

# REVIEW OF LITERATURE ON MENTAL PSYCHOLOGICAL THERAPY'S EFFECT ON CHILDREN WITH HYPERACTIVITY DISORDER

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## Abstract

Children with HDAD are energetic and disruptive by nature, however instructors who are dealing with a disruptive kid may try to handle the issue by removing them from the classroom. Children with HDAD often find themselves excluded from group activities. Because other parents may not want to invite a kid with a reputation for poor behavior, HDAD children may be excluded from birthday parties and other gatherings that are a normal part of growing up. Exclusion exacerbates children's and young people's bad sentiments by reinforcing the notion that they are "naughty" and undesired. Poor peer relationships among HDAD kids make it even more difficult to develop a healthy positive self-concept, which leads to poor adjustment.

**Keywords:** HDAD, children, review, hyperactivity

## 1. Introduction

### ATTENTION DIFFICULTY AND HYPERACTIVITY DISORDER (HDAD)

George Still, a British doctor, was the first to identify and discuss the symptoms of inattention, impulsivity, and hyperactivity as a distinct illness in the early 1900s. However, it was not given a name until the early 1970s, when it was referred to as Minimal Brain Damage or Minimum Brain Disorder (MDD). Further studies revealed that the illness was caused by a biochemical, biological issue rather than "brain injury." The term "Attention Deficit Disorder" (ADD) was first used by the American Psychiatric Association in their "Diagnostic and Statistical Manual of Mental Disorders" in 1968. (DSM II). While the definition for this disorder has been updated on a regular basis, it has always been purely behavioural; that is, professionals diagnose the disorder solely based on a defined constellation of subjectively observed behavioural characteristics in the home, at school, and in social situations.

Sensory hyperactivity and motor hyperactivity are the two forms of hyperactivity identified by Cruickshank (1986). Sensory hyperactive children have a very short attention span and are easily distracted by visual and aural stimulation. They have a tough time staying focused on academic subjects. Motor hyperactive children are always twisting, wiggling, bending, and manipulating everything they can get their hands on. Hyperactive youngsters respond in playgrounds and other open places with many stimuli by running, yelling, and making a lot of noise. No laboratory tests or particular physical findings have been specified as diagnostic criteria for the evaluation of HDAD, according to DSM IV (1994). HDAD has always been difficult to diagnose. All children, to some degree, display the behavioural parameters that have been identified, including inattention, low frustration tolerance, impulsiveness, poor behavior organization, distractibility, and hyperactivity. The fact that these symptoms frequently appear in other disorders, such as learning disability, tourette's syndrome, conduct disorders, phobic and anxiety disorders, lead poisoning, foetal alcohol syndrome, depression, mania, substance abuse, and even some seizure disorders, makes diagnosis even more difficult. These facts have caused substantial complications for both physicians and parents, leading to accusations that HDAD is being overdiagnosed, especially in the United States.

A comprehensive assessment, ideally including various methodologies and informants, is required to diagnose HDAD. A variety of professionals, including psychologists, psychiatrists, educational specialists, neurologists, and paediatricians, may undertake an HDAD diagnostic examination. The American Academy of Paediatrics (AAP) published a set of consensus recommendations for HDAD evaluation and therapy due to the high frequency of HDAD and the scarcity of experts. The guidelines synthesize the empirical evidence and provide best-practice recommendations to community-based clinicians. The necessity of gathering parent and teacher rating scales, utilizing DSM-IV criteria as the foundation for obtaining an HDAD

diagnosis, and assessing for co morbid diseases are all stressed in the assessment guidelines. HDAD was first diagnosed in 1902, when it was thought to be a fundamental problem with children's capacity to control their behavior. Over time, researchers have identified it as an issue related to how unconstrained behavior impairs a kid's grasp of rules and instructions, as well as the child's internal voice or 'conscience,' which helps the child manage his or her behavior. Over the following several decades, clinical experts moved their focus away from identifying the condition and toward potential causes. The involvement of brain processes in this condition led to the term "brain-injured kid syndrome" being coined by scientists. When it was discovered that many youngsters had no underlying brain injury, the term was modified to minor brain dysfunction. The disease was later dubbed hyperactive child syndrome due to the increased attention on behaviors such as hyperactivity. In the 1970s, the notion was broadened to include problems in impulse control and sustained attention, which were both difficult for people with HDAD.

Following that, research on the nature of attention, its many kinds, and the types that may be involved in the condition switched away from activity level studies and toward studies on the nature of attention, its various types, and the types that might be involved in the disorder. At that time, the condition was termed Attention Deficit Hyperactivity Disorder (ADHD) (ADD, with or without hyperactivity). As clinical study progressed, it became obvious that hyperactivity and impulsiveness in children diagnosed with ADD with hyperactivity were closely linked, indicating that they were part of a single condition of inadequate inhibitory control. Furthermore, research has shown that this issue is just as crucial as concentration issues in identifying HDAD from other juvenile diseases. As a result, the word was somewhat altered in 1987 to Hyperactivity Disorder and Attention Difficulty, which is the present nomenclature (Barkley, 2000).

Most clinical specialists, including doctors, psychologists, psychiatrists, and others, now agree that HDAD is caused by three main issues with a person's capacity to manage behavior: difficulty with sustained attention, impulse control or inhibition, and excessive activity. In the United States, the prevalence of HDAD ranges from 2% to 18%, with an estimate of 8% based on a recent research. Males are six times more likely than females to get the disease (United States Public Health Service, 2001). In India, the prevalence ranges from 10% to 20%. (Malhi and Singhi, 2000) A meta-analysis of 175 research on the prevalence of HDAD in children revealed a global average of 7.2 percent (Rae et al, 2015) Although it was formerly considered that Hyperactivity Disorder and Attention Deficit (HDAD) remits in all children, HDAD may last from ten to sixty-six percent of the time throughout adulthood. According to surveys of individuals aged 18 to 44, 4.4 percent of adults fulfill the diagnostic criteria for HDAD, and 3 percent to 6% of persons have HDAD-like symptoms that impair with everyday functioning. These problems may be noticed at work. Employees with adult HDAD have been reported to have lower levels of job performance, a lack of autonomous skills, difficulty completing tasks, and weaker supervisory relationships, according to employers. Poor job performance may result in greater unemployment rates, frequent job changes, and a worse socioeconomic level.

## 2. Review Of Literature

Klein (1992) looked at self-perception in elementary school as a predictor of personal temperament. Susan Harter's self-perception profile for children and the aspects of temperament survey were completed by 131 children in third and fifth grades. Lower activity levels, greater approach, and higher task orientation were all linked to positive self-perception. Different components of self-perception were shown to have different connections with different temperament traits.

Another research, conducted by Dumas and Pelletier (1999), looked at the self-perceptions of HDAD children aged 6 to 11, with 57 children with HDAD (20 girls and 37 boys) and 59 children without HDAD (25 girls and 34 boys) as participants. The Self-Perception Profile for Children was used to evaluate his or her self-perceptions in a variety of areas, including perceived academic competency, social competence, behavioral competence, and athletic ability. Children with HDAD considered themselves to be less competent than children without

HDAD in all categories except athletic ability, according to the findings. As a result, when it came to how they felt about their behavior, their capacity to get along with others, and their ability to succeed in school, children with HDAD had poorer self-perceptions than other children. Not every kid with HDAD assessed their ability in these areas as poor, as in any research that compares children in various groups. Those with HDAD, on the other hand, saw themselves as less capable on average than children without HDAD.

Similar results have been seen in studies of older children and adults. In his study, Vine (1999) discovered that adolescents and adults with HDAD exhibit poorer self-esteem than those who do not have the condition. Parents of children with HDAD who also had co-morbid symptoms felt less competent in their parenting tasks than parents of children who did not have HDAD. The findings also supports the use of multimodal therapy programs to boost self-esteem in children with HDAD, although further research is needed to assess the treatment's long-term benefits.

In early adolescence, Kimberly, Paul, Phil, and Baker (2001) investigated the impact of academic self-concept on HDAD and antisocial behavior. The influence of Academic Self-concept (ASC) on the development of Attention Deficit/Hyperactivity Disorder (HDAD) and antisocial behavior in early adolescence was studied using structural equation modeling approaches. The presence of complete data for the following variables at the specified time periods determined the eligibility of 445 HDAD children: reading at age 7, teacher reports of HDAD and antisocial behaviors at age 7, self-ratings of ASC at ages 9 and 11, and teacher reports of HDAD and antisocial behaviors at age 13. The findings showed that academic self-concept is an essential construct that leads directly to the development of antisocial behaviors rather than HDAD symptoms. The findings also showed that a child's early history of behavioural difficulties and academic achievement help to establish an understanding of the influence of academic self-concept on the development of disruptive behaviors in early adolescence.

A distinctive "positive illusory bias" in the self-evaluation of children with HDAD has been documented in many investigations. Rizzo, Steinhausen, and Drechsler (2010) evaluated whether children with HDAD aged 8 to 10 years can appropriately judge their self-regulatory abilities when tested in another research. When compared to control children, HDAD youngsters regarded themselves as much more dysfunctional. Although overall findings suggested a slight tendency toward a positive bias, self-evaluations of children with HDAD did not differ from parent and teacher ratings to a higher degree than self-ratings of control children in most areas.

Hoza (2012) performed a study with 178 children with HDAD and 86 healthy children ranging in age from 7 to 12 years old. She used the Self-Perception Profile for Children (SPPC) to assess the children before and after they were given monetary incentives based on their instructors' ratings of their academic, social, and behavioral competence. Prior to the incentive, the HDAD children's levels of competence were favorably biased when compared to their instructors'. The youngsters, on the other hand, dropped their competence evaluations in both academic and behavioral categories after receiving monetary incentives. Regardless of the reward, the children's perceptions of their degree of social ability did not change.

Cook, Knight, Hume, and Qureshi (2014) evaluated existing research on the association between self-esteem and HDAD in adulthood with the goal of identifying service needs and possibilities. Despite a small number of research and methodological problems, data suggests that HDAD is linked to reduced self-esteem in adulthood and that self-esteem issues may be addressed, at least in part, by psychotherapy. Future study should concentrate on the assessment of treatment that especially addresses self-esteem issues in this cohort, they said.

On a thorough evaluation battery, Barkley, Anastopoulos, Guevremont, and Fletcher (1991) compared adolescents with Hyperactivity Disorder and Attention Deficit (HDAD) to a control group. HDAD adolescents were more likely than control teens to have Oppositional Defiant Disorder (ODD, 68%) and Conduct Disorder (CD, 39%), and were assessed as having worse social competence, behavioural and emotional adjustment, and school performance by parents

and teachers. The HDAD youngsters, on the other hand, assessed themselves as more well-adjusted than their parents and teachers, varying only in depressive symptoms and antisocial behavior from the controls. The HDAD were also separated from control teens by worse verbal learning and alertness, as well as increased HDAD behaviors during an arithmetic assignment. In a study of 5 to 6 year old children, Paterson and Sanson (1999) aimed to uncover particular temperament, parenting, and family characteristics, as well as their interactions, that predict problem behavior and social skills in children. The findings revealed that diverse combinations of factors predicted each behavioural outcome, with the child's 'fit' in the household being a major predictor of externalizing behavior and social skills. It was discovered that temperamental rigidity and punitive parenting interact in the development of parent-reported externalizing behavior issues. The importance of employing particular indices of temperament, parenting, and family functioning, as well as researching interaction effects, in predicting children's behavioural development, is highlighted in this study.

Klassen et al. (2004) used a standardized questionnaire to interview 131 children with HDAD and their families to assess overall quality of life. They compared the replies to youngsters who did not have HDAD. While the physical health of the two groups was comparable, the HDAD children had higher emotional and mental health problems, including poor self-esteem. The lower a child's quality-of-life score was, the more HDAD symptoms he or she had. The probability of family stress was also predicted by the degree of symptoms. Parents of children with the greatest HDAD symptoms were the most likely to say that their child's difficulties caused them emotional distress and hampered their ability to satisfy their own needs.

## CONCLUSION

- The CBT intervention has been shown to help children with HDAD establish a more accurate self-perception. Emotional literacy and behavioral adjustment are also improved as a result of the intervention in children with HDAD.
- Qualitative analysis revealed that the HDAD children in the experimental group are able to regulate impulsive behavior via emotionally intelligent expression, successfully apply problem-solving techniques, improve task attention, self-control, and social skills. The results of the follow-up interviews with the parents demonstrate that the majority of the children are still behaving well at home and at school.
- Among children with HDAD, there is no significant relationship between self-perception and behavioral adjustment.
- Among children with HDAD, there is no significant link between emotional literacy and behavioral adjustment.

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