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Original Article

Perceived Parental Rejection Predicting Attention Deficit Hyper Activity Disorder Oppositional Deficient Disorder and Conduct Disorder among Pakistani Adolescents

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Abstract

Background: Parental optimistic relations and parental hostile patterns are forecaster of emotional disorders among the school children.
Objectives: The study aimed at examining effect of perceived parental rejection with disruptive behaviors e.g., attention deficit hyper activity disorder, oppositional deficient disorder and conduct disorder in Adolescents of single parents.
Study design, settings and duration: Cross-sectional study was conducted in universities of Rawalpindi and Islamabad for duration of 8 months.
Subjects and Methods: After taking inform written consent 200 adolescents (male= 90, 45%; female=110, 55%) of age 18-23 years studying in universities of Rawalpindi and Islamabad were enrolled. Perceived Parental Rejection was measured with the help of Urdu version of Parental Acceptance-Rejection Questionnaire and Disruptive Behavior Disorders were assessed by Disruptive Behavior Disorder (DBD) rating scale.
Results: Finding of the present study showed that perceived parental rejection is a significant predictor of disruptive behavior disorders e.g., ADHD, oppositional deficient disorder, and conduct disorder in adolescents of single parents with low income. It has been found that there is no significant mean difference between male and females on disruptive behavior disorders.
Conclusion: The perceived parental rejection increase emotional disorders e.g., ADHD**,** oppositional deficient disorder and conduct disorder in children.
Key words: Perceived parental rejection, defiant disorder, attention deficit hyperactivity disorder, conduct disorder, children, single parents.

Introduction

Parents are the primary caretakers of a child. Parental love is crucial for the healthy social and emotional development of children. Adolescents universally need a specific form of positive response acceptance from parents and other primary caregivers. When this requirement is not met suitably, Adolescents worldwide regardless of variations in culture, gender, age, ethnicity, tend to account themselves to be hostile and aggressive, dependent or defensively independent, having self-esteem and self-adequacy, emotionally unresponsive, emotionally unstable and have a negative worldview.

Disruptive behavior disorders (DBDs) are a bunch of disorders define by the constant occurrence of harmful, rebellious or rule-breaking behaviors which are effecting the individual's social, school, domestic or individual functioning. DBDs comprise of oppositional defiant disorder (ODD) attention deficit hyperactivity disorder (ADHD) and conduct disorder (CD). DBDs are linked with a prototype of growing trouble behaviors most important to harmful living penalty, counting societal, educational, professional performance, substance abuse and potentially imprisonment.[1]

According to Diagnostic and Statistical Manual-V (DSM-V)[2] Attention-Deficit/Hyperactivity Disorder (ADHD) is identified as constant pattern of inattention

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SN and KA have done the conceptualization of project and literature search. SN did data collection. Statistical analysis, drafting, revision and writing of the manuscript were done by SN, KA and RZ.

and/or hyperactivity-impulsivity that is persistent for at least 6 months which have significant impact on social and academic/occupational activities of the child. The ADHD is divided into three specifies

1. ADHD inattention
2. ADHD hyperactive/impulsive
3. ADHD combined

The child often experience symptoms of ADHD inattention which are listed below;

These Adolescents often make careless mistakes when they are unable to play close attention to details. They are unable to maintain attention on given task due to higher distractibility, often seems that they are not listening to any verbal conversations. These patients are unable to complete task in organized manner and dislike getting involved in task that require continued mental effort.

These patients often experience five or more symptoms of ADHD Hyperactivity and Impulsivity (for more than 6 months) which are listed below;

These symptoms include feeling of irritability, they often fidgets with hands, they are unable to wait for their turn, they find difficulty in playing silently, they run about (seem driven by motor). These patient's talk excessively, they can't resist waiting for their turn in any conversation, they have difficulty in waiting for their turn in line, leisure activities, often interrupts in different activities. The specifies are only applied depending on symptoms similarity in the individual.

The specifier of ADHD combine is given the patient's experience both symptoms of AHHD, ADHD inattention and ADHD hyperactive/impulsive

Oppositional Defiant Disorder (ODD)[2] is characterized as pattern of angry/ irritable mood, defiant behavior or vindictiveness behavior (for 6 months) in which patient experience four symptoms. In Angry/Irritable mood patient's loses temper, easily annoyed, and are mostly resentful. In Argumentative/Defiant Behavior patient become argumentative toward authority figures (children, adolescents, and adults). These patients have difficulty in complying with the authority figures rules and orders. These patients deliberately irritate others. Lastly these patient's often blame others for their conduct. In Vindictiveness patient's experience spiteful or vindictive toward others.

Conduct Disorder [2] is defined as repetitive and constant behavior which violate the social norms rules regulation of the society (in 12 months duration). These patient's often experience symptoms of aggression to people and animals in which they often bully, threatens other individuals. They also initiates physical fights, they often use weapons (guns, knife, brick, and bottles) in fights that cause serious physical harm to others. These patient's are often physically brutal to people including animals. These patient soften indulge in mugging, breaking into someone house, armed robbery and purse snatching. They often force other individuals into sexual activity. These patient's are often involved in destruction of property, fire setting, intentionally damaged other's property which caused real damage often lie, do forgery in business. As adolescents (before age 13 years) these patient's stay out at night despite parental prohibition, often run away and do not return for a lengthy period. Often (before age 13 years) indulge in school truant behavior.

A number of present researches to the explanation and categorization of disruptive behavior disorders are there. Diagnostic classes ADHD, Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are explained as disruptive behavior disorders.[2] In addition, the behaviors ought to guide to significant destruction in educational and social performance. Conduct disorder is the mainly frequent childhood emotional and behavioral disorders upsetting adolescents of kindergarten and elementary school.[3] These adolescents generally countenance troubles in their families and in school. In near the beginning school age peer rejection and educational troubles are the mainly frequent one.

It was explored that parents are often faced with the multifaceted task of parenting their adolescents within a culture is remarkably unrelated from their culture of origin dysfunction homes typified by divorce or death of parents may spine adolescents into involvement in disruptive behaviors specifically conduct disorder (CD) and oppositional defiant disorder (ODD).[4] The incidence of parental separation may result in shame, low social skill and even make them miss school, do poorly academically and take part in disruptive behaviors.

Previous researches have highlighted that adolescents that perceive over protection from the parent experienced less anxiety feelings whereas adolescents experiencing parental rejection experience higher level of stress.[5] According to the findings of other researches parental acceptance rejection is major factor behind adjustment disorders and increasing the depressive level in the adolescents.[6]

Divorce affects adolescents harmfully to the level that it consequences are pasting of time, support, and warmth given by the noncustodial parent. Mothers and fathers are considered equally significant assets for offspring. In cooperation both are able to provide as sources of realistic support, emotional aid, defense, direction, and custody. On occasion, the amount and value of connection between offspring and leaving parents usually decreases and itis supposed to result in poorer levels of adjustment for these offspring as compared with offspring from unbroken families.[5,6] These family discords are linked with higher emotional disorders among the young adolescents.[7]

Research has also shown that fatherly love is decisive to a person's growth. The significance of a father's love should help prompt many men to become more concerned in fostering child care. Research also highlighted that inspite maternal love paternal love is often more implicated than mothers in the development of behavioral problems such as conduct disorders and oppositional defiant disorder.[8,9] Another study also highlighted that psychological patients perceived lack of parental acceptance and more parental rejection specifically by father that led to onset of emotional disorders such as depression, mania and psychosis.[10]

Unsympathetic and contradictory parenting is the main root of conduct disorders. The persistence aspects of parental rearing styles of Adolescents which are strong discipline; parental dissonance; rejection of the child and insufficient involvement in the Adolescents activities cause disruptive behavior among children.[10] Various research reports have revealed that a large percentage of all disruptive behavior e.g., ADHD, CD, and ODD come from homes that lacked usual parental love and care10. Consideration, love and affection on long way assist better children social development and adjustment as the behavioral problems of most deviants are embedded in their homes.[11] Number of research have provide strong evidence of possible effects of parents acceptance rejection effects on stress,[12] conduct disorder,[13] ADHD, ODD[14] and aggressive disorder.[15]

Researches in Pakistan have been carried out on the Parental rejection and destructive behavior problem's separately with other variables. But none of the research has been conducted to see the relationship of Parental rejection and disruptive behavior problems in adolescents among divorced and late parents. Regarding the present's situation of Pakistan, the growing rate of economic problems, single parenting and behavioral issues such as ADHD, CD ODD have become menace of society. The aim of the present study is how Perceived Parental rejection leads to disruptive behavior disorders in adolescents of single parents.

Subjects and Methods

Data was collected on the basis of purposive sampling. Sample consists of 200 adolescents of age range from 18-23 years were taken from different universities of Rawalpindi and Islamabad. In present the Disruptive Behavior problems in student were identified using the Disruptive Behavior Disorder (DBD) rating scale by Loona and Kamal (2011). The high score on Disruptive Behavior Disorder (DBD) rating scale indicated occurrence of ADHD-inactive, pre-dominantly hyperactive/ impulsive symptoms, ODD symptoms, and CD symptoms among adolescents. The Author of Disruptive Behavior Disorder (DBD) have conducted different interviews and followed the DSM criterion for development of Disruptive Behavior Disorder (DBD) rating scale. The (DSM-V) criterion of Disruptive Behavior Disorder is mentioned in introduction section (See page 2-5). Parental Acceptance-Rejection Questionnaire (PARQ)[10] was used to assess the way adolescents of age 18-23 years perceive their parents' behavior patterns to them on basis of rejection. It consists of separate forms for both parents i.e. mother and father, each having 60 items. Each part consists of four subscales; parental less warmth and affection (20 items); parental hostility and aggression (15 items); parental neglect and indifference (15 items); parental rejection (10 items). PARQ is scored on 4-point Likert type scale with answering categories of "Almost Always True" (scored as 4) and "Almost Never True" (scored as 1). Total range of score was 60-240, elevated the score obtained, more the Adolescents perceives his/her parents as rejecting. Urdu version of Parental Acceptance-Rejection Questionnaire [16] has been used for the current study which was reported as a psychometrically adequate measure of reliability ranging from .72 to .90 (Haque, 1981; 1987). In present study alpha reliability was .81.

Disruptive Behavior Disorder (DBD) Rating Scale [17] was used in present study. The Disruptive Behavior Disorder rating scale comprised of 42 items with response categories ranging from not at all (0) to very much (3). DBD Parent rating scale includes items interrelated to symptoms of ADHD-inactive (9 items) comprising of item number, 9,18, 23, 27, 29, 34, 37, 42 and 44. Pre-dominantly hyperactive/ Impulsive scale comprise of (9 items), including item number 1,7,12,19, 22, 25, 30, and 35. The subscale of ODD (8 items) comprise of item number 3, 13,15, 17, 24, 26, 28 and 29. The subscale of CD (16 items) comprise of item of 5, 6, 20, 31, 32, 36, 40, 45, 16,41, 4, 8, 43, 2, 11, and 38. Scores ranges from 0 to 126. Cronbach's alpha coefficients yielded an internal consistency coefficient of .94 for the entire 42 items of DBD rating scale. An alpha reliability for the 42 items Urdu DBD yielded a reliability of .91of original scale. On the present participants it was .90.The socio-economic status of the students was assessed by using the demographic sheet. According to Pakistan Economic Survey (2014-15) the students were categories into three groups depending upon salary ranges of their parents/guardian. The students with salary range of Rs.4,000- Rs.25,000 Per Month were identified as lower middle class. The students in pay range of (Rs.25,000-Rs.65,000 Per Month) were identified as middle class students. The students in income range of (Rs. 65,000 to Rs. 250,000 per month) were identified to belong to higher upper class. In present study the students of low SES were screen out in initial step to explore the study variables in specific economic group.

Data has been collected on the basis of purposive sampling, first of all informed consent has been taken from respective authorities of universities for data collection.

The officials of the universities were informed regarding the purpose of the study. The students from the social sciences department, management department and engineering department were taken. Students having some emotional difficulties were highlighted by the teachers and they were included in sample depending on the authority reporting. Questionnaires were given to students on individual basis and they have been briefed about how to respond to the questionnaires. It has been reassured that all information will be kept confidential.

Results

Table-1 shows the prevalence of disruptive behavior disorders in present sample. It is revealed that 73% of Adolescents are screen out as having disruptive behavior disorders. While 27% of the sample have no disruptive behavior disorders. The presence of CD is highest among all other subscales i.e. 24%.

Table 1: Occurrence and percentages of disruptive behavior disorders in students. (n=100)

Variables	*Occurrence*	*%*
ADHD inattention	13	13
ADHD hyperactive/impulsive	15	15
ADHD combined	07	07
ODD	14	14
CD	24	24
Total	73	73
Presence of disruptive behavior disorders in children	73	73
Absence of disruptive behavior disorders in children	27	27
Total	100	100

Note: DBD= disruptive behaviors disorders rating scale, ADHD= attention deficit hyperactive disorder, CD= conduct disorder, ODD= oppositional deficit disorder.

Table 2: Regression Analysis for predominantly inactive disorders from parental rejection. (n=100)

	Disruptive behavior (predominantly inactive)		
			Model 1
Variables	*B*		*95 % CI*
Constant	22.645		[15.062, 30.26]
PARQ	-.070		[-.177 , -.022]
R^2		0.079	
F		8.440	

Note: CI = confidence interval. PARQ= Parental acceptance rejection scale, *p > 0.05, **p< 0.01

The Table-2 shows regression analysis for disruptive behavior (predominantly inactive) from parental rejection. As shown in the table1, the Parental acceptance rejection (β= -.282, p< .01), negatively predicted Disruptive behavior (predominantly inactive). Furthermore 7.9% variance is explained by parental rejection towards disruptive behavior disorders.

The Table-3 shows regression analysis for disruptive behavior (predominantly hyperactive/ impulsive) from parental rejection. Table-3 shows that parental rejection is a significant negative predictor of disruptive behavior disorders, showing the beta values (β= -.322, p< .01) furthermore 10.4% variance is explained by parental rejection towards disruptive behavior (predominantly hyperactive/ impulsive) disorder.

Table 3: Regression Analysis for predominantly hyperactive/ impulsive disorders from parental rejection. (n=100)

	Disruptive behavior (predominantly hyperactive/ impulsive)		
			Model 1
Variables	*B*		*95 % CI*
Constant	24.463		[16.772, 32.15]
PARQ	-.081		[-.129 , -.033]
R^2		0.104	
F		11.326	

Note: CI = confidence interval. PARQ= Parental acceptance rejection scale, *p > 0.05, **p< 0.01

Table 4: Regression Analysis for oppositional defiant disorder (ODD) from parental rejection. (n=100)

	Disruptive behavior (ODD)		
			Model 1
Variables	*B*		*95 % CI*
Constant	15.092		[8.002, 22.16]
PARQ	-.027		[.071 ,.071]
R^2		.014	
F		1.440	

Note. CI = confidence interval. PARQ= Parental acceptance rejection scale, *p > 0.05, **p< 0.01

The Table-4 shows regression analysis for disruptive behavior (ODD) from parental rejection. Table-4 shows that parental rejection is a significant negative predictor of disruptive behavior (ODD) disorders, showing the beta values (β= -.120, p< .05) furthermore 1.4% variance is explained by parental rejection towards disruptive behavior (ODD) disorder.

Table 5: Regression Analysis for conduct disorder (CD) from parental rejection. (n=100)

	Disruptive behavior (CD)		
			Model 1
Variables	*B*		*95 % CI*
Constant	41.977		[27.070,56.88]
PARQ	-.027		[-.238 ,-.052]
R^2		.089	
F		9.631	

Note. CI = confidence interval. PARQ= Parental acceptance rejection scale, *p > 0.05, **p< 0.01

Table 6: Mean Standard Deviation & t-values for boys and girls on Disruptive Behavior Rating Scale (DBD). (n=100)

Variables	*Boys (n= 49)*		*Girls (n= 51)*				*95% CL*		*Cohen's d*
	M	*S.D*	*M*	*S.D*	*t*	*p*	*LL*	*UL*	
Predominantly inactive	11.32	4.25	11.76	4.02	-.52	.59	-2.08	1.20	-.10
Predominantly hyperactive/ impulsive	11.06	3.23	11.90	4.98	-.99	.32	-2.51	.83	-.20
Oppositional defiant disorder	10.59	2. 50	11.07	4.52	-.65	.51	-1.95	.98	-.13
Conduct disorder	18.46	7.79	19.09	8.47	-.38	.70	-3.86	2.60	-.07
PARQ	158. 55	16.79	160.49	16.70	-.57	. 58	-8. 58	4.70	.20

Table 7: Mean Standard Deviation & t-values for dead and divorced single parents on Disruptive Behavior problems and parental acceptance rejection. (N=100)

Variables	*Dead (n= 55)*		*Divorced (n= 45)*				*95% CL*		*Cohen's d*
	M	*S.D*	*M*	*S.D*	*t*	*p*	*LL*	*UL*	
Predominantly inactive	11.65	3.76	11.42	4.56	.27	.78	-1.41	1.88	.05
Predominantly hyperactive/ impulsive	11.56	3.81	11.40	4.70	.19	.84	-1.52	1.85	.03
Oppositional defiant disorder	11.27	3.39	10.31	4.01	1.29	.19	-.50	2.43	.25
Conduct disorder	18.58	7.49	19.04	8.88	-.28	.77	-3.71	2.78	-.05
PARQ	151. 11	17.37	161.29	15.83	-.94	. 34	-9. 84	3.48	-.28

The Table-5 shows regression analysis for disruptive behavior (CD) from parental rejection. Table-5 shows that parental rejection is a significant negative predictor of disruptive behavior (CD) disorders, showing the beta values (β= -.299, p< .01) furthermore 8.9% variance is explained by parental rejection towards conduct disorder (CD).

Table-6, shows the mean differences among male (M= 10.59, SD= 2.60) and female (M= 11.07, SD= 11.07) on Oppositional defiant disorder. Similarly the mean difference among male (M= 18.46, SD= 7.79) and female (M= 19.09, SD= 8.47) on Conduct disorder. The findings reflect that there is no significant mean difference between male and female on oppositional defiant disorder and conduct disorder (disruptive behavior disorders).

Table-7 shows the mean differences among dead single parents on oppositional defiant disorder (M= 11.27, SD= 3.39) and divorced single parents (M= 10.31, SD= 4.01) on disruptive behavior rating scale (DBD). Similarly the Adolescents with the divorced parents (M= 19.04, SD= 8.88) are higher on CD as compare to Adolescents from dead families (M= 18.58, SD= 7.49). The results are accordance with the hypothesis.

Discussion

Constructive aspects of parenting such as affection and supportiveness have been experiential to predict both coexisting and later social competency in adolescents. The present study explored the effect of parental acceptance rejection on development of ADHD, CD and ODD among the adolescents. The results of the study highlighted that parental acceptance rejection is significant predicator of disruptive problems in adolescents e.g., ADHD, CD and ODD among the adolescents (Table-1).

The research explored that perceived parental rejection leads to disruptive behavior disorders in children of single parent. The (Table 1- 4) showed that the parental rejection is a significant predictor of disruptive behavior disorders [ADHD, CD and ODD]. These results are comparable to those reported in preceding study, sustaining PAR theory conclusion regarding the worldwide connection among parental acceptance rejection and emotional disorders outcomes.[18] Other studies [13] also reported that when children's parents live in break up households. Even though some parents hang about in conflict for many years, particularly if a divorce occurred, most progressively separate and converse little with one another. At top, the majority adolescents living with single parents practice unconstructive and rejecting parenting which result into emotional, psychological disorders, CD and ODD.[18,19]

A large amount of studies are available on the function of family in adolescents externalizing behaviors problem such as CD and ODD.[20] Of the numerous parenting variables, parental rejection have been repeatedly investigated. Parent-child relations patterns have been constantly appears to be linked with adolescent's psychopathology such as ADHD and CD.[14] In this pathological condition n these adolescents often indulge in fights and impulsive behavior that effect the social and emotional functioning of these adolescents.[20] Numerous studies revealed the power of the parenting attitudes and styles on the improvement of adolescents conduct problems and disruptive behaviors.[21] Unhealthy parenting attitudes such as unsympathetic and conflicting restraint, little parental monitoring and regulation, lack of parental participation, parental rejection and reduced parental warmth have been set up to be correlated to ADHD,[21] CD [21,22] and ODD problems in adults and adolescents.

Other previous researches [23] also found that there was a considerable association between dysfunctional parenting practices and disruptive behavior in adolescents. His study also exposed that particularly two types of parenting variables, lack of parental participation in child's activities and poor parental monitoring and regulation were the powerful predictors of disruptive behavior in adolescents.

It was also hypothesized that disruptive behavior disorders are more common in male than females of single parents, but results shows that disruptive behavior disorders are equally common in the adolescents of single parents.[24] The finding did not support the hypothesis that may be due to small sample size and lack of randomization (Table-5). Literature also shows equal prevalence of disruptive behavior disorders in male and female of single parents. A survey conducted by researcher [24,25] approximate the occurrence rate of disruptive behaviors disorder in adolescents to be 2-16% in the general population.[25,26] Adolescents Prior to teenage years, the situation is more common in males; conversely, after teenage years, it is evenly frequent in male and females as they are found to be involved in same level of CD, ODD and ADHD problems.

It was stated that economic stressors interfered with parental psychological performance, such as escalating depressive symptoms and troubling relationships in the family and also parenting behavior, which add to the risk for disruptive behavioral problems in Adolescents to occur.[26]

It was also hypothesized that Disruptive behavior disorders [ADHD, CD, and ODD] are more among adolescents of divorced parents than late parents having low income (Table-6). Some other researches [27] also show that adolescents from broken families show small but significant differences on measures of socialization and behavioral problems. However these differences are much larger, if measured by teacher behavior ratings, divorced adolescents were found to be significantly more dependent, aggressive, and violent with peers and indulge in disruptive behavior [CD, ODD].[28]

Low SES was found to be related with disruptive behavior problems of adolescents still after the effect of parental education level, mother's age at birth and family organization were restricted. The findings of another study revealed that the effects of low SES on disruptive behavioral problems were largely mediated by the weight of unproductive parenting practices. As showed in several earlier studies, measures of SES were unconstructively connected to unproductive or rejecting parenting practices.[19]

Finding of the present study may be concluded as Disruptive behavior disorders related to parental rejection and single parenting. Low socio economic status has a strong relationship with disruptive behavior disorders. Single parents with low income often are forced to choose between quality and flexibility of child care arrangements. Due to many other burdens single parents are unable to properly care their adolescents as a result the adolescents develop disruptive behaviors.

After considering the nature and objective of the study the major limitation of the present is that the disruptive behavior in longer run is not explored in present study. For that to develop more comprehension about the disruptive behavior the longitudinal study should be carried out to highlight the processes involved in the enhancement of the development of disruptive behavior disorder and the hazard that play its role in developing these disorders. The adolescents of urban areas were only taken as a sample. Comparative study of urban and rural adolescents and their families may have highlighted some other findings relatively. Convenient sampling technique was used in present study other sampling method may have evolved some other findings. The sample size was very small other studies can add up larger size of sample to make their result more generalizable to the population. As the time was limited and sample size was small, the result cannot be generalized to the whole country. For the rationale of generalizing the outcome, the future study should be conducted with large sample size. Other variables like emotional problems suffered by parents, as well as teacher's rating about behavior of these adolescents could also be considered.

Conflict of interest: None declared.

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