of the study and research questions	35
3.3 Paradigmatic Assumptions	36
3.3.1 Introduction	36
3.3.2 Metatheoretical Paradigm	37
3.3.3 Methodological Paradigm	38
3.4 Research Design	40
3.4.1 Introduction	40
3.4.2 Intervention Research Design	40
3.5 Selection of Participants	42
3.5.1 Introduction	42
3.5.2 Define the population	43
3.5.2.1 Children with ADHD	43
3.5.2.2 Parents of Children with ADHD	44
3.5.2.3 Educators and therapists	44
3.6 Research Process	45
3.7 Data Collection	46
3.7.1 Introduction	46
3.7.2 Observation	46
3.7.2.1 Introduction	46
3.7.2.2 Documentation of Observations	46
3.7.2.3 Strengths and limitations of Observations	47
3.7.3 Guided interviews to determine the self-concept awareness and emotion-focused coping as outlined by the indicators in Chapter 2	47
3.7.3.1 Introduction	47
3.7.3.2 Guided Interviews	48
3.7.3.3 Documentation of Guided Interviews	48
3.7.3.4 Strengths and limitations of Guided Interviews	49
3.7.4 Visual Data	49
3.7.4.1 Introduction	49
3.7.4.2 Documentation of Visual Data	50



3.7.4.3	Strengths and Limitations of Visual Data	50
3.7.5	Reflective Journal: Reflexivity	51
3.7.5.1	Introduction	51
3.7.5.2	Documentation of Reflections	52
3.7.5.3	Strengths and Limitations of Reflective Journal	52
3.8	Data Analysis	53
3.8.1	Introduction	53
3.8.2	Analysis and Interpretation of Text	54
3.8.3	Analysis and interpretation of Visual Data	54
3.9	Intervention	54
3.9.1	Introduction	54
3.9.2	Pre- and Post intervention	55
3.9.2.1	Draw-A-Person Technique (D-A-P)	55
3.9.2.2	Kinetic Family Drawing (K-F-D)	56
3.9.2.3	Brink's Incomplete Sentences	56
3.9.2.4	'How is your self-concept inventory'	56
3.10	Ethical Issues	57
3.10.1	Informed consent and voluntary participation	57
3.10.2	Protection from harm and de-briefing	58
3.10.3	Confidentiality and anonymity	58
3.11	Quality Criteria	58
3.11.1	Introduction	58
3.11.2	Credibility	59
3.11.3	Transferability	60
3.11.4	Dependability	60
3.11.5	Confirmability	60
3.12	Challenges of the study	60
3.13	Conclusion	61

	Page
Chapter 4: Data Analysis, Discussion of Results and Literature Control	
4.1 Introduction	62
4.2 Conducting the Interventionist Research	62
4.3 Results of the thematic analysis	66
4.3.1 Results of the thematic analysis: Pre-intervention	66
4.3.1.1 Discussion of the Baseline results	102
4.3.2 Results of the thematic analysis: Post-intervention	102
4.3.2.2 A Comparative Discussion of the results that emerged: Post- intervention	118
4.4. Conclusion	119



	Page
Chapter 5: Conclusions and Recommendations	
5.1 Introduction	120
5.2 Discussion of findings	120
5.3 Addressing the research questions	120
5.3.1 What is the association between self-concept awareness and emotion- focused coping of children diagnosed with ADHD	120
5.3.2 Sub-questions	121
5.4 Conclusions of the study	122
5.5. Limitations of the study	124
5.6 Contributions of this study	125
5.7 Recommendations	126
5.7.1 Recommendations for practice	126
5.7.2 Recommendations for training	126
5.7.3 Recommendations for future research	127
5.8 Concluding remarks	127
6. Reference List	129

LIST OF TABLES

	Page
Table 1.1 Data Collection Strategies	12
Table 3.1 Outline of Participants in this study	42
Table 4.1 Goals of the intervention	65
Table 4.2 Results of the thematic analysis indicating emotion-focused coping and self-concept awareness themes as well as subthemes and categories: <u>Pre-intervention</u>	67
Table 4.3 Definition, subthemes, indicators, exclusions and exceptions related to the theme of self-concept awareness (pre-intervention)	68
Table 4.4 Definition, indicators, exclusions and exceptions related to the category 'self-confidence (pre-intervention)	69
Table 4.5 Definition, indicators and exclusions related to the category 'self-awareness' (pre-intervention)	70
Table 4.6 Definition, indicators, exclusions and exceptions related to the category 'positive interactions with others' (pre-intervention)	73
Table 4.7 Definition, indicators, exclusions and exceptions related to the category 'negative interactions with others' (pre-intervention)	75
Table 4.8 Definition, indicators and exclusions related to the category 'identification and expression of feelings' (pre-intervention)	78

Table 4.9 Definition, subthemes, indicators, exclusions and exceptions related to the theme ‘adaptive emotion-focused coping strategies’ (pre-intervention)	79
Table 4.10 Definition, indicators and exclusions related to the subtheme ‘seeks social support from significant others’ (pre-intervention)	81
Table 4.11 Definition, indicators and exclusions related to the category ‘seeks social support from significant others to communicate and work through stressful situations’ (pre-intervention)	82
Table 4.12 Definition, indicators and exclusions related to the category ‘reliance on social support to deal with stressful situations’ (pre-intervention)	83
Table 4.13 Definition, indicators and exclusions related to the category ‘use of relaxation methods in order to examine the situation from another perspective’ (pre-intervention)	84
Table 4.14 Definition, subthemes, indicators, exclusions and exceptions related to the theme ‘maladaptive emotion-focused coping strategies’ (pre-intervention)	87
Table 4.15 Definition, indicators and exclusions related to the category ‘indirect, active physical aggression’ (pre-intervention)	88
Table 4.16 Definition, indicators and exclusions related to the category ‘heightened physiological arousal in response to stressful situations’ (pre-intervention)	88
Table 4.17 Definition, indicators and exclusions related to the category ‘physical aggression’ as well as exceptional responses to this category (pre-intervention)	90
Table 4.18 Definition, indicators and exclusions related to the subtheme ‘direct- passive aggression’ (pre-intervention)	92
Table 4.19 Definition, indicators and exclusions related to the category ‘helplessness’ (pre-intervention)	94
Table 4.20 Definition, indicators and exclusions related to the category ‘internalizing’ (pre-intervention)	96
Table 4.21 Definition, indicators and exclusions related to the category ‘avoidance’ (pre-intervention)	98

Table 4.22 Definition, indicators and exclusions related to the category ‘projecting blame’ (pre-intervention)	100
Table 4.23 Definition, indicators and exclusions related to the category ‘withdrawal’ (pre-intervention)	101
Table 4.24 Results of the thematic analysis indicating emotion-focused coping and self-concept awareness themes, subthemes and categories: <u>Post-intervention</u>	103
Table 4.25 Definition, subthemes, indicators, exclusions and exceptions to the theme ‘maladaptive emotion- focused coping strategies which remained maladaptive’ (post-intervention)	114

LIST OF FIGURES

	Page
Figure 2.1 Conceptualising the Research Study	21
Figure 2.2 Self-concept awareness cycle addressed in the intervention	22
Figure 2.3 When may emotion- focused coping be relevant?	25
Figure 2.4 Conceptualization of ADHD (Based on Barkley's (1996) Definition)	30
Figure 2.5 Working assumptions of changes in coping post-intervention	33
Figure 3.1 Research Process	45
Figure 4.1 Child 1's interpretation of the D-A-P activity	72
Figure 4.2 Child 2's interpretation of the D-A-P activity	72
Figure 4.3 Child 1's drawing of a positive interpersonal interaction	75
Figure 4.4 Drawing depicting the use of direct- active physical aggression in response to being perceived as weak, fallible and out of control	77
Figure 4.5 Child 1's depiction of the use of direct- active physical aggression in response to being teased. I denote the use of the shapes i.e. stars and triangles with heightened physiological arousal	92
Figure 4.6 Child 1 exploring his positive and negative	

characteristics 105

Figure 4.7 Child 1 using a 'feelings chart' to identify and express the 'happy', 'sad' and 'angry' feelings in response to Significant experiences 110

LIST OF APPENDICES

APPENDIX A: INFORMED CONSENT FORMS

APPENDIX B: ETHICAL CLEARANCE FORM

APPENDIX C: PRE-DEFINED TARGET BEHAVIOURS

APPENDIX D: SELF-CONCEPT AWARENESS INDICATORS

APPENDIX E: EMOTION- FOCUSED COPING INDICATORS

APPENDIX F: BEHAVIOUR CHECKLIST TO PREVENT OBSERVER BIAS

APPENDIX G: PRE- AND POST- INTERVENTION CHECKLISTS

APPENDIX H: PRE- AND POST- INTERVENTION FORMAL INTERVIEW SCHEDULES

APPENDIX I: EXAMPLE OF FIELD NOTES

APPENDIX J: EXAMPLE OF TRANSCRIPTION

APPENDIX K: INTERVENTION

APPENDIX L: EXAMPLES OF INTERVENTION ACTIVITY- BASED DATA DOCUMENTED VISUALLY

APPENDIX M: EXAMPLES OF DATA ANALYSIS AS PART OF THEMATIC ANALYSIS

APPENDIX N: EXTRACTS FROM MY REFLECTIVE JOURNAL

APPENDIX O: RESEARCH SCHEDULE

APPENDIX P: D-A-P, K-F-D, BRINK'S INCOMPLETE SENTENCES AND THE

‘HOW IS YOUR SELF-CONCEPT’ INVENTORY

Chapter 1: Contextualising My Research Study

1.1 Introduction and Rationale

A vast array of literature and statistics explore the persisting and negative symptoms of Attention- Deficit Hyperactivity Disorder related to impaired executive functioning, with particular emphasis on children with ADHD¹, as well as those who are indirectly affected, such as those with whom these children reside and learn alongside. The inclusive education policy encourages learning environments to promote full personal, academic and professional development of all learners regardless of race, age, gender, learning style or disability (NCSNET, 1998). Thus, it seems important to explore how interventionists are responding to the coping needs of children with ADHD. However, with approximately 60% of children diagnosed with ADHD progressing into adulthood with persisting, and even worsening, symptoms associated with ADHD (Jeeva, 2007), I believe that despite using interventions based on their existing resources, skills, and knowledge in attempt to meet the needs of children with ADHD, it appears that the interventions currently being employed are inadequate. Thus, with a large percentage of children continuing to experience escalating symptoms of ADHD in adulthood, the need to identify and implement effective coping strategies in childhood becomes of fundamental importance if they are able to effectively confront and deal with life stressors, and it is for this reason that the study strives to explore an intervention which could promote more effective coping in children with ADHD.

Biederman (1993) and Shekim (1990 as cited in Barkley & Murphy, 1996) state that approximately 50% of adults diagnosed with ADHD are also diagnosed with substance abuse disorders, 40% with anxiety disorders and 35% with major depressive disorders. Statistics like these illuminate the lasting impact of ADHD on the individual, and consequently, on his functioning with/ within various systems. With a large percentage of children continuing to experience escalating symptoms of ADHD in adulthood any many of them developing co-morbid disturbances, the need to identify and implement effective coping

¹ For the purpose of this study, I will be using the abbreviation of the term Attention Deficit Hyper- Activity Disorder- ADHD

strategies in childhood becomes of fundamental importance if they are able to effectively confront and deal with life stressors.

Gonzales and Sellers (2002) suggest that there is a heightened level of awareness in literature with regards to the difficulties that children with ADHD experience. This has resulted in the creation of interventions concerned with cognitive aspects, behavioural manifestations and treatment modalities. However little research has focused on their social and emotional functioning, which play a fundamental role in motivation. Studies conducted by Yamatsaki, Akiko, Kanako (2006) briefly explore emotion-focused coping and stress management in children. However, in my literature survey I could not find literature which applies these findings to children with ADHD. Gonzales and Sellers (2002) outline pertinent literature which supports the need for programmes to increase the ability of children to cope with stress (learning to successfully cope with stress is a pivotal determinant in the long term psychosocial, emotional and physiological effects of stress). This necessitates the need for a study to be conducted which explores the levels of psychological distress experienced by children with ADHD in an attempt to develop interventions aimed at the **acquisition and development of effective coping strategies**.

Thus, the primary purpose of this study is to *explore and describe the association between children with ADHD's self-concept awareness and their emotion-focused coping*. I focus first on the systemic exploration of the experiences of children with ADHD, and how these experiences are impacted on by the symptoms of ADHD. I then go on to explore the role of coping with ADHD related challenges, focusing primarily on resources and assets within this system whilst acknowledging barriers. My study aims to explore and describe the impact of an intervention on self-concept awareness and emotion-focused coping of children with ADHD. I have drawn on existing literature of ADHD and interventions designed to facilitate coping in children with ADHD, and have identified no literature anchored in an asset-based approach. Therefore, my research could contribute to existing literature on therapeutic interventions designed to develop and enhance the coping strategies of children with ADHD. The purpose of my study is thus descriptive and intervention- related.

Besides the clear need for research to be conducted in the field, for reasons detailed above, personal reasons have compelled me to complete this study. As an Intern Educational Psychologist working in a school for learners with special education needs last year, the severity of ineffective coping strategies that children with ADHD presented with was brought to my attention on a daily basis. Children with ADHD were often referred for therapy within social skills groups as well as for individual therapy. Thus, I developed an interest in the

emotion-focused coping strategies used by children with ADHD- particularly the role that self-concept awareness plays in the choice of coping strategies- and how this process could be facilitated by parents and interventionists alike through the use of an intervention to expand the emotion-focused repertoire of children with ADHD . Other than theoretical meaning, this study could prove valuable to professionals, educators and parents in both remedial mainstream schooling environments, for the focus would ultimately be on equipping learners with adaptive emotion-focused skills within the classroom and school setting.

I will now discuss the significance and underlying theoretical principles of my study.

1.1.1. Why ADHD?

Widespread research exists on the impact of ADHD on children and their families which has ignited my interest in ADHD. Of particular interest to me is the research exploring the re-conceptualisations of ADHD, such as that offered by Barkley, Hutchins, Green, Chee and Nash (2007) and Goldstein (2002). Goldstein (2002) re-conceptualizes ADHD as a problem rooted in motivational rather than attentional deficits resulting in difficulties within the intellectual, academic and emotional realms- with social and conduct problems often being associated with ADHD (Lerner, 2003). Barkley, Hutchins, Green, Chee and Nash (2007) conceptualise ADHD as a disorder that results from response disinhibition which **creates impairments** in executive functioning which lead to deficient self-regulation as well as disorganised behaviour **which over time results in deficits in adaptive behaviour**. This definition supports the assertion that interventions for ADHD should be rooted within a system and not targeted only at the individual. Both conceptualisations frame ADHD as a behavioural disorder characterised by deficits in the purposeful associations between the child's behaviour and environmental events as opposed to 'cognitive constructs or capacities' which result in lessened awareness of behavioural consequences and poor rule-governed behaviour- both of which are far cries from traditional definitions of ADHD (Barkley, 1999).

My experiences as an Intern psychologist suggested that learners with ADHD (hyperactive-impulsive type) were often referred to therapy for emotional and social support as a result of **stress** incurred by the above symptoms. Due to impaired executive functioning, children with ADHD are confronted with scholastic, personal and social failure and confrontation on a daily basis in a number of forms. As infants, children with ADHD experience difficulty in attaching to their primary care givers (Jeeva, 2007). **As infants**, they present with sleeping and feeding problems, sensory integration difficulties, allergies, become easily frustrated by changes in routine and are often in conflict with their siblings. Children with ADHD present with a number of **learning difficulties** such as deficient working memory, co-ordination

difficulties, speech and language difficulties, visual and auditory processing difficulties to name a few. Such impairments impact significantly on their ability to perform and achieve scholastically, which results in experiences of failure and negative feedback (Lerner, 1999). Impaired executive functioning seems to result in difficulty forming accurate self-appraisals resulting in inaccurate reflections and understanding of their strengths, limitations and available resources (Goldstein, 2002). Thus, self-appraisals influence not only the child's self-efficacy (which influences a child's effort and perseverance) but also the child's appraisals of events and whether they are deemed stressful or not (Bandura, 2007). A study conducted by Contugno (1995) supports that **children with ADHD have limited coping capacity** resulting in an avoidance of affect-laden stimuli, difficulties with self and interpersonal perceptions and difficulties with social reality perception. **Socially**, children with ADHD have difficulty reading social cues and lack essential pragmatic skills which result in them appearing inadequate in social situations making it difficult for them to establish and maintain friendships (Barkley, 2007). Enduring and intense experiences of negative affect as a result of exposure to significant life stressors result in **deep seated feelings of inadequacy** which may result in anxiety and depression (Barkley, 2007). The working assumption of this study then is that if the child with ADHD is able to come to a greater level of personal competence (accurate self-assessment and self-regulation) through increased self-concept awareness, then he/ she is able to "catch themselves" making inaccurate self-appraisals which may influence their choice of coping strategies.

1.1.2. Why Emotion- Focused Coping?

As research has indicated, ADHD has a lasting and evasive influence on children, their families, schools and communities. Thus, individuals, their parents and their educators and therapists (if applicable) are required to cope with the symptoms and the impact thereof in order to promote the well-being of the child with ADHD. Hudiberg (2007) defines emotion-focused coping as the utilization of behavioural and cognitive strategies to deal with conditions which are viewed as fixed and beyond one's control. It has been my experience as an interventionist working with children with ADHD that emotion-focused coping strategies are being utilised, and utilised ineffectively, by children with ADHD. For example, a child who is involved in conflict with a fellow classmate may lack adequate self-control to modulate their feelings regarding the source of conflict to distance him/ herself long enough to diffuse the situation and deal with it at a later stage. This may result in him/ her becoming physically aggressive towards his/ her peer. When being reprimanded for this action, the child with ADHD has difficulty in acknowledging his/ her role in the conflict. This lack of accountability makes it difficult for a positive reappraisal of the situation to take place which may result in the child with ADHD experiencing the situation negatively, thus re-enforcing a negative self-

concept and influencing future appraisals of self and situations. Accordingly, if the **basic features of a child coping effectively** are the possession of a healthy self-esteem and sense of self competence, which promotes feelings of control, ownership and optimism, then **ineffective coping strategies** manifest behaviourally in underachievement, a lack of perseverance, acting out behaviour, substance abuse and heightened physiological arousal and frustration (Gonzales & Sellers, 2006).

Based on coping and ADHD theory, I have formulated a number of **working assumptions** to guide me through my study. My **first** working assumption is that social support networks act as stress buffers as they provide individuals with affirmation and a sense of belonging. As children with ADHD (hyperactive-impulsive type) struggle to meaningfully bond with friends and maintain friendships, they form part of a limited social support network. Thus, they are exposed to reduced emotional support and ineffective coping strategies. My **second** working assumption is that problematic interpersonal outcomes result in children with ADHD presenting with a low self-esteem and limited efficacy. This results in children with ADHD believing that they do not have the inner resources to cope with presented situations, thus evaluating situations as stressful. My **third** working assumption is that in order to expand a child's emotion-focused repertoire, one would need to change the cognitive and emotional appraisal of events through greater self-concept awareness. My **fourth** working assumption is that children with ADHD tend to perceive the situation to be out of their control, which results in them employing avoidant, emotion-focused coping strategies. This may result in learned helplessness, which serves as a reinforcement for one's negative self-concept and sense of self-efficacy. My premise is that the role of the intervention, then, would be to break this cycle through insight gained by self-concept awareness. My **fifth** working assumption stems from this premise namely that if the self-concept motivates behaviour as proposed by Ebersöhn (2006), should the self-concept change through greater cognitive awareness and regulation, so too will the manner in which one conducts oneself in various situations due to a change in appraisals (for further conceptual elucidation, refer to Figure 1 in Chapter 2).

1.2. Purpose of the Study

This study is **descriptive, exploratory and intervention-related**, making the purpose of my study three fold: my study is **descriptive** as I aim to describe the impact of the **intervention** (or not) on the self-concept awareness and emotion-focused coping strategies of children with ADHD through the use of observation, analysis and rich descriptions pre- and post-intervention (Koh & Owen, 2000). It is through these thick descriptions that I may be able to assess the impact of this **intervention** which I wouldn't be able to investigate otherwise. My study is also **exploratory** as I aspire to gain new insights into the association between self-

concept awareness and emotion-focused coping (Wolfenbarger, 2007). I aim to explore and clarify how children with ADHD, their families and schools cope with the symptoms of ADHD and ADHD-related challenges with existing resources and assets whilst acknowledging barriers.

1.3. Research Question

My study aims to answer the following primary research question:

What is the association between self-concept awareness and emotion-focused coping of children diagnosed with ADHD?

In order to address the above-mentioned primary question, the following sub-questions were explored:

- To what extent were the children with ADHD's self-concept awareness impacted on (or not) by the intervention?
- How were the children with ADHD's emotion-focused coping strategies impacted on (or not) after the intervention?
- To what extent did self-concept awareness influence (or not) the child with ADHD's emotion-focused coping strategies?
- To what extent were children diagnosed with ADHD able to transfer the self-awareness skills and knowledge acquired from the intervention into their everyday interactions within the school and home?

1.4. Clarification of Key Concepts

1.4.1. Introduction

For the purpose of elucidation, I briefly discuss key concepts that feature in my research report. I discuss these concepts in more detail in Chapter 2.

1.4.2. Children diagnosed with Attention- Deficit- Hyperactivity Disorder

The American Psychiatric Association (2000) defines Attention-Deficit/ Hyperactivity disorder as a condition characterized by severe problems of inattention, hyperactivity and/ or impulsivity that are not age and developmentally appropriate. To diagnose ADHD, symptoms need to be apparent for at least six months, with these symptoms having been present before the age of seven within two settings, namely the home and the school (American Psychiatric Association, 2000; Wenar & Kerig, 2000; Rinehart, Bradshaw, Brereton & Tonge,

2002; DeClerq, 2003; Yapko, 2003; Williams & Wright, 2004). Inattention, hyperactivity and/or impulsivity cause clinically significant impairment in social, occupational or academic functioning. In the study, however, I choose to define ADHD as a behavioural disorder characterised by deficits in the purposeful associations between the child's behaviour and environmental events as opposed to 'cognitive constructs or capacities' which result in lessened awareness of behavioural consequences and poor rule-governed behaviour as I align myself with the notion that the core deficit of ADHD is not attentional but rather motivational (Steer, 2007). Barkley, Hutchins, Green, Chee and Nash (2007) conceptualise ADHD as a disorder that results from response disinhibition which creates impairments in executive functioning which lead to deficient self-regulation as well as disorganised behaviour which over time results in deficits in adaptive behaviour. This re-conceptualization defines ADHD as being a problem rooted in motivational rather than attentional deficits which result in difficulties within the intellectual, academic and emotional realms, with social and conduct problems often being associated with ADHD.

1.4.3. Self-concept awareness

According to Ebersöhn (2006), the self-concept is defined as a set of perceptions which are situation-specific and include appraisals of one's identity as well as self-efficacy beliefs. A person's self-concept is multi-faceted, complex and inter related. It consists primarily of the physical, personal, family, social, moral and academic selves. Of particular relevance to the study is that a change in one of the self-concepts, namely the personal self, will influence all other aspects of the self-concept (Kruger, 1994).

Ebersöhn (2006) and Kruger (1998) assert that one's self-concept motivates behaviour as a child will act in accordance with the way he/ she has learnt to see him/ herself. It is through cognitive appraisals that we attribute meaning to the situations with which we are faced, that our behaviour is motivated by deductions made from thought and affect. Ebersöhn (2006) further indicates that the self-concept could be viewed as a life skill, and that should the self-concept change, so too will the manner in which one cognitively and affectively appraises and behaves in chosen situations. Thus, despite a learner with ADHD's best efforts to act empathetically towards others, his/ her behaviour is characterised by a lack of self-regulation which results in his/ her behaviour being construed as abrasive, intolerable and ill-mannered which result in relationships being characterised by rejection and dislike, anxiety and tension. Constant and enduring negative feedback negatively impacts on his/ her self-concept which has a profound impact on the manner in which he/ she responds to people and situations, which has negative connotations for holistic performance and achievement therein (Wicks-Nelson & Israel, 2000).

1.4.4. Emotion-focused coping strategies:

Diener, Lucas and Oishi, as cited in Ebersöhn (2006), state that subjective well-being is related to a person's cognitive and affective evaluations of their lives as well as the amount of control that one feels one has over one's life. In accordance with the above definition of well-being, stress can be defined as the negative emotional state which occurs as a response to events which are perceived (through cognitive appraisals) as taxing or exceeding one's ability to cope (Weir, 2003). For the purpose of the proposed study, coping is defined as behavioural and psychological efforts to master, endure, diminish, or decrease stressful events (Mischara, 2007).

Literature makes the distinction between two types of coping strategies, namely problem-solving strategies and emotion-focused coping strategies, of which emotion-focused coping strategies are the focus of this study. Emotion-focused coping strategies do not change the actual stressful situation, but allow for the regulation of emotional consequences of stressful events (Taylor, 1998). Emotion-focused coping strategies include activities, such as drug abuse, or mental states, such as withdrawal and denial, which prevent the individual from actively addressing the stress provoking situation (Taylor, 1998).

1.4.5. Intervention

On a daily basis and throughout one's development, people are required to adapt to change and cope with stressors. Bender (2007) states that through life skills facilitation and acquisition, the individual is better equipped to function adaptively and autonomously within a community. According to Ebersöhn (2006):

A possible way in which cumulative protection could be developed is by means of an asset-focused life-skills facilitation approach: facilitating adaptation processes of awareness, identification, access and mobilisation of human, social and material capital. Life skills could thus improve the capacity of individuals to respond to threats so as to modify the impact of perils on their lives. However, many children do not have the necessary life skills to cope effectively.

Mischara (2007) states that children have the capacity to become aware of the manner in which coping strategies are chosen through understanding of the situation as well as personal resources and habits. Children who feel overwhelmed by a situation have evaluated that the personal resources they have at their disposal are insufficient to meet the demands of the situations, which result in a stressed response characterised by a lack of belief that they possess the ability to change the situation or their responses to the situation. Ebersöhn

(2006) clearly articulates the role that life skills facilitation plays in the facilitation of coping. I align myself with Ebersöhn's (2006) assertion that the identification of inaccurate thoughts is not sufficient in the acquisition of adaptive life skills. She emphasises that children should be supported to behave in an independent manner in order for them to innovatively cope with the stressors that they face for as is evident in the literature, children with ADHD may lack intrapersonal, and subsequently, interpersonal knowledge resulting in an external locus of control, no assumption of personal responsibility as well as negative appraisals which manifest in ineffective coping strategies. The need exists for the implementation of an intervention program which will empower the child with ADHD to meet the demands of a dynamic and ever-changing world. For the purpose of this study, I selected to apply the asset- focused life skills facilitation model developed by Ebersöhn (2006) in conjunction with Kruger's (1998) programme.

Ebersöhn's (2006) intervention encourages cognitive regulation intervention strategies as a means of altering "thoughts, ideas, assumptions, self- communication, basic philosophies (and therefore cognitive structures and appraisals) that people use for themselves, others and situations" (Ebersöhn, 2006). By applying this intervention with children with ADHD, I hope to explore if children's self-communication at an intrapersonal level will be altered (which may motivate the acquisition of more established external interpersonal skills). Whilst acknowledging the role and existence of deficiencies, the intervention focuses on the strengths, abilities and resources available to children with ADHD which may assist them in best coping within their respective environments. Applying the asset- focused life-skills facilitation model may facilitate the process of empowerment for it implies a shift from working from a deficit approach to an asset- based approach which calls for the mobilisation of already existing assets and resources (Ebersöhn, 2006). This requires of interventionists to design interventions which focus on the developing of resilience as well as focusing on remediation. Through the use of both programmes participants will be involved in the process of assessment and evaluation (refer to table 3.1. in chapter 3).

1.5. Paradigmatic Assumptions

Here I provide a brief discussion of my selected paradigm, methodological choices and processes. More detailed discussions of these aspects are included in Chapter 3.

1.5.1. Metatheoretical Paradigm

My study is based in the *interpretivist* paradigm which asserts the existence of multiple realities over time and space, acknowledging that research is a process characterised by interaction and is shaped by personal histories, gender, race and experiences of the

participants, including myself and those that share their setting (Denzin & Lincoln, 2000). Interpretivism is characterised by the description, understanding and interpretation of the research participants' perceptions (Myers, 2000). Conducting my study from the interpretivist paradigm permits me to gain insight into the children's ways of coping with the symptoms of ADHD through the exploration of detailed and rich descriptions of children with ADHD's attempts to cope with challenging situations in which they find themselves. Pertinent to working from this paradigm is the ontological acknowledgement that all interactions and communications take place within a context, and it is within this context that subjective meaning is ascribed to experience. Thus, each person's context is unique as is their perception of reality.

1.5.2. Methodological Paradigm

I employed the *Qualitative* paradigm as my methodological paradigm. Denzin and Lincoln (1994) define qualitative research as research that is conducted within the natural settings of the participants in order to gain insight into the meanings that the participants attach to their life worlds. The qualitative paradigm is an inductive process requiring of me to not make attempts to understand the situation or phenomenon being studied by introducing pre-existing expectations into the setting (Mouton & Marais, 1991). Instead, my role as researcher is to gather data on as many facets of the situation as possible in order to construct a complete understanding of the participant's unique and dynamic situation, thus adhering to the primary aim of qualitative research which is to capture the unique experiences and interpretations of the participants, mine included (Mouton et. al. 1991).

1.6. Research Methodology and Data Collection Strategies

1.6.1. Research Design: Intervention Research

My study was conducted using by means of *an intervention research design* as conceptualised by Rothman and Thomas (1994). Rothman and Thomas (1994) define intervention research as the development of knowledge about interventions, how to apply this knowledge into social practice and the effectiveness of the intervention within a particular setting. They offer an integrate model of intervention research in an attempt to design and develop interventions to enhance the well-being of the individual and school community. Having said this, a strong emphasis is placed on the participation and of all participants in the research process. I selected intervention research as I argue for a need to research interventions which are aimed at developing and enhancing the coping strategies of children with ADHD.

1.6.2. Selection of Participants

Qualitative research is exemplified by comprehensive inquisition of a phenomenon within its natural context. The interpretivist paradigm is characterised by the emphasis it places on multiple and unique perspectives of the participants within situation-specific contexts, which prioritises description and exploration over generalisation (Jacobs, 2007). Qualitative samples are generally small due to the time and resources required to conduct and to partake in such a study. Thus, purposive sampling was required and selected.

Purposive sampling (Babbie & Mouton, 2004) can be defined as a process in which the researcher selects a sample based on experience and knowledge of the group being selected. I selected various groupings of participants, namely 2 children with ADHD and their respective parents, educators and therapists. I provide a comprehensive discussion on participant selection in Chapter 3.

1.6.3. Data Collection Strategies:

Table 1.1 outlines the various types of data collection strategies employed during the study. I discuss these data collection strategies in more detail in Chapter 3.

1.6.4. Data Analysis and Interpretation

Data analysis involved the identification of themes that emerged during data collection. I used thematic analysis in data analysis in order to conduct this more detailed data analysis (Braun & Clarke, 2006). This required of me to familiarise myself with the various sources of data, reading through the data and documenting primary thoughts and ideas. I then generated initial codes in order to identify and document repeated patterns of meaning as they emerged. At this stage, I linked identified themes back to the research question and existing literature. I engaged in the process of data analysis and interpretation on my own.

1.7. Ethical Considerations

In compliance with the University of Pretoria's Ethics Committee (refer to certificate in Appendix B), I obtained the informed consent of the participants (Appendix A) before commencing with my study, addressing the issues of confidentiality and anonymity (Babbie & Mouton, 2004). Throughout the research process, I adhered to the ethical principles of *confidentiality*, *anonymity* and *privacy*, allowing for me to protect the participants from harm as far as possible (Babbie & Mouton, 2004). For example, I ensured that my reflective journal, which contained my field notes and reflections, were stored in a safe place at all times and that all identifying details were omitted from transcriptions of interviews as well as from photographs taken. I honoured the participant's right to withdraw from the study at any

time. With the permission of the child participant, I took photographs and made audio footage during the intervention activities. These visual images were used during discussions, as well as reports I wrote about the study. I did not share the participants name with those who saw the images. At the request of Child 2, I did not take photos of his intervention activities or make audio recordings of his intervention sessions. All of the information that I collected from the project were stored in locked files in research offices at the University of Pretoria.

Table 1.1. Data Collection Strategies

Source	Type	Documented	Explored	Participants Involved
Observation	*Participant *Non-participant	* Field Notes * Reflective diary	*Participants during intervention *Participants within the classroom setting	* Child 1 and Child 2
Interviews (in and outside of intervention)	*Guided	*Field Notes *Audio recorded *Verbatim transcription	*Accounts of the child's emotion-focused coping strategies and self-concept awareness	*Children with ADHD * Parent/s *Educator/s *Therapists
Visual Data		*Photographs	*Participants engaging in and with the interventions	*Child with ADHD
Reflexivity Reflexivity		*Reflective Journal	*My thoughts, feelings and working assumptions as they evolve through the research process	*Researcher

1.8. Quality Criteria

Throughout my study, I strove to make my research study trustworthy by delineating the impartiality of my research findings and conclusions (Babbie & Mouton, 2004). This required of me to strive for credibility, transferability, dependability and confirmability (Babbie & Mouton, 2004). In Chapter 3 I discuss the strategies I used to ensure rigour in my study.

1.9. Role of Researcher

During the study, I assumed the role of researcher and interventionist- both of which informed the choices made throughout the study. In order to differentiate between these roles, I liaised closely with my supervisor as well as reflected on this process within my

reflective journal. This process became especially important in that I was the sole tool for data collection, analysis and interpretation (Babbie & mouton, 2004).

1.10. Outline of Chapters

Chapter 1: Overview and Rationale

Chapter 1 will be an introductory chapter to the study. The purpose and rationale of the study, conceptual parameters, epistemology, and the research design and methodology of the study will be outlined.

Chapter 2: Conceptual Framework

Chapter 2 outlines the conceptual framework of the study, exploring the concepts of asset-based life skills facilitation, self-concept awareness, emotion-focused coping and Attention-Deficit/ Hyperactivity Disorder.

Chapter 3: Research Design and Methodology

Chapter 3 discusses the study in terms of the research design, selection of participants, data collection and data analysis and interpretation. This chapter will also explore the trustworthiness of the study as well as the manner in which ethical issues were addressed.

Chapter 4: Findings of the Study

Chapter 4 presents and discusses the findings based on data collection, analysis and interpretation. The findings will be discussed against the existing literature, as outlined in Chapter 2.

Chapter 5: Final Conclusions and Recommendations

Chapter 5 includes the final conclusions of the study as well as linking these findings to the research question, as stipulated in Chapter 1. The potential value and challenges of the study will be discussed, and recommendations for further research will be made.

1.11. Conclusion

I provided a general introduction and rationale to my study in this chapter. I formulated and expressed my central research question: *What is the association between self-concept awareness and emotion-focused coping of children diagnosed with ADHD?* Thereafter, I explored and described the key concepts within my study as well as briefly discussed my paradigmatic assumptions, methodological choices and research design. I then discussed my ethical and quality considerations, which will be explored in more detail in chapter three.

In the next chapter, I will contextualise my study within a conceptual framework by exploring existing literature on ADHD, self-concept awareness and emotion-focused coping.

CHAPTER 2: Conceptual Parameters

2.1. Introduction

In Chapter 1, I discussed the aim of my study, which was to investigate the association between self-concept awareness and emotion-focused coping in children with ADHD. Chapter 2 is a detailed discussion of the conceptual parameters of my study. In order to elucidate and situate my study within conceptual parameters, I reviewed a number of literature sources on Attention Deficit Hyperactivity Disorder (ADHD), emotion-focused coping, self-concept awareness and intervention. During my literature survey, I was unable to source studies explicitly exploring the association between these constructs. I therefore attempted to explore these concepts in association with one another. I discuss existing literature, limitations in this knowledge and the gaps that exist within this knowledge base. I conclude Chapter 2 with a presentation of the framework that forms the theoretical backdrop to the intervention in my study.

2.2. Fundamental underpinnings of Attention Deficit Hyperactivity Disorder

2.2.1 An Introduction to Attention- Deficit Hyperactivity Disorder

I explored ADHD as the construct under investigation in this study. In order to contextualise my study, I provided the necessary background by exploring existing literature on ADHD. I then investigated the challenges that children with ADHD experience because of the symptoms of ADHD, as well as the extent to which these symptoms impact on the child's self-concept awareness. I engaged in a discussion around the behavioural manifestations of ADHD (hyperactive-impulsive type) and the extent to which the child's self-concept awareness informs these behaviours. This provided the backdrop for the later exploration of the extent to which the child's self-concept awareness affects his /her chosen emotion-focused coping strategies.

Attention-Deficit Hyperactivity Disorder (ADHD) is one of the most commonly diagnosed behavioural disorders, with approximately three to six per cent of school-going children

currently diagnosed with ADHD (Gonzalez, 2002). Traditionally, ADHD was defined as a condition characterised by severe problems of inattention, hyperactivity and/or impulsivity that are not age and developmentally appropriate. Children diagnosed with ADHD (predominantly hyperactive-impulsive type) display hyperactive, disinhibited and impulsive behaviour. Hyperactive behaviour tends to cause conflict between the learner, his peers and his siblings whereas disinhibited and impulsive behaviour sees children with ADHD giving impulsive, irrelevant answers to questions and they struggle to focus their attention (Bley & Thornton, 2001 as cited in Landsberg et al. 2005). Such children tend to lack insight into the consequences of their behaviour, which results in them reacting to all stimuli, relevant or otherwise. Children diagnosed with ADHD (combined type) display an amalgamation of inattentiveness, hyperactivity and impulsiveness.

For the purpose of this study, I chose to use the definition of ADHD as offered by Steer (2007), who asserts that the core characteristic of ADHD deficit is not attentional but rather motivational in nature. Barkley, Hutchins, Green, Chee and Nash (2007) support Steer's (2007) conceptualisation regarding ADHD as a disorder resulting from response disinhibition. Therefore, response disinhibition creates impairments in executive functioning - leading to deficient self-regulation as well as disorganised behaviour. Over time, this results in deficits in adaptive behaviour. This definition conceptualises ADHD as a behavioural disorder characterised by deficits in the **purposeful** associations between the child's behaviour and environmental events, which result in the use of less effective emotion-focused coping strategies. As opposed to 'cognitive constructs or capacities' which result in lessened awareness of behavioural consequences and poor rule-governed behaviour resulting in difficulties within the intellectual, academic, emotional and social realms (Steer, 2007).

The definition offered by the American Psychiatric Association (2000) sees attentional deficits as intrinsic to the individual, whereas Steer's (2007) definition regards motivational deficits as being a product of **purposeful** and reciprocal interactions between internal (child's behaviour) and external (environmental) factors. This definition challenges the traditional conceptualisation of ADHD as a disorder that is characterised by impaired cognitive structures or capacities resulting in lessened awareness of behavioural consequences and poor rule-governed behaviour. This distinction allowed me to move away from working from a traditional needs-based approach to an asset-based approach, exploring cognitive constructs as well as the child's social and emotional functioning, which encouraged the child with ADHD to arrive at a greater awareness of what motivates behaviour through greater self-concept awareness (Ebersöhn, 2006).

2.2.2. What are the challenges experienced by children with ADHD?

Children with ADHD experience a number of difficulties within the intellectual, academic, social and emotional realms. Emotional difficulties as a result of the latter are the focus of my enquiry (Lerner, 2003). According to Bos, Schumm and Vaughn (2003), children with ADHD display high levels of activity, behaviour problems and a short attention span. The behavioural manifestations of inattentive and hyperactive-impulsive types of ADHD differ significantly, and will now be explored.

Children with ADHD (inattentive type) tend to approach decision-making in a sluggish manner. They tend to honour boundaries and are obedient and polite, which may result in them acting passively in social situations. They tend to be socially withdrawn, making it difficult for them to attract friends. However, once they attract a friend, they are able to bond with them. Children with this type of ADHD are described as introverts, and a percentage of them become depressed in their later years (Bos, Schumm & Vaughn, 2003). Children with ADHD (hyperactive-impulsive type) tend to make impulsive decisions, are rebellious and intrusive of boundaries. They tend to be more aggressive, have an antagonistic demeanour and are often labelled as egotistical or “show offs”. Although they are able to attract friends, they often find it difficult to make meaningful attachments with others (Bos, Schumm & Vaughn, 2003). Children diagnosed with this type of ADHD tend to have greater co-morbidity of conduct disorders. Adopted boys demonstrate greater rates of disruptive disorders, subsequently being less socially integrated and accepted (Goldstein, 1999). A number of sources reviewed identify boys that have been diagnosed with ADHD (hyperactive-impulsive type), particularly pre-adolescent boys, as forming part of a high-risk group that may be in need of support and intervention to develop optimally.

As explored above, impairments in executive functioning result in cognitive deficits that manifest behaviourally. Impairments in executive functioning manifest in children with ADHD in the following ways: difficulty in inhibiting responses and regulating behaviour through the use of inner speech; working memory and control of emotions; problem-solving; effective communication and compromising on accuracy for the sake of speed (Wicks- Nelson et al. 2000). This has a direct link on the child’s ability to exercise self-control. Thus, children with ADHD (hyperactive-impulsive type) may struggle to engage in turn taking when having a conversation, have difficulty withholding a response or reaction, delaying gratification and preventing distractions which interfere with ongoing activities (Bos, Schumm & Vaughn, 2003). The behavioural manifestations of impaired executive functioning influence the way others perceive the child with ADHD, and ultimately influences their relationships (Bos, Schumm & Vaughn, 2003).

Impaired executive functioning and cognition result in children with ADHD experiencing a number of intellectual challenges and learning disabilities. Wicks-Nelson et al. (2000) assert that children with ADHD tend to perform slightly lower on intelligence tests than those children not diagnosed with ADHD. They attribute this to the negative impact of hyperactivity on intellectual performance. However, literature in this regard is contentious, with a lack of clarity with regards to whether factors such as hyperactivity and impulsivity directly interfere with intellectual functioning or whether children with ADHD generally have lower intelligence than other children. What is undisputed in most of the literature is that children with ADHD are generally more prone to developing learning disabilities than children not diagnosed with ADHD. This is particularly apparent in tasks requiring mathematics, spelling and reading skills (Wicks-Nelson, 2000).

It is believed that, in addition to ADHD impacting negatively on scholastic performance, it also diminishes the probability of success within the schooling environment. Jeeva (2007) and Wicks-Nelson (2000) state that academic problems, particularly academic failure, are a core associated characteristic of learners with ADHD. In their opinion, most educators report that children with ADHD tend not to reach their full potential, with many of these children continuously exposed to low test scores, failure, and eventual placement into special classes within mainstream education or placement within remedial school environments. According to Wicks-Nelson (2000), approximately thirty per cent of children with ADHD repeat a grade at school, with forty per cent of these learners experiencing at least one special education placement. As a result, many children with ADHD experience school as a place of little achievement and success, directly impacting on the process of identity formation and self-concept.

Furthermore, because of a general lack of understanding of ADHD, children with ADHD are misunderstood and rejected by significant others in their lives (Jeeva, 2007). Rutherford (2007) postulates that significant others do not have an accurate understanding of the cause and consequences of the behaviour exhibited by children with ADHD, resulting in judgement and subsequent punishment through exclusion. The thoughts and feelings related to exclusion are internalised by the child with ADHD, leaving him believing that despite his greatest efforts, he can do little right (Rutherford, 2007). Through exclusion from formal and informal social situations, the child does not have the opportunity to gain esteem or social support thus perpetuating feelings of isolation. Such negative interpersonal outcomes result in a negative self-concept, limited efficacy and a limited coping repertoire. As the relationships of children with ADHD are increasingly characterised by perceived rejection and

dislike, anxiety and tension are exacerbated and school becomes a place of little pleasure; negatively influencing performance and achievement therein (Wicks-Nelson et al. 2000).

The result of such unsatisfactory relationships appears to persist beyond childhood and adolescence. Approximately sixty per cent of children diagnosed with ADHD progress into adulthood with persisting, and even worsening, symptoms associated with ADHD. These are in more detail in proceeding discussions (Jeeva, 2007).

2.2.3. Challenges associated with ADHD and their impact on the self-concept awareness of the child with ADHD.

According to Ebersöhn (2006), the self-concept is defined as a set of perceptions which are situation-specific and which include appraisals of one's identity as well as self-efficacy beliefs. A person's self-concept is multi-faceted, complex and interrelated. The self-concept consists primarily of the physical, personal, family, social, moral and academic selves. Of particular relevance to my study was that a change in one of the self-concepts, namely the personal self, influences other aspects of the self-concept (Kruger, 1994). Accordingly, it seemed vital to explore the child's awareness of his self-concept. Through increased self-concept awareness, children confronted with a potentially stressful situation may be better able to identify - and confidently rely on - their inner resources to effectively problem-solve and confront the situation.

According to the Illinois State Board of Education (2008), the following are possible indicators of self-concept awareness and provide a useful point of reference from which to work when assessing the participants' self-concept awareness before and after the intervention. In chapter 3 I indicate how I used these characteristics to guide my meaning-making of the analysed data. Self-concept awareness may manifest in:

- **Self-knowledge:**
 - **Knowledge of the influence of the self-concept.**
 - The ability to describe personal likes and dislikes.
 - Describe individual skills required to fulfil different life roles.
 - Describe how one's behaviour influences the feelings and actions of others.
 - Identify environmental factors influencing attitude and behaviour.
 - **Skills to interact positively with others.**
 - Demonstrate respect for the feelings and beliefs of others.
 - Demonstrate an appreciation for people's similarities and differences.

- Demonstrate tolerance and flexibility in interpersonal and group situations.
- Demonstrate skills in responding to criticism.
- Demonstrate effective group membership skills.
- Demonstrate effective social skills.
- **Knowledge of the importance of growth and change.**
 - Identify feelings associated with significant experiences.
 - Identify internal and external sources of stress.
 - Demonstrate ways of responding to others when under stress.
 - Describe changes that occur in the physical, psychological, social and emotional development of the individual.
 - Describe physiological and psychological factors as they relate to emotion-focused coping.
 - Describe the importance of academic, family and leisure activities to mental, emotional and physical well-being.

The self-concept is the vehicle through which we manoeuvre around our intra-personal and interpersonal realms. It is informed by one's identity and self-efficacy beliefs. The self-efficacy beliefs of children with ADHD seem to have a direct bearing on their choice of emotion-focused coping strategies. According to Bandura's social cognitive theory, the individuals self-efficacy beliefs heavily influence the choices that they make and their behaviour as a consequence thereof (Schunk, 1981; Schunk & Hanson, 1985; Schunk, Hanson, & Cox, 1987 in Pajares & Schunk; 2001). He further states that people can engage with situations only when they feel competent enough to do so, and avoid situations when feeling incompetent in dealing with them. Self-efficacy beliefs play a large role in perseverance and the resilience of an individual when confronting adverse situations. Thus, the higher the child's self-efficacy, the more likely they may be to persevere in the face of obstacles and the less likely they may be to experience extreme amounts of anxiety and stress when confronted with stressful situations. Thus, it appears that the self-efficacy beliefs of a child with ADHD result in the employment of ineffective emotion-focused coping strategies.

It is evident that meaning is attributed to the situations with which we are faced through cognitive appraisals; and these cognitive appraisals inform the self-concept. The self-concept has classically been defined in terms of the cognitive appraisals one makes of the hopes, depictions and prescriptions that one holds of oneself (Pajares & Schunk, 2001) Thus, the self-concept may provide the individual with structure, a sense of coherence and personal meaning. Ebersöhn (2006) and Kruger (1998) assert that one's self-concept is one variable

which motivates behaviour, as children act in accordance with the way they have learnt to see themselves. Ebersöhn (2006) further indicates that self-concept formation could be viewed as a life skill, and that, should the self-concept change, so to could the manner in which one cognitively and affectively appraises and behaves in chosen situations (Ebersöhn, 2006). Thus, greater self-concept awareness seems to be one way in which people may come to a greater understanding of the manner in which their cognitive appraisals inform their self-concept and the extent to which the self-concept influences their behaviour both positively and negatively (Ginorio, Yee, Banks and Todd-Bazemore, 2007). I

In order to more completely understand the interactions which influence the self-concept, I refer to Cooley's 'looking glass self' theory (Cooley, 1902 as cited in Pajares & Schunk, 2001). Cooley's (1902) theory asserts that the self-concept is formed primarily as a result of how individuals believe others perceive them. If the self-concept is a by-product of social interactions, he believes it vital for children to learn social interactions as a life skill at school (Lawlis, 2005). The self-concept develops as a consequence of intrapersonal and interpersonal relationships within the self, family, peer and school systems. In Figure 2.1, I conceptualise the above in terms of the child with ADHD. My reasoning allowed me to deduce that despite a child with ADHD's best efforts to act empathetically towards others, his/her behaviour may be characterised by a lack of self-regulation, which probably effects in his/her behaviour being construed as abrasive, intolerable and ill mannered. This, in turn, possibly results in his/her relationships being characterised by rejection and dislike, anxiety and tension. Constant and enduring negative feedback negatively affects his/her self-concept. Such negative feedback has an impact on the manner in which he/she may respond to people and situations in the future. This in turn has negative connotations for holistic performance and achievement (Wicks-Nelson et al. 2000). Children with negative self-concepts tend to have a pessimistic view of life and are critical and judgemental in their behaviour and conversation (Kruger, 1998). They tend to be extremely sensitive to the opinions of others and lack self-confidence within social and academic situations, possibly resulting in the avoidance of challenging situations as well as in destructive behaviour (Kruger, 1998).

In Figure 2.2 I illustrate the main aim of the study, which was to investigate the impact of self-concept awareness on the child with ADHD's emotion-focused coping through the use of an intervention. I placed particular emphasis on the altering of existing cognitive appraisals, which may have influenced the child's choice of emotion-focused coping strategies. Brooks (1994) and Ebersöhn (2006) support the assumption that the self-concept is an effective coping mechanism. For this reason I assessed a child's self-concept prior to and after the

intervention (through the use of interviews, self-report inventories and checklists). This allowed me to ascertain the impact of the intervention as well as to determine the relationship between self-concept awareness and emotion-focused coping.

Based on the statements of Brooks (1994) and Ebersöhn (2006), my working assumption was that through greater self-concept awareness, the child with ADHD could be able to alter their cognitive appraisals thus impacting more positively on their self-concept and ultimately on their emotion-focused coping. Although changes, if any, in the child's emotion-focused coping cannot be solely attributed to changes of the self-concept, such information was valuable in determining the impact of the intervention on self-concept awareness as well as the influence of this awareness on emotion-focused coping. In the next section, I discuss the relevance of emotion- focused coping to a child with ADHD.

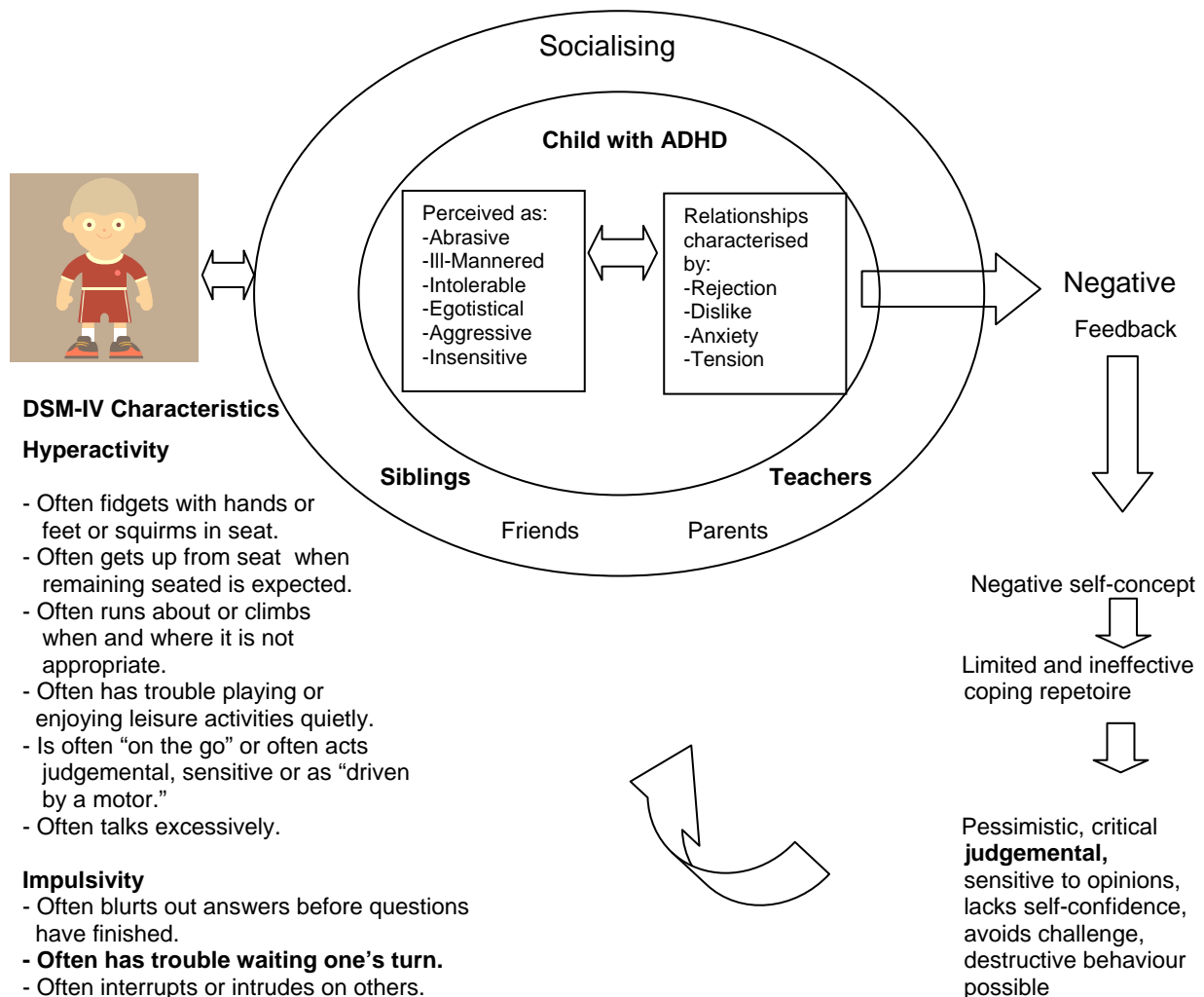


Figure 2.1: Conceptualising the research study

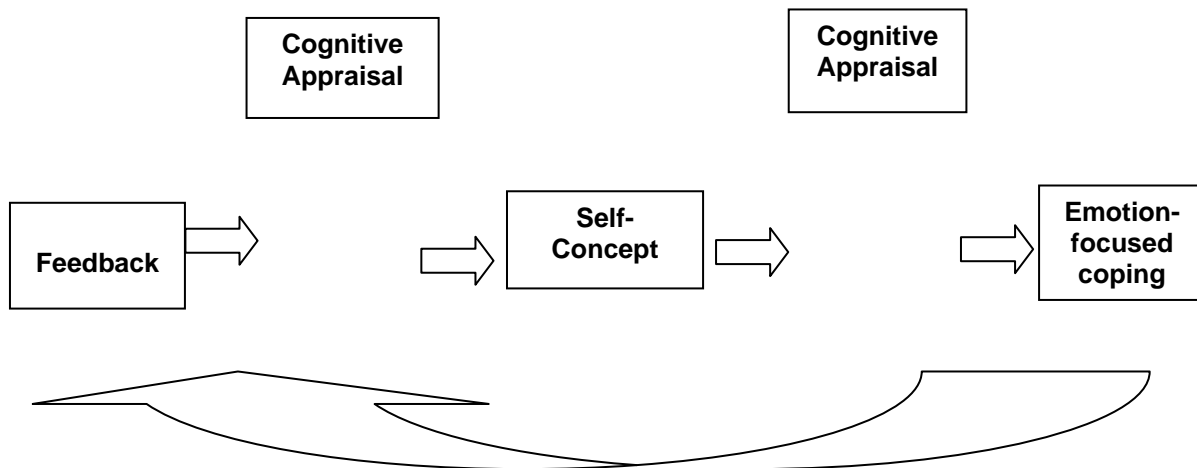


Figure 2.2: Self-concept awareness cycle addressed in the intervention

2.3. Fundamental Underpinnings of Coping

2.3.1. Introduction to Coping

Traditionally, coping mechanisms were considered defence mechanisms used to maintain, as opposed to defend from mental illness, and were characterised by distortions, and even denial, of reality (Dombeck, 2006). According to Dombeck (2006), coping strategies that were reliant on such distortion and denial were chosen out of the desire to appease negative emotions rather than to deal directly with the stressful situation itself. More recently, however, research has focused on coping strategies that promote health and well-being. Dombeck (2006) states that people form habitual modes and methods of managing stress and coping with difficult emotions. The strategies chosen and employed tend to be useful in assisting to immediately diffuse and manage stressful situations, but not all strategies are as effective as others - which could result in a negative impact on an individual's well-being. Dombeck (2006) forges a strong association between emotional maturity and the individual's choice of coping strategies, stating that emotionally immature individuals tend to respond reactively to stressful situations.

Literature offers various definitions of coping. For the purpose of this study, I aligned myself with the definition of coping as offered by Pearlin and Schooler (2007), as cited in Barganoir

(2007), who define coping as a response to strains that occur within the individuals' environment which serve to prevent, avoid or regulate emotional stress. What was particularly appealing about this definition was that it placed specific emphasis on psychological and social resources as well as on the value of the individual's coping responses. By emphasising the role of social resources, those within the systems that the individual interacts in, namely friends and family, shared the responsibility for coping. Psychological resources such as the self-esteem, self-denigration and feelings of control were included and are pertinent areas that I explored in the study. This definition fell well within the confines of the definition as offered by Lazarus and Folkman's transactional model, which highlights the role of situational cognitive appraisals - the single most important factor associated with both the self-concept and emotion-focused coping. I believe this definition supports the move away from the needs-based to the asset-based approach (Ebersöhn, 2006). Thus, cognitive appraisals play a fundamental role in the self-efficacy beliefs of the individual and ultimately in whether one deems a situation is stressful or not. Acknowledging this, **stress** is defined as the negative emotional state which occurs as a response to events which are perceived (through cognitive appraisals) as taxing or exceeding one's ability to cope (Weir, 2003). In alignment with this definition of stress and for the purpose of the study, I defined **coping** as behavioural and psychological efforts to master, endure, diminish, or decrease stressful events (Mischara, 2007).

I will now make a distinction between two types of coping strategies - problem-solving strategies and emotion-focused coping strategies.

2.3.1.1 Problem- Solving Coping Strategies

Problem-solving strategies involve actively engaging in changing the nature of the stressor and/or the manner in which it is perceived in an attempt to alleviate stressful situations. Much of the literature classifies problem-solving strategies as active, more adaptive coping strategies. Examples of problem-solving strategies include actively resolving an argument or conflict or investing more time into activities (Mischara, 2007). Problem-solving coping strategies do not form the focus of this enquiry.

2.3.1.2 Emotion- Focused Coping Strategies

The second group of coping strategies, emotion-focused strategies, formed the focus of this study. I chose to focus on emotion-focused coping strategies, as children with ADHD tend to employ emotion-focused coping strategies ineffectively, resulting in heightened, as opposed to diminished, levels of anxiety and stress (Gonzales & Sellers, 2006). Emotion-focused coping strategies were generally classified under avoidant-coping strategies as they did not

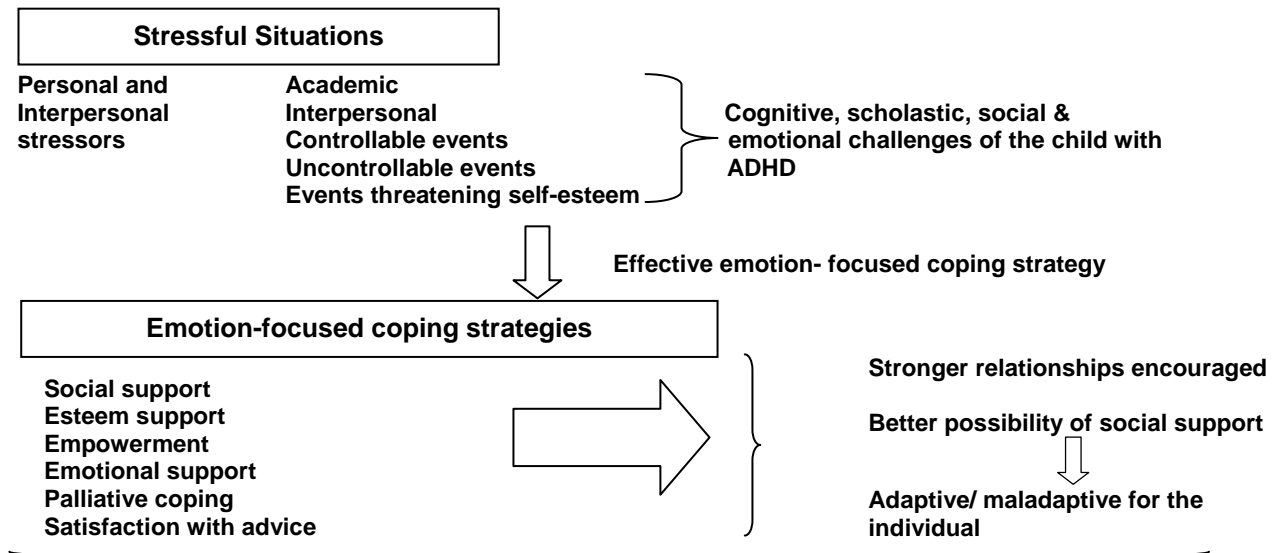
change the actual stressful situation, but allowed for the regulation of emotional consequences of stressful events (Taylor, 1998). Emotion-focused coping strategies include activities, such as drug abuse; or mental states, such as withdrawal and denial, which deter the individual from actively addressing the stress-provoking situation (Taylor, 1998). Taylor (1998) suggests that although the employment of emotion-focused strategies may provide short-term stress relief, used for an extended period of time such avoidant emotion-focused coping strategies may become a psychological risk factor. When exposed to prolonged and intense unaddressed stress, individuals may experience severe emotional problems as well as the development of anxiety and depression (Jeeva, 2000).

However, the mere identification of coping strategies was not sufficient and an evaluation of emotion- focused coping strategies was required.

2.3.1.3. Conceptualisation of Coping in this study

It became apparent to me that few literature sources discussed emotion-focused coping as a positive and adaptive way of dealing with stress, necessitating such an investigation. Such research is particularly relevant for the child with ADHD who tends to use less effective emotion-focused coping strategies as I explained in 2.1. Iwasaki (2007) conducted a study particularly useful in exploring emotion-focused coping as a positive and adaptive way of dealing with stress. He investigated the effectiveness of various coping strategies selected and utilised to deal with a variety of stressful situations.

In Figure 2.3, I illustrate my understanding of Iwasaki's (2007) contentions. He paid special attention to general and leisure-related coping strategies. (For the purpose of elucidation, leisure-related coping strategies fall under the umbrella of emotion-focused coping). Iwasaki (2007) argued that the effectiveness of the coping strategy the individual chose should be situationally contextualised, as opposed to looking at the coping strategies in isolation. He suggests that leisure-related coping strategies (such as social and esteem support) are globally more effective than general coping strategies when dealing with a variety of stressful situations (namely academic, interpersonal, controllable and uncontrollable events as well as events which threaten the self-esteem). He states that in such situations the communication and expression of true intent, thoughts and feelings tend to take place in an informal and relaxed environment. It is through these interactions that stronger relationships throughout the systems are encouraged, which bolsters the possibility of social support. Iwasaki (2007) further states that empowerment, emotional support, palliative coping and satisfaction with advice (all of which are emotion-focused coping strategies) were likely to yield positive outcomes, particularly when dealing with personal and interpersonal stressors.



Informal and relaxed environment

Figure 2.3: When may emotion-focused coping be relevant?

Iwasaki's (2007) study allowed me to posit the possibility that emotion-focused coping strategies could be effective and even necessary in certain situations. Of particular relevance to my study, was that a child with ADHD (hyperactive-impulsive type) seemed to have a limited network of leisure-related friends, which provided them with little opportunity to experience, and be empowered by, the social and esteem support provided by such a network. This may result in children with ADHD employing less effective emotion-focused coping strategies.

In acknowledging the fact that each person's chosen emotion-focused coping strategies are different and unique, it is important to ascertain whether the emotion-focused coping strategies are adaptive or maladaptive for the individual. Although not comprehensive, Gonzales & Sellers (2002) outlined possible indicators of ineffective and effective emotion-focused coping. These indicators provided me with a useful point of reference when evaluating participants' reactions during and after the intervention in my study:

Ineffective coping strategies manifested in:

- **Verbal abuse or physical aggression.** The child with ADHD engaged in direct, active and physical aggression, which manifested behaviourally in activities such as punching, kicking and pinching. Direct, active and verbal aggression manifested in hurling insults. Indirect, active and physical acts of aggression manifested in obstructing an individual's thoroughfare (Net Industries, 2008)
- **Passive-active aggression.** This passive aggression manifested itself in direct, passive and physical acts of aggression such as playing a joke on others, avoidance, internalizing, projecting blame and learned helplessness.
- **Passive-direct aggression.** Passive-direct aggression manifested in tattling as well as in the spreading of malicious rumours and gossip (Net Industries, 2008).
- **Indirect-passive physical and indirect active-verbal aggression:** Indirect, passive and physical aggression manifested in resistance and refusal to perform requested tasks. Indirect-active verbal aggression manifested in responding to others with resistant answers or completely refusing to speak (Net Industries, 2008).

The above mentioned emotion-focused coping strategies interfered with academic, social or occupational functioning, involving unhealthy or dangerous practices i.e. substance abuse, tending to promote avoidance (which may have been beneficial if the stressor was uncontrollable but over extended periods of time may have resulted in chronic physiological arousal) and were associated with negative adjustment and decreased immune functioning.

Effective coping strategies manifested in:

- **Taking positive problem-solving action and avoiding abusive verbal language or physical aggression.** In this manner, the child acknowledged and assumed responsibility for their role in the problem. Such accountability allowed for personal growth through positive reappraisal.
- **Seeking social support from friends or significant adults.** Through the seeking and gaining of emotional support the child felt empowered due to being able to effectively communicate and work through stressful experiences.
- **Examining the situation from another perspective.** This allowed the child to make a cognitive effort to detach from the situation temporarily to create a more positive outlook (distancing).
- **Using relaxation methods.** By employing relaxation methods, the child attempted to modulate feelings or actions regarding the problem, which required of him to exercise significant amounts of self-control.

Throughout the process of data collection and analysis, the above-mentioned coping strategies presented themselves. As delineated above, I needed to co-determine with the participants whether the chosen coping strategies were indeed adaptive or maladaptive for them within their context, providing clear support for this argument. I applied this information to determine the impact of the intervention on the emotion-focused coping of the child with ADHD. (Evidence for the effectiveness (or not) of the intervention on influencing emotion-focused coping were indicated by the participants coping strategies becoming more effective post-intervention based on the above indicators). Refer to chapter 4 in this regard.

2.3.2. Coping Strategies and the Child with ADHD (hyperactive-impulsive type)

The framework above provided the backdrop against which to discuss the coping of the child with ADHD. Hudiberg (2007) defines emotion-focused coping as the utilisation of behavioural and cognitive strategies to deal with conditions that are viewed as fixed and beyond one's control. It has been my experience as an interventionist working with children with ADHD that more often than not, emotion-focused coping strategies were utilised seemingly ineffectively. The following example practically elucidates this process: a child with ADHD who was involved in a conflict with a fellow classmate may have lacked adequate self-control to modulate his feelings regarding the source of conflict in order to distance himself for long enough to diffuse the situation and deal with it at a later stage. This may have resulted in him becoming physically and/or verbally aggressive towards his peer. When being reprimanded for this action, he had difficulty in acknowledging his role in the conflict. This lack of accountability made it difficult for a positive reappraisal of the situation to take place; which may have resulted in the child with ADHD experiencing the situation negatively, thus reinforcing a negative self-concept and influencing future appraisals of self and situations. Thus, if the basic features of a child coping effectively were the possession of a healthy self-esteem and sense of self competence, which promotes feelings of control, ownership and optimism, then ineffective coping strategies manifested behaviourally in underachievement, a lack of perseverance, acting out behaviour, substance abuse, and heightened physiological arousal and frustration (Gonzales & Sellers, 2006).

As I illustrated above, despite possessing an average to above-average intelligence, children with ADHD may have developed a poor self-esteem and a negative self-concept due to difficulties experienced within the social, emotional and academic realms. If a child believes that he/she has the inner resources to cope with a situation, the likelihood of experiencing stress is minimal. However, if he/she perceives his/her resources as inadequate to deal with the situation, he/she may feel threatened and may experience stress. This example also clearly illustrates the centrality of factors that contribute to one's response to stress; namely

issues of explanatory styles and personal control. Feelings of personal control has a direct influence on the child's self-efficacy beliefs. Therefore, the more control they feel they have within a situation, the less likely they were to experience stress.

2.3.3. How do these challenges associated with ADHD impact on the child with ADHD's chosen coping strategies?

Diener, Lucas and Oishi (2002) support the assertion that the individual's locus of control is a strong determinant of subjective well-being. They make particular reference to cognitive and affective evaluations of situations that are influenced directly by the amount of control one perceives he has over the situation. According to Ebersöhn (2006), having a sense of control over a situation allows for one to experience positive emotions, which, in turn, influences one's self-efficacy, self-confidence, sense of autonomy and self-resilience. This feeling of control allows the individual to persevere through hardship whilst remaining optimistic. Ebersöhn (2006) too emphasises the centrality of the locus of control by stating that those who cope well with stress believe that they have personal influence over what happens to them, tending to employ more active coping strategies due to their belief that they can personally initiate change. Those who perceive situations as falling beyond their locus of control, however, tend to employ avoidant, emotion-focused strategies (Taylor, 1998). Ebersöhn (2006) and Ginorio, Yee, Banks and Todd-Bazemore (2007) agree that those who cope poorly with stress tend to feel they have less control over their lives and have a poorer prognosis for psychological adjustment with their behaviour being characterised by learned helplessness. Persistent feelings of self-blame, as well as an external locus of control, could result in poor adjustment and depression.

Literature infers that children with ADHD exhibit an external locus of control. The child with ADHD tends to perceive reality in an idealistic, unfounded and unconventional manner resulting in the distortion of reality leading to further social isolation and discomfort (Gonzales & Sellers, 2002). This may result in enduring and intense experiences of negative effect with these deep-seated feelings of inadequacy resulting in anxiety and depression. As many as sixty per cent of children diagnosed with ADHD progress into adulthood with persisting, and even worsening, symptoms associated with ADHD (Jeeva, 2007). Biederman (1993) and Shekim (1990 as cited in Barkley & Murphy, 1996) state that approximately fifty per cent of children with ADHD become adults with ADHD who suffer from substance abuse disorders; with approximately forty per cent suffering from anxiety disorders and thirty five per cent suffering from major depressive disorders.

A study conducted by Contugno (1995) supports my assumption that due to limited coping capacity, the well-being of the child with ADHD is at risk. Findings of Contugno's (1995) study reveal that children with ADHD have limited coping capacity, which may result in an avoidance of affect-laden stimuli, difficulties with self and interpersonal perceptions and problems with social reality perception. Such research implies that many children with ADHD do not perform to their true potential, with a number of studies, like Contugno's, highlighting the ineffectiveness of the coping strategies they tend to employ. There is ample evidence to suggest that the current interventions designed for and emotion-focused coping strategies employed by children with ADHD are ineffective in assisting them to deal effectively with stress, which seemed to be resulting in a large number of children with ADHD developing co-morbid psychological disturbances as adolescents and adults.

Having said this, Mischara (2007) states that children have the capacity to become aware of the manner in which coping strategies are chosen by understanding the situation as well as personal resources and habits. It appears that the self-efficacy beliefs of a child with ADHD lead to the employment of ineffective emotion-focused coping strategies, which made the need to change cognitive appraisals of critical importance if the child was to adapt to and cope more effectively when confronted by stressors. Children who felt overwhelmed by a situation had evaluated that the personal resources they had at their disposal were insufficient to meet the demands of the situations, which resulted in a stressed response characterised by a lack of belief that they possess the ability to change the situation or their responses to the situation (external locus of control).

Thus, the need existed to enhance the coping strategies of children with ADHD in order for them to function optimally within their environments. The need to identify and develop effective coping strategies in childhood became of fundamental importance if children with ADHD were to be able to effectively confront and deal with life stressors. For this reason Hertzfeld and Powell (1986), as cited in Gonzales and Sellers (2002), advocated that stress-management programs have modules on the establishment and maintenance of a healthy self-esteem implicit within them. Brooks (1994) identified several factors that enable children to become more able to face and deal with difficulty and to increase productivity - namely, a healthy self-esteem and a sense of competence, which permits the establishment and maintenance of a sense of optimism, ownership and personal control. For them, like Ebersöhn (2006), support the belief that the self-concept is an effective coping mechanism, which makes self-concept awareness fundamental in successful emotion-focused coping (Lazarus & Folkman, 1994, as cited in Gonzalez and Sellers, 2002). It was necessary to facilitate the process of self-concept awareness in such a manner to guide, challenge and

scaffold the child through the process, using the tension and anxiety experienced because of greater awareness to influence their emotion-focused coping positively. Thus, an intervention to develop and enhance coping skills was much needed in order for children to be better able to understand their reactions within various situations and to be exposed to various coping strategies.

Figure 2.4 below serves as a point of reference when elucidating Barkley's (1999) definition of ADHD. Figure 2.4 also outlines the manner in which I understand the role that ADHD plays (and how it impacts on) the child with ADHD's self-concept, awareness thereof and ultimately their coping:

The inability to inhibit responses

This resulted in negative interpersonal outcomes, which influenced the self-concept (which is a social construct)



Impaired Executive functioning

Characterised by deficits in self-regulation, impairment in goal-orientated behaviour as well as difficulty adapting socially and behaviourally



Inaccurate self-appraisal (inaccurate understanding of strengths, limitations and resources) which influenced situational appraisals and ultimately self-efficacy (motivation and perseverance)

Children with ADHD have difficulty in accurate self-appraisals possibly leading to learned helplessness (which was the presenting problem that came to the attention of educators and parents alike)

Subjective well-being is rooted in personal control, which influences the appraisal of situations and events and whether they are evaluated as being stressful or not determining the emotion-focused coping strategies selected. Children with ADHD view situations as being beyond their control and fixed. This results in a lack of accountability and negative appraisals of events. This confirms negative self-appraisals.



Deficits in functional, adaptive behaviour

Figure 2.4 Conceptualisation of ADHD (Based on Barkley's (1999) Definition)

2.4. What interventions exist to impact on self-concept awareness and emotion-focused coping?

Gonzales and Sellers (2002) suggest that there is a heightened level of awareness in literature concerning the difficulties that children with ADHD experience. This has resulted in the creation of interventions centred on cognitive aspects, behavioural manifestations and treatment modalities. However, little research had focused on the social and emotional functioning of children with ADHD (which was congruent with the conceptualisation of ADHD as appearing in this study) - all of which played a pivotal role in levels of motivation. Goldstein (1999) states that in order for treatments to be effective, they cannot be removed from their immediate point of performance. I am of the opinion that self-concept awareness was an intangible resource intrinsic to the individual at every point of performance.

Self-concept awareness as a resource could support beliefs such as that of Gonzales and Sellers (2002) who outlined pertinent literature, which supported the need for programmes to increase the ability of children to cope with stress by relying on internal resources. Learning to cope successfully with stress was a pivotal determinant in the long-term psychosocial, emotional and physiological effects of stress. This created the need for a study to be conducted that explored the levels of psychological distress experienced by children with ADHD, in an attempt to develop interventions aimed at the **acquisition and development of effective coping strategies**. Such an intervention placed emphasis on the role of self-concept awareness as the motivator of behaviour - it was through the self-concept that self and situation appraisals were made and coping strategies selected, and it is these principles that are encapsulated in Ebersöhn's (2006) asset-based life skills facilitation programme.

However, many children do not have the necessary life skills to cope effectively. Children with ADHD may lack intrapersonal skills, and subsequently, interpersonal knowledge. This results in an external locus of control, no assumption of personal responsibility, as well as negative appraisals that manifest in ineffective coping strategies. Despite their best intentions, most reviewed interventions were needs-based as opposed to asset-based which seemed to perpetuate the cycle of helpless passivity that children with ADHD exhibited. Based on the large percentage of children with ADHD who become adults with persistent and worsening symptoms of ADHD, the need existed for the implementation of an intervention programme that empowered the child with ADHD to meet the demands of a dynamic and ever-changing world.

There are several suggestions put forward regarding possible interventions that may be beneficial to the child with ADHD. Mischara (2007) states that children have the capacity to become aware of the manner in which coping strategies are chosen through understanding of the situation, as well as personal resources and habits. Ebersöhn (2006) clearly articulates the role that life-skills facilitation plays in the facilitation of coping. I aligned myself with

Ebersöhn's (2006) assertion that the identification of inaccurate thoughts was not sufficient in the acquisition of adaptive life skills, with particular reference to children with ADHD. This is because the child with ADHD has an established understanding and knowledge of what needs to be done, but struggles with the practical execution of this knowledge. She emphasises that children should be supported in their endeavour to cope in an independent manner in order for them to cope innovatively with the stressors that they face (Ebersöhn, 2006). Ebersöhn (2007) developed an intervention which encourages cognitive regulation intervention strategies as a means of altering "thoughts, ideas, assumptions, self-communication, basic philosophies (and therefore cognitive structures and appraisals) that people use for themselves, others and situations" (Ebersöhn, 2006: 69). Through this intervention, children's self-communication at an intrapersonal level was influenced which, in turn, resulted in the acquisition of more established external interpersonal behaviour skills.

For my study, I selected Ebersöhn's (2006) framework in conjunction with Kruger's (1998) programme (refer to Appendix K), where I provide a detailed outline of my intervention). Whilst acknowledging the role and existence of deficiencies, the interventions focused on the strengths, abilities and resources available to children with ADHD that could assist them in best coping within their respective environments. By integrating the two programmes, all participants, including the child with ADHD, were involved in the process of assessment and evaluation. The reason for selecting the intervention as developed by Ebersöhn (2006) was twofold. The first was that the programme focused on key areas in which the child with ADHD was deficient, due to impaired executive functioning and poor self-regulation, namely - emotional, cognitive and behavioural regulation - all of which are prerequisites for effective emotion-focused coping and adaptation (self-awareness and reflexivity play a pivotal role). The second reason for selecting this intervention was that the programme had been implemented successfully with South African children.

As is illustrated in Figure 2.5, the intervention I chose is based on the theoretical assumption that the self-concept is situation-specific and that self talk enables cognitive awareness and self-regulation (Figure 2.5 is an integration of Figure 2.1 and Figure 2.2 to indicate how the study's intervention may theoretically impact on a child with ADHD's coping). Furthermore, through cognitive and emotional regulation, behaviour is impacted on and restructured (Ebersöhn, 2006). The most fundamental theoretical underpinning of this intervention is that it allows for the child with ADHD to involve himself/ herself in the proactive management and regulation of his/ her thoughts, feelings and behaviour (Ebersöhn, 2006). Such empowerment forms the foundation of effective emotion-focused coping, for it allows the child to experience a sense of control and to assume accountability. Children who become

stressed often feel as though they lack the ability to change the situation and their responses because of ineffective coping strategies.



DSM-IV Characteristics

Hyperactivity

- Often fidgets with hands or feet or squirms in seat.
- Often gets up from seat when remaining seated is expected
- Often runs about or climbs where it is not appropriate.
- Often has trouble playing or enjoying leisure activities quietly.
- Is often "on the go" or often acts judgemental, sensitive or as "driven by a motor."
- Often talks excessively.

Impulsivity

- Often blurts out answers before questions have finished.
- Often has trouble waiting one's turn.
- Often interrupts or intrudes on others.

- Perceived as:**
- Ill-mannered
 - Abrasive
 - Intolerable
 - Egotistical 'show offs'
 - Aggressive
 - Insensitive

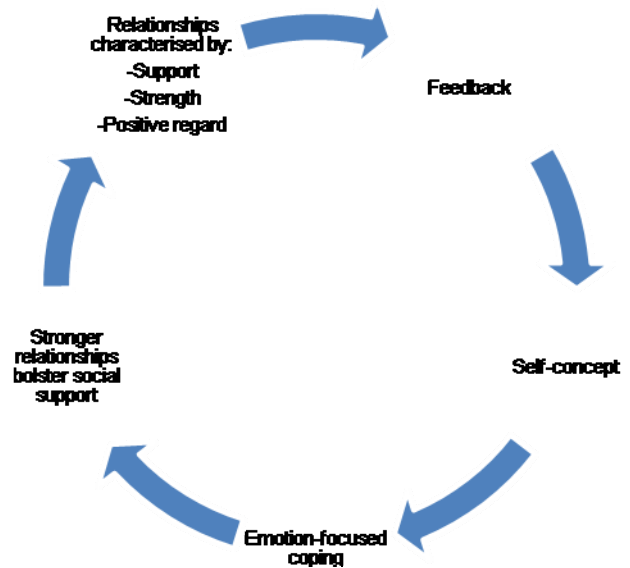


Figure 2.5: Working assumptions of changes in coping post-intervention

The intervention I chose in this study was particularly helpful in this regard. It placed emphasis on the central life skill of conscious proactive self-talk, which assisted the child in monitoring and regulating his behaviour proactively, facilitating more adaptive coping. The intervention explored the process of cognitive regulation, identity formation theory and emotional regulation - all of which are key aspects of effective emotion-focused coping. Ebersöhn (2006) asserts that interpersonal knowledge is borne from greater self-awareness and that this is the foundation for teaching facilitation. The programme incorporated elements of reflexivity to accompany self-awareness, which were pivotal for adaptation. The primary aim of the intervention was to allow the child with ADHD to internalise the intrapersonal skills

learnt and to apply them in a real life situation in order to confront and adapt to stressors using effective emotion-focused coping.

I stress the link between children with ADHD and their situations to other contexts and relationships. Of fundamental relevance to this intervention is the acknowledgement that (i) the self exists within a larger system, and (ii) the role that the meso-, macro- and micro systems play in the formation and maintenance of the self-concept. Thus, in order for the self-concept and emotion-focused coping strategies to be changed sustainably, one needs to include members from as many systems as possible (including the parents, educators and therapists of children with ADHD as participants in the research process). Benefits of these decisions are that they allow various members to come to a greater understanding of the life-world of the participant as well as making the intervention more sustainable.

2.5. Conclusion

This chapter allowed me to position my study within a theoretical framework of existing literature. I commenced the study by exploring the fundamental underpinnings of ADHD, the challenges experienced by children with ADHD and how these challenges impact on the child's self-concept awareness and their chosen coping strategies. Thereafter, I discussed the underpinnings of coping as well as the coping strategies that children with ADHD generally employ. By concluding with the exploration of intervention, I linked self-concept awareness and intervention within the context of the asset-based approach.

Based on this discussion, it appears that the child with ADHD is predisposed towards emotion-focused coping and may be more inclined to employ emotion-focused coping maladaptively (keeping cognisant of the fact that emotion-focused coping may be deemed adaptive as well as maladaptive). However, it is maladaptive emotion-focused coping which probably leads to negative feedback from significant others, which may result in a negative self-concept. The intervention I chose for this study incorporates key theoretical areas in which the child with ADHD is deficient, (due to impaired executive functioning and poor self-regulation) namely: emotional, cognitive and behavioural regulation - all of which are prerequisites for effective emotion-focused coping and adaptation (of which self-awareness and reflexivity play a pivotal role). I hope that the self-concept awareness of the child with ADHD was heightened by engaging with this intervention, resulting in more adaptive emotion-focused coping. Due to adaptive emotion-focused coping strategies, the child with ADHD may have been able to foster increased social support and subsequent positive feedback through the relationships that developed. As a result of this, I hope that the positive

feedback may have resulted in a positive self-concept, and ultimately, more adaptive emotion-focused coping.

In the next chapter, I discuss the empirical study that I conducted based on the theoretical framework as outlined in this chapter. I further explain the methodological choices that I made within the context of my study.

Chapter 3: Paradigmatic Assumptions

3.1 Introduction

Chapter two provided a theoretical framework for my study. Based on the literature reviewed in the previous chapter, I planned and carried out my research study in which I strove to explore and describe (i) the relationship (if any) between self-concept awareness and emotion-focused coping in children with ADHD and (ii) how an intervention might (might not) impact on the self-concept awareness and emotion-focused coping of children with ADHD.

In this chapter, I will discuss the purpose of my study through the exploration of my paradigmatic assumptions within the parameters of my research questions. I will explore the strengths and limitations of my meta-theoretical and methodological choices as well as how I attempted to address each of the identified challenges. Furthermore, I will explore the role that I assumed in the research study as well as the ethical considerations undertaken in order to ensure that my study was trustworthy. This chapter will be followed by a discussion of my findings in Chapter four.

3.2 Purpose of the Study and Research Questions

The purpose of this descriptive and exploratory study was to explore the association between the self-concept awareness and emotion-focused coping of children diagnosed with Attention Deficit Hyperactivity Disorder (hyperactive-impulsive type). This study was **exploratory** as I aspired to gain new insights into the association between self-concept awareness and emotion-focused coping. I strove to explore the possible impact of an intervention on the self-concept awareness and emotion-focused coping repertoire of children with ADHD. Engaging in exploratory research enabled me to define, clarify and explore both of these multifaceted and complex constructs in great detail facilitating idea generation and concept testing (Wolfenbarger, 2007). It also allowed me the flexibility to select research tools I deemed most appropriate to investigate these constructs, allowing for me to re-establish priorities and direction for my study as it became appropriate to do so

(Childers, 2007). Despite the advantages of exploratory research, I was cognisant of the limitations which could have presented themselves.

Literature indicates that exploratory research relies heavily on the expertise and training of the researcher who facilitates discussion (Wolfenbarger, 2007). Such facilitated discussions took place in my study in the form of in-depth interviews (refer to 3.8). As a scholar of psychology, the ability to create a relaxed, conducive environment which facilitates exploration through involvement, flexibility, empathy, understanding, encouragement and positive regard has formed part of my training and daily practice.

In addition, the study was **descriptive** in nature as I aimed to describe the impact that the intervention had (or did not have) on the self-concept awareness and emotion-focused coping strategies of children with ADHD. Descriptive research provided me with the platform to explore the feasibility of this intervention through observation, analysis and rich descriptions of the child participants self-concept awareness and emotion-focused coping strategies pre- and post-intervention (Koh & Owen, 2000). It was through these thick descriptions that I could indirectly assess the impact of this intervention.

As stated in chapter 1, the study therefore aimed to answer the following primary research question:

What is the association between self-concept awareness and emotion-focused coping of children diagnosed with ADHD?

In order to address the above-mentioned primary question, the following sub-questions were explored:

- To what extent were the children with ADHD's self-concept awareness impacted on (or not) by the intervention?
- How were the children with ADHD's emotion-focused coping strategies impacted on (or not) after the intervention?
- To what extent did self-concept awareness influence (or not) the child with ADHD's emotion-focused coping strategies?
- To what extent were children diagnosed with ADHD able to transfer the self-awareness skills and knowledge acquired from the intervention into their everyday interactions within the school and home?

3.3 Paradigmatic Assumptions

3.3.1. Introduction

Research paradigms consist of working assumptions that govern the manner in which I think about and reflect on the experiences being investigated, as well as the actions that ensue (Ferreira, 2006). I entered the research process with my understanding of different concepts based on literature reviewed as well as my thoughts, feelings and values which informed my frame of reference (Ferreira, 2006). I selected the **interpretivist paradigm** (meta-theory), following a **qualitative approach** (methodological paradigm).

3.3.2. Metatheoretical Paradigm

The research study aimed to gain a rich description, understanding and interpretation of the participants' perceptions of the relationship between the participants' self-concept awareness and emotion-focused coping strategies. In order to understand this complex phenomenon, I needed to gain insight into the discovery of meaning, which forms the core of interpretivism (Myers, 2000). Interpretivism argues the existence of multiple realities over time and space, acknowledging that research is a process characterised by interaction and shaped by the personal histories, biographies, gender, race and experiences of the participants; including those that share their setting and me (Denzin & Lincoln, 2000).

In order to achieve the aims of the study, I chose the interpretivist paradigm. By utilising interpretivism, I place emphasis on the subjective and unique experiences of children with ADHD as well as how their self-concept mirrors these experiences and perceptions. The interpretivist paradigm suggests that the nature of reality is fluid. It further states that multiple realities exist and are borne from the individual's subjective experience of his external world (Babbie & Mouton, 2004). Empathetic identification is essential in the process of achieving intersubjectivity and in understanding the nature of the participant's reality. Through empathetic identification, I was able to achieve a greater understanding and level of insight into the generation and sustenance of the values that make up the meaning systems and life-worlds of the participants (Denzin & Lincoln, 2000). To be able to identify with the participants empathetically, I assumed the role of participant observer (a key underpinning of the interpretivist paradigm) (Schurink, 1998; Garrick, 1999; Cohen, Manion & Morrison, 2003). (Refer to 3.8.2.).

The nature of interpretivism is to preserve the original voice of the participants as far as possible with as little interpretation as possible. In order to achieve this, when documenting collected data, I transcribed the actual words of the participants, and allowed for the actual words of the participants to surface during data analysis (refer to Appendix E for an example

of transcription and Appendix M for data analysis). By trying to preserve the original voice of the participants, I acknowledged that each participant's reality was subjective, unique and valid in terms of the manner in which they develop their self-concepts and employ emotion-focused coping strategies.

Despite trying to capture the voices and perceptions of the participants through the recording of their actual words, my interpretations were not free of personal interpretation and attribution of meaning. I acknowledged that the interpretivist paradigm allowed me to be a co-creator of meaning and attempted to address this by writing up my research study in the first person and in an informal style - allowing the reader to hear my voice (Ferreira, 2006). Throughout my research study, I aspired to use language typical of the qualitative approach (Ferreira, 2006).

Also, I needed to remain aware of the ever-present limitations that presented themselves during the research process. Acknowledging that meaning is socially constructed, I was aware that my presence in all interactions could alter the settings and behaviours of the participants (Bogdan & Biklen, 1982, Guba & Lincoln, 1981 & Patton, 1990). In addition to this, I needed to be aware at all times of my perceptions and possible biases. I addressed both of these limitations through reflection-in-action as well as by reflecting on my role as interventionist and researcher within my reflective journal and with my supervisor (Denzin & Lincoln, 2000). The second limitation presented itself in the form of time. Being the only tool for data collection, analysis and interpretation required much involvement on my part, making the process time consuming (Bogdan & Biklen, 1982, Guba & Lincoln, 1981 & Patton, 1990).

3.3.3. Methodological Paradigm

I employed a **qualitative** paradigm in this study. My choice to work from a qualitative paradigm was guided by the purpose and nature of my study as well as by my belief as a researcher that there is no single, objective reality; but that reality is a subjective, context bound experience, which makes it a tool to better understand and describe the world of human experience. Denzin and Lincoln (1994) define qualitative research as research conducted within the natural settings of the participants in order to gain insight into the meanings that the participants attach to their life worlds. Qualitative research advocates that the whole is greater than the sum of its parts, with the context proving crucial when attempting to understand the situation. The qualitative paradigm is an inductive process and as such I did not make attempts to understand the situation or phenomenon being studied by introducing pre-existing expectations into the setting (Mouton & Marais, 1991).

As qualitative researcher, I regarded the participants and myself as active agents in the construction and meaning making of their realities (Mouton et. al. 1991). Through acknowledging and respecting this relationship between the researcher and participants, we established a relationship based on trust. Throughout the research process, I remained cognisant of the importance of maintaining intersubjectivity as well as understanding the outcomes of the observations and interviews through the lens of the participants' personal knowledge. I was required to understand and interpret the situation through gaining insight into the meaning the participants had attached to the situation, which was embedded within the context of their social interactions (Mouton, et. al. 2005).

As stated by McMillan & Schumaker (2001), the hallmark of qualitative research is the level of detail that the narratives of the participants contain which makes their stories appear alive and real. Through understanding the narratives of the participants, the reader is transported into the world of the participant. In order to capture this rich detail and authenticity, I placed emphasis on naturalistic observation and fieldwork (refer to Appendix B for example of field notes) while capturing data, as well as on recording the exact words and terms used by the participants as far as possible (Mouton et. al. 1991). (Refer to Appendix L for examples of visual data and Appendix J for examples of transcriptions).

Lofland (1971) as cited in Mouton & Marais (1991) outlines four elements he deems necessary in a qualitative study, which I utilised, namely:

- I became rigorously engrossed in the participants' contexts in order to gain a detailed acquaintance with the subjective worlds of the participants. I achieved this through the analysis of the participants' acts, activities, meanings, participation, relationship and setting; (refer to Appendix N for example of reflective journal)
- I detailed the situations that the participants were in; (refer to Appendix I for example of field notes)
- I aimed for an in-depth understanding of the manner in which the participants navigated and coped with the situations that they were in; (refer to Appendix N for example of reflective journal)
- I integrated and analysed data collected about the participants' interactions, locations, situations and strategies in order to portray an in-depth picture of the reality of the participants. (Refer to Appendix N for example of reflective journal and Appendix M for example of data analysis).

Critics of the qualitative approach believe that one of the greatest weaknesses of qualitative research is that an element of humanness is maintained throughout the research process

(Mouton & Marais, 1991). They assert that this makes it impossible to escape the subjective experience (which forms the core of quantitative, positivist research). However, for the qualitative researcher, this is a great strength of the approach. The humanness informs the qualitative researcher of the subtleties of the situation needed to understand the richness and depth of the participants' life-worlds through detailed exploration and allows for the reader to have a detailed understanding of the phenomenon being explored (Mouton & Marais, 1991). I remained acutely aware and cognisant of the strengths and weaknesses posed by subjectivity and throughout the research process constantly reflected on this in my research journal as well as with my supervisor. A second weakness of the qualitative research process proved to be the demand it placed on time and commitment (Mouton & Marais, 1991). I attempted to address this weakness by providing approximate time frames for the intervention sessions as well as by delineating the time needed to conduct my research.

3.4 RESEARCH DESIGN

3.4.1 Introduction

I conducted the study using an intervention research design as conceptualised by Rothman and Thomas (1994). They define intervention research as the development of knowledge about interventions, how to apply this knowledge into social practice and the effectiveness of the intervention within a particular setting. They offer an integrated model of intervention research in an attempt to design and develop interventions to enhance the well-being of the individual and school community. Intervention research places a strong emphasis on the participation of all participants throughout the research process.

3.4.2 Intervention Research Design

Intervention research design comprises three main elements, namely intervention knowledge development (results generated which could be used to gain insight to and solve problems), intervention knowledge utilisation (apply knowledge generated from theory and research to human behaviour) and intervention design and development (focuses on the development of new interventions and provides empirical grounds for altering existing interventions) (Thomas & Rothman, 1994).

Bender (2002) states that although the stages of intervention in intervention research are presented sequentially, this is a dynamic process that evolves throughout the intervention and in the face of opportunities and challenges. Based on Thomas & Rothman's model, Bender (2002) further states that each phase has distinctive tasks to carry out in order to

complete the needs of the phase, with each completed stage carried through into the introduction of the next phase. Thomas and Rothman (1994) offer the following integrated model of Intervention Research (which I utilised in designing the study) comprising six phases and corresponding activities. I discuss my application of the phases in Chapter 4.

Phase 1: Problem analysis and project planning

Phase 2: Information gathering and synthesis

Phase 3: Design

Phase 4: Early Development and Pilot testing

Phase 5: Evaluation and advanced testing

Phase 6: Dissemination

Using intervention research presented with a number of limitations (Thomas & Rothman, 1994) which will now be explored. Intervention was time and labour intensive, particularly in the case of this study as I was directly and wholly involved in the actual intervention as well as in the observation and interviewing of the participants. Secondly, the terminology used for different intervention strategies was vast and may result in the study not being easily comparable due to varying terminology. I addressed this challenge through concept clarification as outlined in Chapter 2. Thirdly, the lack of literature available on intervention research made it difficult to **apply a standard and well-researched design** to my study. Lastly, my study made use of a **control participant** in order to evaluate the impact (or not) of the intervention adding which added credibility to my study. Both participant and control participant were selected on the same criteria (refer to 3.5.2.1) and both received the intervention at different times (refer to figure 3.1). The control participant received the intervention on completion of the study (Myers & Dynarski, 2003). Throughout the study, both participants, their parents, their educators and their therapists were granted access to all services not provided by the intervention process and by the school, such as other therapeutic interventions (Myers & Dynarski, 2003).

Despite the above-mentioned weaknesses, there were several advantages to using this research design. The results yielded from the research provided the opportunity to evaluate the materials and programmes currently used by the school, with the possibility of introducing new, more effective interventions should the intervention positively impact on the self-concept awareness and emotion-focused coping of children with ADHD. By establishing rapport with the participants, I gained a rich understanding of and insight into the participant's behaviour and responses, which most other research designs would not permit. Intervention

research design also created opportunities for future empirical research questions and investigation (Goodwin, 2002).

3.5 Selection of Participants

3.5.1 Introduction

Comprehensive inquisition of a phenomenon within its natural context exemplifies Qualitative research. The interpretivist paradigm is characterised by the emphasis it places on multiple and unique perspectives of the participants within situation-specific contexts, prioritising description and exploration over generalisation (Jacobs, 2007). Qualitative samples are therefore generally small due to the time and resources required to conduct such a study.

I selected purposive sampling for the purpose of my study (Babbie & Mouton, 2004). One can define **purposive sampling** as a process in which one selects a sample based on experience and knowledge of the group sampled. Employing purposive sampling was advantageous by allowing me to analyse the data as the sampling progressed (Jacobs, 2007). This gave me the flexibility to add to or change the sample criteria according to the information that emerged. Sampling in this way ensured the vigorousness of the theories generated, which correlated with the essence of qualitative research - to gain an in-depth, rich understanding of the phenomenon. In table 3.1 I provide an outline of the participants in this study.

Table 3.1 Outline of participants in this study

	Gender	Age	Grade
Child 1	Male	10	4
Child 2	Male	11	5
	Gender		Occupation
Parent 1	Female	41	Nurse
Parent 2	Female	38	Accounts Clerk
	Gender	Grade	
Educator 1	Male	5	
Educator 2	Female	4	
	Gender	Grade	Occupation
Therapist 1	Female	5	Psychologist

Therapist 2	Female	5	Speech Therapist
Therapist 3	Female	5	Occupational Therapist
Therapist 4	Female	4	Intern Psychologist
Therapist 5	Female	4	Speech Therapist
Therapist 6	Female	4	Occupational Therapist

Jacobs (2007) outlines steps to be undertaken when selecting a sample (which I adhered to in my study):

3.5.2 Define the population

Last year, I was employed in the capacity of an intern educational psychologist at a government remedial school catering for the special education needs of learners from Grade 1- Grade 12. In the capacity of intern psychologist and member of a multi-disciplinary team², I worked with a number of learners as well as their parents, educators and therapists. This granted me access to research participants, making it viable for me to request volunteers from a group of people who met the general requirements of the study (Goodwin, 2002). I will now discuss the three groups of participants.

3.5.2.1 Children with ADHD

I purposively selected two children with ADHD to participate in the study based on the following criteria:

- The child displayed symptoms of ADHD (hyperactive-impulsive type).
- The child spoke English as their first language.
- The child's intellectual ability fell within the below-average-to-average range at the time of intervention.
- The child came to the attention of the school's multidisciplinary team² displaying ineffective emotion-focused coping.

I selected both children with ADHD from the intermediate phase. Child 1 is a male, aged 11 and currently in Grade 5. Child 2 (the control participant) is a male, aged 10 and currently in Grade 4. I chose boys for the sample because literature identified that boys, particularly pre-adolescent boys, formed part of a high-risk group of the population (refer to 2.2.2). Both learners underwent pre- and post- intervention assessments, however only Child 1 partook in

² The multi-disciplinary team consisted of an educator, assigned speech therapist, occupational therapist and psychologist/ intern psychologist. The multi-disciplinary team would meet once a week to discuss the progress of identified learners and to adapt Individualised Education Plans (IEP) accordingly.

the intervention initially, with Child 2 (the control participant) receiving the intervention on completion of the study. I conducted all interviews and intervention sessions in English. In both cases, the parent/s, educator/s and therapists of the children were involved in the research process. (Refer to Figure 3.1. for an outline of the research process). The Head of the Learning Support division, under whom I was completing my internship as an educational psychologist, contacted the parent/s of the participants. I then met with the parents and, by means of a consent letter (Appendix A), obtained informed consent from them for their children to participate in the study (refer to 3.11.1).

3.5.2.2. Parent/s of children with ADHD

I purposively selected the parents of the children with ADHD because they provided vital biographical information, as well as observations of behaviour within the home and peer situation. Aligned with qualitative research, this information assisted me in better understanding the context within which each child functions. Also theoretically, based on social cognitive theory (refer to 2.2.3. in Chapter 2), the environment plays a crucial role in the development of a child's self-concept. Parental information thus provided me with insight into stressors that children with ADHD were experiencing within their environments.

The Head of the Learning Support division, under whom I was completing my internship as an educational psychologist, contacted the parent/s of the participants. I then met with the parents and, by means of a consent letter (Appendix A), obtained informed consent from the parents for them and their child to participate in the study.

3.5.2.3. Educators and Therapists

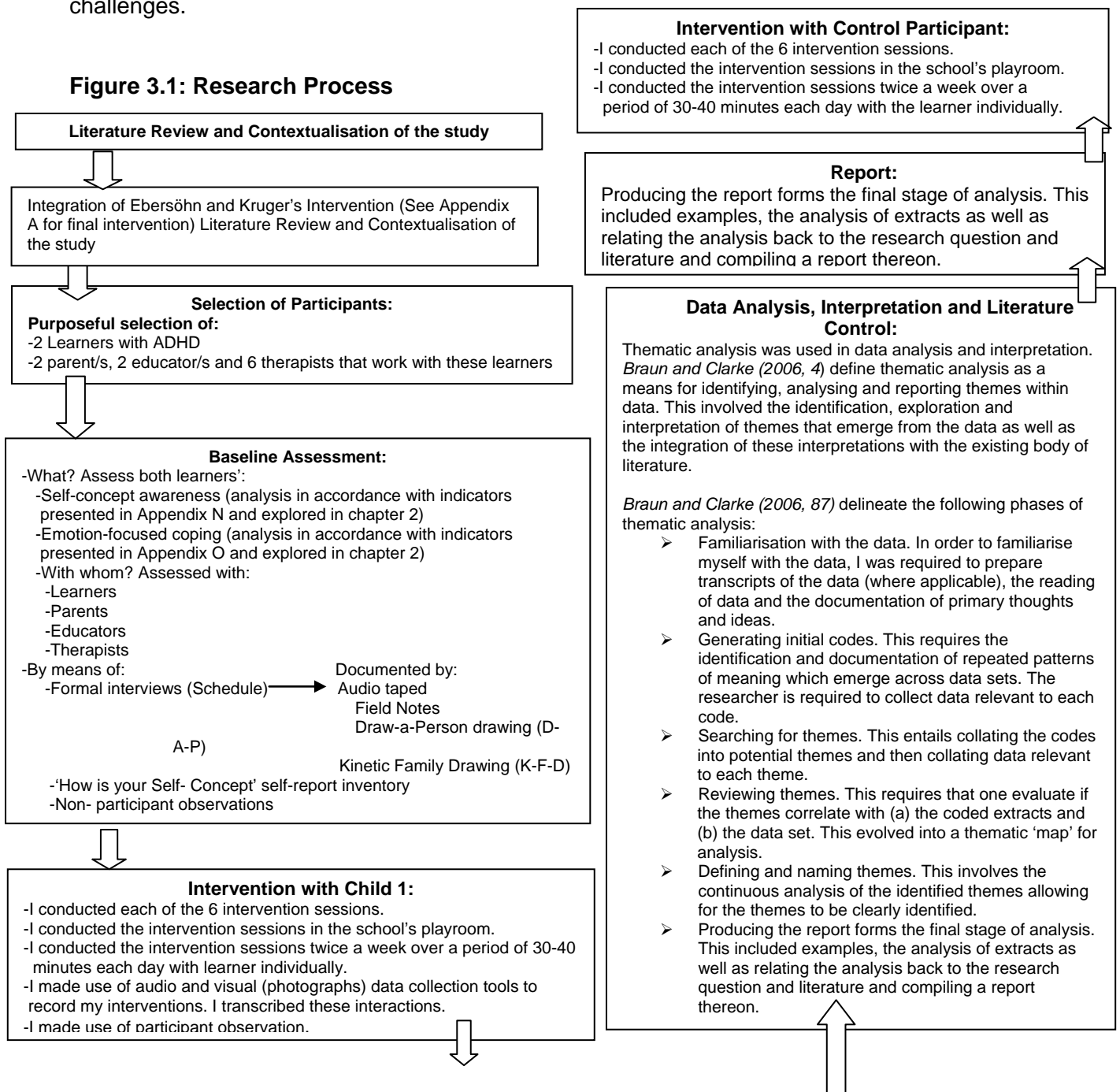
I purposively selected the educators and therapists that work with the child participants. This group of participants consisted of educators, occupational therapists and speech therapists. This team met once a week to discuss the scholastic and therapeutic progress of identified learners within the class. I engaged with the therapists using formal interviews (refer to 3.8.3.). Educators and therapists were in the position to volunteer relevant background information about the learners, with specific emphasis on current emotion-focused coping strategies that had emerged through assessments as well as therapeutic interventions. Through my interactions with the respective therapists, I evaluated the following aspects before and after the intervention: the child's relationships and interactions within the therapeutic setting; the extent to which the therapists felt that the learner's self-concept manifested within the school setting and the influence that this had on his emotional and social functioning. These interviews allowed me to determine the nature of the relationship

between self-concept awareness and emotion-focused coping strategies from the perspective of the educators and therapists.

3.6. Research Process

In figure 3.1 I represent the various phases undertaken during the research process. As discussed, although the stages of the intervention are presented sequentially below, this is a dynamic process that evolves throughout the intervention and in the face of opportunities and challenges.

Figure 3.1: Research Process





Post- Intervention Assessment:

- What? Assessed both learners':
 - Self-concept awareness (analysis in accordance with indicators presented in Appendix N)
 - Emotion-focused coping (analysis in accordance with indicators presented in Appendix O)
- With whom? Assessed with:
 - Learners
 - Parents
 - Educators
 - Therapists
- By means of:
 - Formal interviews (Schedule) → Documented by:
 - Audio taped
 - Field Notes
 - Draw-a-Person drawing (D-A-P)
 - Kinetic Family Drawing (K-F-D)
- 'How is your Self- Concept' self-report inventory
- Non- Participant observations

3.7.1 Introduction

I employed formal interviews and observation as primary data collection strategies (Babbie & Mouton, 2004). I supplemented these data collection techniques with visual data (refer to Table 1.1. in Chapter 1 for overview).

3.7.2 Observation

3.7.2.1 Introduction

I made use of observation as a data collection technique. I observed the learners within a number of settings, using both participant and non-participant observation (Babbie & Mouton, 2004). During the intervention sessions, I used **participant observation**, thereby actively engaging in the intervention with the participants whilst simultaneously observing them (Bailey, 1987). Through participant observation, I more accurately understood the perceptions of and meanings attached to their life worlds (Bailey, 1987). I needed to remain cognisant of the risks involved in observing others as a researcher (Babbie & Mouton, 2004). Observation underpinned all other methods of data collection. When observing the children within the classroom, I used **non-participant observation** (refer to Appendix O for an outlining the times and places of observation with each child). During this time, I assumed the role of observer in order to study the behaviour of the participants within their natural settings (Bailey, 1987). Through observing the child participants' both during the intervention sessions as well as within group situations, I evaluated the information collected from the intervention sessions, as well as from other stakeholders (refer to Appendix D for indicators used for self-concept awareness and Appendix E for emotion-focused coping strategies observed). This allowed me to either validate or refute the information that I gathered as well as allowing me to evaluate the personal meaning I had attributed in my reflective journal.

3.7.2.2 Documentation of Observations

I kept a journal comprising of field notes as well as reflections to record the behaviour of the children with ADHD (Babbie & Mouton, 2004). This allowed me to firstly capture my observation, and secondly, to ascertain whether the behaviour I was observing was ongoing or intermittent. These field notes (Appendix I) included detailed descriptions of what actually happened, as well as my interpretations of what I believed had happened (Babbie & Mouton, 2004). I also recorded my observations during the intervention sessions. I strove to gain a more detailed and intimate understanding of the individuals' thoughts and feelings through the primary relationship I had with the participants' (Bailey, 1987).

3.7.2.3 Strengths and Limitations of Observations

The absence of control, possibility of observer bias and subject reactivity as well as ethical considerations of privacy and informed consent were some of the challenges I encountered when using observation as a method of data collection (Goodwin, 2002). Due to an **absence of control**, I drew inferences from observations with care and caution (Goodwin, 2002). The second challenge could have presented itself in the form of **observer bias**, which may have occurred when I decided what to observe and omit based on preconceived notions (Goodwin, 2002). I made use of behaviour checklists to address the risk of observer bias (refer to this checklist in Appendix F) which allowed for the identification of pre-defined target behaviours (refer to Appendix C) as well as allowing for the recorded interactions to be viewed by another observer in order to ascertain if the records were congruent (Goodwin, 2002). I also engaged in reflection at every stage of the research process, both on my own and with my supervisor. This encouraged introspection of my thoughts and feelings (refer to Appendix N for example of reflective journal). **Subject reactivity** presented as the third possible challenge, which could have become a concern if the participants were acutely aware that they were being audio recorded during the intervention (Goodwin, 2002). Thus, although the participants were aware of recordings, I used as many indirect, unobtrusive methods as possible. This meant concealing the dictaphone as much as possible, particularly when working with the child participants' (Goodwin, 2002). I obtained informed consent and voluntary participation from each of the child participants, their parent/s and educators, and discussed the limits to privacy and confidentiality thoroughly with them (refer to 3.11).

Despite the above-mentioned challenges, there were a number of strengths associated with using observation as a method of data collection. I achieved falsification and inductive support through observation (Goodwin, 2002). Through observation, I explored the participants' nonverbal behaviour, which was sometimes more telling than their verbal explorations and accounts, allowing me to have familiarity with the subject participants (Babbie & Mouton, 2004).

3.7.3. Guided Interviews to determine self-concept awareness and emotion-focused coping as outlined by the indicators in Chapter 2

3.7.3.1. Introduction

For the purpose of my study, the reason for using formal interviews was two-fold. Firstly to use as a tool to determine the impact (or not) of the intervention and secondly to gain a rich and in-depth understanding of the participants' perspective based on their interactions (Denzin & Lincoln, 2000). By using formal interviews, I gained rational and emotional information and responses from the participants.

There were a number of advantages to using formal interviews as methods of data collection. Interviewing eliminated many of the problems encountered by issuing a questionnaire, such as minimising responses such as "I don't know" or failure to answer certain questions. Interviewing also reduced the possibility of misunderstanding questions by giving clarification and guidance (Babbie & Mouton, 2004). By using structured interviews, I gathered rich and diverse information. (Refer to Appendix O for a schedule of dates and places when I conducted guided interviews).

3.7.3.2. Guided Interviews

Guided interviews took place before and after the intervention with both children's parent/s, therapists and educators to capture data that would serve to explore the learners' emotion-focused coping and self-concept awareness (Denzin & Lincoln, 2000) (refer to Appendix D for indicators used to explore self-concept awareness and Appendix E for emotion-focused coping strategies observed). This ensured that I asked all participants the same sets of questions with little variation, minimising interviewee bias (Babbie & Mouton, 2004).

The meanings the participants attached to their situations and experiences became explicit through the guided interviews. I gained insight into the values, beliefs, thoughts and cognitions that influenced the parents' understanding of ADHD and their perceptions of the impact thereof on the children's self-concepts. These interviews provided insight into how the parent participants felt ADHD had or had not impacted on their child's emotion-focused coping. My responsibility was to establish "balanced rapport" (Babbie & Mouton, 2004) - I had to be approachable and yet direct and impersonal - which the structure of the interpretivist, qualitative paradigm supported. Through active listening, I did not evaluate the responses of the participants, but rather, allowed for them to feel heard and understood

(Babbie & Mouton, 2004). Thus, I gained insight into the holistic functioning and development of the child through rich contextual information from multiple people.

3.7.3.3. Documentation of Guided Interviews

During the guided interviews, I made detailed field notes (refer to Appendix I) and I used a dictaphone to record the interviews. I then transcribed the actual words used by the participants (refer to Appendix E). This presented me with the opportunity to review the interview during data analysis and interpretation in order to ascertain if my transcription was complete and accurate (refer to Appendix D for indicators used to document self-concept awareness, Appendix E for indicators used to document emotion- focused coping strategies and Appendix H for interview schedule).

3.7.3.4 Strengths and Limitations of Guided Interviews

Denzin and Lincoln (2000) identify a number of limitations to be aware of when making use of guided interviews as a source of data collection. Many participants are unfamiliar with the interviewing situation, resulting in them assuming roles which influence the accuracy of the information that they render. Factors that influence participants' responses included social desirability, response deviation and response acquiescence (Babbie & Mouton, 2004).

The first possible limitation is **respondent behaviour**. This could occur when participants give responses which are pleasing to the interviewer but prevents the interviewer from gaining an accurate understanding of how participants perceive themselves and their life worlds. Memory lapse may also influence the behaviour and responses of the participants. A second limitation of the guided interview is the **nature of the task**. When engaging in a guided interview, I paid close attention to the sequence of questions and well as to asking the questions as they appeared. By applying such rigour to the interviewing situation, I addressed the threat of inaccurate response behaviour and interviewer error.

Working from an interpretivist paradigm emphasises the role of context in the creation of meaning. Although using a structured interview eliminated a large amount of independent judgement, the context could not be divorced from the creation of meaning. This interview was a social interaction that took place within a context (Denzin & Lincoln 2000). As a researcher, I needed to be aware of how this interaction influenced participants' responses and behaviour. According to Kahn & Kanell (1975) as cited by Denzin & Lincoln (2000), it was important for me to understand the extent to which the participants' responses and behaviour were influenced by their life worlds and their contexts, and how this context either

promoted or hindered the responses they rendered. I encouraged this awareness through reflecting in my reflective journal (refer to example in Appendix N).

3.7.4 Visual Data

3.7.4.1 Introduction

Denzin & Lincoln (2000) advocate that photographs are the “mirror of the memory” allowing us to capture the nuances of everyday life. Harper, as cited in Denzin & Lincoln (2000) summarises the value of photographs in the production of meaning by stating that a sequence of photos provides a link between first person accounts and cultural narratives which transcend both time and space. I took photographs of the work produced by the participants during the intervention sessions. In this manner, I gathered information regarding various aspects of the participant’s social lives, which impacted on their self-concept as well as their coping strategies. The value of the photographs were two-fold; firstly, to provide factual information about the work that the participant produced and secondly, to offer evidence of how the knowledge, skills and values explored in the intervention sessions were integrated into their final pieces of work (Denzin & Lincoln, 2000). By using the photographs for this purpose, I collected information that contributed to my data analysis (refer to Appendix L for examples of visual data).

The visual data collected (refer to example in Appendix L) provided valuable information regarding (a) self-perceptions, (b) self-awareness and (c) coping strategies as well as being a manner in which to (d) document the process the participant went through during the intervention (refer to 4.3.1.1).

3.7.4.2 Documentation of Visual Data

I used visual data as a data collection strategy, in the form of photographs. The photographs were taken of the activities completed before (D-A-P), during (dream chart, list of signature characteristics) and after (D-A-P) the intervention sessions, particularly the participants’ completed activities after each session. Ethically the artefacts and activities photographed throughout the intervention sessions remained the property of the participants on completion of the study.

3.7.4.3. Strengths and Limitations of Visual Data

I support Denzin & Lincoln (2000) who state that photography as a method of data collection is empirical, in that it captures the participant at a certain moment in time. However, I use the term empirical with caution as photographs (despite allowing me to visually document the

research process) cannot be deemed credible pieces of information, for the nature of observation is interpretive (Denzin & Lincoln, 2000). Aware of the fact that photographs depict a social reality which is co-constructed, I attempted to ensure that photographs formed part of the crystallisation process (refer to 3.12.2). I did not interpret photographs in isolation from other sources of data, contributing to the credibility of my study. In the context of my study, photographs “concretised” (Denzin & Lincoln, 2000. p. 725) the observations that I made within the field enhancing crystallisation in the study (refer to 3.12.2).

Using photographs, I formed visual narratives of the research process. Acknowledging that the observations were interpretive by nature, I guarded against the threat of researcher bias. I needed to be fully aware that the reality depicted within photographs was a reality borne out of the choices and decisions made by me as a researcher (Denzin & Lincoln, 2000). Through this reflexivity, I established boundaries and planned data collection strategies with my supervisor as well engaged in reflection within my reflective journal (Ebersöhn & Eloff, 2007) (refer to 3.8.5).

In order to contextualise the visual data within the confines of my study, I obtained detailed knowledge of the participants (Denzin & Lincoln, 2000). I obtained this case history through compiling a detailed history of each of the learners from various participants, namely their parents, educators and therapists. By having a detailed knowledge of the participants, I extended my knowledge of the child participant, for this was the ultimate aim of the study: to gain a rich and in-depth understanding of the impact of an intervention in increasing self-concept awareness in order to impact on emotion focused coping.

3.7.5 Reflective Journal: Reflexivity

3.7.5.1 Introduction

As a qualitative, interpretivist researcher working with an intervention research design, the nature of the research was reflective in that local and substantial meanings were an invaluable part of the research process (Denzin & Lincoln, 2000). Thus, I assumed the role of researcher and interventionist- both of which informed the choices that I made throughout the research process (Ferreira, 2006).

As Ferreira (2006) (in support of Kelly, 2000) eloquently articulates, conducting research from an interpretivist paradigm required of me to assume both an insider and outsider perspective. When engaging with the participants during intervention sessions as well as with their parents, educators and therapists, I assumed an insider approach to allow for the

expression of the participants thoughts, values, feelings and impressions. I then assumed an outsider perspective when interpreting their thoughts, feelings, and impressions, trying at all times to capture and reflect the actual voices of the participants whilst pursuing an answer to my research questions (Ferreira, 2006).

Engaging in discussion and activity with participants for an extended period required me to engage in reflection during and after action in order to attribute my meaning to the research process – acknowledging that I too was a participant in the research process. Denzin & Lincoln (2000) define reflection- in- action and self-reflection as a dynamic, fluid process. I was able to reflect on the impressions and recollections throughout the research process outside the permitted boundaries dictated by theory using a reflective journal (Denzin & Lincoln, 2000) (refer to Appendix N).

In order to differentiate between the dual role of researcher and interventionist, I liaised closely with my supervisor and reflected on this process within my reflective journal. I employed ‘empathetic neutrality’ (Ferreira, 2006) to interact with participants in an empathetic yet nonaligned way. This was especially important, as I was the sole tool for data collection, analysis and interpretation (Denzin & Lincoln, 2000).

3.7.5.2 Documentation of Reflections

Throughout the research process I reflected within my reflective journal (refer to example in Appendix N). I documented my thoughts, feelings and working assumptions based on the literature I had reviewed and the information that has presented itself. This allowed me to reflect on the information collected, my personal thoughts and feelings thereof as well as allowing me to work towards the analysis and interpretation of the data. Denzin & Lincoln (2000) regard the reflective journal as a documentary tool, which fits in with the notion of crystallisation.

3.7.5.3 Strengths and limitations of a reflective journal

In keeping a reflective journal (refer to example in Appendix N), I reflected on my personal experiences of the research process in order to be aware of the role I played in my interactions with participants. This allowed me to reflect on my thoughts and feelings about the research process in order to differentiate between my thoughts and feelings, and those of the participants. This type of self-reflection enhanced the credibility of my study. In addition to this, I believe that by keeping a reflective journal, I evaluated personal growth throughout the research process. Through increased awareness borne from reflexivity, I enhanced not only the research process, but also my personal and professional development.

Despite striving to write detailed notes in my reflective journal whilst interacting with the participants, I found it difficult to do, as I was engaging as completely as possible with the participants. I addressed this possible limitation by writing reflective notes as soon as possible after the actual interactions had taken place in order to remember as much of the detail as possible. Audio recordings of the sessions as well as field notes made during the sessions facilitated the process of writing reflective notes after the sessions.

3.8 Data Analysis and Interpretation

3.8.1 Introduction

Data analysis involved the identification of themes, which emerged from various data sources. I obtained the primary sources of information used for analysis from observation, interviews, visual data and my reflective journal. I was guided throughout the process of data analysis and interpretation by my research question - whether a self-concept awareness intervention encourages self-concept awareness in children with ADHD; and secondly, whether increased self-awareness impacts on emotion-focused coping (refer to Appendix M for examples of data analysis).

I used thematic analysis in data analysis and interpretation. Braun and Clarke (2006) define thematic analysis as a means for identifying, analysing and reporting themes within data. This involved the identification, exploration and interpretation of themes that emerged from the data as well as the integration of these interpretations with the existing body of literature.

Braun and Clarke (2006) delineate the following phases of thematic analysis (refer to Appendix M for examples of data analysis):

- Familiarisation with the data. This required that transcriptions be prepared (where applicable), the reading of data and the documentation of primary thoughts and ideas.
- Generating initial codes. This required the identification and documentation of repeated patterns of meaning which emerged across data sets. I was required to collect data relevant to each code.
- Searching for themes. This entailed collating the codes into potential themes and then collating data relevant to each theme.
- Reviewing themes. This required me to evaluate if the themes correlated with (a) the

coded extracts and (b) the data set.

- Defining and naming themes. This involved the continuous analysis of the identified themes allowing for the clear identification of the themes.
- Producing the report forms the final stage of analysis. This included examples, the analysis of extracts as well as relating the analysis back to the research question and literature and compiling a report thereon.

3.8.2. Analysis and Interpretation of Text

The analysis and interpretation of text encompassed a number of data sources, namely interview transcripts, documented observations, field notes and the reflective journal. I conducted thematic analysis along the guidelines provided by Braun & Clarke (2006) as detailed above in order to analyse the textual data.

I linked identified themes within my theoretical model, and tabulated the themes according to the frequency at which they occurred. This allowed me to reveal the content comprehensively within each of the sources of information (Neuman, 2003). Once I had ascertained the frequency of themes, I interpreted these themes. In order for the content analysis to be reliable and credible, I examined and interpreted the information within the boundaries of relevant contextual information gathered from the visual data as well as from interviews and observations (Neuman, 2003).

3.8.3. Analysis and Interpretation of Visual Data

I attempted to align visual data with textual transcriptions (Ebersöhn & Eloff, 2007). I utilised the following strategies as postulated by Ebersöhn & Eloff (2007) during the inductive analysis of visual data (refer to Appendix L for examples of the analysis of visual data):

- I provided a detailed depiction of the physical environment (what I saw, what the colours were, where and how the objects/ people were placed, what people were wearing).
- I transcribed adjectives next to the objects detailed above.
- I documented emotional observations in my research journal.
- I reflected on the photographs in relation to the social, historical and cultural context – attributing meaning to different people in different social contexts.
- Throughout the process of analysis and interpretation, I made notes according to my

conceptual framework.

- I identified categories based on the above-mentioned descriptions and colour codes.
- I never interpreted visual data in isolation from other sources of data.

3.9 Intervention

3.9.1 Introduction

I selected Ebersöhn's (2006) asset- focused life skills facilitation programme for use in my study in conjunction with Kruger's (1998) programme (Refer to Appendix K where I provide a detailed outline of my intervention). Kruger's programme provided me with the self- concept inventory which allowed me to assess the child participants' self- concept awareness both pre- and post-intervention. By integrating the two programmes, all participants, including the child with ADHD, were involved in the process of assessment and evaluation.

Prior to the commencement of the intervention sessions, I obtained baseline information through the use of formal interviews as well as the D-A-P, K-F-D, 'how is your self-concept inventory' and observation with the child and the child participant's parent/s, educators and therapists. The intervention sessions were then conducted twice a week over a period of three weeks. Each session lasted between 30-40 minutes. All intervention sessions were conducted in the school's playroom.

3.9.2 Pre- and post- intervention

In order to evaluate the impact (or not) of the intervention on child participant's self-concept awareness and emotion-focused coping strategies, I was required to assess their self-perceptions, self-awareness and coping strategies before (baseline image) and after the intervention. In alignment with the interpretivist paradigm, it was important for me to capture not only reports from significant other's on the child participants perceptions of their life worlds, but to allow for the child participants to be able to describe how they perceived their life worlds through the use of various instruments, which I discuss in the following sections:

3.9.2.1 Draw-a-Person Technique (D-A-P)

I selected the Draw-a-Person Goodenough Test (Machover, 1926) as a tool for data collection. I selected the D-A-P to gain insight into both children's self-perceptions. I issued both child participants with the same instruction both pre- and post-intervention; 'draw me a picture of a person.' Child 1 engaged with the task instantaneously. Child 2 refused to speak and to perform the task. After a long while, he requested to complete the tasks home. When Child 2 returned the next week with his drawing, I noted that he depicted himself within a

family unit and without a body. During the *pre-intervention assessment*, I asked each of the child participants to tell me about the person that they had drawn. Child 1 described the various characteristics of his grandmother. Child 2 refused to speak. During the *post-intervention assessment*, Child 1 hastily drew his D-A-P, and was reticent when requested to elaborate on his drawing. I analysed and interpreted the D-A-P to either support or refute the themes that emerged from the formal interviews and my observations (Examples of each of the D-A-P can be viewed in Appendix T).

3.9.2.2 Kinetic-Family Drawing (K-F-D)

I selected that Kinetic- Family- Drawing (Burns & Kaufman, 1970) as a tool for data collection. I selected the K-F-D to provide insight into the participants' perceptions of their family environments as well as their roles therein. I requested of both children to 'draw me a picture of your family'. This request was given during both the pre- and post- intervention assessment phase. During the *pre-intervention assessment*, Child 1 completed the activity in my presence, with Child 2 requesting to complete the activity at home. As was the case with the D-A-P, Child 2 refused to engage in a verbal exploration of the drawings he made. During the *post-intervention assessment*, Child 1 hastily completed the K-F-D in my presence, once again being reticent to elaborate further on his drawing. I analysed and interpreted the K-F-D to either support or refute themes that emerged from the formal interviews and observations (Examples of the K-F-D can be viewed in Appendix T).

3.9.2.3. Brink's Incomplete Sentences

I selected Brink's Incomplete Sentences (1986) to gain insight into both children's appraisals, thoughts and feelings about their intrapersonal and interpersonal well-being. Both of the children requested to complete this activity at home during both *pre- and post- intervention assessment* phases, also, both children were unwilling to explore their responses to these questions in the first session. I analysed and interpreted this data to either support or refute themes that emerged from the formal interviews and observations (Examples of incomplete sentences viewed in Appendix T).

3.9.2.4. 'How is your self-concept inventory'

I used the 'how is your self-concept inventory' from Kruger's (1998) life skills program as a tool for data collection as it provided the child participants with an opportunity to assess their own self-concepts in order to determine their strengths and weaknesses and reflect on those. Both children were given this inventory to complete during both *pre- and post intervention assessment* (refer to process drawing figure 3.1). Once again, both children requested to

complete the sentences at home. I analysed and interpreted the inventory data to either support or refute themes that emerged from the formal interviews and observations (Examples of each of the 'how is your self-concept inventory' can be viewed in Appendix T).

As has been stated, Child 2 requested to complete all activities at home. However, he did not return the post-intervention instruments despite repeated requests. This was noted and taken into consideration against the backdrop of other findings which emerged during the child's post-intervention assessment. Having said this, I used the instruments that I received back in conjunction with other data, to determine if an association (if any) between the child participant's self-concept awareness and emotion- focused coping could be established.

The inclusion of these data sources (3.10.2.1- 3.10.2.4) added fewer insights into the self-concept awareness and emotion-focused coping strategies of the child participants than other sources of data did. The activity- based drawings by Child 1 produced during the intervention provided more insight into his self-concept awareness and emotion-focused coping strategies than did his drawings made during pre- and post-intervention assessment. With hindsight, I would have assessed the children's self-concept awareness and emotion-focused coping strategies qualitatively through participant and non-participant observations. Therefore, I recommend that in future studies, researchers assess children with ADHD's self-concept awareness and emotion-focused coping strategies qualitatively (possibly by means of participant and non-participant observation) to either support or refute themes which emerge from other data sources (refer to 5.7.3).

3.10 Ethical Issues

I anticipated the possibility of negative outcomes associated with the study, and took the necessary steps to protect the participants in the study as recommended by the American Psychological Association as outlined by Elmes, Kantowitz and Roediger (1999). I took the following steps to ensure that my research remained ethically sound throughout the research process (Elmes, Kanotwitz and Roediger, 1999):

3.10.1. Informed Consent and Voluntary Participation

In order to attain informed consent, I informed the participants of all aspects of the research that could influence their willingness to participate in the study (Elmes, Kanotwitz & Roediger, 1999). I obtained written consent from the Department of Education (Appendix A) to conduct the study, as well as from the School Principal (Appendix A), the educators (Appendix A), the parents of the learners who are participating in the study (Appendix A), the learners themselves (Appendix A) and the School Governing Body (Appendix A) and ethical

clearance from the faculty ethics committee (Appendix B). I provided comprehensive information about what the participants were required to do during the research project. With the control participant, his parents and educators, I discussed that the control participant would receive the intervention on completion of the study. I also attained consent from the participants to make audio footage of the interviews and intervention sessions as well as to take photos of all artefacts made in the intervention sessions, as the actual artefacts remain the property of the child. I gave both the participants the opportunity to accept or decline participation in the study (Elmes, Kanowitz & Roediger, 1999). I informed the participants of the purpose of the study, the procedures that would take place, their right to anonymity and confidentiality as well as the possible advantages and disadvantages of the study. I concluded this discussion by informing them that they had the freedom to withdraw from the study at any time (Elmes, Kanowitz & Roediger, 1999).

3.10.2. Protection from Harm and Debriefing

Prior to the commencement of my study, I explained to the child participant's and their parents that my primary role was that of a researcher and my secondary role was that of a therapist. I further elucidated that should it be deemed necessary for the child participants to consult with a psychologist on completion of the study, I would make a referral in this respect.

The research participants were able to contact me preceding their participation in study, which allowed them to receive help and support should they have needed it as a consequence of being participants in the research study (Elmes, Kanowitz & Roediger, 1999). I protected the participants from harm by, prior to the study, explaining the purpose of the research as well as answering any questions in order to minimise misunderstandings (Elmes, Kanowitz & Roediger, 1999). I provided the participants with the contact details of professionals that they could consult with should they experience any negative emotions after the commencement of the study.

3.10.3. Confidentiality and Anonymity

I upheld the principles of confidentiality, anonymity and privacy throughout the research process in order to protect the participants from any harm (Elmes, Kanowitz & Roediger, 1999). I ensured this by not revealing the identities of the participants and treating all data collected in a confidential manner. I ensured that all data collected was securely stored at the faculty of Educational Psychology at the University of Pretoria.

3.11 QUALITY CRITERIA

3.11.1 Introduction

According to Lincoln and Guba, as discussed in Babbie & Mouton (2004), the most crucial indicator of fine qualitative research is trustworthiness, which is delineated in the impartiality of research findings and conclusions. The main thrust of trustworthiness, then, is how one can influence the audience to believe that the findings and conclusions are credible enough to be transferred (Babbie & Mouton, 2004). Babbie & Mouton (2004) describe Lincoln and Guba's model of trustworthiness as follows:

3.11.2. Credibility

Credibility assesses the compatibility between constructed realities and the meanings attached to them through interpretation (Babbie & Mouton, 2004). Seale (2000) proposes that credibility replace 'truth value'. Therefore, the role of the researcher is to strive towards crystallisation in order to construct a complete understanding of the participant's unique and dynamic situation from multiple perspectives (Babbie & Mouton, 2004). Seale (2000) further suggests intensive engagement in the field, constantly engaging in crystallisation exercises, as well as exposing the final research report to fellow peers for criticism, to challenge and question working assumptions and establish credibility. I encouraged credibility by crystallising my data, which assisted me in gaining insight into the various systems and perspectives of the same phenomenon through the analysis of relationships and information from multiple sources of data (child participants, parents, educators, therapists) (Babbie & Mouton, 2004). This added depth and richness to the study encouraging convergence and replication (Babbie & Mouton, 2004).

The data collected provided information from multiple sources about the child with ADHD's self-concept awareness and emotion-focused coping. I made use of various sources of data to ensure crystallisation. Through crystallising my data, I developed a meticulous, intricate, thoroughly equitable understanding of a phenomenon from multiple angles of approach thus ensuring credibility (Richardson, 1992 as cited in Denzin & Lincoln 2000, p. 392). Crystallisation allowed me to capture the dynamic social life worlds of the participants through the process of "reflecting and refracting - creating ever-changing images and pictures of reality" (Richardson, 1992 as cited in Denzin & Lincoln, 2000. p. 873). Accordingly, the ultimate aim of the study was not to find answers to questions posed, but to continually question – positioning the study within the parameters of qualitative, interpretivist research.

I needed familiarity with the various contexts and factors pertaining to each of the participants therein in order to generate rich and credible findings. Thus, I established

adequate rapport with the research participants. The reciprocal interaction between participants and myself was the vehicle through which the participants were able to discuss their experiences in their own words within a confidential and anonymous environment. Through these interactions, I was granted access to various pieces of situational, attributional and environmental information which assisted me in understanding the unique and dynamic context of the participants (Babbie & Mouton, 2004) (refer to discussion on intervention in chapter 4).

3.11.3 Transferability

Babbie & Mouton (2004) describe transferability as the extent to which generated findings can be applied in other contexts and with other respondents. As the study relies on ascribed meaning, I focused on transferability as opposed to generalisation. I ensured transferability by provided a description of contextual data generated during the study (refer to field notes in Appendix to I for an example). This required that I document and transcribe information with much detail, accuracy and precision (Babbie & Mouton, 2004) (refer to Appendix I for an example of field notes and Appendix E for an example of a transcription). By engaging in purposive sampling, I provided a detailed description of the context and allowed for ease in selecting locations and informants for future studies.

3.11.4. Dependability

Babbie & Mouton (2004) describe dependability as the ability to repeat the study with the same or similar participants within the same or similar contexts and yield similar findings. This required of me to outline the details of both the research and intervention process. They further assert that should the study demonstrate credibility, it would be sufficient to determine the presence of dependability. The data and information underwent a process inquiry audit (Babbie & Mouton, 2004). During this process, I engaged extensively with the participants of the study as well as with my supervisor, taking heed of their contributions during data analysis. This strengthened the likelihood of my findings being dependable and comparable to similar situations and similar participants.

3.11.5. Confirmability

Babbie & Mouton (2004) define confirmability as the degree to which the findings are a direct product of the study and not personal biases (refer to evidence in appendices). In order to ensure this, I was required to form a confirmability audit trail (Babbie & Mouton, 2004). This appears contradictory to the interpretivist approach, for my values and motives play an incremental role in the research process. With this awareness, I attempted to understand and

interpret the intentions and meanings that underlie the different interactions as completely as I could to ensure the appropriateness of my findings through crystallisation.

3.12. CHALLENGES OF THE STUDY

As a researcher conducting a qualitative study, the risk of researcher-induced bias was a challenge to the study, for the study relied on the ability to establish rapport with the participants as well as on my perceptions and interpretations. Despite this presenting itself as a challenge, it was indeed the essence of this qualitative study, for the purpose of the study was to gain an in-depth and rich understanding of the participants' life worlds and subsequent experiences. I addressed this challenge by continuously reflecting on my thoughts, feelings and actions, both within my journal and with my supervisor.

The selected methods of data collection and analysis were time consuming. Despite this being a challenge, the time spent on collection and analysis added to the credibility of my study through the richness of the descriptions that I provided.

The complexity of Attention Deficit/Hyperactivity disorder was another challenge for related factors influenced the results of the study. My presence as interventionist influenced the manner in which the participants engaged with the activities and questions posed. I attempted to address this barrier through reflection, as well as by observing the child participants within a number of environments, such within the classroom and intervention sessions, in order to achieve crystallisation of information before identifying and contextualising themes.

I was aware of the influence that the above-mentioned challenges could have on the study. I attempted to give a full account of the challenges faced during the research process in my final report and I included the measures that I had put in place to address and accommodate these challenges.

3.13. Conclusion

In this chapter, I explored my paradigmatic assumptions within the confines of my research questions and the purpose of my study. I explored the strengths and limitations of my methodology as well as how I attempted to address each of these challenges. Furthermore, I explored the role that I assumed in the research study as well as the ethical considerations undertaken in order to ensure that my study was trustworthy. In chapter four, I discuss the findings of my research study.

Chapter 4

Data Analysis, Discussion of Results and Literature Control

4.1 Introduction

In this chapter, I will discuss how the intervention research design was conducted (Rothman & Thomas, 1994). I will provide a detailed discussion of the self-concept awareness and emotion-focused coping themes which emerged through thematic analysis of the data collected during the study. In conjunction with the discussion of the results, I will engage in a literature control which involves an exploration of the results of the study against the background of existing literature. In addition to this, I will discuss the feasibility of a relationship between the children's self-concept awareness and emotion-focused coping strategies.

4.2. Conducting the Interventionist Research

Phase 1: Problem analysis and project planning

Rothman and Thomas (1994) define the first stage of intervention research as problem analysis and project planning. It is during this stage that I **identified and involved** participants in the intervention process (Bender, 2002). I purposefully chose the child participants based on the selected criteria (refer to 3.5.2.) and similarly purposefully selected their respective parents, educators and therapists (refer to table 3.1 for outline of participants in this study).

I contacted the parents of both child participants and arranged to meet with them to discuss the research process with them. During these meetings, I obtained informed written consent from the parents (see Appendix A for an example). Thereafter, I met with the child participants and explained the research and intervention process to them and obtained their informed consent. I then contacted and met with the child participants' respective educator

and therapists, explained the research process to them and obtained their informed consent. Individual sessions (of approximately 30-40 minutes) with the participant were scheduled and implemented during times that were suitable for both myself and the child participant. I collaborated closely with participants in order to establish rapport. Establishing rapport was essential in order for me to **gain the co-operation** of the participants, which in turn played a pivotal role in the research process (Bender, 2002) (Refer to Appendix O for the research schedule indicating dates and duration of contact with all the participants during the research process).

By establishing a 'collaborative relationship' (Bender, 2002: 71) with the participants (the educator/s, parent/s, therapists and child with ADHD), I **gained access** to participants as well as to resources needed to conduct the research (Bender, 2002). I gave a letter of informed consent (Appendix A) to the school principal, the educator/s, the parent/s, the therapists and the children with ADHD in order to gain access. I was in a position to holistically define and analyse the coping strategies of children with ADHD by engaging with the participants. From these interactions, I was able to identify specific objectives for the intervention.

Through formal interviews with the participants, observations and by engaging learners in various self-reporting activities, I identified and analysed the problem (Bender, 2002) (refer to Figure 3.1. and 3.8). The primary **goal and objective** of the study was to explore the impact of self-concept awareness on emotion-focused coping strategies. With the aid of the pre- and post- intervention interview schedule (Appendix H), emotion- focused coping indicators (Appendix E) and self-concept awareness indicators (Appendix D) used during observations, I assessed and explored the child with ADHD's emotion-focused coping strategies before and after the intervention according to his/her educator/s, parent/s and therapists (refer to 3.11). I used this information to assess the impact of the intervention during the data analysis phase.

Phase 2: Information gathering and synthesis

Thomas and Rothman (1994), state that the key activities of this phase are the use of existing information sources, the studying of natural examples and the identification of elements of successful models (refer to chapter 2). This investigation allowed me to explore the interventions designed and implemented in the past to address the emotion-focused coping strategies of children with ADHD in order to address the identified concerns from another perspective.

As discussed in Chapter 2, the intervention selected for this study is based on Ebersöhn's (2006) framework; this was used in conjunction with Kruger's (1998) programme. Ebersöhn (2006) advocates that through the acquisition of life skills, child participants are encouraged and scaffolded to cope more effectively with stress in order to flourish. Ebersöhn suggest the following (which ultimately promote increased self-concept awareness) to facilitate coping:

- To achieve self-knowledge. This includes an understanding of self-confidence and growth (self-regulation: self awareness).
- To develop values and attitudes which emphasize independence and an internal locus of control (self-regulation and self-motivation).
- The establishment of necessary skills for effective functioning (in terms of self-regulation this equates to empathy and interpersonal skills).

In Table 4.2 I present the goals of the intervention sessions (Ebersöhn, 2006).

Whilst acknowledging the role and existence of deficiencies, the interventions focused on the strengths, abilities and resources available to children with ADHD, which could assist them in best coping within their respective environments. Using both programmes, all participants, including the child with ADHD, were involved in the process of assessment and evaluation. Acknowledging that the needs of each child are unique, I was required to adjust intervention sessions accordingly. For example, when discussing his feelings, the participant has requested to draw a feelings chart. This for an interaction to evolve into one which explore the feelings he experienced, when they were experienced, what he thought and consequently, how he acted in each of these situations. Such accommodations were invaluable in the intervention process, for it allowed for the child participant to communicate in a way that was comfortable and familiar to him (refer to Appendix K for a detailed description of the intervention used).

Phase 3: Design

Thomas and Rothman (1994), state that the third stage of intervention research design to be: design, early development and pilot testing. This phase is characterised by the designing of an observational system and the specification of the procedural elements of the intervention (Thomas & Rothman, 1994). Based on a theoretical framework, I developed a checklist (Appendix C) for myself to use throughout the research process to relate my observations to the two main constructs in my research question; namely self-concept awareness and emotion-focused coping strategies. The primary aim of intervention research is to demonstrate the relationship that exists, if any, between the intervention and the behaviours

that define the problem as well as the inclusion of a programme that makes up the intervention (Ibid. 2002). In order to establish if a relationship existed between the intervention and the behaviours, I analysed both pre- and post- intervention data, particularly in terms of the key concepts detailed above. As stated, I used an intervention that was designed, piloted and previously implemented by Ebersöhn (2006) as well as self-monitoring and reporting questionnaires drawn from Kruger's (1998) programme and completed both pre- and post- intervention. I was involved in all observations and interventions undertaken throughout the research process. I documented my dual role as researcher and interventionist in my reflective journal (refer to section 3.8.5 and Appendix N). I implemented the intervention over six weeks, with 30-40 minute sessions once a week.

Table 4.1: Goals of the Intervention

Intervention session:	The goals of this session are:
Intervention session 1	<ul style="list-style-type: none"> - Involve and to establish a relationship between the children participant and the researcher. - Become aware of an ideal self-identity.
Intervention session 2	<ul style="list-style-type: none"> - Ecosystemically, identify various identities which exist in different life settings (life roles). - Knowledge and awareness of mental and physical characteristics: embedded in identity- starting point of self-awareness. - The process of forming positive and negative self-concepts. - The process of forming realistic and unrealistic self-concepts. - Real-life evidence for positive, negative, realistic and unrealistic evaluations (self and situational appraisals). - The central role of self-talk in identity formation.
Intervention session 3	<ul style="list-style-type: none"> - Self-talk is individually controlled by the people themselves. - The personal control takes place with the help of cognitive processes. - The cognitive regulation principles are represented by the ABC model of RBT. - Cognitive dialogue (self-talk) is the continuous crystallisation of self-identity in different situations.
Intervention session 4	<ul style="list-style-type: none"> - Knowledge and understanding of Emotional Intelligence (EQ) as being representative of emotional regulation. - Provisional awareness of how CPS is a common factor in identity formation and cognitive and emotional regulation. - Awareness and regulation of emotions through using CPS. - Self-efficacy (perseverance, delayed gratification, optimism, motivation) through using CPS. - Empathy through using CPS. - Proactively managing relationships (as an introduction to the following session). - The central role of CPS in emotional regulation, and thus EQ. - Intrapersonal involvement, experience and meaning attribution with the help of CPS. - Understanding that intrapersonal (emotional) skill determines the level of interpersonal emotional skill. - The former is therefore a precondition for social maturity (as intro to following session)

Intervention session 5	<ul style="list-style-type: none"> - Last two EQ skills of emotional regulation: (i), empathy arising out of the use of CPS and (ii) proactive management of relationships. - The central role of CPS in the effective realisation of these EQ skills. - Interpersonal involvement, experience and meaning attribution as a result of CPS. - The level of interpersonal emotional proficiency determines the level of interpersonal emotional proficiency. - Life-skilled behaviour is the observable consequence of intrapersonal proficiency. - CPS may facilitate agency in a person to <i>behave proactively</i> and not reactively in life situations.
Intervention session 6	<ul style="list-style-type: none"> - Awareness of the link between the content of all sessions.

Phase 4: Early Development and Pilot testing

According to Rothman and Thomas (1994), the intervention develops during the phase of early development and testing. For the purpose of this study, I made use of an intervention that was designed, piloted and previously implemented by Ebersöhn (2006). In order to determine the impact of this program on children with ADHD, I made use of pre- and post-intervention checklists (Appendix G) to ascertain the impact of the intervention on the child's self-concept awareness and emotion- focused coping. This provided me with a platform from which to assess the child's emotion-focused coping strategies over the course of the intervention, and how able he was to transfer learnt knowledge and skills to his environment. Based on the findings, it appears that the intervention targets key areas in which the child with ADHD is deficient, but there were a number of accommodations I needed to make to the intervention to make it more suitable to the needs of the child participant. For example, the subtheme of avoidance of written tasks (inclusive of drawing tasks) and homework tasks emerged at several intervals during the pre- intervention, intervention and post-intervention. Thus, the child participants both asked to complete tasks requiring writing and drawing at home. In terms of homework tasks assigned, often the child participants would come to the sessions without their homework tasks being done, which would require me to explore those tasks with them during the intervention session. I later make a related recommendation for future practice (refer to 5.7.2).

Phase 5: Evaluation and advanced testing

Rothman and Thomas (1994) outline four activities in this phase of evaluation and advanced testing, namely selecting an experimental design and collecting and analysing data. I discuss these issues in 4.3.

4.3. Results of the thematic analysis

I will be exploring the subthemes that emerged through thematic analysis both pre- and post-intervention of the participant and the control participant in this chapter. I will illustrate the

manner in which the subthemes were grouped together followed by a more detailed discussion of the results of the thematic analysis.

4.3.1. Results of the thematic analysis: Pre-intervention

In total, I identified seven subthemes identified through thematic analysis. I grouped these subthemes together into three themes; self-concept awareness, adaptive emotion- focused coping strategies, and maladaptive emotion-focused coping strategies. Table 4.2 outlines the results of thematic analysis conducted, indicating the frequency of the subthemes that were reported during pre-intervention assessment.

Table 4.2 Results of the thematic analysis indicating emotion-focused coping and self-concept awareness themes as well as subthemes and categories: Pre-intervention

THEME 1: SELF-CONCEPT AWARENESS (PRE-INTERVENTION)	
Subthemes	Categories
1.1 Knowledge of and insight into the self-concept	Self-confidence (9) ³ Self-awareness (13)
1.2 Skills to interact with others	Positive interactions with others (13) Negative interactions with others (12)
1.3 Knowledge of the importance of growth and change	Identification and expression of feelings(4)
THEME 2: ADAPTIVE EMOTION-FOCUSED COPING STRATEGIES (PRE-INTERVENTION)	
2.1 Seeks social support from significant others	Seeks social support from significant others to communicate and work through stressful situations (9) Reliance on social support to deal with stressful situations (9) Use of relaxation methods in order to examine the situation from another perspective.
THEME 3: MALADAPTIVE EMOTION- FOCUSED COPING STRATEGIES (PRE-INTERVENTION)	
3.1 Direct- active physical aggression in response to stressful situations.	Physical aggression directed at others in response to stressful situations (16)
3.2 Indirect-active physical aggression in response to stressful situations.	Heightened physiological arousal in response to a stressful situation (5)
3.3 Direct- passive aggression in response to stressful situations.	Helplessness (15) Internalising (16) Avoidance (16) Projecting blame (8)

The following discussion presents the results of thematic analysis depicting emotion-focused coping strategies and self-concept awareness of children with ADHD pre-intervention- thus a baseline image of the Child 1 and Child 2's self-concept awareness and emotion- focused coping.

THEME 1: SELF-CONCEPT AWARENESS (PRE-INTERVENTION)

Table 4.3: Definition, subthemes, indicators, exclusions and exceptions related to the theme of self-concept awareness (pre-intervention)

Definition	'Implementation of agency in a cognitive system implies that certain beliefs, values and/ or goals represented in the system become, if implicitly, attributed to the self of the agent. When the cognitive system becomes explicitly aware of this attribution, it acquires a self-regulation capacity allowing it to control, modify and develop its self-concept together with the attitudes attributed to the self, adjusting to dynamically changing contexts and personal experience. The leverage of self-awareness understood in this sense consists in increased robustness, flexibility and integrity of the cognitive system, as illustrated by a paradigm of self-regulated learning (Samsonovich, A, Kitsantas, a, Dabbagh, N & De Jong, K,
Subthemes	(1.1) Knowledge and insight into the self-concept, (1.2) interactions with others and (1.3) knowledge of growth and change.
Indicators	All the instances from the raw data where participants made use of phrases such as 'confident', 'self-esteem', 'he likes himself', 'flaunt them', 'self-understanding', ' awareness and understanding of abilities', and 'confident' were considered to be descriptive of this theme. This includes comments about self- awareness and self-confidence as a result of being aware and actualising their abilities.
Exclusions	Instances when the participants referred to 'overly confident', 'a bully' and 'excited' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as 'competence' which one or more of the participants indicated, but which do not fall directly within this theme.

In table 4.3 I provide a definition of self-concept awareness, the subthemes that make up this theme, the indicators and exclusions used during data analysis to determine the constituencies of this theme as well as responses deemed exceptions to this theme. Eight participants reported that both Child 1 and Child 2 displayed some level of self-concept

awareness (refer to Figure 4.1 and Figure 4.2). Three participants commented on the definition of self-awareness as having an accurate understanding of one’s strengths and weaknesses. This theme consists of three subthemes; **(1.1) knowledge and insight into the self-concept**, **(1.2) interactions with others** and, **(1.3) knowledge of growth and change**. I now discuss the categories which make up these subthemes.

SUBTHEME 1.1: KNOWLEDGE AND INSIGHT INTO THE SELF-CONCEPT

Self-confidence and **self-awareness** are categories which form part of the subtheme ‘knowledge and insight into the self-concept’. Findings indicated that the child participants were both **confident** in engaging in activities that they felt competent in, but would **avoid** situations that were deemed overwhelming. This subtheme supports literature which states that people only engage with situations when they feel competent enough to do so and will persevere in these situations, and will avoid situations when feeling incapable of dealing with them (Schunk, 1981; Schunk & Hanson, 1985; Schunk, Hanson, & Cox, 1987 in Pajares & Schunk; 2001). In the case of Child 1, results indicate that he was aware of his well-developed social skills, using them to his advantage interpersonally. Conversely Child 2 was only aware of his inabilities and weaknesses, seemingly resulting in **withdrawal** and **avoidance** of situations that he appraised as too demanding. The same patterns of withdrawal and avoidance of demanding situations was reported in the case of Child 1. Thus, both children withdrew or avoided tasks they deemed demanding and challenging failed at in the past. Having said that, Child 2’s therapists also mentioned Child 2 lacked metacognition. As metacognition is required to process and reflect on himself and situational appraisals, he possibly had difficulty in challenging these negative appraisals of himself and situations. I relate this result to Barkley’s (1999) assertion that impaired executive functioning leads to inaccurate understanding of strengths, limitations and resources which influence situational appraisals.

CATEGORY: SELF-CONFIDENCE

Table 4.4 Definition, indicators, exclusions and exceptions related to the category ‘self-confidence’ (pre-intervention)

Definition	Freedom from doubt and a belief in yourself and your abilities (Wordnet, 2000)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘confident’, ‘good self- concept’, ‘self-esteem’, ‘he likes himself’, ‘flaunt them’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘overly confident’ were not

	considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as 'competence' which one or more of the participants indicated, but which do not fall directly within this theme.

In table 4.4 I provide a definition of 'self-confidence', the indicators and exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. Four participants reported that Child 1 and Child 2 were self-confident. This was a theme predominantly mentioned in the case of Child 1, with the exception of one comment being made about the positive self-confidence of Child 2. All reports indicate that the both children felt confident when engaged in verbal tasks and less confident when engaged in tasks requiring written expression. Thus, there seems to be a link between a perceived sense of competence and self-confidence. It was further reported that Child 1's self-concept was rooted in a good self-concept and a positive self-esteem-resources which he draws on to assist him to cope. This category is supported by the following quotations:

- *'... very confident to talk among his classmates but with a topic that he could control and that he knew. (Therapist 4 (Child 2), unit 8)*
- *'...in terms of school I think he's quite confident here except when he realises that there is something that he can't do... (Parent 1 (Child 1), unit 1,2,3,8)*
- *'...I think he has quite a good self-concept... (Therapist 3 (Child 1), unit 5,8)*
- *'... it (social skills) gives him a good grounding because the confidence is there and the self-esteem is there and that puts him on firmer footing. (Therapist 3 (Child 1) unit 5,8)*
- *'...when it's verbal, he's competent and the confidence comes out but he struggles with written work.' (Therapist 2 (Child 1), unit 5,8)*
- *'...people like him and he likes himself...that in general he is positive.' (Therapist 3 (Child 1), unit 8,9)*
- *'He knows he has good social skills and he'll use them and flaunt them.' (Therapist 3 (Child 1), unit 8, 9)*
- *'...very competent in my groups and very happy to come to me and he is very competent, there is no doubt about that.' (Therapist 3 (Child 1), unit 8,9)*
- *'...he has certain resources that he draws on, he knows that he has good social skills and he knows that he functions optimally when he's on his medication...' (Therapist 3 (Child 1), unit 8,9)*

CATEGORY: SELF-AWARENESS

Table 4.5 Definition, indicators and exclusions related to the category ‘self-awareness’ (pre-intervention)

Definition	Awareness of oneself as an individual (Wordnet, 2000)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘self-understanding’, ‘awareness and understanding of abilities’, ‘knowing his inabilities’, ‘he knows’ and ‘aware’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘self-esteem’, ‘self-concept’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

In table 4.5 I provide a definition of ‘self-awareness’, the indicators and exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. In total, five participants commented on the children’s self-awareness. This category was explored differently by different participants. The majority of the reports made by Child 2’s therapists indicated that his self-awareness pivoted around awareness of his limitations, inabilities, negativity and his syndrome which seem to result in the employment of maladaptive emotion-focused coping strategies such as withdrawal (refer to theme 3), avoidance and over reliance on support structures (refer to theme 2 and Figure 4.1). Child 2’s therapists also referred to the role of metacognition in self-analysis and self-awareness, stating that Child 2 lacked the ability to engage in such metacognitive activity (impeding self-reflection and self-discovery) and ultimately impeding his choice of emotion-focused coping strategies. In contrast to these reports, Child 1’s educator and therapists indicate that Child 1 had an acute understanding of his strengths (good social skills) and resources (medication) which contributed to his self-confidence. Thus reports about **Child 1’s self-concept awareness** were based in a **generally positive awareness of self** whereas reports about **Child 2’s self-concept awareness** indicated a **generally negative awareness of self**. This category is supported by the following quotations and visual data (refer to Appendix P for visual data):

- *‘...he has certain resources that he draws on, he knows that he has good social skills and he knows that he functions optimally when he’s on his medication...’ (Therapist 3 (Child 1), unit 8,9)*
- *‘He knows he has good social skills and he’ll use them and flaunt them.’ (Therapist 3 (Child 1), unit 8, 9)*
- *‘...I don’t think our kids are very aware...’ (Therapist 4 (Child 2), unit 9, 13)*
- *‘I think there is awareness, because there are comments like ‘I haven’t taken my Ritalin.’ (Therapist 5 (Child 2), unit 9,13,7)*
- *‘... it’s awareness of your own abilities and capabilities.’ (Therapist 4 (Child 2), unit*

9,13)

- *'I think that the kids... feel and know when they're left out and when they're not doing well, but they're not constantly aware of...introspective about analysing themselves.'* (Therapist 4 (Child 2), unit 9)
- *'... him knowing his inabilities...so he's got a good, well...I think he's a good understanding of where he is...'* (Therapist 4 (Child 2), unit 9)
- *'...I think that he is aware and that's why he holds back...'* (Therapist 5 (Child 2), unit 9,1,2)
- *'... his awareness of his symptoms and his syndrome, it's making him step back as a way of coping...'* (Therapist 4 (Child 2), unit 1,2,9)
- *'His heightened sense of awareness I think has been contained within a negative framework within the context of ADHD. So much is resolved around ability and inability. He doesn't have an internal, good understanding of where he is. But on a surface level, he does know where his limitations are and he does have a good self-concept, he knows where his limitations are. His awareness at the moment is negative, because he's not given the opportunity to get positive reinforcement.'* (Therapist 4 (Child 2), unit 9)
- *'...I'm not sure to what level he's aware of them...I think he is aware of them but I am not sure to what level and extent he's aware of them...I think he bases it on other people's responses.'* (Parent 2 (Child 2), unit 5,9)
- *'... we have cognitive structures to know that if I'm not good... but they don't have the cognitive awareness. It's not ability.'* (Therapist4 (Child 2), unit 9,13)
- *'... I don't think he has the cognitive skills to, in himself, to fight the negativity...'* (Therapist 4 (Child 2), unit 13)



Figure 4.1: Child 1's interpretation⁴ of the D-A-P⁵ activity

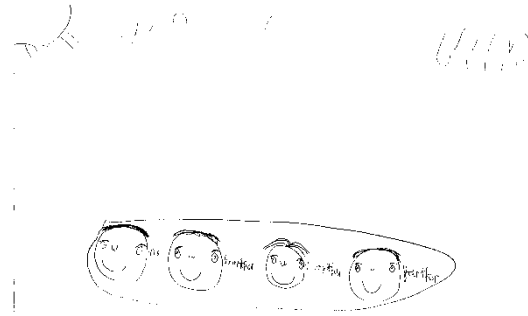


Figure 4.2: Child 2's⁶ interpretation of the D-A-P⁷ activity.

SUBTHEME 1.2: SKILLS TO INTERACT WITH OTHERS

Positive interactions with others and **negative interactions with others** are categories which form part of the subtheme 'skills to interact with others'. Child 1's involvement in interpersonal relationships was referred to 25 times; whereas **Child 2's interpersonal relationships were not discussed. Child 1 had superior social skills** and was able to communicate and converse well with others which assisted him in making friends. Bos, Schumm & Vaughn (2003) comment that although children with ADHD are able to attract friends, they often find it difficult to meaningfully attach with others over longer periods of time. Having said this, it was also reported that Child 1 was able to engage more constructively with a smaller group of friends as opposed to a larger group setting. In a bigger group setting, Child 1 struggled to socialise. He tended to be intolerant of those around him. Therapist 1 reported that he did not know when to inhibit certain responses and behaviours, which resulted in him experiencing difficulty in negotiating and coming to a compromise in discussions. Therapist 1 further reported that others became irritated by his impulsive and hyperactive behaviour which would lead to confrontation and conflict.

CATEGORY: POSITIVE INTERACTIONS WITH OTHERS

Table 4.6 Definition, indicators, exclusions and exceptions related to the category 'positive interactions with others' (pre-intervention)

Definition	Positive interpersonal relations with significant others.
Indicators	All the instances from the raw data where participants made use of phrases such as 'empathises better with', 'friends', 'popular', 'socialises', 'gets along with', 'enjoy one another's company', 'good social skills', 'good pragmatics' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to 'confidence' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Exceptions	This refers to responses such as ‘confidence’ and ‘competence’ which one or more of the participants indicated, but which do not fall directly within this theme.
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In table 4.6 I define ‘positive interactions with others’, the indicators and exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. Four participants commented on Child 1’s positive with a number of significant others. No reports were made about Child 2 engaging in positive interactions with others. This seems to be linked to Child 2’s **over reliance on support** and the tendency to **avoid** and **withdraw** from unfamiliar situations. Child 1’s educator and therapists reported that his **good social skills** and **sound pragmatics** were strengths. They further reported that Child 1 was **aware of these strengths** and that he drew on them when needed. They reported that these strengths assisted him in **making friends** and contributed to him being **well-liked** by his peers. This category is supported by the following quotations and visual data:

- *‘He empathises better with his friends than with others in the class. I’ve noticed that as opposed to how he behaves in the bigger group. I think that at times he can be overly confident with his friends.’ (Therapist 1 (Child 1), unit 11)*
- *‘Most girls liuk (like) me.’ (Child 1, unit 11)*
- *‘I think he’s the popular child. I think he doesn’t have a problem with making friends...’ (Therapist 2 (Child 1), unit 11)*
- *‘...he seems to have a good relationship with his mother...’ (Therapist 3, (Child 1) unit 11)*
- *‘...he socialises okay I mean very much in his small group of friends...’ (Therapist 1 (Child 1), unit 11)*
- *‘...that’s why I think he gets along better with people like xxx, because he’s more verbal and the quiet one and they enjoy and laugh at each other.’ (Therapist 2 (Child 1), unit 11)*
- *‘... that’s why xxx and him enjoy one another’s company so they both are verbal and but the one makes sense more of the time.’ (Therapist 2 (Child 1), unit 11)*
- *‘... he seems to be quite popular in his class, in my opinion, people like him...’ (Therapist 3 (Child 1), unit 11)*
- *‘...I think that he is quite perceptive about stuff like that.’ (Therapist 1 (Child 1), unit 5, 10, 11)*
- *‘... he’s got more social skills than a lot of the children in that class and he uses it positively to his gain. He knows he has good social skills and he’ll use them and flaunt them.’ (Therapist 3 (Child 1), unit 5, 10, 11)*
- *‘...he has certain resources that he draws on; he knows that he has good social*

skills...' (Therapist 3 (Child 1), unit 9, 11)

- '...he's fine and he's popular and he's good at sport...' (Therapist 3 (Child 1), unit 8, 11)
- '... in our social skills groups he has good pragmatics. He actually understands...' (Therapist 2 (Child 1), unit 8)

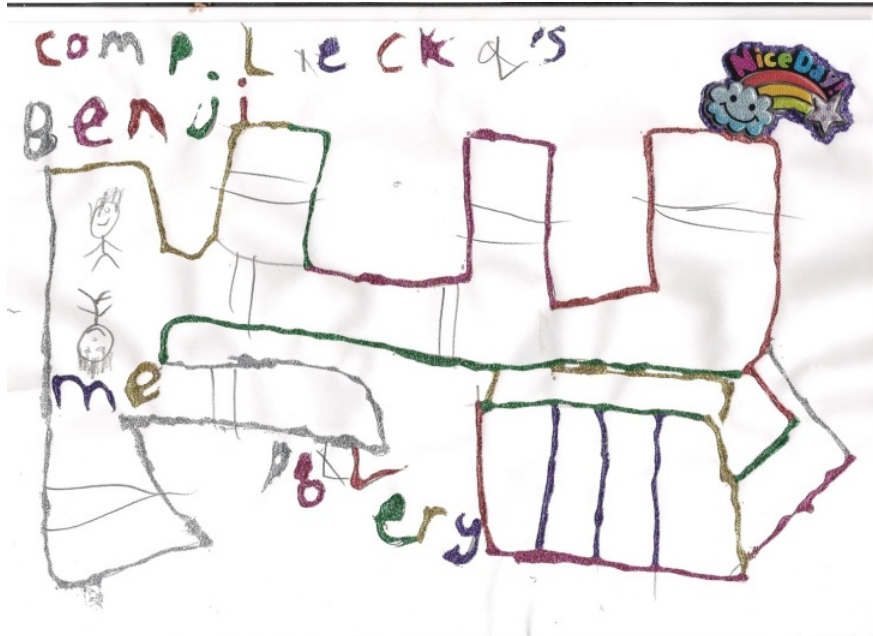


Figure 4.3^b: Child 1's drawing of a positive interpersonal interaction

CATEGORY: NEGATIVE INTERACTIONS WITH OTHERS

Table 4.7 Definition, indicators, exclusions and exceptions related to the category 'negative interactions with others' (pre-intervention)

Definition	Negative interpersonal relations with significant others.
Indicators	All the instances from the raw data where participants made use of phrases such as 'angry those around him', 'intolerant', 'inflexible', 'stubborn', 'overly confident', 'annoyed and irritated with him', 'friction', 'boundaries', 'clash' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to 'outbursts and totally loses it', 'throws a wobbly', 'sometimes uses violence', 'kicking', 'attacking', 'I'll beat you up', 'climbed into', 'throws things around', 'goes to aggression', 'anger', 'aggression', 'crying', 'frustration', 'internalises' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exception	This refers to responses such as 'nobody can bad mouth me' which one of the participants indicated, but which do not directly fall within this theme.

Table 4.7 provides a definition of ‘negative interactions with others’, the indicators and exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. Five participants reported that Child 1 and Child 2 had negative interactions with others. Again, most of the reports were from the educator and therapist of Child 1. It was reported that Child 1’s peers confront him when his impulsive and hyperactive behaviour became destructive which lead to confrontation. Consequently **direct- active physically aggressive** coping strategies (refer to 3.2) resulted, which was the fourth subtheme identified. The theme of negative interactions with others is supported by Gonsalez & Sellers (2002) and Bos, Schumm & Vaughn (2003) who state that children with ADHD (hyperactive- impulsive type) tend to make impulsive decisions, struggle to engage in turn taking when having a conversation, have difficult withholding a response or reaction, delaying gratification, preventing distractions from interfering with ongoing activities and being intrusive of boundaries which see them acting reactively to situations. Gonzales & Sellers (2002) further state that hyperactive behaviour tends to cause conflict between the learner and his peers. However, reports did not indicate that Child 1’s impulsive and hyperactive behaviour resulted in exclusion from formal or informal social situations.

Child 2’s educator made a statement about his negative interactions with his peers, namely that he **acted aggressively** on the playground at times. The reason given for this was because Child 2 tended to prefer relying on his non-verbal skills as opposed to his verbal. Thus, **direct- active physical aggression** seemed to be a way in which Child 2 tried to communicate with others. As mentioned previously, negative social interactions with both children seem to (in the majority of the reports) be linked to direct- active physical aggression, particularly in the case of Child 1. Thus, the theme of negative interactions with others seems closely linked to the maladaptive emotion- focused coping subtheme of **direct- active physical aggression** (refer to 3.2). In the case of Child 1, reports indicate that although he interacted positively within a smaller group situation and amongst his friends, he tended to be **inflexible and intolerant** in larger group social situations possibly resulting in conflict. His **hyperactivity** in the class situation tended to annoy his class mates. His therapists noted that he experienced difficulty in his relationship with his cousin as well as with a classmate. This category is supported by the following quotations and visual data:

- *‘... he gets angry with others around him...’ (Educator 1 (Child 1), unit 2,3,4)*
- *‘I don’t like people who cause trouble.’ (Child 1, unit 2,3)*
- *‘...he isn’t very tolerant... of others around them...’ (Therapist 1 (Child 1), unit 3,10)*
- *‘It makes me very angry when I lous (lose) friends.’ (Child 1, unit 2,3)*
- *‘Can be quite stubborn as well. If he sees something in one way, that’s it. He’s not very flexible or you can’t really negotiate with him if he’s made up his mind about*

something that's it. He battles to see the other side of the situation. To take other points into consideration. This is how he experiences it that's how it is and that's the right way.' (Therapist 1 (Child 1), unit 11)

- '... he empathises better with his friends than with others in the class)... I've noticed that as opposed to how he behaves in the bigger group. I think that at times he can be overly confident with his friends.' (Therapist 1 (Child 1), unit 11)
- '...but there are kids that get, at times, very annoyed and irritated with him, especially when he's in one of his hyper modes when the kids want to work and he's all over the show.' (Therapist 1 (Child 1), unit 11)
- '.. and him and xxx? Sometimes a bit of friction?' (Therapist 1 (Child 1), unit 1, 5, 11,12)
- '...does push the boundaries at times. He doesn't know when he should pull himself back.' (Therapist 1 (Child 1), unit 11)
- '... think that him and xxx clash some times and they don't get on very well and he doesn't like xxx very much.' (Therapist 1 (Child 1), unit 5, 10, 11, 12)
- '...haven't you seen him throw a wobbly when he's like cross... I think it was in response to somebody. Something that somebody said.' (Therapist 1 (Child 1) 1, 3, 5, 12)
- '... didn't have anything positive to say about his dad.' (Therapist 1 (Child 1), unit 11,12)
- '... but on the playground he can be a bully... he's always kicking.' (Educator 2 (Child 2), unit 11, 12)
- '...he had to be pulled off this kid and I think because this kid was running me down without actually knowing me it made him really stressed and nobody can bad mouth me...' (Parent 2 (Child 1), unit 4, 5,12)

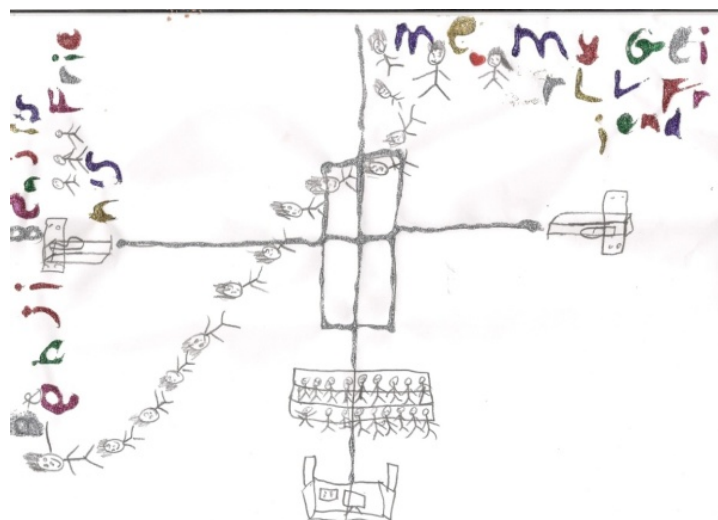


Figure 4.4^o: Drawing depicting the use of direct- active physical aggression in response to being perceived as weak, fallible and out of control.

SUBTHEME 1.3: KNOWLEDGE OF THE IMPORTANCE OF GROWTH AND CHANGE

The **identification and expression of feelings** are categories which form part of the subtheme ‘knowledge of the importance of growth and change’. Child 2’s therapists reported that he struggled to express the way he felt, which often resulted in him acting indifferent in most situations. I relate this phenomenon to impaired executive functioning which limited Child 2’s ability to verbally express and communicate his thoughts and feelings to others (Barkley, 1999).

CATEGORY: IDENTIFICATION AND EXPRESSION OF FEELINGS

Table 4.8 Definition, indicators and exclusions related to the category ‘identification and expression of feelings’ (pre-intervention)

Definition	The identification and expression of feelings associated with significant experiences.
Indicators	All the instances from the raw data where participants made use of phrases such as ‘doesn’t show emotion’, ‘can’t broaden the theme’, ‘expressing what they feel’, ‘say I feel’, ‘he was indifferent’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘internalises’, ‘sad’, ‘angry’ were not included in this theme. It is noted that although there are acute resemblances between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as ‘he was indifferent’ which one or more of the participants indicated. These phrases do not directly fall within this theme, but they are related to it.

Table 4.8 provides a definition of ‘expression and identification of feelings’, the indicators and the exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. Three participants mentioned that Child 2 struggled to **identify and express** his feelings as well as the intensity of his feelings. This seems to be related to poor self-awareness resulting from a lack of metacognitive activity. However, two of the participants also briefly explored the possibility that Child 2 not explicitly identifying and expressing his feelings may have manifested as indifference (a coping strategy employed to conceal stress he experienced). This category is supported by the following quotations:

- *‘... can’t broaden the theme... can say ‘I feel sad’ but can’t describe the grading of sad... they feel the basic sad, happy... they can’t elaborate on those and*

say I feel frustrated because he did this or he did that. They'll only say that they are sad... lack of expressing what they really feel...' (Therapist 6 (Child 2), unit 9, 13)

- *'...he doesn't show emotion at all.'* (Educator 2 (Child 2), unit 9)
- *'... he doesn't (show emotion)... he was indifferent...'* (Therapist 5 (Child 2), unit 9)
- *'...maybe indifference is masking how stressed he is.'* (Therapist 5 (Child 2), unit 9)

THEME 2: ADAPTIVE EMOTION-FOCUSED COPING STRATEGIES (PRE-INTERVENTION)

Table 4.9: Definition, subthemes, indicators, exclusions and exceptions related to the theme 'adaptive emotion- focused coping strategies' (pre-intervention)

Definition	Emotion- focused coping, which consists of dealing with the emotional consequences of enduring a stressful situation, is allegedly a better choice for passive stressors that are not dependent upon one's actions (Levine, Koch & Stern, 2008)
Subthemes	(2.1) seeking social support from significant others, (2.2) examining the situation from another perspective and (2.3) using relaxation methods.
Indicators	All the instances from the raw data where participants made use of phrases such as 'examines the situation from another perspective', 'social support', 'use of relaxation methods', 'asks for assistance', 'gets the support', 'this is what I must do', 'no you're not', 'no but', 'self-soothing', 'acceptance' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ' see what my reactions are', 'anything he's told he is', 'tense muscles', 'withdrawal' and 'avoid' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as 'I say to him', 'I make him', 'the way I speak to him', 'I'll try read him', 'you have to intervene', more than one of the participants indicated, but which do not fall directly within this theme. They have been included under adaptive emotion-focused coping strategies as they assisted in emotional regulation. Thus, although not self-advocated, these emotion-focused coping strategies are adaptive.

Table 4.9 provides a definition of 'adaptive emotion-focused coping strategies', the subthemes that make up this theme as well as the indicators and exclusions used during data analysis to determine the constituencies of this theme as well as responses deemed exceptions to this theme. Nine participants reported that both Child 1 and Child 2 attempted to make use of adaptive emotion- focused coping strategies. As was stated above, despite these coping strategies not always being self-employed, they did assist emotional regulation. Thus, for the purpose of this study, I classified these coping strategies as adaptive emotion-focused coping strategies. This theme consists of three subthemes; **(2.1) seeking social**

support from significant others, and (2.2) use of relaxation methods in order to (2.3) examine the situation from another perspective.

The second most prominent subtheme that emerged from thematic analysis was **seeking social support from significant others in order to communicate and work through stressful experiences**, which included social support, reliance on external support structures and re-framing a situation with social support. The reported instances of Child 1 and Child 2 utilising this coping strategy was 14 times respectively. The use of this strategy seemed almost exclusively used by the participants within their **home environments with their mothers**. **Gonzales & Sellers (2002) state that seeking support is an adaptive emotion- focused coping strategy only when the child feels empowered** enough to adequately communicate and work thorough stressful experiences. Both Child 1 and Child 2 were more inclined to rely on social support to employ relaxation methods and to reframe situations as opposed to employing them autonomously. Both mothers reported that their children sought their guidance, re-assurance and advice when unsure on how to approach stressful situations. Both mothers seemed to assume the role of regulating the child participant's emotional responses to stressful situations. They both expressed that their child would not be able to employ these strategies independently and without their intervention. Child 1's mother assisted her child in employing relaxation methods (such as breathing, temporarily detaching from situations) in order to prevent direct- active and indirect- active physical aggression to emerge in response to stressful situations. Child 2's mother assured her son that she supported him regardless of the outcome of the situation. Both parents re-framed stressful situations for their children, however Child 1 demonstrated the ability to do re-frame independently on occasion.

Literature indicates that **reliance on external support structures could be related to impaired executive functioning** which results in difficulty to inhibit responses, as well as regulating behaviour through the use of various modes of inner speech; working memory and control of emotions as well problem-solving and effective communication. All of these modes influence a child's ability to exercise self-control, their internal working models of self (Wicks-Nelson et al. 2000). Such manifestations of impaired executive functioning have a direct bearing on a child's ability to exercise self-control. Consequently, their internal working models of self are influenced as well as the way others perceive them (ultimately influencing their relationships) (Bos, Schumm & Vaughn, 2003). In referring back to Barkley's (1999) definition of ADHD, the child's reliance on external support structures (as a result of impaired executive functioning) supports the assertion that children with ADHD have difficulty forming accurate self-appraisals. As a result of this, children with ADHD exhibit behaviour

characterised by learned helplessness. Their reliance on external support structures reinforces their external locus of control, resulting in a lack of accountability and negative appraisals of events, confirming negative self-appraisals.

Reliance on external support structures is a subtheme closely related to that of the employment of passive- active aggression in dealing with stressful situations. It seems that the children appraised their resources as being insufficient in meeting the demands of the challenging situation, appraised situations as too demanding and outside of their locus of control. As stated by Ebersöhn (2006), feeling no control over a situation results in one experiencing negative emotions, which, in turn, influences one's self-efficacy, self-confidence, sense of autonomy and self-resilience. Thus, due to poor self-efficacy and a lack of self-confidence, the participating children with ADHD felt dependant on the support of significant others. Findings suggest that this support was sought from significant adults as opposed to peers.

SUBTHEME 2.1: SEEKS SOCIAL SUPPORT FROM SIGNIFICANT OTHERS

Table 4.10 Definition, indicators and exclusions related to the subtheme 'seeks social support from significant others' (pre-intervention)

Definition	Support (and in some instances reliance on this support) provide by friends, relatives, educators and therapists
Indicators	All the instances from the raw data where participants made use of phrases such as 'asks for guidance', 'support', 'doesn't want to ask me', 'learnt to accept him' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to 'see what my reactions are', 'anything that he is told he is', 'it's because of' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.10 provides a definition of 'seeks social support from significant others', the indicators and exclusions used during data analysis to determine the constituencies of this category as well as responses deemed exceptions to this category. **Seeks social support from significant others to communicate and work through stressful situations** and **reliance on social support from significant others to deal with stressful situations** are categories which form part of the subtheme 'seeks social support from significant others'.

CATEGORY: SEEKS SOCIAL SUPPORT FROM SIGNIFICANT OTHERS TO COMMUNICATE AND WORK THROUGH STRESSFUL SITUATIONS

Table 4.11 Definition, indicators and exclusions related to the category ‘seeks social support from significant others to communicate and work through stressful situations’ (pre-intervention)

Definition	Support provide by friends, relatives, educators and therapists
Indicators	All the instances from the raw data where participants made use of phrases such as ‘support’, ‘acceptance’, ‘encouragement’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘come from else where’, ‘external input’, ‘re-assured’, ‘second opinion’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.11 provides a definition of ‘seeking social support from significant others to communicate and work through stressful situations’ as well as the indicators and exclusions used during data analysis to determine the constituencies of this category. Both children’s educators, therapists and parents reported the central role that **social support** played in enabling the children to work through stressful experiences. This was a theme particularly prominent within the **home environment**. Child 1 became irritated if offered assistance within the school environment. Child 2 avoided and withdrew from difficult tasks. Therapist 5 (Child 2) mentioned the important role that the family played in the development and maintenance of a child’s self-concept and self-esteem. This statement is supported by comments made by both Parent 1 and Parent 2 about the manner in which they adapted their lifestyles and ways of communicating with their child in order to make them feel understood within the home environment. These accounts seem to starkly contrast the statement made by Therapist 6 (Child 2) who stated that ‘our children don’t have that positive family structure.’ This category is supported by the following quotations:

- *‘...he sometimes looks at you and asks for guidance without actually asking it’s just the way he looks at you...’ (Parent 1 (Child 1), unit 5)*
- *‘He just looks at me with those eyes...’ (Therapist 3 (Child 1), unit5)*
- *‘...also your kind of support structure ...’ (Therapist 4 (Child 2), unit 5)*
- *‘... but the self-esteem and the self-concept is also reliant on the family structure.’ (Therapist 5 (Child 2), unit 5)*
- *‘...our kids don’t have that positive family structure.’ (Therapist 6 (Child 2), unit 5)*

- ‘...we just sort of like changed to his sort of behaviour to sort of like accommodate him and to make him feel that whatever he’s doing is not always right but we give him that re-assurance that it’s ok.’ (Parent 2 (Child 2), unit 5)
- ‘... but with family and friends and whatever... we have, learnt to accept him whether if he feels like doing or playing we leave him be and if he doesn’t feel like playing, we’ll encourage a bit and we’ll leave him.’ (Parent 2 (Child 2), unit 5)
- ‘My family is close.’ (Child 1, unit)
- ‘...he seems to have a good relationship with his mother and I think that he gets the support that he needs from home.’ (Therapist 3 (Child 1), unit 5)
- ‘...he doesn’t want to ask me to explain it again...he gets very irritated and very angry and he wants to get everything right...’ (Educator 1 (Child 1), unit 1,5)

CATEGORY: RELIANCE ON SOCIAL SUPPORT TO DEAL WITH STRESSFUL SITUATIONS

Table 4.12 Definition, indicators and exclusions related to the category ‘reliance on social support to deal with stressful situations’ (pre-intervention)

Definition	The reliance on external support structures to be able to employ relaxation methods in an attempt to modulate his feelings.
Indicators	All the instances from the raw data where participants made use of phrases such as ‘gotta come from somewhere else’, ‘relies on external input’, ‘reinforcement’, ‘re-assured’, ‘the way I speak to him’, ‘I’ll re-assure him’, ‘he relies on’ ‘see what my reaction is’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred ‘anything that he is told he is’, ‘it’s because of’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.12 provides a definition of ‘reliance on social support to deal with stressful situations’ as well as the indicators and exclusions used during data analysis to determine the constituencies of this category. Child 2’s therapists and parent commented on his reliance on the above mentioned **social support** structures. He relied heavily on **maternal re-assurance and encouragement** to regulate his emotions in order to be better able to engage with his environment. Child 2’s mother reported that his reliance on external support structures, particularly the support provided to him by his parents may have resulted from a

negative self-awareness. Negative self-awareness seemed to have influenced his self-appraisals. This category is supported by the following quotations regarding Child 2:

- *‘...It’s gotta always come from else where...’ (Therapist 4 (Child 2), unit 1,5)*
- *‘... He relies on an external input.’ (Therapist 4 (Child 2), unit 1,5)*
- *‘His awareness at the moment is negative, because he’s not given the opportunity to get positive reinforcement.’ (Therapist 4 (Child 2), unit 1,5)*
- *‘...He’s got to be constantly re-assured that whatever you do, we happy with what you doing.’ (Parent 2 (Child 2), unit 1,5)*
- *‘...but not knowing and feeling very insecure waiting for that re-assurance type thing.’ (Parent 2 (Child 2), unit 1)*
- *‘... not like he’ll do in voluntarily, you’ll have to re-assure him that like ‘go and play with other children...’ (Parent 2 (Child 2), unit 1,5)*
- *‘... we give him that re-assurance that it’s ok.’ (Parent 2 (Child 2), unit 5)*
- *‘... like the stuff that he learns at school he will come and say or ask if it’s wrong or if it’s not.’ (Parent 2 (Child 2), unit 5)*
- *‘... I’m not sure if it’s really wrong or if it’s to see what my reaction is as opposed to his teachers...’ (Parent 2 (Child 2), unit 5)*
- *‘... he might know that whatever it is its wrong and then he just wants to have clarification or want you like second opinion type of thing.’ (Parent 2 (Child 2), unit 5)*

CATEGORY: USE OF RELAXATION METHODS IN ORDER TO RE-EXAMINE THE SITUATION FROM ANOTHER PERSPECTIVE

Table 4.13 Definition, indicators and exclusions related to the category ‘use of relaxation methods in order to examine the situation from another perspective’ (pre-intervention)

Definition	The use of relaxation methods in an attempt to modulate his feelings.
Indicators	All the instances from the raw data where participants made use of phrases such as ‘whistling in class’, ‘self-soothing’, the way I speak to him’, ‘I’ll say to him’, ‘I make him’, ‘I’ll try to read him’, ‘you have to intervene’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘see what my reactions are’, ‘anything that he is told he is’, ‘it’s because of’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.13 provides a definition of ‘use of relaxation methods in order to re-examine the situation from another perspective’ as well as indicators and exclusions used during data

analysis to determine the constituencies of this category. Child 2 seemed to be able to **self-employ relaxation methods**. However he did not seem to consciously make an effort to utilise this coping mechanism. The employment of relaxation methods, such as whistling at the end of a class for example, may have been a result of behaviour inhibition (whistling being his way of releasing the pent up emotion that culminated during class time). This category is supported by the following quotations regarding Child 2:

- *'He's been whistling in class and doing all of these funny things.'* (Educator 2 (Child 2), unit 2)
- *'... I think that that is also his way of self-soothing as a result of more stress.'* (Therapist 4 (Child 2), unit 2)
- *'...because then maybe it's (whistling in class and doing all of these funny things) taking all of his supra- metacognitive skills to inhibit himself and then it's too much and overload of work or whatever and then it's just too much with the overload of work and stuff and he can't inhibit anymore...'* (Therapist 5 (Child 2), unit 2, 12)

Thus in terms of the baseline results, **Child 2 relied on social support** to be able to mediate and cope with stressful experiences. However, **both children** relied on social support to be able to employ relaxation methods for long enough to be able to **re-examine the social situation from another perspective**, particularly Child 1. In the Case of child 1, when he started to react with **direct- active physical aggression**, his mother pre-empted and intervened before this response was actualised. She encouraged him to **temporarily detach** from the stressful situation (which evoked emotions such as frustration and anger) in order to **employ relaxation methods** to decrease physiological arousal (such as breathing). She then encouraged him to return to the activity/ situation that made him feel overwhelmed and to attempt to confront it again. Due to his reported tendency to act impulsively, Child 1's mother stated that he would not be able to employ this coping strategy independent of her support. This category is supported by the following quotations:

- *'...for me it's the way that I speak to him, I don't know. Like I'll say to him 'calm down, think before you do something' so he's fine. And I don't laugh or say anything... try again and get it right.'* (Parent 1 (Child 1), unit 2,3,5)
- *'...If you feel that you're getting angry, then back away from it for a while and then start again...'* (Parent 1 (Child 1), unit 2,3,5)
- *'I make him go outside to calm down and then come and try again.'* (Parent 1 (Child 1), unit 2,3,5)
- *'...I try to read I'm like that but sometimes it's difficult...because he can't do it...'* (Parent 1 (Child 1), unit 2, 3, 5)

- *‘... I’ll just say to him ‘just go away and come back. Go and breathe outside...’
(Parent 1 (Child 1), unit 2,3,5)*
- *(asked if has ever tried to use the strategy himself) ‘...no, no he can’t.’ (Parent 1 (Child 1), unit 2,3)*
- *‘...he gets himself in a tizz before he realises that he should have just waited a bit...’
(Parent 1 (Child 1), unit 2, 3)*
- *‘...he doesn’t know when to stop and you have to intervene to tell him to stop...’
(Parent 1 (Child 1), unit 3, 5)*
- *‘...it didn’t matter that I went onto the field and said ‘calm down...’ (Parent 1 (Child 1), unit 3, 5)*

Despite being reliant on social support to regulate his emotions when confronted with a stressful situation, Child 1 seemed able to independently **re-examine** and **re-frame** potentially stressful situations in order to create a more positive outlook should he not be in a **heightened state of physiological arousal**. This category is supported by the following quotations regarding Child 1:

- *‘... he accepts the situation... says ‘no but my mom’s just the nurse and I don’t have the money therefore I don’t have to like cry to buy like things like everyone else...’
(Educator 1 (Child 1), unit 10)*
- *‘...I would say that actually makes him actually know what is happening if he has to deal with everything nicely you know just deal with it and know that this is how I must do it...’ (Educator 1 (Child 1), unit 9)*

However, both children seemed to **negatively appraise themselves** when confronting failure in some form, influencing self and situational appraisals, and ultimately the children’s **inability to autonomously employ relaxation methods** for long enough to re-appraise situations. This re-enforced the reliance of both children on their mothers to challenge their negative self-appraisals. Both the mothers commented on their sons’ reliance on maternal support to challenge situational appraisals they made when they experienced failure. This category is supported by the following quotations:

- *‘...and then he’ll say ‘oh, I’m so stupid’ and I’ll say to him ‘no, you’re not stupid...’
(Parent 1 (Child 1), unit 1,2,3,5)*
- *‘... then I all the time I like to encourage him and say ‘think about next time’ or ‘next time you’ll do better... it’s ok for now and when you do the next one, who knows, maybe you’ll get ninety out of a hundred’ That type of thing.’ (Parent 2 (Child 2), unit 1, 5)*

THEME 3: MALADAPTIVE EMOTION-FOCUSED COPING STRATEGIES (PRE-INTERVENTION)

Table 4.14 Definition, subthemes, indicators, exclusions and exceptions related to the theme ‘maladaptive emotion- focused coping strategies’ (pre-intervention)

Definition	Under some conditions, the experience and expression of emotion may bring negative consequences (Lopez, Shane, Snyder, 2002)
Subthemes	(3.1) Indirect- active physical aggression (heightened physiological arousal), (3.2) Direct- active physical aggression (physical aggression) and (3.3) Direct-passive aggression (withdrawal, internalising, projecting blame, avoidance, helplessness).
Indicators	All the instances from the raw data where participants made use of phrases such as ‘outbursts and totally loses it’, ‘throws things around’, ‘throws a wobbly’, ‘pulled off’, ‘goes to aggression’, ‘sometimes uses violence’, ‘I’ll beat you up’, ‘kicking’, ‘attack’, ‘climbed into’, ‘anger’, ‘aggression’, ‘eyes’, ‘face’, ‘tizz’, ‘flapping around’, ‘he starts crying’, ‘gets very emotional’, ‘cries out of frustration’, ‘irritable’, ‘totally overwhelmed’, ‘gets very upset’, ‘justify his shortcomings’, ‘struggles’, ‘holding back’, ‘excuse’, ‘blames others’, ‘it’s because of...’, ‘see what my reactions are’, ‘anything that he is told he is’, ‘oh, I’m so stupid’, ‘internalises it’, ‘someone says’, ‘bully’, ‘kicking’, ‘muscles are tense’, ‘gets emotional’, ‘sad’, ‘inhibit’, ‘withdraw’, ‘pulls back’, ‘takes the back seat’, ‘doesn’t venture’, ‘pray for the bell’, ‘step back’, ‘sit and see’, ‘inhibited’, ‘feedback from others’, ‘what they’re saying’, ‘they hear’, ‘the messages that they get’, ‘other people’s responses’, ‘avoid’, ‘shows indifference’, psychosomatic symptoms such as ‘head aches, tummy aches’, ‘excuses’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘examines the situation from another perspective’, ‘social support’, ‘use of relaxation methods’, ‘asks for assistance’, ‘gets the support’, ‘this is what I must do’, ‘no you’re not’, ‘no but’, ‘self-soothing’ and ‘acceptance’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as ‘hyper’, ‘without thinking’, ‘impulsive’, ‘restless’ which more than one of the participants indicated, but which do not fall directly within this theme.

Table 4.14 provides a definition of ‘maladaptive emotion-focused coping strategies’, the subthemes that made up this theme as well as the indicators and exclusions used during data analysis to determine the constituencies of this theme and responses that were exceptional to this theme. Both the children’s parents, educators and all therapists reported that the boys made use of maladaptive emotion- focused coping strategies. This theme consists of three subthemes; **(3.1) indirect- active physical aggression (3.2) Direct- active physical aggression and (3.3) Passive- direct physical aggression.**

Reports indicate that Child 2 employed **direct, active physical aggression** on the playground. Therapist 5 conjectured that this coping strategy could be a result of a limited verbal expression capacity. Reports further indicate that Child 2 often withdrew from social

situations, but with encouragement, joined in to play with others. Through exclusion from formal and informal social situations, Child 2 did not make himself available to gain esteem or social support from his peers perpetuating his isolation. Such negative interpersonal outcomes seem to have resulted in a negative self-concept, limited efficacy and a limited coping repertoire (Wicks-Nelson et al. 2000).

SUBTHEME 3.1: INDIRECT- ACTIVE PHYSICAL AGGRESSION

Table 4.15 Definition, indicators and exclusions related to the category ‘indirect- active physical aggression’ (pre-intervention)

Definition	For the purpose of this study, any action characterised by aggression directed at oneself.
Indicators	All the instances from the raw data where participants made use of phrases such as ‘discomfort’, any reference to a change in physiology i.e. ‘eyes’, ‘face’, ‘tizz’, ‘flapping around’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘hyper’, ‘fidgety’, ‘restless’, ‘irritated’, ‘totally overwhelmed’ were considered unrelated to this theme. It is noted that although there are resemblances between them, they were broken up for the purpose of this study.

Table 4.15 provides a definition of ‘indirect- active physical aggression’ as well as indicators and exclusions used during data analysis to determine the constituencies of this subtheme.

Heightened physiological arousal is a category which forms part of the subtheme ‘indirect-active physical aggression’:

CATEGORY: HEIGHTENED PHYSIOLOGICAL AROUSAL IN RESPONSE TO STRSSFUL SITUATIONS

Table 4.16 Definition, indicators and exclusions related to the category ‘heightened physiological arousal in response to stressful situations’ (pre-intervention)

Definition	Chronic physiological arousal resulting in negative adjustment (Net Solutions, 2008)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘discomfort’, any reference to a change in physiology i.e. ‘eyes’, ‘face’, ‘tizz’, ‘flapping around’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘hyper’, ‘fidgety’, ‘restless’, ‘irritated’, ‘totally overwhelmed’ were considered unrelated to this theme. It is noted that although there are resemblances between them, they were broken up for the purpose of this study.

Table 4.16 provides a definition of ‘heightened physiological arousal’ in response to stressful situations well as the indicators and exclusions used during data analysis to determine the constituencies of this category. Two participants referred to instances in which **heightened physiological arousal** was a precursor for more **direct- active aggression**. The children’s **mothers tried to decrease physiological arousal** in an attempt to facilitate more adaptive coping and functioning (congruent with the need for external support structures to employ relaxation methods) (refer to theme 2). Child 1’s mother reported that she tried to intervene to facilitate the use of relaxation methods in order to prevent the employment of aggressive emotion-focused coping techniques (refer to 3.2). This category is supported by the following quotations:

- *‘...you can see that minute in his eyes that he’s going to attack you and his face just changes...’ (Parent 1 (Child 1), unit)*
- *‘If you feel that you’re getting angry, then back away from it for a while and then start again...’ (Parent 1 (Child 1), unit)*
- *‘... he gets himself in a tizz before he realises... he’s in his little tantrum and little world...’ (Parent 1 (Child 1), unit)*
- *‘... he was very stressed for his age. His muscles are very tense and we have to massage his shoulders...’ (Parent 2 (Child 2), unit 2, 5)*

SUBTHEME 3.2: DIRECT- ACTIVE PHYSICAL AGGRESSION

Physical aggression is a category which forms part of the subtheme ‘direct- active physical aggression’:

CATEGORY: PHYSICAL AGGRESSION

Table 4.17 Definition, indicators and exclusions related to the category ‘physical aggression’ as well as exceptional responses to this category (pre-intervention)

Definition	Overt behaviour aimed at physically causing personal injury to a thing or another person (Net Solutions, 2008)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘throw things around’, ‘outbursts and totally loses it’, ‘throws a wobbly’, ‘pulled off’, ‘goes to aggression’, ‘sometimes uses violence’, ‘I’ll beat you up’, ‘kicking’, ‘attack’, ‘climbed into’, ‘anger’, ‘aggression’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘agro’, ‘totally overwhelmed’, ‘frustration’, ‘sad’, ‘crying’, ‘emotional’, ‘internalises’, ‘gets very upset’, ‘use as an excuse’, ‘irritated’ were considered unrelated to this theme. It is noted that although there are resemblances between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as ‘hyper’, ‘without thinking’, and ‘impulsive’ which one or more of the participants indicated, but which do not fall directly within this theme but which may be symptoms of ADHD, which influence the participants overt behaviour.

Table 4.17 outlines a definition of ‘physical aggression’, the indicators and exclusions used during data analysis to determine the constituencies of this category and exceptional responses to this category. Should social support not be available to address heightened physiological arousal, Parent 1 reported that Child 1 exhibited **physical aggression**. This was reported as occurring in both the home and school settings. Educator 1 reported that Child 2 used physical aggression on the playground. Reasons for the children employing this coping strategy seemed to be due to **negative self appraisals** (possibly resulting in them becoming overwhelmed or frustrated by situational demands). Therapist 5 suggested that Child 2 made use of physical aggression (possibly in an attempt to compensate for a poorly developed ability to engage in social discourse). This category is supported by the following quotations and visual data:

- *‘...when he doesn’t get things right he’s like doing that (hitting fist on the table)...’
(Educator 1 (Child 1), unit)*

- *'... he was very stressed for his age. His muscles are very tense and we have to massage his shoulders and like, we should do it actually everyday, but we don't.'*
(Parent 2 (Child 2), unit 2, 5)
- *'...when he's totally overwhelmed he has those outbursts and he totally loses it.'*
(Therapist 1 (Child 1), unit 2)
- *'...haven't you seen him throw a wobbly when he's like cross?'* (Therapist 1 (Child 1), unit 1,2,3,4,5)
- *'...he has that short, what do you call it, anger thing he gets angry with others around him and he'll just throw things...'* (Educator 1 (Child 1), unit 5)
- *'...he doesn't know how to deal with the fact that he isn't able to do it and then he projects anger, aggression...'* (Parent 1 (Child 1), unit 1)
- *'...he can't deal with the aggression...'* (Parent 1 (Child 1), unit 2, 3)
- *'...he can't handle that and from that crying he goes to aggression...'* (Parent 1 (Child 1), unit 3)
- *'...goes in guns blazing...'* (Parent 1 (Child 1), unit 2,3,4)
- *'... he sometimes uses violence as well to sort of show 'I'm not weak, I'll beat you up and let's see who's weak.'* (Parent 1 (Child 1), unit 1)
- *'... and that's where the kicking and the karate comes in.'* (Parent 1 (Child 1), unit 1)
- *'...you can see that minute in his eyes that he's going to attack you and his face just changes...'* (Parent 1 (Child 1), unit 1)
- *'If you feel that you're getting angry, then back away from it for a while and then start again...'* (Parent 1 (Child 1), unit 2,3,4)
- *'... he gets himself in a tizz before he realises... he's in his little tantrum and little world...'* (Parent 1 (Child 1), unit 1)
- *'...he just climbed into this guy...'* (Parent 1 (Child 1), unit 4)
- *'...he had to be pulled off this kid...'* (Parent 1 (Child 1), unit 4)
- *'... but on the playground he can be a bully... he's always kicking.'* (Educator 2 (Child 2), unit 11, 12)
- *'... he's also a bully, but I don't think he's as bad as (child 2)...I think it's because of (child 2)...'* (Educator 2 (Child 2), unit 11,12)
- *'... it seems to be helping him because he's going for nonverbal skills.'* (Therapist 5, unit 11, 9)

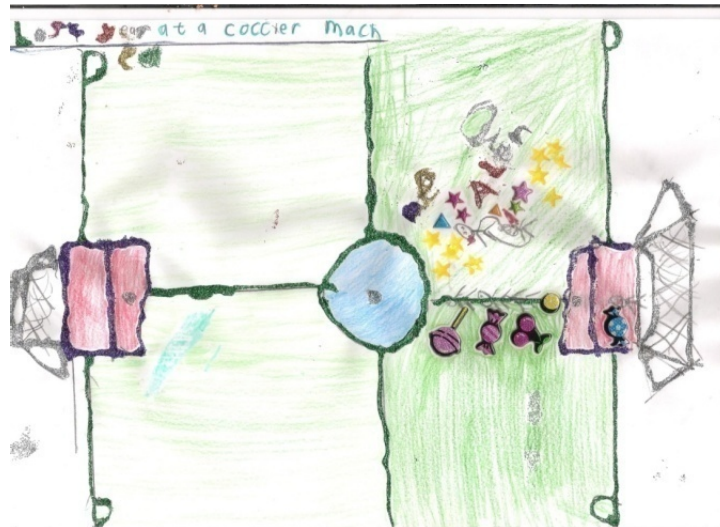


Figure 4.5¹⁰ : Child 1's depiction of the use of direct- active physical aggression in response to being teased. I denote the use of the shapes i.e. stars and triangles with heightened physiological arousal.

SUBTHEME 3.3: DIRECT- PASSIVE AGGRESSION

Table 4.18 Definition, indicators and exclusions related to the subtheme 'direct-passive aggression' (pre-intervention)

Definition	Any actions characterised by avoidance, internalising, projecting blame, learned helplessness.
Indicators	All the instances from the raw data where participants made use of phrases such as 'the way I speak to him', 'I'll say to him', 'I make him', 'I'll try to read him', 'you have to intervene' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to 'see what my reactions are', 'anything that he is told he is', 'it's because of' were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.18 outlines a definition of 'direct- passive aggression' as well as the indicators and exclusions used during data analysis to determine the constituencies of this subtheme. The most **dominant emotion- focused coping strategy** employed by both children was that of **direct- passive aggression** in response to stressful situations. Both children employed indirect- active aggressive coping strategies such as helplessness, internalising, projecting blame and avoidance. Child 1's mother, educator and therapists reported that Child 1 used direct-passive aggressive coping strategies 35 times and Child 2 32 times. The same participants further reported that Child 1 used passive- active aggressive techniques such as

helpless behaviour (crying), **avoidance** (avoiding engagement with a task/ situation which appeared too demanding), projecting blame (blaming external forces to justify behaviour) and **internalising** (forming his identity on other's opinions of him) which hindered him from achieving his goals. In addition, Child 2 employed avoidance tactics in response to stressful situations (which Child 1 did not employ). Internalising is commented on by Cooley (1902) who asserts that the self-concept is a by-product of social interactions. The children in the study tended to internalise negative feedback from others, which resulted in a negative self and situational appraisals. This finding is supported by Bandura's (1997) social cognitive theory which states that people engage with situations only when they feel competent enough to do so, and **avoid** situations when feeling incompetent in dealing with them, much in the same way that both of the participants did. Whether or not one engages with a situation is based on the individual's self-efficacy beliefs, stating that self-efficacy beliefs heavily influence the choices that one makes as well as the behaviour that results from those choices (Schunk, 1981; Schunk & Hanson, 1985; Schunk, Hanson, & Cox, 1987 in Pajares & Schunk; 2001).

As findings from the study suggest, children with ADHD are confronted with failure and negative criticism both within the class and playground setting. As stated by Kruger (1998), such negative interpersonal outcomes result in children with ADHD being extremely sensitive to the opinions of others. In the child participants, these outcomes seem to have resulted in poor self-efficacy beliefs as well as **avoidance behaviour**- which ultimately determined the manner in which they respond to people and situations. In order to avoid future failures, children with ADHD may **project blame** onto others in situations that they feel they have little control over (with this lack of control resulting from the belief that their actions will have little positive bearing on the situation). As a result of feeling disempowered, children with ADHD allow for others to assume responsibility for decision-making.

Being negatively appraised across a number of settings influenced the self-efficacy beliefs of children with ADHD. Thus, the lower the child's self-efficacy, the less likely he may be to persevere in the face of obstacles and the more likely he may be to experience extreme amounts of anxiety and stress when confronted with stressful situations which was evident during pre-intervention assessment (Schunk, 1981; Schunk & Hanson, 1985; Schunk, Hanson, & Cox, 1987 in Pajares & Schunk; 2001). Ebersöhn (2006) and Ginorio, Yee, Banks and Todd-Bazemore (2007) agree that those who cope poorly with stress tend to feel they have less control over their lives and with their behaviour being characterised by learned helplessness. Persistent feelings of self-blame, as well as an external locus of control, could result in poor adjustment and depression. Thus, the self-efficacy beliefs of children with

ADHD have direct and significant bearing on the emotion-focused coping strategies that they employ, which in the case of pre-intervention functioning, resulted in the employment of predominantly passive- active aggressive coping strategies.

I regard the emotion-focused coping strategies explored above as maladaptive as they result in negative consequences. As such, children’s emotional, social and academic functioning was impacted negatively (refer to 2.3.1.2 in chapter 2).

Helplessness, avoidance, projecting blame, internalising, and withdrawal are categories which form part of the subtheme ‘passive- direct physical aggression’:

CATEGORY: HELPLESSNESS

Table 4.19 Definition, indicators and exclusions related to the category ‘helplessness’ (pre-intervention)

Definition	Powerlessness revealed by an inability to act (Miller, 2006)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘he starts crying’, ‘gets very emotional’, ‘cries out of frustration’, ‘irritable’, ‘totally overwhelmed’, ‘gets very upset’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘agro’, ‘internalises’, sees himself as others say he is’, ‘I am stupid’ were considered unrelated to this theme. It is noted that although there are resemblances between them, they were broken up for the purpose of this study.

Table 4.19 outlines a definition of ‘helplessness’ as well as the indicators and exclusions used during data analysis to determine the constituencies of this subtheme. Four of the participants referred to instances in which the children’s behaviour was characterised by **helpless behaviour**. **Crying** was reported as occurring predominantly within the home environment with **irritability and frustration** manifesting predominantly within the class and therapeutic environment. Child 1’s mother reported that her child cried when he felt frustrated or angry as a result of feeling perceived as fallible or weak. Child 1 responded with frustration when unable to successfully complete a task, as well as when he was told to do two tasks simultaneously (possibly creating a stressful situation). Feelings of **frustration** were common to both children, with Child 1 and Child 2 experiencing feelings of helplessness and crying (possibly as a result of not meeting their own expectations as well as the expectations of others). This category is supported by the following quotations:

- *‘...when he isn’t able to be all then he becomes aggressive and very emotional...’*
(Parent 1 (Child 1), unit 1,3)

- *'... awakening of 'hey I can't do that' and then he doesn't know how to deal with the fact that he isn't able to do it and then he projects...or cries out of frustration.'* (Parent 1 (Child 1), unit 1,3)
- *'... when he realises that there is something that he can't do...he starts crying...that happens a lot here at school...'* (Parent 1 (Child 1), unit 1,3)
- *'... he gets teased for crying...'* (Parent 1 (Child 1), unit 1,2,4,5)
- *'...from that crying he goes to aggression...'* (Parent 1 (Child 1), unit 1,2,4,5)
- *'...knows who he is and what he wants and what he wants out of life, but I think because of, of the way that he handles stress- he's very emotional...'* (Parent 1 (Child 1), unit 1,2,3,4,5)
- *'...when he doesn't get things right he's like doing that (hitting fist on the table)...'* (Educator 1 (Child 1), unit 3)
- *'I don't think he comes to school in a good mood and he's just irritable the whole day...'* (Therapist 1 (Child 1), unit 3, 5)
- *'...there is something else that he doesn't like to hear that he knows already, he gets very irritated...'* (Educator 1 (Child 1), unit 3, 5)
- *'...and he got irritated...'* (Therapist 1 (Child 1), unit 3,5)
- *'...when he's totally overwhelmed he has those outbursts and he totally loses it.'* (Therapist 1 (Child 1), unit 2)
- *'... somebody's asking him to do something he gets very upset.'* (Therapist 1 (Child 1), unit 2, 3)
- *'...he would like to take things to the extreme or, I don't know...if he wants to do something, he wants to do it to the extreme, no fault type of thing... If it's not what he expects, he gets quite sad about it...'* (Parent 2 (Child 2), unit 1, 2)
- *'...when we shout at him he gets like very emotional you know like feel want to start crying or I don't know if it's his way of not coping that makes him so emotional...'* (Parent 2 (Child 2), unit 1,2)
- *'... in a sense that it (stress) makes him emotional, forgetful...'* (Parent 2 (Child 2), unit 1,2)

CATEGORY: INTERNALISING

Table 4.20 Definition, indicators and exclusions related to the category 'internalising' (pre-intervention)

Definition	To incorporate, as through learning, socialization and identification (Miller, 2006)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘see what my reactions are’, ‘anything that he is told he is’, ‘oh, I’m so stupid’, ‘internalises it’, ‘feedback’, ‘someone says’ and ‘what they’re saying’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘it’s the way that I talk to him’, ‘just doesn’t know how to deal with it’, ‘asks you for guidance without actually asking’, were considered unrelated to this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as ‘becomes unsure’ which one of the participants indicated but which does not fall directly within this theme but is related to the theme.

Table 4.20 illustrates a definition of ‘internalising’, the indicators and exclusions used during data analysis to determine the constituencies of this theme and exceptional responses to this theme. It seems as though **internalising contributed to both children’s reliance on external support structures and direct- active aggression**. Five participants stated that the children internalised feedback from those within their home and school environments. Two of the participants highlighted the role that academic self-concept played in informing their behaviour. Therapist 6 (Child 2) stated that the feedback that children with ADHD receive is predominantly negative as a consequence of repeated failure. This assertion is supported by a statement made by Child 1’s mother that her child **assimilated negative appraisals and feedback more readily than he did the positive**, possibly resulting in stress. Furthermore, Therapist 3 (Child 1) stated that at times Child 1 did internalise positive feelings and feedback when he experienced success within the therapeutic environment (possibly resulting in feelings of self-confidence). This category is supported by the following quotations:

- ‘... you create your self concept from the feedback that you get from others so it’s just your own perception...’ (Therapist 6 (Child 2), unit 5)
- ‘...so you create a self-concept around what they’re saying...’ (Therapist 6 (Child 2), unit 5)
- ‘... they get a lot of negative feedback and build their self-concept on ‘I can’t actually do this’ or ‘I can’t actually achieve this’ when they actually have the potential but there are so many behaviour factors coming in that they get reprimanded because they not sitting still and they not focusing so they feel that they’re not living up to the standard.’ (Therapist 6 (Child 2), unit 5)
- ‘...If you’re not good at school, that’s what counts. It makes no difference if you’re a champion horse rider. Not in the school environment...’ (Therapist 5 (Child 2), unit 1,5)

- *'...kids with ADHD experience failure from when they were small. They hear 'no, you're not doing what I'm expecting from you.' So from very early age they have to cope with failure. Failing over and over because they are not meeting the criteria you know. Not academically, not behavioural wise...'* (Therapist 6 (Child 2), unit 1,2,5)
- *'... all of the messages that they get are negative and 'you're not coping' and 'you're not doing well' so that's where that comes from...'* (Therapist 6 (Child 2), unit 1,2,5)
- *'...So even though you're good as sport, who cares, Ernie Els doesn't care if you can read or write as long as you can play golf. But they don't get that...'* (Therapist 6 (Child 2), unit 1,5)
- *'...he sees himself as being anything that he is told he is and he internalises it...'* (Parent 1 (Child 1), unit 5)
- *'...he seems to remember more of the negative than the positive. That sticks in his mind the most. It doesn't matter that someone says that he's good and that he's not so bad. He will hang onto the bad points and not the good.'* (Parent 1 (Child 1), unit 5)
- *'...oh, I'm so stupid...'* (Parent 1 (Child 1), unit 2,3,5)
- *'... he's very sensitive...'* (Parent 1 (Child 1), unit 5)
- *'...people like him and he likes himself... He does well in (Therapist 2)'s group and my group therapy...he is positive... he does very well in OT and speech- he's a star there... especially with my stuff that's spatial... very competent in my groups and very happy to come to me and he is very competent, there is no doubt about that'* (Therapist 3 (Child 1), unit 5, 8)
- *'...what he sees at home he sort of like see it that that's the way that it should be...'* (Parent 2 (Child 2), unit 5)
- *'... he will say 'oh ok, I understand now because my teacher said so'...'* (Parent 2 (Child 2), unit 5)
- *'... I think he bases it on other people's responses.'* (Parent 2 (Child 2), unit 5)

Child 1's mother did not explicitly mention internalising, however, she did report self-doubt:

- *'...if he gets teased, like he desperately wants to be a singer and he did that in class and apparently everybody laughed and him and he becomes unsure but he still, it's still something that he wants to do I think. So I think he knows what he wants and the teasing makes him unsure...'* (Parent 1 (Child 1), unit 1, 5)

CATEGORY: AVOIDANCE

Table 4.21 Definition, indicators and exclusions related to the category ‘avoidance’ (pre-intervention)

Definition	Deliberately avoiding, keeping away from or preventing from happening (Weber, 1913)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘justify his shortcomings’, ‘struggles’ and ‘holding back’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘externalises’, ‘it’s because of...’ and ‘blames others’ were not included in this theme. It is noted that although there are acute resemblances between them, they were broken up for the purpose of this study.

Table 4.21 provides a definition of ‘avoidance’ as well as the indicators and exclusions used during data analysis to determine the constituencies of this theme. When the children appraised tasks and situations as ‘*challenging and frightening*’ (Therapist 2, Child 1) they employed **avoidance techniques**. Avoidance behaviour was noted predominantly in the **classroom setting** but also in **therapeutic settings** where performance was emphasised. Child 1 tried to avoid written tasks. Avoidance was not commented on within Child 1’s home environment, but was noted in Child 2’s home environment. Child 1 **made excuses** as to why he was unable to engage with certain tasks resulting in delay to start a task and not completing tasks within the allocated time frame. His educator commented that his avoidance behaviours result in him appearing ‘*disorganized*’ (Educator 1, Child 1). When made aware of his behaviour by his educator and therapists, he attempted to avoid reprimand (for not starting tasks and not completing tasks timorously) by making excuses to justify his behaviour. Child 2 attempted to avoid potentially stressful situations by **withdrawing** from them, and sometimes developing **psychosomatic symptoms** (possibly due to the intensity of the emotions experienced). This category is supported by the following quotations:

- ‘...I think that happens when he finds things difficult and frightening he uses it as an excuse to justify his shortcomings.’ (Therapist 2 (Child 1), unit 1)
- ‘...that he is actually holding back and you find that he can’t complete the task on time really because of that.’ (Educator 1 (Child 1), unit 6)
- ‘...he’s at that age where he thinks that he can use that as an excuse.’ (Therapist 2 (Child 1, unit 6)
- ‘...he’s actually becoming slow in finishing off his tasks like others in his class because he’s putting that (excuses) first...’ (Therapist 2 (Child 1), unit 6)
- ‘...those things they make you a disorganised person...’ (Educator 1 (Child 1), unit 6)
- ‘...he uses that as an excuse sometimes...’ (Educator 1 (Child 1), unit 6)

- *'...at times he's managing at times he uses that just as an excuse...'* (Educator 1 (Child 1), unit 6)
- *'...when it's verbal, he's competent and the confidence comes out but he struggles with written work.'* (Therapist 3 (Child 1), unit 2)
- *'maybe he doesn't understand a certain concept and he doesn't want to ask me to explain it again he will try to fiddle around and when there is something else that he doesn't like to hear that he knows already, he gets very irritated...'* (Educator 1 (Child 1), unit 6).
- *'...he definitely doesn't want to try... If it's one word answers, one line answers yes, but when he has to engage in a narrative or a discourse, he always wants to be the fifth person and there are four people in the group, and he's hoping that the bell will go before it's his turn.'* (Therapist 5 (Child 2), unit 1,2)
- *'...he wasn't the only one who didn't do it but he really...you could see the look on his face- praying for the bell.'* (Therapist 5 (Child 2), unit 1,2)
- *'..he avoids...'* (Educator 2 (Child 2), unit 2)
- *'...showing that indifference or hoping that the bell will go.'* (Therapist 6 (Child 2), unit 2)
- *'...He's not risking the possibility that he could be right...'* (Therapist 4 (Child 2), unit 1,2)
- *'... like with a test. He will always want to get the best and with the result he puts pressure on himself and he has headaches and tummy aches and all kinds of reasons not to do it because of his fear of what the results may be...'* (Parent 2 (Child 2), unit 2)
- *'...he'll try and avoid those people.'* (Parent 2 (Child 2), unit 2)

Despite these similarities in emotion- focused coping strategies employed, two coping strategies employed were unique to each child. In the case of **Child 1, he projected blame** and **Child 2 withdrew** from potentially stressful situations.

CATEGORY: PROJECTING BLAME

Table 4.22 Definition, indicators and exclusions related to the category 'projecting blame' (pre-intervention)

Definition	To project or attribute (inner conflicts or feelings) to external circumstances and
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	causes (American Heritage Dictionary, 2000)
Indicators	All the instances from the raw data where participants made use of phrases such as ‘externalises’, ‘blames others’, ‘it’s because of...’, were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘use as an excuse’, ‘justify’, ‘holding back’, ‘internalises’ were considered unrelated to this theme. It is noted that although there are resemblances between them, they were broken up for the purpose of this study.

Table 4.22 provides a definition of ‘projecting blame’ as well as the indicators and exclusions used during data analysis to determine the constituencies of this theme. In the case of Child 1, **projecting blame** was noted primarily within the therapeutic environment and the classroom. Therapist 1 noted that Child 1 was acutely aware of the influence of the environment on him, explicitly stating that he did not readily accept his influence on his environment. All three of Child 1’s therapists were unanimous in agreeing that he projected blame to avoid accountability of inappropriate behaviour (which could possibly result in reprimand). This category is supported by the following quotations regarding Child 1:

- ‘...I think that he also externalises a lot in that he blames others...’ (Therapist 1, unit 3, 4)
- ‘...it’s other people’s problem or responsibility.’ (Therapist 1, unit 4)
- ‘He doesn’t accept it within himself.’ (Therapist 1, unit 4)
- ‘...when he misbehaves he says ‘you know I’m ADHD so maybe I didn’t take my medication today so that’s why I’m naughty...’ (Educator 1, unit 7)
- ‘...he has insight into his environment and the influences of it but he won’t always accept his role in it but um, and how he influences it at times...’ (Therapist 1, unit 7)
- ‘...then I’ll reprimand him and he’ll say ‘sorry ma’am, I’m waiting for the medication to work’...’ (Therapist 3, unit 7)
- ‘Sometimes he can use that to his advantage and tell you like ‘I have ADHD’ so I didn’t take medication today...’ (Educator 1, unit 7)
- ‘It would make me very happy if you did not give me any homework.’ (Child 1, unit 7)

CATEGORY: WITHDRAWAL

Table 4.23 Definition, indicators and exclusions related to the category ‘withdrawal’ (pre-intervention)

Definition	The act of or process of withdrawing (Wordnet.com)
Indicators	All the instances from the raw data where participants made use of phrases

	such as 'inhibit', 'take the back seat', 'doesn't venture', 'holds back', 'praying for the bell', 'withdraw', 'step back', 'pulls back', 'sit and see', 'inhibited' were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to 'avoid' were considered unrelated to this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.

Table 4.23 provides a definition of 'withdrawal' as well as indicators and exclusions used during data analysis to determine the constituencies of this theme. Child 2's mother and all three of his therapists reported that his behaviour was characterised by **withdrawal**. They reported withdrawal to be a consequence of him fearing failure. Two participants stated that Child 2's fear of failure (and consequent withdrawal) could be a result of an awareness of his inabilities. Furthermore, Therapist 5 suggested that Child 2's withdrawal may manifest in inhibition in a group situation. This category is supported by the following quotations regarding Child 2:

- *'...you ask him 'what do you think' you know he won't freely say 'I think this could be a solution' you know like he will wait to hear if someone else comes up with a solution. I think he's also afraid of getting negative feedback in case it's wrong you know.'* (Therapist 6, unit 1,2,4,5)
- *'... inhibits himself in case he makes a mistake so he'd rather take the back seat rather than be spontaneous and make a mistake. ...'* (Therapist 5, unit 1,2,4,5,11)
- *'...he doesn't venture...'* (Therapist 6, unit 1,2)
- *'...he always wants to be the fifth person and there are four people in the group...'* (Therapist 5, unit 1,2,4,5)
- *'...I think that he is aware and that's why he holds back...'* (Therapist 5, unit 1,9)
- *'... him knowing his inabilities...I think he's good understanding of where he is and... that's probably making him withdraw himself and that's probably his way of coping and dealing with his stress.'* (Therapist 4, unit 1,2,9)
- *'... step back as a way of coping...'* (Therapist 4, unit 1,9)
- *'...he would rather withdraw himself'* (Therapist 6, unit 1,9,11)
- *'...puts a lot of pressure of him like with stress because then he like sort of pulls back...'* (Parent 2, unit 2)
- *'... like change of environment...he'll sort of just wait a while and see what it brings out but he won't just like adapt easily. Like if we were to visit just a stranger or a friend of mine. He would first sit and see before he plays with other children...'* (Parent 2, unit 2,5)
- *'...when he stress, he sort of like just goes quiet and pulls back.'* (Parent 2, unit 2)

- *'...I think (child 2) is inhibited- his spontaneity is inhibited... occasionally the topic overwhelms him and then you see glimpses of his potential... is so exciting for him that he blossoms and shows his potential but unless the intention and the motivation of the topic overwhelms him, then he forgets himself so to speak, and he is generally quite inhibited and he'll take the back seat and I think...it's not a laziness, he's a very obliging and cooperative kid but it's a...a...there is an attitude of um, like, to inhibit himself in case he makes a mistake so he'd rather take the back seat rather than be spontaneous and make a mistake. ...' (Therapist 5, unit 2,3)*

4.3.1.1 Discussion of the baseline results

At the pre-intervention assessment it appears that both participants had limited connections with their intrapersonal realms. This limited awareness into their self-concept seemed to result in the use of passive aggression and active aggression in response to stressful situations. These coping strategies impacted negatively on their interpersonal functioning. In this regard, they had difficulty in being tolerant and flexible in group situations, did not always use effective social skills and responded negatively to criticism. As a result of poor intrapersonal and interpersonal competencies, they seemed to struggle with identifying, communicating and expressing internal and external causes of stress, which again influenced their ability to interact with others. Thus, it appeared that their limited self-concept awareness resulted in less effective emotion- focused coping strategies.

4.3.2. Results of the thematic analysis: Post-intervention

In total, seven subthemes were identified through thematic analysis. As was done in the baseline assessment, subthemes have been grouped together into three themes; self-concept awareness, adaptive emotion- focused coping strategies and maladaptive emotion-focused coping strategies. Table 4.24 outlines the results of thematic analysis conducted, indicating the frequency of the subthemes that were reported.

Table 4.24 Results of the thematic analysis indicating emotion-focused coping and self-concept awareness themes, subthemes and categories: Post-intervention

THEME 4: SELF-CONCEPT AWARENESS (POST-INTERVENTION)	
Subthemes	Categories
4.1 Knowledge of and insight into the self-concept	Self-awareness (22) ¹¹ Self-confidence (8)



4.2 Skills to interact with others	Positive interactions with others (3) Negative interactions with others (6)
4.3 Knowledge of the importance of growth and change	Identification and expression of feelings (4) Demonstrating effective ways of responding to others when under stress (4)
THEME 5: ADAPTIVE EMOTION-FOCUSED COPING STRATEGIES (POST-INTERVENTION)	
5.1 Use of relaxation methods	
5.2 Re-examining situations from another perspective	
THEME 6: MALADAPTIVE EMOTION- FOCUSED COPING STRATEGIES WHICH REMAINED MALADAPTIVE (POST-INTERVENTION)	
6.1 Direct, active physical aggression	Physical aggression (8)
6.2 Direct- passive aggression	Projecting blame (3) Withdrawal and avoidance (17) Internalising (3)

The following discussion presents the results of thematic analysis depicting emotion-focused coping strategies and self-concept awareness of children with ADHD post-intervention.

THEME 4: SELF- CONCEPT AWARENESS (POST-INTERVENTION)

Eight participants commented on Child 1 and Child 2's level of self-concept awareness. Three participants commented on the definition of self-awareness as having an accurate understanding of one's strengths and weaknesses. This theme consists of three subthemes; **(4.1) knowledge and insight into the self-concept, (4.2) interactions with others** and, **(4.3) knowledge of growth and change.**

SUBTHEME 4.1: KNOWLEDGE AND INSIGHT INTO THE SELF- CONCEPT

As was the case in the discussion of baseline results, **self-confidence** and **self-awareness** are categories which form part of the subtheme 'knowledge and insight into the self-concept' during post-intervention assessment:

CATEGORY: SELF- AWARENESS

Post-intervention findings suggest a **marked increase in Child 1's self-awareness and self-confidence**. Four participants reported that Child 1 was **more self-aware** not only of his limitations, but also of his positive and negative characteristics (refer to Figure 4.6) seemingly resulting in a **more positive self-image and greater sense of self-confidence**. This theme emerged in both the **home and school environment**. Most of the participants reported that Child 1 was more aware of his strengths, his weaknesses and his ADHD symptoms. This greater self-concept awareness possibly signifies one way in which Child 1 came to a greater understanding of the manner in which his cognitive appraisals informed his self-concept and the extent to which his self-concept influenced his behaviour both positively and negatively thus informing his choice of emotion-focused coping strategies (Ginorio, Yee, Banks and Todd-Bazemore, 2007). Child 1 started to more readily accept personal responsibility for his actions, allowing him to gain perspective on and positively appraise the situation. Having this insight seemed to motivate Child 1 to persevere at reaching his goals. He was also more aware of the impact of his ADHD symptoms on his behaviour which allowed him to attain a more balanced view of situations. Most of the participants stated that Child 1 was more aware of his short-term and long-term goals and was motivated and determined to reach them. Thus, findings suggest that post-intervention Child 1 possessed a healthy self-esteem and sense of self-competence.

Surprisingly Child 1 transferred this awareness into everyday settings despite his impaired executive functioning. This result challenges the more traditional conceptualisations of ADHD which advocate that deficient cognitive constructs and capacity result in defective behaviour (Steer, 2007). This finding illustrates that the possibility exists that by developing cognitive regulation interventions as a means of altering "thoughts, ideas, assumptions, self-communication, basic philosophies (and therefore cognitive structures and appraisals) that people use for themselves, others and situations" (Ebersöhn, 2006: 69), Child 1 was able to exercise self-control by inhibiting responses and regulating behaviour through the use of inner speech; working memory and control of emotions; and more effective communication and problem-solving (Wicks- Nelson et al. 2000).

This category was supported by the following quotations and visual data regarding Child 1:

- *'...I don't know if it's because he's growing up, but he has done a lot of growing up in the last two months um yeah he knows more about himself, he knows what he wants, and he's quite determined about getting what he wants now. I think he knows he knows his...not his boundaries, his not his limits, he knows he's goals...'* (Parent 1, unit 9)

- ‘... what he wants to do in the long-term...’ (Parent 1, unit 8,9)
- ‘...I think that he definitely has a greater awareness... (Therapist 2, unit 9)
- ‘... he is somewhat better informed I think.’ (Therapist 1, unit 9)
- ‘... obviously aware of it (ADHD) and he’s aware it influences his behaviour...’ (Therapist 3, unit 9,13)
- ‘... I think that he’s self-aware, he knows what it’s about and how it influences him and that helps him to deal with it and put it into perspective.’ (Therapist 1, unit 9)
- ‘... because of his self-concept, almost motivates himself...’ (Therapist 2, unit 9)
- ‘... he knows... he’ll say, look ma’am, I know that I am good at this and he does well... he’ll say I know how to do this and he’ll do it...’ (Therapist 3, unit 8,9)
- ‘...and he knows what he’s not good at either.’ (Therapist 3, unit 9)

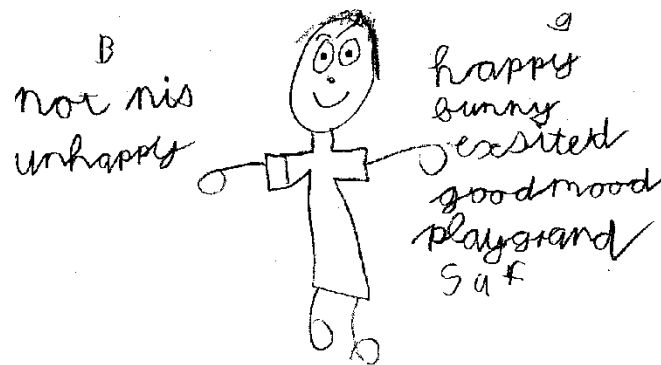


Figure 4.6¹²: Child 1 exploring his positive and negative characteristics.

With reference to Child 2, four participants reported that despite having a basic understanding of his strengths, limitations and ADHD diagnosis, Child 2’s **depth of self-awareness remained inadequate**. Results of the study indicate that **Child 2’s self-awareness seemed to decrease**. One of the contributing factors to this could be that he had been refusing to take his medication for approximately one month prior to the post-intervention assessment. The assumption is that this could have been his way of assuming control over a seemingly overwhelming situation. The lack of control experienced by Child 2 seemed to result in diminished ability to adequately cope with stress (Ebersöhn, 2006). Ginorio, Yee, Banks and Todd-Bazemore (2007) support this notion, stating that the child who copes poorly with stress tends to feel less in control of his life. The lack of control results in behaviour characterised by learner helplessness. Child 2’s continued use of maladaptive emotion-focused coping strategies such as **passive-active aggression (internalising, withdrawal, avoidance, refusal to speak and learned helplessness)** manifested in an **over-reliance on social support**, underachievement, a lack of perseverance, heightened physiological arousal, anxiety and frustration (Gonzales & Sellers, 2006). Bandura (1997)

supports this finding adding that children (such as Child 2) engage in activities where they experience a sense of competence, and avoid situations they appraise as difficult and overwhelming (Schunk, 1981; Schunk & Hanson, 1985; Schunk, Hanson, & Cox, 1987 in Pajares & Schunk; 2001). Possibly Child 2 appraised many situations in this way resulting in his use of maladaptive emotion- focused coping strategies. This inadequate self-awareness seems was **a more profound limitation in post-intervention assessment** than it was during the baseline assessment.

Child 2's educator and therapists further reported that his difficulty to use metacognitive strategies severely impacted his ability to become more self-aware and to employ different emotion- focused coping strategies. This is supported by Contugo's (1995) study which found that children with ADHD have limited coping capacity as a result of impaired executive functioning which results in an avoidance of affect-laden stimuli, difficulties with self and interpersonal perceptions and problems with social reality perception. These reports are supported by Wicks- Nelson et. al. (2000) who state that impairments in executive functioning result in cognitive deficits which manifest behaviourally in difficulties such as the regulation of behaviour through the use of inner speech; working memory and control of emotions; problem-solving and effective communication- all of which are explicitly linked to self-control. Thus, findings support Steer's (2007) conceptualisation of ADHD being a disorder characterised by impaired executive functioning which sees children engaging in negative self and situational appraisals, impairing their motivation and perseverance and ultimately employing coping strategies which result in deficits in functional behaviour influencing his intrapersonal and interpersonal functioning (Bos, Schumm & Vaughn, 2003).

This category is supported by the following quotations regarding Child 2:

- *'...I don't think that he has the meta-cognitive abilities to actually conceptualise the self...' (Therapist 5, unit 9)*
- *'He just 'is' you know he is as opposed to doing 'it'.' (Therapist 5, unit 9)*
- *'There is no process of thinking of ways to cope with the stress...' (Therapist 4, unit 2)*
- *'... he lacks the metacognition process to process his own little world and then get the skills.' (Therapist 4, unit 9)*
- *'... he's not one of those kids that runs for therapy...he doesn't have that process of 'metacogniscising'.' (Therapist 5, unit 9)*
- *'... so there's a lack of metacognition... you know he was aware not to say the swear words...' (Therapist 5, unit 9)*
- *'He'll say 'oh, I'm good at this and he'll do it' (Educator 2, unit 8, 9)*

- *'I think he knows that there's something because he takes meds...'* (Therapist 4, unit 9, 13)
- *'...I'm not sure he does (self-concept awareness influence his coping)...cause he doesn't have that metacognitive- I wouldn't say skills- but... he hasn't had someone do a lot of reflection for him...'* (Therapist 5, unit 9)
- *'... he seems to be unaware or isolated from his own metacognitive or cognition...'* (Therapist 4, unit 9)
- *'...know if he's really got an idea of what ADHD is all about but also in a way he does because my sister's child is also like a very busy child and he sees to him 'I think you need Ritalin' so in a way I think that he does but not to the full extent at times... he said because he can't keep still ...'* (Parent 2, unit 10, 11, 13)

In contrast to Child 1's improved intrapersonal and interpersonal efficiency, Child 2's mother further reported that Child 2 harboured a negative self-image. She believed the negative self-concept to result from feelings of insecurity and a low self-esteem. She further reported that as a result of his poor self-image, Child 2 **negatively appraised situations** before actually engaging with them. This category is supported by the following quotations regarding Child 2:

- *'...it's a lot of insecurities and I would say low self-esteem...'* (Parent 2, unit 1)
- *(when asked if poor self-image influences ability to cope) 'I think it does... he hasn't done it and he's already seen the negative side of it or whatever...'* (Parent 2, unit 1,2)

CATEGORY: SELF-CONFIDENCE

Child 1's heightened level of self-concept awareness seemed to contribute to a **greater sense of self-confidence**. Child 1 found academic activities increasingly important. As an example he set goals for himself which he wanted to achieve. Child 1's mother stated that his self-confidence kept him motivated when working towards actualising his goals, and working through aligned obstacles. As a result of seemingly more positive self-appraisals, he apparently similarly **appraised situations more positively** (possibly believing that others similarly appraise him positively). This increased sense of self-confidence eliminated Child 1's concern in anticipating negative outcomes of meetings (such as parent feedbacks). This category is supported by the following quotations regarding Child 1:

- *'... he knows he's goals and he's not scared to fight for it anymore and his self-confidence has improved.'* (Parent 1, unit 8,9)
- *'... I think he has more self-confidence now than what he had...'* (Parent 1, unit 8)
- *'... this is who I am, you either like me or you don't like me...'* (Parent 1, unit 8, 9, 11).
- *'... he thinks he's brave, which he is. I mean, he's not shy...'* (Parent 1, unit 8,9,11)
- *'... I said to him that I was going to be seeing his mother now and he said that of course I will only say nice things about him...'* (Educator 1, unit 8)
- *'...when I talked about the feedbacks he said I hope I had only good things about him at home that that I only had good things to say about his work, him at school, his work and how he is behaving...'* (Educator 1, unit 8)
- *'... he wasn't worried about it (parent feedbacks)...'* (Educator 1, unit 8)
- *'...very much a take me as I am...'* (Therapist 3, unit 8,9,11)
- *'... he wants to do well in school.'* (Parent 1, unit 8,9)

SUBTHEME 4.2: SKILLS TO INTERACT WITH OTHERS

Positive interactions with others and **negative interactions with others** are categories which form part of the subtheme 'interactions with others':

CATEGORY: POSITIVE INTERACTION WITH OTHERS

The manner in which Child 1 interacted with and responded to others under stress was influenced by **greater intrapersonal efficiency**. As a result of greater self-awareness, a more positive self-image and greater self-confidence, three participants reported that (instead of aggressively responding to criticism) Child 1 responded by ignoring what was said, verbally responding, as well as articulating his view of a situation. This category is supported by the following quotations regarding Child 1:

- *'...He answers back if there is something that needs to be answered or he just ignores the whole thing saying that that's fine and that it doesn't matter...'* (Educator 1, unit 5,8)
- *'...they were all accusing each other of things and some of them were accusing him of teasing him... and he just said it's not true what you say and I can't identify myself with that and that's not how I meant what I was doing to come over kind of like that's your problem if that's how you view it...'* (Therapist 3, unit 5,9,10,12)

- *'... he does get very defensive if someone accuses him of things that he didn't do. He gets quite offended.'* (Therapist 1, unit 5,12)

CATEGORY: NEGATIVE INTERACTIONS WITH OTHERS

Two participants reported that Child 2 continued to be inappropriate and bold during socialisation with his friends. When outside his small circle of companions, it was reported that Child 2 still tended to withdraw. Therapist 5 stated that Child 2 continued to be overly involved in his own world. Seemingly this sustained withdrawal resulted in Child 2 continuing to experience difficulty in engaging with others. This category is supported by the following quotations regarding Child 2:

- *'he's very cheeky with his peers...'* (Therapist 5, unit 11)
- *'it was very inappropriate...'* (Educator 2, unit 11)
- *'I think that in a group situation he tends to mind his own business... when he's in a group of two and two then he interacts but it's usually if he has a partner with him.'* (Therapist 5, unit 8, 10, 11)
- *'... he doesn't really bear a grudge...'* (Therapist 5, unit 5,10,12)
- *'He's more in his own world although he's got friends.'* (Therapist 5, unit 11)
- *'... in his own little world...he's not in that relationship with the other.'* (Therapist 5, unit 9,11)

SUB-THEME 4.3: KNOWLEDGE OF THE IMPORTANCE OF GROWTH AND CHANGE

The **identification and expression of feelings** and **demonstrating ways of responding to others when under stress** are categories which form part of the subtheme 'knowledge of the importance of growth and change':

CATEGORY: IDENTIFICATION AND EXPRESSION OF FEELINGS

Parent 1 reported that as a result of her son's **increased self-awareness** and **self-confidence**, he demonstrated the ability to **identify and express his feelings to significant**

others. This theme is supported by the following quotations and visual data regarding Child 1:

- *'... but I said that then you must go and speak to Mr. xxx and tell him how you feel that you think it's not fair and that you have to do homework for everyone else...'*
(Parent 1, unit 3)



Figure 4.7¹³: Child 1 using a 'feelings chart' to identify and express the 'happy', 'sad' and 'angry' feelings in response to significant experiences.

CATEGORY: DEMONSTRATING EFFECTIVE WAYS OF RESPONDING TO OTHERS WHEN UNDER STRESS

Child 1 seemed to have **developed greater respect for the feelings and beliefs of others which he communicated through empathy.** This impacted on the way he responded to others when under stress, which was markedly different to the manner in which he responded pre-intervention, namely through the employment of aggression. Results further suggest that through a heightened self-concept awareness and greater intrapersonal efficiency, Child 1 increased his **external interpersonal behaviour skills** (a pre-existing strength). These interpersonal skills seemingly resulted in increased **social support from significant others**, namely his mother, educator and therapists (Bos, Schumm & Vaughn, 2003). Therapist 1 mentioned that Child 1's tolerance for criticism seemed to have increased

(he employed relaxation methods and positive re-appraisal of situations autonomously). However, Child 1 continued react aggressively if stress was ongoing. This category is supported by the following quotations:

- *'... he said 'it's ok mom, we understand these things, you were working... which is wow... whereas before, he would have had a rant and a rave and a 'it's not fair, you don't love me' kind of thing.'* (Parent 1, unit 10,11)
- *'... he said 'it's ok mom, we understand these things, you were working... he was able to think through 'ok mom is working, I can't bug her- although it was really something that he needed...'* (Parent 1, unit 10,11)
- *'...its ok mom, you don't have to waste your money...'* (Parent 1, unit 10,11)
- *'...He knows financially sometimes it's a struggle and like if I want to go and buy him a McDonald's, he'll say 'it's ok mom, you don't have to waste your money'... he knows when there's no money or whatever he knows.'* (Parent 1, unit 10,11)
- *'... we were discussing feelings and he discussed anger and he discussed the time when a child bad mouthed his mother and he said that sometimes it's not better to hurt people and that there are other ways other than hitting to get out your anger... he has learnt that that's not how to go about things.'* (Therapist 2, unit 5,9,11)
- *'... I find that he doesn't react as quickly in stressful situations... I get the impression that you need to push him further now a days to get that reaction from him'* (Therapist 1, unit 5,12)

THEME 5: ADAPTIVE EMOTION-FOCUSED COPING STRATEGIES (POST-INTERVENTION)

Four participants reported that Child 1 attempted to make use of adaptive emotion- focused coping strategies. No reports were made about Child 2 attempting to use adaptive emotion-focused coping strategies. This theme consists of two subthemes; **(5.1) use of relaxation methods in order to (5.2) examine the situation from another perspective**. The subthemes which make up this theme are now discussed.

SUBTHEMES: 5.1 USE OF RELAXATION METHODS IN ORDER TO 5.2 RE-EXAMINE A SITUATION FROM ANOTHER PERSPECTIVE

Child 1 was more able to **regulate his emotional reactions** to situations through the autonomous employment of relaxation methods. With greater emotional regulation, he identified and assertively expressed his emotions without apprehension (avoiding physically aggressive reactions). Post-intervention Child 1 had a well- developed understanding of the reciprocity between himself and his environment (i.e. when others tease him, his mother working night shifts). Results indicate that this interactional awareness facilitated his use of different, more effective, emotion- focused coping strategies. In this regard, he ignored others when they teased him (detaching from the situation for long enough to regulate his emotional reactions) and re-appraised a potentially stressful situation (i.e. acknowledging the demands of his mother's occupation and learning to accept it). The above mentioned findings are supported by Mischara's (2007) study which found that children have the capacity to become aware of the manner in which coping strategies are chosen by understanding the situation as well as personal resources and habits. Through increased self-concept awareness (when confronted with a potentially stressful situation) the child is better able to identify and rely on his inner resources to effectively problem-solve and confront the situation. He further stated that such empowerment formed the foundation of effective emotion-focused coping (Mischara, 2007).

This category is supported by the following quotations regarding Child 1:

- *'... what I did I just leave him to calm down he went back to fetch his chair, I didn't even tell him to stop, I kept quiet and carried on with whatever we were doing in class...'* (Educator 1, unit 2,4,5,12)
- *'...he said that you should rather sit down and calm yourself down and think about the situation first...'* (Therapist 2, unit 9,12)
- *'...I think if there's an opportunity to think about it, then he can regulate it.'* (Therapist 1, unit 2,3,4,5)
- *'...he just needs someone to calm him down...'* (Therapist 2, unit 2,4,5,12)
- *'... he's not afraid to tell people how he feels now...'* (Parent 1, unit 8,9)
- *'... he doesn't go for second best anymore...'* (Parent 1, unit 8,9,11)
- *'...we were discussing feelings and he discussed anger and he discussed the time when a child bad mouthed his mother...'* (Therapist 2, unit 5,9,11)

Child 1 demonstrated **the ability to employ relaxation methods** (which seemed to be a **precursor for re-appraising** potentially stressful situations) (refer to Figure 4.7). Three participants reported that Child 1 was able to examine situations from another perspective in order to create a more positive outlook. However, for the majority of the time, Child 1 needed

support from significant others to re-appraise situations. Based on the reports of Child 1's therapists and educator, much of Child 1's re-framing took place after conflict situations. This subtheme is supported by the following quotations and visual data regarding Child 1:

- *'... I said to him 'you know, don't get so upset because he doesn't know me, he doesn't know what goes on so it doesn't bug me so it shouldn't bug you...'* (Parent 1, unit 2, 5)
- *'...you know, I don't like my father, he put me very close to the geyser and it was too hot... What was he thinking? Does he think that I'm an animal? And there was another guy who said 'no, that area is very cold your father actually cares about you and it's not like temperatures in South Africa, it's very cold there and your father knows that you're going to be very cold if he puts you away from where the geyser room... then he said 'ok, I didn't know that'... your father actually cares about you because he knows that you are from South Africa and that you're going to feel to cold there on the other side'* (Educator 1, unit 1, 5, 12).
- *'... think about the situation first...'* (Therapist 2, unit 9,12)
- *'... I think that he's self-aware, he knows what it's about and how it influences him and that helps him to deal with it and put it into perspective.'* (Therapist 1, unit 9)

THEME 6: MALADAPTIVE EMOTION- FOCUSED COPING STRATEGIES WHICH REMAINED MALADAPTIVE (POST-INTERVENTION)

Table 4.25: Definition, subthemes, indicators, exclusions and exceptions related to the theme 'maladaptive emotion- focused coping strategies which remained maladaptive' (post-intervention)

Definition	Under some conditions, the experience and expression of emotion may bring negative consequences (Lopez, Shane, Snyder, 2002)
Subthemes	Direct- active physical aggression in response to stressful situations (physical aggression), indirect- active physical aggression in response to stressful situations (heightened physiological arousal) and passive- active physical

	aggression in response to stressful situations (withdrawal, internalising, projecting blame, avoidance, helplessness).
Indicators	All the instances from the raw data where participants made use of phrases such as ‘outbursts and totally loses it’, ‘throws things around’, ‘throws a wobbly’, ‘pulled off’, ‘goes to aggression’, ‘sometimes uses violence’, ‘I’ll beat you up’, ‘kicking’, ‘attack’, ‘climbed into’, ‘anger’, ‘aggression’, ‘eyes’, ‘face’, ‘tizz’, ‘flapping around’, ‘he starts crying’, ‘gets very emotional’, cries out of frustration’, irritable’, ‘totally overwhelmed’, ‘gets very upset’, justify his shortcomings’, ‘struggles’, ‘holding back’, ‘excuse’, ‘blames others’, ‘it’s because of...’, ‘see what my reactions are’, ‘anything that he is told he is’, oh, I’m so stupid’, ‘internalises it’, ‘someone says’, ‘bully’, ‘kicking’, ‘muscles are tense’, ‘gets emotional’, ‘sad’, ‘inhibit’, ‘withdraw’, ‘pulls back’, ‘takes the back seat’, ‘doesn’t venture’, ‘pray for the bell’, ‘step back’, ‘sit and see’, ‘inhibited’, ‘feedback from others’, ‘what they’re saying’, ‘they hear’, ‘the messages that they get’, ‘other people’s responses’, ‘avoid’, ‘shows indifference’, psychosomatic symptoms such as ‘head aches, tummy aches’, ‘excuses’ were considered to be descriptive of this theme.
Exclusions	Instances when the participants referred to ‘examines the situation from another perspective’, ‘social support’, ‘use of relaxation methods’, ‘asks for assistance’, gets the support’, ‘this is what I must do’, ‘no you’re not’, ‘no but’, ‘self-soothing’ and ‘acceptance’ were not considered part of this theme. It is noted that although there are similarities between them, they were broken up for the purpose of this study.
Exceptions	This refers to responses such as ‘hyper’, ‘without thinking’, ‘impulsive’, ‘restless’ which more than one of the participants indicated, but which do not fall directly within this theme.

Table 4.25 provides a definition of ‘maladaptive emotion-focused coping strategies which remained maladaptive’, the subthemes which made up this theme as well as the indicators and exclusions used during data analysis to determine the constituencies of this theme and exceptional responses to this theme. As was the case in the discussion of baseline results, **direct- active physical aggression** and **direct- passive physical aggression** are subthemes which forms part of ‘maladaptive emotion-focused coping strategies which remained maladaptive’ during post-intervention assessment. These subthemes are now explored in detail regarding Child 1:

SUBTHEME 6.1: DIRECT- ACTIVE PHYSICAL AGGRESSION

Physical aggression is a category which forms part of the subtheme ‘direct- active physical aggression’:

CATEGORY: PHYSICAL AGGRESSION

Child 1’s Therapist 3 reported that Child 1 **still responded defensively** to criticism which he may have experienced as unfounded and inaccurate. Two participants reported that Child 1 **still reacted to others with direct- active physical aggression** on occasion. In this regard,

Child 1's mother stated that his tendency to react assertively towards others with direct-active physical aggression may be attributed to Child 1's increased self-confidence. This category is supported by the following quotations regarding Child 1:

- *'...he still fights a lot he still gets very angry... I don't know if he knows how to handle that yet but he's better than when he used to cry just sit down and cry, but that's a lot better. I don't know if it's a good thing- he's moving from withdrawal to aggression.'* (Parent 1, unit 3,4,5,12)
- *'... I think because he has more self-confidence now than what he had- I suppose that that's where the aggression is coming from now because he feels good about himself and he thinks that nobody can stop him...'* (Parent 1, unit 3,4,5,12)
- *'...I think the aggression is just- he can't control it...'*(Parent 1, unit 1,2,3,4,5)
- *'... he was very angry, very very angry... he pushed the buttons...'* (Therapist 1, unit 4,5,12)
- *'... he was provoked really badly so he (educator) allowed for him to carry on, obviously not to hurt anyone, but he must go through his emotions and then he settled after that...'* (Parent 1, unit 2,4,5)
 - *'... I think he was trying to protect me, because it was all about me...'* (Parent 1, unit 4,5)
- *'...if people persist with it, he gets angry then he really loses it...'* (Therapist 1, unit 3,5,12)
- *'... if you push him and there's no reason, then he's going to snap.'* (Therapist 1, unit 4,5,12)

SUBTHEME 6.2: DIRECT- PASSIVE AGGRESSION

Projecting blame is a category which forms part of the subtheme 'direct- passive physical aggression':

CATEGORY: PROJECTING BLAME, WITHDRAWAL, AVOIDANCE AND INTERNALISING

Two participants referred to instances in which Child 1 **still projected blame**. Projecting blame was noted primarily within the therapeutic environment. Both participants reported that Child 1 was acutely aware of the influence of his ADHD symptoms on his behaviour, often

using this awareness as a means to justify his behaviour (thus possibly avoiding reprimand). This category is supported by the following quotations regarding Child 1:

- *'... on a Monday morning, he will say that his Ritalin isn't working yet...'* (Therapist 3, unit 7,13)
- *'I'm ADHD wait till it (medication) starts to work and then I'll be better...'* (Therapist 3, unit 7,13)
- *'He'll come into your class after second break and he's laughing and giggling and he'll say 'it's because of my ADHD ma'am'...'* (Therapist 2, unit 7,13)

With the exception of **indirect- passive verbal aggression**, Child 2 maintained his coping repertoire, namely dominant emotion-focused coping strategies (**direct- passive physical and indirect- passive verbal aggression**).

The coping strategies employed by Child 2 continued to **distance him from his support structures**. In this regard, his mother reported feelings of frustration at his persistent challenging and **avoidance**, whereas his educator ignored him when he **refused to work**. This finding is supported by Rutherford (2007) who postulates that significant others do not have an accurate understanding of the cause and consequences of the behaviour exhibited by children with ADHD, resulting in judgement and subsequent punishment through exclusion. The thoughts and feelings related to exclusion are internalised by the child with ADHD, leaving him believing that despite his greatest efforts, he can do little right (Rutherford, 2007). Iwasaki (2007) supports Rutherford's (2007) assertion that through exclusion from formal and informal social situations, the child seems to have a limited network of leisure-related friends, which provides him with little opportunity to experience, and be empowered by, the social and esteem support provided by such a network. Thus, he does not have the opportunity to gain esteem or social support thus perpetuating feelings of isolation. Such negative interpersonal outcomes seem to re-inforce a negative self-concept, limited efficacy and a limited coping repertoire making school a place of little pleasure; negatively influencing performance and achievement therein (Wicks-Nelson et al. 2000).

Child 2 continued to **internalise, withdraw** and **avoid**. Child 2 remained sensitive to the opinions and feedback of others, continuing to internalise the appraisals of others and isolating himself from others. This theme is supported by the following quotations regarding Child 2:

- *'... with the school stuff there's also the kind of thing like 'what did the teacher say? Am I good am I not good...'* (Parent 2, unit 5, 11)

- *'...like the other day when I said to him 'you're just becoming impossible' he wrote a note and said I think that I should move out of the house and I said why do you want to move out of the house and he said that it's 'because you said that I was impossible'...' (Parent 2, unit 1,5)*
- *'... he'll say that it's because 'you don't love me anymore' and I say that 'it's not because I don't love you, it's because you're doing things wrong' (Parent 2, unit 1,5)*

When child 2 felt unable to successfully engage with a task or when part of a larger group, he still attempted to **avoid** possible negative outcomes by **withdrawing** from situations. This **avoidance** and **withdrawal** manifested behaviourally in him refusing to speak/ respond, fidgeting or physically withdrawing from the stressful situation. This category is supported by the following quotations regarding Child 2:

- *'...when he can't do anything, he'll draw back and sit there and not say anything...' (Educator 2, unit 1,2,9)*
- *'...on his own, he tends to mind his own business.' (Therapist 5, unit 1,11)*
- *'... sounds like he withdraws...' (Therapist 4, unit 2)*
- *'... there would be nothing to protect him emotionally but instead of finding a coping strategy that could help him in that situation, he just withdraws...' (Therapist 4, unit 2, 9)*
- *'...he just pulls back.' (Parent 2, unit 1,2)*
- *'... when he gets reprimanded...goes to his room and either plays on his own or talks...' (Parent 2, unit 2, 5)*
- *'So as opposed to handling it, he would rather move away from it...' (Parent 2, unit 2)*
- *'...with me he sulks... he knew that he couldn't do it and that it was a lot of work and then he chose to do nothing about it and just lie on his arms and sulk.' (Educator 2, unit 2,3,9)*
- *'...he's falling asleep in class too now... we don't know if it's the medication or if it's stress.' (Therapist 5, unit 2, 9)*
- *'... he avoids the writing... in my therapy, sometimes he avoids the writing... he just doesn't get started' (Therapist 5, unit 2)*
- *'... he's been hiding his meds...' (Therapist 5, unit 1)*
- *'... there's the sulking about what has just happened but not about what happened yesterday...' (Therapist 5, unit 2,3,11)*
- *'...when a situation would be um challenging tasks like a little bit overwhelming he sulks...' (Educator 2, unit 2,3)*

- *'... also complex verbal instructions...he doesn't process them accurately... (how deal with that) delay tactics...sometimes he plays with the things around him and with his hands and stuff.'* (Therapist 5, unit 2,3)
- *'... if he knows that he's done something wrong and he gets a reprimand, then he sulks...'* (Parent 2, unit 2,5)
- *'... he just can't handle it because like I said he just shuts down completely or he'll just decide to have a nap or he'll decide to watch TV you know that sort of like soothing and his way of coping with things...'* (Parent 2, unit 1,2)
- *'... then we'll go are you sulking again and is there something wrong and he'll say no but he's definitely sulking...'* (Parent 2, unit 2,3,5)

Child 2 remained **reliant on maternal support** in being able to deal with stressful situations that he was unable to avoid or withdraw from. This supported by the following quotations:

- *'... if he's in a strange environment then that is stressful for him. He'll want to come lay on you or he'll want attention or something...'* (Parent 2, unit 2)

4.3.2.2. A Comparative Discussion of the results that emerged: Post-intervention

Post-intervention findings indicated that **Child 1 continued to use physical aggression** in response to actions and deeds of others. However, the latter coping strategy was reportedly used less often (and often used as a last resort to dealing with feelings of frustration and anger). It was not reported that the **Child 2** continued to use physical aggression. This may be due to him discontinuing his medication. He subsequently **relied more on passive-aggressive coping strategies**. Child 1's use of passive-aggressive strategies apparently decreased dramatically. Both children used relaxation methods in order to regulate their emotions, however Child 2 to a lesser degree than before. Furthermore, Child 2 continued to make use of external support structures to communicate and work through stressful situations. Child 1 demonstrated greater levels of self-awareness. In this regard, he was able to identify and express feelings associated with significant events (with both positive and negative attributes). His better developed ability to assertively express his feelings seemed to have contributed to a greater sense of self-confidence, which saw him setting goals for himself and putting in plans to achieve them. The heightened level of intrapersonal awareness in Child 1 seemingly permeated into the interpersonal realm as he seemed aware of others emotional states.

Child 2 seemed **less able to communicate** and work through stressful experiences with social support. In addition, Child 2 seemed **more withdrawn**. Avoidance became a more

prominent coping strategy. Child 2's coping strategies could possibly be a result of discontinuing medication.

4.4. Conclusion

This chapter provided a detailed discussion of the self-concept awareness and emotion-focused coping themes which emerged through thematic analysis of the data collected during the study. The themes as well as subthemes and exceptions were presented and discussed during both pre- and post- intervention. In addition to this, there was a discussion about the relationship between the children's self-concept awareness and emotion-focused coping strategies employed both pre- and post- intervention. I will engage in a literature control in the following chapter, as well as conclusions of the study and recommendations.

Chapter 5

Conclusions and recommendations

5.1 Introduction

In this chapter, I draw my study to a conclusion. I attempt to answer my research question, after which i will conclude my study. Finally, I discuss the imitations and contributions of the study with the chapter closing with recommendations for further research.

5.2 Discussion of findings

Findings of the study indicated that Child 1's self-concept awareness had increased, with this awareness being transferred into a number of other settings despite his impaired executive functioning. Child 1's increased self-concept awareness led to amplified use of adaptive emotion-focused coping strategies (namely the use of relaxation methods and the re-appraisal of situations). However, findings also indicated that maladaptive emotion-focused coping strategies (namely direct-active physical aggression and direct-passive aggression) remained.

In the case of Child 2 (who did not receive the intervention), no mention was made of him employing adaptive emotion-focused coping strategies. He continued to employ maladaptive emotion-focused coping strategies (namely direct-passive physical aggression and indirect-passive verbal aggression).

5.3 Addressing the research questions:

5.3.1. What is the association between self-concept awareness and emotion-focused coping of children diagnosed with ADHD?

The findings of the study indicate that increased self-concept awareness positively impacts on emotion-focused coping of the child participant with ADHD. Through the intervention, Child 1 became more acutely aware of his strengths, assets, resources and limitations which seemingly allowed him to arrive at a greater understanding of the manner in which he influences and responds to his environment and visa versa. Greater self-concept awareness also gave him insight into what motivated his behaviour and his response to situations. As his self-concept awareness increased, so too did his ability to employ cognitive and emotional regulation. This was a key factor in him decreasing the use of maladaptive coping strategies (such as strategies reliant on direct-active and direct-passive aggression). This improved cognitive and emotional regulation positively impacted on and re-structured the child's behaviour. Increased self-concept awareness seemed to have contributed to increased employment of adaptive emotion-focused coping strategies (relaxation methods and the positive re-appraisals of events). In turn, increased adaptive emotion-focused coping strategies resulted in stronger relationships with significant others. These relationships with others were characterised by support, strength and positive regard, re-enforcing feelings of optimism and control, and ultimately on the child's emotion-focused coping strategies employed. Thus, the findings of this exploratory study confirm that a relationship exists between self-concept awareness and emotion-focused coping in a child with ADHD. Findings of the study also suggest the possibility that greater a child's self-concept

awareness, the more able he could be to employ more effective and adaptive emotion-focused coping strategies.

5.3.2. Sub-questions

- ***To what extent were the children with ADHD's self-concept awareness impacted on (or not) by the intervention?***

Findings suggest that the intervention facilitated a more proactive involvement by Child 1 in the identification, management and regulation of his thoughts, feelings and behaviour, giving him a sense of control. The intervention explored and challenged pre-existing cognitive appraisals of the self and of situations, which ultimately resulted in a heightened awareness of the manner in which the self-concept is formed and how it influences his functioning. Greater self-concept awareness seemed to be one way in which Child 1 came to a greater understanding of the manner in which his cognitive appraisals inform his self-concept and the extent to which his self-concept influences his behaviour both positively and negatively (Ginorio, Yee, Banks and Todd-Bazemore, 2007). This resulted in greater intrapersonal and interpersonal efficacy resulting in a growth in confidence, a sense of control and more of a willingness to readily assume responsibility, despite demonstrating externalising behaviour on occasion (Ebersöhn, 2006).

- ***How were the children with ADHD's emotion-focused coping strategies impacted on (or not) after the intervention?***

Findings of the study confirmed that the two participants (children with ADHD) were predisposed towards emotion-focused coping and were more inclined to employ emotion-focused coping maladaptively (keeping cognisant of the fact that emotion-focused coping may be deemed adaptive as well as maladaptive). However, it is maladaptive emotion-focused coping which theoretically leads to negative feedback from significant others, possibly resulting in negative self-appraisals and a negative self-concept formation. The intervention developed Child 1's ability to engage in emotional, cognitive and behavioural regulation - all of which are prerequisites for effective emotion-focused coping and adaptation. Through heightened self-concept awareness, Child 1 was better able to employ more adaptive emotion-focused strategies such as the employment of relaxation methods, the positive re-appraisal of situations and the seeking of social support. Due to the employment of more adaptive emotion-focused coping strategies, Child 1 fostered increased social support and subsequent positive feedback through the relationships that developed, thus resulting in more effective emotion-focused coping.

- ***To what extent were children diagnosed with ADHD able to transfer the self-awareness skills and knowledge acquired from the intervention into their everyday interactions within the school and home?***

An aim of the intervention was to allow the child with ADHD to internalise the intrapersonal skills learnt and to apply them in a real life situation in order to confront and adapt to stressors using effective emotion-focused coping. Findings of the study indicate that Child 1 was able to transfer the skills learnt from the intervention sessions into his everyday interactions within the home and school environment, positively impacting on the manner in which he approached situations and responded to others when under stress. Child 1's mother described the change in her child's emotion-focused coping strategies as a maturation, in that he was more acutely aware of his goals, strengths and limitations and persevered to actualising them. This report was supported by Child 1's educator and therapists. It was also noted that he explicitly shared accounts of his heightened self-concept awareness and more adaptive emotion- focused coping strategies within the therapeutic environment.

5.4. Conclusions of the study

The study confirmed that children with ADHD (in this study) cope with stressful situations- almost exclusively- by employing both positive and negative emotion- focused coping strategies. **Maladaptive** emotion- focused coping strategies employed by both participants at several intervals were characterised by direct and indirect acts of aggression. **Adaptive** emotion- focused coping strategies employed by both participants at various intervals included the seeking of social support to communicate and work through stressful situations, the employment of relaxation methods and re-framing stressful situations. During pre-intervention assessment, both children were only able to employ adaptive emotion- focused coping strategies with the support of significant others. During post-intervention assessment, Child 1 was more able to self-employ these emotion- focused coping strategies which seemingly impacted positively on his feelings of personal control as well as on his interpersonal relationships.

Findings of the study support the assumption that social support networks act as stress buffers as they provided the boys with ADHD with affirmation and a sense of belonging. Pre-intervention, both child participants experienced problematic interpersonal interactions, the outcome of which was them struggling to meaningfully bond with friends and maintain friendships, resulting in them presenting with a low self-esteem and limited efficacy. This saw the children form part of a limited social support network, particularly within the school environment. Forming part of a limited support network possibly reinforced their belief that

they did not have the inner resources to cope with demanding situations thus evaluating them as stressful (and employing ineffective coping strategies). The results of the study also indicate that if children with ADHD perceive situations to be out of their control, they seemingly employ avoidant, emotion-focused coping strategies. These appraisals apparently result in learned helplessness, avoidance, internalising, externalising and withdrawal (probably reinforcing their negative self-concept and sense of self-efficacy). However, the intervention seemed apt in mediating a process of encouraging reflexivity, confirming Ebersöhn's (2006) claims that changes in self-concept due to greater cognitive awareness and regulation results in changed situational appraisals and coping behaviour.

With greater intrapersonal awareness, Child 1 demonstrated a more realistic and accurate understanding of his strengths, limitations and behaviours. This insight formed the foundation for more effective interpersonal functioning which was demonstrated by him responding more constructively to criticism; and more empathetically to the feelings and actions of others. This behaviour possibly impacted positively on his self-concept and emotion-focused coping which were also reinforced by stronger relationships with others (characterised by support, strength and positive regard). These findings confirm the assumption that if a child with ADHD is able to come to a greater level of personal competence (accurate self-assessment and self-regulation) through increased self-concept awareness, he seems more able to "catch himself" making inaccurate self-appraisals which negatively influence his choice of coping strategies, and relationships.

When compared to existing literature on ADHD, self-concept awareness and emotion-focused coping, it is clear that because of an inability to inhibit responses and impaired executive functioning, children with ADHD are likely to have limited self-concept awareness. This limited self-awareness results in inaccurate self and situational appraisals and, consequently, in the use of maladaptive emotion- focused coping strategies (which result in deficits in functional behaviour influencing intrapersonal and interpersonal relationships). However, results of the study indicate the possibility that children with ADHD's self-concept awareness and emotion- focused coping can be positively impacted by an intervention that focuses emotional, cognitive and behavioural regulation. *This finding challenges assumptions* that impaired executive functioning (synonymous with ADHD) will *always* result in deficits in functional, adaptive behaviour regardless of intervention, pharmaceutical or therapeutic.

Thus, it seems as though a link exists between increased self-concept awareness and positive changes in adaptive emotion- focused coping. The possibility exists that children

with ADHD may prefer to use relaxation methods and re-appraisals of situations as adaptive emotion- focused coping strategies. Also, it seems as though children with ADHD are more emotion- focused in coping with maladaptive emotion-focused coping remaining persistent (even if self-concept awareness increases). These maladaptive emotion-focused coping strategies may be maintained because of habitual patterns of coping being stronger and more established than those that are newly acquired. So, although new adaptive emotion-focused coping strategies are acquired, existing maladaptive emotion- focused coping remains 'unlearnt'. The findings and conclusions drawn are all hypotheses as this was an exploratory study. These hypotheses could be explored in further investigations.

5.5. Limitations of the study

The study focused on a specific group of participants, namely two male children with ADHD being educated within a remedial school environment, and their respective mothers, educators and therapists. The results therefore are gender specific. They do reflect the responses of male children and their mothers, educators and therapists about the manner in which self-concept awareness and emotion- focused coping reveals itself within this specific context. The possibility exists that the responses received from participants about the self-concept awareness and emotion- focused coping strategies of female children with ADHD and children with ADHD (inattentive type) may be different. However, as this exploratory study was qualitative from an interpretivist paradigm, the primary aim of the study was to capture and reveal the voices of the participants, relating their perceptions about the child's self-concept awareness and emotion- focused coping.

Furthermore, the Draw-A-Person (D-A-P), Kinetic-Family Drawing (K-F-D), Brink's Incomplete Sentences and the 'How is your self-concept inventory' seemed inappropriate to assess the self-concept awareness and emotion- focused coping of the child participants in this study. Thus, I recommended that future research focus on the qualitative assessment of the child participants' self-concept awareness and emotion-focused coping possibly by means of participant and non-participant observation (refer to 5.7.3).

5.6. Contributions of the study

Findings contribute to the following **knowledge bases**; children with ADHD's coping, emotion- focused coping theory and self- concept awareness theory. Findings of the study confirm that children with ADHD cope with stressful situations predominantly by employing emotion- focused coping strategies, which seems to remain unchanged regardless of intervention. This is significant when working with children with ADHD within the home and school environment. As most literature places emphasis on the negative adjustment and

coping strategies of children with ADHD, my study contributes to existing literature on emotion- focused coping strategies and how the use of these strategies can be adaptive as well as maladaptive, particularly in children with ADHD. Furthermore, my study could contribute to and extend on existing literature on therapeutic interventions designed to facilitate coping in children with ADHD, with particular emphasis on the facilitation of coping from a positive psychology, asset based approach. *The findings of my study challenge assumptions* that impaired executive functioning (synonymous with ADHD) will *always* result in deficits in functional, adaptive behaviour regardless of intervention, pharmaceutical or therapeutic.

In addition, my study not only identified the children's level of self-concept awareness and the emotion-focused coping strategies employed, but explored each of the constructs in detail. Each of the constructs were explored to come to a greater understanding of the different contexts in which emotion- focused coping strategies were employed and how this was related to Child 1's appraisals of self and the situation, which ultimately influenced his cognitive and emotional regulation. Thus, I theorise that limited self-concept awareness (manifesting in a lack of knowledge and insight into the self-concept which results in negative interactions with others and a lack of personal change and growth) result in maladaptive emotion- focused coping strategies (acts of aggression). However, increased self-concept awareness (manifesting in a more thorough understanding of one's strengths, assets, resources and limitations resulting in more positive interactions with others and personal growth and change) results in the employment of more adaptive emotion- focused coping strategies (seeking social support in order to communicate and work through stressful experiences, re-appraising stressful situations and the employment of relaxation methods). As previously discussed, it appears that having insight into the child with ADHD's self-concept awareness and emotion-focused coping strategies could inform the practices of his/her educators, therapists and parents.

In terms of **practitioner** contributions, my study placed emphasis on the perspectives and inputs of a number of stakeholders, each playing a fundamental role in scaffolding the development of self-concept awareness and emotion- focused coping. Other than contributing to theoretical findings, my study could inform the practices of professionals, educators and parents in both remedial and mainstream schooling environments who are searching for alternative interventions to make use of with the aim of equipping learners with ADHD with adaptive emotion-focused skills within the classroom and school setting.

5.7. Recommendations

5.7.1. Recommendations for practice:

Based on the previous discussion, it is obvious that professionals working with children with ADHD (including parents) could benefit from an understanding of a child's current level of self-concept awareness and the emotion- focused coping strategies s/he employs within various settings. Such insight may be especially important should one choose to make adaptations to a coping- intervention to more acutely meet the needs of a child. By understanding a child's current level of self-concept awareness and emotion- focused coping strategies s/he employs, parents and professionals may be able to scaffold greater self-concept awareness and adaptive emotion- focused coping within children with ADHD.

Furthermore, it is important to remain aware of the manner in which emotion- focused coping strategies are developed and maintained within a family, school and peer system. One needs to have an acute understanding of the demands made on a child within various settings and how these may impact on his/her self and situational appraisals, as well as the emotion- focused coping strategies that s/he chooses to employ. Such perspective could enable one to establish if emotion-focused coping strategies are adaptive for the individual child within a situation, or leads to maladaptive coping. Such an intervention process requires close and regular collaboration and communication between parents, educators and therapists.

5.7.2. Recommendations for Training

It could be beneficial for training programmes in the field of education and educational psychology to include facets on emotion-focused coping strategies employed by children with ADHD, and how these are impacted on by their self-concept awareness. Such knowledge could equip those working with children with ADHD within the class and therapeutic environment. Understanding why children with ADHD employ the coping strategies that they do and how to support and scaffold the maintenance of existing adaptive emotion-focused coping strategies and the acquisition of new, more adaptive emotion- coping strategies seems a valuable training tool. In addition, knowledge in this regard could equip professionals in communicating insights to parents to understand a child's intrapersonal functioning, and how to support the process of greater self-concept awareness and emotion- focused coping.

5.7.3. Recommendations for Future Research

The findings of my study denote emerged hypotheses deeming future research. I recommend the following investigations:

- Further research is needed to determine the association between self-concept awareness and emotion- focused in children with ADHD (inattentive type).
- Further research is needed to determine the association between self-concept awareness and emotion- focused coping in girls with ADHD (hyperactive- impulsive type) which would determine if the same emotion- focused coping strategies are employed by both genders and types of ADHD.
- A comparative study employing different types of interventions to ascertain their impact on children with ADHD's self-concept awareness and emotion-focused coping.
- Further research is needed to determine the association between self-concept awareness and emotion- focused coping strategies using a larger, more diverse sample size.
- I recommend that researchers assess children with ADHD's self-concept awareness and emotion-focused coping strategies qualitatively (possibly by means of participant and non-participant observation) to either support or refute themes which emerge from other data sources as opposed to using instruments for this purpose.

5.8. Concluding Remarks

Children with ADHD are more inclined to employ emotion-focused coping strategies when responding to stressful situations, with maladaptive emotion-focused coping which leading to negative feedback from significant others, ultimately influencing one's appraisals of self and situations resulting in a negative self-concept. However, few children with ADHD are aware of their self-concepts, probably as a result of much of the literature depicting their impaired executive functioning as being fixed and impenetrable, ultimately influencing the interventions that are chosen to assist children with ADHD cope with stressful situations. Through the use of an intervention research design, this study explored the role of an intervention in facilitating this self-concept awareness in order to ascertain the association between self-concept awareness and emotion- focused coping with results indicating that there was indeed an association between self-concept awareness and emotion- focused, with increased self-concept awareness resulting in the employment of more adaptive emotion- focused coping strategies. Those who work with children with ADHD and their families should have an acute understanding of the self-concept awareness and emotion-focused coping strategies of the child with ADHD and determine the relationship between the two in order to more closely facilitate the development of both constructs with the aim of empowering children with ADHD to self-advocate through increased self-awareness and the employment of more adaptive emotion- focused coping strategies in response to stressful situations.



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