



# REVIEW OF RESEARCH

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## A STUDY OF SELF-PERCEPTION AND BEHAVIOURAL ADJUSTMENT AMONG CHILDREN WITH ADHD

**Vinod Kumar**

**Research Scholar, Dept. of Psychology, Opjs University, Churu (Rajasthan).**

### ABSTRACT

*As a child grows and develops, he learns not only about the world around him and his place in it, but about himself. Such learning is important for both personal happiness and public behaviour. The psychological construct, 'self-perception' or 'self-concept', connotes this area of essentially private experience and self-evaluation - essentially private even though it is in part translated into action by most of the things we say and do, by the attitudes we hold, and by the beliefs we express. Sullivan (1953) considers the self-concept or self-dynamism central to human personality. The self-concept may be thought of as a set of expectations and evaluations of the areas or behaviours with reference to which these expectancies are held. Thus it is considered to be learned. It gradually emerges in the early months of life and shaped and reshaped through repeated perceived experiences particularly with significant others. Individuals perceive different aspects of themselves at different times with varying degrees of clarity.*



**KEYWORDS:** *Self-Perception, Behavioural Adjustment, Children, ADHD, Child Grows, Psychological Construct, Human Personality.*

### INTRODUCTION :

In Reflection on self-concept is helpful to provide insight into one's own behavior of others. It is also a valuable tool in counseling. Any experience which is inconsistent with one's self-concept may be perceived as a threat. The more of these experiences there are, the more rigidly self-concept is organized to maintain and protect itself. When a person is unable to get ride of perceived inconsistencies, emotional problems arise. Faulty thinking patterns, such as dichotomous reasoning (dividing everything in terms of opposites or extremes) or over generalising (making conclusions based on little information) create negative interpretation of one's self. Children with HDAD cannot help being hyperactive and disruptive, but teachers trying to cope with a disruptive child may attempt to manage the situation by excluding them from the classroom. Being excluded from group activities is common for children with HDAD. HDAD children may get excluded from birthday parties and social events which are a natural part of growing up, as other parents may not want to invite a child with a reputation for bad behaviour. Exclusion only adds to negative feelings in children and young people reinforcing the idea that they are 'naughty' and unwelcome. Poor peer relations among the HDAD children furtherhampers the formation of a healthy positive self-concept, which eventually leads to poor adjustment.

### REVIEW OF LITERATURE

Hoza(2012) conducted an experiment involving 178 children with HDAD and 86 healthy children, ranging in age from 7 to 12 years. She evaluated the children using the Self-Perception Profile

for Children (SPPC) before and after they were offered monetary incentives to match their teachers' assessments of their academic, social, and behavioural competence. Prior to the incentive, the HDAD children reported competence levels that were positively skewed compared to those of their teachers. However, after the monetary incentives, the children reduced their competence ratings in both academic and behavioural domains. But there were no decreases in how the children perceived their level of social competence, regardless of incentive.

Cook, Knight, Hume and Qureshi (2014) reviewed previous research about the relationship between self-esteem and HDAD in adulthood with a view to outlining needs and potential opportunities in terms of service provision. Despite a limited number of studies and methodological concerns, there is evidence to suggest that HDAD is associated with lower self-esteem in adulthood and that self-esteem difficulties can be remedied, to at least some extent, by psychotherapy. They recommended that future research should focus on the evaluation of therapy that specifically targets difficulties in self-esteem in this population.

Barkley, Anastopoulous, Guevremont, Fletcher (1991) compared adolescents with Hyperactivity Disorder and Attention Dificit (HDAD) with a control group on a comprehensive assessment battery. More HDAD teenagers had Oppositional Defiant Disorder (ODD, 68%) and Conduct Disorder (CD, 39%) and were rated as more impaired in social competence, behavioural and emotional adjustment, and school performance by parents and teachers than control teens. The HDAD youths, however, rated themselves as better adjusted than did their parents and teachers, differing only from controls in depressive symptoms and antisocial acts. Poorer performances in verbal learning and vigilance and greater HDAD behaviours during a math task also distinguished the HDAD from control teenagers.

Paterson and Sanson (1999) in their study on 5 to 6 year old children, attempted to identify specific temperament, parenting, and family variables, and their interactions, which predict problem behaviours and social skills in children. Results showed different combinations of variables predicted each behavioural outcome, and the child's 'goodness of fit' in the home was a strong predictor of externalising behaviour and social skills. An interaction between temperamental inflexibility and punitive parenting in the development of parent-rated externalising behaviour problems was found. This study highlights the value of using specific indices of temperament, parenting and family functioning and of pursuing interaction effects in the prediction of children's behavioural development.

Klassen et al (2004) surveyed 131 children with HDAD and their families using a standardized questionnaire designed to measure overall quality of life. They compared the responses with those of children without HDAD. While the two groups were similar in terms of physical health, the HDAD children had more emotional and mental health issues, including low self-esteem. The more HDAD symptoms a child exhibited, the lower the quality-of-life score was likely to be. Symptom severity also predicted the likelihood of family stress. Parents of children with the most HDAD symptoms were most likely to report that their child's problems caused them emotional worry and limited the time they had to meet their own needs.

Wilson (2008) investigated whether children with HDAD present with differences in terms of Trait Emotional Intelligence (TEI) profile and Theory of Mind (TOM) ability when compared with their peers. They found no significant difference between the two groups in overall Theory of Mind performance. There was no significant difference in overall TEI-Questionnaire score, but significant differences were found on two individual factors which are Emotional Regulation and Peer Relations. Moderate effect sizes were found in global TEI and 5 of the remaining facets.

Cooper (2008) emphasises the importance of developing Emotional literacy, relaxation, and anger management in HDAD children. Training in relaxation makes the HDAD children more expressive and lower their frustration and emotional or physical outbursts.

Sjöwall, Roth, Lindqvist and Thorell (2013) investigated whether deficits in emotional functioning constitute a dissociable component of HDAD. The study included 102 children with HDAD, 7–13 years of age and a control sample individually matched with regard to age and gender. The administered tasks were designed to tap into three different neuropsychological domains: executive functions (i.e., working memory, inhibition, and shifting), delay aversion, and reaction time variability. Parent ratings of emotion regulation and a test of emotion recognition were also included. Results

showed that children with HDAD differed significantly from controls on all measures, except for delay aversion and recognition of disgust.

Kyrios and Prior (1990) suggested that temperament characteristics exhibit the most predictive relationships with measures of early childhood behavioural adjustment. In their study, the pre-schooler's temperament, word knowledge, stress, health problems, developmental status, his/her environment (such as, parents' child-rearing practices, psychological functioning, and employment and social status) were assessed to determine the most predictive factors for behavioral adjustment at three to four years of age. The path analysis showed that temperament characteristics were most strongly related to children's overall behavioral adjustment and could protect children from the effects of maladjustment in the parental subsystem. They concluded that individual characteristic can influence one's reactions to a negative environmental context. Also, the environment exerts an influence on the manifestation of those individual characteristics. For instance, a highly reactive temperament can intensify the influence of a stressful environment on children's behavioural adjustment. The negative environmental influences may change one's temperamental profile by making a child more reactive or less self-regulatory.

### SELF-CONCEPT AND PERSONAL ADJUSTMENT

Self-concept influences and is revealed by most of a person's behaviour. Persons with good self-concepts are judged to be generally better adjusted, are more effective in groups, are less anxious and are more honest with them and less defensive. The child's self-esteem is shaped by how he or she thinks, what he or she expects of himself, herself and how other people (family, friends, teachers) think and feel about them. Children with HDAD show poor self-perception. They are constantly being corrected by their parents, teachers and other caregivers. This affects how they perceive themselves. Many children with HDAD have problems in school, with teachers and friends and have difficulties at home as well. They find it difficult to make and keep friends. People often don't understand their behaviour and judge them because of it. They are punished for their disruptive behaviour, and children with HDAD often feel bad about themselves. They might think they're mischievous, naughty, bad or a failure. Therefore their self-esteem is affected and they find it hard to think anything positive or good about them. Children with HDAD often struggle socially and academically. According to teacher reports, their behaviour and performance in the classroom falls well below that of their peers. However, when children with HDAD are asked to rate their behaviour or academic and social performance, they often inflate the results. Research shows that these children have an inflated view of themselves when compared to the children with Non HDAD. Several research studies demonstrate that HDAD children have distorted self-perceptions that exceed those of teachers and parents. This could be one reason why children with HDAD do not respond well to treatment that aims to change their behaviours. If these children truly see themselves as achieving or exceeding teachers' expectations, then for them, there is no need to alter their actual failing academic or behaviour patterns. However, some existing research has suggested that offering incentives to children might motivate them to make changes, in spite of their bias. There is a need to make these children have a realistic view about them which will help them to make better adjustment in the school situation and at home.

### EMOTIONAL LITERACY

Emotions play a very important role in our lives. They affect our personal and social adjustments. Adjustment is important for personal satisfaction and it improves one's quality of life. It helps in reaching one's goals in life. It is the process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfaction of these needs. Adjustment refers to the ability of an individual to fit into his environment. In recent years, there has been an increased interest in the role of emotional intelligence in both, academic success of students and their adjustment in school. Emotional intelligence is the driving force behind the factors that affect personal success and everyday interactions with others. Emotional literacy is generally defined as the ability of people to recognise, understand, handle and appropriately express their own emotions and to recognise, understand and respond appropriately to the expressed emotions of others. The phrase

'emotional literacy', was first used by Steiner (1997). There are a number of phrases which, to a greater or lesser extent, tap into the general concept, such as 'social intelligence', 'interpersonal and intrapersonal intelligence' and 'emotional intelligence'. The term, 'emotional literacy', is adopted, not only to avoid the negative associations of the word 'intelligence', but also because some aspects of emotional literacy relate to the concept of literacy as we normally use the word. For example, in reading we have to be able to decode the letters and words on the page, using a variety of strategies, in order to read them and extract meaning. Similarly, the first task of an emotionally literate person is to be able to read or decode signs and symbols physiological signs within ourselves and also facial expressions, other non-verbal aspects of communication and the general ethos of interpersonal situations.

In 1990, John Mayer and Peter Salovey coined the phrase "Emotional Intelligence." They used this phrase to describe the ability to perceive, assess and manage feelings in us and others as well as using these feelings in decision making. Daniel Goleman, describes EI as "the capacity for recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and others." Emotional intelligence may be related to HDAD in that it is related to emotional maturity. In general, children with HDAD mature emotionally more slowly than NonHDAD children of the same age, because their frontal lobes develop more slowly due to the effects of HDAD (Barkley, 2000). One way to overcome this, then, may be to work to improve their EI skills.

### Basic components of Emotional literacy

- **Self-Awareness** -This refers to the ability to recognise and understand our own emotions, preferences, strengths and weaknesses. This first component is the foundation on which the rest of emotional literacy depends. This refers to the child's ability to pinpoint his/her emotional strengths and weaknesses and make good decisions in certain situations.
- **Self-regulation** -This is the ability to balance our emotions, as well as use our emotions to set goals, create plans and motivate ourselves to achieve our goals. It is the ability of the child to control emotions to help him/her in a situation, rather than hinder the progress. This includes the ability to delay gratification and reward in order to focus on the task at hand.
- **Motivation**-This refers to our choice of goals and our determination to reach these goals. Emotionally literate child has worked out certain short-term and long term goals and shows interest in reaching them.
- **Empathy** -It is the ability to understand the emotional nature of those around us, and to use that knowledge to create better relationships. The foundation of empathy is listening and being attentive to the messages that others are sending us.
- **Social Skills** -It refers to our ability to get along with others. The manner with which we react to the emotions of others and read the proper signals in order to fluently handle social situations, solve relationship problems, learn to motivate others, create cooperation and work in a team. One is not born with these skills, they can be learned. With work, one can improve one's emotional intelligence and help one's performance in social situations.

Research shows that children with HDAD have poor emotional literacy when compared with the children without HDAD. Their highly impulsive behaviour affects their interactions with others at home and in social situations. These children may be disruptive and aggressive on the one hand or may be shy and withdrawn on the other. The aggressive and disruptive children may not realise that their behaviour and actions are offensive to others, and have difficulty with predicting their social responses. Those who are withdrawn may show little social initiative and may often spend time in isolation.

Emotional maturity in individuals continues to develop until around the age of 35. This process can be slower in people with HDAD, and they may not reach the level of emotional maturity of a 21 year old until they are in their late 20s or early 30s. HDAD is often associated with other behavioural and emotional disorders. From early infancy, children with HDAD are often reported to be more demanding and difficult to manage. Upto to 45% of children with HDAD have at least one or more additional disorders, such as anxiety, depression, oppositional or defiant behaviour. They are very stubborn and

argue with their parents more than other children. Poor emotional literacy further hampers their behavioural adjustment.

### BEHAVIOURAL ADJUSTMENT

Dodge (1986) developed a theory to explain social skills deficits among children with HDAD. According to him, deficits begin because of perception, understanding, or interpreting environmental cues. There is also a deficit in the child's limited behavioural repertoire to generate possible behavioural solutions to behavioural problems. They know how to behave appropriately, but they seem to be unable to consistently apply their skills in everyday interactions. All parents aspire to raise happy, well behaved and well-adjusted children. Among children with HDAD, this process becomes extremely difficult. Behaviours that usually indicate that a child is "growing up" are not easy for kids who might naturally be inattentive or overly impulsive to learn. Children with HDAD do not notice subtle social cues, and they do not focus on minor details, all these leading to troubled interaction with peers. The child's behavioural adjustment can best be assessed by teachers, who are familiar with the child's relations with others and their ability to perform tasks. Carey and Levine (1992) define behavioural adjustment as relations with people (e.g. his/her degree of competence); performance of tasks (e.g. child's schoolwork or playmastery or underachievement); self-relations (e.g. whether a child is self-assured or troubled with problems in self-esteem, self-care, and self-regulation); general contentment (a sense of well-being or disturbed feelings, anxiety, depression; thinking - phobias, obsessions; or physiological dysfunction - sleep disorder); adaptive or coping style such as handling life's problems. HDAD children frequently have a higher risk for other childhood disorders, including aggression, or Oppositional Defiant Disorder (ODD), and Conduct Disorder (CD) (Barkley et al., 1990). School underachievement is common among HDAD children, and as many as 20% to 30% may have a coexisting primary learning disability as well (Barkley et al., 1990). Social interaction problems with their family members have been consistently documented (Barkley, 1990), and over half of all HDAD children have serious problems in their relations with peers. Many studies of HDAD have shown that the problems associated with the disorder continue into adolescence and beyond for 10% to 60% of patients. Several aspects of college adjustment, social skills, and self-esteem in college students are affected by HDAD. Students with HDAD symptoms show decreased functioning in several areas of college adjustment as well as lower levels of self-reported social skills and self-esteem. It is also suggested that the relation between HDAD and college adjustment is partially mediated by self-reported levels of self-esteem (Shaw-Zirt et al., 2005). Research indicates that problem behaviours which mainly constitute externalizing spectrum of disorders in early adolescents identify a subset of youth who are at an especially high and generalized risk for developing adult psychopathology (McGue & Iacono, 2005). Keeping the negative effects of HDAD in mind, an effective management of HDAD is necessary.

### MANAGEMENT OF HDAD

**An effective treatment plan for children with HDAD includes:**

- 1. Psycho Education.** Parents and caregivers are informed about the nature of the disorder and they learn various ways of managing the children with HDAD.
- 2. Parent training.** Parental involvement in the treatment programme is very essential. A behaviourally based management system that the parents can use and which increases children's motivation by making tasks more interesting and the consequences more valuable, in a consistent, structured, planned way is very effective. Parents must also ensure a stable and cooperative home environment for children with HDAD to thrive.
- 3. Teacher training.** A lot of research is being done to find the types of educational strategies and environments best suited for children with HDAD. It is important to create the best educational climate for the child. In some circumstances, given the co-occurrence of specific learning disabilities, as well as the fact that children with HDAD often fall behind in academic subjects requiring practice for proficiency (e.g., spelling, written language, math facts, etc.), identifying a community based

educational specialist well-versed in HDAD is recommended. Such an individual might work with the child on a regular basis or be consulted as needed.

4. **Behaviour modification** Behaviour modification uses a scheduled approach that rewards desired behaviour and punishes undesired behaviour. With HDAD children a behaviour modification plan and techniques build mastery and competence and promote psychological development.
5. **Medication** HDAD medications that are stimulants act by increasing dopamine and nor epinephrine levels in the brain. These medications are methylphenidate, dextroamphetamine, combination amphetamine salts, dextromethamphetamine, and lisdexamphetamine. In the United States of America, medication is the first line of treatment. While in India, medication is used in extreme cases of HDAD.

## CONCLUSION

This research throws light on the importance of enhancing Self-perception, Emotional literacy and Behavioural adjustment among HDAD children. Poor self-perception, emotional literacy along with their hyperactivity hampers their social and interpersonal adjustment. Poor emotional intelligence would lead to poor social skills and some children may also show anti-social behaviour during adolescence. Therefore it is important to teach the children to control and regulate their emotions. Training in regulating their emotions during their middle and late childhood would help these children and their parents to deal with their hyperactive behaviour better and further leading to better adjustment during their adolescent years. ADHD is a neuron behavioural disorder recognized in children. Along with the core symptoms of inattention, hyperactivity and impulsivity, the children also show poor self-perception, emotional literacy and behavioural problems. Hence there is a need to help the ADHD children to manage their symptoms. Severe form ADHD can be treated with medication. Behaviour modification, Cognitive Behaviour Therapy and social skills training can be used to manage children with ADHD.

## REFERENCES

1. Hoza, B, Alyson C. G, Hinshaw, S. P, Arnold, L. E, and Pelham, W.E (2004). Self-perception of competence in children with HDAD and comparison children. *Clinical Psychology* vol 72, 3. 382-391.
2. Klassen, A. F, Miller, A, and Fine S (2004) Health related Quality of life in children and adolescents who have a diagnosis of Hyperactivity Disorder and Attention Dificit. *Pediatrics* Vol, 114. No 5.
3. Paterson, G, Sanon, A (1999). The association of behavioural adjustment to temperament, parenting and family characteristics among five year old children. *Social Development*, vol.8, 3,293-309.
4. Shaw-Zirt et al (2005). Adjustment, Social skills and self-esteem in college students with symptoms of HDAD. *Journal of attention disorder*. 8. 109-120.
5. Sjöwall, D, Roth, L Lindqvist, and Thorell, L.B (2013) Multiple deficits in HDAD: executive dysfunction, delay aversion, reaction time variability and emotional deficits. *Journal of Child Psychology and Psychiatry*, June 2013, 54(6): 619-627.
6. Wilson, J (2008). An Investigation of Trait Emotional Intelligence and Theory of Mind in School children with HDAD. University College London and Hertfordshire Educational Psychology Service.
7. Barkley, R. A., Anastopoulous, A. D. Guevremont, D. C. and Fletcher, K. E (1991) Adolescents with Hyperactivity Disorder and Attention Dificit: Patterns of Behavioural adjustment, Academic functioning and treatment utilization. *Journal of the American Academy of child and Adolescent Psychiatry*, 30, 752-761.
8. Cook, J, Knight, E, Hume, Ian, Qureshi, A (2014). The self-esteem of adults diagnosed with attention-deficit/hyperactivity disorder (HDAD): a systematic review of the literature. *Pub Med*.
9. Cooper, Selena Ledgerton (2008), Meeting Special Needs: Hyperactivity Disorder and Attention Dificit.